Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Trust Board Meeting
Thursday 28 May 2020

Agenda and papers

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NHS
St George's University Hospitals
NHS Foundation Trust

Trust Board Meeting (Part 1) Agenda

Date and Time: **Thursday, 27 May 2021, 09:00-11:30**
Venue: **MS Teams**

Time	Item	Subject	Lead	Action	Format
1.0 OPENING ADMINISTRATION					
09:00	**1.1**	**Welcome and apologies**	**Chairman**	Note	Oral
	1.2	**Declarations of interest**	**All**	Assure	Oral
	1.3	**Minutes of meeting – 25 March 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 (includes Annual Report and Terms of Reference Review)**	**Committee Chair**	Assure	Report
	2.1.1	***Learning from Deaths Q4 (2020/21) Report****	**CMO**	Assure	Report
	2.1.2	***Clinical Governance Review: Phase 3****	**CN/CMO**	Assure	Report
	2.1.3	***Cardiac Surgery Report****	**CMO**	Assure	Report
09:40	**2.2**	**Integrated Quality and Performance Report***	**COO**	Assure	Report
3.0 CULTURE					
09:55	**3.1**	**Workforce and Education Committee Report (includes Annual Report and Terms of Reference Review)**	**Committee Chair**	Assure	Report
	3.1.1	***Gender Pay Gap****	**CPO**	Approve	Report
10:05	**3.2**	**Culture Programme***	**CPO**	Assure	Report
10:20	**3.3**	**Freedom to Speak Up Q4 (2020/21) Report***	**FTSUG**	Assure	Report
4.0 COLLABORATION					
10:30	**4.1**	**Audit Committee Report (includes Annual Report and Terms of Reference Review)**	**Committee Chair**	Assure	Report
	4.1.1	***Trust Provider Licence Compliance****	***CCAO***	*Approve*	*Report*
10:40	**4.2**	**Finance and Investment Committee Report (includes Annual Report and Terms of Reference Review)**	**Committee Chair**	Assure	Report
10:50	**4.3**	**Finance Report (Month 01)***	**CFO**	Update	Report
11:00	**4.4**	**Trust Strategy Implementation Update**	**CSO**	Assure	Report
11:10	**4.5**	**Board Assurance Framework Q4 (2020/21) Review**	**CCAO**	Endorse	Report
5.0 CLOSING ADMINISTRATION					
11:20	**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	
11:30	**CLOSE**				

Thursday, 29 July 2021, 09:00-12:00 via MS Teams

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

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St George's University Hospitals NHS Foundation Trust

Trust Board
Purpose, Meetings and Membership

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

Membership and In Attendance Attendees		
Members	**Designation**	**Abbreviation**
Gillian Norton	Chairman	Chairman
Jacqueline Totterdell	Chief Executive Officer	CEO
Ann Beasley	Non-Executive Director/Vice Chairman	NED
Elizabeth Bishop	Non-Executive Director	NED
Stephen Collier	Non-Executive Director	NED
Jenny Higham	Non-Executive Director (St George's University Representative)	NED
Dame Parveen Kumar	Non-Executive Director	NED
Pui-Ling Li	Associate Non-Executive Director	ANED
Tim Wright	Non-Executive Director	NED
Andrew Grimshaw	Chief Finance Officer and Deputy Chief Executive Officer	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	
Quorum:	*The quorum of this meeting is a third of the voting members of the Board which must include one non-executive director and one executive director.*	

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

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NHS
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Minutes of the St George's University Hospitals NHS Foundation Trust Board Meeting
In Public (Part One)
Thursday, 25 March 2021
Held virtually via Microsoft Teams

Name	Title	Initials
PRESENT		
Gillian Norton	Chairman	Chairman
Jacqueline Totterdell	Chief Executive Officer	CEO
Ann Beasley	Non-Executive Director	NED
Elizabeth Bishop	Non-Executive Director	NED
Stephen Collier	Non-Executive Director	NED
Prof Jenny Higham	Non-Executive Director	NED
Prof Parveen Kumar	Non-Executive Director	NED
Dr Pui-Ling Li	Associate Non-Executive Director	ANED
Tim Wright	Non-Executive Director	NED
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
IN ATTENDANCE		
Anne Brierley	Chief Operating Officer	COO
Paul Da Gama	Chief People Officer (Workforce)	CPO
James Friend	Chief Transformation Officer	CTO
Stephen Jones	Chief Corporate Affairs Officer	CCAO
Suzanne Marsello	Chief Strategy Officer	CSO
SECRETARIAT		
Tamara Croud	Head of Corporate Governance/Board Secretary	HCG

		Action
1.0	**OPENING ADMINISTRATION**	
1.1	**Welcome, Introductions and apologies** The Chairman welcomed everyone to the meeting and noted that there were no apologies. She also congratulated Anne Brierley on her substantive appointment as Chief Operating Officer and welcomed Paul da Gama to his first meeting of the public Board	
1.2	**Declarations of Interest** There were no new declarations of interest to report.	

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		Action
1.3	**Minutes of the previous meeting** The minutes of the meeting held on 28 January 2021 were approved as a true and accurate record.	
1.4	**Action Log and Matters Arising** The Board reviewed and noted the action log. **The Ockenden Maternity Services Review outlined the requirement that there was greater visibility at Board-level into serious incidents related to maternity services. A proposal on how to give effect to this requirement would be presented to the Quality & Safety Committee.**	**ACN**
1.5	**Chief Executive's Officer (CEO) Report** The Board received the report from the CEO and the following key points were raised and noted: • The Trust, as with other NHS organisation, marked the day of reflection, one year on from the start of the Covid-19 pandemic. The Trust had responded effectively to the crisis and there was only one area outside the intensive care unit in use for patients with Covid and less than 50 Covid-19 inpatients being cared for in the Trust. The Trust was now focusing on how it resumes services and work continued to increase staff uptake of Covid-19 vaccines with 73% of staff vaccinated to date. The Trust had vaccinated circa 30,000 people. It was offering both the Pfizer and Astra Zeneca vaccines to accommodate people who have intolerances. The Trust submits forecasts weekly to NHS England & Improvement and there were robust plans to ensure it was managing its vaccine supplies. The Trust also had effective processes to follow-up with patients and staff who were due for the second dose of the vaccine. The Trust was also now conducting an extensive review of how it had responded to Covid-19. • The Trust's emergency service performance against the four hour standard remained strong. • Work had commenced to build the modular theatres at Queen Mary's Hospital. It was expected that work would be completed and they would be in operation by mid-late May 2021. • Work was underway to evaluate the feedback from the staff survey. The Trust was not where it wanted to be however there are soft signals that the Trust was moving in the right direction. • The Trust had received a grant from the Charity to use to support health and wellbeing initiatives for staff. • The Trust had been working with collaborative provider partners, in particular mental health partners, to give effect to the requirements in the	

		Action
	White Paper to progress initiatives such as joint commissioning. • A significant amount of good work was being undertaken at the Trust and it was important to recognise the fantastic efforts of the executive team and the wider staff. The Board noted the report.	
2.0	**CARE**	
2.1	**Quality and Safety Committee Report** Professor Dame Parveen Kumar, Chair of the Committee, presented the report of the meetings held in February and March 2021, which set out the key matters raised and discussed. Some of the reports discussed by the Committee also featured later on Board agenda. The key matters of note from the Committee related to: • the number of pressure ulcers had increased. This was related to Covid-19 patients who were predominately prone presenting challenges to care for these acutely ill patients; • good progress had be made on understanding and managing nosocomial infections; • the Trust responded to the Immediate Essential Action from the Ockenden Maternity Services review and self-certified as complaint or partially compliant against the safety improvement standards. The Committee was also closely monitoring mandatory and statutory training (MAST) performance. MAST performance had been impacted Covid-19. The Trust was not being able to deliver face to face training in a socially distanced environment and with staff focused on clinical and operational priorities. The Trust had put in place additional capacity and online resources. A particular area of concern was delivery of life-saving training. Whilst the Committee was reassured by the steps to improve performance it would continue to monitor progress. In discussion the Board noted that it was not possible to compare nosocomial infection rates with other organisations. The Trust was, however, working with sector partners and other NHS peers to share learning and improve practice to prevent nosocomial infections. It was also noted that there were appropriate approaches being to manage potential infection control risks related to the demolition work currently underway. The Board noted the report.	
2.1.1	**Learning from Deaths Quarter 3 Report** The Board received and considered the quarter three Learning from Deaths report and considered that the Trust was effectively managing mortality. Whilst the learning from death infrastructure was being developed and embedded it was important to ensure that all areas were being covered and nothing was being missed. It was also good to see that staff were being credited for good areas of practice and care delivered. It was also noted that Pui-Ling Li had taken on the role of non-executive director Board lead for learning from deaths.	

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		Action
2.2	**Integrated Quality and Performance Report (IQPR)** The Board received and noted the IQPR at Month 11 (February 2021), which had been scrutinised at both the Finance and Investment and the Quality and Safety Committees. Beyond the matters raised in the reports from the Committees, the Board noted that: • The Trust had reduced the number of patients waiting for diagnostics treatment especially for those waiting six weeks or more. The most significant reductions have been in cardiology and endoscopy. • As aforementioned, emergency care performance had continued to improve with the Trust achieving the four hour standard - 81.7% in January and 92% in February 2021. • The Trust was supporting effective seven day working with improved discharge process. • There have been fewer 12-hour trolley breaches and the Trust was working closely with mental health partners to ensure that mental health patients were accessing and repatriated to the right care setting. • The Trust was achieving 58% of its elective activity and met the priority two patient activity trajectory. • The Trust was conducting focused work on improving appraisals for clinical and non-clinical performance. • There had been a significant drop in employee relations cases moving from 44 to 26 cases in month which was a result of the Trust implementing the Dido Harding recommendations, improving the systems to manage these cases including the introduction of a disciplinary review panel and provision of more training for managers. The following key points were raised in discussion: • The teams were evidently working very hard and effectively. • Over winter, partner organisations across South West London discussed and agreed the areas where they could mutually support each other especially around Covid-19 and elective activity. The Trust supported Epsom and St Helier and Croydon by receiving diverted patients and providing intensive care capacity. The Trust also supported Kingston Hospital when its emergency department was at full capacity. The Trust was able to deliver its activity whilst effectively supporting these partners. Conversely, there was a willingness across the sector to support the Trust achieve its 52 week waiters targets. South West London (SWL) partners had also agreed to continue with routine children surgery service. • The Trust had done very well in achieving its targets. As the Trust enters a rapid recovery phase there were some very challenging milestones, such as, the aim to be compliant with cancer service targets by April 2021, it was reviewing all the good systems and clinical practice it had put in place to respond to the Covid-19 pandemic such as the introduction of virtual	

		Action
	outpatients appointments. Key streams of work included the improvement work on the outpatient pathway transformation with SWL partners. The Trust continued to review how it managed its elective activity under the assumption that the current pressures would remain. The Trust was reviewing the patient pathway which would include some face-to-face appointments. This was work was being led by clinical teams. The Trust wants to ensure that staff have the opportunity to take a break before elective activity is stepped up to full capacity following the latest surge. The Trust would now focus on opening theatres in order to resume clinical services to meet elective activity targets. • The Trust also had plans to improve its screening services and an evaluation of screening resources would be conducted. • During surge periods there was an increase in the use of interim nurses to support the delivery of operational priorities. This resulted in an increase in the use of agency costs for nurses. The Trust does closely manage and monitor the use of nurses to ensure that patients are treated safely. • The Trust had introduced a number of initiatives to ensure that staff have a break before there was a full resumption of clinical activity. The Board noted the report.	
3.0	**CULTURE**	
3.1	**Workforce & Education Committee Report** Stephen Collier, Chair of the Committee, presented the report of the meetings held in February and March 2021, which set out the key matters raised and discussed. The was lots of work underway and whilst there was not a culture plan there were a number of independent programmes underway which supported embedding the desired cultural change. The Board noted the good work conducted in the diagnostics phase of the culture programme and the Trust had already begun triangulating the intelligence from the staff survey and vaccination programmes. The Board noted the report.	
3.2	**National Staff Survey 2020 Report** The Board received the report on the results of the national staff survey completed in 2020. Overall, there was a positive trajectory and the Trust had seen improvement in seven themes, remained the same in one and saw a decline in performance in three areas especially in relation to diversity and inclusion and staff safety and violence against staff. The Trust was still below the average in eight out of the ten themes. The Trust was now embarking on a new approach, the 'Big 5'. The Trust would publicise the five areas of focus and develop a communications and engagement plan to demonstrate the work the Trust had conducted in these areas to drive improvement and demonstrate that staff were being heard. In discussion, the following key points were raised and noted:	

		Action
	• The Trust had commissioned a further deep dive of the comparative data for other London trusts. London was a unique environment and it would prove useful to understand any distinct themes and actions to progress to support staff. • The Trust recognised the importance of keeping staff engaged and proactively demonstrating to staff that it listened to staff feedback and effected change. • It was important to continue to listen to staff over the year therefore regular pulse checks which were a good source of feedback would be conducted. • The Trust had completed analysis of the staff survey data by care group, division and department. This information was being shared with teams so they may develop and drive key actions to address any material issues or challenges locally. The Board noted the summary analysis of the staff survey and the action plan.	
4.0	**COLLABORATION**	
4.1	**Audit Committee Report** Elizabeth Bishop, Chair of the Committee, provided an update on the meeting held in March 2021. The Committee's discussions focused on the preparations for completing the year-end audit. There would be a material change in the value for money assessment process and reporting for 2021/22. This year, the value for money report would be more qualitative covering three specific areas - governance, financial sustainability and economy, efficiency and effectiveness. The report would provide some very useful information in addition to key benchmarking data, locally and nationally. The Committee also considered six internal audit reviews. One report received substantial assurance, one reasonable however three reports, bullying and harassment, estates maintenance and ICT security received a limited assurance rating and the Committee would continue to monitor these closely. The Board noted the report and approve the audit fee.	
4.2	**Finance and Investment Committee Report** Ann Beasley, Chair of the Committee, provided an update on the meetings held in February and March 2021. Having reviewed its key risks the Committee proposed that the finance risk remain at 20 to reflect that there was only certainty about the first six months of the next financial year. The Committee also conducted a deep dive into the ICT risk. Whilst the way in which the ICT team had responded to Covid-19 was commendable there were fundamental issues which needed to be addressed to secure the ICT infrastructure in the longer-term. There had been, notably, equally good work conducted by the estates team however the lack of an estates strategy represented a risk. The Board would however preview the draft estates strategy in April 2021. The Committee sensed there was a much better understanding of how the hospital works as a result of responding to Covid-19 and this had resulted in better flows across the Trust. The Trust's financial performance had remained relatively stable with the biggest impact coming from external system drivers. The Trust had also spent a significant portion of its capital budget. The	

		Action
	Committee completed its effectiveness review which demonstrated that it was working effectively. The Board noted the report.	
4.3	**Finance Report M11** The Board received and noted the Trust's financial performance at month 11. There was one slight change, where the Trust was now forecasting breakeven as opposed to a £2m surplus which was in line with national guidance. Issues such as stock reconciliation and annual leave accrual payments would also impact on the Trust's gross income and expenditure position but would not materially affect the bottom-line. The Board noted the report.	
4.4	**Corporate Objectives Quarterly Update** The Board noted that this item would be discussed at the next meeting.	
4.5	**Horizon Scanning Report:**	
4.5.1	**Emerging Policy, Regulatory, Statutory and Governance Issues** The Board received and noted the update on emerging policy, regulatory, statutory and governance issues nationally and system-wide.	
4.5.2	**Strategic-Local & Regional** The Board received and noted the update on strategic local and regional system issues.	
5.0	**CLOSING ADMINISTRATION**	
5.1	**Questions from the public and Governors** The following comments and questions from members of the Council of Governors were raised and addressed: • The amazing work of the organisation was noteworthy and should be commended. • It was important that the Trust carries out an assessment of the impact on patient experience in relation to moving to virtual outpatient appointments. The Trust was currently reviewing the experience of patients and the clinical impact of virtual outpatient appointments. This would be a key workstream as the Trust moves out of the second surge in Covid-19 cases. • The Trust had conducted a significant amount of work to embed the learning from death methodology in the organisation. There was a greater understanding of the key metrics. With the introduction of the Medical Examiners' Office, the Learning from Death Lead and a Board lead the visibility of learning from death information had and was improving. Further focus would be given to reviewing the quality of outcomes and how the organisation learns from any issues.	

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	• The recent outbreak (three patients) of *Klebsiella carbapenemase* was not on the risk register. The incident was isolated and managed effectively. The Trust would also consider what other additional measures could be put in place to improve its systems, however it should be noted the Trust had a good track record in relation to this type of infection. • The Trust was cognisant that it had more work to do to develop its internal talent and supporting staff to progress in their careers. This was a key part of the work the Trust would be conducting. The Board thanked Governors for their feedback and input.	
5.2	**Any other risks or issues identified** There were no other risks or issues identified.	
5.3	**Any Other Business** There were no matters of any other business raised.	
Date of next meeting: Thursday, 27 May 2021, Microsoft Teams meetings		

Trust Board Action Log Part 1 - May 2021						
Action Ref	**Section**	**Action**	**Due**	**Lead**	**Commentary**	**Status**
TB25.06.20/02	**Quality & Safety Committee Board Report (June 2020)**	The Board agreed that data on maternal deaths and outcomes for Black, Asian, Minority and Ethnic mothers would be presented to a forthcoming Quality and Safety Committee.	~~31/08//2020~~ ~~26/11/2020~~ ~~28/01/2021~~ ~~25/03/2021~~ 27/05/2021	ACN	***A comprehensive report was presented to the Quality & Safety Committee in April 2021 and this has been uploaded to the Board Reading Room for information and a summary is provided in the Committee report.*** *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.*	**PROPOSED FOR CLOSURE**
TB25.03.21/01	**Action Log and Matters Arising (March 2021)**	The Ockenden Maternity Services Review outlined the requirement that there was greater visibility at Board-level into serious incidents related to maternity services. A proposal on how to give effect to this requirement would be presented to the Quality & Safety Committee.	27/05/2021	ACN	**This action as been delegated to the Quality & Safety Committee. This Board-level Committee has visibility of all maternity serious incidents through the monthly serious incidents report. The Committee provides comprehensive reports to the Board and will ensure that these incidents are expressly flagged. Maternity Services also presents monthly governance reports (which cover serious incidents) to the Patient Safety and Quality Group(PQSG). PSQG provides assurance reports to the Quality and Safety Committee.**	**PROPOSED FOR CLOSURE**

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Meeting Title:	**Trust Board**		
Date:	27 May 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:**	N/A

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Chief Executive's report to the Trust Board
27 May 2021

Covid-19 and the vaccination programme

Since the last Trust Board meeting on 25 March 2021, there has been a phased easing of Covid-19 restrictions across England as community transmission, hospital admissions, and hospital deaths from Covid-19 have fallen since their January 2021 peak.

At the height of the second wave in January, the Trust was caring for 91 Covid positive patients in intensive care beds and a further 263 Covid positive patients on our wards. By contrast, as at 24 May 2021 we are caring for fewer than five Covid positive patients in total across the Trust. Having scaled up our intensive care capacity to 129 ITU beds in January, we have now been able to step this down to our pre-surge level of 66 ITU beds.

While the reduction in Covid-19 cases in recent months is, of course, very positive, we cannot be complacent about the threat that the pandemic continues to pose. We continue to make contingency plans with our partners across South West London - and across the capital as a whole – for a potential third Covid-19 wave later this year. On site, we continue to implement stringent infection prevention and control protocols to minimise the risk of transmission and protect our patients and staff. In recent weeks, we have seen the emergence in the UK of a new variant of Covid-19, first detected in India, which appears to be more transmissible than earlier strains of the virus and cases are rising in some parts of the country. Surge testing and an accelerated vaccination programme is underway in areas where the variant has been identified, and the Government is also urging everyone to remain cautious and follow the current restrictions. Encouragingly, results of a new Public Health England study show that both the Pfizer and AstraZeneca Covid-19 vaccines are highly effective against this variant after two doses.

The Trust continues to play a key part in the national vaccination programme. As at 24 May 2021, over 56,000 Covid-19 vaccinations have been administered at the Trust, and more than 7,800 members of our staff – 84% of our total workforce – having received the vaccine. We have worked hard with all staff groups to encourage uptake of the vaccine and have made significant progress, though we know that uptake among some of our Black, Asian and Minority Ethic staff continues to be lower than among other staff groups. Earlier this month, our Covid-19 vaccine clinic began operating a walk-in service for members of the public, as well as Trust staff. The public walk-in service (first dose only) is currently open to those aged 30 and above.

Over a year since the pandemic began, the scale of its impact on patients, their families and our staff has been immense. Taken together, since March 2020 the Trust has cared for over 2,700 Covid patients. Sadly, 753 patients at the Trust have died and have tested positive for Covid-19.

As I mentioned in my report to the Board in March, we had recently initiated a piece of work to look at how we can learn from the way we have responded to Covid-19. In the coming weeks, we will conclude this work, which has looked at what has worked well, and where we can improve, and a report on this will be presented to the next Board meeting in July.

Elective recovery

Alongside preparing for any future Covid-19 surges, our key priority in recent weeks and months has been on elective recovery. The Trust is working hard to restart as much elective activity and safely treat as many patients as we can. To help us treat more patients, we have now re-opened all of our existing operating theatres at St George's, while at Queen Mary's Hospital, work continues on the four new mobile operating theatres (see more below).

Since the start of the second wave, we have continued to carry out urgent and emergency operations (including for cancer), along with urgent outpatient and diagnostic appointments. The Trust has plans in place to ensure that our longest waiting patients (those waiting longer than 52 weeks) are treated as quickly as possible. The Trust will continue to collaborate closely with neighbouring Trusts and the wider NHS in south west London to treat as many patients as we can.

As a result of this work, we are now undertaking approximately 90% of elective activity when compared to the same period in 2019/2020. In our outpatients' department, we are undertaking approximately 95% of activity compared to 2019/2020. At the same time, our emergency department continues to perform very well, and we have consistently been one of the best performers in the country against the four hour operating standard in recent months.

Queen Mary's modular operating theatres units

In March, as part of our efforts to resume elective services, work began to establish four new modular operating theatres on the Queen Mary's Hospital site in Roehampton.

The new facility is due to open in June 2021, and it will treat patients from across south west London who are waiting longer for routine operations and procedures as a direct result of Covid-19. It will be available for use by surgical teams from St George's, plus other hospitals in south west London. It will only carry out day case procedures.

Two of the four operating theatres will be used for plastic surgery and urology procedures – and a third theatre to treat a range of St George's patients from different specialities. The fourth theatre will be used by surgical colleagues from Kingston Hospital.

Staff health and wellbeing

I continue to be deeply impressed at how staff have responded to the challenge of getting services back up and running, and returning to some sort of normality. As I have said to the Board previously, 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.

May is Health and wellbeing month, and we have used the focus on health and wellbeing month to launch a number of new initiatives – including our new Wellness Actions Plans (WAPs), which are designed to encourage better, more meaningful conversations between line managers and staff about their mental and physical health.

We recognise how busy staff are, but we are also providing them with a number of opportunities to try new things - from free wellbeing classes, to webinars on stress, anxiety and burnout.

Throughout May, our occupational health team have also been facilitating free health and wellbeing MOT sessions – and our staff support team have been running virtual webinars, covering everything from anxiety to sleep and living well.

Support to our colleagues from India

While infection rates have been falling in the UK, Covid-19 continues to affect us all in different ways. We know that a number of our staff have family and friends who have been affected by the devastating surge in Covid-19 cases affecting parts of India, and we have been supporting our colleagues who have been affected by this.

Within the Trust, we have held two virtual sessions for staff affected by the pandemic in India and have issued regular communications that highlight the support available, whilst also urging line managers to be flexible and supportive to those staff who have friends and family in India.

Nationally, NHS England has established a clinical advisory group led by its Chief People Officer, Prerana Isaar, to support India's Covid-19 response, and has worked closely with the Indian High Commission and the Foreign, Commonwealth and Development Office on this. The group is working with Indian institutions such as the All India Institute of Medical Sciences to share experience of managing Covid-19 outbreaks. The group also includes researchers in public and global health, alongside nursing and other health professionals who have experience of the Indian healthcare system. As part of the national health and wellbeing programme for NHS staff, NHS England as developed a number of bespoke support offers for Black, Asian and Minority Ethnic NHS staff. Including colleagues effected by the pandemic in India.

International Nurses' Day

Our nursing and midwifery colleagues play such an important part in hospital life, and International Nurses' Day is a great way for us to recognise the huge contribution they make. On 12 May, we held a virtual celebration to recognise the fantastic work of our nurses and midwives. We held a minute's silence to recognise those nursing colleague who have sadly

passed aware over the past year, and we also announced the winners of our annual International Nurses' Day awards. I would like to congratulate:

- **Nurse of the Year:** Florence Kukula
- **Nursing Team of the Year:** Intensive Care Unit and everyone who was deployed to support our patients
- **Healthcare Assistant of the Year:** Lisa Payne
- **Midwife of the Year:** Tola Awogboro
- **Contribution to Covid-19 Award:** Infection Control Team
- **Dental Nurse of the Year:** Sonia Steer
- **Unsung Hero of the Year:** Jonathan Silver
- **Student Nurse of the Year:** Mae Albert Baltero
- **Preceptor of the Year:** Jusma Garg
- **Mentor of the Year:** Jennifer Pamiloza
- **Housekeeper of the Year:** Agnieszka Zajac
- **Nursing Associate of the Year:** Jesley Mendes

As well as congratulating the award winners, I would also like to say a big thank you to St George's Hospital Charity, Mitie, plus the event sponsors, and the many teams who supported the events to mark International Nurses' Day.

International Day of the Midwife

As well as marking the contribution of our nurses, over the past month we have also celebrated the crucial role played by our midwives. The International Day of the Midwife was held on 5 May 2021 and, as with International Nurses' Day, we marked the occasion with a set of awards for our fabulous midwifery colleagues. The Chairman and I were delighted to attend the event, and I would like to congratulate:

- **Midwife of the Year:** Tola Awogboro
- **Medical colleague of the year:** Stephan Ramnarie
- **Non-clinical staff member of the year:** Leon Cumberbatch
- **Clinical support staff of the year:** Afsana Ahad
- **Student of the year:** Tokunba Giwa
- **Inspirational Leader:** Janet Bradley
- **Inspirational mentor of the year:** Laura Pitfield
- **Unsung Hero of the Year:** Gloria Green
- **Lifetime achievement award:** Josephine Omari

Strengthening our culture

At our last meeting in March, I updated the Board on the progress of the work to strengthen the culture of the organisation. I am delighted that we are now in a position to bring to the Board our proposed action plan, which is later on the Board's agenda. We know that among our staff the appetite for change is huge, and we have benefitted from the input of a large number of our staff in developing our plans. Getting the culture of the organisation right is

key to delivering our goal of providing outstanding care, every time to our patients, staff and the communities we serve.

Our plans to strengthen the culture of the Trust are based on our key pillars: implementing a Trust-wide diversity and inclusion and organisational development action plan; engaging and inspiring our staff; introducing a "patient first" approach which will shape our business planning, priority setting, and approach to quality improvement; and delivering on other strategies, such as estates and ICT, that have a significant bearing on how people feel and shape our culture.

Alongside this, we have launched a plan for addressing the key themes arising from the 2020 NHS Staff Survey. Between May and September, we are focusing on our "Big 5" priorities: in May we have been promoting mental health and wellbeing, helping staff to look after their physical and mental health; "let's talk" is our theme for June, which focuses on speaking up and raising concerns; in July, we will be concentrating on flexible working, supporting flexible working for the benefit of patients and staff; in August, career progression will be our focus, making building a culture where progression is based on merit and hard work; and finally in September we will be focusing on creating a better workplace, where we will concentrate on giving staff the tools and equipment they need to do their job effectively. Of course, our efforts to deliver improvements do not start and end with our Big 5 - and the NHS staff survey results helped shine a light on many areas for improvement, which we are already working hard to address. But the Big 5 gives us a focus and gives you all clarity about where we are directing our energies.

Baby Surgeons: Delivering Miracles – Channel 4

Our new three-part documentary series Baby Surgeons: Delivering Miracles aired on Channel 4 in April and May. The series, which started on Monday 26 April, was broadcast across three consecutive Mondays and attracted millions of viewers. Following expectant parents as they navigate medically and emotionally complex pregnancies, each episode reveals how, or even if, the parents and staff should intervene with the pregnancies.

As one of the UK's leading fetal medicine units, the series showcases some of the most pioneering baby surgery performed, by our specialist teams, both inside and outside of the womb to save and improve the lives of babies. Reaction to the series was extremely positive, with The Times calling it 'extraordinary' and The Guardian describing it as 'absorbing watch'.

St George's and the wider NHS

As always, we remain engaged with key discussions and developments at a regional and national level. IN February 2021, the Government published its white paper setting our proposals for NHS and social care reform, with a strong focus on collaboration between the NHS, local government, and delivery partners. The new legislation was announced in the Queen's Speech as one of the Bill's to be presented to the new Session of Parliament, and we will take a close interest in the development of the legislation and monitor the impact of the changes on St George's.

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Leadership update

Finally, we have continued to strengthen our divisional teams through a number of key appointments. Following the news in March that Anne Brierley has been appointed as our Chief Operating Officer on a permanent basis, we have made the following appointments:

- Anna Clough has been appointed as Deputy Chief Operating Officer alongside her role as Divisional Director of Operations for our Surgery, Neurosciences, Cancer and Theatres Division;
- Julie Scrivens has been appointed as Divisional Director of Operations for our Medicines and Cardiovascular Division; and
- Rachel Benson has been appointed as Divisional Director of Operations for our Children's, Women's, Diagnostics and Therapies Division.

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St George's University Hospitals NHS Foundation Trust

2.1

Meeting Title:	**Trust Board**		
Date:	**Thursday, 27 May 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 April and May 2021.		
Recommendation:	**The Board is asked to:** • **Note the updates from the April and May 2021 meetings; and** • **Receive, consider and note the following reports:** o **Quarter 4 learning from deaths report (2.1.1)** o **Clinical Governance Phase 3 Review (2.1.2)** o **Cardiac Surgery Report** • **Endorse Committee Annual Review and approve the proposed changes to the Terms of Reference;**		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	All CQC domains		
Single Oversight Framework Theme:	Quality of care, Operational Performance, Leadership and Improvement Capability		
Implications			
Risk:	Relevant risks considered.		
Legal/Regulatory:	CQC Regulatory Standards		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A
Appendices:	N/A		

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St George's University Hospitals NHS Foundation Trust

2.1

Quality and Safety Committee Report

Matters for the Board's attention

The Quality and Safety Committee met on 28 April and 20 May 2021. The Committee considered and discussed the following matters of business at these meeting:

April 2021	May 2021
• Integrated Quality & Performance Report (M12) • Serious Incident Monthly Report • Surgical Site Safety (Deep Dive) Follow-up • Outpatient Transformation Programme Update • Maternity Services Update • Children's Cancer: Clinical Model • Clinical Governance Reviews: Phase 1-2 Update • Clinical Audit 2021/22 annual Plan • National Adult Inpatient Survey Results 2019: Update on Actions • Board Assurance Framework Monthly Report • Patient Safety & Quality Group Monthly Report	• Integrated Quality & Performance Report (M01) • Serious Incidents Monthly Report • Nurse Safe Staffing Report (M11/12) • Update on Care Quality Commission Action Plan • Draft Quality Report & Accounts 2020/21 • Clinical Ethics Committee Annual Report • Learning from Deaths (Q4) Report • Clinical Governance Review: Phase 3 • Board Assurance Framework Monthly Report (Q4) • Patient Safety & Quality Group Monthly Report • Committee Annual Review

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

1. Surgical Site Safety

The Committee received the follow-up report on the deep dive it conducted into surgical site safety which focused on the use of the World Health Organisation (WHO) Safer Surgery Checklist and the Local Safety Standards for Invasive Procedures (LocSSIPs). The Committee had noted and was reassured by the good progress made in implementing the actions however given there had been serious incidents related to surgical site safety the Committee would conduct a further review of the impact and embedding of the actions before it can provide the Board with assurance that these issues have been fully addressed. The Committee would conduct a further review in the next six months unless any trends in the monthly serious incidents give rise to any urgent concerns.

2. Integrated Quality and Performance Report (IQPR)

The Committee considered the key areas of quality and safety performance in months 12 (2020/21) and 01(2021/22). The Committee is aware that the Board would also consider the month 01 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:
  There were no falls with a 'moderate' or 'high' risk assessment rating in M12;
  Processing of complaints and serious incidents within the required timeframe remained good However the complaints team was very challenged partly related to capacity, and the Trust would engage an external peer review;

  Only one Covid-19 patient was on a Trust ward and the number of nosocomial infections had dropped significantly; and

  The number of methicillin-sensitive Staphylococcus aureus (MSSA) had increased to 47 against the internal trajectory of 25. Whilst this was not monitored at national level

the Trust was concerned by the increase in cases and would conduct a root cause analysis review of the cases.

- 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. This represented an area of risk for the Trust given that this was also an outstanding Care Quality Commission action.

  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. The Trust had set a target of 2-3 months to turn this position around.

The Committee was also reassured to learn that the Trust:

had an action plan in place to recover the breast screening trajectory and was working with other provider partners to reduce the waiting list for breast screening.

had a robust follow-up process for people who do not attend virtual appointments including a follow-up call with one hour of the missed appointment, which was followed by a letter to the patient with a new appointment.

Clinicians review their patient's lists for patients waiting 52 weeks or over. There was also a clinical harm review under way for patients waiting over 90 weeks and a sample of those waiting shorter periods. The review would be presented to the Committee in due course.

The Committee recognised the challenges facing the organisation and on balance agreed there was room for improvement to ensure that quality and safety risks were managed effectively to deliver high quality services and to safely care for patients.

3. 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 took particular note of the following:

The good progress on the action plan which addressed the issues identified in the Trauma Audit & Research Network and previously reported to the Board. The steps taken supported the continued improvement in data quality and 80% of the relevant cases have been subject to a clinical review;

The improved internal governance processes enabled the Trust to identify some outliers in relation to mortality in care groups related to mortality. The actions taken are detailed in the report however the Committee was assured that the Trust's internal systems had flagged the issues, a detailed investigation had been undertaken, an action plan developed to drive improvement, and the teams in the care group had engaged positively with the internal process.

The Committee also welcomed the news that the Trust would undertake a review of Covid-19 mortality as part of the wider review of Covid-19 impact currently underway.

4. Cardiac Surgery Report

The Committee also received the cardiac surgery report presented below under agenda item 2.1.3 for the Board's consideration.

5. 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 40 of the 46 improvement actions with robust supporting evidence. One (related to mixed sex breaches on Children and Young people inpatient ward areas) required further evidence to demonstrate sufficient improvement before it could be closed with a trajectory set for August 2021. The other five improvement actions would be incorporated into business as usual with exception reports presented to the Committee.

6. Draft Quality Report & Accounts 2020/21

The Committee received the early draft of the quality report and accounts for 2020/21. The Trust had opted to produce the report despite there being no regulatory requirement to produce the document. The Trust had made good progress on developing the document which would be sent to key stakeholders for input. The document required further input and the final year end data, but was at a very advanced stage. The quality report and accounts would not be subject independent scrutiny for external audits in line with same 2019/20 provisions put in place by NHS Improvement in order to ease the administrative burden on trusts. To compensate the Trust was conducting additional data quality checks to ensure the robustness and soundness of the data included in the report. The draft report was also presented to the Audit Committee and final drafts would be presented to the Board for approval in June following a further review by the Committee.

7. Serious Incident Reporting

The Committee considered the serious incident reports which covered the period February to April 2021. During these periods:

A total of 12 serious incidents were declared (3 in April 2021, 9 in March 2021);

Similarly five serious investigations had been concluded (3 in March 2021, 2 in February 2021).

The Committee had previously flagged to Board that it had expected an increase in serious incidents in March 2021 given that there had been no incidents reports in February 2021. The Committee noted that this was due to the peak of the recent wave of Covid-19 cases which occurred in February 2021.

The Committee was very assured that the Trust's improved governance systems had identified and flagged two serious incidents which occurred some years ago (6 and 16 years ago) and the correct steps were taken to investigate these incidents and ensure that the Trust's systems were such to ensure that mechanisms were put in place to manage the risks around any such future events.

8. Outpatient Transformation Programme

In recognition of the move to virtual appointments and the impact on quality, safety and patient experience the Committee requested an update on the programme of work transforming outpatient services. At its April 2021 meeting the Committee heard that the Trust, subject to any further Covid-19 surges, was committed to recovering the outpatient referral to treatment standard by March 2022. As a result of the Covid-19 pandemic the Trust had managed to deliver two-thirds of the deliverables in the outpatient transformation

strategy and moving to a virtual platform. The Trust rolled out the five year plan in six weeks and clinicians adapted rapidly to the new approach.

The Trust had a good understanding of the unintended consequences of moving to the virtual outpatients' platform at such pace. These included aligning clinical templates to reflect the virtual appointments, and the increase in the time between appointment and diagnosis if a patient required diagnostic interventions. The Trust planned to deliver at least 35% of its outpatient's activity 'virtually' against the 25% national standard however it had work to do to bespoke the outpatient pathway to respond to the treatment needs of the patients. This would be supported by initiatives such as a 'one stop' outpatient clinics and greater engagement with primary care and removing variations whilst recognising the individual needs of the patients.

The Trust was also one of the Vanguard organisations for the single patient initiated follow-up which would support people to access their information and better engage with their treatment pathway

The Committee was reassured by the steps taken and would continue to monitor quality, safety and patient experience impact.

9. Nurse Staffing Report (Planned vs. Actual)

The Committee considered the nurse safe staffing report for March and April 2021. The overall fill rate was 88%% and 93% 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 25 red flags raised in April 2021 which was an increase from the 11 reported in March 2021. However in both these months they were all managed effectively and mitigated with no harm to patients.

10. Maternity Services Report

The Committee received a very comprehensive report on maternity services which has been uploaded to the Diligent Reading Room for information. The services had good outcomes, met all required standards and in areas of challenge the Trust had in place a robust plan to improve quality. The Committee also welcomed the statistics on access and use of the service in relation to diversity and inclusion. The Committee was substantially assured by the report and recommend that Board members read the full report for information.

11. Clinical Governance Reviews

The Committee considered (in April 2021) the progress the Trust had made against the agreed actions from the phase one and two clinical governance reviews. The Trust had made good progress against the key actions included engaging the right level of support for the mortality and morbidity governance forums. In May 2021, the Committee received the report from the phase three clinical governance review of quality and safety monitoring and reporting. The report identified 36 areas of ward -to- board reporting and concluded that in 10 areas there were no improvements required, minimal improvements in 12 areas and in 14 areas substantial improvements were required. The Trust had mapped out the recommendations and suggested actions from the review. It noted that a number of actions had been taken, a number had been accepted with programme of works to complete these actions, and the others were being completed with an alternate approach to that suggested by the external reviewer in recognition of the change in the way the Trust was working since the review had been commissioned in March 2020. The Committee welcomed the recommendations from the phase three clinical governance review in that they would support enhancing the governance around the material actions taken as part of the phase

one and two reviews. The Committee however recognised the limitations of the review given that the surveillance and diagnostics work was carried out during the Covid-19 pandemic.

The Committee would continue to monitor progress on implementing the actions from the review and the report is presented under agenda item 2.1.2 for the Board's information and note.

12. Clinical Ethic Committee Annual Report

The Committee received and noted the annual report from the Clinical Ethics Committee. The report covered the breadth and depth of work carried out by the Clinical Ethics Committee and asked the Committee agreed to provide support to raise the profile and increase the transparency of the work of this forum.

13. Board Assurance Framework & Corporate Risk Registers

The Committee received the Board Assurance Framework (BAF) and Corporate Risk Register and considered 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 scores, given the focus on managing Covid-19 wave two and other operational pressures. The quarter four BAF report is presented under agenda item 4.5 for the Board's consideration.

14. Patient Safety & Quality Group (PSQG) Reports

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

15. Annual Committee Review

The Committee also completed its annual review and effectiveness in line with good practice. The Committee's annual report, work plan and the effectiveness review is attached for information and endorsement by the Board. The Committee also recommends that the Board approves the proposed minor changes to its terms of reference which include the following:

implementing the recommendations of the phase three clinical governance review to structure the terms of reference around the principal roles of the Committee in relation to patient safety, patient experience and clinical effectiveness and patient outcomes.

Streamlining further responsibilities of the Committee and aligning this with key areas of focus in the Board Assurance Framework

Updating the governance reporting structure to reflect changes to the executive operational governance structures.

Recommendation

The Board is asked to:

- **Note the updates from the April and May 2021 meetings; and**

- **Receive, consider and note the following reports:**
  - **Quarter 4 learning from deaths report (2.1.1)**
  - **Clinical Governance Phase 3 Review (2.1.2)**
  - **Cardiac Surgery Report**

- **Endorse Committee Annual Review and approve the proposed changes to the Terms of Reference;**

Dame Parveen Kumar
Committee Chair
May 2021

ANNUAL BOARD COMMITTEE REPORT

QUALITY & SAFTY COMMITTEE

1 April 2020 – 31 March 2021

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Quality and Safety Committee: 2020/221 Annual Report

1 Introduction

The Quality and Safety Committee is the principal Committee of the Board responsible for overseeing and providing assurance to the Board on patient safety, clinical effectiveness, clinical and quality governance and patient experience.

This report sets out the work of the Committee during the reporting period 1 April 2020 to 31 March 2021. The Committee submits a report to the Board after each meeting setting out the key discussions of the Committee, areas of assurance and matters for escalation to the Board. The purpose of this annual report is to provide a wider perspective on the work of the Committee over the past year and in so doing provide assurance to the Board that the Committee has discharged its role in line with its approved terms of reference.

2 Committee purpose and duties

The Committee's purpose and duties are set out in its terms of reference as approved by the Board on 28 May 2020. These set out that the Committee should review and seek assurance in relation to:

> all aspects of the quality of care, safety of services, standards of care provided to patients, patient outcomes and effectiveness, and patient experience;
>
> the effectiveness of clinical governance systems, structures and processes;
>
> the effective management of risks related to quality, safety and clinical governance including the oversight of strategic risks on the Board Assurance Framework assigned by the Board to the Committee;
>
> regulatory standards in relation to quality and safety;
>
> research and development;
>
> oversight of the implementation of the Trust's quality and safety and research strategies.

In line with the Board Assurance Framework for 2020/21 Committee is responsible for overseeing the following Strategic Risks:

- Strategic Risk 1: Our patients do not receive safe and effective care built around their needs because we fail to build and embed a culture of quality and learning across the organisation
- Strategic Risk 2: We are unable to provide outstanding care as a result of weaknesses in our clinical governance
- Strategic Risk 10: Research is not embedded as a core activity which impacts on our ability to attract high calibre staff, secure research funding and detracts from our reputation for clinical innovation

In line with good governance practice, the Committee's terms of reference have been reviewed and the proposed changes are detailed in section 6.

3 Membership and Committee Meeting Attendance

3.1 Members and Attendees

During the reporting period (April 2020 – March 2021) the following individuals were members of, or regular attendees at, the Committee:

Members/ Attendees	Role		Period
Dame Parveen Kumar	Chair	Non-Executive Director	April 2020 – March 2021
Prof. Jenny Higham	Member	Non-Executive Director	April 2020 – March 2021
Elizabeth Bishop	Member	Non-Executive Director	April 2020 – March 2021
Pui-Ling Li	Member	Associate Non-Executive Director	April 2020 – March 2021
Avey Bhatia	Member	Acting Chief Operating Officer	April – September 2020
Anne Brierley	Member	Chief Operating Officer (Interim Until March 2021)	October 2020 – March 2021
Dr Richard Jennings	Member	Chief Medical Officer	April 2020 – March 2021
Robert Bleasdale	Member	Acting Chief Nurse/Director of Infection Prevention & Control	April 2020 – March 2021
Gillian Norton	Attendee	Trust Chairman	April 2020 – March 2021
Jacqueline Totterdell	Attendee	Chief Executive Officer	April 2020 – March 2021
Stephen Jones	Attendee	Chief Corporate Affairs Officer	April 2020 – March 2021
Alison Benincasa	Attendee	Director of Quality Governance and Compliance	April 2020 – March 2021
Stephanie Sweeney	Attendee	Interim Deputy Chief Nurse	July 2020 – March 2021

In addition to members of the Trust's Council of Governors the following individuals regularly attend and observe the Committee:

Observers	Role	Period
Elizabeth Berner	Healthwatch Wandsworth Representative	April 2020 – March 2021
Sarah Cook	Healthwatch Merton Representative	April 2020 – March 2021

3.2 Committee Meeting Attendance

In 2020/21, the quorum for each meeting of the Committee was three members which needed to include one non-executive director and one executive director (either the Chief Nurse or the Chief Medical Officer).

The Committee held a total of 12 meetings in the reporting period and the attendance of members are recorded below. All meetings were quorate.

Members/ Attendees	Role	Attendance
Dame Parveen Kumar	Chair	12/12
Prof. Jenny Higham	Member	12/12
Elizabeth Bishop	Member	12/12
Pui-Ling Li	Member	12/12
*Avey Bhatia**	*Member*	*6/6*
Anne Brierley	Member	6/6
Dr Richard Jennings	Member	12/12
Robert Bleasdale	Member	12/12

**No longer members of the Committee*

The attendance of regular attendees at the Committee across the 12 meetings held in the reporting period are recorded below. These individuals were not members of the Committee and did no form part of the quorum.

Members/ Attendees	Role	Attendance
Gillian Norton	Attendee	9/12
Jacqueline Totterdell	Attendee	7/12
Stephen Jones	Attendee	11/12
Alison Benincasa	Attendee	11/12
Stephanie Sweeney	Attendee	8/9

In addition to the individuals who attended the meeting to present specific agenda items the following regular attended the meeting as observers:

Members/ Attendees	Role	Attendance
Sarah Cook	Healthwatch	3
Cherill Scott	Healthwatch	1
Elizabeth Berner	Healthwatch	8
John Hallmark	Governor	5
Nasir Javed Khan	Governor	3
Khaled Simmons	Governor	3
Alfredo Benedicto	Governor	3
Mia Bayles	Governor	1
Hilary Harland	Governor	2
Sarah Forester	Governor	1

4 Committee activity and focus

The Committee develops a forward programme of work (see Appendix 1) at the start of each financial year which is intended to ensure it fulfils its purpose and duties as set out in the Committee's agreed terms of reference. The Covid-19 pandemic resulted in many of the Trust's governance forums pausing whilst the organisation focused on operational priorities. While the Committee continued to meet its agenda focused on core business as usual activities especially at the peak of the surge in cases.

The matters discussed and considered at the Committee during the period (April 2020 – March 2021) are set out in Appendix 2 mapped across the key duties as recorded in the approved terms of reference.

Each meeting of the Committee had a full agenda and the Committee submitted monthly reports to the Board following each meeting. The key areas of focus for the Committee in 2020/21 are outlined below. This draws on the matters set out within the monthly report to the Board during 2020/21.

4.1 Covid-19 Pandemic

Like all other NHS hospitals, the Trust faced significant challenges related to Covid-19. The Trust made fundamental changes to upscale its intensive care bed capacity and altered the patient pathway in order to ensure the Trust provided high quality care for both Covid positive and non-Covid patients and mitigated the risks of nosocomial infection. It redeployed staff to reflect the intense operational pressures on both ITU and general and acute beds during the first and second waves of the pandemic, and made changes to the physical layout of the hospital to protect patients. The Trust responded to new, enhanced and sometimes frequently changing national guidance for patient care, infection prevention control and end of life care as our understanding of the virus

developed. The breadth, depth and pace with which the Trust responded to these issues were significant and were made possible by the commitment and dedication of our staff.

The Committee received regular reports on the Trust's response to the Covid-19 pandemic, changes in guidance especially those related to infection prevention and control, plans for managing future surges in cases as well as managing the winter pressures and flu. It also receives reports on personal protective equipment for staff, including mask fit testing, and on the roll-out of the vaccination programme. Overall the Committee was assured by the level of services delivered to patients, the actions taken to support patient experience, support families and protect and support staff. At the peak of cases during the first wave, the Committee was concerned about the availability of personal protective equipment and was assured by the Trust's approach to managing supply while noting the impact of supply and quickly changing guidance. The Committee commended how effectively the Trust managed these challenges and responded to the requirements around fit-testing staff for masks. Nosocomical infections arose as a concern when the Trust as well as other organisations nationally became aware of the significant risks around hospital acquired Covid-19. The Committee was assured by the additional measures the Trust took to protect patients and staff members for example mandating mask wearing for all staff and patients, reinforcing social distancing measures for staff and visitors to the Trust.

During the Covid-19 surges the Trust kept priority cancer services and certain other elective work going, but needed to suspend other clinical activity, and the Committee examined the impact this would have on patients waiting to access services. The Committee also sought assurance in relation to the Trust's planning for the safe resumption of services and the Committee was assured by the plans which included clinical review of all patient cases on the waiting list. Likewise, the Committee took a close interest in the demand for emergency care, and sought assurance in relation to the Trust's approach to encouraging and reassuring patients who needed emergency treatment to come on site and seek the care they needed.

The Committee recognised the impact of the pandemic on other clinical performance standards, for example the increased number of pressure ulcers with patients requiring longer stays in the intensive care units, the impact on patients unable to see their family members and the need to support them, the impact on delivering training to staff to either take on new roles or work differently.

The Committee also considered and endorsed the NHS England Board Assurance Framework for Infection Prevention and Control. The Trust was asked to complete this assurance tool and submit it to NHS England/improvement in August 2020. The Committee gained assurance from the robustness of the infection prevention measures in place and endorsed the submission.

Overall, the Committee was, and continued to be, assured by the measures the Trust was taking to manage Covid-19 surges and provide safe and effective care to Covid positive and non-Covid patients. It also indicated that during 2021/22 it would be focusing on areas which had been adversely impacted because of focus on Covid-19 for example mandatory and statutory training and ensuring that no adverse clinical harm was caused by patients.

4.2 Deep dives

As part of its annual work programme, the Committee planned to have regular deep dives across a range of quality and safety issues within its remit where it considered further assurance may be needed. As a result of operational pressures due to Covid, the Committee conducted three deep dives into the following areas:

- Serious Incidents Thematic Analysis

- Core Services Review: Medical Care
- Surgical Safety

The deep dives originally planned for 2020/21 will be incorporated into the Committee's 2021/22 work programme.

In 2019/20 the Committee began receiving month reports into the serious incidents. This increased the visibility of serious incidents and an understanding of the outcomes of root cause analysis and investigations. The Committee sought to understand if there were any trends or themes from serious incidents at the Trust and the Committee was assured by the deep dive looking at thematic analyses of serious incidents which demonstrated that the Trust was not an outlier for the number of incidents or any particular areas of concerns. The Trust would conduct the same deep dive in 2021/22.

The receipt of regular serious incidents report enabled the Committee to understand the challenges related to increased number of incidents and never events related to surgical safety. The Committee's deep dive into the surgical safety focused on the use of the surgical checklist and the protocols for Local Safety Standards Invasive Procedures (LocSSiPs). The deep dive identified that there were inconsistencies in the application and use of the surgical safety checklists and local procedures. The review resulted in the Trust producing an plan to improve compliance with the systems and in April 2021 when the Committee received an update on implementation of the actions it was pleased by the progress made and appreciated the actions the Trust was taking to ensure that surgical safety risks were being mitigated. This will remain an area of focus for the Committee during 2021/22.

All the Trust services have been under significant pressure as a result of the managing the Covid-19 pandemic. Despite these challenges the Committee was assured by the work conducted to care for patients. The Committee commended the work of the service which had seen significant improvement especially with the improved performance in the emergency care pathway which sustained performance against the four hour standards. The Committee was further assured by the standard of patient care delivered across the Trust.

4.3 Compliance and clinical governance

A core element of the Committee's focus in 2020/21 was monitoring of the Trust's completion of the outstanding actions from the 2019 Care Quality Commission (CQC) Inspection. The Committee can do no more that commend the Trust for continuing to focus on the actions to address the CQC recommendations.

The strengthening of clinical governance was another area of focus for the Committee in 2020/21, following the commissioning of a series of external clinical governance reviews by the Board in the previous year. The Committee considered and reviewed the outcomes of the phase 1 and phase 2 reviews prior to their consideration by the Board and closely monitored the implementation of the actions and recommendations of these reviews during the year. While it was disappointed at the progress in implementing the actions, the Committee were confident that the correct structures had been identified to begin to drive key improvements especially in relation the multi-disciplinary team and mortality monitoring meetings which underpin clinical governance systems across the Trust. These themes were also scrutinised by the Committee and as part of the follow-up deep dive into the serious incident thematic analysis into radiology, communication and cardiology.

The Committee has continued to closely scrutinise the actions being taken to improve the quality, safety and operation and implement the actions for the independent external mortality review of cardiac surgery patients treated between April 2013 and December 2018 which had been commissioned by NHS Improvement and published in March 2020. The Committee considered a

range of metrics regarding the safety and quality of the service and was assured by the progress achieved in improving the governance and safety of the service, which was independently verified by the findings of the CQC's inspection report published in December 2019. The Committee will continue to review the performance cardiac surgery service and will monitor key quality and safety metrics.

The Committee receives quarterly reports on learning from deaths and medicines management. The Trust's management of medicines and the Committee was assured by the actions taken including to promote use of e-prescribing across the Trust but tasked management to keep continue to keep this under close scrutiny. On mortality, the Committee examined the issues flagged in the Trauma Audit & Research Network and was assured that on closer scrutiny and review the Trust was not an outlier. While there were some improvements still to be put in place the Committee commended the robustness of the processes which were enacted to examine concerns in the service.

A key area of national focus related to maternity services. In addition to its regular updates on implementation of the maternity services improvement action plan the Committee also considered the Trust's response to the immediate essential actions from the NHS England and NHS Improvement Ockenden review and was assured that the Trust was fully compliant with most of the standards with robust plans to address areas of non/partial compliance. The Committee also received a comprehensive update on the maternity services and would keep under scrutiny the development of the strategy for maternity services.

4.4 Annual reporting

As part of the Committee's annual cycle it received thirteen annual reports and were assured by the performance of infection prevention and control, safeguarding, learning disabilities services, human tissue authority, research, duty of candour and complaints. The Committee also approved the draft of the quality accounts/report for 2019/20 and the quality priorities for 2020/21. The Committee were very pleased by the improved performance of complaints and impressed by the quality of service delivered by the learning disabilities team.

4.5 Strategy

In April 2019, the Trust published its new clinical strategy 2019-24. To assist in the delivery of the clinical strategy, a number of supporting strategies were developed. Among these were the Quality and Safety Strategy and the Research Strategy. The Committee took a close interest in and carefully scrutinised the development of both strategies during 2019/20 and, following this, recommended their approval to the Board. During 2020/21 the Committee kept under review progress in delivering the strategies and, despite the impact of the pandemic, was assured that progress was being made. Looking forward, the Committee will monitor the implementation of the strategies and will provide assurance to the Board on this, including escalating any concerns.

4.6 Strategic risk

The Committee closely monitored the three strategic risks on the Board Assurance Framework for which it is responsible for scrutinising and providing assurance to the Board and considered a range of additional and emergent risks relevant to quality and safety. In relation to Strategic Risk 1, which related to patient safety, the Committee recognised the work done to keep Covid and non-Covid patients safe, maintain supplies of personal protective equipment for staff, Covid testing and infection control. It also welcomed the positive changes to establish standardised processes for disseminating learning from complaints across the clinical divisions. In relation to Strategic Risk 2, which related to clinical governance, the Committee monitored the implementation of the first and second clinical governance reviews, particularly in relation to strengthening M&M and MDT meetings and in relation to strengthening the medical directorate, as well as the progress made in implementing the action arising from the independent mortality review in cardiac surgery. With the completion of the third and final phase of the clinical governance review, the Trust action plan

provides the Committee with a clear basis for monitoring the Trust's actions to mitigate this risk over the coming year. However, the Committee also recognised the impact of Covid on the pace of implementing the clinical governance recommendations during 2020/21. In relation to Strategic Risk 10, on research, the Committee was concerned by the impact of the pandemic on non-Covid research but welcomed the significant achievements to date in relation to Covid research, with the Trust being the UK lead for the Novavax vaccine study. It was also assured by the progress in implementing the research strategy, despite the impact of the pandemic, and was assured by the establishment of the Translational and Clinical Research Institute.

5 Committee Effectiveness

The Committee conducted a review of its effectiveness and the report is attached in Appendix 5. Overall, the results of the review suggest that the Committee is working effectively, with some marginal actions identified to improve future performance. All respondents stated that the Committee was either "very effective" or somewhat effective.

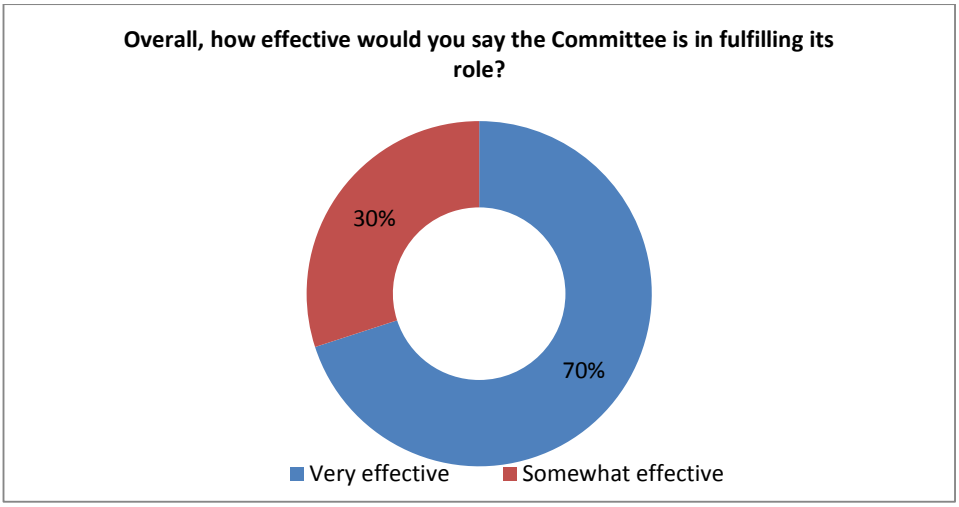


Figure 1

It was evident from the results of the 2020/21 review that the actions taken by the Committee had led to significant improvements in these areas and only areas for development included:

- Timely circulation of papers
- Increased focus on assurance and risk
- Induction/training for new members of the Committee
- Improve flow of meeting supported by the Committee Chair

6 Committee Forward Plan and Terms of Reference

The Committee's proposed forward work plan for 2021/22 is attached, alongside the work plan that had previously been agreed for 2020/21 and on which this reporting year is based. The proposed work plan for 2021/22 at Appendix 4 sets out the matters for consideration by the Committee. This seeks to build in the feedback on the previous forward work plan and seeks, where possible, to streamline this and focus the Committee on the key issues. Over the coming months, while it will work to the agreed plan, it may be necessary to adjust this (subject to these operational pressures) to focus on areas of immediate priority.

The Board previously agreed the Committee's terms of reference in May 2020. The key changes proposed to the terms of reference relate to the feedback from the Clinical Governance Review, phase 3, and which the Board is asked to agree include:

- implementing the recommendations of the phase three clinical governance review to structure the terms of reference around the principal roles of the Committee in relation to patient safety, patient experience and clinical effectiveness and patient outcomes.
- Streamlining further responsibilities of the Committee and aligning this with key areas of focus in the Board Assurance Framework
- Updating the governance reporting structure to reflect changes to the executive operational governance structures.

7 Conclusion and Assurance Statement

During 2020/21, the Committee worked hard to deliver its duties and in doing further strengthen its own operation and effectiveness, recognising that there was more than needs to be done. The Committee can assure the Board that there were many areas of good practice in the Trust and despite the significant challenges related to Covid-19 the Trust had managed to demonstrate strong governance mechanisms and leadership and improvement. The Committee will, in 2021/22, maintain its focus on the implementation of the clinical governance reviews, reviewing plans for future surges in Covid-19, scrutiny of surgical safety and core service reviews. The Committee also recognised that the improved transparency and escalation of quality and safety issues to the Committee was testament to improvements in culture, on which the Board was focusing in particular over the coming year.

8 Appendix 1: Committee Workplan 2020-2021

Quality and Safety Committee Forward Work Plan 2020/21														
Month	**Frequency**	**Lead**	**Authors**	23/04/2020	21/05/2020	18/06/2020	23/07/2020	20/08/2020	17/09/2020	22/10/2020	19/11/2020	17/12/2020	21/01/2021	18/02/2021	18/03/2021
COVID-19															
COVID-19 - Overview and Safety Dashboard (inc. workstream updates)	Monthly	CN/CMO	Various												
Clinical Safety Strategy during COVID-19 pandemic	Monthly	CMO	CMO												
DEEP DIVE															
Deep Dives (clinical issues, areas and themes) - Programme of topics to be agreed by Committee in May 2020	Monthly	CN	Various												
SAFETY & QUALITY IMPROVEMENT															
Integrated Quality and Performance Report (including Quality Improvement Dashboard)	Monthly	CN	PDM and DPM												
Serious Incidents Report (including never events)	Monthly	CMO	CMO												
Serious Incidents: Thematic Analysis	Bi-Annually	CMO	CMO												
Update on CQC Action Plan (Must/Should Do)	Quarterly	CN	DQGC												
Patient Safety & Quality Group Report	Monthly	CN	DQGC												
Cardiac Surgery Report	Quarterly	CMO	CMO												
Mortality Monitoring Committee and Learning from Patient Deaths	Quarterly	CMO	CMO		**Q4**			**Q1**			**Q2**			**Q3**	
Nurse Staffing Report (Planned Vs Actual)	Bi-Monthly	CN	DCN												
Infection Control Report (Including Antimicrobial Stewardship)	6 Monthly	CN	David Shakespeare											**6 Month**	
Quality Improvement and Transformation Programme Update	Bi-Annually	CN	DQGC												
Maternity Service Action Plan Update	Quarterly	CN	DDO-CWDT												
Head and Neck Services	As required	CMO	DC-SNTC												
EFFECTIVENESS															
Clinical Governnace Reviews - Phase 1/2/3	x3 / year	CMO	CMO												
Clinical Audit Annual Plan	Annual	CN	CEAM												
Trust-wide Policy Updates: Patient Care	Bi-Annually	CCAO	Secretariat												
Medicine Management and Controlled Drugs Report	6 monthly	CMO	Vin Kumar												
Clinical Ethics Committee and Key Ethical Decisions	As required/Annual	CMO	CMO	**(COVID)**	**(COVID)**	**(COVID)**									
Seven Days Services Compliance (NHS Returns)	Adhoc	CMO	CMO												
EXPERIENCE															
Patient Experience and Engagement Report	Biannual	CN	HoPE												
National Patient Survey (Published 2020/21)	Annual	CN	Various				**Adult Inpatient**						**Maternity Services**		
STRATEGY, GOVERNANCE & RISK															
Board Assurance Framework & Corporate Risk Register	Monthly	CCAO	CCAO												
Quality Strategy Implementation Updates	Quarterly	CN	CN												
Quality Priorities (report on performance / proposed new priorities)	As required	CN	DQGC												
Research & Development Strategy Implementation	Quarterly	CMO	Dan Forton												
CQC Statement of Purpose	Annual	CN	DQGC												
ANNUAL TRUST REPORTING/REVIEWS															
Quality Accounts/Report (1st Draft/Final Draft) (NHS Returns)	Annual	CN	DQGC		**Draft**	**Final**									
Complaints Annnual Report	Annual	CN	HoPE					**Annual**							
Duty of Candour Annual Report	Annual	CMO	DCN/CIL							**Annual**					
Caldicott Guardian Annual Report	Annual	CMO	CMO								**Annual**				
Nurse Establishment Annual Review	Annual	CN	DCN		**Annual**										
Safeguarding Adults - Annual Report	Annual	CN	HoS			**Annual**									
Safeguarding Children and Young People – Annual Report	Annual	CN	HoS			**Annual**									
Learning Disability Services - Annual Report	Annual	CN	Padraic Costello						**Annual**						
Mental Capacity Act Report/Deprivation of Liberty Annual Report	Annual	CN	MCA/DOLsP				**Annual**								
Infection Control Report Annual Report	6 Monthly/Annual	CN	David Shakespeare					**Annual**							
Clinical Neglience Scheme for Trusts: Renewal for Maternity Services	Annual	CN	CN				**Annual**								
Human Tissue Authority Report (Designated Individual) (NHS Returns)	Annual	CMO	CMO												
Research & Development Annual Report	Annual	CMO	Dan Forton						**Annual**						
COMMITTEE GOVERNANCE & OTHER MATTERS															
Annual Review of Committee Effectiveness (Approve Process/**Report**)	Annual	CCAO/CN	Secretariat									**Process**		**Annual**	
Annual Review of Terms of Reference	Annual	CCAO/CN	Secretariat												
Annual Review of Committee Work Programme	Annual	CCAO/CN	Secretariat												
Annual Committee Review Report to Board	Annual	CCAO/CN	Secretariat												

9 Appendix 2: Items Considered by the Quality & Safety Committee - April 2020 – March 2021

Compliance	Learning when Things Go Wrong	Performance against Quality Measures	Covid-19	Patient Experience	General Governance	Evidence-Based Clinical Practice	Research and Development	Audit
Human Tissue Authority: Designated Persons Report	Quarterly Learning from Deaths Report	Monthly Integrated Quality & Performance Report	**Covid-19: Overview and Safety Dashboard:** • Capacity and Demand (inc. equipment) • Safety Standing Down Other Activity (incl. risk assessments of services stood down) • Workforce Update • Staff Testing	Patient Experience and Engagement Group Update	Clinical Governance Review Reports (Phase 1 and 2)	End of Life Care (Deep Dive Follow-Up)	Research & Development Annual Report	Clinical Audit Programme Report
Annual Infection Prevention and Control Report 2019/20	Deep Dive: Surgical Safety	Quality Improvement Transformation Programme Report	Covid-19 Surge, Flu & Winter Plan 2020-21	National Adult Inpatient Survey	Update on Trust-wide Policies: Patient Care	Clinical Ethics Committee Update	Research Strategy Implementation (Quarterly)	
Annual Mental Capacity Act and Deprivation of Liberty Services Act	Deep Dive: Serious Incidents Thematic Analysis	Head and Neck External Review Update	**Covid-19:** • Infection Prevention and Control Assurance Framework • Fit Testing - FPP3 Masks	National Cancer Services Survey	Committee Annual Report & Forward Plan 2020/21			
Quality Priorities 2020/21 and forward plan for 2020/21	Deep Dive: Core Services Quality & Safety Review - Medical Care	Maternity Services Improvement Plan Update	Impact of Covid-19 on treatment times	National Maternity Services Survey	Monthly Board Assurance Framework			
Annual Safeguarding Adults Report	Legal Services Update	Learning Disability Services Annual Report	Clinical Ethics: Decision Making Framework (Covid-19)					
Annual Safeguarding Children Report	Duty of Candour	Quality & Safety Strategy 2020/21: Implementation Plan and Progress Update	Covid-19 Update					
Infection Prevention and Control Briefing: Recent Infection Control Issues	Monthly Serious Incidents Reports	Quarterly Cardiac Surgery	Complaints Investigation Process During Covid-19 Pandemic					
Annual Learning Disability Services Report	Complaints: Revised Investigations and Response Process	Monthly Nurse Safe Staffing	Covid-19: Summary Report & Safety Dashboard					
Care Quality Commission: Must and Should & Exception Report: Outstanding	TARN Review Briefing Note	Monthly Patient Safety and Quality Group Reports						
Quarterly Medicine Management Report	Ockenden Review Maternity Services& Trust Response							
Care Quality Commission: Statement Purpose	Complaints Annual Report 2019/20							
Seven Day Service Report: Progress on Implementation	Head and Neck External Review Update							

Other Appendices not embedded

10 Appendix 3: Revised Terms of Reference

11 Appendix 4: 2020/21 Draft Committee Workplan

12 Appendix 5: Committee Effectiveness Review

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

2.1

Quality and Safety Committee Terms of Reference

Approved by the Trust Board: TBC

Outstanding care every time

Approval and review dates

Profile	
Document name	Quality and Safety Committee Terms of Reference
Version	2.0
Executive Sponsor	Chief Medical Officer; Chief Nurse and DIPC
Author	Chief Corporate Affairs Officer
Approval	
Approval group	Trust Board of Directors
Date of approval	28 May 2020
Date for next review	April 2021

Quality and Safety Committee Terms of Reference

1. Name of Group

The Quality and Safety Committee.

2. Authority

Establishment: The Quality and Safety Committee has been established as a Committee of the Trust Board of Directors. Its constitution and terms of reference are set out below, and are subject to amendment by the Board as necessary.

Powers: The Quality and Safety Committee is authorised by the Board of Directors to:

i. Investigate any activity within its terms of reference
ii. Seek any information it requires and all staff are required to cooperate with any request made by the Committee
iii. Request attendance of individuals and authorities from inside and outside the Trust with relevant experience and expertise if it considers this is necessary

Cessation: This is a standing Committee of the Board and may only be disbanded or its remit amended on the authority of the Board.

3. Purpose of the Group

The Quality and Safety Committee will provide assurance to the Board of Directors on the quality of care provided to the Trust's patients, specifically in relation to patient safety, clinical effectiveness and patient experience. The Committee will do this by:

- Ensuring that the Trust has in place appropriate quality and clinical governance systems, processes and controls in place to achieve consistently high quality care and to meet the Trust's legal and regulatory obligations;
- Review progress against the Trust's quality and safety strategy, quality priorities and any quality improvement plans;
- Seeking assurance that the key risks relating to quality of care, as included on the Board Assurance Framework and the Corporate Risk Register, are being effectively managed and mitigated;
- Identifying and reviewing themes and trends in key quality indicators, seeking assurance that appropriate action is being taken to respond to and learn from these;
- Seeking assurance that appropriate progress is being made in implementing action plans put in place to address any shortcomings in quality of care.
- Seeking assurance in relation to the implementation of the Trust's research strategy.

In relation to performance, the Quality and Safety Committee will review the quality indicators in the Trust's monthly Integrated Quality and Performance Report, with wider scrutiny of the operational performance metrics being undertaken by the Finance and Investment Committee.

In fulfilling its role, the Committee will actively demonstrate the Trust's values, providing an appropriate balance of challenge and support.

4. Duties of the Group

The key duties of the Quality and Safety Committee are to:

(a) Review and seek assurance in relation to the structures, systems, processes and controls in place in relation to **patient safety** within the Trust, with a particular focus on the key patient safety objectives as set out in the Trust's Quality and Safety Strategy, Quality Priorities and Quality Account. This will include reviewing patient safety metrics in the monthly Integrated Quality and Performance Report.

(b) Review and seek assurance in relation to the structures, systems, processes and controls in place in relation to **patient experience** and engagement within the Trust, with a particular focus on the key patient experience objectives as set out in the Trust's Quality and Safety Strategy, Quality Priorities and Quality Account. This will include a twice yearly patient experience report focusing on key themes and trends, learning and improvement.

(c) Review and seek assurance in relation to the structures, systems, processes and controls in place in relation to **clinical effectiveness and patient outcomes** within the Trust, with a particular focus on the key clinical effectiveness objectives as set out in the Trust's Quality and Safety Strategy, Quality Priorities and Quality Account.

(d) Review and seek assurance in relation to the structures, systems, processes and controls in place in relation to **research** within the Trust, with a particular focus on the delivery of key priorities set out in the Trust's research strategy.

Further specific duties of the Committee include:

i. Monitor the implementation of Trust strategies and plans within its remit, including the Quality and Safety Strategy and Research Strategy.

ii. Receive and review reports on significant concerns or adverse findings highlighted by regulators, peer review exercises, surveys and other external bodies in relation to areas under the remit of the Committee, seeking assurance that appropriate action is being taken to address these.

iii. Undertake deep dives in relation to areas of material concern in relation to quality, safety and clinical governance, particularly where performance is persistently below expectations

iv. Receive and review those entries on the Board Assurance Framework (BAF) and the Corporate Risk Register (CRR) which are to be overseen by the Quality and Safety Committee and ensure that they are appropriately reflected on the Committee's work programme to enable the Committee to gain assurance on the effectiveness of the controls in place and progress in addressing gaps in control and assurance. The Committee will escalate matters as necessary to the Board.

v. Review the development of the annual Quality Account, including the annual quality objectives, ahead of submission to the Board of Directors.

vi. Review the findings of Internal and External Audit reports covering matters within the remit of the Quality and Safety Committee, seeking assurance that appropriate actions are identified and implemented in response to recommendations and that learning is shared across the organisation.

vii. Review the annual Clinical Audit Programme and monitor its delivery.

viii. Receive assurance that that the Trust is compliant with relevant Trust-wide policies and procedures related to the Committee's role and purpose.

ix. Receive the following annual reports and plans on behalf of the Board:
- Infection Prevention and Control
- Safeguarding Children

- Safeguarding adults
- Mental Capacity Act and Deprivation of Liberty Standards
- Patient experience
- Complaints
- Medicines optimisation
- Clinical audit
- Learning disabilities
- Duty of Candour
- Clinical Ethics Committee

x. Receive monthly reports from the Patient Safety and Quality Group.

xi. Seek assurance that the Trust is compliant with the requirements of its registration with the Care Quality Commission and oversee any remedial action that may be required, and monitor progress against any must and should do actions identified by the CQC.

xii. Consider the arrangements for the assessment by the Chief Medical Officer and Chief Nurse relating to the quality and safety impacts of schemes within the Trust's Cost Improvement Plans and transformation programme.

xiii. On behalf of the Finance and Investment Committee, consider the clinical and safety aspects of all business cases worth more than £1m prior to their consideration by the Trust Board.

xiv. Review any quality and safety issues referred to the Committee by the Board of Directors, the Finance and Investment Committee, Workforce and Education Committee, and Audit Committee.

xv. Review the structures, systems and processes and controls in place in relation to health and safety compliance in the Trust.

xvi. Undertake any other responsibilities as delegated by the Board of Directors.

5. Chairperson and Executive Lead(s)

A Non-Executive Director will chair the Quality and Safety Committee.

The Chief Medical Officer and Chief Nurse are the Executive Leads for the Quality and Safety Committee.

6. Composition of the Group

Membership: The membership of the Committee shall comprise three Non-Executive Directors, the Associate Non-Executive Director, the Executive leads and the Chief Operating Officer.

The current membership of the Committee is:

Name	Title	Role in the group
Prof. Dame Parveen Kumar	Non-Executive Director	Committee Chair
Elizabeth Bishop	Non-Executive Director	Member
Jenny Higham	Non-Executive Director	Member
Pui-Ling Li	Associate Non-Executive Director	Member
Robert Bleasdale	Chief Nurse and Director of infection Prevention and Control	Member
Richard Jennings	Chief Medical Officer	Member
Anne Brierley	Chief Operating Officer	Member

Members are expected to make every effort to attend all meetings and a register of attendance shall be maintained.

7. Regular and Other Attendees

The following individuals are not members of the Committee but will instead attendance the Committee on a regular basis:

- Chief Corporate Affairs Officer
- Deputy Chief Nurse
- Director of Quality Governance and Compliance

The Trust Chairman and Chief Executive will also periodically attend meetings of the Committee.

At the discretion of the Committee Chair, the Committee may also request other members of the Executive team and other relevant members of staff to attend meetings of the Committee or to attend for specific agenda items.

The following may also attend the Committee's meetings as observers:

- Healthwatch representatives
- Trust Governors (up to a maximum of three)

Deputies can attend the Committee with the permission of the Committee Chair, though they must be suitably briefed and supported by the individual for whom they are deputising in advance.

8. Quoracy

The quorum for any meeting of the Quality and Safety Committee shall be three members, of of which must be a Non-Executive Director and one must be either the Chief Medical Officer or the Chief Nurse. Regular or other attendees do not count towards the quorum.

Non-Quorate Meetings: Non-quorate meetings may go ahead unless the Chair decides not to proceed. Any decisions made by the non-quorate meeting must however be formally reviewed and endorsed either at the subsequent quorate meeting or on email circulation by sufficient number of Committee members to ensure the decision is valid.

In the absence of the Committee Chair, the Committee should nominate another Non-Executive Director to chair the Committee's meeting(s).

9. Declaration of Interests

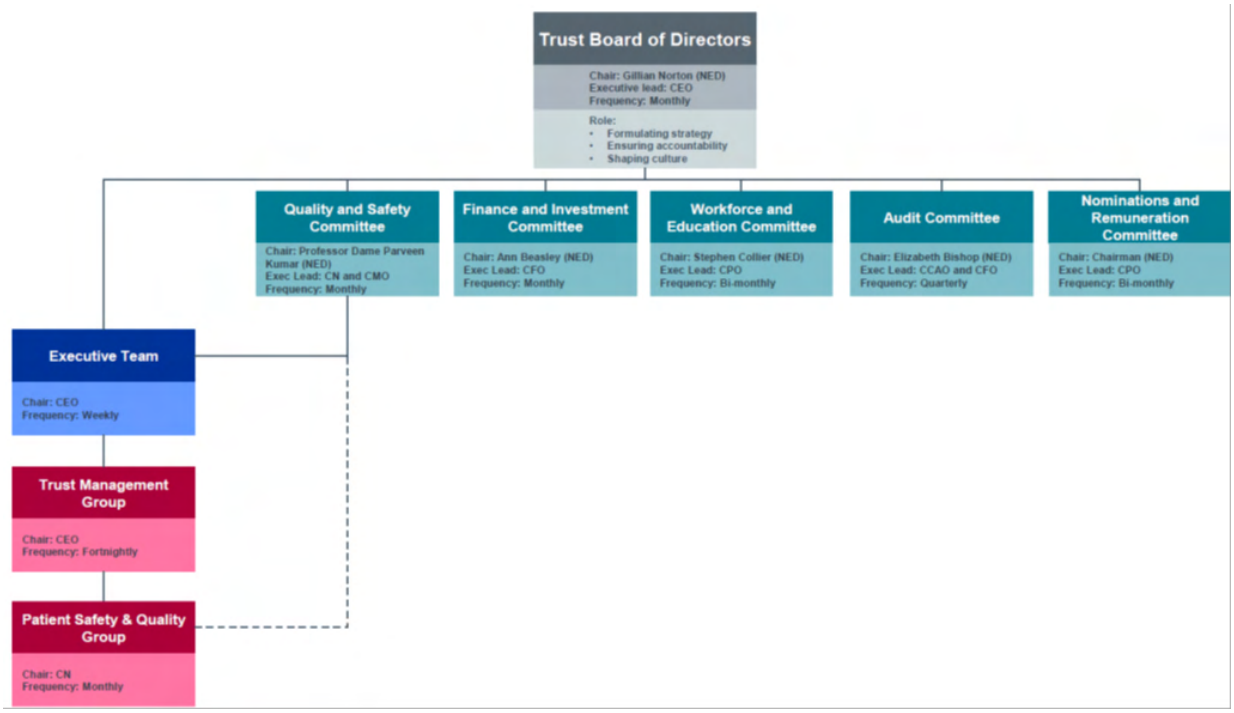
All members and those in attendance must declare any actual or potential conflicts of interest; these shall be recorded in the minutes. Anyone with a relevant or material interest in a matter under consideration must be excluded from the discussion.

10. Meeting Frequency

The Quality and Safety Committee shall meet monthly, typically on the penultimate Thursday of each month. The frequency of meetings may be changed only with the agreement of the Trust Board.

11. Relationship with other groups and committees

The Committee will report to the Trust Board.



12. Meeting arrangements and Secretarial support

i. An annual schedule of meetings of the Quality and Safety Committee shall be established at the start of each financial year;
ii. The Corporate Governance team will provide secretariat support to the Committee. This will include taking accurate minutes of each meeting, producing and managing timely delivery of items on the action log, ensuring that the planning for and outcomes of Committee meetings are shared appropriately.
iii. The agenda for the meeting will be agreed and compiled through discussion between the Committee Chair and Executive Leads.
iv. All papers and reports to be presented at the Quality and Safety Committee must be submitted as final Executive approved reports on the Tuesday one week before the meeting.
v. The agenda and supporting papers for the meeting will be circulated not less than three working days ahead of the meeting.

13. Agendas

Agendas for Committee meetings will be drawn from the Committee's annual cycle of business (forward plan) and will be agreed with the Committee Chair and Executive Lead(s).

14. Annual cycle of business

An Annual cycle of items and reports to be received by the Committee will be agreed by the Committee. The annual cycle shall be reviewed on an annual basis prior to the start of the financial year and should be reported to the Board alongside the Committee's annual report.

15. Report to the Board

The Committee Chair will prepare a report for the Trust Board after each meeting of the Committee. This will set out the key issues considered at each meeting and the degree to which the Committee was assured on these, specifically highlighting any areas in which there is a lack of assurance.

The Committee will, in addition, prepare an annual report to the Board setting out the key areas of focus in the previous financial year.

16. Review of Committee Effectiveness and Terms of Reference

The Committee will conduct a review of its effectiveness each year, the results of which will be reported to the Board.

The Committee's Terms of Reference shall be subject to an annual review. This review should consider the performance of the Quality and Safety Committee including the delivery of its purpose, compliance with the terms of reference and progress against its planned forward cycle of business. Any changes to the Terms of Reference require the approval of the Board.

Quality and Safety Committee Forward Work Plan 2021/22

Month	Frequency	Lead	Authors	28/04/2021	20/05/2021	17/06/2021	22/07/2021	19/08/2021	23/09/20201	21/10/20201	18/11/2021	16/12/2021	20/01/2022	17/02/2022	24/03/2022
DEEP DIVE															
Deep Dives (clinical issues, areas and themes)	Monthly	CN/CMO	Various	**Surgical Safety-Follow-Up**											
SAFETY & QUALITY IMPROVEMENT															
Integrated Quality and Performance Report (including Quality Improvement Dashboard)	Monthly	CN	PDM and DPM												
Serious Incidents Report (including never events)	Monthly	CMO	CMO											**Inc. Thematic**	
CQC Preparedness (Action Plan, Clinical Service Reviews, Insight)	Quarterly	CN	DQGC												
Cardiac Surgery Report	Quarterly	CMO	CMO		**(Annual)**										
Mortality Monitoring Committee and Learning from Patient Deaths	Quarterly	CMO	CMO		**Q4**			**Q1**			**Q2**			**Q3**	
Nurse Staffing Report (Planned Vs Actual)	Bi-Monthly	CN	DCN												
Infection Control Report (Including Antimicrobial Stewardship)	6 Monthly	CN	David Shakespeare											**6 Month**	
Quality Improvement and Transformation Programme Update	Bi-Annually	CN	DQGC												
Maternity Service Update	Bi-Annually	CN	DDO-CWDT												
General Surgery incl Head and Neck Services	As required	CMO	DC-SNTC												
Health and Safety Report	Bi-Annually	CFO	AD-HSFS												
EFFECTIVENESS															
Clinical Governance Reviews - Phase 1/2/3	x3 / year	CMO	CMO		**(Phase 3)**										
Clinical Audit Annual Plan	Annual	CN	CEAM	**(Annual)**						**6 Month**					
Trust-wide Policy Updates: Patient Care	Bi-Annually	CCAO	Secretariat												
Medicine Management and Controlled Drugs Report	6 monthly	CMO	Vin Kumar												
Clinical Ethics Committee and Key Ethical Decisions	As required/Annual	CMO	CMO		**(Annual)**										
Seven Days Services Compliance (NHS Returns)	Adhoc	CMO	CMO				**Q1**			**Q2**			**Q3**		
EXPERIENCE															
Patient Experience and Engagement Report	Biannual	CN	HoPE												
National Patient Surveys (Exepected Publication 2021/22)	Annual	CN	Various							**Urgent and Emergency Care Survey**		**Adult Inpatients & Children and Young People**		**Maternity**	

Month	Frequency	Lead	Authors	28/04/2021	20/05/2021	17/06/2021	22/07/2021	19/08/2021	23/09/20201	21/10/20201	18/11/2021	16/12/2021	20/01/2022	17/02/2022	24/03/2022
STRATEGY, GOVERNANCE & RISK															
Patient Safety & Quality Group Report	Monthly	CN	DQGC												
Board Assurance Framework & Corporate Risk Register	Monthly	CCAO	CCAO				(SR1 Deep dive)		(SR10 Deep Dive)		(SR2 Deep Dive)		(SR1)		(SR10)
Quality Strategy Implementation Updates	Quarterly	CN	CN				(Q1)			(Q2)			Q3		
Quality Priorities (report on performance / proposed new priorities)	As required	CN	DQGC												
Research & Development Strategy Implementation	Quarterly	CMO	Dan Forton			(Q1)			(Q2)			(Q3)			(Q4)
CQC Statement of Purpose	Annual	CN	DQGC												
Quaity assessment of Business Cases	As required	CN / CMO	Various	As required											
Issues arrising from internal audit reviews (Limited assurance)	As required	CN / CMO	Various	As required											
ANNUAL TRUST REPORTING/REVIEWS															
Quality Accounts/Report (1st Draft/Final Draft) (NHS Returns)	Annual	CN	DQGC		Draft	Final									
Complaints Annual Report	Annual	CN	HoPE				Annual								
Duty of Candour Annual Report	Annual	CMO	DCN/CIL							Annual					
Caldicott Guardian Annual Report	Annual	CMO	CMO								Annual				
Nurse Establishment Annual Review	Annual	CN	DCN			Annual									
Safeguarding Adults - Annual Report	Annual	CN	HoS				Annual								
Safeguarding Children and Young People – Annual Report	Annual	CN	HoS				Annual								
Learning Disability Services - Annual Report	Annual	CN	Padraic Costello						Annual						
Mental Capacity Act Report/Deprivation of Liberty Annual Report	Annual	CN	MCA/DOLsP						Annual						
Infection Control Report Annual Report	6 Monthly/Annual	CN	David Shakespeare					Annual						6 Month	
Clinical Negligence Scheme for Trusts: Renewal for Maternity Services	Annual	CN	CN			Annual									
Human Tissue Authority Report (Designated Individual) (NHS Returns)	Annual	CMO	Amy Gass (DI)												
Research & Development Annual Report	Annual	CMO	Dan Forton						Annual						
COMMITTEE GOVERNANCE & OTHER MATTERS															
Annual Review of Committee Effectiveness (Approve Process/**Report**)	Annual	CCAO/CN	Secretariat									Process		Annual	
Annual Review of Terms of Reference	Annual	CCAO/CN	Secretariat												
Annual Review of Committee Work Programme	Annual	CCAO/CN	Secretariat												
Annual Committee Review Report to Board	Annual	CCAO/CN	Secretariat												

2.1

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NHS
St George's University Hospitals
NHS Foundation Trust

Quality & Safety Committee Effectiveness Review 2020/21

Survey results and action plan

As reported to the Committee in March 2021

Stephen Jones
Chief Corporate Affairs Officer

Tamara Croud
Head of Corporate Governance

18 March 2021

1. Introduction

Purpose, context , summary and recommendation

1. Purpose

This paper presents the results of the Quality & Safety Committee review of effectiveness for 2020/21 which was undertaken since the last meeting of the Committee in December 2020, and highlights potential action points for consideration based on the feedback received through the survey.

2. Background and context

All Committees of the Board are required to undertake reviews of their effectiveness on an annual basis.

The Committee Chair, on behalf of the Committee, agreed plans for undertaking the effectiveness review. The survey was conducted between 28 February 2021 and 11 March 2021. Responses to the survey were provided via an online survey tool.

Conclusion/Summary:

In conclusion, in comparison to 2019/20 the respondents in 2020/21 were positive about the Committee and its achievement and the areas for improvement reflect similar areas as highlighted in the previous year. An updated action plan is set out in the report.

3. Recommendation

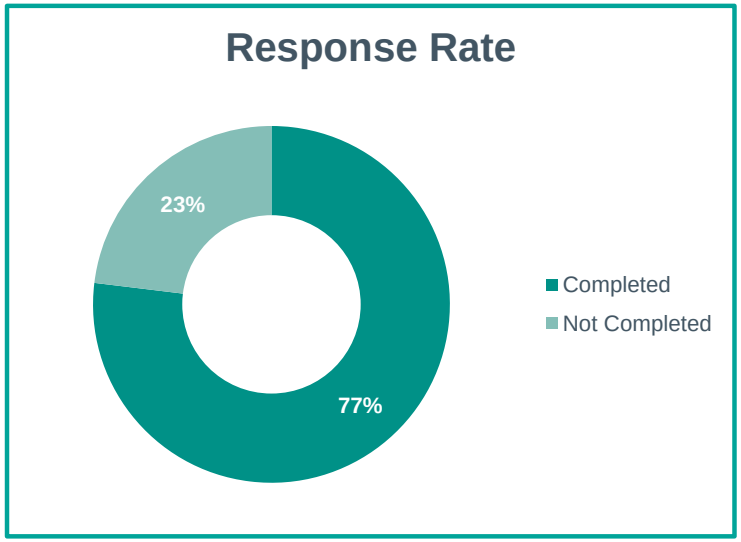
The Committee is asked to note the results from the Committee Effectiveness Review 2020/21 and the proposed actions to further improve the effectiveness of the Committee.

1. Introduction
Engagement

The following groups were invited participated in the survey:

- Non-Executive Director Committee members
- Executive Director Committee members including the Executive Committee Lead
- Trust Chairman
- Chief Executive
- Regular attendees – in line with the Terms of Reference
- Regular Observer - Healthwatch

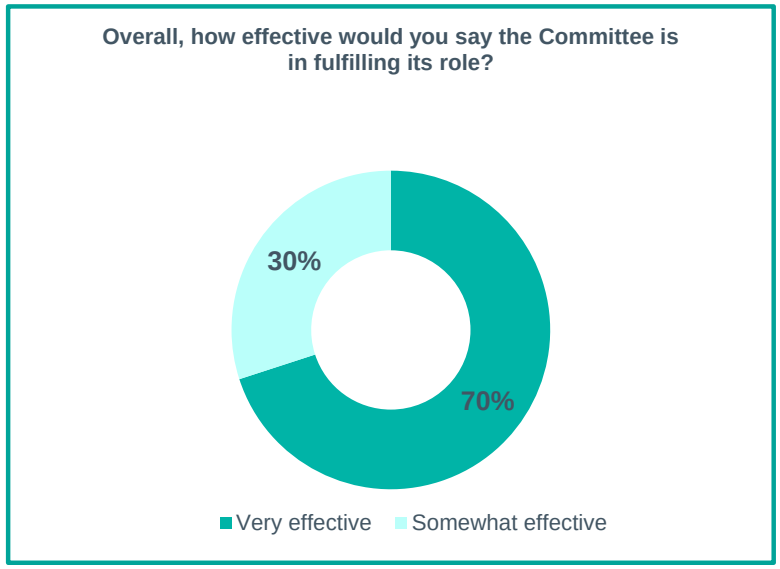
There was positive engagement with the review. 10 of the 13 individuals asked to respond did so, providing a response rate of 77%. This was an decrease on the 92% response rate for 2019/20. This may be as a result of Trust staff being focused on operational priorities.



2. Key findings from Audit Committee Effectiveness Review 2020/21

Overall effectiveness

The results of the review suggest that the Committee is working effectively. Respondents stated that the Committee was either, “very effective” (7 responses) or somewhat effective (3 responses). No respondents stated that the Committee was ineffective. This was a slight improvement, taking account of the reduced response rates, from 2019/20 where respondents 64% of respondents stated that the Committee was “very effective” and 36% stated “somewhat effective”.



Summary of findings

The following two slides summarises the responses from the 2020/21 survey. Overall, the respondents reflected that the Committee had improved its effectiveness over the past two years and it had adopted a sprit of continuous improvement. The support to the Committee was strong and it was managed well overall.

When the Committee completed the 2019/20 survey it agreed that further work would be completed in the following areas to improve the effectiveness of the Committee:

- *Develop a workplan (framed around the strategic risks which included a robust deep dive programme*
- *Develop and implement robust report drafting guidance and template for assurance reporting*
- *Improve circulation of reports in a timely way.*
- *Develop a serious incident report*
- *Revise format of Board report to ensure here was clarity on level assurance and key areas of risks*
- *Placeholder on Committee workplan for emerging issues*

It was evident from the results of the 2020/21 review that the actions taken by the Committee had led to significant improvements in these areas and only areas for development included:

- Timely circulation of papers
- Increased focus on assurance and risk
- Induction/training for new members of the Committee
- Improve flow of meeting supported by the Committee Chair

Respondents also suggested additional areas for the Committee to give focus to in 2021/22 including discharge and access arrangements, immediacy of patient and carer experience, the emerging patient involvement and engagement themes and insights into quality and safety aspects of ICT, estates and health and safety.

In conclusion, in comparison to 2019/20 the respondents in 2020/21 were positive about the Committee and its achievement.

2a. Summary of responses

NB: It should be noted that there were two partially completed response and some respondents skipped certain questions.

Area	Response Summary
Terms of Reference	90% of respondents noted that the Committee Terms of Reference was fit for purpose and the other 10% of respondents could not recall reviewing the Terms of Reference.
Workplan	100% of respondents thought the workplan was fit for purpose. Respondents noted that the plan was adequately flexed to respond to emerging issues and national events. It was also noted that the matters were also rearranged to give focus and sufficient time to key areas.
Sufficiency of time on agenda to explore issues in appropriate depth	70% of respondents stated that there was sufficient time on the agenda extra issues at appropriate depth however 30% did not agree. The free text commentary recognised the complexity and depth of the work conducted by the Committee which necessitate very detailed reports. This however resulted in meetings being overloaded at times and it would be useful for presenters to stick to the key points.
Circulation of papers	60% of respondents felt that the papers were circulated in a timely way and 40% did not believe this was the case. The commentary reflected on the fact that a number of papers were not circulated until the Monday before the Thursday meetings. Respondents did recognise the particular challenges presented by Covid-19 and operational pressures but noted that work should be done to ensure papers are distributed in a timely way ahead of the meeting.
Committee papers	100% of respondents noted that the Committee papers were clear concise and provided enough information for the committee to take informed decision and included details of risks and the implications. The respondents commended the improvement in the quality of papers, noted there was room for improvement especially in developing the executive summaries and placing the detail in appendices, setting out the risks and key implications and developing a consistent approach to reports.
Reporting governance forums	100% of respondents' stated the Committee had a clear understanding of the governance forums which reports directly into it.
Membership & Attendance	All respondents (100%) stated that the Committee had the correct membership. The commentary provided suggest that attendance was good however this was starkly different to Finance & Investment Committee which had more Board representatives. There was also contrasting views about the benefits of additional staff attending to present papers at the meeting. 90% of respondents agreed that the Committee had good attendance. Comments suggest that there was variable attendance citing the meeting did not seem a priority and that the COO and CEO had not been available much during the year.
Skills	All respondents (90%) agreed that the Committee collectively have the range of skills needed to ensure the Board receives the assurance it needs on quality and safety issues and risks and the he wider skills to be fully effective. The other 10% did not agree however no free text comments were provided.
Induction and training arrangements	The feedback on induction and training was mixed with 70% stating new members received an effective induction and training whilst 30% stated that this was not the case. Respondents requested a standard approach across all Committees and that the process is clearly articulated.

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2b. Summary of responses

NB: It should be noted that there were two partially completed response and some respondents skipped certain questions.

Area	Response Summary
Examining quality, safety and compliance data	All respondents (100%) stated that the Committee have the opportunity to examine specific quality, safety and compliance issues in detail on areas of concern. Respondents reflected that there had been challenges delivering the deep dive programme in the year and that sometimes teams were not adequately prepared and did not provide the assurance required to the Committee.
Committee Chairing	70% of respondents agreed that the Committee was chaired effectively however 30% stated that this was not the case. Key comments reflected that the Chair was new in post and had to develop in the role almost entirely remotely. Chairing of the Committee was "work in progress" and this was not helped that "on occasions discussions can deviate from the agenda item" this sometimes led to elongating the time of the meeting and add another layer of complexity. Respondents suggested focusing on areas where there was less assurance and moving through areas where assurance was clear and asked for more succinctness.
Challenge	90% of respondents agreed that the Committee provided insight and strong, constructive challenge on the matters outlined in the Terms of Reference. One respondent stated the opposite was true. Comments suggest that whilst the non-executive directors provided strong and well-directed challenge and there was room for more effective challenge.
Seeking assurances and reviewing evidence	Whilst 90% of respondents agreed that the Committee sought assurances and required evidence that decisions were implemented and were effective 10% disagreed. Respondents reflected on the introduction of the new assurance RAG rating which required an additional level of self-scrutiny. The Committee also used the reports from the Patient Quality and Safety Group or request further report to support its assurance.
Cascade of issues, risks and assurances to other forums	All respondents (90%) agreed that the Committee effectively escalated risks, assurances and issues to other forums such as the Board and its Committees.
Committee's report to the Board	All but 20% of the respondents agreed that the Committee's report to the board sufficiently described the matters considered, level of assurance and describe the evidence to support assurance. Comments suggest that there was room for improvement and noted that whilst there was now a formal way of recording the Committee's assurance level this was only recently introduced.
Review of Board Assurance Framework	70% of the respondents agreed that the Committee systematically reviewed, scrutinised and challenged the risks allocated to it from the Board Assurance Framework and receive assurance that actions were in place to manage and control effectively the risks identified. 30% of respondents disagreed and the comments suggest that there was little discussion about strategic risks normally due to a lack of time at the end of the agenda. It was suggested that the Committee discuss risks at the top of the agenda and possibly introduce periodic deep dives into certain quality and safety risks areas.
Understanding broader quality and safety risks	90% of respondents agreed that the Committee had a clear understanding of the broader risks around workforce and education facing the organisation and the actions being taken to address and mitigate them. However the free text commentary reflect that health and safety and ICT issues largely bypass the Committee as this was dealt with at Finance & Investment Committee. There were also suggestions that the Committee receive a report on Discharge to Access arrangements and also consider how it can be appraised of the views of commissioners.

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3. Areas of Development and Progress Update

Progress against 2019/20 development actions

In December 2020 the Committee noted the following progress update on the 2019/20 review development actions.

- Develop robust Committee workplan which covers the key matters which fall within the Committee's remit. The Committee workplan should include a robust deep dive programme, patient experience, transformation, and annual review of the quality and safety strategy, CQC full action plans, review of divisional performance against quality indicator, research and development, placeholders for reviewing business cases with for quality and safety implications and regular review of compliance with NICE and HSE. **The Committee 2020/21 workplan includes all these elements and a deep dive programme**
- *The workplan should also be framed from the BAF risk allocated to the Committee – **Whilst the Committee's workplan is informed by the BAF it was not framed from the BAF risk – with proposed changes to the Board working the 2021/22 work plan would be reframed in this way.**
- A mechanism should be put in place for the Committee to receive explicit feedback and assurance from the relevant governance forums - **The Committee receives updates from the Patient Quality & Safety Group and there was an effective process for cascading and escalating issues from the relevant governance forums.**
- Develop a robust programme of deep dives, and plan these in for the year ahead leaving some space in the forward plan for newly emergent issues that require / warrant a deep dive so that the Committee can respond to new issues – **This was completed with key issues such as General Surgery and Head and Neck accommodated in the agenda.**
- *Develop and implement robust report drafting guidance and template for assurance reporting, which is being picked up as part of the Board report writing improvement project. Improve circulation of reports in a timely way. There should be particular attention paid to develop a serious of report which reflects how learning has been embedded especially in relation to serious incidents, complaints, never events and deep dive reports – **With the exception of the Board report writing improvement project, which was paused during Covid-19, which was still ongoing this action was completed and due to complete in April 2021.**
- *Revise the format of the Committee's report to the Board to ensure that there was clarity on level of assurance and key areas of risk, recognising that this piece of work is already underway with the objective of rolling out the new format at the start of the new financial year – **Committee reports to the Board have been modified to incorporate the Committee's judgement about the level of assurance received for each item discussed.**
- Add a placeholder on the Committee's agenda for raising emerging risks and provide the opportunity for the Committee to decide what matters it would like to explore further – **Completed examples include Head and Neck, General Surgery.**

*Carried forward from 2019/20 actions

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3. Areas of Development and Progress Update – cont'd

Proposed 2021/22 development actions

As reported overleaf 70% of respondents agreed that the Committee was either 'very effective' . There was evidently some work to do to respond to the 30% of respondents who believed the Committee was only 'somewhat effective'. As noted earlier the following areas of development have been identified and the relevant actions proposed including those carried over from the previous year that were not fully completed.

***The workplan should also be framed from the BAF risk allocated to the Committee. In addition more time would be afforded on the agenda to discuss the BAF at each meeting.**

***Develop and implement robust report drafting guidance and template for assurance reporting, which is being picked up as part of the Board report writing improvement project. Improve circulation of reports in a timely way.**

***Revise the format of the Committee's report to the Board to ensure that there was clarity on level of assurance and key areas of risk, recognising that this piece of work is already underway with the objective of rolling out the new format at the start of the new financial year.** This work had already started but would continue to improve the Committee report to the Board.

Provide clarity on the induction and training programme for new members joining the Committee.

With the leadership of the Chair streamline discussions to key assurance issues to support the flow of meetings. Also reinforce the requirement for presenters to address only the salient points of a report.

Ensure that the key implications, risks and assurances were pulled out in the executive summary of each report. This will be supported by the work to develop report drafting guidance as outlined in the action above.

**Carried forward from 2019/20 actions*

Quality & Safety Committee Effectiveness Review 2020/21
St George's University Hospitals NHS Foundation Trust

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2.1

Meeting Title:	**Trust Board**		
Date:	27th May 2021	**Agenda No**	2.1.1
Report Title:	Learning from Deaths and Mortality Monitoring Committee (MMC) Report – Quarter 4 2020/21 (January - March 2021)		
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:	Assurance		
Executive Summary:	The paper provides an overview of the work of the MMC and Learning from Deaths in Q4 2020/21. A brief outline of work in progress to strengthen governance processes is outlined. This includes recruitment of the Mortality & Morbidity Coordinators Team, initial work to map current M&M processes and designing a standardised format for M&M meetings. The recent engagement of a Non-Executive Director is also noted. 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, whilst highlighting learning and action derived from mortality review. In order to demonstrate processes in relation to monitoring and investigating mortality outlier alerts, current work related to cardiology is presented, including improvement actions being considered. Brief updates on investigations of major trauma, neurosurgery and covid-19 are included. National mortality measures are also reported. Both our SHMI and HSMR remain lower than expected. Investigations underway to examine mortality at a more granular level are summarised. This paper was discussed at Quality and Safety Committee on 20 May 2021.		
Recommendation:	The Board is asked to note the contents of 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:	Quality & Safety Committee	**Date**	20/05/2021
Equality Impact Assessment:	N/A This is in line with the principles of the Accessible Information Standard		

1.0 **PURPOSE**

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 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.

2.0 **LEARNING FROM DEATHS**

The external governance review completed in April 2019 recommended that improvements be made to the mortality governance structure of the Trust to ensure there are robust mortality review processes across the Trust that allow learning to be identified and shared and actions agreed and monitored. Central to this is investment in a Mortality & Morbidity (M&M) Team, whose role will be to support clinical teams with their M&Ms. Five coordinators and a Team Leader have been recruited. The Team Leader, Maureen Ijomoni, took up post on 29th March 2021 and the coordinators are joining the team in July. The M&M Team are managed by the Head of Mortality Services.

The Head of Mortality Services and the M&M Team Leader attended the Clinical Governance leads meeting in April to introduce the team. Additionally, the M&M Team Leader is meeting with these leads individually to outline the aims for the service and gain an understanding of the support needed. A current picture of M&M activity is also being gathered, including frequency, structure, attendance, documentation, identification of learning and management of actions. Contact has been made with all care groups and to date meetings have been held with 29 and scheduled for six. The Team Leader is following up initial contact with eight remaining care groups and anticipates that meetings will be completed within the next month.

Alongside this, the M&M Team are evaluating review tools in use, against validated methods such as those published by the Royal College of Surgeons and the Royal College of Physicians. The intention is to work with clinical teams to co-design a standardised format and structure for M&M meetings. This will be an iterative process to ensure that the system developed considers effective processes already in place and is adaptable to the needs of different specialties, whilst supporting consistency and the promotion of shared learning.

We are fortunate that one of our Non-Executive Directors, Dr Pui-Ling Li, has agreed to provide oversight of our learning from deaths activity. Engagement of a Non-Executive Director to provide overview, critique and challenge is identified nationally as best practice and is a requirement of the Trust's recently revised Learning from Deaths policy. An introductory meeting between Dr Li, the Chief Medical Officer, Deputy Chief Medical Officer, Learning from Deaths Lead, Lead Medical Examiner and Head of Mortality Services has been held and was very constructive. A programme of activity to familiarise Dr Li with the breadth of mortality work was agreed and it is anticipated the group will meet on a quarterly basis.

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

To support the delivery of safer maternity care NHS Resolution continues to operate the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme. Trusts must demonstrate compliance with ten key safety actions to receive a rebate on the yearly CNST premium.

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 and that learning is identified and change is driven, 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. 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 21/06/2020-20/09/2020 and the actions and learning arising from them. In this quarter 21 cases were notified to PMRT and 16 reports were completed.

Standards from CNST Safety Action One	Compliance
1. A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, will have been started within four months of each death. This includes deaths after home births where care was provided by the trust staff and the baby died.	We are **compliant** with this standard. 100% of 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 review will have been completed to the point that at least a PMRT draft report has been generated by the tool, within four months of each death	We are **compliant** with this standard. 100% of babies suitable for a review using the PMRT who were born and died at St George's trust had at least a draft report within four months of the death of the baby
3. For 95% of all deaths of babies who were born and died in your trust from Friday 20 December 2019, the parents were told that a review of their baby's death will take place, and that the parents' perspectives and any concerns they have about their care and that of their baby have been sought. This includes any home births where care was provided by your trust staff and the baby died	We are **compliant** with this standard. 100% of parents of babies suitable for a review using the PMRT who were born and died at St George's trust were contacted informing them of the review taking place

Of the 16 completed reports, 14 were graded as having either no issues, or issues that would not have made a difference to the outcome. There was one neonatal death which related to the care given at another maternity unit and feedback has been provided to the relevant Trust. Two prominent themes from the mortality reviews were incomplete documentation post-bereavement and issues with sending placental histology samples.

During this period two stillbirths were declared as serious incidents (ref V211694 and V210801). The investigations have been completed and both have been reported to the Quality and Safety Committee, in February 2021 and December 2020 respectively.

In the first death the primary issue related to non-adherence to the new reduced fetal movement pathway. The SI concluded that it is difficult to ascertain, but unlikely that different care would have affected the baby's outcome. The post-mortem findings and the SI found that the root cause of death of this baby was indeterminate. In the second death key issues related to communication with

parents and support after their bereavement. The SI panel did not conclude that different care would have changed the outcome for this baby.

A number of actions have been agreed in order to address the themes from both the PMRT reviews and from the two serious incident investigations.

Improvement area	Action
Bereavement documentation	A full-time equivalent Bereavement Midwife has been recruited and the bereavement pathway is under review. Parts of the pathway have been re-written to ensure compliance with the National bereavement pathway. Further changes are expected this year to streamline the documentation process for clinicians.
Placental histology	A new placental histology form has been created to enable clinicians to complete documentation in a timelier manner. The form is being trialled in South West London and will be audited once implemented.
Reduced fetal movement pathway	The updated pathway was not followed in one case. Detailed recommendations are included in SI report (V211694), focussing on the education of all staff regarding the new pathway and ensuring that clinicians know how to escalate concerns.
Communication with parents and ongoing bereavement support	A theme has been identified regarding communication with parents after they have experienced a loss; detailed recommendations are included in SI report V210801. Actions focus on the way monitoring is discussed with parents and the pathway post bereavement. A full-time equivalent Bereavement midwife has been recruited to ensure leave is covered and that the service is not reliant on one individual. Review of the maternity bereavement pathway will further support improvements.

The report also highlights organisational factors which require action. The Maternity Unit and Neonatal Unit have identified the need for a PMRT coordinator. As a tertiary referral centre, intra- and extra-uterine transfers of complex cases increase the number of cases. Administrative support is recommended nationally and is required to ensure CNST criteria continue to be met. Increasing the number of PMRT panels that include an external member is also a priority. The South West London maternity service group has agreed to collaborate to achieve this national recommendation.

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=14) and those in which the ME has detected a potential issue with care or in which there is an opportunity for learning (n=7).

All deaths that have followed elective admission have been reviewed (5 cases this quarter). In line with the recently revised Learning from Deaths Policy five deaths in a specialty that is subject to enhanced oversight, one death as a result of a family concern and one 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 January to March 2021

Between January and March 2021 there were 608 deaths. Members of the Mortality Review Team (MRT) reviewed 40 deaths, representing 6.6% 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 40 deaths reviewed this quarter, problems were identified in relation to 12 (30 %) patients. In total 15 problems were identified, as one patient experienced 2 problems and another experienced 3 problems. In one instance it was thought that a problem related to clinical monitoring led to harm.

Problem in healthcare	No harm	Possible harm	Harm	TOTAL
Assessment	1	1	0	2
Medication	1	1	0	2
Treatment	2	0	0	2
Infection control	0	1	0	1
Procedure	1	3	0	4
Monitoring	0	1	1	2
Resuscitation	1	1	0	2
Communication	0	0	0	0
Other	0	0	0	0
TOTAL	6	8	1	15

A judgement regarding avoidability of death is made for all reviews. A breakdown of the avoidability judgment is shown below:

- 32 of 40 (80%) deaths reviewed were assessed as definitely not avoidable
- 3 of 40 (7.5%) deaths reviewed were assessed as slight evidence of avoidability
- 4 of 40 (10%) deaths reviewed were assessed as possibly avoidable
- 1 death (2.5%) was judged to be probably avoidable

No deaths were judged to be definitely avoidable.

The death judged by the SJR process to be probably avoidable was also the case in which a problem in clinical monitoring was thought to have caused harm. This was a case of post-operative complications, where the structured judgement review raised questions about complications related to a raised INR. The death was discussed at the Serious Incident (SI) Declaration Meeting on 08/03/2021. It was agreed that the incident did not meet the criteria of a SI but that an Adverse Incident (AI) investigation should be undertaken. The (AI) report is due to be presented to the SI Declaration Meeting in June.

Avoidability of death judgement	Number	Percentage
Definitely not avoidable	32	80.0
Slight evidence of avoidability	3	7.5
Possibly avoidable but not very likely (less than 50:50)	4	10.0
Probably avoidable (more than 50:50)	1	2.5
Strong evidence of avoidability	0	0
Definitely avoidable	0	0
Total	**40**	

An assessment of overall care is also provided for each death reviewed. For 32 patients (80%) care was felt to have been good; for the remaining 7 patients (17.5%) care was felt to have been adequate. In one death (2.5%) the care was observed as being poor.

The death that was observed as having poor care, had an avoidability score of 4 (possibly avoidable). This was a patient that had suffered a stroke and the reviewer raised questions about the timeliness of CT investigation. Further insight was sought from the clinical team, who explained that more rapid imaging would not have altered the treatment or outcome as the patient would not have been eligible for acute stroke treatment. The clinical team's response addressed the reviewers queries satisfactorily.

Overall care judgement	Number	Percentage
Excellent care	0	0
Good care	32	80
Adequate care	7	17.5
Poor care	1	2.5
Very poor care	0	0
Total	**40**	

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 closely together 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 Q4 2020/21. In total there have been 47 deaths, with reviews completed for each.

This quarter there have been 7 LD deaths; 6 adult and 1 paediatric. None of the deaths were thought to be avoidable and 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**	**Q4 20/21**
TOTAL DEATHS	1	3	3	2	3	7	4	2	4	4	7	7
REVIEWS COMPLETED	1	3	3	2	3	7	4	2	4	4	7	7
Definitely not avoidable	1	3	3	2	3	7	4	2	4	4	6	7
Slight evidence of avoidability	0	0	0	0	0	0	0	0	0	0	1	0
Possibly avoidable, not very likely (< 50:50)	0	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	0
Strong evidence of avoidability	0	0	0	0	0	0	0	0	0	0	0	0
Definitely avoidable	0	0	0	0	0	0	0	0	0	0	0	0

4.0 LEARNING FROM MORTALITY

The following summaries give an overview of a mortality investigation that has recently concluded and an update on two previously reported investigations. Detail is provided which demonstrates current processes for monitoring mortality data, identifying alerts, examination of potential causes and consideration of any actions required. Also introduced is the ongoing work related to mortality due to covid-19.

4.1 Cardiology

4.1.1 Investigation to date

Through ongoing monitoring of data via the Dr Foster platform, the MMC identified a number of diagnostic and procedure groups related to cardiology where mortality appeared to be higher than expected. In response the care group investigated inpatient mortality between January and June 2020 in patients admitted with acute coronary syndrome (ACS) or undergoing coronary angiography. In tandem, an analysis of patients with a discharge diagnosis of acute coronary syndrome (ACS) over the same period was conducted. The outcome of this work was presented to the MMC in April 2021.

Over the period examined there were 716 admissions and 36 inpatient deaths: a crude mortality rate of 5 per cent. The major cause of death was cardiogenic shock or failure and almost all deaths were in patients presenting with ACS. Retrospective clinical review of each death was conducted; in the large majority it was found that care and treatment were appropriate. There were two patients who may have benefitted from earlier admission to the catheter lab; however, there were very clear, well documented reasons and the review agreed with the contemporaneous decision.

The retrospective review identified three patients who could possibly have been managed differently. Each presented with ST elevation myocardial infarction (STEMI) and cardiogenic shock. Two of the patients were young and underwent timely primary percutaneous coronary intervention (PPCI); both had persisting deep cardiogenic shock post intervention and were admitted to critical care. It was felt that in these two patients early mechanical support via an Impella device may have had a positive impact. The Trust do not currently have Impella devices, which are designed to provide temporary ventricular support.

4.1.2 Actions currently being considered

The mortality review identified several improvement actions. To improve outcomes in this group of patients it was suggested that the collection and evaluation of our door to balloon time, i.e. the time from admission to intervention, should be strengthened. Improving the way in which we identify and classify cardiogenic shock is also likely to be beneficial. Currently the classification is binary, and management is largely reactive, whereas, a more proactive and nuanced approach may improve outcomes. This practice is followed at Harefield Hospital and uses simple and readily available parameters to classify the level of shock and to guide the need for invasive monitoring and improved treatment early in the clinical course. Standardising our approach to acute myocardial infarction - cardiogenic shock (AMI-CS) patients is also required.

The service has identified that the latter improvement points could be achieved through introduction of a Shock Team. This would require the input of Cardiothoracic ITU and the Coronary Care Unit (CCU) and the development of an AMI-CS standard operating procedure. This should be underpinned by education and the use of right heart catheterisation and mechanical support. The service feels that that this approach is essential in order to remain contemporary.

Alongside the mortality review, the wider review of the ACS service which looked at 5 key performance areas, suggested additional areas for action. Good performance was observed in relation to timely cardiology review, assessment of left ventricular function and valve function prior to discharge, and appropriate discharge medication. However, the timeliness of procedure and the level of inter-hospital transfers could both be improved. Moving to a model of ‘treat and return’ or ‘treat and discharge’ was recommended as a way of achieving this. This would require ring-fencing a small number of beds. This practice is followed in other hospitals with higher levels of inter-hospital transfers; it results in shorter waiting times for all angiography patients, and also generates income.

The committee took assurance from the thorough review and concluded that no further investigation of mortality is currently required. It recommended that the actions identified should be driven and overseen at a divisional level, suggesting that it may be helpful to establish a Task and Finish group to drive improvements. The clinical team are liaising with the Medicine and Cardiovascular Divisional Governance Team to take this forward. It was agreed that the MMC would receive an update on progress in a few months and in the meantime will continue to monitor mortality.

4.2 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. Previous Learning from Death reports have explained in detail the nature of the alert, work already undertaken and a plan for comprehensive investigation.

On 14th 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. However, more recent data, for the period June 2018 to May 2020 suggests that our outcomes remain in the lower quartile of Major Trauma Centres.

As part of the ongoing investigation considerable efforts have been placed on making essential improvements to data quality and completeness. The impact of these changes will not be seen in these latest data; however, it reinforces the need to complete the clinical review of cases which is currently underway. Eighty per cent of the clinical reviews have been completed and the working group is committed to completing the remaining cases without delay. The group will then meet to consider the outcome and formulate a proposal for next steps, which will be presented to MMC in June 2021. The conclusion of this work will be shared in the next Learning from Deaths report.

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 work already undertaken to provide assurance regarding clinical care and to validate the coding and classification of these cases has been explained in detail in previous Learning from Death reports.

The final stage of this investigation, to conduct a comprehensive benchmarking exercise to determine if there are differences in our coding practices and/or case-mix, is underway. Colleagues within the Strategic Business Intelligence team are supporting this work and external analysis from Dr Foster has been requested. The outcome of this work will be presented to MMC in May and will inform the committee's decision regarding appropriate further action. The outcome of this work will be reported in the next quarterly Learning from Deaths report.

4.4 **Learning from mortality related to Covid-19**

The Mortality Monitoring Committee has requested that covid-19 mortality observed during the first and second waves of the pandemic is analysed in order to identify learning and to contribute to preparations for a third wave.

Preliminary analysis led by Dr Yee Ean Ong (Consultant in Respiratory Medicine) was shared with the MMC in April. This includes comparative analysis of mortality in wave 1 and wave 2, according to age and the requirement for critical care admission. The outcomes of patients on different treatments is a key focus and differences according to ethnicity and deprivation are also being explored.

At the time of presentation in April this investigation was in progress, pending final outcomes for a small number of patients admitted in wave 2 and data quality checks. It is anticipated that this will be completed and presented to MMC in June and shared in the Q1 2021/22 version of this report.

This work will actively coordinate with the broader Trust learning from covid initiative (overseen by the Chief Transformation Officer) which has four workstreams, one of which is 'Better Treatment Plans', co-led by Dr Carolyn Johnston and Dr Dan Forton. This workstream includes examination of clinical outcomes.

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 December 2019 to November 2020, was published on 8th April 2021. The Trust's overall mortality is categorised as 'lower than expected' at 0.86. We are one of 13 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.

During the 12-month period there were 69,145 inpatient spells at the Trust, with 1,620 deaths observed, compared to 1,890 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 might not be 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 the 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	1.06	As expected
Cancer of bronchus; lung	0.33	Lower than expected
Fluid and electrolyte disorders	0.55	Lower than expected
Fracture of neck of femur (hip)	1.33	As expected
Gastrointestinal haemorrhage	1.02	As expected
Pneumonia (excluding TB/STD)	0.84	As expected
Secondary malignancies	0.79	As expected
Septicaemia (except in labour), shock	1.09	As expected
Urinary tract infections	0.89	As expected

5.2 **Hospital Standardised Mortality Ratio (HSMR)** [source: Dr Foster]

For the most recent 12 months of data available via Dr Foster (February 2020 to January 2021) our mortality is lower than expected. In contrast to NHS Digital, Dr Foster Intelligence has not excluded Covid-19 activity from their analysis.

HSMR analysis: February 2020 – January 2021	Value	Banding
HSMR (all admission methods)	92.8	Lower than expected
HSMR: Weekday emergency admissions	86.3	Lower than expected
HSMR: Weekend emergency admissions	113.0	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 have been investigated. In relation to the signal reflecting three deaths in the procedure group 'Transplantation of kidney' a report that considers both the service level response and independent review of each case will be presented to MMC in May.

Diagnosis/Procedure Group	Current status of investigation
Coronary atherosclerosis and other heart disease	Investigated as part of review detailed in 4.1
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 section 2.1
Residual codes unclassified	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 impacted significantly on other groupings and on HSMR for these months. This issue arose due to a delay in the coding of deceased patients. The Head of Information Services arranged for resubmission of corrected data to ensure the accuracy and to enable effective monitoring of mortality. This improved our data retrospectively; however, the greatest improvement appears to have come from improvements to coding practices. Since April 2020 there are significantly fewer episodes and lower mortality in this grouping. To provide assurance that there has been no deterioration in practice this grouping continues to be monitored.
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. Increased understanding of outcomes and assurance is provided by the quarterly PMRT report which is summarised in each of these reports.
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. Deaths are observed once again in the most recent data and we expect to see an increase in the coming months, reflecting the second Covid-19 surge.
Coronary angioplasty (PTCA)	Investigated as part of review detailed in 4.1
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 reflects a change in coding practice nationally, which took effect from

Diagnosis/Procedure Group	Current status of investigation
	April 2020. Coders are required to assign a code every time an NG tube is inserted.
Transplantation of kidney	This signal was first observed in February 2021 and includes 3 deaths over the last 12 months. Each of these deaths was subject to comprehensive scrutiny at the time of the event. The Clinical Lead for Transplantation has prepared a response to the signal and independent review of each of the deaths has also been completed. A report will be presented to MMC in May 2021.
Crushing injury or internal injury	This is a new signal and a preliminary review of the data is being conducted.

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Appendix 1: National Quality Board Dashboard – data to 31st March 2021

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

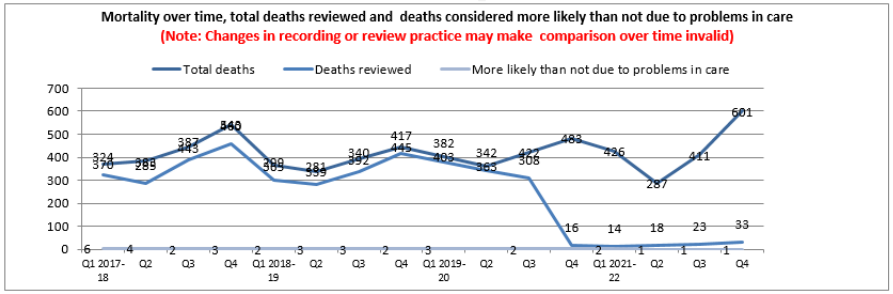
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

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

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

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered more likely than not due to problems in care PRISM Score<=3 or equivalent measure	
This Month	Last Month	This Month	Last Month	This Month	Last Month
113	181	13	8	0	1
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
601	411	33	23	1	1
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
1725	1671	88	1048	5	5

Time Series: Start date 2017-18 Q1 End date 2020-21 Q4



Total Deaths Reviewed, categorised by SJR Avoidability Score

Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	1	7.7%	This Month	0	0.0%	This Month	12	92.3%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	1	3.0%	This Quarter (QTD)	4	12.1%	This Quarter (QTD)	3	9.1%	This Quarter (QTD	25	75.8%
This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	5	5.7%	This Year (YTD)	6	6.8%	This Year (YTD)	14	15.9%	This Year (YTD)	63	71.6%

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

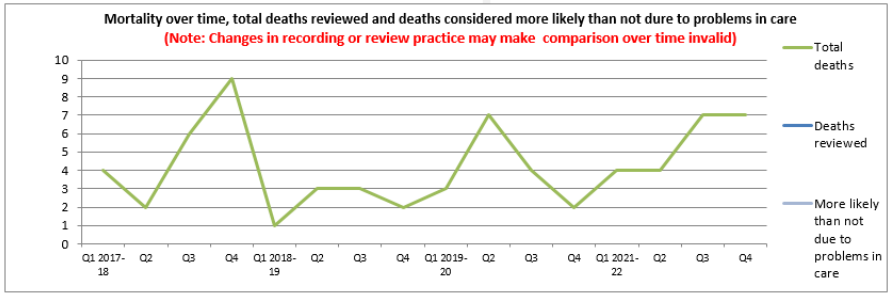
Summary of total number of learning disability deaths and total number reviewed under the LeDeR methodology. Please note that all LD deaths are reviewed using our standard approach, pending reviews as directed by the LeDeR process. The outcome of these local reviews is displayed in the second data grouping 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
0	3	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
7	7	0	1	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
22	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
0	3	0	3	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
7	7	7	7	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
22	16	22	16	0	0

Time Series: Start date 2017-18 Q1 — End date 2020-21 Q4



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2.1

Meeting Title:	**Trust Board**		
Date:	27 May 2021	**Agenda No**	**2.1.2**
Report Title:	Clinical Governance Review: Phase 3		
Lead Director/ Manager:	Robert Bleasdale, Chief Nurse and Director of Infection Prevention and Control Richard Jennings, Chief Medical Officer Stephen Jones, Chief Corporate Affairs Officer		
Report Author:	Alison Benincasa, Director Quality Governance and Compliance		
Presented for:	Assurance		
Executive Summary:	**Background** The findings of the 2018 external review of the Trust's cardiac surgery service by Professor Mike Bewick were critical of internal governance of cardiac surgical outcomes and the failure for this process to prompt remedial actions. The Trust took the decision to obtain an independent perspective of its governance arrangements, and undertake the work necessary to ensure the Board receives accurate, evidence-based, and timely information and assurance across the breadth of its areas of responsibility relating to the quality and safety of services provided. **Phase 1 and Phase 2 Clinical Governance Reviews** In 2019 the Trust commissioned two independent governance reviews: the phase 1 review looked at the Trust's approach to learning from deaths, and particularly the variability of Mortality and Morbidity meetings; and the phase 2 review looked at the capacity and resilience of the teams under the Chief Medical Officer (CMO), Chief Nurse and Director of Infection Prevention and Control (CNO) and clinical divisions, as well as the legal services function under the Chief Corporate Affairs Officer (CCAO). The reviews showed that there was a need for significant strengthening of clinical governance. The Trust developed an integrated action plan organised around the following four key improvement themes: 1. Right infrastructure (staffing, strategy and policy framework) 2. Right skills (training and leadership) 3. Right information (data and performance measures) 4. Right assurance (reporting and monitoring) **Phase 3 Clinical Governance Review** A third external review was commissioned in March 2020. At this time the Trust was in quality and financial special measures and following the first two reviews received advice from the NHSI Improvement Director to undertake the third review. The review was financially supported by Quality Special Measures money from NHSI. The phase 3 review was to: • review quality and safety monitoring and reporting, and assurance structure from the ward up to the Patient Safety and Quality Group, Quality and Safety Committee and Trust Board		

	• make evidence based recommendations for improvement based on good practice and learning from other high performing Trusts The progress of the phase 3 review was impacted by Covid-19 between March and June 2020 and between December 2020 and January 2021. The phase 3 report and its recommendations was received in the Trust in February 2021. This paper describes the: • methodology of the phase 3 review • improvements found since Phase 1 and Phase 2 reviews • levels of assurance on ward to Board reporting • those areas the reviewer found required substantial improvement to achieve substantial assurance where the Trust considers minimal improvement is required and the rationale for this • improvement recommendations for inclusion in the Trust's Clinical Governance Improvement Plan 2021/22 • link with Strategic Risk 3 on the Board Assurance Framework: We are unable to provide outstanding care as a result of weaknesses in our clinical governance		
Recommendation:	The Board is asked to: **1.** Note the summary findings of the third governance review and the improvement recommendations for inclusion in the Trust's Clinical Governance Improvement Plan 2021/22 **2.** Note the development of the Clinical Governance Improvement Programme 2021/22 and quarterly progress monitoring at Quality and Safety Committee		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	Safe, Effective, Caring and Well led		
Single Oversight Framework Theme:	N/A		
Implications			
Risk:	None		
Legal/Regulatory:	Enforcement undertakings applicable to SGUH Compliance with the Health & Social care Act 2008 (Regulations 2014) and CQC Registration Regulations		
Resources:	N/A		
Equality and Diversity:	No issues to consider		
Previously Considered by:	Trust Executive Group Quality and Safety Committee	**Date**	17.05.21 20.05.21
Appendices:	Appendix 1: Clinical Governance Review Phase 3 Summary Presentation		

2.1

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Trust Board

Clinical Governance Review: Phase 3

Summary presentation

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

Richard Jennings, Chief Medical Officer

Stephen Jones, Chief Corporate Affairs Officer

27 May 2021

Context

Background

The findings of the 2018 external review of its cardiac surgery service by Professor Mike Bewick were critical of internal governance of cardiac surgical outcomes and the failure for this process to prompt remedial actions. It is against this background that the Trust took the decision to achieve an independent perspective of its current governance arrangements, and undertake the work necessary to ensure the Trust Board receives accurate, evidence-based, and timely information and assurance across the breadth of its areas of responsibility relating to the quality and safety of services provided.

Phase 1 and Phase 2 Governance Reviews

In 2019 the Trust commissioned two independent governance reviews: the phase 1 review looked at the Trust's approach to learning from deaths, and particularly the variability of Mortality and Morbidity meetings; and the phase 2 review looked at the capacity and resilience of the teams under the Chief Medical Officer, Chief Nurse and clinical divisions, as well as the legal services function under the Chief Corporate Affairs Officer. The reviews showed that there was a need for significant strengthening of clinical governance. The Trust developed an integrated action plan and is in the process of implementing the recommendations, but progress was impacted by Covid-19 from March until June 2020 and from December 2020 to March 2021.

In October 2020 the Quality and Safety Committee received a report on the existing integrated action plan addressing the recommendations from the phase 1 and 2 reviews. The integrated action plan had been summarised to create an improvement programme approach and was organised around the following four key improvement themes, and received a further progress report in April 2021:

1. Right infrastructure (staffing, strategy and policy framework)
2. Right skills (training and leadership)
3. Right information (data and performance measures)
4. Right assurance (reporting and monitoring)

Phase 3 Governance Review

A third external review was commissioned in March 2020. At this time the Trust was in quality and financial special measures and following the first 2 reviews received advice from the NHSI Improvement Director to undertake this review. This was financially supported by Quality Special Measures money from NHSI. The phase 3 review was to review quality and safety monitoring and reporting, and assurance structure from the ward up to the Patient Safety and Quality Group (PSQG), Quality and Safety Committee (QSC) and Trust Board, and make evidence based recommendations for improvement based on good practice and learning from other high performing Trusts. The progress of this review was impacted by Covid-19 between March and June 2020 and between December 2020 and January 2021. The phase 3 report and its recommendations was received in the Trust in February 2021.

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Phase 3 Governance Review Terms of Reference (ToR)

The Executive Team agreed the ToR for the third governance review in February 2020 and for it to cover the following three aspects:

1. **The architecture of reporting:** Building on the work undertaken by the Chief Corporate Affairs Officer to map the groups that existed below Board Committee and Trust Executive Committee, the review examined the network of groups which reported into the Patient Safety and Quality Group (PSQG), Trust Executive Committee, now named Trust Management Group (TMG), and Quality and Safety Committee (QSC), their ToR and membership

2. **Information flows from ward to Board:** The review assessed how effectively information on the three components of quality were shared at PQSG, TMG, QSC and Board

3. **Coverage of key quality issues at PSQG and QSC (sub-Committee of the Board)**: The review examined the coverage of patient experience, patient safety and effectiveness over the period of the 2019/20 financial year.

In parallel, the Trust also undertook a review of risk management by its independent auditors, TIAA, with input from NHSI in establishing its scope and ToR. This independent audit report was received in the Trust in June 2020 and the management actions were completed in March 2021. A further risk management audit was undertaken by TiAA and the report was received in the Trust in March 2021. The agreed management actions are currently underway and progress will be reported through Risk and Assurance Group to TMG and the Trust's Audit Committee.

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Phase 3 Governance Review and Methodology

In addition to the ToR the reviewer was provided with an initial piece of work which aimed to identify the many committees and groups that contributed to the Trust's quality reporting architecture. This piece of work was completed by the Director of Quality Governance and Compliance and the NHSI Improvement Director in February 2020. The reviewer had access to and examined a number of documents, which included:

- Board and committee papers – corporate and divisional
- Board Assurance Framework (BAF)
- Corporate structures showing lines of reporting to executive and board committees
- ToR for all committees and groups within the ward to Board structure relating to quality
- Findings from the TiAA internal audit review of risk management for 2019/20

The approach and methodology were necessarily modified to take account of the need for remote working during the period of the pandemic, and therefore, a desktop approach was taken and the volume of meetings and observations was reduced from the original plan. The reviewer was however able to meet remotely with the 16 key stakeholders identified by the Trust and observed 6 meetings via Microsoft Teams outlined below, namely:

- Risk and Assurance Group: 2 September 2020
- Trust Management Group (weeks 2 and 4): 9 and 23 September 2020
- Patient Safety and Quality Group: 16 September 2020
- Quality and Safety Committee: 17 September 2020
- Trust Board: 24 September 2020

The key individuals were identified to try to enable the reviewer to obtain a corporate, divisional and care group perspective of the Trust's quality governance arrangements. In addition to meetings, the reviewer provided a self-assessment tool to each of the three divisions to complete in order to further inform the review. The tool is aligned to the key lines of enquiry (KLOEs) for acute healthcare providers, published by the care quality commission (CQC). This assisted divisions in highlighting any gaps in their governance oversight of their areas of responsibility and supported meetings with members of the divisional triumvirate. In total, in excess of 170 documents were provided and reviewed in order to inform the report.

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Improvement found since Phase 1 and Phase 2 Reviews

The following 12 points were highlighted where improvement was observed

These improvements align to CQC key line of enquiry Well- Led

1. The Trust had made significant investment in its staffing structure in the offices of the CNO and the CMO to strengthen governance capacity and capability

2. The Trust had developed its Board Assurance Framework (BAF) document to strengthen the identification and mapping of the main sources of assurance against its identified strategic risks. Included was a table of Covid-19: implications for the BAF. This was helpful to highlight to the Board the potential and real impact of the pandemic on the management of its strategic risks

3. The governance structure supporting the function of the Trust Executive and reporting to the Board had been further developed

4. There was evidence that the Board was steering the Trust towards building a different approach to quality improvement together with relevant QI work being undertaken

5. Work on improving staff culture was underway

6. The Trust had altered its risk management governance with the introduction of the Risk and Assurance Group, an executive-led forum, with the focus on overseeing and ensuring line of sight on key areas of risk

7. The effectiveness of risk management, compliance and assurance processes within the Trust had been strengthened.

8. The Clinical Effectiveness and Audit Group had re-commenced

9. The Divisional chairs chaired monthly divisional governance meetings, previously delegated to DDNG

10. The overall profile and accountability for quality oversight at divisional triumvirate level had been strengthened with each of the divisions having tested its governance and assurance arrangements across directorates and care groups

11. There was monthly reporting to the newly formed Trust Management Group (TMG) by divisions on all aspects of their performance, including quality

12. The was significant improvement in divisional governance meetings with more focus and organisation, flagging the right areas for discussion with appropriate challenge from medical and nursing staff

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excellent
kind
responsible
respectful

Key Findings: Levels of Assurance on ward to Board reporting

There were 36 areas of ward to board reporting considered in the review as outlined in the tables below:

- 10 areas were found to provide substantial assurance with ward to Board reporting
- 12 areas were found to require minimal improvements to the existing reporting lines to achieve the required level of assurance with ward to Board reporting
- 14 areas were found to require substantial improvement to achieve the required level of assurance with ward to Board reporting

However, given the internal improvement work the Trust has undertaken during the period of the review the Trust considers the 8 areas shown in amber text below do not require substantial improvement as found in the review. The 8 areas now require minimal improvement which mainly relates to time required for the improvements to embed in the Trust's revised governance and accountability framework. Therefore the Trust recognises 6 areas where substantial improvement is required to achieve the required level of assurance with ward to board reporting.

No improvement required, Substantial Assurance in place

10 areas required no improvement in reporting

- ✓ Quality and Safety Committee
- ✓ Trust Management Group
- ✓ Patient Safety and Quality Group
- ✓ Risk and Assurance Group
- ✓ Water Safety Monitoring
- ✓ Divisional reporting to PSQG
- ✓ Research Governance Committee
- ✓ Patient Group Directions approvals
- ✓ Clinical Safety Strategy Group (covid-19 response)
- ✓ Patient and Public Experience Group

Minimal improvement required to achieve Substantial Assurance

12 areas required minimal improvement in reporting

a. Joint safeguarding reporting to the PSQG
b. Infection control
c. Antimicrobial Stewardship
d. Radiation Safety
e. Nursing, Midwifery and AHP board
f. Falls prevention
g. Medicines optimisation
h. Mortality Monitoring Committee and Learning from Deaths
i. Human Tissue Authority
j. Learning Disability – work with partners
k. Executive Management Team
l. Divisional Governance Groups

Substantial improvement required to achieve Substantial Assurance

8 areas required minimal improvement in reporting (not substantial improvement as found in the review)

m. Patient Records and Consent
n. Implementation of NatSSIPs and LocSSIPs (surgical safety)
o. Medicines Governance – specifically drugs and therapeutics committee
p. Clinical Audit and Effectiveness
q. New and Novel Procedures
r. Responding to external safety alerts and other sources of learning
s. Mental Health Act compliance and deprivation of liberty/dementia and delirium
t. Effective pain assessment and management for people who have difficulty communicating

6 areas required substantial improvement in reporting

u. Deteriorating patient, including sepsis identification and response
v. Joint Safeguarding Committee and relationship with other areas including domestic violence and female genital mutilation
w. Equality regarding patient access and avoidance of discrimination when making care and treatment decisions
x. Resuscitation
y. Medical devices
z. Health promotion and prevention

Trust position on Substantial improvement required to achieve Substantial Assurance

The following 8 areas were considered by the external reviewer as requiring substantial improvement to achieve Substantial Assurance in ward to Board reporting. However, a number of improvements occurred within the 11 month duration of the phase 3 review and the rationale provided below indicates the Trust response as to why it is considered minimal attention being required to gain substantial assurance.

Ref	Minimal or no attention required to achieve Substantial Assurance	Rationale	Assurance Reporting to	Frequency
m.	Patient Records and Consent	Identified as MUST do in the CQC inspection report 2019. Targeted improvement plan and evidence of implementation discussed in March 2021 PSQG meeting. Included in the Clinical Audit Programme 2021/22	PSQG	Quarterly
n.	Implementation of NatSSIPs and LocSSIPs (surgical safety)	Included in the quality and safety performance reports and in the Trusts Clinical Audit Programme 2021/22. Update on Trust position to Quality and Safety Committee in April 2021	DGB PSQG	Monthly Quarterly
o.	Medicines Governance – specifically drugs and therapeutics committee	Medicines Optimisation Group (MOG) receives monthly governance reports from Medicine Safety Pharmacist. Medicines safety incidents highlighted to PSQG through divisional governance reports.	MOG PSQG QSC	Monthly Quarterly Bi-annual
p.	Clinical Audit and Effectiveness	Clinical Effectiveness and Audit Group (CEAG) established from August 2020 with agreed terms of reference approved at PSQG	PSQG	Quarterly
q.	New and Novel Procedures	CEAG terms of reference revised to include New and Novel Procedures in November 2020	CEAG PSQG	Quarterly Quarterly
r.	Responding to external safety alerts and other sources of learning	External Safety Alerts and responding actions and learning from the National Incident Reporting System discussed at the weekly Serious Incident declaration Meeting (SIDM) and reported to PSQG	SIDM PSQG	As required Quarterly
s.	Mental Health Act compliance and deprivation of liberty/dementia and delirium	Head of Mental Health now in post. Review of compliance underway with reporting line to Divisions and PSQG. Mental Health Clinical Outcome Review Programme a mandated audit included the Trust's Clinical Audit Programme 2021/22	DGB PSQG QSC	Monthly Monthly Monthly
		Frequency of reporting cycle increased together with requirement for reports to include triangulation with incidents, complaints and learning from deaths. Dementia audit is a mandated audit included the Trust's Clinical Audit Programme 2021/22 together with the local audit for Mental Capacity Act and DOLs compliance	PSQG	Bi-annual
t.	Effective pain assessment and management for people who have difficulty communicating	Included as part of the ward accreditation programme and the Clinical Audit Programme 2021/22	DGB PSQG	Monthly Quarterly

Recommendations for Improvement

The external reviewer identified a number of recommendations to improve and strengthen to reporting from ward to Board and the coverage of key quality issues for the Trust.

- 21 principle recommendations were made by the reviewer after distilling the various findings in the report (shown in black text);
- 27 additional observations/ recommendations were made by the reviewer throughout the report and are drawn out for the purpose of executive scrutiny for inclusion or not in the final set of agreed recommendations in the Governance Improvement Programme 2021/22 (shown in blue);
- 9 areas for improvement were recognised by the Trust prior to the receipt of the phase 3 report and have already been acted upon (shown in green).

(It should also be noted that some of the principal recommendations will be taken forward as business as usual (BAU) as part of the relevant executive portfolio and will not feature in the final Governance Improvement Plan).

The CMO/CNO and CCAO reviewed each of the recommendations detailed in the tables below for inclusion in the Trust's Clinical Governance Improvement Plan 2021/22. These recommendations were discussed and supported by the Trust Executive Group and Quality and Safety Committee meetings in May 2021.

Improvement Area	Link to assurance level ref (slide 7)	Principle recommendations in the report	Recommendation	Comments
1. Patient Safety and Quality Group	m-z	Address capacity challenges and alter structure of PSQG delegating responsibilities to a combined patient safety and clinical effectiveness group	Alternative approach suggested	PSQG to increase meeting frequency to manage its agenda and allow more capacity for discussion
	m-z	Address gaps in clear lines of governance and assurance in the groups reporting to PSQG	Accepted and completed	PSQG ToR revised to included the 6 identified areas of reporting, and this is reflected on the forward plan
	h	Increase the frequency of reporting for Learning Disabilities and include children with learning disabilities in this report	Accepted	Learning disability activity to be considered for inclusion in safeguarding report quarterly. Bi-annual stand alone LD report to PSQG on forward planned
	N/A	Review membership of PSQG in light of changes to quality governance roles in corporate team in particular medical representation	Complete	ToR have been updated to include Head of Patient Safety, Head of Risk, DCMO and inclusion of a patient representative
	N/A	Review terms of reference to ensure oversight of quality and clinical strategies	Complete	PSQG receives reports for quality and safety strategy and research strategy, which also report to QSC

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Recommendations for Improvement

Improvement Area	Link to assurance level ref (slide 7)	Principle recommendations in the report	Recommendation	Comments
2. Trust Management Group	No specific link	Ensure there is ownership of corporate risk register; capture this in the TMG terms of reference and forward plan	Alternative approach suggested	The Risk and Assurance Group holds this responsibility and provides a monthly written report to TMG currently. The ToR for TMG will be reviewed in June 2021 to ensure the monitoring of risk through TMG is reflected
	No specific link	Streamline the TMG terms of reference and include a generic reference to patient safety, patient experience, and clinical effectiveness and avoid duplication with Operational Management Group	Accepted	The ToR for TMG, OMG, RAG and PSQG are scheduled for review in June 2021. They will be updated to reflect reference to patient safety, experience and effectiveness.
	No specific link	The quality of reporting from sub-groups needs strengthening, as does the quality of the challenge from members, particularly with regard to the PSQG	Accepted	The CCAO will produce a guide/framework to assist standardising reporting expectations from the subgroups reporting to TMG
3. Quality and Safety Committee	No specific link	Chair to work with CMO and CNO to link the QSC forward plan with assurance expectations of Board Assurance Framework	Accepted	The QSC forward plan for 2021/22 includes deep dives into each of the strategic risks.
	No specific link	Reorganise the agenda to start with the BAF to ensure members have it in mind throughout their discussions	Accepted	This recommendation will be implemented from the next QSC meeting (June 2021)
	p, r	Strengthen the frequency and content of reporting on the forward work plan e.g. clinical audit plan (which is presented annually), and include NICE compliance and patient safety alerts within the effectiveness section	Alternative approach suggested	Monitoring of the Clinical Audit Programme will be through the re-established Clinical Effectiveness and Audit Group (CEAG) chaired by the DCMO. CEAG reports into PSQG on a quarterly basis and progress included in the PSQG report to QSC. There will also be a bi-annual audit report to QSC detailing activity and key findings NICE Compliance is monitored on a monthly basis at PSQG and the position reported in the PSQG report to QSC Patient Safety Alerts are reported to PSQG and the position reported in the PSQG report to QSC, with any of concern specifically being escalated
	N/A	Streamline and strengthen the terms of reference by using the recognised headings of patient safety, patient experience and clinical effectiveness	Complete	
	N/A	Consider raising profile of maternity service and children service within board quality governance arrangements	Complete	

Recommendations for Improvement

Improvement Area	Assurance level link (slide 7)	Principle recommendations in the report	Recommendation	Comments
4. Reports and Committee papers	c, d, i, m, n, r, s, t,	Strengthen Integrated Quality and Performance Report, adding links to Board Assurance Framework (and national frameworks or standards)	Accepted	The IQPR will be reviewed by the end of Q2 to ensure appropriate metrics are reflected and aligned also to BAF
	No specific link	Develop a generic quality dashboard based on metrics across the three quality domains	Alternative approach suggested	The IQPR and existing internal metrics will be reviewed by the end of Q2 to ensure they are accurately reflected and aligned to patient safety, experience and effectiveness
	No specific link	Avoid duplication of reports to different governance fora where the requirement differs in terms of detail and understanding	Alternative approach suggested	The CCAO will produce a guide/framework to assist standardising reporting expectations, which details writing for assurance
	No specific link	Avoid the overuse of data in quality reporting focusing on intelligence from examining themes and trends and information from more than one source to highlight areas needing support and potential intervention to improve	Accepted	Thematic reviews have been included in the forward plan of QSC, such as Serious Incident and Patient Experience
	No specific link	Reduce quantity of papers presented at key meetings	Alternative approach suggested	The CCAO will produce a guide/framework to assist standardising reporting expectations, which details writing for assurance. This will help to ensure reports are clear and concise, with key issues on the cover sheet
	No specific link	Ensure papers presented at key meetings arrive in good time	Accepted	This is part of BAU, but it is recognised that focus is required to ensure timely circulation. This will be assisted through circulation of forward plans
	No specific link	Provide access to Diligent to DDNGs	Accepted	This is part of BAU and will be addressed
	No specific link	Refresh the framework and content of reporting to achieve a standardised format that is in line with the board integrated quality and performance report to provide consistency in the data capture and associated messaging. If adopted, this approach should be replicated at directorate, divisional, and corporate levels, including reporting to the TMG's performance review	Alternative approach suggested	The deputies group are reviewing the information provided and reporting frameworks at directorate and divisional level. This will need to be aligned to the patient first work for the Trust this year
	l	Divisional Governance Reports to include learning from deaths, serious incidents and complaints	Accepted	Divisional quarterly performance reporting template to be revised by June 2021
	h	The section on preventing future deaths (PFD) in the Serious Incidents Report to contain details of in-year PFD reports	Accepted	To commence from the next report – June 2021
	No specific link	Ensure reports are prepared in a way that takes account of the purpose and the audience receiving the information. For example, members of the QSC are not necessarily NHS professionals and as such, need to receive information in a way that assists them in carrying out their role of scrutiny and challenge	Alternative approach suggested	The CCAO will produce a guide/framework to assist standardising reporting expectations, which details writing for assurance. This will help to ensure reports are clear and concise, with key issues on the cover sheet
	N/A	Improve the Quality of the report to TMG and QSC	Complete	

Recommendations for Improvement

Improvement Area	Link to assurance level ref (slide 7)	Principle recommendations in the report	Recommendation	Comments
5. Risk management and board assurance	No specific link	Continue to develop the Board Assurance Framework	Accepted	This is part of BAU and is included as part of the annual review of the BAF, led by the CCAO
	No specific link	Introduce a risk management strategy and procedure that takes account of areas for improvement; including a revised risk matrix	Accepted	Included in the management actions in response to the internal audit of Risk Management undertaken by TiAA
	No specific link	Ensure that the risk management training needs of all staff and the board are clearly defined and that there is sufficient capacity and capability to deliver training at the various levels	Accepted	Included in the management actions in response to the internal audit of Risk Management undertaken by TiAA
	No specific link	Ensure training needs of the Board are understood and supported with reference to risk management and board assurance	Accepted	This will be covered as part of the Board development programme in 2021/22
	No specific link	Ensure regular review of risks on the risk register	Accepted	This was included in the management actions in response to the internal audit of Risk Management undertaken by TiAA
	No specific link	Review Datix system to ensure learning from serious incidents and complaints, outcomes from clinical and third-party litigation and inquests is aggregated to highlight areas of risk that may not otherwise have attracted attention	Accepted	This action will be addressed through the re-introduction of the Complaints, Litigation, Inquests, PALS & Incident
	No specific link	TMG to consider escalation/de-escalation of risks to/from the corporate risk register. This is seen as a missed opportunity and one which could support senior divisional nurses having a role on the group given their leadership of risk management within their divisions	Accepted	The Risk and Assurance Group holds this responsibility and provides a written report to TMG. The guide for reports to TMG will include the expectation to include any suggested changes to the corporate risk register for TMG to endorse
	No specific link	TMG needs to ensure the relationship between RAG and TMG in relation to accountability for divisional and corporate risk is synchronised	Alternative approach suggested	The ToR of both groups will be reviewed to ensure that they are aligned to the processes as reflected in the Risk Management Policy
	N/A	Ensure that risk ownership and escalation is clear to all those with a key responsibility for managing risk as part of their role, and that risk is able to move dynamically through the hierarchy of risk registers	Complete	
	N/A	Ensure RMCG sub-group has an operational focus, including scrutiny of the management of divisional and directorate risks and their recording on risk registers	Complete	

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Recommendations for Improvement

Improvement Area	Link to assurance level ref (slide 7)	Principle recommendations in the report	Recommendation	Comments
6. Quality Improvement	No specific link	Consolidate and communicate Trust's approach to continuous quality improvement, reflecting Western Sussex way	Accepted	The development of the Patient First initiative will be considered by the executive team to ensure maximum engagement and delivery supported by Sussex University Hospitals
	No specific link	Q&S Strategy: recommended that a communications exercise is undertaken to ensure that at divisional, directorate and care group level, clinical staff are engaged in the strategic direction of the Trust in terms of its quality improvement aspirations and key milestones, ahead of the start of the process of preparing for the 2020/21 published Quality Account	Alternative approach suggested	The priorities for 2021/22 will be focused and communicated with the divisions. It is anticipated that the development of the Patient First approach will supersede this
	I	Include the spread of quality improvement initiatives referenced in the improvement system maturity matrix as reported to QSC in September 2020 in divisional performance reporting	Accepted	Quality Improvement initiatives will be included as part of the divisional reports to PSQG
7. Serious Incidents	No specific link	Provide serious incident investigation training, including human factors	BAU	In progress led by the Risk Manager and the Simulation Team
	No specific link	Ensure proactive engagement of patients and families; link with learning from deaths and duty of candour; and review and approve the approach to duty of candour	BAU	In place through the Medical Examiners Office, Lead Clinicians and Divisional Governance Managers
	h	Re-introduce reporting of themes and trends and sharing from analysis of contributory factors, and reinstate opportunities for peer discussion and learning with particular reference to learning from serious incidents and deaths	BAU	In progress led by the DCMO
	TBC	Introduce a reporting approach which triangulates with other sources to add value and expand learning	BAU	In place as part of the serious incident declaration panel which was extended to include DDNGs (as per Phase 2 governance review recommendation) and the re-introduction of the DCMO led reporting of themes and trends as outlined above
8. Learning from deaths and the deteriorating patient	h, u, x,	Integrate work streams of learning from deaths, deteriorating patient and resuscitation to be led by a deputy chief medical officer	Accepted	Following the implementation of the phase 1 and 2 governance review and recruitment to the 3 DCMO posts, one DCMO will be allocated the lead for these aspects
	u,	Add to the deteriorating patient, a focus on the identification, diagnosis and management of sepsis in children, young people in a medical emergency to reduce avoidable harm and death	Accepted	The named DCMO will review current structure to ensure integration
	h	Identify non-executive director responsible for Learning from Deaths	Accepted	Non-executive director has been appointed to this position
	N/A	Update Learning from Deaths Policy and Strengthen Mortality Monitoring Meetings	Complete	

Recommendations for Improvement

Improvement Area	Link to assurance level ref (slide 7)	Principle recommendations in the report	Recommendation	Comments
9. Overall governance and assurance	No specific link	Avoid "over engineering" governance arrangements. Focus on deeper understanding of achievements made on behalf of patients rather than acquisition of evidence	Accepted	It is anticipated that this will be achieved through the implementation of each of the governance reviews and the implementation of the Patient First approach
	No specific link	It was noted that the diversity and inclusion group reports to the board via the people management group. Although outside the scope of the review, consider whether board assurance in relation to the equalities act and how it impacts on patient access, patient information, patient care, treatments and outcomes is fully considered in the information it receives.	Accepted	Whilst the Trust has a diversity and Inclusion lead for staff, it is noted this does not cover patients. There is a requirement to deliver the equalities duty which covers patient engagement, and review of service provision. A review of the internal resource should take place with opportunities for collaboration with external organisations explored
	No specific link	Consider a seat at the board table the midwifery division given the breadth and complexity of the division	Alternative approach suggested	The CNO holds the executive responsibility for Maternity services and is professionally the lead for midwives. The frequency of reporting for Maternity services has been increased to PSQG and QSC where the Director of Midwifery would attend to present the report. It should be noted there is also an Executive and Non-executive with the role of Maternity Safety Champion on the Board
	l	Rename Divisional Governance Boards, for example divisional management meeting	Accepted	
	l	Divisional self-assessments should be kept up to date and that any gaps highlighted are resolved.	Accepted	Self assessments against the KLOE will be included as part of the quarterly reports to PSQG and they also feature on the QSC plan
	No specific link	The role of the audit committee may wish to consider how the BAF assists them in their consideration of the organisation's 'audit needs' and help drive the annual audit plan.	Accepted	The internal audit proposals are aligned to the Trusts risks in the BAF. The audit plan is considered at QSC and subgroups of TMG for any additions
	n	Clinical governance processes must include the requirement for regular audit of compliance with all LocSSIPs.	Accepted	Included in the Trust audit plan with quarterly reporting. Also part of deep dive on QSC forward plan
	g, j, o,	Board: remove the following reports from its plan: quality improvement and transformation report, complaints, medicines management, national inpatient survey, learning disability service, seven-day services and leave to QSC scrutiny		

Recommendations for Improvement

Improvement Area	Link to assurance level ref (slide 7)	Principle recommendations in the report	Recommendation	Comments
9. Overall governance and assurance	g, j, o,	Board: remove the following reports from its plan: quality improvement and transformation report, complaints, medicines management, national inpatient survey, learning disability service, seven-day services and leave to QSC scrutiny	Accepted	Included in the Trust audit plan with quarterly reporting. Also part of deep dive on QSC forward plan
			Accepted	This has been addressed through the November 2020 approach to the Board and sub-committee ways of working
	No specific link	Board: receive an integrated assurance report from the CMO and CNO at each meeting alongside the integrated quality and performance report (IQPR) to summarise and triangulate the various assurance information received during the preceding month for the board, augmenting the IQPR, and linking assurance to that described in the BAF against the three principal quality risks	Alternative approach suggested	Review the sub-committee report to the board to ensure the links to Patient Safety, Experience and Outcomes are clearly articulated
	p, s	Board: add the following annual reports to its plan: information governance and SIRO report, health, safety and security annual report, mental health law report (this could combine, the mental capacity and mental, health acts, as well as deprivation of liberty), clinical audit work plan and annual report	Alternative approach suggested	Health and Safety report has been included in QSC plan, and the frequency of the audit report increased. In addition a Mental Health and complex decisions group has been established that will report to PSQG. Through November 2020 way of working these will then report to the Board through the sub-committees
	N/A	Update the Trust's structure of board committees and groups to reflect the current position, particularly the introduction of the people management and operational management groups	Complete	

Governance Improvement Programme

Impact on Strategic Risk 2 on the BAF: We are unable to provide outstanding care as a result of weaknesses in our clinical governance

The table below outlines the summary position as of quarter 4 2020/21 for Strategic Risk 2 on the BAF with reference to the current risk score, proposed assurance rating and the progress made in year in mitigating the risk.

The impact of the delivery of agreed governance improvement actions in 2021/22 will see the assurance rating move from Partial to Reasonable and the achievement of the target risk score of 8 (4x2).

SR2 position at Q4 2020/21: Summary		
Proposed risk score at Q4:	**12** (4 consequence x 3 likelihood)	The current risk score for SR2 of 12 continues to reflect the level of risk around our clinical governance in the context of the continuing implementation of the phase 1 and 2 clinical governance reviews and the recent receipt of the phase 3 clinical governance review. Last reviewed by Patient Safety and Quality Group on 21 April 2021.
Year end target risk score	**8** (4 consequence x 2 likelihood)	The target risk score at year-end has not been met. This is largely due to the impact of Covid-19 operational pressures on the implementation of the actions arising from the phase 1 and 2 clinical governance reviews and the delays in considering the findings of the phase 3 review.
Proposed assurance rating at Q4:	**Partial** ⟷	We have considered whether the assurance rating can be upgraded in the light of the actions taken to date to address gaps in controls. However, there has been slippage in the original timetable for a number of actions to address gaps, including the following actions: Develop and implement MCA level 3 training module; The update Cerner OrderComms catalogue; Finalising the eDischarge form to be included onto iClip; Fully recruit to the new governance posts, albeit only one post out of 14 remaining; Delay in receipt of the phase 3 external governance report and the development of the associated improvement actions. It will be possible to upgrade the assurance rating when these actions are completed.
Change from last month:	**No change**	No changes are proposed to the overall risk score or to the assurance rating at Q4. Risk score: Unchanged due to ongoing actions to mitigate risk and address gaps. Assurance rating: Unchanged due to slippage in actions to address gaps
SR2 In year-risk mitigation – actions taken to address gaps in control and assurance		
In year progress in mitigating risks	**Gaps in assurance and control closed in-year to date**	During 2020/21, this risk has been mitigated by the completion of a number of identified gaps in control and assurance: ➢ MCA Steering Group membership established ➢ The electronic template for Capacity Assessment and best interest has been approved and launched in November 2020 supported by appropriate training. ➢ Appointment to key roles within the governance to drive learning ➢ Full implementation of the Cardiac surgery action plan

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2.1

Meeting Title:	**Trust Board**		
Date:	27 May 2021	**Agenda No**	**2.1.3**
Report Title:	**Cardiac Surgery Report – Quarter 4 2020/21**		
Lead Director	Richard Jennings, Chief Medical Officer		
Report Author(s):	Steve Livesey, Associate Medical Director for Cardiac Surgery Mark O'Donnell, Senior Nurse for Quality & Governance – CVT & CCAG Kelly Davies, Head of Nursing – Cardiovascular Services		
Presented for:	Review and Assurance		
Executive Summary	Following the publication of the Independent Mortality Panel's Review and Independent Scrutiny Panel's Review on 26th March 2020, Trust Board reviewed the comprehensive sources of assurance that the Cardiac Surgery Service at St George's is safe, and the Trust Board also reviewed the assurance that all the recommendations of these reports had been or were being acted upon. Based on this assurance around safety and learning it was agreed at the Trust Board on 30th April 2020 that for the next twelve months cardiac surgery reports be made quarterly to the Quality and Safety Committee (QSC), and then to Trust Board. The Trust Board received a report for Quarter 3 (Q3) of 2020/21 on 28th January 2021. This report is the report for Q4 2020/21, and the quality and safety assurances provided in this report were considered at the Quality and Safety Committee on 20th May 2021. It is proposed that the Quality and Safety Committee will continue to receive quarterly reports on the Cardiac Surgery Service for the next year, and that any material information will be highlighted to the Trust Board through the Quality and Safety Committee, or through other routes, if and as necessary. This paper provides Trust Board with an update on the following: 1 The quality and safety of the service in Q4 2020/21 (01 January 2021 – 31 March 2021); 2 The actions that have been taken since the Q3 paper to the Trust Board, which was received in January 2021, to address the recommendations of the Independent Mortality Review and the Independent Scrutiny Panel; 3 The communication and support being offered to the bereaved families of deceased patients; 4 The latest cardiac surgery risk register - there have been no changes to this risk register since the Q3 update received by Trust Board in January 2021; 5 An update on Coroner's inquests; 6 The financial impact of the issues relating to cardiac surgery since the financial year 2017/18;		

	7 An update on the arrangements at St George's for cardiac surgery in the light of the Covid-19 pandemic; 8 An update on the cardiac surgery networking discussions in South London; 9 The arrangements in place for continuing internal and external assurance and oversight of the St George's cardiac surgery service; 10 Agreement to lift the restrictions on planned operations.
Recommendation:	The Board is asked to note and discuss the updated information on safety assurance and other on-going actions.
Supports	
CQC Theme:	Safe, Well Led
Single Oversight Framework:	Quality of Care Leadership and Improvement Capability
Implications	
Appendices:	

Cardiac Surgery Trust Board Report – Quarter 4 2020/21

1.0 Quality and Safety

Following the publication of the reports of the Independent Mortality Review Panel and the Independent Scrutiny Panel on 26th March 2020, the Trust Board reviewed the comprehensive sources of assurance that the Cardiac Surgery Service at St George's is safe, and the Trust Board also reviewed the assurance that all the recommendations of these two reports had been, or were being, acted upon. This section provides Trust Board with an update on the sources of assurance that the Cardiac Surgery Service has remained safe through into Quarter 4 (Q4) of 2020/21. This assurance is based on:

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

There was one Serious Incident declared in Q4.

1.1 Patient safety outcomes – Mortality

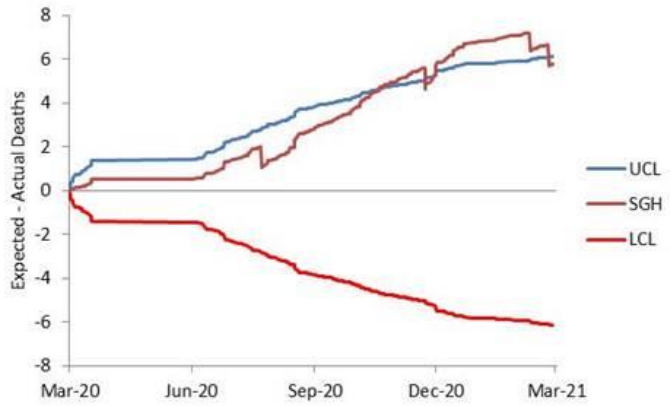
Cardiac Surgery continued to offer its normal elective and non-elective service throughout much of Q3 until the Covid-19 pandemic precluded this; elective cardiac surgery stopped in Q3 on 15th December 2020 and restarted in Q4 on 4th February 2021.

The Cardiac Surgery Service monitors mortality and the updated data, which is presented below, is an important part of the assurance that the service remains safe. In Q4 76 patients were operated on, with 6 deaths (7.9%). In the twelve months April 2020 – March 2021, 346 patents were operated with a mortality rate of 2.31%, which is well within national norms.

1.2 VLAD plots

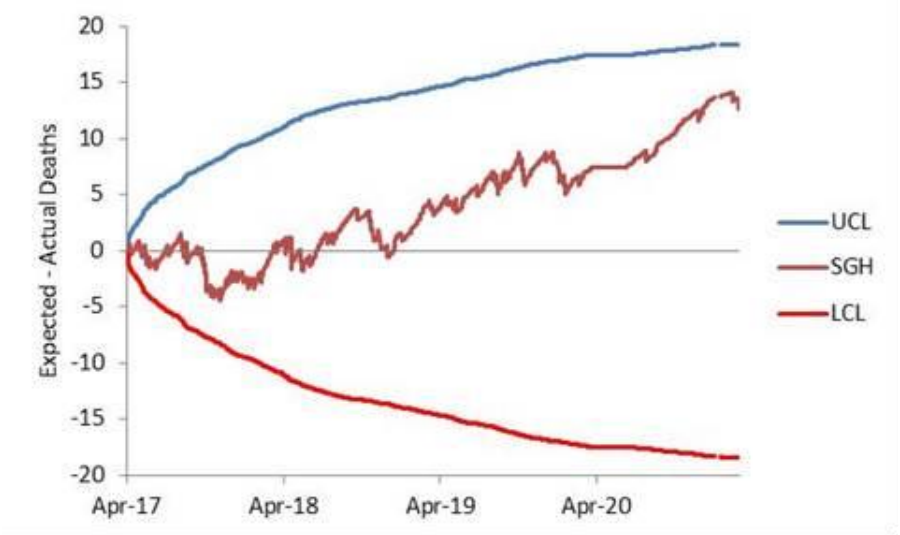
A VLAD plot showing performance the period March 2020 – March 2021 is displayed below. This shows satisfactory performance throughout the year (the flat period in the beginning of the plot corresponds to the time period during which there was no cardiac surgery performed at St George's during the first Covid-19 wave).

Graph 1: VLAD plot for 2020 - 2021



Graph 2: VLAD plot April 2017 – March 2021

The VLAD plot below shows continued improvement since April 2017 (when the current method of risk assessment using EuroSCORE II began).



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

1.3 Post-operative complications in Q4 2020/21

The Trust routinely tracks patient safety outcomes in terms of the significant commonly recognised complications of cardiac surgery (return to return to theatre, stroke, new haemofiltration and wound infection). In addition, the Trust tracks the rate of healthcare acquired infections (HCAIs). The updated data is another important source of assurance that the Cardiac Surgery Service remains safe.

In Q4 three patients underwent resternotomies. All cases of resternotomies are discussed at the Cardiac Surgery Morbidity, Mortality & Governance Meetings.

In Q4, there were no post-operative strokes.

In Q4 there were four patients who required new post-operative haemofiltration. All cases of haemofiltration are discussed at the Cardiac Surgery Morbidity, Mortality & Governance Meeting.

There was one deep sternal wound infection in Q4, which related to a patient who underwent surgery in December 2020. The patient was discharged home well, but was readmitted two weeks later with signs of a wound infection. The patient underwent further treatment and was discharged after six weeks and remains well on out-patient review.

1.4 Serious Incidents (SIs) that occurred, were declared or closed in Q4 2020/21

There was one new SI declared in Q4 (DW149877; StEIS 2021/5872) following discussion at the Trust's Serious Incident Declaration Meeting (SIDM). The investigation is on-going at the present time and the outcome and learning will be reported to Quality and Safety Committee.

There were no Serious Incidents still under investigation from Q3 that were closed in Q4.

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

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

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

Recommendation 3

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

The Trust engaged Ms Gill Bellord, Independent HR Consultant, to undertake the third and final phase of work focussing on team-working (both internal and external) within the Cardiac Surgery Service. During the conduct of this piece of work, Ms Bellord conducted interviews with Cardiology, Intensive Care and all of the Cardiac Surgery Surgeons; Ms Bellord noted that all the clinicians engaged positively with these interviews.

Ms Bellord has now concluded this piece of work and the completed report was received by the Executive on 7th April 2021.

In the course of Ms Bellord's work with the Cardiac Surgery team, the clinicians reaffirmed their commitment to the original mediation agreement produced by Problem Resolution in December 2017. This mediation agreement will be signed on behalf of the Trust by the Chief People Officer (CPO) and the CPO's signature will signify the Trust's commitment to the monitoring of this agreement. The mediation agreement itself specifies the detail and frequency of monitoring, which will be overseen at Divisional level.

Recommendation 10

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

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

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

After the Trust wrote to all bereaved families to communicate the findings of the Independent Mortality Review Panel with regard to the care given to their deceased relatives (just before the publication of the report), a total of 42 families asked for meetings with the trust to discuss this further. Six of these meetings took place before the report publication date (26th March 2020). Fourteen meetings were held in Quarters 1 – 3 of 2020/21 (eight in Q1, one in Q2 and five in Q3),

In terms of outstanding meetings, nine families expressed a wish to wait for a face-to-face meeting once Covid-19 restrictions are lifted, five are still deciding how they wish to proceed, seven made no reply to a further enquiry on how they wished to proceed and two decided they no longer wished to proceed with any

meeting. The Trust has now made the decision that face-to-face meetings can resume, and families are being contacted to make arrangements for these to go ahead.

4.0 Risk register

The table below shows the cardiac surgery risk register. There have been no changes to this risk register since the Q3 report received by Trust Board in January 2021.

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

Ref	Opened	Title	Risk level (current)	Rating (current)	Reasoning for change
CVT-1660	12/09/2018	Risk to patient safety within cardiac surgery	Moderate	8	This risk was reduced from 'high' to 'moderate' in June 2020. This change was made because of the collective assurance provided by the outcome data, including mortality, regarding safety within the Cardiac Surgery Service.
CVT-1642	29/08/2018	Reputational Impact of service challenges within Cardiac Surgery unit at St Georges	Moderate	9	This was reduced from 'high' in October 2020 by the Divisional Triumvirate as there was no evidence of a deteriorating perception of the unit.
CVT-1661	12/09/2018	Strategic risk of loss of cardiac surgery service	Moderate	8	This risk was previously closed by the Directorate in April 2020 following the publication of the Independent Mortality Review's report in March 2020, as the Report did not recommend any discontinuation of the service. However, there is a clear pan-London plan for cardiac surgery, and networking discussions continue in South-London, and so this risk is now rated as 'moderate'.
CVT-1608	23/07/2018	Loss of income within the Cardiac Surgery service	Low	4	This risk has been reduced from 'moderate' to 'low' in June 2020. Following review from the divisional triumvirate the risk was reduced to 'low' as cardiac surgery income has been appropriately factored into the trust's projected financial performance for 2020/21.
CVT-2219	02/02/2021	Cardiac pacing boxes at end of life	Moderate	9	New pacing boxes have been ordered.

5.0 Update on Coroner's inquests

Prior to the publication of the Independent Mortality Review (March 2020), 20 cardiac surgery cases had already been through the inquest process. Since the publication of the Review, a further 16 cases have been through the inquest process and have been concluded (including 14 cases in which the Structured Judgement Review undertaken by the Independent Mortality Review Panel gave a "Contribution to Death" (CtD) score of between 1 and 3, indicating that in the view of the Panel that problems in care definitely or probably contributed to the death). Another 7 cases (all with CtD scores of between 1 and 3) have been scheduled between 19th May 2021 and 8th September 2021. Additionally, the Coroner has requested reports from clinicians on a further 17 cases - these will be scheduled for inquests in due course.

In summary, of the 67 cases in which the Independent Mortality Review Panel attached a CtD score of between 1 and 3, 20 cases have concluded. 7 cases have got an inquest date. Another 17 cases will be scheduled in due course. The Coroner may open investigations into the remaining 23, given that she has indicated that she may have to open investigations and potentially proceed with inquests for all cases where the CtD score was 1 – 3. It is possible that there may be further inquests into other cases in addition to these.

6.0 Financial impact of issues related to the Cardiac Surgery Service since the financial year 2017/18

The combined legal, external team intervention, and Human Resources costs incurred by the Trust from May 2017 to the present is £936,130 which includes externally facilitated mediation in December 2017, the commissioning of the independent report on the cardiac surgery service by Professor Bewick, a report by an external HR consultant, external HR support to employee relations cases, and external support from an organisational development consultant during the period 2019 to 2021. Of this, the total costs directly relating to employee relations legal processes was £795,565, which were incurred over a three year period between 2018/19 and 2020/21.

7.0 Developing changes in the Trust's Cardiac Surgery service in response to successive waves of Covid-19

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

The Trust re-opened to elective cardiac surgery in Q4 on 4th February 2021. The Trust currently has seven operating lists per week, taking both elective and non-elective work.

8.0 Developments towards networking cardiac surgery in South London

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

The South London Cardiac Provider Collaborative is now focusing on elective recovery after the second wave of Covid-19.

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

The Single Item Quality Surveillance meetings, convened by NHS London, continue to oversee the quality and safety of St George's Cardiac Surgery Service, for the time-being. The group last met on 7th April 2021. The next meeting will be held in July 2021.

10.0 Agreement to lift restrictions on planned operations

In September 2018 restrictions were introduced on the level of risk and types of operations that could be performed at St George's.

The St George's Cardiac Services Single Item Quality Surveillance Group was held on 7th April 2021 and following a full and careful discussion, the Trust's proposal to lift the restrictions was accepted. The approved proposal has now been shared with the Trust's cardiac surgeons, and a meeting has been held with the cardiac surgeons on 18th May 2021 with the CMO and Deputy CMO for Cardiac Surgery to discuss the operational details. The aim is to move to the unrestricted working by the beginning of June 2021.

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St George's University Hospitals NHS Foundation Trust

2.2

Meeting Title:	**Trust Board**		
Date:	27 May 2021	**Agenda No**	**2.2**
Report Title:	Integrated Quality & Performance Report		
Lead Director/ Manager:	James Friend, Chief Transformation Officer		
Report Author:	Kaye Glover, Emma Hedges, Mable Wu		
Presented for:	Assure		
Executive Summary:	This report consolidates the latest management information and improvement actions across our productivity, patient access and performance for the month of April 2021. All metrics have been rebased to April 2019. **Our Finance & Productivity** Outpatient activity in April 2021, excluding COVID activity, is expected to reach the same level as April 2019 once coding and cashing up is complete. Outpatient activity is focussed on treating long-waiting patients with the aim of eliminating the backlog by the end of July. Face-to-face activity will increase as a proportion of overall activity and services will review and refresh clinic their templates to ensure patients receive the right information for their attendance. Daycase and Elective activity was 79.9% of the activity carried out in April 2019 and is expected to reach the submitted 80% activity trajectory once coding is complete. All theatres are open with 4 additional modular theatres to open at the Queen Mary Hospital (QMH) site on 14 June. ITU have introduced a new booking process to ensure sufficient capacity is in place, to minimise cancellation and maximise theatre flow. Length of Stay for non-elective admissions continues above the upper control limit at 5.9 days. Flow remains a priority with the Trust continuing its 7 day discharge service and challenging directorates to expedite patients to the most appropriate care setting. **Our Patient Perspective** All life support training sessions have targeted actions plans to improve uptake. Specifically, for ITU/CTITU and NNU will receive targeted training in Advanced Life Support; Intermediate Life Support will start having weekly training session and Resus champions are assisting Basic Life Support training assessments and facilitating sessions. In April, there were no Never Events and no Serious Incidents reported. The rate of Category 3 pressure ulcers per 1,000 bed days returned to within control limits. In month, there were two Hospital Onset, Healthcare Acquired COVID-19 nosocomial infections. Three services achieved their targets of having “Good” or “Very Good” overall ratings as measured by the Friends and Family Test (FFT) – Inpatients, Community and Maternity Postnatal. The Emergency Department is investigating their fall in performance and response rate. Outpatients is deploying floor walkers to increase their response rates and will be taking deep dives into identified issues. In maternity, over 35% of women were booked onto a Continuity of Care. For Black and Asian women, 38% were booked onto a Continuity of Care pathway. The aim in 2021/22 is to have over 50% of women booked onto a Continuity of		

	Care pathway. Progress continues to implement immediate and essential actions recommend by the Ockenden Report. **Our Process Perspective** The Trust met the Four Hour Operating Standard performance with 95.2% of patients being admitted, discharged or transferred within four hours of their arrival. Attendance numbers continue to climb and are returning to pre-COVID levels. The team is actively working towards ensuring that patients are treated in the most appropriate settings with emphasis on redirecting appropriate patients to the Enhanced Primary Care Hub at Queen Mary's Hospital. Furthermore, they are working with local Mental Health providers to address the needs of adult and paediatric patients who need urgent care but with mental health requirements. For March, the Trust met the 14-day standard for Cancer, the 31-Day Second or subsequent Treatment (Drug), and the 31-Day Second or subsequent Treatment (Surgery). Cancer services have access to increased theatre capacity to treat its patients. Breast services remains a challenge with high volumes and a recovery plan is in place developed and supported by the Care Group lead, the Chief Operating Officer and the Divisional Director of Operations. The Trust reported a continued improvement in performance against the six-week diagnostic standard with a performance of 8.5% compared to 10.2% in March. London performance has been added against all modalities for benchmarking purposes. Endoscopy services have increased their capacity and are now operating from 9 rooms sited across St. George's estates. Audiology patients at QMH will be transferred to Kingston Foundation Trust on 15 May 2021. Echocardiography are developing and refining a demand and capacity model working with NHS Improvement/England in order to effectively manage resources and plan accordingly. March 2021's RTT performance was 69.3% against a National target of 92% with 2,644 patients waiting longer than 52 weeks. Additional theatre capacity along with improved outpatient processes are key actions being undertake to reduce the backlog. **Our Workforce Perspective** Trust sickness absence rate was 3.4% compared to 3.1% from the previous month. Appraisal rates for non-medical staff were at 75.3% which is the highest rate since April 2019. Appraisal rates for medical staff has returned to common cause variation with 75.3% completed Formal Employee Relation cases have risen from 47 cases to 52 cases. Timely completion of cases remains a focus which is also supported by weekly Employee Relations team sessions where consistency and lessons learnt are reviewed and discussed.
Recommendation:	The Committee is requested to note the report
Committee Assurance:	The Committee is also asked that in considering contents of this report, its supporting documents and the discussion at the meeting which of the following assurance rating it would provide to the Trust Board. • **Substantial Assurance:** The report and discussions assured the Committee that there are robust systems of internal controls operating effectively to ensure that quality and safety risks are managed to deliver high quality services and care to patients.

	• **Reasonable Assurance:** The report and discussions assured the Committee that the system of internal controls is generally adequate and operating effectively but some improvements are required to ensure that quality and safety risks are managed to deliver high quality services and care to patients. • **Limited Assurance:** The report and discussions supported the Committee's conclusion that that the system of internal controls is generally inadequate or not operating effectively and significant improvements were required to ensure that the quality and safety risks are managed effectively to improve the position and ensure that high quality services and care is provided to patients. • **No Assurance:** The report and discussions led the Committee to conclude that there was a fundamental breakdown or absence of core internal controls and systems to enable the Trust to deliver high quality services and care to its patients.		
Supports			
Trust Strategic Objective:	Treat the Patient Treat the Person Right Care Right Place Right Time		
CQC Theme:	Safe, Caring, Responsive, Effective, Well Led		
Single Oversight Framework Theme:			
Implications			
Risk:	NHS Constitutional Access Standards are not being consistently delivered and risk remains that planned improvement actions fail to have sustained impact		
Legal/Regulatory:			
Resources:	Clinical and operational resources are actively prioritised to maximise quality and performance		
Equality and Diversity:			
Previously Considered by:	Trust Executive Committee Finance & Investment Committee Quality & Safety Committee	**Date**	17 May 21 20 May 21 20 May 21
Appendices:			

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St George's University Hospitals NHS Foundation Trust

2.2

Integrated Quality and Performance Report

For Trust Board
Meeting Date – 27 May 2021

James Friend, Chief Transformation Officer

13 May 2021

Our Outcomes

How Are We Doing?

April 2021

Daycase and Elective Surgery operations

Actual: **3,895**

2019 Actual: **4,878**

6 Week Diagnostic Performance

Actual: **8.5%** Target: **1%**

Four Hour Emergency Standard

Actual: **95.2%**

Plan: **95%**

Whole Trust Inpatient Friends and Family Test

Actual **98.3%**

Target **95%**

Outpatient First Attendance

Actual **16,897**

2019 Actual: **17,802**

March 2021

Referral to Treatment Standard - Number of 52 Week Breaches

2,644

Outstanding care every time

Balanced Scorecard Approach

Executive Summary – April 2021 (1 of 2)

	What the Information tells us	Actions and Quality Improvement Projects

Finance & Productivity Perspective	• Outpatient activity, excluding COVID-19 activity, was 96.7% of 2019-20 activity with further gains expected once coding is completed
	• Outpatient DNA rates remain low with 6.9% of patients not attending their appointments
	• Daycase & Elective activity was 79.9% of 2019-20 and, once coding is complete, will exceed the 80% submitted activity trajectory
	• Non-Elective Length of Stay (LOS) was 5.9 days continuing a sustained increase above the 2019/20 mean
		• Services are focussing on eliminating the backlog by end of July and improving cashing up process to be completed within 48 hours.
		• Outpatient templates are being reviewed and refreshed to ensure patients are given the correct information on their appointment
		• Daycase & Elective acitivity
		  • All operating theatres are open with 4 modular theatres to be open on QMH site by 14 June.
		  • New ITU booking process introduced to ensure sufficient capacity and maximise productivity
		• Flow remains a priority in the Trust with 7 day discharge service, fully electronic discharge processes implemented and focus on ensuring patients are discharged on their Estimated Discharge Dates

Patient Perspective	• The number of 2222 calls and Cardiac Arrests per 1,000 adult inpatient admissions has remained consistently above the 2019-20 mean
	• All Life Support training completion rates are consistently below the 2019-20 baseline
	• Category 3 Pressure ulcers occurrences rate have returned to common cause variation
	• There were two Hospital Onset Healthcare Associated (HOHA) COVID-19 Infections
	• NEL readmission rates have returned to common cause variation as activity is starting to return
	• Over 35% of women in maternity services were booked on the Continuity of Care pathways with the aim to have over 50% booked by March 2022
	• Carmen Suite was open for over 90% of shifts in months and this led to 52 babies being born there in the month
	• Three Services achieved their Friends & Family Test (FFT) target where patients rate our services as “Good” or “Very Good” – Inpatients, Community and Maternity Postnatal.
		• Life Support Training
		  • Targeted training to be delivered to ITU/CTITU and NNU
		  • Online self assessments are becoming operational with communications plans to commence with wards and departments
		  • Resus champions assisting with Basic Life Support assessments and session facilitations
		• Concurrent exercises are taking place at the Trust and across the sector to review and collate lessons learned from COVID-19 second wave
		• Work continues to meet Ockenden immediate and essential actions including a workforce bid submission
		• Birth Centre Virtual Tours are being launched to encourage more women to choose a midwifery led birth where appropriate
		• FFT
		  • ED – review underway to determine drop in performance
		  • Outpatients – Floor walkers are working to increase response rates and to enable the Trust to have deep dives into specific issues

Executive Summary – April 2021 (2 of 2)

	What the Information tells us	Actions and Quality Improvement Projects

Process Perspective	• The Trust met the Four Hour Operating Standard with 95.2% of patients either admitted, discharged or transferred within four hours of their arrival against a target of 95%
	• For March, the Trust met the 14-day standard for Cancer, the 31-Day Second or subsequent Treatment (Drug), and the 31-Day Second or subsequent Treatment (Surgery)
	• Six week diagnostic standard improved to 8.5% from 10.2%
	• Referral to Treatment for March:
	  • 69.3% of patients were treated within 18 weeks of referral
	  • 2,644 patients have been waiting over 52 weeks since referral of which 1,439 have a Decision to Admit
	  • 44,960 patients on the waiting list to begin treatment of which 7,309 have a Decision to Admit
		• Four Hour Operating Standards actions
		  • Engagement with Mental Health providers to address Adult and Paediatric patients with Mental Health needs
		  • Focussed work to redirect appropriate patients to Enhanced Primary Care Hub at the Queen Mary's Hospital
		• Cancer
		  • Services have access to increased theatre capacity, to treat all the Priority 3 patients by the end of April
		  • Operational plans have been developed and supported by the care group lead, DDO and COO to support recovery in Breast service
		• Diagnostics
		  • Audiology patients will be transferred to Kingston on 15 May 2021
		  • Endoscopy services has increased capacity and it operating from 9 rooms sited across Tooting, QMH and Nelson. Recovery is forecast to be achieved by October 2021
		  • Echocardiography progressing recovery programme working with NHS England and NHS Improvement
		• Referral to Treatment actions remains focussed on three key areas:
		  • Triage timescale reduced to 48 hours
		  • Increase surgical activity through QMH
		  • Outpatient outcomes recorded within 48 hours (reduction of uncashed attendances)

People Perspective	• Trust sickness absence rate was 3.4% which did not meet its goal of no more than 3.2% of staff are absent due to sickness • Appraisal rates for non-medical staff reversed showed special cause improvement with 75.3% of staff having an up-to-date appraisal however the target is 90% • Appraisal rates for medical staff has returned to common case variation at 75.3% • Formal Employee Relation cases have risen from 47 to 52 cases	• The Employee Relations team is working closely with managers to ensure timely referral to Occupational Health and to commence sickness absence meetings. • HR partners are meeting with managers to encourage completion of appraisals for non-medical staff • The Employment Relations Team have a weekly shared learning session which supports embedding a consistent approach to case management across the Trust and builds on lessons learnt.

Balanced Scorecard Approach

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

Key

Current Month

A Previous Month

Scorecard RAG rating based on PreCOVID-19 plan

Activity Summary

		Activity compared to 2019/20			Activity compared to previous year			Activity compared to 2020/21		
		Apr-19	Apr-21	Variance	YTD 19/20	YTD 20/21	Variance	Apr-20	Apr-21	Variance
ED	ED Attendances	13,845	11,602	-16.20%	13,845	11,602	-16.20%	5,599	11,602	107.22%
Inpatient	Non Elective	4,888	3,418	-30.07%	4,888	3,418	-30.07%	2,312	3,418	47.84%
	Elective & Daycase	4,878	3,895	-20.15%	4,878	3,895	-20.15%	1,191	3,895	227.04%
Outpatient	OP Attendances	49,624	47,987	-3.30%	49,624	47,987	-3.30%	35,246	47,987	36.15%

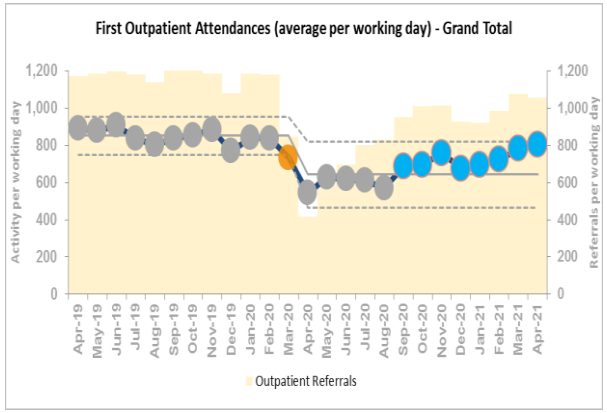
>= 2.5% and 5% (+ or -)
>= 5% (+ or -)

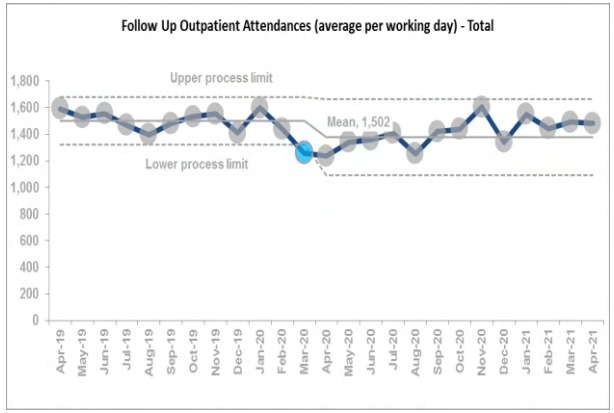
Note: Figures quoted are as at 12/05/2021 and do not include an estimate for activity not yet recorded e.g. un-cashed clinics, To Come In's (TCI's).

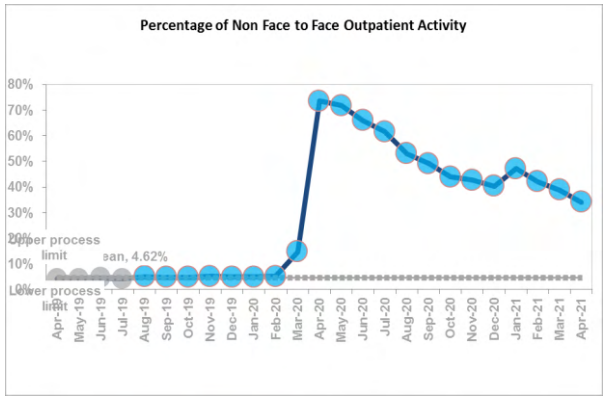
Activity levels for April 2021 have been shown against activity levels reported in April 2019. For reference the grey boxes compare activity levels to 2020/21.

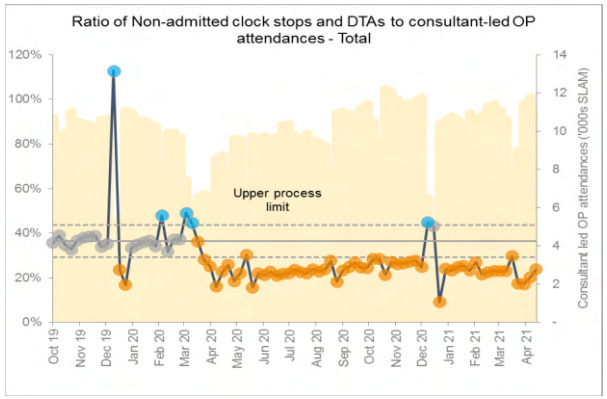
Outpatient data above **excludes COVID-19 activity**. Activity data presented above is based on POD1

Outpatient Productivity (1 of 2)









Actions and Quality Improvement Projects

As part of the Elective care recovery programme, we are treating a large volume of patients who have waited a long time for their appointments and therefore, a higher proportion requiring an appointment in a face-to-face setting. It is anticipated that we will see a lower volume of virtual activity as we work through our backlog.

An improvement trajectory has been set to reduce the backlog of missing eCDOFs/uncashed appointments. The aims are to have eliminate the backlog by the end of July and to complete the eCDOF/cashing process within two working days, or sooner. Excellent progress has been made this month, with significant improvements across all services.

An Outpatient Steering Group meeting will commence in May, which will have oversight of all key Outpatient KPIs and transformation workstreams. This will report into the newly established Elective Care Recovery Programme Board.

- 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 continued to increase throughout April with 805 attendances daily compared to 783 in March. Activity levels have been above the mean for the past eight months and first attendances for the month was 90% of April 2019.

All Directorates' first outpatient activity continues to increase. Women's services activity levels have risen above the upper control limit with Specialist Medicine, Cardiology and General Surgery maintaining higher activity levels similar to March.

At Trust level, follow-up activity shows common cause variation. In April there was on average, 1,480 attendances daily compared to 1,492 patients in March.

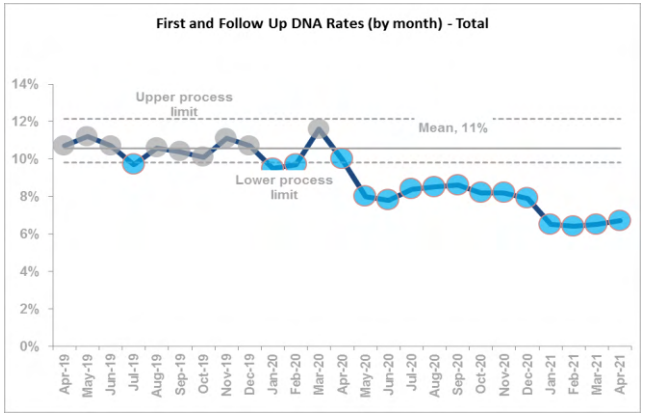
All outpatient activity in April 2021 was 97% of the activity reported in April 2019 and is expected to rise when coding catch up is completed.

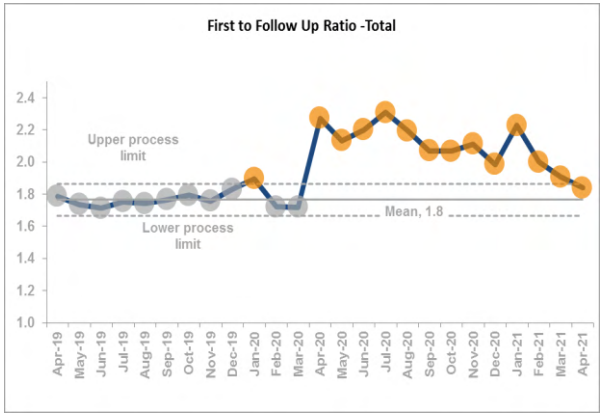
In April, 34% of our outpatient attendances were undertaken in a virtual setting, a decrease of 4% compared to the previous month.

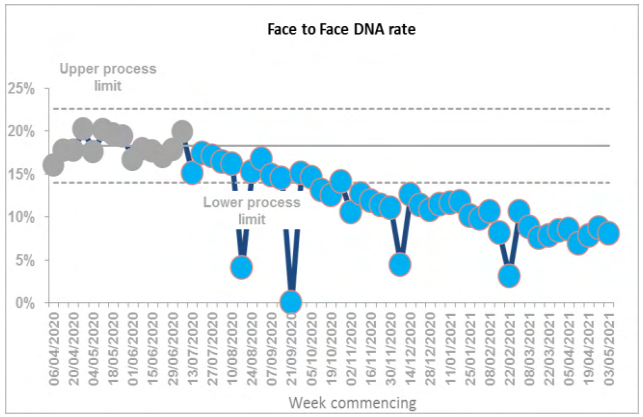
At Trust level, pre-COVID, there was a clock stop or a decision to admit for every 2.7 Consultant-led OP attendances. The ratio is now 4.2 consultant OP attendances to each clock stop or DTA.

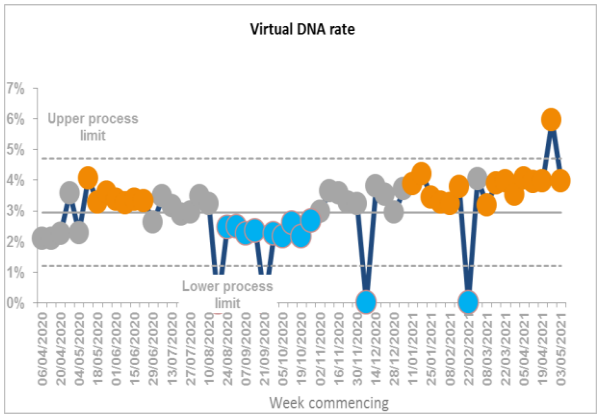
Please note that COVID-19 related OP activity in this financial year has been excluded from the charts.

Outpatient Productivity (2 of 2)









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

What the information tells us

The number of patients not attending their outpatient appointment remained stable in April.

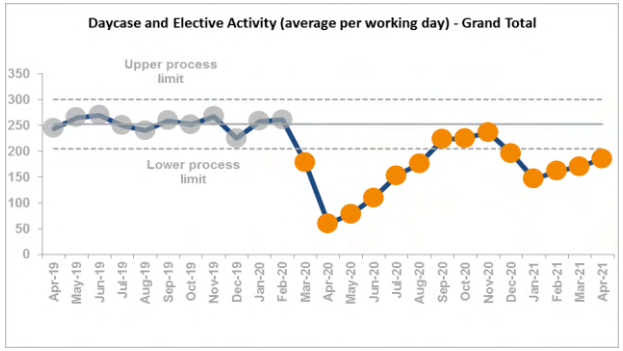
Renal and Oncology have seen DNA rates reduce from 9% in April 2019 to 4% in April 2021 showing a sustained improvement below the lower control limit, similarly with Specialist Medicine.

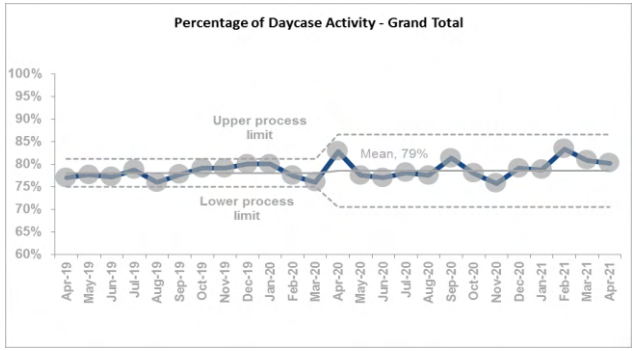
Although the DNA rate for patients attending a face to face (F2F) appointment remains below the lower control limit, there remains a significant difference when compared to patients seen in a virtual setting with 4.9% patients not attending a virtual appointment.

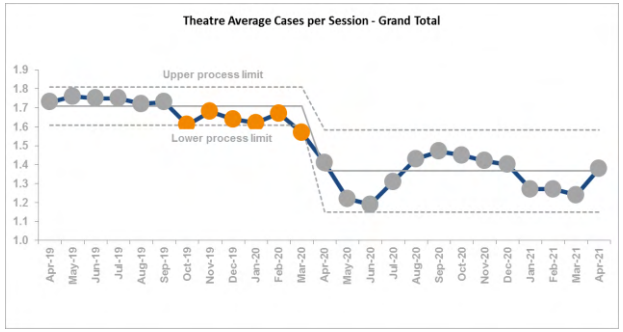
Actions and Quality Improvement Projects

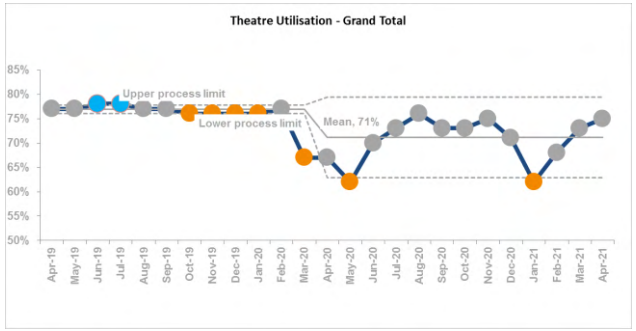
As services restart, they will need to review their templates to ensure patients are booked into the correct media type and therefore receive the correct text message. The creation of the eCDOF Standard Operating Procedure will provide specific guidance around virtual appointment DNAs with the intention or reducing these numbers.

Elective Activity & Theatre Productivity









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

What the information tells us

Elective activity in April remains below the lower control limit although continuing to show a month on month increase since January 2021.

On average, 186 patients were treated per day compared to 170 in March (not all this activity is theatre based). Overall elective activity was 80% of that reported in April 2019.

Activity levels within Gynaecology and Obstetrics have returned to within the upper and lower control limits in the month of April whilst Clinical Haematology, Endoscopy, ENT, Neurology and Plastics have all seen the average treatments in April increase.

In this financial year, Theatres have run 1,055 theatre sessions, compared to 1,269 in the same period in 2019. This month there has been an increase in both the average cases per sessions and theatre utilisation rates which rose to 75%. Theatres continue to adhere to process changes implemented because of COVID-19.

Actions and Quality Improvement Projects

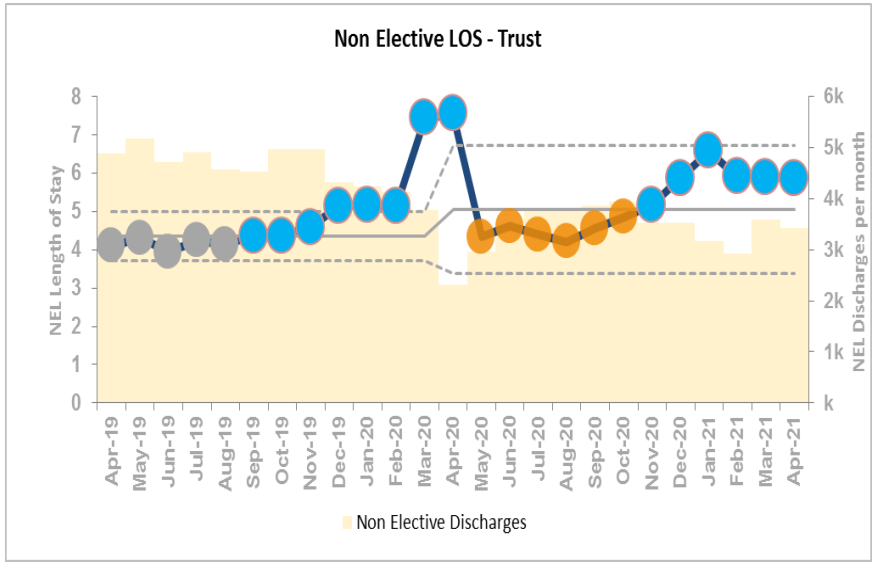
The theatre template was increased to full capacity at the end of April with all theatre lists re-established within week to increase. We now have 29 of 29 operating theatres open with a greater number of sessions than pre-COVID to meet our expected activity goals.

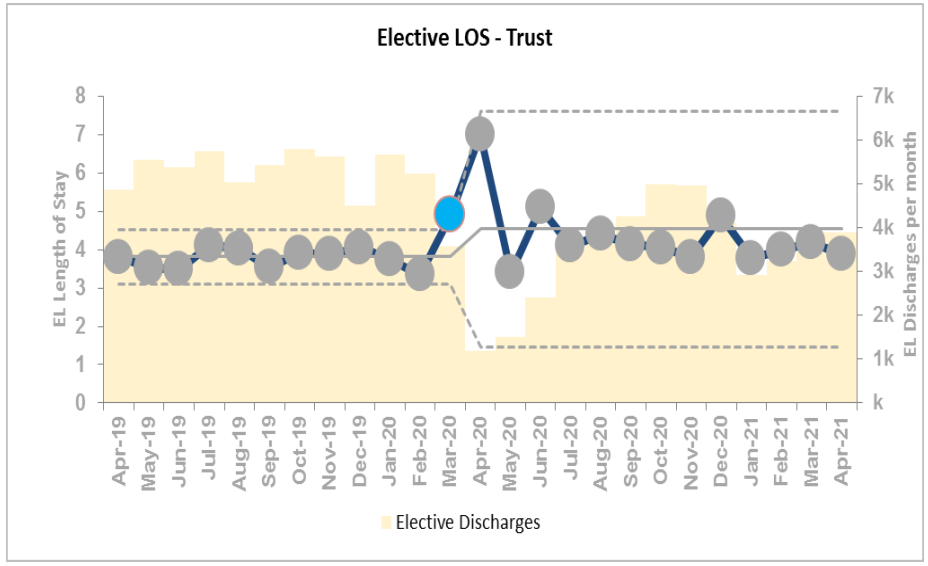
Independent sector was dramatically reduced with only a few lists occurring in April.

We are planning to open 4 modular theatres at the QMH site on 14 June, with a phased approach to significantly support activity targets and backlog recovery plans.

We have now launched the Theatre Elective Recovery Group (TERG) to maximise productivity and exceed 2019 activity levels.

Length of Stay





What the information tells us

Non-elective length of stay remains above the mean with patients admitted via a non-elective pathway staying on average 5.9 days. Within the month, Children's & Women's and Therapeutics saw a decrease in length of stay. Patients staying for more than seven days has reduced by 12% compared to the previous month with the number of patients under Acute Medicine decreasing by approximately 9% this month. Both 14 and 21 day long stayers remain below the lower control limit although seeing an increase in April.

Elective length of stay remains within the upper and lower control limits showing only common cause variation.

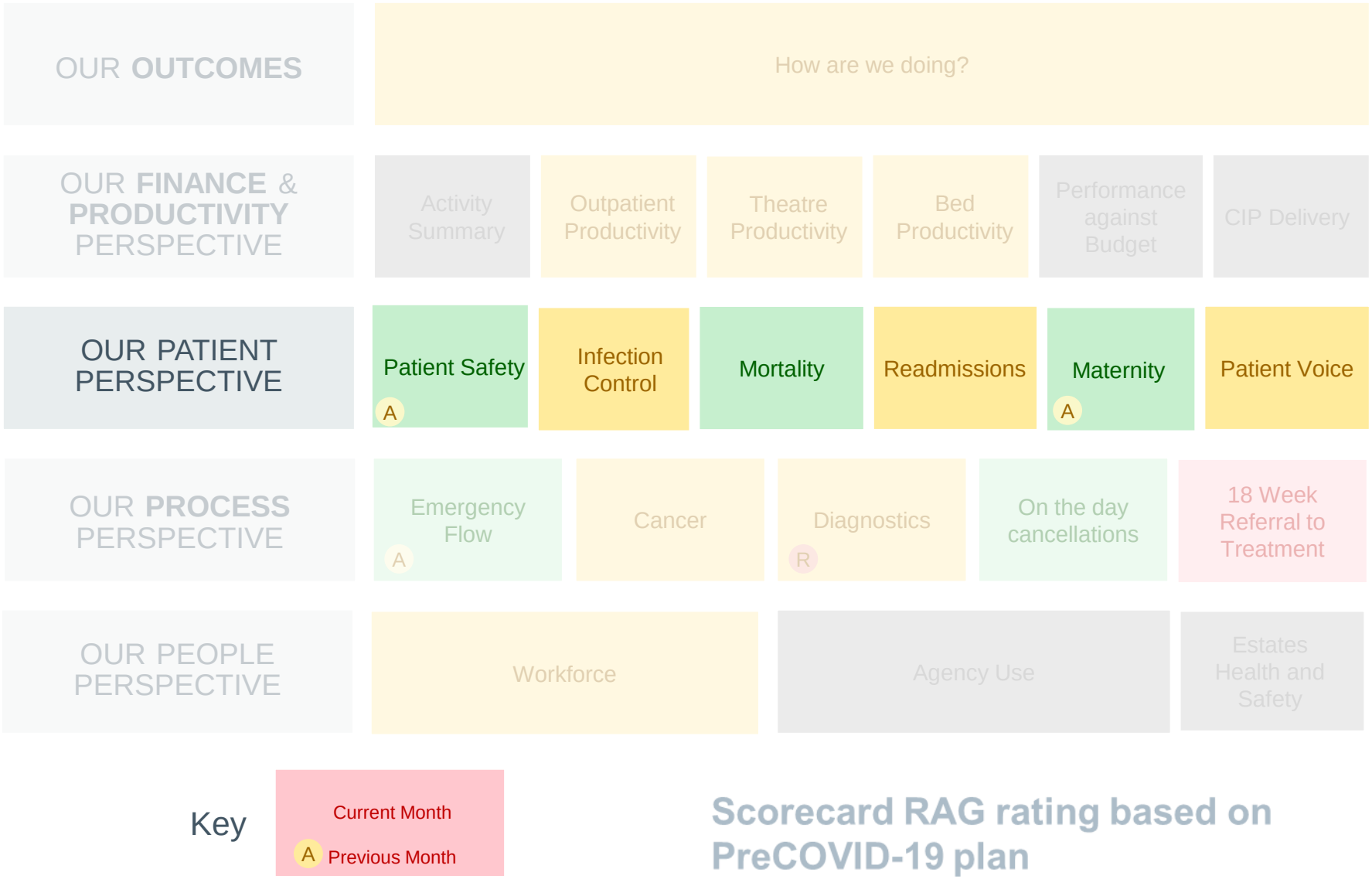
Actions and Quality Improvement Projects

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

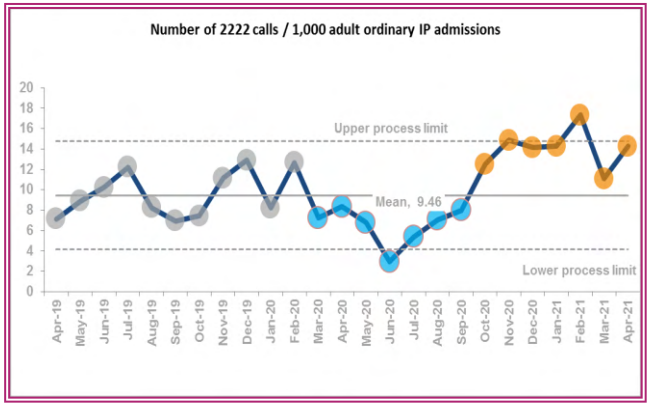
Discharge 2 Assess – D2A has now transitioned from paper referrals to electronic iClip referrals.

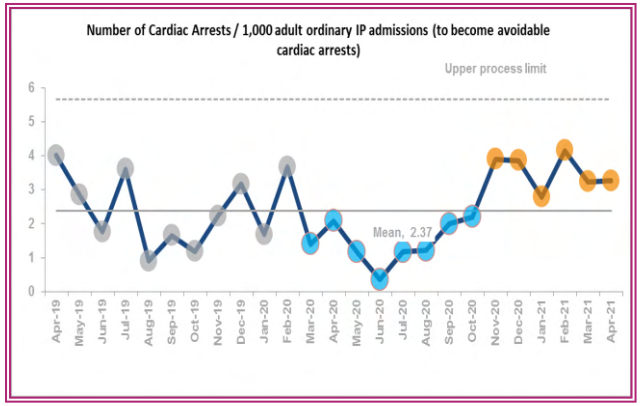
Long length of stay coding analysis - improved data collection and dissemination of internal/external actions for inpatients to maintain predicted Estimated discharge dates (EDDs), check and challenge on criteria to reside and reduce any delays in discharges.

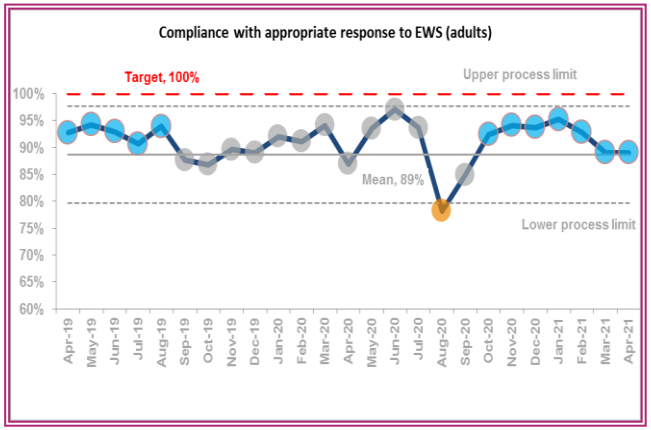
Balanced Scorecard Approach

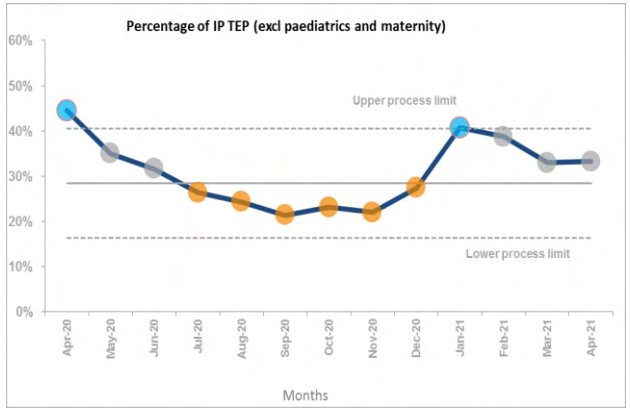


Quality Priorities – Treatment Escalation Plan









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

All metrics have been rebased to April 2019

What the information tells us

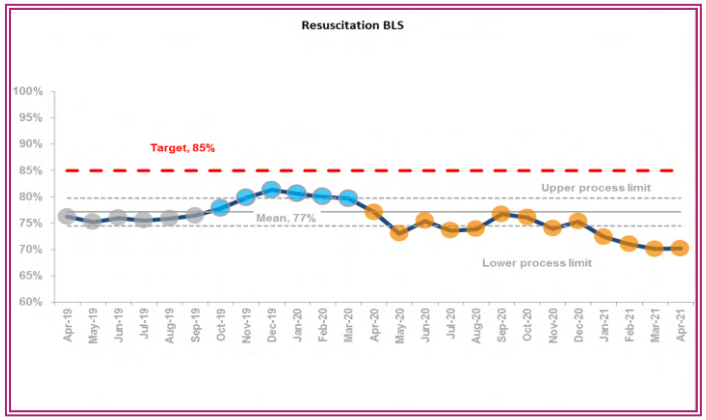
- The rate of 2222 calls per 1,000 Inpatient (IP) admissions and the rate of cardiac arrests per 1,000 adult ordinary inpatients shows special cause variation.
- Compliance with appropriate response to Early Warning Score (EWS), despite a further fall in performance to 88%, continues to show special cause improvement.
- TEP completion rate was consistent with that seen last month, showing common cause variation.

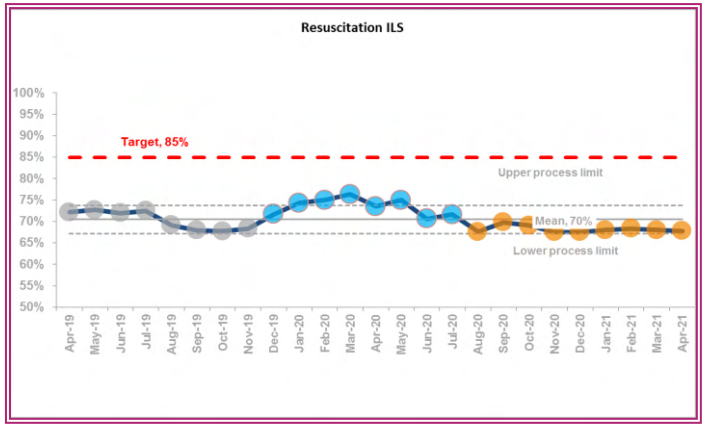
Actions and Quality Improvement Projects

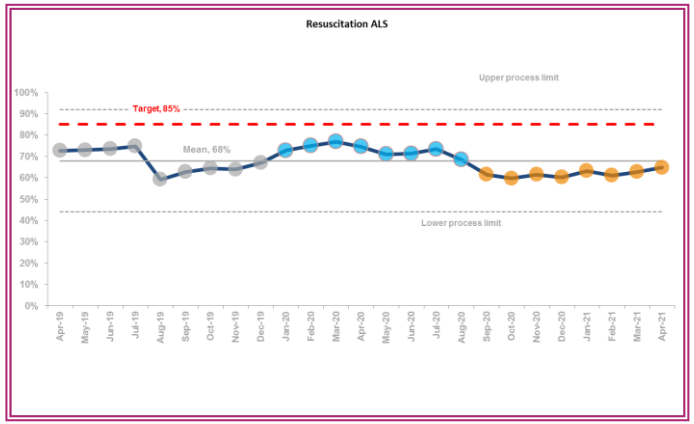
2.2

Our Patient Perspective

Quality Priorities – Deteriorating Patients







- BLS (Basic Life Support) training performance shows special cause variation with performance at 70.2% this month, and an average of 74.1% for the 2020/21 year
- ILS (Intermediate Life Support) shows special cause variation, with performance at 67.8% for this month, and an average of 69.7% for the 2020/21 year
- ALS (Advanced Life Support) training performance shows special cause variation with an improved position in month at 64.7%, and an average of 65.7% for the 2020/21 year
- All training life support training modules have not achieved their targets.

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

All metrics have been rebased to April 2019

Actions and Quality Improvement Projects

A further review of the training needs analysis in progress with the MAST team as a number of staff have completed ALS when not required to do so for their role therefore reducing the number of training slots for those with a requirement for ALS

Unit specific ALS courses planned for ITU/CTITU and NNU in order to deliver targeted training

ILS – Weekly courses to commence from August 2021 with up to one year of course dates available on Totara. Staff will be able to book in advance and plan appropriately with a review to reducing the number of DNAs

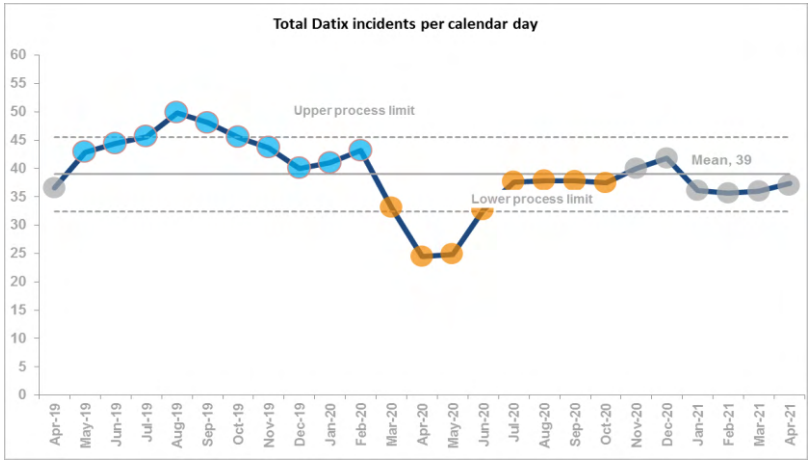
One Brayden-online (Self assessment) pod is now operational. Communication commenced with wards and departments – one pod is open and after completion of Monckton Well project in June 2021 staff will have open access to self assessment of BLS 7 days a week and 24 hours a days

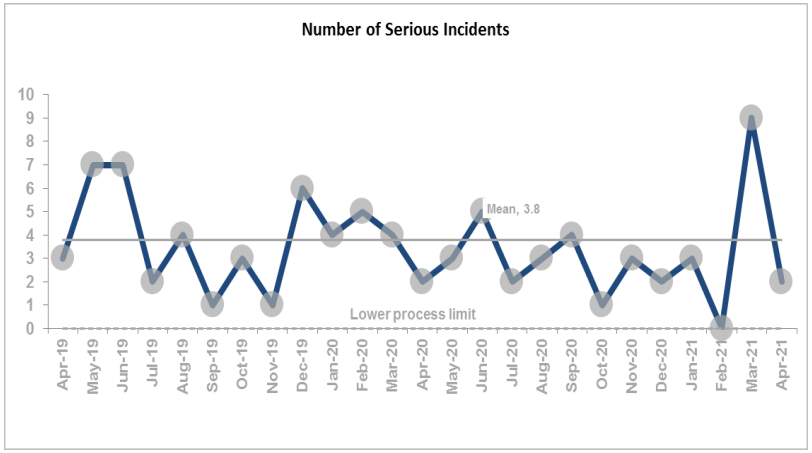
Resus champions assisting with BLS assessments and facilitating sessions in their own areas

The People Management Group is considering options for the management of non-attendance particularly with those staff who have booked on to multiple courses

Quality Priorities – Learning from Incidents

Indicator Description	Threshold/ Target	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
Monthly percentage of Incidents of Low and No Harm		93.0%	94.0%	95.0%	97.0%	97.0%	95.0%	97.0%	95.0%	96.0%	95.0%	96.0%	97.0%	data one months in arrears
Open SI investigations >60 days	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Duty of Candour completed within 20 working days, for all incidents at moderate harm and above	100%	84.0%	80.0%	89.0%	87.0%	93.0%	94.0%	89.0%	96.0%	96.0%	85.0%	75.0%	data two months in arrears	
Total Datix incidents per calendar day		24	25	33	38	38	38	37	40	42	36	36	36	37





What the information tells us

- Serious Incident (SI) investigations are being completed in line with external deadlines, 60 working days.
- This month common cause variation is seen in the number of Serious Incidents and the number of Serious Incidents per 1,000 bed days.
- There were no Never Events.

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

All metrics have been rebased to April 2019

Actions and Quality Improvement Projects

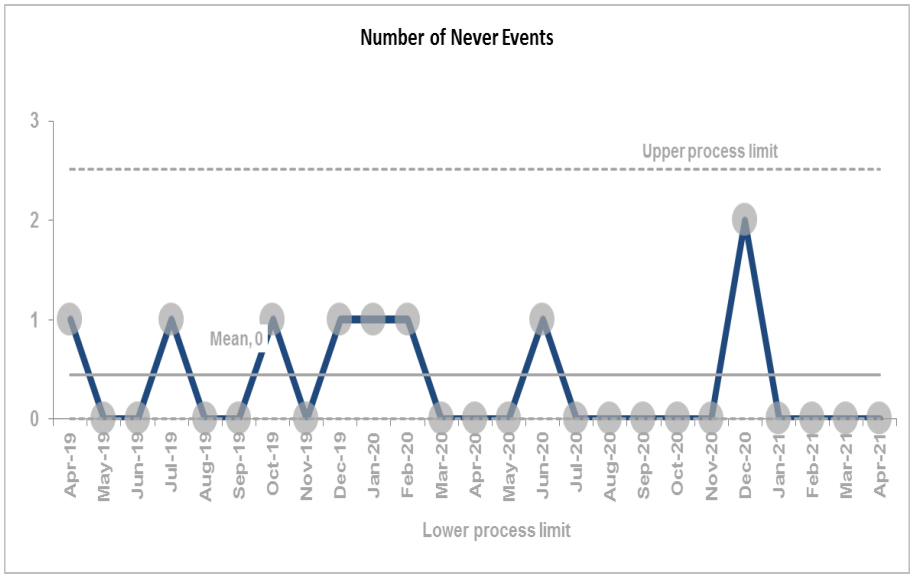
There were 32 qualifying incidents for Duty of Candour (DoC) in February 2021 of which 24 had DoC completed within 20 working days

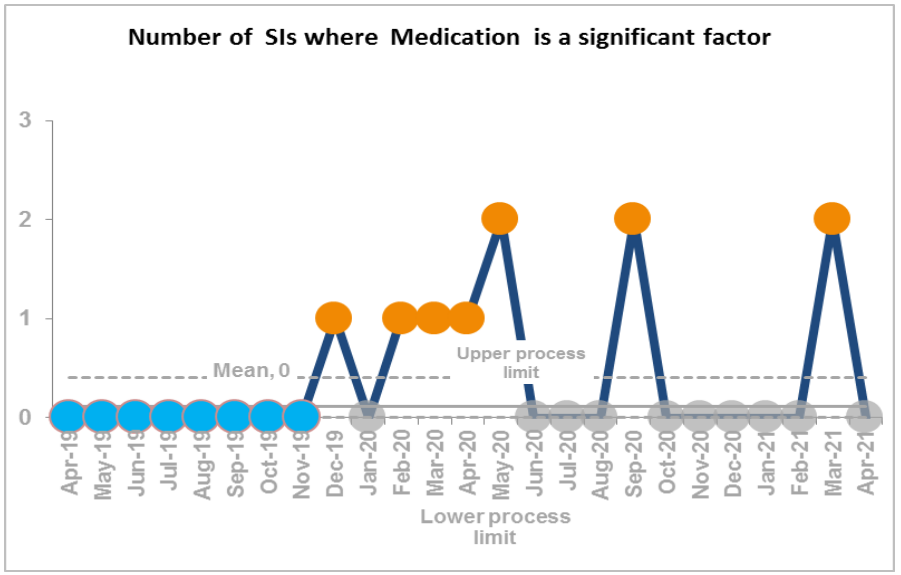
There were 8 incidents within CWDT Division for which DoC was not completed within 20 working days. Progress with DoC compliance continues to be monitored by the CWDT Divisional Governance Manager, in conjunction with the Patient Safety Manager. Support continues to be provided to the relevant departments in order to improve compliance

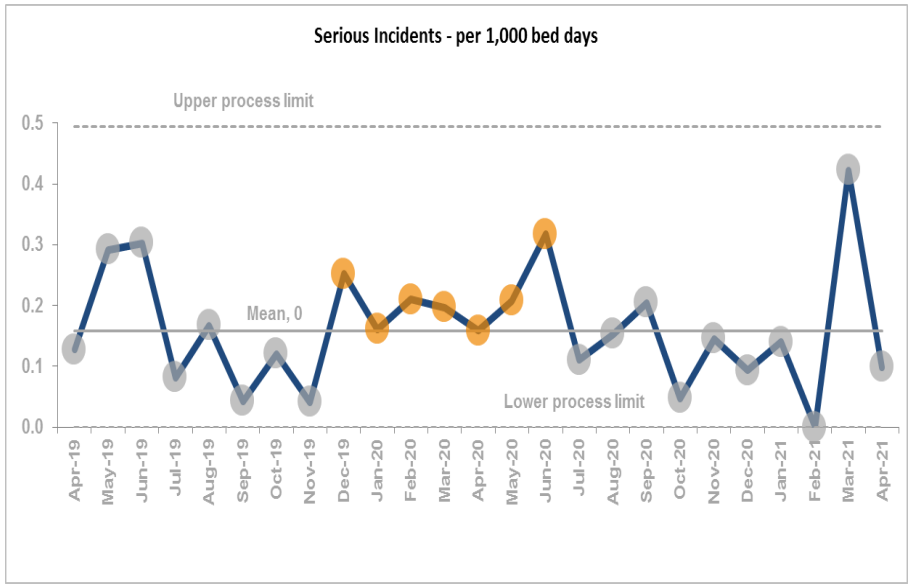
Our Patient Perspective

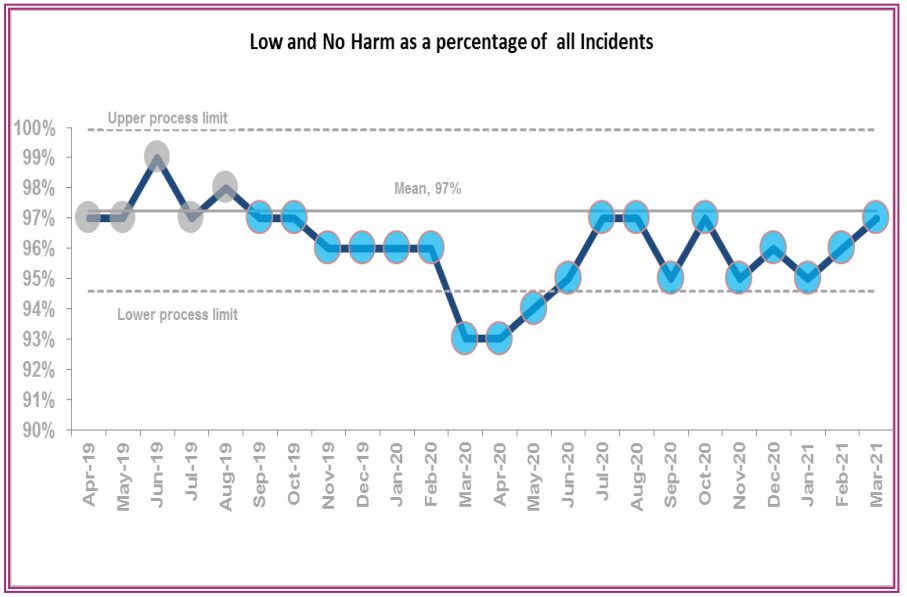
Quality Priorities – Learning from Incidents

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







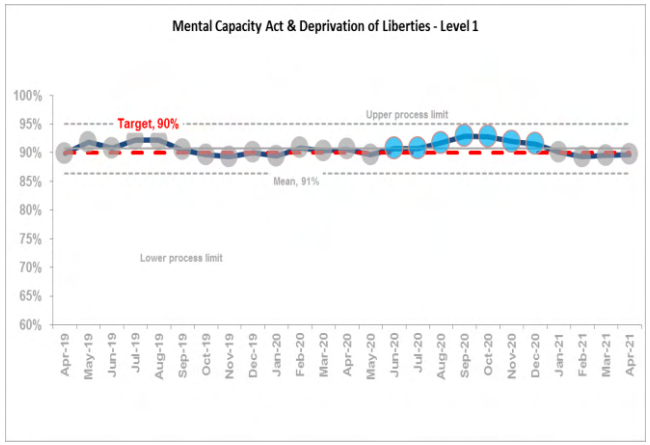


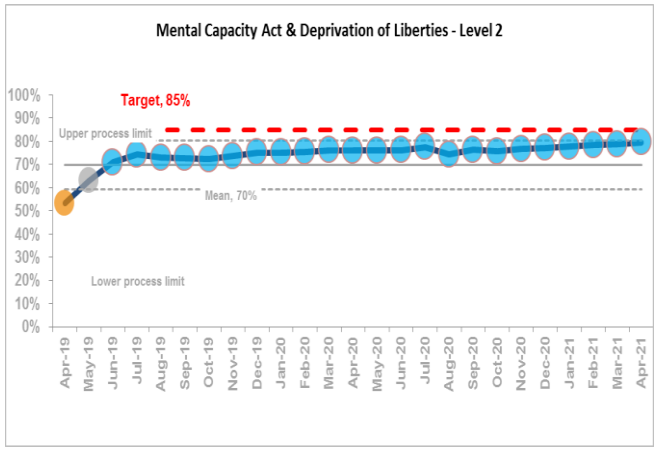
Data is one month in retrospect.

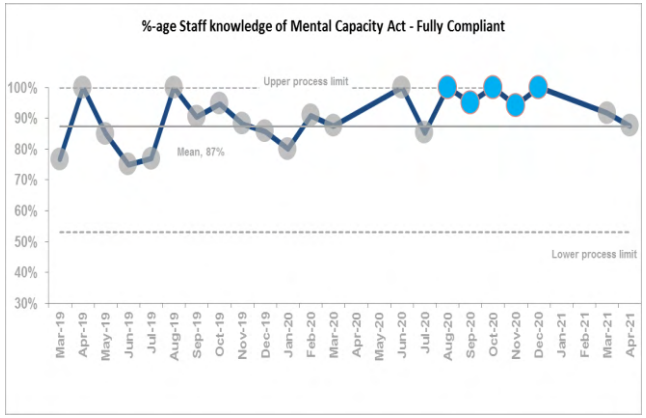
2.2

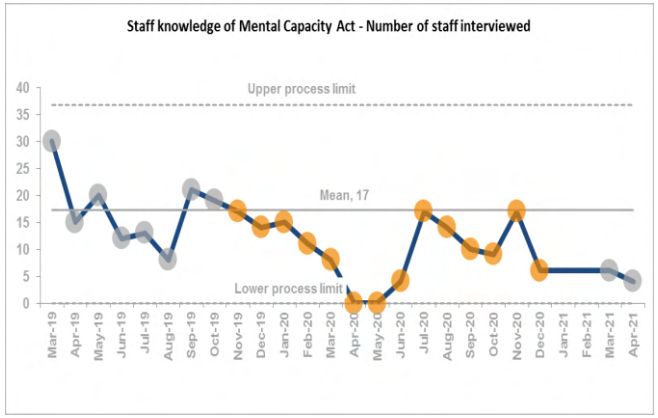
Our Patient Perspective

Quality Priorities – Mental Capacity Act & Deprivation of Liberties









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

All metrics have been rebased to April 2019

What the information tells us

- Mental Capacity Act and Deprivation of Liberties (MCA/DoLs) Training – Level 1 shows special cause variation, with a deteriorating position
- Level 2 training performance has plateaued. Overall Level 2 compliance was 80% this month.
- Metrics showing the number of staff interviewed and their level of knowledge was suspended in January and February 2021 as part of the ward accreditation process due to COVID-19. These interviews resumed in March and show common cause variation.

Actions and Quality Improvement Projects

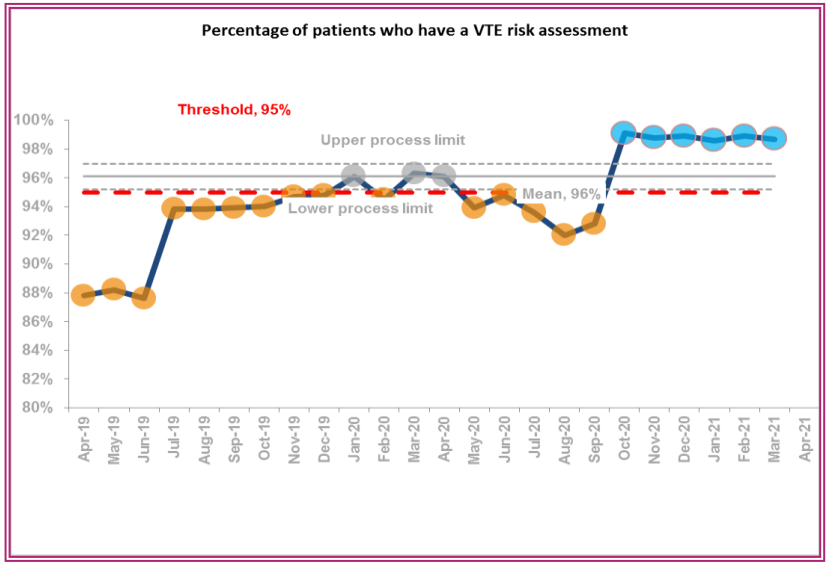
The MCA team is currently working with senior stakeholders at the Trust to prepare for the change from Deprivation of Liberty Safeguards (DoLS) to the Liberty Protection Safeguards (LPS) in April 2022. This change is set to significantly increase The Trust's roles and responsibilities relating to patients who might meet the criteria for Deprivation of Liberty. This work includes:

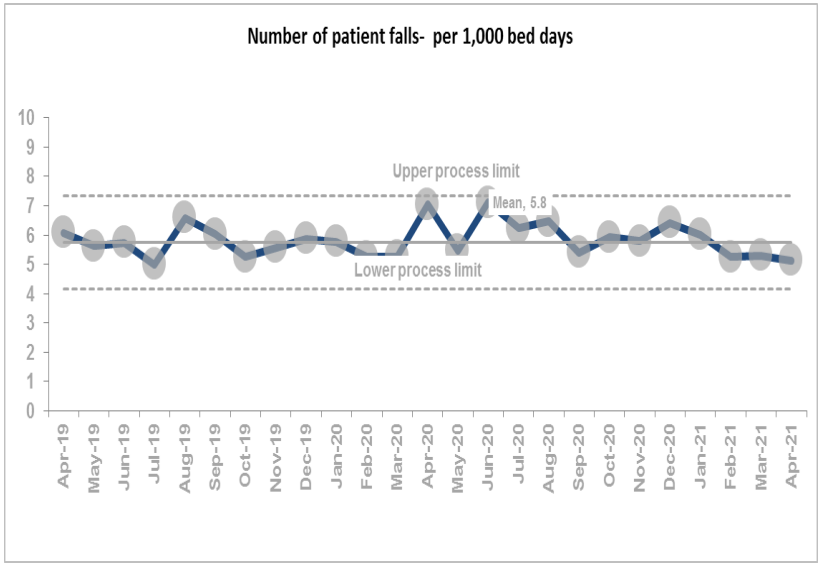
- Developing a new referral pathway for potential deprivations of liberty
- Enrolling all patient facing staff who work with 16 and17 year olds into newly developed MCA training
- Working with the communications team and senior stakeholders to develop a centrally supported communications plan to include awareness raising; training; resource signposting and key areas to focus on in preparation for the change

Patient Safety

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

All metrics have been rebased to April 2019





What the information tells us

- The percentage of patients who have had a VTE risk assessment was 98.7% against a target of 95%.
- The Number of Patient Falls per 1,000 bed days show common case variation alongside a decrease in the number of falls as shown in the following slide.
- There were no falls in month with moderate and above severity.
- On the following slide, total number of Category 2 Pressures ulcers shows special cause variation and Category 2 Pressure ulcers per 1,000 bed days shows commons cause variation.
- The number of Category 3 Pressure ulcers fell this month and the number of Category 3 Pressure ulcers per 1,000 bed days shows common cause variation.

Actions and Quality Improvement Projects

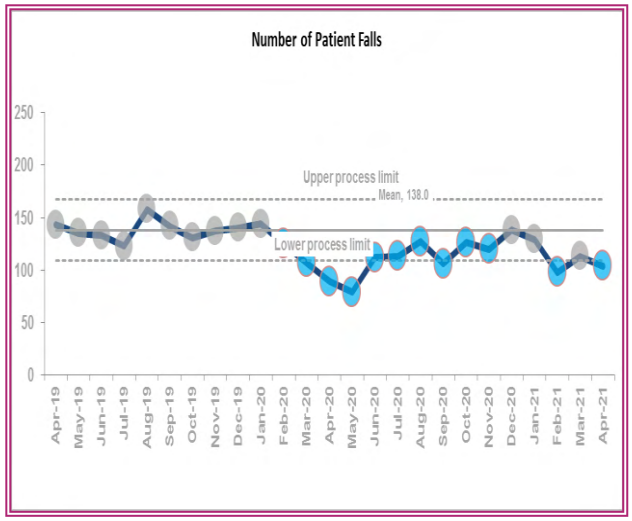
Verbal update to be given

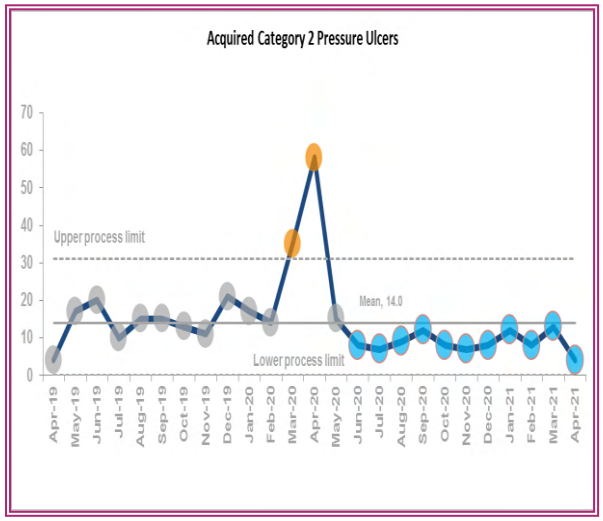
Our Patient Perspective

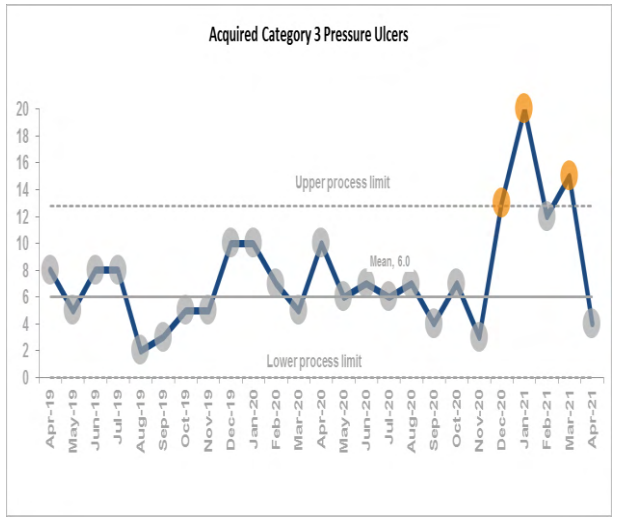
Patient Safety

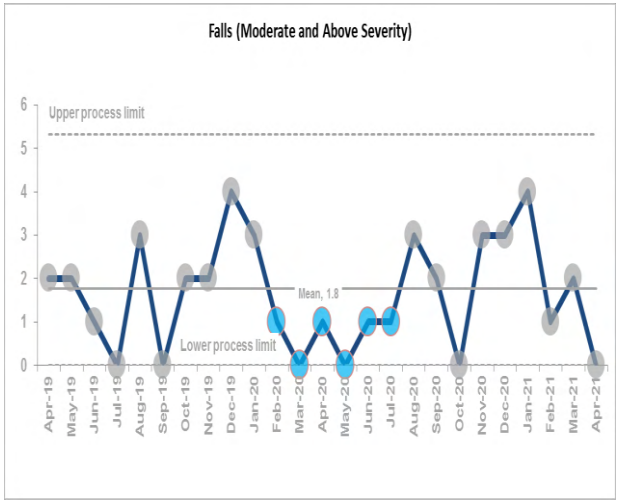
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

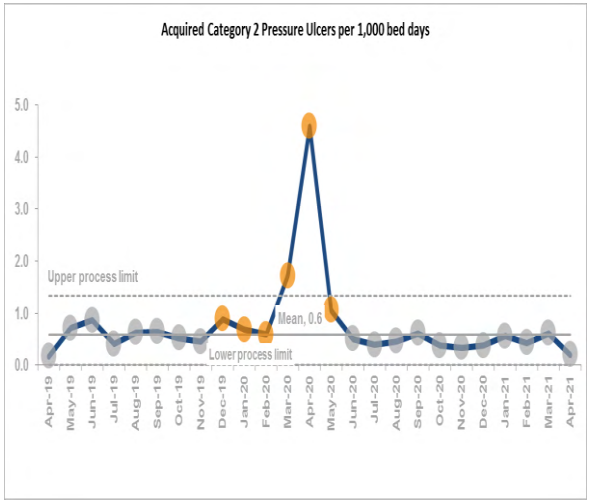
All metrics have been rebased to April 2019

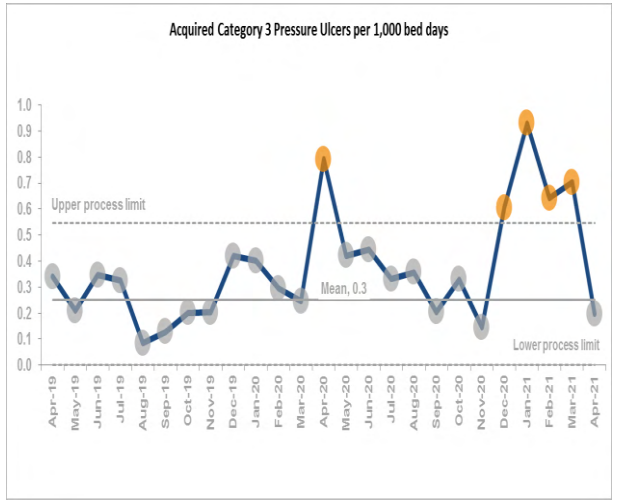










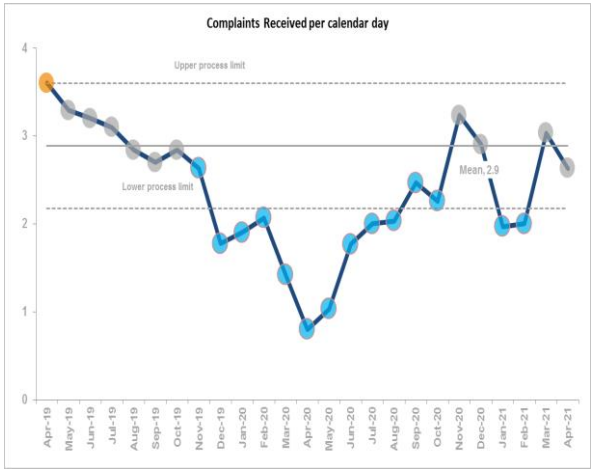


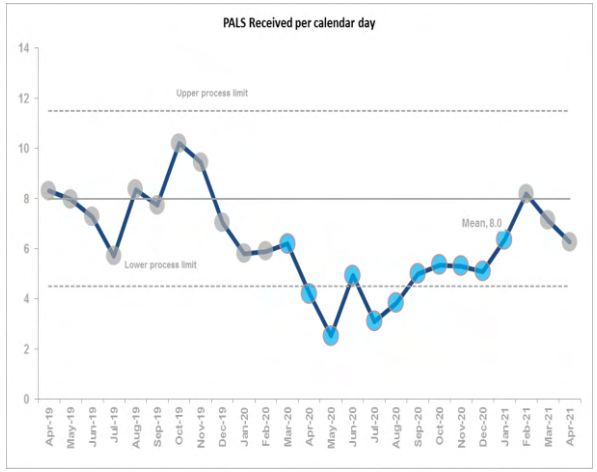
2.2

Our Patient Perspective

Complaints

Indicator Description	Target	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
Complaints Received per calendar day		0.8	1.0	1.8	2.0	2.0	2.5	2.3	3.2	2.9	2.0	2.0	3.0	2.6
% of Complaints responses to within 25 working days	85%	57%	100%	100%	100%	100%	100%	100%	100%	98%	100%	100%	100%	100%
% of Complaints responses to within 40 working days	90%	75.0%	100%	100%	95%	100%	100%	94%	90%	100.0%	91%	90%	92%	100%
% of Complaints responses to within 60 working days	100%	100%	100%	100%	N/A	100%	N/A	N/A	N/A	100%	100%	100%	100%	N/A
Number of Complaints breaching 6 months Response Time	0	0	0	0	0	0	0	0	0	0	0	0	0	0



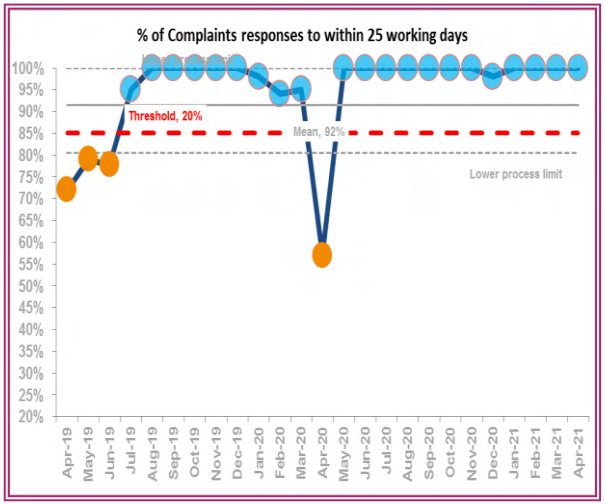


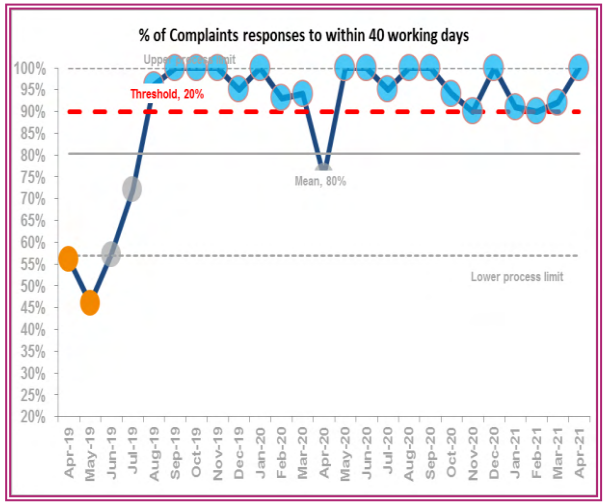
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

All metrics have been rebased to April 2019

What the information tells us

- The number of complaints continues to show common cause variation
- All response categories are achieving target consistently





Actions and Quality Improvement Projects

The daily complaints comcell continues to maintain the focus on sustained performance across all responses categories

Infection Control

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

What the information tells us

There were no MRSA bacteraemia reported.

In April the trust reported 3 incidents of patients with C. *difficile* infections against a presumed threshold of no more than 48 cases for 2021-22; or no more than 4 cases per month. The Trust is therefore under this presumed trajectory. Of these 3 cases, 2 were classified as Hospital Onset Healthcare Associated (HOHA) and 1 was classified as Community Onset Healthcare Associated (COHA).

There were 5 patients with Trust apportioned MSSA cases in April and were 7 cases of Trust apportioned *E. coli* bacteraemia.

No targets are set for MSSA or *E-Coli.* There were a total of 60 *E.coli* cases reported during 2020-21 compared to 74 during 2019-20. There were 47 MSSA reported compared to 36 during 2019-20 with the number of cases per calendar day increasing and showing special cause variation with a deteriorating position for the last seven months.

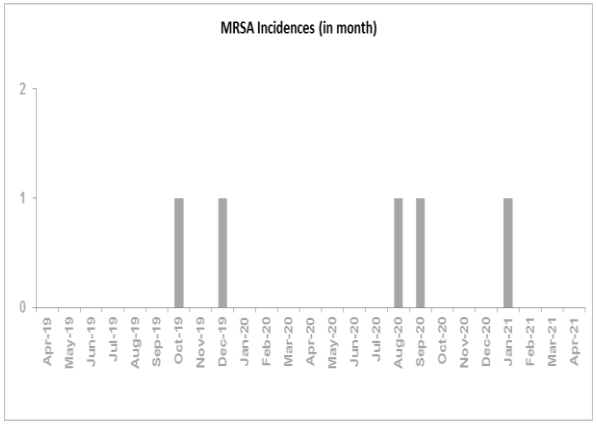
There were 2 Hospital Onset Healthcare Associated cases (HOHA) of Covid-19 during April 2021, where the sample was taken >14 days after admission and no Hospital Onset Probable Associated (HOPA) cases where the specimen was taken 8-14 days after admission.

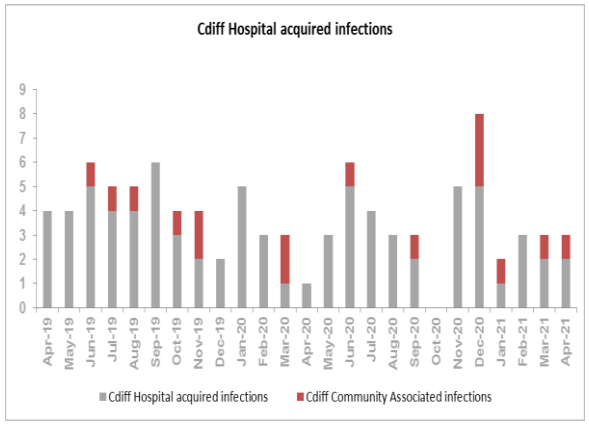
Actions and Quality Improvement Projects

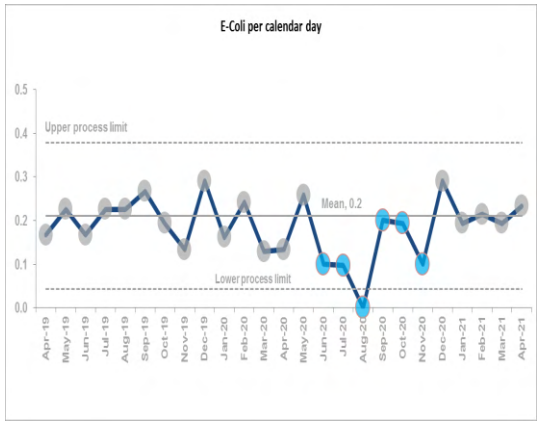
- National COVID-19 data submissions continue to be validated daily and signed off by the Director Infection Prevention and Control
- Concurrent exercises are taking place at the Trust and across the sector to review and collate lessons learned from COVID-19 second wave
- Infection Prevention and Control Annual Report for 2020-21 in development

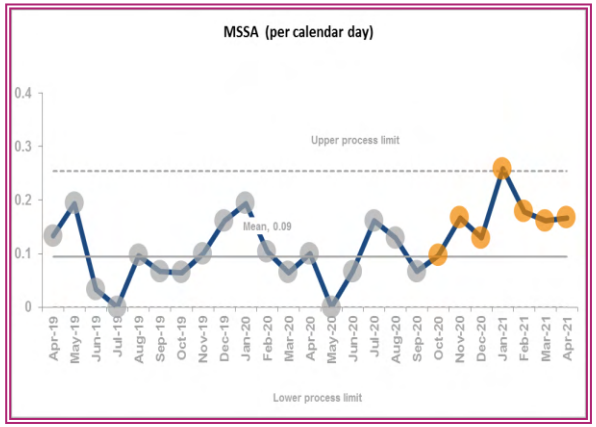
Infection Control

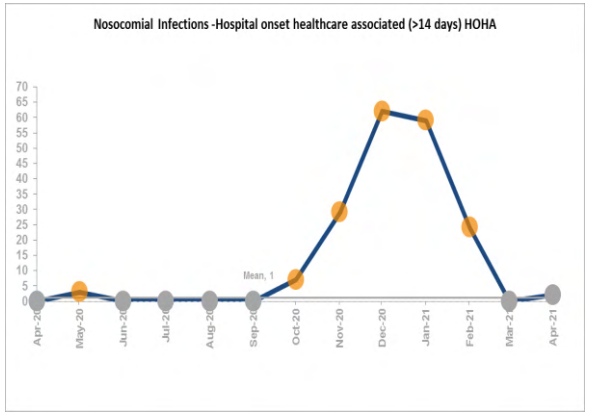
Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance

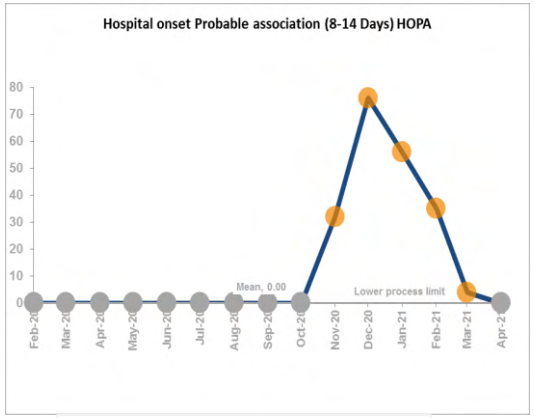












All metrics have been rebased to April 2019

2.2

Our Patient Perspective

Mortality and Readmissions

Indicator Description	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-20	Jan-21	Feb 2020 to Jan 2021
Hospital Standardised Mortality Ratio (HSMR)	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	85.7	120.9	92.8
Hospital Standardised Mortality Ratio Weekend Emergency	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	118.2	141.8	113.0
Hospital Standardised Mortality Ratio Weekday Emergency	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	79.6	122.2	86.3

Indicator Description	Aug18 - Jul19	Sep18-Aug19	Oct18-Sep19	Nov18-Oct19	Dec18-Nov 19	Jan-19-Dec 19	Feb-19-Jan 20	Mar-19-Feb-20	Apr-19-Mar-20	May-19-Apr-20	June-19-May-20	July-19-June-20	Aug-19-Jul 20	Sep-19-Aug-20	Oct-19-Sep-20	Nov-19-Oct-20	Dec-19-Nov-20
Summary Hospital Mortality Indicator (SHMI)	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	0.85	0.86

Indicator Description	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Emergency Readmissions within 30 days following non elective spell (reporting one month in arrears)	7.9%	10.7%	10.1%	10.4%	11.2%	11.3%	9.7%	9.5%	9.6%	8.9%	10.6%	10.6%	9.7%

Note: HSMR data reflective of period February 2020– January 2021 based on a monthly published position. This month we see discharges to January 2021
SHMI data is based on a rolling 12 month period and reflective of period December 2019 to November 2020 published (April 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 December 2019 – November 2020. We are one of 13 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. Unfortunately, there appears to have been an error in either data submission or processing, resulting in the latest data refresh from Dr Foster (source for HSMR) containing incomplete data for January 2021, which means that the data for that month is un-interpretable.

However, the impact of this error on the complete 12 months of data (February 2020 to January 2021) is less and therefore we can be confident that our mortality as measured by the HSMR remains 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. It should be noted that SHMI and HSMR have taken differing approaches to managing the impact of Covid-19, which is now included in the periods reported.

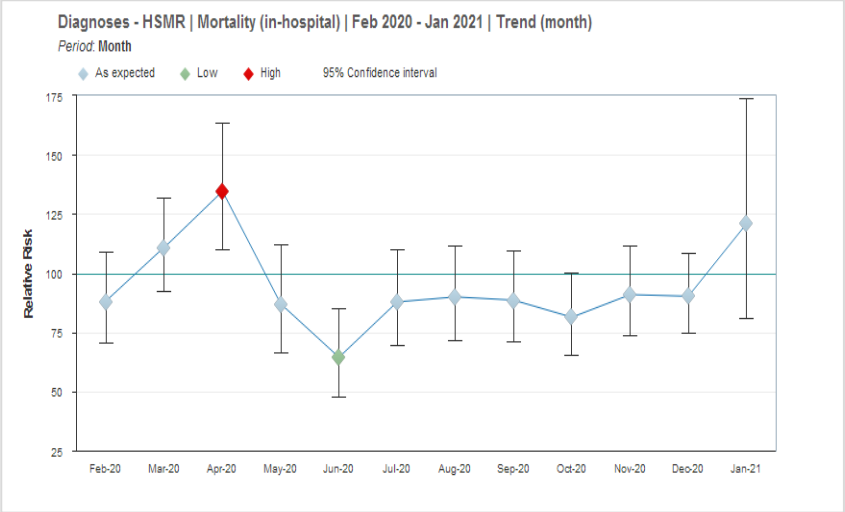
Actions and Quality Improvement Projects

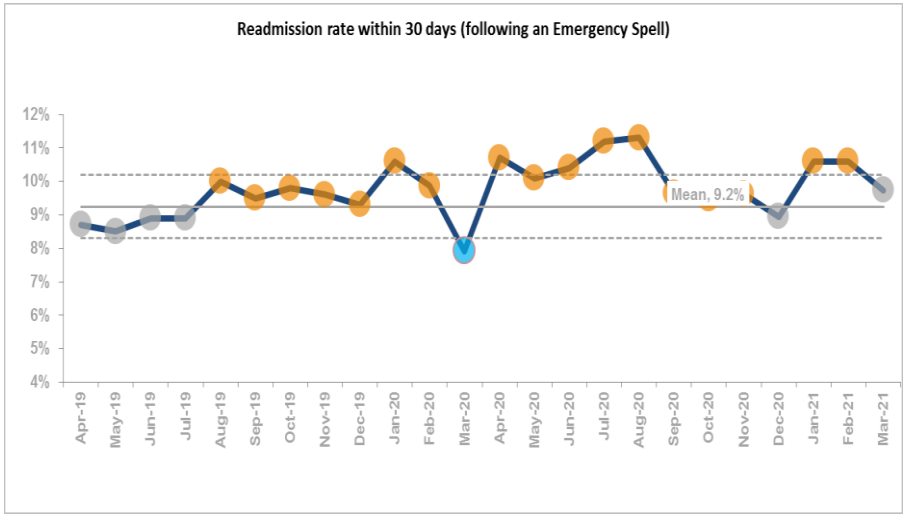
We continue to monitor and investigate mortality signals in discrete diagnostic and procedure codes from Dr Foster through the Mortality Monitoring Committee (MMC).
In April Cardiology presented the investigation of mortality in patients admitted with acute coronary syndromes or undergoing coronary angiography over the period January to June 2020. A mortality rate of 5 per cent was observed. There were two patients where it is was felt that the improvements suggested by the simultaneous service review may have had a positive impact.
An action plan was presented, and this will now be taken through divisional processes, with an update to MMC in a few months. Investigations still underway related to intracranial injury and major trauma are expected to be completed in the next quarter. The committee is also engaged with work that is focussing on identifying learning from wave 1 and 2 of the COVID-19 pandemic. The committee's interest is centred around mortality and we anticipate a more complete picture being available within the next quarter.

Mortality and Readmissions (Hospital Standardized Mortality Rate)

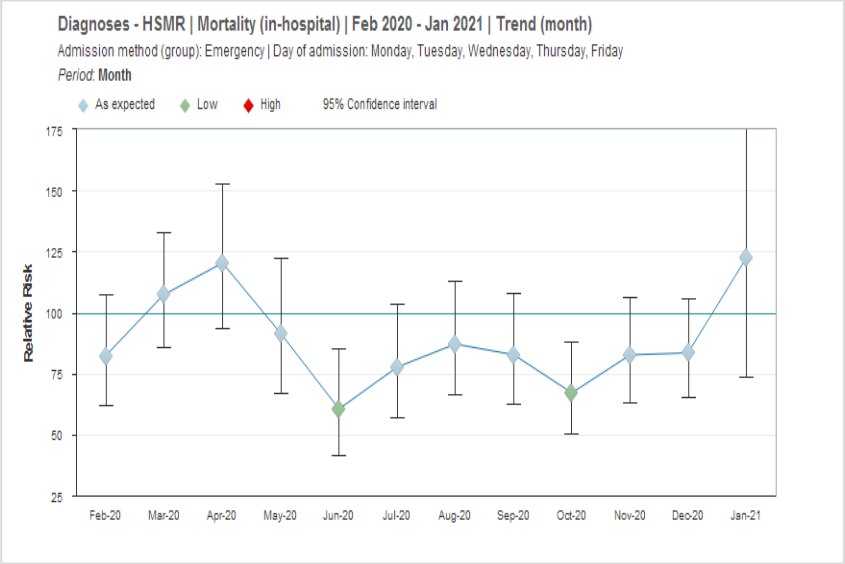
Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance

HSMR

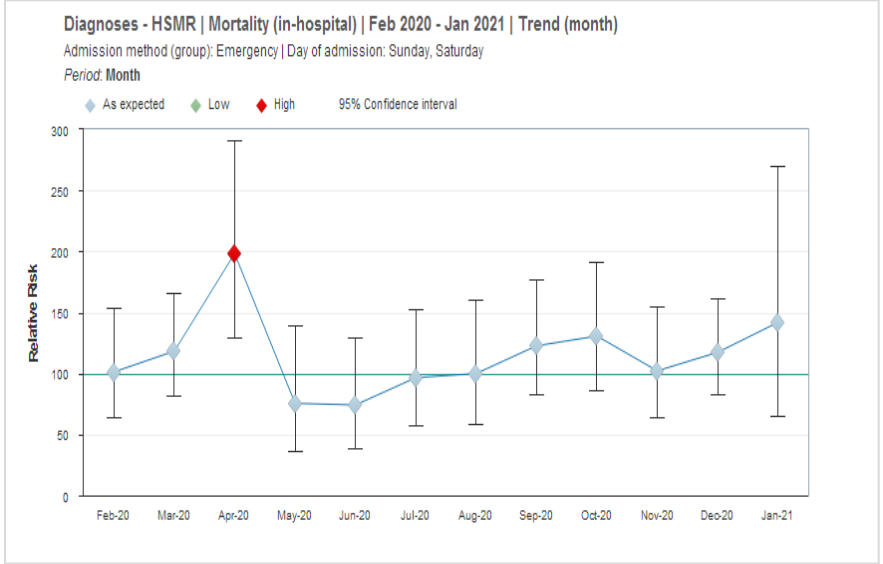




HSMR Weekday



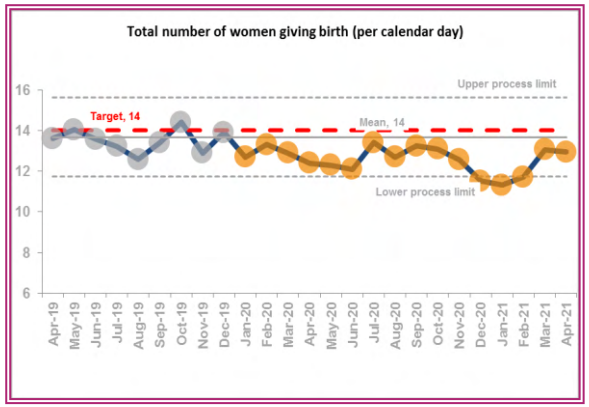
HSMR Weekend

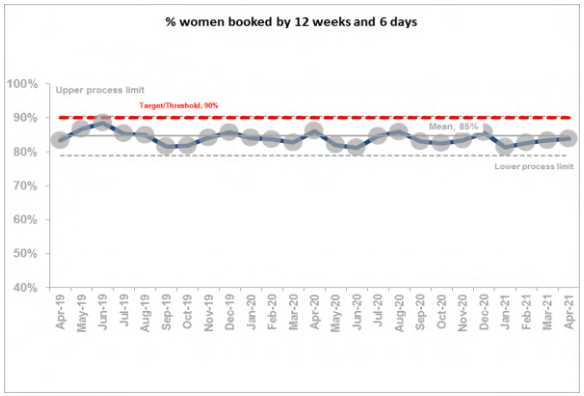


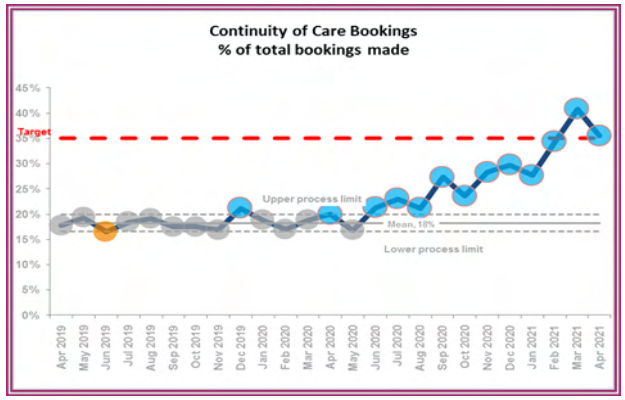
Maternity

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

All metrics have been rebased to April 2019







What the information tells us

- Over 35% of women continued to be booked to continuity of carer teams, including more than 35% of Black, Asian and Mixed Race women. Outcomes for women giving birth having had continuity suggest a higher rate of vaginal birth and use of the birth centre so far
- Carmen Suite was open for over 90% of shifts in months and this led to 52 babies being born there in the month – the highest number in the last six months. This was achieved due to improvements in staffing numbers across the unit and the almost consistent provision a supernumerary midwife; apart from on one shift
- There were two stillbirths in the month: at 32 weeks and 2 days where the umbilical cord was sadly wrapped around the baby's leg; and at 37 weeks with no obvious cause. Both cases are being investigated by the team
- The number of term babies being admitted to Neonatal Unit (NNU) fell in month and focus on the first hour of life is continuing with the neonatal team. There was one baby admitted to NNU at 38 weeks and 4 days with suspected Hypoxic Ischaemic Encephalopathy following an acute and sudden antepartum haemorrhage during the induction process; this case is being investigated by Healthcare Safety Investigation Board (HSIB)
- The number of women sustaining 3rd and 4th degree tears and Post Partum Haemorrhage remain low. The service continues to promote a healthy reporting culture to support safety and promote best practice

Actions and Quality Improvement Projects

Workforce bid submitted to NHSi in line with the Ockenden Immediate and Essential actions following the return of the Birthrate Plus report for midwifery. Birth Centre Virtual Tours launched to encourage more women to choose a midwifery led birth where appropriate.

The previous quarterly reporting frequency on the dashboard related to the number of babies with Hypoxic Ischaemic Encephalopathy (HIE) was shown as an in-month position of zero (0) which was misleading as no data should have been reported. This has now been rectified and the number of babies with HIE is now reported on a monthly basis

Review underway of process and pathway for registering antenatal referrals with Corporate Outpatients to improve booking by 12weeks and 6 days an important Key Performance Indicator (KPI).

Maternity

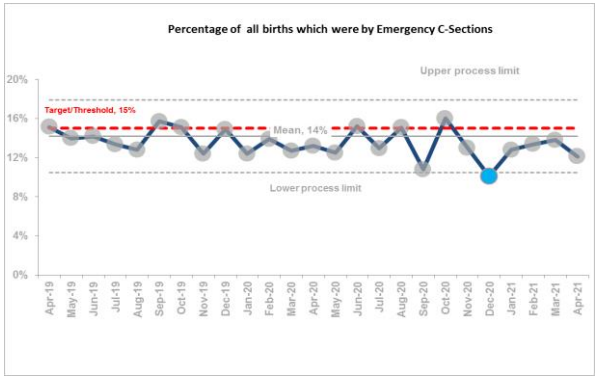
Maternity Dashboard

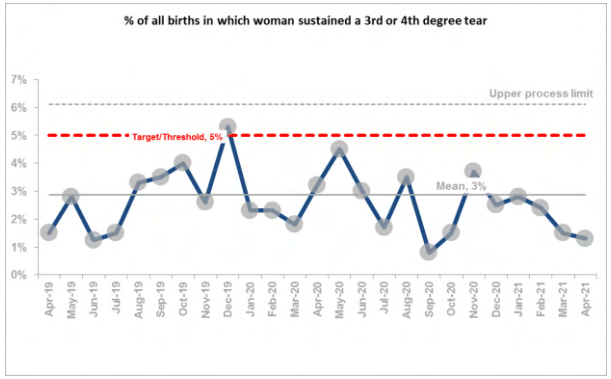
Definitions	Target	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
Total number of women giving birth (per calendar day)	14 per day	12.4	12.3	12.1	13.4	12.7	13.2	13.1	12.6	11.5	11.3	11.7	13.1	12.9
Caesarean sections (Total Emergency and Elective by Delivery date)	<28%	24.9%	22.3%	29.4%	24.1%	27.1%	23.4%	30.9%	27.3%	23.8%	28.5%	28.0%	29.1%	25.5%
% deliveries with Emergency C Section (including no Labour)	<8%	1.9%	2.6%	2.7%	3.1%	4.6%	3.0%	3.7%	2.9%	3.4%	2.3%	3.4%	4.0%	3.4%
% Time Carmen Suite closed	0%	10.0%	8.1%	8.3%	24.2%	48.4%	35.0%	19.4%	6.7%	39.0%	12.9%	9.0%	26.0%	8.3%
% of all births in which woman sustained a 3rd or 4th degree tear	<5%	3.2%	4.5%	3.0%	1.7%	3.5%	0.8%	1.5%	3.7%	2.5%	2.8%	2.4%	1.5%	1.3%
% of all births where women had a Life Threatening Post Partum Haemorrhage >1.5 L	<4%	2.9%	2.1%	1.4%	1.9%	2.0%	5.3%	2.5%	2.9%	2.5%	3.1%	1.2%	3.2%	2.8%
Number of term babies (37+ weeks), with unplanned admission to Neonatal Unit		9	9	15	20	11	13	20	16	11	13	9	11	8
Supernumerary Midwife in Labour Ward	>95%	100.0%	96.8%	96.7%	96.8%	93.5%	90.0%	100.0%	98.3%	91.9%	100.0%	94.6%	98.4%	98.3%
Number of babies born with Hypoxic Ischaemic Encephalopathy (/1000 babies)	<2	0.0	0.0	11.0	0.0	0.0	2.5	0.0	0.0	8.4	5.7	0.0	2.5	2.6
Still Births per 1000 Births	<3	8.0	7.9	8.2	16.9	12.6	2.5	7.4	8.0	5.6	2.8	9.1	4.9	2.6
Neonatal Deaths (KPI 72) per 1000 Births	<3	2.7	2.6	8.2	2.4	0.0	2.5	12.3	2.7	5.6	0.0	3.0	2.5	2.6
Continuity of Care Bookings- % of total bookings made	35%	20.0%	16.8%	21.3%	23.0%	21.4%	27.3%	23.6%	28.3%	29.7%	27.7%	34.3%	40.08%	35.22%
Percentage of all births which were by Emergency C-Sections	15%	13.2%	12.5%	15.2%	12.9%	15.1%	10.8%	16.0%	13.0%	10.1%	12.80%	13.4%	13.8%	12.11%
% women booked by 12 weeks and 6 days	90%	86.1%	82.0%	81.2%	84.6%	85.8%	83.0%	82.4%	83.4%	85.6%	81.3%	82.6%	83.3%	83.8%
Number of term babies (37+ weeks), with unplanned admission to Neonatal Unit as a percentage of deliveries	6%	2.4%	0.2%	4.1%	4.8%	2.8%	3.3%	5.1%	4.1%	2.8%	3.3%	2.3%	2.8%	2.0%

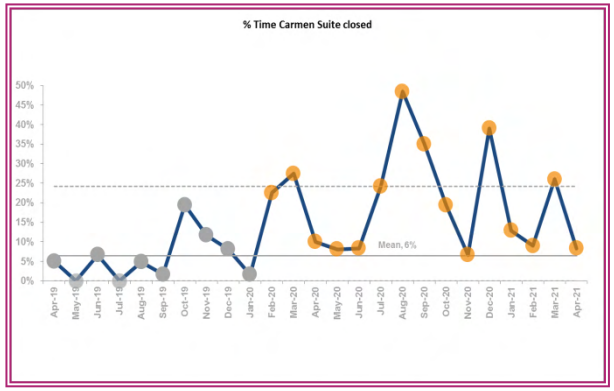
Maternity

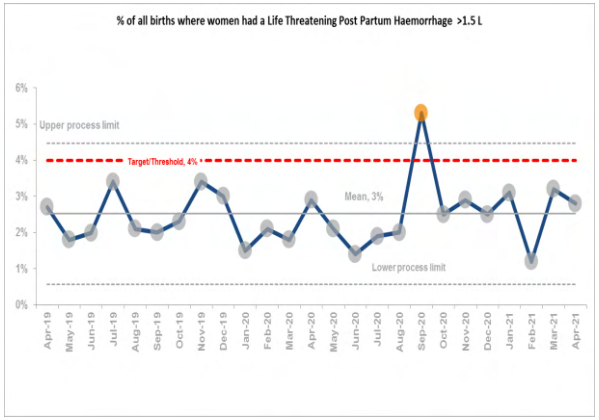
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

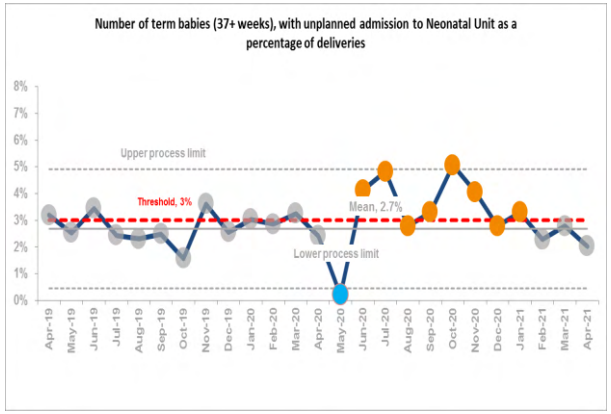
All metrics have been rebased to April 2019

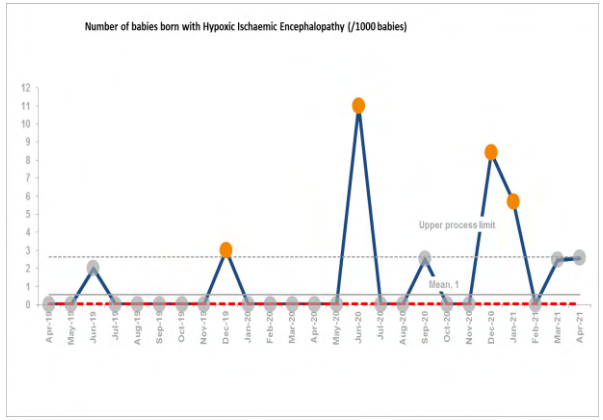












Friends & Family Survey

Indicator Description	Target	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
Emergency Department FFT - % positive responses	90%	93.9%	93.6%	90.0%	89.7%	90.1%	89.5%	89.7%	89.2%	84.9%	92.1%	90.8%	88.8%	86.4%
Inpatient FFT - % positive responses	95%	100.0%	97.2%	93.6%	97.7%	97.2%	96.3%	97.1%	98.6%	97.9%	99.0%	98.3%	99.3%	98.3%
Maternity FFT - Antenatal - % positive responses	90%	100.0%	100.0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	50.0%	N/A
Maternity FFT - Delivery - % positive responses	90%	N/A	100.0%	N/A	100.0%	N/A	66.7%	N/A	94.6%	100.0%	90.4%	93.0%	91.6%	88.9%
Maternity FFT - Postnatal Ward - % positive responses	90%	N/A	0.0%	0.0%	88.9%	100.0%	N/A	100.0%	0.0%	100.0%	N/A	N/A	81.8%	100.0%
Maternity FFT - Postnatal Community Care - % positive responses	90%	N/A	100.0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Community FFT - % positive responses	90%	N/A	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	91.7%
Outpatient FFT - % positive responses	90%	98.2%	89.9%	88.8%	90.3%	89.1%	89.0%	89.1%	89.5%	90.3%	96.9%	90.4%	95.2%	88.7%
Mixed Sex Breaches	0	0	0	0	Report suspended until March 2021									

What the information tells us

- Three of our services did not achieve their target for positive FFT responses, Emergency Department, Maternity Delivery and Outpatients.

Actions and Quality Improvement Projects

For the Emergency Department, the service moved from an external provider to the Trust's FFT collection system. A review is currently underway to understand the reason for the drop in performance.

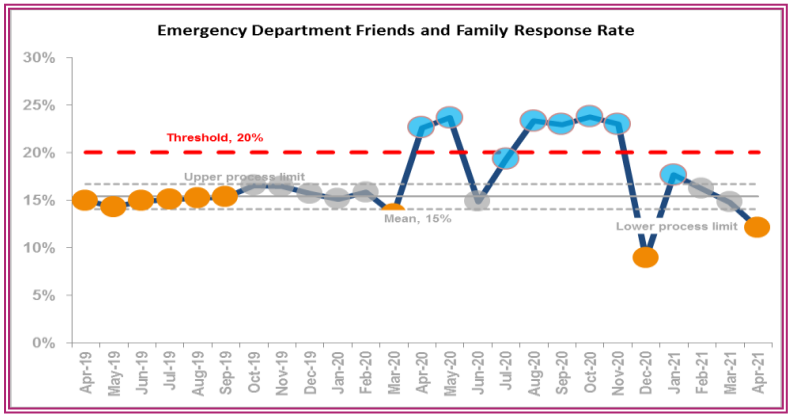
For Midwifery Services delivery, April was again a busy month with a number of high risk deliveries which may have influenced waiting times in triage and bed allocation, although there were no reported delays in pain relief.

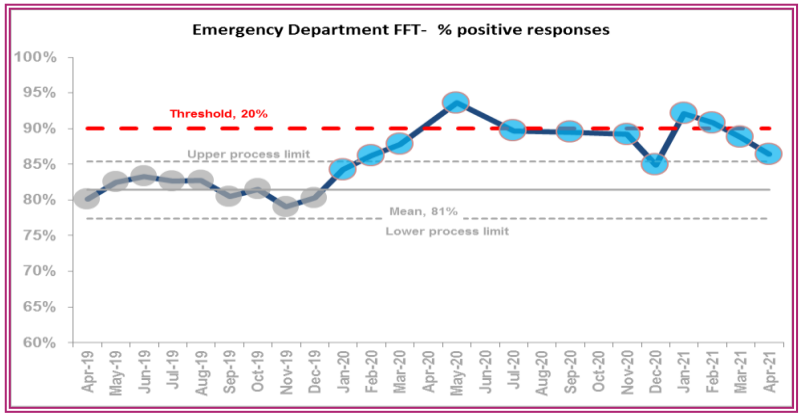
For Midwifery Services post-natal, text message surveys continue to be sent to women who have given birth in the previous month. Women are also providing very useful narrative comments alongside their quantitative feedback which is shared with the senior team.

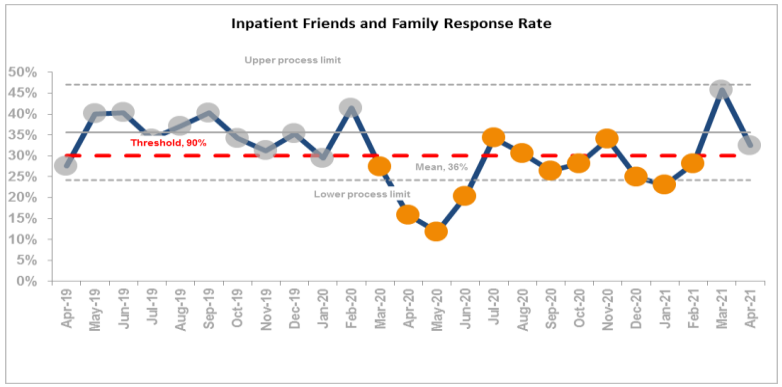
For Outpatient Services due to an increase in face to face activity levels and car parking related issues, the clinic waiting times have increased in some areas, which has seen an increase in dissatisfaction. Students are currently on work experience with the Trust and 'walking the floor' specifically focussing on FFT; firstly to help us ensure we have greater response rates and also to undertake some deep dives in specific areas to help us better understand the feedback we are receiving so we can further improve the service.

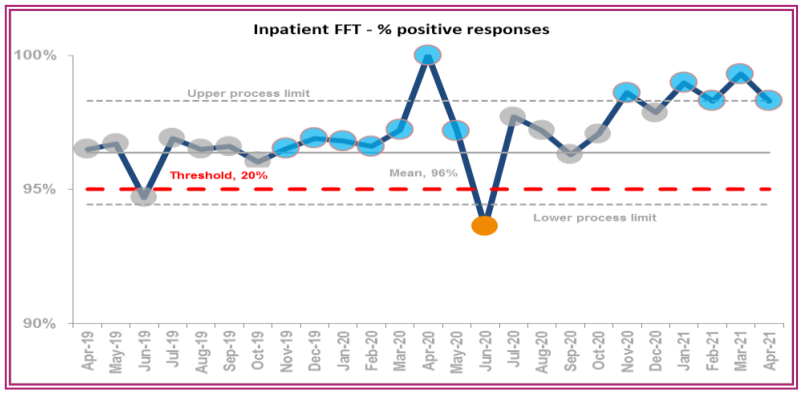
Friends and Family Test

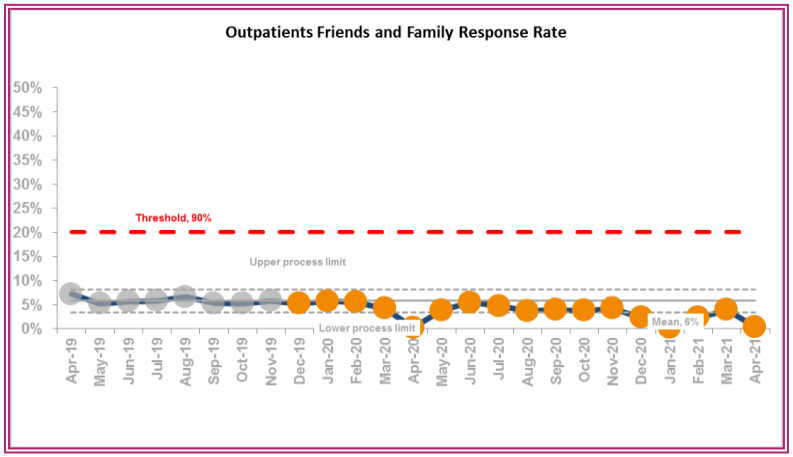
Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance

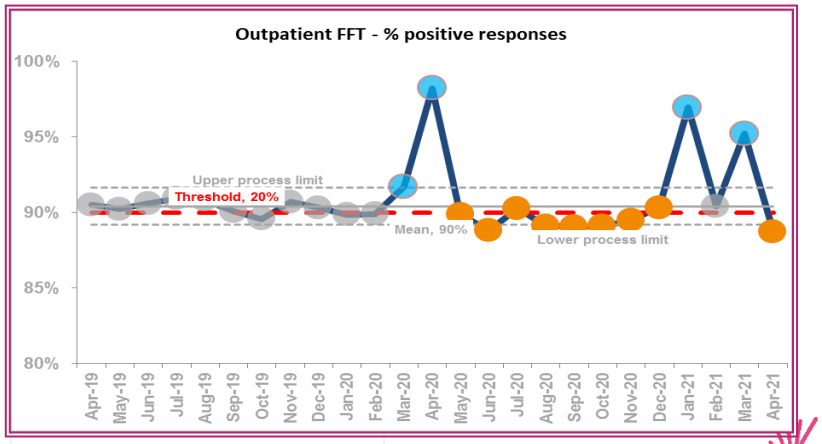








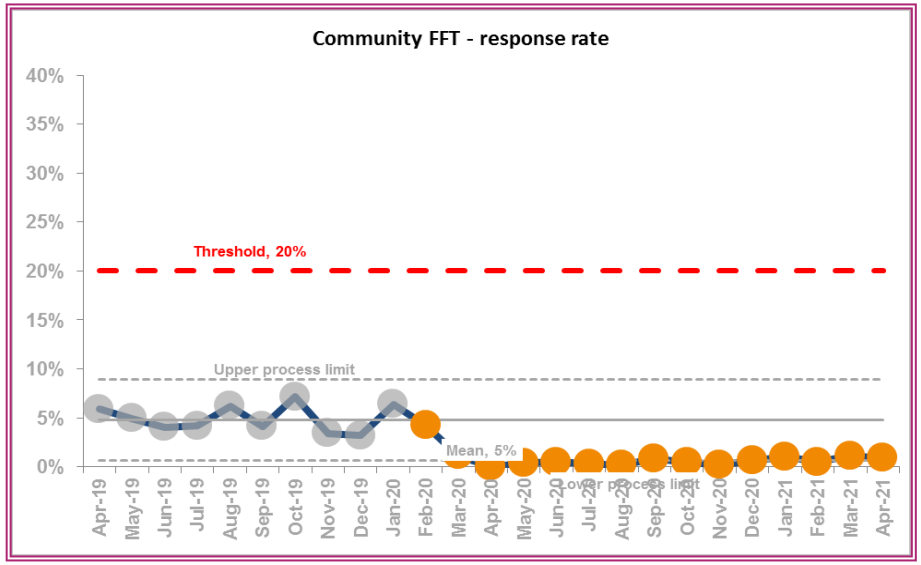


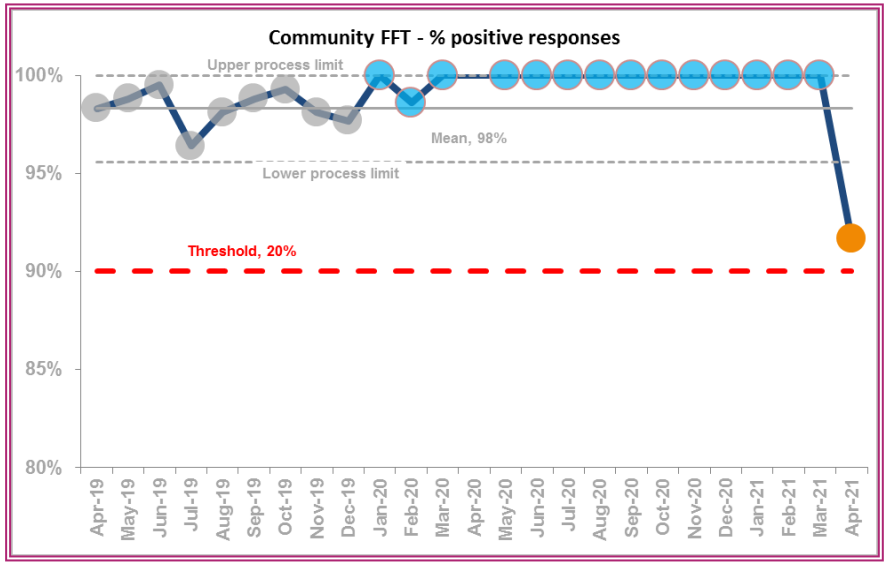


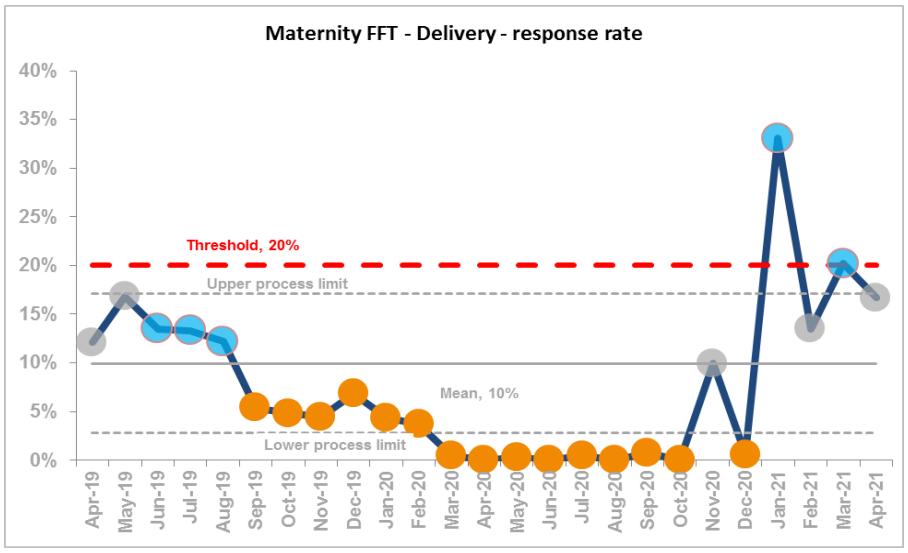
All metrics have been rebased to April 2019

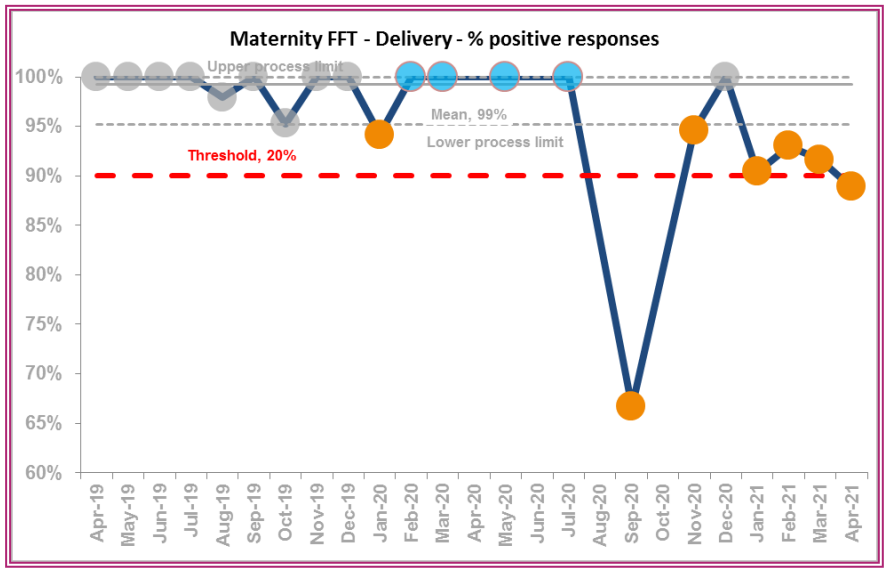
Friends and Family Test

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









Balanced Scorecard Approach

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

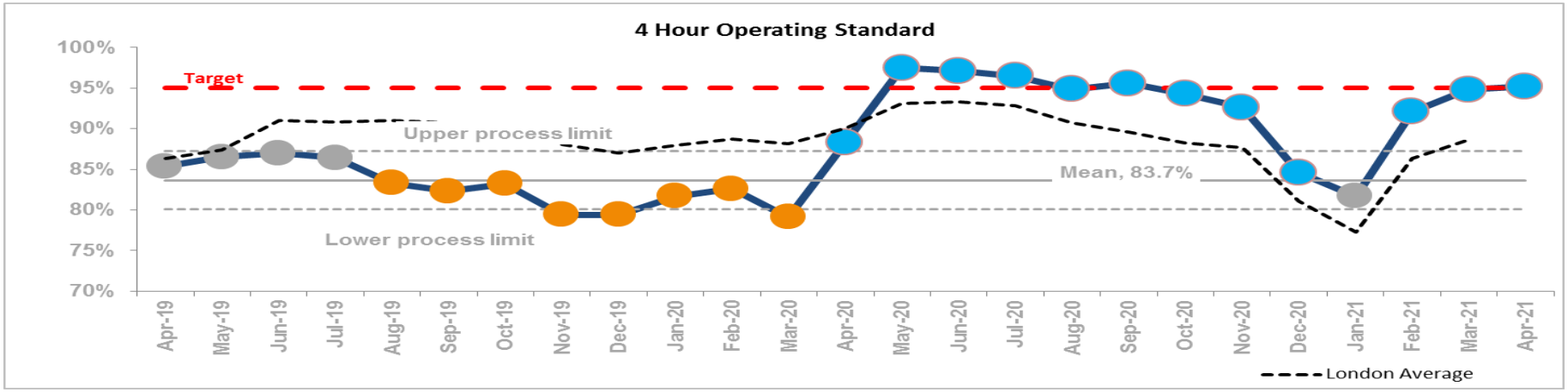
Key

Current Month

A Previous Month

Scorecard RAG rating based on PreCOVID-19 plan

Emergency Flow



What the information tells us

The Trust improved its Four Hour Operating Standard performance in April, exceeding the national target with 95.2% of patients attending the emergency department being able to either go home, be admitted or transferred within four hours of their arrival.

We have seen throughout the month a daily increase of, on average 70 patients per day attending the department, and although activity levels continue below the lower control limit, the department continues to see a continued upward trend in demand. Both the admitted and non-admitted pathway performance remains above the upper control limits with non-admitted performance consistently above 95%. The proportion of walk-in patients increased by 16% in April compared to the previous month whilst also seeing an increase in ambulance arrivals by, on average four attendances per day. On average, 48% of patients scored between 1-3 against the Manchester Triage Score System compared to 49% in March. Flow has been challenged at times with insufficient capacity for demand mixed with high volumes of patients. The midday occupancy rate on AMU ward increased above 80% for most days throughout the month impacted by the need to wait on COVID-19 swab results before admitting patients to downstream wards. However, the discharge profile and the decrease in patients with a length of stay of over 7 days has helped maintain flow from ED.

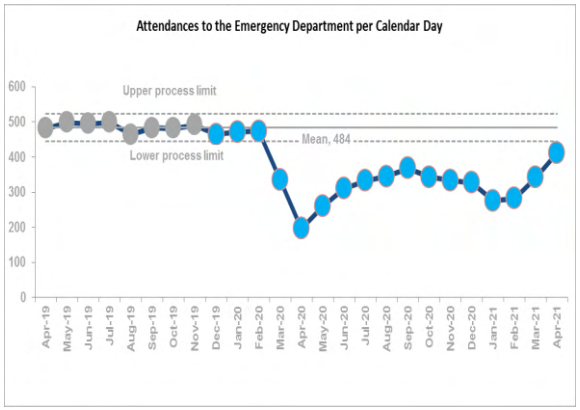
Ambulance handover performance against the 30-minute standard has improved with performance above the mean and above the London average.

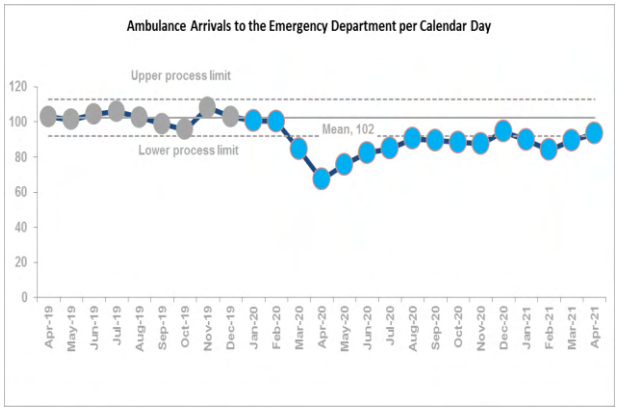
Actions and Quality Improvement Projects

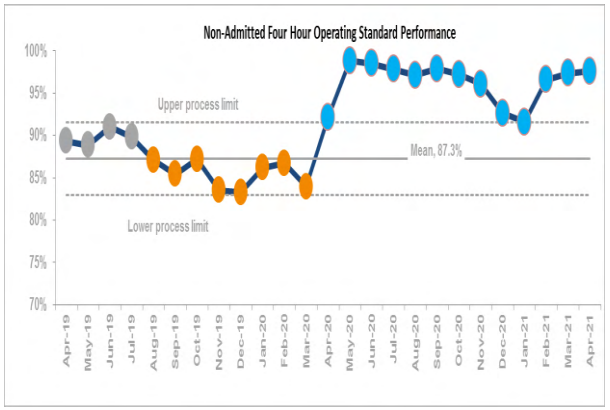
- ED continues to hold daily internal reviews of the previous day's performance and additionally continues to meet regularly with other clinical and non-clinical areas to explore opportunities for improvement.
- Focussed piece of work is looking to ensure appropriate patients within the QMH locality are directed to the Enhanced Primary Care Hub (EPCH) rather than being advised by 111 or their GP to attend SGUH.
- Continuing issues with the number of adult and paediatric mental health patients attending the department and the capacity of partners to support their care needs, this is being addresses through engagement with COOs of SGUH and the mental health providers.
- Work has commenced on understanding and measuring performance against the new Emergency Care Standards.

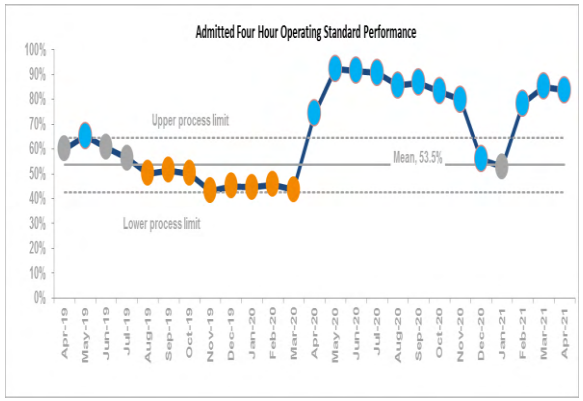
Emergency Flow

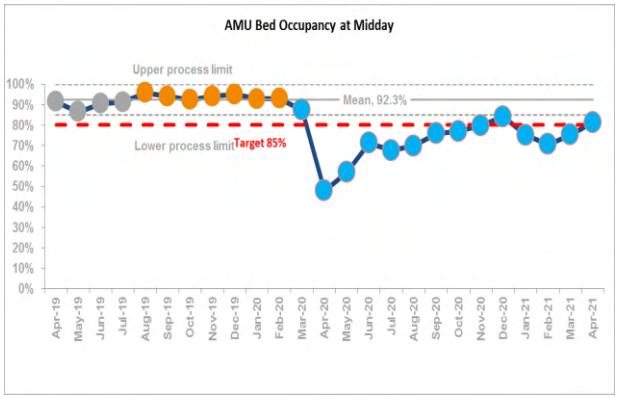
Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance

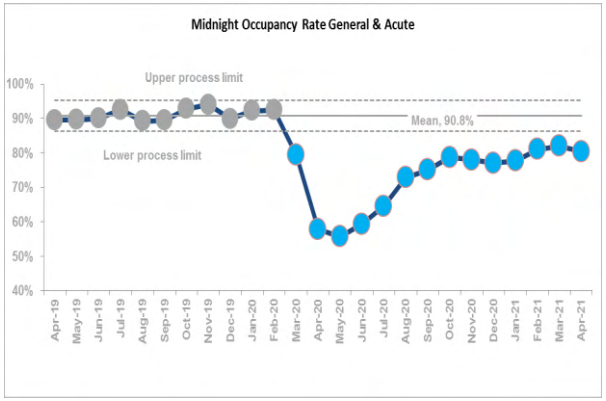


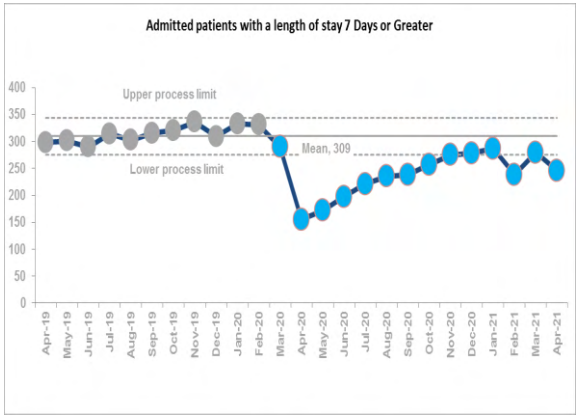


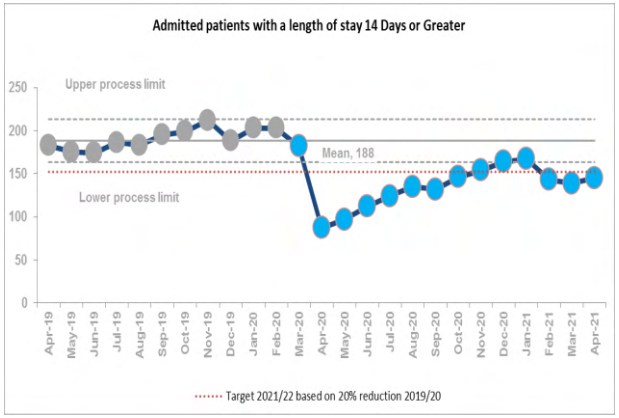


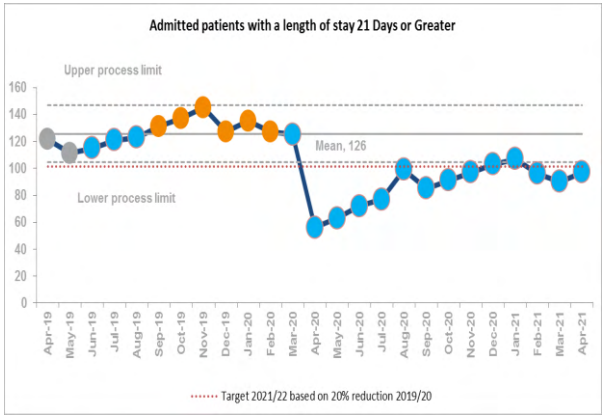






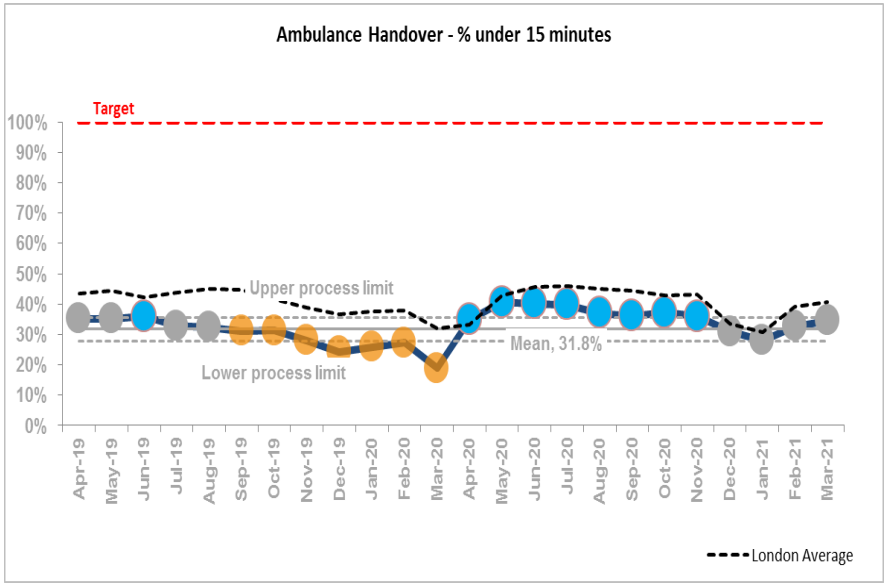


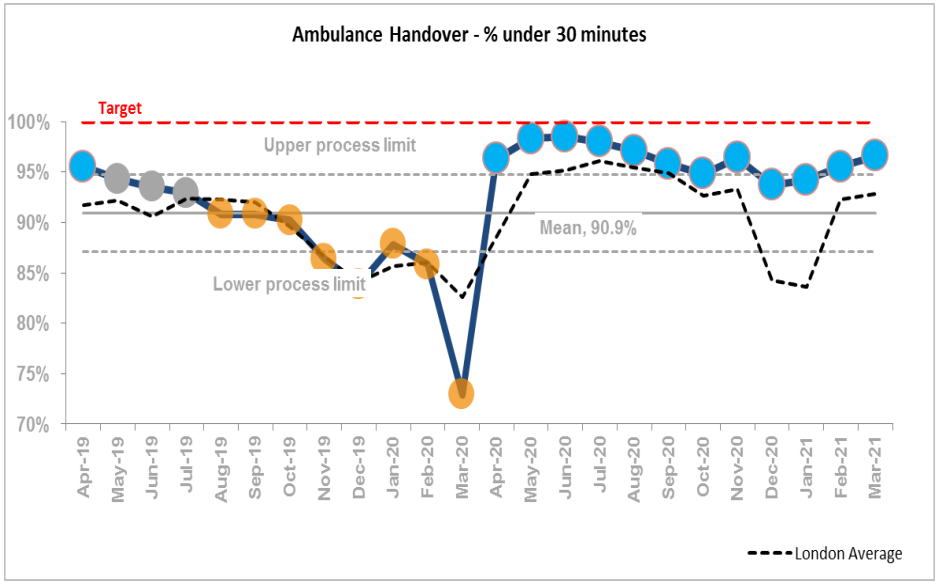


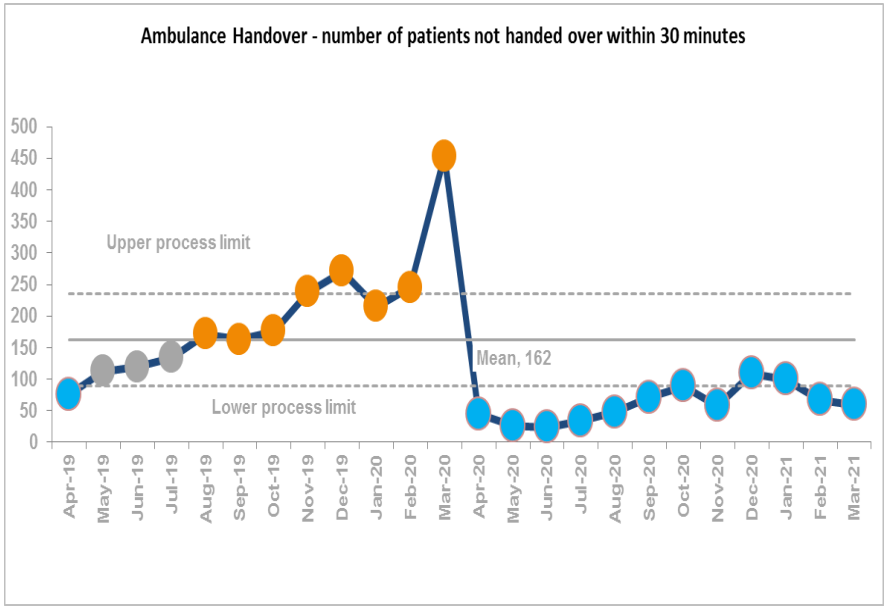


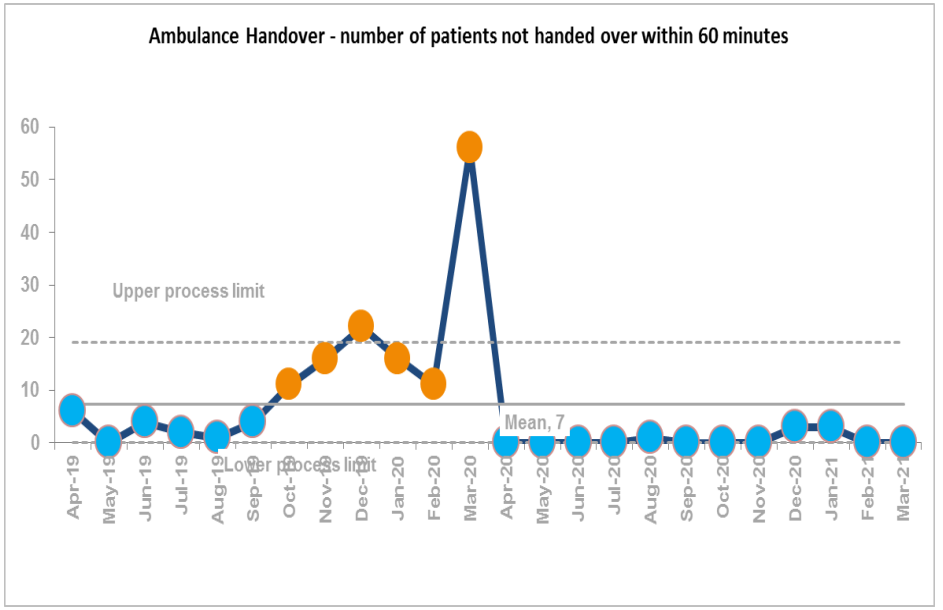
Emergency Flow

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



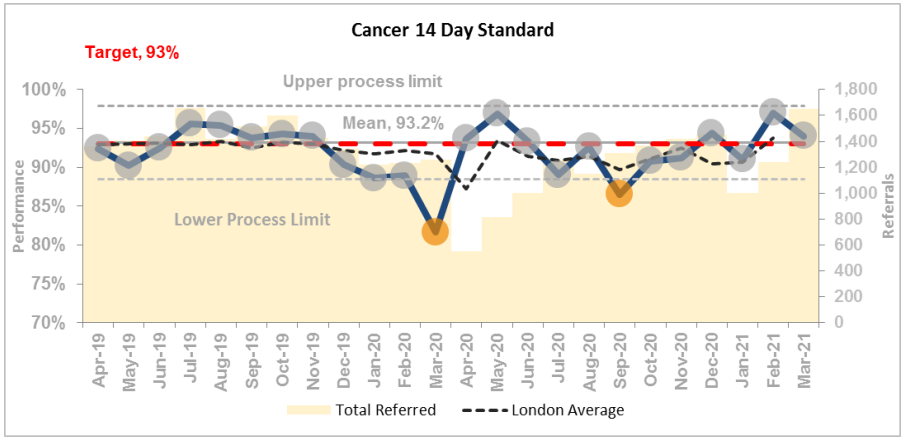


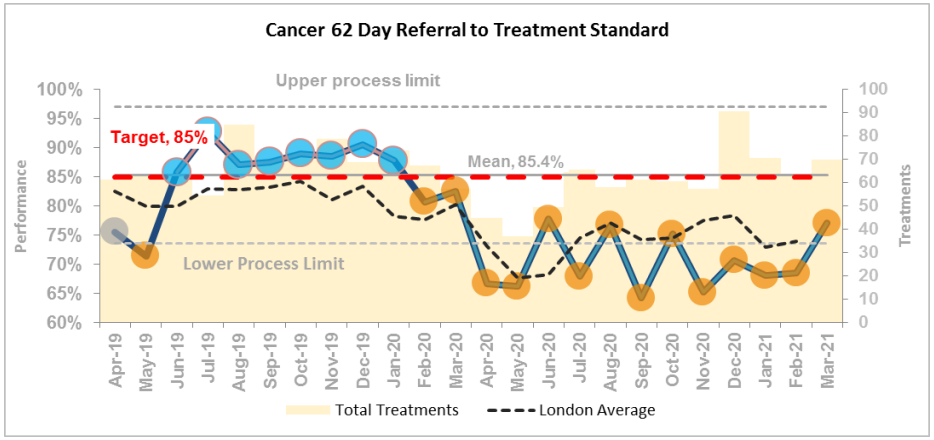




Ambulance handover data is one month in arrears

Cancer





What the information tells us

In March, the Trust achieved three of the seven cancer standards - 14 Day Standard, Cancer 31 Day Subsequent Treatment (Surgery) and Cancer 31 Day Subsequent Drug Treatment.

Performance against the 14-day standard remained compliant with 94% of patients being seen within 14 days. There were 2149 2WW referrals in March 1640 against a base line 1901 in March 2019, an increase of 120. The increases were seen in breast and skin. All tumour groups were compliant with the exception, Breast and Haematology. Performance against the 14 Day Breast Symptomatic was 77.2%. Total Breast referrals were 515 in March 2019 and increased to 623 in March 2021 but remained within the control limit. The Trust will not report a compliant 2WW position for April or May, due to the issues within the Breast service.

Performance against the 31-day treatment standard remains below the lower control limit reported with 92.2% of patients receiving treatment within 31 days of diagnosis compared to 94.1% in February, the number of patient treatments were in line with the baseline pre-COVID with the same levels of activity being maintained. This is attributed to the priority 3 patients being brought forward for surgery. Six tumour groups were above the standard of 96%. A return to compliance is expected once the 63 day plus backlog returns to the BAU level in September.

There were 71 accountable treatments on the 62-day GP pathway, of which 55 patients received treatment within 62 days. The trust moved away from a focus on NHSE priority 2 patient and theatre capacity was increased to treat P3 patients. Monthly performance increased moving within the upper and lower control limits, with a performance of 77.5% in month. There were 16 breaches of the 62 Day standard, attributed to IPC guidance, other COVID delays, clinical complexity, late inter trust transfer and patient choice. Currently there are 133 patients on the 63 day plus patient tracking list. Specialities have agreed a trajectory to have treated all the P3 patients in the backlog by the end of Quarter 1 and a return to the pre-covid level of 90 by September 2021. The Trust should return to 62-day compliance from Q3.

Actions and Quality Improvement Projects

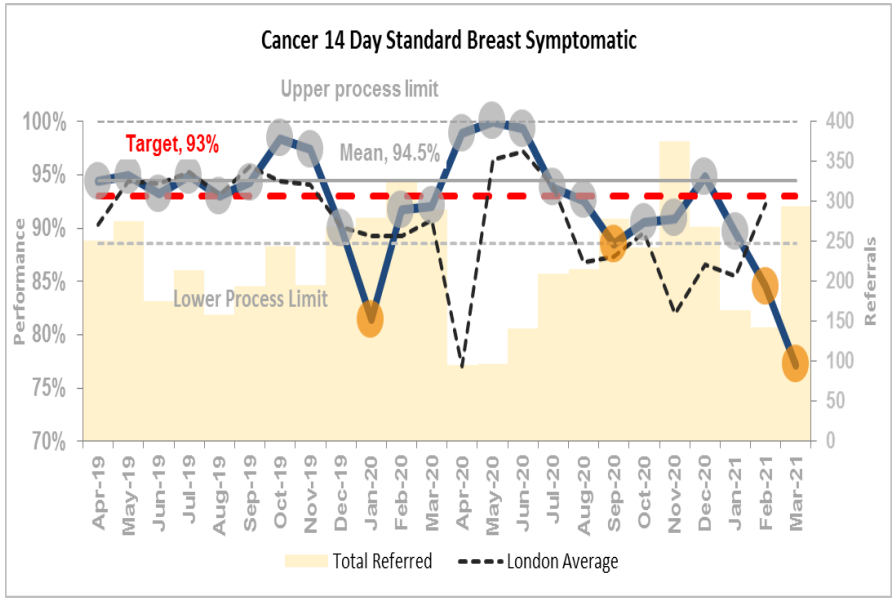
TWR – All services with the exception Breast have returned to compliance in the month of March. Challenges are seen in GI and Breast – a recovery plan is in place. All services have been given revised demand projections for the next 12 months and are working to ensure that the capacity is available

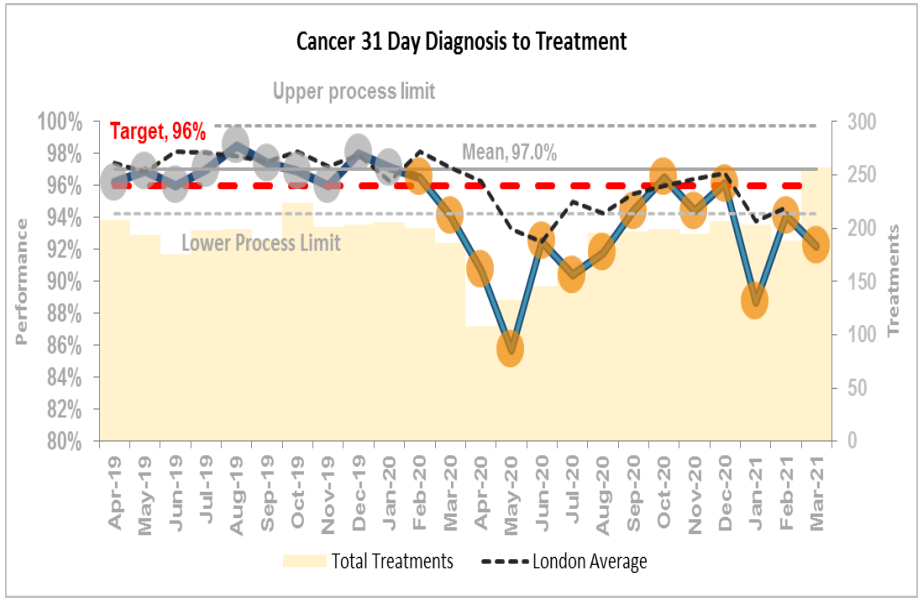
The **Rapid Diagnostic Clinic** is supporting the earlier diagnosis of cancer in patients who have a range of vague symptoms and has been running since January 21. The RDC model has thus so far has demonstrated its ability to support the early diagnosis of cancer patients; having achieved 97.1% in March in seeing patients by day 14 and 100% of confirmed cancer were treated for cancer by day 62.

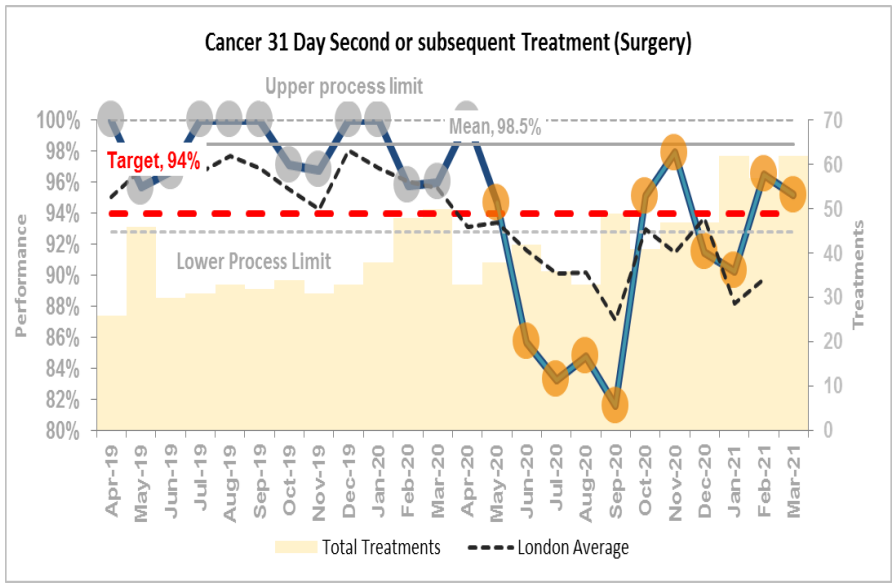
63+ days – It is expected that the numbers of patients over 63 days will return to the BAU baseline by September. Treatment trajectories have been set and agreed with services to achieve this

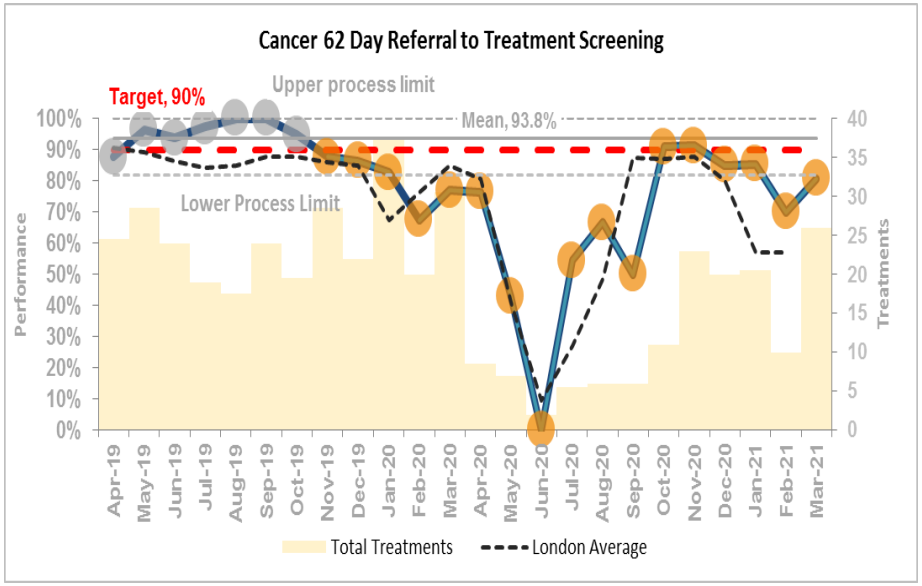
Cancer

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









Cancer

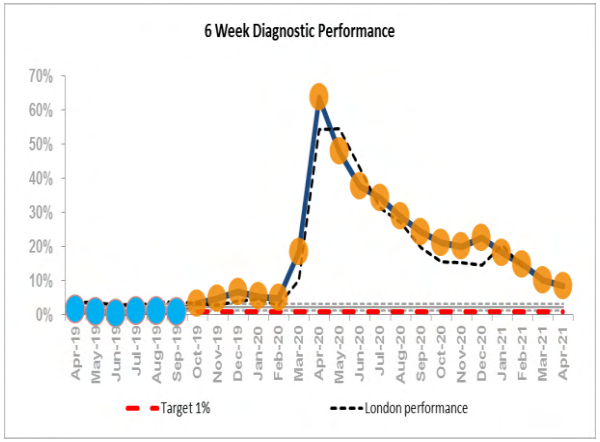
14 Day Standard Performance by Tumour Site - Target 93%

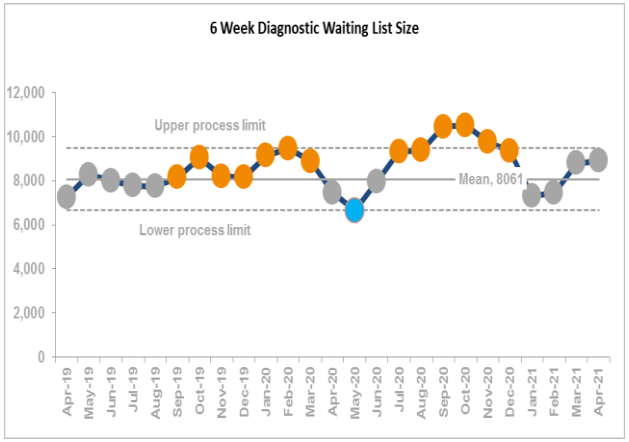
Tumour Site	Target	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	No of Patients
Brain	93%	-	-	-	-	-	-	-	-	-	-	-	-	-	
Breast	93%	93.3%	97.5%	100.0%	98.6%	95.5%	94.3%	88.6%	92.0%	91.6%	95.0%	86.6%	92.5%	82.9%	334
Children's	93%	100.0%	-	83.3%	100.0%	75.0%	75.0%	100.0%	75.0%	100.0%	100.0%	100.0%	100.0%	100.0%	3
Gynaecology	93%	86.9%	93.0%	96.3%	93.8%	92.5%	97.2%	91.6%	91.9%	94.3%	91.6%	79.3%	94.9%	94.9%	117
Haematology	93%	100.0%	100.0%	100.0%	100.0%	75.0%	91.3%	96.0%	96.2%	96.2%	96.2%	95.5%	100.0%	90.0%	30
Head & Neck	93%	90.8%	97.1%	100.0%	97.7%	96.1%	96.2%	84.1%	93.7%	96.0%	98.8%	91.6%	96.4%	94.6%	166
Lower Gastrointestinal	93%	63.8%	86.8%	95.6%	93.6%	86.9%	78.7%	61.8%	83.1%	76.4%	92.2%	99.3%	98.6%	98.2%	225
Lung	93%	85.7%	83.3%	90.9%	72.7%	62.5%	80.0%	90.5%	100.0%	94.4%	76.5%	90.0%	100.0%	94.4%	18
Skin	93%	84.1%	93.2%	96.7%	91.4%	87.4%	97.0%	95.4%	93.7%	95.1%	93.0%	90.7%	98.7%	98.0%	512
Upper Gastrointestinal	93%	75.5%	93.5%	98.4%	93.1%	84.4%	95.8%	93.0%	94.8%	90.6%	98.0%	95.3%	100.0%	95.4%	108
Urology (Suspected testicular cancer)	93%	93.9%	94.0%	85.5%	82.4%	80.4%	78.3%	85.6%	83.3%	93.3%	98.2%	95.3%	98.9%	97.1%	139

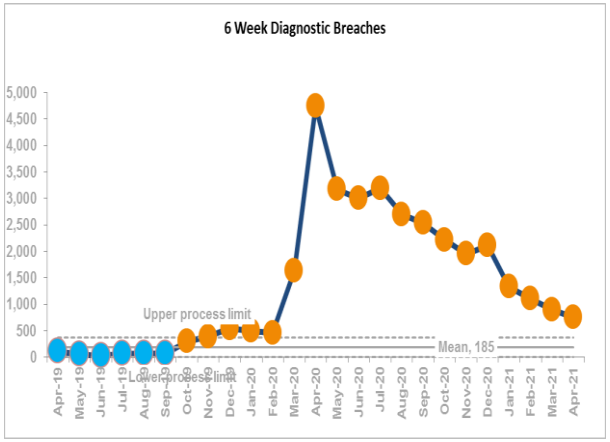
62 Day Standard Performance by Tumour Site - Target 85%

Tumour Site	Target	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	No of Treatments
Brain	85%	-	-	-	-	-	-	-	-	-	-	-	-	100.0%	0.5
Breast	85%	58.8%	100.0%	100.0%	100.0%	100.0%	50.0%	92.3%	83.3%	84.6%	84.6%	75.0%	62.5%	100.0%	10
Children's	85%	-	-	-	-	-	-	-	-	-	-	-	-	-	0
Gynaecology	85%	100.0%	0.0%	50.0%	50.0%	100.0%	100.0%	71.4%	33.3%	100.0%	0.0%	50.0%	-	50.0%	4
Haematology	85%	33.3%	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	77.8%	87.5%	100.0%	88.9%	100.0%	4.5
Head & Neck	85%	81.0%	50.0%	66.7%	83.3%	52.4%	100.0%	25.0%	60.0%	61.5%	57.1%	52.9%	57.9%	83.3%	9
Lower Gastrointestinal	85%	75.0%	42.9%	50.0%	-	100.0%	60.0%	22.2%	25.0%	42.9%	38.5%	60.0%	33.3%	33.3%	9
Lung	85%	100.0%	62.5%	0.0%	85.2%	50.0%	60.0%	77.8%	55.6%	33.3%	100.0%	50.0%	73.3%	100.0%	4
Skin	85%	100.0%	52.9%	81.8%	85.2%	82.4%	100.0%	100.0%	100.0%	50.0%	81.5%	87.1%	88.9%	92.6%	13.5
Upper Gastrointestinal	85%	-	0.0%	33.3%	71.4%	80.0%	100.0%	28.6%	100.0%	100.0%	53.8%	50.0%	71.4%	33.3%	3
Urology	85%	81.5%	100.0%	64.3%	25.0%	27.3%	78.8%	55.6%	71.4%	57.1%	78.4%	57.6%	73.3%	70.8%	12
Other	85%	100.0%	0.0%	100.0%	100.0%	28.6%	-	0.0%	100.0%	100.0%	-	-	57.1%	100.0%	0.5

Diagnostics







What the information tells us

In April, the Trust reported a continued improvement in performance against the six-week diagnostic standard with a performance of 8.5% compared to 10.2% in March. The number of patients on the waiting list continues showing common cause variation with a total of 8,904 patients, an increase of 1.2% compared to the previous month. However, the proportion of patients below six weeks continues to rise increasing by 3% compared to the previous month.

At the end of April, 753 patients were waiting beyond six weeks compared to 897 patients in the previous month - a decrease of 16%. Decreases in the month have been impacted by decreases within Audiology, Colonoscopy and Gastroscopy. The largest proportion of six-week breaches are within Gastroscopy however this has reduced by 15.4% compared to March. Sleep Studies returned to compliance with no patients waiting beyond six weeks.

The average wait time for all modalities is 2.9 weeks - continuing a downward trend. There are currently five modalities where the average wait is over six weeks, they are: Audiology, Electrophysiology, Cystoscopy, Gastroscopy and Urodynamics.

Actions and Quality Improvement Projects

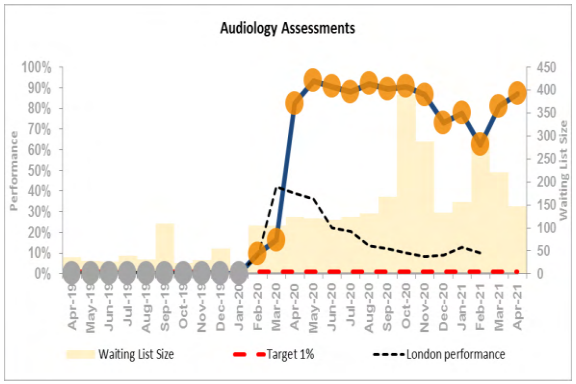
Audiology – Patients on the waiting list at the Queen Mary's site are due to be transferred to Kingston on the 15th May.

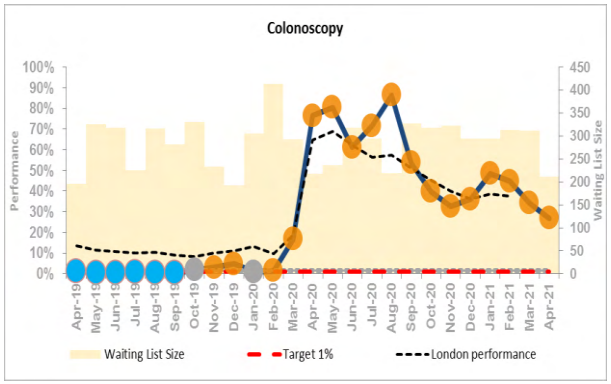
Endoscopy – has stepped up capacity from 6 April and is now operating from 9 rooms across SGH/QMH and Nelson sites. Recovery is forecast to be achieved by October 2021.

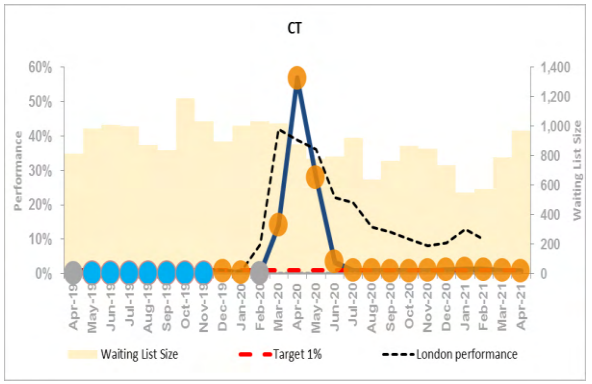
Echocardiography – Recovery trajectory is going to plan with waits above six weeks reducing on a monthly basis. Plan to stop use of insourcing by external company by August 2021. The Cardiology diagnostic service is currently working with NHS England and NHS Improvement on the Echo Recovery Project for South West London using demand and capacity tools over the next twelve week period.

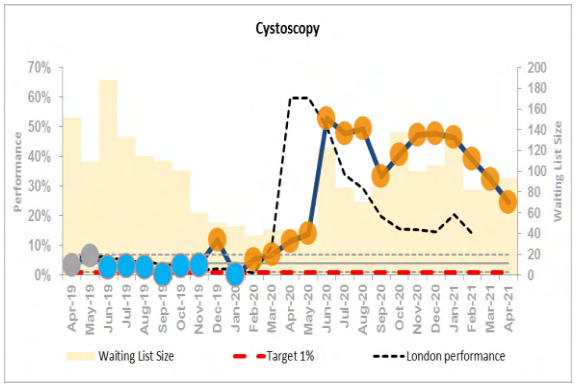
Diagnostics

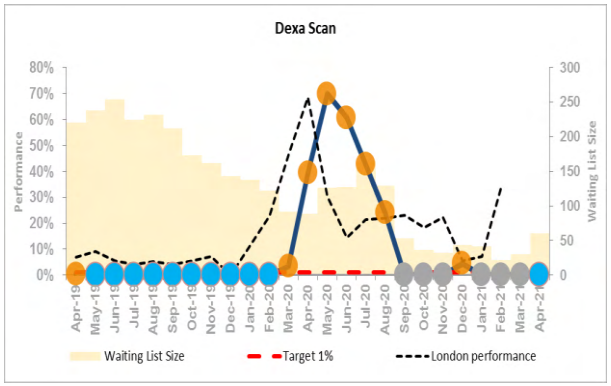
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

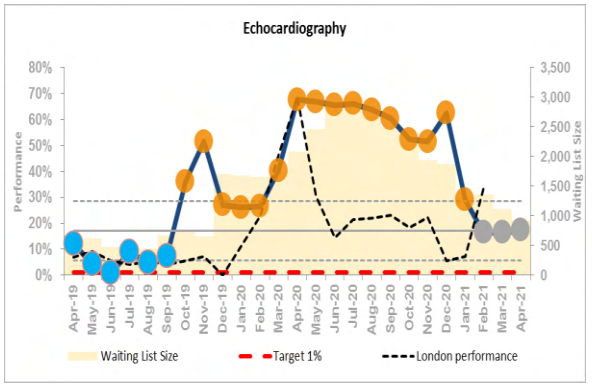


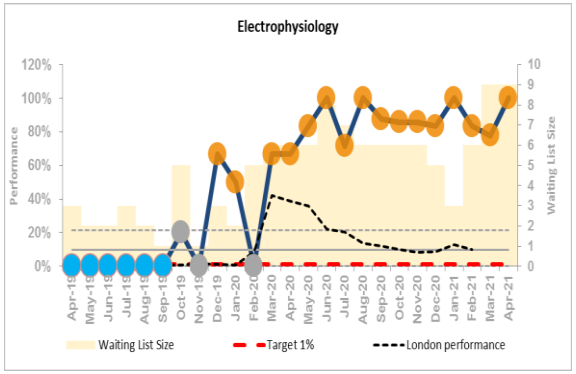


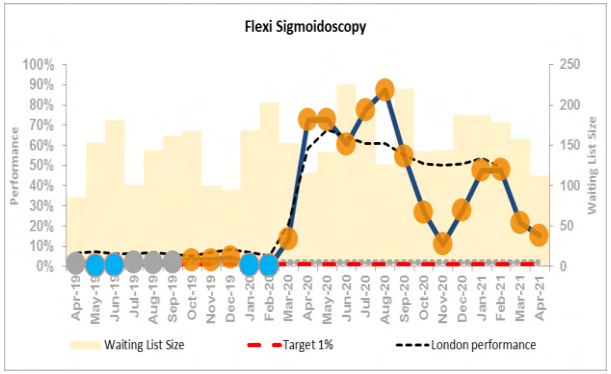


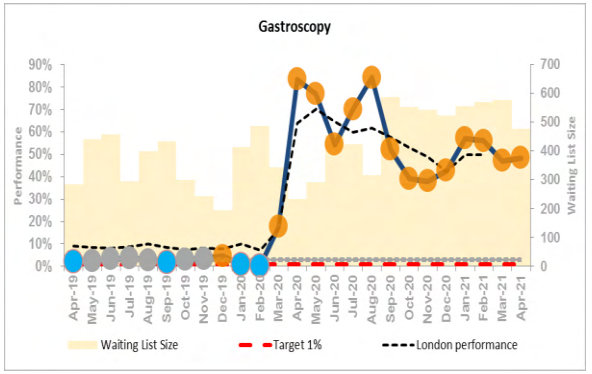






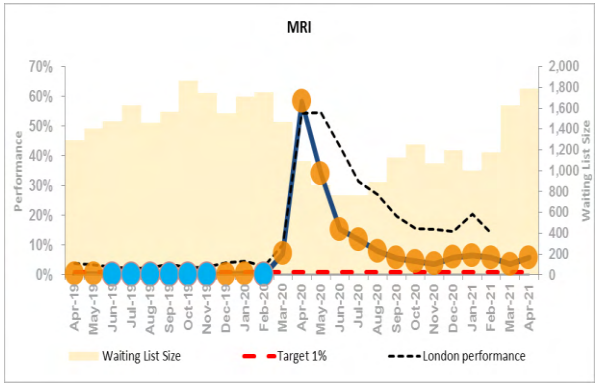


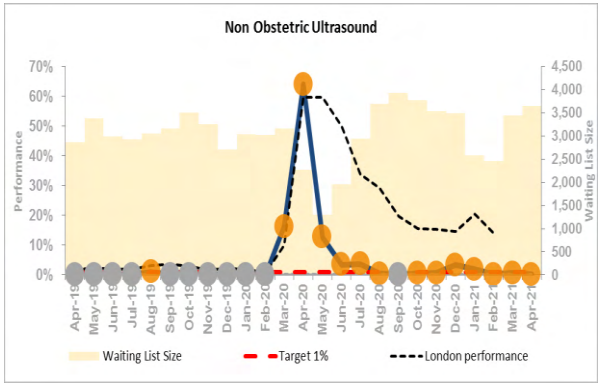


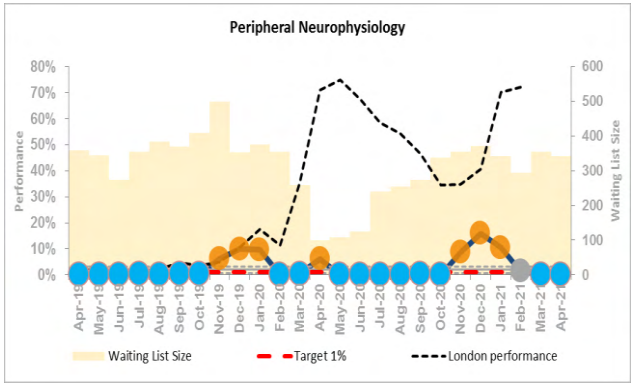


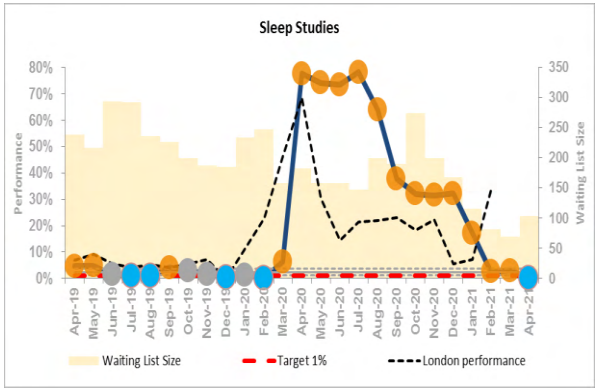
Diagnostics

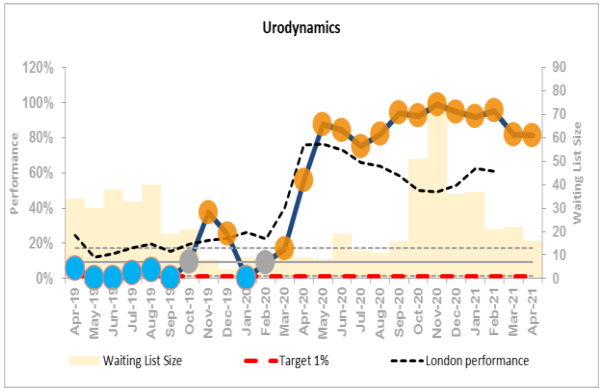
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance



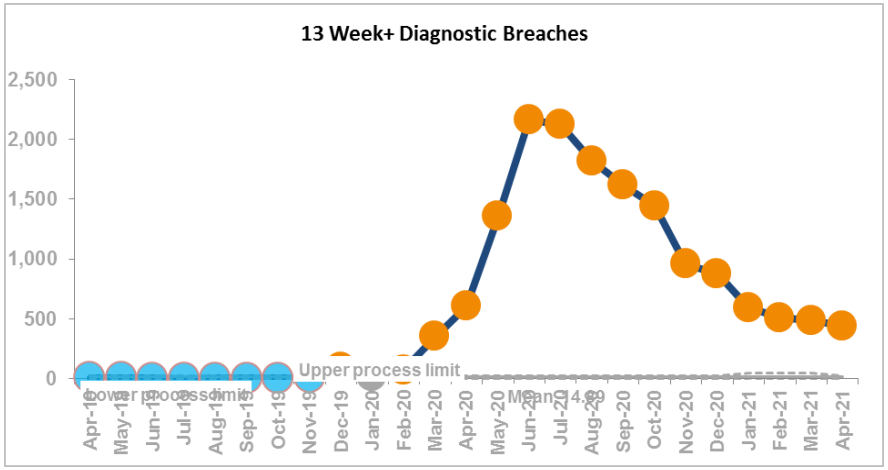


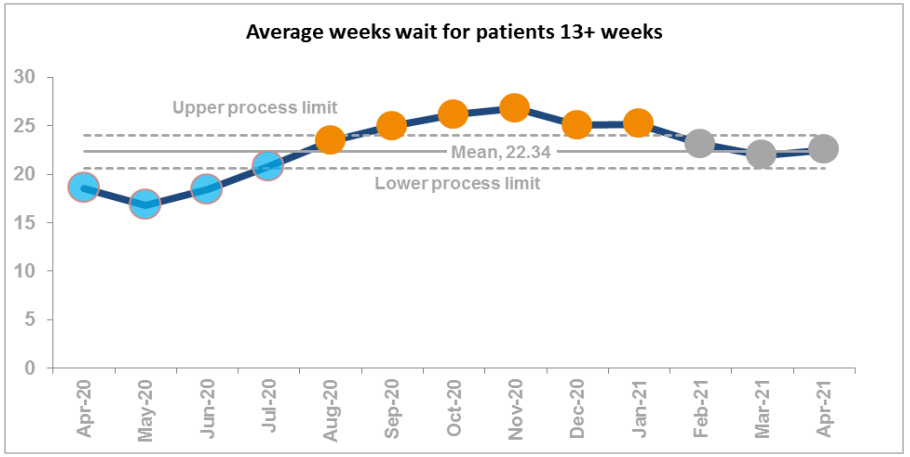






Diagnostics – Patients waiting for more than 13 Weeks





Modality	Feb-21	Mar-21	Mar-21	Variance last month	% Variance last month
Audiology - Audiology Assessments	95	124	69	-55	-44%
Cardiology - echocardiography	154	99	84	-15	-15%
Cardiology - electrophysiology	4	4	6	2	50%
Colonoscopy	90	32	47	15	47%
Computed Tomography	4	4	4	0	0%
Cystoscopy	22	25	16	-9	-36%
Flexi sigmoidoscopy	36	21	13	-8	-38%
Gastroscopy	163	142	177	35	25%
Magnetic Resonance Imaging	19	21	15	-6	-29%
Respiratory physiology - sleep studies	2	1	0	-1	-100%
Urodynamics - pressures & flows	12	13	11	-2	-15%
Grand Total	601	486	442	-44	-9%

What the information tells us

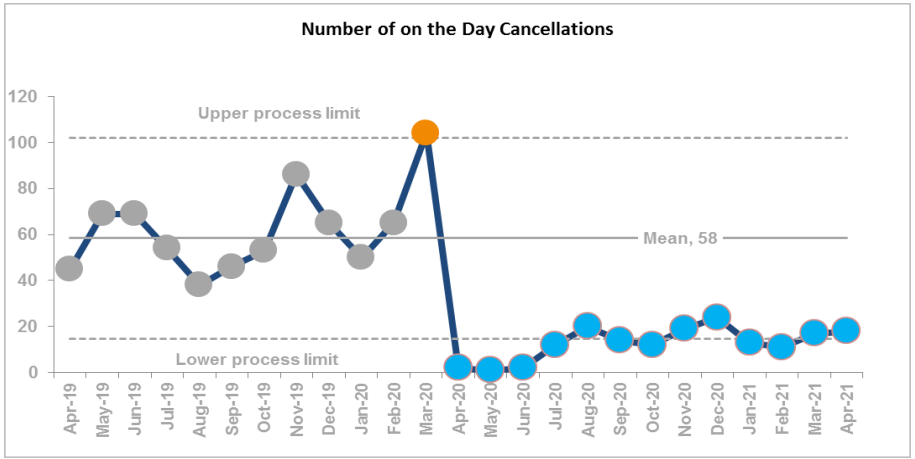
In April, 442 patients were waiting for more than thirteen weeks which is a decrease of 9% (44 patients) compared to March. The average weeks wait for these patients is currently 22 weeks.

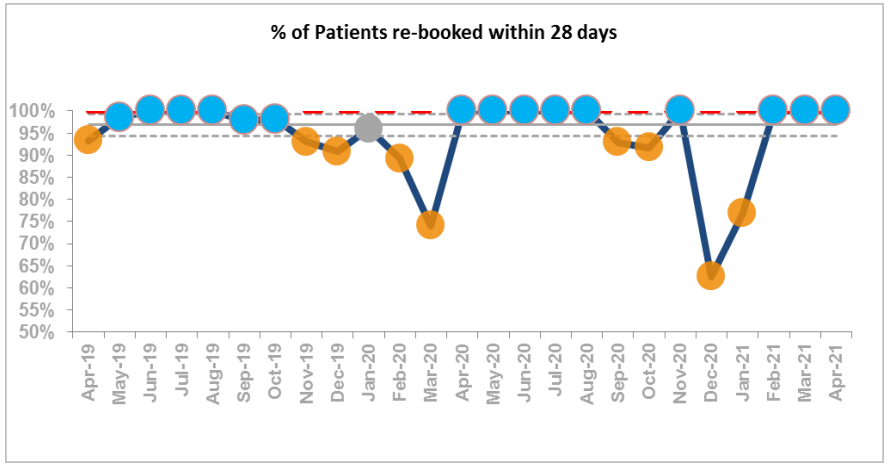
Endoscopy although has seen a reduction in six-week waiters**,** the number of patients waiting more than thirteen weeks has increased in April, the average waiting time for these patients is improving, from an average waiting time of 21 weeks in March to 19 weeks in April. Gastroscopy has had the largest impact overall with an increase of 35 patients. The larger Endoscopy waits have been driven by the Tooting site Endoscopy unit being converted to an ITU surge area during the second wave of the pandemic. The unit has returned to diagnostics with capacity stepping up from 6 April. 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.

Echocardiography continues a downward trend in patients waiting for more than thirteen weeks with a decrease of 15 patients compared to the previous month (15%). The reduction is driven by both increased activity using insourcing capacity and waiting list review. 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.

Audiology – Additional capacity was provided to reduce overall waiting times for patients needing audiology assessments and in the month of April the number of patients waiting greater than thirteen weeks has reduced by 44%. From 15 May, patients waiting for audiology diagnostics on the Queen Mary's site will be transferred to the care of Kingston Hospital reducing St George's Patient Tracking List.

On the Day Cancellations for Non Clinical Reasons





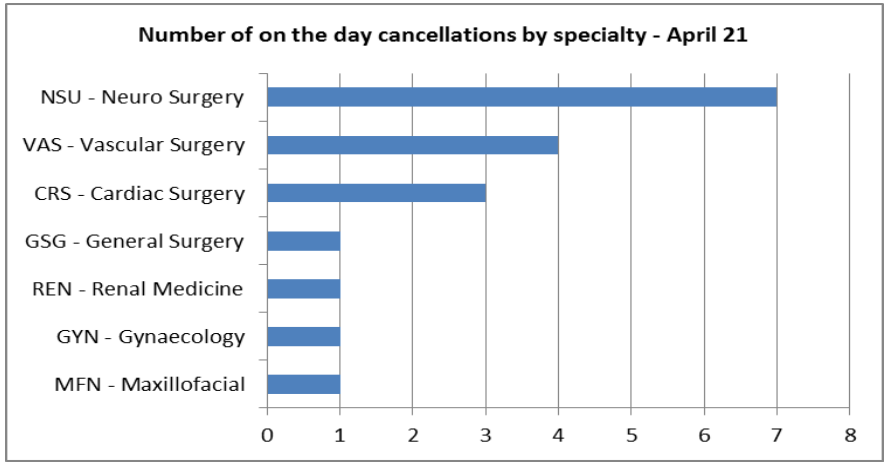
What the information tells us

The number of on-the-day cancellations for non-medical reasons remain below the mean. In April, a total of eighteen patients were cancelled on the day of which all patients were offered a rebooking date within 28 days reporting 100% compliance for a consecutive month.

Neurosurgery had the largest proportion of on-the-day cancellations in the month with 57% of those due to emergency cases taking priority.

Cancellation reasons are broken down as follows:

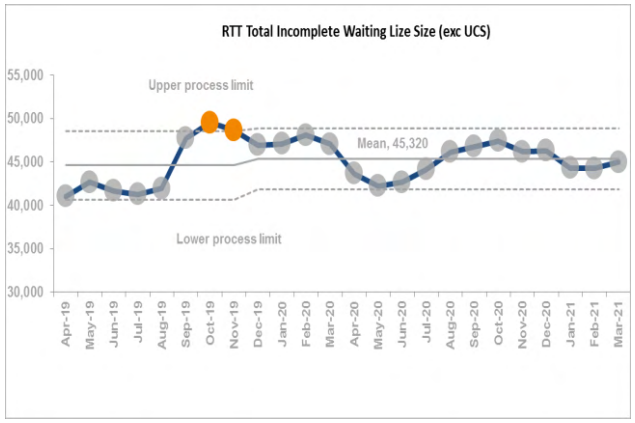
Timing – Emergency case took priority – 6
Timing – List over booked – 5
Timing – Complication - previous case/-s – 3
Staffing – 2
Bed – No Critical Care bed available – 2

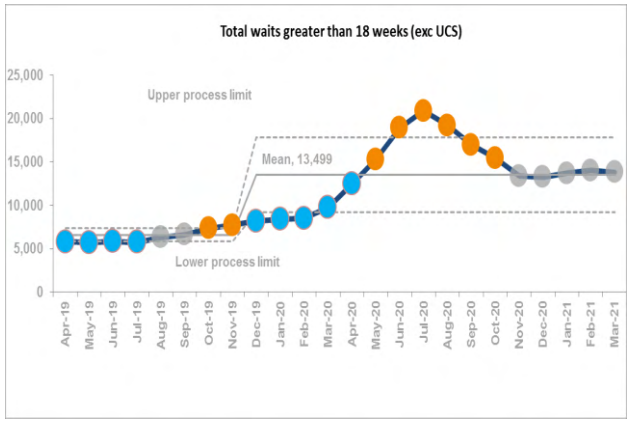


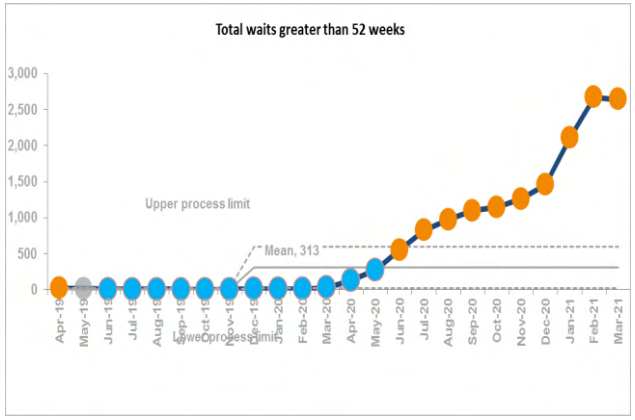
Actions and Quality Improvement Projects

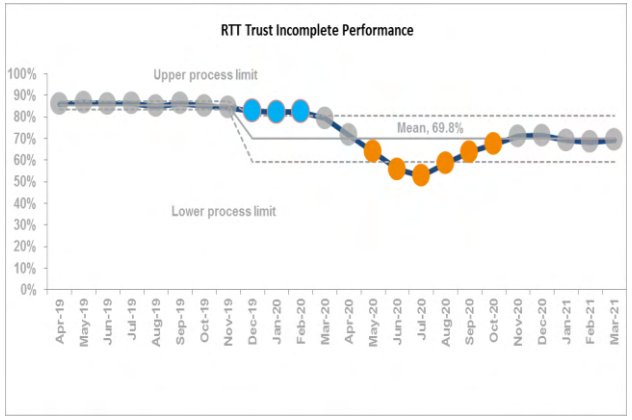
- 14 of the 18 cancellations were as a result of timing issues (emergency took priority, list over booked or complication) – however all patients were subsequently rebooked within 28 days.
- To mitigate this risk of cancelling for an emergency, more capacity has been provided. However where mixed elective and emergency lists occur (Vascular and Neuro), cancellations may happen to ensure lists are full optimised and more patients treated as a result.
- Cancellation avoidance policies involving divisional silver and DDO have been reintroduced to prevent unnecessary cancellations.
- Forward planning and 6-4-2 processes in place to ensure staffing is confirmed ahead of the day of surgery.
- New ITU booking process introduced to identify bed requirements to ensure sufficient capacity so patients aren't cancelled on-the-day due to bed availability.

Referral to Treatment — March 2021









Note: Unknown Clock Starts (UCS) have been excluded from the above metrics. For context the number of UCS in March was 404, a increase from 374 in February. Compared to the same month last year this is a 63% improvement.

What the information tells us

In the month of March, there were 44,960 patients waiting for treatment on the Patient Tracking List (PTL), seeing an overall increase of 1.6% compared to the previous reporting month with the waiting list size within the upper and lower control limits showing only common cause variation. Compared to the same month last year the PTL size this month is 4% lower.

The Trust continues to see a positive reduction within the non-admitted pathway with the number of patients waiting for treatment beyond 18 weeks reducing by 6% compared to February and the number of 52 week breaches reducing from 1,361 patients in February to 1,205 patients in March, impacted by larger drops within Audiology, Dental, Dermatology, Gynae, Max Fax and Neuro.

Within the admitted pathway the number of patients waiting for treatment beyond 18 weeks has moved above the upper control limit with an increase of 405 (11%) compared to February. Compared to the previous month we have seen a larger increase within the Surgical Specialties as expected with the pause in elective activity. The highest proportion of waits over 18 weeks within the admitted pathway is in Cardiology, General Surgery and ENT. At the end of March, we reported 1,439 patients waiting for more than 52 weeks for treatments on an admitted pathway, compared to 1,310 patients in February.

Actions and Quality Improvement Projects

More outpatient areas and theatres reopened in March, which accelerated our recovery plans. In April, we were able to open all operating theatres so expect the position to continue to improve at pace.

To monitor progress and improvements, we have established a recovery plan for overseeing elective care recovery and the response to national planning guidance. This plan is focused on treating the longest waiting patients and actively reducing the number of patients waiting more than 52 weeks for treatment. Within this plan, we aim to:

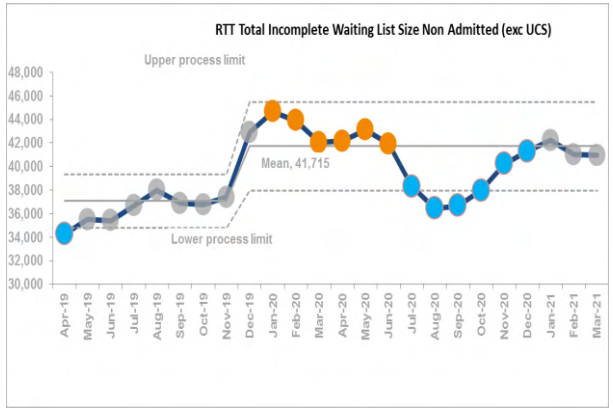
- Eradicate non-admitted 52 week pathways by end October.
- Eradicate all pathways over 78 weeks, regardless of specialty or admission status by the end of July
- Focus on treating High Volume, Low Complexity (HVLC) 52 week wait pathways as soon as possible (target date TBC)

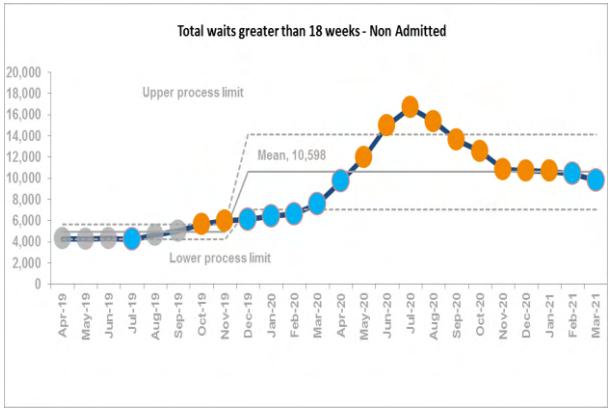
As part of this plan, there is an active focus on the following areas

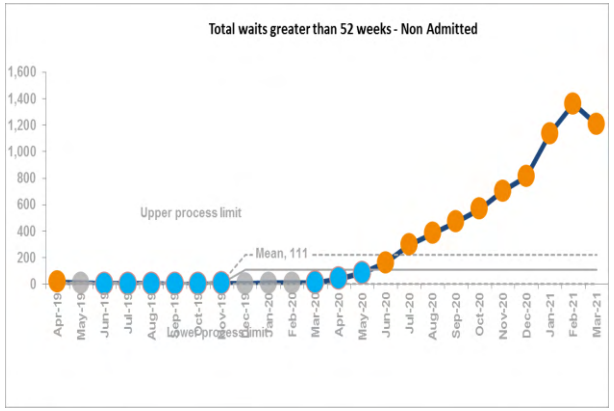
- Uncashed outpatient attendances – target to cash up all attendances within 48 hours
- Triage timescales – reduce to 48 hour turnaround time
- Increasing surgical activity through the use of QMH modular theatres

Referral to Treatment — March 2021

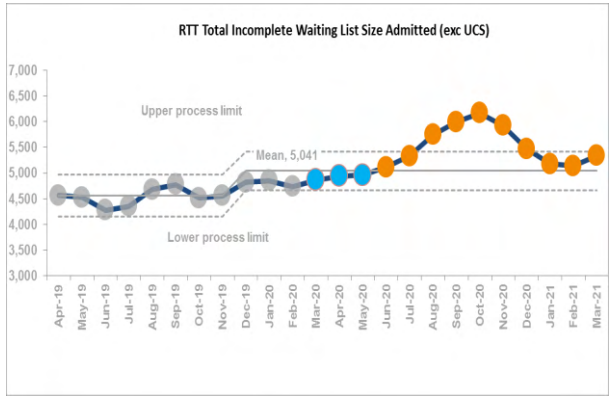
Non Admitted PTL

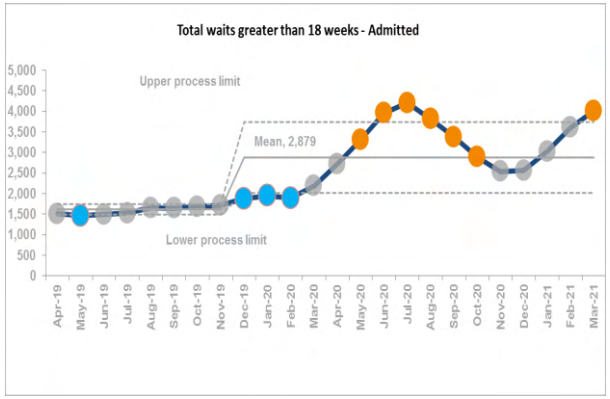


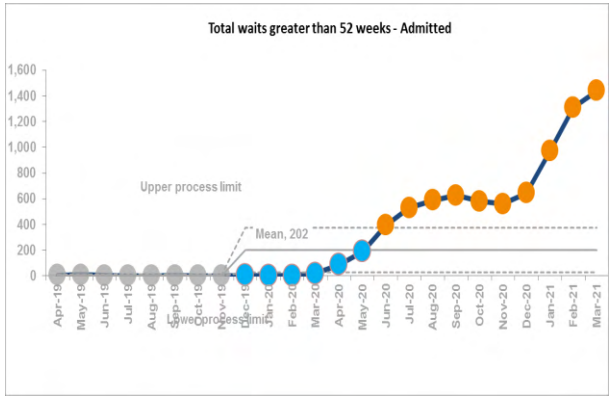




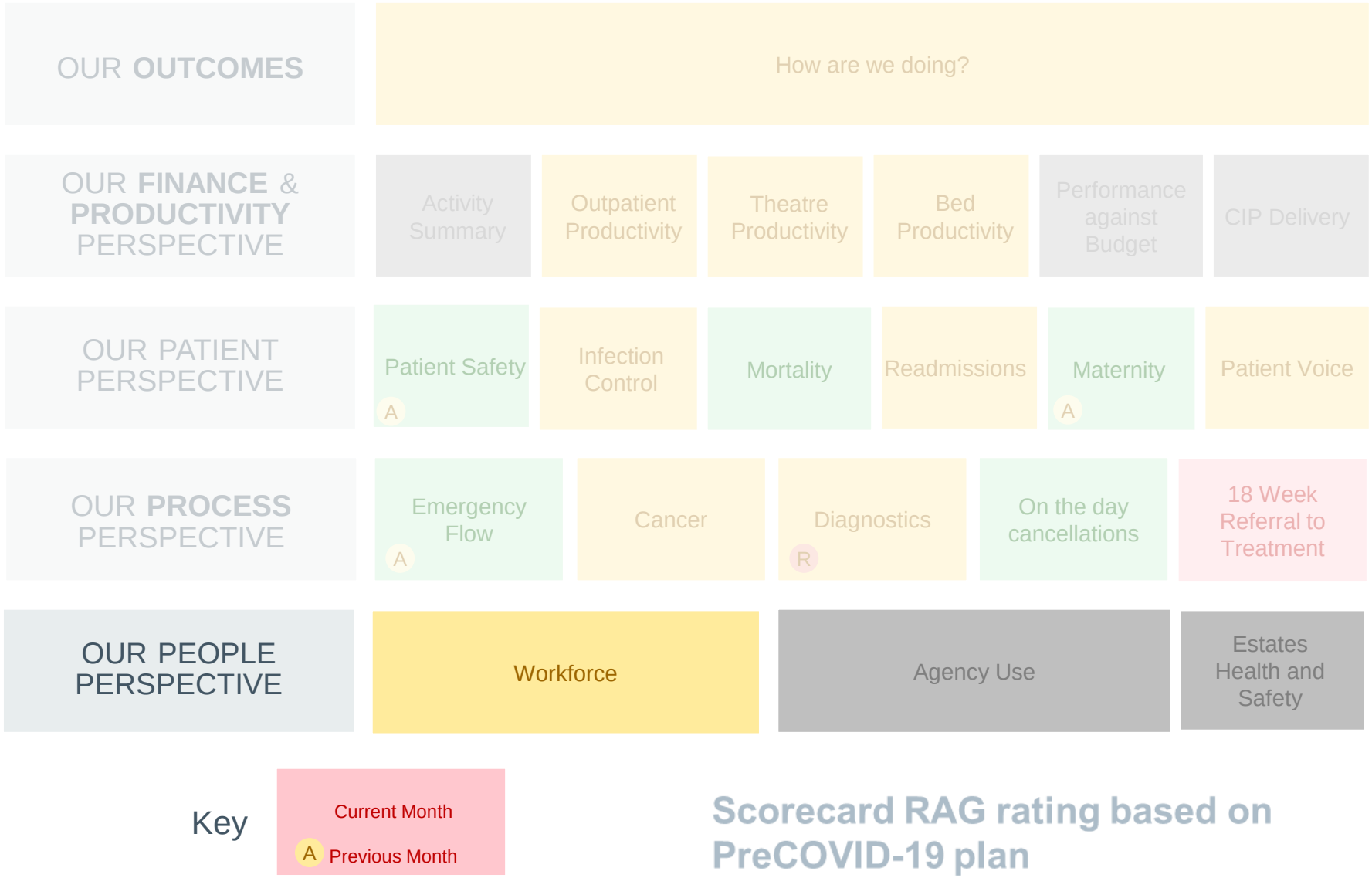
Admitted PTL







Balanced Scorecard Approach



Workforce

Indicator Description	Target	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
Trust Level Sickness Rate	3.2%	5.6%	4.1%	3.5%	3.2%	3.4%	3.6%	3.3%	3.3%	3.9%	4.2%	3.6%	3.1%	3.4%
Trust Vacancy Rate	10%	10.5%	6.8%	8.3%	8.4%	8.2%	9.1%	9.4%	9.1%	8.5%	7.8%	8.6%	8.2%	9.6%
Trust Turnover Rate* Excludes Junior Doctors	13%	16.7%	16.1%	15.3%	15.1%	15.2%	15.4%	15.3%	15.3%	15.0%	15.0%	14.7%	14.4%	14.5%
Total Funded Establishment		9,373	9,098	9,289	9,256	9,263	9,265	9,320	9,331	9,336	9,330	9,451	9,454	9,568
IPR Appraisal Rate - Medical Staff	90%										63.8%	66.6%	72.3%	75.3%
IPR Appraisal Rate - Non Medical Staff	90%	67.9%	67.6%	69.9%	73.6%	74.6%	72.4%	71.7%	70.6%	69.6%	65.8%	65.6%	70.5%	75.3%
Overall MAST Compliance %	85%	90.2%	89.7%	89.9%	89.8%	89.9%	89.9%	90.5%	90.0%	89.4%	88.9%	88.2%	88.7%	89.4%
Ward Staffing Unfilled Duty Hours	10%	17.4%	3.0%	1.6%	2.8%	3.7%	5.4%	6.3%	10.4%	15.8%	19.9%	16.6%	11.8%	
Trust Stability Index	85%	83.7%	84.2%	84.9%	85.4%	86.3%	86.1%	85.8%	87.0%	88.5%	87.7%	88.0%	88.5%	88.2%

What the information tells us

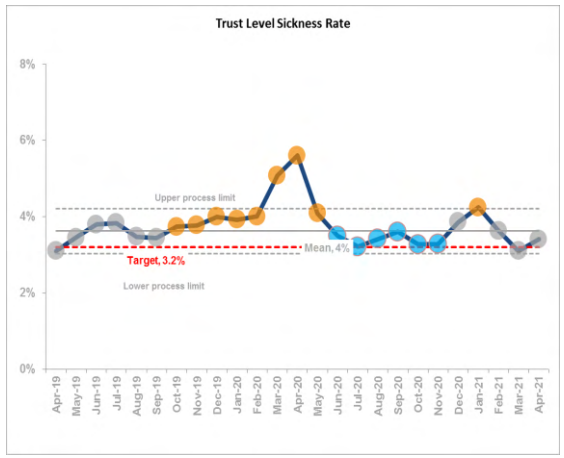
- The Trust's sickness rate is at 3.4% not meeting our Trust target of 3.2%. The Employee Relations (ER) team is working closely with managers to ensure timely referral to Occupational Health and management.
- Vacancy Rate is at 9.6% and is below the set target of 10%, showing a sustained improvement.
- The Trust turnover rate increased slightly and remains above the set target of 13%.
- Completion of appraisals for non-medical staff continues to be encouraged and this is improving at 75.3% compared to 70.5% in the month of March but remains below the target, 90%.
- Stability Index is at 88.2% is above target, and is used to inform retention strategies.

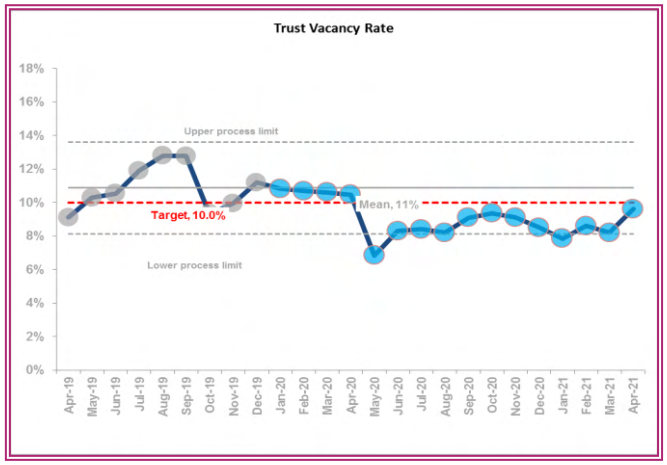
Actions and Quality Improvement Project

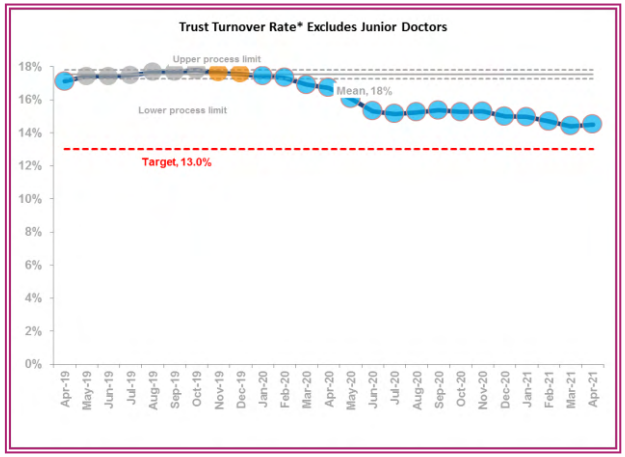
- Focus on management of sickness absence continues with the ER team providing a monthly report on management progress.
- The HR Business Partners are working with their Divisions to identify the hard to recruit posts, to develop a strategy including discussions on alternative roles where appropriate. Divisional Workforce action plans will be developed.
- Completion of appraisals for non-medical staff continues to be encouraged with HRBPs working on trajectories for improvement.

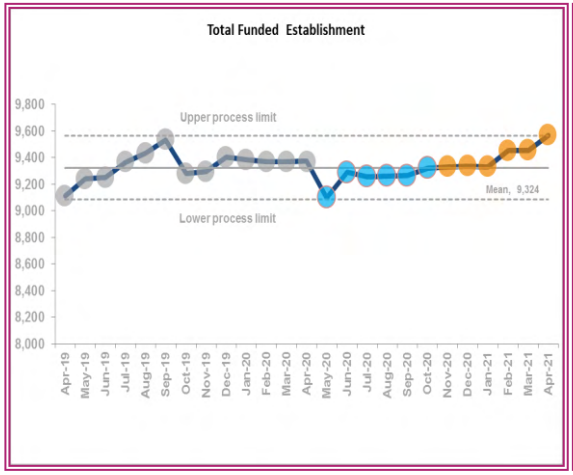
Workforce

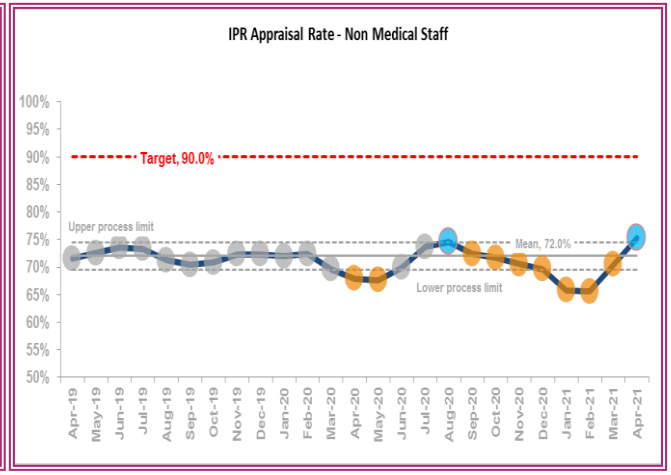
Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance

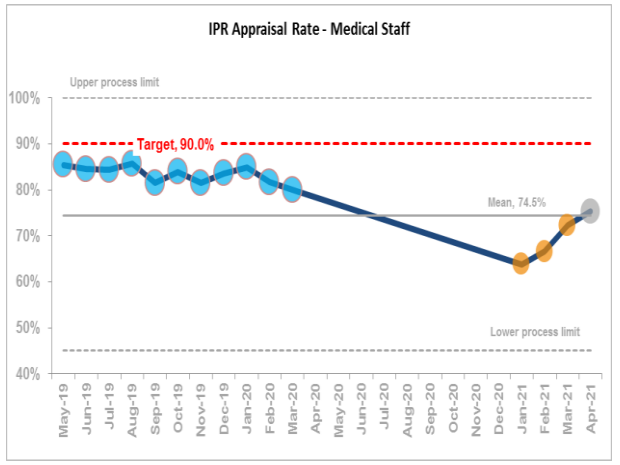












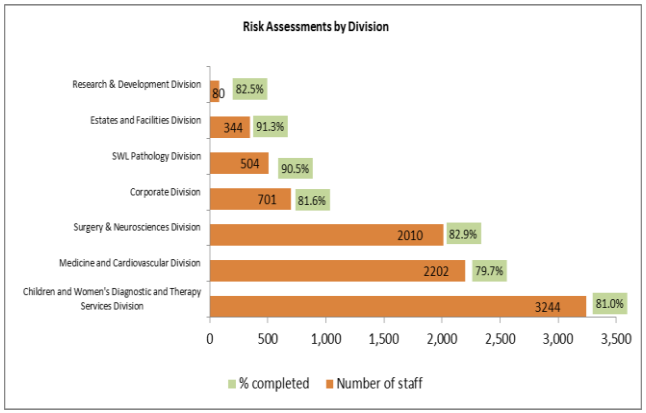
Our People Perspective

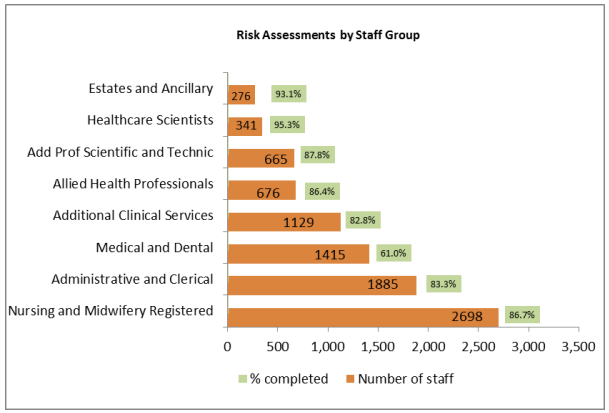
Workforce – COVID-19 Risk Assessment

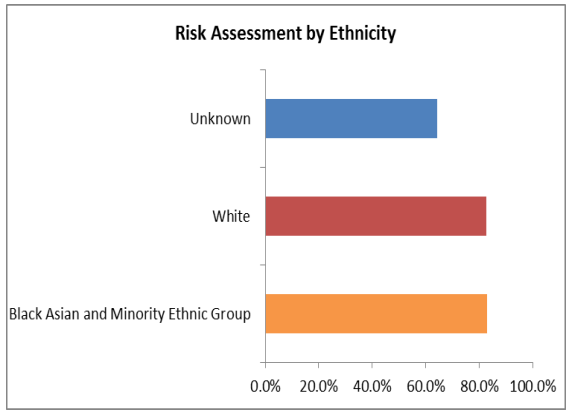
Division	Number of forms completed	Number of staff	% completed
Children and Women's Diagnostic and Therapy Ser	2628	3244	81.0%
Medicine and Cardiovascular Division	1756	2202	79.7%
Surgery & Neurosciences Division	1666	2010	82.9%
Corporate Division	572	701	81.6%
SWL Pathology Division	456	504	90.5%
Estates and Facilities Division	314	344	91.3%
Research & Development Division	66	80	82.5%
Trust Total	7458	9085	82.1%

Staff Group	Number of forms completed	Number of staff	% completed
Nursing and Midwifery Registered	2340	2698	86.70%
Administrative and Clerical	1570	1885	83.3%
Medical and Dental	863	1415	61.0%
Additional Clinical Services	935	1129	82.8%
Allied Health Professionals	584	676	86.4%
Add Prof Scientific and Technic	584	665	87.8%
Healthcare Scientists	325	341	95.3%
Estates and Ancillary	257	276	93.1%
Grand Total	7458	9085	82.1%

Ethnicity	No of forms completed	Total number of staff	% completed
Black Asian and Minority Ethnic Group	3581	4319	82.9%
White	3660	4428	82.7%
Unknown	217	338	64.2%
Trust Total	7458	9085	82.1%







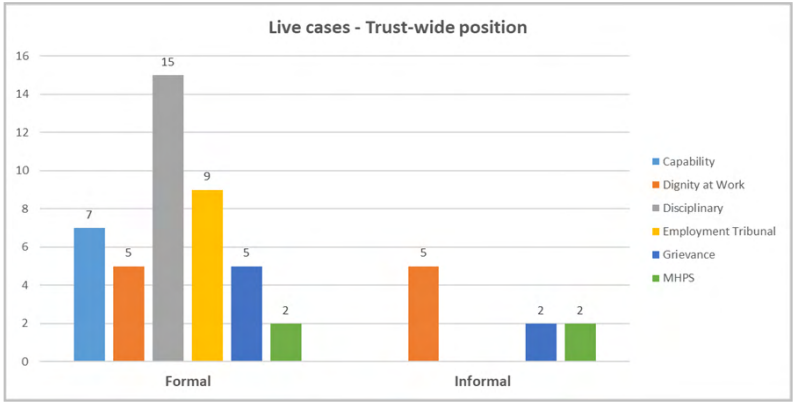
What the information tells us

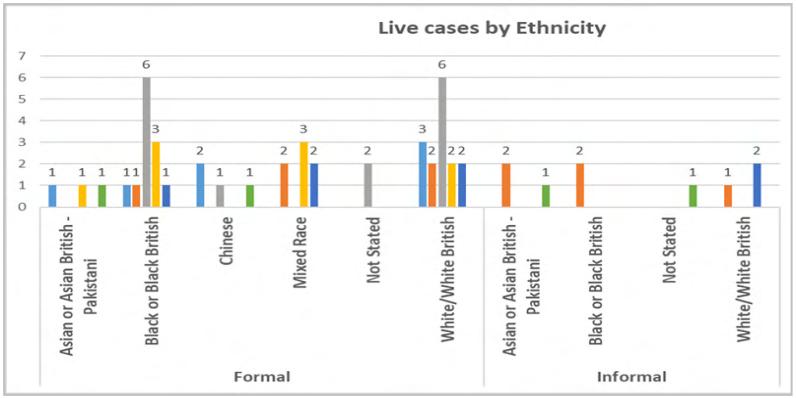
- The table shows completion of COVID risk Assessment as at 01 May 2021.
- The Trust completion rate is at 82.1%. Completion rate for BAME staff stands at 82.9% and White staff 82.7%.

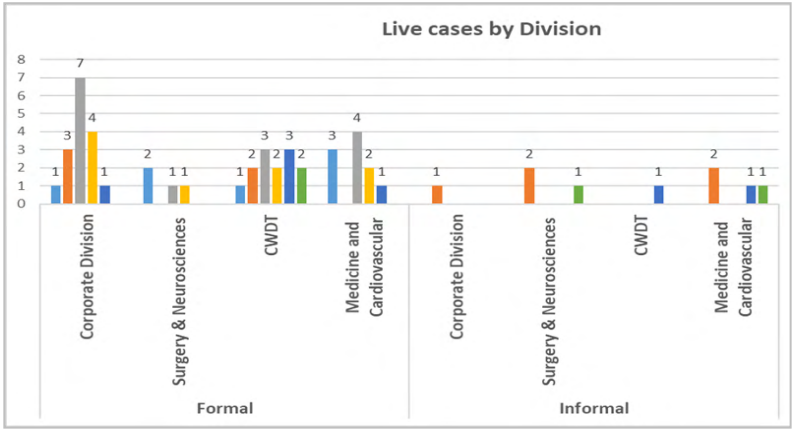
Actions and Quality Improvement Project

The Director of Medical Education and Chief Medical Office supported by the Human Resources 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 30th April 2021







What the information tells us

- There were 52 live employee relations cases as at 30 April 2021; 43 Formal cases and 9 Informal cases. The number of cases have increased by 5 from March.
- Disciplinary cases remain the highest case type at 15. This is followed by 10 Dignity at work cases, 9 Employment Tribunal cases and 7 Grievances.
- Corporate Division has the highest number of cases at 17, CWDT and MedCard have 14 cases each; Surgery has the lowest number of cases at 7.
- Staff identifying as White/White British have the highest number of cases at 18, followed by Black/Black British at 14.
- Suspensions – As at end of April 2021, there were 3 staff on suspension

Actions and Quality Improvement Project

Employee Relations surgeries run on a monthly basis to equip line managers with knowledge and skills on how to resolve cases informally.

The use of the digital platform, Selenity, for case management and recording of the employee relations activity has increased focus on timely completion of cases.

The shared learning, done every Wednesday, within the ER team is supporting the embedding of a consistent approach to case management across the Trust. These sessions also allow for learning to take place to increase capability within this team. Lessons learnt exercises also take place during these session

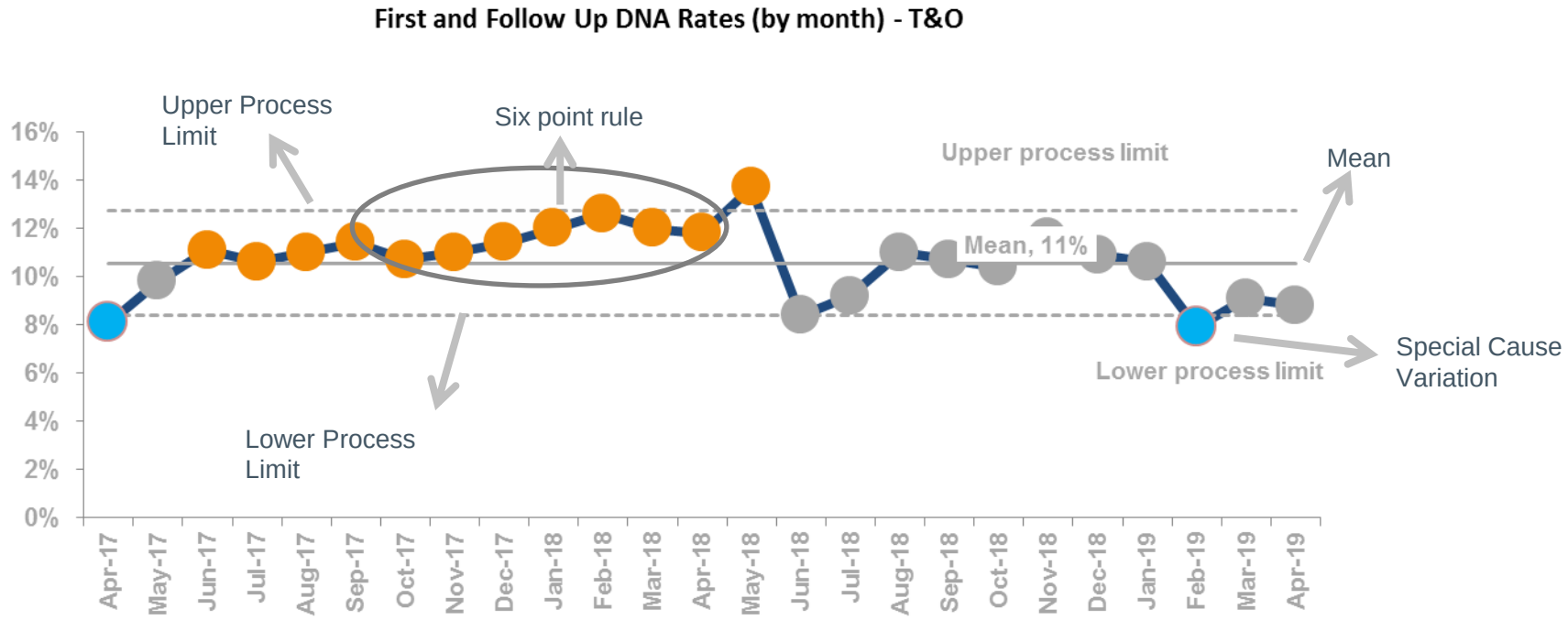
Dignity at Work
Disciplinary
Employment Tribunal
MHPS
Disciplinary (Bank)
Stage 3 Capability Hearing
Capability
Grievance stage 3

2.2

Our People Perspective

Appendix
Additional Information

Interpreting SPC (Statistical Process Control) Charts



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

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

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

RTT Performance - March 2021

Indicator Description	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
RTT Trust Incomplete Performance	79.3%	71.5%	63.8%	55.7%	52.7%	58.4%	63.7%	67.4%	71.0%	71.4%	69.1%	68.3%	69.3%
RTT Total Incomplete Waiting Lize Size (exc UCS)	47,048	43,643	42,196	42,672	44,117	46,139	46,755	47,399	46,142	46,290	44,291	44,236	44,960
Total waits greater than 18 weeks (exc UCS)	9,755	12,440	15,268	18,924	20,863	19,177	16,974	15,443	13,365	13,251	13,695	14,027	13,801
Total waits greater than 52 weeks	32	129	274	554	825	972	1,097	1,146	1,261	1,456	2,108	2,671	2,644
RTT Incomplete Performance - Admitted	57.2%	49.0%	42.4%	34.1%	31.8%	35.6%	38.3%	44.2%	50.6%	51.9%	49.2%	45.6%	45.1%
Total waits - Admitted	5,112	5,330	5,746	5,997	6,165	5,923	5,470	5,178	5,141	5,335	5,950	6,634	7,301
Total waits greater than 18 weeks - Admitted	2,186	2,720	3,308	3,955	4,207	3,816	3,373	2,891	2,541	2,564	3,025	3,608	4,013
Total waits greater than 52 weeks - Admitted	20	88	190	393	529	588	626	579	559	643	971	1,310	1,439
RTT Incomplete Performance -Non Admitted	82.0%	74.6%	67.2%	59.2%	56.1%	61.8%	67.1%	70.3%	73.6%	73.9%	72.2%	72.3%	74.0%
Total waits - Non Admitted	41,936	38,313	36,450	36,675	37,952	40,216	41,285	42,221	41,001	40,955	38,341	37,602	37,651
Total waits greater than 18 weeks - Non Admitted	7,569	9,720	11,960	14,969	16,656	15,361	13,601	12,552	10,824	10,687	10,670	10,419	9,788
Total waits greater than 52 weeks - Non Admitted	12	41	84	161	296	384	471	567	702	813	1,137	1,361	1,205

Note: Unknown Clock Starts (UCS) have been excluded from the above metrics. For context the number of UCS in March was 404, a increase from 374 in February. Compared to the same month last year this is a 63% improvement.

RTT Performance – March 2021

Specialty	Admitted		Non Admitted		Incomplete Pathway					
	Total	% within 18 weeks	Total	% within 18 weeks	Within 18 weeks	Over 18 weeks	Total	% within 18 weeks	Over 42 weeks	Over 52 weeks
GENERAL SURGERY	658	31.0%	814	63.3%	719	753	1,472	48.8%	63	180
UROLOGY	504	51.8%	1,566	87.0%	1,623	447	2,070	78.4%	26	78
TRAUMA & ORTHOPAEDICS	260	47.7%	1,528	69.2%	1,182	606	1,788	66.1%	13	36
ENT	827	32.8%	3,361	64.8%	2,448	1,740	4,188	58.5%	127	491
OPHTHALMOLOGY			825	23.4%	193	632	825	23.4%	50	233
ORAL SURGERY			193	74.1%	143	50	193	74.1%	1	18
NEUROSURGERY	281	42.3%	1,856	73.1%	1,476	661	2,137	69.1%	39	77
PLASTIC SURGERY	583	43.7%	475	73.5%	604	454	1,058	57.1%	20	156
CARDIOTHORACIC SURGERY			2	1	2	0	2	100.0%	0	0
GENERAL MEDICINE			24	87.5%	21	3	24	87.5%	0	0
GASTROENTEROLOGY	785	74.6%	2,527	66.4%	2,263	1,049	3,312	68.3%	16	21
CARDIOLOGY	1,212	41.7%	1,988	78.4%	2,064	1,136	3,200	64.5%	109	263
DERMATOLOGY	1	0.0%	2,260	79.6%	1,799	462	2,261	79.6%	7	44
RESPIRATORY MEDICINE	2	100.0%	1,103	92.8%	1,026	79	1,105	92.9%	0	0
NEUROLOGY	25	96.0%	1,651	89.2%	1,497	179	1,676	89.3%	3	0
RHEUMATOLOGY	4	1	816	68.1%	560	260	820	68.3%	5	1
GERIATRIC MEDICINE			43	83.7%	36	7	43	83.7%	0	0
GYNAECOLOGY	242	34.3%	2,129	75.2%	1,683	688	2,371	71.0%	30	84
Other	1,925	44.6%	14,490	75.7%	11,820	4,595	16,415	72.0%	195	962
Grand Total	**7,309**	**45.1%**	**37,651**	**74.0%**	**31,159**	**13,801**	**44,960**	**69.3%**	**704**	**2,644**

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

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

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

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

RTT Performance – March 2021

Specialty	Admitted		Non Admitted		Incomplete Pathways					
	Total	% within 18 weeks	Total	% within 18 weeks	Within 18 weeks	Over 18 weeks	Total	% within 18 weeks	Over 42 weeks	Over 52 weeks
Audiology	1	0.0%	2,532	54.9%	1,391	1,142	2,533	54.9%	57	277
Breast Surgery	86	39.5%	881	98.0%	897	70	967	92.8%	2	10
Cardiac Surgery	71	83.1%	26	92.3%	83	14	97	85.6%	0	0
Chest Medicine	0		75	97.3%	73	2	75	97.3%	0	0
Chiropody	0		4	100.0%	4	0	4	100.0%	0	0
Clinical Genetics	0		1,329	90.0%	1,196	133	1,329	90.0%	3	1
Clinical Haematology	22	100.0%	675	94.4%	659	38	697	94.6%	0	0
Clinical Infection Unit	0		119	89.9%	107	12	119	89.9%	0	1
Dental	282	45.0%	336	89.0%	426	192	618	68.9%	4	50
Dermatology	0		83	77.1%	64	19	83	77.1%	1	2
Diabetes/Endocrinology	5	60.0%	1,143	64.7%	742	406	1,148	64.6%	5	5
ENT	68	0.0%	222	65.3%	145	145	290	50.0%	13	67
Gastroenterology	1	0.0%	511	75.0%	383	129	512	74.8%	1	2
General Surgery	374	33.7%	1,750	61.8%	1,207	917	2,124	56.8%	51	243
Gynaecology	1	100.0%	189	96.8%	184	6	190	96.8%	0	0
Interventional Radiology	23	56.5%	22	50.0%	24	21	45	53.3%	2	5
Maxillofacial	269	47.2%	599	68.8%	539	329	868	62.1%	11	115
Neurology	0		3	100.0%	3	0	3	100.0%	0	0
Not Known	0		1	100.0%	1	0	1	100.0%	0	0
Oncology	4	100.0%	141	97.2%	141	4	145	97.2%	0	0
Paediatric Intensive Care Unit	0		1	100.0%	1	0	1	100.0%	0	0
Paediatric Medicine	33	72.7%	1,710	86.8%	1,509	234	1,743	86.6%	1	1
Paediatric Surgery	252	58.3%	668	78.3%	670	250	920	72.8%	9	19
Pain Clinic	37	32.4%	329	88.5%	303	63	366	82.8%	4	2
Pathology	0		9	44.4%	4	5	9	44.4%	0	0
Plastic Surgery	39	59.0%	52	78.9%	64	27	91	70.3%	4	6
Radiology	22	40.9%	14	78.6%	20	16	36	55.6%	0	4
Renal Medicine	21	61.9%	286	95.8%	287	20	307	93.5%	1	0
Theatres	10	70.0%	54	81.5%	51	13	64	79.7%	2	5
Thoracic Surgery	5	100.0%	111	94.6%	110	6	116	94.8%	0	0
Trauma & Orthopaedics	62	71.0%	41	68.3%	72	31	103	69.9%	1	5
Unassigned	8	100.0%	4	100.0%	12	0	12	100.0%	0	0
Vascular Surgery	229	21.8%	570	69.8%	448	351	799	56.1%	23	142
Grand Total	1,925	44.6%	14,490	75.7%	11,820	4,595	16,415	72.0%	195	962

Outstanding care every time

Early Warning Score

Indicator Description	Threshold	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
Compliance with appropriate response to EWS (Adults)	100%	86.9%	93.5%	97.0%	93.6%	78.2%	84.8%	92.4%	94.1%	93.7%	95.2%	92.8%	89.0%	87.9%
Number of EWS Patients (Adults)		290	403	474	512	634	465	474	426	478	230	360	510	453

Meeting Title:	Trust Board Meeting		
Date:	27 May 2021	**Agenda No.**	**3.1**
Report Title:	Workforce and Education Committee Report		
Lead Director/ Manager:	Stephen Collier, Chair of Workforce and Education Committee		
Report Author:	Stephen Collier, Chair of Workforce and Education Committee		
Presented for:	Information		
Executive Summary:	This report sets out a summary of the matters reviewed by the Committee at its meetings on 15th April and 18 May. From an assurance perspective, there are no matters which require re-assessment of any of the ratings of risks assigned to the Committee for monitoring. The Committee reviewed and confirmed its recommendations on the year-end risk ratings of the two Trust-wide risks allocated to the Committee. More detailed analysis and reporting on data relating to the Trust's staff has facilitated a more granular review of some issues, notably the responses to the recent NHS Staff Survey and staff turnover. A summary of the discussion on these is set out in the Report. The culture programme has been re-set under four core pillars, and an associated implementation plan has been agreed, which includes individual timescales and an overall target impact. The Chief People Officer has been able to secure agreement of other Trusts within south west London to a positive action programme, to help ensure that minority ethnic staff are able to progress up the managerial ladder. Early indications show some progress on this across AfC bands 6 - 9 within the Trust, but a highly visible backward movement amongst our very senior managers (VSMs) - (see commentary below and Annex C).		
Recommendation:	The Board is asked to: • **Note this report;** • **Endorse Committee Annual Review and approve the proposed changes to the Terms of Reference (attachment 3.1b); and** • **Endorse the Gender Pay Gap report (agenda item 3.1.1).**		
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

Data analysis and reporting has recently been uprated, with the consequence that we now have more granular information in a number of areas, which prompts new questions. These questions are not motivated by a change of circumstances or increased concerns, rather they simply derive from the deeper insight we now have.

The core of the April meeting was getting to grips with a more detailed analysis of the experiences of groups of staff of different ethnicities. Some excellent analysis allowed us to go beyond 'BAME' as a categorisation. And what that demonstrated was that, for some groups of staff in particular, their daily experience of work is simply not acceptable. The executive had already seen the analysis and it was helpful (and reassuring) that they are formulating plans to address this, in all likelihood within the wider culture work. Certainly our culture will not be right if this experience continues to be the norm for any of our staff.

We had a useful discussion on staff turnover, noting that over 50% of our leavers have been employed for two years or less. This clearly requires action, and Trust management are keen to address this and are already on the case. We will return to this in a future meeting.

Solid progress is being made with the finalisation of arrangements around holiday for bank staff, and subject to further progress having been made this might be an issue for a briefing in Part 2 of the Board meeting.

The Culture programme is under way again, and it was good to see a detailed delivery plan – with target objectives and a clear timescale.

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

2. Key points:-

Board Assurance

Theme 1 - Engagement

NHS Staff Survey – Detailed Review of SGH results. This was an uncomfortable discussion, but an important one - and one which was based on some really helpful analysis of a large dataset derived from the Staff Survey. The data analysis was of a series of responses from individual groups of staff which had previously been aggregated under the category 'BAME'. We appreciate the work that Joseph Pavett-Downer and Humaira Ashraf have done in analysing the data and helping draw informed conclusions from it.

The clear reality is that the experiences of minority ethnic groups within the Trust are very different, and a clear take-out from the discussion was that the BAME label does not describe a homogenous group with the experience. The experiences of staff who identify as Indian, Asian, African, Caribbean are different, and in some areas very different. The analysis we reviewed began to bring out some of the detail behind this difference in the experiences of different minority ethnic groups, and the impact of this on those staff.

The Committee explored the apparent lack of career progression for black staff in AfC bands 2-5, and their under-representation in bands 7-9 (see Annex A). It is clear that a more active management of each staff member's career progression is an important factor in addressing some of the cultural determinants of an individual's ability to grow and develop in their work role. The executive are re-shaping the culture change programme to reflect this with an increased focus upon improving the internal hire rate so that Trust staff are able to feel that they are able to fully develop and progress their careers at the Trust.

We endorsed the suggestion from the Chief People Officer that there should be a more managed approach to positive action and support for staff, and greater emphasis on talent management within the Trust - particularly for those who may be less likely to put themselves forward for new or expanded responsibilities. It is good that this idea has gained traction across south west London Trusts generally. It was also clear that for some groups of staff, experience of discrimination was materially more routine than for the BAME group as a whole. Annex B summarises the experience of racial discrimination across different minority ethnic groups.

The positive from this analysis was a clear commitment from the executive, now that it can see the starkness of the position of some ethnic groups, to do something about it. Likewise, similar issues were identified for staff with a disability. We anticipate that staff retention, career progression, and greater focus on talent management of all staff will likely be brought into the culture programme as critical workstreams. We fully support that approach. In addition, we agreed as a Committee to make staff progression and staff retention subjects for future deep dives.

Culture Programme – we received an update from Humaira Ashraf and Daniel Scott on the Programme. This has been re-set under four core pillars, and an associated implementation plan has been agreed, which includes individual timescales and an overall target impact. The key risk here relates to resourcing, in relation to which discussions continue. The Committee recognised the pressure on funding and resources, but equally that culture change is an absolute priority for the Trust - and its staff.

Freedom to Speak Up Report, Q4 – Karyn Richards joined the May meeting to report on the level and nature of concerns being raised in Q4, and for the year as a whole. This paper is coming to Board as a stand-alone item, so I will not repeat what is in it other than to note three things: first, concerns continue to increase – with over half directed at leadership or team functioning and a third at bullying and harassment. Of all concerns raised, almost 90% are resolved informally; second, there is a continuing resource challenge to undertaking FSU investigations; third, some line managers are not engaging with FSU as an important indicator of staff concerns.

Diversity and Inclusion – ***Update***. We received a detailed update from Joseph Pavett-Downer at the May meeting. As indicated, a positive action programme had been initiated across the Trust and south west London Trusts to support minority ethnic staff in their career progression. The Trust's D&I Steering Group had been re-initiated, following its suspension during the pandemic. Joseph also updated us on initial feedback from representatives of black staff to the detailed analysis of the Staff Survey.

Participation of recruitment inclusion specialists (RIS) on staff interview panels had fallen, and this was being addressed. We reviewed a report (see Annex C) showing progress in the proportion of BAME staff in different AfC bands over the last six months. The exception was in the VSM band, where the percentage of BAME staff had actually declined. It was pointed out that, as this is the most visible part of the Trust leadership, its effect on staff perception of career progression for BAME staff was highly adverse. It was also noted that this had in part been mitigated by an increase in the proportion of band 9 staff from a BAME background.

Bullying and Harassment – Internal Audit Review. At our April meeting we reviewed the report that had already been discussed in the Audit Committee. It was agreed that the next step for WEC was to review management responses in relation to the up to date position as, we were advised, a large number of the outstanding actions were now being completed. This review was undertaken at the May meeting, in a discussion led by Theresa Ekendu. It was clear from this that nine separate initiatives had been planned for implementation in January of this year, but paused as a result of the pandemic. Theresa updated us on progress on each of these, and the implementation of the new Selenity system and the adoption of the new Dignity at Work Policy.

It was helpful to have this update as it showed that active progress was being made here, and that there is a clear plan and structure to allow the Trust and its management to create a consistent and managed approach to this important area. We will check later in the year (probably July) that all scheduled work has been completed, but on the basis of the report received we do not regard this as a material risk to the Trust.

Staff Support and Wellbeing – Dr Rhia Gohel updated the May meeting on progress of the Trust's initiatives to meet the health and wellbeing needs of staff. It was clear that although the pandemic has subsided, its effects on staff remain. Staff are making good use of the available support, including group therapies and 1:1 counselling. Rhia emphasised the critical role that line managers play in the wellbeing of their staff, and how this was being reinforced. The impact of poor line managers could be very negative, although the REACT training was helping minimise this. The Committee discussed the experience of staff and how the perception of not feeling valued could be addressed by line managers, and the Trust more widely.

Theme 2 – Leadership and Progression

Workforce Update – We have recently undertaken a review of the data we receive as a Committee and are grateful to Sion Pennant-Williams for the work he has put into updating the datasets and dashboards for the Committee. These more focussed reports have given us greater insight, but equally have prompted a set of new questions. It is important that the Board recognises that these questions are not motivated by a change of circumstances or increased concerns, rather they simply derive from the deeper insight we now have.

The current level of Covid vaccinations within Trust staff is c 75% (though within this staff categorised as white have a level of c82% and staff categorised as BAME have a level of c 68%). Staff sickness (excluding Covid) is running at 3.6%, and active steps are being taken to manage this down.

Staff turnover continues to fall, and currently stands at c15% (measured on a trailing 12 month basis). This represents about 1,600 leavers per annum. However, c 35% of our leavers have been with us less than 1 year (suggesting they are finding it difficult to adjust to work at the Trust, or that our induction and support in the early stages could be improved). A further 20% of our leavers have been with us for between 1 and 2 years. We had a wide discussion on how this could be addressed and it is clear that the executive are already on the case here, and have some very sensible ideas that they are developing. We will return to this at a future meeting.

Non-Medical Appraisal - we received a helpful update from Alison Stott on the new Performance and Development Review (PDR) programme, which is intended to replace the current non-medical appraisal system. The key difference is a more continuous cycle of feedback, rather than a once-a-year discussion. The intention to require a completed PDR as a gateway to movement up AfC pay bands was to be communicated once the new system was up and running. In the meantime, the completed appraisal rate had been moved from 65% to 75% in the last two months (though still below target), and this continued to receive focus.

Theme 3 - Workforce Planning and Strategy

Workforce Strategy – Implementation Plan – we received an update on implementation of the Strategy. This is proceeding well, albeit that two of the six workstreams have been subject to some slippage as a result of the pandemic. We received a briefing on how these were being recovered and noted the revised timings that would run through to the end of June. The remaining four workstreams were on track to complete all actions identified by the end of March.

Education Strategy – Humaira Ashraf provided a helpful update to the May meeting on the Implementation Plan for the 20-21 fiscal year. The pandemic had shifted staff attitudes to the

value of on-line training, and so a wider range of training and development modules was to be made available. Demand for this was high. The key risks around delivery related to the Trust's IT infrastructure and its ability to deploy this, and available space for face-to-face training.

Maintaining High Professional Standards – we received a short update in April on where things stood with the proposed new 'Conduct, Performance and Ill-Health' policy. This has been long delayed. There was recognition of the need, post-pandemic, to improve engagement and re-set the relationship with the Trust's Local Negotiating Committee, which acts as a representative body for our medical workforce. A return to face-to-face meetings between the Trust and the LNC was regarded as important in helping re-set the working relationship and allow for the policy to be discussed and, hopefully, agreed. In the meantime, the Trust is working to the existing (2017) policy, which should have been reviewed last year.

General Medical Council, 2020 National Training Survey - we were joined by Dr Indranil Chakravorty, the Trust's Director of Postgraduate Medical Education. Indranil set out the importance to the Trust of its education role and then moved on to summarise the findings of the survey, noting that overall the Trust had performed well. However, the performance in some specialties (intensive care; gastroenterology; haematology; and acute internal medicine) had been marked down in specific areas which the Trust was now focussed on addressing. These actions were being led by divisional triumvarates, and Indranil regarded this as the right approach. Additional steps were being taken to ensure that these initiatives gained traction. What was also reassuring was the way in which a number of the steps being taken within medical education are paralleled by similar initiatives in other clinical areas (e.g. the Emerging Leaders programme, which will run across medical, nursing and AHP staff).

Contingent staffing - the Committee reviewed a schedule showing how the Trust's establishment level staffing was being delivered over the last 12 months. What was encouraging was the steadily increasing use of bank staff, and the steadily reducing use of more expensive agency staff. We expressed the hope that, as the pandemic recedes and the Trust continues its elective recovery, this trend can be continued. We will continue to monitor this.

Medics e-Roster project – the executive reported that implementation of this programme will likely slip, given some internal concerns raised by a small number of areas in having to implement a generic rostering system where currently something more tailored may be in place. We accepted the need to build consensus before implementation, but equally recognised the value that a deadline can bring. We will continue to monitor progress here.

Theme 4 – Compliance.

Bank Staff Holiday Pay – continued progress in the discussions with staff-side. For report at Board.

Report from Guardian of Safe Working Hours. Dr Serena Haywood, the Trust's Guardian, joined us to provide a focussed commentary on her Q4 and Full Year Report. Serena's overall update was that the Trust was rapidly returning to normal rota planning, including foundation training. Although the Trust had coped well with the pandemic, the move to a mega-rota had been disruptive to training and it was therefore good to see the shift back to Departmental rotas. There were some rota gaps (notably in ITU (6) and anaesthetics (6)), but these continued to be reduced over time. Planning for covid catch-up leave was under way, to ensure minimal disruption as that leave was taken.

There had been 58 exception reports in the first four months of 2021 which, given the circumstances, was regarded as unexceptional. All related to extended, end-of-day, working

and none had raised an Immediate Safety Concern. The Guardian is currently focussed on helping ensure appropriate catch-up training is put in place, and discussions on this continue. This is a critical issue and the Committee has asked to be kept up to date here. Rest space for junior doctors remains an issue, although some funding is available to address this. Initial discussions are under way with the Estates Department. Attendance at the Junior Doctors Forum had fallen away during the pandemic, and work was under way to increase this.

Gender Pay Gap Report (19-20) – Joseph Pavett-Downer and Sion Pennant-Williams summarised the continuing movement in the gender pay gap, based on the measures at March 2020. The consultant workforce remained an outlier (excluding it, the gap for the rest of the Trust workforce was 1.27% in favour of females). Some progress had been made in numbers of female consultants applying for, and receiving, Clinical Excellence Awards but it would take some time before this fed through into the overall numbers. A copy of the full Report is in the Board papers for our May meeting, and the Committee commends this to the Board for approval.

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.

Committee Annual Review

The Committee also completed its annual review and effectiveness in line with good practice. The Committee's annual report, work plan the effectiveness review is attached for information and endorsement by the Board. The Committee also recommends that the Board approves the proposed minor changes to its terms of reference which include the following:

- Update the duties of the Committee to reflect the breadth of matters currently discussed at the Committee (section 4)
- Update the membership and attendees lists to reflect current working of the Committee (section 6)
- Minor updates to quoracy text of the meeting arrangements (sections 7 and 10)

Stephen J Collier

Committee Chair, 20 May 2021

Appendix A

Appendix B

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

3.1

Appendix C

D&I Dashboard – Trend Highlights

9

BAME Staff

- See table below for BAME staff data from September 2020 to March 2021
- February data showed a decrease in % BAME staff in bands 8c and 8d, however this has now increased in March

% of BAME Staff	% BAME staff Sept 2020	% BAME staff Mar 2021	% +/- SEP 20 – Mar 21		FTE +/-
% of BAME staff Band 6	49.3%	50.2%	+ 0.9%	↑	+23.47
% of BAME staff Band 7	36.5%	38.3%	+1.8%	↑	+37.33
% of BAME staff Band 8a	29.5%	29.7%	+0.2%	↑	+7.8
% of BAME staff Band 8b	24.6%	26.8%	+2.2%	↑	+4.8
% of BAME staff Band 8c	25.5%	26.7%	+1.2%	↑	+3.2
% of BAME staff Band 8d	13.2%	16.6%	+3.4%	↑	+2
% of BAME staff Band 9	11.6%	26.0%	+14.4%	↑	+2.9
% of BAME staff VSM	20.8%	9.1%	-11.7%	↓	-3

ANNUAL BOARD COMMITTEE REPORT

WORKFORCE & EDUCATION COMMITTEE

1 April 2020 – 31 March 2021

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Workforce and Education Committee: 20120/2021 Annual Report

1 Introduction

The Workforce and Education Committee is the Committee of the Board responsible for overseeing and providing assurance to the Board on workforce, organisational development, leadership, culture, and education.

This report sets out the work of the Committee during the reporting period 1 April 2020 to 31 March 2021. The Committee submits a report to the Board after each meeting setting out the key discussions of the Committee, areas of assurance and matters for escalation to the Board. The purpose of this annual report is to provide a wider perspective on the work of the Committee over the past year and, in so doing, provide assurance to the Board that the Committee has discharged its role in line with its approved terms of reference.

There were three developments that impacted on the operation of the Committee during the period which are noteworthy:

- As with all other Trust governance fora, the Committee work programme and timetable was impacted by the focus on responding to the Covid-19 pandemic. The Trust took the decision at the onset of the pandemic to streamline governance arrangements in order to enable staff greater capacity to focus on operational priorities. As a result, the planned May 2020 meeting of the Committee was cancelled and business as usual items were either deferred to later meetings or compressed over the reminder of the year.

- In July 2020, in the context of the experience of our Black Asian and Minority Ethnic staff during the first wave of the pandemic and in aftermath of the George Floyd murder in the United States, the Board took the decision to give additional focus to, and seek assurance on, culture, diversity and inclusion by convening additional meetings of the Committee from September 2020 onwards. These meetings largely, with some minor exceptions, focused on culture, diversity and inclusion. The Committee, therefore, welcomed the Programme Director, Culture and Organisation Development and the new Diversity and Inclusion Lead as regular attendees at these additional meetings.

- In May 2020, the Trust's Chief People Officer, Harbhajan Brar left the Trust after more than three years in post. While the Trust recruited a substantive replacement the two Deputy Chief People Officers acted-up to the Chief People Officer role, one with responsibility for Workforce and the other Culture and Organisational Development. During this timeframe, Martin Kirke, an HR professional and non-executive director at Epsom and St Helier University Hospitals NHS Trust, was engaged to support the Acting Chief People Officers. Mr Kirke attended the relevant meetings of the Committee until the new Chief People Officer, Paul Da Gama joined the Trust in February 2021.

2 Committee purpose and duties

The Committee's purpose and duties are set out in its terms of reference as approved by the Board on 25 June 2020. These set out that the Committee should provide:

- Robust oversight of the delivery of the Trust's strategic aims in relation to its workforce
- Detailed consideration of the development and implementation of the Trust's workforce and education strategies

- Effective oversight and monitoring of workforce planning
- Effective oversight of the delivery of the Trust's diversity and inclusion strategy, and monitoring of performance in relation to the Workforce Race Equality Standard and the gender pay gap
- Adequate information is available on key issues to enable clear decisions to be made, to ensure compliance with the guidance of regulatory bodies
- The impact of workforce performance on the Trust's overall performance is closely monitored
- Staff well-being and development is monitored effectively
- Appropriate governance arrangements are in place in relation to workforce and education issues and that the Committee is able to provide the Trust Board with assurance on these matters as appropriate.

In 2019 the Committee conducted a comprehensive review of its terms of reference making changes designed to strengthen the functioning of the Committee as an assurance forum of the Board. These changes were approved by the Board and no substantive changes were made in 2020 with the exception of updating the memberships and the revise the name of the Trust Executive Committee to Trust Management Group.

To reflect the additional focus on culture, diversity and inclusion minor changes have been proposed to the Terms of Reference. These changes reflect the current working of the forum and breadth of matters being considered at each meeting.

3 Membership and Committee Meeting Attendance

3.1 Members and Attendees

During the reporting period (April 2020 – March 2021) the following individuals were members of, or regular attendees at, the Committee:

Members/ Attendees	Role	Designation	Period
Stephen Collier	Chair	Non-Executive Director	April 2020 – March 2021
Tim Wright	Member	Non-Executive Director	April 2020 – March 2021
Prof Dame Parveen Kumar	Member	Non-Executive Director	April 2020 – March 2021
Pui-Ling Li	Member	Associate Non-Executive Director	April 2020 – March 2021
Harbhajan Brar/* Paul Da Gama	Member	Chief People Officer	*April 2020 – May 2021* February 2021 – March 2021
Elizabeth Nyawade	*Member* Attendee	Acting Chief People Officer (Workforce)	*June 2020 – February 2021* February 2021 – March 2021
Humaira Ashraf	*Member* Attendee	Acting Chief People Officer (Culture and Organisational Development)	*June 2020 – February 2021* February 2021 – March 2021
Dr Richard Jennings	Member	Chief Medical Officer	April 2020 – March 2021
Robert Bleasdale	Member	Acting Chief Nurse/Director of Infection Prevention & Control	April 2020 – March 2021
Gillian Norton	Attendee	Trust Chairman	April 2020 – March 2021
Stephen Jones	Attendee	Chief Corporate Affairs Officer	April 2020 – March 2021
Emily Perry/* Gemma Philips	Attendee	Divisional Director of Operations – CWDT	*April 2020 – January 2021* February 2021 – March 2021
Mandy Woodley/*	Attendee	Divisional Director of Operations -	*April 2020 – December 2020*

Members/ Attendees	Role	Designation	Period
Neil Hardy-Lofaro		MedCard	January 2021 – March 2021
Anna Clough	Attendee	Divisional Director of Operations – SNCT	April 2020 – March 2021
Karen Daly/* Lucinda Etheridge	Attendee	*Associate Medical Director – Workforce* Deputy Chief Medical Officer	*April 2020 – December 2020* January 2021 – March 2021
Jacqueline McCullough	Attendee	Deputy Director of Human Resources	June 2020
Sion Pennant-Williams	Attendee	Workforce Intelligence Manager	April 2020 – March 2021
Liz Wells	Attendee	Staff Engagement Lead/ Listening into Action Lead	April 2020 – March 2021
Martin Kirke	Attendee	Workforce Consultant	July 2021 – December 2020

**No longer members of / attendees at the Committee/ change in status on the Committee*

Members of the Trust's Council of Governors also regularly attended to observe the Committee meetings during the period.

3.2 Committee Meeting Attendance

In 2020/21, the quorum for each meeting of the Committee was three members, including at least one Executive Director and two Non-Executive Directors (one of whom shall be the Committee Chair or, in his/ her absence another Non-Executive Director Committee member nominated to Chair the meeting).

The Committee held a total of nine meetings in the reporting period and the attendance of members (membership based on the revised 2020 terms of reference) are recorded below. All meetings were quorate. These nine meetings included the five meetings which focused on core workforce issues and the additional four meetings which focused on culture, diversity and inclusion matters.

Members/ Attendees	Role	Attendance
Stephen Collier	Chair	9/9
Tim Wright	Member	9/9
Prof Dame Parveen Kumar	Member	9/9
Pui-Ling Li	Member	8/9
Paul Da Gama	Member	2/2
Elizabeth Nyawade	*Member* Attendee	*7/7* 1/2
Humaira Ashraf	*Member* Attendee	*7/7* 2/2
Dr Richard Jennings	Member	6/9
Robert Bleasdale	Member	8/9
Gillian Norton	Attendee	6/9
Stephen Jones	Attendee	9/9
Emily Perry/* Gemma Philips	Attendee	*3/7* 1/2
Mandy Woodley/* Neil Hardy-Lofaro	Attendee	*2/7* 4/6
Anna Clough	Attendee	4/9
Karen Daly/* Lucinda Etheridge	Attendee	*5/6* 3/3

Members/ Attendees	Role	Attendance
Jacqueline McCullough	Attendee	1/1
Sion Pennant-Williams	Attendee	7/9
Liz Wells	Attendee	1/9
Martin Kirke	Attendee	3/6

**No longer members of / attendees at the Committee/ change in status on the Committee*

The attendance of regular attendees at the Committee across the nine meetings held in the reporting period are also recorded above. These individuals were not members of the Committee and did not form part of the quorum.

The Chief Executive Officer, Jacqueline Totterdell, also attended a number of meetings during the year. In addition, Joseph Pavett-Downer, Diversity and Inclusion Lead, also became a regular attendee at the meeting and his status at the meeting has been enshrined in the revised terms of reference. As mentioned in section one the Programme Director, Culture, Diversity & Inclusion also attended those meetings where the culture programme was being discussed.

The following is a record of the members of the Council of Governors that also attended the meeting during the period.

Members/ Attendees	Role	Attendance
Richard Mycroft	Governor	2
Sandhya Drew	Governor	1
Hilary Harland	Governor	1
Shalu Kanal	Governor	3
Nasir Javed Khan	Governor	3

4 Committee activity and focus

The Committee developed and approved a forward workplan in June 2020. The forward programme (Appendix 1) was intended to ensure the Committee fulfils its purpose and duties as set out in the Committee's agreed terms of reference. While additional meetings were scheduled for the Committee the matters discussed at the meeting were already set out in the original workplan, however more time was made available at the additional meetings to cover culture, diversity and inclusion in greater depth. The matters discussed and considered at the Committee during the period (June 2020 – March 2021) are set out in Appendix 2 mapped across the key duties as recorded in the approved terms of reference.

Each meeting of the Committee had a full agenda and the Committee submitted regular reports to the Board following each meeting. The key areas of focus for the Committee in 2020/21 are outlined below. This draws on the matters set out within the reports to the Board during 2020/21.

In year, the Committee continued to actively seek and test assurance it receives and, in turn, seeks to provide the Board with an accurate assessment of where the Board can take assurance and where there continue to be gaps. The Committee's ability to work effectively was supported by the embedding of the People Management Group within the management governance framework.

4.1 Board Assurance

One of the means by which the Committee seeks to provide assurance to the Board is through its assessment of the strategic risks in the Board Assurance Framework allocated to the it by the Board. During the year the Committee had the following two Strategic Risks (SR) assigned to it:

		Assurance	Risk Score	Target Risk
SR8	**We fail to build an open and inclusive culture across the organisation which celebrates and embraces our diversity because our staff do not feel safe to raise concerns and are not empowered to deliver to their best**	**Partial**	**Extreme - 20**	**Extreme - 16**
SR9	We are unable to meet the changing needs of our patients and the wider system because we do not recruit, educate, develop and retain a modern and flexible workforce and build the leadership we need at all levels	**Partial**	**Extreme - 16**	**Extreme - 16**

The Committee monitors the risk ratings assigned to each Strategic Risk in the light of the level of assurance it is able to provide. At the start of the year, the Board agreed a risk score of 20 for Strategic Risk 8 (culture) based on gaps identified in relation to culture, diversity and inclusion and raising concerns. The assurance level for this risk was also rated as limited. During the year the Committee scrutinised this risk closely and, in February 2021, having sought and received assurance regarding the progress of the programme of work to strengthen the culture of the organisation, the development of a new freedom to speak up strategy and action plan, and the ongoing implementation of the diversity and inclusion action plan, recommended to the Board that the risk score for Strategic Risk 8 be reduced from 20 to 16 and the assurance rating be increased from limited to partial. In so doing, the Committee oversaw the assurance necessary for the Trust to meet the target risk score for Strategic Risk 8 by the end of financial year. In relation to Strategic Risk 9, while the Committee was not in a position to recommend a reduction in the risk score, the Committee was pleased to see the progress being made in mitigating the risk, particularly in relation to the strengthening of the management of employee relations cases and the position of workforce key performance indicators, and to have achieved the target risk score of 16 at year end.

Overall whilst the risk score for both Strategic Risks remained high the Committee recognised the work being undertaken to manage these risks.

4.2 Theme 1 - Engagement

Engagement was a key factor in the work of the Committee during the period. The work to strengthen the culture of the organisation, supporting staff throughout the Covid-19 pandemic, developing and delivering the diversity and inclusion action plan, and responding to national issues around race relations necessitated a rigorous engagement programme for staff. The Committee commended and was assured by the extent of the work to complete the discovery and diagnostic phase of culture change programme, work which was supported by a number of champions from spectrum of staff groups. The diagnostic work was completed despite the focus on managing the surges in Covid cases and the wealth of information identified complemented the feedback in the staff survey and other intelligence. The Committee was also assured by the plans to develop a clear

action plan arising from the diagnostic phase and held a wider meeting of the Committee in January 2021 in which a number of non-executive directors who are not members of the Committee participated and provided input into the development of the plan.

The Committee noted the good progress and the improved systems around raising concerns which coincided with the move of the freedom to speak up function under the Chief Corporate Affairs Officer resulting in the approval of a Freedom to Speak Up Strategy in September 2020, a visit from the National Freedom to Speak Up Guardian in October 2020 and improved reporting and monitoring of cases. The Committee recognises that significant work remains needed to ensure staff feel safe and supported to raise concerns, and to see a material improvement on the national FTSU Index, but it was assured by the early progress in implementing the new strategy and looks forward to a further strengthening of the Trust's approach to raising concerns in 2021/22.

The Committee recognised that there was more to be done to improve diversity and inclusion in the Trust. The work to ensure that that there was an inclusion representative on interview panels for senior posts (Band 8a and above) had progressed well but the Committee were keen to ensure that the Trust progressed its culture, diversity and inclusion work to address the issues outlined in the Workforce Race Equality Standards, the feedback from the Black Asian and Minority Ethnic (BAME) staff group in the national NHS Staff survey and the Trust's internal data which highlighted disparities in how BAME staff get access to career progression. The Committee were assured that a comprehensive diversity and inclusion action plan had been developed and was being implemented, and it welcomed the focus that had been brought to this issue over the past year.

4.3 Theme 2 – Leadership and Progression

The Committee sees the development of the capability of the Trust's middle management as a key factor in making progress. The Committee will continue to monitor how the Trust progresses and develops its leadership programme, provide coaching and development opportunities and begin to manage its talent to support retention and recruitment. The Committee recognised that this would be pivotal to also supporting BAME staff to progress in their careers at the Trust and recognised that the introduction of inclusion specialists on interview panels would help. The Committee is committed to this work to address these systemic issues and would continue to review progress in the coming year.

4.4 Theme 3 - Workforce Planning & Strategy

The Committee was pleased to note that the Trust's workforce strategy largely met the requirements outlined in the NHS People Plan published in the Summer of 2020 with more work to be done on providing flexibility in the workforce. The Trust had been forced to be flexible in response to Covid-19 with a number of staff needing to work from home at short notice and adapting and delivering training and support to staff redeployed to other areas to manage Covid-19. The Committee was monitoring the learning exercise which was looking at how the Trust returns to normal and embeds the reactive actions into business as usual.

The Committee was reassured by the reduction in staff turnover, the reducing staff vacancies, decline in staff sickness and the positive move reliance in agency staff usage with the increase in bank staff numbers and usage.

The Trust developed and rolled out very positive programmes around Covid-19 risk assessment for staff put in place systems to support staff that had to shield. The Committee also monitored staff health and wellbeing during surges in Covid cases and as the organisation resumed clinical services. The Trust had a robust programme of work and the Committee would continue to monitor the effectiveness of these systems.

The Committee also supported the progress made on improving the systems and transparency around employee relations issues in the Trust. The Committee was assured that there were robust systems in place supported by the new policies to manage disciplinary cases and the Committee had greater visibility on this data and interrogating any egregious trends impacting on any particular group of staff.

4.5 Theme 4 – Compliance

The Committee has continued to monitor a number of key performance indicators (KPIs) in relation to compliance, including safe staffing. In addition a number of policies and action plans have been reviewed, including:

- Disciplinary Policy – the Committee reviewed and endorsed the policy which was updated to reflect the Dido Harding recommendations.
- MHPS – the Committee was updated on the work being done to update the Trust's policy on Managing High Performance Standards for Consultants and Hospital Doctors.
- Junior Doctors, Safe Working – the Committee received regular updates from the Trust's Guardian of Safe Working and noted that focus on Covid-19 had impacted on the engagement of junior staff
- Modern Slavery Statement & Policy – the Committee approved the policy and statement around Modern Slavery.

At each of its meetings the Committee formally seeks assurance from the Trust's Chief People Officer that he is not aware of any areas where there had been or was any non-compliances by the Trust.

5 Committee Effectiveness

The Committee conducted a review of its effectiveness and the report is attached in Appendix 5. Overall, the results of the review suggest that the Committee is working effectively. Respondents stated that the Committee was either, "extremely effective" or "very effective". See figure 1 below

It was evident from the results of the 2020/21 review that the actions taken by the Committee in 2019/2 had led to significant improvements.

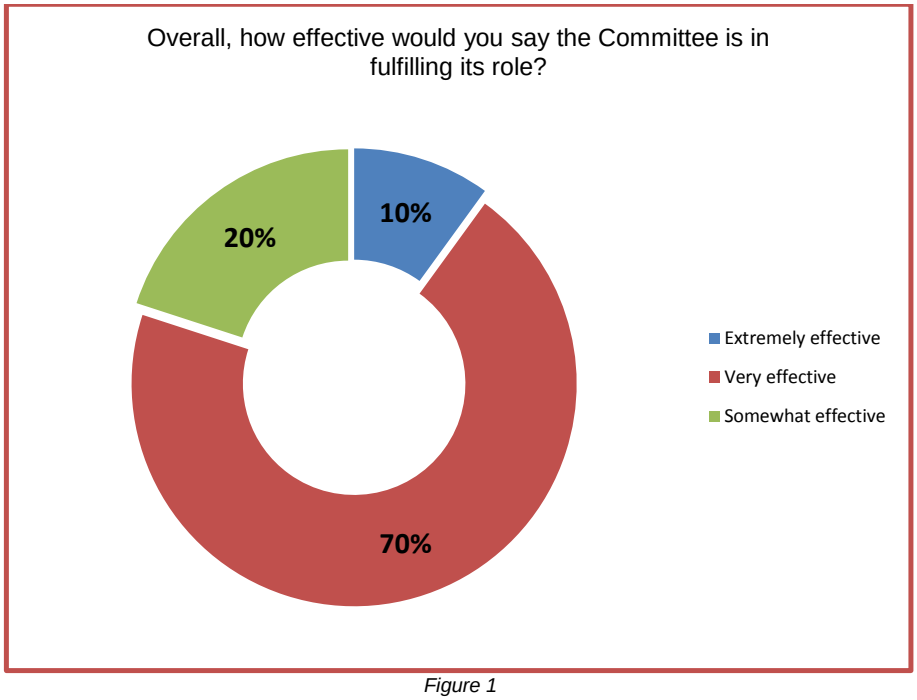

Figure 1

In 2019/20 the Committee agreed that further work would be completed in the following areas to improve the effectiveness of the Committee and the Trust made significant progress on these actions:

- *Regularly divisional representation at the meetings*
- *Induction and training programme for new members*
- *Quality reports and the inclusion of key workforce performance metrics*
- *More constructive challenge*
- *Comprehensiveness and reliability of the assurances received at the Committee*

The Committee would focus on the following actions in 2021/22

- *Committee members engagement with the Terms of Reference*
- *Induction/training for new members of the Committee*
- *Verification of actions being implemented and review of evidence to gain assurance*
- *Attendance by divisional directors of operations*

6 Committee Forward Plan and Terms of Reference

The Committee's proposed forward work plan for 2021/22 is attached in Appendix 4, alongside the work plan that had previously been agreed for 2020/21 and on which this reporting year is based.

The nature of the Committee's work means that it does cover a broad scope of matters on behalf of the Board. The proposed work plan for 2021/22 sets out the matters for consideration by the Committee. This builds on the learning from the previous years and supports giving more focus on culture, education and health and wellbeing of staff. The workplan supports the Committee in providing the right level of assurance on key workforce matters. Over the coming months, while it will work to the agreed plan, it may be necessary to adjust this (subject to these operational pressures) to focus on areas of immediate priority.

The Committee had a robust terms of reference approved in June 2020 and the changes proposed were reflective of the working of the Committee during the year, the increased meeting and the focus on culture, diversity and inclusion.

7 Conclusion and Assurance Statement

During 2020/21, the Committee worked hard to deliver its duties and in doing so had started strengthen its own operation and effectiveness. Whilst there was more that needs to be done on the assurance front, and that in parallel the using the intelligence from the People Management Group further step back from operational oversight and into a wholly-assurance and strategic focus.

The Committee can assure the Board that there were better systems in place to manage workforce matters in the Trust. There was better grip ad greater visibility on the key risks and the executive have been responding effectively to these matters as they arise and then putting in place robust systems to either prevent or effectively manage issues in the future exampled by employee relations issues and bank staff pay.

Last year the Committee was unable to full assurance on the diversity and inclusion matters however this year the Committee commended the significant work done on the developing the diversity and inclusion action plan, and completion of the culture programme discovery and diagnostics and development of an action plan. The Committee was however concerned about the feedback from BAME staff and the lack of traction on some endemic issues which have resulted in the Trust being below average on diversity and inclusion issues flagged in the national staff survey.

The Committee's 2021/22 forward plan would give focus to these areas of risk.

Appendix 1: Committee Workplan June 2020 – March 2020 (Business As Usual)

Scheduled, Standing Agenda Item	Frequency	Lead	Author(s)	Committee	11/06/2020	13/08/2020	15/10/2020	10/12/2020	11/02/2021
OPENING ADMINISTRATION									
Welcome, Introductions and Apologies for Absence	Standing	All	Secretariat	N/A	√	√	√	√	√
Declarations of Interest	Standing	All	Secretariat	N/A	√	√	√	√	√
Minutes of Previous Meeting	Standing	Chair	Secretariat	N/A	√	√	√	√	√
Matters Arising (Tracker) and Action Log	Standing	Chair	Secretariat	N/A	√	√	√	√	√
DEEP DIVES									
Deep Dive Programmes	Standing	CPO	Various	N/A	√	Workforce Race Equality Standard	Employee Relations	Non-Medical Staff Appraisals	Trust turnover rates
WORKFORCE & LEADERSHIP									
Chief People Officer Workforce Report	Standing	CPO	CPO/DDHR	TMG	√	√	√	√	√
Workforce statistics and KPI	Standing	CPO	WiM	TMG/PMG	√	√	√	√	√
Annual Workforce Plan & Budget	Annual	CPO	DCPO(W)	TMG/PMG		√			
Guardian of Safe Working	Standing	CMO	GSW	TMG/PMG	√(Annual)	√(Q1)	√(Q2)		√(Q3)
Safe Staffing: Nurse Establishments	Standing	CN/DIPC	CN/DIPC	TMG/QSC		√			
Update on Implementing Dido Harding Recommendations	Annual	CPO	DCPO(W)	TMG/PMG			√		
Maintaing High Professional Standards in the NHS Policy Update	Annual	CPO	DCPO(W)	TMG/PMG				√	
Employee Relations Update	Bi-Annual	CPO	DCPO(W)	TMG/PMG			√	√	
CULTURE, DIVERSITY, WELL-BEING & EDUCATION									
Culture & Leadership Update	Bi-meeting	CPO	LiAM	TMG/PMG	√		√	√	
Staff Engagement Plan	Bi-meeting	CPO	LiAM	TMG/PMG		√	√	√	
NHS Staff Survey	Annual	CPO	HRBP	TMG/PMG					√
Freedom to Speak Up Guardian Report	Standing	CPO	SEL	TMG/AC/PMG	√	√	√	√	√
Medical Engagement Score (MES) Report (Update)	Bi-Annual	CMO	MHRM	TMG/PMG			√		√
GMC National Training Survey	Annual	CMO	ADW-ED	TMG/PMG		√	√		
Learning & Development Allocations	Annual	CMO	ADW-ED	TMG/PMG		√			
Undergraduate Medical Education *(date TBC either August/October)*	TBC	CMO	ADW-ED	TMG/PMG		√	√		
Staff Health and Well-Being Report	Bi-Annual	CPO	DCPO(C)	TMG/PMG			√		√
COMPLIANCE:									
WRES Annual Report	Annual	CPO	D&IM	TMG/PMG					√
WDES Annual Report	Annual	CPO	D&IM	TMG/PMG					√
Gender Pay Gap Annual Report	Annual	CPO	WiM/ D&IM	TMG/PMG					√
Ethnicity Pay Gap Annual Report	Annual	CPO	WiM/ D&IM	TMG/PMG					√
Medical Revalidation	Annual	CMO	AMD(HR)	TMG/PMG		√			
Nursing Revalidation	Annual	CN	tbc	TMG/PMG		√			
Modern Slavery Annual Statement	Annual	CPO	DCPO(W)	TMG/PMG				√	
Equality Delivery System	Annual	CPO	DCPO(W)	TMG/PMG				√	
STRATEGY AND RISK									
Workforce Strategy Delivery	Twice Yearly	CPO	CPO	TMG/PMG	√		√	√	
Education Strategy	Annual	CPO	ADW-ED	TMG/PMG	√		√	√	
Board Assurance Framework and Corporate Risk Register	Standing	CPO	DQ	TMG/PMG	√	√	√	√	√
GOVERNANCE:									
TRUST GOVERNANCE & COMPLIANCE									
Internal Audit reports (as required)	As required	CPO	DDHR	PMG		√	√	√	√
Review of Workforce Policies (as required and including Grievance, B&H, Disciplinary)	As required	DDHR	DDHR	PMG	√	√	√	√	√
Trust-Wide Policies Update - Workforce, OD, Education Focus	Bi-Annual	CCAO	HCG	TMG		√		√	
COMMITTEE GOVERNANCE									
Review of Committee effectiveness	Annual	Chair	Secretariat	N/A					√
Review of Committee Terms of Reference	Annual	Chair	Secretariat	N/A	√				√
Review of Committee Forward work plan	Annual	Chair	Secretariat	N/A	√				√
Committee annual report to the Board	Annual	Chair	Secretariat	N/A	√				√
CLOSING ADMINISTRATION									
Report to the Board	Standing	Chair	CPO	N/A	√	√	√	√	√
Any new risks or issues identified and for escalation to Board or other Trust Forums	Standing	Chair	CPO	N/A	√	√	√	√	√
Any other business	Standing	All	Secretariat	N/A	√	√	√	√	√
Reflection on the meeting	Standing	All	Secretariat	N/A	√	√	√	√	√

Appendix 2: Items Considered by the Workforce & Education Committee- April 2020 – March 2021

Workforce Planning and Performance	Culture, Diversity & Inclusion	Staff Engagement	Education & Organisational Development	Staff Wellbeing	Risk	Workforce and Education Strategy	General Workforce Governance	Committee Governance
Workforce Key Performance Indicators (Intelligence) and Key Workforce Development (Bi-monthly) Reports	Freedom to Speak Up Guardian Report (Quarterly)	NHS Staff Survey (2020) Report	Clinical Staff Annual Revalidation Report: Nurse and Medical	Supporting Staff Health & Wellbeing	Covid-19 Staff Risk Assessment	Workforce Strategy Implementation Update	People Management Group Report (Bi-monthly)	Committee Effectiveness Review: Plan and Results
Guardian of Safe Working Hours Report (Quarterly)	Culture Change Programme Update (Bi-monthly): Initial Programme, design	NHS Staff Survey (2020) Report	Undergraduate Medical Education	Flu Report	Board Assurance Framework	Education Strategy Implementation Update	Trust Wide Policies Update: Workforce, OD and Education Focus	Committee Annual Review incl: Terms of Reference, Workplan
Guardian of Safe Working Hours Report (Annual Report)	Diversity & Inclusion Update (Bi-monthly)	2020 NHS Staff Survey & Pulse Survey	Safe Staffing: Nurse Establishment Report	Health & Wellbeing Report (Covid-19 Recovery Focus)	Internal Audit Report: Staff Appraisal	NHS People Plan		
Covid-19 Workforce Implications	Workforce Race Equality Standards (Annual) Report	Medical Engagement Score: Action Plan Update						
Safe Staffing: Nurse Establishment Report	Freedom to Speak Up: Proposed and Final Strategy	Staff Engagement Update						
Employee Relations	Diversity & Inclusion Action Plan, Progress Update and Dashboard (Bi-monthly)	NHS Staff Survey (2021) Benchmarking Data						
Disciplinary Policy (Adopting Dido Harding Recommendations)	Diversity and Inclusion Delivery & Impact Tracker (Bi-monthly)							
Modern Slavery Annual Statement and Policy (Reviewed and Approved)	Diversity and Inclusion Report: Recruitment and Facilitator Toolkit - 'Lets talk about race'							
Maintaining High Professional Standards Policy: Progress on Development & Draft	Workforce Disability Equality Standards (Annual) Report							
Bank Staff Holiday Pay Arrangements (Confidential: Report and Update)								

Other Appendices not embedded

Appendix 3: Updated Terms of Reference

Appendix 4: 2020/21 Draft Committee Workplan

Appendix 5: Committee Effectiveness Review

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Workforce and Education Committee Terms of Reference

Approved by the Trust Board ~~25 June 2020~~[TBC]

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Approval and review dates

Profile	
Document name	Workforce and Education Committee Terms of Reference
Version	1.2
Executive Sponsor	Chief People Officer
Author	Chief Corporate Affairs Officer
Approval	
Approval group	Trust Board of Directors
Date of approval	25 June 2020
Date for next review	March 2021

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Workforce and Education Committee Terms of Reference

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1. Name of Group

The Committee shall be known as the Workforce and Education Committee.

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2. Authority

Establishment: The Workforce and Education Committee has been established as a sub-Committee of the Trust Board.

Powers: The Workforce and Education Committee is authorised by the Board of Directors to:

i. Investigate any activity within its terms of reference
ii. Seek any information it requires and all staff are required to cooperate with any request made by the Workforce and Education Committee
iii. Request attendance of individuals and authorities from inside and outside the Trust with relevant experience and expertise if it considers this is necessary

Cessation: The Workforce and Education Committee is a standing group within the governance structure and can only be disbanded on the authority of the Trust Board.

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3. Purpose of the Group

The Workforce and Education Committee's purpose, as aligned to the Trust's strategic objectives, is to oversee the development of an empowered workforce that is both modern and flexible, with a culture that supports people to deliver to their best. The Trust's ambition is to be an employer of choice in south west London, working in partnership across the local health economy ensuring that the Trust has the right workforce to deliver its strategy. The Committee provides the Board with assurance that there are robust mechanisms in place to ensure:

i. Robust oversight of the delivery of the Trust's strategic aims in relation to its workforce and organisational culture
ii. Detailed consideration is given to the development and implementation of the Trust's workforce, ~~and~~ education and freedom to speak up strategies
iii. Effective oversight and monitoring of workforce planning
iv. Effective oversight of the delivery of the Trust's diversity and inclusion strategy and action plan, and monitoring of performance in relation to the Workforce Race Equality Standard and the gender pay gap
v. Adequate information is available on key issues to enable clear decisions to be made, to ensure compliance with the guidance of regulatory bodies
vi. The impact of workforce performance on the Trust's overall performance is closely monitored
vii. Staff health and well-being and development is monitored effectively
viii. Appropriate governance arrangements are in place in relation to workforce and education issues and that the Committee is able to provide the Trust Board with assurance on these matters as appropriate.

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4. Duties of the Group

The Workforce and Education Committee will discharge the following duties that have been delegated by the Board of Directors:

(a) Workforce, ~~and e~~Education and Freedom to Speak Up ~~s~~Strategies~~y~~

i. To monitor and provide assurance to the Trust Board on the delivery of the workforce, ~~and~~ education and raising concerns components of the Trust clinical strategy 2019-24
ii. To oversee and provide assurance to the Trust Board on the ~~development of new~~implementation of strategies in relation to workforce and education, aligned to and in support of the Trust clinical strategy 2019-24, including ~~and~~ the freedom to speak up ~~guardian~~ strategy
iii. To consider the strategic implications of cross-system working and integration on the development of the Trust's workforce and related strategies~~y~~

(b) Workforce planning and Employee relations

i. Review and provide challenge in relation to the development of the draft annual workforce plan
ii. Oversee the delivery of the workforce plan in year
iii. Improve the efficiency and productivity of the Trust workforce
iv. Review the workforce aspects of the Trust's Cost Improvement Programme
v. Oversee Trust-wide use of agency staff and provide assurance in relation to meeting the agency cap set annually by NHS Improvement
vi. Oversee the working hours of junior medical staff and actions to drive improvements
vii. Provide assurance in relation to the operation of the Trust's employee relations activities, including ~~r~~Rreceivinge regular confidential reports on disciplinary matters, including in relation to Maintaining High Professional Standards cases, ensuring that due process is followed
viii. Receive regular reports from the Partnership Forum
~~Receive regular confidential reports on disciplinary matters, including in relation to Maintaining High Professional Standards cases, ensuring that due process is followed~~
~~v.~~

(c) Staff engagement

i. Provide oversight of plans to improve engagement by the Trust with its staff, with the aim of securing increasing levels of staff engagement
ii. Review the results of the annual NHS staff survey and oversee the development and implementation of actions plans to address issues identified
iii. Review engagement across all staff groups and relevant engagement survey's (e.g. Medical Engagement Score) and pulse checks
~~ii.~~iv. Review the key trends and themes arising from concerns raised by staff

(d) Culture, Diversity and inclusion

i. To oversee the development and implementation of the Trust's culture programme and action plan
ii. To oversee the implementation of the Trust's diversity and inclusion strategy and action plan
~~i. To oversee the development and implementation of the Trust's culture progammee~~
~~ii.~~iii. To review the Trust's performance in relation to the ~~Workforce Race Equality Standard~~key workforce equality standards for example, Workforce Race Equality Standards, Workforce Disability Standards
~~iii.~~iv. To review the Trust's performance in relation to the gender pay gap and the ethnicity pay gap

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(e) ~~Staff well-being~~Education, Organisational Development

i. Oversee performance on staff appraisal rates (clinical and non-clinical)
ii. Oversee performance in relation to mandatory and other training
iii. Seek assurance in relation to the development and implementation of plans for leadership development
iv. Oversee key any emerging risk and/or ~~-~~issues in relation to the following:
- Undergraduate and postgraduate education
- Education of future workforce
- Careers pathways and continuing personal development
- Parity of esteem
- Wider ~~D~~development plans and pathways

~~iii. Receive regular reports from the Partnership Forum~~
~~iv. Receive regular confidential reports on disciplinary matters, including in relation to Maintaining High Professional Standards cases, ensuring that due process is followed~~

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(f) Risk

i. On behalf of the Trust Board, the Committee shall regularly scrutinise the Trust's significant risks in relation to workforce and education issues, satisfying itself of the adequacy of the controls in place to mitigate the risks. This includes scrutinising the Board Assurance Framework risks allocated to the Committee.

(g) General governance

i. To consider matters referred to the Workforce and Education Committee by the Trust Board or by the groups which report into it
ii. Every year, to set an annual work plan and conduct a review of the Committee's effectiveness (including achievement of the work plan and a review of the Committee's terms of reference) and report this to the Board
iii. To ensure that all relevant policies and procedures that fall under the Committee's areas of interest are in place and up to date.
iv. As required, to review any relevant Trust strategies relevant to the Committee's terms of reference prior to approval by the Board (if required) and monitor their implementation and progress.

5. Chairperson

A Non-Executive Director will chair the Workforce and Education Committee. In his/her absence, an individual to be nominated by remaining members of the Committee will take the chair.

The Chief People Officer (CPO) will be the Executive Lead for the Workforce and Education Committee

6. Composition of the Group

Membership: The following individuals will be members of the group with full rights. Members are expected to make every effort to attend all meetings and attendance register shall be taken at each meeting.

Name	Title	Role in the group
Stephen Collier	Non-Executive Director	Committee Chair

Parveen Kumar	Non-Executive Director	Member
Pui-Ling Li	Associate Non-Executive Director	Member
Tim Wright	Non-Executive Director	Member
Paul Da Gama ~~(Vacant)~~	Chief People Officer	Member
Robert Bleasdale	Acting Chief Nurse and Director of Infection Prevention and Control	Member
Richard Jennings	Chief Medical Officer	Member

Deputies can attend the group with the permission of the chairperson, though they must be suitably briefed and supported by the individual for whom they are deputising in advance.

Attendees: The following individuals are not members of the group with full rights and are instead expected to be in attendance for the purpose outlined below:

Title	Role in the group / committee	Attendance guide
Director of Education and Organisational Development	Regular Attendee	Every meeting
Director of Workforce	Regular Attendee	Every meeting
Deputy Chief Medical Officer – Workforce	Regular Attendee	Every meeting
Chief Corporate Affairs Officer	Regular Attendee	Every meeting
Divisional Director of Operations – CWDT	Regular Attendee	Every meeting
Divisional Director of Operations - MedCard	Regular Attendee	Every meeting
Divisional Director of Operations – SNCT	Regular Attendee	Every meeting
~~Associate Medical Director~~Deputy Chief Medical Officer – Workforce	~~Regular Attendee~~	~~Every meeting~~
~~Deputy Director of Human Resources~~	~~Regular Attendee~~	~~Every meeting~~
~~Associate Director of Workforce – Education & Development~~	~~Regular Attendee~~	~~Every meeting~~
Diversity and Inclusion Lead	Regular Attendee	Every meeting
Workforce Intelligence Manager	Regular Attendee	Every meeting
Staff Engagement Lead	Regular Attendee	Every meeting
~~Deputy Chief People Officer – Culture/Education~~	~~Regular Attendee~~	~~Every meeting~~
~~Deputy Chief People Officer – Workforce/Leadership~~	~~Regular Attendee~~	~~Every meeting~~

The Trust Chairman and Chief Executive Officer shall be regular attendees ~~of~~ at the Committee.

Deputies can attend the group with the permission of the Committee Chair, though they must be suitably briefed and supported by the individual for whom they are deputising in advance.

In addition to anyone listed above as a member or attendee, at the discretion of the chairperson the group may also request individuals to attend on an ad-hoc basis to provide advice in support of specific items.

Governors shall be invited to attend the meeting as observers.

7. Quoracy

Number: The minimum number of members for a meeting to be quorate is three members, including at least one Executive Director and two Non-Executive Directors (one of whom shall be the Committee Chair or, in his/ her absence another Non-Executive Director Committee member nominated to Chair the meeting).

~~As an ex-*officio* member of the Committee, the Trust Chairman shall count towards the quorum for the Committee.~~
Attendance by a nominated deputy will not count towards the quorum.

Non-quorate meetings: Non-quorate meetings may go ahead unless the chair decides not to proceed. Any decisions made by the non-quorate meeting must, however, be formally reviewed and ratified at the subsequent quorate meeting.

8. Declaration of Interests

All members and those in attendance must declare any actual or potential conflicts of interest; these shall be recorded in the minutes. Anyone with a relevant or material interest in a matter under consideration must be excluded from the discussion.

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9. Meeting Frequency

Meetings of the Workforce and Education Committee shall be held six times per year, typically every other month. The frequency of meetings may be changed only with the agreement of the Trust Board.

10. Meeting arrangements and Secretarial support

i. An annual schedule of meetings of the Workforce and Education Committee shall be established prior to the start of each financial year;
ii. The Chief Corporate Affairs Officer will oversee the provision of secretariat support for the Workforce and Education Committee, and the Secretary to the Committee will be a member of the Corporate Governance team, which will work closely with the Executive Lead and Non-Executive Committee Chair. This will include taking accurate minutes, producing an action log and issuing follow up actions, ensuring that the planning for and outcomes of Committee meetings are shared appropriately. Alternative arrangements for secretariat support may be agreed by the Committee.
iii. The agenda for the meeting will be agreed and compiled through discussion between the Committee Chair, Executive Lead and ~~Director of~~ Chief Corporate Affairs Officer.
iv. All papers and reports to be presented at the Workforce and Education Committee must be submitted to the identified secretarial support for the group at least 5 working days prior to the meeting, unless otherwise agreed with the Committee Chair.
v. The agenda and supporting papers for the meeting will be forwarded to each member and planned attendees a minimum of 4 working days in advance of the meeting taking place.

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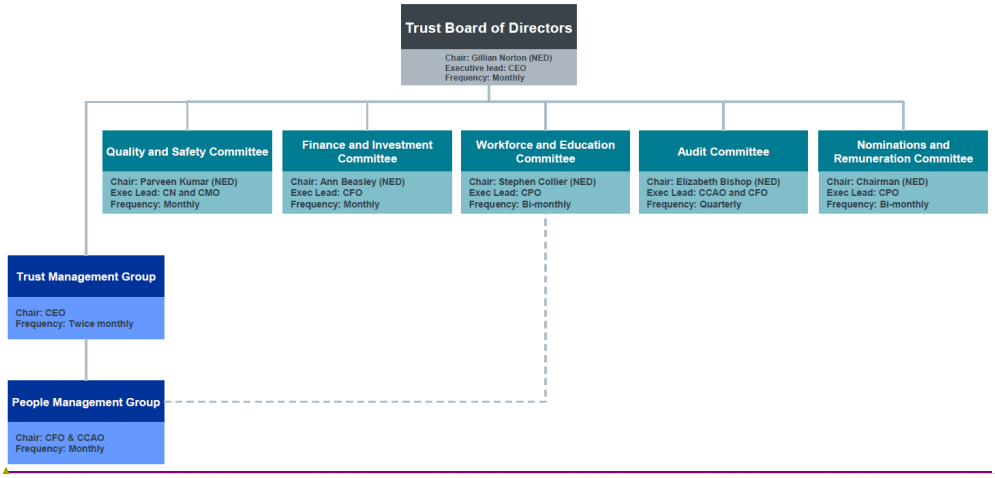
11. Relationship with other groups and committees

The Committee will report to the Trust Board.



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The People Management Group (PMG), which is chaired by the Chief People Officer, is a sub-group of ~~the Trust~~the Trust Management Group. The PMG will provide assurance to the Workforce and Education Committee on the issues within the Committee's remit. ~~A diagram of the groups reporting to the Board on workforce and education issues is attached at Appendix 1.~~

12. Report to the Board

The Committee Chair will prepare a report for the Trust Board after each meeting of the Committee. This will set out the key issues considered at each meeting and the degree to which the Committee was assured on these, specifically highlighting any areas in which there is a lack of assurance.

The Committee will, in addition, prepare an annual report to the Board setting out the key areas of focus in the previous financial year.

13. Agenda

Agendas for Committee meetings will be drawn from the Committee's annual cycle of business (forward plan) and will be agreed with the Committee Chair and Executive Lead(s).

14. Forward cycle of business

An Annual cycle of items and reports to be received by the Committee will be agreed by the Committee. The annual cycle shall be reviewed on an annual basis prior to the start of the financial year and should be reported to the Board alongside the Committee's annual report.

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15. Review of Terms of Reference

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The Committee will conduct a review of its effectiveness each year, the results of which will be reported to the Board.

The Committee's Terms of Reference shall be subject to an annual review. This review should consider the performance of the Quality and Safety Committee including the delivery of its purpose, compliance with the terms of reference and progress against its planned forward cycle of business. Any changes to the Terms of Reference require the approval of the Board.

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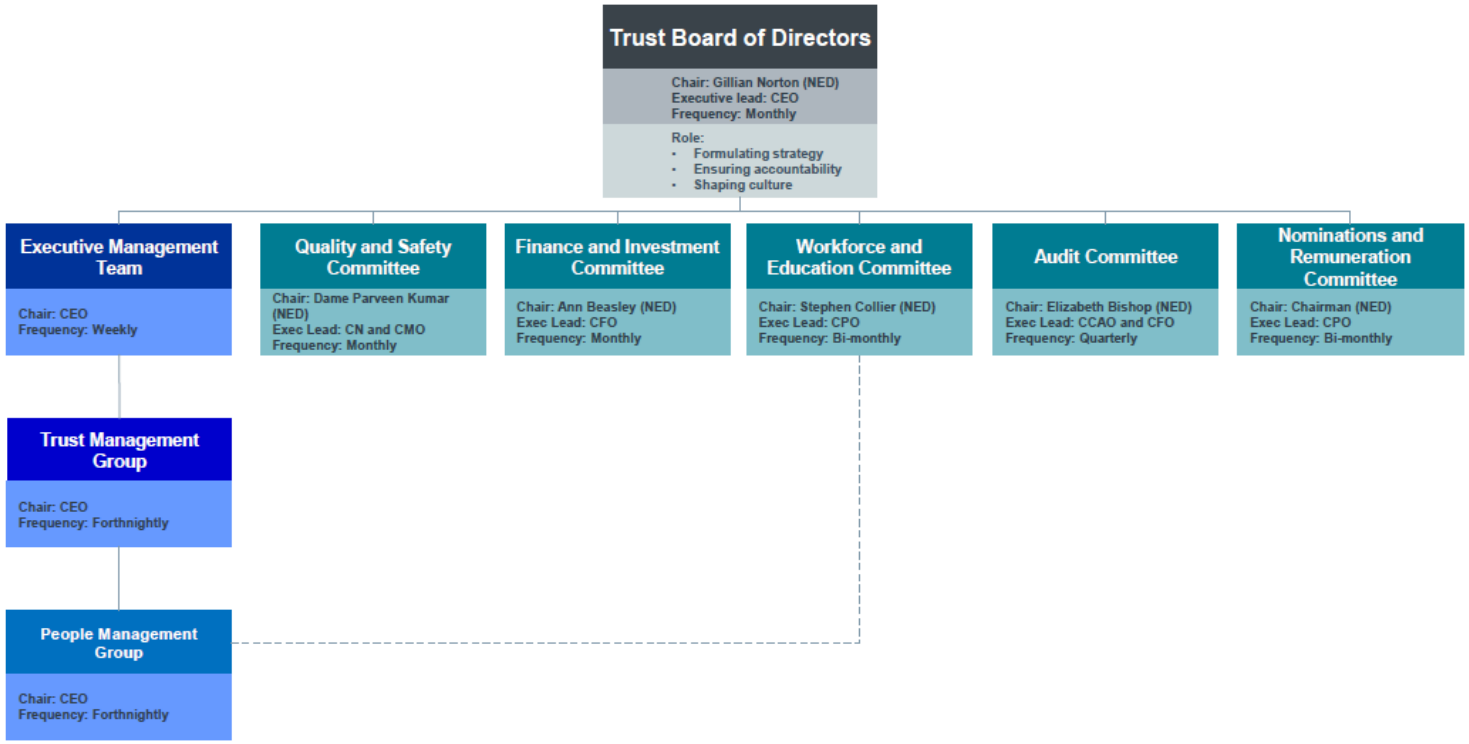
APPENDIX 1: GROUPS REPORTING TO THE BOARD ON WORKFORCE AND EDUCATION ISSUES



Workforce Education Committee
Proposed Workplan 2021/22

Scheduled, Standing Agenda Item	Frequency	Lead	Author(s)	Governance Forums	15/04/2021	18/05/2021	10/06/2021	15/07/2021	12/08/2021	16/09/2021	15/10/2021	11/11/2021	09/12/2021	13/01/2022	11/02/2022	10/03/2022
OPENING ADMINISTRATION																
Welcome, Introductions and Apologies for Absence	Standing	All	Secretariat	N/A												
Declarations of Interest	Standing	All	Secretariat	N/A												
Minutes of Previous Meeting	Standing	Chair	Secretariat	N/A												
Matters Arising (Tracker) and Action Log	Standing	Chair	Secretariat	N/A												
DEEP DIVES																
Deep Dive Programmes	Standing	CPO	Various	N/A		**Non-Medical Staff Appraisals**		**Learning from Covid-19 - Working in Different Ways**		**Employee Relations**		**Trust turnover rates**		**Workforce Race Equality Standard**		
WORKFORCE SUPPLY																
INTERNAL SUPPLY																
Bi-Monthly Workforce Report, Statistics and Key Performance indicators to incl: *Mandatory and Statutory Training* **Staff turnover and vacancy rates* **Recruitment activity* **Sickness Absence* **Employee relations* **Appraisal (Clinical/Non-Clinical)* **Workforce Cost and Efficiencies* **Bank and agency usage*	Bi-Monthly	CPO	DCPOs/WiMs	TMG/PMG												
Safe Staffing: Nurse Establishment	Annual	CN/DIPC	CN/DIPC	TMG/PSQG												
Guardian of Safe Working	Quarterly	CMO	GoSW	TMG/PMG	(Q4)			(Q1)/ Annual Report			(Q2)			(Q3)		
UP-SKILLING EXISTING WORKFORCE																
Leadership Development Programme - Growing Internal Talent	Bi-Annual	CPO	DCPO©	PMG/TMG												
Learning & Development Allocations	Annual	CMO	CPO(C)/ DMCO(ED)	TMG/PMG												
General Medical Council National Training Survey	Annual	CMO	CPO(C)/ DMCO(ED)	TMG/PMG												
Undergraduate Medical Education	Bi-Annual	CMO	CPO(C)/ DMCO(ED)	TMG/PMG												
WORKKFORCE PLANNING																
Annual Workforce Planning & Budget incl. NHS People Plan and South West London Integrated Care System Priorities	Annual	CPO	DCPO(W)	TMG/PMG												
Updates on South West London Partnership Workforce Developments and Projects (as required)	*Bi-Annual*	*CPO*	*DCPO(W)*	*TMG/PMG*												
RENTENTION																
NEW WAYS OF WORKING																
Review of New Ways of Working - Update on Covid review (follow on from July Deep Dive)	As Required	CPO	DCPO (W)	TMG												
HEALTH & WELLBEING																
Staff Health & Wellbeing Report	Quarterly	CPO	DCPO(C)	TMG/PMG		(Q4)		(Q1)			(Q2)			(Q3)		
Flu Vaccination Programme	Bi-Annual	CPO/CN	DCMO(W)	TMG/PMG												
STAFF ENGAGEMENT																
STAFF ENGAGEMENT																
NHS Staff Survey	Annual	CPO	DCPO(C)	TMG/PMG												
Staff Engagement Programme Update	Bi-Annual	CPO	SEL	TMG/PMG												
Medical Engagement Score (MES) Report (Update)	Bi-Annual	CMO	DCMO(W)	TMG/PMG												

Workforce Education Committee
Proposed Workplan 2021/22

Scheduled, Standing Agenda Item	Frequency	Lead	Author(s)	Governance Forums	15/04/2021	18/05/2021	10/06/2021	15/07/2021	12/08/2021	16/09/2021	15/10/2021	11/11/2021	09/12/2021	13/01/2022	11/02/2022	10/03/2022
CULTURE, DIVERSITY & INCLUSION AND ORGANISATIONAL DEVELOPMENT																
Strengthening Culture Update	Bi-monthly	CPO	DCPO(C)	TMG/PMG												
Diversity & inclusion Update	Bi-meeting	CPO	DCPO(C)/DIM	TMG/PMG												
Freedom to Speak Up Guardian Report	Quarterly	CCAO	FTSUG	TMG/PMG		(Q4)		(Q1)			(Q2)			(Q3)		
Workforce Race Education Standards Annual Report	Annual	CPO	DCPO(C)/DIM	TMG/PMG												
Workforce Disability Education Standards Annual Report	Annual	CPO	DCPO(C)/DIM	TMG/PMG												
Gender Pay Gap Annual Report	Annual	CPO	DCPO(C)/DIM	TMG/PMG												
Ethnicity Pay Gap Annual Report	Annual	CPO	DCPO(C)/DIM	TMG/PMG												
Equality Delivery System	Annual	CPO	DCPO(W)	TMG/PMG												
Staff Network Updates (Network Chairs)	Annual	CPO	DCPO(W)	TMG/PMG												
STRATEGY AND RISK																
Workforce Strategy Implementation and Delivery	Quarterly	CPO	DCPO(W)	TMG/PMG	(Q4)			(Q1)			(Q2)			(Q3)		
Education Strategy Implementation and Delivery	Annual	CPO	CPO(C)/ DMCO(ED)	TMG/PMG		(Q4)		(Q1)			(Q2)			(Q3)		
Board Assurance Framework and Corporate Risk Register	Quarterly	CCAO	CCAO	TMG/PMG		(Q4)		(Q1)			(Q2)			(Q3)		
GOVERNANCE																
TRUST GOVERNANCE & COMPLIANCE																
People Management Group Report	Monthly	CPO	CPO	PMG/TMG												
Culture, Diversity and Inclusion Programme Board Report	Monthly	CPO	CPO	PMG/TMG												
Medical Revalidation	Annual	CMO	DCMO(W)	TMG/PMG												
Nursing Revalidation	Annual	CN	CN	TMG/PMG												
Modern Slavery Annual Statement	Annual	CPO	DCPO(W)	TMG/PMG												
Trust-Wide Policies Update - Workforce, OD, Education Focus	Bi-Annual	CCAO	HCG	TMG												
Review of Workforce Policies (as required and including Grievance, B&H, Disciplinary)	*As required*	*CPO*	*CPO*	*TMG/PMG*												
Internal Audit reports (as required)	*As required*	*CPO*	*CCAO*	*PMG*	(Bullying & Harassment)											
COMMITTEE GOVERNANCE																
Review of Committee effectiveness (**Plan**/**Results**)	Annual	Chair	Secretariat	N/A												
Review of Committee Terms of Reference	Annual	Chair	Secretariat	N/A												
Review of Committee Forward work plan	Annual	Chair	Secretariat	N/A												
Committee annual report to the Board	Annual	Chair	Secretariat	N/A												
CLOSING ADMINISTRATION																
Report to the Board	Standing	Chair	CPO/CCAO	N/A												
Any new risks or issues identified and for escalation to Board or other Trust Forums	Standing	Chair	CPO	N/A												
Any other business	Standing	All	Secretariat	N/A												
Reflection on the meeting	Standing	All	Secretariat	N/A												

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Workforce Committee Effectiveness Review 2020/21

Survey results and action plan

As presented to the Committee in March 2021

Stephen Jones
Chief Corporate Affairs Officer

Tamara Croud
Head of Corporate Governance

15 March 2021

1. Introduction

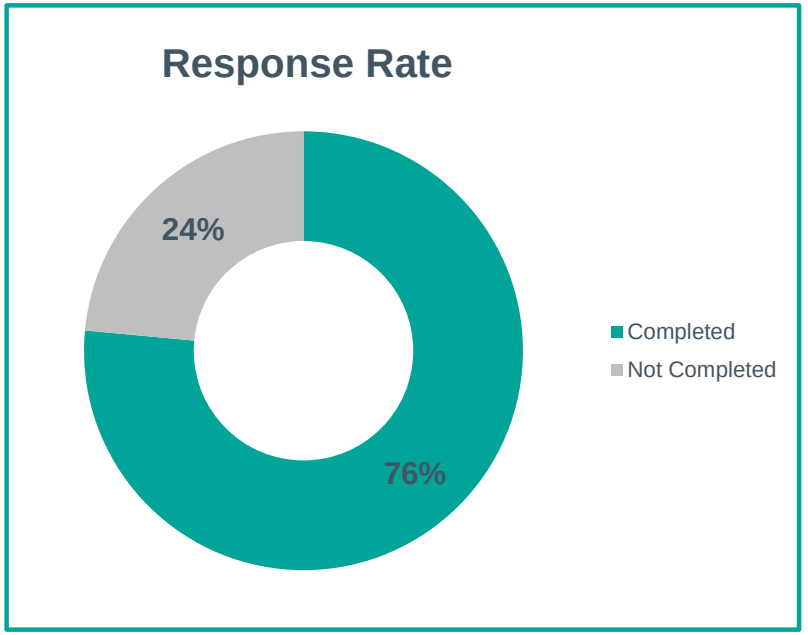
Engagement

The following groups were invited participated in the survey:

- Non-Executive Director Committee members
- Executive Director Committee members including the Executive Committee Lead
- Trust Chairman
- Chief Executive
- Regular attendees – in line with the Terms of Reference

There was positive engagement with the review. 13 of the 17 individuals asked to respond did so, providing a response rate of 76%. This was an improvement on the 65% response rate of 2019/20

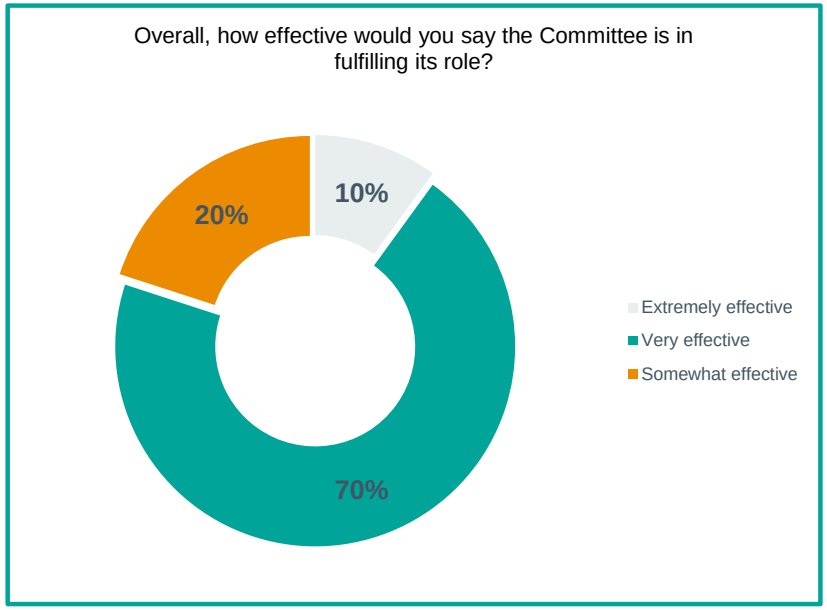
A few of the new members to the Committee did not feel able to complete the survey because they had only recently started to attend the Committee.



2. Key findings from Audit Committee Effectiveness Review 2020/21

Overall effectiveness

The results of the review suggest that the Committee is working effectively. Respondents stated that the Committee was either, “extremely effective” (1 response) “very effective” (7 responses) or somewhat effective (2 responses). No respondents stated that the Committee was ineffective. Three respondents skipped the question.



Summary of findings

The following two slides summarises the responses from the 2020/21 survey. Overall, the respondents reflected that there had been noticeable improvement in the Committee, particularly in the last year, and with the addition of extra meetings to move the Committee to monthly meetings.

When the Committee completed the 2019/20 survey it agreed that further work would be completed in the following areas to improve the effectiveness of the Committee:

- *Regularly divisional representation at the meetings*
- *Induction and training programme for new members*
- *Quality reports and the inclusion of key workforce performance metrics*
- *More constructive challenge*
- *Comprehensiveness and reliability of the assurances received at the Committee*

It was evident from the results of the 2020/21 review that the actions taken by the Committee had led to significant improvements in these areas and only areas for development included:

- Committee members engagement with the Terms of Reference
- Induction/training for new members of the Committee
- Verification of actions being implemented and review of evidence to gain assurance
- Attendance by divisional directors of operations

In conclusion, in comparison to 2019/20 the respondents in 2020/21 were positive about the Committee and its achievement and whilst the above areas for development have been identified it should be noted that there were no wholesale consensus in these areas.

2a. Summary of responses

NB: It should be noted that there were two partially completed response and some respondents skipped certain questions.

Area	Response Summary
Terms of Reference	58% of respondents noted that the Committee Terms of Reference was fit for purpose. Whilst this number is lower than expected the other 42% stated that they did not recall reviewing the Terms of Reference.
Workplan	90% of respondents stated that the Committee's workplan was fit for purpose with the remaining 10% stating that they did not know.
Sufficiency of time on agenda to explore issues in appropriate depth	80% of respondents stated that there was sufficient time on the agenda extra issues at appropriate depth.
Circulation of papers	All respondents (100%) felt that the papers were circulated in a timely way.
Committee papers	90% of respondents noted that the Committee papers were clear concise and provided enough information for the committee to take informed decision and included details of risks and the implications with the other 10% stating that this was not the case. Supporting commentary suggest that sometimes papers can be too long and lack clear executive summaries and the actions in reports were sometimes *'challenging to distil and monitor*'. In addition a respondent noted that it was sometimes evident that the key issues and discussions had not been appropriately addressed at other governance forums.
Reporting governance forums	80% of respondents' stated the Committee had a clear understanding of the governance forums which reports directly into it however 20% of respondents had the opposite opinion. In the comments provided respondents requested a diagram of the reporting forums to be used as an aide memoire and also noted that many of the reporting governance forums were new and still not *"fully bed in"*.
Membership & Attendance	All but 10% of respondents stated that the Committee had the correct membership. The respondents (90%) also felt that attendance was good but there were again comments about the lack of operational engagement (divisional directors of operations) however respondents recognised that it had been particularly challenging year with Covid-19. There was also a reflection that the reduction in required attendees compared with previous years was much better.
Skills	All respondents (100%) agreed that the Committee collectively have the range of skills needed to ensure the Board receives the assurance it needs on workforce-related issues and risks and the he wider skills to be fully effective.
Induction and training arrangements	The feedback on induction and training was mixed with 60% stating new members received an effective induction and training whilst 40% stated that this was not the case. The commentary ranged from people stating that there was no induction/training, mention of a discussion with the chair on joining the Committee or they had not received any induction.

2b. Summary of responses

NB: It should be noted that there were two partially completed response and some respondents skipped certain questions.

Area	Response Summary
Examining workforce data	All respondents (100%) stated that the Committee have the opportunity to examine specific workforce and compliance issues in detail on areas of concern. Respondents reflected that this was the case in recent months and that there was deep dive programme.
Committee Chairing	90% of respondents agreed that the Committee was chaired effectively with attributable comments such as 'excellent and very effective'.
Challenge	90% of respondents agreed that the Committee provided insight and strong, constructive challenge on the matters outlined in the Terms of Reference. One respondent stated the opposite was true.
Seeking assurances and reviewing evidence	Whilst 80% of respondents agreed that the Committee sought assurances and required evidence that decisions were implemented and were effective 20% disagreed. An example given in the commentary related to the recent *'failure to communicate the link between appraisal and pay spine progression'* and noted that the Committee should do more verification.
Cascade of issues, risks and assurances to other forums	All respondents (100%) agreed that the Committee effectively escalated risks, assurances and issues to other forums such as the Board and its Committees.
Committee's report to the Board	All but 10% of the respondents agreed that the Committee's report to the board sufficiently described the matters considered, level of assurance and describe the evidence to support assurance.
Review of Board Assurance Framework	Whilst the commentary suggested there was room for improvement 90% of the respondents agreed that the Committee systematically reviewed, scrutinised and challenged the risks allocated to it from the Board Assurance Framework and receive assurance that actions were in place to manage and control effectively the risks identified.
Understanding broader workforce and education risks	100% of respondents agreed that the Committee had a clear understanding of the broader risks around workforce and education facing the organisation and the actions being taken to address and mitigate them. However the free text commentary suggest that this was limited as *"most members of the Committee were not exposed to the wider UK or NHS workforce, and prevailing issues" and the Committee "could do better at following market trends and developments"*.

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3. Areas of Development and Progress Update

Progress against 2019/20 development actions

In December 2020 the Committee noted the following progress update on the 2019/20 review development actions.

Improve representation from Divisional Directors of Operations – Between April-November 2020 there had been more divisional representation however there was further work to improve this. It should be noted that there had been changes to the divisional triumvirate which would impact on this.

Introduce a programme of deep dives – A deep dive programme was developed and agreed by the Committee in July 2020, albeit delivery of this was not fully completed.

Improve the range and reporting of workforce metrics - The Committee reporting had improved and a new report was introduced in October/November 2020 which also included Employee Relations, stability and Covid-19 risk assessment reporting.

+Enhance the quality of reports to the Committee and ensure there is a consistent approach to assurance reporting – the report for the Committee had improved but there was still more to be done to ensure there was sufficient evidence to provide the Committee with assurance.

+Enhance the level of challenge from the Committee and ensure there is sufficient evidence to support assurance reports – The degree to which this action had been achieved would be reflected in the response to the 2020/21 review.

Proposed 2021/22 development actions

As reported overleaf 80% of respondents agreed that the Committee was either 'extremely effective' or 'very effective'. There was evidently some work to do to respond to the 20% of respondents who believed the Committee was only 'somewhat effective'. As noted earlier the following areas of development have been identified and the relevant actions proposed.

***Improve representation from Divisional Directors of Operations (DDOs)** – despite improvements in 2020/21 DDOs have been focused on operational priorities however work would be done to further improve their engagement with the Committee. The Trust also now had two new DDOs which should improve attendance.

Provide clarity on the induction and training programme for new members joining the Committee.

Terms of Reference and reporting governance forums – the terms of reference for the Committee is reviewed annually by the Committee as part of the annual report and workplan development. It was proposed that a report on the terms of reference and progress against the workplan be presented 6 months into the Committee annual cycle to remind Committee members about the requirements of the Committee.

Verification of actions being implemented and review of evidence to gain assurance. This action was similar to the two 2019/20 actions (marked with **+**). It was proposed that where the Committee interrogates a particular action or agree an approach to respond to a key workforce matter that it programmes in a 6 month review which was supported by a report which contains sufficient evident to assure the Committee that the action had been completed and was embedded.

**Carried forward from 2019/20 actions*

Outstanding care every time

St George's University Hospitals NHS Foundation Trust

3.1

Meeting Title:	Trust Board		
Date:	27 May 2021	**Agenda No**	**3.1.1**
Report Title:	Gender Pay Gap Report (GPG Report)		
Lead Director/ Manager:	Paul Da Gama, Chief People Officer Humaira Ashraf, Director of Education, Culture & OD		
Report Author:	Joseph Pavett-Downer, D&I Workforce Lead		
Presented for:	Endorse		

Executive Summary:

The Equality Act 2010 (Gender Pay Gap Information Regulations 2017) requires all organisations with over 250 employees to report on and publish their gender pay gap on a yearly basis. This is based on a snapshot from 31st March of each year - this report captures data from **31st March 2020.**

Of the 8,858 staff counted as part of the GPG reporting, 6,375 were female compared to 2,483 male.

Year:	2019/2020	2018/2019	+/- %
Mean GPG	**13.71%**	**14.83%**	**-1.12%**
Median GPG	**9.49%**	**7.85%**	**+1.64%**

The mean hourly pay for males is £3.31 higher than that of females, which is a gap of 13.71%. Male median pay is £1.99 higher than females, which is a gap of 9.49%.

Mean Pay Gap

Since the previous reporting year (2018/19) the mean pay gap has decreased by 1%, though female employees are still paid on average £3.31 less than male employees. The workforce headcount across the organisation has fluctuated, however there have been no significant changes over the reporting year to the gender split by band.

This reporting year (2019/20) the Gender Pay Gap for AFC averages at 0.19%, this compares to a gap of 0.90% in 2018/19. In AfC band 4-6 the average hourly pay for female staff has increased 1.93% vs. 0.84% in 2018/19 (average across the bands). In AfC bands 8c-9 the average hourly rate for male staff has increased 3.26% vs. -0.34% in 2018/19.

Medical Staff and Drs in Training

The biggest gap in hourly pay is in the medical staff group and as with previous years it is this pay gap that is the most significant.

In the Dr in Training roles the gap has decreased significantly from 6.2% in 2018/19 to 2.77% in 2019/20. The pay gap has also decreased for Consultants, though there is still a £1.65 difference in hourly pay between

	males and females in this role. The medical staff group consists of 1,358 staff so these differences (above) are notable and where the overall pay gap lies. **If medical staff were removed from the overall total then the gender pay gap would be 1.27% in favour of female staff.** **Median Pay Gap** The median is based on the hourly rate that is in the middle when lined up from lowest to highest. Keeping in mind that the Trust profile is 72% female to 28% male, females are over-represented in the middle quartiles, whilst slightly under-represented in the lower quartile. However, in the upper quartile males are over-represented at 39%. The overall median figure for hourly pay across the Trust regardless of gender is £19.38, which is much close to the female figure of £18.97 than the male figure of £20.96. **Next Steps** The GPG report was introduced in March 2017/18 however the first report was not due until the following year, March 2019. This was to allow time for organisations to implement systems to collect the required data on the GPG. This one-year lag has continued nationally and resulted in GPG reports always being one year behind, any findings and resulting next steps may already be redundant at the time of publishing. In addition to the 19/20 report, St George's will produce and publish our 2020/21 report before the end of 2021 to bring the reporting in line with the reporting year. We will present these findings to the Women's Staff Network (TWSN) and establish a set of objectives, in collaboration with the network, to improve the Gender Pay Gap. This will include a specific look at medical staff GPG as this is the most significant across the organisation.
Recommendation:	**The Board is asked to consider and approve the report which was also endorsed by the Workforce & Education Committee. The report would be published to the Trust's website.**
Supports	
Trust Strategic Objective:	Culture
CQC Theme:	Well led
Equality and Diversity:	
Appendices:	

Gender Pay Gap Reporting 2019/20

Introduction

The Equality Act 2010 (Gender Pay Gap Information Regulations 2017) requires all organisations with over 250 employees to report on and publish their gender pay gap on a yearly basis. This is based on a snapshot from 31st March of each year, and each organisation is duty bound to publish information on their website. This report captures data as at 31st March 2020.

St George's University Hospitals NHS Foundation Trust employs over 8,500 staff in a number of staff groups, including administrative, medical, nursing, and allied health roles. All staff except for medical and Very Senior Management (VSM) are on Agenda for Change (AfC) payscales, which provide a clear process of paying employees equally, irrespective of their gender.

What is the gender pay gap?

The Gender Pay Gap (GPG) is the difference between the average hourly earnings of men and women. The Gender Pay Gap highlights any imbalance of pay across an organisation. For example, if an organisation's workforce is predominantly female yet the majority of senior positions are held by men, the average female salary could be lower.

The Gender Pay Gap is not the same as equal pay which is focuses on men and women earning equal pay for the same / similar jobs or work of equal value. It is unlawful to pay people unequally because of their gender.

What do we have to report on?

The statutory requirements of the Gender Pay Gap legislation is that each organisation must calculate the following:

- The mean basic pay gender pay gap
- The median basic pay gender pay gap
- The proportion of males and females in each quartile pay band
- The mean bonus gender pay gap
- The median bonus gender pay gap
- The proportion of both males and females receiving a bonus payment

Definitions of pay gap

The **mean pay gap** is the difference between the pay of all male and female employees when added up separately and divided by the total number of males, and the total number of females in the workforce.

The **median pay gap** is the difference between the pay of the middle male and middle female, when all male employees and then all female employees are listed from the highest to the lowest paid.

Who is included?

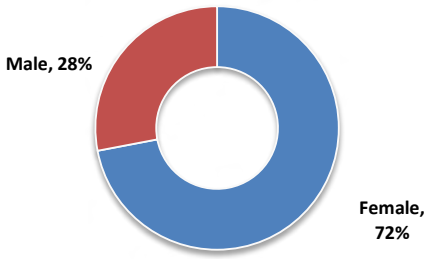
All staff who were employed by St George's and on full pay on **31st March 2020** are included. Bank staff who worked a shift on the snapshot date are included. Consultant Additional Programmed Activities (APA's) are included, but general overtime pay and expenses are excluded.

Employees who are on half or nil absence or maternity leave, hosted staff (e.g. GP Trainees) and agency staff have not been included.

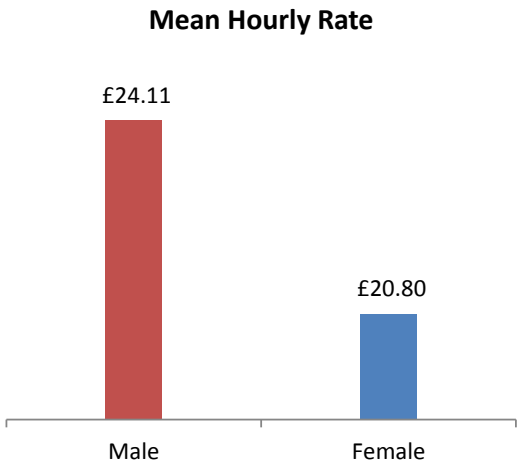
Bonus pay is defined as any remuneration that is in the form of money, vouchers, securities or options and relates to profit sharing, productivity, performance, incentive or commission. This therefore also includes CEA's and also Distinction Awards. Recruitment & retention payments (RRP's) are only included if they are a one-off payment at the start of recruitment, not if they are continuous. Workplace vouchers that are paid in addition to basic salary should be included, but not if they take the form of a salary sacrifice arrangement.

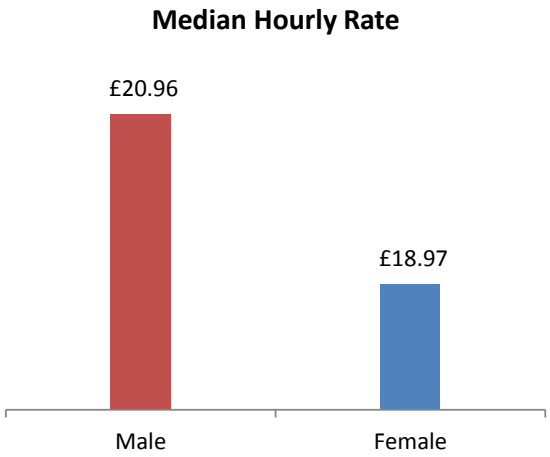
Trust Gender Profile (based on headcount)

St George's University Hospitals NHS Trust, as is typical of the NHS, has a higher proportion of females to males in its workforce – of the 8,858 staff counted as part of the gender pay gap reporting, 6,375 were female compared to 2,483 male.



Gender Pay Gap



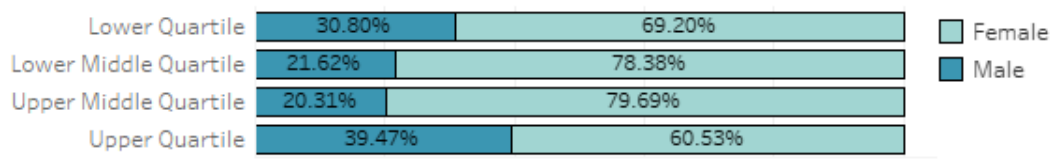


Mean gender pay gap– 13.71%
(2018/19 – 14.83%)

Median gender pay gap – 9.49%
(2018/19 – 7.85%)

The above figures show that the mean hourly pay for males is £3.31 higher than that of females, which is a gap of 13.71%. Male median pay is £1.99 higher than females, which is a gap of 9.49%.

Pay quartile split:



What does this mean?

Mean Pay Gap

Since 2018/19 the mean pay gap has decreased, though female employees are still paid on average £3.31 less than male employees. To help identify the cause/s of the mean pay gap we need to examine the gender composition and pay gaps in each individual pay grade. This breakdown is shown below, with the higher average pay by gender highlighted in green.

Grade	No. of male staff	No. of female staff	Male Hourly Rate*	Female Hourly Rate*	Diff.	2019/20 Gap[ı]	2018/19 Gap[ı]
Band 2	407	740	12.29	12.16	0.13	1.05%	-0.56%
Band 3	179	372	12.89	12.58	0.30	2.35%	1.34%
Band 4	147	460	13.53	13.93	-0.40	-2.99%	-1.78%
Band 5	141	567	16.89	17.33	-0.44	-2.61%	-1.15%
Band 6	244	993	20.77	20.81	-0.04	-0.20%	0.40%
Band 7	232	937	24.54	24.27	0.27	1.11%	-1.15%
Band 8a	115	287	28.54	27.98	0.57	1.99%	2.21%
Band 8b	32	79	32.23	32.74	-0.52	-1.61%	0.92%
Band 8c	22	25	38.09	37.36	0.73	1.92%	0.23%
Band 8d	21	33	44.87	43.40	1.47	3.27%	1.22%
Band 9	5	5	55.59	53.04	2.56	4.60%	-2.46%
VSM	9	6	70.21	78.08	-7.87	-11.21%	-10.05%
Med- Non Consultant	357	391	28.35	27.56	0.79	2.77%	6.20%
Med- Consultant	332	278	47.90	46.25	1.65	3.45%	4.33%

*refers to the mean hourly rate

[ı] negative values mean that the difference and the gap are favourable to females

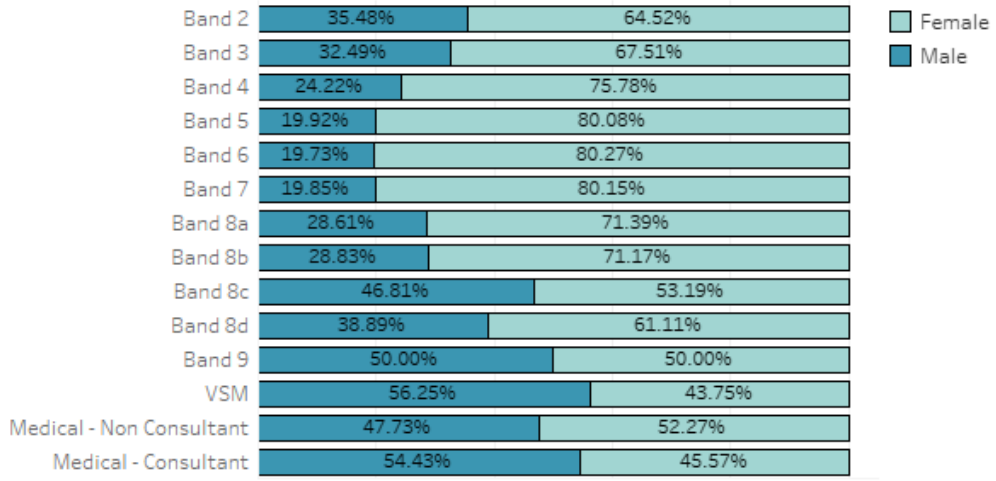
Gender split by band – based on headcount:

The mean gender pay gap has decreased by just over 1% in the last year (13.71% vs. 14.83% LY). The table below shows the gender split by band, there have been no significant changes over the past year. The headcount has fluctuated, however, this is part of the constant movement of the Trust staff profile, which remains fairly consistent across reporting years.

For 2019/20 the Gender Pay Gap averages at 0.19%, this compares to 0.90% in 2018/19 (AfC Bands only). In AfC Band 4-6 the average hourly pay for female staff has increased 1.93% vs. 0.84% in

2018/19 (average across the bands). In AfC Band 8c-9 the average hourly rate for male staff has increase 3.26% vs. -0.34% in 2018/19.

In the past 3 years the proportion of female staff in Bands 8a and above has increased year on year. Most notably, this reporting period female staff in Band 8d see a lift of 7% from 54% in 2018/19 to 61% in 2019/20.



The biggest gap in hourly pay is in the medical staff group (see below), and as with previous years it is this pay gap that is the most significant. In the Dr in Training roles the gap has decreased siginificantly from 6.2% in 2018/19 to 2.77% in 2019/20. The pay gap has also decreased for Consultants, though there is still a £1.65 difference in hourly pay between males and females in this role. The medical staff group consists of 1,358 staff and so these differences are notable and once again this is where the overall pay gap lies. If medical staff are removed from the overall total then the gender pay gap would be 1.27% in favour of females.

Medical Staff

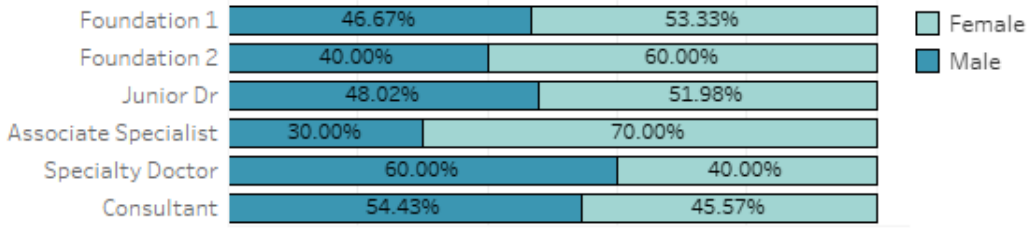
Medical staff group comprises of all Dr in Training to Consultant roles. The pay gap for Medical staff as a whole is 6.46% (down from 10.82% last year) - males get paid on average £2.44p/h more than females. The proportion of male to female staff is 50.74% to 49.26%.

Grade	No. of male staff	No. of female staff	Male Hourly Rate*	Female Hourly Rate*	Difference	2019/20 Gap[ı]	2018/19 Gap[ı]
Foundation 1	14	16	14.93	15.44	-0.51	-3.42%	0.76%
Foundation 2	6	9	18.84	18.66	0.18	0.96%	0.65%
Junior Dr	328	355	28.87	28.07	0.80	2.77%	4.26%
Associate Specialist	3	7	42.19	39.55	2.64	6.26%	-14.60%
Specialty Doctor	6	4	33.59	29.87	3.72	11.07%	21.82%
Consultant	332	278	47.90	46.25	1.65	3.45%	4.33%

*refers to the mean hourly rate

[ı] negative values mean that the difference and the gap are favourable to females

Gender Split by Medical Role – based on headcount



Consultants

Consultants are one of the highest paid roles in the Trust, and are eligible to receive clinical excellence awards (CEAs) and Additional Programmed Activities (APAs) which are consolidated into their basic pay calculations. St George's had 610 consultants in post on 31st March 2020.

There are more male consultants than female (54% male to 46% female). Whilst male consultants were paid,on average, £1.65 p/h more than their female counterparts in 2019/20, this has reduced from £2.12 p/h in the previous reporting year (2018/19).

Drs in Training Posts

The Trust has over 600 Dr's in Training, most of which have a National Training Number and are assigned to the organisation by Health Education England.

The proportion of female doctors at Foundation Year 1 has decreased by 18% from 71% in 2018/19 to just 53% in 2019/20. Male doctors increased from 29% in 2018/19 to 47% in 2019/20. It is difficult to indentify the reason/s for this as Foundation Year 1 allocations to the organisation are managed centrally by the South Thames Foundation School. However, the data would suggest that less females students entered the training programme from medical school or that there were a signifcantly higher proportion of male students moving from medical school into the Foundation training programme.

There are 10 spine points on the basic Dr in Training payscale which dictates the hourly rate at which they will be paid. The overall pay gap for Drs in Training has decreased from 4.26% to 2.77%, and although there is a higher proprtion of females in these roles, male Drs in Training are paid on average £0.8 p/h more than female counterparts.

Male Drs in Training tend to be on the higher spine points which suggests that males are progressing through the spine points or through training years at a faster rate than female Drs in Training. This may be due, in part, to females being impacted, finanically, by any time taken for periods of leave, such a Maternity.

Median Pay Gap

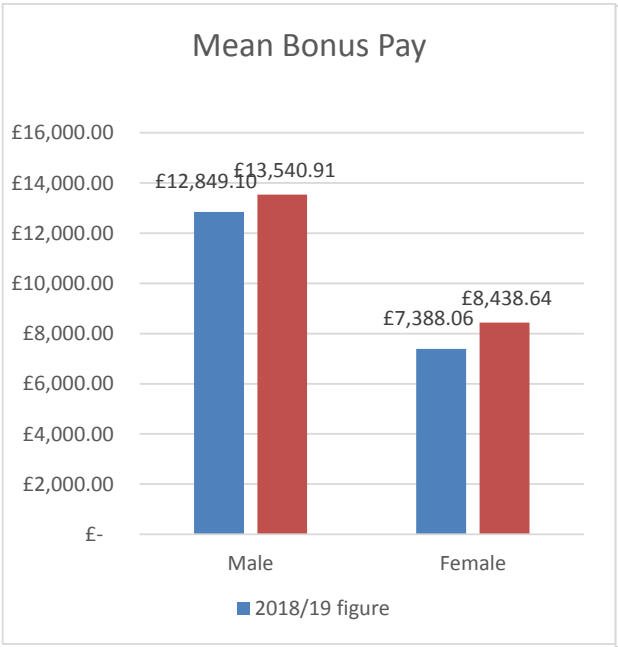
The median is based on the hourly rate that is in the middle when lined up from lowest to highest. Keeping in mind that the Trust profile is 72% female to 28% male, females are over-represented in the middle quartiles, whilst slightly under-represented in the lower quartile. However, in the upper quartile males are over-represented at 39%. The proportion of males and females in each quarter is shown below:

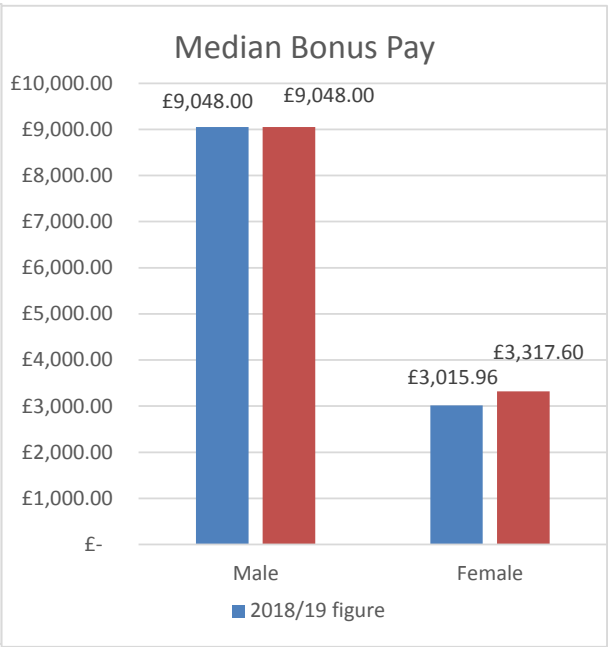
	Males	Females
Lower Quartile	682	1,532
Lower Middle Quartile	479	1,737
Upper Middle Quartile	451	1,770
Upper Quartile	871	1,336

The highest concentration of males is in the upper quartile, whereas this is where the lowest concentration of females sits. We can see that this disproportionately high number of males in the Upper Quartile is affecting where the median gap is – the middle number in the total number of females is 3,187, which would be in the lower middle quartile, whilst for males the middle number is 1,242, which would be in the upper middle quartile.

It is worth noting however that the overall median figure for hourly pay across the Trust regardless of gender is £19.38, which is much close to the female figure of £18.97 than the male figure of £20.96.

Bonuses





Mean gender pay gap – 37.68%
(2018/19 42.5%)

Median gender pay gap – 63.33%
(2018/19 66.67%)

Since 2018/19 there has been a significant increase for bonus awards, this has continued into 2019/20. This is due to the recipients of the Long Service Awards (LSA) receiving a voucher for £50, which is classed as a bonus due to it's monetary value. In previous years they were gifted a crystal bowl which would which would not be included in the figures for bonus awards.

As the Trust profile is 72% female most of these LSA bonuses were given to female staff. The other bonuses paid in the time frame (1st April 2019 to 31st March 2020) were to medical Consultants in the form of CEA's and Distinction Awards. These were paid mainly to males, and have a much higher value. We know from the analysis from previous years when LSA weren't included in these calculations that the main issue in the provision of bonuses is that the CEA's are typically paid more to males than females, therefore although it is this higher pay gap that we will have to report on to the government, the following analysis will look at the bonus pay gap with the long service awards excluded.

Mean gender pay gap – 29.23%
(2018/19 25.4%)

Median gender pay gap – 33.33%
(2017/18 36.11%)

Aside from the Long Service Awards the only bonuses paid were the Distinction Awards and Clinical Excellence Awards, both paid only to Consultants. Only 4 Distinction Awards were paid (3 to male Consultants and 1 to female Consultants) compared to 191 CEA's so this analysis will focus on the CEA's.

An encouraging sign is that the proportion of females now receiving CEA's in the lower age range has increased, suggesting a positive change for addressing the bonus pay gap in the future:

2019/20		
Age Range	**Female**	**Male**
31-40	100%	0%
41-50	48%	52%
51-60	40%	60%
61-70	16%	84%
71+	0%	100%

2018/19		
Age Range	**Female**	**Male**
31-40	86%	14%
41-50	42%	58%
51-60	34%	66%
61-70	0%	100%

Including the Long Service Awards there were a total of 210 bonuses paid in the period. 85 of these were to females, which is 1.33% of the total female employees in the Trust. In comparison 125 were paid to males, which is 5.03% of the total male employees in the Trust.

When compared with the proportion of male Consultants to female Consultants, 60% of bonuses were paid to males when they make up 54% of the role. 40% were paid to females, who make up 46% of the role.

Year on Year

Though we are unable to determine trends with 4 years' worth of data, the figures for each metric over the year are presented here for reference.

	2016-17	2017-18	2018-19	2019-20
Mean Pay Gap	13.94%	13.61%	14.83%	13.71%
Median Pay Gap	2.11%	4.96%	7.85%	9.49%
Mean Bonus Pay Gap	15.05%	12.25%	25.40%	29.23%
Median Bonus Pay Gap	15.36%	17.19%	36.11%	33.33%
% males getting bonus	5.28%	4.98%	4.83%	5.03%
% females getting bonus	1.08%	1.11%	1.15%	1.33%

Note: The above figures for bonus pay gap exclude the Long Service Awards (LSA) for ease of comparison with previous years data, however the % of staff getting bonus includes long service awards.

Next Steps

The GPG report was introduced in March 2017/18 however the first report was not due until the following year, March 2019. This was to allow time for organisations to implement systems to collect the required data on the GPG. This one-year lag has continued nationally and resulted in GPG reports always being one year behind, any findings and resulting next steps may already be redundant at the time of publishing. In addition to the 19/20 report, St George's will produce and publish our 2020/21 report before the end of 2021 to bring the reporting in line with the reporting year.

We will present these findings to the Women's Staff Network (TWSN) and CMO Office to establish a set of objectives to improve the Gender Pay Gap. This will include a specific look at medical staff GPG as this is the most significant across the organisation.

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3.2

Meeting Title:	Board Meeting		
Date:	27th May 2021	**Agenda No**	**3.2**
Report Title:	St George's Culture Programme - Design Outline		
Lead Director/ Manager:	Paul da Gama, Chief People Officer		
Report Author:	Humaira Ashraf, Director of Education, Culture and OD/Deputy CPO Daniel Scott, Head of OD		
Presented for:	Assurance		
Executive Summary:	Appendix (A) provides an outline of the Culture Programme design. It has been developed to communicate a programme overview as opposed to a detailed analysis. In this paper the 4 pillar model is introduced, integrating three new elements with the existing (but further refined) D&I and OD Action Plan. In part B section of the document a high-level action plan is proposed for each pillar. Part C provides an outline of our proposals for programme governance, impact measures and resource considerations.		
Recommendation:	To review the revised structure of our culture programme and arrangements we are putting in place to monitor and measure implementation progress.		
Supports			
Trust Strategic Objective:	Culture		
CQC Theme:	Well led		
Single Oversight Framework Theme:			
Implications			
Risk:	Without a detail and effectively managed culture programme there is a risk that we won't retain, motivate and engage our staff.		
Previously Considered by:		**Date**	

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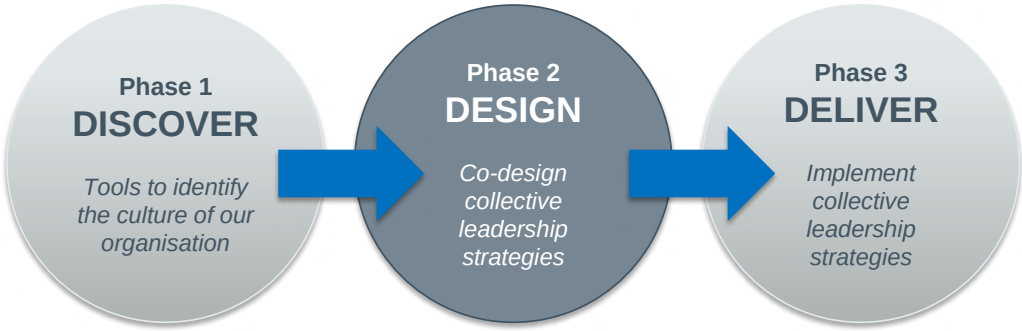
Appendix (A)

St George's Culture Programme Design Outline



Contents & Document Aims

Aims of this document

- This document sets out an outline of the Culture Programme design.
- It has been developed to communicate a programme overview as opposed to a detailed analysis.
- The 4 pillar model is introduced, integrating three new elements with the existing (but further refined) D&I and OD Action Plan.
- A high-level action plan is proposed for each pillar, followed by proposals for programme governance, impact measures and resource considerations.

Design and delivery of culture change is an iterative process and therefore as we progress along the culture change journey we will regularly review and update our plans as necessary.

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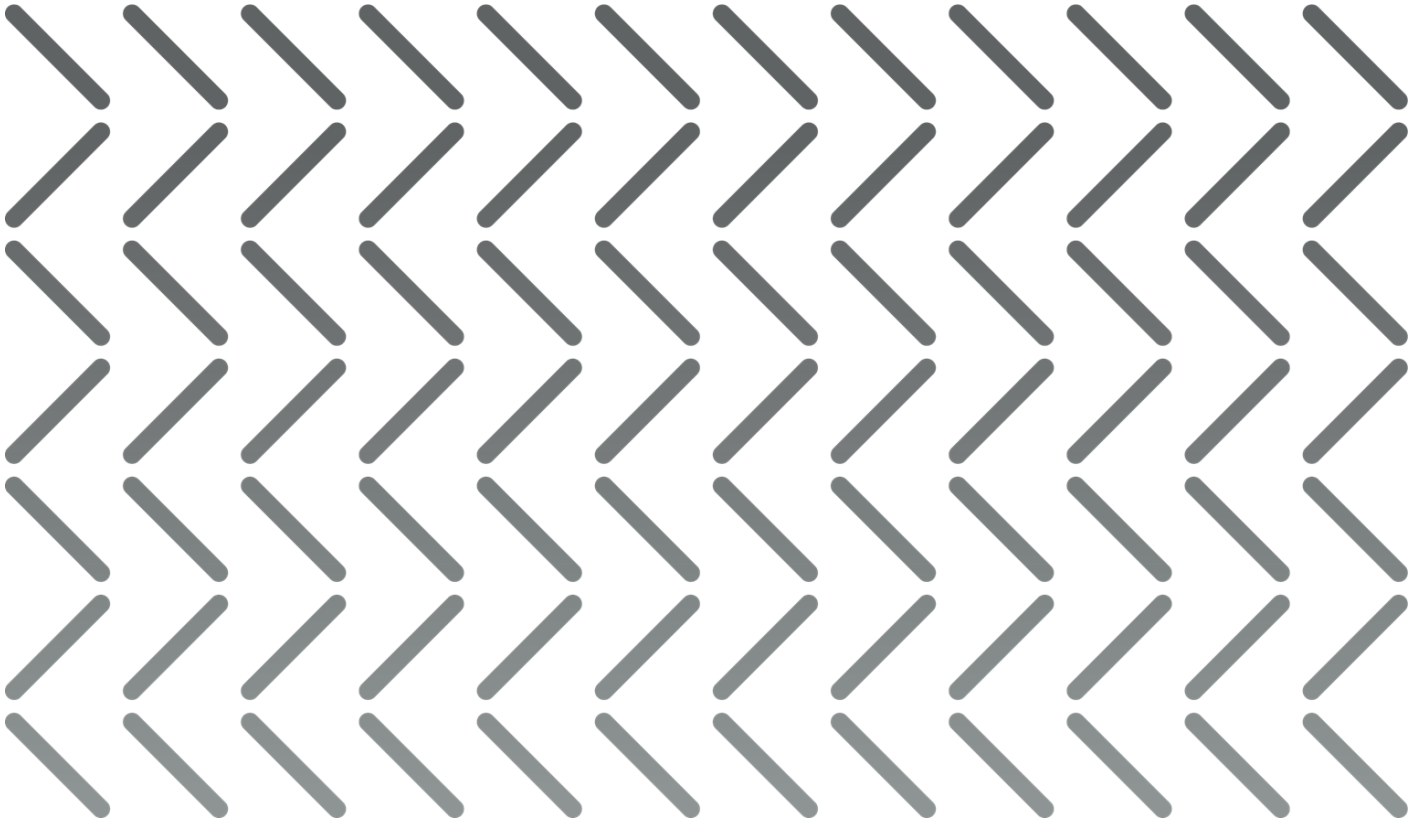
Part A) Overview of the Revised Culture Programme Model



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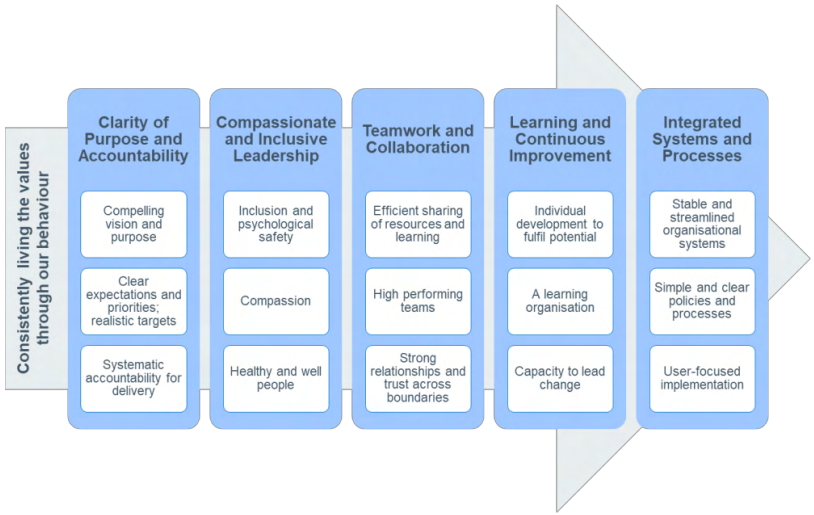
Moving to the Design Phase
What culture are we trying to shape?

Identifying the main areas of culture potential

- The main report of the 'Discover' phase identified a set of 17 strengths and weaknesses in our culture. These were later synthesised into a set of 6 main themes (See Appendix A for both), included in the report summary that was published in November 2020.
- For the purpose of developing an initial programme design, these themes were further developed into 5 main areas of potential plus 1 cross-cutting theme around living our values (see below).
- While these are largely still accurate, the main themes or workstreams have evolved in line with developments, such as the need to make our D&I goals much more central to the culture programme.



Culture 'target' statements and a culture programme identity

- As we realign the programme design and supporting OD plan, it is also clear that we need to shape a clearer expression of what the 'target culture' is, in a way that will be understood and easily related to by all of our people.
- Starting with the 5+1 areas of potential identified, a set of 'target statements' will need to be brainstormed and developed with input form Comms and staff reps.
- These culture 'target statements' will encapsulate the Discover findings, ensure D&I and values are at the centre, and offer an accessible overall identity/title for the Culture programme.
- *The image below is for illustrative purposes only – this work is yet to be done.*

Four Pillars of our Culture Programme

- The Initial Culture Programme Design centred on a corporate, Trust-wide OD plan - the content of which remains a relevant and key component of the culture programme design, albeit structured with new headings.
- Feedback has emphasised the need for the design to reflect a significant body of work around engaging and inspiring staff, Trust-wide stakeholder engagement and enabling local culture change.
- The Trust intends to adopt a 'Patient First' approach which will influence our work around business planning, setting priorities, QI and local innovation. This will have strong benefits for and dependencies with our culture programme.
- It has also become clear that a number of parallel strategies will also positively influence our culture, which also need to be integrated.
- The diagram opposite sets out the OD Plan and these new areas into '4 pillars' of the culture programme. The first pillar reflects similar content to previous versions (some elements have been redistributed to the 'Patient First' and 'Other Strategies' pillars), while the other 3 reflect emergent areas of work described above.
- All 4 pillars will work toward achieving our 'target culture', which will be represented in the 'apex' by the target statements and programme identity that is under development.

Trust-wide D&I and OD Action Plan	Engaging and Inspiring Our Staff	Introducing 'Patient First'	Other Strategies and Plans Shaping our Culture
•The D&I Action Plan consisting of 7 workstreams •Other culture shaping initiatives in our OD strategies including on Values, Building Accountability, Teamwork, Leadership & Talent •Supported by BAU areas of OD work including H&WB, L&D, PDR etc. •All aligned to the findings of the Discover phase	•Building ownership, connection and participation with 9,000+ staff •Supporting local implementation and culture change activity •Stakeholder engagement: and comms through diversity networks, culture champions, leaders etc. •Creating 'the St George's Story' to inspire pride in our culture's history, current achievements and future ambitions	•What is Patient First? Why, and why now? •Aims, outputs and alignment with Discover phase findings •Prioritisation of initiatives and deployment of ways of working	•Improving our physical work environment •Remote and flexible working •Ensuring good ICT provision and services •Staff engagement strategy, including 'Big 5' initiatives •Professional standards •Other plans TBD

Trust-wide Diversity & Inclusion and OD Action Plan
Overview

- The existing D&I action plan is central to this programme and critical to achieving cultural change
- A range of supporting OD solutions will enable and sustain new cultural patterns
- Mostly solutions are from (or derived from) the evidence based NHSI Design Toolkit, with some solutions proposed specifically for St George's
- Proposed solutions are based on input from the NEDs, EMT, other senior leaders, and culture champions
- Much of this work is already underway or part completed
- The table opposite summarises the proposed OD plans that will support the culture programme –
- See the full OD Action Plan in Part B.

Area	OD Solutions
Diversity & Inclusion	• D&I Action Plan
Living Our Values	• Values into behaviours • Values-based recruitment and induction
Clarity of purpose and accountability	• Aligned goals and objectives (Business planning) • PDR (appraisal) system transformation • Team level goals
Leadership & Talent Development	• Inclusive management and leadership development • Inclusive talent management – including a commitment to positive action development • Coaching and mentoring
Teamwork and Collaboration	• Supported team based working • System leadership development – including a commitment to positive action development

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Engaging and Inspiring Our Staff
Overview

- This pillar is about building ownership, connection and participation among our **9000+** staff and inspiring people to get involved
- Sometimes this will be about translating organisational OD work to the local level, and sometimes culture initiatives will start and build locally
- It will involve extensive Trust-wide communications with all stakeholders and staff, and the continuous sharing of ideas and successes.
- The St George's Story (project title tbc) will aim to inspire greater recognition of and pride in our culture's history, current achievements and future ambitions
- This pillar requires some further development and definition with stakeholders. Some of it by the nature of culture change should remain emergent, however we anticipate three main areas of work as described opposite

Area of Focus	Likely Activities
Supporting Local Implementation and Culture Change Activity	• Establishing local centres/hubs of representation and culture change activity • Team communications and events, guided by tools and core messages • Local piloting and trialling of new ways of working • Will involve training and skills development for champions and local change agents
Trust-wide Stakeholder Engagement and Communications	• Develop of a culture programme name and 'identity' • Stakeholder engagement strategy and plans • Via culture champions, existing networks and forums • Ongoing multi-directional dialogue
Storytelling: 'The Story of St Georges'	• Creating and sharing the story of St George's that honours our history and invites people to shape our future • Rebuilding confidence and inspiring pride and trust across the organisation • Integrating and sharing successes across teams and divisions

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Introducing ‘Patient First’
Overview

- This pillar will firstly explain what we mean by Patient First, where it came form, and why we are seeking to integrate it through St George’s now
- It will propose a number of aims and main projects - some of which formerly appeared in the Culture OD action plan, but which now align more with the ‘Patient First’ pillar.
- There will be strong links with the business planning and strategic objective setting process

Area of Focus	Likely Activities
Team Reflexivity and Continuous Learning	• Local tools and processes to support quality reflection and learning
Integration of QI in day to day work	• Continuing to embed tools, processes, ways of working and local cultures that will support QI methodologies to thrive
Project and Programme Management	• Introducing and embedding an organisation wide project and programme methodology
Systems and Processes that work	• Ensuring accurate specification and consistent implementation of new systems and processes • Aims to avoid unfit for purpose processes and workarounds

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Other Strategies and Plans Shaping our Culture

Overview

- There are a number of other strategies, programmes or initiatives across St George's that will have a large impact on our culture and address some of the main concerns that came out of the Discover phase
- Some of these are noted opposite, and it is likely there will be more to add

Strategies/Plans	Activities
Staff Engagement Strategy	• Including planned initiatives within the 'Big 5' areas of focus prioritised by staff after publication of annual staff survey results
Remote & Flexible Working	• Updating policies and processes to enable staff to work where and when is most suitable • Ensuring COVID onset ways of working are properly established and supported
ICT Enhancement	• Ensuring a good standard of ICT provision and services • Addressing some of the basic concerns like internet bandwidth, access to computers, hardware shortages, and ongoing software workarounds
Estates Strategy	• Improving our physical work environment including offices, clinical areas, shared staff spaces and public zones • Enhanced workspaces will positively influence the way we work
Professional Standards	• Developing and embedding clear standards of professional and operational leadership
Education Strategy	• Using technology to modernise our channels of delivery of training and education (EDIT programme) • Creating learning tools and environments that will enhance learning experience and impact
'Business As Usual' OD	• Health and Wellbeing services and projects • Corporate Learning & Development and Clinical Education programmes
Best Practice Local Culture Initiatives	• Identifying, communicating and integrating local culture change initiatives across the organisation • Examples include culture initiatives in Child Therapies and ED

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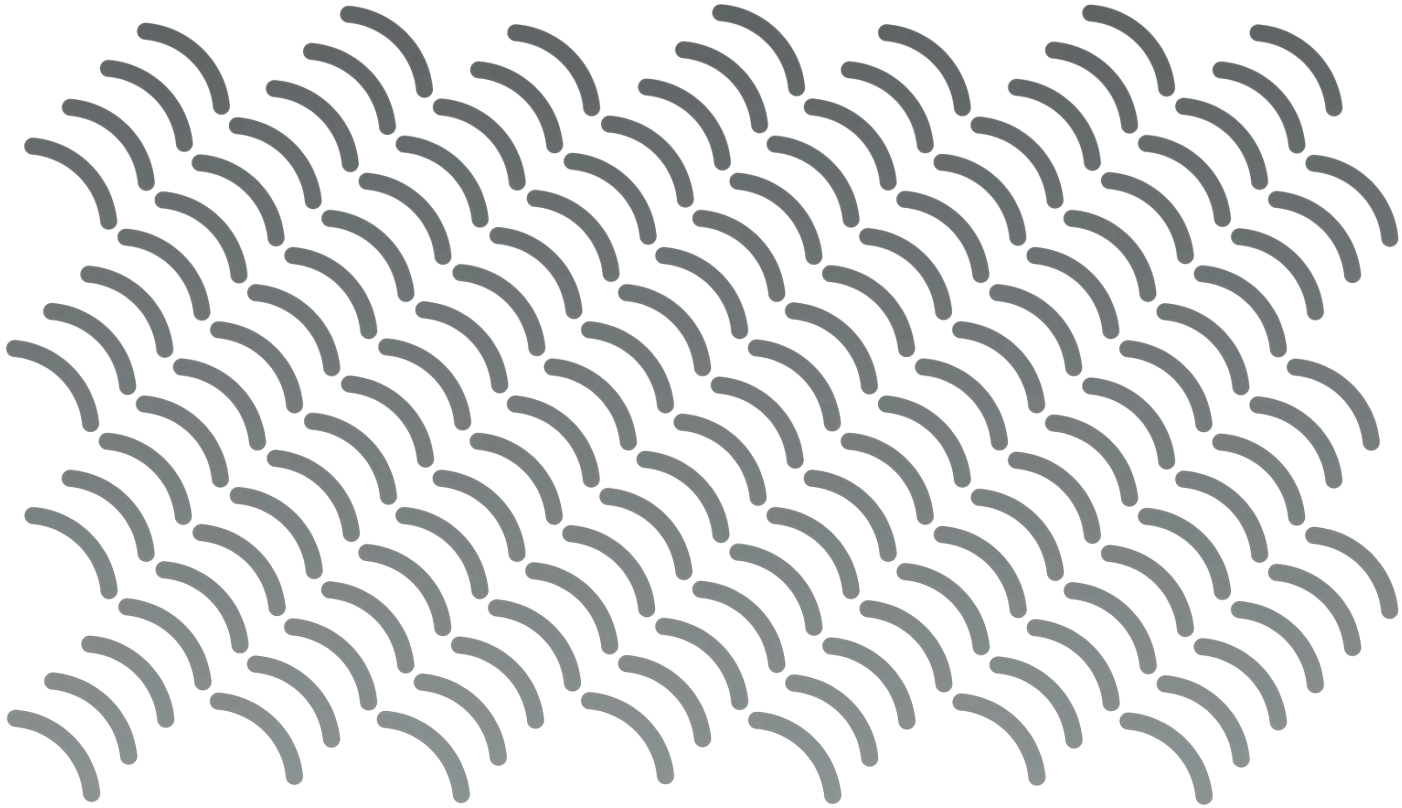
Part B) Action Plans



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Trust-wide Diversity & Inclusion and OD Action Plan

DIVERSITY & INCLUSION			
Solution	*Actions*	*Timing*	*Progress*
Strengthening diversity and building a culture of inclusion (Please refer to the existing **D&I Action Plan**, which includes 7 workstreams)	1. Improving the **career progression of BAME Staff**, and making career opportunities equal • Diverse interview panels (RIS scheme for B7+) • Mandatory recruitment training including D&I elements • Coaching & mentoring schemes • Interview training • D&I interview questions/criteria 2. Improving **development opportunities and ensuring equal access** for staff • Transparent application processes • Diverse selection panels for all high value opportunities • Supporting personal development and career planning • Inclusive talent management and succession planning 3. Listening, Supporting and Responding to Concerns Raised by BAME and all staff; creating a culture of **psychological safety** • Clarify issue raising routes • Supporting local OD interventions • Trust-wide communications and updates • 'Let's Talk about Race and Inclusion' toolkit **4. Leadership commitment** to advance and role model D&I • Maintaining Executive level sponsorship and championing of D&I • D&I ingrained in decision making at all levels • Development of inclusive leadership competencies, reflected throughout all leadership training • Local D&I priorities identified, action plans developed 5. Building **Awareness and Understanding around inequalities** and a culture of inclusion • Exploring and challenging bias training • Diversity celebrations and events • Information and education resources 6. Implementing the **London Workforce Race Equality Strategy Recommendations** • Increased BAME representation among FSUGs • Development of inclusion competencies (see leadership development above) • Allyship programme and Frontline Staff forum • De-biased secondment processes 7. The aims and work of our **4 D&I support networks**: BAME, LGBTQ+, Women's, Disability • Priorities and actions identified and agreed by each network will be incorporated	July 2020-March 2022	◑

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Trust-wide Diversity & Inclusion and OD Action Plan

LIVING OUR VALUES			
Solution	*Actions*	*Timing*	*Progress*
Values into behaviours	• Develop and articulate behavioural expectations of 'living our values' for staff and leaders including behaviour that *does and doesn't* reflect our values • Develop and support facilitation of workshops at all levels of the Trust to explore what our values look like (and don't look like), gaining input form staff • Ensure that accountability for living our values is consistently reinforced at all levels	July 2021 - Dec 2022	○
Values-based recruitment and induction	• Make our values integral to recruitment to attract and select people who share our values • Redesign recruitment processes and tools to reflect value-based assessment and decision making • Make our values and expectations for 'living' them central to induction events and processes	Jan 2022- June 2023	◔

CLARITY OF PURPOSE AND ACCOUNTABILITY			
Solution	*Actions*	*Timing*	*Progress*
Aligned goals and objectives (Business planning)	• Enhance our organisational annual business planning process to achieve visible and continual alignment between organisational vision/mission and strategy, with Divisional, Directorate and team plans (from 'board to ward' *and* 'ward to board')	Sep 2020 - Nov 2021	◔
PDR (Appraisal) system transformation	• Ensure every staff member and leader has clear annual individual objectives that they are accountable for delivering on • Integrate expectations of behaviour that reflect our values (values-based PDR) • Strengthen personal development planning and career conversations within the PDR cycle	Sep 2020 - Oct 2021	◔
Team level goals	• Introduce team-level goals, where each team will have at least one shared team goal for which they are collectively accountable	Mar - Nov 2022	○

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Trust-wide Diversity & Inclusion and OD Action Plan

LEADERSHIP AND TALENT DEVELOPMENT			
Solution	*Actions*	*Timing*	*Progress*
Management and leadership development	• Develop a model of leadership excellence for St George's and a leadership development framework based on common design principles and 4 golden threads: ○ Our values and associated behaviours ○ Current corporate strategic priorities and objectives (e.g. remote leadership) ○ Our D&I goals and action plan ○ Aims of the Culture Programme • The framework will also detail the consistent values-based, inclusive and compassionate behaviour that is expected of all leaders • Integrate, review and develop existing and new leadership training programmes for all levels and professions including: ○ First-time manager training, including for a large population of admin/clerical staff ○ Ward Managers and AHPs leadership development programme ○ Matrons/Senior Clinicians programme ○ King's fund Senior Leadership Development Programme ○ Emerging Leaders Programme	Mar 2021-Dec 2022	◔
Talent management	• Establish, agree and implement a Trust-wide talent management strategy and processes, including: ○ Attraction and employer brand ○ Clear links to leadership and management development ○ Inclusive and values-based talent management ○ Retention and employee value proposition ○ Establishing career pathways and succession planning ○ Deployment of high potential ○ Career management for all	Jul 2021-Mar 2023	○
Coaching and mentoring	• Develop frameworks for the providing coaching and mentoring, including policies, processes and guidance • Link in with existing NHS regional and national services and offers • Develop internal banks of coaches and mentors, training workshops and resources	Jun 2021-Dec 2022	◔

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Trust-wide Diversity & Inclusion and OD Action Plan

TEAMWORK AND COLLABORATION			
Solution	*Actions*	*Timing*	*Progress*
Supported team-based working	• Define team-based working and the associated values-based and inclusive behaviours • Develop tools to support teams to strengthen team-working (e.g. ATPI model) • Pilot and implement team-based working interventions	Oct 2021-June 2023	○
System leadership development	• Define system (cross-boundary) leadership for St George's, based on the 5 system leadership principles • Develop a work-based ('on the job') leadership development offer for groups of cross-boundary leaders to develop and ingrain these principles (including Flow Coaching) • Pilot and implement approaches widely	Feb 2022 – Oct 2023	○

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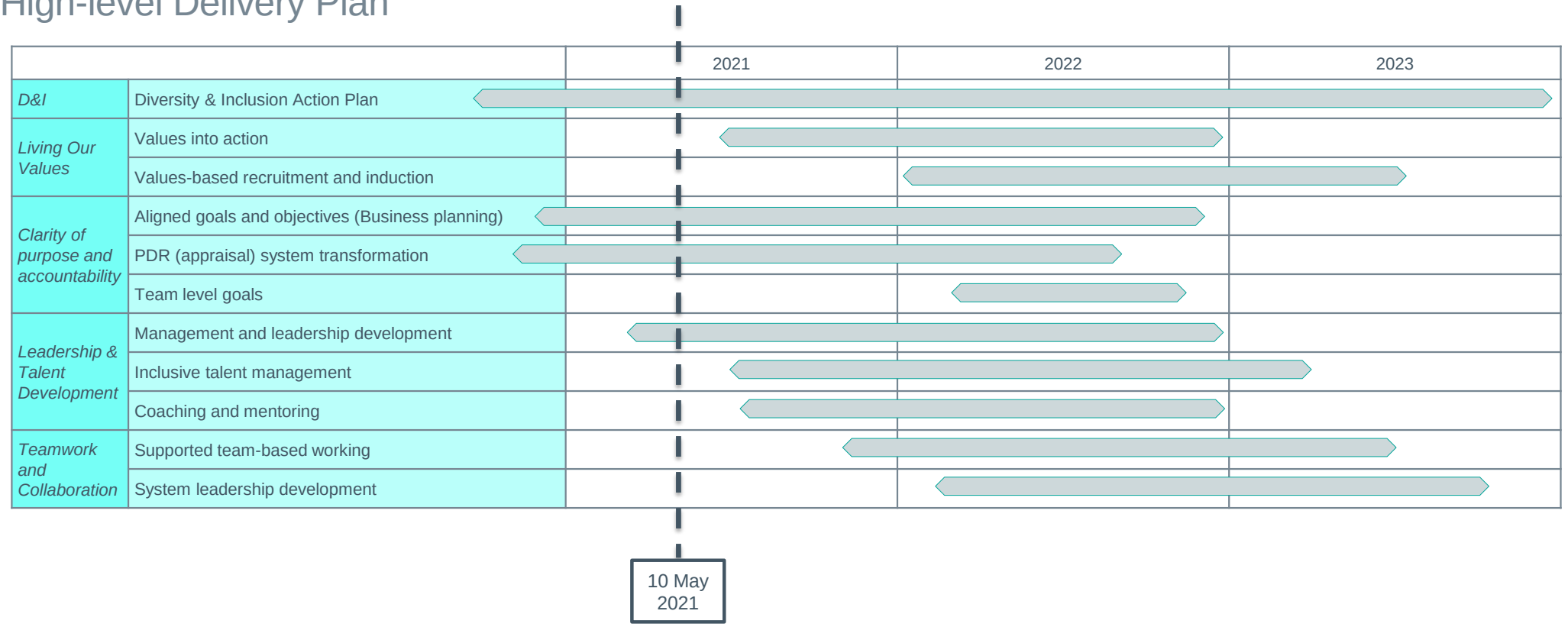
Trust-wide Diversity & Inclusion and OD Action Plan

High-level Delivery Plan



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Engaging and Inspiring Our Staff
Action Plan

Solution	*Actions*	*Delivery Phase*	*Progress*

Supporting Local Implementation and Culture Change Activity	• Establishing local centres/hubs of representation and culture change activity
	  ○ Team communications, dialogues and events, guided by clear remits, tools and core messages
	  ○ Local piloting and trialling of new ways of working
	  ○ Led by culture champions and supported by the Culture team
	  ○ Encouraging local ideas and actions for improving culture to surface and take shape
	• Continuing to support the culture champions
	• Ensuring that this approach is undertaken in an inclusive way
	• Training and skills development for culture champions and other local change agents
		Jan 2021 ongoing	◑

Trust-wide Stakeholder Engagement and Communications	• Development of a recognisable culture programme name and 'identity' to help contain, pull together and promote the breadth of culture initiatives • Identifying, mapping and segmenting stakeholder groups to build a stakeholder engagement strategy and plan • As well as via culture champions, stakeholders will be engaged through other existing networks and forums, e.g. diversity networks, Frontline Staff Forum, Induction, Senior Leaders, etc. • Ongoing multi-directional dialogue (vertical and horizontal) and sharing of successes	Ongoing	◔
Storytelling: 'The Story of St Georges'	• Define and implement a comms project that will support us in engaging and inspiring all 9000+ staff • Aim is to rebuild confidence and inspire pride across the Trust • Boost visibility of our history, current achievements and our ambitions for the future • Creating and sharing the story of St George's that honours our history and invites people to shape our future • Integrating and sharing cultural best-practice and successes across all teams and divisions • Project will require sourcing specific external expertise in internal communications	Jun – Dec 2021	○

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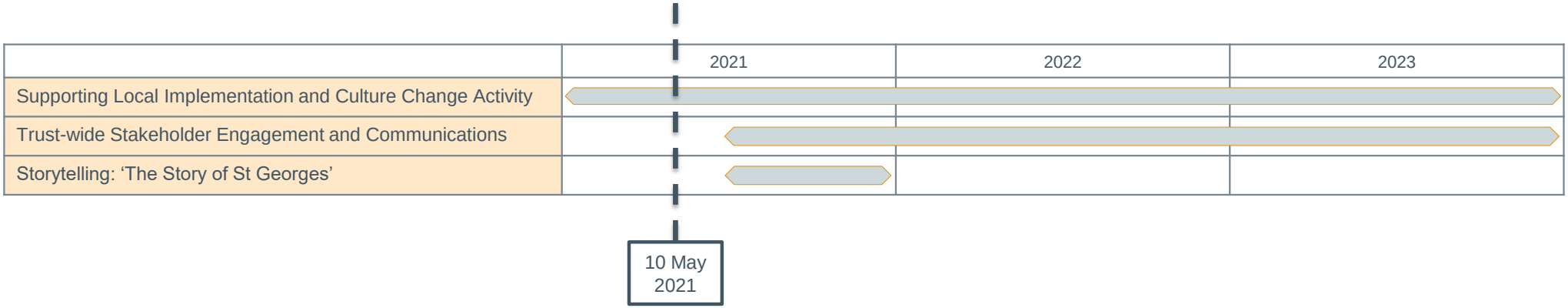
Engaging and Inspiring Our Staff

High-level Delivery Plan



Introducing 'Patient First'
Action Plan (solutions and actions TBD)

Solution	*Actions*	*Timing*	*Progress*
Team reflexivity and continuous learning	• Define team reflexivity as a regular process of reflection, planning and action/adaptation, and its benefits around team learning and improvement, wellbeing and inclusion • Develop tools and guidance to support teams practice reflexivity, including effective pre- and post-shift briefings (e.g. 'start well and end well') • Support/facilitate teams to build knowledge and capability to adopt reflexivity practices	TBD	◔
Integration of QI in day to day work	• Clarify and communicate our organisation-wide QI methodology, benefits and expectations around integration in day to day work • Develop an ongoing training and support programme to build capability to apply the methodology consistently and achieve its benefits • Define processes and develop tools to support application of the methodology in day to day work	TBD	◑
Project and Programme Management	• Introducing and embedding an organisation wide project and programme methodology • Potentially a Trust-wide PMO	TBD	◔
Ensure accurate specification and consistent implementation of new systems and processes	• Develop approaches that align with QI and project/programme methodologies to introduce new organisational systems and processes	TBD	○

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Introducing ‘Patient First’
High-level Delivery Plan

	2021	2022	2023
Team reflexivity and continuous learning	TBD		
Integration of QI in day to day work	TBD		
Project and Programme Management	TBD		
Ensure accurate specification and consistent implementation of new systems and processes	TBD		

10 May 2021

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Other Strategies and Plans Shaping our Culture
Action Plan

Solution	*Actions*	*Timing*	*Progress*
Staff Engagement Strategy	• Implement the 2020 staff survey 'Big 5' programme consisting of 5 themes: (i) Health and wellbeing (ii) Let's talk (iii) Flexible working (iv) Fairer career development (v) Creating a better work place • Conduct the 2021 staff survey including local dissemination of results, and annual Big 5 programmes	ongoing	
Remote & Flexible Working	• Health & Wellbeing – Wellness Action Plans, individual and group support for remote workers • Health & Safety – role-mapping checklist (managers), home-working checklist (staff) • Leadership & Management – remote/flexible working on-line training module – commission/design/launch • ICT/Equipment – input to policies re: equipment maintenance, etc,, min ICT requirements defined for each role • Policies & Procedures – including staff employment contract changes etc.	April– July 2021	
ICT Enhancement	• TBD		
Estates Strategy	• Blackshaw annex refurbishment to enable open-plan, non-hierarchical team working • Review of staff common spaces and toilet facilities • Other elements TBD	Nov 2020-Nov 2023	
Professional Standards	• Assessing feasibility of establishing and implementing professional standards • Linked to organisational values and behaviours	April 2021-Nov 2023	
Education Strategy	• Education Delivery Information Technology (EDIT) Group – current position, future design, IT Strategy alignment	ongoing	

'Business As Usual' OD	• Health and Wellbeing
	  ○ Staff support services for psychological and mental health support
	  ○ HWB communications
	  ○ Training (MH Awareness, REACT, Overseas Nurses)
	  ○ Physical activity free classes
	  ○ Wellness Action Plans and supporting wellbeing conversations
	  ○ COVID-19 recovery interventions
	• Learning & development; Clinical education
		ongoing	

Best Practice Local Culture Initiatives	• Identifying and integrating local best-practice culture change initiatives, e.g. local D&I successes in Children's Therapies	ongoing	

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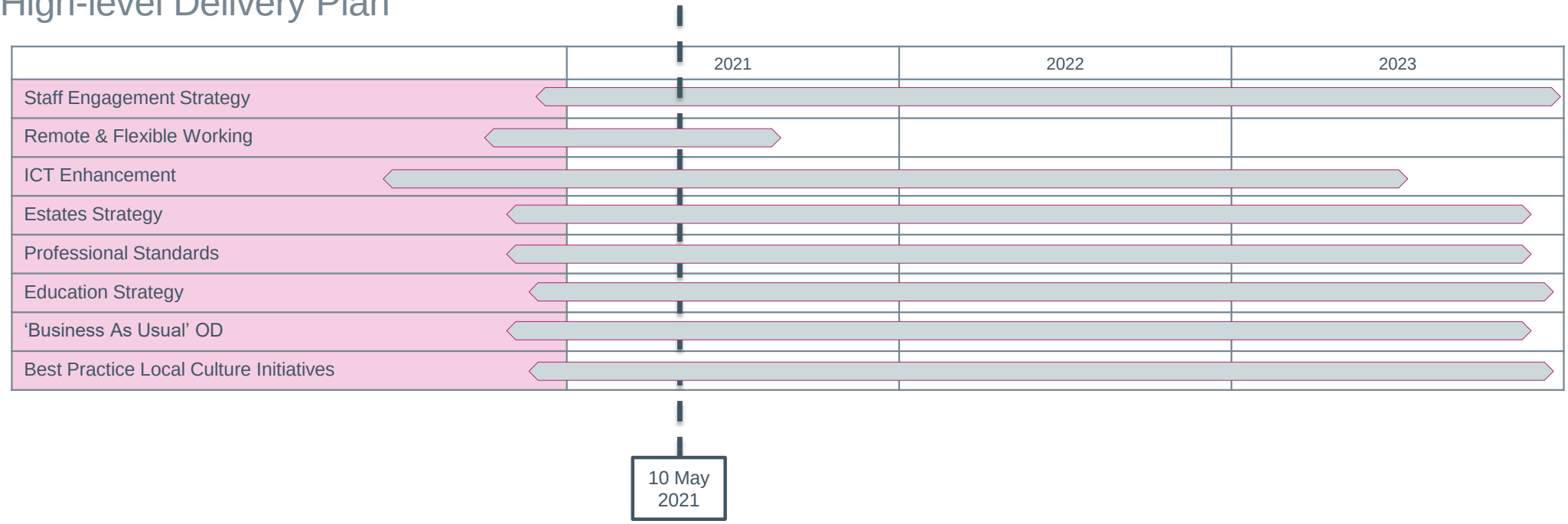
Other Strategies and Plans Shaping our Culture

High-level Delivery Plan



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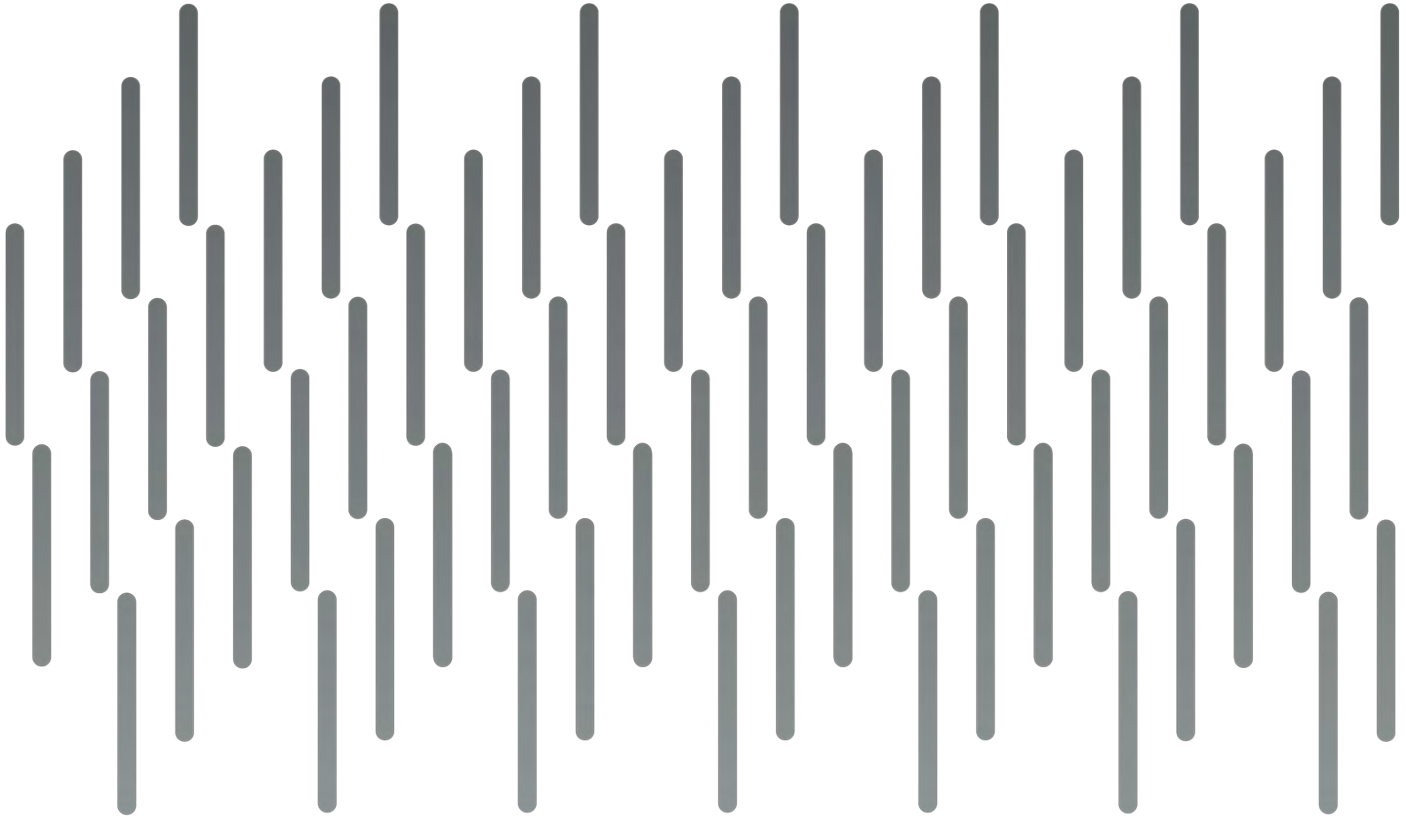
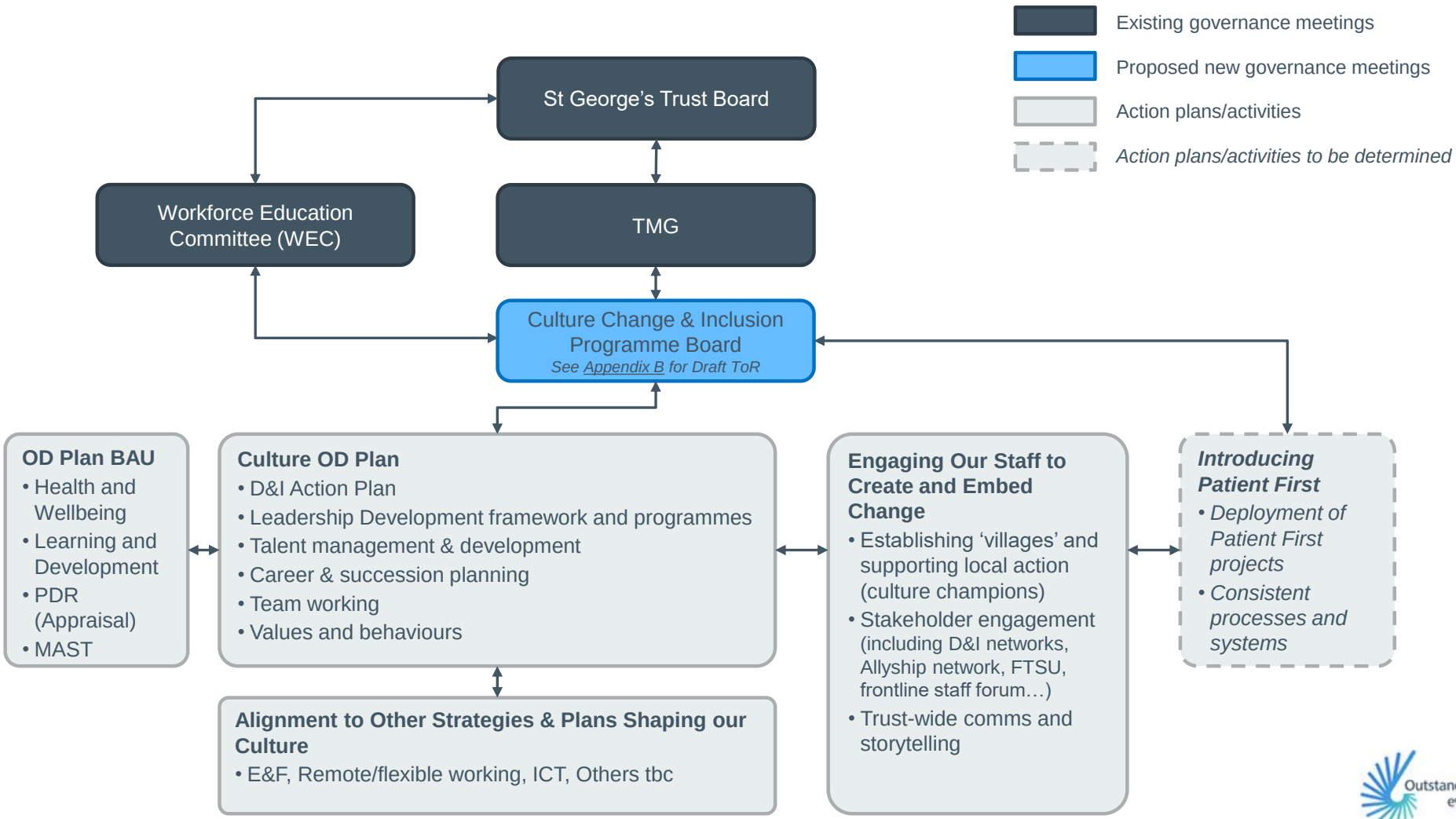
Part C) Organising for Programme Delivery



Culture & Inclusion Programme Governance



Measuring Impact

We will know we are successful when we see positive changes in three main areas as outlined below.

Note: All targets below require further consultation before agreeing exact figures.

1. Staff survey results

Measurement	Baseline	Targets		
	2020 Oct	**2021**	**2022**	**2023**
Increase in overall engagement score	7.0	7.1	7.3	7.5
Increase in employee morale score	6.0	6.1	6.4	6.7
Reduced intention to resign/leave score	TBC	TBC	TBC	TBC
Increase in Equality, Diversity and Inclusion score	8.4	8.6	8.9	9.3
Increase in Safety culture score	6.6	6.7	7.0	7.3
Increase in Quality of appraisals score	5.7	5.8	6.0	6.2
Increase in Immediate manager score	6.6	6.8	7.1	7.3
Increase in Health and wellbeing score	5.9	6.1	6.3	6.6
Increase in Team working score	6.4	6.5	6.8	7.0

2. Workforce statistics

Measurement	Baseline	Targets		
	2021 Mar	**2022**	**2023**	**2024**
Sickness Rate (%)	3.1	3.0	2.9	2.7
Turnover Rate (%), excludes Junior Doctors	14.4	14.0	13.5	13.0
Vacancy rate	8.6	8.4	8.00	7.7

3. Percentage of staff identifying as BAME

Band	Baseline	Targets			Comments
	2020 Sep	**2021**	**2022**	**2023**	
Band 6	49.8	52	53	53	Overall target is for the BAME workforce to reflect the overall workforce at all levels, therefore more than 50% is over-representation
Band 7	37.2	51	55	60	
Band 8a	28.7	31	35	39	
Band 8b	24.2	28	35	40	
Band 8c	25.0	26	30	36	Currently workforce figures suggest a decline from 25% in Sep 2020 to 24.3% in Feb 2021
Band 8d	14.8	15	20	35	Currently workforce figures suggest a decline from 14.8% in Sep 2020 to 13.9& in Feb 2021
Band 9	13.1	30	36	40	
VSM	20.8	20	30	40	Currently workforce figures suggest a decline from 20.8% in Sep 2020 to 9.5% in Feb 2021

Other measurement factors:

- Staff pulse survey
- Improvements in WRES/WDES metrics

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Resource Considerations

An initial outline of the resources required are listed below under three main areas with an indication of whether each is a staff or budget cost.

Leadership Development

- Interim L&D staff capacity to redesign existing programmes and ensure alignments to our framework and model of leadership (staff)
- Commissioning design and delivery of various leadership training and development programmes for different leadership levels and professional groups (staff and budget)
- External venue hire for training and workshops (budget)

Inclusive Talent Management

- Permanent staff to lead talent management system, and interim staff capacity to support establishment, piloting and implementation of processes and systems (staff)

Team Building and Development

- Interim capacity to support and deliver targeted team development interventions for team experiencing teamwork challenges (staff)
- Psychometric tools, e.g. personality profiling (budget)
- Aston Team Performance Inventory (ATPI) tool introduction, implementation and training of trainers (budget)

Specialist Comms Expertise

- Interim capacity to provide specialitst comms expertise
- Creation and dissemination of ‘The St George’s story’ that pulls together our history, target culture aims and an inspiring picture of the future
- To build recognition of our achievements to date, and inspire a greater sense of pride among all staff

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Key Priorities: Next 3 Months

- *It is important to remember that various elements of the Culture and D&I work is already happening and well underway.*

Trust-wide D&I and OD Action Plan	• Continue D&I Action Plan delivery
	  ○ Proposals and plans to revise internal recruitment process to strengthen D&I, focusing on senior leadership levels
	  ○ Revising terms of reference of D&I networks
	  ○ Developing a D&I charter
	  ○ Introduce BAME positive action leadership programmes
	• Continuing building the leadership development framework and programmes
	• Continue with the PDR transformation project
	• Scoping the Affina (formerly Aston) team development tools and training

Engaging and Inspiring Our Staff	• Continuing regular meetings and support for culture champions and establishing packages of work to 'sign up' to • Establish and begin to implement our wider stakeholder engagement plan including stakeholder mapping exercise • Shape the 'Story of St George's' project and begin sourcing external expertise
Introducing 'Patient First'	• Awaiting decisions from EMT to determine next steps • Aligning proposals/ideas with the QI/Transformation team
Other Strategies and Plans Shaping our Culture	• Launch the Big 5 and ensure that it's clear that this is a key deliverable of our C and D&I programme • Continue the various Remote working project workstreams • Continue scoping the development of professional standards • Blackshaw Annex refurbishment
Programme Management	• Finalise the Culture and D&I Action Plan and all deliverables within it • Agree the resource and team to deliver the plan, including appropriate programme support • Create and establish the governance to support the programme - first CDI programme board to be held by the end of May

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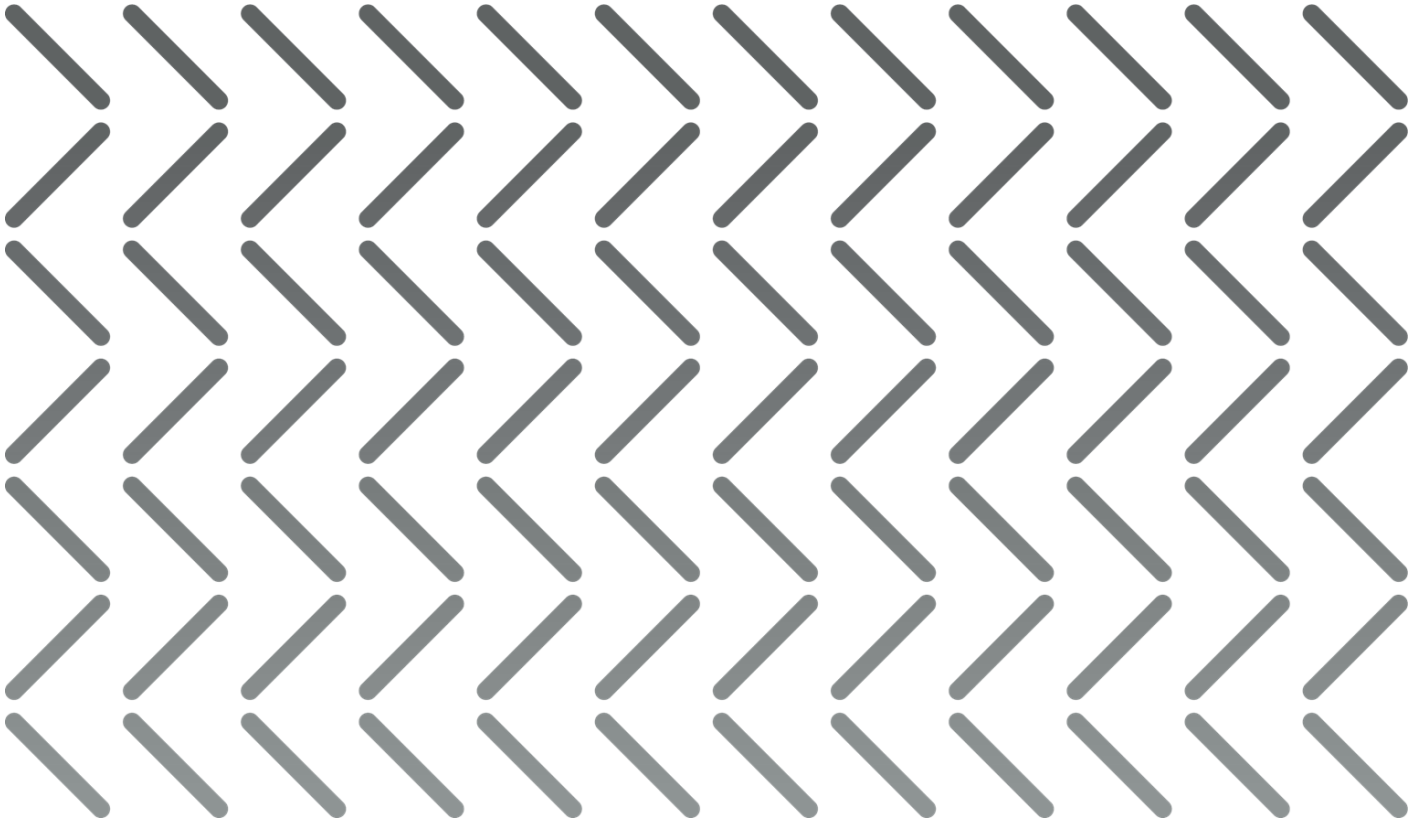
Appendices



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Appendix A
Discover Phase: Linking back to the diagnostic themes

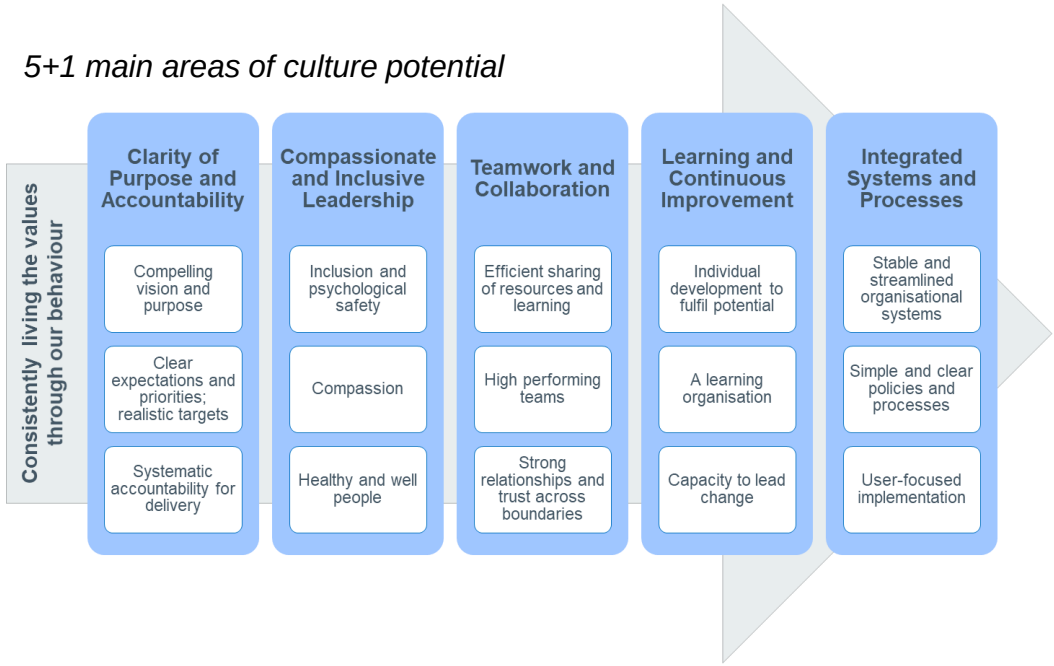
Findings from the main report…

Strengths	*Areas for Improvement*
• Pride in patient care • Stability of Executive Team • Delivering despite constraints • Some exemplary managers • University connection • Appetite for change	• Varied clarity of vision • Accountability for delivery • Unrealistic targets • Workaround culture • Compassion not 'landing' • Mixed leadership skill • Low psychological safety • Bulling, harassment and discrimination • Working in siloes • Unfulfilled drive to learn • Clinical leadership collaboration

Conclusions in the report summary…

1. Clearer decisions on the Trust's priorities which balance the needs of the organisation, staff and patients
2. An environment where staff feel empowered to work together and improve services
3. Investment in building strong leadership across all levels
4. An environment where people feel safe to share their views and learning
5. Learning, innovation and teamwork at the heart of how we do things
6. A commitment to long term improvement, supported by consistent processes and structures

5+1 main areas of culture potential



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Appendix B
Overview of Terms of Reference

Meeting	Overview of purpose of group	Proposed membership
Culture and D&I Programme Board	The purpose is to lead, drive and enable success of the CDI programme, through: • Overseeing delivery of actions and outcomes of the D&I and Culture action plans • Supporting thorough and meaningful stakeholder engagement • Reviewing and contributing to programme outputs • Shaping priorities and agreeing the programme of work to be implemented as part of phase 3 (Delivery) • Overseeing the progress of the implementation of key culture change priority areas, as identified through review of the diagnostic data • Providing direction to the implementation and resourcing of the leadership development plans • Overseeing and providing direction to the design, implementation and resourcing of the 'Values & Behaviours' training programme/process • Mitigating potential risks to the delivery of the CDI programme that have been escalated to the CDI Programme Board • Resolving escalated issues and dependencies	Jacqueline Totterdell Paul da Gama Humaira Ashraf Daniel Scott Rebecca Greenwood Ed Donald Ralph Michell Martin Haynes 2 x Culture Champion Reps D&I Network Chairs Staff Side rep Robert Bleasdale or Steph Sweeney Carolyn Johnson or Richard Jennings Andrew Asbury Andrew Grimshaw Anne Brierly Clinical Chair? DDO? DDNG?

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3.3

Meeting Title:	**Trust Board**		
Date:	27 May 2021	**Agenda No**	**3.3**
Report Title:	**Freedom to Speak Up Report: Q4 2020/21 Report**		
Lead Director/ Manager:	Stephen Jones, Chief Corporate Affairs Officer & Executive Lead for Freedom to Speak Up		
Report Authors:	Karyn Richards-Wright, Freedom to Speak Up Guardian		
Presented for:	Assurance		
Executive Summary:	This report provides the Trust Board with an overview of the concerns raised with the Trust's Freedom to Speak Up Guardian as at Q4 2020/21. The report sets out the number of concerns raised and breaks this down by staff group. It also provides an update on the current investigations underway at the end of Q4. The report sets out the progress in implementing the new FTSU vision and strategy, particularly in relation to the 2020/21 immediate priority areas. It also highlights the key themes emerging from the 2020 national Freedom to Speak Up Guardian Survey and the recommendations from the National Guardian's Office in response. The annual Freedom to Speak Up Index report, which benchmarks providers' FTSU culture, is expected to be published within the next two months. The Trust will undertake a major communications and staff engagement push on raising concerns and speaking up as part of the "Let's Talk" month in June, part of the "Big 5" programme of initiatives following the 2020 NHS Staff Survey.		
Recommendation:	The Board is asked to: • Note the increase in concerns raised with the FTSU Guardian in 2020/21 and the themes which emerge from this; • Note the current position in relation to concerns raised via the FTSU Guardian that are going through a formal process, including the challenges around timeliness of investigations; • Note the update on the implementation of the FTSU strategy agreed by Board in September 2020; • Note the key themes emerging from the 2020 FTSU Guardians Survey.		
Supports			
Trust Strategic Objective:	Champion Team St George's		
CQC Theme:	Well Led		
NHS Oversight Framework Theme:	Leadership and Improvement Capability (Well Led)		
Implications			
Risk:	Failure to comply with the requirements around Freedom to Speak Up, a regulatory requirement, risks undermining staff confidence in the leadership of the Trust and would be a reputational risk to the organisation.		
Legal/Regulatory:	NHSI, Freedom to Speak Up: Raising Concerns (Whistleblowing) Policy for the		

	NHS, April 2016. Sir Robert Francis QC, Freedom to Speak Up: An independent report into creating an open and honest reporting culture in the NHS, 2015.		
Resources:	As set out in the report.		
Equality and Diversity:	As set out in the report.		
Previously Considered by:	Workforce and Education Committee Executive Management Team People Management Group	**Date**	18 May 2021 17 May 2021 5 May 2021
Appendices:	N/A		

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3.3

Freedom to Speak Up

Freedom to Speak Up Report Q4 2020/21
to the Trust Board of Directors

Report author:
Karyn Richards-Wright
Freedom to Speak Up Guardian

Executive Lead:
Stephen Jones
Chief Corporate Affairs Officer

27 May 2021

1. Executive Summary

Purpose

This reports provides an update from the Freedom to Speak Up Guardian on recent raising concerns cases. It sets out current activity and themes emerging and areas in which concerns are being raised. Although a small proportion of the total cases, the report provides an update on current formal investigations / reviews. It provides an update on our progress in implementing the FTSU strategy agreed by the Board in September 2020. This report was considered by the Workforce and Education Committee on 18 May 2021.

Key issues

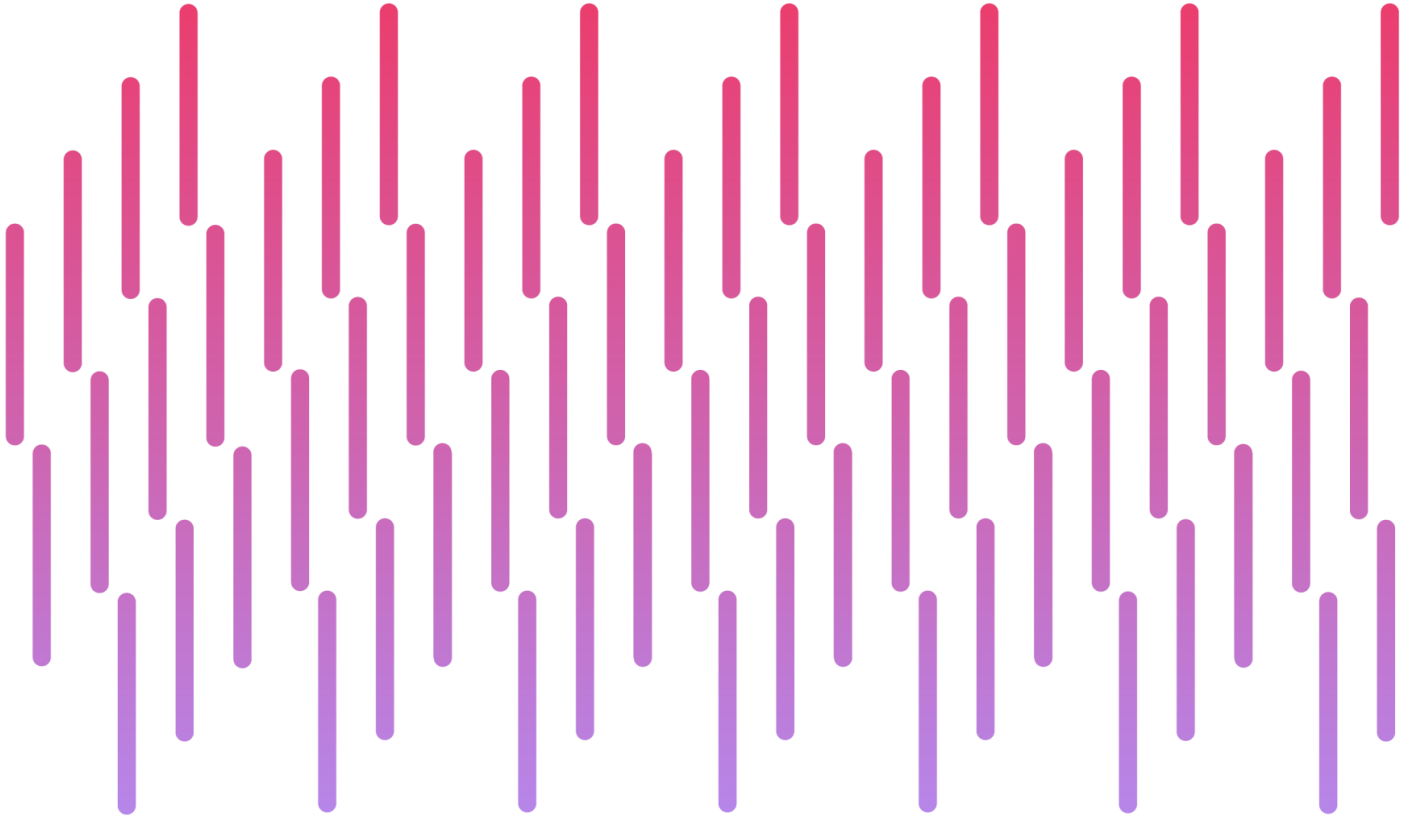
- The number of concerns raised with the Trust's Freedom to Speak Up Guardian has increased significantly this year, with a total of 128 concerns raised in 2020/21 (51 concerns raised in Q1 and a further 20 concerns raised in Q2, 33 concerns in Q3 and 24 raised in Q4.
- The significant rise in concerns, especially in Q1 2020/21 is attributable in significant part to concerns broadly related to Covid-19 – including concerns around the availability of Personal Protective Equipment, shielding and staff support during the first wave of the pandemic, and the treatment of staff from BAME backgrounds. Themes around bullying and harassment and conflicts within teams and with line managers have continued as the major themes during 2020/21, having been themes identified in previous years. We have seen an increase in concerns relating to Leadership during Covid-19 especially around working from home, role mapping and risk assessments.
- Administrative and clerical staff continue to be staff group which raise the highest number of concerns – 38% of all concerns raised with the FTSU Guardian this year come from administrative and clerical staff, and the number of concerns from this staff group has risen steadily over the past four years. 2020/21 has also seen an increase in the number of medical staff raising concerns – up significantly on previous years. Maintenance staff, porters and catering staff remain the staff groups least likely to raise concerns with the FTSU Guardian
- The vast majority of concerns raised with the FTSU Guardian are dealt with informally, typically through signposting to the appropriate route for handling the issue (e.g. a relevant HR process). A small number of concerns are formally investigated. As at the end of Q4 2020/21, there are 8 live Freedom to Speak Up investigations. The timeliness of investigations remains a concern, following which the Guardian and Executive Lead have reviewed their escalation process to enable swifter executive level interrvention when it is clear that resolution of the concerns will not be forthcoming within the agreed timescales.
- The priorities for FTSU over the coming months include: promoting speaking up through the "Let's Talk" month of June 20201 as part of the "Big 5" actions in response to the NHS Staff Survey, holding our first FTSU / Raising Concerns Summit to triangulate a range of data and identify emerging and potential hotspots to enable sand support timely intervention by divisional and corporate teams; publishing a FTSU Charter for staff setting out clearly what they can expect when they raise a concern; and beginning a recruitment drive to strengthen and diversify our network of FTSU Champions. We are also reviewing our FTSU and Raising Concerns policy and developing a divisional reporting pack on FTSU for each clinical and corporate division. The Guardian now attends Divisional management meetings on a regular basis to ensure that divisions are sighted on themes and learning in relation to FTSU within their areas.

Recommendation

The Trust Board is asked to:

- Note the increase in concerns raised with the FTSU Guardian in 2020/21 and the themes which emerge from this;
- Note the current position in relation to concerns raised via the FTSU Guardian that are going through a formal process, including the challenges around timeliness of investigations and actions being implemented to assist in addressing this;
- Note the key themes emerging from the 2020 FTSU Guardians Survey;
- Note the priorities for the function over the next 6 months.

2. Current Freedom to Speak Up activity and themes



Freedom to Speak Up

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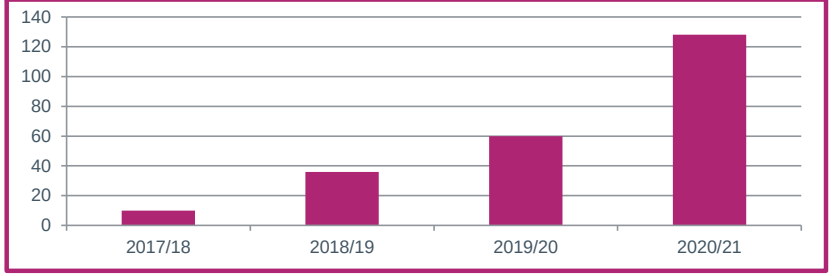
2. Current activity and themes

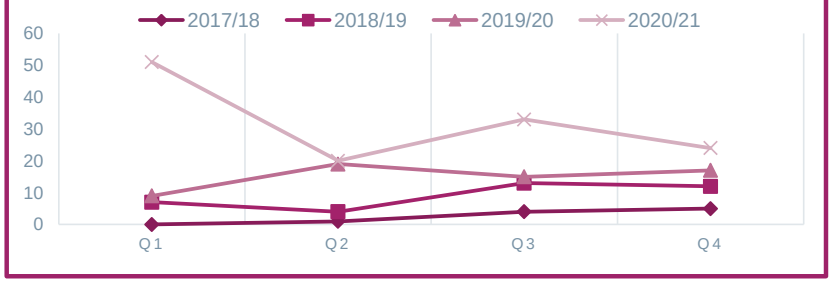
Number of concerns raised with FTSU Guardian 2020/21

Quarter (2020/21)	Number of concerns raised with the FTSU Guardian
Q1	51
Q2	20
Q3	33
Q4	24
Year-in-full	128

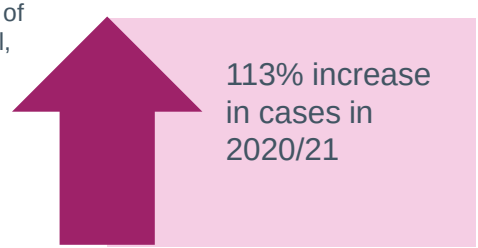
Total number of concerns raised to the FTSU Guardian 2017/18 – Present



Total number of concerns raised to the FTSU Guardian 2017/18 – Present: Quarter by Quarter comparison



- At total of 128 concerns have been raised with the Trust's Freedom to Speak Up Guardian in 2020/21.
- Q1 2020/21 saw the highest number of concerns (51) logged. The number of concerns fell back in Q2 (20), before rising again in Q3, and Q4 saw 24 concerns raised.
- The number of concerns raised with the Freedom to Speak Up Guardian in 2020/21 is more than double the total number of concerns raised in the previous financial year and more than three times higher than in 2018/19. Put another way, the number of concerns raised in 2020/21 is around a 20% more than the combined number of concerns raised in the three-year period between 2017/18 and 2019/20.
- The increase in cases recorded with the Trust's Freedom to Speak Up Guardian this year so far is reflected in the experience of other Trusts across the country. Nationally, cases raised with FTSU Guardians increased from 7,087 in 2017/18, to 12,244 in 2018/19, to 16,199 in 2019/20, the latest full year for which national data is available. In the first two quarters of 2020/21, there were a total of 9,754 speaking up cases, an increase of 33.7% on the same period in the previous year.
- The increases in the cases reported that we have seen at St George's the broader national pattern, but the rate of increase at the Trust has been significantly higher still, albeit from a lower base.



Freedom to Speak Up

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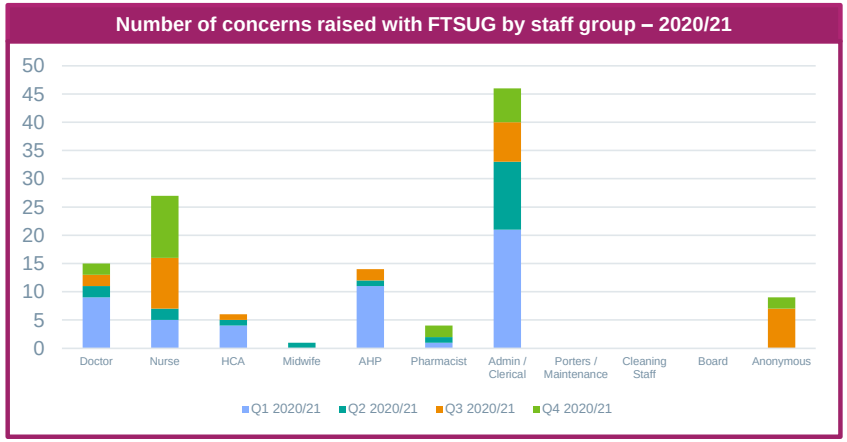
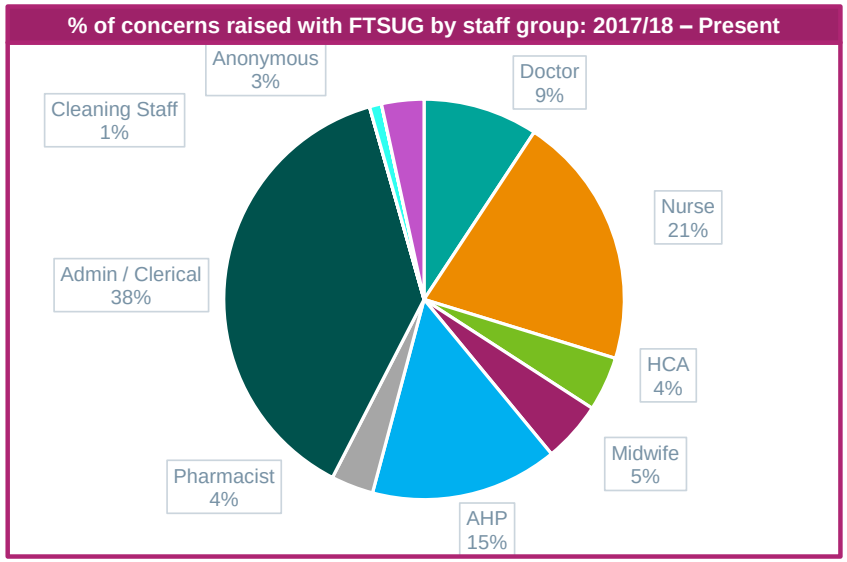
2. Current activity and themes

Concerns raised by staff group 2020/21 (1 of 2)





- Overall in 2020/21, the staff groups which have raised the greatest number of concerns are: administrative and clerical; nursing; allied health professionals; and doctors.
- **Administrative and clerical staff, by some margin, raised the most concerns in 2020/21.**
  - A total of 46 concerns have been raised by administrative and clerical staff so far this year. This is significantly higher than among the next three highest staff groups for raising concerns this year: nurses, AHPs and doctors.
  - There has been significant year on year increases over the past four years in the number of administrative and clerical staff raising concerns this. For each of the past two years, the number of concerns raised by administrative and clerical staff has been more than double the number of concerns raised by the next highest staff group.
  - The number of concerns raised by administrative staff has declined over the course of the year, from 21 concerns in Q1, 12 in Q2, 7 in Q3 and 6 in Q4.
- **Porters, maintenance and cleaning staff have raised no concerns with the FTSU Guardian so far this year.**
  - The absence of concerns among this staff group is consistent with previous years. There have been no concerns raised among porters and maintenance staff with the FTSU Guardian over the last four years. Only two concerns have been raised by cleaning staff.
  - The Guardian is engaging with these staff groups to promote awareness of the role of the Guardian and how to speak up, and working with them to understand the barriers that exist to speaking up and understand how best these can be addressed. The Guardian is also continuing to encourage members of these staff groups to become FTSU champions

Freedom to Speak Up

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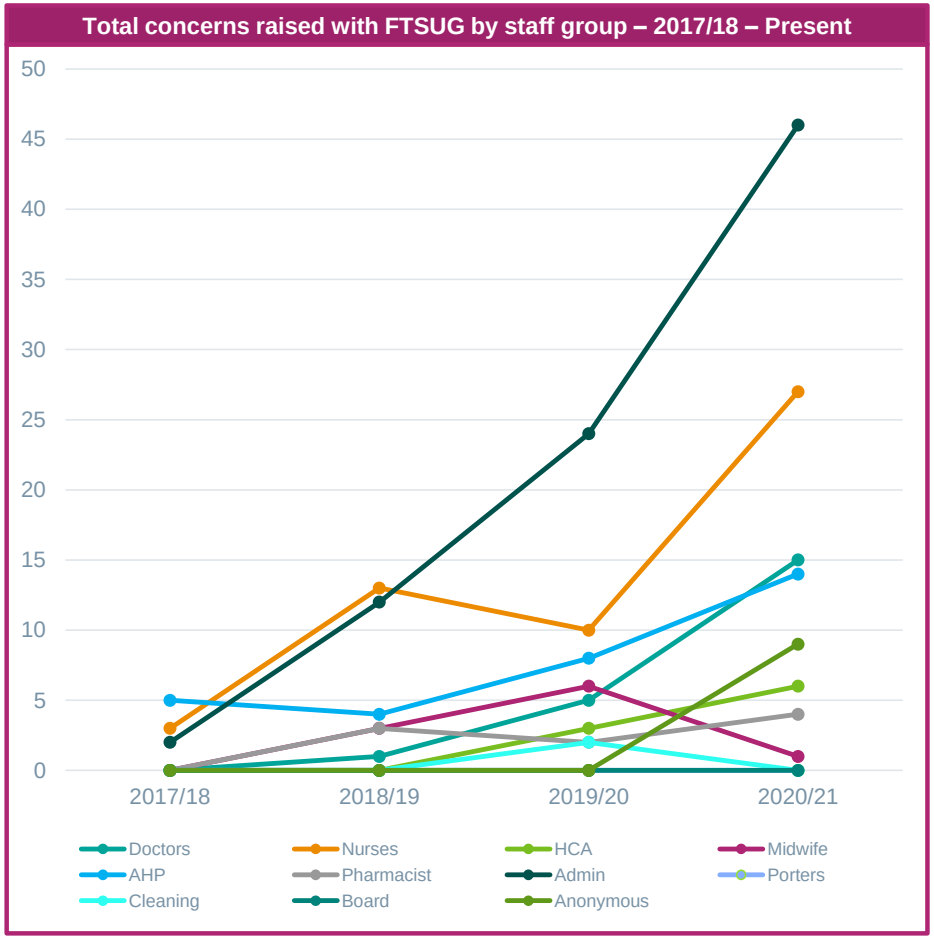
2. Current activity and themes

Concerns raised by staff group 2020/21 (2 of 2)



- **There has been a significant increase in the number of concerns raised by doctors in 2020/21 compared with previous years**.
  - Concerns raised by doctors account for 11.5% of the concerns raised this this year so far, compared with 6% in the period 2017/18 to 2019/20. Between 2017/18 and 2019/20, the cumulative total number of concerns raised by doctors was 6; in 2020/21 to date doctors have raised 15 concerns.
- **Nursing staff were the second highest staff group in terms of the number of concerns raised with the FTSU Guardian to date this year.**
  - Nurses accounted for 21% of the total concerns raised to date in 2020/21. This is lower than the 24% of the total number of concerns raised (26 of a total of 106) for nurses in the period 2017/18 to 2019/20.
  - The number of concerns raised by nurses in Q4 2020/21 (11) was significantly higher than in previous quarters this year (5 in Q1, 2 in Q2 and 9). It is however to be noted that one of the concerns raised was by 4 nurses from the same area. Managers from the area are receiving management support and some staff are going through mediation with a view to resolving the issues of concern.
- **Midwives and Cleaning staff are the only staff groups that have seen a fall in the number of concerns raised with the FTSU Guardian this year.** All other staff groups have seen increases in the number of concerns raised with the Guardian.
- **There has been an increase in the number of anonymous concerns raised to the FTSU Guardian in 2020/21.** Eight anonymous concerns have been raised this year; none were received in the three previous years.

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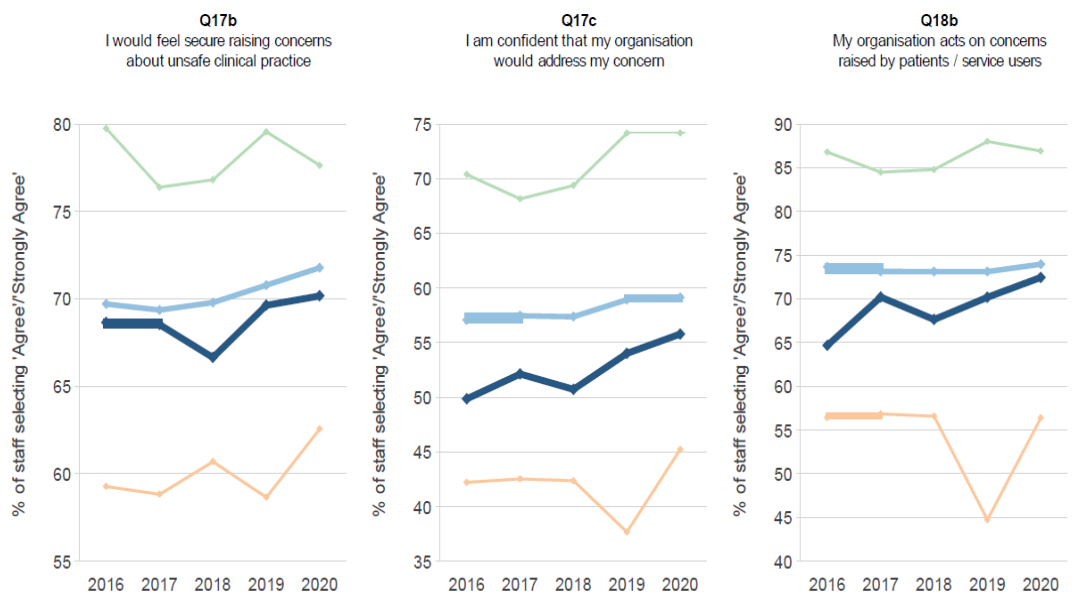
2. Current activity and themes

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

Survey Coordination Centre

2020 NHS Staff Survey Results > Theme results > Detailed information > Safety culture 2/2

NHS England



	2016	2017	2018	2019	2020
Best	79.7%	76.4%	76.8%	79.6%	77.6%
Your org	68.6%	68.5%	66.7%	69.6%	70.2%
Average	69.7%	69.4%	69.8%	70.8%	71.8%
Worst	59.3%	58.8%	60.7%	58.7%	62.6%

	2016	2017	2018	2019	2020
Best	70.4%	68.2%	69.4%	74.2%	74.2%
Your org	49.9%	52.1%	50.7%	54.0%	55.8%
Average	57.1%	57.5%	57.4%	58.9%	59.1%
Worst	42.2%	42.5%	42.4%	37.7%	45.2%

	2016	2017	2018	2019	2020
Best	86.8%	84.5%	84.8%	88.0%	86.9%
Your org	64.7%	70.2%	67.6%	70.2%	72.5%
Average	73.7%	73.1%	73.1%	73.1%	74.0%
Worst	56.4%	56.9%	56.6%	44.8%	56.4%

- 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.

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2. Current activity and themes

Concerns by Division and themes arising 2020/21 (1 of 2)

Total concerns raised with FTSUG by staff group – 2017/18 – Present						
Division	**Q1**	**Q2**	**Q3**	**Q4**	**YTD**	**Themes in concerns**
CWDT (3,265 staff)	24	11	16	7	**58**	Bullying and harassment Conflict within teams Conflict with line manager Shielding during Covid-19 Lack of support during bereavement during Covid-19 Personal Protective Equipment during Covid-19 BAME concerns
MedCard (2,194 staff)	11	3	4	5	**23**	Bullying and harassment Conflict within teams Shielding during Covid-19 Personal Protective Equipment during Covid-19 BAME concerns
SNCT (2,016 staff)	10	2	6	8	**26**	Bullying and harassment Personal Protective Equipment during Covid-19 BAME concerns
Corporate (inc Estates & Facilities) (1,036 staff)	6	4	7	4	**21**	Bullying and harassment Processes Conflict with line manager Shielding during Covid-19
Total concerns	**51**	**20**	**33**	**24**	**128**	

- **The increase in the number of concerns raised in 2020/21 can be attributed to a significant degree to Covid-19.**
  - This was particularly the case in Q1 2020/21 where Covid-19 related concerns accounted for a large proportion of the concerns received by the Freedom to Speak Up Guardian.
  - The number of Covid-19 related concerns fell during Q2 2020/21, which coincided with the decline in the number of Coved positive patients at the Trust and the decline in the transmission rate of Coved among the population.
  - Concerns during Q3 rose to to 33. Covid operational pressures at the Trust increased at the end of Q3.
  - Q4 concerns decreased to 24 with the majority of the themes in Q4, as in Q3 related to mainly to behaviour, conflict and conduct issues. The Guardian is working closely with teams, managers and HRBP to support the teams and managers.
- **Patient safety concerns remain a small percentage of the total number of concerns.**
  - There have been 10 concerns directly related to patient safety raised with the Trust's Freedom to Speak Up Guardian to date this year (7 part of a collective concern). Patient safety concerns therefore amount to 8% of the total concerns raised with the Guardian this year so far.
  - One anonymous concern was sent to chief executive relating to patient safety and is being investigated at this time by the Trust and two concerns in Q4 reported through an executive.

Freedom to Speak Up

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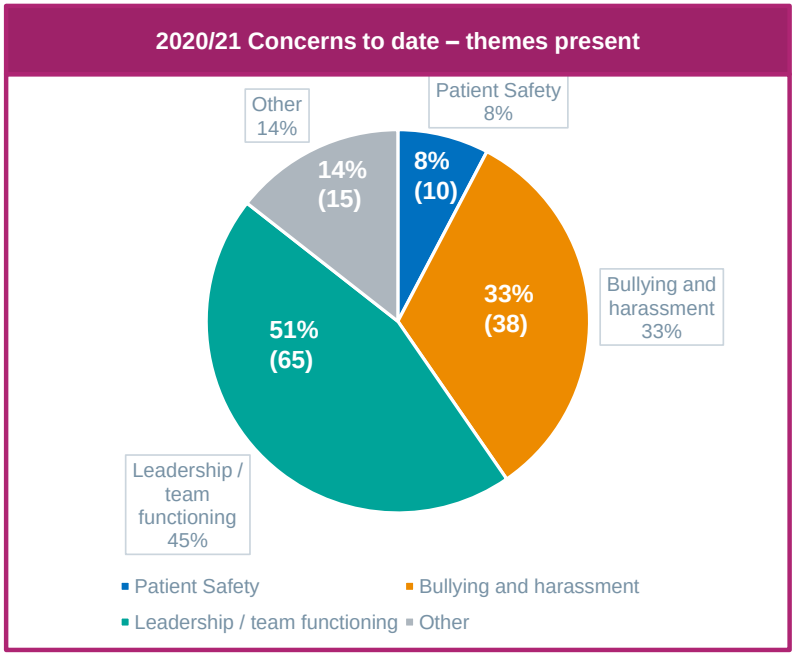
2. Current activity and themes

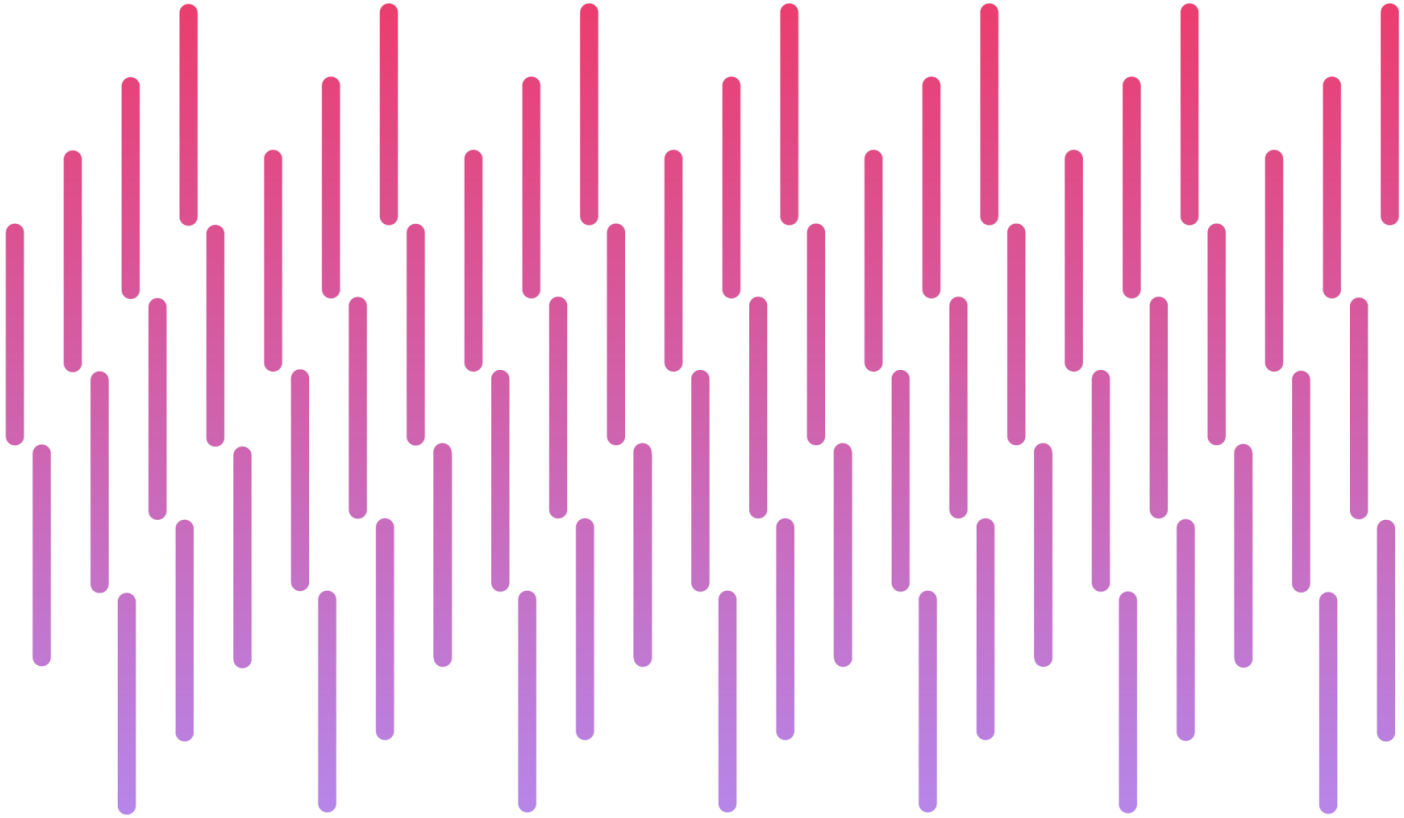
Concerns by Division and themes arising 2020/21 (2 of 2)



** "Other" category includes principally what might be termed pure signposting – where a staff member has sought advice from the FTSU Guardian but which does not fall within these categories*

- **Cultural, behavioural and inclusion issues constitute by far the greatest proportion of concerns.**
  - Bullying and harassment still remains a recurrent theme in concerns being raised to the Guardian across all divisions, both clinical and non-clinical.
  - There has been an increase in the number of concerns related to diversity and inclusion, with greater numbers of BAME staff speaking up.
  - Broader behavioural and leadership issues are also prevalent – for example, conflict with line managers, conflict within teams.
- The division with the highest number of concerns is the Children's Women's Diagnostics and Therapies Division (CWDT), which is also the largest division. At 58 concerns in the year to date, accounts for just under half of the total concerns raised by staff in 2020/21 to date. The Guardian is actively working with and supporting managers and teams within CWDT together with actively working with HR Colleagues and encouraging access to the newly released online modules released recently by HEE and the National Guardian's Office.
- The Guardian has recently started attending Divisional management meetings to further share data and themes at divisional level and to provide Divisions with high level information, themes and learning from FTSU cases within each Division.

3. Current Freedom to Speak Up investigations / reviews



Freedom to Speak Up

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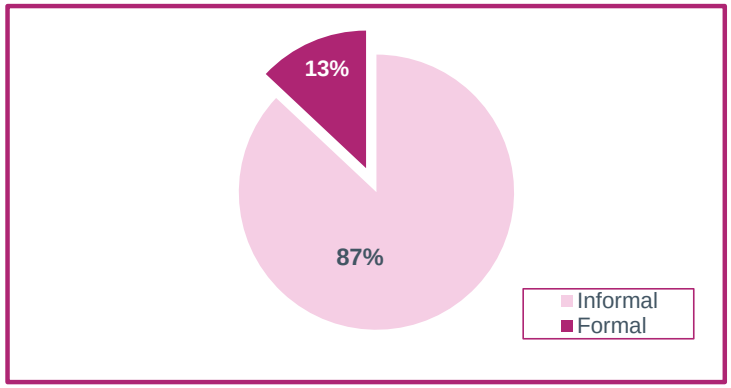
3. Current FTSU investigations / reviews

Current investigations – 2020/21 (1 of 2)



Division	Q 1	Q 2	Q 3		YT D	Resolution
CWDT	24	11	16	7	**58**	9 out of 58 referred for formal investigation/response
MedCard	11	3	4	5	**23**	2 out of 23 referred for formal investigation/response
SNCT	10	2	6	8	**26**	4 out of 26 referred for formal investigation /response
Corporate (inc. Estates & Facilities)	6	4	7	4	**21**	2 out of 21 referred for formal response/investigation (collective concerns)

- **The vast majority of concerns raised with the FTSU Guardian are resolved informally and rapidly; concerns raised with the Guardian that are formally investigated are a very small proportion of the total number of concerns raised.**
  - Out of 128 concerns raised with the Freedom to Speak Up Guardian so far in 2020/21, 87% have been closed through informal – and often rapid – action to resolve the issue, with 13% of concerns being referred for formal investigation or response.
  - The Guardian is able to resolve the majority of concerns informally and rapidly, typically through signposting to the appropriate route for handling the issue (e.g. a relevant HR process) or through raising with the relevant team to enable prompt action to be taken to address the concern raised.
  - The Guardian works closely with Staff Support and is also a trust mediator so is also able to facilitate resolution of concerns.
- **Timeliness of formal investigations and / or responses remains an issue.**
  - One formal investigation open from Q4 2019/20 will close imminently and following investigation a further "cultural" piece of work with the team involved is due to begin shortly. The Non-Executive lead for Freedom to Speak Up has been briefed and a full review of the issues identified and lessons learnt is being developed and will be shared with the NED lead. The Guardian and Executive Lead have reviewed their processes for escalation in line with reflective learning from this and other cases.
- **Staff training, including training of managers, will help with addressing timeliness of investigations but further training for those who take forward investigations / reviews raised under FTSU may also be needed.** The FTSU Guardian and Executive Lead are exploring how best to address this including potentially the training of a pool of staff who in investigating concerns raised to the Freedom to Speak Up Guardian.
- The new IT platform is now in place however has had some teething problems with the trust server which the Guardian is regularly in contact with IT and the platform suppliers to resolve.

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3. Current FTSU investigations / reviews

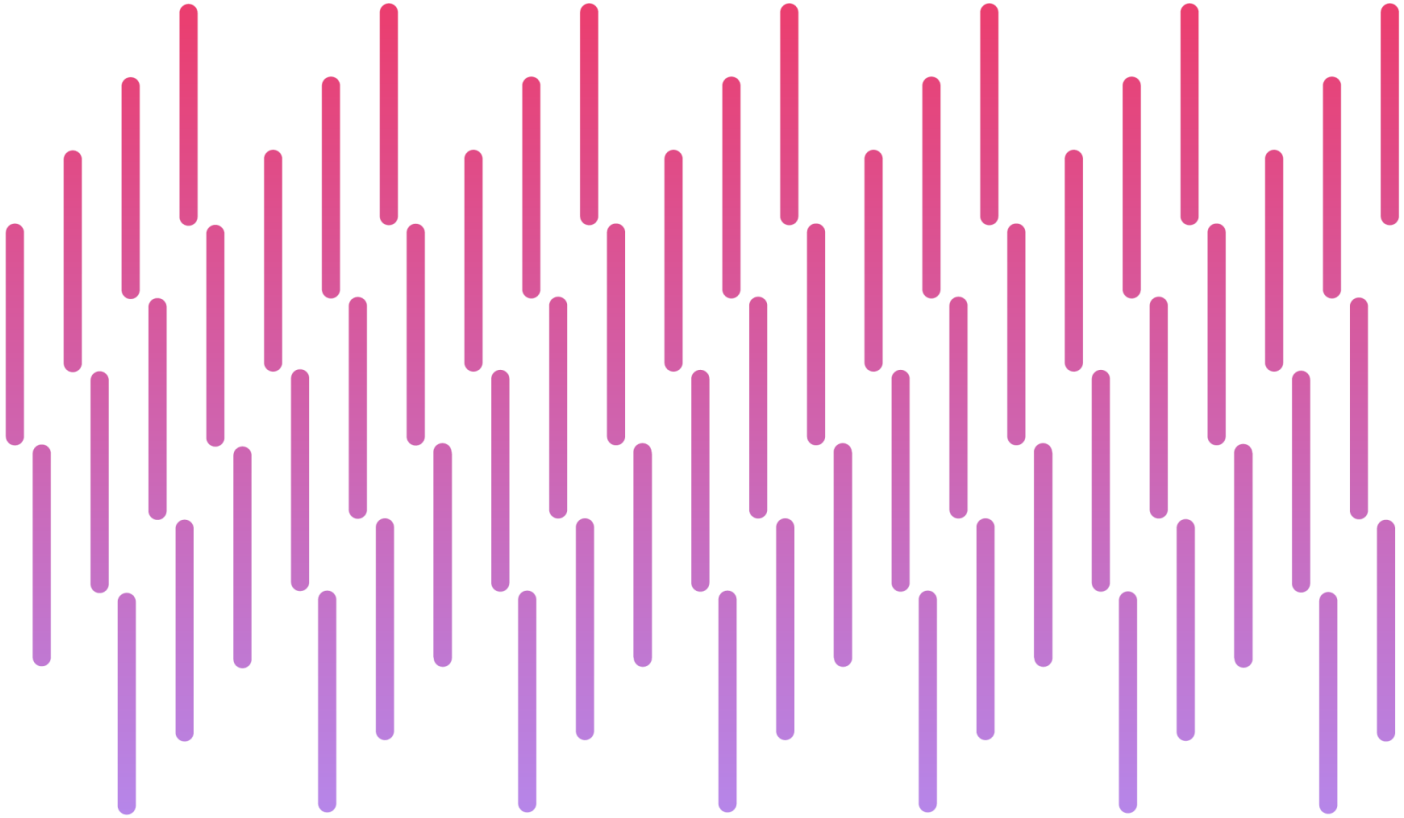
Current investigations – 2020/21 (2 of 2)

Division	Area	Status
CWDT	Mary Seacole	Awaiting outcome
	Pharmacy	Appreciative enquiry underway
	Looked after children	Formal response to FTSUG pending
	Maternity	Outcome imminent
MedCard	Haematology	Response provided Appreciative enquiry underway
	Cardiology	Investigation ongoing
SCNT	General Surgery General Surgery	Awaiting outcome Ongoing

- The table opposite sets out the investigations / reviews currently in progress following the raising of issues with the FTSU Guardian.
- Due to the confidentiality of the concerns raised, the table sets out the areas, divisions and the status of the investigations / reviews only.
- Cases are maintained on the FTSU Guardian case management tool. High level summaries of the cases are shared with the Executive Lead for Raising Concerns, the Non-Executive Lead for Raising Concerns and the Chief Executive.
- Investigations / reviews which risk or breach the 12-week timeline set out for the investigation of concerns are escalated to the Executive Lead for Raising Concerns.

4. Progress in implementing the FTSU Strategy

The Board approved the Trust's new FTSU vision and strategy at its meeting in September 2020. Implementing the steps identified as priority areas for 2020/21 has been the focus of the FTSU function since then and the table below sets out the commitments made and a progress update against each area. There has been very positive feedback on our new FTSU vision and strategy from the national FTSU team at NHSE&I, which is using it as a strategy exemplar with other Trusts.



4. Implementation of the Trust's new Freedom to Speak Up Vision and Strategy

Strengthen the FTSU function	• Create dedicated and more senior FTSU role focused solely on FTSU • Create dedicated FTSU budget • Create a new role of Deputy FTSU Guardian to build strength in depth of FTSU function	• New Band 8a FTSU role now established. • Dedicated FTSU budget now created. • Resources to establish Deputy FTSU Guardian currently being explored and a bid through business planning has been submitted
Refresh the FTSU Champions network	• Clarify role of FTSU Champions & revisit role description and time commitment • Ensure all parts of the Trust have champions, and that the Champions network reflects the diversity of our staff, and identify champions for specific staff groups	• New role description and advertisement for FTSU Champions has been developed and was approved by the People Management Group and Risk and Assurance Group. It will be launched in June 2021. • Recruitment to be phased to ensure appropriate training for new Champions
Develop FTSU Charter	• I have spoken up – what can I expect? • Someone has spoken up about me – what can I expect?	• Draft FTSU Charter has been prepared and taken through People Management Group and Risk and Assurance Group • Staff Side to be engaged • Plans to publish Charter in June 2021.
Refresh FTSU Policy	• Review of the policy to ensure it is fully up-to-date with national guidance and best practice • Review policy in light of agreed FTSU strategy • Ensure policy is clear about the range of routes for raising concerns	• Policy has been reviewed. Further amendments will be made following publication of new national guidance which is expected imminently. Policy has been extended by 3 months to enable review in light of national policy changes. • Policy has been reviewed with assistance from National Guardian's Office's FTSU Policy Review Tool
Establish FTSU summits	• Develop proposals for establishing a group to triangulate issues and concerns with a range of other data • Develop ToR for the group • Ensure group is supported by range of data relating to safety, culture, workforce and other sources	• Draft Terms of Reference prepared including proposals for membership and material to feed in for triangulation • Intention of holding initial meeting in June 2021.
Develop FTSU communications plan	• Develop communications campaign to raise awareness of how to raise concerns • Develop and promote an annual calendar of FTSU events and activities • Use full range of channels inc CEO weekly message, eG, case studies, video clips	• Communications drive undertaken around FTSU month in June (as part of The Big 5) and October (National Freedom to Speak up Month). Further concerted communications push to coincide with new policy and launch of Charter and expanded Champions network. • CEO weekly message and Senior Leaders is used for promoting FTSU. • Dedicated FTSU pages on the new intranet. User experience to be incorporated.
Develop FTSU reporting	• Develop a model for regular reporting to the Trust Board and the sources of assurance and data to include in the report • Develop an FTSU annual report for the Board • Board level training in FTSU	• New Board and Committee report developed and will be refined further • Reporting to Divisions currently in preparation • Awaiting release of last e-learning module from HEE and NGO . Two staff and manager modules already published.

4. Implementation of the Trust's new Freedom to Speak Up Vision and Strategy
Raising Concerns Policy

Raising Concerns Policy

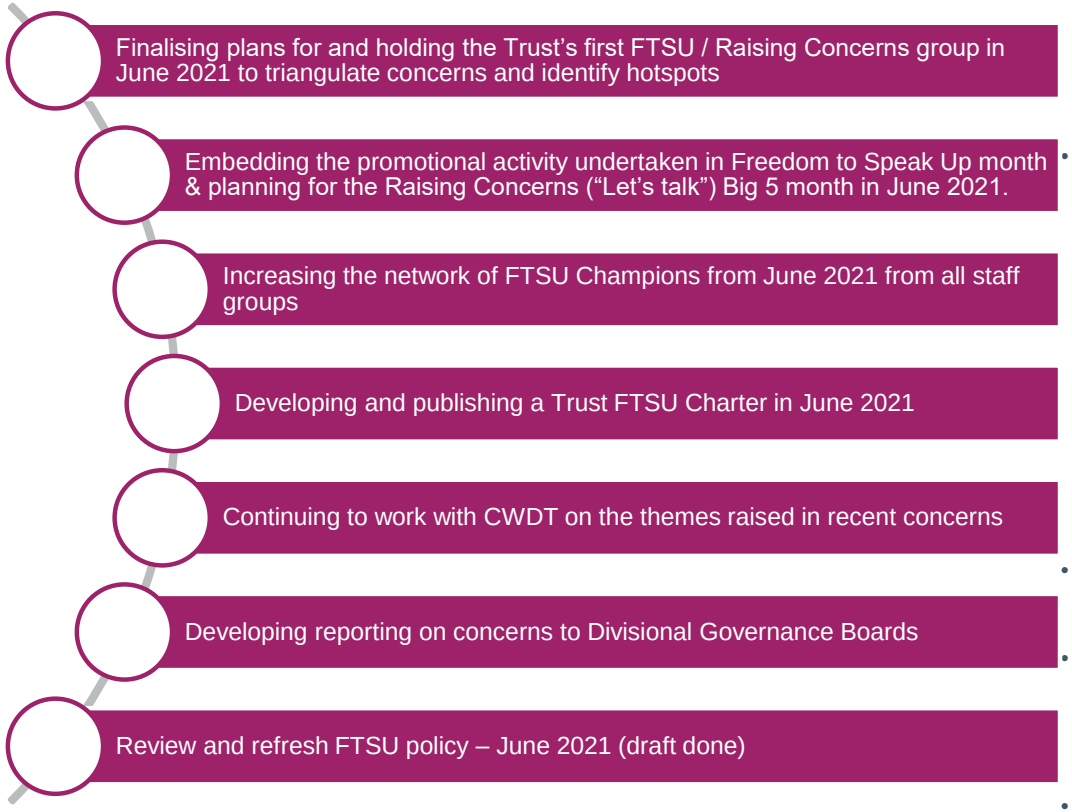
- As noted in earlier meetings, the Raising Concerns Policy was due for review at the end of January 2021. We are anticipating new guidance and an updated model policy to be published by the National Guardian's Office imminently (it was originally due to be published in December and was moved back to January). It is important that any significant overhaul and communication of the updated policy reflects the updated national guidance.

- Alongside this, work is ongoing within the Trust to clarify aspects of how the Trust deals with wider concerns and this work is expected to be completed by mid May, the existing policy has been reviewed and while there are opportunities to further strengthen this, it is suggested that an updated policy be brought for approval and communicated to staff once the internal work to resolve broader handling of concerns is completed and the national guidance is published which is imminently anticipated.

- In line with the Trust's broader approach on Trust-wide policies, it was previously agreed that the review date on the policy be extended by three months to allow for the national guidance and internal work to be completed.

4. Implementation of the Trust's new Freedom to Speak Up Vision and Strategy

Priorities for the next quarter



- The FTSU Guardian's priorities over the next quarter focus on the actions necessary to implement the new FTSU vision and strategy agreed by the Board in September 2020, including those steps identified as priority actions for 2020/21 that would have an immediate impact on the profile and impact of FTSU.

- A new role description for FTSU Champions has been developed and this will be launched in the coming weeks with a view to refreshing the Champions' network. A number of FTSU Champions have withdrawn from the roles in recent months citing work pressures connected with Covid-19. The Guardian at this time has recruited 1 new champion band 6 biomedical scientist working in the histopathology department and is currently in discussion with two porters. Our ultimate aspiration is to recruit several dozen new Champions, including a Champion in every Care Group and across each of the corporate departments. This, however, will take time and we are taking a step-by-step approach to recruitment to ensure we have the time and resource to put in place appropriate training and support to new Champions. We are seeking to recruit Champions that reflect the full diversity of our staff – both in terms of roles and protected characteristics.

- Further collaborative working with HR – currently being finalised and update will be provided in next report.

- By June to coincide with "Speak up Month" we plan to launch a new FTSU Charter – setting out clearly what staff can expect when they raise a concern and for staff who have a concern raised in relation to them what they too can expect from the process. We will also be consulting Staff Side on this.

- In May, we plan to hold our first Raising Concerns group, a meeting designed to bring together and triangulate a broad range of data – FTSU, Employee Relations, patient safety, complains and other data – to identify emerging hotspot areas that may require / benefit from additional support and / or early intervention to address emerging issues.

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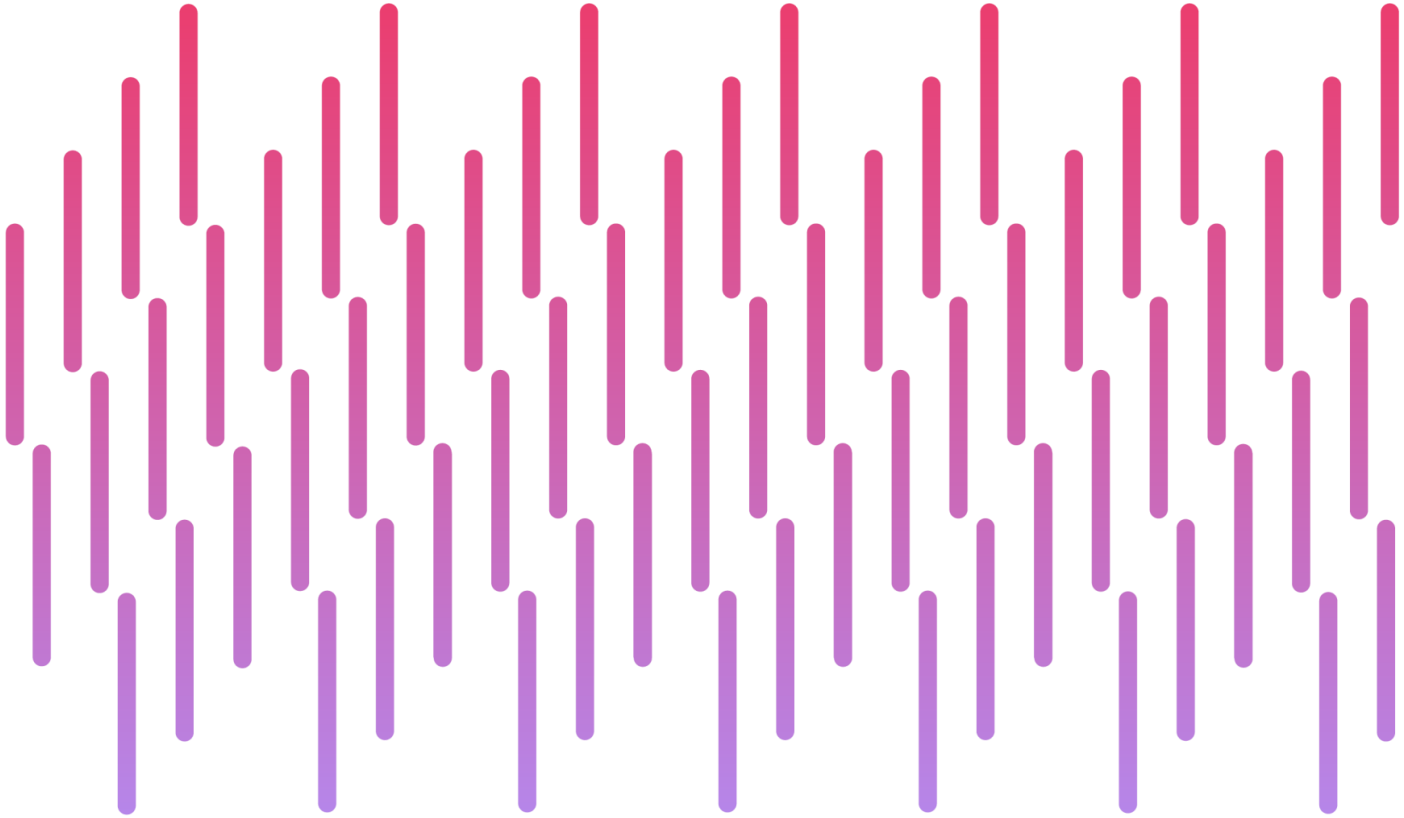
5. Freedom to Speak Up Guardian Survey 2020

High level themes



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5. Freedom to Speak Up Guardian Survey 2020
Key themes and issues

- 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 pages that follow set out the major themes and recommendations for action that emerge from the 2020 FTSU Guardians Survey. Given the timing of the publication, further analysis and implications for the Trust will be conducted and will be presented to the Committee in the next report.
- 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.

5. Freedom to Speak Up Guardian Survey 2020

Key findings

Support for the FTSU Guardian role

- There is a gap between how valued FTSUGs felt by senior leaders compared with middle managers. 85% of FTSUGs said they felt valued by senior leaders, compared with feeling valued by 68% of middle managers.
- Almost all FTSUGs (95%) felt valued by the individuals they supported.
- 83% of FTSUGs said they had access to the support they needed to carry out their role, and this had increased by 9% on the previous year.

Perceptions of speaking up

- More respondents felt the FTSUG role was making a difference in their organisation, 86% in 2020, up from 80% the previous year.
- Two thirds of respondents said their organisation had a positive culture of speaking up. But this varied by CQC rating: 90% of FTSUGs in “outstanding” organisations; 43% in organisations rated “requires improvement”.
- 80% of respondents said senior leaders supported staff to speak up (67% in RI rated organisations). Half of the respondents believed that managers supported staff to speak up (31% in RI organisations).

Demographics & characteristics of FTSU Guardians

- BAME groups are under represented in Guardian roles nationally: 90% of FTSUGs identified as white compared with 79% of the overall NHS workforce. 9% of FTSUGs were from BAME groups.
- Almost three quarters (74%) of FTSUGs were female. 6% identified as LGBTQ+. 17% said they had a physical or mental health condition or long term illness.
- Most respondents said that their age, ethnicity, gender, sexual orientation and other protected characteristics has no influence on whether workers spoke up to them.

Detriment after speaking up

- Detriment after speaking up remained a concern. Less than half (48%) of respondents said people in their organisations did not suffer for speaking up.
- There were diverse sources of detriment with line managers and middle managers more likely to be reported as a common source. Board members were less likely to be a source of detriment.
- 39% of respondents said that action taken in response to reports of detriment for speaking up was improving. 36% said it was the same and 2% said it was getting worse.

Barriers to speaking up

- There is a link between CQC rating and barriers to speaking up. 50% of respondents said that significant barriers to speaking up did not exist in their organisation. The figure was 67% for organisations rated “outstanding”, 51% for “good”, and 30% for “requires improvement”.
- Groups identified as most commonly facing barriers to speaking up were: BAME groups; LGBTQ+ groups; disabled groups and those with long term conditions; workers without regular IT access; lower banded staff; students; junior doctors on rotation.

Speaking up training

- 71% of respondents said speaking up training was available to all workers in their organisations. The figure was 66% among “requires improvement” rated organisations.
- Many FTSUGs said speaking up training should be mandatory. Such training was already mandatory in many organisations. Where training was not mandatory, take up was often low.
- The Covid-19 pandemic had had a negative impact on speaking up training, with training being paused or moved online.

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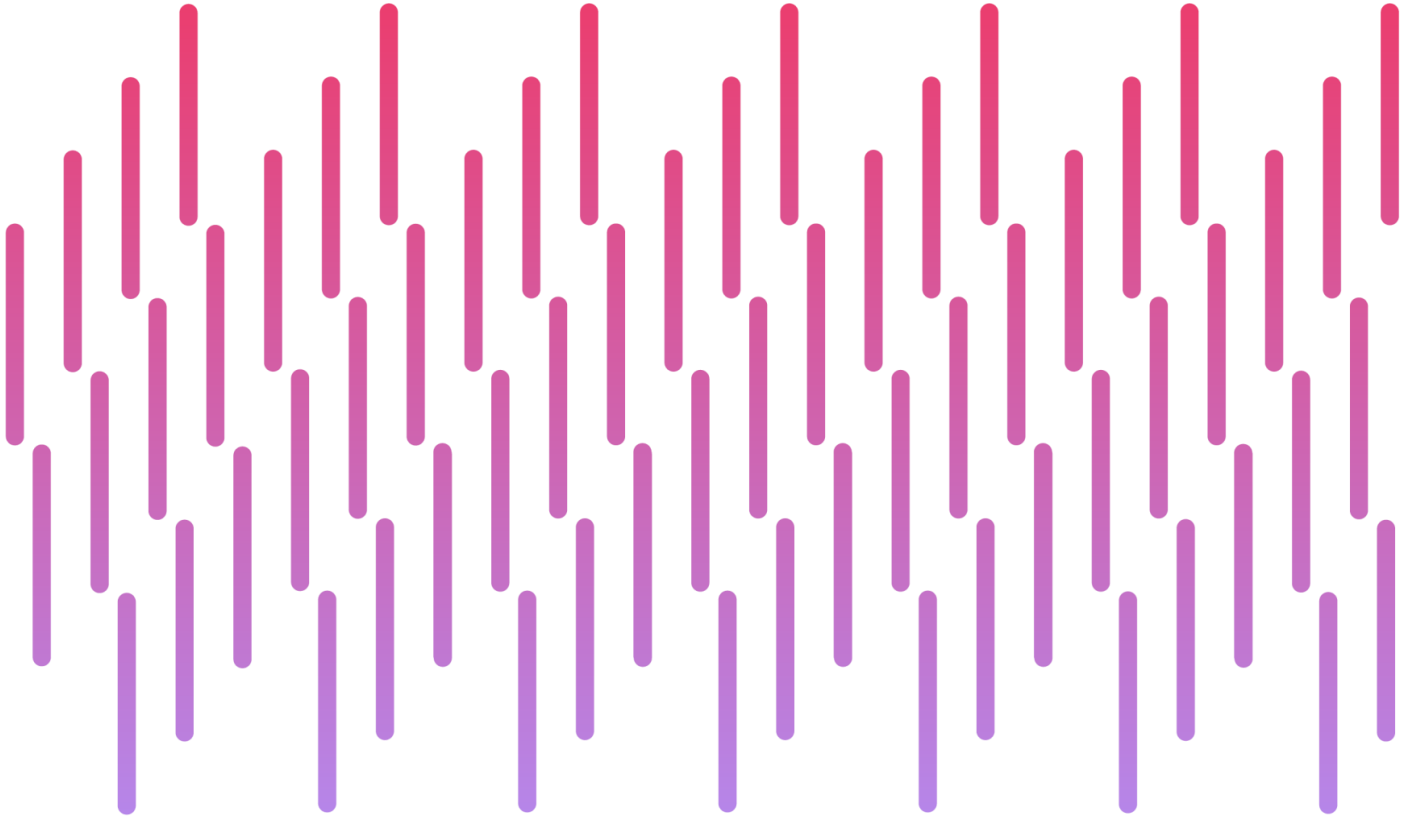
5. Freedom to Speak Up Guardian Survey 2020

Recommendations and actions for FTSU Guardians, leaders and the system

- The 2020 FTSU Survey also contained a number of recommendations to organisations. These are set out below.
- The FTSU Guardian and Executive Lead will work with colleagues to ensure that the Trust's plans for strengthening FTSU at St George's incorporates these:

Appointment	Leaders should appoint FTSU Guardians through fair and open competition; assure themselves that there are no barriers to anyone who may want to apply for the FTSU role; and take steps to assure themselves that existing arrangements have the confidence of the workforce
Ring-fenced time	Leaders should provide FTSU Guardians with ring-fenced time for the role, taking account of the time needed to carry out the role and meet the needs of workers in their organisation. Leaders should be able to demonstrate the rationale for their decisions about how much time is allocated to the role.
Feedback on performance	FTSU Guardians must, with the necessary support of their leaders, including provision of sufficient ring-fenced time, gather feedback on their performance.
Speaking Up training	Leaders should provide effective speaking up training for all workers, ensuring this meets the expectations set out in the national guidelines published by the NGO.
Barriers to speaking up	Leaders should work with their FTSU Guardians to identify potential groups that face barriers to speaking up, and work towards addressing those barriers.
FTSU Guardian characteristics	Leaders should seek assurance that their speaking up arrangements are effective for workers.
Detriment	Leaders must communicate that detriment will not be tolerated, act to prevent detriment occurring and look into cases of detriment when it is reported.



Freedom to Speak Up: Q4 2020/21 Report to the Trust Board
St George's University Hospitals NHS Foundation Trust

Freedom to Speak Up

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4.1

Meeting Title:	**Trust Board**		
Date:	27 May 2020	**Agenda No**	**4.1**
Report Title:	**Audit Committee Report**		
Lead Director/ Manager:	Elizabeth Bishop, Chair of the Audit Committee		
Report Author:	Elizabeth Bishop, Chair of the Audit Committee		
Presented for:	Assurance		
Executive Summary:	The report sets out the key issues discussed and agreed by the Committee at its meetings on 15 April 2021 and 18 May 2021.		
Recommendation:	The Board is asked to: • **Note this report;** • **Endorse Committee Annual Review and approve the proposed changes to the Terms of Reference; and** • **Approve the Provider Licence Self-Assessment (agenda item 4.1.1).**		
Supports			
Trust Strategic Objective:	Balance the books, invest in our future.		
CQC Theme:	Well Led		
Single Oversight Framework Theme:	Finance and use of resources, Leadership and Improvement capability		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A
Appendices:	Committee Annual Report and associated appendices		

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4.1

Audit Committee Report
27 May 2021

Matters for the Board's attention

The Audit Committee met on 15 April and 18 May 2021 and agreed to bring the following matters to the attention of the Board.

1. External Auditors Report & Annual Report and Accounts 2020-21 Preparations

1.1. External Audit 2020-21 Plan

The Committee considered the progress made to date in completing the 2020-21 external audit which would be completed by Grant Thornton. The Committee was assured that good progress was being made. In March, auditors had attended three of the Trust's year-end stock takes given the centrally procured stock to the audit this year. There remained uncertainty as to whether or not stock would be material, however Grant Thornton reported that the current risks around stock had been addressed. External auditors also suggested that the Trust was in a good position and ahead of other Trusts in the level of progress made on completion of the audit despite the complex regulatory environment and the added challenges presented by Covid-19. As previously reported, the auditors would develop a more in-depth value for money assessment report and the Committee learnt in May 2021 that the National Audit Office, in recognition of the complexity of the report, had decoupled the deadline for the report from the NHS Improvement (NHSI) timeframe for submission of the Annual Report and Accounts. The Committee would consider the final value for money report in July 2021 a head of the September 2021 submission to the National Audit Office. The Committee also reflected on the challenges facing the Trust in relation to confirming sustainability, particularly in the context of there being clarity only on the first six months of the 2021/22 financial year.

1.2. 2020-21 Annual Accounts – Finance Update

The Committee explored the early assumptions and the draft annual financial statements at its April and May meetings respectively. The Trust continued to explore how to manage centrally allocated stock with other South West London providers. The Trust's annual financial statement was in line with the month 12 position reported to the Finance and Investment Committee in April 2021. This year, the level of the Trust's impairment (£31.5m) had increased as a result of the independent assessment of the Trusts land and property valuation. The increase related to demolished buildings and this sum would be written-off. Whilst the Committee noted and understood the reason for the increased impairment sum it asked the Finance and Investment Committee to conduct a wider exploration of how the Trust spends capital monies which do not add long-term value. External auditors would validate the findings from the independent land and property valuation. The Trust assumes an increase in the cash position, currently £36m, due to an increase in payable debt. This cash position would reduce as the Trust makes payments for such project as the development of the Queen Mary Hospital theatres. The Trust had also made significant good progress on recovering its aged debts.

The Committee was pleased with the very good progress made on developing the financial accounts noting that preparations for the year end accounts were in good shape.

1.3. 2020-21 Draft Annual Report

The Committee considered an early draft of the annual report at its meeting in May 2021 having considered the overarching themes and messages at its meeting in April 2021. As reported previously, the requirements for the annual report had been modified this year to

limit the reporting requirements on Trusts in the context of Covid-19. These were set out in the NHS Foundation Trust Annual Reporting Manual published in February 2021 and included dispending with the requirements for the inclusion of a section on performance analysis and the inclusion of the quality report. However, given the high degree of public focus on the NHS in light of the pandemic, the Trust had decided to proceed with a fuller annual report than the regulations required given the level of public interest in the NHS as a result of the pandemic, and the importance of public accountability during what had been an extraordinary year for the Trust and the NHS as a whole. The Committee noted that the draft annual report was in a very good place, read well and was coherent. The Committee noted the sections where content was awaited from various teams and requested more information be included on the environmental and sustainability analysis and in relation to cardiac surgery. The Committee will review a further draft at the start of June ahead of considering the full and final draft report at its meeting on 14 June.

1.4. 2020-21 Draft Quality Report & Accounts

The Committee considered the early draft of the annual report in May 2021 ahead of the discussion at the Quality and Safety Committee. As was the case last year the Trust was not required to produce a quality report and accounts for 2020/21 in light of the wider-NHS response to Covid-19 pandemic. Consequently, the external auditors would not scrutinise or provide an independent assurance report on the quality report and account. The Trust would instead ensure that it could evidence the robustness of the data included in the reports with additional scrutiny steps included in the process. The Committee commented that the priorities around nosocomial infections should be strengthened with more effective triangulation with other areas of work and learning.

The Committee commended the progress made on developing the report which was a voluntary endeavour. The Committee also noted that in spite of the focus on Covid-19 the Trust had made good progress on some of the 2020/21 priorities.

2. Internal Auditors Reports

The Committee considered the following reports from internal auditors:

- Internal Auditors Progress Reports and Recommendation Tracker
- Draft Head of Internal Audit Opinion
- Friends and Family Test (Reasonable Assurance)
- Safeguarding Children (Reasonable Assurance)
- Temporary Staffing (Reasonable Assurance)

While there had been steady progress completing internal audits for 2020/21 the Committee was minded that staff engagement had been impacted by the Trust being heavily focused on managing the impact of new waves of Covid-19 cases. This had also impacted on the completion of internal audit recommendations and the Committee had agreed to send a targeted message to key executive leads about the lack of progress against outstanding audit recommendations and progressing completion of key internal audits such as the audits on Consent and the action related to development of the Cyber Security plan.

Despite the lack of progress made on completing the quarter four audit programme the Committee was pleased that the internal audit reviews completed all received '*reasonable assurance'*. Many of the findings related low level issues related update documentation consistently across the Trust which was the case in the Friends and Family Test, issues with the capacity in safeguarding team which were addressed after the review was completed and administration and regularising reporting of agency and bank staff usage related to the temporary staffing report.

Whilst there were a number of actions internal reviews to be completed the draft head of internal audit report for 2020/21 have concluded that there was '*reasonable assurance'* that the Trust had effective controls in place.

3. Internal Compliance and Assurance

The Committee considered the following compliance and internal control reports:

- Counter Fraud Report, 2020/21 Self-Assessment and Annual Report and 2021/22 Workplan
- Review of Board Assurance Framework Internal Controls and Governance Mechanisms
- Annual Self-Certification with Foundation Trust Licence (*see agenda item 4.1.1*)
- Breaches and Waives Report
- Losses & Special Payments Report
- Aged Debts Report

3.1. Review of Board Assurance Framework Internal Controls and Governance Mechanisms

The Committee conducted a comprehensive review into the internal controls, systems and mechanisms in place to manage the development and scrutiny of the Board Assurance Framework and the systems related to general risk management. The Committee recognised that the BAF had been developed significantly in 2020/21 and that it was now clear about the controls in place, sources of assurance and actions being taken to address identified gaps. It noted that there was variation in how some Committees of the Board reviewed the BAF and explored how to evidence that Board Committees had effectively reviewed the strategic risks assigned to it in order to provide assurance to the Trust Board that these risks were being managed. The Committee recognised that the quarterly discussion of the BAF at the Board provided an opportunity for the Board collectively to review and challenge the assurances received at Committee, but requested that further consideration be given to how to demonstrate effective scrutiny of the Board Assurance Framework by Board Committees. The Committee noted that the target risk scores set by the Board in September 2020 would not be achieved across a number of strategic risks. In some cases, this had been due to the impact of the Covid-19 pandemic and in others targets set by the relevant Executive leads and Committees had been realistic within year.

3.2. Annual Self-Certification with Foundation Trust Licence

The Committee considered and endorsed the annual self-assessment with foundation trust licence which is presented on agenda item 4.1.1. The Committee commends the report to the Board for approval.

3.3. Counter Fraud

The Committee also received the Counter Fraud report and there were no material matters of concern raised. The Committee endorsed the annual self-assessment, annual report and 2021/22 workplan. The Committee also note that the Trust, when compared with other trusts, did very well in terms of Counterfraud cases created, closed and civil sanctions. It was however noted that when compared with other organisation the Trust did not do so well with the level of high value fraud recovered.

3.4. Losses and Special Payments Report

The Committee considered and noted the report on losses and special payments.

3.5. Aged Debts Report

The Committee noted the report on the management of aged debts. The Trust had conducted a detailed analysis of the debt provision. At month 12 the bad debt provision had increased to £14.7m due to the change in age profile of the debt and the considered increase in the amount of doubtful debt. The Trust had exhausted all possible avenues to recover aged debt and therefore improved its performance.

3.6. Breaches and Waivers

At the request of the Committee noted the enhanced report on breaches and waivers quarter four report which included more detail behind each breach and/or waiver. As expected the number of waivers related to capital had increased but the value had not increased. Changes in staff had resulted in the increase in breaches and therefore more training would be provided to teams. Positive engagement across the Trust had resulted in a better performance.

3.7. Committee Annual Governance

The Committee also completed its annual effectiveness review in line with its terms of reference good corporate governance practice. The Committee's annual report, work plan the effectiveness review is attached for information and endorsement by the Board. The Committee also recommends that the Board approves the proposed minor changes to its terms of reference which include the following:

Update the membership and attendees lists to reflect current working of the Committee (section 7)

Inclusion of updates governance structure reflecting changes made to Executive operational governance groups in 2020/21 (section 11);

Updates to reflect changes in Executive job titles (section 12);

A minor changes to the requirements of the Committee's report to include specific reference to highlighting any areas where the Committee felt it lacked assurance (section 13)

Recommendation

The Board is asked to:

- **Note this report;**
- **Endorse Committee Annual Review and approve the proposed changes to the Terms of Reference; and**
- **Approve the Provider Licence Self-Assessment (agenda item 4.1.1).**

Elizabeth Bishop
Audit Committee Chair, NED
March 2021

4.1

ANNUAL BOARD COMMITTEE REPORT

AUDIT COMMITTEE

1 April 2020 – 31 March 2021

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Audit Committee: 2020/2120 Annual Report

1 Introduction

The Audit Committee has been established to ensure that that the Trust has in place effective mechanisms and systems of internal control and provides the Board of Directors with an independent review of the Trust's financial, corporate governance, assurance and risk management processes. It utilises, oversees and draws on the work of independent internal and external auditors to provide assurance that these systems are sound and being adhered to across all areas of the Trust.

This report sets out the work of the Committee during the reporting period 1 April 2020 to 31 March 2021. The Committee submits a report to the Board after each meeting setting out the key discussions of the Committee, areas of assurance and matters for escalation to the Board. The purpose of this annual report is to provide a wider perspective on the work of the Committee over the past year and in so doing provide assurance to the Board that the Committee has discharged its role in line with its approved terms of reference, in line with good corporate governance practice.

2 Committee purpose and duties

The Committee's purpose and duties are set out in its terms of reference as approved by the Board on 28 May 2020. These set out that the Committee should:

- Provide the Board of Directors with an independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the Trust's activities (clinical and non-clinical) both generally and in support of the Annual Governance Statement.
- Oversee the work programmes for external and internal audit and receive assurance of their independence and monitor the Trust's arrangements for corporate governance.
- Review the integrity of financial statements prepared in support of the Trust's Annual Accounts and oversee the production of the Annual Report and Accounts on behalf of the Board.
- Play a key role in ensuring the Trust is well led and governed effectively and that it has in place the systems, internal controls and risk assurance processes that enable the Trust to deliver on its strategic and corporate objectives.

In line with good corporate governance practice, the Committee's terms of reference have been reviewed. There are minor changes are proposed as set out in section 6 of this report and in Appendix 2.

3 Committee Membership and Meeting Attendance

3.1 Members and Attendees

During the reporting period (April 2020 – March 2021) the following individuals were members of, or regular attendees at, the Committee:

Members/ Attendees	Role		Period
Elizabeth Bishop	Chair	Non-Executive Director	April 2020 – March 2021
Ann Beasley	Member	Non-Executive Director	April 2020 – March 2021
Tim Wright	Member	Non-Executive Director	April 2020 – March 2021

Members/ Attendees	Role		Period
Pui-Ling Li	Member	Associate Non-Executive Director	April 2020 – March 2021
Stephen Jones	Attendee	Chief Corporate Affairs Officer	April 2020 – March 2021
Andrew Grimshaw	Attendee	Chief Financial Officer	April 2020 – March 2021
Tom Shearer	Attendee	Acting Chief Financial Officer	January – March 2020

In 2020/21, the membership of the Audit Committee included the chairs of the Finance and Investment Committee and a non-executive Committee member of the Quality and Safety Committee and of the Workforce and Education Committee. The internal and external auditors attended each meeting of the Committee.

3.2 Committee Meeting Attendance

In 2020/21, the quorum for each meeting of the Committee was two members. For the avoidance of doubt only non-executive directors were members of the Committee.

The Committee held a total of five formal meetings in the reporting period and the attendance of members is recorded below. All meetings were quorate.

Members/ Attendees	Role	Period
Elizabeth Bishop	Chair	5/5
Ann Beasley	Member	4/5
Tim Wright	Member	4/5
Pui-Ling Li	Member	4/5

The attendance of regular attendees at the Committee across the 5 meetings held in the reporting period are recorded below. In line with the requirements that audit committees should only comprise non-executive directors as members, these individuals were not members of the Committee and did not form part of the quorum.

Members/ Attendees	Role	Period
Stephen Jones	Attendee	4/5
Andrew Grimshaw	Attendee	4/5
Tom Shearer	Attendee	4/5

Other executive directors and senior leaders including the Chief People Officer, Chief Nurse, Chief Medical Officer, Chief Information Officer, Counter Fraud Lead also attended meetings of the Committee during the year to present specific reports or provide updates on internal audit reviews.

4 Committee activity and focus

The Committee develops a forward programme of work (see Appendix 1) at the start of each financial year which is intended to ensure it fulfils its purpose and duties as set out in the Committee's agreed terms of reference. The matters discussed and considered at the Committee during the period (April 2020 – March 2021) are set out in Appendix 2 mapped across the key duties as recorded in the approved terms of reference.

Each meeting of the Committee had a full agenda and the Committee submitted reports to the Board following each meeting. The key areas of focus of the Committee in 2020/21 are outlined below. This draws on the matters set out within the Committee's report of each meeting to the Board during 2020/21.

4.1 External Audit

The Committee members periodically held private meetings with the external auditors, Grant Thornton LLP, ahead of its meetings and during these meetings there were no issues of material concern raised. During the period the Committee received regular progress updates at each meeting from the external auditors on the preparations for and completion of the external audit of the Trust year-end financial statements, the annual report and the quality accounts during the period. The Committee supported the completion of a successful audit process of the 2019-20 financial year despite the material changes in the approach to the audit process as a result of the Covid-19 pandemic and the changes in the reporting requirement. The Committee reviewed the plans for conducting the 2020/21 audit and agree to recommend to the Board the audit fee for the 2020/21 audit. External auditors have also supported the Trust to understand the implications for the introduction of the new regulations under International Financial Regulation 16 (Leases).

4.2 Internal Audit

The Committee members periodically held private meetings with the internal auditors, TIAA, ahead of its meetings and during these meetings there were no issues of material concern raised. During the period the work of internal auditors was impacted by the onset of the Covid-19 pandemic. With key staff focused on delivering operational priorities, particularly during the first wave of the pandemic, much of the audit work was deferred in quarter one to later in the financial year. The Committee considered 11 internal audit reviews with six reviews work in progress at the time of this report.

Assurance Assessments	2020/21	2019/20
Substantial Assurance	1	4
Reasonable Assurance	7	10
Limited Assurance	3	5
No Assurance	0	0

The Committee was pleased that no reviews received a '*no assurance*' rating, one was rated *'substantial assurance'*, seven rated *'reasonable assurance'* and three had a '*limited assurance'* rating. The Committee's close scrutiny of the internal audit recommendation tracker, and the prior review of this by the Risk and Assurance Group, resulted in the outstanding recommendations being proactively progressed, however the operational focus on Covid-19 had impacted on progressing some outstanding actions and the Committee sought assurance that overdue actions were being progressed.

The Committee was pleased that, one again, it was able to give assurance that the Trust had in place good financial internal controls which was reflected in the substantial assurance ratings for the Trust financial reporting and budgetary control and core finance systems.

The Committee also commended the areas such as safeguarding children, procurement, risk management, payroll, friends and family and complaints, which received a reasonable assurance rating during the period. In many of these areas the Committee was assured that the executive understood the issues and had a grip on the actions to improve the systems of internal governance and control.

The Committee had flagged concerns about Consultant Job Planning but was reassured by the good progress made on the use of medical consultants. Culture, diversity and inclusion were significant areas of focus for the Trust and, as a result, the Committee asked the Workforce and Education Committee to keep

under review the progress against the bullying and harassment internal audit recommendations. While the Committee appreciated the challenges and good work done by the estates and ICT teams it was also concerned by the limited assurance ratings received in both audits. It was reassured that the management team was now taking control of the issues but recognised that future Covid-19 surges my impact these areas. In particular, the Committee indicated it would continue to monitor areas around data protection and cyber-security given the risks involved.

4.3 Governance, Internal Control and Risk Management and Governance Manual

In addition to reviewing the outputs of external and internal auditor, a core element of the Committee's focus in 2020/21 was monitoring the Trust's corporate governance, compliance and systems for internal control.

To this end the Committee reviewed and recommended that the Board approve an update to the Trust's Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions. This made changes to the provisions relating to estates governance following an independent external report. The Committee also considered and endorsed the progress made in strengthening the internal controls and increased transparency around the Trust's declaration of interests and Trust-wide policies. The Committee reviewed in detail the internal control environment in relation to the Board Assurance Framework and Freedom to Speak Up, and noted the improvements in both areas achieved during 2020/21. The Committee also approved an updated Risk Management Policy. The Committee recognised and welcomed the indications of additional rigour in the Trust's internal governance processes which had resulted in issues such as HR employee relations control, bank staff pay and patient transport issues being effectively escalated to the Committee. Although these highlighted issues of internal control, some of which were historic, overall this demonstrated that the Trust's systems and governance framework was working well and issues were being identified and escalated appropriately.

4.4 Trust Annual Report and Accounts

In June 2020, the Committee endorsed the final draft annual report, annual accounts and quality report for 2019/20 along with the external auditor's opinions and assurance of the production and the true and accurate nature of the financial reports for 2019/20. As noted above, the audit process was impacted by the Covid-19 pandemic. This resulted in changes to the reporting requirements as set out in an updated NHS Foundation Trust Annual Reporting Manual including the extension of the timeline to produce and submit the year-end reports, changes in the requirement to produce a quality report, and a decision that there would be no external assurance from auditors on the quality report. In light of this, the Committee asked the Quality and Safety Committee to provide detailed scrutiny of the quality report given the absence of external assurance.

The Trust had received an adverse opinion from external auditors in relation to its value for money position since 2014/15 however as a testimony to the Trust's strong financial governance and controls the external auditor, Grant Thornton, issued a qualified 'except for' value for money conclusion which demonstrates that the Trust had proper arrangements to secure economy, efficiency and effectiveness in its use of resources. The audit opinion was predicated on the good progress the Trust had made to improve its financial position, the Trust moving out of quality special measures and reducing its annual deficit. The Trust, however, remained in financial special measures until December 2020.

The Committee recognised the significant level of good work to produce these reports and ensure, in unprecedented times, that the audit was completed effectively and it thanked staff for their hard work.

In March 2021, the Committee reviewed and agreed plans for the production of the 2021/22 annual report and accounts, the requirements and timelines for the submission of which had again been impacted by the Covid-19 pandemic.

4.5 Financial Reporting and Accounts Review

The Committee received regular reports on aged debts, losses and compensation and breaches and waivers. The Committee was able to confirm that these internal controls and systems had significantly improved which had resulted in a significant reduction in values of age debts, losses and compensation and number of breaches and waivers.

4.6 Counter Fraud

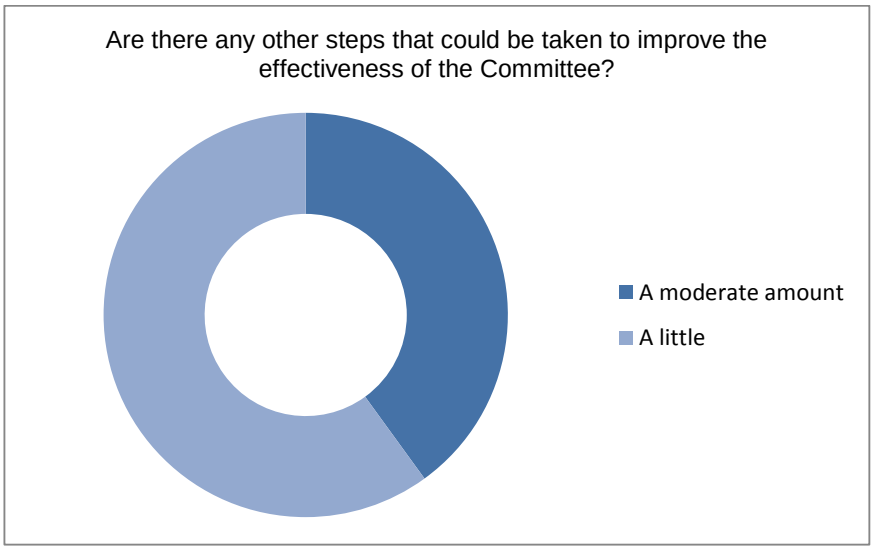
The Trust's counter fraud reporting had improved during the year and the Committee gained assurance on the robustness of the processes in place. Internal Auditors had been providing support to the Trust's counter fraud team which resulted in increased training and awareness around the Trust.

5 Committee Effectiveness

The Committee conducted a review of its effectiveness and the report is attached in Appendix 5. Overall, the results of the review suggest that the Committee is working very effectively, albeit with some areas in which it can improve. The Committee had completed all the actions from the 2019/20 survey and as a result only the following actions were identified to improve the working of the Committee:

- Ensure that right papers are submitted to the Committee and they were sufficiently concise
- Effectively using assurance mapping to target the areas of greatest risk
- Induction/training for new members of the Committee

Figure 1



6 Committee Forward Plan and Terms of Reference

The Committee's proposed forward work plan for 2021/22 is attached (see Appendix 4. The nature of Committee means that key aspects of its work are driven by the work of the internal auditors, external auditors and counter fraud teams. The workplan for 2021/22 reflects the principles set out in the NHS Audit Committee Handbook and also reflects the required matters for the Committee's review.

The Committee's terms of reference have been reviewed and minor changes are proposed to to reflect changes to the Trust's executive governance structures introduced in June 2020 and update the list of regular attendees at the Committee to include the Deputy Chief Financial Officer. The Terms of Reference are set out at Appendix 2, and proposed amendments are set out as tracked changes.

7 Conclusion and Assurance Statement

During 2020/21, the Committee worked hard to deliver its duties. Its effectiveness is reflected in the 100% effectives score from the Committee Effectiveness review. Through the work of the Committee the external auditors found no new areas unknown to the Trust that gave cause for concern and reflecting on the Head of Internal Audit Opinion the Committee can give an reasonable assurance rating on the Trust's internal controls, mechanisms and systems of corporate governance.

Appendix 1: Audit Committee Workplan 2020-2021

ITEMS	Purpose	Lead	Author(s)	Committee	07/05/2020	11/06/2020	16/07/2020	08/10/2020	14/01/2021
PRIVATE MEETINGS WITH AUDITORS									
Private meeting with Internal Auditors	Discuss	NEDs Only	N/A	N/A					
Private meeting with External Auditors	Discuss	NEDs Only	N/A	N/A					
ANNUAL REPORT, QUALITY REPORT AND ANNUAL ACCOUNTS									
Annual Report, Accounts & Quality Accounts Plans & Timetables	Note	CCAO/CFO	CCAO/CFO	TEC					
Annual Accounts, Financial Statements, Going Concern Statement including NHS Debt Write-off (Draft/Final)	Discuss/ Approve	CFO	CFO	TEC/FIC					
Annual Report including Remuneration, Workforce Report, Annual Governance Statement etc. (Draft/Final)	Discuss/ Approve	CCAO/CFO	CCAO/CFO	TEC/FIC					
Annual Quality Accounts (Draft/Final)	Discuss/ Approve	CN	DQGC	QSC/CoG					
Accounting Policies	Approve	CFO	CFO	TEC					
EXTERNAL AUDIT									
External Audit Progress Report	Discuss	EA	EA	N/A					
Annual Audit Plan & Fees	Approve	EA	EA	N/A					
Benchmarking Annual Report	Note	EA	EA	N/A					
External Audit Findings (Final)	Endorse	EA	EA	N/A					
Letter of Representation (Financial Audit) (Final)	Endorse	CEO/CFO	CEO/CFO	N/A					
Reports to Council of Governors - Quality (Account) Report and Limited Assurance Opinion (Final)	Endorse	EA	EA	N/A					
External Audit Annual Audit Letter	Receive/ Endorse	EA	EA	N/A					
INTERNAL AUDIT									
Internal Audit Progress Report	Note	IA	IA	TEC					
Internal Audit Recommendation Tracker	Note	IA	IA	TEC					
Final Internal Audit Review Reports	Note	IA	IA	TEC					
Draft Internal Audit Plan (Draft/Final)	Discuss/ Approve	IA	IA	TEC					
Draft Annual Report & Head of Internal Audit Opinion (Draft/Final)	Endorse	IA	IA	TEC					
Sector Updates and Digests (including Fraud)	Inform	IA	IA	TEC					
COUNTER FRAUD									
Counter Fraud Update Report	Discuss	CFO	CFL	TEC					
Counter Fraud Annual Report & Self-Assessment	Approve	CFO	CFL	TEC					
Counter Fraud Work Plan and Risk Assessment 2020/21	Approve	CFO	CFL	TEC					
Review of Anti-Fraud/Anti-Bribery Policy (every three years)	Approve	CFO	CFL	TEC					
FINANCE & PROCUREMENT									
Losses & Special Payments	Discuss/ Endorse	CFO	CFO	TEC/FIC					
Breaches & Waivers	Discuss/ Endorse	CFO	CFO	TEC/FIC					
Aged Debt	Discuss/ Endorse	CFO	CFO	TEC/FIC					
INFORMATION GOVERNANCE									
Information Governance Compliance Update & Annual Report	Discuss/ Endorse	SIRO	CIO	IGG/TEC					
DSP Toolkit: Update (Data Quality/Security)	Discuss/ Endorse	SIRO	CIO	IGG/TEC					
RISK MANAGEMENT									
Annual Review of Risk Management Strategy & Policy	Approve	CN	DQGC	Board					
Review of Board Assurance Framework Internal Controls and Governance Mechanisms	Discuss/ Endorse	CCAO	CCAO	Board					
CORPORATE GOVERNANCE/COMPLAINCE									
Review of Internal Auditors Effectiveness	Discuss	CCAO	CCAO	TEC					
Standing Orders, Scheme of Delegation & Standing Financial Instructions (Annual Complaince Review)	Review/ Approve	CCAO/CFO	CCAO/CFO	TEC					
Annual Review of Trust Conflicts of Interest Complaince	Note	CCAO	CCAO	TEC					
Annual Review of Compliance with Trust Policies Protocols	Note	CCAO	CCAO	TEC					
Annual Review of Trust's Clinical Audit Programme	Note	CN	DQGC	QSC					
Freedom to Speak-up Internal Controls and Policies	Discuss/ Endorse	DHROD	DHROD	WEC					
Use of Trust Seal	Note	CCAO	CCAO	Board					
COMMITTEE GOVERNANCE									
Review of Committee Effectiveness	Discuss/ Endorse	CCAO	CCAO	N/A					
Annual Committee Report to Board including Terms of Reference Update and Committee Forward Workplan	Discuss/ Endorse	CCAO	CCAO	Board					

Appendix 2: Items Considered by the Audit Committee - April 2020 – March 2021

Governance, Internal Control and Risk Management and Governance Manual	Internal Audit/External Audit		Trust Annual Report and Accounts	Financial Reporting and Accounts Review	Counter Fraud/Bribery/Corruption Arrangements and Raising Concerns
Clinical Audit Annual Programme	Internal Audit Progress Updates	Staff Appraisals	Draft/Final Annual Accounts (including financial statements)	Losses & Compensation	Counter Fraud Updates
Data Security Protection Toolkit	Internal Audit Recommendation Trackers	Core Finance	Draft/Final Annual Report (including Annual Governance Statement, Remuneration and Staff Reports)	Aged Debts	Annual Counter Fraud Report
Review of Trust Policies	Use of Staff Survey Results	Payroll	Draft/Final Annual Quality Account	Breaches and Waivers	Annual Counter Fraud Workplan & Risk Assessments
Risk Management and Board Assurance Framework Update	Key Financial Controls	Planned Maintenance	Letter of Representation (Financial Audit)	Accounting Policies	Annual Counter Fraud Compliance Self-Assessment
Declarations of Interest (Managing Conflict of Interest)	Declarations of Interest	Head of Internal Audit Opinion	Letter of Representation (Quality Account)		Counter Fraud Investigation Reports
Use of Trust Seal	Use of Consultants	Internal Audit Annual Plan & Strategy	Report on Quality Report incl. Limited Assurance Opinion to Council of Governors		Freedom to Speak-Up Guardian (Internal Controls and Mechanisms) Reports
Information Governance Compliance Update & Annual Report	Risk Management	Client Briefings and Sector Updates and Newsletters	External Audit Findings		
Standing Orders, Standing Financial Instructions, Scheme of Delegation	Data Security and Protection	Theatre and Outpatient Productivity	Report on the Audit of Financial Statements to Council of Governors		
Compliance with Trust Constitution and Code of Governance	Cerner - EPMA Project	Procurement			
Review of Internal Auditors Effectiveness	ICT Disaster Recovery	External Audit Progress Report and Sector Updates			
Board Assurance Framework - Internal Control and Mechanisms	Risk Management	External Auditors Annual Audit Plan & Fees			
IFRS 16 Review & Update					
Use of Medical Consultants (Internal Review)					
HR Internal Controls					

Other Appendices not embedded

Appendix 3: Current Terms of Reference

Appendix 4: 2021/21 Committee Workplan

Appendix 5: Committee Effectiveness Review

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

4.1

Audit Committee Terms of Reference

Approved by the Trust Board: ~~28 May 2020~~

Approval and review dates

Profile	
Document name	Audit Committee Terms of Reference
Version	1.1
Executive Sponsor	Chief Corporate Affairs Officer, Chief Finance Officer
Author	Chief Corporate Affairs Officer
Approval	
Approval group	Trust Board of Directors
Date of approval	28 May 2020
Date for next review	April 2021

1. Name of Group

The Audit Committee.

2. Authority

Establishment: The Audit Committee has been established as a Committee of the Trust Board. It is a statutory Committee as set out in the NHS Act 2006 (as amended) and is accountable to the Trust Board. Its constitution and terms of reference are as set out below, subject to amendment by the Board as necessary.

Powers: The Audit Committee is authorised by the Board of Directors to:

i. Investigate any activity within its terms of reference
ii. Seek any information it requires and all staff are required to cooperate with any request made by the Committee
iii. Request attendance of individuals and authorities from inside and outside the Trust with relevant experience and expertise if it considers this is necessary

Cessation: This is a standing, statutory Committee. Such a Committee can only be disbanded or its remit amended on the authority of the Board.

3. Purpose of the Group

The Audit Committee shall provide the Board of Directors with an independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the Trust's activities (clinical and non-clinical) both generally and in support of the Annual Governance Statement. In addition, it shall oversee the work programmes for external and internal audit and receive assurance of their independence and monitor the Trust's arrangements for corporate governance. The Committee shall also review the integrity of financial statements prepared in support of the Trust's Annual Accounts and oversee the production of the Annual Report and Accounts on behalf of the Board.

The Committee plays a key role in ensuring the Trust is well led and governed effectively and that it has in place the systems, internal controls and risk assurance processes that enable the Trust to deliver on its strategic and corporate objectives. In exercising its duties the Committee supports the Trust in achieving its vision of delivering outstanding care, every time.

4. Duties of the Group

The Audit Committee will discharge the following duties on behalf of the Board of Directors:

(a) Governance, Internal Control and Risk Management: The Committee shall review the establishment and maintenance of an effective system of integrated governance, internal control and risk management across the whole of the Trust's activities (both clinical and non-clinical) that supports the achievement of the Trust's objectives. In particular, the Committee shall:

i. Review the risk and control related disclosures statements prior to endorsement by the Board. This shall include the Annual Governance Statement, Head of Internal Audit Opinion, External Audit Opinion and / or other appropriate independent assurances.

ii. Ensure the provision and maintenance of an effective system of financial risk identification and associated controls, reporting and governance structure.
iii. Maintain an oversight of the Trust's general risk management structures, processes and responsibilities especially in relation to the achievement of the Trust's strategic and corporate objectives and provide assurance to the Board on the effectiveness of these.
iv. Oversee the robustness of the arrangements for providing the Board with assurance on the strategic risks identified in the Board Assurance Framework
v. Receive reports from other assurance committees of the Board regarding their oversight of risks relevant to their activities and assurances received regarding controls to mitigate those risks. This shall include the clinical audit programme overseen by the Trust's Quality and Safety Committee.
vi. Review the adequacy and effectiveness of policies and procedures: (a) by which staff may, in confidence, raise concerns about possible improprieties or any other matters of concern, (b) to ensure compliance with relevant regulatory, legal and conduct requirements.

(b) Internal audit: The Committee shall ensure that there is an effective internal audit function that meets mandatory standards and provides appropriate independent assurance to the Committee, Chief Executive and the Board of Directors. It shall achieve this by:

i. Reviewing and approving the Internal Audit strategy and annual Internal Audit plan to ensure that it is consistent with the audit needs of the Trust (as identified in the Assurance Framework)
ii. Consider the major findings of internal audit work, their implications and the management's response and the implementation of recommendations and ensuring coordination between the work of internal audit and external audit to optimise audit resources.
iii. Conduct a regular review of the effectiveness of the internal audit function.
iv. Periodically consider the provision, cost and independence of the internal audit service.

(c) External audit: The Committee shall review the findings of the external auditors and consider the implications and management's response to their work. In particular, the Committee shall:

i. Discuss and agree with the external auditor, before the audit commences, the nature and scope of the external audit as set out in the external audit plan and ensure coordination with other external auditors in the local health economy, including the evaluation of audit risks and resulting impact on the audit fee.
ii. Review external audit reports including the report to those charged with governance and agree the annual audit letter before submission to the Board.
iii. Agree any work undertaken outside the annual external audit plan (and consider the management response and implementation of recommendations).
iv. Ensure the Trust has satisfactory arrangements in place to engage the external auditor to support non-audit services which do not affect the external auditor's independence.

The Committee shall also work with the Council of Governors on the appointment or retention of the external auditors.

(d) Financial reporting and accounts review: The Committee shall ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to the completeness and accuracy of the information provided to the Board. The Committee shall review financial reporting through the year and the financial statements and annual report before submission to the Board. Particularly focusing on:

i. The wording of the Annual Governance Statement and any other disclosures relevant to the terms of reference of the Committee.
ii. All narrative sections of the Annual Report to satisfy itself that a fair and balanced picture is presented which is neither misleading nor consistent with information presented elsewhere in the document.
iii. Changes in, and compliance with, accounting policies, practices and estimation techniques.
iv. The meaning and significance of the figures, notes and significant changes.

v. Areas where judgement has been exercised and any qualitative aspects of financial reporting.
vi. Explanation of estimates or provisions having material effect.
vii. The schedule of losses and special payments, ensuring these have received appropriate approval.
viii. Any unadjusted (mis)statements.
ix. Significant adjustments arising from the audit.
x. Any reservations and disagreements between the external auditors and management which have not been satisfactorily resolved.
xi. The Letter of Representation.

In line with the Trust's Scheme of Delegation (sections 11.1 and 11.2) the Committee shall also monitor the integrity of the Trust's financial statements of the Trust, and any formal announcements relating to the Trust's financial performance, reviewing significant financial reporting judgements contained in them, to ensure the completeness and accuracy of information provided to the Board.

(e) Counter Fraud, Bribery and Corruption Arrangements: The Committee shall ensure that the Trust has in place:

i. Adequate measures to comply with the Directions to NHS Bodies and Special Health Authorities respect of Counter Fraud 2017.
ii. Appropriate arrangements to implement the requirements of the Bribery Act 2010.
iii. A means by which suspected acts of fraud, corruption or bribery can be reported.

The Committee shall review the adequacy and effectiveness of policies and procedures in respect of counter fraud, bribery and corruption.

The Committee shall formally receive an annual report summarising the work conducted by the Local Counter Fraud Specialist for the reporting year in line with the Secretary of State's Directions.

(f) Raising concerns: The Committee shall review arrangements that allow staff of the Trust and other individuals where relevant, to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters to ensure that:

i. there are systems in place that allow individuals or groups to draw formal attention to practices that are unethical or violate internal or external policies, rules or regulations.
ii. arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action.
iii. concerns are promptly addressed.
iv. safeguards for those who raise concerns are in place and operating effectively.

(g) General governance

i. On behalf of the Board of Directors, review the operation of and proposed changes to the standing orders, standing financial instructions, codes of conduct, standards of business conduct and the maintenance of registers.
ii. Examine any significant departure from the requirements of the foregoing, whether those departures relate to a failing, overruling or suspension.
iii. Review the schemes of delegation and authority.
iv. Review compliance against the Constitution, Licence and Code of Governance.

(h) Management

The Committee shall request and review reports and positive assurance from directors and managers on the overall arrangements for governance, risk management and internal control and may also request specific reports from individual functions within the Trust as necessary.

(i) Annual work plan and Committee effectiveness

Agree an annual work plan with the Trust Board based on the Committee's purpose (above) and conduct an annual review of the Committee's effectiveness and achievement of the Committee work plan for consideration by the Trust Board.

In exercising its duties, the Committee will provide appropriate challenge and support whilst living the Trust's values.

5. Chairperson

A Non-Executive Director will chair the Audit Committee and his/her absence, an individual to be nominated by the remaining members of the Committee will take the chair.

The Chief Corporate Affairs Officer and Chief Financial Officer will be the Executive Leads for the Audit Committee.

6. Composition of the Group

Membership:
The Committee membership comprises three Non-Executive Directors, one of whom is the Committee Chair, and one Associate Non-Executive Director. Only Non-Executive Directors (other than the Trust Chairman) may serve as members of the Audit Committee.

Name	Title	Role in the group
Elizabeth Bishop	Non-Executive Director	Committee Chair
Ann Beasley	Non-Executive Director	Member
Tim Wright	Non-Executive Director	Member
Pui-Ling Li	Associate Non-Executive Director	Member

Members are expected to make every effort to attend all meetings and attendance register shall be taken at each meeting. In the absence of the Committee Chair, the Committee should nominate another member to Chair the Committee.

7. Attendance

The following are regular attendees at the Committee:

- Chief Financial Officer
- Chief Corporate Affairs Officer
- Deputy Chief Financial Officer
- External Auditors
- Internal Auditors

Other members of the Executive team may be required to attend the Committee at the Committee's request. This includes where there is an internal audit review with limited or no assurance, and where an internal control issue has been identified in that Director's portfolio.

At the discretion of the Committee Chair, other individuals may be invited to attend on an ad hoc basis or in support of specific agenda items. This would typically include:

- ~~Local~~ Counter Fraud Lead ~~Specialist~~
- Head of Technical Accounting – for the Annual Accounts
- Chief Nurse and / or Director of Quality Governance – for the Quality Account

Deputies can attend the group with the permission of the Committee Chair, though they must be suitably briefed and supported by the individual for whom they are deputising in advance.

8. Quoracy

The quorum for any meeting of the Audit Committee shall be the attendance of a minimum of two members. Regular or other attendees do not count towards the quorum.

Non-Quorate Meetings: Non-quorate meetings may go ahead unless the Chair decides not to proceed. Any decisions made by the non-quorate meeting must however be formally reviewed and ratified at the subsequent quorate meeting.

9. Declaration of Interests

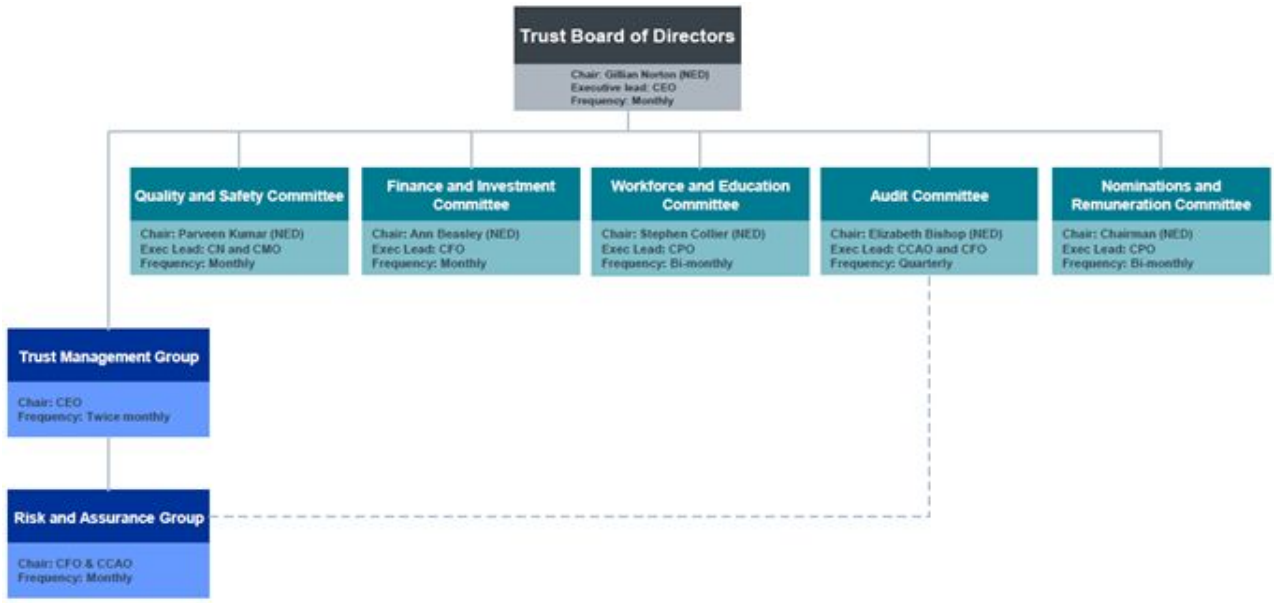
All members and those in attendance must declare any actual or potential conflicts of interest; these shall be recorded in the minutes. Anyone with a relevant or material interest in a matter under consideration must be excluded from the discussion.

10. Meeting Frequency

Meetings of the Committee shall be held five times per year, usually on the second Thursday of the month. The frequency of meetings may be changed only with the agreement of the Trust Board.

11. Relationship with other groups and committees

The Committee will report to the Trust Board.



12. Meeting arrangements and Secretarial support

i. An annual schedule of meetings of the Audit Committee shall be established prior to the start of each financial year;
ii. The ~~Director of~~ Chief Corporate Affairs Officer will oversee the provision of secretariat support for the Audit Committee. This will include taking accurate minutes, producing an action log and issuing follow up actions, ensuring that the planning for and outcomes of Committee meetings are shared appropriately.
iii. The agenda for the meeting will be agreed and compiled through discussion between the Committee Chair and Executive Leads.
iv. All papers and reports to be presented at the Audit Committee must be submitted as final Executive approved reports on the Tuesday one week before the meeting.
v. The agenda and supporting papers for the meeting will be circulated not less than three working days ahead of the meeting.

13. Report to the Board

The Committee Chair will prepare a report for the Trust Board after each meeting of the Committee. This will set out the key issues considered at each meeting and the degree to which the Committee was assured on these, specifically highlighting any areas in which there is a lack of assurance.

The Committee will, in addition, prepare an annual report to the Board setting out the key areas of focus in the previous financial year.

14. Agenda

Agendas for Committee meetings will be drawn from the Committee's annual cycle of business (forward plan) and will be agreed with the Committee Chair.

15. Annual cycle of business

An Annual cycle of items and reports to be received by the Committee will be agreed by the Committee and is included at Appendix 1 of this terms of reference. This shall be used to set the agenda for each meeting.

The annual cycle shall be reviewed on an annual basis prior to the start of the financial year and should be reported to the Board alongside the Committee's annual report.

16. Review of Terms of Reference

These Terms of Reference shall be subject to an annual review. This review should consider the performance of the Audit Committee including the delivery of its purpose, compliance with the terms of reference and progress against its planned forward cycle of business. Any changes to the Terms of Reference require the approval of the Board.

Appendix 4

AUDIT COMMITTEE FORWARD WORKPLAN
01 April 2021 - 31 March 2022

ITEMS	Purpose	Lead	Author(s)	Governance Forums	15/04/2021	18/05/2021	14/06/2021 (TBC)	15/07/2021	07/10/2021	13/01/2022
PRIVATE MEETINGS WITH AUDITORS										
Private meeting with Internal Auditors	Discuss	NEDs Only	N/A	N/A						
Private meeting with External Auditors	Discuss	NEDs Only	N/A	N/A						
ANNUAL REPORT, QUALITY REPORT AND ANNUAL ACCOUNTS										
Annual Report, Accounts & Quality Accounts **Plans & Timetables** & High level Themes	Note	CCAO/CFO	CCAO/CFO	TMG						
Annual Accounts, Financial Statements, Going Concern Statement including NHS Debt Write-off (**Draft**/**Final**)	**Discuss**/ **Approve**	CFO	CFO	TMG/FIC						
Annual Report including Remuneration, Workforce Report, Annual Governance Statement etc. (**Draft**/**Final**)	**Discuss**/ **Approve**	CCAO/CFO	CCAO/CFO	TMG/FIC						
Annual Quality Accounts (**Draft**/**Final**)	**Discuss**/ **Approve**	CN	DQGC	QSC/CoG						
Accounting Policies	Approve	CFO	CFO	TMG						
EXTERNAL AUDIT										
External Audit Progress Report	Discuss	EA	EA	N/A						
Annual Audit Plan & Fees	Approve	EA	EA	N/A						
External Audit Findings (Final)	Endorse	EA	EA	N/A						
Letter of Representation (Financial Audit) (Final)	Endorse	CEO/CFO	CEO/CFO	N/A						
Reports to Council of Governors - Quality (Account) Report and Limited Assurance Opinion (Final)	Endorse	EA	EA	N/A						
External Audit Annual Audit Letter	Receive/ Endorse	EA	EA	N/A						
INTERNAL AUDIT										
Internal Audit Progress Report	Note	IA	IA	RAG						
Internal Audit Recommendation Tracker	Note	IA	IA	RAG						
Final Internal Audit Review Reports	Note	IA	IA	RAG						
Draft Internal Audit Plan (**Draft**/**Final**)	Discuss/ Approve	IA	IA	RAG						
Draft Annual Report & Head of Internal Audit Opinion (**Draft**/**Final**)	Endorse	IA	IA	RAG						
Sector Updates and Digests (including Fraud) (*as required)*	Inform	IA	IA	RAG						

Appendix 4

AUDIT COMMITTEE FORWARD WORKPLAN
01 April 2021 - 31 March 2022

ITEMS	Purpose	Lead	Author(s)	Governance Forums	15/04/2021	18/05/2021	14/06/2021 (TBC)	15/07/2021	07/10/2021	13/01/2022
COUNTER FRAUD										
Counter Fraud Update Quarterly Reports	Discuss	CFO	CFL	RAG						
Counter Fraud Annual Report & Self-Assessment	Approve	CFO	CFL	RAG						
Counter Fraud Work Plan and Risk Assessment 2020/21	Approve	CFO	CFL	RAG						
Review of Anti-Fraud/Anti-Bribery Policy (every three years)	Approve	CFO	CFL	RAG						
FINANCE & PROCUREMENT										
Losses & Special Payments	Discuss/ Endorse	CFO	CFO	TMG/FIC						
Breaches & Waivers	Discuss/ Endorse	CFO	CFO	TMG/FIC						
Aged Debt	Discuss/ Endorse	CFO	CFO	TMG/FIC						
IFRS 176 (Leases) Update on Implementation and Preparations	Note	DCFO	CFO	TMF/FIC						
INFORMATION GOVERNANCE										
Information Governance Compliance Update & Annual Report	Discuss/ Endorse	SIRO	CIO	IGG/RAG						
DSP Toolkit: Update (Data Quality/Security)	Discuss/ Endorse	SIRO	CIO	IGG/RAG						
RISK MANAGEMENT										
Annual Review of Risk Management Strategy & Policy	Approve	CN	DQGC	Board						
Review of Board Assurance Framework Internal Controls and Governance Mechanisms	Discuss/ Endorse	CCAO	CCAO	Board						
CORPORATE GOVERNANCE/COMPLAINCE										
Review of Internal Auditors Effectiveness	Discuss	CCAO	CCAO	TMG/RAG						
Standing Orders, Scheme of Delegation & Standing Financial Instructions (Annual Complaince Review)	Review/ Approve	CCAO/CFO	CCAO/CFO	TMG/RAG						
Annual Review of Trust Conflicts of Interest Complaince	Note	CCAO	CCAO	TMG/RAG						
Annual Review of Compliance with Trust Policies Protocols	Note	CCAO	CCAO	TMG/RAG						
Annual Review of Trust's Clinical Audit Programme	Note	CN	DQGC	QSC						
Freedom to Speak-up Internal Controls and Policies	Discuss/ Endorse	DHROD	DHROD	WEC						
Use of Trust Seal	Note	CCAO	CCAO	Board						
COMMITTEE GOVERNANCE										
Review of Committee Effectiveness (**Plan/Results**)	Discuss/ Endorse	CCAO	CCAO	N/A						
Annual Committee Report to Board including Terms of Reference Update and Committee Forward Workplan	Discuss/ Endorse	CCAO	CCAO	Board						

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4.1

Audit Committee Effectiveness Review 2020/21

Survey results and action plan

As presented to the Committee in April 2021

Stephen Jones
Chief Corporate Affairs Officer

Tamara Croud
Head of Corporate Governance

15 April 2021

1. Introduction

Purpose, context , summary and recommendation

1. Purpose

This paper presents the results of the Audit Committee review of effectiveness for 2020/21 which was undertaken in March 2021, closing 08 April 2021, and highlights potential action points for consideration based on the feedback received through the survey.

2. Background and context

All Committees of the Board are required to undertake reviews of their effectiveness on an annual basis.

The Committee Chair, on behalf of the Committee, agreed plans for undertaking the effectiveness review. Responses to the survey were provided via an online survey tool.

3. Conclusion/Summary:

In conclusion, in comparison to 2019/20 the respondents in 2020/21 were positive about the Committee and its achievements over the past year resulted in good feedback. The response rates for the survey was lower and it may be useful to conduct the survey over a different timeframe when there were not as many other surveys taking place.

4. Recommendation

The Committee is asked to note the results from the Committee Effectiveness Review 2020/21 and the proposed actions to further improve the effectiveness of the Committee.

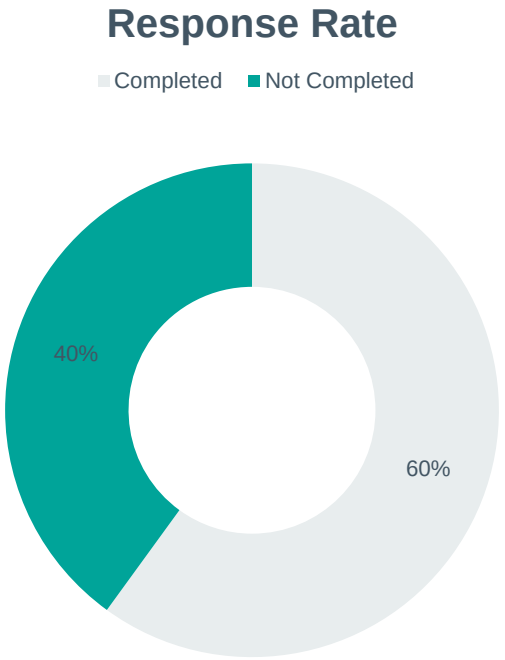
1. Introduction
Engagement

The following groups were invited participated in the survey:
- Non-Executive Director (NED) Committee members (4)
- Executive Director Leads/attendees (2)
- Other regular attendees – Deputy Chief Financial Officer and Counter Fraud Lead (2)
- Internal and External Auditors (one organisational response) (2)

The response rate as disappointing for this review however on reflection this could be correlated with the number of other year-end surveys being completed in the same period.

A majority of the NED Committee members completed the survey, both executive leads and the internal auditors. The minimum response should have been ten however the Trust only received six, providing a response rate of 60%. In 2019/20 the survey was issued to 17 individuals including the Trust Chairman and garnered a 82% response rate.

To improve responses in future survey's it is proposed that the Committee considers condensing the number of questions.



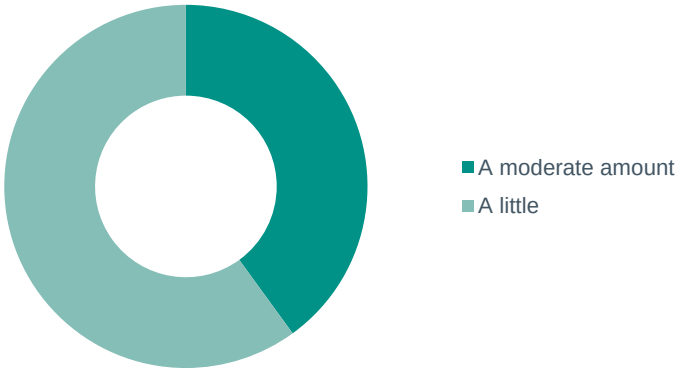
2. Key findings from Audit Committee Effectiveness Review 2020/21

Overall effectiveness

The results of the review suggest that the Committee is working effectively. Respondents (100%) stated that the Committee was “very effective”. No respondents stated that the Committee was ineffective. This was a slight improvement, taking account of the reduced response rates, from 2019/20 where respondents 14% stated that the Committee was “somewhat effective” in completing its role.

40% of respondents stated that there was a moderate amount of work to do to improve the effectiveness of the Committee whilst 60% there was a little steps that could be taken to improve the effectiveness of the Committee – apart from the comment that there was ‘always more that can be done’ there was no suggestions offered as to the steps which were required.

Are there any other steps that could be taken to improve the effectiveness of the Committee?



Summary of findings

The following two slides summarises the responses from the 2020/21 survey. Overall, respondents were positive about the work of the Committee and whilst there was a suggestion that were moderate to little steps to drive further improvement there were no material issues identified in the survey.

When the Committee completed the 2019/20 survey it agreed that further work would be completed in the following areas to improve the effectiveness of the Committee:

- *Requirement for Executive leads to attend Committee for internal audits in their areas*
- *Seek feedback on Audit Committee focused induction of incoming members and review plans as necessary*
- *Introduce more systematic reporting from other Committees to the Audit Committees on new areas of risk or control issues*
- *Review risk management processes of the Committee following external review of Trust risk management policy and process*
- *Ensure Committee and Board make greater use of assurance mapping as part of 2020/21 approach to the BAF*
- *Clarify the distinct roles of the Audit Committee and Workforce Committee in relation to Freedom to Speak Up so as to avoid duplication of reporting*

All the actions from 2019/20 were completed and it was evident from the results of the 2020/21 review that the actions taken by the Committee had led to significant improvements in these areas and only areas for development included:

- Ensure that right papers are submitted to the Committee and they were sufficiently concise
- Effectively using assurance mapping to target the areas of greatest risk
- Induction/training for new members of the Committee

In conclusion, there were no outlier areas of ineffectiveness in the Committee therefore it may be useful for the Committee to continue to build on its work in 2019/20 to ensure that the Committee can receive an overall rating of Extremely Effective in the 2021/22 survey.

2a. Summary of responses

NB: It should be noted that there was one partially completed survey and percentages were rounded up to the highest whole number.

Area	Response Summary
Terms of Reference & Standing Governance practices	100% of respondents agreed (50% strongly agree) that the Committee Terms of Reference was fit for purpose and agreed that Committee members and regular understood the roles and responsibility of the Committee. All respondents (66% agree) agreed that material interests were recorded at each meeting and appropriate actions taken.
Workplan and Committee work	100% (50% strongly agree) of respondents thought the workplan was fit for purpose. 83% of respondents also noted that the programme covered the assurance needs of the board through a balance of appropriate agenda items. All respondents agreed that the Committee: • Lead on the assessment of the annual Governance Statement for the Board including the provision of advice on tis preparation and scope. • Gave sufficient and timely attention to financial management and reporting issues, including the consideration of key accounting policies, estimates and judgements and the quality of year-end financial statements. • Reviewed the adequacy of anti-fraud, anti-bribery and anti-corruption arrangements, and receive an annual report from the Local Counter Fraud Specialist for the reporting year. • Reviewed arrangements that allow staff of the Trust and other individuals where relevant to raise concerns (freedom to speak up), standing order, standing financial instructions schemes of delegation and compliance with the Constitution and Code of Governance • Reviewed the establishment and maintenance of an effective system of governance, internal control and risk management Most respondents stated that the Committee used assurance mapping to target the areas of greatest risk in the Trust,. One respondent neither agreed or disagreed with free text comment suggesting that this process should be used more effectively.
Work of internal and external auditors.	All respondents recognised that the Committee reviewed and approved the internal audit plan and strategy and tracked all recommendations and held the organisation to account. All respondents also agreed that here was sufficient challenge to both auditors. All respondents also noted that the Committee regularly met with internal and external auditors privately.
Sufficiency of time on agenda to explore issues in appropriate depth	All respondents (83% agree) stated that there was sufficient time on the agenda extra issues at appropriate depth.
Quality and circulation of papers	83% of respondents felt that the papers were circulated in a timely way and 17% (one individual) did not believe this was the case. All but one of the respondents agreed that the Committee papers were clear, concise and provides enough information for the Committee to reach informed conclusions and provide appropriate assurance to the Board. Free text comment reflected that 'brevity' was not achieved and that sometimes papers were 'included unnecessarily'.
Seeking assurances and reviewing evidence	A majority (67%) of respondents did not agree or disagree that the Committee proactively commission additional assurance work where it has identified a risk or control issue which is not subject to sufficient review. A comment reflected this was not typically done this and that there was scope for the Committee to call for this.

2b. Summary of responses

NB: It should be noted that there was one partially completed survey and percentages were rounded up to the highest whole number .

Area	Response Summary
Quality and circulation of papers	83% of respondents felt that the papers were circulated in a timely way and 17% (one individual) did not believe this was the case. All but one of the respondents agreed that the Committee papers were clear, concise and provides enough information for the Committee to reach informed conclusions and provide appropriate assurance to the Board. Free text comment reflected that 'brevity' was not achieved and that sometimes papers were 'included unnecessarily'.
Membership & Attendance	All respondents (100%) stated that the CFO, CCAO and Internal and External Auditors regularly attended the meetings of the Committee. Committee had the correct membership. Respondents were also satisfied with the range, frequency and numbers of executive and other participants at the meeting. Similarly all respondents agreed that the Committee had the required Committee members, three non-executive directors including the Committee Chair.
Skills & knowledge	All respondents agreed that at least one member (NED) had recent or relevant financial experience sufficient to allow the Committee to competently analyse financial statement and good financial management. All respondents (100%) agreed that the Committee collectively have the range of skills needed to ensure the Board receives the assurance it needs on needed to ensure the Board receives the assurance it needs on governance, risk management, the control environment, and on the integrity of all elements of the Annual Report and Accounts. Similarly the respondents agreed that the Committee the wider skills to be fully effective. All respondents also agreed that the Committee had sufficient understanding of the organisation's overall control environment, including its governance and any outsourcing arrangements, and review its effectiveness regularly to provide assurance that arrangements are responding to risks within the organisation.
Induction and training arrangements	The feedback on induction and training was mixed with 60% stating new members received an effective induction and training whilst 20% stated that this was not the case with the other 20% agnostic. Respondents commented that the pandemic and move to remote work had hampered the delivery of induction of new members whilst other respondents was not clear whether or not there were induction arrangements in place.
Committee Chairing	100% of respondents agreed that the Committee Chair was appropriately independent and chaired the meetings effectively.
Challenge and Critical review	83% of respondents agreed that the Committee provided insight and strong, constructive challenge to the organisation where required with one responded agnostic. All respondents also agreed that the Committee critically reviewed the comprehensive and reliability of the assurances it received.
Cascade of issues, risks and assurances to other forums	All respondents (83% agree) agreed that risks and control issues were escalated by other Board Committees to the Committee and that the Committee escalated these appropriately.
Committee's report to the Board	All respondents agreed that the Committee's report to the Board sufficiently described the matters considered and the level of assurance. All respondents (83% agree) agreed that the Committee discussed matters for reporting and escalation to the Board. It was also noted that he Committee drew the attention of the Board to the results of its work on risk.

3. Areas of Development and Progress Update – cont'd

Proposed 2021/22 development actions

As reported overleaf 100% of respondents agreed that the Committee was 'very effective' . As noted earlier the following areas of development have been identified and the relevant actions proposed including those carried over from the previous year that were not fully completed.

Ensure that right papers are submitted to the Committee and they were sufficiently concise

Effectively using assurance mapping to target the areas of greatest risk

Provide clarity on the induction and training programme for new members joining the Committee.

**Carried forward from 2019/20 actions*

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4.1

Meeting Title:	**Trust Board**		
Date:	27 May 2020	**Agenda No**	**4.1.1**
Report Title:	**Annual Self-Certification of Compliance with Foundation Trust Licence**		
Lead:	Stephen Jones, Chief Corporate Affairs Officer		
Report Author:	Stephen Jones, Chief Corporate Affairs Officer		
Presented for:	Approval		
Executive Summary:	Each year each NHS Foundation Trust must undertake a self-certification of compliance with its licence. The self-certification covers three licence conditions: • Systems for compliance with licence conditions and related obligations (Condition G6); • Availability of resources (Condition CoS7(3)); • NHS foundation trust governance arrangements (condition FT4(8)); • Training of Governors NHS Foundation Trusts are no longer required to submit their self-certifications to NHS England and NHS Improvement (NHSE&I). However, NHSE&I selects a number of Trusts to audit the self-certifications. St George's was selected for audit in 2018 and NHSI (as it was at the time) was content with its self-certification. As there have been no material changes in the process, the self-certification set out in this paper adopts the same overall approach as used by the Trust in the past three years. The self-certification must be published on the Trust's website by 30 June 2021. The views of Trust Governors have been sought in making the declaration relating to Governor training in 2020/21 and Governors have confirmed that they are content the Trust provides a positive self-certification in relation to this. The Audit Committee reviewed and endorsed the annual self-certification at its meeting on 18 May 2021.		
Recommendation:	The Board is asked to review the self-certification against each of the licence conditions, including the proposed response in each area.		
Supports			
Trust Strategic Objective:	All objectives		
CQC Theme:	Addresses all five themes: Safe, Effective, Caring, Responsive and Well-led		
NHS Oversight Framework Theme:	Well-led		
Implications			
Risk:	As set out in the paper.		
Legal/Regulatory:	An assessment of compliance with licence conditions is required to be undertaken annually and to be approved by the Board.		
Resources:	There are no resource implications.		
Previously Considered by:	Audit Committee Executive Management Team	**Date**	18 May 2021 17 May 2021
Equality Impact Assessment:	N/A		
Appendix:	N/A		

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Annual Self-Certification of Compliance with Foundation Trust Licence

Trust Board, 27 May 2021

4.1

1.0 PURPOSE

1.1 This paper sets out the Trust's proposed annual self-certification against its provider licence. The proposed self-certification was reviewed and endorsed by the Audit Committee on 18 May 2021.

2.0 BACKGROUND

2.1 NHS England and NHS Improvement (NHSE&I) requires all NHS Foundation Trusts to undertake a self-certification on an annual basis against three licence conditions and one further activity, the training of governors. The purpose of the self-certification is to provide assurance that the Trust is compliant with the conditions of its licence. Compliance with the licence is routinely monitored through the NHS Oversight Framework but the annual self-certification is intended to provide additional assurance.

2.2 Providers were previously required to submit their self-assessments to NHSI via a dedicated portal. However, since 2018 this is no longer the case and NHSE&I instead selects a number of Trusts to ask for evidence that they have self-certified by providing the completed self-certification or relevant Board minutes and papers recording sign-off. In 2018, St George's was selected as one of the Trusts whose self-certification was audited. The Trust provided its self-certification and related documentation, as approved by the Board, and NHSI was satisfied that the process had been completed appropriately. The 2021 self-certification follows the same format and approach undertaken in recent years.

3.0 SELF-CERTIFICATION REQUIREMENTS

3.1 The Trust is required to self-certify the following conditions after the financial year end:

- That the Trust has taken all precautions to comply with the licence, NHS Acts and NHS Constitution. This involves the Trust self-certifying that it has systems and processes that identify risks to compliance with the licence, NHS acts and NHS Constitution and that guard against those risks occurring (Condition G6).

- That the Trust has a reasonable expectation that required resources will be available to deliver designated services over the coming 12 months (Condition CoS7(3)). The Trust is required to self-certify against one of the following statements:

    - The required resource will be available for 12 months from the date of the statement;
    - The required resources will be available over the next 12 months, but specific factors may cast doubt on this; or
    - The required resources will not be available over the next 12 months.

  The required resources include: management resources, financial resources and facilities, personnel, physical and relevant asset guidance.

- That the Trust has appropriate governance structures and systems in place. There is no set approach for demonstrating this, but NHSE&I expects a compliant approach to involve a review of the effectiveness of the Board and Committee structures, reporting lines and performance and risk management systems (Condition FT4(8)).

- That the Trust has provided adequate and appropriate training to its governors to enable them to carry out their roles.

3.2 For each condition or activity the Trust must either:

- Confirm it has complied with the specific requirement; or
- Confirm it has not complied with the specific requirements, and explain why.

3.3 It is considered good practice to set out a brief statement explaining how the Trust considers it has complied, including any risks and mitigating actions. These will not be submitted to NHSE&I, though NHSE&I may review these should it select the Trust for audit purposes.

3.4 The deadline for submission of self-certifications, except for FT4(8), is the end of May. For FT4(8), the deadline is the end of June, but there is no reason not to provide all responses at the same time. The self-certifications must be published on the Trust's website by 30 June 2021.

4.0 SELF-ASSESSMENT

4.1 The self-assessment set out at Appendix 1 proposes that the Trust is compliant with all three conditions, as well as the additional declaration in relation to the training of governors.

4.2 In relation to licence condition CoS7(3) (sufficient resources to deliver services over the coming 12 months), in previous years the Board has agreed that the Trust confirm that it is compliant notwithstanding the fact that it was in financial special measures. With the Trust's exit from financial special in December 2020, it is proposed the Trust again state that it is compliant.

4.3 In relation to FT4(8), the views of the Council of Governors have been sought as to whether Governors are content the Trust makes a positive self-certification in relation to Governor training. Governors have confirmed that they are content with providing a positive assessment.

5.0 RECOMMENDATION

5.1 The Board s asked to review the self-certification against each of the licence conditions, including the proposed response in each area.

Stephen Jones
Chief Corporate Affairs Officer
27 May 2021

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APPENDIX 1: SELF CERTIFICATION AGAINST LICENCE CONDITIONS 2020/21: CERTIFICATION DECLARATIONS AND STATEMENTS

Licence condition	Description of licence condition	Suggested declaration (Confirmed / Not confirmed)	Suggested statement
G6	Has the Trust taken appropriate steps to establish, review and maintain systems to identify and effectively manage risks?	*Confirmed*	*The Trust has taken appropriate steps to establish sound arrangements for risk management in the Trust. The Board has developed a Board Assurance Framework and process for assessing the strategic risks set out in the BAF. The BAF was updated significantly in May 2020 following a review of the strategic risks and processes for overseeing the BAF. The BAF contains the controls in place to manage the risk, the sources of assurance that exist, identified gaps in control and assurance and the actions identified to close those gaps. The BAF was formally reviewed by the Board on a quarterly basis during 2020/21. A further annual review of the BAF is currently being undertaken alongside the development of the Trust's corporate objectives and the arrangements for regular review of the BAF by the Board will continue in 2021/22. In addition, the full BAF will continue to be presented to the Board in public in 2021/22, which addresses feedback provided by the CQC in its December 2019 inspection of the Trust.* *Strategic risks on the BAF are allocated to the Committees of the Board, with the exception of one strategic risk (SR4 - System Working) that is reserved to the Board. The Board Committees review the risks allocated to them on a regular basis and consider the risk scores, including any changes, and assurance statements to the Board. In 2020/21, executive responsibility for the BAF transferred to the Chief Corporate Affairs Officer. The Audit Committee received a paper setting out the internal control position for the BAF at its meeting in April 2021 and an internal audit on the BAF is planned for Q4 2021/22.* *Risks on the Corporate Risk Register are scrutinised monthly by each of the sub-groups of the Trust Management Group (Patient Safety and Quality Group; People Management Group; Operations Management Group; and Risk and Assurance Group). The Risk and Assurance Group (RAG) providers oversight of corporate risk management at Executive level and reports on this to the Trust Management Group (TMG). RAG is supported by the Risk Management and Coordination Group which ensures consistency in the application of the risk management policy. The risks on the Corporate Risk Register inform the risk scoring of the BAF.* *The Trust updated its risk management policy in March 2021. The Audit Committee receives an annual report on the application of the risk management policy. An internal audit of the Trust's risk management processes was undertaken in 2019/20 and was considered by the Trust's Audit Committee in June 2020. The review had an assurance rating of 'reasonable assurance'. An independent clinical governance review has looked at the Trust's risk management process as part of its work. This will be reported to the Board in May 2021 and contains findings and recommendations in relation to further strengthening risk management, which the Trust will implement.*

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Licence condition	Description of licence condition	Suggested declaration (Confirmed / Not confirmed)	Suggested statement
FT4(8)	Does the Trust have in place the governance systems necessary achieve the objectives set out in the licence condition?	*Confirmed*	*Following an external review of governance undertaken in 2017/18, the Trust made a number of changes to strengthen its Committee structures, reporting lines and risk management systems. The changes agreed have been implemented fully.* *The Trust has in place established Board and Committee structures. Committees review their effectiveness on an annual basis and these and these are used to identify areas for improvement. Every Committee of the Board conducts an annual review of its effectiveness. In 2020/21, Committee effectiveness reviews were conducted for the Quality and Safety Committee, Finance and Investment Committee, Audit Committee and the Workforce and Education Committee. These effectiveness reviews seek non-attributed feedback from members and regular attendees. All Committee in 2020/21 were judged to be effective, albeit specific actions to further improvement each Committee's effectiveness were identified and have been built in to each Committee's plans for 2021/22. Terms of reference for the Committees of the Board are agreed by the Board, and in 2020/21 the Board agreed changes to the Terms of Reference of the Quality and Safety Committee and Finance and Investment Committee. The Terms of Reference of the Quality and Safety Committee, Finance and Investment Committee, Workforce and Education Committee and Audit Committee are due to be considered by the Board at its meeting on 27 May 2021.* *There is an established risk management system (see statement above relating to condition G6). The Trust's performance is reviewed by the Board at each meeting, supported by the work of its sub-Committees.* *In 2019/20, the Trust conducted an in-depth review of its compliance with the NHS Foundation Trust Code of Governance and with its Constitution and reported on the results of this to the Audit Committee. A similar review is planned for 2021/22. The results demonstrated the Trust was substantially compliant with both.* *The progress the Trust has made in improving its governance systems and processes was evidenced in the latest inspection report by the CQC and the decision of NHS England and NHS Improvement, on the recommendation of the CQC, to take the Trust out of special measures for both quality and finance in March 2020 and December 2020 respectively. These were a significant steps for the Trust, which had previously been placed in special measures for quality in November 2016 and for finance in April 2017.*

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Licence condition	Description of licence condition	Suggested declaration (Confirmed / Not confirmed)	Suggested statement
CoS7(3)	Does the Trust have a reasonable expectation that it will have the required resources available to deliver designated services for the next 12 months?	*Confirmed*	*The Trust was taken out of financial special measures by NHS England and NHS Improvement in December 2020.* *In line with the revised planning processes in place for 2021/22, the Trust has prepared and submitted a high level financial plan to the SWL ICS for the first 6 months of the year, and will submit a final financial plan for this period in line with planning requirements by 3 June 2021. The draft financial plan demonstrates a small deficit at the end of the first 6 months, £0.6m. Work will continue to review this prior to the final submission in June, and then further in the financial plan for the second 6 months of the year, with the submission date for this only being known when planning guidance for this period is issued. The key risks to the financial plan for the first 6 months of the year are delivering against the Elective Recovery Fund, non-NHS income recovery and ensuring costs are managed in line with plan as the Trust emerges from the Pandemic; standing down the pandemic response and standing up the recovery of normal services. The Trust's planning assumptions include that the costs of Covid testing and NHSE drugs are supported and vaccination hub costs are excluded and will be covered by additional funding. No assumption has been made about pay inflation pending confirmation of any award and funding from NHSI* *The Trust recognises that aspects of its IT infrastructure and estate, in particular, need further investment. Within the financial plan submitted in May the availability of capital funding for the full year is very constrained. Work continues to investigate the impact of this on the management of risks in estates and IT; the available capital is being focused on known priorities.* *On IT, significant work has been undertaken in 2020/21 to reduce a significant number of IT risks facing the Trust. However, further work is needed and the timeline for completing the work is dependent on the availability of capital funds.* *On estates, the Board has significantly increased its assurance regarding the management of the estate, and action has been taken to develop a new estates strategy which will be presented to the Board for approval in the coming months.* *Management resources were maintained by appointments to the Board. The Board appointed a new Chief People Officer in October 2020 following the departure of the previous post-holder and the new CPO started at the Trust in February 2021. The Trust's two Deputy Chief People Officers for Workforce and Culture, respectively, covered the role of CPO until the new appointee started in post. The Board also appointed a new Chief Operating Officer in March 2021. Further senior appointments were made in*

Licence condition	Description of licence condition	Suggested declaration (Confirmed / Not confirmed)	Suggested statement
			2020/21: three new Deputy Chief Medical Officers were appointed in December 2020 and these significantly strengthen the Trust's medical directorate; a new role of Deputy Chief Operating Officer was also established and appointed to; and there are now substantive appointments of Divisional Directors of Operations across all three clinical divisions. In 2020/21, the Trust appointed a Diversity and Inclusion Manager and established a new dedicated Freedom to Speak Up Guardian role. *The capability and continuity of the Board was also maintained through the re-appointment of one of the Trust's Non-Executive Directors to a further three-year term of office from September 2020. One of the Trust's existing Non-Executive Directors signalled her intention to step down from the Board later this year and an appointments process is underway.*
-	Has the Trust taken steps to ensure Governors are equipped with the skills and knowledge they require to fulfil their roles?	*Confirmed*	*The Trust has continued to provide a range of training and development opportunities for Governors to support them in their roles throughout 2020/21. The Covid-19 pandemic has meant that Governors have not had their usual opportunities to attend the Trust for meetings or to participate in PLACE inspections, Ward accreditation visits, and Meet Your Governor events. However, online meetings of the Council of Governors and its Committees, online development sessions, online Members talks, and an online Governor constituency engagement event have all been held during 2020/21.* *In response to the Council of Governors effectiveness review in December 2019, the Trust developed a new approach to Governor training and development and significantly extended the range of opportunities for Governors to participate in such training. During 2020/21, the following training and development activities were provided to Governors:* • *May 2020: The Trust held a briefing session for Governors focused on the Covid-19 pandemic and the Trust's response.* • *August 2020: The Trust held a half-day Governor development session which was externally facilitated by NHS Providers. This provided an introduction to the NHS and the NHS landscape, an overview of NHS governance and the role of Foundation Trust Governors, and training in effective questioning and challenge. This was attended by 18 members of the Council of Governors.* • *September 2020: The Trust provided Governors with a confidential briefing on closer collaboration with Epsom and St Helier University Hospitals NHS Trust and on the development of a joint renal service. This was attended by 18 members of the Council of Governors.*

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Licence condition	Description of licence condition	Suggested declaration (Confirmed / Not confirmed)	Suggested statement
			• *October 2020: The Trust held a Council of Governors development seminar, supported internally by the Trust. The areas of focus included: strategy and NHS system working; the Trust's workforce, staff engagement and culture change programme; and training in risk management and the Board Assurance Framework. This session was attended by 20 members of the Council of Governors.* • *January 2021: A further half day development session for Governors supported by NHS Providers was delivered in January 2021, which focused on NHS finance and quality. This was attended by 19 members of the Council of Governors.* • *March 2021: The Trust held a Governor development seminar focused on the Trust's estate and facilities management, digital and information technology, and closer collaboration with Epsom and St Helier University Hospitals. This was attended by 17 members of the Council of Governors.* *In 2020/21, as part of the programme of formal Council meetings, Governors had briefings on Covid-19 and the Trust's response, the Trust's financial position, patient partnership and engagement, the Trust's CQC action plan, and the Trust's cultural change programme, as well as confidential briefings on the Trust's cardiac surgery service and collaboration with Epsom and St Helier.* *Following elections to the Council of Governors in November 2020, the Trust undertook a focused induction programme with new Governors during December 2020 and January 2021, ahead of the newly elected Governors' terms of office commencing on 1 February 2021. One session focused on the role of the Council and of individual Governors in holding the NEDs individually and collectively to account for the performance of the Board and representing the interests of members and the public. It set out how the Council fitted within the governance structure of the Trust and the range of formal powers the Council exercises in relation to appointments and approval of significant transactions and the Constitution. Further sessions have included briefings on NHS finances and quality. This followed a set of online briefing events for prospective Governors ahead of the elections in which the Trust set out what being a Governor meant in practice.* *Governors receive Parts 1 and 2 Board papers and are welcome to attend Part 2 of the Board as well as the Board Committees as observers. This ensures Governors have a wide range of information available to help them perform their roles effectively.*

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4.2

Meeting Title:	**Trust Board**		
Date:	27 May 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 22nd April 2021 and 20th May 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		

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Finance and Investment Committee – April 2021 & May 2021

The Committee met on 22 April and 20 May. In addition to the regular items on strategic risks, operational performance and financial performance, it also considered papers on Short Term Estates planning, Annual Planning for 2021/22, SLR/PLICS, PACS FBC, Paediatric Cancer, NEPT, Renal, the Annual Committee report for Trust Board, the Procurement Report, Closer working with ESH- Finance Chapter, Reviewing the Committee Terms of Reference, SWLP Update and the SWLP 4TPP.

Committee members discussed the Board Assurance Framework (BAF) risks on ICT and Estates via their respective 'deep dives', as well as reports by exception in May on all risks ahead of an overview BAF risk review at Trust Board. The Committee praised the improved operational performance following the reduction in COVID positive patients from the most recent surge. The Committee discussed current financial performance, cash management and capital expenditure as the Trust ended the financial year 2020/21 and began 2021/22. **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 April the committee discussed the extreme ICT Risks and plans to improve the respective functional risk scores. Finance risks were covered in other sections of the committee and Operational Risk update by exception in April noted challenges in the Breast Screening 2-week rule backlog and Child and Adolescent Mental Health Services (CAMHS).

1.2 Estates Report and Risks – in May the Director of Estates & Facilities (DE&F) introduced a number of papers. The quarterly BAF update led to discussion on uninterrupted power supply (UPS) risk. The Short Term planning papers focussed on progress with major projects such as MRI and Cath Labs.

1.3 Activity Performance – the Chief Operations Officer (COO) noted the improved performance in daycase and elective targets during March and April due to reduced COVID-19 pressures. The expected performance of 77% in March and 87% in April confirmed this improvement.

1.4 Emergency Department (ED) Update – the performance of the Emergency Care Operating Standard was recorded at 95.2% in April, achieving the national target. The Committee commended this excellent performance, and discussed the increased mental health patient pressure in both adults and paediatric areas.

1.5 Diagnostics Performance – the COO noted that the six-week diagnostic standard performance was 8.5% in April compared to 10.2% in March. The COO also noted the focus on Endoscopy and Cath Lab diagnostics, to further improve trust wide performance.

1.6 Cancer Performance – the COO noted improvements in Cancer performance in March where 3 of the 7 targets were met. 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 March of 69.3% had improved against the previous month's value of 68.3%, with the number of 52 week waits of 2,644 being less than the previous month's 2,671. The size of the waiting list (including QMH patients) was 44,960 patients.

1.8 Financial Performance– the DCFO noted performance in 2020/21 of an £3.1m deficit, subject to an 'allowable miss' of £3.1m for unfunded annual leave accrual. At M1 for 2021/22, the financial position was an expected variance to plan of £0.6m, for the unconfirmed impact of the elective

recovery fund. It was noted that the M1 position may be subject to change in M2, as national guidance and a phased financial plan had not been agreed as yet.

He noted the cash balance as at 31st March 2021 was £36.6m. This is due to payment of capital creditors due at year end in 2021/22. The Trust spent £98.3m of capital in 2020/21, which is in line with CDEL allocation from NHS London.

1.9 PLICS/SLR – the DFP noted the latest update on SLR/PLICS, focussing on the plans for the costing system once the software being out of contract in September.

1.10 Planning 21-22 – the DCFO noted the progress being made on planning for 2021/22, including a detailed financial pack for the new financial year in May. Discussions at committee focussed on CIP, ERF and Capital planning.

1.11 Annual Committee Report 2020/21 – the Committee noted the report compiled of the year's committee content. The Committee agreed some additions ahead of being presented at Trust Board.

1.12 Terms of Reference Review – the CCAO noted the update to the Committee's TOR, which had minor amendments that were agreed ahead of approval at Trust Board.

1.13 Procurement Report – the AD-Procurement highlighted the changes in the Procurement function following the commencement of SWL Procurement and the committee discussed future Procurement savings plans.

1.14 SWLP Report – the DCFO noted the paper on the financial outturn of SWL Pathology, as well as further developments in that area. The Committee welcomed the update.

2.0 Recommendation

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

Ann Beasley
Finance & Investment Committee Chair,
May 2021

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4.2

Meeting Title:	**Trust Board**		
Date:	27 May 2021	**Agenda No**	**4.2.2**
Report Title:	**Finance and Investment Committee report 2020/21**		
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 in 2020/21. The Committee also revised and approved the revised Terms of Reference: • Green text represents new wording included; • Red strikethrough text represents wording removed from the previous version approved by the Board in May 2020; and • Orange text represents existing text which has been moved to elsewhere in the document without changes to the wording.		
Recommendation:	Board is requested to note the update and approve the changes to the Committee's Terms of Reference.		
Supports			
Trust Strategic Objective:	Balance the books, invest in our future.		
CQC Theme:	Well Led.		
Single Oversight Framework Theme:	N/A		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A
Appendices:	N/A		

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Finance and Investment Committee – 2020/21

The Committee met on a monthly basis in 2020/21. Items of discussion were the standing items on Estates, ICT, operational and financial strategic risk, operational performance and financial performance, as well as other items including the New Financial Plan for 2021/22, Costing and PLICS, Procurement and SWLP updates, Policies, Strategies and Technical Updates and the various tendering and business case decisions requiring the committee's recommendation.

Meetings were constructive and included rigorous challenge from committee members. All attendees participated in a mature discussion of issues, based on reliable data. A number of reflections at the end of each meeting were focussed on the high quality of papers produced, healthy level of non-executive challenge and openness of executives in describing the challenges that remain in delivering the relevant KPIs. Feedback on committee performance was formally recorded following completion of the Committee Effectiveness survey, where all 12 responses felt the Committee was extremely effective or very effective in fulfilling its role. The Committee also approved the new Terms of Reference and now asks the Trust Board to do the same.

The financial year's discussions inevitably focussed on the COVID-19 pandemic, where staff have responded exceptionally in the most challenging of circumstances. The operational and financial implications were outlined to the committee to give a good understanding of the impact, and will continue to be monitored as the nation moves out of the latest peak period, and the Trust is able to focus attention on elective activity. Positive news during the year included the report from ECIST which had fed back that the Trust was an exemplar in terms of ED team culture and performance in October, as well as the confirmation from NHSE/I that the Trust would be exiting Financial Special Measures.

The Committee brought the following items to the Board's attention during the year:

1.1 Finance Risks- the Committee was regularly updated on the changing nature of financial risk during the year. The Trust's funding settlement for the financial year allowed the Trust to reduce the overall finance risk score from '25' to '20'. Future year funding is believed to be less certain which prevented any further reduction in risk score.

1.2 ICT Risks - ICT risk updates were received which detailed the actions being undertaken to address risks, the most severe of which relate to having a single data centre and the current ICT disaster recovery plan. Discussions at committee have focussed on Cyber Security and the impact of the global pandemic.

1.3 Estates Risks and Strategy – Estates updates to the Finance & Investment Committee focussed on the Risks and the emerging strategy for the Trust's estate. Risk discussions were mainly on fire risk, oxygen supply (supporting COVID patients) and uninterrupted power supply (UPS). Strategy items were mainly related to the development of the site, with demolition of older estate and the proposed use of the space vacated.

1.4 Activity- the Committee was updated on the performance against activity targets throughout the year. The Elective Incentive Scheme set a target of 90% of equivalent prior year month activity for electives and 100% for Outpatients from October 2020 – February 2021. The Trust achieved these targets in the period leading up to the second surge in December 2020 and also met the Outpatient target throughout the whole period.

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1.5 Emergency Department (ED) update – the Committee has seen a much improved year on ED performance in 2020/21 as the Trust adapted to the pandemic by changing the way patients flow through the department and wards. The Committee commended the findings of ECIST, which had fed back that the Trust was an exemplar in terms of ED team culture and performance in October. The Trust consistently performed above the London average during the year and scored above 90% on the 4 hour operating standard for 7 consecutive months (May 2020-November 2020).

1.6 Referral to Treatment (RTT) - the Trust waiting list and RTT performance has been fundamentally affected by the COVID-19 pandemic. The Trust has prioritised COVID-19 patients in its bed capacity which has led to cancellations and postponement of elective activity which has mirrored the RTT performance in the rest of the country. By January 2021 RTT performance was 69.1% with 2,108 patients having waited over 52 weeks.

As the Trust moves out the latest surge, plans are in place to address the backlog of patients by specialty, including discussions with partner organisations in South West London.

The Trust has reported RTT for the whole of 2020/21 and 2019/20 following a gap of non-reporting from May 2016 to January 2019 and began reporting QMH data following iClip implementation at that site in September 2019.

1.7 Cancer Performance- In a similar way to RTT performance, Cancer target achievement has been impacted significantly by COVID. The Trust has worked to minimise clinical risk while capacity was restricted and is expecting improved performance in the coming months as capacity comes back on line.

1.8 Diagnostics- the 1% Diagnostic target performance has gradually improved as the year has gone on, as the impacts of the 1st COVID surge (cancelling non-urgent Diagnostic activity) have been addressed by the Trust. February 2021 performance of 14.8% is much lower than the high of April 2020 (63.6%).

1.9 Financial Performance & Forecast- as at March 2021, performance in 2020/21 is expected to be on forecast against the breakeven control total. This is a significant achievement for the Trust, following a year of additional COVID-related costs being offset by reduced non-COVID (elective activity) costs owing to capacity constraints from COVID positive patients. Capital expenditure is expected to be in line with the agreed CDEL, and cash is expected to be spent in M12 on capital to significantly reduce from the balance of £116.7m at M11.

1.12 Annual Planning Updates – the annual plan was produced for final review at the Committee in March. The Trust is expected to have a plan to breakeven, and incur capital expenditure of £95.9m (as at March 2021).

1.13 Business cases and tendering decisions – a number of business case and tendering decisions were brought to the committee in 2019/20, to approve or recommend to the Trust Board. These included the Emergency Floor, MRI, SWLP LIMS interoperability and SWLP 4TPP cases.

1.14 Technical & Policy updates – the committee remains up to date on policies following approvals during the year. Technical updates are given on a 6-monthly basis.

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1.15 SWLP Report – the committee receives a quarterly update on the financial performance of South West London Pathology. At Q3, SWLP was expected to deliver its financial plan in 2020/21.

1.16 Procurement Report – the Committee has received welcome updates on the procurement team in 2020/21. The main highlight was the implementation of the SWL Procurement, hosted by the Trust.

2.0 Recommendation

2.1 The Board is recommended to receive the report from the Finance and Investment Committee in 2020/21 for information and assurance.

Ann Beasley
Finance & Investment Committee Chair,
April 2021

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APPENDIX 1: PROPOSED CHANGES TO THE FIC TERMS OF REFERENCE

4.2

Finance and Investment Committee Terms of Reference

Approved by the Trust Board: ~~28 May 2020~~

Approval and review dates

Profile	
Document name	Finance and Investment Committee Terms of Reference
Version	1.2
Executive Sponsor	Chief Finance Officer
Author	Chief Corporate Affairs Officer
Approval	
Approval group	Trust Board of Directors
Date of approval	28 May 2020
Date for next review	April 2021

Finance and Investment Committee Terms of Reference

1. Name of Group

The Finance and Investment Committee.

2. Authority

Establishment: The Finance and Investment Committee has been established as a Committee of the Trust Board. Its constitution and terms of reference are as set out below, subject to amendment by the Board as necessary.

Powers: The Finance and Investment Committee is authorised by the Board of Directors to:

i. Investigate any activity within its terms of reference
ii. Seek any information it requires and all staff are required to cooperate with any request made by the Committee
iii. Request attendance of individuals and authorities from inside and outside the Trust with relevant experience and expertise if it considers this is necessary.

Cessation: This is a standing Committee of the Board which may only be disbanded or its remit amended on the authority of the Board.

3. Purpose of the Group

The Committee has been established to assist the Trust to maximise its healthcare provision subject to its financial constraints. In this, the Committee considers patient safety to be of paramount importance. It achieves its aim by providing assurance to the Board that there are robust mechanisms in place to ensure:

i. detailed consideration is given to the Trust's financial, investment and associated performance issues to ensure that the Trust uses public funds wisely; and
ii. compliance with the guidance of regulatory bodies and achievement of the Trust's strategic aims and objectives by ensuring that adequate information is available on key issues to enable clear decisions to be made;
iii. detailed consideration is given to operational performance, and the impact of this on the Trust's financial position;
iv. effective oversight of assurance in relation to key risks relating to the Trust's estates and information technology infrastructure;
v. effective oversight of the implementation of the information technology and estates strategies.

~~*This Committee will monitor the effectiveness of measures to tackle Financial Special Measures and return the Trust to a position of financial and run rate balance.*~~

4. Duties of the Group

The Finance and Investment Committee will discharge the following duties on behalf of the Board of Directors:

(a) Finance and Business Planning:

i. Consider the ~~content of~~ planning assumptions, and principles underpinning, and development of the Annual Plan and provide scrutiny to the development of the Trust's Long Term Financial Model prior to submission to the Board for approval.
ii. ~~Agree~~ Consider the size and allocation of the Capital Programme as part of the budget setting process.
iii. Approve the process for the submission of the National Reference Cost Return prior to submission and review the results.
iv. Regularly review Patient Level Costing reports to understand efficiency, productivity and profitablility by service line, workforce group etc.

(b) Financial Strategy and Management:

i. Review financial performance and forecast against income, expenditure, working capital and capital and seek assurance that the position is in line with approved plans, targets and milestones and that any corrective measures that are being taken are effective.
ii. Review all significant financial risks and measure the Trust's financial risk rating using the scoring metrics in the NHS Oversight Framework (and NHS System Oversight Framework once implemented).
iii. ~~Recommend~~ Approve the Managing Operating Cash Policy ~~to the Board~~, receive reports in accordance with the Managing Operating Cash Policy.
iv. Review arrangements for effective compliance reporting in respect of loan covenants in place or other requirements relating to borrowed funds.
v. Seek assurance on the arrangements to ensure delivery of the Cost Improvement Programme and income growth, including monitoring performance against plan and any proposed in-year changes.

(c) Contract Management:

i. Review the Trust's negotiating position prior to annual contracting round with commissioners.
ii. Review financial and performance activity against contracts and if corrective action is required, be assured that the measures being taken are effective.
iii. Consider any tender opportunities with an annual income value exceeding £1m.

(d) Procurement and South West London collaboratives:

i. Oversee the implementation of the Trust's Procurement Strategy;
ii. Receive an annual report in respect of the Annual Procurement Plan;
iii. Seek assurance in respect of the effective operation and financial management of any South West London collaborative activity hosted by the Trust, for example South West London Pathology.

(e) Business Cases, Benefits Realisation and Return on Investment:

~~On behalf of the Board:~~

i. Undertake a robust appraisal of new business cases and re-investment business cases valued at over £1m, ensuring that the outcomes and benefits are clearly defined, measurable, support the delivery of key objectives for the Trust and that they are affordable.
ii. Approve business cases with a value of up to £5 million in line with the delegations set out in the Trust's Standing Orders, Schedule of Delegation and Standing Financial Instructions.
iii. Review benefits realisation and return on investment of major projects.

(f) Capex:

i. Consider any significant infrastructure investment prior to proposals being put to the Board for consideration/approval.
ii. Review the Medical Equipment Strategy and assurances around the Medical Equipment Replacement programme.
iii. Consider any estate disposal, acquisition or estate change of use in accordance with the Trust's Strategy and recommend to the Board.
iv. Review the Trust's arrangements for facilities management.

(g) Operational performance:

i. Undertake detailed consideration of and seek assurance in relation to the operational performance of the Trust, including scrutiny of the range of performance indictors set out in the Integrated Quality and Performance Report and in particular in relation to the operational standards set out in the NHS Constitution.
ii. Review any performance issues referred to the Committee by the Board of Directors;
iii. Review and seek assurance in relation to Emergency Preparedness, Resilience and Response, and consider the annual submission to NHS England and NHS Improvement on behalf of the Board of Directors.

~~(h) Transformation and Cost Improvement:~~

~~i. Seek assurance on the arrangements to ensure delivery of the Cost Improvement Programme and income growth, including monitoring performance against plan and any proposed in-year changes.~~

(i) Strategy and Risk:

i. Monitor the implementation of the Trust's Information Technology and Estates strategies;
ii. On behalf of the Board, ~~the Committee shall regularly~~ scrutinise the Trust's significant risks in relation to finance, operational performance, estates and information technology as set out in the Board Assurance Framework and Corporate Risk Register satisfying itself of the adequacy of the controls in place to manage and mitigate the risks. ~~This will include seeking assurance in relation to the safe operation of the Trust's estate and the robustness of estates governance.~~
iii. Provide oversight and seek assurance in relation to the Premises Assurance Model

(j) General Governance:

i. Consider matters referred to the Committee by the Board or by the groups which report to it;
ii. Review material findings arising from internal audit reports covering matters within the Committee's remit and seek assurance that appropriate actions are taken in response.
iii. Ensure there is a system in place to review and approve relevant policies and procedures that fall under the Committee's areas of interest.
iv. As required, to review any other relevant Trust strategies relevant to the Committee's terms of reference (eg those associated with procurement) prior to approval by the Board (if required) and monitor their implementation and progress.

In exercising its duties, the Committee will provide appropriate challenge and support whilst living the Trust's values.

5. Chairperson

A Non-Executive Director will Chair the Finance and Investment Committee. In his/her absence another Non-Executive member of the Committee, to be nominated by the remaining Committee members, will take the chair.

The Chief Financial Officer is the Executive Lead for the Finance and Investment Committee.

6. Composition of the Group

Membership: The membership of the Committee shall comprise four Non-Executive Directors, the Chief Finance Officer, Chief Operating Officer, Chief Medical Officer, and Chief Nurse.

The current membership of the Committee is:

Name	Title	Role in the group
Ann Beasley	Non-Executive Director	Committee Chair
Elizabeth Bishop	Non-Executive Director	Member
Stephen Collier	Non-Executive Director	Member
Tim Wright	Non-Executive Director	Member
Andrew Grimshaw	Chief Finance Officer & Deputy Chief Executive	Member
Robert Bleasdale	Chief Nurse and Director of infection Prevention and Control	Member
Richard Jennings	Chief Medical Officer	Member
Anne Brierley	Chief Operating Officer	Member

Members are expected to make every effort to attend all meetings and a register of attendance shall be maintained.

7. Attendance

The following are regular attendees at the Committee:

- Deputy Chief Finance Officer
- Director of Financial Planning
- Director of Estates and Facilities
- Chief Information Officer
- Chief Corporate Affairs Officer
- Chief People Officer
- Chief Strategy Officer
- Chief Transformation Officer
- Head of Financial Reporting

Senior representatives from each of the Trust's Divisions, e.g. Divisional Chair or Divisional Director of Operations, will attend the Committee as required.

~~*Whilst the Trust is in Financial Special Measures the NHS Improvement Financial Improvement Director will be a regular attendee.*~~

Deputies can attend the group with the permission of the Committee Chair, though they must be suitably briefed and supported by the individual for whom they are deputising in advance.

At the discretion of the Committee Chair, the Committee may also request other members of the Executive team and other relevant members of staff to attend meetings of the Committee or to attend for specific agenda items.

Governors shall be invited to attend the meeting as observers (up to three).

8. Quoracy

The quorum for the Committee shall be the attendance of a minimum of ~~three~~ four members, including at least ~~one~~ two Executive and two Non-Executive members. Regular or other attendees do not count towards the quorum.

Non-Quorate Meetings: Non-quorate meetings may go ahead unless the Chair decides not to proceed. Any decisions made by the non-quorate meeting must however be formally reviewed and ratified at the subsequent quorate meeting.

9. Declaration of Interests

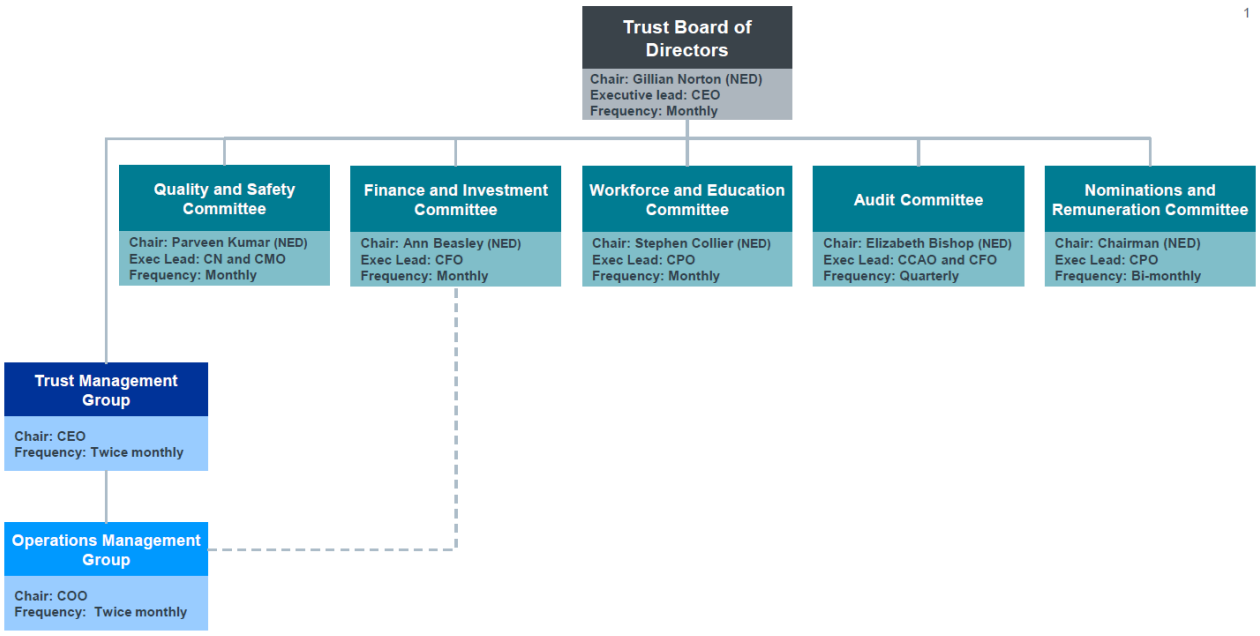
All members and those in attendance must declare any actual or potential interests; these shall be recorded in the minutes. Anyone with a relevant or material interest in a matter under consideration may be excluded from the discussion.

10. Meeting Frequency

Meetings of the Committee shall be held monthly, one week before the Board. The frequency of meetings may be changed only with the agreement of the Trust Board.

11. Relationship with other groups and committees

The Committee will report to the Trust Board.



12. Meeting arrangements and Secretarial support

i. An annual schedule of meetings of the Finance and Investment Committee shall be established prior to the start of each financial year;
ii. The Chief Finance Officer will oversee the provision of secretariat support for the Committee. This will include taking accurate minutes, producing an action log and issuing follow up actions, ensuring that the planning for and outcomes of Committee meetings are shared appropriately.
iii. The agenda for the meeting will be agreed and compiled through discussion between the Committee Chair and Executive Lead.
iv. All papers and reports to be presented at the Committee must be submitted as final Executive approved reports on the Friday before the meeting.
v. The agenda and supporting papers for the meeting will be circulated not less than three working days ahead of the meeting.

13. Report to the Board

The Committee Chair will prepare a report for the Trust Board after each meeting of the Committee. This will set out the key issues considered at each meeting and the degree to which the Committee was assured on these, specifically highlighting any areas in which there is a lack of assurance.

The Committee will, in addition, prepare an annual report to the Board setting out the key areas of focus in the previous financial year.

14. Annual cycle of business

An Annual cycle of items and reports to be received by the Committee will be agreed by the Committee. This shall be used to set the agenda for each meeting.

The annual cycle shall be reviewed on an annual basis prior to the start of the financial year and should be reported to the Board alongside the Committee's annual report.

15. Review of Committee Effectiveness and Terms of Reference

The Committee will conduct a review of its effectiveness each year, the results of which will be reported to the Board.

These Terms of Reference shall be subject to an annual review. This review should consider the performance of the Committee including the delivery of its purpose, compliance with the terms of reference and progress against its planned forward cycle of business. Any changes to the Terms of Reference require the approval of the Board.

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4.3

Meeting Title:	**TRUST BOARD**		
Date:	**27th May 2021**	**Agenda No**	**4.3**
Report Title:	**M1 Financial Performance (Interim)**		
Lead Director/ Manager:	Andrew Grimshaw, Chief Financial Officer		
Report Author:	Tom Shearer, Deputy Chief Financial Officer		
Presented for:	Update		
Executive Summary:	With so much uncertainty remaining around certain elements of the financial plan, namely Elective Recovery Fund Payments, and phasing of income plans off the back of this, reporting a financial position against a plan in month 1 becomes a material challenge. It should be noted that the Trust is not required to report a position externally for M1. It is expected that prior to the plan submission in June, these issues around reporting should be cleared up, and the Trust will be able to report a position consistent with this framework, and national principles. Therefore this position may be amended to reflect this at M2 reporting. The Trust has continued to run month end, and will report a M1 position to budget holders, as many budgets remain unaffected by this uncertainty, and the Trust needs to maintain grip and control of the financial position at budget holder level in order to deliver the plan. With the exception of the unknown quantity of income and elective recovery fund income, the Trusts reported financial position for all other aspects is broadly in line with the plan as stated in the planning paper. Below is a summary of this by plan element. As per the plan, with no ERF income the Trust would expect to report a deficit position. It is the receipt of this ERF income that brings the Trust position back in line with the position stated in the plan. Based on a first cut of activity numbers, the Trusts expects to meet this plan, although this is only an estimation at this stage.		
Recommendation:	The Trust Board notes the Interim M1 position for 2021/22		
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.		

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St George's University Hospitals NHS Foundation Trust

Previously Considered by:	N/A	**Date**	N/A
Appendices:	N/A		

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M1 Financial Performance (Draft)

4.3

Andrew Grimshaw
Chief Financial Officer

27th May 2021

Executive Summary

- With so much uncertainty remaining around certain elements of the financial plan, namely Elective Recovery Fund Payments, and phasing of income plans off the back of this, reporting a financial position against a plan in month 1 becomes a material challenge.
- It should be noted that the Trust is not required to report a position externally for M1.
- It is expected that prior to the plan submission in June, these issues around reporting should be cleared up, and the Trust will be able to report a position consistent with this framework, and national principles. Therefor this position may be amended to reflect this at M2 reporting.
- The Trust has continued to run month end, and will report a M1 position to budget holders, as many budgets remain unaffected by this uncertainty, and the Trust needs to maintain grip and control of the financial position at budget holder level in order to deliver the plan.
- With the exception of the unknown quantity of income and elective recovery fund income, the Trusts reported financial position for all other aspects is broadly in line with expectations. Below is a summary of this by plan element.
- As per the plan, with no ERF income the Trust would expect to report a deficit position. It is the receipt of this ERF income that brings the Trust position back inline with the position stated in the plan. Based on a first cut of activity numbers, the Trusts expects to meet this plan, although this is only an estimation at this stage.

	Indicative Budget M01 £m	Reported value £m	How robust is the reported value?	Comment
Block income	tbc	67.7		Reported value represents 1/12 plan total. Phasing of reported value may vary once profiled plan confirmed.
Other income	tbc	14.3		Reported value represents actual reported income to 30th April. Not expected to change
Pay	tbc	-48.5		Reported value represents actual reported pay expenditure to 30th April. Not expected to change.
Non-Pay	tbc	-31.4		Reported value represents actual reported non-pay expenditure to 30th April. Not expected to change.
Depreciation	tbc	-3.7		Reported value represents actual reported depreciation expenditure to 30th April. Not expected to change.
CIP	tbc	0.5		No specific CIPs reported in this iteration, This will be reviewed when CIP phasing confirmed. Any actual CIP for M01 would come from NR means
Surplus/(deficit) pre ERF		**-1.1**		A deficit pre-ERF seen as robust. Variance from plan to be confirmed once plan profile confirmed.
ERF income	tbc	2.1		Activity trajectories delivered on first cut of activity. However, value of income recovered to be confirmed by NHSI. It is unclear how this will work in detail. Value shown here in line with our plan value.
Surplus/(deficit) post ERF		**1**		A surplus post-ERF should be seen as possible pending confirmation of ERF income.

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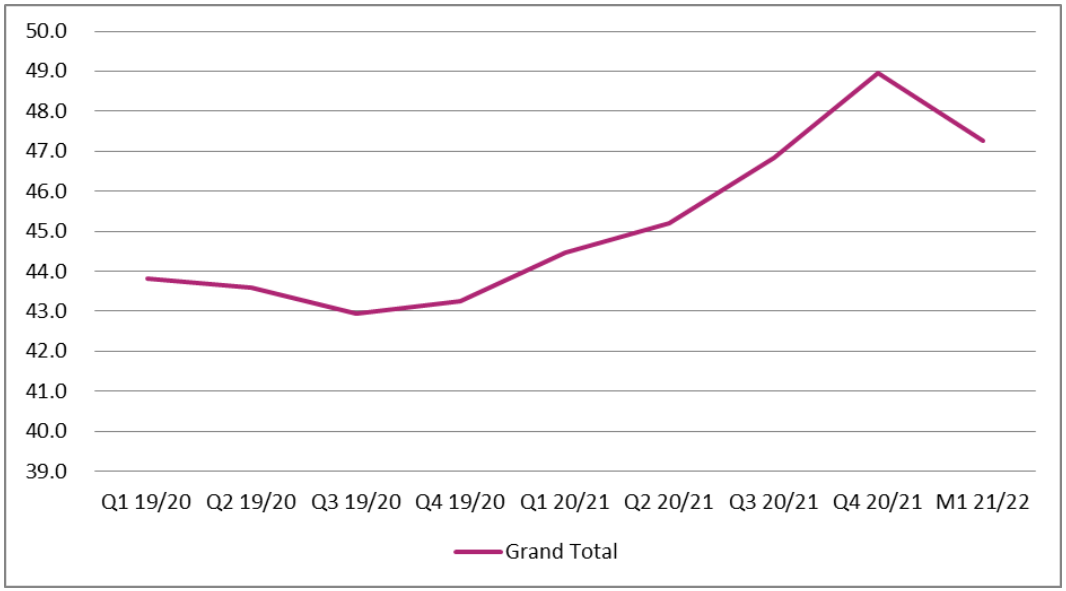
Operational Pay Run Rate

- The below shows the average monthly pay spend by quarter, against the M1 pay spend (this is not consistent with the figure shown in slide 1 due to central adjustments eg. Contingency).
- This shows the increase in pay spend over the last year as a result of the pandemic, as well as the settling of this increase in M1 21/22.
- This run rate is consistent with the budget position set for H1 21/22

Staff Type	Q1 19/20	Q2 19/20	Q3 19/20	Q4 19/20	Q1 20/21	Q2 20/21	Q3 20/21	Q4 20/21	M1 21/22
Pay Consultants	8.0	8.3	8.2	8.4	8.7	9.0	8.9	9.3	8.7
Pay Jnr Drs	4.8	5.0	5.1	4.9	5.0	5.4	5.7	5.8	5.7
Pay Non Clinical	7.6	7.2	6.8	6.8	7.3	7.6	7.9	8.7	8.2
Pay Nursing	15.2	15.0	14.9	15.3	15.4	15.8	16.1	16.7	16.4
Pay Sci, Techs, Therap	8.0	7.9	7.6	7.5	7.8	8.0	8.1	8.4	8.3
Pay Other	0.2	0.2	0.3	0.2	0.2	- 0.5	0.1	0.0	0.1
Grand Total	**43.8**	**43.6**	**42.9**	**43.2**	**44.5**	**45.2**	**46.8**	**48.9**	**47.3**



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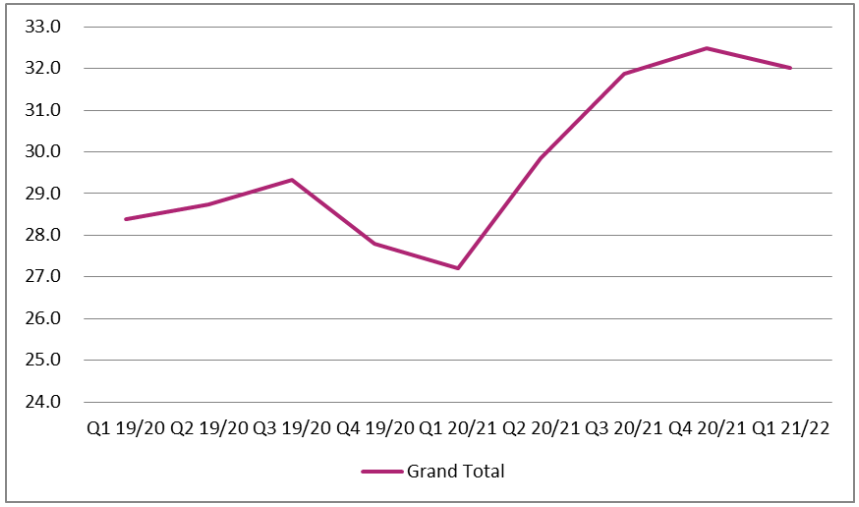
Operational Non-Pay Run Rate

- The below shows the average monthly non-pay spend by quarter, against the M1 non-pay spend. (this is not consistent with the figure shown in slide 1 due to central adjustments eg. Contingency)
- This shows the increase in non-pay spend over the last year as a result of the pandemic, as well as the settling of this increase in M1 21/22.
- This run rate is consistent with the budget position set for H1 21/22

Staff Type	Q1 19/20	Q2 19/20	Q3 19/20	Q4 19/20	Q1 20/21	Q2 20/21	Q3 20/21	Q4 20/21	Q1 21/22
Clinical Consumables	8.6	8.6	9.2	9.1	7.2	7.9	9.2	8.6	9.9
Clinical Negligence	2.0	2.0	2.0	2.0	2.2	2.2	2.1	2.4	2.2
Drugs	6.6	6.8	7.0	6.9	6.6	8.1	8.2	7.5	7.6
Establishment	1.1	1.0	1.2	1.1	1.0	1.4	1.5	2.0	1.9
General Supplies	1.8	1.5	1.6	1.5	2.1	1.8	2.5	2.0	1.9
Non Pay Other	4.1	4.3	3.9	3.3	3.5	3.6	3.7	4.5	3.2
PFI Unitary payment	0.5	0.5	0.5	0.6	0.5	0.5	0.5	0.5	0.9
Premises	3.7	3.9	4.0	3.4	4.0	4.3	4.1	5.0	4.4
Grand Total	**28.4**	**28.7**	**29.3**	**27.8**	**27.2**	**29.8**	**31.9**	**32.5**	**32.0**



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Actions prior to M2 reporting

- Work with SWL ICS to clarify Elective Recovery Fund position, and quantify risk or opportunity following this alongside the Trust activity trajectory.
- Continue to work on elective recovery plans to maximise activity within these ahead of final submission.
- Full review of M1 financial performance with divisions with actions to bring down overspends, as underspends are likely to erode away as activity is stood back up.
- Further develop CIP plan to underpin delivery of the plan through Q2 of H1.
- Continue to develop workforce plans to support delivery of Trusts objectives throughout 21/22.
- Worth through implications of further national guidance around reporting when this becomes available.

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4.4

Meeting Title:	Trust Board		
Date:	27th May 2021	**Agenda No**	**4.4**
Report Title:	**2020/21 Strategy Implementation Plans – Progress Report**		
Lead Director/ Manager:	Suzanne Marsello, Chief Strategy Officer		
Report Author:	Phoebe Foster, Strategy Projects Manager Ralph Michell, Deputy Chief Strategy Officer		
Presented for:	Assurance		
Executive Summary:	**Context** In April 2019, the Trust Board approved a Clinical Strategy for the Trust. When the Board approved the strategy, it agreed that implementation should be monitored through the development of annual implementation plans (by each Clinical Directorate), with regular progress reports to Board against those plans. Due to Covid, the Strategy Implementation Plans for 2020/21 were approved later than usual, by Trust Management Group in August 2020, and Trust Board in September 2020. It should therefore be noted that the progress update represents progress made over a 9 month period, rather than a full 12 months. Each Clinical Directorate has provided a progress update against their 2020/21 plans, which have been reviewed by the Clinical Divisions, Operational Management Group and Trust Executive. **Progress** Despite the challenge that the organisation and its clinical services have faced with Covid since March 2020, a significant amount of progress has been made in relation to progressing the Clinical Strategy. Progress has been delivered for the agreed priority clinical areas: Cancer, Children's, Neurosciences and Renal (added as a priority by the Trust Board in 2020). For some areas, such as Out-Patients, Covid has fast-tracked much of the strategy that it was previously thought would have taken 2-3 years to deliver. The Trust is on track in delivering against most of the objectives set out in the strategy implementation plans, but there are a number of objectives in the Clinical Directorate plans where there has been slippage or a risk of slippage reported. The majority of these present a low risk to making progress against delivery of the overall Trust Strategy, apart from one rated as high risk (linked to the Children's Cancer review being led by NHSE London); and two rated as medium risk (development of QMH as a Neurosciences Hub under review due to the need to reassess the plan in light of Covid; and development of a closer partnership with RMH delayed linked to the Children's Cancer review). The full detail of the directorate level progress reports, which sits behind the highlight and exception report provided to Board, has been reviewed by the Operational Management Group and the Trust Executive. In five cases, the areas of slippage relate directly to the BAF strategic risk (SR4): *As part of our local Integrated Care System, we fail to deliver the fundamental changes necessary to transform and integrate services for patients in South*		

West London.

These are highlighted in the paper: three relate to cancer services (including the children's cancer review) and the relationship with RMH; and two relate to collaborative work with ESTH (Joint Paediatric Gastroenterology Service and Joint Maternal Medicine Centre). This reinforces the challenge of making progress where partnership with other providers is key for delivery, and also the importance of partnership working and developing relationships of trust to allow timely progress to be made.

The progress update also reinforces the challenge for the Trust in pursuing its clinical strategy in a difficult financial environment, with a range of projects dependent on availability of funds (e.g. refurbishment of the paediatric estate, the development of robotic surgery, expansion of neuroscience services at QMH).

Progress in context

These progress reports relate to the second year of a five-year strategy. The Trust has made progress against the strategy overall, despite the impact of COVID in the second year. It has made good progress in building strong foundations (coming out of quality and financial special measures, and delivering a range of estates/digital infrastructure projects. It has made significant strides against its ambitions to deliver excellent local services (for instance, radically altering its outpatient offering; taking a lead role in the development of the Wandsworth Borough Estates Strategy). It has played a leading role in the development of a more collaborative system across South West London. And as a leading tertiary provider, it has made improvements to its cancer, neuroscience and paediatric offering, and laid the foundations for more radical change (for instance with the case for a joint renal unit, and the development of proposals for paediatric cancer).

The third year of the five-year strategy will however be a key year: the Trust will need to embed some of the positive change delivered through the pandemic (e.g. outpatient transformation). It will be a critical year for the Collaboration Programme with Epsom St Helier, and for the development of the ICS and Place-based leadership– with major implications for the Trust's strategic ambition to be more collaborative partner in South West London. And the work to design how specialised services are devolved, approval of the case to create one of the largest tertiary renal services in the country, and NHS England's decision on the future of paediatric cancer services could all have a major impact on the Trust's ambition to consolidate its position as the tertiary provider for South West London and Surrey.

The Government's White Paper reinforces the relevance of the four pillars of the strategy:

- Getting the basics right: the new Estates Strategy will be key to this
- Delivering excellent local services: reinforced through the move to Place-based leadership (at Borough level)
- Closer collaboration: the importance of provider collaboratives has been reinforced
- Leading Specialist Healthcare: links to the proposals to devolve specialised services and specialist services provider collaboratives

	Going forward, the Trust is reviewing its approach to strategy deployment (for instance, reviewing approaches used elsewhere such as at Western Sussex). Priorities for 2021/22 will be developed in alignment with this planned work.		
Recommendation:	**The Board is asked to review the progress update**		
Supports			
Trust Strategic Objective:	1. Treat the patient, treat the person 2. Right care, right place, right time 3. Balance the books, invest in our future 4. Build a better St. George's 5. Champion Team St. George's 6. Develop tomorrow's treatments today		
CQC Theme:	**Well Led:** the leadership, management and governance of the organisation make sure it's providing high-quality care that's based around your individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.		
Single Oversight Framework Theme:	▪ Strategic Change ▪ Leadership and Improvement Capability (well-led)		
Implications			
Risk:	As set out in the paper		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	MedCard Divisional triumvirate CWDT Divisional triumvirate SNCT Divisional triumvirate Operational Management Group Trust Executive	**Date:**	w/c 3 May 2021 w/c 3 May 2021 w/c 3 May 2021 w/c 10 May 2021 17 May 2021
Appendices:	2020/21 Strategy Implementation Plans – Progress Report		

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4.4

Trust Board

27th May 2021

2020/21 Strategy Implementation Plans – Progress Report

Suzanne Marsello, Chief Strategy Officer
Ralph Michell, Deputy CSO
Phoebe Foster, Strategy Projects Manager

Context and purpose

- In April 2019, the Trust Board approved a Clinical Strategy for the Trust.
- When the Board approved the strategy, it agreed that implementation should be monitored through the development of annual implementation plans (by each clinical directorate), with regular progress reports to Board against those plans.
- This is a report to Board on progress in 20/21.
- Each clinical directorate has drafted a progress update against their 20/21 plans.
- This paper sets out a summary of on track implementation plan objectives and an exception report for all objectives not on track. The detail of the full set of updates from clinical directorates was reviewed and agreed by the Operational Management Group and Trust Executive.
- **Board is asked to review the progress made to date**

Highlights

With the exception of those objectives set out in the exception report on the following slides, the Trust is on track in delivering against directorate 20/21 strategy implementation plans – making progress in many areas despite COVID. A (non-exhaustive) summary of key highlights includes:

Pillar of Trust strategy	Highlights
Strong foundations	Work on a number of major infrastructure projects is progressing. Work on the new **Cathlabs** has begun; ground has been broken on the installation of new **MRI capacity**. Implementation of the Trust's corporate support strategies (quality, digital etc.) is also progressing and will be reported to Board separately.
Excellent local services	The Trust's response to COVID-19 included a rapid acceleration of the shift to **virtual outpatient clinics**, with a larger number of virtual clinics now being delivered more quickly than envisaged in the Trust's Outpatient Strategy. The development of the business case for a **new Emergency Floor** is on track. QMH has been proposed as the early implementer site **Community Diagnostic Hub for** SWL, and there is on-going work to support this, which has already resulted in capital investment to provide new diagnostic equipment.
Closer collaboration	Amongst a range of collaborative projects across the clinical directorates, the joint project with Epsom and St Helier to bring together the Trusts' **renal services** is on track, and the Trust has played a leading role in mobilising a **genomic medicine** service alliance for the South East of England with Guy's and St Thomas'. There has been a strong collaborative approach to **elective recovery post-COVID-19**, with the development of surgical hubs and 'mutual aid' between SWL Providers. The Trust now has a formal **Collaboration Programme with Epsom St Helier** in place.
Leading specialist healthcare	In cancer care, the Trust is on track with the development of what is likely to be one of London's largest **Rapid Diagnostic Centres**. Work to strengthen **neuroscience networks** across South West London and Surrey is also on track and there is an agreement that the SWL and Surrey Accountable Neurology Network will be supported as a national pilot. The renal development will further strengthen the Trust's position as a leading tertiary centre. The Trust has also made significant progress in developing proposals for the Principal Treatment Centre (PTC) in **Children's Cancer,** including a joint proposal with RMH – although the NHSE timetable for options appraisal has been extended and there remains the major strategic risk that the Trust could lose the PTC.

However there are also areas of slippage against the Trust's 20/21 strategy implementation plans. These exceptions are set out on the following slides, with an assessment of the relative risk of the delay for each to delivery of the 5-year Trust strategy.

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Exception Report – CWDT

Directorate	2020/21 Strategic Objectives	Notes, including reason for slippage & mitigation	Relative Risk of delays to delivering strategy
Children's Services	Establish a Paediatric Pain Management Service.	Capacity now in place, but recruitment delays mean planned 6 month review has not yet taken place (now planned for Q1 2021)	Low
	Commence at least 1 Paediatric Ward Refurbishment; completion by end Q4.	Paediatric wards have not been prioritised as part of the Ward Refurbishment Programme, however key areas have received upgrade works. Directorate has approached the charity to support greater refurbishment.	Low
	Develop the Paediatric Cancer Model jointly with RMH.	The Trust is developing two propositions for paediatric cancer services, including one jointly with RMH in line with the process and timescales being led by NHSE London.	High
	Develop a Paediatric Gastro Service jointly with ESTH.	Governance processes across Trusts now aligned. Awaiting feedback from NHSE before further work (including on finance and contractual model) can be completed with ESTH.	Low
	Brand Children's Services and launch in Q4.	Delayed to align with NHSE process for deciding on the future of paediatric cancer services (see above)	Low
Diagnostic Services	Maintain and strengthen clinical genetics service	GMSA bid submitted & approved and a St George's clinician has been appointed Clinical Director – however elements of the GMSA's operational plan are still being discussed with NHSE.	Low
Critical Care Services	Agree the approach to capacity/ demand and long-term needs, aligned to the emerging Estates Strategy,	Funding for expansion secured, but final decision on shape of expansion expected Q1 2021/22, to enable it to be built on lessons from the second wave of COVID.	Low
	Embed further the Outreach Team and learning from Y1.	Further work to embed Outreach Team undertaken, but review of workforce requirements will be needed following expansion project and potential incorporation of SWL Transfer Service in 2021/22.	Low
Outpatient Services	Embed the shift to virtual clinics post-COVID.	Major expansion in virtual clinics delivered, but work to refine and embed the shift is on-going and will continue into 21/22	Low
	Finalise and implement outpatient structure for new landscape.	Final approval of model April 2021, and some posts have been recruited to. Roll out underway, on track for completion, with benefits expected 21/22	Low
Women's Services	Apply to become the Maternal Medicine Centre/ Hub in SWL, alongside assessing the benefits of an ESTH/ SGUH partnership in relation to this.	External requirement has changed (from application to NHSE, to agreement via local maternity system). On-going discussion about potential joint hub with ESTH.	Low
	Approval of the approach to Gynaecological Cancer Services	Proposal to maintain status quo over the next 2 years. On-going discussion with RMH	Low

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Exception Report - MedCard

Directorate	2020/21 Strategic Objectives	Notes, including reason for slippage & mitigation	Relative Risk of delays to delivering strategy
Renal, Haematology Oncology	Develop joint renal unit with Epsom St Helier	Internal Trust work on track (business case completed and submitted, with further design work underway), but NHSI approval delayed into 2021/22.	Low
	Deliver improvements against Renal Operational Delivery Network (ODN) priorities such as transplant work-up, vascular access and supportive care	Additional consultant capacity recruited to support improvement, supportive care nursing not recruited due to service development funding redirected to support Covid resource needs. Support care strategy is under development with the funding for the care nursing as a priority on the directorates service development priories for 21/22 Progress with ODN improvement priorities were paused due to COVID pressures, This is a priority area for 21/22	Low
Cardiology	Construction of new Cathlabs	Refurbishment has commenced – but full delivery now expected May 2022 rather than by end of 2021/22.	Low
Cardiac, vascular and thoracic surgery	Relocate varicose vein service to outpatients	Second Covid surge prevented moving forward and no capacity identified. Vanguard theatres at QMH due to be operational June 2021, providing service capacity to operate on this site	Low
	Explore future use of robotics in thoracic surgery	A business case has been developed for a replacement of the Trust's permanent surgical robot, but capital was not available in 20/21. That case, and the potential for expanding robotics use in other areas will be explored in 21/22.	Low
Acute Medicine & Senior Health	Optimise existing and develop new models of ambulatory care in General Medical, Acute Medicine and Senior Health Specialties	Ambulatory Gastro and Liver Disease Unit piloted, but plan for where it will be situated in the long-term impacted by COVID and not yet agreed – decision expected Q1 21/22. . Implementation of new same-day emergency care pathways across SWL delayed into 21/22 by COVID.	Low
	Develop services to meet the needs of ageing population (community geriatric assessment, Older Peoples Assessment Liaison, Frailty Network membership) – subject to commissioner investment	Some successful developments including piloting senior health liaison into GI surgery and ENT – but development of new community support models delayed by COVID. These discussions with system partners are now resuming with a view to delivering change in 2021/22 (dependent on investment).	Low

Exception Report – SNCT

Directorate	2020/21 Strategic Objectives	Reason for slippage & mitigation	Relative Risk of delays to delivering strategy
Cancer	Develop closer partnership with RMH	Significant progress in developing a joint proposition for the future of paediatric cancer services. The Trust Cancer Strategy Group agreed to delay pursuing broader collaborative opportunities with RMH until NHSE make a decision on the future of those paediatric services (now expected 2021/22), and until the Trust's future relationship with ESTH has become clearer.	**Medium**
Neurosciences	Develop QMH as a neurosciences hub and NHS leader for Functional Neurological Disorders and rehabilitation	Work on expanding neuroscience provision at QMH was paused whilst the Trust considered options for making greater use of QMH to aid elective recovery. This has led to the development of theatre capacity at QMH, due to open in 2021/22. The Trust will now need to consider options for the long-term future of the site, which will drive whether to continue exploring expansion of neuroscience services on the site. The Executive are due to consider this question in Q1 2021/22.	**Medium**
	Strengthen collaborative networks with acute and community providers across SW London and Surrey	A Service Level Agreement (SLA) for joint working across neurology with Royal Surrey is not yet signed – but is expected to be imminently. While the SWL Neurosciences Network includes representatives from Surrey-based trusts, it is not yet a formal network with Terms of Reference. To support this ambition, the Trust is engaging with NHSE (London and National teams) on piloting the Accountable Neurology Network model across SWL / Surrey in 21/22 as part of a national pilot, which will establish a formal SWL & Surrey network.	**Low**
Major Trauma	Improve rehab provision for trauma patients, by developing bespoke trauma rehab service at QMH in collaboration with neurosciences	Work on expanding rehab provision at QMH was paused whilst the Trust considered options for making greater use of QMH to aid elective recovery. This has led to the development of theatre capacity at QMH, due to open in 2021/22. The Trust will now need to consider options for the long-term future of the site, which will drive whether to continue exploring expansion of rehab services on the site. The Executive are due to consider this question in Q1 2021/22. SWL Recovery Board also considering an alternative proposal for inpatient rehab for some of these patients.	**Low**
	Develop a new model of for the major trauma service including paediatric care	Work to improve the paediatric major trauma care is complete, and the SWL & Surrey Trauma Network is overseeing improvement in trauma education. However, estates work required to implement a designated trauma ward has been delayed due to competing Covid related priorities for space and funding. The Trust has committed to ensuring a designated Major Trauma Ward is in place, per instructions from NHS England. This is currently designated to be developed in Holdsworth Ward. However, there is a need to align the development of the Major Trauma Ward with the wider Trust Estates Strategy. In addition, SWL has decreased the 21/22 capital allocation for the Trust. Currently, the Major Trauma Ward estates work is not included in the 21/22 plan, but will be a priority if further capital becomes available in Q3 or Q4.	**Low**
	Explore options to improve access to major trauma services through 24/7 Helipad access at St George's	Competing priorities during COVID recovery meant that additional costs were not able to be funded. This strategic objective remains relevant, but there is a need for the Trust to review whether this should continue to be pursued with commissioners. If agreed, further conversations with the SWL CCG will be progressed, to enable the increase in revenue required to improve access.	**Low**
Theatres and Anaesthetics	Develop specialist provision such as spinal surgery, emergency transplant theatres and robotic surgery	A business case was approved for temporary additional robotic surgery capacity for urology, and implemented in the latter half of 20/21 (ongoing in early 21/22). An outline business case for a replacement of the Trust's permanent surgical robot was approved by the SNCT DMB, but capital was not available in 20/21. That case, and the potential for expanding robotics use in other areas, will be explored in 21/22.	**Low**

Objectives in exception report linked to BAF strategic risks

2020/21 Strategic Risks: (SR4) As part of our local Integrated Care System, we fail to deliver the fundamental changes necessary to transform and integrate services for patients in South West London		
Service	**Related areas of slippage in 20/21 strategy implementation plans**	**Implications of the delay**
Children's Services	Develop the Paediatric Cancer Model jointly with RMH	This is being progressed in line with the process being led by NHSE London.
	Develop a Paediatric Gastroenterology Service jointly with ESTH	Governance processes across trusts now ;the Trust is awaiting feedback from NHSE and joint meeting with ESTH to take place. The finance and contractual model is still to be agreed. This presents a low risk as there is still ongoing discussion re collaboration and strengthening our relationship with ESTH.
Women's Services	Apply to become the Maternal Medicine Centre/ Hub in SWL, alongside assessing the benefits of an ESTH/ SGUH partnership in relation to this	The delay presents a low risk as there continues to be on-going discussion internally, with ESTH and with the Local Maternity System (LMS) about how to progress, building on the already well-established Maternal Medicine Team at St George's.
	Approval of the approach to Gynaecological Cancer Services as a networked solution, in partnership with the RMH	The delay presents a low risk as a proposal to maintain status quo over the next 2 years is being discussed with RMH.
Cancer	Develop closer partnership with RMH	See above

Analysis

- A number of areas of slippage relate to collaboration with system partners. This reinforces the **challenge of making progress where partnership with other providers is key for delivery**, and also the importance of partnership working and developing relationships of trust to allow timely progress to be made. This is an area that the executive team are committed to continuing to develop.

- The progress update also reinforces the **challenge for the Trust in pursuing its clinical strategy in a difficult financial environment**, with a range of projects dependent on availability of funds (e.g. refurbishment of the paediatric estate, the development of robotic surgery, development of neuroscience services at QMH).

- These progress reports relate to the **second year of a five-year strategy**. The Trust has made progress against the strategy overall, despite the impact of COVID in the second year. It has made good progress in building strong foundations (coming out of quality and financial special measures, and delivering a range of estates/digital infrastructure projects. It has made significant strides against its ambitions to deliver excellent local services (for instance, radically altering its outpatient offering; taking a lead role in the development of the Wandsworth Borough Estates Strategy). It has played a leading role in the development of a more collaborative system across South West London. And as a leading tertiary provider, it has made improvements to its cancer, neuroscience and paediatric offering, and laid the foundations for more radical change (for instance with the case for a joint renal unit, and the development of proposals for paediatric cancer).

- The **third year of the five-year strategy will however be a key year**: the Trust will need to embed some of the positive change delivered through the pandemic (e.g. outpatient transformation). It will be a critical year for the Collaboration Programme with Epsom St Helier, and for the development of the ICS and Place-based leadership– with major implications for the Trust's strategic ambition to be a more collaborative partner in South West London; plus the work to design how specialised services are devolved, approval of the case to create one of the largest tertiary renal services in the country, and NHS England's decision on the future of paediatric cancer services could all have a major impact on the Trust's ambition to consolidate its position as the tertiary provider for South West London and Surrey.

Summary

- Despite the challenge that the organisation and its clinical services have faced with Covid since March 2020, a significant amount of progress has been made in relation to progressing the Clinical Strategy.
- Progress has been delivered for the agreed priority clinical areas: Cancer, Children's, Neurosciences and Renal (added as a priority in 2020)
- For some areas, such as Out-Patients, Covid has fast-tracked much of the strategy that it was previously thought would have taken 2-3 years to deliver.
- The majority of objectives which are delayed present a low risk to making progress against delivery of the overall Trust Strategy, apart from one rated as high risk (linked to the Children's Cancer review being led by NHSE London); and two rated as medium risk (development of QMH as a Neurosciences Hub under review due to the need to reassess the plan in light of Covid; and development of a closer partnership with RMH delayed linked to the Children's Cancer review).
- 2021/22 will be a key year for delivery of the Trust's strategy, with a range of significant projects coming to a head (e.g. paediatric cancer, new renal unit, collaboration with ESTH, devolution of specialised services).
- Going forward, the Trust is reviewing its approach to strategy deployment (for instance, reviewing approaches used elsewhere such as at Western Sussex). Priorities for 2021/22 will be developed in alignment with this planned work.

- **Board is asked to review the progress made to date**

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St George's University Hospitals NHS Foundation Trust

4.5

Meeting Title:	**Trust Board**		
Date:	27 May 2021	**Agenda No**	**4.5**
Report Title:	**Board Assurance Framework (BAF) – Quarter 4 2020/21**		
Lead Director/ Manager:	Stephen Jones, Chief Corporate Affairs Officer		
Report Author:	Maria Prete, Risk Manager Alison Benincasa, Director of Quality Governance and Compliance		
Presented for:	**Approval, Assurance**		
Executive Summary:	This paper presents the Trust Board with the Board Assurance Framework as at Q4 2020/21 and sets out the proposed risk scores and assurance ratings, as well as the actions being taken to address identified gaps in control and assurance. With the exception of Strategic Risk 4, which is reserved to the Board, the information set out for each strategic risk has been reviewed by the relevant Board Committee, following review by the responsible sub-Group of the Trust Management Group and by the Executive Management Team. **Risk scores:** There are 7 extreme risks, 2 high risks and 1 moderate risk. Since the Board reviewed the BAF at quarter 3 in January 2021, there has been one change to the headline strategic risk scores. In February 2021, the Workforce and Education Committee agreed to lower the risk score for Strategic Risk 8 (culture) from 20 (4 consequence x 5 likelihood) to 16 (4 consequence x 4 likelihood) and to increase the assurance rating from "limited" to "partial" on the basis of the improvements achieved during the year. Following review by the relevant Board Committees, no further changes to the risk scores are proposed at Q4. **Quarter 4 Assurance ratings:** Eight of the ten strategic risks have a 'partial' assurance rating; one has a 'limited' assurance rating; and one has a 'good' assurance rating (see appendix for detail and annex for definitions). One change is proposed to the assurance ratings at Q4 – an increase from "partial" to "good" of the assurance rating for SR4 (system working). Since the Board last reviewed the BAF at Q3, the Workforce and Education Committee have recommended increasing the assurance rating for SR8 from "limited" to "partial". **Strategic Risks for the Board – SR4:** The Board is asked to review and agree the risk score and assurance level for this risk. In July, the Board set the risk score at 12 (4 consequence x 3 likelihood), with an assurance rating of 'partial'. This represented an increase in the risk score compared with the equivalent risk on the 2019/20 BAF, due to the increased significance and risks around cross-system working. When the Board reviewed this at Q3, it considered that while the Trust had made significant progress in working as part of the SWL ICS, the inherent risks around system working that went beyond the Trust's control warranted the risk score being maintained at 12. At Q4, a score of 12 is also proposed, however an increase in the assurance rating from "partial" to "good" is proposed on the basis of the progress achieved in-year. **Strategic Risks in 2021/22** At the start of each new financial year, the Board typically reviews its strategic risks to ensure these remain appropriate and comprehensive given developments within the organisation and in light of changes in the Trust's external environment alongside assessing whether the overarching strategy		

	remains valid. This year, the Trust has embarked on a review of its corporate objectives and, linked to this, is also considering its strategic priorities. As a result, it is proposed that the existing strategic risks on the BAF for 2020/21, which were set against the Trust's five-year strategy, are carried forward and reviewed at the point at which the revised corporate objectives, as part of the 'patient first' approach, are developed.
	The Board is asked: a) For the Strategic Risk reserved to itself (SR4) to: • Agree the proposed score of 12 (4c x 3l) (no change) • Agree to increase the assurance rating from 'partial' to 'good'. b) For the 9 risks assigned to its assuring Committees to: • Endorse the risk scores and assurance ratings proposed following review by the relevant Board Committee, including the change to the risk score of SR8 (culture) as agreed by the Workforce and Education Committee in February 2021; • Note that the in-year target risk scores for SR8 and SR9 have been achieved by year-end; • Note the progress achieved in year in mitigating identified gaps in control and assurance. c) To note that a review of the strategic risks on the BAF will be undertaken alongside the work currently in progress to review the Trust's corporate objectives, and implement the 'patient first' approach.
Supports	
Trust Strategic Objective:	All
CQC Theme:	Well led
Single Oversight Framework Theme:	Quality of Care Leadership and Improvement Capability
Implications	
Risk:	The strategic risk profile
Legal/Regulatory:	Compliance with Heath and Social Care Act (2008), Care Quality Commission (Registration Regulations) 2014, the NHS Act 2006, NHSI Single Oversight Framework, Foundation Trust Licence
Resources:	N/A
Previously Considered by:	Quality and Safety Committee Finance and Investment Committee Workforce and Education Committee Executive Management Team
Date	20.05.2021 20.05.2021 18.05.2021 17.05.2021
Equality and diversity:	The BAF reflects agreed risks in relation to quality and diversity and the actions being taken to address these.
Appendices:	Board Assurance Framework Q4 2020/21

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Board Assurance Framework 2020/21

Trust Board
Quarter 4 2020/21 BAF Report

Stephen Jones
Chief Corporate Affairs Officer

27 May 2021

Executive Summary

1. Purpose

This paper presents the Trust Board with the Board Assurance Framework as at Q4 2020/21 and sets out the proposed risk scores and assurance ratings, as well as the actions being taken to address identified gaps in control and assurance. With the exception of Strategic Risk 4, which is reserved to the Board, the information set out for each strategic risk has been reviewed by the relevant Board Committee, following review by the responsible sub-Group of the Trust Management Group and by the Executive Management Team.

2. Background

The Board Assurance Framework (BAF) brings together in one place all of the relevant information on the risks to the delivery of the Board's strategic objectives mas set out in its five-year clinical strategy, *Delivering Outstanding Care, Every Time*. The BAF acts as the source of evidence the Board can rely on to be confident that risks are being managed and controlled effectively. The BAF provides a structured approach for identifying and mapping the main sources of assurance and coordinating them to best effect. It also highlights where there are gaps in assurance and / or ineffective controls that need to be addressed. The BAF provides a framework through which the Board can understand the sources and levels of assurance relevant to the management of its strategic risks, and it provides an evidence-base of effective oversight of risks to the organisation and its strategic objectives.

The Board approved the new Strategic Risks on the Board Assurance Framework (BAF) at its meeting in May 2020. In July 2020, the Board agreed a set of "stretching but realistic" year-end target risk scores, which were proposed by the Executive Director responsible for each individual strategic risk and endorsed by the relevant Board Committee. The Board Committees are assigned the Strategic Risks as follows, with Strategic Risk 4 (system working) reserved to the Board:

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

At Executive level, the sub-groups of the Trust Management Group oversee the following risks:

- Patient Safety and Quality Group: SR1, SR2, SR10
- Operations Management Group: SR3, SR5, SR6
- People Management Group: SR8, SR9
- Risk and Assurance Group: SR4, SR7

In line with the decision of the Board in May 2020, the impact of Covid-19 has been measured against each strategic risk on the BAF. The Board considered including a stand alone Covid-19 strategic risk, but considered that given that the pandemic had implications across the BAF it would be more appropriate to track the impact of the pandemic against the existing strategic risks. Defined Covid-19 risks are set out on the Corporate Risk Register.

Executive Summary

3. Quarter 4 2020/21 Update:

- **Risk scores:** There are seven extreme risks, two high risks and 1 moderate risk.
- **Assurance Ratings**: Eight of the ten strategic risks currently have a 'partial' assurance rating; one has a 'limited' assurance rating; and one has a 'good' assurance rating (see appendix for detail and annex for definitions). One change to assurance ratings is proposed at Q4 – an increase from "partial" to "good" for the SR4 (system working) assurance rating.
- **Target risks:** Target risks were defined by the Board in September 2020. Performance against the target risks were reviewed by the Board Committees prior to submission of the Q4 BAF to the Board. Target risk scores have been achieved for three of the ten strategic risks (SR4, SR8 and SR9).
- **Supporting risks:** A review of the supporting risks on the corporate and divisional risk registers is regularly undertaken, and these are considered by the relevant Sub-Groups of the Trust Management Group.
- **Progress in mitigating risks:** Included in the summaries of each strategic risk are overviews of the actions completed in-year to address identified gaps in control and assurance. This is intended to demonstrate to the Board the progress achieved in mitigating the strategic risk even where this has not progressed to the point where a change in the risk score can be recommended.

Since the Board reviewed the BAF at quarter 3 in January 2021, there has been one change to the headline strategic risk scores. In February 2021, the Workforce and Education Committee agreed to lower the risk score for Strategic Risk 8 (culture) from 20 (4 consequence x 5 likelihood) to 16 (4 consequence x 4 likelihood) and to increase the assurance rating from "limited" to "partial" on the basis of the improvements achieved during the year. Following review by the relevant Board Committees, no further changes to the risk scores are proposed at Q4.

Strategic Risks 4 (system working) is reserved to the Board. The Board is asked to review and agree the risk score and assurance level for this risk. In July, the Board set the risk score at 12 (4 consequence x 3 likelihood), with an assurance rating of 'partial'. This represented an increase in the risk score compared with the equivalent risk on the 2019/20 BAF, due to the increased significance and risks around cross-system working. When the Board reviewed this at Q3, it considered that while the Trust had made significant progress in working as part of the SWL ICS, the inherent risks around system working that went beyond the Trust's control warranted the risk score being maintained at 12. At Q4, a score of 12 is also proposed, however an increase in the assurance rating from "partial" to "good" is proposed on the basis of the progress achieved in-year.

4. Strategic Risks in 2021/22

At the start of each new financial year, the Board typically reviews its strategic risks to ensure these remain appropriate and comprehensive given developments within the organisation and in light of changes in the Trust's external environment alongside assessing whether the overarching strategy remains valid. This year, the Trust has embarked on a review of its corporate objectives and, linked to this, is also considering its strategic priorities. As a result, it is proposed that the existing strategic risks on the BAF for 2020/21, which were set against the Trust's five-year strategy, are carried forward and reviewed at the point at which the revised corporate objectives, as part of the 'patient first' approach, are developed.

Executive Summary

5. Recommendation

The Board is asked:

(a) For the Strategic Risk reserved to itself (SR4) to:
- Agree the proposed score of 12 (4c x 3l) (no change)
- Agree to increase the assurance rating from 'partial' to 'good'.

(b) For the 9 risks assigned to its assuring Committees to:
- Endorse the risk scores and assurance ratings proposed following review by the relevant Board Committee, including the change to the risk score of SR8 (culture) as agreed by the Workforce and Education Committee in February 2021;
- Note that the in-year target risk scores for SR8 and SR9 have been achieved by year-end;
- Note the progress achieved in year in mitigating identified gaps in control and assurance.

(c) To note that a review of the strategic risks on the BAF will be undertaken alongside the work currently in progress to review the Trust's corporate objectives, and implement the 'patient first' approach.

Executive Summary

Strategic Risk 1: Our patients do not receive safe and effective care built around their needs because we fail to build and embed a culture of quality and learning across the organisation.

SR1 position at Q4 2020/21: Summary		
Proposed risk score at Q4:	**16** (4 consequence x 4 likelihood)	The current risk score for SR1 of 16 continues to reflect the level of risk around delays in treatment due to Covid-19. Last reviewed by Quality and Safety Committee on 20 May 2021.
Year end target risk score	**12** (4 consequence x 3 likelihood)	The target risk score at year-end has not been met. This is due to ongoing risks around Covid-19 (impact on patients, elective work, transmission). Absent Covid, our calculation is that the risk score would be 12.
Initial risk score – July 2020	**16** (4 consequence x 4 likelihood)	The Board set an initial risk score of 16 for SR1 at its meeting in July 2020.
Proposed assurance rating at Q4:	**Partial**	There has been slippage in the original timetable for the following actions: Implementation of Divisional action plans to achieve seven day clinical service standards compliance; Deliver recruitment plan to Critical Care; Improve Early Warning Score electronic device availability in the wards through Wi-Fi and address cold spots; Recruit to new positions within governance, albeit all 14 posts from the original business case have now been recruited to
Change from last quarter:	⟺ **No change**	No changes are proposed to the overall risk score or to the assurance rating at Q4. Risk score: Given the level of risk in relation to Covid-19 to patients, the impact on waiting times and elective care, it is not considered possible to reduce this risk further at this stage. Assurance rating: Given that a significant number of gaps in control and assurance remain, and there has been slippage in completion, it is not considered the appropriate time to increase the assurance rating, but as 4 of the 5 actions to address identified gaps in control and assurance are due by August 2021, it may be possible to increase the assurance rating at this stage.
SR1 In year-risk mitigation – actions taken to address gaps in control and assurance		
In year progress in mitigating risks	**Gaps in assurance and control closed in-year to date**	During 2020/21, this risk has been mitigated by the completion of a number of identified gaps in control: ➢ Development and approval of the implementation plan for year 1 of the Quality and Safety Strategy ➢ Established a standardised process for distributing key messages for learning from complaints throughout the divisions ➢ Friends and Family Test – SMS surveys for inpatient surveys set up. The Trust has also implemented a SMS feedback method for virtual and face to face outpatient appointments ➢ Electronic sepsis screening tool live on iClip ➢ Procurement of PPE is more stable as the Trust deals with UK manufacturing and suppliers ➢ Covid-19 testing is carried out on day 1, 3 and 7 of admission ➢ Mask wearing introduced for in-patients ➢ Emergency floor development has increased the number of single room isolation facilities

Executive Summary

Strategic Risk 2: We are unable to provide outstanding care as a result of weaknesses in our clinical governance

SR2 position at Q4 2020/21: Summary		
Proposed risk score at Q4:	**12** (4 consequence x 3 likelihood)	The current risk score for SR2 of 12 continues to reflect the level of risk around our clinical governance in the context of the continuing implementation of the phase 1 and 2 clinical governance reviews and the recent receipt of the phase 3 clinical governance review. Last reviewed by Quality and Safety Committee on 20 May 2021.
Year end target risk score	**8** (4 consequence x 2 likelihood)	The target risk score at year-end has not been met. This is largely due to the impact of Covid-19 operational pressures on the implementation of the actions arising from the phase 1 and 2 clinical governance reviews and the delays in considering the findings of the phase 3 review.
Initial risk score – July 2020	**12** (4 consequence x 3 likelihood)	The Board set an initial risk score of 12 for SR2 at its meeting in July 2020.
Proposed assurance rating at Q4:	**Partial**	We have considered whether the assurance rating can be upgraded in the light of the actions taken to date to address gaps in controls. However, there has been slippage in the original timetable for a number of actions to address gaps, including the following actions: Develop and implement MCA level 3 training module; The update Cerner OrderComms catalogue; Finalising the eDischarge form to be included onto iClip; Fully recruit to the new governance posts, albeit only one post out of 14 remaining; Delay in receipt of the phase 3 external governance report and the development of the associated improvement actions. It will be possible to upgrade the assurance rating when these actions are completed.
Change from last quarter:	⟷ **No change**	No changes are proposed to the overall risk score or to the assurance rating at Q4. Risk score: Unchanged due to ongoing actions to mitigate risk and address gaps. Assurance rating: Unchanged due to slippage in actions to address gaps
SR2 In year-risk mitigation – actions taken to address gaps in control and assurance		
In year progress in mitigating risks	**Gaps in assurance and control closed in-year to date**	During 2020/21, this risk has been mitigated by the completion of a number of identified gaps in control: ➢ MCA Steering Group membership established ➢ The electronic template for Capacity Assessment and best interest has been approved and launched in November 2020 supported by appropriate training. ➢ Appointment to key roles within the governance to drive learning ➢ Full implementation of the Cardiac surgery action plan

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Strategic Risk 3: Our patients do not receive timely access to the care they need due to delays in treatment and the inability of our technology and transformation programmes to provide accessible care built around our patients' lives

SR3 position at Q4 2020/21: Summary		
Proposed risk score at Q4:	20 (5 consequence x 4 likelihood)	The current risk score for SR3 continue to reflect the level of risk around new processes to delivery care and their implementation due to technology constraint. Last reviewed by Finance and Investment Committee on 20 May 2021.
Year end target risk score	12 (4 consequence x 3 likelihood)	The target risk score at year-end has been met. It reflects a realistic year end position for this risk due to the current position for 52 week waits and the overall PTL.
Initial risk score – July 2020	**20** (5 consequence x 4 likelihood)	The Board set an initial risk score of 20 for SR3 at its meeting in July 2020.
Proposed assurance rating at Q4:	**Limited**	There has been slippage in the original timetable for the following actions: implementation of the divisional action plan to achieve compliance with the seven day clinical service; improvement on cyber security; improve the ICT disaster recovery plan; progression on the virtual clinics; improvement on the data warehouse; improving the fragmented clinical records; replacement of ICT network infrastructure
Change from last quarter:	⟷ **No change**	No changes are proposed to the overall risk score or to the assurance rating at Q4. Risk score: Unchanged due to ongoing actions to mitigate risk and address gaps due for completion later in the year. Assurance rating: Considerable progress has been achieved with patient flow and the compliance with the 4 hours standards in ED; a number of ICT risks have been mitigated and on truck to mitigate the remaining extreme risks. However a significant number of gaps in control and assurance remain, and there has been slippage in completion, it is not considered the appropriate time to increase the assurance rating.
SR3 In year-risk mitigation – actions taken to address gaps in control and assurance		
In year progress in mitigating risks	**Gaps in assurance and control closed in-year to date**	During 2020/21, this risk has been mitigated by the completion of a number of identified gaps in control and assurance: ➢ Improvement in patient flow across the trust; ➢ Improvement in compliance with the 4 hour emergency standards; ➢ Successful recruitment of a cardiac physiologies within the ECHO; ➢ 50% of ICT extreme risks have been closed since December 2018; ➢ Continue roll out of Windows10 and MS teams to facilitate virtual clinical services and video conferencing ➢ EDM solution - data has been moved from the EDM trust server to a cloud based solution ➢ CDOF form incorporated within iClip

Executive Summary

Strategic Risk 4: As part of our local Integrated Care System, we fail to deliver the fundamental changes necessary to transform and integrate services for patients in South West London

SR4 position at Q4 2020/21: Summary		
Proposed risk score at Q4:	**12** (4 consequence x 3 likelihood)	The current risk score for SR4 of 12 continues to reflect the significance and importance of system working, and attendant risks
Year end target risk score	**12** (4 consequence x 3 likelihood)	The target risk score at year-end has been met. An in-year target risk score of 12(4x3) was proposed to reflect a realistic year end position for this risk
Initial risk score – July 2020	**12** (4 consequence x 3 likelihood)	The Board set an initial risk score of 12 for SR4 at its meeting in July 2020. This represented an increase in the risk score compared with the equivalent risk on the 2019/20 BAF, due to the increased significance and risks around cross-system working.
Proposed assurance rating at Q4:	**Good**	The Trust is playing an active role across the South West London system in response to the Covid-19 pandemic and in relation to elective recovery and has established and made significant progress with its collaboration programme with Epsom and St Helier Trust. It is proposed that the progress achieved warrants an increase in the assurance rating from "partial" to "good"
Change from last quarter:	↑ **Improvement**	No changes are proposed to the overall risk score or to the assurance rating at Q4. Risk score: Unchanged due to strategy long term plan for implementation of all mitigations Assurance rating: Proposed increase in assurance rating from "partial" to "good".
SR4 In year-risk mitigation – actions taken to address gaps in control and assurance		
In year progress in mitigating risks	**Gaps in assurance and control closed in-year to date**	During 2020/21, this risk has been mitigated by the completion of a number of identified gaps in control and assurance: ➢ Active participation by the Trust in the SWL ICS and Acute Provider Collaborative, particularly in relation to the management of the Covid-19 pandemic and elective recovery ➢ Establishment of a formal programme of opportunities for closer collaboration between St George's and Epsom and St Helier Trust and progress to date with this work including the establishment of a programme board established and Strategic Committees-in-Common ➢ Extension of South West London Pathology Partnership to include Epsom and St Helier Trust from April 2021 ➢ Establishment of South West London Recruitment Hub ➢ Establishment of South West London Procurement Partnership from April 2021

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Strategic Risk 5: We do not achieve financial sustainability due to under delivery of cost improvement plans and failure to realise wider efficiency opportunities

SR5 position at Q4 2020/21: Summary		
Proposed risk score at Q4:	**20** (5 consequence x 4 likelihood)	The current risk score for SR5 of 20 continues to reflect the level of risk in relation to the Trust's finances, the level of uncertainty, and the role of the system in relation to the Trust achieving its financial targets Last reviewed by Finance and Investment Committee on 20 May 2021
Year end target risk score	**12** (4 consequence x 3 likelihood)	The target risk score at year-end has not been met, however the risk score was downgraded from 25(5x5) to 20(5x4) in December 2020 on the basis of improved Trust financial position and the system-wide financial arrangements now in place
Initial risk score – July 2020	**25** (5 consequence x 5 likelihood)	The Board set an initial risk score of 25 for SR5 at its meeting in July 2020.
Proposed assurance rating at Q4:	**Partial**	There is no proposed change to the assurance rating.
Change from last quarter:	⟺ **No change**	Risk score: Risk score was downgraded from 25 to 20 in December 2020. No change proposed at Q4. Assurance rating: Assurance rating remains as 'Partial'
SR5 In year-risk mitigation – actions taken to address gaps in control and assurance		
In year progress in mitigating risks	**Gaps in assurance and control closed in-year to date**	During 2020/21, this risk has been mitigated by the completion of a number of identified gaps in control and assurance: ➢ A year end position (unaudited) has been delivered inline with forecast ➢ Divisions are being met on a monthly basis by the Deputy CFO to review overspends and underspends ➢ Draft plan in place for financial balance in first 6 months of 21/22 in line with NHSI/E control total, albeit with some risk. Second half of the year is still a work in progress in line with national frameworks.

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Strategic Risk 6: We are unable to invest in the transformation of our services and infrastructure, and address areas of material risk to our staff and patients, due to our inability to source sufficient capital funds

SR6 position at Q4 2020/21: Summary		
Proposed risk score at Q4:	**20** (4 consequence x 5 likelihood)	The current risk score of 20 reflects the challenges the Trust faces in investing in transforming our services and the delivery of care. Last reviewed by the Finance and investment Committee on 20 May 2021
Year end target risk score	**12** (4 consequence x 3 likelihood)	The target risk score at year-end has not been met as the Trust continues to work to ensure funding for 21/22 and beyond
Initial risk score – July 2020	**20** (4 consequence x 5 likelihood)	The Board set an initial risk score of 20 for SR6 at its meeting in July 2020.
Proposed assurance rating at Q4:	**Partial**	Currently there is no change to the assurance rating. A review will be undertaken in 2021/22
Change from last quarter:	⟷ **No change**	No changes are proposed to the overall risk score or to the assurance rating at Q4. Risk score: Unchanged due to ongoing actions to mitigate risk and address gaps. Assurance rating: There has been a slippage in the completion of actions.
SR6 In year-risk mitigation – actions taken to address gaps in control and assurance		
In year progress in mitigating risks	**Gaps in assurance and control closed in-year to date**	During 2020/21, this risk has been mitigated by the completion of a number of identified gaps in control and assurance: ➢ Alternative methods of financing programme have been identified for 20/21. ➢ Trusts capital plans have funding confirmed against them for 20/21 and have been delivered. ➢ SWL prioritisation in progress for 21/22 schemes, with material pressure in the capital plan for 21/22 and beyond.

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Strategic Risk 7: We are unable provide a safe environment for our patients and staff and to support the transformation of services due to the poor condition of our estates infrastructure

SR7 position at Q4 2020/21: Summary		
Proposed risk score at Q4:	**20** (4 consequence x 5 likelihood)	The current risk score for SR7 of 20 reflect the level of risk in relation to the challenges the Trust faces with its estate. Last reviewed by Finance and Investment on 20 May 2021. A number of key gaps remain, particularly in relation to capital planning and the need for a more sustainable approach for year-on-year investment for the long term. This will be mitigated by the approval of a new estate strategy There has been a slight slippage in the originally identified timetable due to Covid pressures such as oxygen supply to the Trust which has been largely successful and offered opportunities for shared learning across other compliance areas.
Year end target risk score	**16** (4 consequence x 4 likelihood)	The target risk score at year-end has not been met, however it is anticipated that this reduction will be possible within the first quarter of 2021/22.
Initial risk score – July 2020	**20** (4 consequence x 5 likelihood)	The Board set an initial risk score of 16 for SR7 at its meeting in July 2020.
Proposed assurance rating at Q4:	**Partial**	An assurance rating of 'partial' was agreed for Q3 and it is proposed that a rating of "partial" remains appropriate at Q4.
Change from last quarter:	⟷ **No change**	No changes are proposed to the overall risk score or to the assurance rating at Q4. Risk score: Unchanged due to ongoing review to ensure that all risks and appropriate mitigations are captured Assurance rating: the assurance rating will be re-assessed once the review of the risks is fully completed
SR7 In year-risk mitigation – actions taken to address gaps in control and assurance		
In year progress in mitigating risks	**Gaps in assurance and control closed in-year to date**	During 2020/21, this risk has been mitigated by the completion of a number of identified gaps in control and assurance: ➢ The Estates and Assurance Group has been established. The Group will review PAM data together with assurance reports prepared for working groups. ➢ Completed an independent review of Estates organisational design and performance, with a 12-18 month implementation plan now being finalised. ➢ Demolition of the Knightsbridge, Clare House and Bronte House together with a wide range of capital improvement projects ➢ Good progress made on development of new estate strategy

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Strategic Risk 8: We fail to build an open and inclusive culture across the organisation which celebrates and embraces our diversity because our staff are not empowered to deliver to their best and do not feel safe to raise concerns

SR8 position at Q4 2020/21: Summary		
Proposed risk score at Q4:	**16** (4 consequence x 4 likelihood)	The current risk score for SR8 of 16 reflect the level of risk in relation to culture across the organisation which embraces diversity. The Trust continues to face significant challenges in relation to diversity and inclusion. Last reviewed by Workforce and Education committee on 11 February 2021.
Year end target risk score	**16** (4 consequence x 4 likelihood)	The target risk score at year-end has been met. This is largely due to the completion of a number of identified gaps in controls and gaps in assurance: the implementation of the culture change action plan; progress in improving D&I; improving staff confidence in speaking up; the launch of the survey pulse tool system.
Initial risk score – July 2020	**20** (4 consequence x 5 likelihood)	The Board set an initial risk score of 20 for SR8 at its meeting in July 2020.
Proposed assurance rating at Q4:	**Partial**	In light of the progress in addressing identified gaps in control and assurance, in February 2021 Workforce and Education Committee agreed that assurance rating for SR8 be increased from limited to partial, in recognition of the fact that there is increased evidence available to demonstrate that systems and processes are being applied, albeit that at this stage there remain a number of gaps in assurance, a number of which will be addressed through agreed plans in relation to D&I, FTSU and through the development of the culture change action plan.
Change from last quarter:	↑ **Improvement**	Risk score: Lowered from 20 (4 consequence x 5 likelihood) to 16 (4consequence x 4 likelihood) Assurance rating: Improved from “Limited” to “Partial”
SR8 In year-risk mitigation – actions taken to address gaps in control and assurance		
In year progress in mitigating risks	**Gaps in assurance and control closed in-year to date**	During 2020/21, this risk has been mitigated by the completion of a number of identified gaps in controls: ➢ A new D&I action plan was agreed by the Board in July 2020 ➢ Plans to ensure all interview panels for Band 8a and above posts have been implemented with the training and deployment of inclusion representatives ➢ A new Freedom to Speak Up Strategy was agreed by Board in September 2020, and the Guardian has seen greater numbers of staff speaking up, and ➢ New central databases for recording FTSU concerns and bullying and harassment concerns have been launched ➢ Dignity at Work and Equality, Diversity and Inclusion policies updated ➢ Training programme has been established for staff supporting disciplinary investigations, with standardised documentation also developed ➢ The diagnostics phase of the culture change programme has been delivered with wide-ranging input from staff ➢ A Culture Diversity and Inclusion Programme Board has been established to oversee and drive forward work to strengthen our culture ➢ Software system (Selenity) in place to manage employee relations data including B&H ➢ Staff well-being group setup to respond to emerging staff concerns. Regularly attended by DoW + DoE&OD

Executive Summary

Strategic Risk 9: We are unable to meet the changing needs of our patients and the wider system because we do not recruit, educate, develop and retain a modern and flexible workforce and build the leadership we need at all levels

SR9 position at Q4 2020/21: Summary		
Proposed risk score at Q4:	**16** (4 consequence x 4 likelihood)	The current risk score for SR9 of 16 continues to reflect the level of risk in relation to recruitment, retention, education and development. The Trust faces challenges of recruitment and retention; vacancy rate remains above target as does the turnover rate. Training and developing remains a particular gap. Last reviewed by Workforce and Education Committee on 11 February 2021. The Trust believes it will be possible to reduce the score of the risk during the first quarter of 2021/22.
Year end target risk score	**16** (4 consequence x 4 likelihood)	The target risk score at year-end has been met, albeit that the Board did not consider it realistic to set a target risk lower than 16. A number of key risks and gaps in assurance remain, particularly in relation to the development of a workforce plan for the year ahead, the development and governance around the establishment of new roles to deliver patient care, and the implementation of the apprenticeship strategy. Clarity around the governance arrangements for the SWL Recruitment Hub (SLAs, KPIs etc.) is also a gap that the Trust is working with its partners across SW London to address. It is considered that a lowering of this risk score may be possible during the first half of 2021/22.
Initial risk score – July 2020	**16** (4 consequence x 4 likelihood)	The Board set an initial risk score of 16 for SR9 at its meeting in July 2020.
Proposed assurance rating at Q4:	**Partial**	An assurance rating of 'partial' was agreed for Q3 and it is proposed that a rating of "partial" remains appropriate at Q4.
Change from last quarter:	⟺ **No change**	No changes are proposed to the overall risk score or to the assurance rating at Q4. Risk score: Unchanged due to slippage in completion of actions to mitigate risk and address gaps Assurance rating: Given that a significant number of gaps in control and assurance remain, and the slippage in completion of actions, it is not considered the appropriate time to increase the assurance rating.
SR10 In year-risk mitigation – actions taken to address gaps in control and assurance		
In year progress in mitigating risks	**Gaps in assurance and control closed in-year to date**	During 2020/21, this risk has been mitigated by the completion of a number of identified gaps in control and assurance: ➢ An implementation plan for the delivery of the Workforce Strategy has been developed and has been agreed by WEC ➢ An implementation plan for the delivery of the Education Strategy has been developed and has been agreed by WEC ➢ A new central database for the tracking of Employee Relations cases ➢ New compliant contracts of employment have been developed and uploaded to TRAC and circa 600 employees with incorrect contracts have been issued with the correct contract since 6 April 2020 ➢ Guidance on Performance and Development Review (Appraisal) has been developed and implemented ➢ HR Department restructure has been implemented ➢ The approval of the Performance and Development Review (Appraisal) guidance; ➢ Funding established for NMAP staff ➢ The implementation of the updated flexible working policy / procedure ➢ Implementation of new process to keep records for honorary contract

Executive Summary

Strategic Risk 10: Research is not embedded as a core activity which impacts on our ability to attract high calibre staff, secure research funding and detracts from our reputation for clinical innovation

SR10 position at Q4 2020/21: Summary		
Proposed risk score at Q4:	**9** (3 consequence x 3 likelihood)	The current risk score for SR10 of 9 continues to reflect the level of risk in relation to research, and it is considered what this balances the strong progress on Covid research against the impact of the pandemic on non-Covid research and the absence of clarity on funding. Last reviewed by Quality and Safety Committee on 20 May 2021.
Year end target risk score	**6** (3 consequence x 2 likelihood)	The target risk score at year-end has not been met. This is largely due to the impact of Covid-19 operational pressures on non-Covid research and the absence of clarity on research funding.
Initial risk score – July 2020	**9** (3 consequence x 3 likelihood)	The Board set an initial risk score of 9 for SR10 at its meeting in July 2020.
Proposed assurance rating at Q4:	**Good**	We have considered whether the assurance rating can be upgraded. While the assurance rating is "good", it is not considered to yet meet the requirements of "substantial" given the impact of Covid and the limitations on the Trust's control environment to mitigate to the risk to non-Covid research.
Change from last month:	⟺ **No change**	No changes are proposed to the overall risk score or to the assurance rating at Q4. Risk score: Unchanged due to ongoing actions to mitigate risk and address gaps due for completion later in the year. Assurance rating: Actions to address gaps on track but not yet due. There has been no slippage in actions.
SR10 In year-risk mitigation – actions taken to address gaps in control and assurance		
In year progress in mitigating risks	**Gaps in assurance and control closed in-year to date**	During 2020/21, this risk has been mitigated by the completion of a number of identified gaps in control and assurance: ➢ The Translational and Clinical Research Institute (TACRI) has been set up ➢ Initial funding has been used to implement the research strategy, with a manager appointed for TACRI and statistical support commencing for researchers. ➢ St George's has been successful in undertaking Covid clinical research, with over 6,000 patients recruited to 39 clinical trials. We have had a high profile in Covid vaccine studies, with St George's being the UK lead for the Novavax vaccine study.

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

Strategic Objective	Corporate Objective	Risk Reference	2020/21 Strategic Risks	Assurance Rating	Risk Score	Target Risk Score
1. Treat the patient, treat the person	Care	SR1	Our patients do not receive safe and effective care built around their needs because we fail to build and embed a culture of quality improvement and learning across the organisation	Partial	Extreme - 16	High -12
	Care	SR2	We are unable to provide outstanding care as a result of weaknesses in our clinical governance	Partial	High - 12	Moderate - 8
2. Right care, right place, right time	Care	SR3	Our patients do not receive timely access to the care they need due to delays in treatment and the inability of our technology and transformation programmes to provide accessible care built around our patients' lives	Limited	Extreme - 20	High-12
	Collaboration	SR4	As part of our local Integrated Care System, we fail to deliver the fundamental changes necessary to transform and integrate services for patients in South West London	Partial	High - 12	High -12
3. Balance the books, invest in our future	Collaboration	SR5	We do not achieve financial sustainability due to under delivery of cost improvement plans and failure to realise wider efficiency opportunities	Partial	Extreme - 20	High - 12
	Collaboration	SR6	We are unable to invest in the transformation of our services and infrastructure, and address areas of material risk to our staff and patients, due to our inability to source sufficient capital funds	Partial	Extreme - 20	High - 12
4. Build a better St George's	Care	SR7	We are unable provide a safe environment for our patients and staff and to support the transformation of services due to the poor condition of our estates infrastructure	Partial	Extreme - 20	Extreme - 16
5. Champion team St George's	Culture	SR8	We fail to build an open and inclusive culture across the organisation which celebrates and embraces our diversity because our staff do not feel safe to raise concerns and are not empowered to deliver to their best	Partial	Extreme - 16	Extreme - 16
	Culture	SR9	We are unable to meet the changing needs of our patients and the wider system because we do not recruit, educate, develop and retain a modern and flexible workforce and build the leadership we need at all levels	Partial	Extreme - 16	Extreme - 16
6. Develop tomorrow's treatments today	Collaboration	SR10	Research is not embedded as a core activity which impacts on our ability to attract high calibre staff, secure research funding and detracts from our reputation for clinical innovation.	Good	Moderate - 9	Low - 6

Outstanding care every time

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

	Corporate Objective	Risk Reference	2020/21 Strategic Risks	Covid-19: Implications for the Board Assurance Framework
1. Treat the patient, treat the person	Care	SR1	Our patients do not receive safe and effective care built around their needs because we fail to build and embed a culture of quality improvement and learning across the organisation	• Implemented a programme approach for rapid change to clinical pathways to protect patients and staff from infection whilst continuing to provide essential services • Patient Partnership and Experience Group members supported the development of messages to Loved Ones and were involved in the revised hospital visiting policy • Delay in implementing recommendations from phase 1 and 2 governance review • Demand for services in wave 2 is significant and bed occupancy remains high despite temporary suspension of priority 3 and 4 activity
	Care	SR2	We are unable to provide outstanding care as a result of weaknesses in our clinical governance	• Temporary suspension of improvement work associated with the improvement actions from the 2019 CQC inspection. This work has now recommenced with revised dates, however progress has been impeded again due to the second wave • Clinical Safety Strategy developed • Delay in implementing recommendations from phase 1 and 2 governance review • Delay in receipt of the outcome of the phase 3 governance review and Trust response to the findings
2. Right care, right place, right time	Care	SR3	Our patients do not receive timely access to the care they need due to delays in treatment and the inability of our technology and transformation programmes to provide accessible care built around our patients' lives	• No specific COVID risks related to ID were identified • Vaccine hubs have been established and vaccines offered initially to high risk patient groups and staff (working in SW London Hospitals) and now open to all staff working with/ alongside patient facing staff and partner organisations • The Winter Plan 2020/21 includes comprehensive plan to respond to a second wave of Covid-19 including temporary suspension of priority 3 and 4 activity
	Collaboration	SR4	As part of our local Integrated Care System, we fail to deliver the fundamental changes necessary to transform and integrate services for patients in South West London	• The Trust is continuing to work with system partners to integrate Covid-19 recovery activity/ governance arrangements with pre-existing plans/ governance structures • The SWL Integrated Care System (ICS) has established a Covid-19 Recovery Board which has overseen the development, and will oversee delivery, of the SWL ICS Covid-19 recovery plan. The Trust CEO is a member of the SWL ICS Covid-19 Recover Board • The collaborative approach adopted across SWL in the response to Covid-19 has accelerated cross boundary working and the integration and transformation of services albeit barriers to further integration exist due to existing legal/ statutory frameworks
3. Balance the books, invest in our future	Collaboration	SR5	We do not achieve financial sustainability due to under delivery of cost improvement plans and failure to realise wider efficiency opportunities	• New financial framework in place for 2020/21 aimed at addressing Covid-19 activity, as well a standing back up elective activity • Monthly reporting will review spend to ensure costs are stepped down where expected, and cost increases due to COVID-19 are reasonable and justified • Top up funding has been received to cover costs in M1-5, with M6 funding confirmation pending. • An interim block arrangement for NHS income is to continue through M7-12 of 2020/21
	Collaboration	SR6	We are unable to invest in the transformation of our services and infrastructure, and address areas of material risk to our staff and patients, due to our inability to source sufficient capital funds	• The Trust has committed to material capital spend in response to the COVID-19 pandemic (£7.8m), for which it awaits confirmation of £1.8m of funding • Further spend has been included in the Trusts capital plan for 2020/21 relating to standing back up elective activity, and addressing urgent IT issues associated with virtual working

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

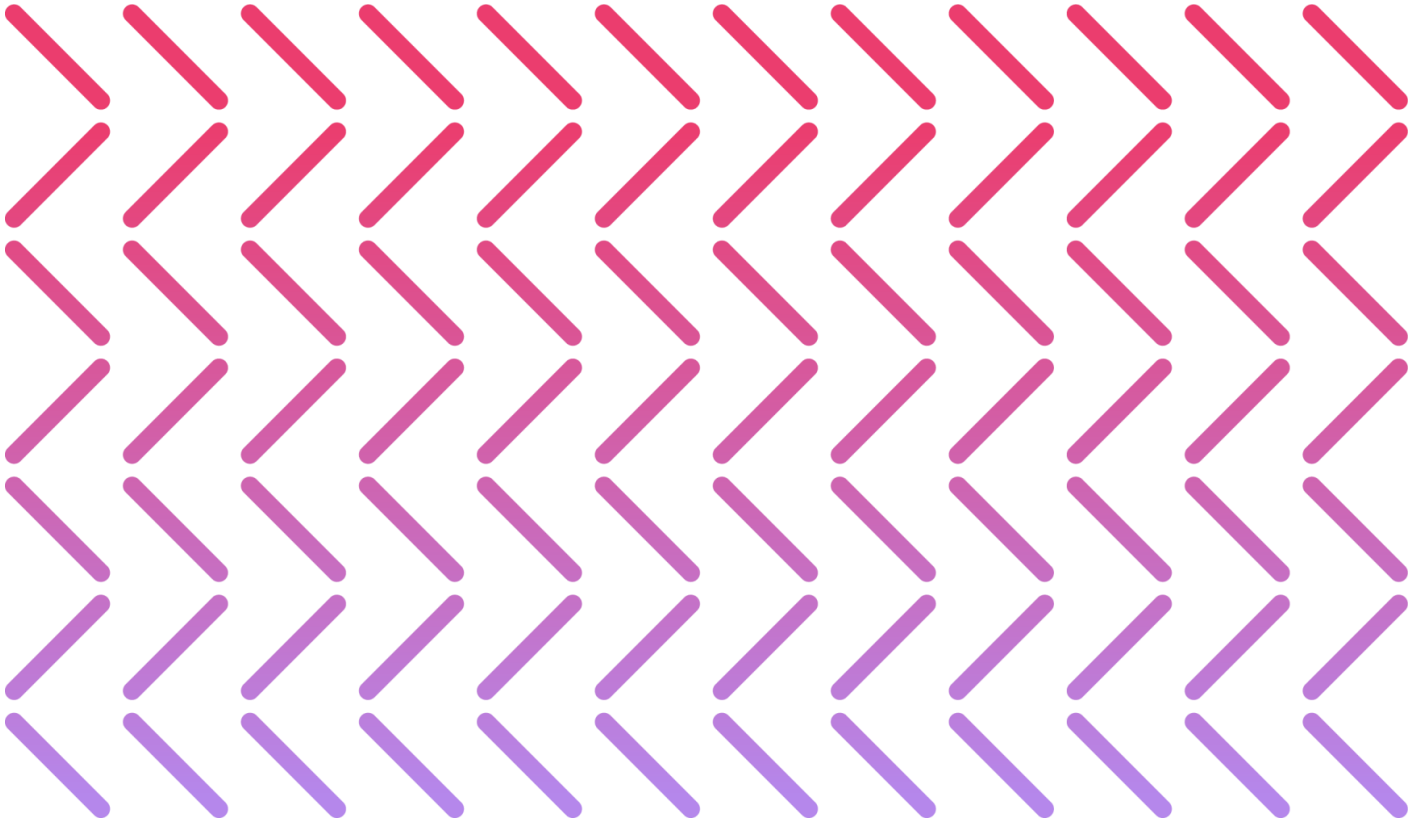
Strategic Objective	Corporate Objective	Risk Reference	2020/21 Strategic Risks	Covid-19: Implications for the Board Assurance Framework
4. Build a better St George's	Care	SR7	We are unable provide a safe environment for our patients and staff and to support the transformation of services due to the poor condition of our estates infrastructure	• Enhanced infrastructure requirements due to Covid-19 could create a wider gap between the condition of the existing estate and operational requirements • Some projects have been delayed due to Covid-19 (although others have been able to accelerate due to availability of spaces), longer term social distancing may also affect contractor timescales for delivery.
5. Champion team St George's	Culture	SR8	Our staff do not feel safe to raise concerns and are not empowered to deliver to their best because we fail to build an open and inclusive culture across the organisation which celebrates and embraces our diversity	• Fostered elements of a Team St George's spirit and staff network groups have continued to meet (and faith calendar days have been celebrated) • A number of engagement events have been paused (Go Engage pilot; TeamTalk) • Covid-19 had an impact on the completion of the diagnostic phase of the culture programme and the second wave has impacted on the timings of the development of the action plan. • Covid-19 highlighted certain underlying issues in relation to diversity and inclusion that the Trust is now seeking to address. • There has been an increase in the number of staff raising concerns during the pandemic. • Additional staff support systems have been implemented together with regular Trust wide communications
	Culture	SR9	We are unable to meet the changing needs of our patients and the wider system because we do not recruit, educate, develop and retain a modern and flexible workforce and build the leadership we need at all levels	• Staff were placed under intense pressure during the first surge, however the Trust was able to successfully redeploy staff and been able to reduce its agency spend during this period. Appraisal rates, however, have fallen and a number of education and training programmes have been delayed / deferred. • Staff remain under significant pressure in the second wave. Redeployment has again been successful but agency spend has increased over the Christmas period and due to the current levels of staff sickness and Covid-19 related absence
6. Develop tomorrow's treatments today	Collaboration	SR10	Research is not embedded as a core activity which impacts on our ability to attract high calibre staff, secure research funding and detracts from our reputation for clinical innovation.	• Non-Covid-19 clinical research studies recommenced • The Trust has had the opportunity to participate in numerous Covid-19 clinical research studies and has currently recruited to 21 Covid-19 studies, placing the Trust joint highest in England.

Outstanding care every time

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

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

SR2:
We are unable to provide outstanding care as a result of weaknesses in our clinical governance



Strategic Objective	Treat the patient, treat the person	*Corporate Objective 2020/21:*	*Care*

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

Risk Appetite / Tolerance	LOW	Patient safety is our highest priority and we have a **low appetite** for risks that impact on patient safety. Our appetite for risks affecting patient experience is also low, but is higher than for risks impacting on patient safety. If patient experience conflicts with patient safety, the safety of services will always be our highest priority.

Assurance Committee	**Quality and Safety Committee**
Executive Group	Patient Safety and Quality Group
Executive Lead(s)	Chief Nurse & DIPC Chief Medical Officer
Date last Reviewed	20 May 2021

Current risk and assurance assessment

Improvements have been noted which saw the Trust formally removed from Quality Special Measures in March 2020 but the Trust still faces a number of challenges.

The Trust has key controls and sources of assurance in place, for example the process for the investigation and reporting of serious incidents which was rated by internal audit as providing substantial assurance and availability of Treatment Escalation Plans on iClip which facilitates their promotion and auditability.

However, there are number of gaps in controls and sources of assurance, in particular delivering the clinical standards for seven day services.

The current risk score of 16 (Extreme) highlights the level of risk the Trust is balancing with particular reference to infection control and avoidable harm across nine supporting risks (five of which relate to Covid-19).

The assurance strength is rated as partial to reflect the gaps in controls and the sources of assurance outlined above and overleaf which means there are weaknesses related to controlling this strategic risk.

An in-year target risk score of 12(4x3) was approved at Board in September 2020 to reflect a realistic year end position for this risk due to the expected delivery of the identified actions to mitigate the risk and therefore reduce the risk score. This includes steps to recruit to new clinical governance positions across corporate and divisional areas, steps to improve the Trusts position on seven day services, and the role of the Trust's new Covid-19, flu and winter plan in keeping the Trust's patients safe during the next six months to year-end.

Overall SR Rating – Quarterly Scores

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

Summary COVID-19 Impact

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

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

During January and early February the Executive Team held a daily Covid-19 Gold meeting to oversee the significant associated operational issues and priorities and to review a Covid-19 daily dashboard.

Strategic Objective	Treat the patient, treat the person	*Corporate Objectives 2020/21:*	*Care*
SR1	**Our patients do not receive safe and effective care built around their needs because we fail to build and embed a culture of quality improvement and learning across the organisation**		

Key risk controls in place	Control effectiveness				Key sources of assurance	Lines of assurance (positive/ negative)		
	Q1	Q2	Q3	Q4		1	2	3
Quality and Safety Strategy in place and approved by the Trust Board (January 2020) supported by an implementation plan	**S**	**S**	S	S	• Trust removed from Quality Special Measures in March 2020 following improvements documented in CQC inspection report published in Dec 2019 • Treatment Escalation Plan (TEP) in place and implementation tracked in IQPR • Quarterly progress delivery reports to committee		x x	x
Serious Incident reporting and Investigation Policy including electronic incident reporting system (Datix) in place	**S**	**S**	S	S	• Weekly review of serious incidents at serious incident declaration meeting and monthly report to PSQG and QSC (Note the Trust is currently awaiting the new Patient Safety Incident Reporting Framework) • Internal Audit report including internal management action plan: rated substantial assurance		x x	x x
Complaints Policy in place	**G**	**G**	G	G	• Quarterly complaints report to Patient Safety Quality Group identifying emerging themes and learning • Internal Audit report including internal management action plan: rated reasonable assurance • Learning from complaints included in divisional governance reports		x x x	x
Friends and Family Test – *SMS feedback method in place for virtual and face to face outpatient appointments* SMS surveys for inpatient surveys set up	N/A	N/A	N/A	G	• Friends and Family Test: provides a measure of how we learn from our complaints • Testing phase completed in December 2020 which confirmed workability of alternative methodology		xx x	x
Infection Control Policy including Root Cause Analysis (RCA) for all C. Diff cases to ensure learning in place	S	S	S	S	• Infection control audit reports identifying emerging themes and improvement actions • Ward round monitoring to ascertain that infection control requirements are in place and followed and periods of increased Surveillance and Assessment (PISA)	x x	x x	
Early Warning Score training in place	G	G	G	G	• nEWS assurance audit completed over August/September 2020: Complete set 83%; Correctly scored 88%; Appropriate response 60%; Frequency 82%	x	x	
Sepsis tool live on iClip	G	G	G	G		x		
COVID-19 measures: patient testing, masks, and facilities	N/A	N/A	N/A	G	Covid testing carried out on day 1, 3 and 7 of admission; Masks wearing for in-patients; Emergency floor development increased number of single isolation facilities	x		

Strategic Objective	Treat the patient, treat the person	*Corporate Objectives 2020/21:*	*Care*
SR1	**Our patients do not receive safe and effective care built around their needs because we fail to build and embed a culture of quality improvement and learning across the organisation**		

Gaps in controls and assurances	Actions to address gaps in controls and assurances	Complete by (date)	Progress
Gaps in resourcing of governance functions within the corporate and divisional teams impacting on learning across the organisation	**Recruit to new positions as approved within the business plan** *All new posts have now been appointed to* • *Deputy CMO posts commenced in post 7 December 2020* • *Head of Patient Safety and Clinical Effectiveness commenced in post 11 January 2021* • *Recruitment to legal services team: all new post holders commenced in post* • *Team leader M&M and MDT Co-ordinator: commenced in post 29 March 2021* • *M&M and MDT Co-ordinators: all five posts appointed to, start dates in June 2021* • *Head of Risk and Compliance: appointed, start date 9 August 2021*	~~Sep 2020~~ May 2021	
Seven day clinical services standards (also see SR3)	**Implementation of Divisional action plans to achieve seven day clinical service standards compliance.** *All Care Groups have updated their risk assessment. Directorates have defined plans to address all non-compliance.* *Provision of MRI has an action plan which depends on re-tendering for the expansion, which has been paused. In the meantime, the Trust is planning to mitigate the impact by expanding the staffing of the current MRI capacity.*	~~Sep 2020~~ Sep 2021	
Critical Care Outreach team not recruited to full establishment	**Deliver recruitment plan to Critical Care** *Critical Care recruitment plan reviewed and revised as partial recruitment only achieved due to Covid-19. The multidisciplinary make-up of the team is being reassessed which may involve recruiting more senior nurses B7. Re-costing models currently being finalised*	~~July 2020~~ Aug 2021	
Early Warning Score electronic devices not reliable due to IT issues as patient observations are not visible by the bedside. Lack of handheld devices to facilitate nurses' awareness of vital signs	**Improve Early Warning Score electronic device availability in the wards through Wi-Fi and address cold spot** *Wi-Fi will be addressed through the ICT Network improvement Project which is expected to run until the end of 2021*	~~Jan 2021~~ Dec 2021	
Divisional reporting by ward to PSQG on the number of Treatment Escalation Plans in place for all non-elective adult patients within 24 hours of admission	**Commencement of divisional reporting on TEPs** Divisional reports to Patient Safety and Quality Group amended to ensure reporting from Quarter 1 2021/22 onwards	Jul 2021	

Strategic Objective	Treat the patient, treat the person	*Corporate Objectives 2020/21:*	*Care*
SR1	**Our patients do not receive safe and effective care built around their needs because we fail to build and embed a culture of quality improvement and learning across the organisation**		

Lead indicators	RAG Rating Q1	Q2	Q3	Q4	Lead indicators: Progress update
All adult inpatients to have a Treatment Escalation Plan in place within 24 hours of admission	S	S	S	P	April 2021 - TEP completion rates at 34 % continued to show common cause variation
Compliance with appropriate response to Early Warning Score (adult)	P	P	P	P	April 2021 - Compliance with appropriate response to EWS (adults) was 88%
Severity of reported incidents	S	S	S	S	Severity of adverse incidents – 97% No harm/ Low harm in March 2021
Number of declared serious incidents	P	P	P	P	2 serious incidents were declared in April 2021
Open serious incident investigations > 60 days	S	S	S	S	All serious incident investigations continue to be completed within the 60 day timeframe
Number of declared Never Events per month (0)	S	S	P	P	No Never Events were declared in April 2021
Infection Control (MRSA, C. Diff, MSSA, E-Coli)	P	P	P	P	MRSA 0, Hospital Acquired CDiff 2; MSSA 5; and E-Coli 7 reported in April 2021
Number of hospital acquired pressure ulcer category 3 and above	P	P	P	P	4 category 3 pressures ulcers in April 2021
Safety Thermometer percentage of patients with Harm Free Care (new harm)	S	S	N/A	N/A	National reporting paused since April 2020
Friends and Family Test	S	S	S	S	In April 2021 3 services did not meet their target for positive FFT response

Emergent / future risks	Future opportunities
• Culture shift to embed quality improvement and learning does not happen, or does not happen quickly enough • Reputation of speciality services and impact on business • System working related to hospital specific clinical pathways may mean that we cannot manage our own activity • Impact of any future surge of Covid-19 on the Trust's ability to provide care to all patients in a timely way and on its capacity to learn from incidents • Unable to ensure effective patient engagement as a result of the impact of Covid-19 • Quality Improvement Academy does not have traction to effectively promote a culture of learning across the Trust	• We can utilise the data we hold related to our patients and the activity across our services to improve our learning in the organisation and how we plan and/ or deliver our services. We can also develop, adopt and promote key safety measurement principles and use culture metrics to better understand how safe our care is • The new National Patient Safety Incident Reporting Framework with its enhanced focus on learning will enable us to work together with our patients and their families to improve our investigation of incidents • Covid-19 provides opportunities to think differently about how we engage with patients, service users and their families

Strategic Objective	Treat the patient, treat the person			Corporate Objectives 2020/21:	Care					
SR2	**We are unable to provide outstanding care as a result of weaknesses in our clinical governance**									
Risk Appetite / Tolerance	**LOW**	We have a **low appetite** for risks that affect the robustness of our clinical governance structures, systems and processes as these can impact directly on the quality of care patients receive.	**Assurance Committee**	**Quality and Safety Committee**						
			Executive Group	Patient Safety and Quality Group						
			Executive Lead(s)	Chief Nurse & DIPC Chief Medical Officer						
			Date last Reviewed	20 May 2021						
Current risk and assurance assessment	Improving clinical governance is a key priority in the Trust's Quality and safety Strategy 2019-24. The independent governance reviews undertaken in 2019 show that there is a need for significant strengthening of clinical governance. The Trust is in the process of implementing the recommendations from the reviews, but progress has been impacted by Covid-19. Following the publication of the Independent Mortality Panel's Review and Independent Scrutiny Panel's Review on 26 March 2020 Trust Board reviewed the comprehensive sources of assurance that the cardiac surgery service at St George's is safe, and the Trust Board also reviewed the assurance that all the recommendations of these reports had been or were being acted upon. The CMO and the Associate Medical Directors continue to progress improvement actions and drive engagement. The Board has requested a comprehensive report on cardiac surgery one year on from the publication of the review. The Trust has key controls and sources of assurance in place, for example the implemented Medical Examiner service and weekly care Group Leads meeting led by the Chief Medical Officer. There are number of gaps in controls and sources of assurance in particular the work to strengthen clinical governance as highlighted above by reducing variation in our processes for Mortality and Morbidity monitoring at care group level. The current risk score of 12 (High) highlights the level of risk the Trust is balancing across seven supporting risks including failure to act on diagnostic findings, to comply with the Mental Capacity Act and to improve clinical governance. The assurance strength is rated as partial to reflect the gaps in the controls and sources of assurance outlined and above overleaf which means there are weaknesses related to controlling this strategic risk. The target risk score of 8(4x2) was approved at Board in September 2020 to reflect a realistic year end position for this risk due to the expected delivery of the identified actions related to the phase 1 and phase 2 governance reviews and the completion of the phase 3 external governance review.									
			Overall SR Rating – Quarterly Scores	**Period 2020/ 2021**	**Risk Score**	**Assurance Strength**	**Change** (last reporting period)	**Inherent Risk Score**	**Target Risk Score For 2020/21**	
				Q1	**High** 12= 4(C) x 3(L)	**Partial**	**N/A**	**20 = 4(C) x 5(L)**	**8 = 4(C) x 2(L)**	
				Q2	**High** 12= 4(C) x 3(L)	**Partial**	**N/A**			
				Q3	**High** 12= 4(C) x 3(L)	**Partial**	**N/A**			
				Q4	**High** 12= 4(C) x 3(L)	**Partial**				
			Summary COVID-19 Impact	Covid-19 resulted in a temporary suspension of improvement work in particular relating to the Must and Should do actions within the Trust CQC action plan and the actions associated with the phase 1 and 2 governance reviews. The CNO and CMO have reviewed and revised the delivery dates for the improvement actions in the integrated clinical governance improvement plan with the agreement of the CQC. There have been delays in implementing recommendations from phase 1 and 2 governance review and a delay in delay in receipt of the outcome of the phase 3 governance review and the Trust engagement with the review. Other plans have also been delayed due to resources being diverted to other Covid-19 priorities.					

Strategic Objective	Treat the patient, treat the person	*Corporate Objectives 2020/21:*	*Care*
SR2	**We are unable to provide outstanding care as a result of weaknesses in our clinical governance**		

Key risk controls in place	Control effectiveness				Key sources of assurance	Lines of assurance (positive/ negative)		
	Q1	Q2	Q3	Q4		1	2	3
Action plan to deliver improvements identified by the CQC	S	S	S	S	• CQC inspection report December 2019: negative references to accuracy and safe storage of records and documentation of consent; positive references to services managing safety incidents well; and improved CQC rating for well led and a number of core services • Trust exiting Quality Special Measures • CQC reviewed progress against the CQC action plan at the Trust engagement meeting on 13 October 2020	X	X	X X X
Board agreement to invest in identified improvements to clinical governance	S	S	S	S	• Phase 1 and phase 2 external governance reviews			X X
Improvement plan for Cardiac Surgery services	S	S	S	S	• Independent external mortality review • CQC inspection report December 2019: recognised improvements in Cardiac Surgery governance processes • NICOR: The Trust is out of alert for cardiac surgery is within the expected mortality range	X	X	X X X
Risk management framework in place	R	R	R	R	• CQC inspection report December 2019: negative references to documentation of risks on risk registers • Internal audit report (internal management action plan in development)		X X	X X
Mental Capacity Act (MCA) and Liberty Protection Safeguards (LPS) strategy in place	S	S	S	S	• MCA Steering Group reports to PSQG demonstrating progress against MCA strategy		X	
MCA level 1 and level 2 training programme in place	R	R	R	R	• MCA level 1 and 2 training levels across all staff groups reported	X X	X X	
Electronic templates for the recording of Capacity Assessment and best interest decisions			G	G	• Electronic templates for the recording of Capacity Assessment launched on 2 November 2020	X		
Medical Examiner System in place	S	S	S	S	• Medical Examiner office reviewed all non-coronial inpatient deaths in May 2020		X	X
Mortality Monitoring Committee and Learning from Deaths lead in place	G	G	G	G	• Learning from Deaths report including SHMI and sources of individual mortality alerts e.g. NICOR		X	
Updated IT technical system to support eDischarge summary	R	R	R	R	• Trust does not comply with NHS England Standard Contract for Discharge Summary			X

Outstanding care every time

Strategic Objective	Treat the patient, treat the person	*Corporate Objectives 2020/21:*	*Care*
SR2	**We are unable to provide outstanding care as a result of weaknesses in our clinical governance**		

Gaps in controls and assurances	Actions to address gaps in controls and assurances	Complete by (date)	Progress
Gaps in resourcing of governance functions within the corporate and divisional teams impacting on learning across the organisation	**Recruit to new positions as approved within the business plan** *All new posts have now been appointed to* • *Deputy CMO posts commenced in post 7 December 2020* • *Head of Patient Safety and Clinical Effectiveness commenced in post 11 January 2021* • *Recruitment to legal services team: all new post holders commenced in post* • *Team leader M&M and MDT Co-ordinator: commenced in post 29 March 2021* • *M&M and MDT Co-ordinators: all five posts appointed to, start dates in June 2021* • *Head of Risk and Compliance: appointed, start date 9 August 2021*	~~Sep 2020~~ May 2021	
The architecture of clinical governance structures and forums need updating to further strengthen ward to Board reporting	**Review and develop action plan to address agreed recommendations of the phase 3 clinical governance review** The final report will be taken through Executive and Board governance. A proposed action plan will be part of the proposals submitted to Board.	May 2021	
Full implementation of the Cardiac Surgery action plan to address all recommendations from the reviews	**Implement the Cardiac Surgery action plan** *The outstanding recommendations of this and the St George's Cardiac Independent Oversight Panel Report have been completed. A further report will be presented to Board setting out the implementation of the recommendations.*	~~Jan 2021~~ Mar 2021	
MCA level 3 training module not developed	**Develop and implement MCA level 3 training module. Level 3 / Champions programme** *There is limited resource to develop and implement the level 3 MCA training module. However, the module development is underway and will be implemented in Quarter 1 2021/22.*	Mar 2021	
No audit process for patient record documentation including consent	**Develop and implement audit process for patient record documentation including consent and monitor resultant action plans** *Trust wide audit was completed in December 2020 with reports received at the Patient Records Group and Patient Safety and Quality Group in March 2021. Bi-annual audits have been included in the Clinical Audit Programme 2021/22 and output reports will be received at the relevant committees.*	Mar 2021	
OrderComms catalogue not kept up to date therefore not all results are reported via Cerner	**Update Cerner OrderComms catalogue:** *Delayed as resources diverted to set up COVID vaccine hub*	TBC	
eDischarge Summary Form not available on iClip	**Finalise the eDischarge form to be included onto iClip:** *Awaiting Cerner solution. The Trust is mitigating this risk by sending discharge documentation electronically via DOCMAN*	TBC	
Quality Surveillance Programme has been paused due to Covid-19	**Re-start programme to support the development of improvement plans**	TBC	

Strategic Objective	Treat the patient, treat the person	*Corporate Objectives 2020/21:*	*Care*
SR2	**We are unable to provide outstanding care as a result of weaknesses in our clinical governance**		

Lead indicators	RAG Rating Q1	Q2	Q3	Q4	Lead indicators: Progress update
Progress against phase 1 and phase 2 governance reviews	P	P	P	G	Learning from Deaths lead in place. Successful recruitment to all 14 posts in the original business case
Maintaining the SHIMI within the confidence level (<0.1)	S	S	S	S	SHMI is 0.856 and is lower than expected for the year December 2019 – November 2020
Open serious incident investigations > 60 days	S	S	S	S	All serious incident investigations continue to be completed within the 60 day timeframe
Readmission within 30 days (linked to failure in discharge planning)	P	P	P	P	9.7% readmission rate in March 2021, compared with 10.2% in February 2021
Number of open actions on CQC Trust wide action plan (2 Must dos: 44 should dos)	P	P	P	P	40 actions now completed, 5 actions to be carried forward as business as usual in the Trust's Operational Recovery Plan and Capital Programme for 2021/22, 1 action remains open whilst further improvement work is undertaken. CQC action plan close report to QSC on 20 May 2021
MCA level 1 and level 2 training performance	P	P	P	P	April 2021 - Level 1 MCA training compliance is above target, level 2 compliance is 80% against the 85% target, 79% in March 2021
Diagnostic indicators – DM01	L	L	L	L	April 2021, the Trust did not achieve the six week diagnostic standard with an adverse performance of 8.5% against the target threshold of 1% compared with 10.2% in March 2021

Emergent / future risks	Future opportunities
• The second wave of Covid-19 may impact on the delivery of improvement actions in the Trust CQC action plan and the Integrated Clinical Governance review action plan	• The phase 3 governance review, looking at ward to Board reporting and monitoring of quality and safety, will help to provide further clarification on reporting structures and further strengthen the Trust's reporting and accountability framework • IT developments to support new ways of working e.g.care group meetings and communication

Strategic Objective	Right care, right place, right time	*Corporate Objectives 2020/21:*	Care

SR3	Our patients do not receive timely access to the care they need due to delays in treatment and the inability of our technology and transformation programmes to provide accessible care built around our patients' lives

Risk Appetite / Tolerance	LOW	We have a low appetite for risks that impact on operational performance as this can impact on patient safety, but our appetite here is higher than for risks that directly affect the safety of our services

Assurance Committee	**Finance and Investment Committee**
Executive Lead(s)	Chief Operating Officer
Date last Reviewed	20 May 2021

Current risk and assurance assessment

Improvements have been made in our technology and the Trust has key controls and sources of assurance in place, for example the continued roll out of Windows10 and Microsoft teams has facilitated the provision of virtual clinical services and the video conferencing system for patients (Attend Anywhere) is now in use with supporting laptops, webcams and headsets installed.

However, there are a number of gaps in controls and sources of assurance as given the significant increase in the number of virtual users, the existing infrastructure now requires significant investment to ensure its stability and functionality.

In addition, although some progress has been made the Trust has not achieved the clinical standards for seven day services.

The assurance strength is rated as limited to reflect the impact of Covid-19 and the gaps in controls and the sources of assurance outlined above and overleaf which means there are weaknesses related to the control of this strategic risk.

The target risk score has been revised from 6(3x2) to 12(3x4) to reflect the current position for 52 week waits and the overall PTL.

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

Overall SR Rating – Quarterly Scores

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

Summary COVID-19 Impact

During the winter 2020 COVID surge, the Trust has sustained timely treatment for Priority 1 and urgent Priority 2 cancer and non-cancer activity. ED performance was compromised against the 4 hour standard during January and February, reflecting the challenges of flow through in-patient beds prompted by the complexities of managing infection prevention pathways across acute beds; however, as surge pressures have reduced then ED performance has strongly recovered, and is at or near the 95% standard consistently once more. The Trust continued with far more diagnostics during this most recent surge, although we reduced endoscopy activity by 45% during January and February to create the 3rd ITU surge area. Diagnostic recovery of long waiters continues to make steady progress across all modalities. The Trust ring-fenced paediatric elective capacity through this surge, recognising that the clinical prioritisation from the Royal Colleges does not always factor in the impact on a child's developmental milestones caused by safe delay in some surgical interventions; this has meant that the elective position for paediatrics currently is in a strong position.

Strategic Objective	Right care, right place, right time	*Corporate Objectives 2020/21:*	Care
SR3	**Our patients do not receive timely access to the care they need due to delays in treatment and the inability of our technology and transformation programmes to provide accessible care built around our patients' lives**		

Key risk controls in place	Control effectiveness				Key sources of assurance	Lines of assurance (positive/ negative)		
	Q1	Q2	Q3	Q4		1	2	3
Clinical Safety Strategy	S	S	S	S	Clinically driven plan agreed at Operational Management Group and approved at Quality and Safety Committee		X	
Insourced company to manage adult and paediatric ECHO. New physiologist appointed within cardiac physiology	R	R	R	R	Performance included in Integrated Quality and Performance Report (IQPR)	X	X	
ED rapid assessment and triage process in place	G	G	G	G	Clinical pathway and Standard Operating Procedure (SOP)	X		
Direct access pathways	G	G	G	G	Clinical Pathway and SOP	X		
Partnership working between ED and local Mental Health organisations to improve care and waiting time for patients attending the ED with mental health needs	R	R	R	R	Clinical Pathway, Memorandum of Understanding/ COMPACT, and local service performance metrics	X		
UCC direct pathways	G	G	G	G	Clinical Pathway and SOP	X		
Clinical Decision Outcome Form (CDOF) not incorporated within iClip	NA	N/A	N/A	R		X		
Digital strategy - ICT Work plan aligned to Digital strategy	G	G	G	G	Digital strategy aligned to Clinical Strategy and outpatient strategy		X	X X
The Informatics Governance Group (IGG) considers the strategy, work and risks throughout ICT on a monthly basis	G	G	G	G	Membership from range of disciplines, chaired by DCEO&CFO			
ICT membership in the Operational Management Group and Risk and Assurance Group	G	G	G	G	Operational requirements and priorities communicated for the provision of ICT for patients and clinicians			
Specific task to finish groups to address key issues around accessible care as they arise, chaired by DCEO&CFO	G	G	G	G	Rapid response group as an example			

Strategic Objective	Right care, right place, right time	*Corporate Objectives 2020/21:*	Care
SR3	**Our patients do not receive timely access to the care they need due to delays in treatment and the inability of our technology and transformation programmes to provide accessible care built around our patients' lives**		

Gaps in controls and assurances	Actions to address gaps in controls and assurances	Complete by (date)	Progress
Availability of paediatric trained physiologist / ECHO technicians to carry out ECHO	Recruitment of vacant post within the new cardiac physiology structure Appointment of one member of staff.	Complete	
Clinical Decision Outcome Form (CDOF) not incorporated within iClip	Incorporate CDOF into iClip. A standard CDOF was launched for Covid-19 in Apr 2020 to support virtual clinics	Complete	
Seven day clinical services standards	Implementation of Divisional action plans to achieve seven day clinical service standards compliance All Care Groups have updated their risk assessment. Directorates have defined plans to address all non- compliance. Provision of MRI has an action plan which depends on re-tendering for the expansion, which has been paused. In the meantime, the Trust is planning to mitigate the impact by expanding the staffing of the current MRI capacity.	Sep 2020	
ICT network infrastructure is old and not sufficiently resilient or able to meet today's demands for Wi-Fi and video-conferencing	Replacement of network core in Q1 2021/22 followed by campus network and Wi-Fi completing Q4 2022/23 Phased improvement over this time period	Mar 2023	
Telephony infrastructure is old and not sufficiently resilient to meet todays demands for integrated communications	Development and implementation of telephony / communications strategy enabling full business continuity and uninterrupted communications for clinicians and patients. VOIP provision expansion in immediate term	Mar 2024	
Potential loss of very old CVIS system in Cardiac Catheter Laboratory which would limit essential cardiac interventions for patients	Project to deliver replacement CVIS is aiming for May 2021 go live.	May 2021	
Virtual by Design – requirements to undertake clinical activity in a virtual environment	A variety of workstreams to deliver virtual working capability for clinical requirements. Implemented remote working, Virtual clinics with paperless records and Attend Anywhere for videoconferencing Rapid response for immediate needs including equipment and ease of system access.	Sep 2021	
Old data warehouse requiring replacement to process changing ways of extracting and processing data for reporting, including clinical data used for patient care	Improvement project identifying alternative models of data management, with requirements developed to consider other organisations in SW London. Implementation following selection.	April 2022	
Patient tracking – improved systems developed for new requirements identifying and tracking patients on the waiting list	Upgrade current reporting systems	Dec 2021	
clinical systems which do not interoperate leading to fragmented clinical records	Current projects to replace Theatreman with surgery functionality in iClip, and some results and documents reported in old EPR system moving into iClip. Maternity systems currently under consideration	Dec 2021	

Strategic Objective	Right care, right place, right time	*Corporate Objectives 2020/21:*	Care
SR3	**Our patients do not receive timely access to the care they need due to delays in treatment and the inability of our technology and transformation programmes to provide accessible care built around our patients' lives**		

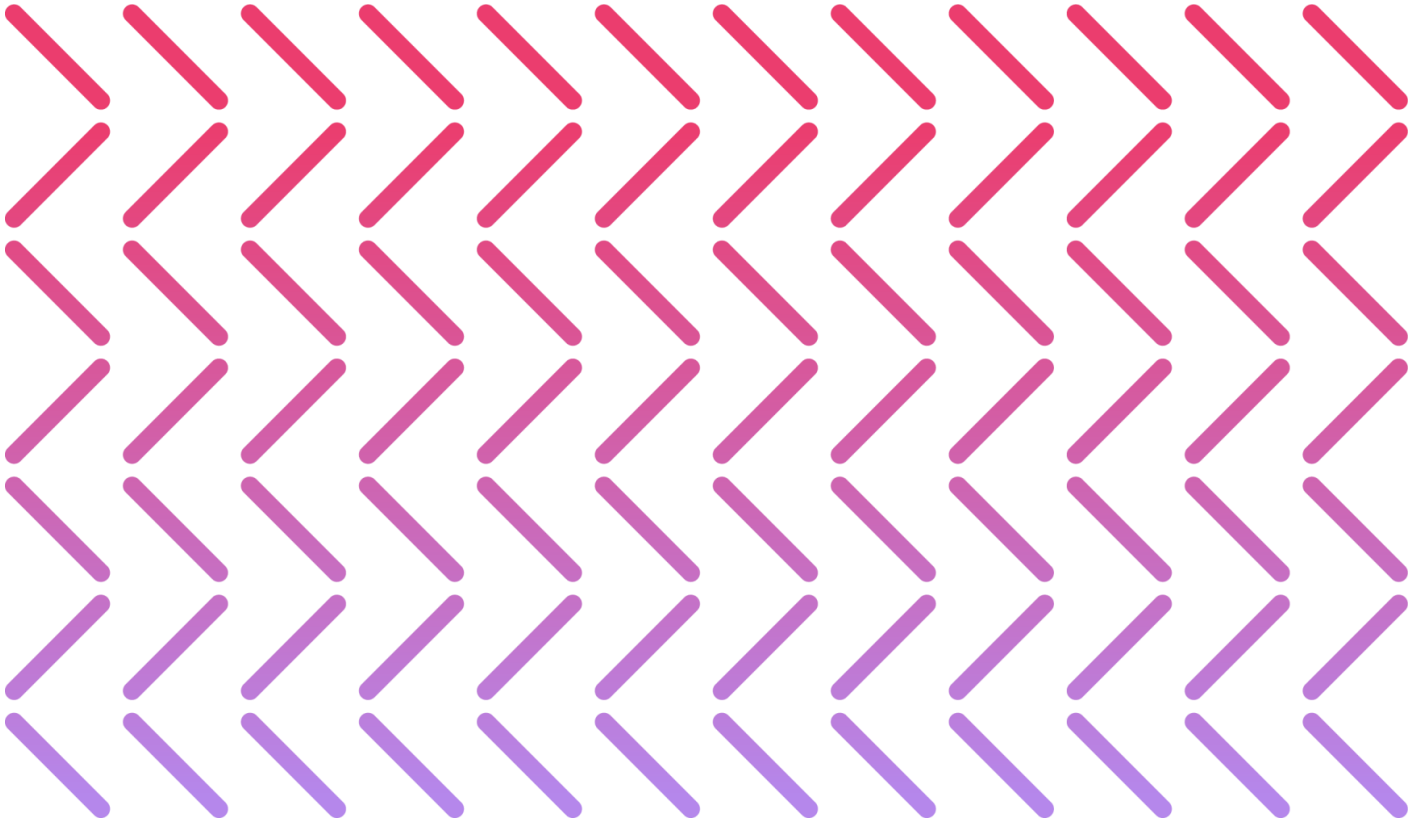
Lead indicators	RAG Rating Q1	Q2	Q3	Q4	Lead indicators: Progress update
ED attendances					March 2021 – 10558 ED Attendances. 6.36% more than March 2020
Inpatient – non elective					March 2021 – 3586 Non Elective Spells. 4.93% less than March 2020
Inpatient – elective and day case					March 2021 – 3907 Day case / Elective activity. 9.53% more than March 2020
Outpatient attendances					March 2021 – 52334 Attendances. 32.23% more than March 2020
RTT					January 2021 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. And an increase of 444 patients waiting for more than 18 weeks overall.
6 week Diagnostic Performance					In March 2021 performance against the six-week diagnostic standard was 10.2% compared to 14.8% in February
ED 4hr operating standard					March 2021 performance was 94.8%. Throughout March, a daily performance of over 95% was achieved on eighteen of the days and in the last week of March, performance again exceeded the national target of 95% and was the top performing Trust in the Region
Cancer 14 Day Standard					February 2021 Performance against the 14 day standard returned to compliance achieving 97% compared to 91% with performance moving above the mean in February
Cancer 62 Day referral to Treatment Standard					Performance in February 2021 was at 68.5%

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

Strategic Objective 2: Right Care, Right Place, Right Time
Strategic Risks SR3 and SR4

SR3:
Our patients do not receive timely access to the care they need due to delays in treatment and the inability of our technology and transformation programmes to provide accessible care built around our patients' lives

SR4:
As part of our local Integrated Care System, we fail to deliver the fundamental changes necessary to transform and integrate services for patients in South West London



Strategic Objective	Right care, right place, right time	*Corporate Objectives 2020/21:*	Collaboration

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

Risk Appetite / Tolerance	**MODERATE**	Because we recognise that significant changes are necessary across the South West London system, we have a moderate appetite for risks that impact on system transformation and cross-system working in order to facilitate changes that will improve care for patients across South West London.	**Assurance Committee**	**Trust Board**
			Executive Lead(s)	Chief Strategy Officer
			Date last Reviewed	28 January 2021

Current risk and assurance assessment

The SWL Integrated Care System's five year plan sets out how it will deliver the priorities within the NHS Long Term Plan. The Trust is a member of the SWL ICS and contributed to developing the five year plan. As the Trust works towards SWL system priorities there is a risk that these may not directly link with St George's. The Trust is an active member of the various forums across the SWL ICS and has opportunity to influence the future direction which also provides opportunity for the Trust to better understand its role in delivery. The Trust's CEO is a chair of the Acute Provider Collaborative which has a focus on developing standardised clinical pathways. The Trust is also represented on the SWL 'enabler' workstreams such as workforce, digital , estates and finance. The Trust's workforce strategy which was approved by Trust Board in November 2019 will support the Trust to develop the future workforce models required to deliver the ambitions. The management and clinical capacity within the Trust does pose a challenge going forward to enable sufficient engagement with the clinical priorities at SWL and Borough level.

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

An in-year target risk score of 12(4x3) was considered by the Board to be a realistic year end position for this risk to reflect the significant and impact of system working changes. There remains an inherent tension between the statutory framework which places accountability on individual organisations and the move to greater system working, and this tension will continue pending legislative change.

Overall SR Rating – Quarterly Scores

Period 2020/ 2021	Risk Score	Assurance Strength	Change (last reporting period)	Inherent Risk Score	Target Risk Score For 2020/21
Q1	High 12= 4(C)x3(L)	Partial	N/A	16 = 4(C) x 4(L)	12 = 4(C) x 3(L)
Q2	High 12= 4(C)x3(L)	Partial	N/A		
Q3	High 12= 4(C)x3(L)	Partial	N/A		
Q4	High 12= 4(C)x3(L)	Good	Proposed increase in assurance		

Summary COVID-19 Impact

There is a risk to delivery of pre-Covid strategic priorities due to the required focus on Covid recovery plans. The Trust is continuing to work with system partners to integrate Covid recovery activity / governance arrangements with pre-existing plans/governance structures. The SWL ICS has established a Covid-19 Recovery Board which has overseen the development of, and will oversee delivery of, the SWL ICS Covid-19 recovery plan. The Trust CEO is a member of the SWL ICS Covid-19 Recovery Board. The collaborative approach adopted across SWL in the response to Covid-19 has accelerated cross boundary working and the integration and transformation of services albeit barriers to further integration exist due to existing legal/ statutory frameworks.

Strategic Objective	Right care, right place, right time	*Corporate Objectives 2020/21:*	Collaboration
SR4	**As part of our local Integrated Care System, we fail to deliver the fundamental changes necessary to transform and integrate services for patients in South West London**		

Key risk controls in place	Control effectiveness				Key sources of assurance	Lines of Assurance (positive / negative)		
	Q1	Q2	Q3	Q4		1	2	3
The SWL ICS Programme Board on which the Trust CEO is a member	R	R	R	R	• CEO representation on the Board • Quarterly SWL ICS Updates to Trust Board		X	X
The Trust is a member of the SWL Acute Provider Collaborative	R	R	R	R	• The APC is chaired by the Trust CEO and has a focus on clinical pathway standardisation		X	X
SWL Covid-19 Recovery Structure has been established	R	R	R	R	• Trust representation on key workstreams • CEO is a member of the Recovery Board and chair of the Elective Recovery Programme		X	X
SWL Clinical Senate - set the clinical priorities for SWL	R	R	R	R	• The Trust is represented on the Clinical Senate by the CMO		X	X
SWL ICS Five Year Plan - the Trust contributed to developing the five year plan which set the priorities for SWL	R	R	R	R	• The Trust is represented at all SWL Integrated Care System meetings • The SWL ICS and Acute Provider Collaborative Forums allow general oversight of commissioner and provider plans to develop relationships outside the sector • The Trust is an active contributor to the key 'enabling' workstreams across the SWL ICS e.g. Workforce, Digital, Finance		X	X
A Wandsworth and Merton Provider Partnership Board is in place	R	R	R	R	• The Trust is represented on this Board and is a forum for agreeing the approach to place-based transformation		X	X
SWL Covid-19 Recovery Plan - driving greater collaboration	R	R	R	R	• The Trust CEO is a member of the SWL ICS Covid-19 Recovery Board , Steering Group and is chair of the Acute Cell		X	X
The Trust Workforce Strategy approved by Trust Board in November 2019 – a key driver being delivery of the SWL five year plan as well as the Trust's clinical strategy	R	R	R	R	• Implementation plans are in place and being delivered against		X	
Annual review of Trust Strategy	R	R	R	R	• The review of Trust strategy undertook in June confirmed that the priorities are still relevant taking account the changes in the external environment.		X	
Trust contribution to the Wandsworth and Merton Local Health and Care Plans	R	R	R	R	• The CSO is a member on both of the Borough Health and Care Partnership Boards • The CSO chairs the Wandsworth Borough Estates Strategy Working Group which will reflect any changes in clinical priorities		X	X
Exploration of opportunities for closer collaboration between St George's and Epsom and St Heliers Hospitals			R	R	• Programme Board established and Strategic Committees in Common set up, with ToR approved by both Boards		X	

Strategic Objective	Right care, right place, right time	*Corporate Objectives 2020/21*	Collaboration
SR4	**As part of our local Integrated Care System, we fail to deliver the fundamental changes necessary to transform and integrate services for patients in South West London**		

Gaps in controls and assurances	Actions to address gaps in controls and assurances	Complete by (date)	Progress
Limited clinical and management capacity within the Trust to engage with and deliver the clinical priorities for Wandsworth and Merton as set out in their respective Local Health and Care Plans	Both Wandsworth and Merton Health and Care Partnership Boards have reviewed the priorities in the LCHP in light of Covid-19 and this will provide an opportunity to re-assess the Trust's role in delivering these (The Trust is represented on both Boards) Future business planning activities to take account of the Trust's contribution to delivering the key priorities in the LHCP. NHSE/I have delayed business planning due to COVID, so this will be completed later than March 2021	March 2021	
With Covid-19 recovery being planned at SWL ICS level there is potential for Wandsworth and Merton Borough level priorities to be over-looked	Wandsworth and Merton Provider Board meetings which are attended by the Trust CEO are to identify any particular issues and so to act as the bridge between borough and system level planning	March 2021	
Trust's ability to fully utilise the space most effectively at QMH as part of the Covid-19 recovery response is constrained by financial agreements in place	The CFO to have discussions with the CCGs to agree principles as part of the wider QMH programme priorities Agreement with CCG that given SWL-wide financial control total, costs of rental will not be moved around the system	Complete	

Strategic Objective	Right care, right place, right time	*Corporate Objectives 2020/21:*	Collaboration
SR4	**As part of our local Integrated Care System, we fail to deliver the fundamental changes necessary to transform and integrate services for patients in South West London**		

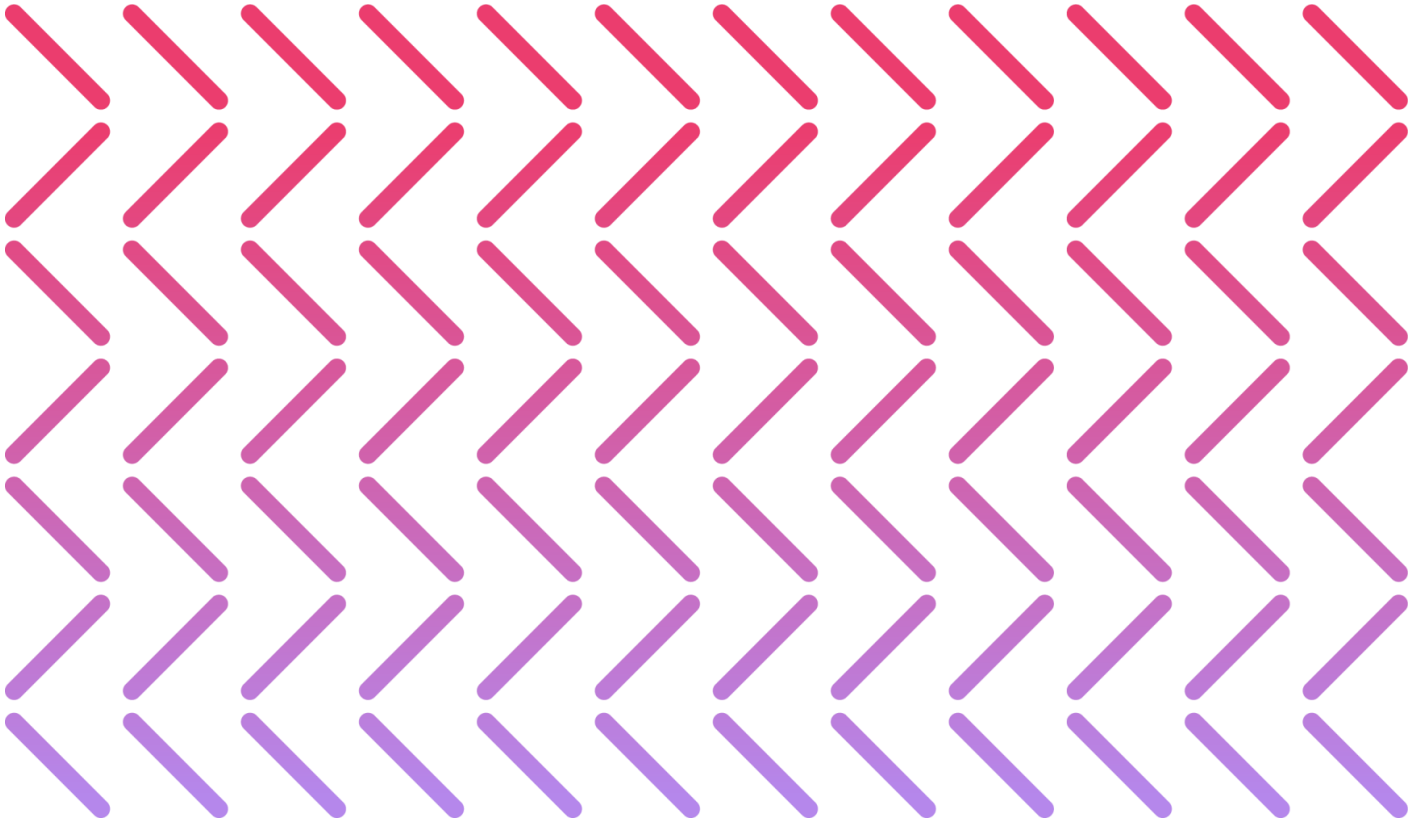
Lead indicators	RAG Rating Q1	Q2	Q3	Q4	Lead indicators: Progress update
A SWL Covid19 recovery plan in place					The Trust is represented on the SWL Recovery Board and associated workstreams leading the development of the Covid-19 recovery plan, which has now been agreed.
Clinical Safety Strategy in place and has identified revised clinical pathways across SWL					14 SWL clinical networks have now been established – though some elements of their work programmes have been paused due to COVID
The number of clinical networks which are fully established for which SGUH is the lead provider					SGUH clinicians have leadership roles in 8 of the 14 networks
The number of key SWL meetings that have appropriate representation from SGUH					The CEO is a member of the SWL ICS Programme Board and SWL Recovery Board , chair of the Elective Recovery Programme and APC. Borough level meetings are represented by the Chief Strategy Officer.
Delivery of Clinical Strategy implementation plans	n/a				Plans have been revised during Q2 to reflect any implications of Covid-19 and first progress report was presented to Trust Board in September 2020
Delivery of Corporate Support Strategy implementations plans	n/a				Implementation plans have been developed and approved during Q2. First progress report was presented to Trust Board September 2020

Emergent / future risks	Future opportunities
The continued focus on the response to Covid-19 may put additional pressure on the clinical and management capacity within the Trust to focus on SWL five year plan priorities The outcome of the Building Your Future Hospitals (BYFH, previously Improving Healthcare Together or IHT) programme may present some risks to the Trust's ability to manage the potential increase in demand. The Trust has set out the capital investment it would require from the programme, as well as enabling investment in ED required from other sources, but these have not yet been confirmed.	The SWL Covid-19 Recovery Programme Board and associated recovery plan will provide an opportunity for enhanced collaborative working to achieve greater integration and transformation of services The outcome of the Improving Healthcare Together programme may provide an opportunity for greater collaboration between St George's, Epsom and St Helier and the Royal Marsden The consultation on the future of Integrated Care Systems may support closed system working and provide a statutory framework on which to build closer collaboration and integration.

Strategic Objective 3: Balance the books, invest in our future
Strategic Risks SR5 and SR6

SR5:
We do not achieve financial sustainability due to under-delivery of cost improvement plans and failure to realise wider efficiency opportunities

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



Strategic Objective	Balance the books, invest in our future
SR5	**We do not achieve financial sustainability due to under delivery of cost improvement plans and failure to realise wider efficiency opportunities**

Risk Appetite / Tolerance	**LOW**	We have a low appetite for risks that will threaten the Trust's ability to deliver services within our financial resources	**Assurance Committee**	**Finance and Investment Committee**
			Executive Lead(s)	Chief Finance Officer
			Date last Reviewed	20 May 2021

4.5

Current risk and assurance assessment

Financial planning in the NHS was postponed at the beginning of the pandemic, which included the requirement to develop a CIP plan in its traditional sense. This provides a risk to the organisation getting out of the 'rhythm' of delivering CIPs. This position is continued into Q1 21/22, and is highly likely to continue through Q2.

The Trust has continued pursuing limited delivery of CIPs with procurement, lead by the CFO and Director of Procurement. Engagement has been challenging due to operational and clinical focus on the response to COVID 19.

Divisional financial performance is being picked up through the Operational Management Group, through to Trust Management Group.

Divisions are being met on a monthly basis by the Deputy CFO to review overspends, and underspends. Equal attention is being given to both as ensuring underspends on areas of lower activity due to the pandemic will form a material part of the financial recovery plan.

The year end, unaudited financial position is consistent with the forecast presented through to NHSI by the Trust.

Financial envelopes for 21/22 are yet to be confirmed for H2, with some risks existing in the H1 envelope (non-NHS income funding, CIPs). For this reason, it is felt prudent to keep the risk score at 20, but the Trust is assured that the new envelopes and frameworks move this risk score.

Overall SR Rating – Quarterly Scores

Period 2020/ 2021	Risk Score	Assurance Strength	Change (last reporting period)	Inherent Risk Score	Target Risk Score
Q1	**Extreme 25 = 5(c) x 5(L)**	**Partial**	**N/A**	**25= 5(c) x 5(L)**	**12 4(c) x 3(L)**
Q2	**Extreme 25 = 5(c) x 5(L)**	**Partial**	N/A		
Q3	**Extreme 20 = 5(c) x 4(L)**	**Partial**	↓ Risk reduced to 20 from 25		
Q4	**Extreme 20 = 5(c) x 4(L)**	**Partial**	N/A		

Summary COVID-19 Impact

- New financial framework in place for 20/21 aimed at addressing COVID 19 activity, as well a standing back up elective activity. This will continue into H1 21/22.
- Monthly reporting will review spend to ensure costs are stepped down where expected, and cost increases due to COVID are reasonable and justified.
- Top up funding has been received to cover costs in M1-6 funding
- An interim block arrangement for NHS income continued through M7-12 of 20/21.

Strategic Objective	Balance the books, invest in our future
SR5	We do not achieve financial sustainability due to under delivery of cost improvement plans and failure to realise wider efficiency opportunities

Key risk controls in place	Control effectiveness				Key sources of assurance	Lines of Assurance (positive / negative)		
	Q1	Q2	Q3	Q4		1	2	3
Monthly divisional finance meetings with in place with DCFO to discuss areas for escalation (underspends/overspends)	S	S	S	S	Monthly divisional finance reports	xx	xx	
Monthly reporting of financial issues through to OMG, TMG, FIC and Trust Board	S	S	S	S	Monthly Trust finance reports	xx	xx	
Monthly external review of Trust position by NHSE/I as part of monthly top-up payment review	S	S	S	S	Top up payment made to Trust		x	x
Bottom up forecast in place, with monthly performance being scrutinised vs both budget and forecast.	S	S	S	S	Monthly report to Finance and Investment Committee		x	
South West London FAC continued to develop system financial management processes in support of delivery of control totals.	L	L	G	G	SWL Monthly Finance Report			x
Plan in place for financial balance in 21/22 , or in line with NHSI/E control total			P	P	Plan agreed as part of SWL for financial balance in 21/22.			x

Strategic Objective	Balance the books, invest in our future
SR5	We do not achieve financial sustainability due to under delivery of cost improvement plans and failure to realise wider efficiency opportunities

Gaps in controls and assurances	Actions to address gaps in controls and assurances	Complete by (date)	Progress
Baseline budgets that are out of date with current situation	- Financial forecast to be developed to drive improvement and efficiency within divisional positions	Complete	
Lack of consistent performance management within divisions, down to directorate and Care Group level	- DCFO to seek assurance of divisional financial governance arrangement, and intervene where necessary. - Issues picked up by CFO following monthly review. Escalation in place via HoFs.	Complete	
No formal CIP plan of efficiency plan in place	- CIP/efficiency targets to be established alongside financial forecast - Limited is scope due to constraints of COVID - Trust reporting balanced financial position including some efficiencies. Delivery to be monitored through monthly reporting.	Complete	
Current forecast predicts c£75m shortfall against current levels of funding	- Challenge to be made through divisional financial reviews - Issues to be raised through SWL ICS to NHSEI regarding funding shortfalls - Awaiting confirmation of M7-12 funding to confirm scale of challenge.	Complete	
South West London financial performance management structure in place to drive and ensure financial performance and best practise within sector	- Trust to lead development of financial governance with SWL ICS - Framework agreed by CFOs and CEOs - Further work required to ensure full benefit realised from SWL working.	Sept 20	
Capacity plan not fully developed inline with new working environment post COVID	- Capacity plan to be agreed in line with financial forecasts and performance trajectories through OMG - Capacity plan agreed as part of activity trajectory's. Still a work in progress - Whilst complete for theatres and inpatient beds, further work required on outpatients.	Sept 20	
Lack of accountability within services for financial performance and delivery	- Finance to be included within objectives of all leadership posts with financial responsibility within the organisation	Nov 20	
Plan for 21/22 currently year still in infancy, with no clarity in level of income the Trust will be in receipt of	- Continue to progress work as per planning timetable internally and with SWL ICS - Await planning guidance, and funding enveloped so scale of challenge, and action required can be confirmed.	Mar 21	

Strategic Objective	Balance the books, invest in our future
SR5	We do not achieve financial sustainability due to under delivery of cost improvement plans and failure to realise wider efficiency opportunities

Lead indicators	RAG Rating Q1	Q2	Q3	Q4	Lead indicators: Progress update
Financial balance achieved YTD					Deficit position reported YTD due to shortfall of non-NHS income, which the Trust is awaiting final confirmation of.
Financial balance forecast through to year end					Balanced forecast submitted, pending confirmation of £13m non-NHS income funding.
CIP/improvement plan to be agreed and delivered					Efficiency plan in place for 20/21. Further work required on stepping back up recurrent efficiency programme ahead of 21/22.
SWL plan to be developed to remain within control total					SWL position remains balances, although risks in some providers being offset by favourable positions in others.

Emergent / future risks	Future opportunities
- Financial envelopes for 21/22 risk not being at the level the Trusts needs for recovery. - Non-NHS income recovery will continue to be challenged, with the Trust continuing to be reliant on this being covered by further NHS block income. - Competing priorities within divisions meaning finance isn't prioritised	- Financial improvement/mitigation through further collaboration within the SWL ICS

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

Risk Appetite / Tolerance	**LOW**	Due to the importance of securing investment in the Trust's ageing estates infrastructure, we have a low appetite for risks that could impact on the availability of capital	**Assurance Committee**	**Finance and Investment Committee**
			Executive Lead(s)	Chief Finance Officer
			Date last Reviewed	20 May 2021

Current risk and assurance assessment

- Prioritisation completed at SWL level as part of planning process
- The entire 20/21 plan was funding in full.
- Monthly reviews taking place with DCFO to ensure limited funds are prioritised and risks articulated from funding shortfalls.
- Trusts capital plans for 21/22 and beyond do not have sources of funding confirmed against them.
- SWL prioritisation in progress for 21/22 schemes.
- Significant shortfall currently in existence across South West London when comparing essentially plans to CDEL allocation. Mitigation being worked through in the ICS, but has a material impact on St George's.

Overall SR Rating – Quarterly Scores

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

Summary COVID-19 Impact

- The Trust has committed to material capital spend in response to the COVID 19 pandemic (£8.8m), for which funding has now been confirmed.

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

Key risk controls in place	Control effectiveness				Key sources of assurance	Lines of Assurance (positive / negative)		
	Q1	Q2	Q3	Q4		1	2	3
Monthly reporting to FIC and Trust Board on key areas of risk, both financially, and due to non-investment.	S	S	S	S	Monthly finance reports		X	
Weekly COVID Capital funding update and discussion at OMG, to review clinical urgency of requests.	S	S	S	S	Weekly update to OMG on status of COVID capital bids		X	
Evolution and development of capital prioritisation at SWL level through CFO meeting (FAC)	S	S	S	S	SWL Capital Plan report		X	

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

Gaps in controls and assurances	Actions to address gaps in controls and assurances	Complete by (date)	Progress
Confirmation of emergency financing to fund essential programme of capital works	Pursue emergency funding through the ICS through to NHSI/E London through CFO As there is some external delay in confirmation of national funding regime, it is expected that this action will be completed by September 2020	Aug 20	
No alternative means of financing identified to fund programme	Alternative methods of financing current programme to be developed by DCFO Further work is ongoing to ensure all options are explored between now and the end of the year. Awaiting confirmation of national funding regime. All funding secured for 20/21 programme.	Aug 20	
Confirmation of funding for 21/22 programme in place	Further work required through ICS to ensure funding for 21/22 (and beyond) in place.	Mar 21	

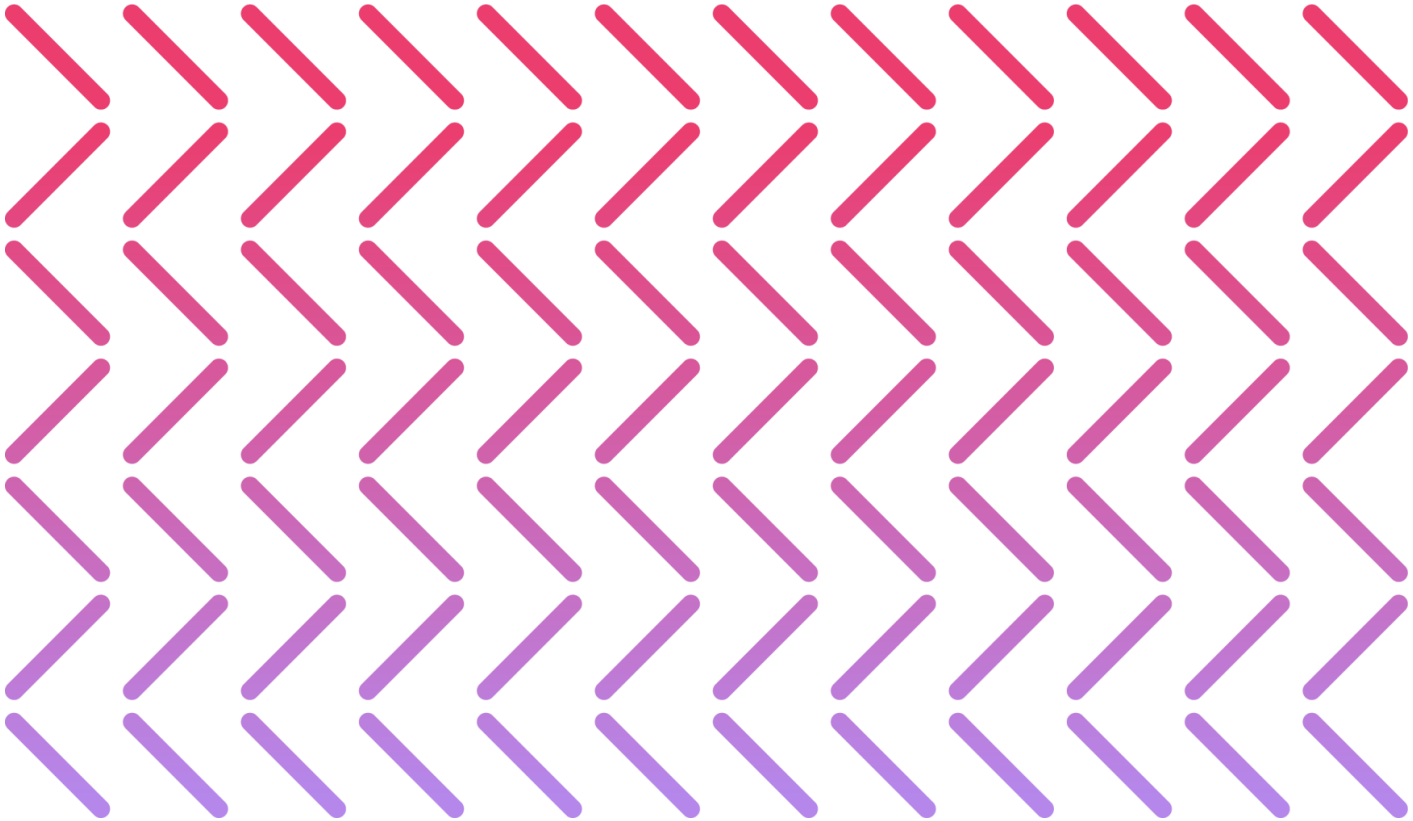
Strategic Objective	Balance the books, invest in our future
SR6	We are unable to invest in the transformation of our services and infrastructure, and address areas of material risk to our staff and patients, due to our inability to source sufficient capital funds

Lead indicators	RAG Rating				Lead indicators: Progress update
	Q1	Q2	Q3	Q4	
Funding confirmed for full 20/21 capital programme					Funding confirmed for 20/21 plan.
Funding confirmed for 5 year capital plan					No further clarification on additional sources of finance for 21/22 and beyond.
Reduction of clinical risk resulting from old equipment estate infrastructure and IT					Additional risks emerging due to COVID. Spending continuing at risk to mitigate risks.,
Capital spend at full value of plan in 20/21					Full spend forecast, although risks and mitigations in place for higher spend forecast in Q4

Emergent / future risks	Future opportunities
- Funding for 21/22 BAU and projects still to be identified/confirmed. - Funding relating to the Trusts key strategic priorities, and the estates strategy is still to be found.	- Emergency capital funding made available from NHSE/I - Further prioritisation within SWL to move money to address material and urgent risk at St George's, as well as ITU expansion.

Strategic Objective 4: Build a better St George's
Strategic Risk SR7

SR7:
We are unable to provide a safe environment for our patients and staff and to support the transformation of services due to the poor condition of our estates infrastructure



Strategic Objective	Build a better St George's	*Corporate Objective 2020/21*	*Care*
SR7	**We are unable provide a safe environment for our patients and staff and to support the transformation of services due to the poor condition of our estates infrastructure**		

Risk Appetite / Tolerance	**LOW**	We have a low appetite for risks that affect the safety of our patients and staff	**Assurance Committee**	**Finance and Investment Committee**
			Executive Group	Risk and Assurance Group
			Executive Lead(s)	Chief Finance Officer
			Date last Reviewed	20 May 2021

Current risk and assurance assessment

Our current risk assessments indicate that this continues to be an extreme risk for the Trust.

We have reviewed those significant risks that escalate up to the corporate risk register and have proposed that 3 out of 6 can be reduced, this will need to be endorsed at the relevant approval groups. The detail of this has been reviewed at the Risk Management and Coordination Group.

As we move out of reacting to COVID requirements we are reinvigorating our work on the Premises Assurance Model. The external review of Estates management has been launched to the management team, workforce and unions and implementation begun.

We have presented the key findings of the Estate Strategy to the Trust Board, who approved the direction of travel. The detailed strategy will be taken through governance groups for comments through June, with a final version coming for Board Approval at the end of July.

All capital projects for 20/21 are being successfully delivered and the consequences of this are taken into account with our risk review. We are finalising our prioritisation for the 21/22 capital plan.

Overall SR Rating – Quarterly Scores

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

Summary COVID-19 Impact

- Covid-19 has had an impact on the timescales for reviewing the governance groups that sit within the estates directorate and work is not progressing with this.
- Covid-19 has affected some risk and assurance activities, which will need to be caught up in the next six months.
- Works to ED were undertaken in order to enable social distancing and these are now complete.
- ITU permanent expansion options are being agreed.

Strategic Objective	Build a better St George's	*Corporate Objective 2020/21*	*Care*
SR7	**We are unable provide a safe environment for our patients and staff and to support the transformation of services due to the poor condition of our estates infrastructure**		

Key risk controls in place	Control effectiveness				Key sources of assurance	Lines of Assurance (positive / negative)		
	Q1	Q2	Q3	Q4		1	2	3
Risk adjusted backlog maintenance programme informed by Authorised Engineer reports and independent condition surveys	S	S	S	S	Independent surveys and AE reports provide assurance on key issues but their renewal has been delayed due to COVID Safety working groups have been postponed during COVID, but are now running again PAM now provides enhanced assurance, this has now been assessed externally and improvements being implemented.. CQC report 2019 - technical assurance has been provided on the key areas of concern where reactive maintenance could potentially impact patient care		x x xx x	
Investment profile provides plans to manage backlog maintenance investment	W	W	W	W	The new capital plan provides additional funding to undertake work on high risk maintenance backlog areas and will prioritise the key corporate estates risks.		xx	
Governance systems in place to provide oversight on critical estates issues	P	P	P	P	We now have an independently verified application of PAM			x
Estate Assurance Group to review all key assurance and activities	N/A	N/A	P	P	The Group will review PAM data together with assurance reports prepared for working groups.		xx	

4.5

Strategic Objective	Build a better St George's	*Corporate Objectives 2020/21:*	Care
SR7	**We are unable provide a safe environment for our patients and staff and to support the transformation of services due to the poor condition of our estates infrastructure**		

Gaps in controls and assurances	Actions to address gaps in controls and assurances	Complete by (date)	Progress
Gaps in both capital requirements and available budget, together with a lack of long-term planning, makes effective use of capital difficult to plan	The high level principles of the estate strategy have been agreed, which will greatly aid capital planning for the future	Jan 2021	Complete
Current Estate Strategy is not aligned with Clinical Strategy	The high level principles of the estate strategy have been agreed, including the alignment of our clinical modelling together with clinical engagements and strategy.	Mar 2021	Complete
Areas of risk have not been formally identified on the risk register	We have reviewed all of our risk registers and undertaken significant reviews of our high level risks and are confident that we have now captured significant areas of risk	May 2021	Complete
No centralised data management system in place to ensure all required information is available and coordinated	Data and Systems review within E&F to be undertaken, New post being created to manage data and systems across the team, post advertised, interviews held, but preferred candidate declined so will need re-advertising.	Jan 2021	
Governance groups are not aligned with new wider assurance arrangements	Groups restarting with reviews of ToRs being undertaken. Albeit slightly delayed by COVID. Estates activities to be overseen by new Estates Assurance Group, which is now meeting. Suggesting wider governance review to be undertaken over next quarter	Feb 2021	

Strategic Objective	Build a better St George's	*Corporate Objectives 2020/21:*	Care
SR7	**We are unable provide a safe environment for our patients and staff and to support the transformation of services due to the poor condition of our estates infrastructure**		

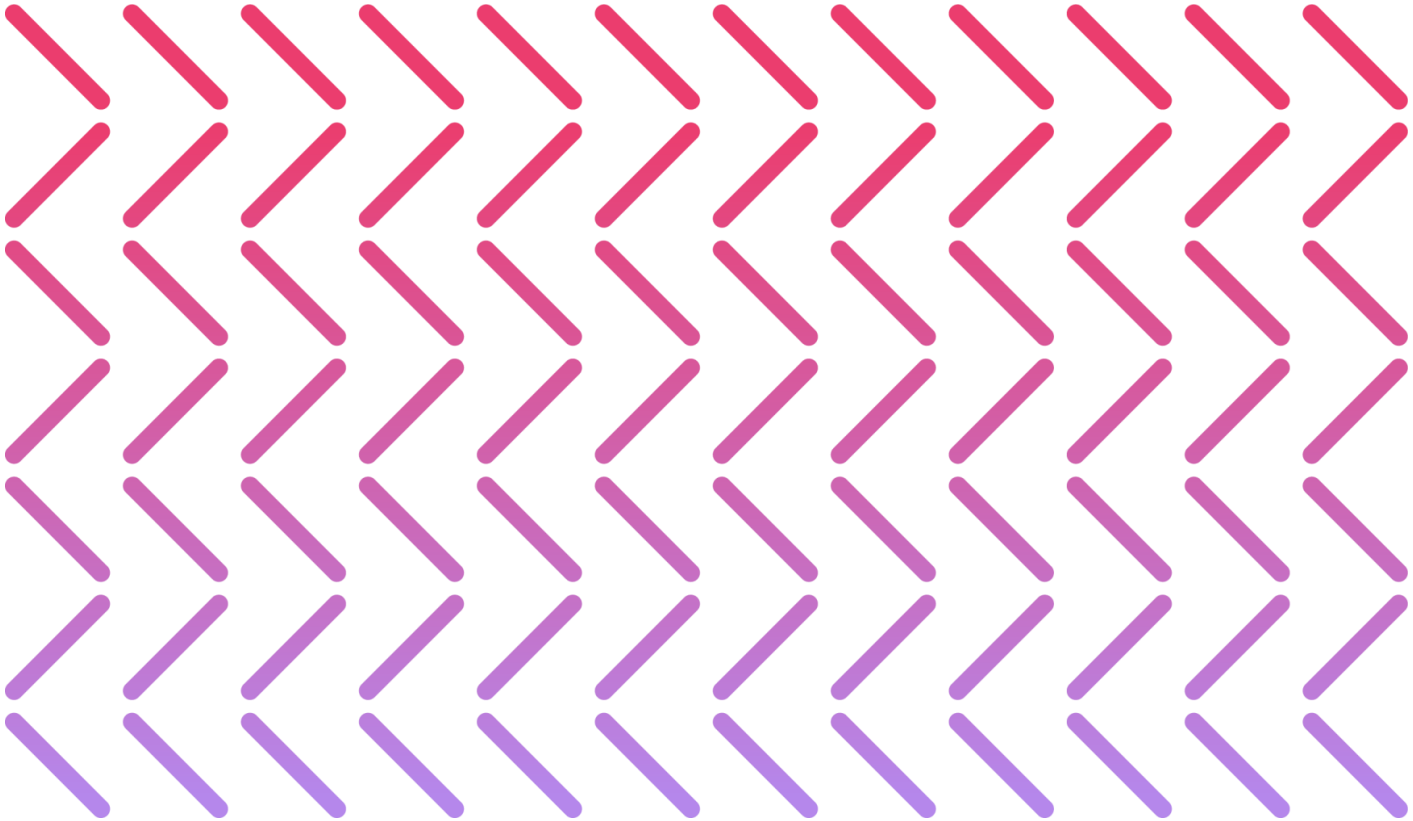
Lead indicators	RAG Rating Q1	Q2	Q3	Q4	Lead indicators: Progress update
% of reports on items of statutory compliance completed to required timescales					Delay in report production due to COVID
% of backlog maintenance tasks (reactive / planned) undertaken in line with plan					Currently over 80% of planned works being undertaken
Capital expenditure spend profile against agreed plan					Significant progress has been made on capital expenditure
% of PAM compliance					PAM reporting now maturing

Emergent / future risks	Future opportunities
Lack of sustainable investment leads to further deterioration, therefore Trust is unable to deliver its wider strategic objectives Failure to secure HIP funding as first building block of estate strategy Relationship with University blocks future development of the site	HIP funding provides transformational impact to site development More effective organisational design improves service design Identification of development sites provide commercial opportunities for alternative capital investment

Strategic Objective 5: Champion Team St George's
Strategic Risks SR8 and SR9

SR8:
We fail to build an open and inclusive culture across the organisation which celebrates and embraces our diversity because our staff do not feel safe to raise concerns and are not empowered to deliver to their best

SR 9:
We are unable to meet the changing needs of our patients and the wider system because we do not recruit, educate, develop and retain a modern and flexible workforce and build the leadership we need at all levels



Strategic Objective	Champion Team St George's	*Corporate Objective 2020/21:*	Culture
SR8	**Our staff are not empowered to deliver to their best and do not feel safe to raise concerns because we fail to build an open and inclusive culture across the organisation which celebrates and embraces our diversity**		

Risk Appetite / Tolerance	**LOW**	Due to concerns around bullying and harassment and the ability of staff to speak up without fear, we have a low appetite for risks that could impact on the culture of the Trust	**Assurance Committee**	**Workforce and Education Committee**
			Exec Review Group	People Management Group
			Executive Lead(s)	Chief People Officer
			Date last Reviewed	18 May 2021

4.5

Current risk and assurance assessment

The Board has identified the need to strengthen organisational culture as a key strategic priority. The are a number of significant risks that impact on this. The Trust continues to face significant challenges in relation to diversity and inclusion, staff do not always feel able to raise concerns without fear of detriment, and the culture diagnostics work, while highlighting a number of positive elements, set of the scale and significance of the work to strengthen our culture.

During 2020/21, this risk has been mitigated by the completion of a number of identified gaps in control and assurance:

- A new D&I action plan was agreed by the Board in July 2020
- Plans to ensure all interview panels for Band 8a and above implemented
- A new Freedom to Speak Up Strategy was agreed by Board in September 2020, and the Guardian has seen greater numbers of staff speaking up, and
- New central databases for recording FTSU concerns and bullying and harassment concerns have been launched
- Dignity at Work and Equality, Diversity and Inclusion policies updated
- Training programme has been established for staff supporting disciplinary investigations, with standardised documentation also developed
- The diagnostics phase of the culture change programme has been delivered with wide-ranging input from staff
- A Culture Diversity and Inclusion Programme Board has been established to oversee and drive forward work to strengthen our culture

A number of key risks and gaps in assurance remain, particularly in relation to the development of the culture change action plan, seeing further progress in improving D&I, improving staff confidence in speaking up. While the Trust has approved a range of new plans and strategies to strengthen areas associated with this risk, the Trust remains in the early phases of delivery.

Overall SR Rating – Quarterly Scores

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

Summary COVID-19 Impact

Covid-19 has had a significant impact on staff health and wellbeing, which is an increasingly significant area of focus for the Trust, and on the original timescales for developing our programme of work to strengthen our organisational culture. Covid-19 has also highlighted underlying issues in relation to diversity and inclusion, particularly in relation to the experience of our BAME staff, which the Trust is now working to address through its new D&I action plan. A number of engagement events have been paused (Go Engage pilot; TeamTalk). At the same time, the pandemic has highlighted and helped foster elements of a Team St George's spirit and staff network groups have continued to meet (and faith calendar days have been celebrated), it has also revealed issues relating to diversity and inclusion and the willingness of staff to speak up which has enabled the organisation to develop plans for addressing these long-standing issues.

The most pressing impact of Covid-19 at present is its impact on staff health and wellbeing. Winter is historically a challenging period for staff, but the added pressures of a second Covid-19 surge has put extraordinary pressure on staff.

Strategic Objective	Champion Team St George's	*Corporate Objective 2020/21:*	Effective
SR8	We fail to build an open and inclusive culture across the organisation which celebrates and embraces our diversity because our staff are not empowered to deliver to their best and do not feel safe to raise concerns		

Key risk controls in place	Control effectiveness				Key sources of assurance	Lines of Assurance (positive / negative)		
	Q1	Q2	Q3	Q4		1	2	3
Workforce strategy in place and approved by the Trust Board	S	S	S	S	Workforce Strategy approved by Trust Board.		X	
The Diversity and Inclusion action plan agreed by the Trust Board in July 2020	N/A	G	G	S	Progress of D&I action plan delivery reviewed at PMG fortnightly -	X	X	
Robust Diversity and Inclusion Strategy delivery plan	W	S	S	S	D&I action plan, delivery tracker and impact tracker in use to track progress -		X	
Culture change programme established with clear timelines for delivery	S	S	S	G	Culture diagnostics findings reported to Board in Nov 2020; action plan being developed; Culture, Diversity and Inclusion Programme Board established – Due to Covid, culture change action plan has yet to be agreed. Delay of start of implementation.		X	
Freedom to Speak Up Strategy and Vision in place	N/A	N/A	S	S	FTSU vision and strategy approved by Trust Board		X	
Freedom to Speak Up function established with dedicated Guardian in place	R	G	G	G	Trust is rated 204 out of 230 Trusts in England on FTSU Index			X
Policy framework in place (EDI, Dignity at Work, Raising Concerns)	R	G	S	S	Approved by PMG and available on intranet.		X	
Staff networks in place to support particular groups	G	G	S	S	Networks in place and meeting regularly. Positive early engagement from staff in staff network groups	X	X	
Staff Support helpline established supplemented by access to Staff Support	R	R	R	S	Staff survey			X
Leadership and Management Development Programmes in place (paused during COVID-19 and challenges in organising new meetings	R	R	R	R	Likelihood of BAME staff entering formal disciplinary process (BAME staff are 2.38 times more likely to enter disciplinary process than white staff)		X	
Board visibility through Board visits and Chairman and CEO monthly TeamTalks	S	S	S	S	Executive and Board visibility assessed through staff survey and Culture diagnostic review.		X X	
Trust D&I lead recruited and in place	W	G	S	S	D&I Lead in post.	X		
Inclusion of BAME Recruitment Inclusion Specialists (RIS) on panels at Bands 8a+	W	R	S	R	Percentage of 8a+ panels that include a RIS monitored DI Dashboard (79% in March)	X		
IT software package to record FTSU concerns	W	R	G	S	Case management solution in place to support FTSU case tracking and reporting	X		
Software system (Selenity) in place to manage employee relations data including B&H	N/A	G	G	S	Selenity implemented on 22 February 2021	X		
Covid surge plan and Health and Well-being plan available on the Intranet	N/A	N/A	G	S	Plan reviewed by PMG, OMG. Surge plan includes initiatives in place to support staff about the physical and emotional well-being of staff		X	
Staff well-being group setup to respond to emerging staff concerns. Regularly attended by ACPO(C) + ACPO(W)	N/A	N/A	R	S	Emerging themes reviewed at PMG as part of the Health and Well-being update	X	X	

Strategic Objective	Champion Team St George's	*Corporate Objective 2020/21:*	Effective
SR8	**We fail to build an open and inclusive culture across the organisation which celebrates and embraces our diversity because our staff are not empowered to deliver to their best and do not feel safe to raise concerns**		

Gaps in controls and assurances	Actions to address gaps in controls and assurances	Complete by (date)	Progress
Staff access to MS Teams (required as on-line meetings replace face-to-face meetings) is inconsistent across the Trust	Work with IT to ensure all staff can access MS Teams All substantive staff in the trust with a trust email account are able to access MS Teams via laptops, PCs, mobile phones using their email address and computer login password. TCP process on trust intranet	Complete	
Survey pulse tool yet to be agreed	Agree which survey pulse tool to be used. Go Engage tool has been discontinued. Decision on which pulse tool to use now postponed until July 2021. Further discussion with CPO	~~Sep 2020~~ Jul 2021	
Positive shift in culture whereby staff feel engaged, safe to raise concerns and are empowered to deliver outstanding care	Complete culture diagnostics phase and define action plan to address key findings Diagnostic phase completed 11/2020, Design phase in progress (output = action plan to address key findings) due to complete 05/2021.Implementation/delivery phase has informally started. Formal action plan is in draft form and still to be agreed by Board. In the meantime, culture change initiatives are underway.	Feb 2021	
Staff do not feel safe to raise concerns and lack confidence that actions will be taken where concerns are raised	Implementation of 2020/21 FTSU action plan, including development of FTSU Charter, revision of raising concerns policy, development of JD for FTSU champions, review of FTSU champions network, development of reporting pack on concerns for sharing / engagement with divisions JD for FTSU champions already completed and agreed through sub-TMG groups, with recruitment / communications taking place this month. Review of FTSU policy likely to slip by one month as the publication of the updated national guidance (inc. model policy) due in December has been postponed and we need to ensure our updated policy takes account of this.	~~Mar 2021~~ Jun 2021	
Need for skilled Organisational Development capability and capacity to deliver agreed culture programme and D&I interventional activities and training programme	Build Organisational Development capacity for the delivery of the D&I and Culture programmes Operational pressures due to Covid have redirected focus on health and well-being, development of OD capacity plan has been delayed. Deferred to start in June, after the completion of the HR Stocktake Review.	~~Mar 2021~~ Jun 2021	
Time allocation of Network Chairs and member engagement in network activity not clearly established	Develop proposal to address challenges faced by D&I staff networks (including time allocation of Network Chairs and member engagement in network activity) to be submitted to May PMG/ and June WEC	~~Mar 2021~~ Jun 2021	

4.5

Strategic Objective	Champion Team St George's	*Corporate Objective 2020/21:*	Effective
SR8	**We fail to build an open and inclusive culture across the organisation which celebrates and embraces our diversity because our staff are not empowered to deliver to their best and do not feel safe to raise concerns**		

Lead indicators	RAG Rating Q1	Q2	Q3	Q4	Lead indicators: Progress update
Number of Freedom to Speak Up concerns raised with Guardian	P	P	P	P	The number of cases raised with the FTSUG has continued to rise, though at a slower rate compared with Q1 2020/21
Quarterly Friends and Family Staff Survey (via Go Engage)	W	W	W	W	Paused in Q1 2020/21 as a result of Covid-19, Still paused
Number of BAME staff entering formal disciplinary processes	W	W	W	P	This continues to be significantly higher for BAME staff compared with white counterparts. BAME staff are 2.38 times more likely to enter into a formal disciplinary process compared to White staff. Annual report expected in August 2021. New disciplinary process now in place (Nov 2020)
Trust turnover rate	P	P	P	P	March 2021 turnover rate (excluding junior doctors) was 14.4% against a target of 13%
Number of BAME staff in band 6, 7 and 8a roles	P	P	P	W	BAME recruitment Mar 2021 band 6 = 50.2% (50.2% in Jan); band 7 = 38.3% (37.6% in Jan) band 8a = 29.7%, band 8b = 26.8%, band 8c = 26.7%, band 8d = 16.6%, band 9 = 26%, VSM 9.1%

Emergent / future risks	Future opportunities
• Impact of Covid-19 on staff health and well-being, particularly following the second Covid-19 surge, which is an increasingly significant issue and plans are being developed to address this. • Covid-19 has led to the cancellation and / postponement of a range of training and development opportunities for staff, including management training • Risk that culture programme does not deliver anticipated changes / improvements	• Delivery of the culture change programme • Embedding support for staff health and wellbeing into plans for recovery of services following the second Covid-19 surge • Learning from Trusts with positive FTSU cultures and from NHSE&I's ongoing support on FTSU. • Intelligence from latest NHS staff survey can be used to further inform and develop our plans for supporting staff and developing our culture change programme.

4.5

Strategic Objective	Champion Team St George's	*Corporate Objective 2020/21:*	Effective

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

Risk Appetite / Tolerance	LOW	Due to concerns regarding quality and diversity in our workforce, we have a low appetite for risks relating to workforce. However, in relation to developing future roles and recruitment and retention strategies our risk appetite is higher

Assurance Committee	**Workforce and Education Committee**
Exec Review Group	People Management Group
Executive Lead(s)	Chief People Officer
Date last Reviewed	18 May 2021

Current risk and assurance assessment

The Board has identified recruitment, education, development and retention of staff as a key risk to the delivery of its strategy.

During 2020/21, this risk has been mitigated by the completion of a number of identified gaps in control and assurance:

- An implementation plan for the delivery of the Workforce Strategy has been developed and has been agreed by WEC
- An implementation plan for the delivery of the Education Strategy has been developed and has been agreed by WEC
- A new central database for the tracking of Employee Relations cases has been procured and deployed
- New compliant contracts of employment have been developed and uploaded to TRAC and circa 600 employees with incorrect contracts have been issued with the correct contract since 6 April 2020
- Guidance on Performance and Development Review (Appraisal) is being developed and implemented
- HR Department restructure has been implemented
- Flexible working policy / procedure has been updated

Some key challenges and gaps in assurance remain. Although COVID-19 has eased immediate challenges of recruitment and retention due to our ability to redeploy staff across the organisation, our vacancy rate remains above target as does our turnover rate. Training and developing our leaders remains a particular gap and this links to the cultural development work set out in Strategic Risk 8. Junior doctor supply continues to be an issue. We have not yet introduced fully the upgrade of Totara. When in place this will enable us to better track appraisals and put in place clearer talent management processes.

It is considered that it will be realistic to reduce the risk score for SR9 during the first half of 2021/22.

Overall SR Rating – Quarterly Scores

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

Summary COVID-19 Impact

Covid-19 has placed staff under intense pressure, however the Trust has been able to successfully redeploy staff meaning that it has been able to reduce its agency spend during this period. Appraisal rates, however, have fallen and a number of education and training programmes have been delayed / deferred due to the pandemic.

Social distancing requirements have impacted the delivery of education programmes (due to lack of suitable space large enough for face-to-face training and infrastructure for remote provision). Additionally, there is an increasingly significant risk, particularly following the second Covid-19 surge, in relation to staff health and well-being due to both the intense pressures of responding to the pandemic, particularly within certain teams, and as a consequence of reduced face-to-face staff and network meetings which contribute to feelings of isolation and exclusion among some of our staff. Additional workforce capacity from the Army (63 headcount) supporting the work in ITUs – started 18/01, staying until end of March 2021. Recruitment is ongoing from SWL Acute Provider Collaborative (APC) for additional staff to support with Covid vaccinations and also to work in some of the ITU areas.

Strategic Objective	Champion Team St George's	*Corporate Objective 2020/21:*	Effective
SR9	**We are unable to meet the changing needs of our patients and the wider system because we do not recruit, educate, develop and retain a modern and flexible workforce and build the leadership we need at all levels**		

Key risk controls in place	Control effectiveness				Key sources of assurance	Lines of Assurance (positive / negative)		
	Q1	Q2	Q3	Q4		1	2	3
Workforce Strategy in place and approved by the Trust Board (Nov 2019)	S	S	S	S	Good performance in ward staffing unfilled duty hours – tracked in IQPR		X	
Workforce strategy implementation plan	N/A	S	S	S	Quarterly report to Trust Board		X	
Education Strategy in place and approved by the Trust Board (Dec. 2019)	S	S	S	S	Education strategy implementation progress report to WEC		X	
Education implementation plan	N/A	S	S	S	Monthly Strategy group meeting to monitor progress with all key stakeholders		X	
Development of new roles (i.e. ACPs) to help fill the gaps in vacancies	S	S	S	S	Workforce report to PMG and WEC		X	
Monthly review of the funded establishment	S	S	S	S	Monthly reports to Trust Board		X	
Advanced Clinical Practitioner Working Group established to work with HEE	G	G	G	S	Working group reports quarterly to PMG			X
Recruitment open days for healthcare assistants and nursing now run by the Recruitment Hub.	S	S	S	S	Quarterly report received from Recruitment Hub.		X	X
Appraisal training sessions / ad hoc training in place	R	R	R	R	Training completion log in Education Centre booking system		X	
New compliant (section 1 update) contracts of employment templates on TRAC	N/A	N/A	G	S	New contract uploaded that is being issued to new starters (from 01/10/2020)	X		
Performance and Development Review (Appraisal) guidance reviewed and in place	W	W	G	R	Appraisal completion monitoring via ESR, appraisal training available for all appraisers. PDR system transformation programme (including Totara upgrade) in progress. Completion rate not yet on target,	X		
CPD funding system process	N/A	N/A	G	G	Funding established for NMAP staff		X	
Apprenticeship Strategy	N/A	N/A	R	R	Current apprenticeship strategy is not as comprehensive as it should be.		X	
Disciplinary policy in place which includes 'Dido Harding' approach. Staff trained on the new approach to disciplinary cases	N/A	N/A	G	S	Policy in place and staff trained to support (completed Nov 2020)		X	
Flexible Working Policy/procedure implemented	N/A	N/A	N/A	S	On intranet, available to staff.		X	
Process to keep records for honorary contracts	N/A	N/A	N/A	S		X		

Strategic Objective	Champion Team St George's	*Corporate Objective 2020/21:*	Effective
SR9	**We are unable to meet the changing needs of our patients and the wider system because we do not recruit, educate, develop and retain a modern and flexible workforce and build the leadership we need at all levels**		

Gaps in controls and assurances	Actions to address gaps in controls and assurances	Complete by (date)	Progress
Trust-wide workforce plan that sets out recruitment requirements for 2021/22	Develop Trust-wide workforce plan for 2021/22 which includes the review of funding establishment against Staff in Post to identify the gap, review use of contingency workforce, and develop required recruitment strategies to fill the gaps, the review of service demand and capacity to identify gaps; and the development of plans to recruit MTIs to address ongoing medical workforce rota gaps. Delay due to competing interests post-Covid surge	~~Mar 2021~~ Apr 2021	
Trust-wide workforce plan that sets out retention policies, practices and requirements	Develop and implement Trust-wide workforce plan that sets our retention policies, practices and requirement. (Implement NHS People Plan; Develop/ launch Health & Well-being/ staff support initiatives. New exit survey has been implemented; flexible working policy/procedure & role mapping toolkit has been developed, and the Flexible Working policy/procedure has been implemented. Plan to improve appraisal completion rates are being addressed by HRBPs Delay due to competing interests post-Covid surge	~~Mar 2021~~ Apr 2021	
Governance process for existing extended roles – ACPs and PA	Deploy new roles on relevant patient pathway – for ACPs and PAs Delayed due to 2nd Covid surge. Likely to complete in July.	~~Mar 2021~~ Jul 2021	
Structured identification and development of new roles required to deliver patient care	Develop governance process for the identification of new roles and required funding. On-going identification of new roles and development governance process for the new roles identified Identified training needs required and funding where relevant Delayed due to 2nd Covid surge	~~Mar 2021~~ Jul 2021	
International Recruitment Strategy for hard to recruit to posts	HRBPs to identify hard to recruit to posts . ACPW - Develop an International Recruitment Strategy working with SWL APC Recruitment Hub Delay due to competing interests post-Covid surge	~~Mar 2021~~ Apr 2021	
Comprehensive Apprenticeship Strategy	Rework apprenticeship strategy. Apprenticeship manager has been recruited to facilitate the implementation of the Apprenticeship strategy. Apprenticeship Roles to be identified. Aim to complete in Q2 2021.	Apr 2021	
Trust-wide workforce plan that sets out education & development needs to upskill existing and future workforce	Develop Trust-wide workforce plan that sets our Education & Development needs: HRBPs to Conduct Training Needs Analysis for each division by staff group; Deliver advanced leadership programme; Develop programme of blended on-line/face-to-face training Delayed due to capacity issues. Envisaged to be completed in Sept 2021.	May 2021	
No minimum CPD funding allocated for non-NMAP staff	Include the CPD funding for non-NMAP into the 2021/22 business planning process	Jul 2021	
Senior leadership that reflects the diversity of the workforce	Develop inclusive talent management, succession planning and career planning pathways to be developed. Further embed fair and equitable recruitment & selection process at senior level (further intervention over and above a RIS on every recruitment panel is needed	Oct 2021	
Inadequate ICT infrastructure, hardware and software to access on-line learning	Established Education Delivery IT (EDIT) Group to review current position on training delivery technology, future design and gap analysis. The group includes representatives from IT	Oct 2021	

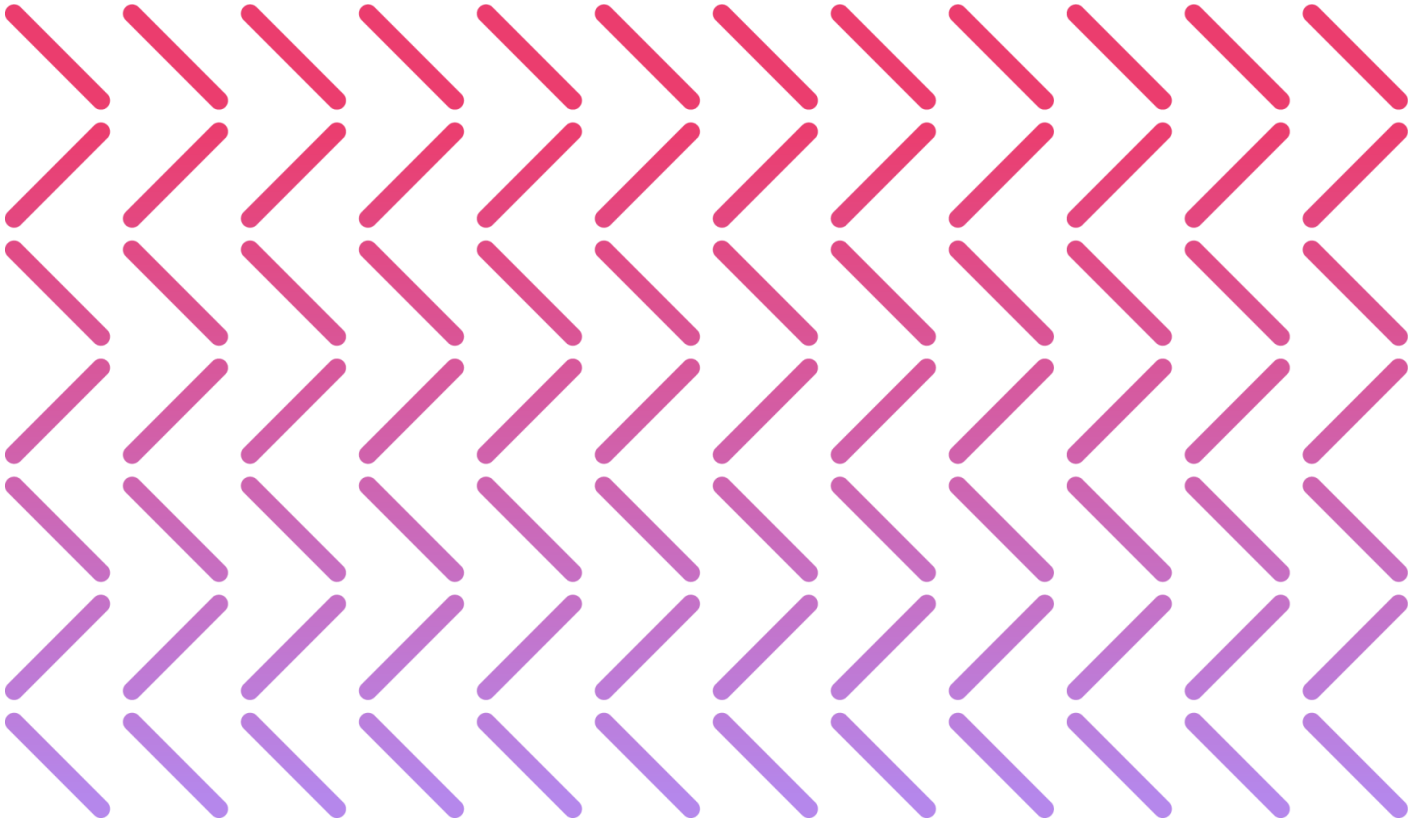
Strategic Objective	Champion Team St George's	*Corporate Objective 2020/21:*	Effective
SR9	**We are unable to meet the changing needs of our patients and the wider system because we do not recruit, educate, develop and retain a modern and flexible workforce and build the leadership we need at all levels**		

Lead indicators	RAG Rating				Lead indicators: Progress update
	Q1	Q2	Q3	Q4	
Trust vacancy rate	S	S	S	S	Trust vacancy rate in March 2021 was 8.2% against a target of 10%
Turnover Rate	P	P	P	P	Trust turnover rate (excluding junior doctors) in March 2021 was 14.4% against a target of 13%
Sickness absence rates	P	P	P	S	Trust sickness absence rate of 3.1% in March 2021 compared with Trust target of 3.9%
Bank and agency rate	S	S	S	S	The Trust remains well below its NHSI agency ceiling due to staff redeployment due to COVID-19
IPR appraisal rate medical staff	W	W	W	P	Appraisal rates for medical staff in March 2021 were at 72.3%
IPR appraisal rate non-medical staff	W	W	W	P	Appraisal rates for non-medical staff in March 2021 were at 70.5% compared with Trust target of 90%. Target not met throughout 2019/20
MAST compliance percentage	S	S	S	S	March 2021 performance of 88.7% compared with Trust target of 85%
Stability Index	N/A	N/A	S	S	March 2021 88.5% (target 85%)

Emergent / future risks	Future opportunities
• Staff remote working requirements • Scaling back of HEE funding • Establishment of clear governance arrangements for SWL Recruitment Hub (SLAs, KPIs)	• Further collaboration with SWL ICS and the Acute Provider Collaborative • Development of different roles • Links to University – opportunity to develop more 'in-house' training / courses with the university, cost effective, accredited • Apprenticeships

Strategic Objective 6: Develop tomorrow's treatments today
Strategic Risk SR10

SR10:
Research is not embedded as a core activity which impacts on our ability to attract high calibre staff, secure research funding and detracts from our reputation for clinical innovation



Strategic Objective	Develop tomorrow's treatments today			Corporate Objectives 2020/21:	Collaboration
SR10	**Research is not embedded as a core activity which impacts on our ability to attract high calibre staff, secure research funding and detracts from our reputation for clinical innovation**				
Risk Appetite / Tolerance	**HIGH**	We have a high appetite for risks in this area in order to pursue research and innovation	**Assurance Committee**	**Quality and Safety Committee**	
			Executive Group	Patient Safety and Quality Group	
			Executive Lead(s)	Chief Medical Officer	
			Date last Reviewed	20 May 2021	

Current risk and assurance assessment	Overall SR Rating – Quarterly Scores	Period 2020/ 2021	Risk Score	Assurance Strength	Change (last reporting period)	Inherent Risk Score	Target Risk Score For 2020/21
There has been a significant boost to the research profile in the Trust due to a 100% increase in patient recruitment to clinical trials over the previous three years. The Trust is remains highly active in Covid-19 research studies and is implementing the approved Research Strategy 2019-24, in particular the set up of the Translational and Clinical Research Institute (TACRI) and the four Clinical Academic Groups (CAGs), although implementation has been slower than anticipated in some areas due to Covid-19. The Trust has a number of key controls and sources of assurance in place, for example regular research resource and portfolio review meetings with research teams and documented progress reports, and identified funding for the research portfolio. The current risk score of 9 (Moderate) highlights the strong progress of research in the Trust including in Covid research, whilst recognising that Covid has caused the suspension of most of our clinical research in the Spring of 2020 and Winter of 2021 and delayed part of the strategy implementation. We are now progressing well in our strategy implementation, and anticipate substantial progress in 2021/22, however we have not yet had the outcome of the £500K Trust investment for strategy implementation we have sought for 2021/22 so cannot proceed with research staff initiatives until we have this. The assurance strength is now rated as good to reflect the sources of assurance and completed actions to address the previously identified gaps in controls. Governance and risk management arrangements provide a good level of assurance that the risks identified are managed effectively. Evidence is available to demonstrate that systems and processes are generally being applied and implemented though with delays in some areas due to Covid. The in-year target risk score of 6 (3x2) was approved at Trust Board in September 2020 to reflect a realistic year end position for this risk and the anticipated continuing implementation of the research strategy. With the second wave of Covid leading to the suspension of most of our clinical research in January 2021, this target score will not be achieved until 2021/22.		Q1	Moderate 9 = 3(c) x 3(L)	Good	N/A	16 = 4(c) x 4(L)	6= 3(c) x 2(L)
		Q2	Moderate 9 = 3(c) x 3(L)	Good	N/A		
		Q3	Moderate 9 = 3(c) x 3(L)	Good	N/A		
		Q4	Moderate 9 = 3(c) x 3(L)	Good	N/A		
	Summary COVID-19 Impact	Most non-Covid-19 clinical research studies were suspended in March 2020. Though many studies were able to resume in the Summer and Autumn of 2020, in January 2021 we had to suspend most studies again due to the second wave of Covid. We have now begun the process of re-starting studies. The Trust has successfully participated in a large number Covid-19 clinical research studies and has currently recruited over 6,000 patients to 39 Covid-19 studies. We are one of two South London Covid vaccine hubs and Prof Paul Health of St Georges is the UK lead for the Novavax Covid vaccine trial. The implementation of the Research Strategy was impacted by Covid-19 but is now progressing well. We have sought £500K Trust investment to support implementation in 2021/22.					

Strategic Objective	Develop tomorrow's treatments today	*Corporate Objectives 2020/21:*	Collaboration
SR10	**Research is not embedded as a core activity which impacts on our ability to attract high calibre staff, secure research funding and detracts from our reputation for clinical innovation**		

Key risk controls in place	Control effectiveness				Key sources of assurance	Lines of Assurance (positive / negative)		
	Q1	Q2	Q3	Q4		1	2	3
Research Strategy 2019-24 : approved by the Trust Board in December 2019 and supported by an implementation plan for the research strategy	S	S	S	S	Increased numbers of clinical research studies led from St George's	x		
Partnership between St George's and St George's University London	G	G	G	G	Partnership in place. TACRI and all four Clinical Academic Groups, which are joint Trust/University structures, have been set up	x	x	
Key role in south London Clinical Research Network (chaired by CEO)	S	S	S	S	Leadership positions in the Clinical Research Network St George's CEO now chairs the CRN Partnership Board and Prof Paul Heath of St George's co-chairs the South London Vaccine Task Force.		x	x
Implementation of process of horizon scanning clinical studies, including 'easy win' studies to balance portfolio against lower recruiting more intensive studies	S	S	S	S	We have increased the numbers of patients recruited to clinical trials, which doubled over 3 years.	x	x	
Regular research resource and portfolio review meetings with research teams	S	S	S	S	JRES holds regular meetings with research teams to review patient recruitment and troubleshoot any problems.	x		
Joint Research and Enterprise Services review and ratify (with researchers) all study targets and resources required	S	S	S	S	There is annual target setting process for patient recruitment which is monitored and supported by JRES	x	x	x
Translational and Clinical Research Institute (TACRI) Steering Committee set up	S	S	S	S	Steering Committee in place and reports to Patient Safety Quality Group and QSC	x	x	
Funding to implement 2019-24 research strategy approved for 2020/21	S	S	S	S	£200K initial funding to implement the research strategy agreed. Statistical support for TACRI commenced. We await the outcome of the 2021/22 funding request.		x	
TACRI Steering Committee set up	S	S	S	S	Bi-monthly meetings		x	
Four Clinical Academic Groups formerly established	S	S	S	S	Four CAGs have been established, and a CAG Director has been appointed for each.		x	

Strategic Objective	Develop tomorrow's treatments today	*Corporate Objectives 2020/21:*	Collaboration
SR10	**Research is not embedded as a core activity which impacts on our ability to attract high calibre staff, secure research funding and detracts from our reputation for clinical innovation**		

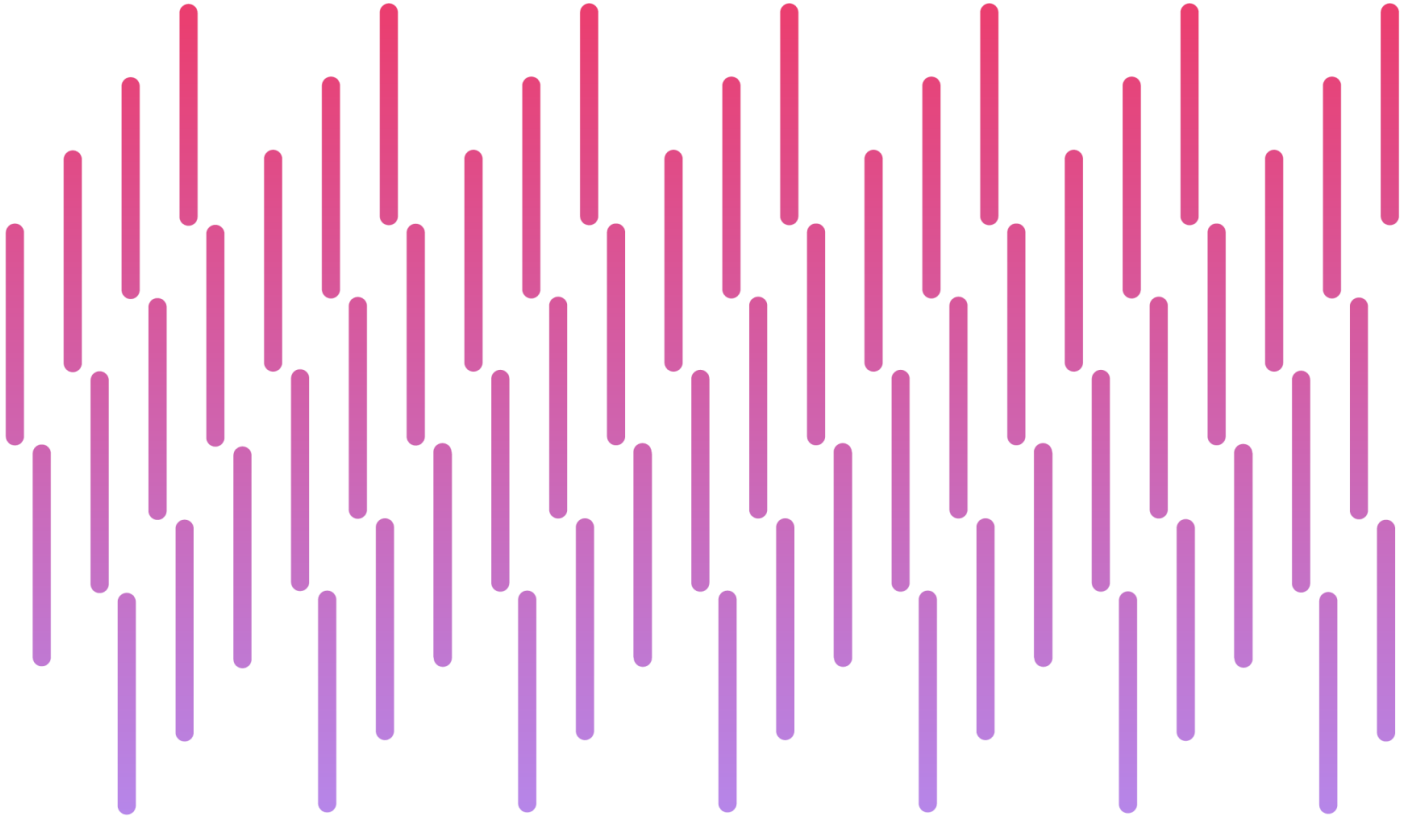
Gaps in controls and assurances	Actions to address gaps in controls and assurances	Complete by (date)	Progress
Few clinical academics - Many areas of Trust activity are not reflected in St George's University London research	**Seek investment to allow more clinical academic appointments** *TACRI will help to mitigate this. Longer term, investment will be needed from both the Trust and SGUL if new clinical academic posts are to be appointed. Investment of £500K sought for 21/22.*	December 2021	
Poor research IT infrastructure	**Seek investment /work with IT to set up research data warehouse** *We have established interest in a data warehousing project from both Trust and SGUL researchers and have held initial discussions with Trust IT and IT companies to look at options to establish a research data warehouse*	December 2021	
Translational and Clinical Research Institute (TACRI) fully functioning	**Establish functional TACRI** *Administrator started in January 2021. TACRI launch event December 2020.Membership to be established February 2021; website to be launched Spring 2021; Statistical support to commence February 2021; seminar series and training to commence Spring 2021.*	December 2021	

Strategic Objective	Develop tomorrow's treatments today	*Corporate Objectives 2020/21:*	Collaboration
SR10	**Research is not embedded as a core activity which impacts on our ability to attract high calibre staff, secure research funding and detracts from our reputation for clinical innovation**		

Lead indicators	RAG Rating Q1	Q2	Q3	Q4	Lead indicators: Progress update
Percentage of patients recruitment in south London Clinical Research Network at St George's	S	S	S	S	17% (final figure, 2019/20) NIHR have advised prioritisation of Covid research for the past year. The 2020/21 figure will not impact CRN funding.
Patient recruitment numbers	S	S	S	S	10,538 (final figure, 2019/20). NIHR have advised prioritisation of Covid research for the past year, with most non-Covid research suspended during the first and second waves of Covid.
Number of clinical research studies led from St George's	P	P	P	P	59 (current St George's Trust/ University sponsored clinical research studies on National Institute for Health Research portfolio). Recently awarded major Covid pregnancy vaccine trial, to be led by St George's.

Emergent / future risks	Future opportunities
• Restrictions on funding/ investment to extend research activities, with consequent inability to exploit research opportunities in full • Alignment of St George's and St George's University research priorities recognised as a risk in the Research Strategy • Reduced availability of National Institute for Health research funding	• National Institute for Health Research call for core Clinical Research Facility funding – deadline September 2021. • Opportunity for a greater research leadership role in SW London / partnership with other Acute Provider Collaborative Trusts • Build on current profile related to Covid-19 research activity/ studies • Develop closer collaboration between St George's and St George's University

Appendix 1: Individual risks contributing to strategic risks
Linked risks on the Corporate Risk Register



Outstanding care every time

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

Risk short form title	CRR Ref	Description	Open Date	Inherent Score	Current Score May 2021
Strategic Risk 1	**Our patients do not receive safe and effective care built around their needs because we fail to build and embed a culture of quality improvement and learning across the organisation**			**20**	**16**
Covid-19-wait too long (2)	COVID-2105	Non Covid-19 patients not known to the Trust wait too long for treatment (patients group B) (also see SR3)	Apr 2020	**20 (4x5)**	**16 (4x4)**
Covid-19-wait too long (1)	COVID-2104	Non Covid-19 patients, known to the Trust, wait too long for treatment (patient group A) (also see SR3)	Apr 2020	**20 (4x5)**	**16 (4x4)**
Covid-19 - exposure	COVID-2051	Risk of exposure to Covid-19 virus	Feb 2020	**20 (5x4)**	**15 (5x3)**
7 Day Service Standards	MD1118	Failure to comply with 4 standards of the Seven day Service due to resource limitation and/or lack of defined operating model	Nov 2016	**12 (3x4)**	**12 (3x4)**
Infection control	CN2050	C Diff; MRSA; MSSA; E.Coli	Mar 2020	**12 (3x4)**	**12 (3x4)**
Covid-19-Fit test	COVID-2106	Lack of fit test for FFP3 masks	Apr 2020	**12 (4x3)**	**12 (4x3)**
Covid-19-PPE	COVID-2107	Lack of PPE to effectively manage exposure to Covid-19 virus	Apr 2020	**20 (4x5)**	**8 (4x2)**
Learning from incidents	CN1166	Failure to learn from incidents	Nov 2016	**15 (5x3)**	**8 (4x2)**
Deteriorating patients	MD1527	Staff fail to recognise, escalate and respond appropriately to the signs of a deteriorating patient. This may happen because the Early Warning Score is inaccurately recorded or the escalation process is not applied correctly	Dec 2016	**20 (5x4)**	**8 (4x2)**
Learning from complaints	CN2009	Failure to learn from complaints	Dec 2019	**15 (3x5)**	**6 (3x2)**

4.5

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

Risk short form title	CRR Ref	Description	Open Date	Inherent Score	Current Score May 2021
Strategic Risk 2	**We are unable to provide outstanding care as a result of weaknesses in our clinical governance**			20	12
Compliance with the CQC regulatory framework	CN-1179	Failure to comply with the CQC regulatory framework and deliver actions in response to CQC inspections may prevent the Trust achieving an improved rating at our next inspection	Jan 2017	20 (5x4)	12 (4x3)
Diagnostic findings	MD1526	Acting on diagnostic findings	Jul 2016	16 (4x4)	12 (4x3)
Mental capacity Act	CN751	Failure to comply with Mental Capacity Act (MCA)	Jun 2016	16 (4x4)	12 (4x3)
Improving the quality of clinical governance	CN-2056	There is a risk that we may not improve the quality of clinical governance following the external reviews of mortality monitoring & MDT and clinical governance in a timely manner which may have an adverse impact on patient care	Sep 2019	12 (4x3)	12 (4x3)
Cardiac surgery service – patient safety impact	CVT-1661	There is a risk that we may not make effective improvements to patient safety following the second NICOR mortality alert for cardiac surgery	Sep 2018	16 (4x4)	8 (4x2)
Discharge	MD2052	Non-compliance with the eDischarge Summary Standard	Mar 2020	16 (4x4)	TBC
HealthCare Record (accuracy)	TBC	Healthcare Record (accuracy)	TBC	TBC	TBC
Learning from deaths	MD1119	Variation in practice in M&M / MDT meetings may mean we fail to learning from deaths and fail to make improvement actions to prevent harm to patients	Nov 2016	TBC	TBC
Strategic Risk 3	**Our patients do not receive timely access to the care they need due to delays in treatment and the inability of our technology and transformation programmes to provide accessible care built around our patients' lives**			20	20
Network outage	CRR-1395	Infrastructure - Risk of further major network outages due to out-dated, unreliable, and prone to failure network, as a result of a lack of investment and maintenance in the Trust's ICT Network Infrastructure	Sec 2017	25 (5x5)	20 (5x4)
ICT Disaster Recovery Plan	CRR-803	In the event of an ICT disaster, there is a RISK this would result in delays or a complete failure in the Trust's ability to recover its ICT systems.	Feb 2011	20 (5x4)	20 (5x4)
Covid-19-wait too long (2)	COVID-2105	Non Covid-19 patients not known to the Trust wait too long for treatment (patients group B) (also see SR1)	Apr 2020	20 (4x5)	20 (4x5)
Paediatric ECHO delivery	CCAG-1980	Inability of safely provide a paediatric ECHO service at St Georges Hospital	Nov 2019	20 (4x5)	16 (4x4)

Individual Risks contributing to Strategic Risks

Linked risks on the Corporate Risk Register

Risk short form title	CRR Ref	Description	Open Date	Inherent Score	Current Score May 2021
Strategic Risk 3 (continue)	**Our patients do not receive timely access to the care they need due to delays in treatment and the inability of our technology and transformation programmes to provide accessible care built around our patients' lives**			**25**	**20**
ECHO Service Delivery	CCAG-1950	Risk of delay in delivery of planned ECHOs in favour of delivering ECHO in patients who are on a 6 week diagnostic pathway, (DM01)	Oct 2019	**20 (4x5)**	**16 (4x4)**
Electronic document management solution	CRR-1592	There is a risk of no access to clinical records if the EDM software fails impacting on delivery of patient care based on lack of recent/historical information stored	Jul 2018	**16 (4x4)**	**Proposed for closure**
Virtual by Design	IT-2157	There is a risk that IT Audiovisual/infrastructure are not met by IT resources, impacting on patient care	Sep 2020	**20 (4x5)**	**16 (4x4)**
Telephony	CRR-1292	Infrastructure - Potential failure of the Trust's central telecoms system (ISDX) (1), radio tower system (DDI) (2), and/or VoIP platform (500 handsets) (3) due to aged telecoms infrastructure	Jul 2017	**20 (5x4)**	**16 (4x4)**
Data Warehouse/ Information Management Fragmentation	CRR-1312	Information - Risk of poor daily operational performance reporting due to difficulties to retrieve data stored on multiple storage	Aug 2017	**20 (4x5)**	**16 (4x4)**
Covid-19-wait too long (1)	COVID-2104	Non Covid-19 patients, known to the Trust, wait too long for treatment (patient group A) (also see SR1)	Apr 2020	**20 (4x5)**	**16 (4x4)**
Patient flow	TBC	Risk of inadequate patient flow in the Trust (and across the health care system) for emergency admission	TBC	**20**	**12**
Emergency care 4hr operating standard	ED-1514 ED-852	Failure to deliver and sustain the 95% Emergency Care Operating Standard	May 2014	**20 (4x5)**	**12 (4x3)**
Management of RTT	TBC	Risk that patient pathways and waiting times (RTT) are not accurately monitored or managed due to poor data quality and lack of management process	July 2020	**20**	**12**
Exposure to Cyber or Malware attack	CRR-0013	Infrastructure - Risk of potential successful malware / cyber attack due to weakness in the ICT infrastructure. This could lead to loss of data and operational disruption	Apr 2016	**20 (4x5)**	**12 (4x3)**
Fragmented Clinical Records	CRR-1398	Unavailability of all the correct and up to date clinical information at point of care due to fragmented patient records as a consequence of: Cerner implementation, multiple clinical system running in parallel but separate from Cerner,	Dec 2017	**20 (4x5)**	**12 (4x3)**
Diagnostic findings	MD1526	Acting on diagnostic findings	Jul 2016	**16 (4x4)**	**12 (4x3)**
7 day services	MD1118	Failure to be compliant with 4 of the Seven Day Services clinical standards	Nov 2016	**12 (3x4)**	**12 (3x4)**

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

Risk short form title	CRR Ref	Description	Open Date	Inherent Score	Current Score Apr 2021
Clinical Decision Outcome Form	S2030	There is an on-going risk that patients on any elective pathway could be lost to follow up. This can be caused by the incorrect outcome being recorded on the Clinical Decision Outcome	Mar 2020	12	12
VDI Sub-optimal	IT- 1717	Sub-optimal Virtual Desktop Infrastructure (VDI) due to insufficient licenses, insufficient compute power, and upgrade to Win10.	Nov 2018	12 (3x4)	12 (3x4)
Diagnostics within 6 weeks	TBC	Risk that under-compliance with 6 week diagnostic standard will allow patient harm	TBC	20	9
Strategic Risk 4	**As part of our local Integrated Care System, we fail to deliver the fundamental changes necessary to transform and integrate services for patients in South West London**			16	12
Other providers' strategies conflicting with Trust Strategy	CRR-1899	There is a risk that other acute providers in SWL will pursue clinical/commercial relationships with other tertiary providers that pose a strategic threat to SGUH		15 (5x3)	TBC
Devolution of specialised commissioning	STR-2220	There is a risk that the devolution of NHSE specialised commissioning is effected in a way that conflicts with the Trust's strategy to be the tertiary centre for SWL and Surrey	Feb 2021	12 (4x3)	12 (4x3)
Lack of collaboration across SWL Acute Providers	STR1496	There is a risk that the Trust and system partners (CCG, Kingston) are unable to agree on future use of QMH	Oct 2018	12 (4x3)	8 (4x2)
Strategic Risk 5	**We do not achieve financial sustainability due to under delivery of cost improvement plans and failure to realise wider efficiency opportunities**			25	20
Managing Income & Expenditure in line with budget	CRR-1411	Risk the Trust is not able to manage income and expenditure against agreed budgets to delivery the financial plan.	Dec 2017	25 (5x5)	20 (5x4)
Managing an effective financial control environment	CRR-0028	Risk of not meeting statutory obligations, prevent fraud, mismanagement of funds or inappropriate decision making by Trust officers due to ineffective financial systems and processes	Oct 2016	20 (4x5)	20 (4x5)
Identifying and delivering CIPs	CRR-1865	Risk that the Trust doesn't have sufficient capacity and capability to deliver CIPs at the level required to hit the financial plan.	Apr 2019	20 (5x4)	20 (5x4)
Future cash requirements are understood	CRR-1416	Risk that future cash requirements are not understood	Dec 2017	20 (5x4)	15 (5x3)
Manage commercial relation with non-NHS organisations	Fin-1856	Risk that the Trust does not have sufficient capacity, or skills to manage commercial relationships with non-NHS organisations procuring services from the Trust.	May 2019	12 (4x3)	12 (4x3)
Processes to manage cash and working capital	CRR-1417	Risk that the Trust does not have up to date processes to manage cash and working capital	Dec 2017	20 (5x4)	12 (4x3)

every time

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

Risk short form title	CRR Ref	Description	Open Date	Inherent Score	Current Score May 2021
Strategic Risk 5 continue	**We do not achieve financial sustainability due to under delivery of cost improvement plans and failure to realise wider efficiency opportunities**			25	20
Understanding cost structures	Fin-1372	A risk that we do not understand our current cost and performance baseline and structures, or benchmark ourselves against others in this area to identify efficiencies and improvements.	Nov 2017	15 (5x3)	9 (3x3)
Maintaining a five year forward view	CRR-1413	The Trust has insufficient capacity to develop a five year long term financial plan that is aligned to an agreed clinical strategy.	Dec 2017	16 (4x4)	9 (3x3)
Maintaining an effective procurement environnent	Fin-1083	Risk the Trust has insufficient capacity and capability to ensure best value is achieved on all procurement.	Oct 2016	15 (3x5)	9 (3x3)
Managing within new contract forms (block contracts)	Fin- 1858	There is a risk that the Trust could be financially impacted by a failure to manage performance inline with new contract models, specifically a block contract.	May 2019	9 (3x3)	9 (3x3)
Risk that the Trust could be financially penalised due to non-delivery of control totals within South West London	Fin-1857	Risk that the Trust could be financially penalised due to non-delivery of control totals within South West London. It is unclear within planning guidance what the impact of other organisations within the South West London patch not hitting control totals will be on the organisations.	May 2019	9 (3x3)	9 (3x3)
Unsupported finance and procurement system		A risk that the Trust has an unsupported finance and procurement system.		8	8
Strategic Risk 6	**We are unable to invest in the transformation of our services and infrastructure, and address areas of material risk to our staff and patients, due to our inability to source sufficient capital funds**			20	20
Funding for 5 year capital plan		The Trusts does not have funding sources confirmed to deliver years 2 through to 5 of the 5 year capital plan.		20	20
Funding for current year capital plan		The Trusts does not have funding sources confirmed to deliver the next 1 year of the capital plan		12	5

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

Risk short form title	CRR Ref	Description	Open Date	Inherent Score	Current Score May 2021
Strategic Risk 7	**We are unable provide a safe environment for our patients and staff and to support the transformation of services due to the poor condition of our estates infrastructure**			**20**	**20**
Bacterial contamination of water supply	CRR-0016	Risk from exposure to potential pathogenic bacteria in water	May 2014	**20 (5x4)**	**20 (5x4)**
Inability to address infrastructure backlog maintenance to maintain safe site	CRR-0008	Inability to address infrastructure backlog maintenance to maintain safe site due to lack of capital	Jul 2016	**20 (4x5)**	**20 (4x5)**
Risk of fire starting in Lanesborough Wing developing into a major fire	EF2036	Risk that an undetected and immediately extinguished fire could develop into a major fire resulting in area evacuation	Feb 2020	**20 (5x4)**	**20 (5x4)**
Cardiac Catheter Labs breakdowns	CCAG-1025	Cardiac Catheter Labs breakdown /failure due to old equipment/ infrastructure	Sep 2016	**20 (4x5)**	**20 (4x5)**
Electrical Infrastructure - Risk of non-compliance	CRR-1311	Risk of electrical non-compliance with Electricity at Work Regulations and BS7671 due to lack of regular testing	Aug 2017	**16 (4x4)**	**16 (4x4)**
Lack of UPS/IPS power supplies	EF2061	Lack of UPS/IPS power supplies	Mar 2020	**20 (5x4)**	**15 5x3)**
Data Centre	CRR-810	Risk that a fire, flood, power failure in the Data Centre could cause loss of data due to having a single data centre hosting all on-site critical systems	Mar 2014	**20 (5x4)**	**15 (5x3)**

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

Risk short form title	CRR Ref	Description	Open Date	Inherent Score	Current Score May 2021
Strategic Risk 8	**Our staff are not empowered to deliver to their best and do not feel safe to raise concerns because we fail to build an open and inclusive culture across the organisation which celebrates and embraces our diversity**			**20 (4x5)**	**16 (4x5)**
Organisational culture	HR-2178	There is a risk that we fail to achieve a significant shift in culture to support the delivery of the Trust strategic objectives	Sep 2020	**20 (4x5)**	**16 (4x5)**
Diversity and Inclusion	HR-1967	There is a risk that we are unable to deliver our Diversity and Inclusion Strategy or that it does not have the required impact	Jul 2019	**20 (4x5)**	**16 (4x4)**
Raising Concerns	HR-1978	There is a risk that our staff a) don't know how to raise concerns at work b) don't know who to raise concerns with c) are not confident the concerns will be properly address and d) don't feel safe in raising concerns	Nov 2019	**20 (4x5)**	**16 (4x4)**
Bullying and Harassment	HR-881	There is a risk that our staff continue to report high levels of bullying and harassment compared with peers and that we have not taken adequate measures to address this	May 2010	**20 (4x5)**	**16 (4x4)**
Effective Engagement	HR-1364	There is a risk that we fail to engage effectively with our staff	Apr 2016	**15 (3x5)**	**12 (3x4)**
Organisational Development	HR-1360	There is a risk that we do not ensure that our senior managers are developed to have the right leadership skills to be able to deliver our vision of outstanding care every time	Nov 2017	**12 (3x4)**	**12 (3x4)**
Recognise good practice	HR-1361	A risk that we do not recognise success or good practice amongst our workforce.	Nov 2017	**12 (3x4)**	**12 (3x4)**

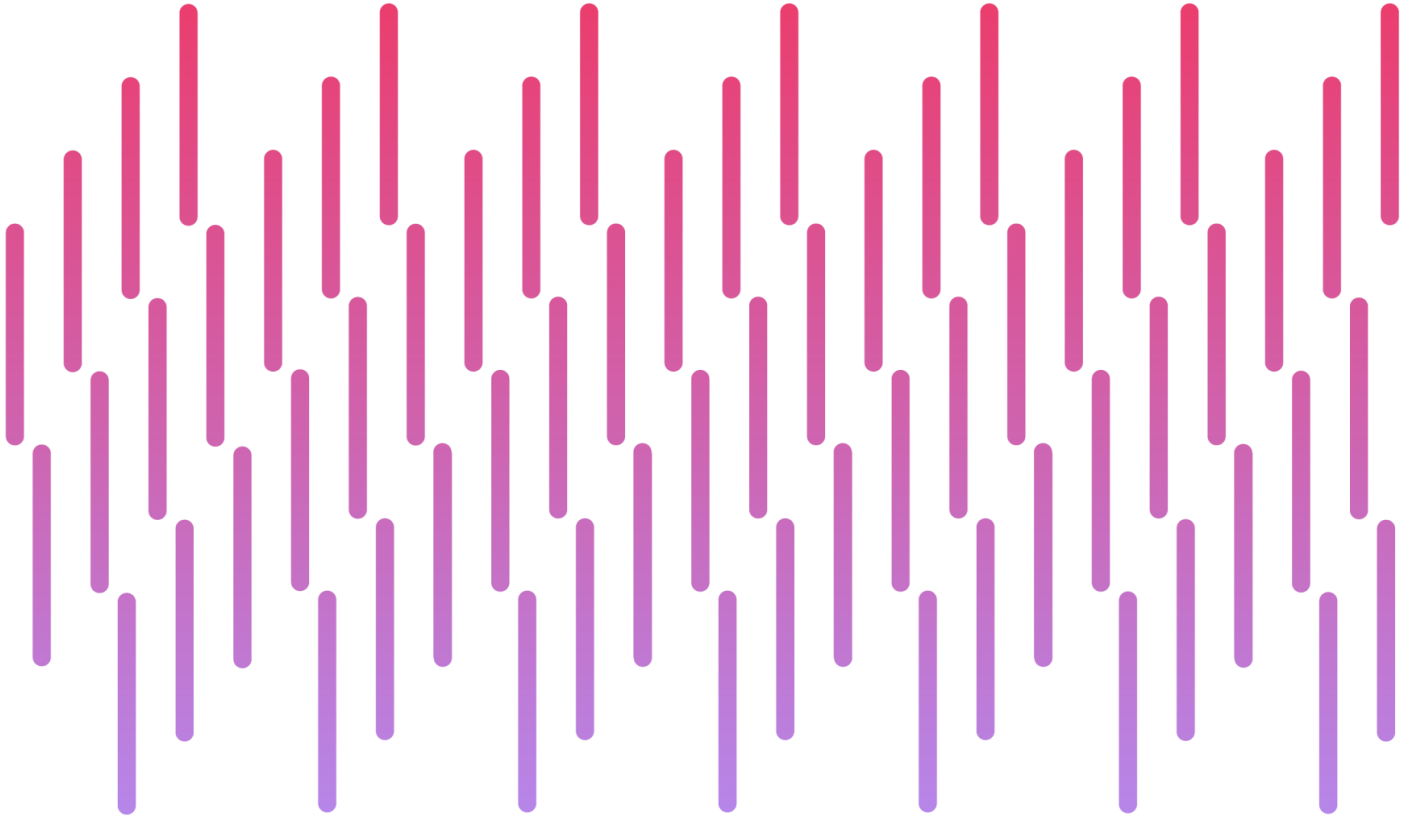
Individual Risks contributing to Strategic Risks
Linked risks on the Corporate Risk Register

Risk short form title	CRR Ref	Description	Open Date	Inherent Score	Current Score May 202
Strategic Risk 9	**We are unable to meet the changing needs of our patients and the wider system because we do not recruit, educate, develop and retain a modern and flexible workforce and build the leadership we need at all levels**			**20**	**16**
Junior Doctors vacancies	CRR-1684	There is a risk that we are unable to fill Junior Doctor rota vacancies, leading to rota gaps which may impact on patient safety	Oct 2018	**20** (4x5)	**16** (4x4)
Recruitment and Retention	CRR-0025	There is a risk that we fail to recruit and retain sufficient and suitable workforce with the right skills to provide quality of care and service at appropriate cost	Jan 2015	**16** (4x4)	**16** (4x4)
High quality appraisals	HR-1363	Risk that we do not ensure all of our staff have a high quality appraisal.	Nov 2017	**12** (3x4)	**12** (3x4)
Health and Wellbeing	HR-2242	There is a risk that health and wellbeing is not embedded in the organisation.	Apr 2021	**12** (3x4)	**9** (3x3)
Education Strategy	HR-2179	Failure to deliver the Education Strategy due to potential lack of organisational engagement and financial constraints	Oct 2020	**9** (3x3)	**9** (3x3)
Workforce Strategy	HR-2038	There is a risk that the identified priorities in the Workforce Strategy do not produce the improvements or changes desired.	Feb 2020	**9** (3x3)	**9** (3x3)
Impact on pension tax on the NHS	CRR-1884	Pension tax impacting on the Trust. There are two elements to this risk. 1. Senior members of staff choose to leave the NHS as they have reached their Life Time Allowance (LTA) pension cap. 2. The impact of the annual allowance, where consultants are taking early retirement, reducing their hours, turning down additional work which is having an operation impact on the Trust. This leaves gaps in service cover	Jul 2019	**16** (4x4)	**Closed**
Risk posed by a 'no deal' exit from the EU	CRR-1824	There is a risk that we are unable to retain our EU staff post EU exit	Apr 2019	**16** (4x4)	**Closed**
Compliance with section 1 of the Employment Rights Act (1996)	HR-2164	Failure to comply with changes to the Section 1 of the Employment Rights Act (1996) statement come into effect on 6 April 2020	Sep 2020	**16** (4x4)	**Closed**
Employee relations activities	HR-2163	Inability to provide historical data on Employee relations activity	Sep 2020	**20** (4x5)	**Closed**
Disciplinary process	HR-2165	Risk that fair, effective, independent and objective disciplinary actions are not taken changed from 10(5x2) to 5(5x1)	Sep 2020	**20** (5x4)	**Closed**
Administration of honorary contracts staff	HR-2166	Risk that Trust does not comply with the training/legal requirement for medical staff on honorary contract	Sep 2020	**12** (4x3)	**Closed**

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

Risk short form title	CRR Ref	Description	Open Date	Inherent Score	Current Score Apr 2021
Strategic Risk 10	**Research is not embedded as a core activity which impacts on our ability to attract high calibre staff, secure research funding and detracts from our reputation for clinical innovation**			16	9
The profile of research in SGHT being low	MD-1133	There is a risk that insufficient focus is given to research in SGHT. This could lead to a lack of investment in research, impacting on research delivery, income, reputation and ability to recruit and retain high calibre staff	Nov 2016	**12 (3x4)**	**9 (3x3)**
Research partnership with St George's University	MD-1495	There is a risk that if research priorities are not aligned across SGUH and SGUL we will miss opportunities to translate academic research in to improved patient outcomes	Mar 2018	**12 (3x4)**	**9 (3x3)**
MHRA accreditation of the research department	MD-1405	There is a risk that the research department does not retain its MHRA accreditation due to poor infrastructure/ compliance	Dec 2017	**16 (4x4)**	**8 (4x2)**
Clinical Research recruitment reduction	MD-1132	Risk of Clinical Research recruitment reduction. could result in a significant shortfall in overall (CRN and Commercial) recruitment and therefore reduction in research funding and income	Nov 2016	**12 (3x4)**	**6 (3x2)**

Appendix 2: Scoring the Board Assurance Framework
Risk Assessment & Assurance sources and descriptors



Outstanding care every time

Scoring the Board Assurance Framework

Risk Assessment and tracking of actions to address gaps in controls

Calculating Risk Scores

Risk Grading (Scoring)

CONSEQUENCE INDEX			LIKELIHOOD INDEX*		
5	Catastrophic	Multiple deaths caused by an event; ≥£5m loss; May result in Special Administration or Suspension of CQC Registration; Hospital closure due to enforcement action; Total loss of public confidence	5	Almost Certain	No effective control; or ≥ 1 in 5 chance within 12 months
4	Major	Severe permanent harm or death caused by an event; £1m - £5m loss; Prolonged adverse publicity; Prolonged disruption to one or more Divisions; Extended service closure	4	Likely	Weak control; or ≥1 in 10 chance within 12 months
3	Moderate	Moderate harm – medical treatment required up to 1 year; £100K - £1m loss; Temporary disruption to one or more Divisions; Service closure	3	Possible	Limited effective control; or ≥ 1 in 100 chance within 12 months
2	Minor	Minor harm – first aid treatment required up to 1 month; £50K - £100K loss; or Temporary service restriction	2	Unlikely	Good control; or ≥ 1 in 1000 chance within 12 months
1	Insignificant	No harm; 0 - £50K loss; or No disruption – service continues without impact	1	Rare	Very good control; or <1 in 1000 chance (or less) within 12 months

*Use of relative frequency can be helpful in quantifying risk, but a judgment may be needed in circumstances where relative frequency measurement is not appropriate or limited by data.

Risk scoring matrix

L/C	1	2	3	4	5
5					
4					
3					
2					
1					

Calculating Strength of Controls

Strength of controls

Control Strength	Description
Substantial	The identified control provides a strong mechanism for helping to control the risk
Good	The identified control provides a reasonable mechanism for helping to control the risk
Reasonable	The identified control provides a partial mechanism for controlling the risk but there are weaknesses in this
Weak	The identified control does not provide an effective mechanism for controlling the risk

Scoring the Board Assurance Framework
Assurance sources and descriptors

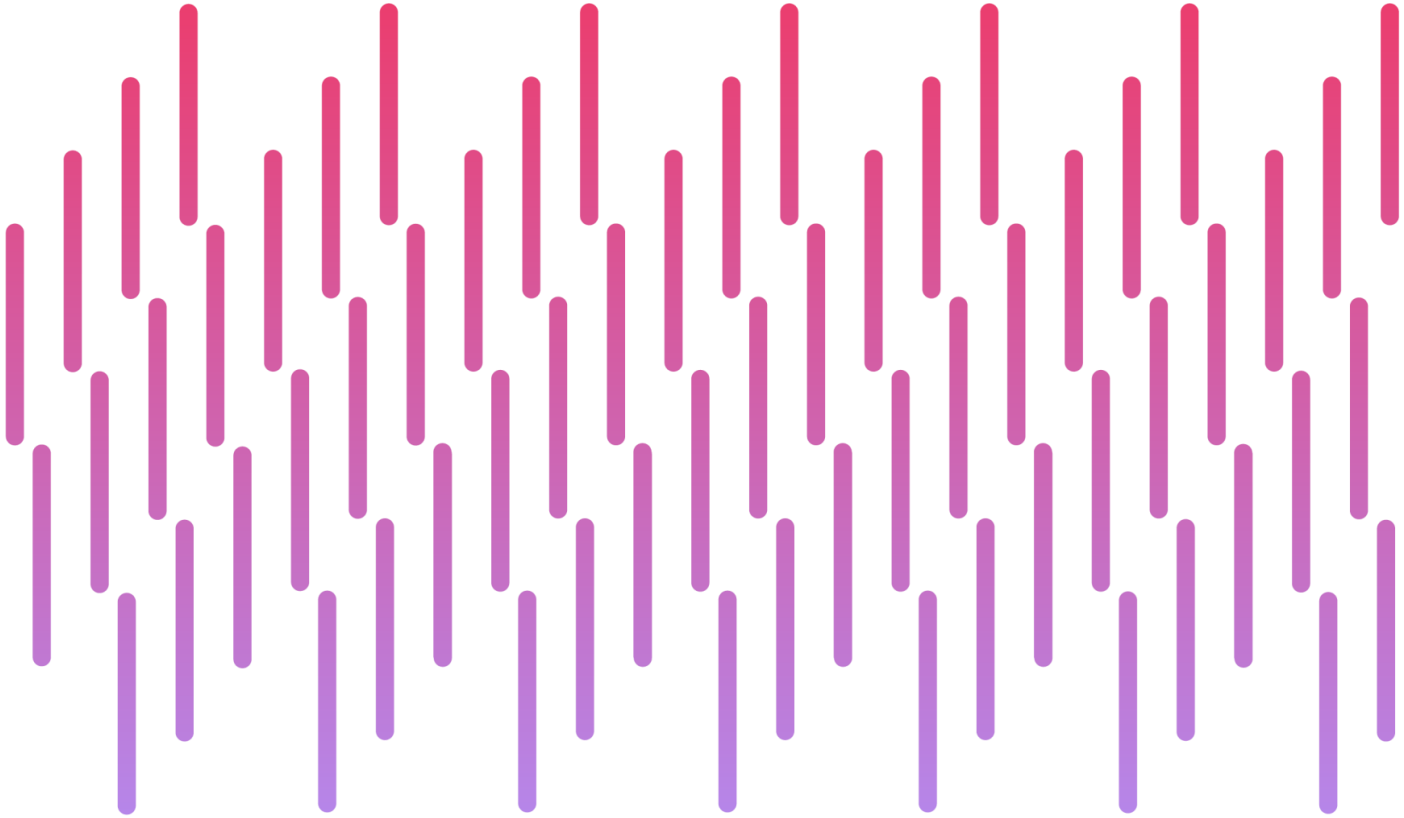
Sources of Assurance

Sources of Assurance			
Line of Assurance	**First Line Assurance**	**Second Line Assurance**	**Third Line Assurance**
Description	Care Group / Operational level	Corporate Level	Independent and external
Examples	Service delivery / day-to-day management Care Group level oversight Divisional level oversight	Board and Board Committee oversight Executive oversight Specialist support (e.g. finance, corporate governance)	Internal audit External audit Care Quality Commission NHSE&I Independent review Other independent challenge

Progress on actions to address gaps in control / assurance	
Delivered	
On track to deliver to agreed timescale	
Slippage against agreed timescales (non-material)	
Progress materially off track	
Action not delivered to agreed timescale	

Calculating Levels of Assurance

Assurance Levels	
Level of Assurance	**Description**
Substantial	Governance and risk management arrangements provide substantial assurance that the risks identified are managed effectively. Evidence provided to demonstrate that systems and processes are being consistently applied and implemented across relevant services. Outcomes are consistently achieved across all relevant areas
Good	Governance and risk management arrangements provide a good level of assurance that the risks identified are managed effectively. Evidence is available to demonstrate that systems and processes are generally being applied and implemented but not across all relevant services. Outcomes are generally achieved but with inconsistencies in some areas
Partial	Governance and risk management arrangements provide reasonable assurance that the risks identified are managed effectively. Evidence is available to demonstrate that systems and processes are being applied but insufficient to demonstrate implementation widely across services. Some evidence that outcomes are being achieved but this is inconsistent across areas and / or there are identified risks to current performance
Limited	Governance and risk management arrangements provide limited assurance that the risks identified are managed effectively. Little or no evidence is available that systems and processes are being consistently applied or implemented within relevant services. Little or no evidence that outcomes are being achieved and / or there are significant risks identified to current performance



Board Assurance Framework 2020/21
St George's University Hospitals NHS Foundation Trust

Outstanding care every time