Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Trust Board Meeting

Thursday 30 September 2021

Agenda and papers

Outstanding care every time

St George's University Hospitals NHS Foundation Trust

Trust Board Meeting (Public) Agenda

Date and Time: **Thursday 30 September 2021, 09:00 – 11:05**
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 – 29 July 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					
09:15	**2.1**	**Quality and Safety Committee Report**	**Committee Chair**	Assure	Report
	2.1.1	***Learning from Deaths Report Q1 2021/22****	**CMO**	Assure	Report
	2.1.2	***Infection Prevention and Control Annual Report****	**CN**	Assure	Report
	2.1.3	***Learning Disabilities Annual Report****	**CN**	Assure	Report
09:35	**2.2**	**Integrated Quality and Performance Report***	**COO**	Assure	Report
3.0 CULTURE					
09:50	**3.1**	**Workforce and Education Committee Report**	**Committee Chair**	Assure	Report
	3.1.1	**Workforce Race Equality Standards Report***	**CPO**	Endorse	Report
	3.1.2	**Revalidation Reports*** • **Responsible Officer Annual Report** • **Nursing Registration and Revalidation Annual Report**	**CMO/CN**	Endorse	Report
4.0 COLLABORATION					
10:10	**4.1**	**Audit Committee Report**	**Ann Beasley**	Assure	Report
	4.1.1	***External Audit Value for Money Audit Report***			
10:20	**4.2**	**Finance and Investment Committee Report**	**Committee Chair**	Assure	Report
10:25	**4.3**	**Finance Report (Month 5)***	**CFO**	Update	Report
5.0 CLOSING ADMINISTRATION					
10:35	**5.1**	**Questions from Governors and the Public**	**Chairman**	Note	Oral
	5.2	**Any new risks or issues identified**	**All**	Note	
	5.3	**Any Other Business**		Note	
10:45	**5.4**	**Patient Story**	**CN**	Note	Oral
11:05	**CLOSE**				

Date of Next Meeting:
Thursday 25 November 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.

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
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	Chief Nurse & Director of Infection, Prevention & Control	CN
Richard Jennings	Chief Medical Officer	CMO
In Attendance		
Paul da Gama	Chief People Officer	CPO
Stephen Jones	Chief Corporate Affairs Officer	CCAO
Suzanne Marsello	Chief Strategy Officer	CSO
Anna Clough	Acting Chief Operating Officer	ACOO
Secretariat		
Geoff Stokes	Interim Head of Corporate Governance and Board Secretary	HCGBS
Apologies		
Elizabeth Bishop	Non-Executive Director	NED
Anne Brierley	Chief Operating Officer	COO
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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St George's University Hospitals
NHS Foundation Trust

Minutes of the St George's University Hospitals NHS Foundation Trust Board Meeting
In Public
Thursday 29 July 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	CPO
Stephen Jones	Chief Corporate Affairs Officer	CCAO
Suzanne Marsello	Chief Strategy Officer	CSO
Karen Richards-Wright	Freedom to Speak Up Guardian *(item 3.1.1)*	FTSUG
Andrew Asbury	Director of Estates and Facilities *(item 4.4)*	DEF
Estelle Le Galliot	Macmillan Centre Manager *(item 5.4)*	MCM
Caitlin Harvey	Macmillan Lead Clinical Nurse Specialist for Personalised Care *(item 5.4)*	MLCNS-PC
Janice Minter	Head of Nursing for Surgery, Neurosurgery and Theatres *(item 5.4)*	HN-SNCT
SECRETARIAT		
Tamara Croud	Head of Corporate Governance/Board Secretary (minutes)	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. The Chairman noted that James Friend, Chief Transformation Officer, had left the	

		Action
	organisation on secondment as Digital Director to NHS England and NHS Improvement (NHSE&I) London Region, working on London-wide IT projects. The Trust would miss him and the Board expressed its thanks for his contribution over the past four years. The Board noted that he had brought an emphasis on the importance of data which had been of real benefit to the Trust in helping to make improvements. The Board also noted the sad death of Professor Peter Kopelman who had previously served as both a member of the Trust Board and Principal of St George's, University of London. Professor Kopelman had also made a significant contribution to the work of the St George's Hospital Charity and to research. The Board expressed its gratitude for Professor Kopelman's contribution and recognised his legacy at both the Trust and the University. The Board noted and agreed the appointment of Stephen Collier as Senior Independent Director on the Board, succeeding Ann Beasley.	
1.2	**Declarations of Interest** As previously advised, Ann Beasley reminded the Board that she had been appointed as a Non-Executive Director on the Board of Epsom and St Helier University Hospitals NHS Trust from 1 June 2021.	
1.3	**Minutes of the previous meeting** The minutes of the meeting held on 27 May 2021 were approved as a true and accurate record.	
1.4	**Action Log and Matters Arising** The Board reviewed and noted the action log. In relation to action TB27.05.21/01 (gender pay gap), progress had been made in validating the Gender Pay Gap Report ahead of publication, but this was yet to be shared with Ann Beasley. It was also noted that the deadline for submission and publication of the Gender Pay Gap Report had been deferred until later in the year. Accordingly, the Board agreed that this action would remain open.	
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: • While there had been an overall reduction in Covid-19 infection rates both nationally and in London, there had been an uptick in the number of Covid-19 hospital admissions in recent weeks. • The Trust continued to enforce mask wearing by staff, patients and visitors across its sites in line with national guidance. St George's University of London, which shared the Tooting site with the Trust, had done likewise and the two organisations had worked closely together on this. There continued to be good compliance with mask wearing across the Trust, and this would be kept under close scrutiny to ensure the risk of hospital-acquired Covid-19 was minimised. • The Trust had seen particularly high activity levels in its emergency	

		Action
	department. Operational and clinical teams across the Trust had been working hard to balance these pressures with delivery of planned elective care and activity to address the elective backlog that had developed during the pandemic. Good progress was being made in relation to the elective backlog and the new surgical treatment centre at Queen Mary's Hospital in Roehampton was playing a key role in helping to address this, both for patients of the Trust and across South West London as a whole. • The stakeholder engagement process had commenced in relation to the joint renal unit with Epsom and St Helier Hospitals (ESTH). • Amanda Pritchard had been appointed as the CEO for NHS England and NHS Improvement, succeeding Sir Simon Stevens. The Trust Chairman asked about the measures the Trust was taking to ensure staff complied with lateral flow testing requirements. In response, the CAN/DIPC reported that: • The Trust had issued over 7,500 lateral flow tests to staff (including contracting staff) since receiving supplies from NHSE&I towards the end of the second wave of the pandemic earlier in the year. At that time, the Trust had developed its own internal reporting system to track compliance among staff. Subsequently, the Government had changed the process for lateral flow testing, and staff were now required to order lateral flow tests via a Government portal. The central system ensured greater transparency and visibility in the collection, submission and reporting, but this made it more complex for the Trust to monitor compliance. • The Trust had undertaken a concerted staff communications campaign to ensure all staff were undertaking twice weekly lateral flow tests and additional targeted messages would focus on certain groups where compliance was lower. • The Trust had put in place additional measures for staff working in higher risk areas, such as intensive care, renal, oncology and haematology. All staff in those areas were required to take weekly PCR tests. As a result, these groups of staff did not need to complete lateral flow testing alongside this. The Trust was one of the largest recruiters to the Siren study with significant numbers of nurses and medical staff being tested every two weeks. • In addition, 86% of Trust staff had received the first dose of a Covid-19 vaccine and 75% of staff had received a second dose, providing an additional dimension of protection for staff and patients. 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 June and July 2021, which set out the key matters raised and discussed. Some of the reports discussed by the Committee also featured later on the Board agenda.	

		Action
	The following key matters were highlighted by the Committee and noted by the Board: • The anti-coagulation serious incidents deep dive had provided the Committee with greater insight into the actions that had been implemented to prevent recurrence of previously recorded issues. In response to a question from Ann Beasley, the CMO advised that as part of the deep dive process evidence was found to indicate that key learning from anti-coagulation incidents had been identified and steps had been put in place to prevent further such incidents in future. • The Trust had received 50% of the bid funding from the Ockenden Maternity Review to invest in staffing. In addition, duty of candour and complaints performance had continued to improve. • Mandatory and statutory training (MAST) performance remained a material issue in relation to the completion of the three levels of resuscitation training. However, the Committee was assured to learn that good progress was being made in raising compliance. The Chairman noted that this had been a longstanding issue for the Trust and reiterated that steps needed to be taken to ensure that there was sufficient grip and that improvements were made promptly. • There had been a Never Event which related to a retained guide wire. In this case, no harm had been caused to the patient. However, the Committee had noted that this was not the first Never Event involving a retained guide wire and it would continue to seek assurance that the Trust had learned from this and previous incidents. The Board noted the report.	
2.1.1	**Complaints Annual Report 2020-21** The Board received and considered the annual Complaints report for 2020/21, which had previously been reviewed by the Quality and Safety Committee. The following key points were raised and noted: • There was a new theme emerging in complaints relating to the attitude and communication of some staff. Over the past year, staff had faced intense pressures and, at times, some members of staff had not always engaged with patients in the right way. The Trust recognised that further work was needed around values-based leadership and it planned to refine the questions around communication in the ward accreditation programme. • The Trust would review how it presented its data on complaints to ensure information on whether or not a complaint had been 'upheld' was clearly referenced in future reports. • The Trust had restructured the Complaints Team two years ago, however during the past year there had been a number of absences related to Covid and there had been some turnover in the team which had created some challenges. While national guidance had permitted the Trust to pause reporting of complaints response times compliance during the peak of the pandemic, the Trust had continued to do so as it considered it important to respond to	

		Action
	concerns raised by patients and their families in a timely way, irrespective of operational pressures. There had, however, been some challenges with providing prompt responses and actions were being taken to improve the working of the team. The Board noted the report.	
2.1.2	**Safeguarding Annual Report 2020-21** The Board received and considered the annual Safeguarding Report 2020/21, which had previously been reviewed by the Quality and Safety Committee. The following key points were raised and noted in discussion: • Due to the nature of the services it provided, the Trust inevitably became involved in multiple safeguarding case reviews. The Trust undertook a rapid investigation where it was part of a review which enabled the Trust to identify key issues, any lapses in care or immediate amendments to practice which needed to be undertaken while the full review was completed. • The number of children and young people who had attempted suicide in the last quarter had increased significantly. Some of these children were already on a mental health pathway. The Trust regularly engaged with mental health organisations and other key stakeholders including clinical commissioning groups, local authorities, and general practitioners to ensure these patients were on the right care pathway and that the organisations worked collaboratively to safeguard the health of these patients. The Committee received and noted the report.	
2.2	**Integrated Quality and Performance Report (IQPR)** The Board received and noted the IQPR at Month 3 (June 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: • While the emergency department had faced significant challenges, teams were working effectively to treat urgent and emergency patients and maintain elective activity. Emergency performance against the four hour operating standard was 91% for June 2021. Although this was lower than in previous months, St George's remained one of the best performing trusts in London against this standard. • The Trust was making good progress on elective recovery. The key pressures in relation to elective work were ENT, cardiology, general surgery and audiology. The Trust was working with local partners and the independent sector to provide mutual aid and the Trust was making use of the new surgical treatment centre at Queen Mary Hospital to address the elective backlog. There were currently 1,240 people waiting more than 52-weeks for treatment and the Trust planned to reduce this to fewer than 1,000 patients in the coming weeks. By the end of August 2021, all 250 patients who had waited more than 78 weeks would be treated. There were eight patients who had waited more than 104 weeks and these patients would be treated by the end of September 2021. • The Trust had faced particular challenges in relation to cancer targets. These	

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	challenges related largely to staffing capacity to deliver against the two-week standard. The focus on achieving the agreed elective recovery trajectories had impacted on the Trust's ability to achieve its targets in relation to certain screening programmes. The Trust was completing a review of these areas and would bring an evaluation report to the Quality and Safety Committee in due course. The Trust was on trajectory to achieve the 62-day position by the end of September 2021. The Trust had received funding to examine missing diagnoses of cancers at GP practice level during the pandemic and had identified resources for this work. • A significant risk for the Trust related to the lack of anaesthesiologist capacity across the NHS and within the Trust. This shortage could impact on the Trust's ability to effectively deliver against its elective recovery trajectory. The Trust was working with the Royal College in relation to job planning for anaesthetists. • The Trust had seen an increase in the number of medically fit tertiary patients waiting to be discharged to district general hospitals. The Trust was managing this to ensure that patients waiting to be treated at the Trust could gain access to services once these beds become available. • The Trust was continuing to focus on staff health and wellbeing, including making sure staff took their allocated annual leave so that they could rest and recover following the intense pressures of the past 18-months. There was a focus on retention and supporting new starters given that the Trust's data showed that over 55% of new starters leave within the first two years. The Trust had recently improved its exit interview process and planned to use this intelligence to inform its retention strategy. The following key points were raised in discussion: • Stephen Collier commented that while there were clear pressures, the report demonstrated a number of areas of progress and positive performance, and suggested that teams should be congratulated for this. • In relation to elective recovery, the Trust recognised that, in light of the uncertainties around potential future Covid-19 surges and the continuing high pressures on ED, it could not guarantee continued over performance against the agreed elective recovery trajectories. While the Trust was not planning to do so, there remained a possibility that the Trust may need to step back elective work in the event that Covid-19 cases increased substantially. Preparation for these scenarios was being factored into the Trust's winter planning processes. • On the issue of staff wellbeing, the importance of developing and monitoring a set of wellbeing metrics was discussed. The Trust had recently undertaken the first of its new pulse surveys the purpose of which was to obtain a real-time perspective on how staff were feeling, including in relation to their health and wellbeing. The Workforce and Education Committee would review the results of these surveys. **The Board noted IQPR and the plans to present to the Quality and Safety Committee a review of the delays in relation to the screening programme.**	**COO**
2.3	**Covid-19 and Surge Planning** The Board received and considered the update on Covid-19 and surge planning:	

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	• The Trust continued to strengthen and increase its capacity on its green (non-Covid) elective pathway. This segregation of patients had helped mitigate the risks of nosocomial infections on these pathways during the second wave of the pandemic. The Trust had a reliable point-of-care testing regime for Covid-19 and flu which would support the treatment of patients and keep them safe while in hospital. • In the context of the increase in community infection of Covid-19, the Trust was working hard to sustain a high pace of elective work as long as possible. Community transmission had not yet seen a marked increase in Covid-19 hospital admissions, but were this to transpire it would have an impact on the volume of elective work that could be undertaken. Unlike during previous Covid-19 surges, hospitals across the South West London Integrated Care System (SWL ICS) had agreed to manage their Covid-19 intensive care capacity for as long as possible. This contrasted with the approach taken earlier in the pandemic where the Trust had been an ITU surge hub within South West London and beyond. This change in approach would enable the Trust to maintain a greater proportion of its tertiary activity in the event of significant increases in Covid-19 ITU admissions over the coming months. • The Trust was using the learning from the second Covid-19 wave to implement actions to support staffing. Key actions included the establishment of a redeployment hub, increasing executive visibility and putting in place support measures for staff. The following key points were raised and noted in discussion: • Tim Wright commented that the surge plan appeared well thought through, but queried the capacity of the Trust to respond flexibility to the combined challenges of a future Covid-19 surge, significant flu outbreak, and a forecast increased in children's RSV. It was reported that the Trust had additional plans in place to prepare for these provisions and the executive had approved proposals for increasing capacity in children's services for example. Together, these measure help the Trust to manage the demands and pressures on the hospital. Winter plans were being developed, but the Trust expected to face considerable operational pressures both before and during winter. • In relation to the third Covid-19 wave, it was reported that the general thinking across the NHS was that the third wave may be lower in amplitude but longer in duration than the first and second waves. At present, it appeared unlikely that there would be further lockdowns and so the Trust had to be ready to respond to an extended period of community transmission and hospital admission. • Professor Dame Parveen Kumar reflected that in light of the pressures on staff it was important to keep staff abreast of developments and plans for responding to future Covid-19 waves and wider operational pressures. The Trust had identified a cohort of nurses who could be deployed rapidly to manage increases in Covid-19 admissions. The Board noted the report.	
3.0	**CULTURE**	

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		Action
3.1	**Workforce & Education Committee Report** Stephen Collier, Chair of the Committee, presented the report of the meetings held in June and July 2021, which set out the key matters raised and discussed. The overall sense of the Committee was that there was steady progress across a number of areas, recognising that there remained more work to do. There was a wide range of activities to support the work to strengthen organisational culture and the results of these workstreams were increasingly visible. The Committee was assured by the Trust's work on staff wellbeing with the focus on the psychological wellbeing of staff. There was evidence to demonstrate that these interventions were having a positive effect. The Committee also welcomed the positive progress that had been made in relation to freedom to speak up, which the Board would hear more about later in the agenda. **The Board noted the report and approved the proposed change to the Committee's terms of reference, adding the COO to the list of regular attendees in place of the three divisional directors of operations.**	
3.1.1	**Freedom to Speak Up Guardian Quarter 1 (2021/22) Report** The Board considered the Quarter 1 2021/22 Freedom to Speak Up (FTSU) report which had been considered at the Workforce and Education Committee. The Freedom to Speak Up Guardian reported that 17 concerns had been raised via the Guardian in quarter one. Although this was a reduction compared with the same period in the previous year, it was consistent with patterns seen in other trusts and with the trend seen in recent quarters. No patient safety concerns had been raised in quarter one. The key themes reported related principally to leadership, team working and wellbeing. In terms of the staff groups raising concerns, the majority of concerns raised in quarter one had been raised by nursing staff. This compared with previous quarters where administrative and clerical staff were the groups which had raised the most concerns. In quarter one, all concerns had been resolved informally through direct engagement with teams and/or signposting to relevant human resources processes. As reported previously, two formal concerns – in pharmacy and haematology – which had been raised in 2020/21 were being addressed through appreciate enquiries, with the COO and CMO acting as Senior Responsible Officers for the enquiries in pharmacy and haematology respectively. The enquiries had commenced earlier in the year and the outcomes were awaited. In response to the 2020 Staff Survey, the Trust had identified five key priorities for action and the Trust was focusing on one priority each month; one of these "Big 5" priority areas was "let's talk", which had been held in June 2021 and was about supporting staff to raise concerns. There had been a positive response to this among staff. In late May 2021, the National Guardian's Office for Freedom to Speak Up had published the annual Freedom to Speak Up Index, which sought to measure the healthiness of the speaking up culture within NHS organisations. The Index score was calculated on the basis of responses to four questions in the most recent staff survey, undertaken in autumn 2020. The Trust had risen nine places in the Index compared with the previous year, moving from 204th out of 230 trusts to 195th. While it was positive to see the improvement, the Index also demonstrated the scope for further improvement. The Index, however, was also a point in time	

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	measure and did not reflect the work undertaken by the Trust since the approval of the FTSU strategy in September 2020 to strengthen the Trust's approach to raising concerns. In relation to training, over 250 new staff had undertaking the FTSU training module developed by the National Guardian's Office, and in line with the FTSU strategy the Guardian was seeking to ensure that speak up training was integrated into the Trust's programme of mandatory training. A report would be presented to the mandatory and statutory training steering group in early August to formalise the FTSU e-learning module. The Trust had also recruited 18 new FTSU Champions who were undertaking the required training during August and September. The following key points were raised in discussion: • The visibility and approachability of the FTSUG was a key element of the success of the service and function. • The CCAO, as Executive Lead for FTSU, explained that the Trust had been working to encourage staff to raise concerns about patient safety in addition to raising other types of concerns. The Trust was exploring undertaking targeted campaigns around raising patient safety issues, and was also integrating learning from other trusts with a higher score on the Index. • There had been a focus on behaviours in the organisation and this remained a core part of the Trust's culture programme. • The trusts at the top of the national FTSU index had demonstrated strong visibility of the FTSUG. It was also clear that there was an inextricable link between a healthy speaking up culture, the wider organisational culture, and a robust training and education programme. • In the most recent Index, a new question had been asked which focused on whether staff felt safe to speak up. This did not inform the scoring of the Index this year, but the Trust had performed well on this metric, and higher than some other London trusts. The Board noted report.	
4.0	**COLLABORATION**	
4.1	**Audit Committee Report** Elizabeth Bishop, Chair of the Committee, provided an update on the meeting held in July 2021. The Committee had reviewed the outline of the value for money audit, which it had received in draft, and had noted that the management team were addressing the draft recommendations. The Trust submitted the DSP Toolkit compliance report but it was noted that cyber security remained an area of concern. The Chairman noted her disappointment with the limited assurance rating of recent internal audit reports. The Committee shared those concerns but was reassured that management were responding to actions and focusing on documenting compliance with previous recommendations. The Board also recognised that, in many cases, the Trust selected areas for focus by internal audit where there were underlying concerns which needed focus. The Trust recognised that it needed to	

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	demonstrate that it was effectively learning from these reviews and implement any actions that arose. The Board noted the report.	
4.2	**Finance and Investment Committee Report** Ann Beasley, Chair of the Committee, provided an update on the meetings held in June and July 2021. The Committee had reviewed the risks related to the availability of capital funding which was particularly pressured across South West London. While the Trust would continue to invest to mitigate key risks, this would constrain the Trust's ability to progress with key ICT and estates projects. The Committee had reviewed and endorsed the draft estates strategy, which the Board would discuss later in the agenda. In the meantime, the estates risk on the Board Assurance Framework remained unchanged, but there appeared scope to revisit these later in the year. In relation to financial planning, the Committee heard that national guidance for the second half of the financial year was not yet available and that this created significant uncertainty. The Committee noted changes in the arrangements for the Elective Recovery Fund and likely efficiency requirements, both of which were expected to make the second half of the year significantly more challenging than the first, and more challenging than 2020/21. The Committee also considered the latest costing returns and noted the relative improvements made to date. The Board noted the report.	
4.3	**Finance Report M03** The Board received and noted the Trust's financial performance at month 3. The Trust remained on plan at the end of June 2021. The income and expenditure position was expected to become more challenging in the second half of the year given the significant uncertainty which remained in the absence of planning guidance, the changes to the Elective Recovery Fund, and the likelihood of the introduction of efficiency targets. The Trust was spending a significant amount of available capital to close schemes started last year. The Trust was working with partners in the South West London (SWL) Integrated Care System (ICS) to plan the system budget and manage system finances for 2021/22. The Trust's underlying cash position remained weak as a consequence of overspending 3-4 years previously. The Trust, as with the wider NHS, was under pressure from NHS England and NHS Improvement, to improve its compliance with the Better Payment Practice Code which now required payment of 95% of non-NHS invoices within 30 days. This was something the Trust had previously found challenging and steps were being taken to utilise cash to manage this carefully and improve performance. The Board noted the report.	
4.4	**Estate Strategy & Green Plan** The Board received and considered the Estate Strategy and Sustainable Development Plan ("Green Plan") which had been discussed by the Finance and Investment Committee earlier in the month. Early thinking on the strategy had previously been reviewed at a Board seminar in April 2021. The drafts had also been presented to the Council of Governors in July 2021 ahead of presentation to the Board. The following key points were raised in discussion:	

		Action
	• The Trust had conducted a significant amount of work on developing the Estate Strategy and the Green Plan over the past 6 months and there had been wide-ranging engagement with key stakeholders throughout the process. Following the feedback received, a summary document had been developed which presented the key aspects of the Estate Strategy and the Green Plan in an accessible way. • The Estate Strategy set out an ambitious vision for the Trust's Tooting estate which envisaged a phased renewal of the whole site over the next two decades. It provided a framework that would help guide estates-related investment decisions in a coordinated way. Realising the strategy was, naturally, dependent on the necessary funding being available and the Trust was already working hard to secure the necessary funding. • The Green Plan went hand-in-hand with the Estate Strategy and set out the roadmap for the Trust becoming carbon neutral by 2040, and the key milestones on that journey, including highlighting further work that would be needed. One of the key challenges with the Trust improving its position in relation to environmental sustainability was the condition of its estate, and the renewal of the site envisaged in the Estate Strategy would help significantly in delivering the Green Plan. Sustainability, of course, went further than this and the Trust was working on a complementary travel plan, the purpose of which would be to promote more environmentally friendly means of staff and patients visiting the site. • Work was already underway to operationalise plans in the strategy and effectively engage all staff in supporting these areas of work. • There had been strong feedback from some members of Council of Governors as to whether the targets set out in the Green Plan were sufficiently ambitious and whether the plan considered wider measures beyond those intended to curb the trust's carbon emissions. • Professor Dame Parveen Kumar, as the NED lead for sustainability, commented on the link between the Estate Strategy and the Green Plan, emphasising that developing and overhauling the poor condition of the current estate as envisaged in the Strategy would go a significant way to delivering key parts of the Green Plan. • Pui-Ling Li reflected that the case for the Estate Strategy was clearly evident and it was important to progress this with vigour. It was important, however, that the Estate Strategy was aligned with the estates needs of the South West London system more broadly, and that it provided flexibility for the future. The DEF and CFO explained that the Strategy had been developed in close collaboration with local partners across the SWL ICS and the plans set out took account of these needs. • The Department of Health and Social Care had recently announced the process to allow trusts to apply to the hospital infrastructure scheme. Subject to endorsement of the Strategy by the Board, the Trust wished to submit an expression of interest document to the Department with a view to securing the capital funding necessary to progress the first phase of the plans. The capital value of the initial phase of the scheme would be in the region of £600m. The expression of interest would need to be submitted by 9 September 2021.	

		Action
	• The Finance and Investment Committee would receive regular reports on the progress of the Trust implementing key actions set out in the Estate Strategy and Green Plan. The Chairman commented that the presentation of the Estate Strategy and Green Plan was a milestone for the Trust. She thanked the Director of Estates and Facilities and his team for all of their hard work in developing the strategy and in strengthening assurance to the Board on estates matters more generally. **The Board approved the Estates Strategy and Green Plan, endorsed the Trust submitting an expression of interest to be one of the eight trusts on the hospital infrastructure project scheme. The Board noted that the Finance and Investment Committee would monitor progress on the delivery of the Green Plan.**	
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. Of particular note was the fact that the Health and Care Bill had received its second reading in Parliament and was on track to receive Royal Assent towards the end of the financial year. There had been changes in the Care Quality Commission's approach to its inspection regime, with the CQC seeking to place more emphasis on intelligence and ongoing monitoring alongside on site inspections. The General Medical Council had published its annual survey of doctors in training, which had highlighted the impact of the pandemic on medical training over the past year and the pressures under which junior doctors were operating.	
4.5.2	**Strategic-Local & Regional** The Board received and noted the update on strategic local and regional system issues.	
4.6	**Board Assurance Framework Quarter One (2021/22) Report** The Board considered the Board Assurance Framework (BAF) report at quarter one 2021/22. The BAF had been considered by the relevant executive groups and the Board Committees, which had reviewed the strategic risks allocated to them by the Board. There were no proposed changes to the risk scores at quarter one over and above those already agreed by the Board in May 2021. It was proposed that the assurance rating for Strategic Risk 8 (culture) be increased from "partial" to "good" to reflect the progress made with the work on strengthening culture, the initiatives in place to deliver the diversity and inclusion plan, and the steps taken to strengthen the Trust's speaking up processes. While a reduction in the risk score was not considered appropriate at the present time, there was far greater assurance on which the Board could rely than had previously been the case, and the steps being taken by the Trust were now starting to gain traction. In relation to SR4 (system working), which was reserved to the Board, the Board agreed to retain the risk score of 12 (4 consequence x 3 likelihood) and the assurance rating at "good". It was envisaged that changes to the risk score of SR9 (workforce) and	

		Action
	SR7 (estates) may be possible over the course of the next two quarters. All Committees had agreed target risk scores for year-end 2021/22. However, the Board recognised that a review of the strategic risks on the BAF would be undertaken following the review of corporate objectives, which was due to be presented to the Board in September 2021. **The Board noted the current BAF position and endorsed the increase in the assurance rating for SR8 from "partial" to "good".**	
5.0	**CLOSING ADMINISTRATION**	
5.1	**Questions from the public and Governors** In response to a question from Richard Mycroft, Lead Governor, in relation to the funding for the Estate Strategy and Green Plan, CFO/DCEO explained that the Trust would make the strongest possible case for securing capital funding. However, it was important to recognise that while the need to modernise and improve the Trust's estate was very strong, the Trust was not the only hospital in the country which could make a compelling case for capital funding. In the short and medium term, the Trust would continue to focus on areas where it could make improvements within its current capital budget. As and when more funding became available, the Trust would make progress on key elements and would iterate its plan to ensure it was best placed to receive additional funding. 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** The Board thanked Elizabeth Bishop for her dedicated work and commitment as a Non-Executive Director and Chair of the Board's Audit Committee since February 2020, and wished her the very best for the future. Although she would continue to serve as a member of the Board until the end of September 2021, this was her final Board meeting. Elizabeth Bishop stated that it had been a huge privilege to serve as a Non-Executive Director at the Trust. She also reflected on the high quality of care she and her family had experienced at St George's. The Chairman updated the Board on the process for appointing a new Non-Executive Director to succeed Elizabeth Bishop, explaining that interviews had been held earlier in the month and a recommendation would be put to the Council of Governors for consideration the following week.	
5.4	**Staff Story – MacMillan Cancer Centre** The Trust welcomed Estelle Le Galliot, Macmillan Centre Manager, Caitlin Harvey, Macmillan Lead Clinical Nurse Specialist for Personalised Care and Janice Minter, Head of Nursing for Surgery, Neurosurgery and Theatres. Estelle outlined the significant work carried out in the Macmillan Information and Support Centre to support and guide cancer patients and carers through the Covid-19 pandemic. She outlined the role of the Centre and the service provided (pre-Covid) and explained how the pandemic had impacted on the service, with patients having had to shield and with significant changes implemented to patient pathways. A key area for	

		Action
	development was to raise the profile of the Centre with clinicians at the Trust. The Board thanked Estelle for her presentation and the significant amount of work done to continue to provide support to patients and undertake changes to ensure the service was fully accessible to all. It was hard to underestimate the importance of a service like this during what had been an extremely isolating period for many of the most vulnerable patients who had been required to shield during the pandemic. It was evident from the presentation that little things could have a huge impact on patient care and experience. The Trust had a strong relationship with Macmillan and it was exciting to see the development and passion from the teams, which had culminated in a nomination for an award by the Nursing Times.	
Date of next meeting: Thursday, 30 September 2021, MS Teams		

Trust Board Action Log Part 1 - September 2021						
Action Ref	**Section**	**Action**	**Due**	**Lead**	**Commentary**	**Status**
TB27.05.21/01	**Gender Pay Gap**	The Board noted report and endorsed the report subject to Stephen Collier and Ann Beasley agreeing the final data analysis.	~~24/06/2021~~ 30/09/2021	CPO/ Stephen Collier/ Ann Beasley	**CPO to provide oral update at meeting**	**DUE**
TB29.07.21/01	**Integrated Quality and Performance Report**	The Board noted the IQPR and the plans to present to the Quality and Safety Committee a review of the delays in relation to the screening programme.	25.11.2021	COO	Not yet due	**NOT YET DUE**

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Meeting Title:	**Trust Board**		
Date:	30 September 2021	**Agenda No.**	**1.5**
Report Title:	**Chief Executive Officer's Report**		
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

It has been two months since the last Trust Board meeting, and our focus in recent weeks has been finalising our plans for the upcoming winter period. We have done this while facing a particularly challenging summer, responding to a third wave of covid, increasing pressure in our emergency department, while also recovering elective surgery.

It is thanks to the enormous efforts of all our staff that the Trust was one of the best performing Emergency Departments in London during parts of August, despite the volume of patients coming to our doors. Patients waiting over 52 weeks for elective surgery has also fallen from a peak of 2,644 patients in March 2021 to 1,041 patients as of September 21.

All this has been achieved despite higher numbers of covid patients than last summer. But this pressure in summer has meant we have not been able to catch our breath before rolling up our sleeves for Winter. And we now must keep up the momentum on recovering services and addressing the backlog while also looking after our staff and making sure they too get time to recover. Our staff well being will be central to our winter plan.

Earlier this month the government announced an additional £5.4bn for the NHS Covid 19 response over the next six months. The Trust is working with the ICS and NHS London on the impact of this additional funding to support elective recovery.

We are however expecting the second half of the year to be more challenging. While funding settlements have yet to be confirmed, it is anticipated that an increased level of efficiency will be required to manage financial pressures resulting from elective recovery and increased emergency activity.

Group Model

In August, after years of collaboration and creating closer working ties, we announced that the Boards of St George's and Epsom and St Helier agreed to form a hospital group, and I was honoured to be appointed Group Chief Executive.

Collaboration between the two hospital has been happening for some time with both trusts working together to bring specialist kidney care into a single £80m unit and, during the pandemic, the two organisations teamed up on the Novavax vaccine trial. Plans are continuing for further collaboration, for example, we are looking at how Patient Transport Services can be run for both trusts by Epsom and St Helier - helping reduce the amount of patient journeys across south west London.

There is a huge amount to be proud of in this work, and I am delighted to be building on this strong foundation. I am now spending time at both trusts and have started a consultation on changes to the executive leadership structure at both hospitals.

The executive leadership structure of the group will reflect the strength in depth, expertise and broad skills of the leadership teams of the two organisations. It will result in a blended Executive team from both Trusts for the new group.

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Covid booster jabs

In September the JCVI advised that booster vaccines should be offered to those more at risk from serious disease including all adults aged 50 years or over and frontline health and social care workers. The JCVI advises that the booster vaccine dose is offered no earlier than 6 months after completion of the primary vaccine course.

St Georges began offering booster jabs on 23 September and hundreds of staff have already visited the clinic to get their third dose to protect themselves, their patients and their loved ones. The trust also used this moment to encourage any hesitant staff to get their first and second jabs by sharing short clips, pictures and words of those getting vaccinated across both internal and external communication channels.

St George's and the wider NHS

As always, we remain engaged with key discussions and developments at a regional and national level and I am pleased to note the Health and Care bill is progressing well through Parliament.

In August, NHS England and NHS Improvement published its guidance on provider collaboratives, setting out how providers should work together and the principle around local decision making. This follows the ICS Design Framework which was published in June, setting out how they will be expected to operate by April 2022 when ICS partnerships and new statutory integrated care boards will be established.

Our provider collaborative - the South West London Acute Collaborative (APC) has been working together for some time now. It is working well, leading elective recovery for South West London where performance remains the strongest in the capital. APC has recently met with ICS chair Millie Banerjee and Sarah Blow ICS SRO to discuss their plan and priorities for ICS transition taking the new provider collaborative guidance into account.

SWL Health and Well Being Board members, Local Authority and NHS leaders have been invited to a series of engagement events to discuss their views on how the ICS in SW London is developed. Specifically, they are seeking views on the development of the SWL Integrated Care Partnership, and Place-based Partnerships, so we can be actively involved in their design. I have been invited to the listening events for Merton, Sutton and Wandsworth.

The current ICS chair Millie Banerjee has been confirmed as the NHS Integrated Care Board (ICB) Chair. Recruitment for ICB CEO has begun and is expected to conclude by end of October.

Engaging with our communities

We continue to engage with our local communities, and earlier this month, we held our annual members' meeting remotely inviting members, local residents, staff and patients to join us online. We reflected on the challenging year we had and celebrated some of our successes. Lead Nurse Toyin Oladotun represented staff and spoke of her pride in setting up one of the first Covid-19 vaccination clinics at St George's back in December 2020. Patients Randika and Paul – who featured in the Channel 4 documentary Baby Surgeons - spoke of the outstanding care they received at the Trust. We were asked a number of

questions from members and the public ranging from the services we provide and plans to work more closely with our partners in the local community.

Creating a better place to work

Our Big 5 has come about as a result of the feedback we received from the annual NHS staff survey – through this we have been able to identify and focus on areas for improvement that matter to our staff, including flexible working or fairer career progression. September was our final month in which we focused on creating a better place to work and making sure staff had the tools and equipment to do their job effectively. We were pleased to be able to offer staff a range of activities, webinars and events as part of our work on the Big 5. For instance during May's Health and Wellbeing month, we organised a timetable of weekly wellbeing activities, free of charge and open to all St George's staff. The activities on offer included Zumba, yoga, mindfulness and deskercise. This year's annual staff survey will be opened on October 4 and we will again encourage all our staff to give their views so we can listen to what they say and take action to make improvements.

Queen Mary's Surgery Treatment Centre

The President of the Royal College of Surgeons, Professor Neil Mortensen, and Stephen Hammond, Member of Parliament for Wimbledon, visited the Surgery Treatment Centre at Queen Mary's Hospital in September.

The Centre opened in June 2021 and up to 120 procedures can be carried out per week in the new centre, which offers protected theatre time to ensure patients waiting for routine procedures can get the treatment they need.

It's been possible for some surgical training to happen again too, helping trainees to catch up on some of the time they missed last year. Professor Mortensen and Mr Hammond were given a tour of the centre which has four dedicated operating theatres and a recovery area for patients. Professor Mortensen said he was 'inspired by their commitment and their collaborative and innovative approach'. He was also interviewed on Times Radio and mentioned the facility, saying it was fantastic and illustrates what cane be done to tackle waiting lists. Mr Hammond said one of its most impressive features was its state of the art development. My personal thanks to Mr Ben Ayres, Consultant Urological Surgeon and Care Group Lead for Urology, Dr Emma Evans, Consultant Anaesthetist, and Avelino Magallanes, Matron, for providing a tour of the centre.

New lifesaving Covid treatment

I'm proud to report that St Georges is one of the first hospitals in England to offer Ronapreve, a new treatment for critically ill covid patients. Just days after it was approved for use, clinical teams were able to offer the treatment to anyone who tests positive for covid-19 but is unable to build their own immune response to fight the disease due to being immunosuppressed. ITV News reported from St George's which, with St George's university, is also a UK leader in covid-19 research, having undertaken 60 covid-19 studies and recruited 7019 participants into trials. Major advances such as the use of this new lifesaving treatment, have come about because we have been successful in embedding research into everyday NHS practice and through the hard work of our research nurses, doctors and the commitment from our patients.

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Awards

Yet again our fabulous St George's staff have been nominated for a series of awards.

Four of our teams have been shortlisted for the 2021 Nursing Times Awards for cancer nursing, infection protection and control, nursing in mental health and surgical nursing. Our finalists will find out if they have won at the awards ceremony taking place on 27 October.

A team working in our Emergency Department have been shortlisted for an HSJ Award, in the "Driving Efficiency through Technology" category, for their involvement in a project aiming to reduce waiting times for emergency patients needing a Covid PCR test. Good luck to everyone involved who find out if they win in November.

The Grierson Trust, organisers of the annual British documentary awards, have shortlisted two St George's documentaries for awards: Channel 4's Baby Surgeons and BBC3's Sudden Death – My Sister's Silent Killer. The winners will be announced in November.

Although they didn't win this time, our communications team were shortlisted for two awards at the NHS Communicate awards run by NHS Providers. Better luck next year team.

Leadership update

Finally, we have continued to strengthen our teams through a number of key appointments.

- Anna Macarthur has been appointed as Director of Communications and Engagement and joins us on secondment from NHS England and NHS Improvement.
- Louise Ludgrove has been appointed as interim Director of Workforce, succeeding Elizabeth Nyawade who left the Trust in August.

My thanks also goes to Mitchell Fernandez, Assistant Chief Nurse, who left the Trust on 21 September following a promotion to a role at another London Trust.

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2.1

Meeting Title:	**Trust Board**		
Date:	30 September 2021	**Agenda No**	**2.1**
Report Title:	**Quality and Safety Committee Report**		
Lead Director/ Manager:	Prof. Dame Parveen Kumar, Chair 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 August and September 2021.		
Recommendation:	The Board is asked to note the updates from the August and September 2021 meetings.		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	All CQC domains		
Single Oversight Framework Theme:	Quality of care, Operational Performance, Leadership and Improvement Capability		
Implications			
Risk:	Relevant risks considered.		
Legal/Regulatory:	CQC Regulatory Standards		
Resources:	N/A		
Previously Considered by:	N/A	Date:	N/A
Appendices:	N/A		

Quality and Safety Committee Report

Matters for the Board's attention

The Quality and Safety Committee met on 19 August and 23 September 2021 and considered the following matters of business at these meetings:

August 2021	September 2021
• Board Assurance Framework Monthly Report • Integrated Quality & Performance Report (M4) • Serious Incident Monthly Report • Learning from Patient Deaths (quarter 1)* • Learning from Covid-19 • Infection Control Annual Report* • Care Quality Commission Insight Report • Patient Experience and Engagement Report • Patient Safety & Quality Group Monthly Report • Diagnostics Testing (Internal Audit report) • Patient Data: Ethnicity (Internal Audit report)	• Mandatory Training - Resuscitation • Board Assurance Framework Monthly Report • Integrated Quality & Performance Report (M5) • Serious Incidents Monthly Report • Nurse Safe Staffing Report (Planned vs. Actual) • Health and Safety Report • Winter, Flu and Covid Planning Update* • Seven Day Services Compliance (NHS Returns)* • Patient Safety & Quality Group Monthly Report • NIHR Research Bid Application • Trust-wide Policy Updates: Patient Care • Learning Disability Services – Annual Report*

*These items are also presented to the Board for consideration at the September 2021 Board meeting.

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

1. Integrated Quality and Performance Report (IQPR)

The Committee considered the key areas of quality and safety performance in months 4 and 5 (2021/22) and would like to highlight the following issues, conscious that the Board will discuss the month 5 performance data later on the agenda:

- Areas of good or improving performance:
  - The Trust continues to see an improvement in resuscitation training compliance (as reported in the IQPR), with basic life support (BLS) at 80%, intermediate life support (ILS) at 67% and advanced life support (ALS) at 72%. Targets for ILS (85%) and ALS (95) training are expected to be achieved by December 2021. (Data in relation to life support training was discussed as a separate item at the September Committee meeting and demonstrated that these figures had increased; as at 21 September 2021, BLS training stood at 84% and was on target to achieve the 85% target by the

end of September; ILS training was at 70% compliance, with a trajectory to achieve 85% by 31 December 2021; and ALS training compliance was 80% with training on track to achieve the 85% target by 31 December 2021.)

- There had been an increase in the number of patients for cardiology MRI. Two new catheter labs are expected to open shortly, and this should see performance improve.
- The local clinical commissioning group (CCG) had commissioned general practitioners (GPs) to provide additional support to the Trust for paediatric patients, of which approximately 30% were expected to be seen virtually.

- Areas of challenge:
  - The Birth Centre remained closed during the reporting period and homebirth services were suspended due to staffing challenges in August across maternity services. As a safety measure, the affected women had been moved to the Delivery Suite and although their births remained midwife-led the change of location was a change to their birth plan.
  - There were 58 'on the day' cancellations in July and 38 in August 2021, due to a combination of unavoidable factors.
  - Urgent and emergency cases continue to be a challenge and the committee heard of the mitigating plans.
  - There had been pressures in relation to ITU and cardiology as a result of staff sickness and planned leave, and actions were being taken to address these.

The Committee received reasonable assurance from the report and the discussion.

2. Serious Incident Reporting

The Committee considered and noted the serious incident reports which covered the period July and August 2021. During these periods:

- 8 serious incidents were declared (6 in July, 2 in August);
- 13 serious incident investigations were concluded (7 in June, 6 in July).

The Committee heard of three investigations at the August 2021 meeting and two more in September 2021 which identified some specific learning points that will be implemented and monitored by the Patient Safety and Quality Group. These learning points included taking opportunities to intervene, ensuring staff are aware of appropriate pathways, ensuring appropriate clinical supervision of more unusual procedures, and more precision in prescribing instructions.

The Committee were assured by the robustness of the investigations and the processes in place to learn from these incidents.

3. Learning from Patient Deaths (quarter 1 2021/22)

The report was discussed by the Committee and it was noted that the Mortality and Morbidity Co-ordinators' Team has now been recruited and the co-ordinators have been allocated across the organisation. They are expected to achieve the implementation target detailed in the Quality and Safety Strategy by the end of 2021/22.

Medical examiner services have been operational since January 2020 but had been impacted by the Covid-19 pandemic. There is a plan to expand the service, in consultation with the CCG.

The Trauma Audit and Research Network had confirmed an improvement in data quality and the Trust was no longer considered to be an outlier.

The Committee noted the development of the Mortality and Morbidity Team in line with the Quality and Safety Strategy.

4. Learning from Covid-19

The Committee received a report from a learning exercise related to the clinical management of Covid-19 and the implementation of emerging research into clinical practice. The Committee noted that crude mortality, as well as ITU mortality, reduced significantly between waves one and two. This was due to differences in treatment methods, particularly with regard to medication and the mode of mechanical respiratory support. The third wave was less disruptive to hospital services presumably due to increased immunity in the population.

It was identified that there is a need to improve treatment escalation planning overall, not just for Covid-19 cases. It was also noted that Specialist Palliative Care services had been extremely challenged in both waves one and two, especially in terms of capacity.

The Committee received reasonable assurance from the report.

5. Infection Control Annual Report

The Committee received the annual report for 2020/21 which included confirmation that the Trust is fully compliant with the Hygiene Code (2008).

The report also highlighted that there had been 41 cases of *C. difficile* apportioned to the Trust compared to 51 cases in 2019/20. There were also 3 cases of MRSA (no change from the previous year), 47 MSSA cases (36 in 2019/20) and 60 *E.coli* cases (74 in 2019/20). The Infection Control Committee will continue to monitor *E.coli* cases.

The Trust played a lead role in developing a digital urinary catheter passport and standardisation of urinary catheter products across the health economy of South West London (SWL) through the SWL Catheter Workstream.

The Committee received reasonable assurance from the annual report.

6. Care Quality Commission (CQC) Insight Report

The Committee received the CQC Insight Report, which brought together the information held by the CQC about the Trust and provided insight about the performance of the eight core Trust services against national standards. Due to the pandemic, the report was produced based on available data. It was acknowledged that some of the data was out of date and may therefore represent an inaccurate position for the Trust.

Onsite CQC inspections continue to take place to assess areas of significant concern. However, following a consultation exercise the CQC inspection regime has now moved to an application-based assessment. The Chief Nurse and Chief Medical Officer meet with the Lead Inspector every three months.

7. Patient Experience and Engagement Report

The Committee received the report and noted significant improvement in pain management of patients suffering from sickle cell disease attending the emergency department. Other updates included the improvements in the hospital environment, work of the Children and Young People's Council and alternative modes of patient contact to facilitate virtual visiting during the pandemic.

8. Patient Safety & Quality Group (PSQG) Monthly Report

The report identified an increase in falls per 1,000 bed days, although the majority were classified as low or no harm. There was a focus on the completion of comprehensive risk assessments for un-witnessed falls.

New measures were being put in place to ensure staff in radiopharmacy had appropriate protection including the provision of new equipment and ceiling-suspended lead screens. Current mitigations included the use of lead glasses for staff, which will continue.

Following changes arising from the external phase 3 governance reviews, the PSQG agenda had been modified and a separate quarterly Divisional Quality and Safety Performance review meeting had been established in September 2021.

9. Diagnostics Testing (Internal Audit Report)

The internal auditors' report on diagnostics testing was referred for review to the Committee by the Audit Committee. The Committee received assurance from the Chief Operating Officer (COO) who made a number of points, including that the number of patients who did not have a booked appointment was approximately 9,000, fewer than had been reported. The COO also pointed out that there had been a significant improvement in DM01 (the key metric for diagnostic screening) performance. All actions identified in the report had been completed apart from finalising the access policy relating to diagnostics.

10. Patient Data: Ethnicity (Internal Audit report)

The Audit Committee also referred the above report to the Committee for review and the Chief Nurse provided an update. There is no 'reverse' system to validate the data collected from outpatient appointments and the Chief Information Officer is working with the General Manager of outpatients to address the issue.

The Data Quality and Health Record Policy was being reviewed to address recommendations in the report and to meet the requirements of the Equality Act 2010.

11. Winter, Flu and Covid-19 Planning Update

Good progress had been made in assessing and modelling the capacity needed to address the anticipated pressures on the Trust and its staff that will inevitably arise over the coming winter. More detail will be provided to the Board, but the Committee were impressed with the level of detail and sophistication that has been employed to determine plans needed to try and mitigate what will be a very challenging period for the Trust and the NHS as a whole.

12. Mandatory Training – Resuscitation

The Committee were informed of the work that has been done to improve the position relating to compliance with BLS, ILS and ALS training and the reasons why the position had deteriorated, not least due to operational pressures caused by the pandemic. The team had been reinforced and there had been a deliberate focus on ensuring all relevant staff had BLS training and those in response teams are up to date with higher levels of training. Innovative methods of training had been introduced to ensure the team can focus their efforts on the more complex training that fewer people need and there is sufficiently capacity to ensure all relevant staff are trained by the end of the calendar year. As at 21 September 2021, BLS training compliance stood at 84% against a target of 85%, which would be achieved by 30 September 2021; ILS training compliance was at 70% and ALS at 80%, and both were on track to achieve compliance by 31 December 2021.

The Committee was pleased to see progress and accepted the assurance that relevant targets will be met for BLS by the end of September 2021) and for ILS and ALS by the end of December 2021.

13. Learning Disability Services – Annual Report 2020/21

The report from the Learning Disability Liaison Nursing Team was well received and gave assurance to the Committee about the focus by the Trust leadership on the care for this cohort of patients. The number of referrals to the team have decreased by 14% when compared with the previous year and benchmarking against NHSE/I standards shows excellent feedback from patients, their carers and staff, compared with other Trusts.

14. Health and Safety Report

The Committee heard of improvements to the governance arrangements for health and safety that have occurred since an external review was commissioned by the Board. Work continued to align health and safety and patient safety activities and it was suggested that reporting on health and safety should be seen at the Board, at least annually.

15. Farewell to Elizabeth Bishop

As this was Elizabeth Bishop's final meeting of the Committee, Committee members thanked her contributions and insights, especially in bringing a more data-focussed approach to the work of the Committee.

16. Recommendation

The Board is asked to note the updates from the August and September 2021 meetings.

Dame Parveen Kumar

Committee Chair

September 2021

Meeting Title:	**Trust Board**		
Date:	30 September 2021	**Agenda No**	**2.1.1**
Report Title:	**Learning from Deaths and Mortality Monitoring Group (MMG) Report – Quarter 1 2021/22 (April – June 2021)**		
Lead Director:	Dr Richard Jennings, Chief Medical Officer		
Report Author:	Kate Hutt, Head of Mortality Services Mr Ashar Wadoodi, Lead for Learning from Deaths		
Presented for:	Assurance		
Executive Summary:	The paper provides an overview of the work of the MMG and Learning from Deaths in Q1 2021/22. A brief outline of progress against the Quality and Safety Strategy priority related to the implementation of Mortality & Morbidity Coordinators Team is included. Key milestones have been met: all members of the team are in post and are actively supporting M&M meetings across the Trust. 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. Key actions related to improving bereavement care are highlighted. To demonstrate processes in relation to monitoring and investigating mortality outlier alerts, an update on ongoing work related to major trauma is presented. The conclusion of the investigation into intracranial injury is also provided. A brief summary of analysis of Covid-19 activity and outcomes during waves one and two of the pandemic is included, with comparison to national benchmarks where possible. National mortality measures are also reported. Both our SHMI and HSMR remain lower than expected.		
Recommendation:	The Board is asked to: • Note and support progress against Quality and Safety Strategy through implementation of the M&M team. • Note that the Trust is fully compliant with all CNST requirements in this quarter and continues to use this work to drive improvement. • Consider the assurance provided that current outlier alerts are being investigated robustly and that there is a granular understanding of our mortality data. • Note the analysis of data available regarding wave 1 and 2 of the covid-19 pandemic that can be used to assist understanding of our outcomes.		
Supports			
Trust Strategic Objective:	Care. Reducing avoidable harm.		
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 and Safety Committee	**Date**	19 August 2021
Equality Impact Assessment:	N/A This is in line with the principles of the Accessible Information Standard		

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Learning from Deaths and Mortality Monitoring Group (MMG) Report:
Quarter 1 2021/22 (April – June 2021)
Trust Board, 30 September 2021

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 Group (MMG) 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

2.1 Implementation of the M&M Team

This quarter recruitment of the Mortality & Morbidity Coordinators Team has been completed and all team members are now in post. The team consists of five coordinators and a team leader and is managed by the Head of Mortality Services. The M&M team leader, Maureen Ijomoni, has met with all Clinical Governance leads to outline the aims for the service and gain an understanding of the support needed. All services now have a coordinator allocated to them and the team are actively supporting M&M meetings across the Trust.

The new M&M team is an area of focus in the Implementation Plan 2021-22 of the Quality and Safety Strategy 2019-2024, as detailed in the table below. The deployment of this team to support the introduction of consistent processes which are focussed on learning, underpins the Trust's strategic priority to improve patient safety by minimising avoidable harm. Strengthening mortality governance processes also assists achievement of one of the quality priorities described in the Quality Account 2021-22, namely, to improve patient safety through learning from deaths.

Strategic priority		1: Improve patient safety by minimising avoidable harm	
Area of focus		We will establish and implement standardised Mortality and Morbidity monitoring processes supported by relevant documentation, performance metrics and processes for shared learning	
Link to corporate objective & strategic risk		Care 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]	
Executive Lead		Chief Medical Officer	
Operational Lead		Medical Lead for Learning from Deaths	
Implementation stages	Q1	Complete recruitment process for M&M coordinators	Met
	Q2	Embed M&M coordinators in practice • Map M&M meetings and allocate coordinators • Define core data set and essential elements of M&M meetings • Implement standardised M&M agenda and supporting documentation (pilot) • Highlight and share the learning	In progress
	Q3	Embed M&M coordinators in practice • Revise standardised documentation and embed in practice • Highlight and share the learning	

	Q4	Embed M&M coordinators in practice • Highlight and share the learning	
Success measure/target		Maintain SHMI within control limits (value <1) Scheduled M&M monitoring meetings in place, supported by M&M coordinator with standardised documentation and feedback via: • Care group leads meetings • Divisional performance reviews • Learning from Deaths report • Patient Safety Bulletin	

2.2 **Medical Examiner Service**

Each quarter all Medical Examiner (ME) offices are required to make a return directly to the office of the National ME. This quarterly return is used for financial reimbursement of costs, and to quantify the level of activity and outcomes of each service. The St George's return showed that all 298 in-hospital deaths were scrutinised. Only four medical certificates of cause of death were rejected by the registrar and the ME spoke to all but 18 families. Timeliness of processes related to death continues to be good, with only 21 certificates not completed within three calendar days of death.

Where the ME service identifies potential governance issues that need to be further explored these continue to be referred either to the Lead for Learning from Deaths, to the Risk Team or to the clinical team involved with the patient's care. These cases are included in section 3 of this report.

This quarter St George's ME Office has taken forward a significant amount of engagement work to educate, support and consult. We have met with individual teams, such as ED, for detailed conversations about the service and how we can participate and support training and education. The Lead ME was a keynote speaker at the Trust's annual St George's Day Conference, which is a long established educational and governance event. The Head of Mortality Services delivered a seminar to the Council of Governors which explained the ME service and particularly the link with Learning from Deaths. In addition, a meeting was held with 16 Muslim faith leaders. The purpose of the meeting was to explain the ME process and discuss how the service can be sensitive to the needs of faith groups.

In June notification was received from NHSE and NHSI, formalising the expectation that all ME services will begin to expand scrutiny to include non-acute non-Coronial deaths. ME services are expected to be scrutinising all deaths by April 2022, at which point it is anticipated that the ME system will be made statutory. St George's ME service will be required to scrutinise all deaths that occur in Wandsworth and Merton. This represents a significant change and the number of deaths considered by the office will approximately double. In August the Lead ME and Head of Mortality Services will meet with the CCG as a first step in the engagement of colleagues in non-acute care. As recommended by the national and regional ME teams an incremental, pilot-based approach will be followed.

To support this increase in workload St George's will receive funding for 3.2 WTE (whole time equivalent) Medical Examiner Officers; however, there are no plans to extend ME funding centrally above the existing 1.1 WTE. A recruitment plan has been agreed and interviews for the MEO posts are scheduled for the end of September. The MEOs will work to support the MEs and will be essential for the successful expansion of the service.

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

The Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme is being run by NHS Resolution for a third year. The scheme requires Trusts to demonstrate compliance with ten key safety actions in order to receive a rebate on the yearly CNST premium.

Safety Action One measures compliance with the 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.

The service provides a quarterly report to demonstrate that quality and safety are being reviewed and that learning is identified and drives change. The comprehensive report is considered at divisional governance meetings and is subsequently presented to MMG. 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.

Standards from CNST Safety Action One	Compliance
1. i) All perinatal deaths eligible to be notified to MBRRACE_UK must be notified within 7 working days and required surveillance information must be completed within 4 months. **1.** ii) A review using PMRT of 95% of eligible deaths between 20/12/2019 and 15/03/2021 will have been started by 15/07/2021	We are **compliant** with this standard. Achieved 100% We are **compliant** with this standard. Achieved 100%
2. At least 50% of eligible deaths of babies who were born and died at the Trust, including home births, from 20/12/2019 to 15/03/2021 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 before 15/07/2021	We are **compliant** with this standard. Achieved 100%
3. For 95% of all deaths of babies who were born and died in the Trust from 20/12/2019, the parents will have been told that a review will take place, and that the parents' perspectives and any concerns have been sought. This includes any home births where care was provided by Trust staff.	We are **compliant** with this standard. Achieved 100%
4. Quarterly reports will have been submitted to Trust Board from 01/10/2020. These reports should be discussed with the Trust maternity safety champion.	We are **compliant** with this standard.

This summary relates to all eligible perinatal deaths in the period 21/09/2020-20/12/2020 and the actions and learning arising from them. In this quarter 20 cases were notified to PMRT and 16 reports were completed. 15 of the completed cases were graded as having no issues or issues which would not have made a difference to the outcome. There was one stillbirth case in which issues were identified including the failure of the booking hospital to prescribe

aspirin antenatally. These care issues involved care given at another maternity unit; feedback has been provided to the relevant Trust.

Several care themes which did not directly impact care were also noted. These included failure to offer parents the opportunity to take the baby home and failure to provide a cold cot. One case also identified inappropriate patient communication and transfer of the patient to a tertiary referral centre as an issue. A number of actions have been agreed in order to address these themes.

Improvement area	Action
Bereavement documentation	This action has previously been reported and is ongoing. Following recruitment to a full-time equivalent Bereavement Midwife post the bereavement pathway is under review. Parts of the pathway have been re-written to ensure compliance with national standards and further changes are expected this year to streamline the documentation process for clinicians.
Communication with parents and ongoing bereavement support	The bereavement team have revised the documentation used to support parents following bereavement. Education and training of staff is being undertaken to ensure that they are fully equipped to offer appropriate advice to parents.
Inappropriate referral to tertiary unit	Discussions are underway to explore the possibility of implementing MDT patient reviews via Microsoft Teams to ensure appropriate and timely referral.

The report also highlights organisational factors which require action. The Maternity Unit and Neonatal Unit have previously identified that a PMRT coordinator is required to ensure that CNST criteria continue to be met. As of February 2021, the Neonatal unit has allocated funding to support this role and the Maternity Unit continue to work on identifying funds for this nationally recommended administrative support. Increasing the number of PMRT panels that include an external member is also a priority. This quarter there were no cases completed with an external panel member in attendance. The South West London maternity service group has agreed to collaborate to promote greater involvement.

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=4), severe mental health diagnosis (n=10) and those in which the ME has detected a potential issue with care (n=10).

All deaths that have followed elective admission have been reviewed (5 cases this quarter). In addition to these 5, 4 cases were reviewed because they were in a specialty that is subject to enhanced oversight, 2 deaths were reviewed because of a family concern and 1 death was reviewed as a result of a query raised by a specialist team. The findings from these structured judgement reviews are shown below.

It should be noted that the SJR is completed by a consultant who is independent of the care of the patient and is a first stage review process. Where the reviewer has questions or concerns these are raised with the clinical team and/or the Risk team and therefore the judgements reached at the initial review, and documented here, may not constitute final conclusions about treatment and care.

3.2 **Overview of April to June 2021**

Between April and June 2021 there were 298 deaths. Members of the Mortality Review Team (MRT) reviewed 36 deaths, representing 12.1% 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 36 deaths reviewed this quarter problems were identified in relation to 10 (27.8%) of the patients reviewed. In total 14 problems were identified, as two patients experienced 2 problems and one patient experienced 3 problems.

Problem in healthcare	No harm	Possible harm	Harm	TOTAL
Assessment	0	0	0	0
Medication	1	1	0	2
Treatment	1	1	0	4
Infection control	0	0	0	0
Procedure	1	2	1	4
Monitoring	0	3	0	3
Resuscitation	0	0	0	1
Communication	0	2	0	2
Other	0	1	0	1
TOTAL	3	10	1	**14**

In one instance it was thought that a procedure-related problem led to harm. Although this death was not felt to be avoidable, it was referred to the responsible clinical team to query whether the CT scan was essential based on the primary procedure and if the patient's neurology would have been reversible if the patient had undergone immediate re-exploration. The case was also discussed at SI declaration meeting (SIDM) (DW154137) and was felt it did not meet the criteria for an SI but that detailed discussion should be held in each of the M&M meetings of the specialties involved (neurosurgery, plastics and anaesthetics).

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

- 27 of 38 (75%) deaths reviewed were assessed as definitely not avoidable
- 6 of 38 (16.7%) deaths reviewed were assessed as slight evidence of avoidability
- 2 of 38 (5.6%) deaths reviewed were assessed as possibly avoidable
- 1 death (2.8%) was judged to be probably avoidable

No deaths were judged to be definitely avoidable.

The death judged to be probably avoidable was a case in which a patient referred for inpatient angiography did not undergo the procedure due to a lack of access to the coronary catheter lab. The case was referred to the Coroner and for discussion at SI declaration meeting (SIDM). This death is currently being investigated as a serious incident (DW153205). The investigation is due to be completed by the end of August.

Avoidability of death judgement	Number	Percentage
Definitely not avoidable	27	75.0%
Slight evidence of avoidability	6	16.7%
Possibly avoidable but not very likely (less than 50:50)	2	5.6%
Probably avoidable (more than 50:50)	1	2.8%
Strong evidence of avoidability	0	0
Definitely avoidable	0	0
Total	**36**	

An assessment of overall care is also provided for each death reviewed: In 1 death (2.8%) the care provided was felt to be excellent, for 27 patients (75%) care was felt to have been good; for 7 patients (19.4%) care was felt to have been adequate. In 1 death (2.8%), the care provided was felt to be poor.

The death in which care was felt to have been poor, had an avoidability score of 4 (possibly avoidable). This was a case of a patient admitted following a diagnosis of perforation which was then managed conservatively for 9 days. When the patient was taken to theatre extensive bowel ischaemia was noted. The death had been discussed at the service's Mortality and Morbidity meeting and it was concluded that the timing of surgery did not impact the eventual outcome. The consensus reached was that conservative management with regular review was the correct approach in the first instance. The clinical team's response addressed the reviewer's queries satisfactorily.

Overall care judgement	Number	Percentage
Excellent care	1	2.8%
Good care	27	75.0%
Adequate care	7	19.4%
Poor care	1	2.8%
Very poor care	0	0
Total	**36**	

3.3 **Learning disabilities**

All deaths that occur in patients with learning disabilities are reported 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 of every death of a patient with learning disability (LD) using our standard methodology. The table below summarises these deaths from the beginning of 2018/19 to the end of Q2 2021/22. In total there have been 51 deaths, with reviews completed for each.

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	Q1 21/22
TOTAL DEATHS	1	3	3	2	3	7	4	2	4	4	7	7	4
REVIEWS COMPLETED	1	3	3	2	3	7	4	2	4	4	7	7	4
Definitely not avoidable	1	3	3	2	3	7	4	2	4	4	6	7	2
Slight evidence of avoidability	0	0	0	0	0	0	0	0	0	0	1	0	2
Possibly avoidable, not very likely (< 50:50)	0	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	0
Strong evidence of avoidability	0	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	0

This quarter there have been 4 LD deaths. None of the deaths were thought to have been avoidable. Overall care was judged to be good for 3 patients and adequate for 1 patient. In one case the reviewer identified possible harm related to communication problems. The Learning from Deaths Lead sought clarification from the Learning Disability Nursing Liaison Team at the time of the review and it was clarified that there were several discussions with the patient's identified next of kin regarding the gravity of his condition, as the patient was too unwell to contribute to the decision-making processes associated with treatment escalation plans and resuscitation decisions. Following these discussions, it was agreed with the patient's next of kin that the patient would be for treatment escalation, but resuscitation would not be in the patient's best interest. Consequently, no potential learning was identified.

4.0 LEARNING FROM MORTALITY

The following summaries give an update on mortality investigations that are currently underway. Both alerts have been reported in previous versions of this report. Some of the work undertaken to understand mortality related to covid-19 is also summarised from a comprehensive report presented separately to Quality and Safety Committee in August 2021.

4.1 Trauma Audit & Research Network (TARN)

Last year 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, and previously for 2016 to June 2018. Earlier 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 were no longer to be considered an outlying hospital and that our outcomes were within the normal range. TARN considered 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 reinforced the need to complete the clinical review of cases. This review has now been completed and has reported to both the MMG and to the TARN working group.

The investigation was carried out by five consultants, from Trauma & Orthopaedics (T&O), General Surgery, Neurosurgery and ED. The deaths of 99 ED trauma-called patients whose probability of survival was 80% or greater were included. The analysis grouped cause of death into broad categories, showing 3 peaks. 11.1% of deaths were related to chest injuries (specifically chest wall injuries), 24.2% to polytrauma and the highest proportion (28.3%) were due to neurotrauma.

Clinical pathways for these groups of patients have been discussed. It is acknowledged that guidelines tend to focus on care and treatment in ED and the immediate admission period and that there is the potential to strengthen these through wider involvement and extending the pathway to the post-admission phase. An audit of chest wall injuries is underway, and this will inform the first of these pathway reviews.

Compliance with national quality measures identified the potential for improvement in consultant presence in ED and more timely surgical intervention. Discussion of the neurosurgery pathway has resulted in agreement that TARN data and the progress of the working group needs to be shared amongst a wider group (to date involvement has largely been from trauma enthusiasts). A meeting will be arranged to include key colleagues involved in the pathway from ED Resus through to Neurosurgery, including consultant neurosurgeons, neurointensivists, trauma anaesthetists, neuroradiology and ED consultants.

A review of major trauma patients who had not been admitted as a trauma call has also been completed. Most of these patients had suffered low energy falls and were either frail or had other comorbidities. As over half of these patients were admitted under medical teams, significant work is underway to improve the identification and management of these patients. This includes introduction of a screening tool and consideration of adapting the major trauma nursing practitioner role to incorporate a medical liaison function.

Patients who were admitted directly to specialty teams were either patients with pelvic injury admitted under T&O or neurosurgery patients. It has been agreed that all patients with pelvic injury will be admitted via an ED trauma call. For neurosurgery patients an audit is being conducted to evaluate the likely impact of admission via ED, prior to any change being introduced. Based on data from TARN it is expected that this would represent 3 or 4 patients a week; ED consultants are confident they will be able to manage this workload.

To inform potential improvement actions a visit to one or more high performing major trauma centres is planned. In order to maximise the learning that can be gathered from peer organisations the Lead for Major Trauma is currently defining the objectives of such a visit and establishing which colleagues should participate.

The working group will continue to meet until major trauma outcomes are fully understood and a quality improvement plan has been launched. It is proposed that the outcome of this work will be shared in the Learning from Deaths report following its conclusion.

4.2 **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. It should be noted that this diagnosis grouping differs from the TARN cohort.

The final stage of this investigation (conducting a comprehensive benchmarking exercise to determine if there are differences in our coding practices and/or case-mix) has been

completed. Colleagues within the Strategic Business Intelligence (SBI) team supported this work and external analysis was provided by Dr Foster Intelligence.

The outcome of this work was presented to MMG in May. The SBI team utilised data available through the Healthcare Evaluation Data (HED) platform to compare our performance with 21 other major trauma centres. This showed that our mortality for this diagnosis grouping is fifth highest. It appears that there is room to make some small improvements to comorbidity scores, which will impact our expected mortality, but that this is not likely to have a significant impact. Audit reports have been designed which will support coding of comorbidities.

Dr Foster Intelligence conducted a brief analysis which suggested our outcomes are improving. Comparison to a peer group of major tertiary providers showed several other trusts with higher standardised mortality ratios than St George's and comparison to the Shelford Group (a collaboration between 10 of the largest teaching and research NHS trusts in England) shows us to be in line with average performance. The analysis suggested that we have a high proportion (60%) of patients with zero comorbidity, compared to the national average (47%). There was also a high proportion of patients with a low risk of death, compared to the national average. Both factors will impact our expected mortality and consequently our mortality ratio. It is anticipated that the coding audit reports designed by the SBI will support improvements in this area.

The most up-to-date data available to us through Dr Foster Intelligence, covers discharges between March 2020 and February 2021; no mortality signal was observed. MMG agreed that as the initial coding review, two clinical reviews, and this benchmarking exercise, have not identified significant concerns and there is indication of an improved position then the investigation would be closed. However, the grouping will continue to be monitored and any further signal will trigger prospective review.

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

The Mortality Monitoring Group requested that covid-19 mortality observed during the first and second waves of the pandemic be analysed in order to identify any potential for learning and to contribute to preparations for a third wave. Mr Ashar Wadoodi, Lead for Learning from Deaths, led this work. The main findings are presented here.

An overview of mortality showed that despite an increased number of covid-19 admissions in wave 2, the crude mortality rate was lower than in wave 1(Table 1). Data from Dr Foster Intelligence show that St George's outcomes closely followed the average London trend, falling by approximately 10% between waves 1 and 2. As shown in Table 2, admissions to ITU were greater in the second wave; however, mortality decreased. Conversely, ward-based mortality increased.

Table 1	1st wave	2nd wave
Dates	05 Dec 2019 to 10 Jun 2020	26 Aug 2020 to 29 Mar 2021
Total admissions	888	1793
Outcome: Died	298 (34%)	448 (25%)
Outcome: Discharged alive	590 (66%)	1345 (75%)

Table 2	1st wave		2nd wave	
	Discharged n = 590	Deceased n = 298	Discharged n = 1345	Deceased n = 448
Ward	489 (73%)	188 (27%)	1139 (64%)	258 (36%)
ITU	101 (48%)	110 (52%)	206 (58%)	190 (42%)

In relation to respiratory support, there was a significant change in the ratio of invasive ventilation compared to positive pressure ventilation between wave 1 and 2, falling from 6:1 to 1:1. This pattern is seen across London hospitals and suggests that significant lessons were learnt from wave 1.

Changes in medical therapies were also analysed. This shows a clear increase in the use of dexamethasone, in line with current national recommendations. There was also a large increase in the use of Remdesivir, with a smaller rise in Tocilizumab. Table 3 shows the proportion of covid-19 patients who received each of these medications.

Table 3	1st wave	2nd wave	Total
Dexamethasone	6.5%	68.3%	48.0%
Remdesivir	0.0%	31.6%	21.2%
Tocilizumab	2.6%	12.6%	9.3%

Comparison of the use of treatment escalation plans (TEP) shows that documented decisions decreased from 86% in wave 1 to 80% in wave 2. In addition, there was evidence in the clinical record that the decision support tool for TEPs was being used more in wave 1 than in wave 2. Feedback from Covid teams suggest that patients who were initially admitted under surgical specialties had poor documentation of past medical and social history, both of which are essential to informing the TEP tool. This is something that should be addressed with surgical teams in order to improve treatment escalation plans on an ongoing basis, and in case of a third wave.

Detailed analysis of nosocomial infection has been completed and presented to Quality and Safety Committee in July 2021.

Patient care during the pandemic was challenging; however, despite the difficulties faced by staff and patients alike during the pandemic there was a fall in patient complaints during these periods. In part this will relate to the reduction in elective and outpatient activity, but it is reassuring to see that complaints did not increase.

The Palliative Care Team is made up of 2.4 whole time equivalent consultant posts as well as a specialist nursing team. During the surge further staff members who had had palliative care experience were redeployed to the team, including 5 consultants and two senior nurses. A 7-day consultant service was created to support the weekend specialist nurse service, and this was maintained despite staff shortages and sickness.

During the peak of wave 1 (March & April 2020) the palliative care team reviewed 52% of all patients who went on to die at St George's hospital. In this period there were 25% more referrals than in the same period during the previous year and almost 50% more deaths. During the pandemic the team published several clinical guidelines to support clinical teams to deliver end of life care.

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 March 2020 to February 2021, was published on 8th July 2021. The Trust's overall mortality is categorised as 'lower than expected' at 0.83.

During the 12-month period there were 62,275 inpatient spells at the Trust, with 1,430 deaths observed, compared to 1,715 expected deaths. It should be noted that NHS Digital are excluding Covid-19 activity from the SHMI publication in order to make the indicator values as consistent as possible with those from previous reporting periods. The SHMI is not currently designed for pandemic activity and the statistical modelling used to calculate the SHMI may not be as robust if such activity was included. Excluding Covid-19 activity means that, as far as possible, consistency is maintained and each SHMI publication can be interpreted in the same way.

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

Diagnosis Group	SHMI value	SHMI banding
Acute bronchitis	0.91	As expected
Acute myocardial infarction	1.26	As expected
Cancer of bronchus; lung	0.34	Lower than expected
Fluid and electrolyte disorders	0.56	Lower than expected
Fracture of neck of femur (hip)	1.19	As expected
Gastrointestinal haemorrhage	1.01	As expected
Pneumonia (excluding TB/STD)	0.82	Lower than expected
Secondary malignancies	0.73	Lower than expected
Septicaemia (except in labour), shock	1.02	As expected
Urinary tract infections	0.91	As expected

5.2 **Hospital Standardised Mortality Ratio (HSMR)** [source: Dr Foster]
For the most recent 12 months of data reported by Dr Foster (April 2020 to March 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: April 2020 – March 2021	Value	Banding
HSMR (all admission methods)	91.7	Lower than expected
HSMR: Weekday emergency admissions	85.8	Lower than expected
HSMR: Weekend emergency admissions	111.6	As expected

Unfortunately, over the last few months Dr Foster has not been able to provide updated data. Currently we are unable to access data beyond February 2021; therefore, MMG has not been able to evaluate risk-adjusted mortality at diagnosis and procedure group level. The Trust is considering utilising an alternative platform (Healthcare Evaluation Data) to monitor mortality rather than Dr Foster as we are committed to considering consistent and reliable data.

It should be noted that no external mortality outlier alerts have been received in this period and the SHMI diagnosis level data available through NHS Digital do not suggest any areas of concern.

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Appendix 1: National Quality Board Dashboard – data to 30th June 2021

St George's University Hospitals NHS Foundation Trust: Learning from Deaths Dashboard - June 2021-22

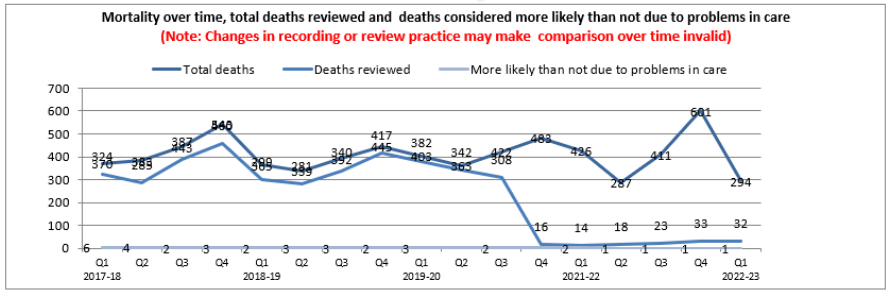
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

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

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

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered more likely than not due to problems in care PRISM Score<=3 or equivalent measure	
This Month	Last Month	This Month	Last Month	This Month	Last Month
102	109	10	13	0	1
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
294	601	32	33	1	1
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
294	1725	32	88	1	5

Time Series: Start date 2017-18 Q1 End date 2021-22 Q1



Total Deaths Reviewed, categorised by SJR Avoidability Score

Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	2	20.0%	This Month	8	80.0%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	1	3.1%	This Quarter (QTD)	2	6.3%	This Quarter (QTD)	4	12.5%	This Quarter (QTD	25	78.1%
This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	1	3.1%	This Year (YTD)	2	6.3%	This Year (YTD)	4	12.5%	This Year (YTD)	25	78.1%

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St George's University Hospitals NHS Foundation Trust: Learning from Deaths Dashboard - June 2021-22

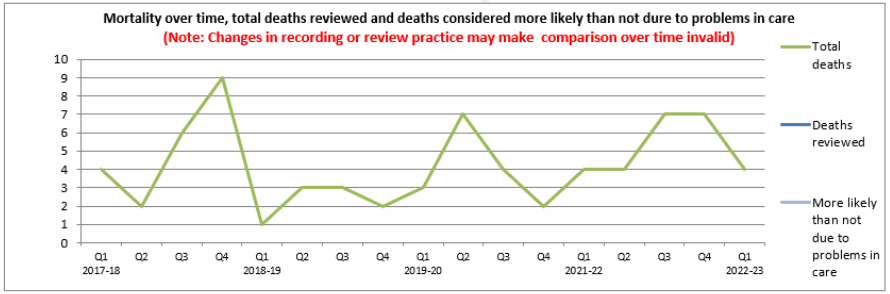
Summary of total number of learning disability deaths and total number reviewed under the LeDeR methodology. Please note that all LD deaths are reviewed using our standard approach, pending reviews as directed by the LeDeR process. The outcome of these local reviews is displayed in the second data grouping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

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

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered more likely than not due to problems in care	
This Month	Last Month	This Month	Last Month	This Month	Last Month
1	2			0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
4	7			0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
4	22			0	0

Total Number of Deaths in scope		Total Deaths Reviewed Through the Local Review Methodology		Total Number of deaths considered more likely than not due to problems in care	
This Month	Last Month	This Month	Last Month	This Month	Last Month
1	2	1	2	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
4	7	4	7	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
4	22	4	22	0	0

Time Series: Start date 2017-18 Q1 End date 2021-22 Q1



Outstanding care every time

St George's University Hospitals NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	30 September 2021	**Agenda No**	**2.1.2**
Report Title:	**Infection Prevention and Control Annual Report 2020-21**		
Lead Director:	Robert Bleasdale, Chief Nurse and Director of Infection Prevention and Control		
Report Author:	David Shakespeare, Head of Infection Prevention and Control Dr Aodhan Breathnach, Consultant Microbiologist / Infection Control Doctor		
Presented for:	Assurance		
Executive Summary:	The Infection Prevention & Control (IPC) Annual Report presents a summary of activity pertaining to IPC during 2020-2021 and sets out key priorities for 2021-2022 The Committee is asked to receive for assurance the IPC Annual Report 2020-2021 and approve the IPC Priorities for 2021-2022 Content of the report includes: • IPC element of SARS-CoV-2 pandemic response • 41 cases of Trust apportioned *C. difficile* with 4 lapses in care reported (comparing to 51 cases reported during 2019-20) • 3 MRSA bacteraemia comparing to 3 during 2019-20 • 47 MSSA bacteraemia comparing to 36 during 2019-20 • 60 *E. coli* bacteraemia comparing to 74 during 2019-20 The Trust declared full compliance with the Hygiene Code (2008) for the year 2020-21 and evidence of compliance to the ten criteria of the code was received by the Infection Control Committee during the year.		
Recommendation:	The Board is asked to receive for assurance the IPC Annual Report for 2020-21.		
Supports			
Trust Strategic Objective:	Treat the patient, treat the person		
CQC Theme:	Safe, Well Led		
NHS Oversight Framework Theme:	Safe, Well Led		
Implications			
Risk:	N/A		
Legal/Regulatory:	The Health and Social Care Act (2008): The Hygiene Code - code of practice on the prevention and control of infections. (Updated 2015) https://www.gov.uk/government/publications/the-health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance Accessed August 2021 Health and Social Care Act 2008) Regulated Activities Regulations 2014: Regulation 12 Safe Care and Treatment The Health and Safety at Work Act 1974		
Resources:			
Previously Considered by:	Quality and Safety Committee Patient Safety and Quality Group Infection Control Committee	**Date**	19 August 2021 18 August 2021 15 June 2021

Equality Impact Assessment:	N/A

St George's University Hospitals NHS Foundation Trust

Annual Report
Infection Prevention and Control
2020 – 2021

Contents **Page**

Executive summary

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

The Trust has been considerably impacted by the global pandemic of SARS-Cov-2, the virus that causes Covid-19. In total 2639 patients required hospital admission and were subsequently discharged between April 2020 and March 2021 inclusive. There were also sadly 749 deaths in patients positive for SARS-CoV-2 Covid-19 during the same period.

The Trust responded to the pandemic by reducing normal business and increasing capacity in critical care and other ward areas to care for patients confirmed with Covid-19. Patient pathways were introduced for suspected cases, patients testing positive and also patients testing negative, with a view to preventing nosocomial (within the hospital) transmission.

Guidance in the Trust was informed by nationally issued guidance from Public Health England which formed the basis of all infection prevention decisions made during the pandemic. Lessons are also being extrapolated from the experience of Covid-19 at the Trust as part of plans proposed to manage any future wave of the virus.

During 2020-21 the Trust recorded three cases of Trust apportioned Meticillin resistant *Staphylococcus aureus* (MRSA) bacteraemia (blood stream infection). There compares to 3 during the previous year 2019-20.

There were 41 cases of Trust apportioned *Clostridium difficile* infection against an NHS Improvement presumed target of no more than 48 cases. This represents an improvement on the 51 cases reported during 2019-20. There were 4 lapses in care recorded.

There were 47 Trust apportioned cases of Meticillin sensitive *Staphylococcus aureus* (MSSA) bacteraemia during 2018-19 compared to 36 during 2018-19.

There were no cases of influenza reported during the winter season 2020-2021 which is thought to be a consequence of social distancing and wearing of face masks in response to the Covid-19 pandemic. This reflects a national position of very low numbers of influenza cases.

There was also very low Norovirus activity and only one small outbreak was reported and managed.

An excellent achievement has been the uptake of staff influenza vaccination, which at 85.6%, is once again is among the highest uptake of hospitals in London.

There continue to be low levels of colonisation and infection with multi-drug resistant bacteria.

A note of thanks to all our staff who continue to take seriously that prevention of infection at the Trust is everyone's business during a difficult time due to the Covid-19 pandemic. We continue look forward to further strengthening infection prevention and control at the Trust during 2021-22. This will include appointment to the role of Healthcare Surveillance Scientist which will bring epidemiological skills to the Infection Prevention & Control Team and inform future infection prevention strategy at the Trust.

1. Infection Control Team and reporting arrangements

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

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

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

The *Assistant Chief Nurse* provides leadership for the patient safety and quality agenda at the Trust of which IPC is a key element.

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

The *IPCC* is the main forum for governance and monitoring of action around IPC practice at the Trust. The membership of the IPCC includes representation from all Divisions at the Trust, plus a representative from Public Health England. The IPCC is chaired by Chief Nurse / DIPC. A quarterly report from the IPCC is received at the Patient Safety & Quality Group and a 6 monthly report is received at the Quality & Safety Committee, which is a subcommittee of the Board, where the IPC annual report is also received.

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

It is agreed to advertise the post of Healthcare Surveillance Scientist at the Trust during 2021-22. This will be a senior post all will bring epidemiological skills to the IPCT and Infectious Diseases Physicians and will help analyse data and trends in HCAI and Infectious Diseases in our local population to help inform the future strategy for IPC at the Trust.

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

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

2. Compliance with the Hygiene Code

The Trust is required to demonstrate compliance with The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (The Hygiene Code). Evidence of compliance to each section of the Hygiene Code was reviewed periodically during the year and was received at the Infection Prevention & Control Committee. The Trust declared compliance with all ten criteria of the Hygiene Code (listed below) during 2020-21.

Criterion one: Systems to manage and monitor the prevention & control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them **Evidence of compliance considered by Infection Prevention & Control Committee on 16/03/21**
Criterion two: Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections **Evidence of compliance considered by Infection Prevention & Control Committee on 16/03/21**
Criterion three: Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance **Evidence of compliance considered by Infection Prevention & Control Committee on 16/07/20**
Criterion four: Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing / medical care in a timely fashion **Evidence of compliance considered by Infection Prevention & Control Committee on 16/07/20**
Criterion five: Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people **Evidence of compliance considered by Infection Prevention & Control Committee on 08/09/20**
Criterion six: Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection **Evidence of compliance considered by Infection Prevention & Control Committee on 08/09/20**
Criterion seven: Provide or secure adequate isolation facilities **Evidence of compliance considered by Infection Prevention & Control Committee on 08/09/20**
Criterion eight: Secure adequate access to laboratory support as appropriate **Evidence of compliance considered by Infection Prevention & Control Committee on 08/09/20**

Criterion nine: Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections **Evidence of compliance considered by Infection Prevention & Control Committee on 17/11/20**
Criterion ten: Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection **Evidence of compliance considered by Infection Prevention & Control Committee on 16/03/21**

A rolling programme of collation of evidence of compliance with the hygiene code will continue during 2021-22 as part of the calendar of business of the Infection Prevention & Control Committee.

3. Summary of Infection Prevention and Control Performance

Trusts are required to participate in six mandatory reporting schemes;

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

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

3.1 MRSA Bacteraemia

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

There have been three episodes of Trust-apportioned MRSA bacteraemia during the financial year 2020-21, the same position as 2019-20.

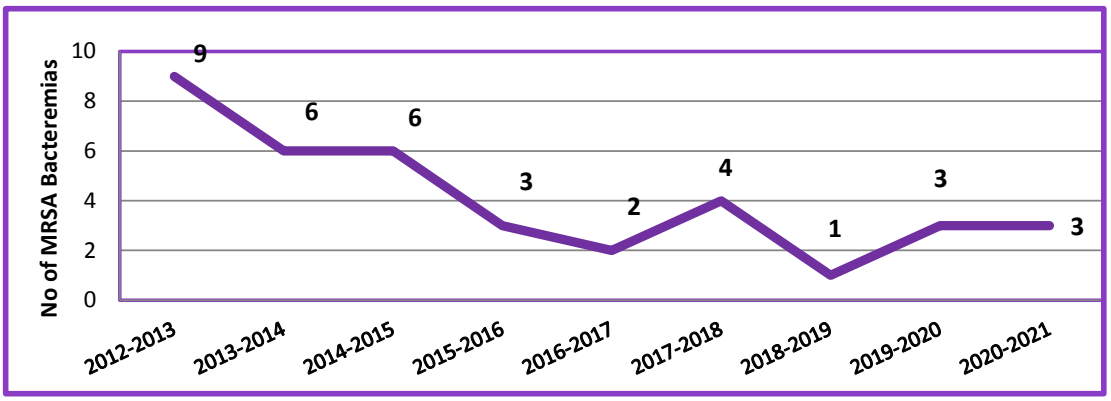
A case in August 2020 was likely to be related to the patient's pre-existing condition.

A case in September 2020 was likely to be associated with a surgical site related infection, though no lapses in care could be identified in relation to theatre.

A case in January 2021 was thought to be in relation to insertion or management of a line inserted for renal dialysis, but it was difficult to ascertain if the acquisition of MRSA was while the patient was on dialysis or during a line insertion. Some governance arrangements around a local dialysis unit have been under investigation with a view to strengthening key performance indicators during 2021-22.

Reported cases of MRSA bacteraemia at the Trust have maintained a downward and steady trajectory since 2012-13 (Figure 1).

Figure 1: MRSA bacteraemia St George's University Hospitals NHS Foundation Trust (SGH) 2012-2021

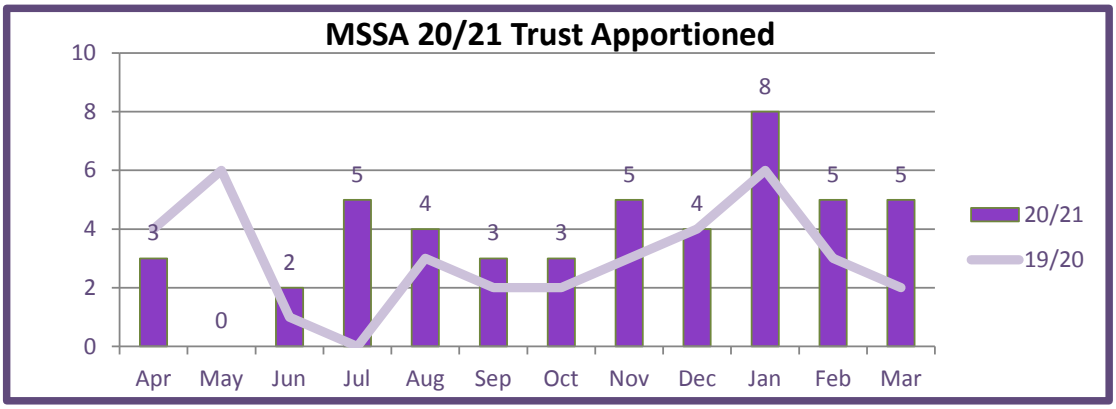


3.2 MSSA Bacteraemia

There were 47 episodes of MSSA bacteraemia during 2020-21 apportioned to the Trust, where the blood culture was taken after the second day of admission (Figure 2). This compares to 36 during 2019-20, 27 during 2018-19, 28 during 2017-18, 31 during 2016-17 and 36 during 2015-16. Of the 46 cases, 15 were thought to be associated with intravenous lines. Other key cause groups are respiratory and gastrointestinal infection.

There are no national or local thresholds for MSSA bacteraemia in place at present.

Figure 2: MSSA bacteraemia SGUH 2020-21



3.3 *Clostridium difficile*

Clostridium difficile infection (CDI) is a major cause of antibiotic-associated diarrhoea Figure 3 shows CDI Trust apportioned 2012-21 against NHS Improvement set targets.

During 2020-21 St George's recorded 41 episodes of Trust apportioned *Clostridium difficile* infection against a presumed NHS England / Improvement

target of no more than 48 cases. This compares to 51 cases during 2019-20. No actual threshold was set for 2020-21, most probably due to the constraints of the Covid-19 pandemic and so the target of no more than 48 cases was carried over by the Trust from 2019-20.
The method of counting cases of CDI consists of

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

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

The method of counting CDI changed for 2019-20 onwards when the time period after which a case is classified as hospital attributable was reduced by one day.

Of the 41 cases reported during 2021-21, 34 were classified as Hospital Onset Healthcare Associated (HOHA) and 7 were classified as Community Onset Healthcare Associated (COHA)

As per CDI standard operating procedure (SOP), episodes that were Trust-apportioned underwent root cause analysis (RCA). As an outcome of this, four lapses in care were identified. These included a delay in isolation, lack of indication for antibiotics and an issue with cleanliness of equipment. These issues were not necessarily causative of the infection but were identified on RCA. Following the RCA review, feedback is given to the relevant Division and the outcomes of RCA are noted at the Infection Prevention & Control Committee.

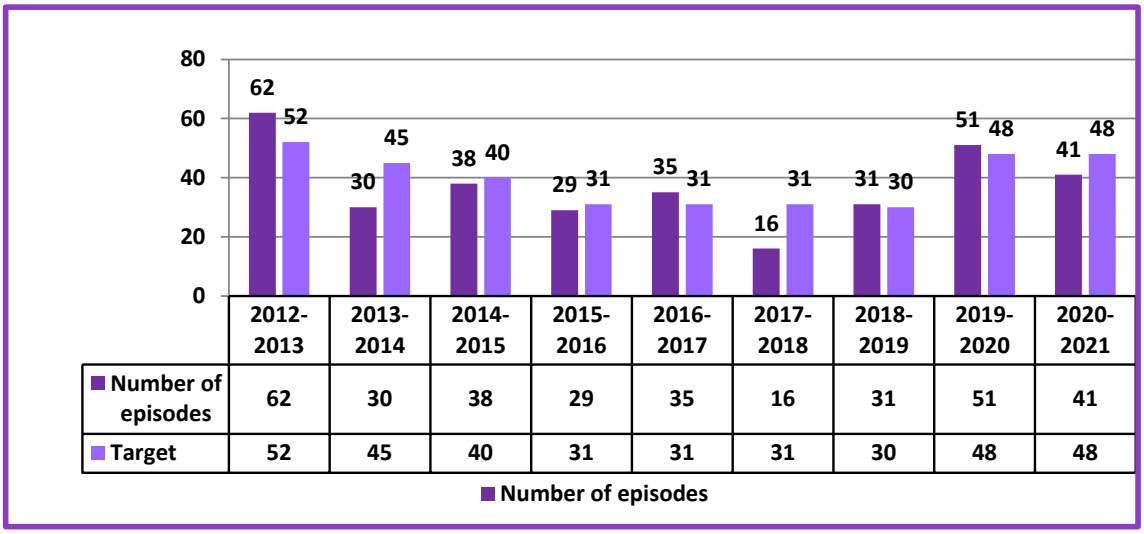
In addition, all isolates of *C difficile* were sent for ribotyping to look for any evidence of cross-infection.

One period of increased incidence was reported, where there were two cases of CDI on one ward area within 28 days. However, ribotyping was different, indicating the cases were not linked by cross infection.

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

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

Figure 3: *Clostridium difficile* at St George's University Hospitals Foundation Trust 2012-13 to 2020-21



	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019	2019-2020	2020-2021
Number of episodes	62	30	38	29	35	16	31	51	41
Target	52	45	40	31	31	31	30	48	48

3.4 Gram-negative bacteraemia

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

4.4.1 *E. coli*

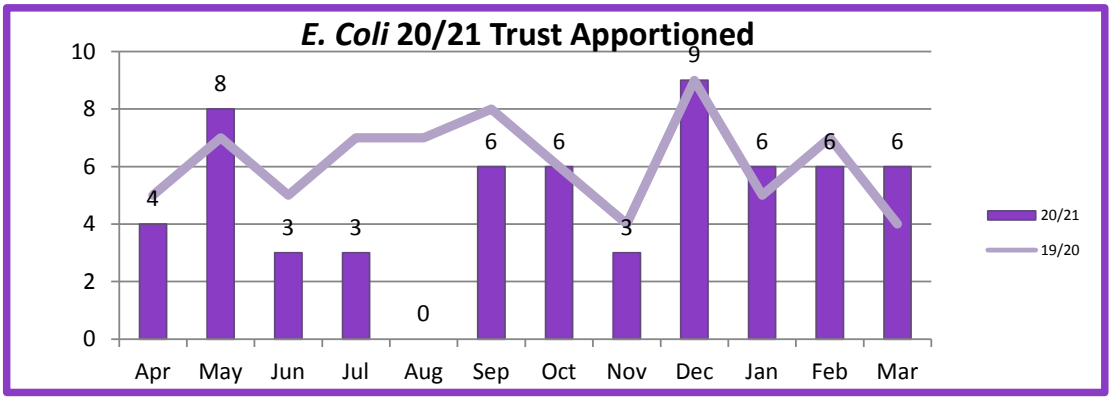
E. coli bacteria are frequently found in the intestines of humans and animals and can survive in the environment. There are many different types of *E. coli*, which can cause a range of infections including urinary tract infection, cystitis and intestinal infection. When primary *E. coli* infection spreads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

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

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

For 2020-2 a total of 60 Trust apportioned *E. coli* bacteraemia were reported (Figure 4). This compares to 74 during 2019-20 and 47 during 2018-19 and 68 during 2017-18. Predominant cause groups were upper urinary tract and gastrointestinal tract. Work has continued across South West London health sector to agree a standard urinary catheter passport to encourage best practice in urinary catheter care.

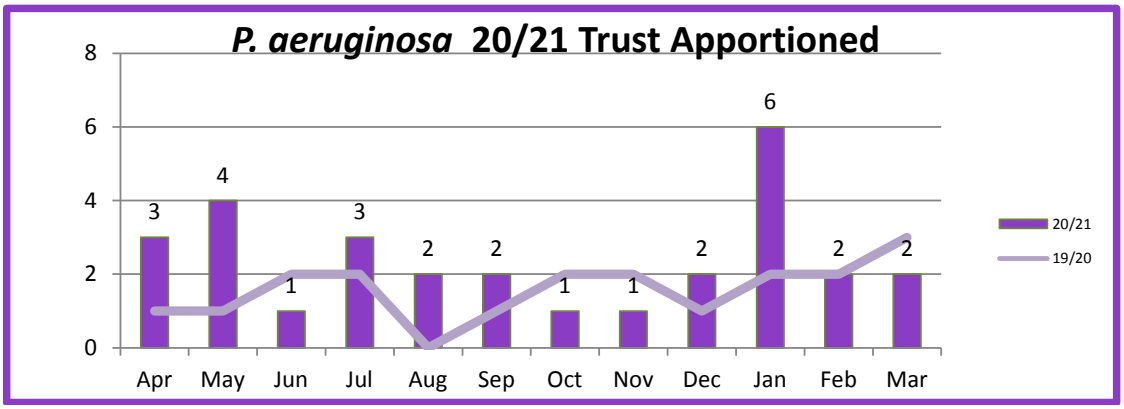
Figure 4: Trust apportioned *E coli* bacteraemia 2020-21 showing 2019-20 figures



4.4.2 *Pseudomonas aeruginosa*

There were 31 cases of Trust apportioned *Pseudomonas aeruginosa* bacteraemia during 2020-21 (Figure 5). This compares to 19 cases during 2019-20, 16 during 2018-19 and 27 during 2017-18.

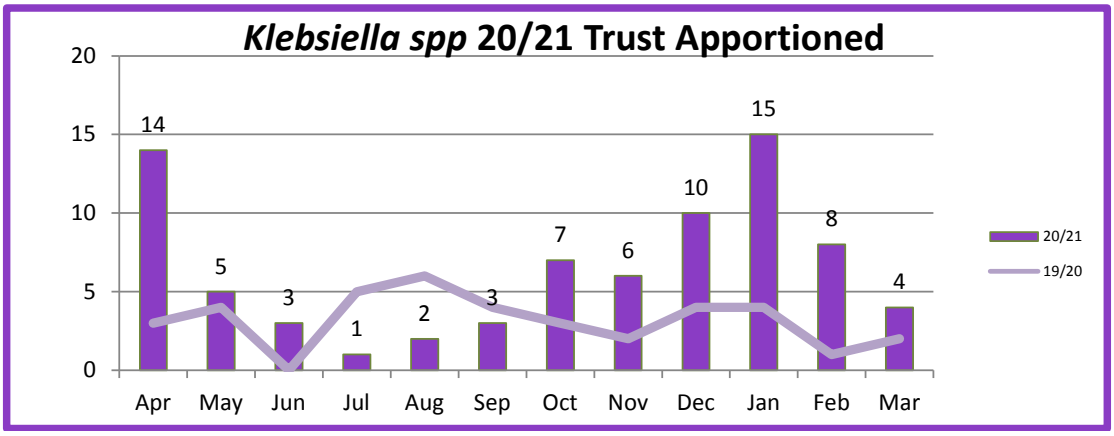
Figure 5: Trust apportioned *P. aeruginosa* bacteraemia 2020-21 showing 2019-20 figures



4.4.3 *Klebsiella*

There were 78 cases of Klebsiella bacteraemia reported during 2020-21, comparing to 38 during 2019-20 (Figure 6), 21 cases during 2018-19 and 29 cases during 2017-18 (Figure 6).

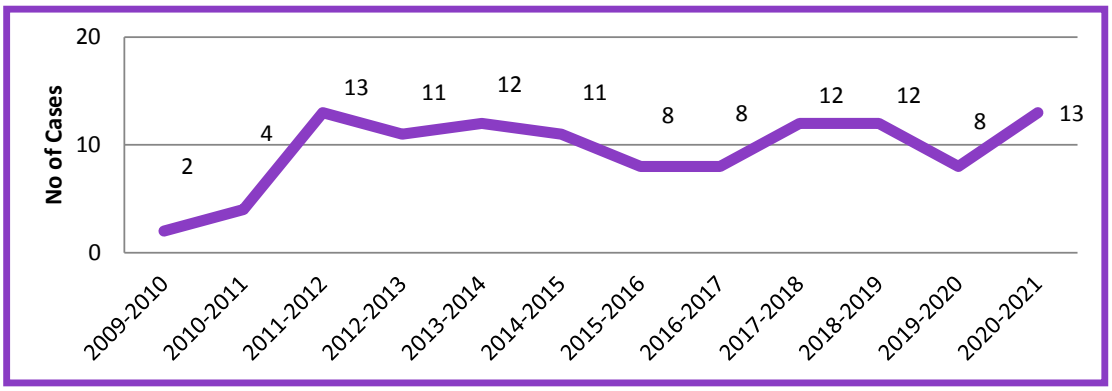
Figure 6: Trust apportioned *Klebsiella* bacteraemia 2020-21 showing 2019-20 figures



4.4.4 Glycopeptide resistant enterococcal bacteraemia (GRE)

St George's figures are illustrated below (Figure 7). There are no national thresholds. St George's has maintained low levels of GRE and 13 cases were reported during 2020-21.

Figure 7: GRE bacteraemia 2009-10 to 2020-2021



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

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

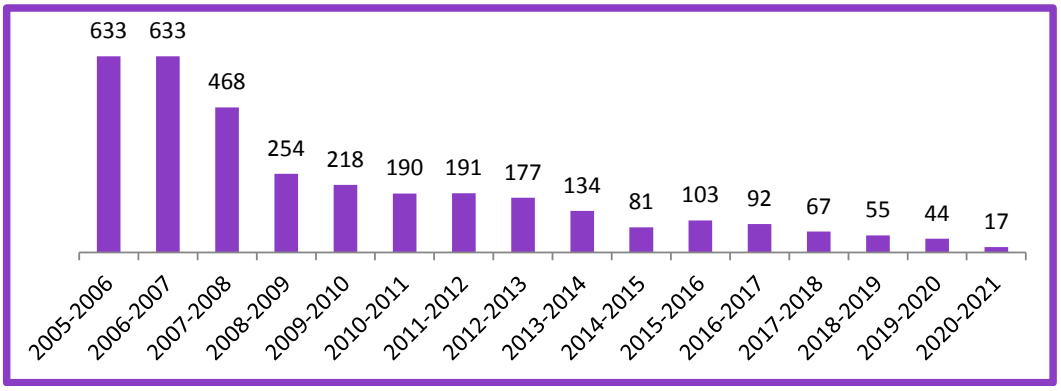
The Trust reports episodes to the voluntary PHE operated CPE database as well as submitting antibiotic resistance data to the PHE.

3.5 MRSA acquisitions

The Infection Prevention and Control (IPC) team record all new MRSA acquisitions in the Trust as part of alert organism surveillance i.e. MRSA grown from clinical samples other than blood cultures, including screening swabs. There were 17 cases during 2020-21 where a patient became colonised with MRSA where there was no previous history and it is likely to have been acquired in the hospital.

The acquisitions are shown 2005-21 in Figure 8.

Figure 8: MRSA acquisitions 2005-06 to 2020-21



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

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

4. Surgical Site Infection (SSI) Surveillance

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

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

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

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

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

Results are then submitted to Public Health England (PHE). During 2020-21 the Trust participated in SSIS modules in reduction of long bone fracture, coronary artery bypass graft (CABG) surgery and spinal surgery.

In 2020, due to the SARS-CoV-2 pandemic, no surveillance was conducted during the second quarter, April – September 2020, and data was collected and submitted

only for CABG in Q4 October – December 2020. It had been previously been collected for January to March 2020.

4.1 Reduction of Long Bone Fracture

Data for 2020 (Table 1 as published by PHE are shown below). These are the figures for St George's Hospital all SSIS:

Table1: 2020 Reduction of Long Bone SSI data at St. George's

Year and Period	No. operations	Inpatient & readmission		Post discharge confirmed		No patient reported		All SSI*	
		No.	%	No.	%	No.	%	No.	%
2020 Q1	114	0	0.0%	3	2.6%	0	0.0%	3	2.6%
2020 Q3	92	1	1.1%	0	0.0%	0	0.0%	1	1.1%

***All SSI = Inpatient & readmission, post-discharge** confirmed **and patient reported**
This table refers to data collected over the selected periods for which data has been submitted and reconciled (Q1 Jan-Mar 2020, Q3 Jul-Sep 2020).

(Source: Public Health England SSIS Service, Summary Reports Jan – Dec 2020)

In the period of Jan – March 2020, there were three post discharge follow up infections, of which two were classified as superficial and one deep infection.

In the period July – Sept 2020, there was one deep incisional SSI reported at readmission.

Surveillance is undertaken for up to one year after an implant is placed. Patients may still present with SSI for up to one-year post-op and this is also reported to PHE as part of the surveillance.

Table 2: 'All Hospitals' SSI for Reduction of Long Bone 2020

SSI period 2020	St George's	All hospitals
January – March	2.6%	1.6%
July - September	1.1%	1.5%

Table 3: Cumulative Incidence of SSI Reduction of Long bone 2020

SSI period 2020	St George's	All hospitals
January – March	0.0%	0.9%
July - September	1.1%	0.8%

The cumulative incidence of SSI (Table 3 above) are benchmark figures for the cumulative percentages for patient and readmission figures for 2020. St. George's

results are higher than the benchmark in 1 quarter (July to September) but lower for all hospital data (Table 2).

4.2 Coronary Artery Bypass Grafts (CABG)

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

Tables 4-6 show figures for St. George's Hospital CABG SSIs 2020.

Year and Period	No. operations	Inpatient & readmission		Post discharge confirmed		No patient reported		All SSI*	
		No.	%	No.	%	No.	%	No.	%
2020 Q1	95	3	3.2%	0	0.0%	0	0.0%	3	3.2%
2020 Q3	73	3	4.1%	0	0.0%	2	2.7%	5	6.8%
2020 Q4	80	4	5.0%	2	2.5%	0	0.0%	6	7.5%

***All SSI = Inpatient & readmission, post-discharge confirmed, and patient reported**
This table refers to data collected over the selected periods for which data has been submitted and reconciled (Q1 Jan-Mar 2020, Q3 Jul-Sep 2020, Q4 Oct-Dec 2020).

Table 4: 2020 CABG SSI Data at St. George's

(Source: Public Health England SSIS Service, Summary Reports Jan – Dec- 2020)

Table 5: SSI 'All Hospitals' SSI for CABG 2020 (as published by PHE)

SSI period 2020	St George's	All hospitals
January – March	3.2%	5.8%
July - September	6.8%	5.9%
October - December	7.5%	5.8%

Table 6: Cumulative Incidence of SSI for CABG 2020

SSI period 2020	St George's	All hospitals
January – March	3.2%	2.8%
July - September	4.1%	2.8%
October - December	5.0%	2.8%

All wound infections were assessed by cardiac surgery CNS team and/ or surgical consultant/ registrar, with follow-up as an outpatient. Root Cause analysis carried out by CNS and surgeon for all deep wounds.

4.3 Spinal surgery

Spinal infection surveillance at SGH was introduced from April 2019. Data was collected, submitted, and reconciled for 2 periods, Q2 Apr-Jun 2019 and Q3 Jul-Sep 2019. Data for Q4 Oct-Dec 2019 was collected locally but not submitted to PHE. In 2019, the SSI risk of infection at St George's hospital had a reduction of 2.8%, from 4.6% detected during Q2 to 1.8% during Q4 (Data for Q4 Oct-Dec 2019 was collected locally but not submitted to PHE).

During 2020 SSIS for Spinal surgery was carried out for 2 quarters, Q1 January-March and Q3 July- September (Tables 7-9). During these periods SSI rates continued to decrease, although still above the national benchmark of 1.1% (Table 9).

Year and Period	No. operations	Inpatient & readmission		Post discharge confirmed		No patient reported		All SSI*	
		No.	%	No.	%	No.	%	No.	%
2020 Q1	204	5	2.5%	0	0.0%	0	0.0%	5	2.5%
2020 Q3	194	4	2.1%	0	0.0%	0	0.0%	4	2.1%

***All SSI = Inpatient & readmission, post-discharge confirmed and patient reported**
This table refers to data collected over the selected periods for which data has been submitted and reconciled (Q1 Jan-Mar 2020, Q3 Jul-Sep 2020).

Table 7: 2020 Spinal surgery SSI data at St. George's

(Source: Public Health England SSIS Service, Summary Reports Jan – Dec 2020)

Table 8: 'All Hospitals' SSI for Spinal Surgery 2020 (as published by PHE)

SSI period 2020	St George's	All hospitals
January – March	2.5%	1.7%
July - September	2.1%	1.6%

Table 9: Cumulative Incidence of SSI for Spinal Surgery 2020

SSI period 2020	St George's	All hospitals
January – March	2.5%	1.1%
July - September	2.1%	1.1%

For Q1, January – March 2020, a high outlier letter was sent by PHE. There were five SSI reported for this period, three superficial incisional, one deep incisional and one organ/ space infection. The patients' admitting consultants were contacted and feedback received confirming the infections.

4.4 Future actions

The Trust plans several actions to reduce SSI.

- Revising and adapting a SSI root cause analysis tool in collaboration with clinical teams to ascertain any lessons for future clinical practice with feedback to clinicians and Divisional Governance Teams. Due to Covid-19 surge RCA finalisation had to be deferred. It is expected to resume meetings at an opportune time during 2021-22
- Continue to monitor compliance with standard NICE guidance regarding theatre procedures including sutures. Sutures have been discussed with theatres and they have moved from staples to sutures in orthopaedic and cardiac surgery. They are using triclosan coated antimicrobial sutures currently
- Continue with feedback to surgical teams and other relevant stakeholders regarding infections, rates of SSIs and PHE reports
- IP&C walkabouts in theatres have been undertaken. Continued monitoring of theatres will be carried out with theatre staff with feedback
- Strengthen links with the T&O clinic to alert when patients return with SSI or suspected SSI

- Review the method of finding post discharge and patient reported SSIs

5. Water Safety

The monitoring and preventative measures of *Legionella* and *Pseudomonas* in taps and showers continue. A system of filtering outlets remains in both St James wing and Lanesborough wing and water outlet testing remains is in place. Capital estates works to improve the quality of water has been completed for St James Wing and nears completion for Lanesbourgh Wing. The Water Safety Team have implemented a continuous improvement strategy to manage existing estate and water sampling during the year shows low levels of contamination.

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

6. Outbreaks and incidents

6.1 Influenza infections and outbreaks

There were no cases of influenza reported during the winter season 2020-21. This is thought to be due to the social distancing and wearing of face masks in response to the Covid-19 pandemic. This also reflects the position across south west London and the national position of very low numbers of influenza cases.

6.2 Staff Influenza vaccination

The Trust's staff influenza vaccination campaign successfully led to an uptake of 85.6% by patient facing staff, ranking once again high in uptake for hospitals in London.

Table 10 shows uptake among a range of patient facing staff groups

Staff Group	Total flu jab
All Doctors	85%
Registered Nurses	75%
Midwives	50%
Clinical – Allied Health Professional	88%

Support to Clinical + Admin	89%
Patient facing students	100%
Total patient facing staff	85.6%

6.3 Norovirus infections and outbreaks

Only one ward was closed due to an outbreak of Norovirus (Table 11).

Table 11 shows outbreaks of Norovirus occurring at the Trust

Ward	Outbreak reported	Ward fully reopened	Total patients tested positive	Number of staff affected
Frederick Hewitt (Paediatrics)	01/06/2020	06/06/2020	2	8

Trust response to Norovirus

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

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

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

Routine cleaning with chlorine was put into place from November 2019 as a precaution for admitting areas in the Trust in order to help prevent spread of Norovirus in the Trust and was put in place in the Emergency Department and Richmond Acute Medical Unit.
Daily outbreak meetings are held for any ward closure attended by Consultant Microbiologist, Infection Prevention & Control Team, clinical team members from the affected area (usually Ward Manger, Matron or Head of Nursing and Deputy DIPC.

6.4 SARS-CoV-2 pandemic (Covid-19)

The novel respiratory coronavirus SARS-CoV-2 which causes Coronavirus Disease 2019 (COVID-19) emerged in Wuhan, China in December 2019. The first cases in the UK were confirmed in late January 2020. COVID-19 surveillance in the UK has been on-going since January 2020. The first inpatients with Covid-19 at St George's Hospital were seen in March 2020. As with the rest of the NHS, St George's had to manage two surges in the pandemic, with peaks in March 2020 and January 2021.

The work of the IPC team was significantly impacted by the COVID-19 pandemic from mid-January 2020, initially with the management of potential cases of SARS-CoV-2 as a high consequence infectious disease (HCID); and then as significant numbers of cases were managed in the Trust between March and June 2020 when a Covid-19 surge plan was developed and enacted. The dual priorities of the team were to try to help protect staff and patients (who did not already have COVID) from getting infected.

As the pandemic progressed, St George's University Hospitals NHS Foundation Trust followed national guidelines and recommendations in ceasing elective work, reconfiguring acute services with increased intensive care (ICU) capacity, and redeployment of the workforce. Meeting the challenge of the Covid-19 pandemic was a whole trust effort.

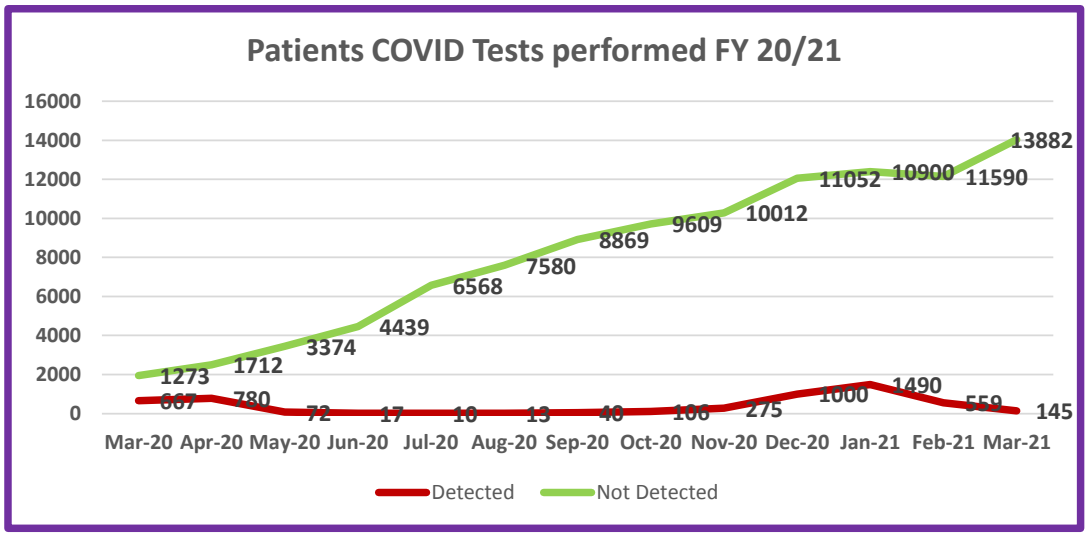
Some of the actions and support offered by the IPCT during this time included but were not limited to:

- Rapid development of COVID-19 Infection Control and PPE guidance based on national guidance issued from Public Health England (PHE)
- Training and education for staff, including redeployed staff and medical students
- PPE donning and doffing protocol development and training in accordance with PHE guidance
- Hand hygiene training and audits
- The Trust held boot camps for the re-training of staff to enhance their competencies for redeployment in both established and newly created critical care areas
- Extension of IPC nursing service to 7-day cover
- Support for setting up the Trust POD for patient and staff testing
- Covid-19 clinical guidance and protocols
- Support for dedicated Trust intranet Covid-19 home page
- Liaison between laboratories and the clinical site management team regarding Covid-19 testing results

<u>Patient and staff testing</u>

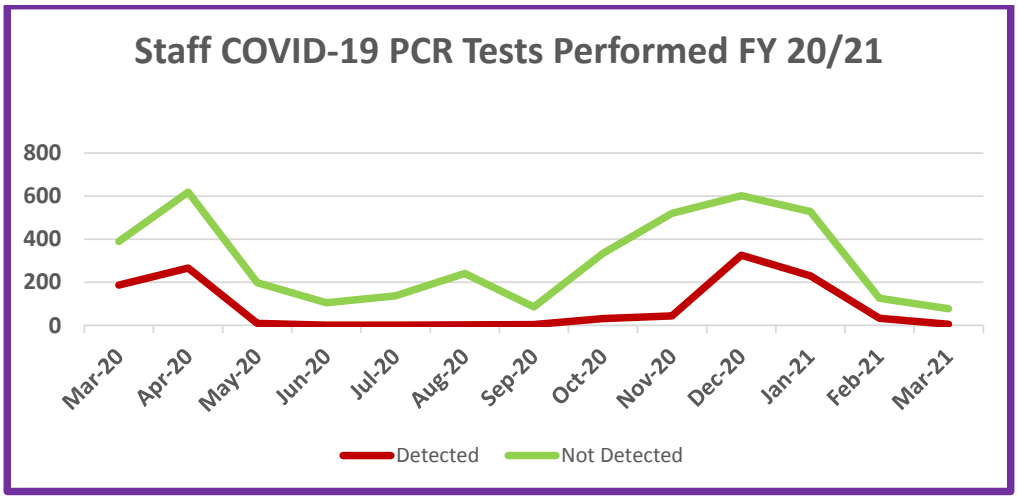
Patient testing first commenced using a 'drive through' system established at St George's Hospital, for patients in the community who were referred through the NHS 111 system. Hospital inpatients were first tested for Covid in early March, initially testing patients with severe community acquired lower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

Figure 9: SARS CoV-2 patient tests



Testing for front line staff was offered from late March 2020 (Figure 10) and a staff testing pathway was introduced for referral to the on-site POD testing centre. Symptomatic household members of Trust staff were offered testing since April 2020 and the testing site operates a 7-day service. 498 staff tested positive by PCR in the first wave of the pandemic. The highest proportions of positive staff were in Emergency Medicine (17% of all staff PCR-positive) and in Acute Medicine (10% of all staff PCR positive), though cases were seen in all parts of the Trust, and we have been informed that sadly 3 members of staff employed at the Trust have died of COVID-19.

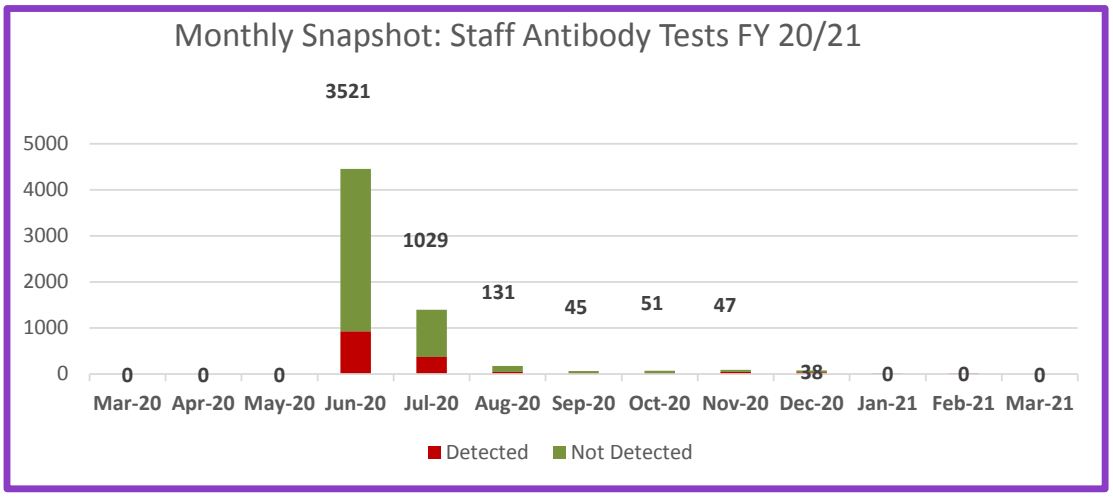
Figure 10: SARS Cov-2 staff tests



In June 2020, the Trust offered SARS-CoV-2 antibody testing to all staff, as part of a national policy (Figure 11). This would indicate whether staff had prior COVID-19. 5792 staff (over half of the Trust) were tested, and 1312 (23%) had antibodies detected. If this is representative of the whole Trust, is suggests that nearly a quarter of our staff acquired COVID in the first wave of the pandemic. We are unable to say how many acquired their infection at work either from colleagues or patients, and how many acquired their infection in the community.

In the second wave of the pandemic, we also experienced a significant amount of staff absence and illness due to COVID-19, with 521 staff testing positive by PCR. Again, the highest rates were seen in Emergency Medicine and Acute Medicine, as well as in Renal Medicine.

Figure 11: Staff Antibody tests



Our ability to test all patients on admission and at intervals through their stay improved through the pandemic. In addition, particularly in the second wave of the pandemic, when we were expected to continue treating as many non-COVID-19 patients as possible (in contrast to the first wave, when fewer non-COVID patients were treated). Nonetheless it proved impossible to prevent all hospital-acquired cases, as seen from table 11 below. The difficulty was due to a number of intrinsic factors – the long incubation period of the virus, the airborne route of spread, the fact that many infections are asymptomatic, and the relative lack of single rooms in most areas of the hospital. The IPCT with ward colleagues made intensive efforts to contain clusters and outbreaks of COVID-19, and this task occupied much of the IPCT time in the winter of 2020-21. It is important to see the numbers in perspective: they are consistent with the rates of nosocomial COVID in the rest of the SW London sector Trusts, this was an NHS-wide challenge. The risk of acquiring COVID-19 when admitted electively during the second wave on a 'green pathway' (i.e. shielding for 14 days pre-admission) was one patient in 342; the risk for patients with unplanned admissions (and who therefore had not shielded pre-admission) was one in 43.

Table 12 shows cases by reporting category whereby for cases occurring during 2020-21 reporting year, 9.1% all cases positive in hospital were hospital onset hospital acquired (HOHA) and 9.8% were hospital onset probable association (HOPA) = 18.9% of all cases tested in hospital were probably or confirmed hospital acquired. There were 9.4% of cases positive in the hospital which were of indeterminate association (HOIA) and 71.7% which were definitely community associated (COCA) = 81.1% were indeterminate or confirmed community acquired.

This equates to 19% of cases tested in the hospital are definite or hospital onset and 81% are indeterminate and community associated.

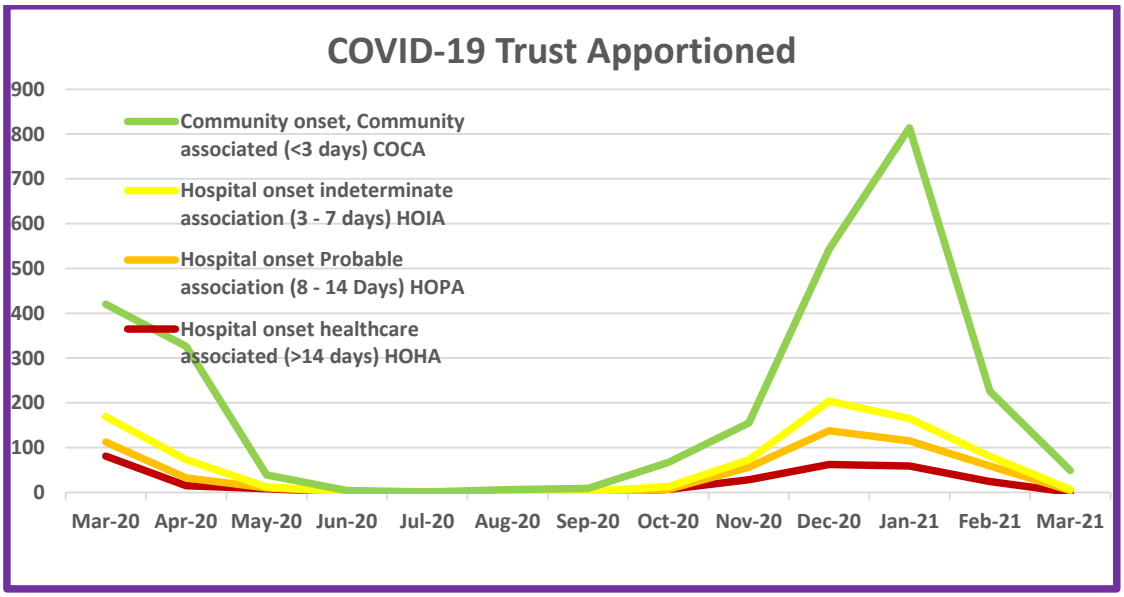
Figure 12 shows the cases distributed both waves of the pandemic

An exercise to establish key IPC learning from the second wave has been underway as part of a wider Trust initiative of 4 workstreams and continues into 2021-22. The IPC workstream is being led by Consultant Microbiologist / Infection Control Doctor and has incorporated input from IPC, Occupational Health, Estates and Facilities, Procurement, site managers, Divisional Leads, Health and Safety and others. Issues covered have included PPE and fit testing, diagnostics, estates provision, outbreak and incident management, data collation, corporate and board assurance issues. A similar exercise has been undertaken jointly with other local IPC Teams in SW London Trusts. A final report will be shared with the Trust Board in due course.

Table 12: Covid-19 including HOHA from July 2020- April 2021

Positive SARS Cov-2 March 2020 - March 2021 inclusive	April 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Total	% of Total
Hospital onset healthcare associated (>14 days) HOHA	15	8	1	0	0	0	7	28	62	59	24	0	**204**	**9.1**
Hospital onset probable association (8-14 days)	17	2	0	0	1	0	0	28	76	56	35	4	**219**	**9.8**
Hospital onset indeterminate association (3-7 days) HOIA	41	2	1	0	1	2	6	17	66	50	21	3	**210**	**9.4**
Community onset community associated (<3 days) COCA	253	27	2	1	4	7	54	82	338	649	146	42	**1605**	**71.7**

Figure 12: distribution of cases over first and second wave during 2020-21 but also incorporating the wider availability of testing during wave 2



7. Infection Control compliance and audit

7.1 Hand Hygiene

Effective hand hygiene remains the single most important action staff can take to prevent the spread of infection. St George's has placed hand hygiene and monitoring of compliance with hand hygiene technique as a key ongoing priority for infection prevention. To ascertain compliance, each clinical area undertakes a monthly audit via the 'Saving Lives' programme. The audit includes a check on hand hygiene compliance for a range of members of the multi-disciplinary team including Nurses, Doctors, Physiotherapists and Occupational Therapists. The audit scores reflect the units' compliance and allow them to demonstrate any areas of concern.

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

In 2020-2021 a total of 60755 observations were recorded, which reflecting more hand hygiene audits performed. The total compliance Trust wide was 97.98% (Figure 13).

Hand hygiene audit results are displayed within Saving Lives scorecard and discussed at Care Group and Divisional meetings and in Divisional reports to the IPCC. Compliance by Division is shown below (Figure 14).

Figure 13: Hand hygiene compliance Trust wide 2019-20

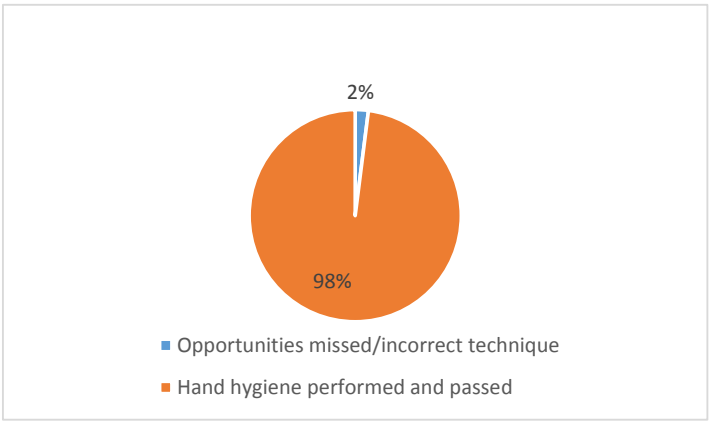
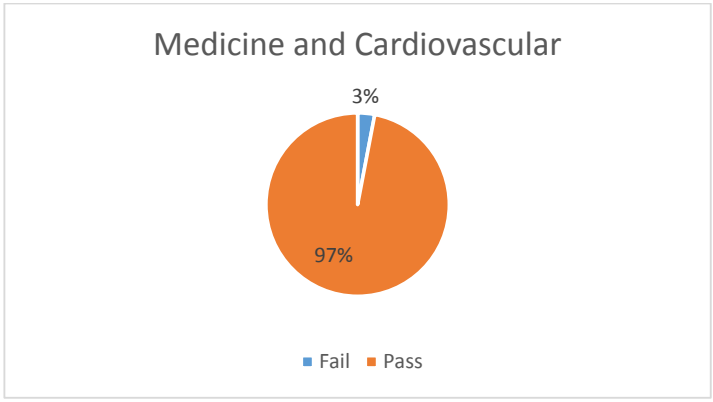
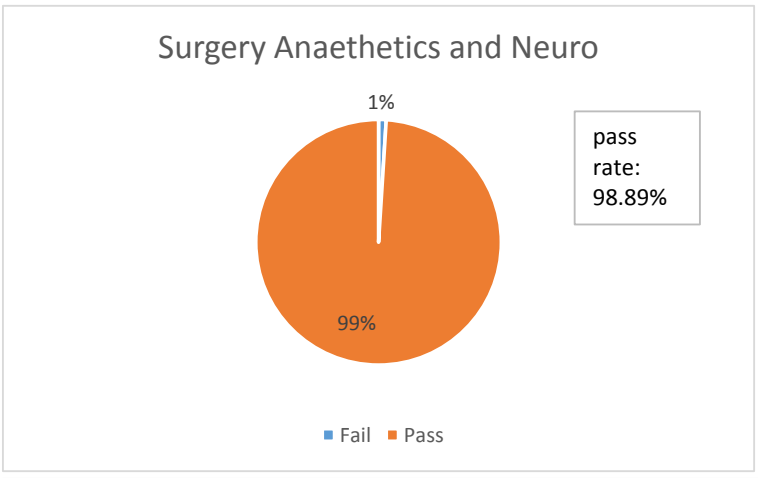
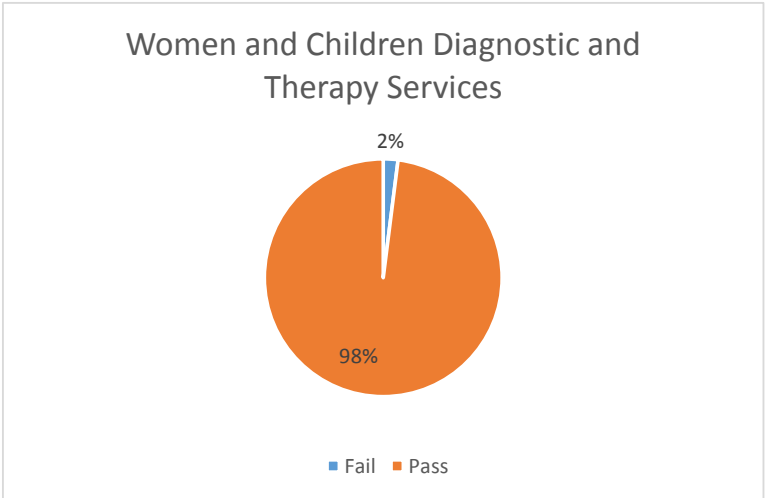


Figure 14: Hand hygiene compliance by Division 2019-20







7.2 Bare below the elbow (BBE)

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

7.3 Period of Increased Surveillance and Audit (PISA)

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

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

There were three MRSA blood stream infections allocated to the trust for 2020-21 and the PISA process was carried out for all three.

19 wards were put on PISA for 41 Healthcare Associated cases of *Clostridium difficile.*

In addition, PISA were initiated in all the wards where an outbreak of Covid-19 was identified to ensure that basic IPC precautions and practices were in place. Feedback was given to the ward team as part of outbreak meetings.

7.4 Saving Lives Audits

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

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

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

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

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

7.5 Estates and Facilities

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

In 2020-21 the E&F team also continued to be part of the audit teams for the ward accreditation programme. These included audits across the community sites, and Queen Mary's Hospital and actions were then taken to rectify any concerns when noted.

7.6 Cleanliness in Hospitals

Cleaning in hospitals is governed by the National Specifications for Cleanliness in Hospitals (2007) and the NHS Cleaning Manual (2009) but are being superseded by new National Specifications for Cleanliness in Hospitals in 2021. Each site has a target score which considers different risk categorisation and cleaning frequencies.

The Trust actual average score cleanliness for 2020-21 was 93%. For very high-risk areas including critical care the score was 99%

Very High Risk	99%
High Risk	97%
Significant Risk	93%
Low Risk	84%
Overall 2020-2021	93%

7.7 Ward and Department Accreditation Audits

The ward accreditation was designed to engage staff and empower leaders to improve and maintain standards and quality of patient care and staff experience. The accreditation framework is based around 13 standards that were developed in

line with the CQC key lines of enquiry (KLOEs). The wards progress through four levels (Requires improvement, Bronze, Silver and Gold) following formal accreditation visits based on standards of performance against agreed metrics.

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

8. Venous Access Service

8.1 The Venous Access Service is the primary service for insertion of all types of lines in the Trust and is committee to high standards of IPC in relation to the insertion and on-going care and management of vascular devices.

8.2 The team undertake weekly surveillance on the management of long-term vascular access devices and monitors any variation in weekly dressing compliance. If there is evidence of non-compliance, then this is addressed at the time with the bedside nurse and the nurse in charge. In addition, this measurement of compliance has now been added to the question set for the Trust's Ward Accreditation programme, along with observation of any peripheral cannulas. The Venous Access Team continues to work alongside the IPCT and the iCLIP (patient management system) Team to further adapt the recording of venous access devices to ensure that it is as intuitive and user friendly as possible to record observations of venous access care.

9. IPC Mandatory and Statutory Training (MAST), Training and Education

9.1 IPC MAST Compliance

All wards and departments were encouraged to ensure that their compliance with MAST on-line training was greater than 85%. As at 20/4/2021, the compliance rate for IPC *clinical* on-line MAST was 87% (n= 5165) and for *non-clinical* on-line MAST was 91% (2639) compared to 19/20 when compliance was 85% and 93% respectively.

Healthcare Scientists (84%) and Medical and Dental (77%) clinical staff were the least compliant groups.

The MAST training (for both clinical and non-clinical) was updated by the IPC team, and this is awaiting uploading by the MAST team.

9.2 Education and Training

The IPC nurses continued to deliver a range of training across the organisation throughout the year, where this was possible. Due to Covid-19 restrictions and social distancing some sessions were inevitably cancelled.

However, when safe, training was delivered to the following groups, primarily nurses.
These included staff from the following locations and groups:

- CTICU
- GICU
- Medicine and Senior Health
- NICU

- NNU
- Nurse Induction
- Paediatrics
- Physician Associates
- PICU
- Renal
- Student Nurses
- Surgery, Trauma and Orthopaedics
- Wheelchair Services

Hand hygiene training was also significantly impacted by Covid-19 so that it was not possible to take the Surewash machines to as many wards or departments as usual. Nevertheless, 210 staff were still able to practice their hand hygiene technique using Surewash. The IPC team now have 3 working Surewash machines, one of which is portable and can be taken to other trust sites.

9.3 Personal Protective Equipment (PPE) – Donning and Doffing Training

In response to the Covid-19 pandemic, the IPC team carried out PPE donning and doffing training across the organisation to key staff groups and individuals, using a train-the-trainer model, to ensure safe practices. This continued throughout the year, as necessary and when requested, including additional training when outbreaks of Covid-19 were reported.

9.4 IPC Study Day

Unfortunately, the scheduled annual IPC study day scheduled for July 2020 was cancelled due to Covid-19. It is anticipated a new study day will be arranged when social distancing rules have been relaxed to allow an in person event.

9.5 Additional Training Events

IPC link meetings and annual World Health Organisation Hand Hygiene Day (May 2020) were cancelled due to Covid-19. However, for the Infection Prevention and Control Week (October 2020) we carried out additional Donning and Doffing sessions. It is anticipated that the World Health Organisation Hand Hygiene Day wil go ahead for May 2021.

10. Antimicrobial Stewardship

10.1 Key activities February 2020 to date since the advent of Covid-19

Widespread increases in antimicrobial prescribing in Covid-19 on the wards and ICUs. High demand on Infection specialist time to support management of Covid and undertake stewardship on both the wards and expanded ICUs.
Reduced pharmacy capacity due to redeployment of AMS pharmacists - limiting data collection and reducing capacity for ward based stewardship.

10.2 New guidelines that have been developed, ratified by our Antimicrobial Stewardship Committee and published in the past year include:

- Covid-19 diagnostic and management pathways
- Antibiotic guidelines for Covid-19
- Dexamethasone for Covid-19
- Remdesivir for Covid-19

- Revision of the following guidelines to reflect new European guidance on dosing required for certain organisms/agents: Community acquired pneumonia, sepsis, complicated UTI, intra-abdominal and diabetic foot infections, cellulitis, VAP or confirmed Pseudomonas infection
- Group B Streptococcus prophylaxis policy
- Recurrent UTI

Guidelines under development/imminently to be presented to ASC

- Aminoglycoside dosing in patients with CKD
- Animal and human bites
- Aspergillosis in Covid-19
- Strongyloides screening for pulsed methylprednisolone
- Vancomycin and gentamicin dosing in dialysis

New formulary applications including:

- Dalbavancin – new drug on formulary
- Cefiderocol - new drug on formulary

10.3 Covid-19 Education/Stewardship

- Grand round presentation on rationalising antibiotic use in early Covid disease
- Twice weekly AMS ward round on Covid wards
- Trustwide comms and posters to educate on judicious use of antibiotics in early Covid

10.4 Routine ward based AMS

- Twice weekly protected antibiotic AMS rounds
- Clostridium difficile post-infection review rounds once per week
- Weekly anti-fungal stewardship round
- Ongoing Monday to Friday ward rounds on all ICUs

Antimicrobial usage data

Figure 15 Defined daily doses (DDD) of antimicrobials Q1 2017-18 – Q3 2020-21

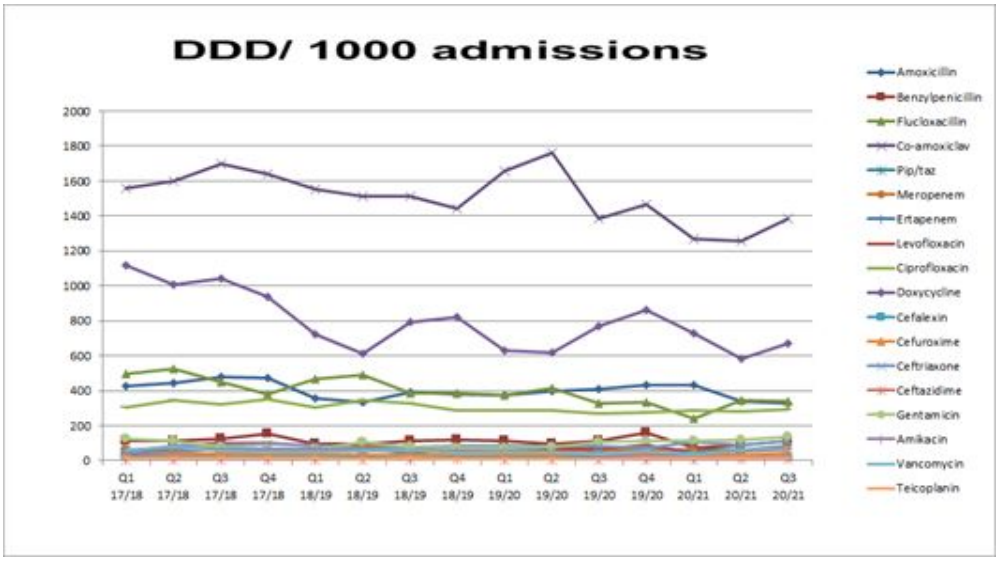
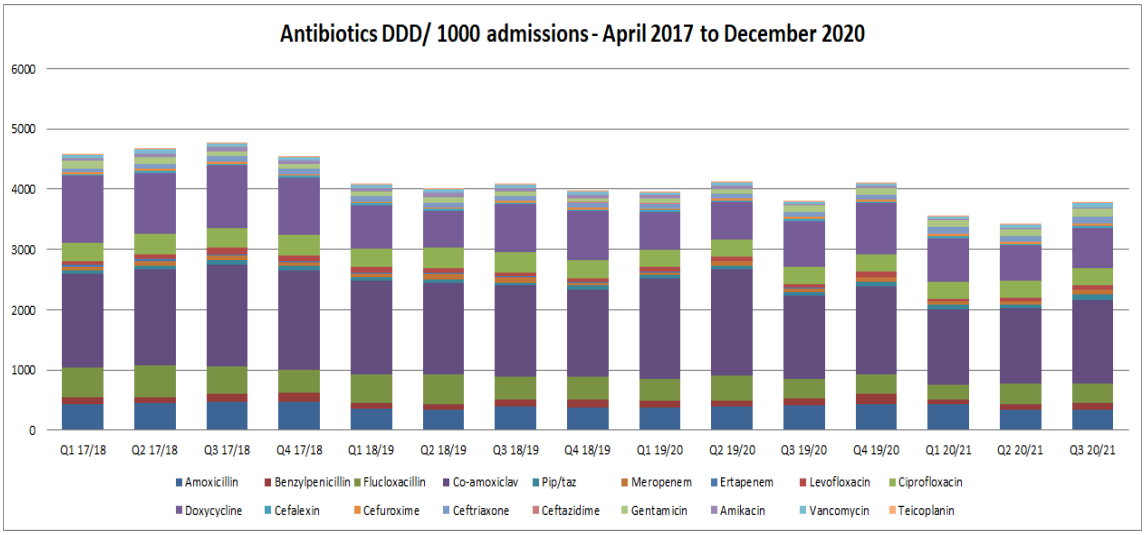


Figure 16 Antimicrobials Defined daily does (DDD) Q1 2017-18 – Q3 2020-21 indicating downward overall trend in prescribing of antimicrobials at the Trust



The above two graphs indicate that the trend in antimicrobial prescribing has been broadly stable with ongoing low prescribing of carbapenems. This is an achievement considering the large number of admission of Covid-19 patients who, particularly in the first wave, were prescribed antimicrobials.

10.5 Antimicrobial Action Plan 2021/22

Key focus for this year: Reducing our use of broad-spectrum antibiotics by education of medical and surgical teams and their engagement in audit and QI projects.

Antimicrobial Audits

We will be re-commencing the quarterly audits (2 pharmacy led and 2 Divisional led), annual IV-PO switch audit and surgical prophylaxis audits.

Institutional antibiogram

Antibiotic resistance patterns need to be updated this to ensure current empirical antibiotic selection is appropriate.

11. Support from Public Health

The IPC team continues to work closely with and are indebted to the consultants and scientists based at the South London Health Protection Unit for the continuing support received. A member of that team will usually be part of any outbreak/incident investigation team and the help and advice received at those times is invaluable.

12. Priorities for 2021-22

A number of actions will be prioritised by the IPCT during 2021-22. Some actions are brought forward from 2020-21 which were not fully addressed due to focus on the Coronavirus pandemic

- Implement national guidance to resume normal services following SARS-CoV-2 (Covid-19) pandemic and any new guidance in the event of a further wave
- Develop lessons for Infection Prevention & Control as part of wider trust learning from the second wave of SARS-CoV-2 pandemic in preparation for a further wave
- Continue to aim for zero cases of MRSA bacteraemia
- Implement targeted screening for MRSA colonisation in low risk elective surgery and low risk emergency admissions
- Develop and implement revised trust strategy for screening of carbapenem-resistant organisms
- Introduce an enhanced screening programme for critical care areas for new admissions and weekly thereafter for a range of organisms
- Continue to work collaboratively within the Trust and with other local NHS organisations to reduce the rate of *E. coli* bacteraemia
- Continue to sustain high rates of compliance with hand hygiene and 'Bare below Elbow'
- Develop improved surveillance of optimal practice in intravenous line care
- Improve the process of investigation for surgical site infections

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13. Glossary of terms

Bacteraemia / BSI	The presence of bacteria in the blood / blood stream infection
C *difficile*	A bacterium that is one of the most common causes of infection of the colon. It can sometimes produce a toxin leading to colitis
Colonisation	Germs in or on the body but which not make the person unwell
CPE	Carbapenemase producing Enterobacteriaceae are Gram-negative bacteria that are resistant to the carbapenem class of antibiotics, considered the drugs of last resort for such infections
E. coli	*Escherichia coli* form part of the normal intestinal microflora in humans with some strains having the ability to cause disease. These can include food poisoning e.g. E. coli 0157 or infections of the urinary tract and bacteraemia
GRE	Glycopeptide resistant enterococci are bacteria resistant to the Glycopeptide antibiotics (vancomycin and teicoplanin) and are sometimes known as Vancomycin Resistant Enterococci (VRE)
Gram staining	A common technique used to differentiate two large groups of bacteria based on their different cell wall constituents. The Gram stain procedure

	distinguishes between Gram positive and Gram negative groups by colouring these cells differently, thus affecting treatment options
HCAI	Healthcare Associated Infection: Any infection that develops as a result of receiving healthcare treatment
Influenza	A respiratory illness associated with infection with the influenza virus. Symptoms frequently include headache, fever, cough, sore throat, aching muscles and joints
MDT	Multi-disciplinary Team: A meeting of a range of specialists who are experts in different areas with different professional backgrounds, united as a team for the purpose of planning and implementing treatment programs for complex medical conditions
MSSA	Meticillin sensitive *Staphylococcus aureus*: a bacteria that commonly lives on the skin or inside the nose without causing problems, but which is capable of causing infections e.g. in a wound or blood stream
MRSA	Meticillin resistant *Staphylococcus aureus*: strains of *Staphylococcus aureus* which is resistant to a number of antibiotics
RCA	Root cause analysis: A process for identifying “root causes” of problems or events leading to an approach for responding to them
SGH	St George’s Hospital (St George’s University Hospitals NHS Foundation Trust)
NHSI	NHS Improvement – an NHS body that oversees Trust driving quality improvement

Outstanding care every time

St George's University Hospitals NHS Foundation Trust

2.1

Meeting Title:	**Trust Board**		
Date:	30 September 2021	**Agenda No:**	**2.1.3**
Report Title:	**Learning Disabilities Annual Report 2020/2021**		
Lead Director/ Manager:	Robert Bleasdale, Chief Nurse and Director of Infection Prevention and Control		
Report Author:	Padraic Costello/Aisling Cotter Learning Disability CNSs		
Presented for:	Assurance		
Executive Summary:	The purpose of this summary is to provide an overview of the work of the Learning Disability Liaison Nursing Team (LDLNT) in association with patient experiences for adults with a learning disability accessing St George's Hospital site during April 2020 - March 2021. A total of 1,141 referrals were received by the LDLNT for the period of April 2020 to March 2021. This represents a fall in referral numbers for the first time in 8 years and a decrease of 14% on the previous year. During the Covid19 pandemic, The LDLNT was asked to support fewer people accessing the St George's Hospital site. The team saw a 11% reduction in the number of people admitted compared to the previous year (219 v 247) and a decrease of 43% in referrals to support people at Out Patient Department appointments in comparison to 2019 (164 v 283). The latter figure is not surprising, given the overall reduction in face to face Out Patient Department appointments occurring over the past year. The reasons for admission to hospital were varied but comprised predominately of care and treatment for aspiration pneumonia, generalised infection, epilepsy related events, falls and strokes. At SGUHFT, there is strong evidence to suggest that people with learning disabilities and their carers continue to benefit greatly from the intervention of the LDLNT and those providing their care and treatment, evidenced by the number of expressions of gratitude received via email and general correspondence. Feedback has also been received in a report to the Trust from NHS England and NHS Improvement measuring performance against the national Learning Disability Improvement Standards. All deaths that occur in patients with learning disabilities are reported 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. The mortality review team carry out a local review of every death of a patient with a learning disability (LD) using a standard methodology. In total there have been 47 deaths, with reviews completed for each. 46/47 deaths were not avoidable with one showing slight evidence of avoidability. The NHSE & NHSI Learning Disability Improvement Standards review is a national data collection, commissioned by NHS England and NHS Improvement (NHSE & NHSI) and run by the NHS Benchmarking Network (NHSBN). In order to measure performance, Trusts are expected to provide data on completion of an organisational survey in addition to patient and staff questionnaires. A total of 208 Trusts participated in the benchmarking review in 2019.		

	For that review, the Trust was requested to identify 100 people with a learning disability (or their carers on their behalf) who had accessed St George's Hospital in the preceding year and to comment on their patient experience via an easy read questionnaire. Participants were requested to return responses directly to NHSE. A total of 55 people with a learning disability who accessed St George's Hospital over the past year, reported on their patient experiences, the 4th highest response rate nationally. The Trust was also requested to identify a minimum of 50 members of staff to report on their experiences of how well the Trust does in how its supports people with a learning disability and/or autism. A total of 51 members of staff participated and The Trust was listed in joint 16th place nationally in terms of staff responses received. It is noted how 100% of staff respondents were aware of systems in place in the Trust for identifying and recording that a child, young person or adult has a learning disability. The LDLNT has not been notified by the Trust's Compliments and Complaints Department of any formal complaints regarding the care of a patient with a learning disability over the past year. The team however was frequently contacted by family members or paid carers of patients with a learning disability with concerns, often about the apparent lack of reasonable adjustments. Examples include family members/paid carers not receiving ward based updates for patients who were unable to comprehend their treatment plans or carers not being provided with sufficient information at the point of a patient's discharge. A number of concerns were also expressed by family members who believed they were being left to perform ward based tasks ordinarily undertaken by nursing staff e.g. provision of personal care, assistance with mobility. Some family members expressed dissatisfaction when patients who were unable to use a handset to participate in Out Patient Department telephone consultations during the pandemic, were subsequently discharged back to their GP. The Learning Disability Liaison Nursing Team however has continued to receive regular compliments from family members, paid carers and professionals to reflect positive patient experiences. The national report 'Treat Me Well' (Mencap 2018) highlights how an estimated 1,200 adults with a learning disability die avoidably in the UK each year due to poorly met health needs but there have been no such deaths attributed to St George's over the past 7 years. There have been no Serious Untoward Incidents involving the care and treatment of an adult with a learning disability at St George's Hospital, notified to the LDLNT over the past 7 years. The LDLNT is represented at number local fora aimed at developing pathways of health promotion for people who have a learning disability, in partnership with other agencies. The Wandsworth Clinical Reference Group for people with a learning disability hosted by Wandsworth Clinical Commissioning Group and The Learning Disability Patient Partnership Engagement Group (LDPPEG) at St George's Hospital. Over the past year, The LDPPEG has developed 16 new accessible information leaflets which are currently in draft form but will be sent to the LDPPEG membership for comments. The leaflets have been designed to enable people with a learning disability to receive information about hospital services in a format which is understandable to them. The leaflets cover a

	variety of topics and examples include information on having an MRI Scan, having a flexi-sigmoidoscopy, fasting instructions before surgery and the Friends and Family Test. The pandemic brought additional distress for people with a learning disability. Many found increased difficulty coping with a break in routine. A total of 40 adults with a learning disability diagnosed with COVID-19, were treated at St George's. Sadly 12 of those patients did not survive the hospital admission and COVID-19 was recorded as the cause of death. Flagging in patient records is a recommendation from the NHS Learning Disability Improvement Standards which is applicable to all NHS Trusts. The LDLNT continues to apply a flag to the electronic records of patients with a learning disability. A total of 923 adults patients with a learning disability now have a flag attached to their medical records. The LDLNT is mindful that the number of formal and informal complaints about adult patients with a learning disability is low and this may be a testament to the high level of quality care patients receive. The team however hopes to have in place an accessible format of the Complaints Procedure to ensure that patients with a learning disability have easier access to report any concerns or shortcomings related to their care and treatment. The Trust will be expected to participate in the next national annual benchmarking review to measure its performance against the Learning Disability Improvement Standards. It is noted that the LDLNT has yet to finalise an action plan in response to the report from the last review. This action plan will identify how The Trust will provide a number of reports on activities not yet available, when submitting future information. This includes information related to patients with a learning disability on waiting lists, comparative information about readmission rates at the Emergency Department for patients with a learning disability versus the general public, data related to patient safety incidents and how the Trust engages with patients who have a learning disability when services are being developed. The Oliver McGowan Mandatory Learning Disability Training will require all NHS employees to receive learning disability awareness training. Whilst this is not in place yet, its requirement is imminent and an e-learning module will need to be devised by the LDLNT in consultation with Training and Development Department.
Recommendation:	The Board is asked to note this report.
Supports	
Trust Strategic Objective:	- Treat the Patient – treat the patient - Right care, right place, right time
CQC Theme:	Safe/Caring/Well Led
Single Oversight Framework Theme:	
Implications	
Risk:	
Legal/Regulatory:	The Annual Report references the Trust's legal and regulatory duties in relation to the safe care and treatment of patients with a learning disability
Resources:	The Annual Report references the currently available resources
Equality and	

Diversity:			
Previously Considered by:	Quality and Safety Committee	**Date**	23 September 2021
Appendices:			

St George's University Hospitals NHS
NHS Foundation Trust

Learning Disability Liaison Nursing Team (LDLNT)

Annual Report 2020/2021

Reena Dhaligadoo, Learning Disability Nursing Associate

Aisling Cotter, Clinical Nurse Specialist, Learning Disabilities

Padraic Costello, Clinical Nurse Specialist, Learning Disabilities

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

Contents Page

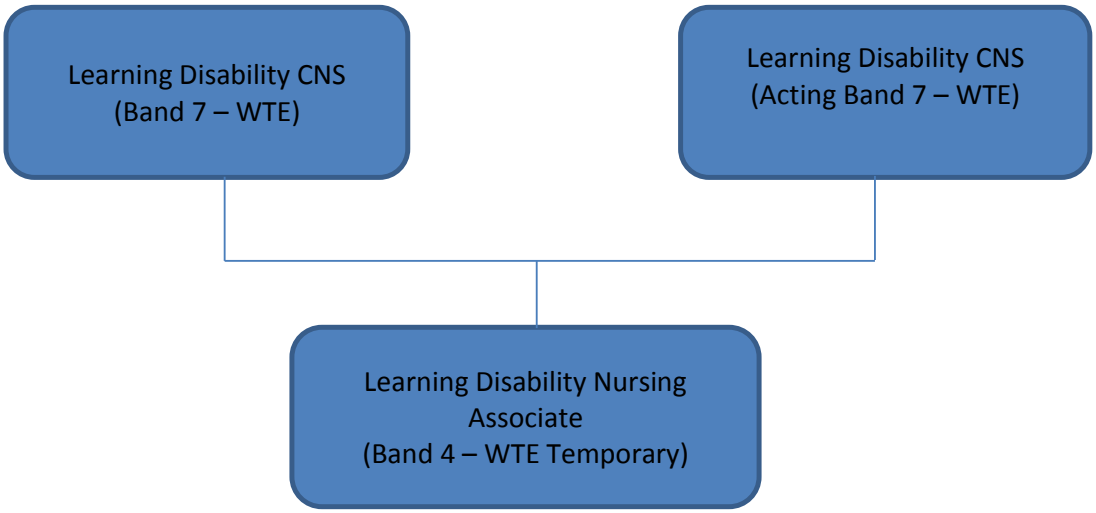
Introduction:

The purpose of this summary is to provide an overview of the work of the Learning Disability Liaison Nursing Team (LDLNT) in association with patient experiences for adults with a learning disability accessing St George's Hospital site during April 2020 - March 2021.

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

In October 2020, the team had difficulty recruiting a Band 6 nurse to cover the Maternity Leave of one of its nurses, resulting in a temporary restructure. The service restructured with one Band 6 nurse acting up at Band 7 from October 2020 and the secondment of a Band 4 Nursing Associate to the team in February 2021. It is anticipated that the team will revert to its original structure in September 2021.

Temporary Team Structure



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

The objectives of this service are:

- To enable patients with a learning disability to access high quality care and treatment through navigation of services provided by SGUHFT

- To work in partnership with the other professionals and agencies to ensure that the patient remains safe along the pathway of care from the point of admission to discharge
- To facilitate discussion and guidance around best interest decision making in accordance with the Mental Capacity Act (2005)
- To coordinate and implement reasonable adjustments where appropriate as required in accordance with the Equality Act (2010).

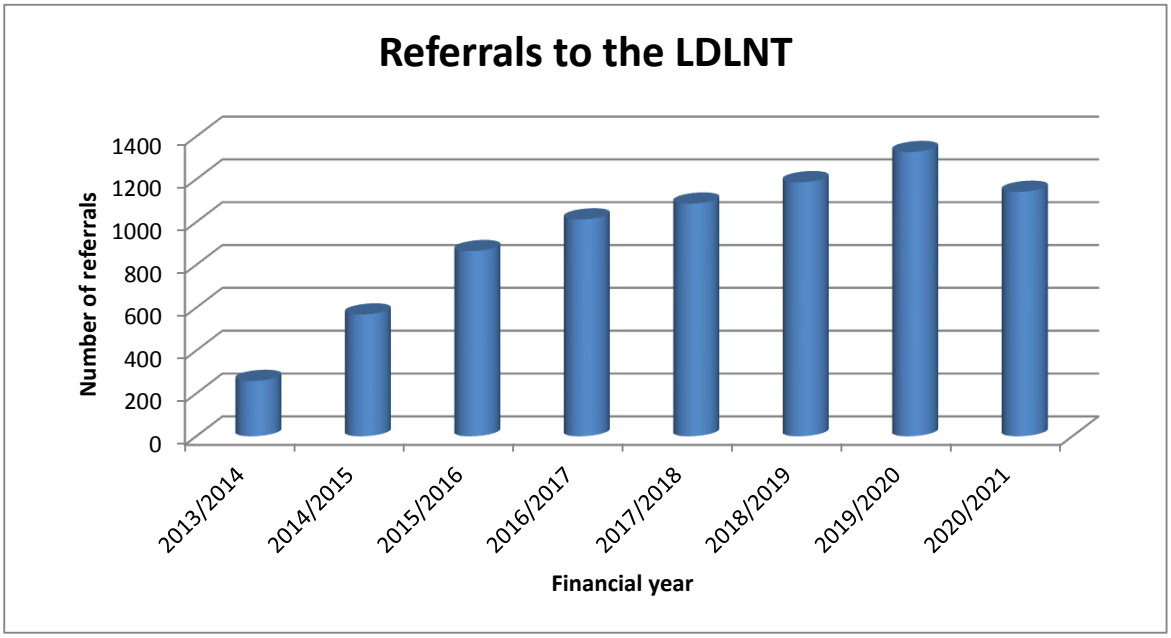
The service operates between 8.30am and 5.50 pm Monday – Friday. Referrals can be made by any source to the team via email, telephone, and bleep or in general correspondence.

Referrals:

A total of 1,141 referrals were received by the LDLNT for the period of April 2020 to March 2021. This represents a fall in referral numbers for the first time in 8 years and a decrease of 14% on the previous year. During the Covid19 pandemic, The LDLNT was asked to support fewer people accessing the St George's Hospital site. The team saw a 11% reduction in the number of people admitted compared to the previous year(219 v 247) and a decrease of 43% in referrals to support people at Out Patient Department appointments in comparison to 2019 (164 v 283). The latter figure is not surprising, given the overall reduction in face to face Out Patient Department appointments occurring over the past year.

The majority of referrals were received from nursing and medical staff working at SGUHFT. Referrals were also received from health and social care colleagues in community settings and parent/carers, in advance of elective interventions and treatments. A small number of referrals (4%) were self-referrals from people who have a learning disability, highlighting that some users feel confident in contacting the LDLNT directly without need for support from carers. Hospital admissions accounted for 19% of all referrals received (unchanged from 2020).

General referrals accounted for 50% of all referrals received to the LDLNT (a decrease of 1% from 2019). These referrals related to pathway planning, addressing informal concerns, responding to queries related to the patient's experience and the implementation of reasonable adjustments in addition to facilitating best interest discussions. Outpatient appointment related matters accounted for 15% of the overall referrals received for the year. 14% of referrals were terminated following fact finding, the majority of which resulted in onward referral to another service, an increase of 5% on the previous year.



The majority of referrals received were from the boroughs of Wandsworth (45.97%) and Merton (19.63%). Over the past year, a notable increase in referrals (7.27%) was seen for those ordinarily resident in Wandsworth and a small increase in referrals was noted for those residing in Lambeth (0.68%). Small reductions in referrals were noted from people living in Croydon (1.47%) and Sutton (1.78%) whilst a reduction of 2.99% was noted in the number of referrals received from outside of the London Boroughs compared to 2019/20.

The reasons for admission to hospital were varied but comprised predominately of care and treatment for aspiration pneumonia, generalised infection, epilepsy related events, falls and strokes.

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

Borough	2018/19 (1186 referrals)	2019/20 (1327 referrals)	2020/2021 (1141 referrals)
Wandsworth	39.9%	38.70%	45.97%
Merton	19.1%	19.06%	19.63%
Croydon	6.1%	8.13%	6.66%
Surrey	6.0%	6.93%	5.87%
Kingston	6.0%	6.56%	5.34%
Lambeth	5.9%	6.33%	7.01%
Sutton	3.9%	5.72%	3.94%
Other	13.1%	8.57%	5.58%

Patient journeys supported by the LDLNT:

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

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

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

Whilst there was a 43% reduction in referrals for Out Patient Department support this year, the LDLNT has further developed its relationships with Out Patient Departments and Patient Pathway Coordinators to enable patients with a learning disability to have a fast track experience when it is known that a delay in the waiting room area may cause distress to the patient or others.

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

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

The experience of those using the service

At SGUHFT, there is strong evidence to suggest that people with learning disabilities and their carers continue to benefit greatly from the intervention of the LDLNT and those providing their care and treatment. This is supported by the number of expressions of gratitude received via email and general correspondence. Feedback has also been received in a report to the Trust from NHS England and NHS Improvement measuring performance against the national Learning Disability Improvement Standards.

NHSE & NHSI Learning Disability Improvement Standards Review

The NHSE & NHSI Learning Disability Improvement Standards review is a national data collection, commissioned by NHS England and NHS Improvement (NHSE & NHSI) and run by the NHS Benchmarking Network (NHSBN). The data collection has been designed to fully understand the extent of Trust compliance with the published NHSE & NHSI Learning Disability Improvement Standards and identify improvement opportunities. The improvement standards reflect the strategic objectives and priorities described in national policies and programmes, in particular those arising from Transforming Care for People with Learning Disabilities – next steps and the Learning Disabilities Mortality Review (LeDeR) Programme. Compliance with these standards requires Trusts to assure themselves that they have the necessary structures, processes, workforce and skills to deliver the outcomes that people with learning disabilities, their families and carers, expect and deserve. It also demonstrates a commitment to sustainable quality improvement in developing services and pathways for people with learning disabilities and autism or both. The standards review aims to collect data from a number of perspectives to understand the overall quality of care.

All NHS Trusts are required to meet the following Learning Disability Improvement Standards.

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

In order to measure performance, Trusts are expected to provide data on completion of an organisational survey in addition to patient and staff questionnaires. A bespoke report was received by The Chief Nurse in March 2021, highlighting the performance of SGUHFT against the Learning Disability Improvement Standards based upon the national benchmarking review undertaken on 2019, in which 208 Trusts participated nationally. The Trust was requested to identify 100 people with a learning disability (or their carers on their behalf) who had accessed St George's Hospital in the preceding year and to comment on their patient experience via an accessible questionnaire. Participants were requested to return responses directly to NHSE. A total of 55 people with a learning disability who accessed St George's Hospital (coded as IS181 below) over the past year, reported on their patient experiences, the 4th highest response rate nationally. An extract from the report is highlighted on the next page.

The Trust was also requested to identify a minimum of 50 members of staff to report on their experiences of how well the Trust does in how its supports people with a learning disability and/or autism. A total of 51 members of staff participated and The Trust was listed in joint 16th place nationally in terms of staff responses received. 69% of respondents reported how they had received training on meeting the needs of children, young people and adults with a learning disability, and autistic people, during the course of their work. 3% of those who responded believed the Trust does not have policies and procedures to ensure the rights of autistic people are respected and protected. It is noted how 100% of respondents were aware of systems in place in the Trust for identifying and recording that a child, young person or adult has a learning disability.

Responses relating to aspects of the organisational survey highlighted how the Trust continues to make improvement against the standards. Some of the strengths highlighted included how the Trust

- has a board level lead responsible for monitoring and assessing the quality of services being provided to children, young people and adults with a learning disability and autistic people.
- provides training to help those who provide day to day care and support, to understand how to recognise and respond to signs of emerging health problems for children, young people and adults with a learning disability or autism
- employs people with a learning disability or autism
- provides a number of reasonable adjustments for people with a learning disability to have equitable access to its services

The report also noted how the Trust is yet to meet some aspects of the standards as follows;

- Monitoring/comparing the emergency readmission rates for children, young people and adults with a learning disability, with those of people without learning disabilities
- Isolating/disaggregating specific outcome data regarding patients with a learning disability
- Holding a list of children, young people and adults with a learning disability waiting for assessment and/or treatment

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

Concerns raised to the LDLNT:

The LDLNT has not been notified by the Trust's Compliments and Complaints Department of any formal complaints regarding the care of a patient with a learning disability over the past year. The team however was frequently contacted by family members or paid carers of patients with a learning disability with concerns, often about the apparent lack of reasonable adjustments. Examples include family members/paid carers not receiving ward based updates for patients who were unable to comprehend their treatment plans or carers not being provided with sufficient information at the point of a patient's discharge.

A number of concerns were also expressed by family members who believed they were being left to perform ward based tasks ordinarily undertaken by nursing staff e.g. provision of personal care, assistance with mobility.

Some family members expressed dissatisfaction when patients who were unable to use a handset to participate in Out Patient Department telephone consultations during the pandemic, were subsequently discharged back to their GP.

Compliments:

The Learning Disability Liaison Nursing Team has continued to receive regular compliments from family members, paid carers and professionals to reflect positive patient experiences. Examples include the following extracts

'First of all, a big thank-you to you and your team. Your hard work and drive to support people with Learning Disabilities in the hospital is incredible and I know all of us at Xxxxx are so happy to have the connection we do with you and the team.' (Health Facilitator from a local charity supporting adults with a learning disability in the community setting)

The sister of a patient with a severe learning disability posted the following tweet...'*Grateful to St George's for looking after my sister who didn't understand her breast cancer diagnosis or the Covid related delays. Your respect, care, reassurance, flexibility and acts of kindness made mum and I cry with gratitude and my sister smile'.*

'..A long overdue thank you but I must thank you both for the support that you gave to X and myself during her stay at St George's. You made a huge difference to the whole experience….I will be attending 2 workshops organised by Mencap; 1) 'Know your rights in Hospital' and 2) 'Treat me well for better healthcare for people with a Learning Disability'. I will certainly be telling everyone present about the great work you do and my experience of it'. (Card received from the mother of a patient with a learning disability)

'I just wanted to thank you and the team for all the help over the past few years, you guys have been incredibly helpful and always impressed me with how organised and professional you and your team have been. (Email from a Patient Pathway Coordinator).'

'*We would just like to take this opportunity to say a massive thank you for your continuous support and guidance. It is with knowledge and reassurance that we have you there at the end of the phone'* (Card received from the manager of a local residential home for adults with a learning disability).

Premature mortality in the population of people with a learning disability has led to the national LeDeR Programme where all deaths of people with a learning disability in England are subject to independent and external review. The Chair of the local area LeDeR Steering Group wrote to the LDLNT in September 2020 expressing gratitude on behalf of external independent reviewers and families of deceased patients, when citing;

'Reviewers and other colleagues have nothing but only praises for the liaison team which were voiced through mainly family members on behalf of their loves ones who have passed away and those who are still using services through the team's hard work and dedication in going over and above to provide service users and their family members with compassionate care and reasonable adjustments. There is a lot of evidence of best practice that are coming through the liaison team in the LeDeR reviews.'

The sister of a lady with a learning disability, who died during the first wave of Covid19 when visiting was not permitted, was grateful to receive a daily video call from a nurse in LDLNT. She sent an email of gratitude to the nurse with the following words*. 'I have not forgotten what you did for us when*

Xxxxxxxxx was in hospital. I know it's your job but still these past months have been testing. I took such comfort that Xxxxxxxxx could at least hear our voices and that she knew we loved her at such a scary time for her. Words can't really express my thanks and even though I've not meet you, I will never forget what yourself and everyone in the hospital has done for so many.'

The LDLNT was awarded a national Safeguarding Medal for its work supporting people with a learning disability at St George's. The Clinical Lead for Safeguarding at NHS England and NHS Improvements who awarded the medal to the team noted, '*the outstanding work they do for people with learning disabilities especially during the whole period of Covid 19……. you have worked exceptionally well to prevent further deterioration of people with LD'.*

I would just like to thank yourself and all members of the team that worked tirelessly to try and treat him. The level of care and respect XX received from St Georges was second to none. Please thank the Xxxxxxxx xxxx ward and all the staff that worked so hard on XX, myself and the staff at Xxxxxx Xxxx are eternally grateful. Thank you. (Email from the registered manager of a home for residents with learning disabilities)

Serious Incidents:

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

Raising Awareness

Almost 300 members of at St George's availed of a learning disability awareness training session provided by the LDLNT in the past year. Attendees have included Preceptorship Nurses, HCAs on the Foundations of Psychological Care course, junior doctors, therapists, ICT staff and ward and clinic staff.

Evidence from evaluation of the sessions indicates new learning which participants were intending to introduce to their future practice. The key themes of new learning were reported to be a greater understanding of the distinction between a learning disability and learning difficulty, the usefulness of the Hospital Passport, a greater awareness of the legal requirement for reasonable adjustments, the importance of person centred care for patients with a learning disability, awareness of diagnostic overshadowing and using alternative communication strategies with some patients who have a learning disability. This new learning can only add to the quality and safety of the patient experience in hospital. When feedback on the sessions was requested from participants, many attendees had suggested an extension of the standard one hour training session.

Patient Representation and Partnerships

The LDLNT is represented at number local fora aimed at developing pathways of health promotion for people who have a learning disability, in partnership with other agencies.

Examples include the Wandsworth Clinical Reference Group for people with a learning disability facilitated by Wandsworth Clinical Commissioning Group.
Prior to the pandemic, the Learning Disability Patient Partnership Engagement Group (LDPPEG) was meeting. The LDPPEG is member-led and membership is cross sectional. It includes people with a learning disability, family members, paid carers from community support groups, nurses from the LDLNT and other health professionals. It seeks to represent the whole community and to be accessible, inclusive and openly run. Aside from the aforementioned stakeholders, the LDPPEG includes in its membership; Beverley Dawkins OBE, the author of Death By Indifference (2007), the first national study to examine premature deaths of people with a learning disability in the UK. The LDPPEG has had to confine its main activity to email exchanges over the past year owing to the challenges faced by people with a learning disability accessing virtual communication technology. The group however has been consulted by various departments at St George's Hospital and its members helped to design accessible information leaflets about Vagus Nerve Stimulation on behalf of the Neurology Department and a Transition Clinic facilitated by the Audiology Department.

The LDPPEG sought the support of a local charity which recently undertook a project exploring the challenges faced by people with a learning disability accessing virtual communication technology. The report found that those people with a learning disability who had skills to use the technology were more likely to have a mild learning disability and to have small packages of care that did not provide for the support required to use the technology. The LDPPEG will continue to explore alternative means to enable people with a learning disability to make a meaningful contribution to the group

Over the past year, The LDPPEG has developed 16 new accessible information leaflets which are currently in draft form but will be sent to the LDPPEG membership for comments. The leaflets have been designed to enable people with a learning disability to receive information about hospital services in a format which is understandable to them. The leaflets cover a variety of topics and examples include information on having an MRI Scan, having a flexi-sigmoidoscopy, fasting instructions before surgery and the Friends and Family Test.

The LDLNT has maintained its joint partnership with students from The Share Community, a local charity supporting people with a learning disability. Its work involves educating adults with a learning disability with appropriate access to local health services. Students participate in a health module developed by The Share Community and are assessed at the end of the module. An information sheet about services at St George's Hospital forms part of that assessment and a copy of the information sheet is pasted on the following page.

St George's University Hospitals NHS
NHS Foundation Trust

Share

Name: _____

I can find my way around the hospital If you have a hospital appointment you'll need to find your way around the hospital. Starting at the entrance to the Grosvenor Wing (Main entrance) can you find your way around? Tick as you complete each activity.		
Symbol	**Activity**	**Tick if you've done this**
 Reception	Can you find the main reception at the entrance of the Grosvenor Wing? If you have an appointment what might you ask reception?	
 Toilets	If you walk through the Grosvenor wing you'll find the toilets.	
 Pharmacy	Looking at the big map can you find the pharmacy which is in the Lanesborough wing if you walk through Grosvenor wing? What would people use the pharmacy for?	
 Scan	Can you find scanning? What is that? Don't go in just walk along yellow line shown on the map.	
 Sanitiser	Can you see hand sanitiser as you are walking around? Why do they have this before entering the wards?	
 Outpatient	In the Lanesborough wing can you find the outpatient department? Don't go in but see if you can find the entrance. What is an outpatient?	
 999 Emergency	Go back the way you came to the entrance of the Grosvenor wing. If you are standing outside the Grosvenor wing can you see ambulances? They are taking people to A&E. What is A&E? Why might people go to A&E? What number do you call in an emergency?	

Patient Story:

The Learning Disability Liaison Nursing Team (LDLNT) was contacted by the parents of a 19 year old patient who was scheduled to have elective surgery at St Georges Hospital. The patient's parents were concerned that their son was not consulted with appropriately or provided with the information required to make an informed decision in relation to the proposed surgery. The patient's family wanted to ensure the Mental Capacity Act (MCA) 2005 was being appropriately followed and asked the LDLNT for advice and support. The patient was not previously known to the LDLNT so over the course of a few weeks a nurse from the LDLNT communicated with the patient and family via phone and email in order to obtain collateral history and build a rapport. The family was keen to empower their son to understand the information required to make an informed decision about the proposed surgery. He was capacitous in a number of areas of his life and his family believed that if he was given accessible information about the intervention, sufficient time to review the information and could be supported by his family at home in a familiar environment then he may be further capacitous in accordance with the MCA 2005.

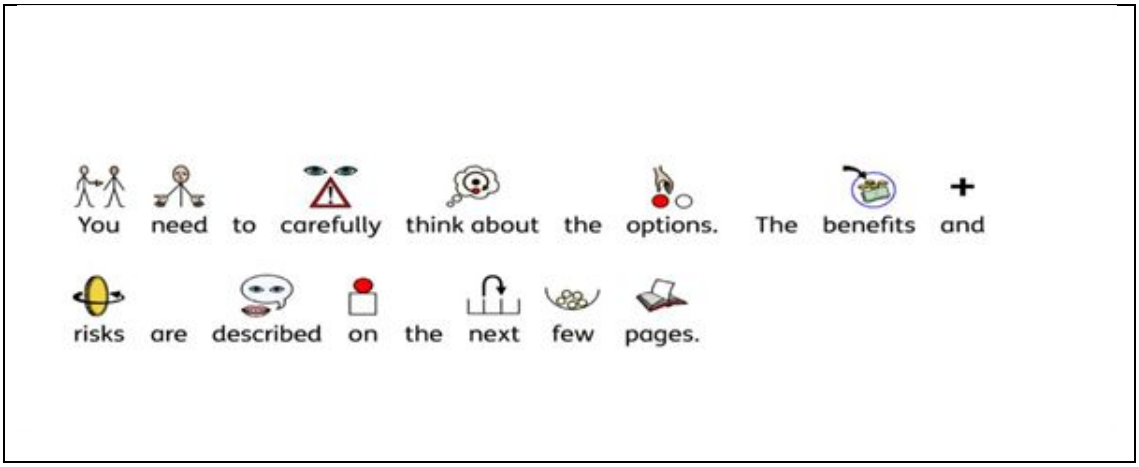
The LDLNT liaised with the treating team and discussed the use of the MCA. The surgical team understood the patients need for further support and education in relation to the proposed surgery and a plan was formulated to support the patient in his understanding.

The LDLNT agreed to create a bespoke document about the surgical intervention using an Easy Read format. Easy Read is a method of presenting written information to make it easier to understand for people with a learning disability. The LDLNT has created a number of bespoke Easy Read Documents for patients where Easy Read information is not available or if a patient requires a bespoke document for specific treatment.

Once the bespoke document was created it was shared with the treating team who reviewed the information to ensure it was accurate and appropriate. The document was approved by the Consultant and the LDLNT shared the document with the family. The patient used SymWriter which is a symbol writing programme where a symbol appears under each word on the document, the family used this programme on the bespoke document to create a symbol supported document which aided the patients understanding by using images and text.

The patient is due to return to clinic in the coming months. The LDLNT will ensure the necessary reasonable adjustments are implemented to include, having a double appointment slot, provision of a quiet and low stimulus waiting area and efforts to minimise any delays in clinic in advance of meeting the treating team. The treating team will then assess the patient's capacity to establish if he meets the threshold as per the MCA. The LDLNT will also attend this appointment and provide advice and support if required.

For purposes of illustration, a couple of lines from the symbolic information are included below.



The LDLNT support patients, families, carers and members of the MDT in a variety of ways to ensure that patients with a learning disability receive equitable access to their care. This patient story demonstrates the type of liaison work completed by LDLNT on a daily basis. On this occasion the liaison work of the LDLNT benefited the patient, family and treating team as it ensured the patient was receiving sufficient accessible information from the treating team and it confirmed the principles of the MCA were satisfied.

The LDLNT works with numerous departments to ensure that treating teams are working within the legal framework by promoting and safeguarding decision making. This can involve sourcing Easy Read information, creating bespoke Easy Read documents, having supportive conversations with patients about treatment options, providing family members or carers with information to support a patient's understanding in a familiar environment, supporting treating teams in relation to assessing a person's capacity to consent to treatment, attending, chairing or minuting best interest decision making meetings and accurately documenting the outcome of such meetings.

The patient story above demonstrates how the work of the LDLNT supported and empowered a patient to become more autonomous in his decision making, placing him at the heart of the decision making process which is one of the key messages of the MCA, a framework designed to protect vulnerable people.

COVID-19 and patients with a Learning Disability:

The pandemic brought additional distress for people with a learning disability. Many found increased difficulty coping with a break in routine. A total of 40 adults with a learning disability diagnosed with COVID-19, were treated at St George's. Sadly 12 of those patients did not survive the hospital admission and COVID-19 was recorded as the cause of death. The LDLNT used video technology to communicate with patient's families prior to the development of the Trust's Interim Visiting Policy. Carers reported how this form of contact offered some consolation in the absence of being able to visit.

In the earlier stages of the pandemic, there was nationwide concern about the use of the Clinical Frailty Scale (CFS) when making difficult and quick decisions to determine which patients who would benefit most from a referral to a critical care environment to ensure best use of NHS resources. It soon became clear; the CFS discriminated against some people with a learning disability and especially many young people with a physical disability. NICE guidance was amended and the advice to decision makers, was to avoid use of the CFS in the population of people with a learning disability when making clinical decision around treatment escalations.

The LDLNT gathered some low level data related to the experiences of people with a learning disability admitted to St George's Hospital with Covid19. The team found that 12 patients with a learning disability were admitted to an ICU environment. At least 14 patients (35%) were from BAME communities. 4 patients were admitted for a reason other than Covid 19 but were subsequently found to be positive when swabbed. No patient or patient's carer reported a change in taste or smell when symptoms of Covid 19 were recorded for patients with a learning disability admitted to St George's. It was noted that the mean age of death for a patient with a diagnosis of Covid19 dying at St George's Hospital was 50.5 years.

Deaths of Patients with a Learning Disability:

Deaths of patients with a learning disability are subject to an internal Structured Judgement Review when the experience of the patient's final hospital admission is examined through each stages of care, including initial management, perioperative care and end of life care. Additionally, all adult patients with a learning disability who die at St George's Hospital have their death notified to the national Learning Disability Mortality Review Programme (LeDeR). These notifications are made by the LDLNT.

People with learning disabilities are more likely to experience health inequalities (Michaels 2008) (Emerson and Baines 2010). These inequalities have led to the reporting of avoidable deaths (Mencap 2007) (University of Bristol 2013). The contributory factors to avoidable death identified in national reports, have had cores themes and relate to inadequate admission planning, poor information sharing, omissions in the delivery of care, failure to understand the law and inadequate discharge planning.

The LeDeR Programme:

The Learning Disabilities Mortality Review (LeDeR) is a national programme which was established in 2015. The aim of the programme commissioned by NHSE is to develop a better understanding of causation factors of premature mortality in the learning disability population and to identify any shortcomings or aspects of best practice with care-giving to inform service improvement initiatives. CIPOLD (2013) highlights that people with a learning disability die on average 23 to 27 years earlier than the generic population. The LeDeR programme is led by the University of Bristol and it involves reviewing the deaths of all people with a learning disability in England. The programme has also commissioned local area steering groups throughout England. The steering group local to St George's Hospital is led by Wandsworth and Merton CCG.

In 2019 NHSE introduced standards related to LeDeR reviews notified to CCG's with an expectation that all deaths notified to the CCG's a reviewer should be assigned within 3 months and the review must be completed within 6 months of the notification received.

The local area reviewer requests information from agencies and services that supported the deceased individual. Requests for information from St George's are directed to the Medical Records Department. The LeDeR programme has Section 251 of the NHS Act 2006 approval which means that St George's can disclose identifiable information without consent. This confirms that the work can be justified in the public interest and it is either:

- necessary to use identifiable information, or
- not practicable to anonymise or code the information
- and, in either case, not practicable to seek consent.

As discussed above all deaths that occur in patients with learning disabilities are reported 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. Members of the Learning Disability team here in St Georges are trained to lead on these reviews

The mortality review team carry out a local review of every death of a patient with a learning disability (LD) using a standard methodology. The table below summarises these deaths from the beginning of 2018/19 to the end of Q4 2021/22. In total there have been 47 deaths, with reviews completed for each. 46/47 deaths were not avoidable with one showing slight evidence of avoidability.

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

Wandsworth Local Area Steering Group:

The Local Area Steering Group is led by Wandsworth and Merton CCG and is represented by health, social and voluntary care agencies. Its membership also includes representatives of local advocacy services, bereaved family members, a GP with specialist interest in learning disability, LeDeR reviewers and commissioners of specialist learning disability services. A

nurse from the LDLNT also attends the bi monthly meetings of the steering group. Meetings are chaired by the LAC.

The purpose of the meetings is for members to

- Review the reporting of local deaths of people with a learning disability
- Review the recommendations and action plans that arise out of multi-agency reviews or safeguarding reviews post death
- To ensure that themes and learning are disseminated through individual agencies, appropriate forum and boards
- To ensure learning from the review of deaths of people with learning disabilities is shared across the health economy in order to improve quality and outcomes for patients and their families

Minutes of meetings are circulated to Steering Group members in addition to commissioners of local services for people with a learning disability, the head of community learning disability services and safeguarding leads at commissioning providers

Impact of reviews for those patients who have died at St Georges Hospital:

A review of the death of a patient in one ward at St George's highlighted the absence of reasonable adjustments, although this was not reported as a contributory factor to the patient's death. The concern had already been noted by a nurse from the LDLNT at the time of the patient's admission and was the catalyst for a learning disability awareness training session delivered to ward staff shortly afterwards. Another review noted '*LD Liaison at SGH was outstanding in this case. There were frequent visits to XX throughout her multiple stays'.*

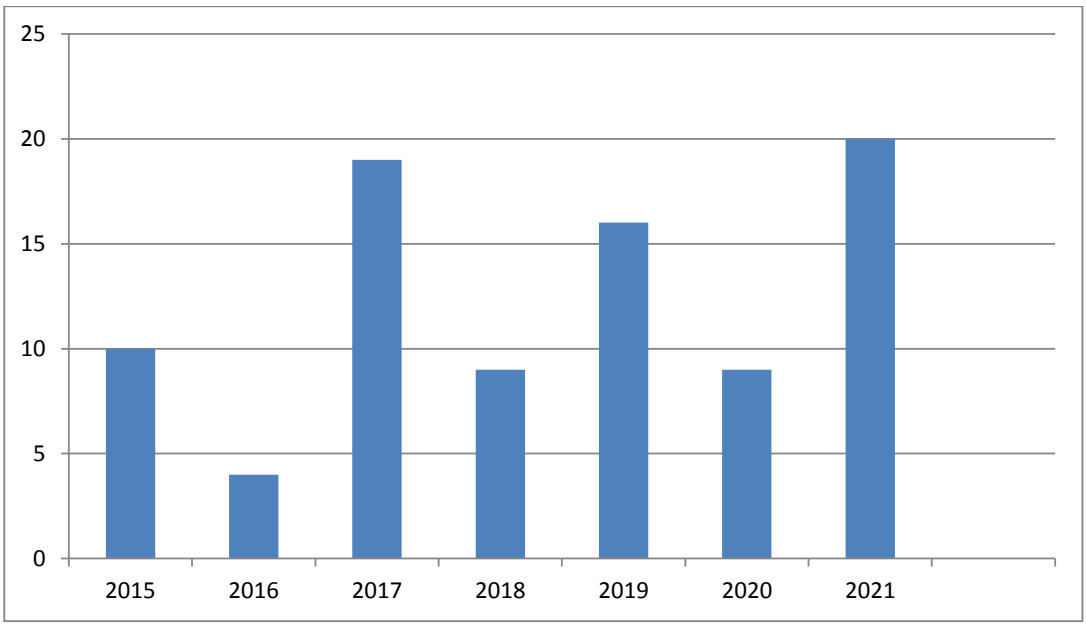
The sister of another patient with a learning disability who died at St George's described a ward as 'neglectful and chaotic'. However there was no evidence to support the assertion that the patient was neglected. The patient only came to the attention of the LDLNT on the day before her death. A review of her death noted that *'early involvement with LD Liaison and a healthcare passport may have improved the experience for XX and her family'.*

This review also highlighted that all wards should be compliant with the NHS Friends and Family Test *(FFT).* An identified action in the current LDLNT Development Plan is for the team to devise an accessible FFT for patients with a learning disability.

The accuracy of reporting came in to question when the death of a man with a learning disability on another ward was reviewed. The patient died on the day following discharge. There was initial criticism that St George's Hospital did not involve the LDLNT in the patient's discharge.
It subsequently came to light that the reviewer had not reviewed all of the notes to confirm that the LDLNT liaised closely with the ward concerned throughout the patient's admission and also the patient's carers through to the point of discharge. Evidence subsequently came to light that reasonable adjustments were considered in relation to the patient's discharge and it could not have been predicted that the patient would die on the following day.

Owing to competing demands, nurses from the LDLNT are challenged at present to commit to completing LeDeR reviews although one review undertaken by a nurse from the LDLNT was highlighted by the University of Bristol last year as an example of excellence.

Deaths of adult patients with a learning disability at St George's Hospital:



From a review of 75 deaths of patients with a learning disability known to the LDLNT from the period 03/04/2014 to 09/10/2020 – more patients died in April (12), January (9) and October (9) and only 2 patients died in the month of May. The LeDeR Programme noted through analysis of deaths reviewed, more patients died nationally in the months of October, November and December. From an analysis of Structured Judgement Reviews, there is no recorded avoidable death of a patient with a learning disability at St George's Hospital in recent years. More patients died this year than in the preceding 6 years.

Causes of Death at St Georges:

Pneumonia has been the most commonly listed primary cause of death for patients with a learning disability at St George's for each of the past 2 years, followed by Aspiration Pneumonia. Other causes have included hypoxic brain injury, Status Epilepticus, Covid-19, urosepsis, gastric bleeding and cardiac arrest. Of a total of 34 deaths of adults with a learning disability reported between 12/04/2018 and 09/10/2020 only 6 deaths were reported to the Coroner's Office. Over the past year, Covid19 Pneumonitis was listed in Part 1a of the death certificate for 9 adult patients with a learning disability.

Developments over the past year;

Flagging in patient records is a recommendation from the NHS Learning Disability Improvement Standards which is applicable to all NHS Trusts. The LDLNT continues to apply

a flag to the electronic records of patients with a learning disability. A total of 923 adults patients with a learning disability now have a flag attached to their medical records.

The LLDLNT has now secured access to Tableau, a patient information system, which can identify the number of bed spaces being occupied by patients with a learning disability at a given time, based upon a learning disability flag. Access to this information alerts the LDLNT to patients with a learning disability who might not yet have been referred by ward staff.

The Learning Disability Patient Partnership Engagement Group (LDPPEG) has reviewed a number of documents with a view to supporting departments to create their own Easy Read information. The LDPPEG assisted in the development of easy read information for the Neurology and Audiology Departments in relation to their respective patient information leaflets. The LDLNT also developed an easy read information leaflet about the Discharge to Assess (D2A) Process to enable patients with a learning disability to have a better understanding of the patient pathway options at the point of discharge during the pandemic.

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

The LDLNT worked in partnership with the Chief Nurse to ensure the Trust participated in the national Learning Disability Improvement Standards benchmarking exercise for NHS Trusts. This involved the completion of 90 audit questions related to the organisations support to patients with a learning disability, the dissemination of an electronic questionnaire to 50 members of Trust staff and sending 100 easy read questionnaires to people with a learning disability and/or their carers to comment on patient experiences at St George's. All information had to be returned directly to NHSi and the Trust will receive a report highlighting its performance against the learning disability improvement standards.

A joint piece of work between the LDLNT and the Coding Department has resulted in the development of guidance for clinical coders to ensure that patients with a diagnosis of a learning disability have the classification of their learning disability recorded accurately.

The LDLNT has developed 16 easy read information leaflets to enable patients with a learning disability to have easier access to information and services provided at St George's Hospital. Examples include an introduction to the Compliments and Complaints Policy, receiving oxygen and having an MRI Scan. The leaflets remain in draft form and will soon be discussed with the relevant departments and the LDPPEG for commenting and editing before eventual ratification.

The development of the Trust's new Intranet has enabled the LDLNT to promote its work and how it supports patients with a learning disability. The LDLNT page contains a Learning Disability information pack for all wards and departments, access to blank Hospital Passports for completion, FAQs and access to a link which contains in excess of 380 easy read healthcare resources.

The LDLNT has worked jointly with a local Community Learning Disability Team that was keen to understand more about the health needs of people with a learning disability in their catchment area. A pathway was developed to ensure that patients with a learning disability discharged from St George's Hospital had access to a follow up visit from a Community Learning Disability Nurse in the community setting shortly after leaving hospital. The rationale for the work included enabling people with a learning disability to have a greater understanding of their discharge summaries and to improve health outcomes that might prevent readmission to hospital.

Future Plans

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

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

The Trust will be expected to participate in the national annual benchmarking review to measure its performance against the Learning Disability Improvement Standards. It is noted that the LDLNT has yet to finalise an action plan in response to the report from the last review. This action plan will identify how The Trust will provide a number of reports on activities not yet available, when submitting future information. This includes information related to patients with a learning disability on waiting lists, comparative information about readmission rates at the Emergency Department for patients with a learning disability versus the general public, data related to patient safety incidents and how the Trust engages with patients who have a learning disability when services are being developed. The standards are prominent in the learning disability ambitions of the NHS Long Term Plan and are now included in the NHS standard contracts and are expected to apply to all NHS-funded care by 2023/24.

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

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

Padraic Costello and Aisling Cotter
Clinical Nurse Specialists
Learning Disability Liaison Nursing Team
September 2021

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Outstanding care every time

St George's University Hospitals NHS Foundation Trust

2.2

Meeting Title:	**Trust Board**		
Date:	30 September 2021	**Agenda No**	**2.2**
Report Title:	Integrated Quality & Performance Report		
Lead Director/ Manager:	Andrew Grimshaw, Deputy Chief Executive Officer		
Report Author:	Kaye Glover, Emma Hedges, Mable Wu		
Presented for:	Assurance		
Executive Summary:	This report consolidates the latest management information and improvement actions across our productivity, performance and workforce for the month of August 2021. **Our Finance & Productivity** Outpatient activity in August 2021 was 99% of the activity reported in August 2019 and is expected to rise to 104% after data catch-up which is higher than the 95% trajectory by 9%. Elective and Daycase performance is expected to be behind trajectory (after estimated catch up), with a percentage of 92%, lower than the 95% trajectory submitted for August. Theatre specialties are at 90%, with non-Theatre specialties at 92%. Some of the decline in activity in August is due to increased annual leave quotas across all staff groups that have led to fewer lists running. Improvement projects have been launched to address issues around Scheduling, Pre-Operative Assessment (POA), Recovery Flow and Recruitment. Non-elective Length of Stay (LOS) remains above the mean of the 2019 baseline as patients stayed on average 6.7 days in August. This continues to be driven by the number of and increase in the acuity of patients being admitted, COVID-19 recovering patients, and delays in patients waiting external care. Increasing patients staying in excess of 7, 14 and 21 days and higher occupancy rates has impacted flow across the Trust. Early Bird programme commenced focusing on early patient identification to enable discharge before 10 am and to spread out discharges throughout the day. **Our Patient Perspective** Basic and Advance Life Support training completion rates continued to rise both indicators showing special cause improvement. Mental Capacity Act (MCA) & Deprivation of Liberties – Level 1 training completion rate has fallen to 85.2% showing special cause deterioration. A new MCA lead was appointed in September and MCA renewal training is under development. All patient safety indicators showed special cause improvement or common cause variation. In month, there were 18 Hospital Onset Healthcare Associated cases (HOHA) of COVID-19 during August 2021, where the sample was taken >14 days after admission and 10 Hospital Onset Probable Associated		

(HOPA) cases where the specimen was taken 8-14 days after admission. There has been a significant outbreak of COVID-19 on a ward with 21 cases: 14 HOHA and 5 HOPA cases. The outbreak is currently the subject of a serious incident investigation.

In maternity, clinical acuity compounded by staffing challenges have continued resulting in the Carmen suite being unavailable for 74% of the time and Supernumerary midwife staffing level at 90.3%. However, the clinical outcomes show common cause variation evidencing a safe service.

The centralised Maternity Telephone Helpline is on schedule to go live by October 2021 which will provide timely access to advice and information and will facilitate consistent and documented advice as well as clinically appropriate signposting. Work continues with our Maternity Voices service user group and wider volunteer groups to create emergency 'care packs' for un-booked, refugee and asylum seeker families who we have noted to be represented more highly this month. Recruitment has continued for the additional midwives and Obstetric Consultant secured from the Ockenden Workforce bid and the team is working on further bids to secure additional funding

Inpatient and Community services achieved FFT targets where patients rated the services as "Good" or "Very Good". Performance for Emergency Department FFT fell to 78% this month showing special cause deterioration. In January 2021, ED changed their FFT service provision and there has been a significant decrease in response rate. Along with operational pressures, the service, along with the Trust are developing posters with QR codes to increase response rates and capture additional feedback to improve services.

Our Process Perspective

In August 81.5% of patients were admitted, discharged or transferred within four hours of their arrival. There has been high variation in the number and acuity of patients attending the Emergency Department and with the impact of COVID 19 still widely evident, capacity and flow throughout the Trust has been challenged. The Trust escalated to Internal OPEL 3 status for 16 days of the month. Eleven patients breached the 12-hour ED target where no patient should wait longer than 12 hours before they are admitted to a ward.

For July, the Trust met three of the seven cancer standards:

- 31-Day Diagnosis to Treatment
- 31-Day Second or subsequent Treatment (Drug), and
- 31-Day Second or subsequent Treatment (Surgery)

The Trust is not expecting to report compliance with the 14 Day Standard until issues within breast services are resolved. The Trust is seeking mutual aid from other SWL providers to accept additional GP referrals for both Breast Symptomatic and Suspected Cancer referrals

It is expected that the numbers of patients over 63 days will rise in August, related to increasing referrals from other Trusts in Head and Neck, issues within the breast service and in Lower GI, where previous diagnostic delays have lengthened pathways

	The Trust reported a continued improvement in performance against the six-week diagnostic standard in August 2021 with a performance of 3.5% compared to 4.3% in July 2021. Action plans in place for the most challenged areas particularly within Sleep Studies and Cardiac MRI with additional short term capacity coming on line to recovery the position. July 2021's RTT performance was 76.2% against a National target of 92% with 1,106 patients waiting longer than 52 weeks which is ahead of trajectory. Admitted clock stops remained broadly on trend, with clock stops performing better than plan despite a planned reduction in activity. An increase in available theatre capacity in July (compared to 19/20) allowed continued improvements in Daycase and Elective activity. **Our Workforce Perspective** Trust sickness absence rate increased for the fifth consecutive month by 0.2% in August to 4.1% and remains above the target of 3.2%. A rise in sickness levels have been seen across all Divisions with the exception of MedCard. Focus on management of sickness absence continues. Appraisal rates for non-medical staff and medical staff was 72.9% and 77.4% respectively and completion of appraisals continues to be encouraged. There were 58 live Employee Relation cases, 45 of which were Formal and 13 Informal as at 31 August 2021. Employee relations surgeries are being run to equip line managers with the skills to manage HR related matters. The Trust's total pay for August was £48.86m. This is £0.32m adverse to a plan of £48.54m. The biggest areas of overspend were Interims (£0.40m) , Healthcare Scientists (£0.09m) and AHP (£0.09m).		
Recommendation:	The Board is asked to note the report		
Supports			
Trust Strategic Objective:	Treat the Patient Treat the Person Right Care Right Place Right Time		
CQC Theme:	Safe, Caring, Responsive, Effective, Well Led		
NHS Oversight Framework	Operational Performance; Well Led		
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:	N/A		
Previously Considered by:	Executive Management Team Finance and Investment Committee	**Date**	20 September 2021 23 September 2021

	Quality and Safety Committee		23 September 2021
Appendices:			

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St George's University Hospitals NHS Foundation Trust

2.2

Integrated Quality and Performance Report

Trust Board – 30 September 2021

Andrew Grimshaw - Deputy Chief Executive Officer

17 September 2021

Our Outcomes

How Are We Doing?

August 2021

Daycase and Elective Surgery operations

Actual: 4,133

2019 Actual: 5,037

6 Week Diagnostic Performance

Actual: 3.5% Target: 1%

Four Hour Emergency Standard

Actual: 81.5%

Plan: 95%

July 2021

Referral to Treatment Standard - Number of 52 Week Breaches

1,106

Whole Trust Inpatient Friends and Family Test

Actual 98.4%

Target 95%

Outpatient First Attendance

Actual 16,381

2019 Actual: 16,831

Balanced Scorecard Approach

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

Key

Current Month

(A) Previous Month

Executive Summary – August 2021 (1 of 2)

	What the Information tells us	Actions and Quality Improvement Projects

Finance & Productivity Perspective	• Outpatient activity was 99% of August 2019 activity and is expected to be 104% after catch-up; the target trajectory is 95%
	• Elective and Daycase performance was 82% of August 2019 activity and is expected to be below trajectory,(after estimated catch up) at 92% with Theatre specialties at 90% and non-Theatre specialties at 92%.
	• Non-Elective Lengths of Stay (LOS) show special cause deterioration at 6.7 days compared to 5.9 days in July. Elective LOS continues to show common cause variation
		• Outpatient Transformation programmes are underway with care groups reviewing their clinical pathways with the aim of redesign and improvement
		• Daycase & Elective activity
		  • Pre-operative assessment ASA1 project commenced to improve efficiency for low risk patients
		  • Recruitment drive for anaesthetists, nurses and ODPs has commenced.
		• Length of Stay
		  • Focus on early patient identification to facilitate discharges before 10 am
		  • Established System Therapies steering group to address workforce issues using a collective approach whilst flexing workforce on an opportunistic basis to mitigate community staff shortage

Patient Perspective	• Basic Life Support Training completion rate is 82%, the highest performance since March 2020; Advanced Life Support training completion rate has increased monthly for the past six months
	• Mental Capacity Act (MCA) & Deprivation of Liberties – Level 1 training completion rate has fallen to 85%; target is 95%.
	• All Patient Safety indicators such as Falls and Pressure Ulcers show common cause variation or special cause improvement
	• There were 18 Hospital Onset Healthcare Associated cases (HOHA) of Covid-19 and 10 Hospital Onset Probable Associated (HOPA) cases
	• In maternity, clinical acuity compounded by staffing challenges have impacted staffing ratios resulting in lower Birth Centre accessibility, and Supernumerary midwife availability at 90.3%.
	• Inpatient and Community services achieved FFT targets where patients rated the services as "Good" or "Very Good". All other services saw a fall in performance.
		• Internal drive by the Chief Nurse and the Chief Medical Officer which includes open drop in sessions, Immediate Life Support Monday and additional resus training capacity.
		• New MCA lead appointed and training modules renewed to include competency "quiz" to evidence existing knowledge and streamline training process.
		• Several patient safety initiatives are under way including:
		  • Falls prevention coordinator has resumed ward visits and National Falls Awareness week events are planned
		  • Focus work on Medical device related pressure ulcer in underway
		• Investigation is currently underway regarding the an outbreak of Covid-19 on a ward
		• Recruitment has continued for the additional 15.6WTE midwives and 0.5WTE Obstetric Consultant secured from the Ockenden Workforce bid. .
		• FFT– ED review completed with findings; additional methods of feedback are being implemented using QR codes

Executive Summary – Aug 2021 (2 of 2)

	What the Information tells us	Actions and Quality Improvement Projects

Process Perspective	• Four Hour Operating Standards
	  • 81.5% of patients either admitted, discharged or transferred within four hours of their arrival; the target is 95%
	  • There were eleven 12-hour beaches in July
	• July Cancer performance
	  • the Trust met the Cancer 31 Day Diagnosis to Treatment, 31-Day Second or subsequent Treatment (Drug), and the 31-Day Second or subsequent Treatment (Surgery) standards
	  • 14 Day Performance was 84.9% decreasing from 91.2% reported in June
	• Six week diagnostic standard improved to 3.5% from 4.3%
	  • 42 patients were waiting for more than 13 weeks and endoscopy does not have any patients waiting over 13 weeks
	• Referral to Treatment for July:
	  • 76.2% of patients were treated within18 weeks of referral
	  • 1,106 patients have been waiting over 52 weeks since referral compared to the June plan number of 1,240.
	• On the day cancellations - Increase seen in July with 38 patients cancelled on the day for non-clinical reasons, of which two patients were not able to be re-booked within 28 days
		• Four Hour Operating Standards actions
		  • New Point of Care Test (POCT) being introduced that will allow accurate COVID tests within 20 minutes enabling flow to wards
		  • In-Hours GP service will be taken over by SGH in October which will allow for improved capacity and consistency of GP provision within the ED
		• Cancer
		  • A forward view of September shows all services, except for breast, are expected to have returned to compliance
		  • The Trust is seeking mutual aid from other SWL providers to ensure patients are seen in a timely manner for Breast referrals
		• Diagnostics
		  • All 13+ patients reviewed with DDO support weekly
		  • External support within Echo continues until recruitment completed
		  • Sleep studies 10 week recovery programme underway
		• Referral to Treatment - Network support in place to reduce the number of patients waiting over 78 weeks as soon as possible with current risks within Cardiology, ENT, General Surgery and Plastics
		• On the day cancellations
		  • Consultant, nursing and ODP recruitment underway
		  • Golden Patient process re-launched to reduce late starts, cancellations and overruns

People Perspective	• Trust sickness absence rate increased for the fifth consecutive month and was at 4.1%
	• The percentage of COVID Risk assessments have fallen each month since October 2020.
	• Total Employee Relations cases are showing special cause variation as numbers have been above the mean for the six consecutive months
	• Agency cost was £1.99m which is £0.74m adverse to the monthly target of £1.25m, however total August Trust pay is £0.32m adverse to plan
		• Trust sickness absence rate
		  • The Chief Nurse meets with Divisional Directors of Nursing bi-weekly for an update on sickness absence management.
		  • Human Resources Business Partners (HRBPs) share reports with Divisions.
		• Employee relations surgeries are being run to equip line managers with the skills to manage HR related matters

Balanced Scorecard Approach

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

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		
		Aug-19	Aug-21	Variance	YTD 19/20	YTD 20/21	Variance	Aug-20	Aug-21	Variance
ED	ED Attendances	13,798	12,493	-9.46%	71,451	64,122	-10.26%	10,232	12,493	22.10%
Inpatient	Non Elective	3,805	3,340	-12.22%	19,920	16,795	-15.69%	3,135	3,340	6.54%
	Elective & Daycase	5,037	4,133	-17.95%	26,622	24,402	-8.34%	3,707	4,133	11.49%
Outpatient	OP Attendances	46,163	45,903	-0.56%	248,650	244,279	-1.76%	39,587	45,903	15.95%

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

Note: Figures quoted are as at 08/09/2021 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 August 2021 have been shown against activity levels reported in August 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 Finance definition of POD1).

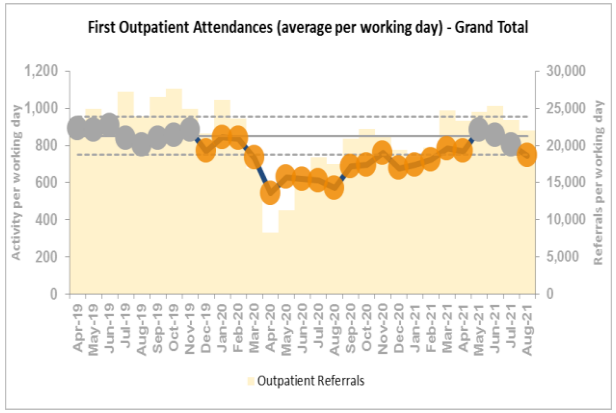
August Activity Performance v Trajectories – Elective, Daycase & Outpatients

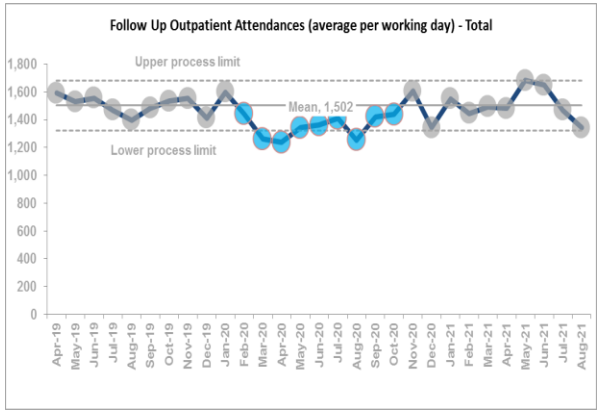
Note: The below activity information is shown in 'SLAM' currency, as this is the currency the Trust is used to seeing and reporting. In addition it allows us to price up this activity to allow a high level estimation of potential ERF payments. The currency used nationally will be 'SUS', to which a price cannot be allocated. The Trust is given detail on ERF payments up to 2 months in retrospect. A reconciliation will be completed between SUS and SLAM, and the below should be taken as directional for now. For information, the ERF target for August is 95%, following a change in rules from NHSI/E (originally the target was 85%).

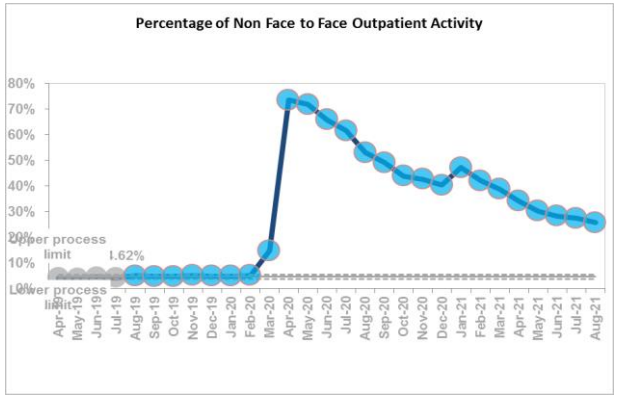
	ACTIVITY QUANTUMS					ACTIVITY %s				
Specialty	August Trajectory	August Activity	August catch up estimate	August Activity after catch up	variance activity	August Trajectory	August Actual	August catch up estimate	August Activity after catch up	variance activity
Cardiac Surgery (172)	41	30	1	31	-11	114%	83%	1%	85%	-30%
Colorectal Surgery (104)	35	49	4	53	18	60%	84%	7%	91%	31%
Ear, Nose & Throat	166	113	12	125	-41	111%	76%	8%	84%	-28%
General Surgery (100)	53	25	2	27	-26	76%	36%	3%	39%	-37%
Gynaecology (502)	171	157	13	170	-1	92%	84%	7%	92%	0%
Neurosurgery (150)	92	112	7	119	26	60%	73%	4%	78%	17%
Trauma & Orthopaedics (110)	54	80	9	89	34	44%	66%	7%	73%	28%
Urology (101)	351	297	31	328	-23	130%	110%	11%	121%	-9%
Total Theatre Specialties	**964**	**863**	**77**	**940**	**-23**	**91%**	**83%**	**7%**	**90%**	**-1%**
Gastroenterology (301)	1,235	1,008	147	1,155	-80	88%	72%	10%	82%	-6%
Cardiology (320)	220	195	6	201	-19	84%	74%	2%	77%	-7%
Dermatology (330)	12	0	0	0	-12	100%	0%	0%	0%	-100%
Neurology (400)	658	491	23	514	-145	107%	80%	4%	84%	-24%
Paediatrics (420)	18	33	3	36	18	84%	157%	12%	169%	85%
Paed Surgery (171)	85	100	5	105	20	92%	109%	5%	114%	22%
Clinical Haematology (303)	186	119	40	159	-27	200%	128%	43%	171%	-29%
Medical Oncology (370)	98	89	2	91	-7	114%	103%	2%	105%	-8%
All Other Specialties	1,306	1,235	192	1,427	121	93%	88%	14%	101%	9%
All Other	**3,818**	**3,270**	**415**	**3,686**	**-132**	**96%**	**82%**	**10%**	**92%**	**-4%**
Total Daycase / Elective	**4,781**	**4,133**	**493**	**4,626**	**-155**	**95%**	**82%**	**10%**	**92%**	**-3%**
Outpatients	**43,855**	**45,903**	**2,295**	**48,198**	**4,344**	**95%**	**99%**	**5%**	**104%**	**9%**

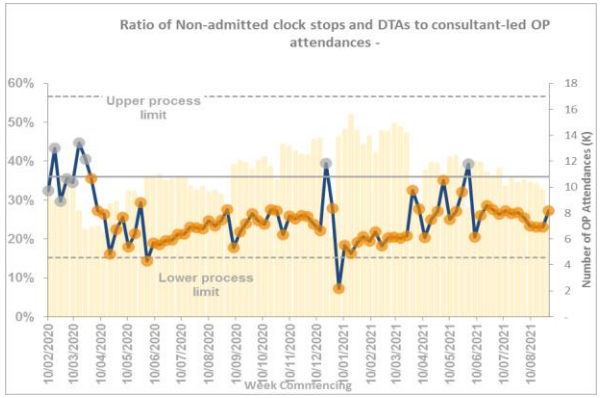
- The adjacent table shows performance against the elective and day case activity trajectories split between theatre specialties, and other specialties. It also shows Outpatient performance as a trust. Diagnostic mapping to ascertain performance against trajectories is being worked through with commissioning colleagues.
- Elective and Daycase performance is expected to be behind trajectory (after estimated catch up), with a percentage of 92%, lower than the 95% trajectory submitted for August. Theatre specialties are at 90%, with non-Theatre specialties at 92%.
- Outpatient performance is expected to be 104% after catch-up, which is higher than the 95% trajectory by 9%.

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 there is 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 and as services decide that patients require a face-to-face appointment as part of their care.

For some services, virtual clinics will be a core part of their service offering moving forwards, for other services this will be less appropriate. All Care Groups are currently reviewing their Outpatient clinical pathways with a view to re-designing and improving them.

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

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

What the information tells us

First outpatient activity throughout August fell below the lower control limit, a pattern seen in previous years due to the summer holidays. On average, there were 745 attendances daily compared to 803 in July. Activity reported in August 2021 was 97% of activity reported in August 2019 showing a favourable position against elective recovery programme trajectory expected to increase once coding is completed. Women's and Renal and Oncology Services continue to see activity levels consistently above the mean of 2019 baseline.

At Trust level, follow-up activity continues to show common cause variation with performance remaining within the upper and lower control limits. In August, there were on average, 1,342 attendances daily compared to 1,468 patients in July. All follow-up outpatient activity in August 2021 was 101% of the activity reported in August 2019.

All outpatient activity in August 2021 was 99% of the activity reported in August 2019, performance is expected to be 104% after catch-up, which is higher than the 95% trajectory by 9%.

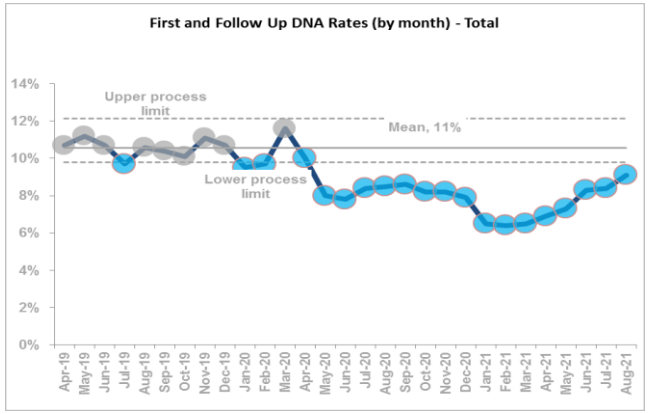
In August 25.8% of our outpatient attendances were undertaken in a virtual setting, a decrease of 1.7% compared to the previous month.

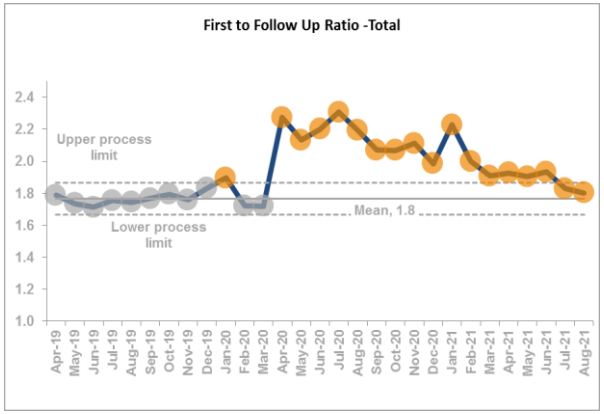
At Trust level, pre-COVID, there was a clock stop or a decision to admit for every 2.8 Consultant-led OP attendances. At the end of August the ratio was now 4.2 consultant OP attendances to each clock stop or DTA.

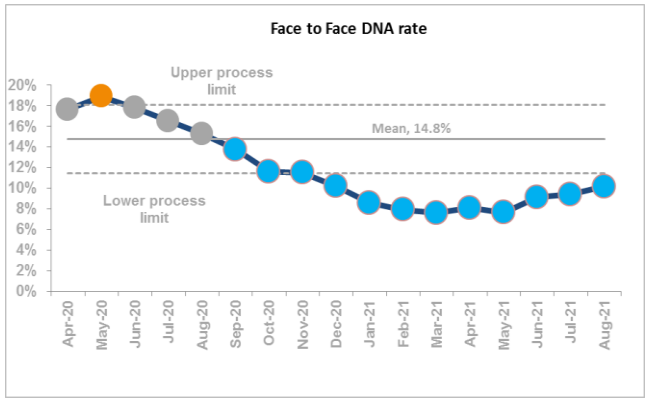
Please note that COVID-19 related OP activity has been excluded from the charts.

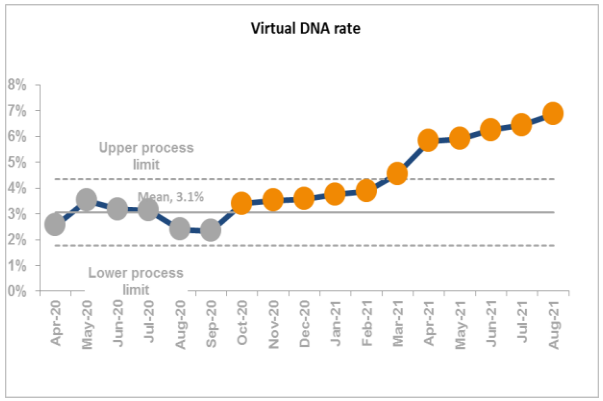
Outpatient Productivity (2 of 2)

- 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 below the lower control limit in August against the 2019 mean, although seeing a steady increase in recent months. Across the month of August 9.1% of patients did not attend the outpatient appointment, representing on average 256 DNA's per working day.

With the increased first outpatient attendances the first to follow-up ratio has seen a reduction over the past six month period. In August where we are currently reporting lower follow-up attendances the new to follow-up has decreased.

With an increase in the number of patients being seen in a face to face setting, the number of patients that did not attend has started to increase, although remaining below the lower control limits. Throughout August 6.9% of patients with a virtual outpatient booking did not attend their appointments.

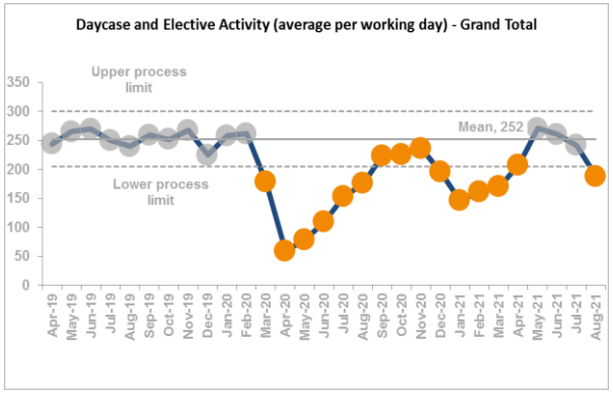
Actions and Quality Improvement Projects

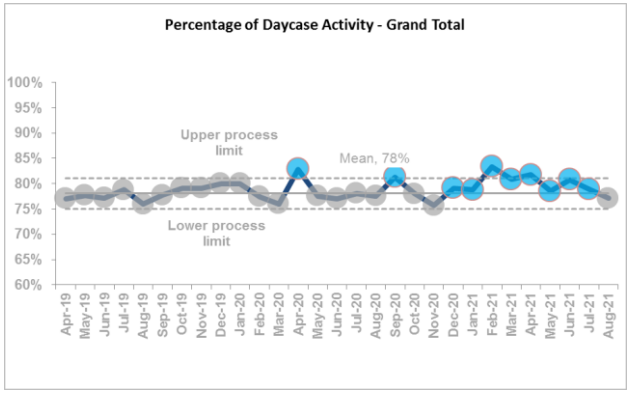
Services are undertaking clinic reviews to reflect the needs of their backlog. Some clinics may have additional new appointments depending on where the demand lies. This is expected to change permanently from September when all patients at 18 weeks should receive a first appointment. After this a review will need to be undertaken to review the clinic format.

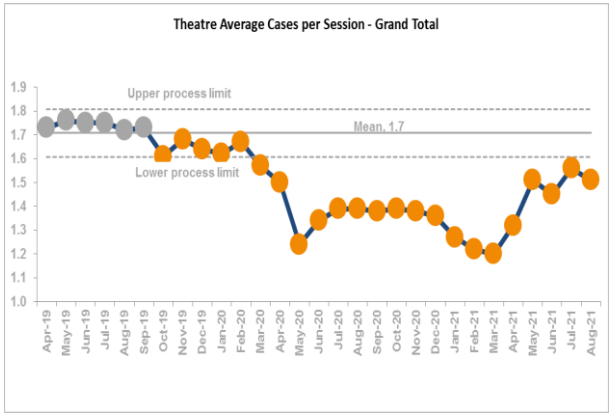
The DNA rates are below the target. Services are being asked to review the correspondence to ensure that patients who have virtual appointments are receiving the correct text messages and letters so that they can prepare. Given the increase in virtual DNAs, this may relate to an increase in the overall capacity for virtual appointments. Overall the DNA rate is very low and a significant improvement.

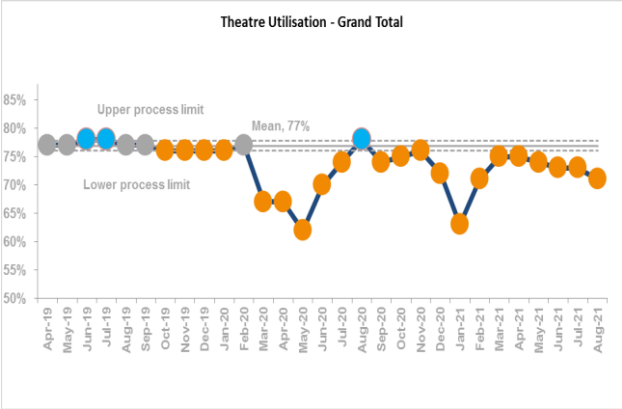
Elective Activity & Theatre Productivity

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









What the information tells us

In August the number of elective treatments reduced, with activity levels falling below the lower control limit and significantly below the mean of 2019 baseline.

On average, 188 patients were treated per day compared to 242 in July. Overall elective activity was 82% of that reported in August 2019 and is expected to rise to 92%, lower than the 95% trajectory submitted for August.

Ahead of coding all services apart from Renal and Oncology have seen activity levels decrease in August compared to the previous month.

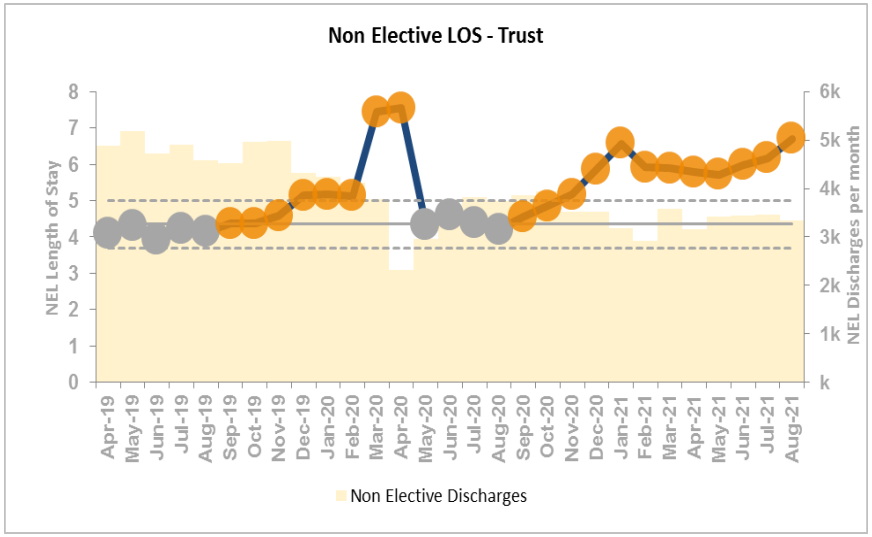
In August, Theatres ran 886 theatre sessions, compared to 896 in the same period in 2019. The average cases per session in August decreased. Theatres continue to adhere to process changes implemented because of COVID-19.

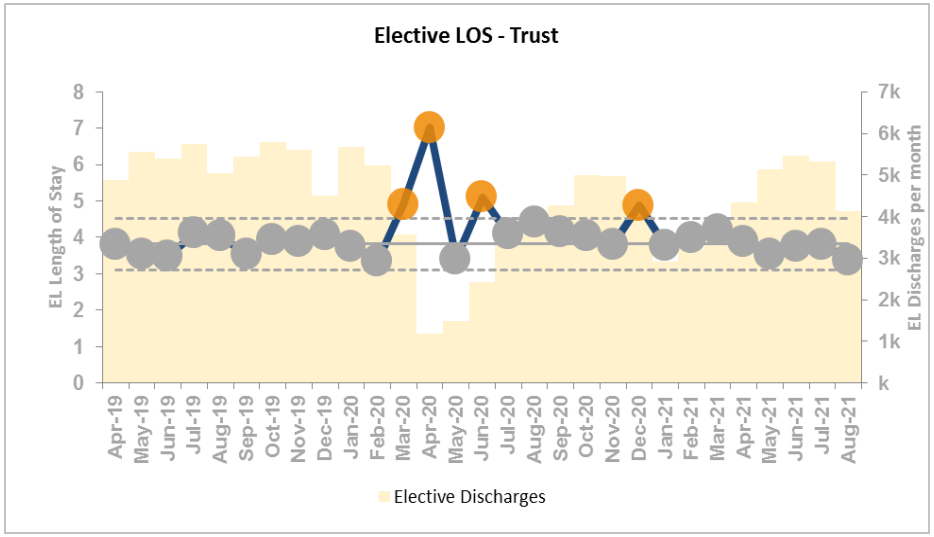
Actions and Quality Improvement Projects

Some of the decline in activity in August are due to increased annual leave quotas which have led to fewer lists running. Improvement projects have been launched to address issues around Scheduling, Pre-Operative Assessment (POA), Recovery Flow and Recruitment:

- **Scheduling:** List Planning has been re-vamped. Daily huddles with Patient Pathway Coordinators (PPCs) and individual team targets have been introduced to monitor and drive performance. This is already having a positive impact in September.
- **POA:** POA is using scarce capacity to carry out in-depth reviews of ASA1 patients (the lowest anaesthetic risk banding) – 34% of SGH patients are ASA1 and otherwise fit and healthy. An 'ASA1 Streaming' project has been launched to enable safe streaming of these patients 'straight to swab'. This will increase POA capacity.
- **Recovery flow:** New processes are being introduced to improve flow through recovery and reduce overruns which will avoid cancellations due to a lack of recovery capacity and staff unavailability.
- **Recruitment:** A recruitment drive is underway to increase numbers of anaesthetists, nurses and ODPs.

Length of Stay





What the information tells us

Non-elective Length of Stay (LOS) remains above the mean of the 2019 baseline seeing an increase in August with patients staying on average half a day longer compared to July. In August, on average non-elective inpatients stayed in a hospital bed for a total of 6.7 days. The increase is driven by an increase in the acuity of patients being admitted, COVID-19 recovering patients as well as new admissions, and increased delays in patients waiting external care. Occupancy continues to rise with AMU midday occupancy exceeding 90% throughout August and General & Acute Bed midnight occupancy at 86%; high occupancy coupled with increasing patients staying in excess of 7, 14 and 21 day has impacted flow across the Trust.

Elective length of stay shows common cause variation. On average patients stayed in a hospital bed for 3.4 days compared to 3.8 days in July.

Actions and Quality Improvement Projects

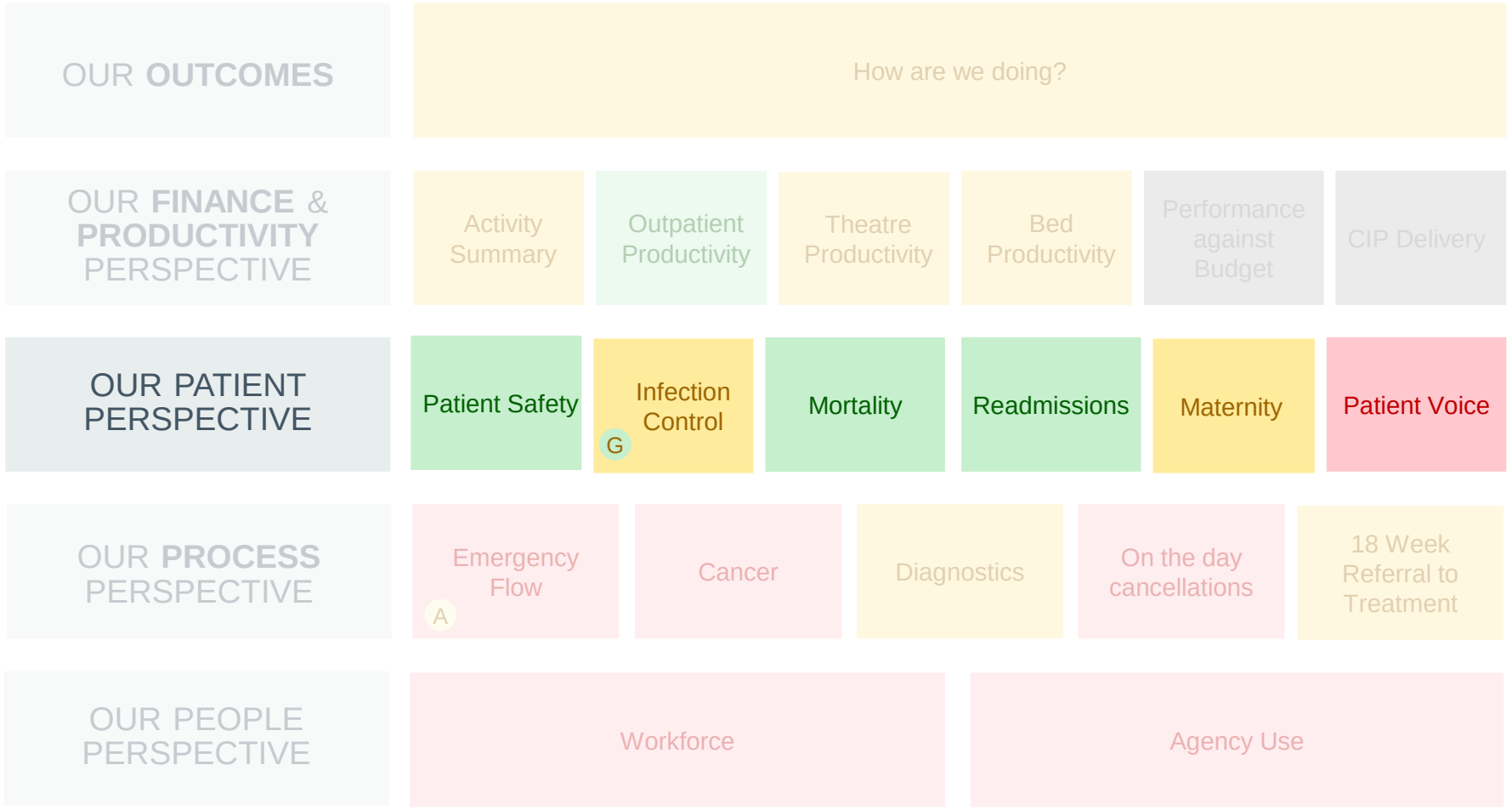
Early Bird programme commenced focusing on early patient identification to enable discharge before 10 am and support flow from ED to the wards.

Community Therapies are at capacity with Community Wandsworth D2A team unable to accept referrals. Issue has been escalated via the COO and system partners' senior teams.

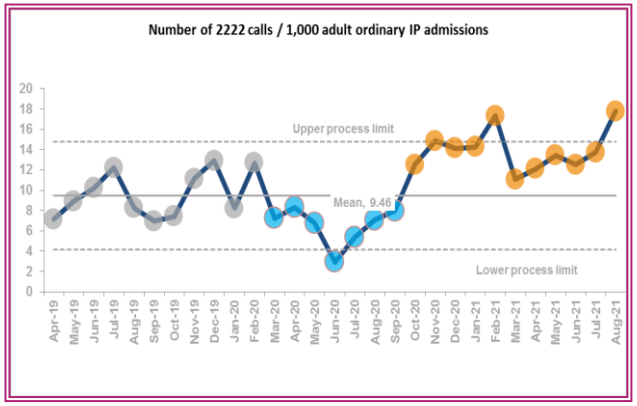
Daily negotiations are on-going to support community by flexing therapies workforce on an opportunistic basis.

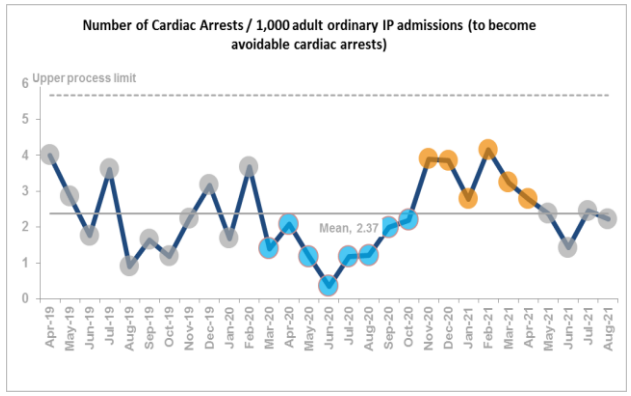
Acute and Community Therapies Steering Group established to address workforce shortages and issues using a collective approach

Balanced Scorecard Approach

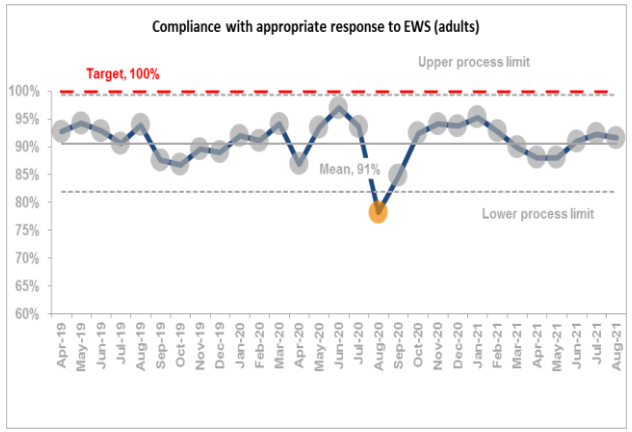


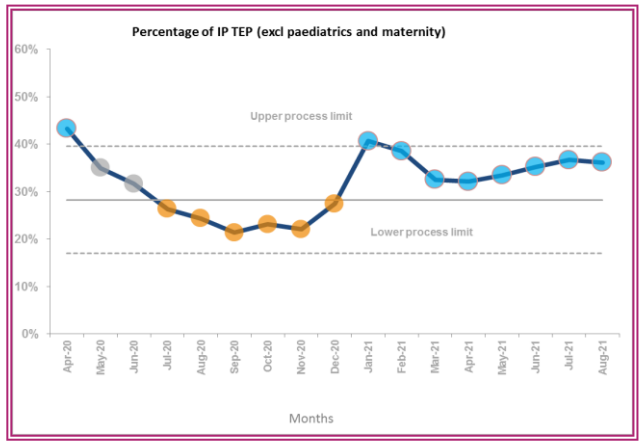
Quality Priorities – Treatment Escalation Plan





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





What the information tells us

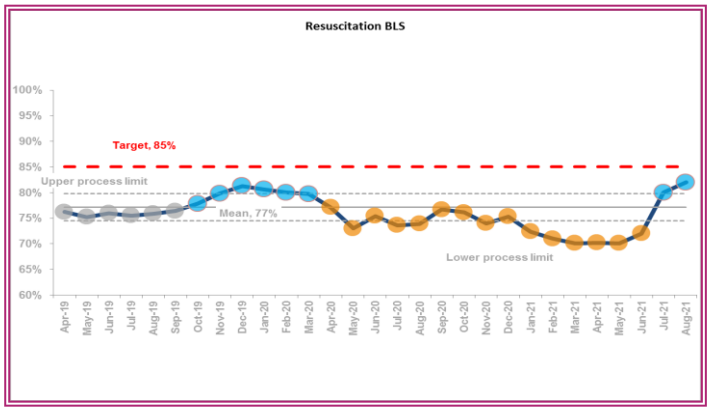
- The rate of 2222 calls per 1,000 Inpatient (IP) admissions shows special cause variation however the rate of cardiac arrests per 1,000 adult ordinary inpatients shows common cause variation.
- Compliance with appropriate response to Early Warning Score (EWS), is 92% this month and continues to show common cause variation.
- Treatment Escalation Plan completion rate show special cause variation, improving with performance increasing month on month

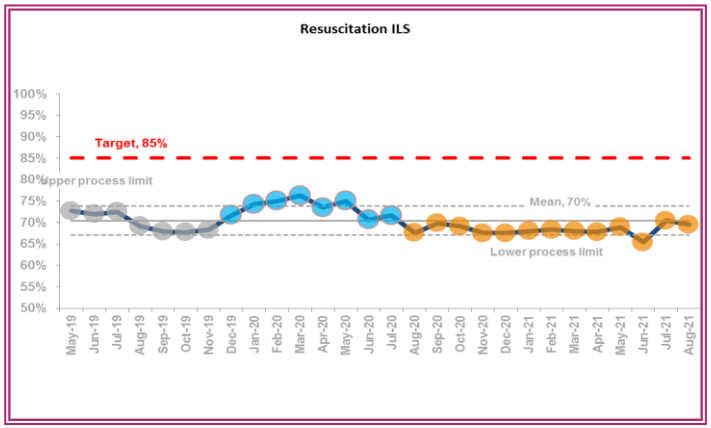
Actions and Quality Improvement Projects

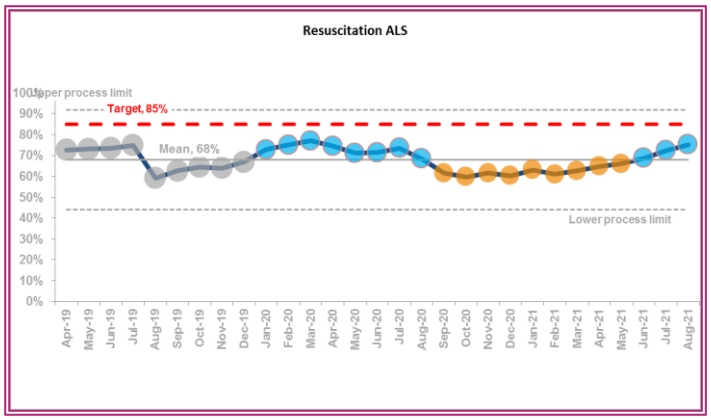
In order to continue to improve Treatment Escalation Plan (TEP) completion rates the following initiatives are in development for implementation by 31 March 2022:

- Electronic dashboard to see how many patients in any clinical area have not had a TEP completed to target TEP completion where indicated
- Easy electronic link to TEP from CERNER iCLIP eTCI document to promote TEP completion
- Simulation sessions to help clinicians to have conversations with patients about treatment escalation planning
- Update intranet webpage to include case studies about resuscitation

Quality Priorities – Deteriorating Patients







- BLS (Basic Life Support) training performance shows special cause improvement with a steady increase in performance which is now 82%, the highest performance seen since March 2020.
- ILS (Immediate Life Support) shows special cause variation, with performance at 69.5% for this month.
- ALS (Advanced Life Support) training performance shows an improved position in month at 75.2% compared to 72.3% last month, best performance seen since April 2020.
- Staff completion of all life support training modules continues to show improvement despite not having met Trust targets.

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

Actions and Quality Improvement Projects

BLS - Open drop in sessions continue for staff supported by weekly focused emails and monitoring by Chief Nursing Officer

Brayden self-assessment will 'go-live' by the end-September 2021

ILS – ILS Monday has commenced. Resus team scoping the development of eILS recertification course: the ILS equivalent is 2.5 hours face-to-face with on-line learning

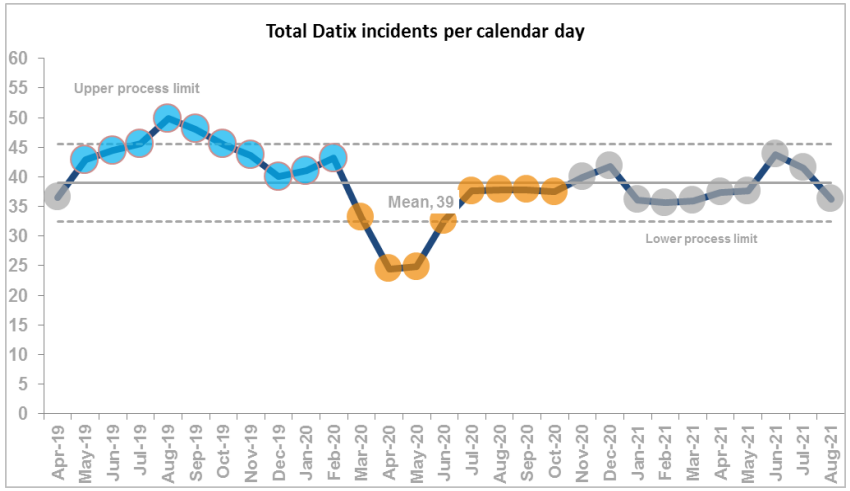
Additional Resus training capacity (seconded 0.5 WTE) started with the Team on 13 September to support increasing ILS and BLS compliance

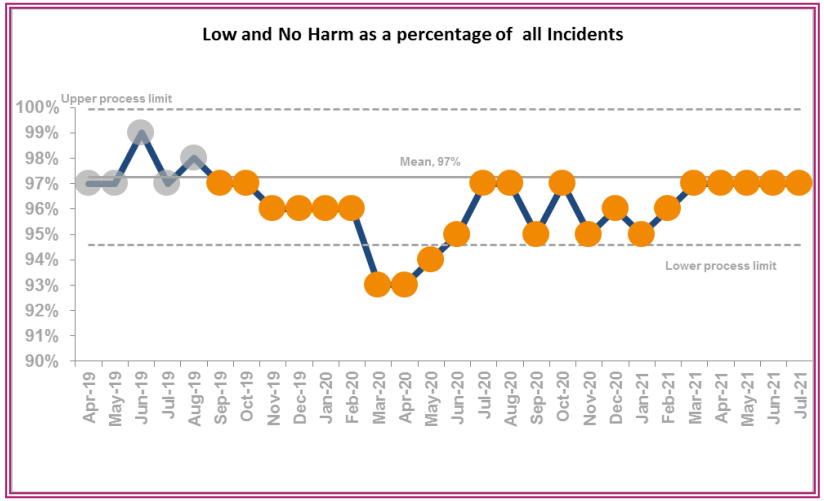
ALS – Resus Team attending medical staff induction; ALS certificates requested and uploaded where available and training courses highlighted.

Quality Priorities – Learning from Incidents

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

Indicator Description	Threshold/ Target	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
Monthly percentage of Incidents of Low and No Harm		97.0%	95.0%	97.0%	95.0%	96.0%	95.0%	96.0%	97.0%	97.0%	97.0%	97.0%	97.0%	data one months in arrears
Open SI investigations >60 days	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Duty of Candour completed within 20 working days, for all incidents at moderate harm and above	100%	93.0%	94.0%	89.0%	96.0%	96.0%	85.0%	75.0%	90.0%	100.0%	100.0%	96.0%	data two months in arrears	
Total Datix incidents per calendar day		38	38	37	40	42	36	36	36	37	38	44	42	36





What the information tells us

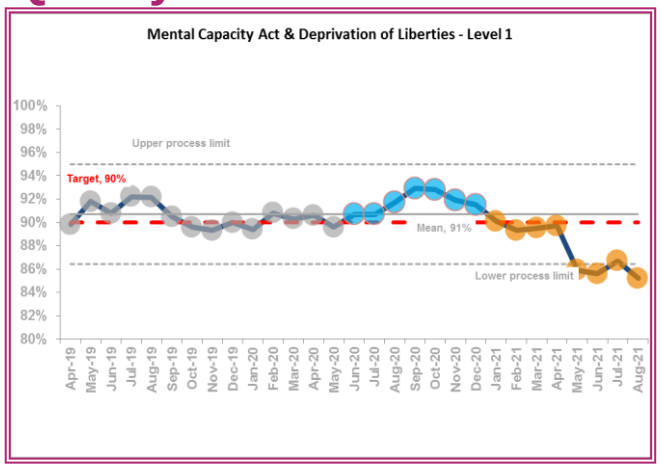
- Open Serious Incident (SI) investigations are being completed in line with external deadlines, 60 working days.
- 96% of incidents at moderate harm and above have had a Duty of Candour completed within 20 working days.

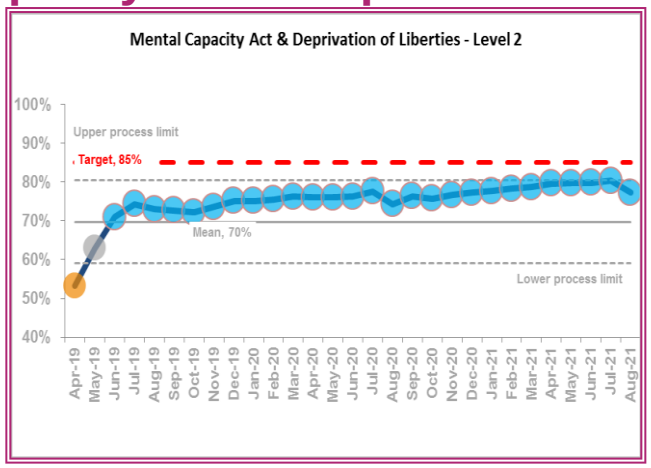
Actions and Quality Improvement Projects

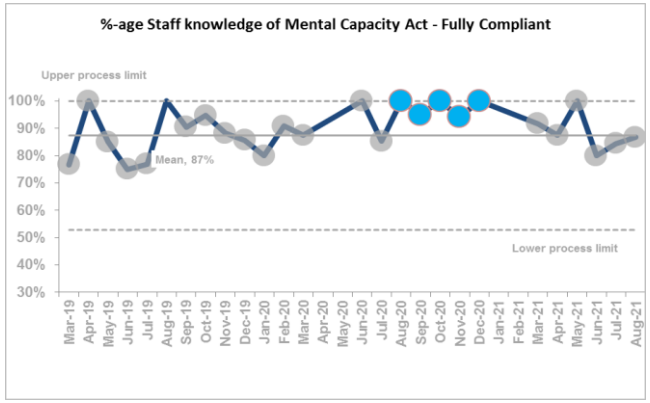
Duty of Candour (DoC) - There were 27 qualifying incidents reported in June 2021 and DoC was completed for 26 incidents within 20 working days.

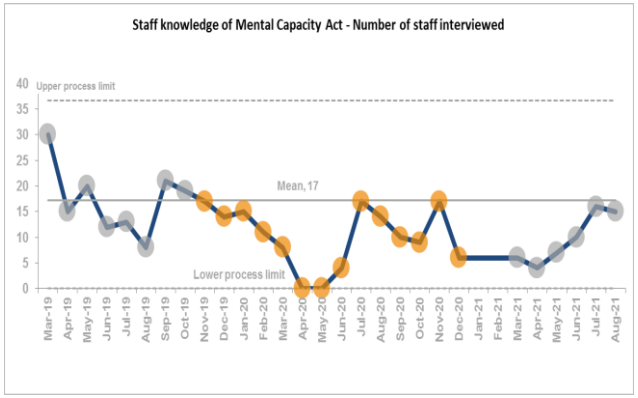
Significant improvement has been noted with DoC compliance. This continues to be monitored and support provided to the relevant departments in order to continually improve compliance.

Quality Priorities – Mental Capacity Act & Deprivation of Liberties









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

What the information tells us

- Mental Capacity Act and Deprivation of Liberties (MCA/DoLs) Training – Level 1 shows special cause deteriorating performance with the past seven months below the 2019/20 average.
- Level 2 training performance has seen a consistent increase. Overall Level 2 compliance was 77% this month.
- Metrics showing the number of staff interviewed and their level of knowledge was suspended in January and February 2021.These interviews resumed in March.

Actions and Quality Improvement Projects

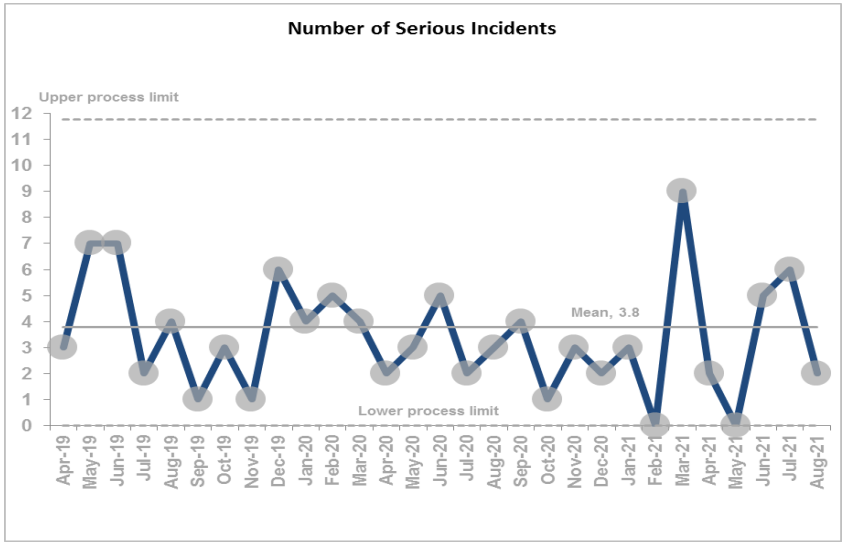
The Trust has successfully appointed a new MCA Lead who started in September 2021.

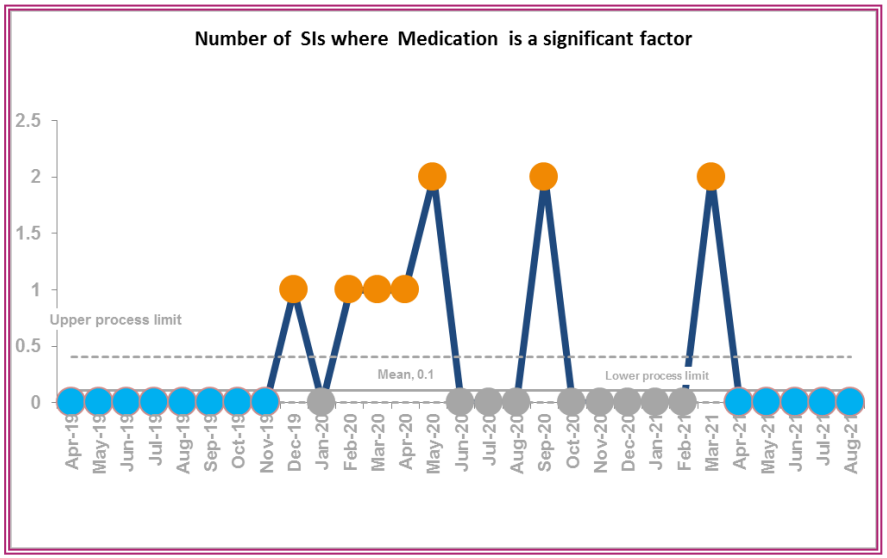
The MCA renewal training includes a competency ‘quiz’ to evidence existing knowledge and streamline the process for clinical staff. This is currently under development with support from the training and education team. It is expected for the project to be completed in October 2021.

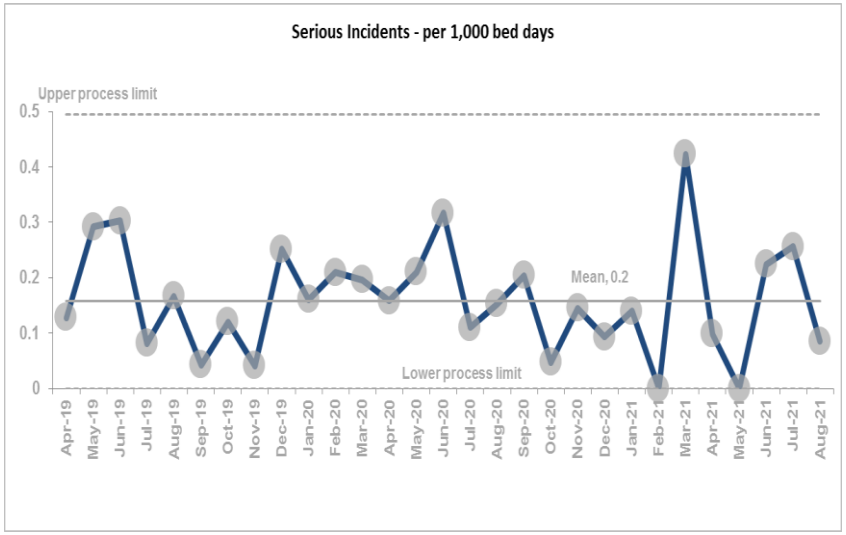
The team is working with senior stakeholders to prepare for the change from Deprivation of Liberty Safeguards (DoLS) to the Liberty Protection Safeguards (LPS) in April 2022. This change will significantly increase the Trust’s role and legal responsibilities relating to patients who might meet the criteria for Deprivation of Liberty. The MCA and LPS Steering Group will oversee training, audit, and plan for LPS implementation.

Patient Safety- Serious Incidents

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



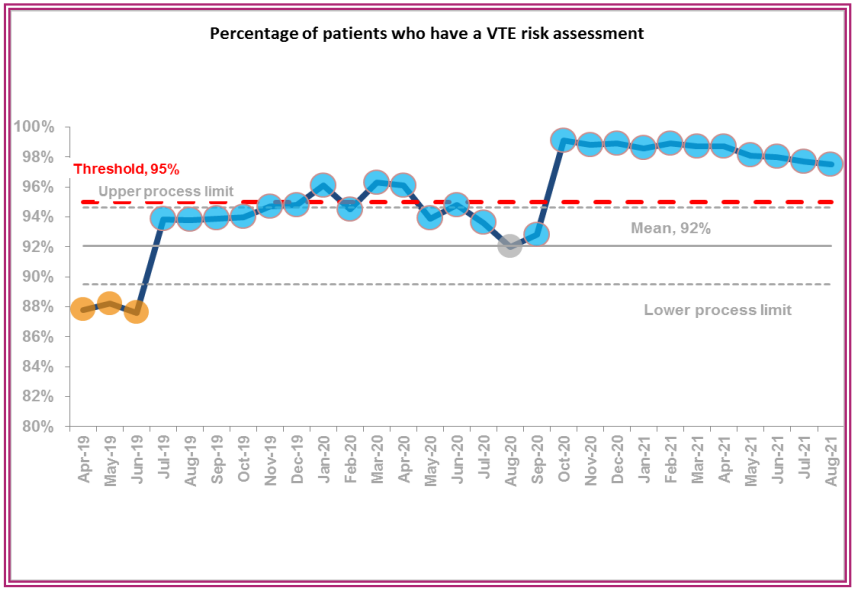


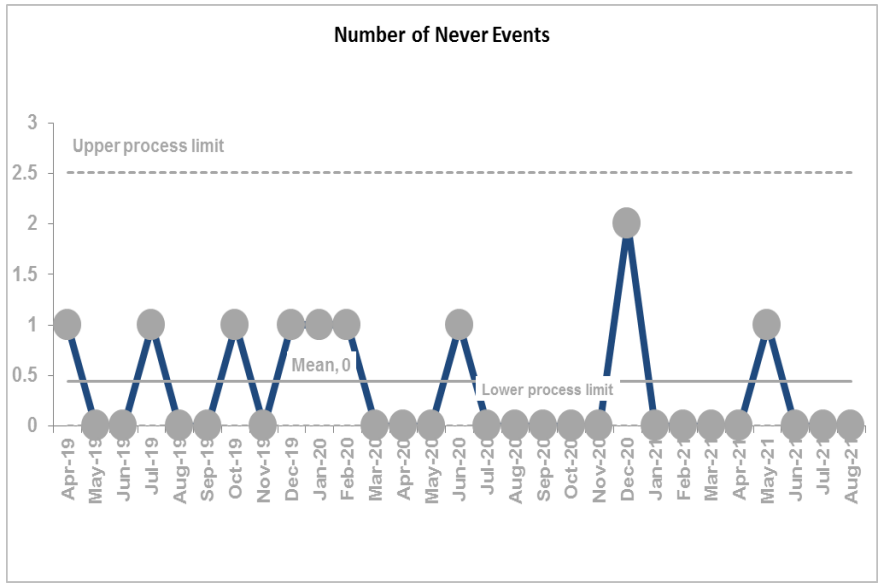


What the information tells us

- Serious Incident (SI) investigations are being completed in line with external deadlines, 60 working days.
- Common cause variation is seen in the number of Serious Incidents and the number of Serious Incidents per 1,000 bed days.

Patient Safety- VTE and Never Events





What the information tells us

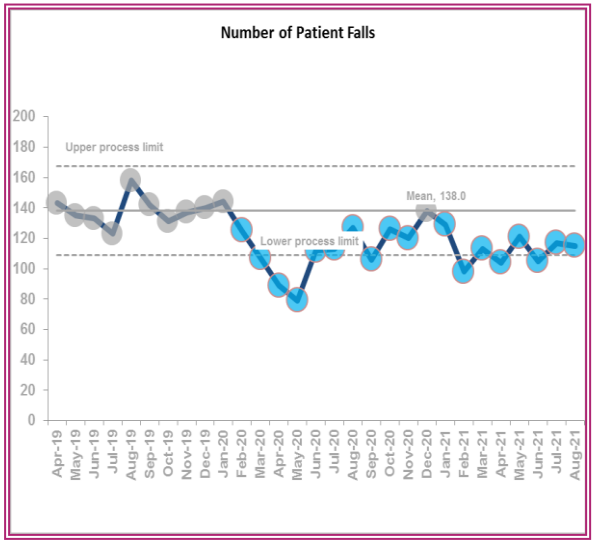
- The percentage of patients who have had a VTE risk assessment was 97.5% against a target of 95%.
- There were no Never Events declared in August 2021.

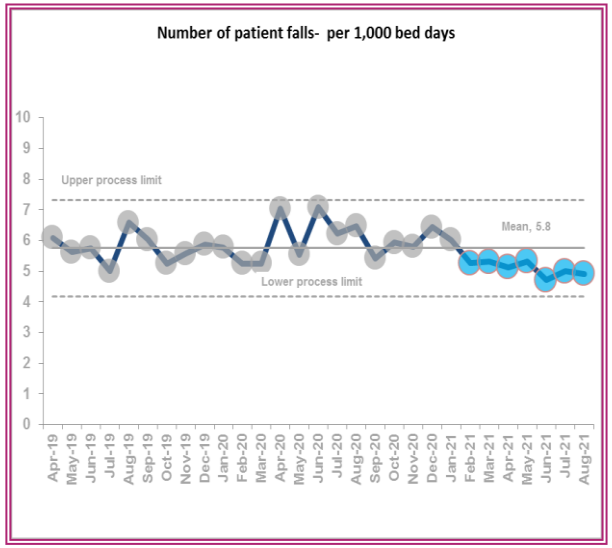
Actions and Quality Improvement Projects

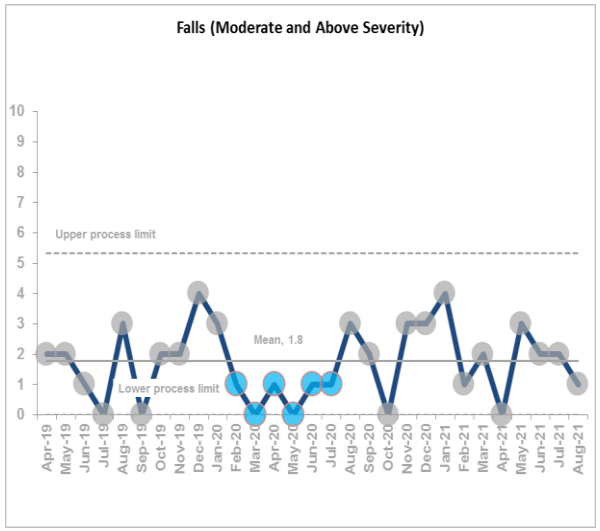
- The Hospital Thrombosis Group (HTG) continue to monitor VTE performance through Tableau reporting, the pharmacy VTE audit and hospital acquired thrombosis root cause analysis.
- The Covid VTE prophylaxis policy has also been updated based on NICE guidance published in September 2021.

Patient Safety- Falls

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







What the information tells us

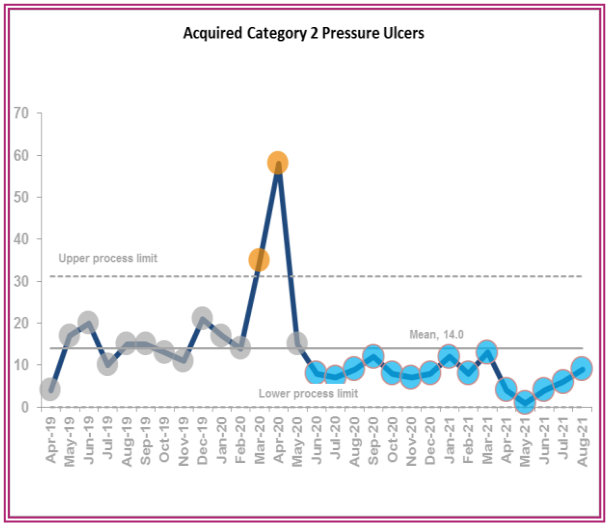
- The number of Patient Falls per 1,000 bed days shows special cause improvement.
- One patient had a fall in month with a severity of moderate or above.

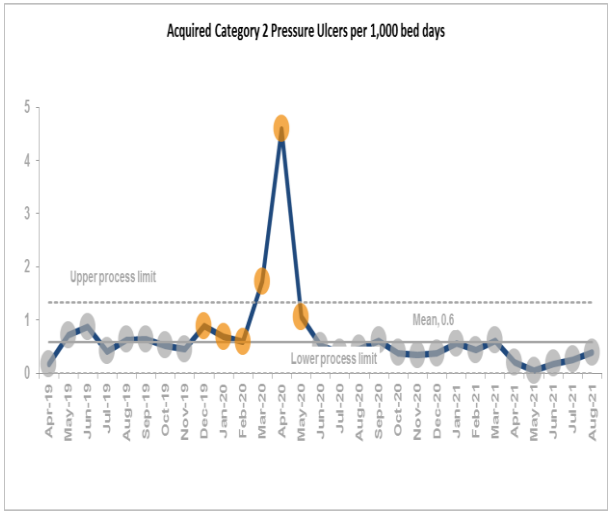
Actions and Quality Improvement Projects

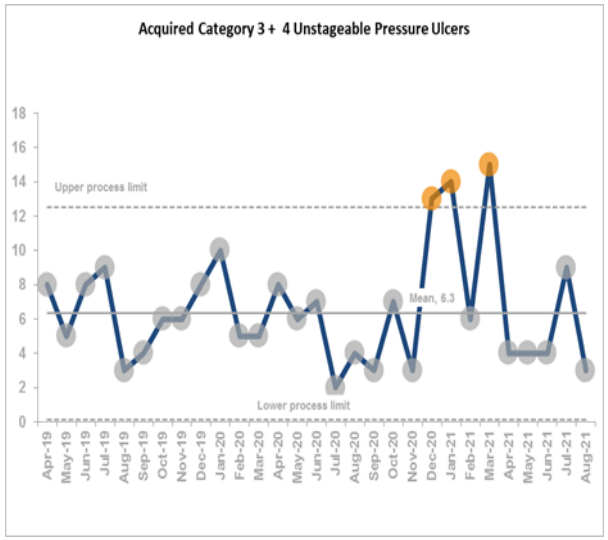
- Falls prevention measures continue to be implemented across inpatient wards and falls incidents are monitored and reviewed locally by senior nursing teams.
- National Falls Awareness week is 20 to 26 September 2021 and the following initiatives are planned:
  - Falls Prevention Study day on 21 September 2021
  - Falls Awareness Stand hosted in the Courtyard of Atkinson Morley wing on 23 September 2021
  - Regular communication throughout the week to increase awareness about the risks of falls and how to maintain patient safety.

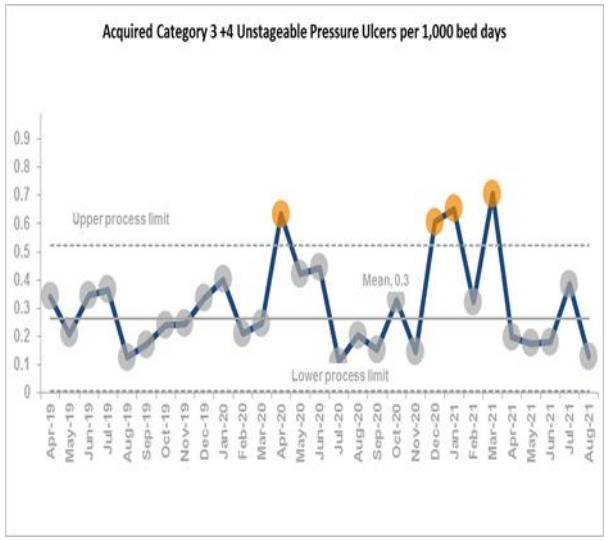
Patient Safety- Pressure Ulcers

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









What the information tells us

- The number of Category 2 Pressure ulcers shows special cause variation with an improving.
- Both 2 Pressure ulcers per 1,000 bed days show common cause variation..
- The number of Category 3 & 4 Unstageable Pressure Ulcers shows common cause variation.
- Category 3, 4 and Unstageable Pressure ulcers per 1000 bed days shows special cause variation with a deteriorating position

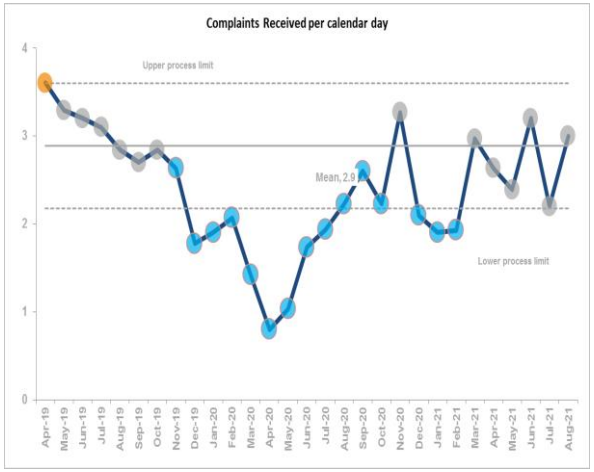
Actions and Quality Improvement Projects

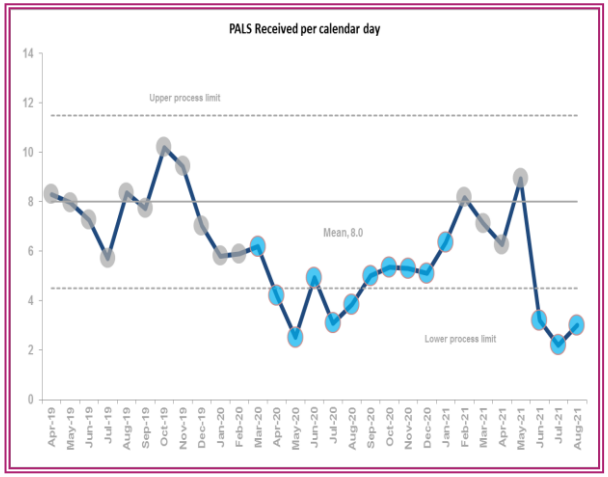
The trust IQPR report reflects the NHSI 2018 recommendations for the report of pressure ulcers.

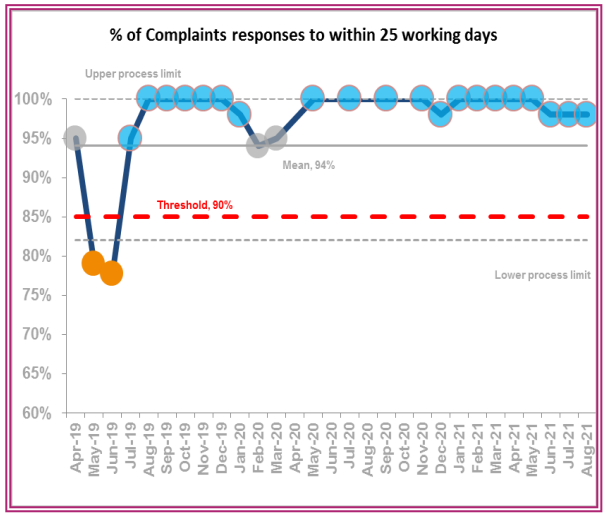
- Acquired category 2 pressure ulcers;
- Acquired category 2 pressure ulcers caused by medical devices;
- Acquired category 3, 4 and unstageable pressure ulcers;
- Acquired category 3, 4 and unstageable pressure ulcers caused by medical devices.

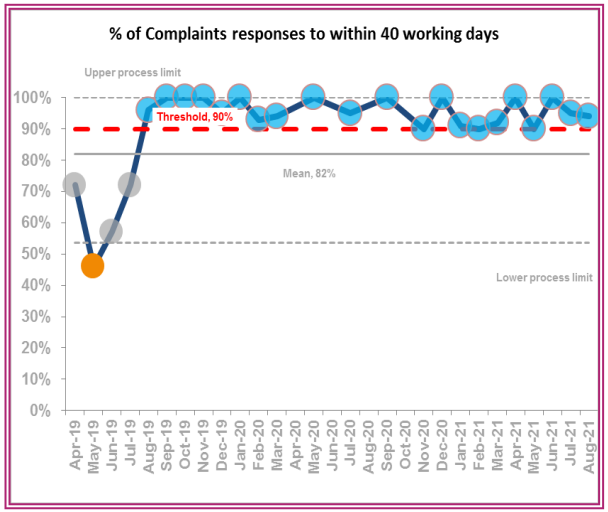
Complaints

Indicator Description	Target	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
Complaints Received per calendar day		2.2	2.6	2.2	3.3	2.1	1.9	1.9	3.0	2.6	2.4	3.2	2.2	3
% of Complaints responses to within 25 working days	85%	100%	100%	100%	100%	98%	100%	100%	100%	100%	100%	98%	98%	98%
% of Complaints responses to within 40 working days	90%	100%	100%	94%	90%	100.0%	91%	90%	92%	100%	90%	100%	95%	94%
% of Complaints responses to within 60 working days	100%	100%	N/A	N/A	N/A	100%	100%	100%	100%	N/A	100%	50.0%	N/A	N/A
Number of Complaints breaching 6 months Response Time	0	0	0	0	0	0	0	0	0	0	0	0	0	0









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

What the information tells us

- The number of complaints per calendar day shows common cause variation.
- All response categories continue to be within target.

Actions and Quality Improvement Projects

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

Our Patient Perspective

Outstanding care every time

Infection Control

Indicator Description	Threshold 2021-2022	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	YTD Actual
MRSA Incidences (in month)	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0
Cdiff Hospital acquired infections	52	3	2	0	5	5	1	3	2	2	2	2	0	3	12
Cdiff Community Associated infections		0	1	0	0	3	1	0	1	1	0	0	0	2	
MSSA	25	4	2	3	5	4	8	5	5	5	3	3	3	3	14
E-Coli	111	0	6	6	3	9	6	6	6	7	6	5	6	5	29
Nosocomial Infections Hospital Onset healthcare associated (>14 days) HOHA	N/A	0	0	7	28	62	59	24	0	2	0	0	0	18	20
Nosocomial Infections Hospital Onset Probable associated (8-14 days) HOPA	N/A	1	0	0	28	76	56	35	4	0	1	1	0	10	12

What the information tells us

There were 18 Hospital Onset Healthcare Associated cases (HOHA) of Covid-19 during August 2021, where the sample was taken >14 days after admission and 10 Hospital Onset Probable Associated (HOPA) cases where the specimen was taken 8-14 days after admission. There has been a significant outbreak of Covid-19 on a ward with 21 cases: 14 HOHA and 5 HOPA cases. The outbreak is currently the subject of a serious incident investigation.

There were no MRSA bacteraemia reported in August 2021.

There were 5 incidents of patients with C. *difficile* infection during August. This consisted of 3 Hospital Onset Healthcare Associated, where the specimen was taken beyond admission day plus one day; and 2 Community Onset Healthcare Associated (COHA), where the specimen was taken within admission day plus one day and where the patient had also been an inpatient in the previous 4 weeks. Each case will be reviewed to identify if there were any lapses in care e.g. in antimicrobial prescribing, patient isolation or environmental or medical device cleanliness. Since April 2021 there have been a total of 12 cases consisting of 9 HOHA and 3 COHA cases. NHSI/E have set a trajectory of no more than 52 cases for 2021-22 or no more than 4.3 cases per month. At the end of August, the Trust has 12 cases against a trajectory of no more than 21 for this point in the year. The Trust is therefore under this trajectory.

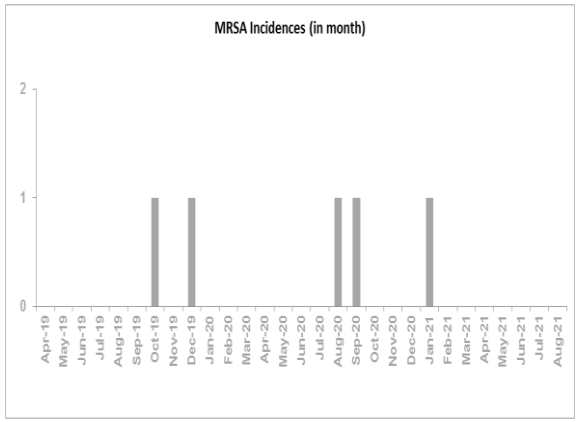
There were 3 patients with Trust apportioned MSSA cases in August and 5 cases of Trust apportioned *E. coli* bacteraemia. A new NHSI/E trajectory has been set for *E.coli* bacteraemia of no more than 111 cases for 2021-2022 or no more than 9 cases per month. Since April 2021, there have been a total of 29 cases, against a trajectory of no more than 45 for this point in the year. The Trust is therefore under this trajectory.

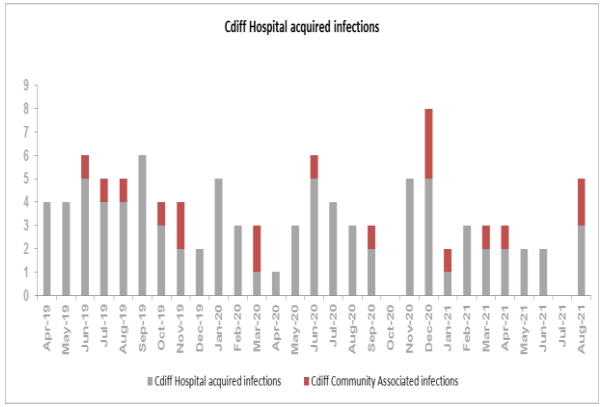
Actions and Quality Improvement Projects

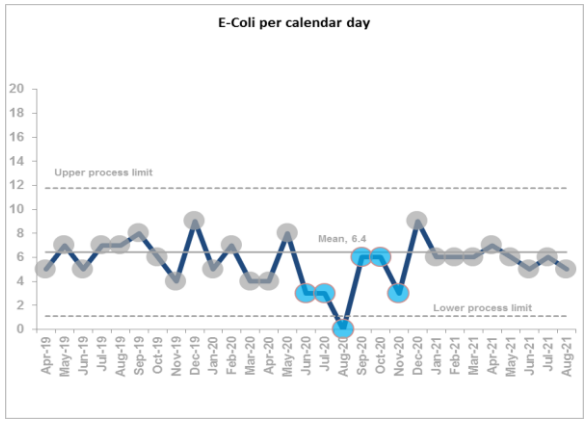
National COVID-19 data submissions continue to be validated daily and signed off by the Chief Nurse and Director of Infection Prevention and Control. IPC has been involved in winter planning discussions.

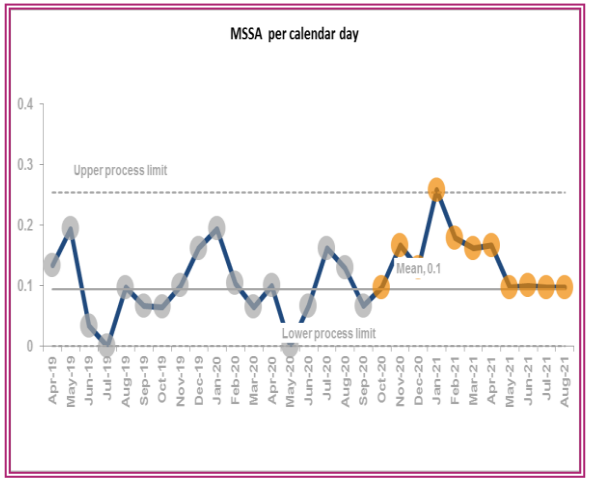
Infection Control

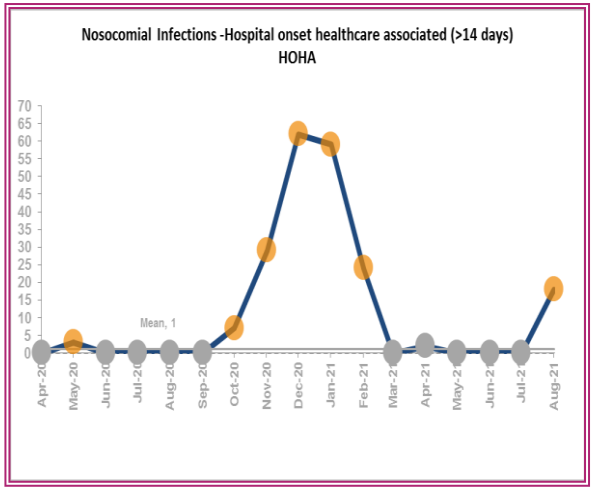
Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance

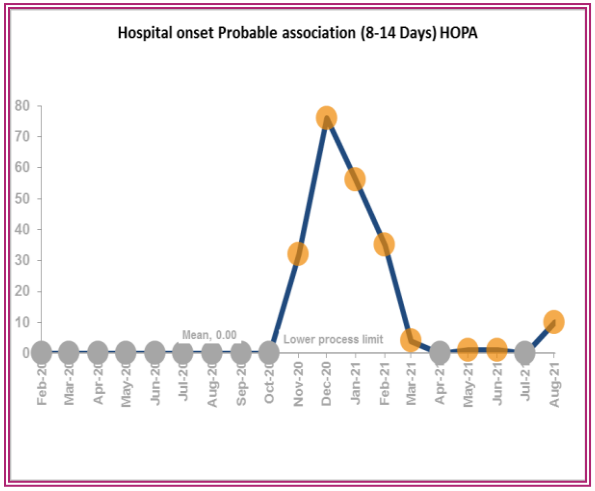












2.2

Our Patient Perspective

Mortality and Readmissions

Indicator Description	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-21	Mar-21	Apr-21	May 2020 to Apr 2021
Hospital Standardised Mortality Ratio (HSMR)	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	108.7	108.7	108.7	91.7
Hospital Standardised Mortality Ratio Weekend Emergency	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	120.9	120.9	120.9	111.6
Hospital Standardised Mortality Ratio Weekday Emergency	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	107.3	107.3	107.3	85.8

Indicator Description	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	Jan-20-Dec-20	Feb-20-Jan-21	Mar-20-Feb-21	Apr-20-Mar-21
Summary Hospital Mortality Indicator (SHMI)	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	0.84	0.83	0.83	0.82

Indicator Description	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21
Emergency Readmissions within 30 days following non elective spell (reporting one month in arrears)	10.4%	11.2%	11.3%	9.7%	9.5%	9.6%	8.9%	10.6%	10.6%	10.0%	9.7%	10.0%	10.0%	8.8%

Note: HSMR data reflective of period April 2020– March 2021 based on a monthly published position. This month as a result of problems with Dr Foster there is no update to the data previously reported showing discharges Mar 2021.

SHMI data is based on a rolling 12 month period and reflective of period April 2020 to March 2021 published (August 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 May 2020 – April 2021. We are one of 14 trusts in this category, and one of 11 trusts that also had a lower than expected number of deaths for the same period in the previous year. Unfortunately, we have not been able to access updated HSMR from the Dr Foster platform as Telstra Health UK, who provide the Dr Foster platform, continue to encounter issues with their data processing.

The data quoted above therefore remains the same as reported the previous month, which was provided directly by Telstra. This shows that for April 2020 - March 2021 both our HSMR and the HSMR for patients admitted as an emergency on a weekday are lower than expected. For patients admitted as an emergency at the weekend our mortality is as expected.

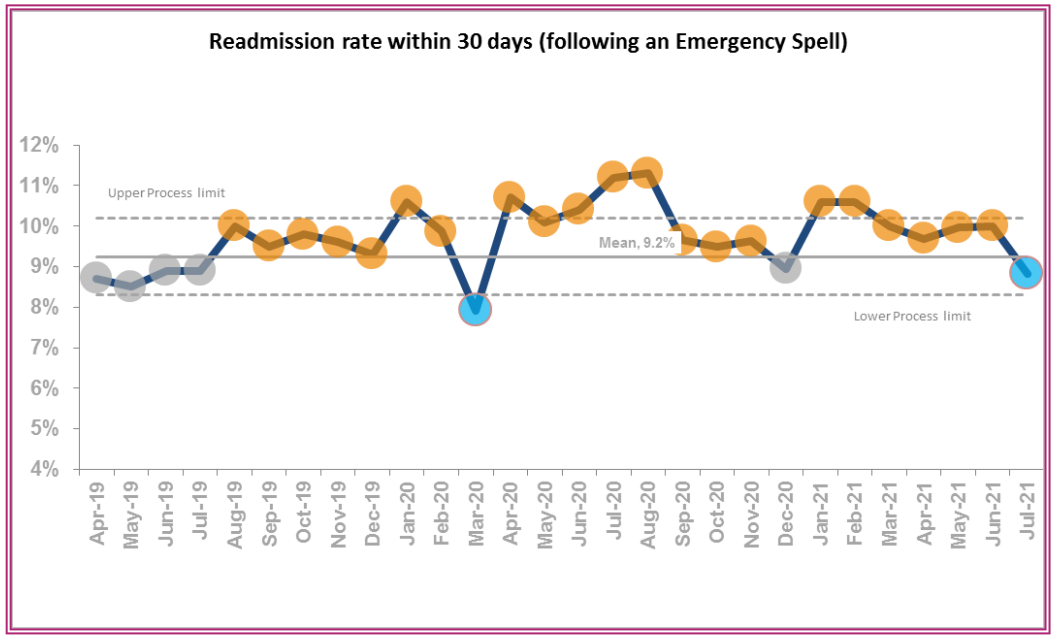
Actions and Quality Improvement Projects

In order to provide some level of assurance that outcomes as measured by the HSMR have not changed significantly since the last Dr Foster update we have sourced information from an alternative platform, Healthcare Evaluation Data (HED).

This platform shows that our HSMR for the period July 2020 to June 2021 is 86.35, which is lower than expected. For June 2021 the HSMR is 73.1, which is within expected range. The Trust is considering utilising HED data to monitor mortality rather than Dr Foster as we are committed to considering consistent and reliable data

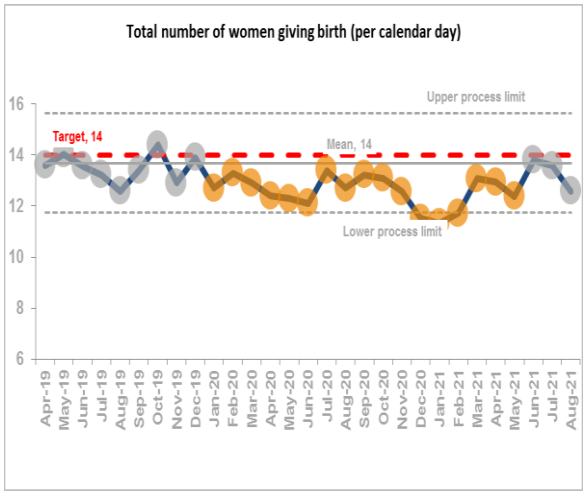
Mortality and Readmissions (Hospital Standardized Mortality Rate)

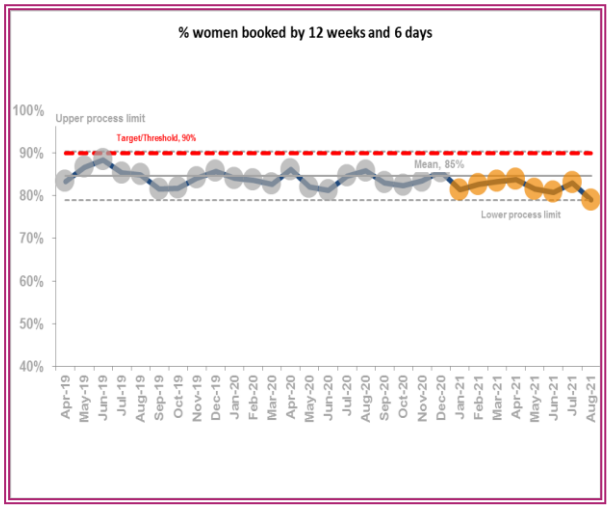
Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance

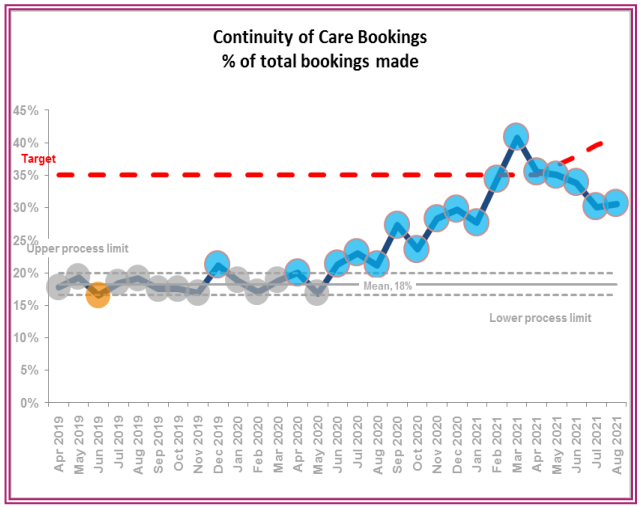


Maternity

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







The clinical acuity and complexities remained high in August. Significant staffing challenges also continued and the difficult but right decision was made to proactively divert Birth Centre staff and activity to the Delivery Suite to ensure patient safety. This resulted in closure of the Carmen Suite of 74.2% . We achieved a lower than expected rate of supernumerary status of the Labour Ward coordinator at 90% which was reflective of the midwifery staffing challenges. There was 1 neonatal death of a female infant at 24 weeks. There were no stillbirths in month. There were 2 unexpected adult admissions to ITU this month which will be reviewed via the maternity governance process.

Actions and Quality Improvement Projects

The current staffing challenges have not enabled the anticipated improved position in antenatal bookings by 12+6 weeks. Antenatal screening has not been affected. There is further administrative and workflow analysis to improve this position as staffing allows. All non-patient facing midwives, matron and speciality teams have been supporting the clinical areas and service by working clinically 50% of the time.

The centralised Maternity Telephone Helpline is on schedule to go live by October 2021. This will provide timely access to advice and information and will facilitate consistent and documented advice as well as clinically appropriate signposting.

Work continues with our Maternity Voices service user group and wider volunteer groups to create emergency ‘care packs’ for un-booked, refugee and asylum seeker families who we have noted to be represented more highly this month. Support has been provided in the provision of basic hygiene and sanitary products for mother and baby which our Maternity Voices, charity and local ‘Little Village’ team have helped to supply.

Recruitment has continued for the additional 15.6WTE midwives and 0.5WTE Obstetric Consultant secured from the Ockenden Workforce bid. The teams have also submitted a bid to Capital Midwife to take part in International Recruitment of Midwives to support the workforce gap. The team have also submitted a bid for an additional £50K to introduce a leadership role to support Preceptorship midwives in clinical practice throughout their transition period as new registrants.

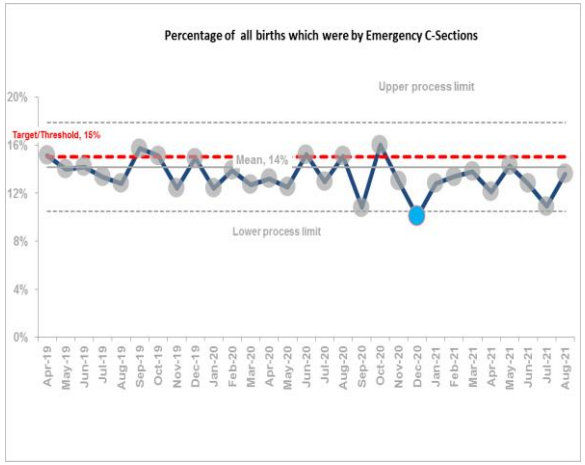
Maternity

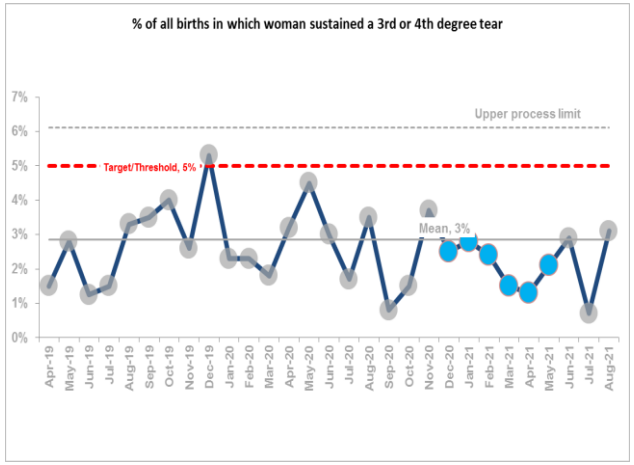
Maternity Dashboard

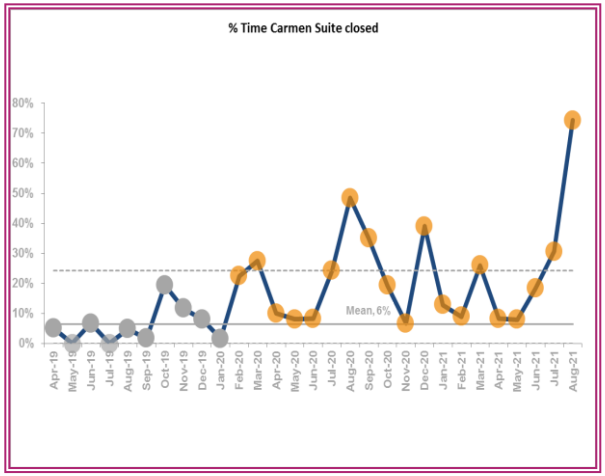
Definitions	Target	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
Total number of women giving birth (per calendar day)	14 per day	12.7	13.2	13.1	12.6	11.5	11.3	11.7	13.1	12.9	12.4	13.8	13.6	12.6
Caesarean sections (Total Emergency and Elective by Delivery date)	<28%	27.1%	23.4%	30.9%	27.3%	23.8%	28.5%	28.0%	29.1%	25.5%	27.6%	24.6%	24.7%	27.2%
% deliveries with Emergency C Section (including no Labour)	<8%	4.6%	3.0%	3.7%	2.9%	3.4%	2.3%	3.4%	4.0%	3.4%	3.9%	1.9%	3.6%	2.6%
% Time Carmen Suite closed	0%	48.4%	35.0%	19.4%	6.7%	39.0%	12.9%	9.0%	26.0%	8.3%	8.0%	18.3%	30.6%	74.2%
% of all births in which woman sustained a 3rd or 4th degree tear	<5%	3.5%	0.8%	1.5%	3.7%	2.5%	2.8%	2.4%	1.5%	1.3%	2.1%	2.9%	0.7%	3.1%
% of all births where women had a Life Threatening Post Partum Haemorrhage >1.5 L	<4%	2.0%	5.3%	2.5%	2.9%	2.5%	3.1%	1.2%	3.2%	2.8%	4.2%	2.4%	3.6%	2.3%
Number of term babies (37+ weeks), with unplanned admission to Neonatal Unit		11	13	20	16	11	13	9	11	8	13	14	13	16
Supernumerary Midwife in Labour Ward	>95%	93.5%	90.0%	100.0%	98.3%	91.9%	100.0%	94.6%	98.4%	98.3%	98.4%	97.0%	88.7%	90.3%
Still Births per 1000 Births	<3	12.6	2.5	7.4	8.0	5.6	2.8	9.1	4.9	2.6	5.2	2.4	7.1	0.0
Neonatal Deaths (KPI 72) per 1000 Births	<3	0.0	2.5	12.3	2.7	5.6	0.0	3.0	2.5	2.6	0.0	0.0	0.0	2.6
Continuity of Care Bookings- % of total bookings made (Target increases monthly by 1.5% towards a 51% target in Mar 22)	36.5%	21.4%	27.3%	23.6%	28.3%	29.7%	27.7%	34.3%	40.08%	35.22%	35.0%	33.8%	30.1%	30.6%
Percentage of all births which were by Emergency C-Sections (KP25+26)	15%	15.1%	10.8%	16.0%	13.0%	10.1%	12.80%	13.4%	13.8%	12.11%	14.30%	12.80%	10.90%	13.6%
% women booked by 12 weeks and 6 days	90%	85.8%	83.0%	82.4%	83.4%	85.6%	81.3%	82.6%	83.3%	83.8%	81.5%	80.8%	83.0%	79.0%
Number of term babies (37+ weeks), with unplanned admission to Neonatal Unit as a percentage of deliveries	6%	2.8%	3.3%	5.1%	4.1%	2.8%	3.3%	2.3%	2.8%	2.0%	3.3%	3.5%	3.3%	4.1%

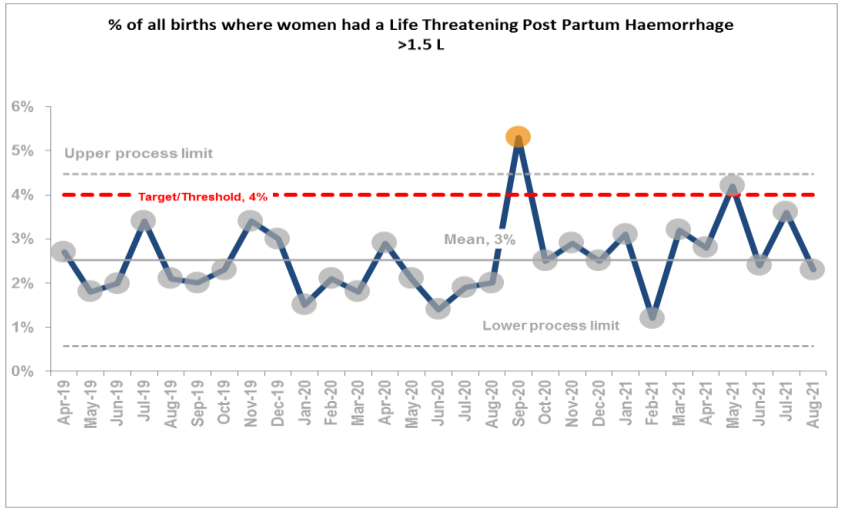
Maternity

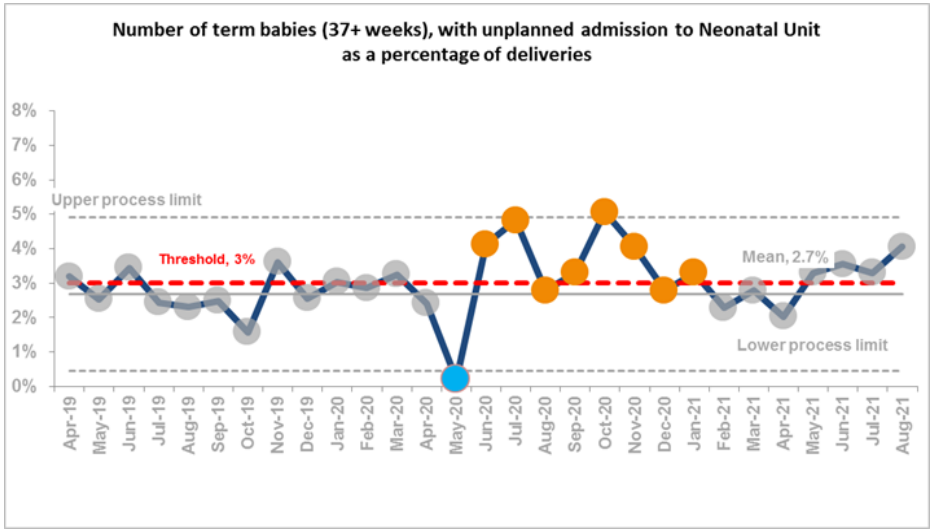
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance











Friends & Family Survey

Indicator Description	Target	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
Emergency Department FFT - % positive responses	90%	90.1%	89.5%	89.7%	89.2%	84.9%	92.1%	90.8%	88.8%	86.4%	83.4%	79.8%	81.6%	78.0%
Inpatient FFT - % positive responses	95%	97.2%	96.3%	97.1%	98.6%	97.9%	99.0%	98.3%	99.3%	98.2%	97.1%	97.5%	97.2%	98.4%
Maternity FFT - Antenatal - % positive responses	90%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	50.0%	N/A	N/A	N/A	100.0%	50.0%
Maternity FFT - Delivery - % positive responses	90%	N/A	66.7%	N/A	94.6%	100.0%	90.4%	93.0%	91.6%	88.9%	100.0%	90.0%	100.0%	N/A
Maternity FFT - Postnatal Ward - % positive responses	90%	100.0%	N/A	100.0%	0.0%	100.0%	N/A	N/A	81.8%	100.0%	95.8%	91.9%	100.0%	0.0%
Maternity FFT - Postnatal Community Care - % positive responses	90%	N/A	N/A	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%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	91.7%	87.5%	91.7%	100.0%	100.0%
Outpatient FFT - % positive responses	90%	89.1%	89.0%	89.1%	89.5%	90.3%	96.9%	90.4%	95.2%	88.7%	91.3%	90.7%	91.0%	89.8%

What the information tells us

- Inpatient and Community services achieved FFT targets where patients rated the services as "Good" or "Very Good“. All other services saw a fall in performance. Performance for Emergency Department FFT fell to 78% this month showing special cause deterioration.

Actions and Quality Improvement Projects

For the Emergency Department, the service moved from an external provider to the Trust’s FFT collection system in January 2021, since then there has been a significant drop in reported response rate and additionally there have been significant operational pressures in the department which has impacted on waiting times. Feedback request posters with a QR code have been created within the department and exit areas to give patients and visitors further opportunity to feedback at the time of discharge from the Emergency Department.

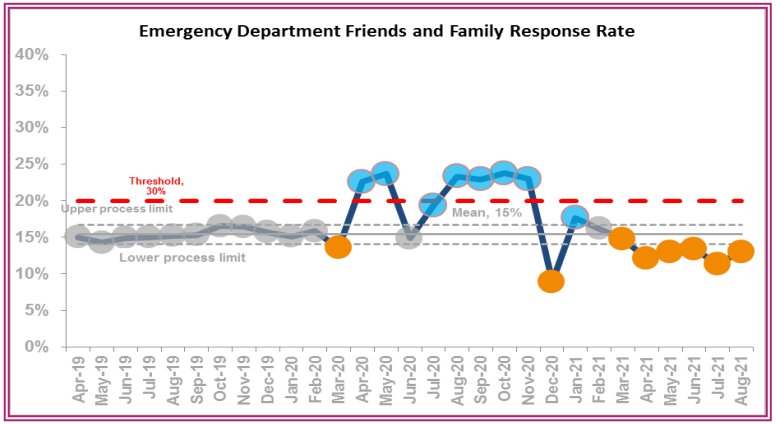
Work continues with the Corporate Nursing Quality team to verify current patient contact details in iCLiP fields checking they are present and in correct place to improve percentage of attendees asked to give feedback.

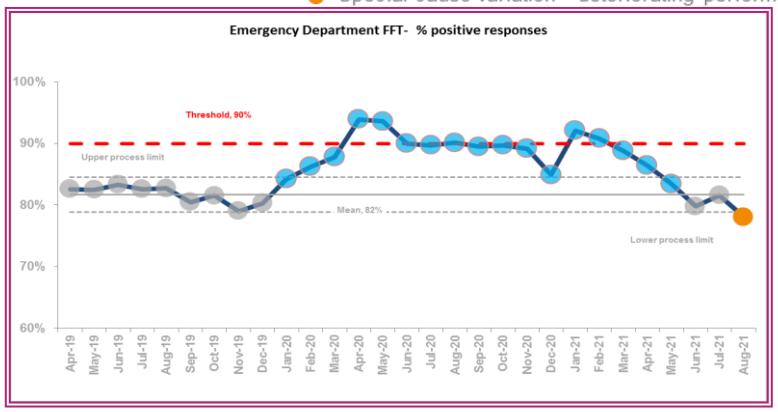
For the postnatal ward and antenatal services previous data capture had been undertaken by Trust volunteers and since Covid-19 the service has not had this support hence the variable nature of non-reporting above. In July support to capture FFT was identified in antenatal services for that month only. Going forward the service will discuss the return of volunteers to the postnatal ward environment to assist with this data capture, allocate the task to a HCA with overview by Midwife in Charge (where maternity staffing permits), and refresh posters and signage encouraging women to request to complete.

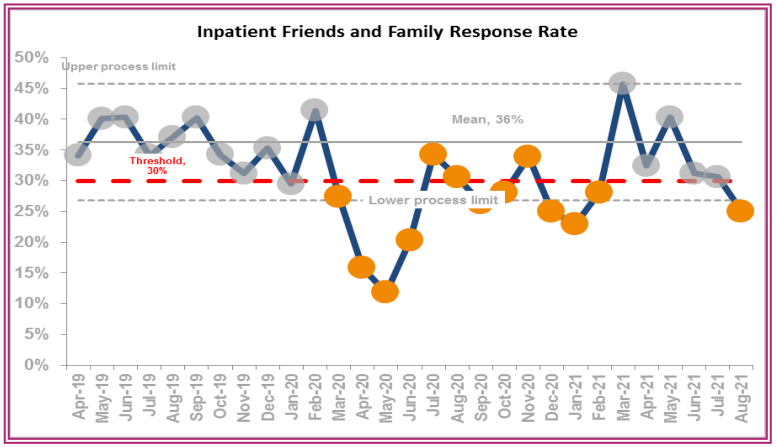
Posters will also be developed with QR codes for display in areas across the Trust to assist with the capture of FFT.

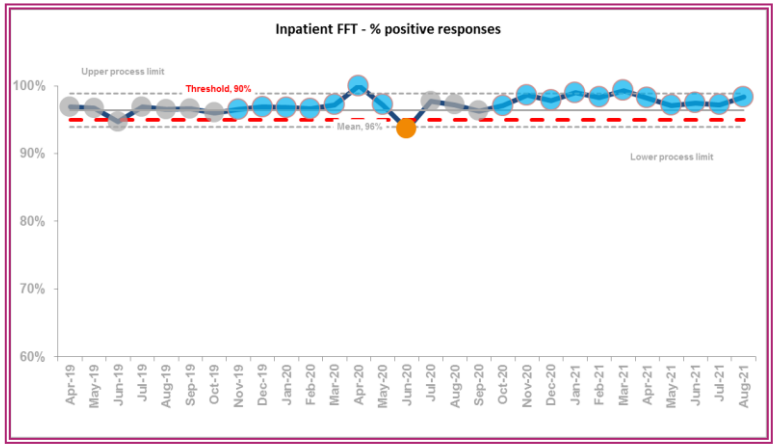
Friends and Family Test

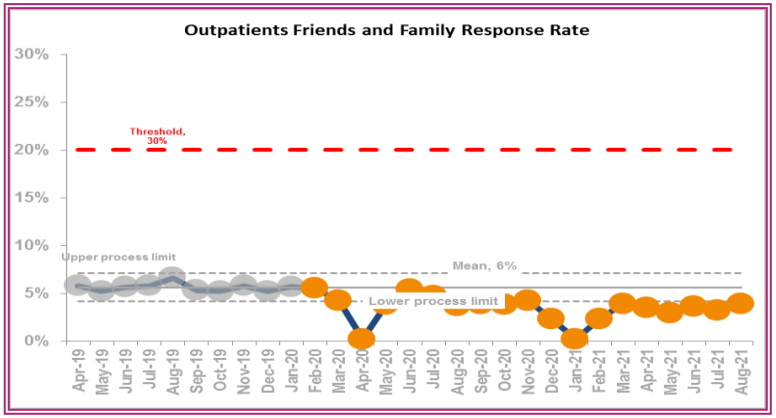
Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance

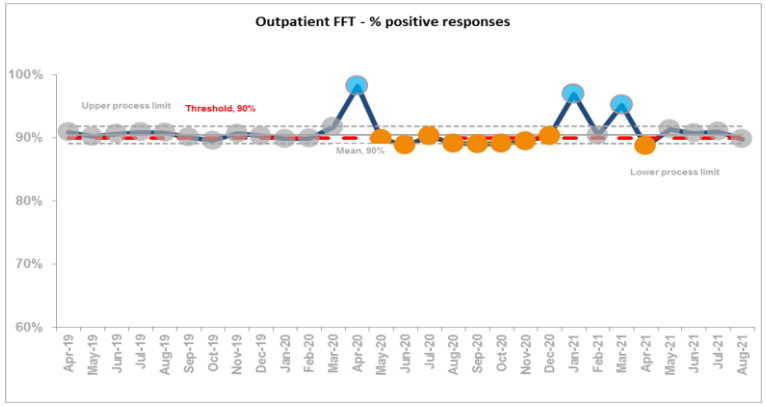










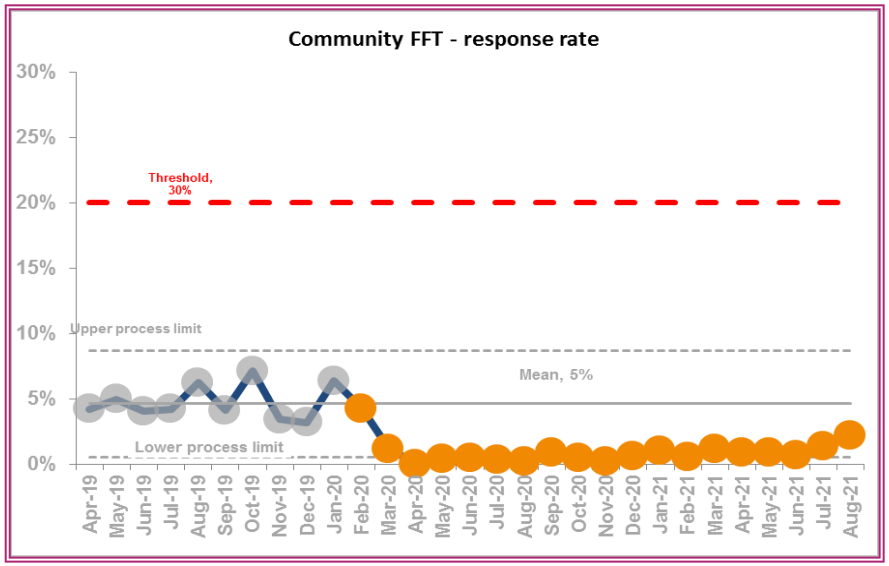


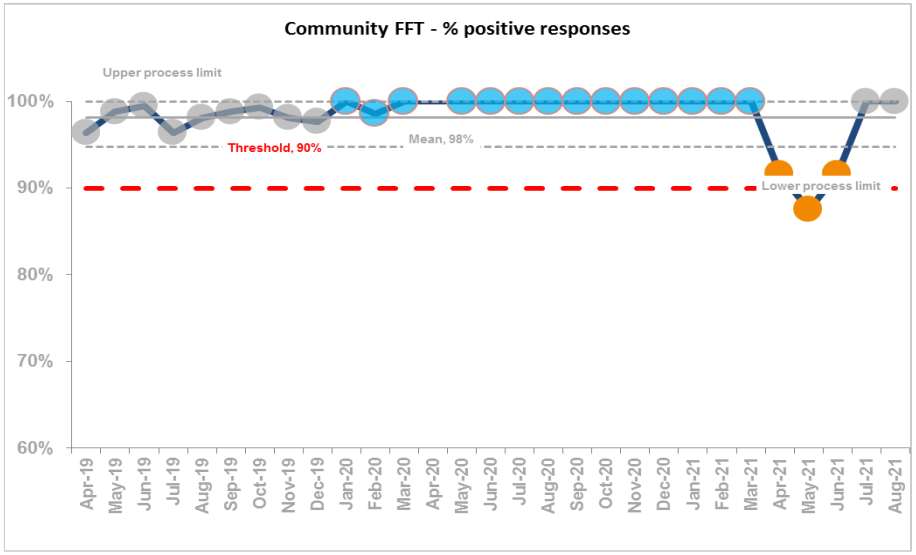
2.2

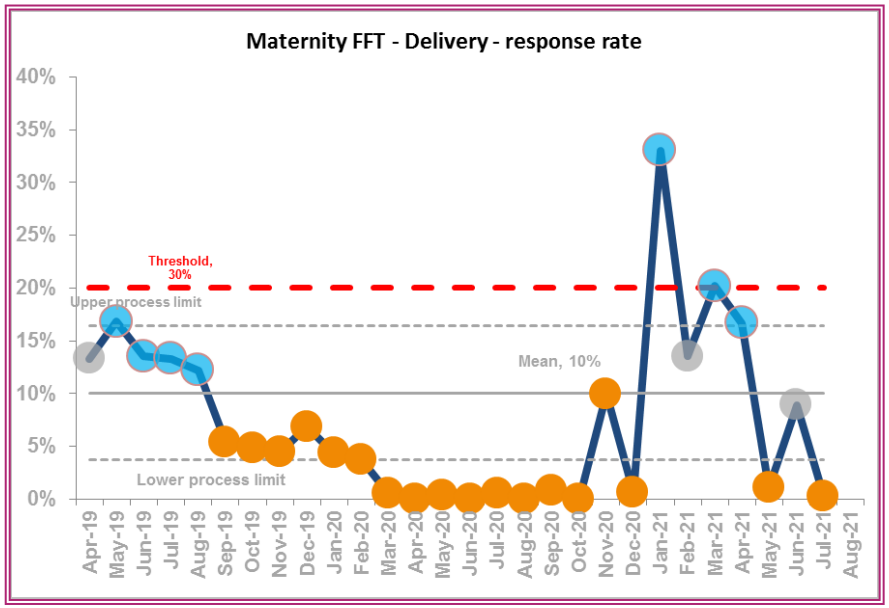
Our Patient Perspective

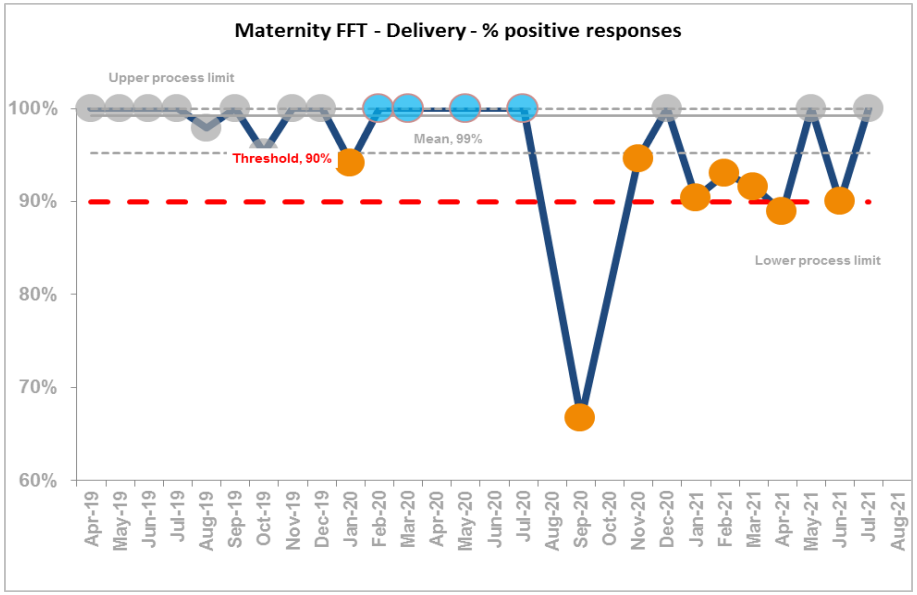
Friends and Family Test

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









Balanced Scorecard Approach

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

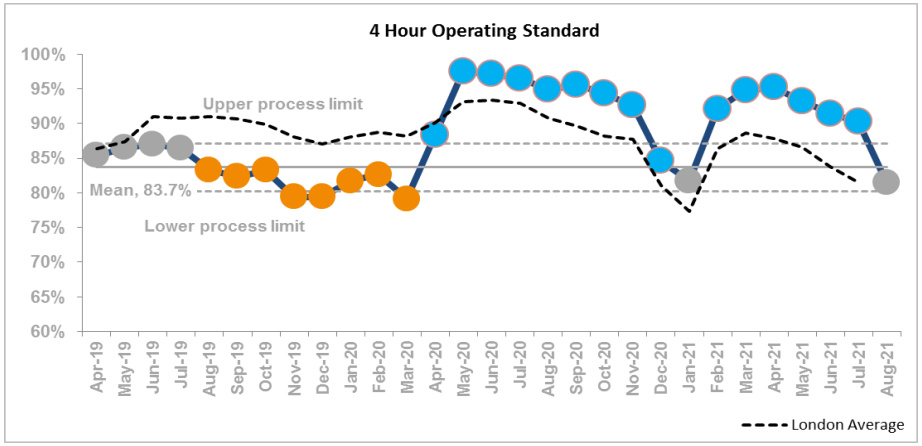
Key

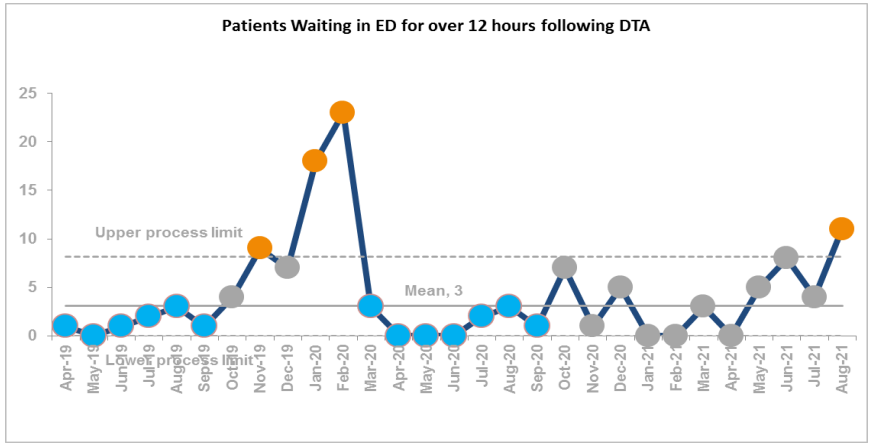
Current Month

A Previous Month

Scorecard RAG rating based on PreCOVID-19 plan

Emergency Flow





What the information tells us

Performance against the Four-Hour Operating Standard fell in August with 81.5% of patients attending the Emergency Department (ED) either discharged, admitted or transferred within 4 hours of their arrival. Compared to the same month in 2019 daily attendances were on average 13% lower with Four Hour performance 1.8% lower, however with the impact of COVID 19 still widely evident, and the acuity of patients attending the emergency department is 5% higher than August 2019; capacity and flow throughout the Trust has been challenged. The Trust escalated to Internal OPEL 3 status for 16 days of the month.

Admitted pathway performance although remaining above the upper control limit has seen a downward trend against a rising bed occupancy rate. Non-admitted pathway performance remains consistently above the upper control limit showing special cause improvement.

Occupancy continues to rise with AMU midday occupancy exceeding 90% and General and Acute Bed midnight occupancy at 86%; high occupancy coupled with increasing patients staying in excess of 7, 14 and 21 day has impacted flow across the Trust.

A higher level of acuity was seen in the patients attending ED throughout August with, on average, 48% of patients scoring between 1-3 on the Manchester Triage Score System with very high variation daily with some days reaching 61% of patients being acutely unwell.

Eleven patients breached the 12-hour ED target where no patient should wait longer than 12 hours before they are admitted to a ward.

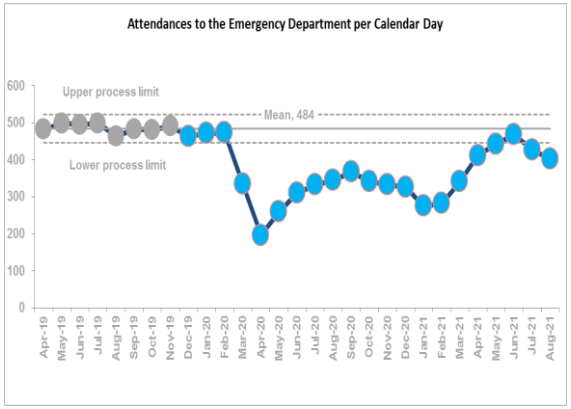
London Ambulance handover times against the 30-minute standard fell below the upper control limit, this was in line with the London average falling.

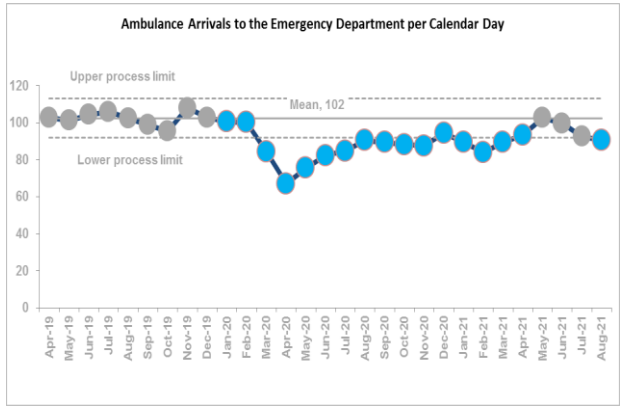
Actions and Quality Improvement Projects

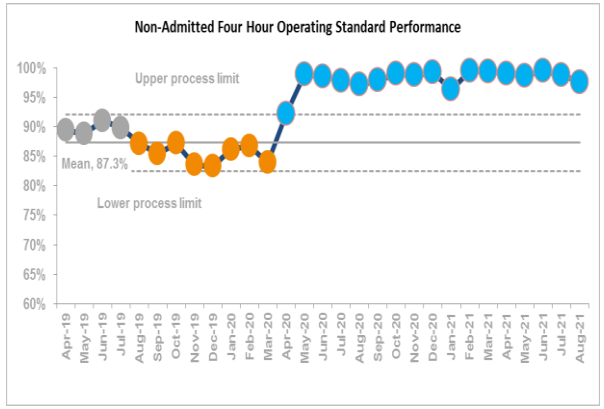
- New LIAT POCT being introduced in late September, will allow fully accurate COVID tests within 20 mins helping flow from the Department and for patients to go directly to most appropriate ward
- Currently conducting an audit to determine if there are any issues with respect to primary care access and will share findings with commissioners.
- In-Hours GP service will be taken over by SGH in October which will allow for improved capacity and consistency of GP provision within ED.
- EDCK.IN is being further developed in September to enable patients to be called back to ED when they are near to being seen to help decompress the waiting room and enhance patient experience.
- 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 addressed through engagement with the mental health providers.

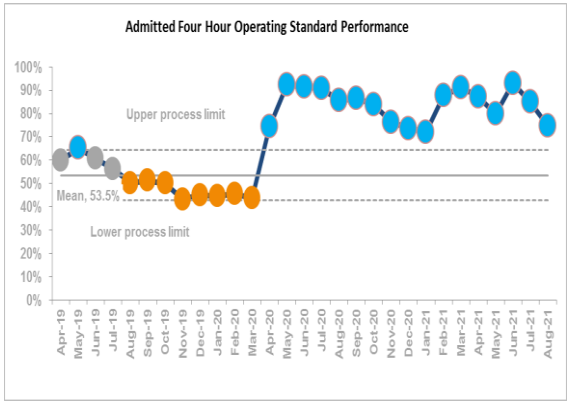
Emergency Flow

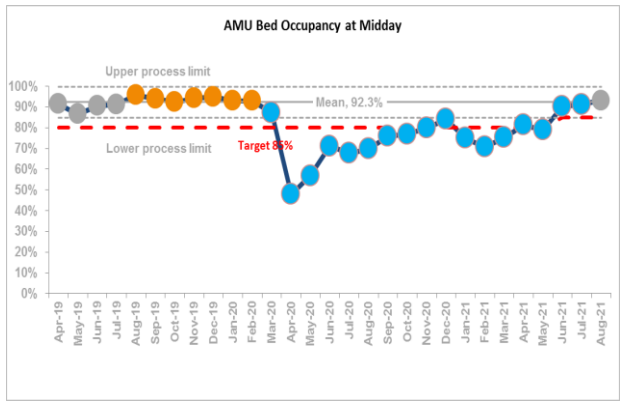
Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance

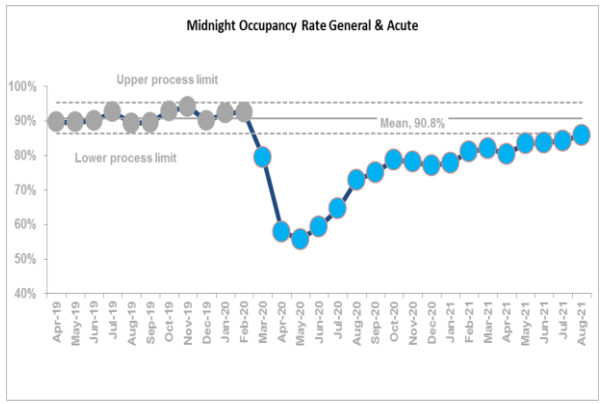


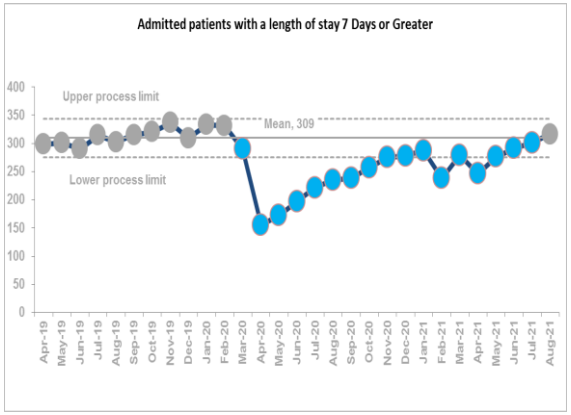


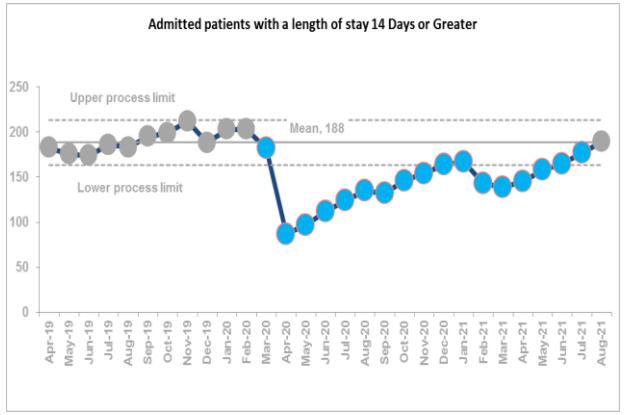


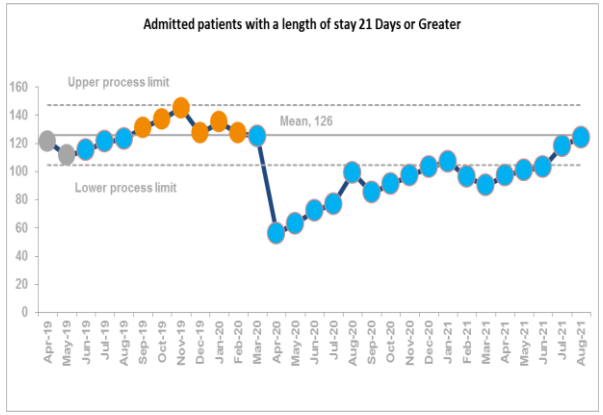






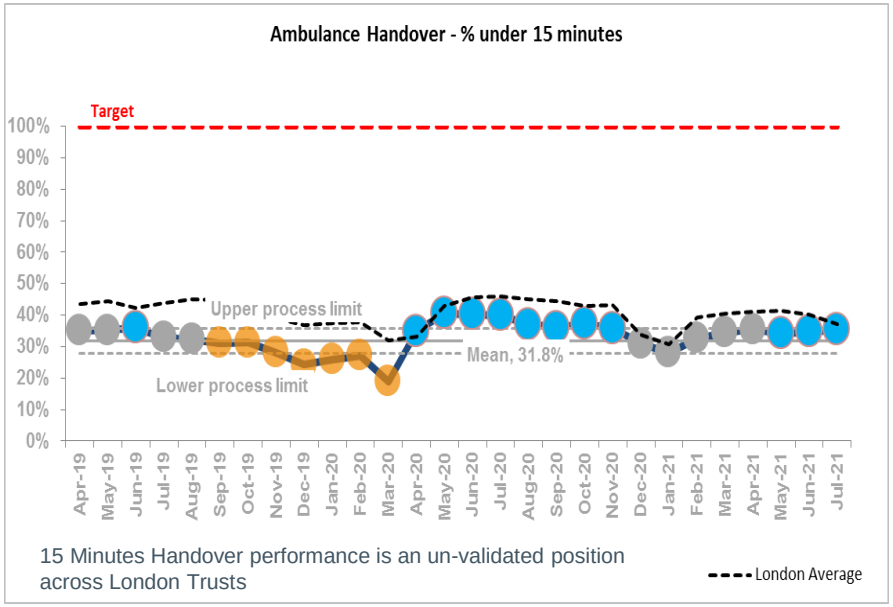




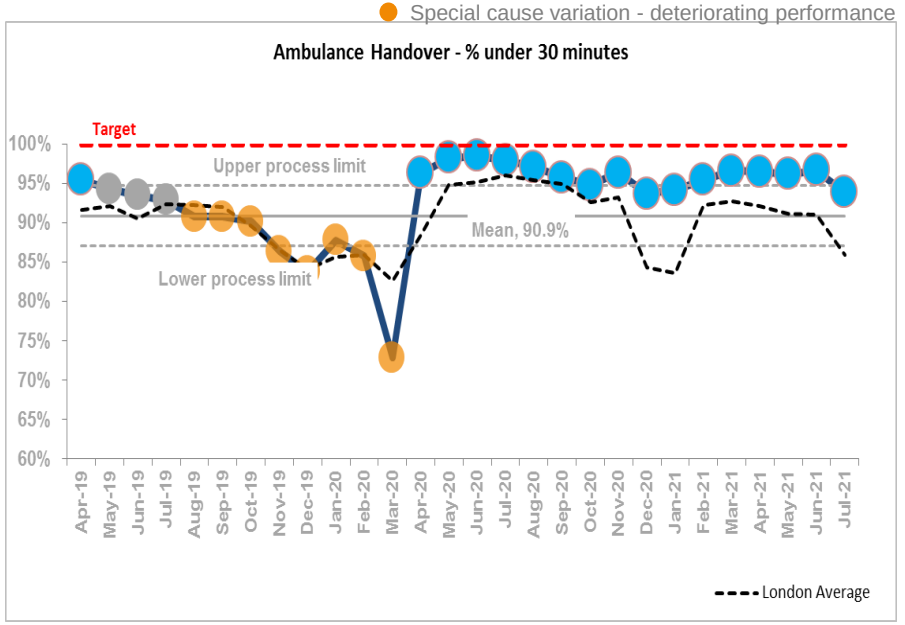


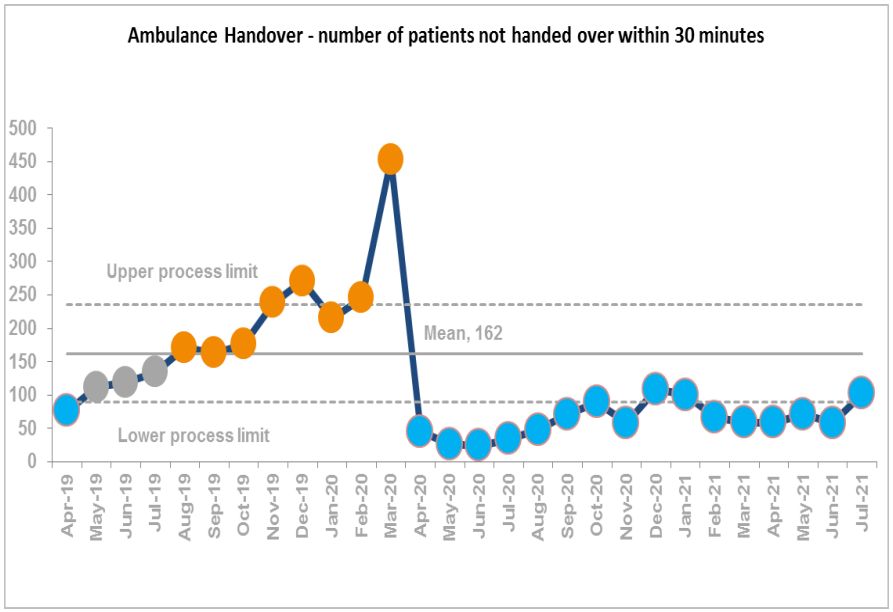
Emergency Flow

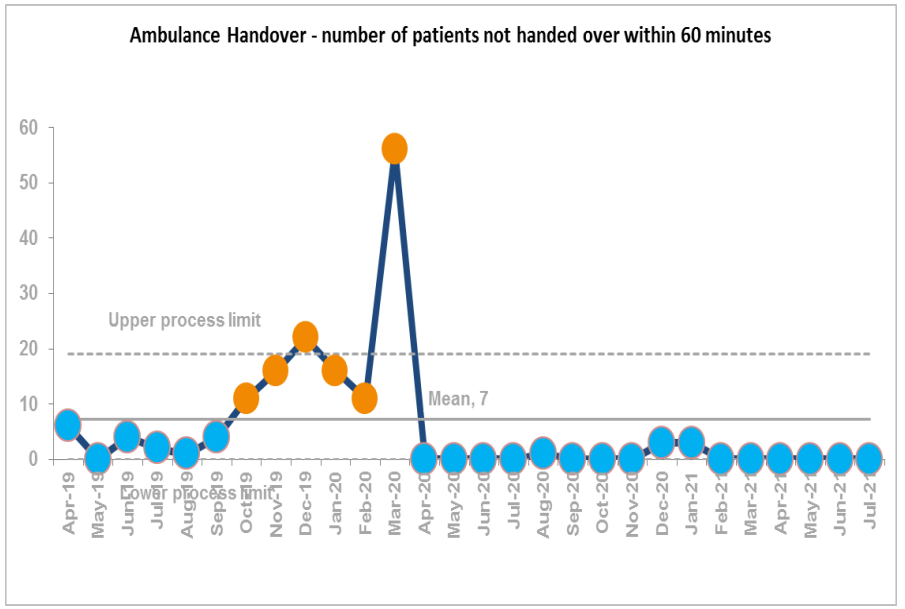
Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance



15 Minutes Handover performance is an un-validated position across London Trusts

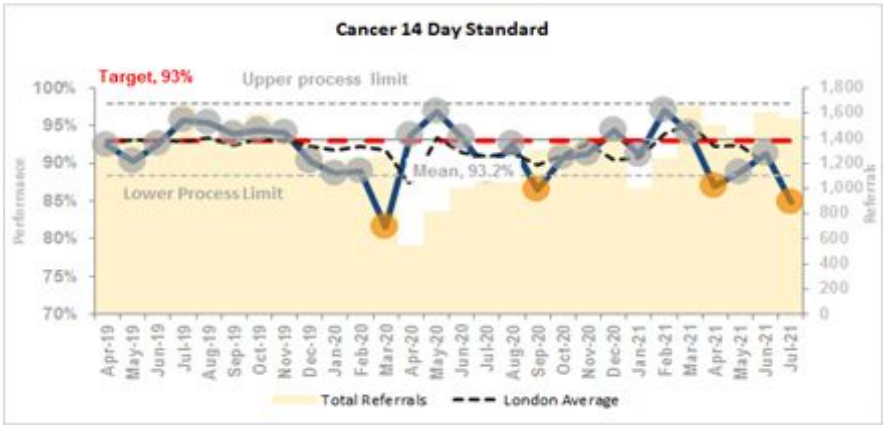


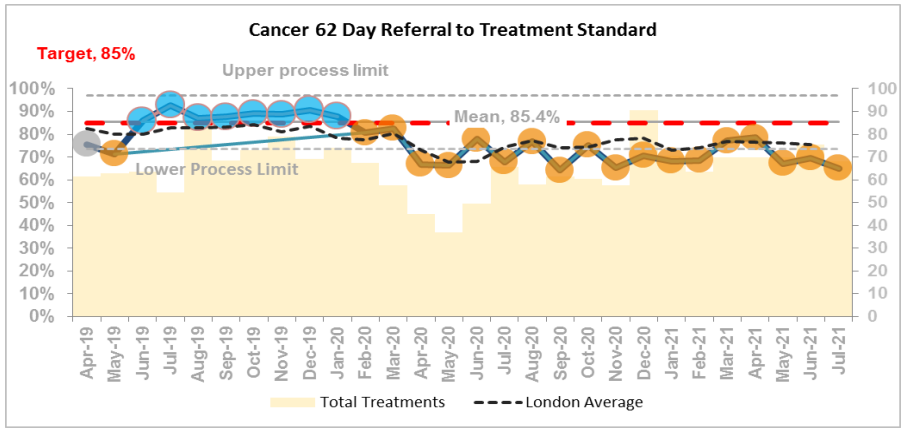




Ambulance handover data is one month in arrears

Cancer





What the information tells us

In July, the Trust achieved three of the seven cancer standards - Cancer 31 Day Diagnosis to Treatment, Cancer 31 Day Subsequent Treatment (Surgery) and Cancer 31 Day Subsequent Drug Treatment, all continuing to positively maintain compliance .

Two-week rule referrals continue to be higher than pre COVID baseline. Performance against the 14-day standard decreased in July with 84.9% of patients being seen within 14 days compared to 91.2% in June, performance showing special cause variation due to falling below the lower control limit. Several tumour groups are achieving the 93% standard with 6 of 11 tumour groups consistently seeing most patients within 14 days of referral. Gynae and Lower GI returned to compliance in July with four tumour groups non-compliant; Breast with performance falling to 26.9%, Haematology 79.3%, Lung 74.3% and Skin 91.4% with almost all the breaches being attributable to patient choice

Performance against the 31-day treatment standard continues to be achieved and although performance is below 2019 average is within the upper and lower control limits and in line with London average. Performance for the month was 96.4%, compared to the 96.6% reported in June. The number of patient treatments remain above pre-COVID baseline, compared July 2019 26% higher in July 2021.

There were 83 accountable treatments on the 62-day GP pathway, of which 54 patients received treatment within 62 days. Monthly performance remains below the lower control limit showing special cause variation. In July 65.1% of patients received treatments within 62 days of referral against the national target of 85%; similar performance was seen within London. There were 29 breaches of the 62 Day standard, attributed to Infection Prevention & Control (IPC) guidance, other COVID delays, clinical complexity, patient choice and an increase in late inter-trust transfers. All tumour groups apart from Upper GI were non-compliant. Head & Neck and Lower GI saw the more significant increase in patients breaching due to front end delays including CT Colon delay and follow-up capacity constraints both impacting overall performance.

At the end of July there were 135 patients on the 63 day plus patient tracking list, although this has increased slightly in August. Specialities have agreed a trajectory to return to the pre-COVID level of 90 by the end of September 2021. The Trust should return to 62-day compliance from Q4.

Actions and Quality Improvement Projects

14 Day Standard

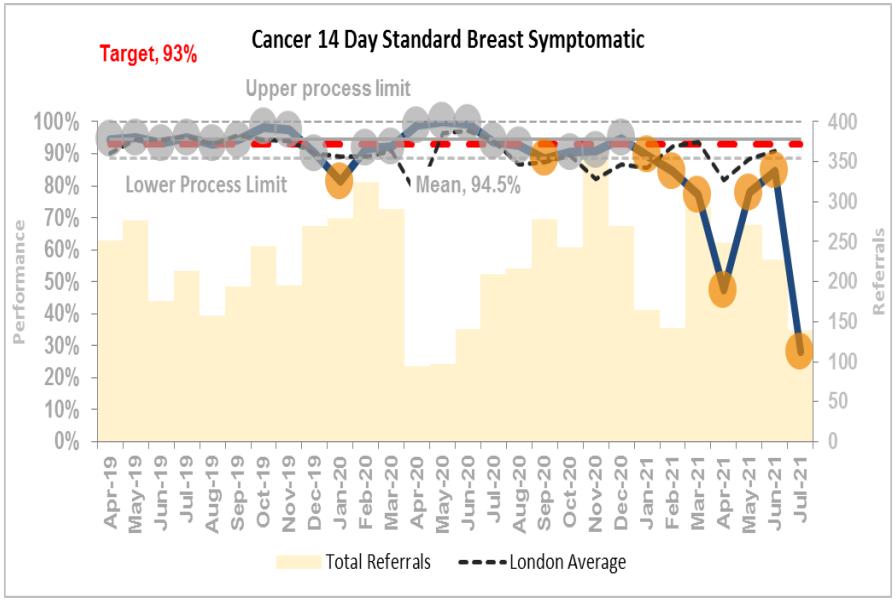
- Trust is not expecting to report compliance with the 14 Day Standard until the issues within the breast services are resolved. The Trust is seeking mutual aid from other SWL providers to accept additional GP referrals for both Breast Symptomatic and Suspected Cancer referrals
- A forward view of September shows all services, except for breast, are expected to have returned to compliance
- All services have been given revised demand projections for the next 12 months and are working to ensure that the capacity is available.

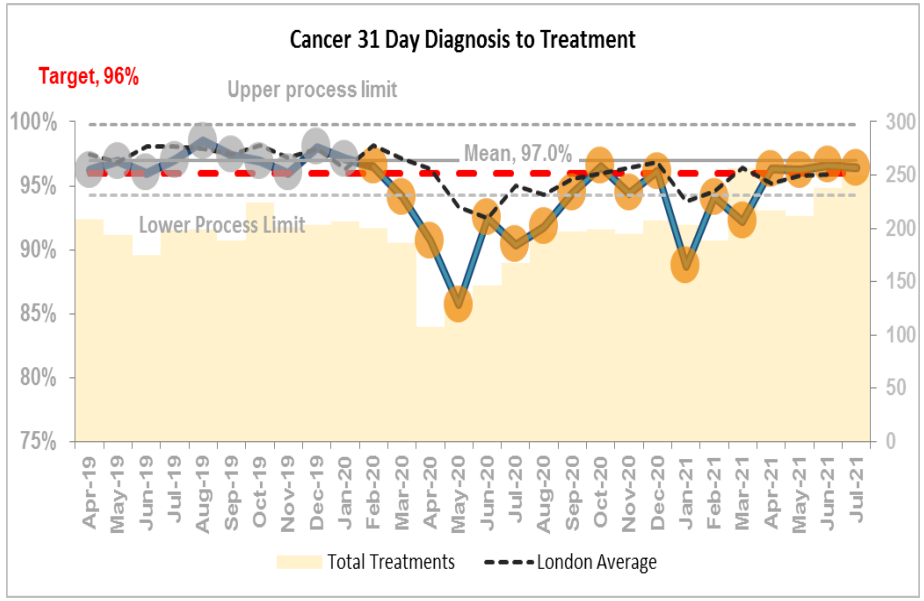
63+ Days

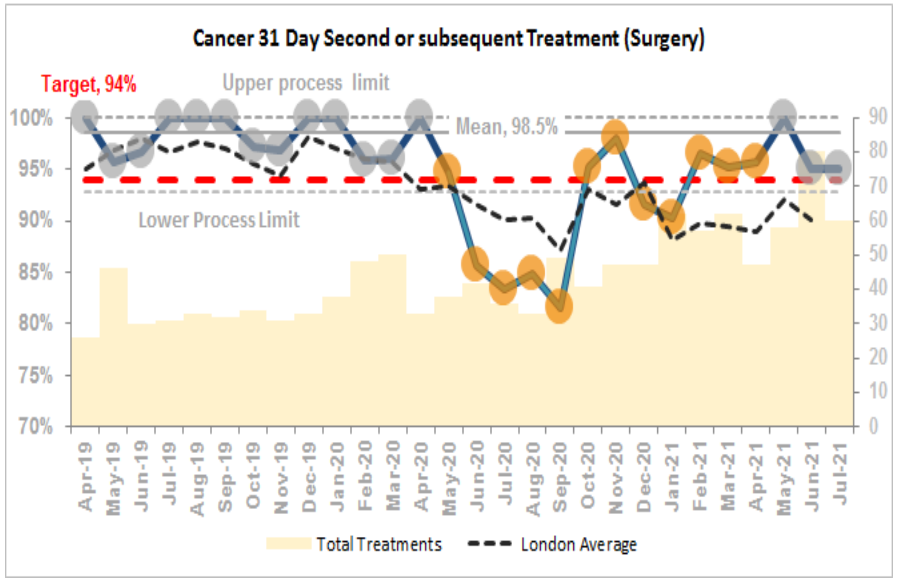
- It is expected that the numbers of patients over 63 days will rise in August, related to increasing referrals from other Trusts in Head and Neck, issues within the breast service and in Lower GI, where previous diagnostic delays have lengthened pathways.

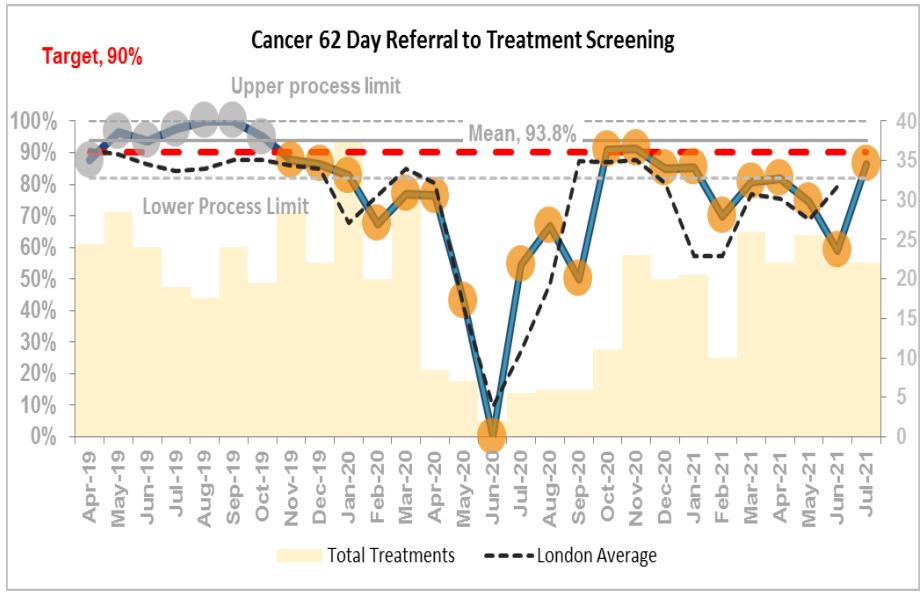
Cancer

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









Our Process Perspective

Cancer

14 Day Standard Performance by Tumour Site - Target 93%

Tumour Site	Target	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	No of Patients
Brain	93%	-	-	-	-	-	-	-	-	-	-	-	-	-	
Breast	93%	95.5%	94.3%	88.6%	92.0%	91.6%	95.0%	86.6%	92.5%	82.9%	54.5%	78.7%	86.1%	26.9%	201
Children's	93%	75.0%	75.0%	100.0%	75.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	2
Gynaecology	93%	92.5%	97.2%	91.6%	91.9%	94.3%	91.6%	79.3%	94.9%	94.9%	87.2%	92.6%	91.7%	95.0%	120
Haematology	93%	75.0%	91.3%	96.0%	96.2%	96.2%	96.2%	95.5%	100.0%	90.0%	96.4%	100.0%	95.5%	79.3%	29
Head & Neck	93%	96.1%	96.2%	84.1%	93.7%	96.0%	98.8%	91.6%	96.4%	94.6%	95.7%	96.9%	93.4%	95.5%	178
Lower Gastrointestinal	93%	86.9%	78.7%	61.8%	83.1%	76.4%	92.2%	99.3%	98.6%	98.2%	95.9%	67.6%	82.2%	96.7%	246
Lung	93%	62.5%	80.0%	90.5%	100.0%	94.4%	76.5%	90.0%	100.0%	94.4%	91.9%	97.5%	93.9%	74.3%	35
Skin	93%	87.4%	97.0%	95.4%	93.7%	95.1%	93.0%	90.7%	98.7%	98.0%	93.6%	97.5%	94.5%	91.4%	524
Upper Gastrointestinal	93%	84.4%	95.8%	93.0%	94.8%	90.6%	98.0%	95.3%	100.0%	95.4%	98.1%	96.9%	97.4%	96.6%	117
Urology (Suspected testicular cancer)	93%	80.4%	78.3%	85.6%	83.3%	93.3%	98.2%	95.3%	98.9%	97.1%	89.6%	97.0%	98.3%	98.1%	105

62 Day Standard Performance by Tumour Site - Target 85%

Tumour Site	Target	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	No of Treatments
Brain	85%	-	-	-	-	-	-	-	-	100.0%	-	-	-	-	
Breast	85%	100.0%	50.0%	92.3%	83.3%	84.6%	84.6%	75.0%	62.5%	100.0%	91.7%	78.6%	80.0%	83.3%	12.0
Children's	85%	-	-	-	-	-	-	-	-	-	-	-	-	-	0
Gynaecology	85%	100.0%	100.0%	71.4%	33.3%	100.0%	0.0%	50.0%	-	50.0%	75.0%	40.0%	60.0%	50.0%	2
Haematology	85%	100.0%	100.0%	100.0%	100.0%	77.8%	87.5%	100.0%	88.9%	100.0%	100.0%	66.7%	50.0%	80.0%	5
Head & Neck	85%	52.4%	100.0%	25.0%	60.0%	61.5%	57.1%	52.9%	57.9%	83.3%	90.9%	46.7%	70.6%	50.0%	16
Lower Gastrointestinal	85%	100.0%	60.0%	22.2%	25.0%	42.9%	38.5%	60.0%	33.3%	33.3%	75.0%	46.2%	66.7%	18.2%	5.5
Lung	85%	50.0%	60.0%	77.8%	55.6%	33.3%	100.0%	50.0%	73.3%	100.0%	90.9%	100.0%	62.5%	25.0%	2
Skin	85%	82.4%	100.0%	100.0%	100.0%	50.0%	81.5%	87.1%	88.9%	92.6%	78.8%	87.9%	78.8%	76.5%	17
Upper Gastrointestinal	85%	80.0%	100.0%	28.6%	100.0%	100.0%	53.8%	50.0%	71.4%	33.3%	60.0%	-	100.0%	100.0%	2
Urology	85%	27.3%	78.8%	55.6%	71.4%	57.1%	78.4%	57.6%	73.3%	70.8%	56.5%	45.8%	47.8%	69.2%	19.5
Other	85%	28.6%	-	0.0%	100.0%	100.0%	-	-	57.1%	100.0%	100.0%	-	100.0%	50.0%	2

Cancer

Table 6 - Number of patients waiting over Day 63 on 62 Day PTL - Data as at : 06/09/2021

Go to Table 6 Breakdown

Tumour Group Name	Pre-covid baseline	volume 63 to 103 Days	volume 104 Plus Days	Vol Total Backlog	Week Difference
Brain/CNS	0	0	0	0	0↔
Breast	10	16	7	23	8↑
Childrens	0	0	0	0	0↔
Gynaecology	9	12	2	14	3↑
Haematology	0	4	1	5	0↔
Head & Neck	15	29	8	37	1↑
Lower GI	11	28	6	34	3↑
Lung	4	2	0	2	-1↓
Skin	14	5	3	8	-1↓
Upper GI	20	12	4	16	-2↓
Urology	7	8	6	14	-3↓
Other	0	0	0	0	0↔
Grand Total	90	116	37	153	8↑

Actions and Quality Improvement Projects:

There are currently 153 patients who have waited more than 62 days since referral against a trajectory of 100. Six tumour groups are not meeting this trajectory.

There are 37 patients waiting over 104 days; which compromises of complex patients, patient choice and late inter trust transfers (ITT) from peripheral hospitals.

Breast

- The Trust has asked the Cancer Alliance to support a request for mutual aid from other providers in SWL to divert GP referrals for both Breast Symptomatic and Suspected referrals. The Breast backlog will increase over the next three months whilst these plans are put in place
- A Harms review process is in place, with all patients with a diagnosed cancer being reviewed
- Additional sessions are taking place on a weekly basis
- Recruitment plan has been agreed and is in train

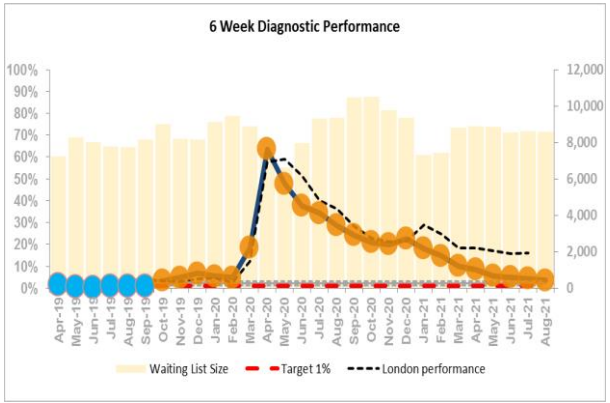
Lower GI

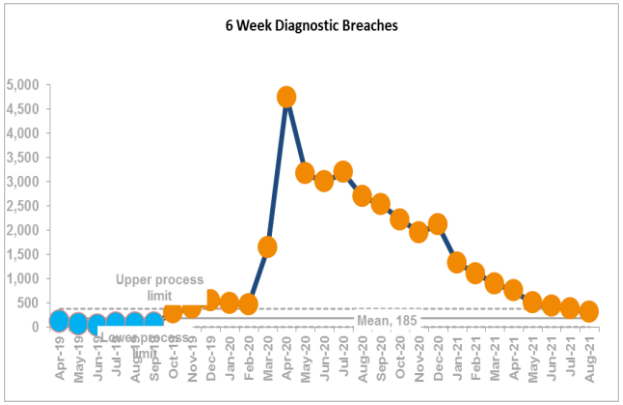
- The increase in patients is related to issues with 14-day performance and diagnostic delays, in previous months; additional resources are being identified by the service to review and discharge patients. CT Colon delays have now largely been resolved with additional capacity

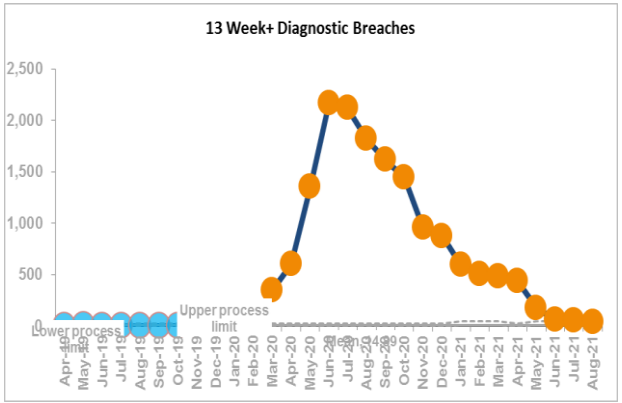
Urology

- Backlog increase is predominately related to late referrals from diagnostic centres

Diagnostics







What the information tells us

A continued improvement against the six-week diagnostic standard was seen in August, with 3.5% of patients waiting for more than six weeks compared to 4.3% at the end of July whilst holding a sustained waiting list size. In total, 304 patients were waiting for more than six weeks for a diagnostic test, this is a 18% reduction compared to July. The Trust continues to perform ahead of the London average. The average wait time for all patients on the diagnostic tracking list continues a downward trend. In August, 42 patients waited over 13 weeks for diagnostics in either Cardiac MRI or Sleep Studies; an overall 29% reduction compared to July.

The decrease in performance throughout August has been largely been due to a reduction within Echocardiography, where the number of patients waiting for more than six weeks reduced by 100 patients (72%), with performance against the national standard reducing from 12.7% in July to 3.6% this month. Performance recovery within Endoscopy has shown a sustained improvement with Colonoscopy and Flexi Sigmoidoscopy returning to National compliance of under 1%. There were no patients waiting above 13 weeks within Endoscopy. All modalities within Endoscopy are performing better than the London average.

There are four areas that remain challenged and have the highest proportion of breaches; Echocardiography capacity challenges within Stress Echo, Neurophysiology capacity and staffing challenges, Sleep Studies staffing capacity, Cardiac MRI capacity. All areas have action plans in place to recover the position

Actions and Quality Improvement Projects

Directive from NHSE/I for diagnostic departments to now conduct an administrative and clinical review of long waiting patients by the end of August 2021. All 10+ patients are reviewed at the weekly performance meeting with DDO support where areas are challenged.

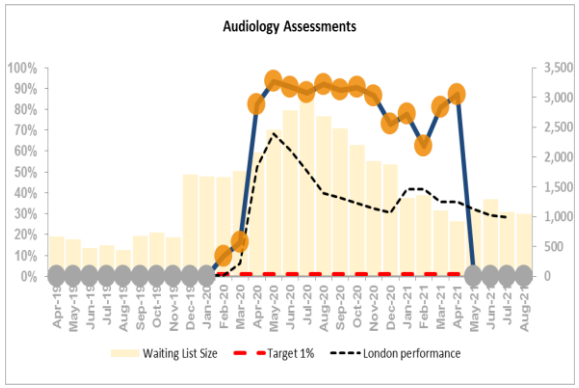
Echocardiography recruitment delayed so unable to switch from External Elective Services at the end of August, Elective Services to continue until the posts have been recruited to; aiming for end of October 2021. Only Trust in South London that offers a stress echo service.

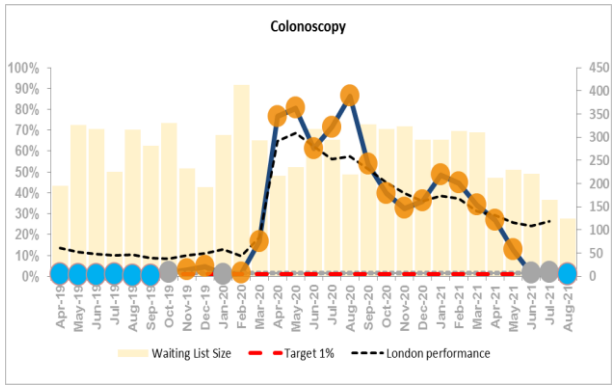
Sleep Studies - Recovery plan in progress with capacity at QMH. The service are exploring options such a locum cover and have also recruited to all four posts as well as having an agreement in place to use External capacity made available for breaching patients via CDH funding.

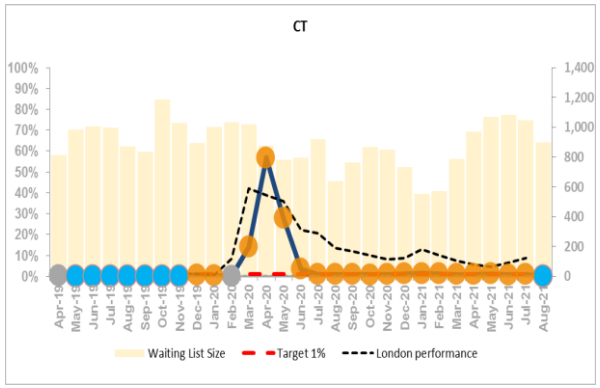
Cardiac MRI - Utilisation of the Monday Cardiac MRI session in late Sept for month end breach avoidance. Reviewing General Radiology capacity to convert sessions to Cardiac MRI

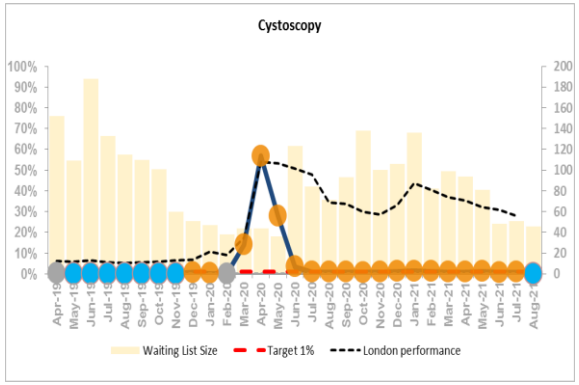
Diagnostics

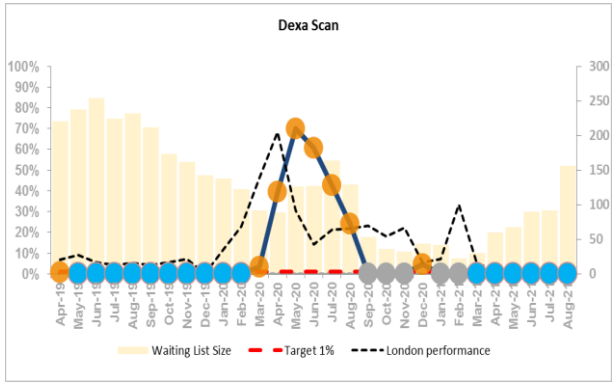
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

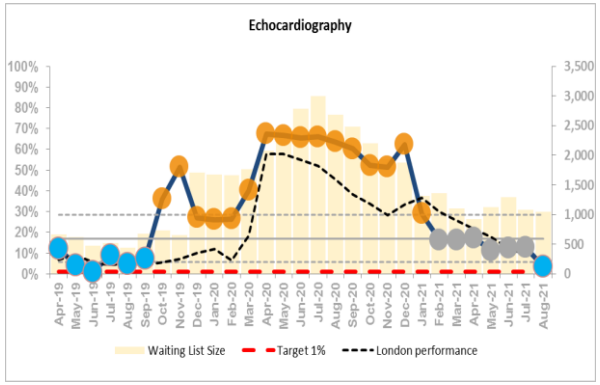


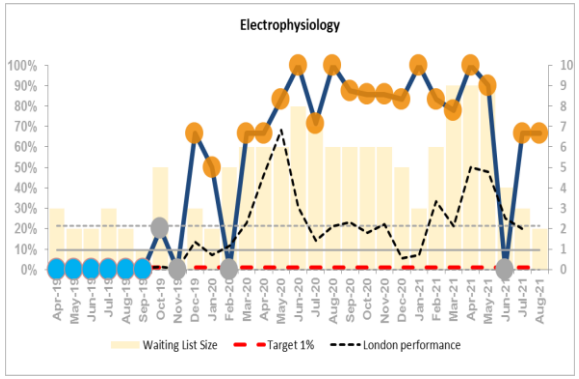


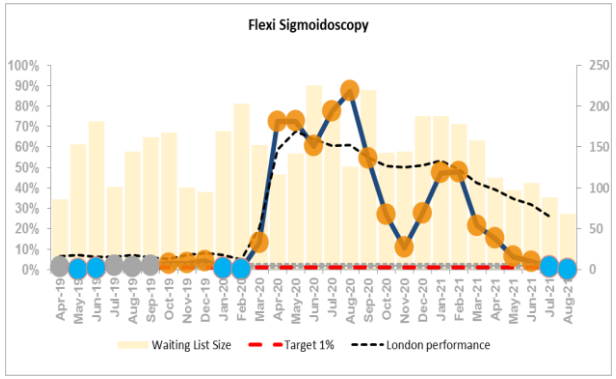


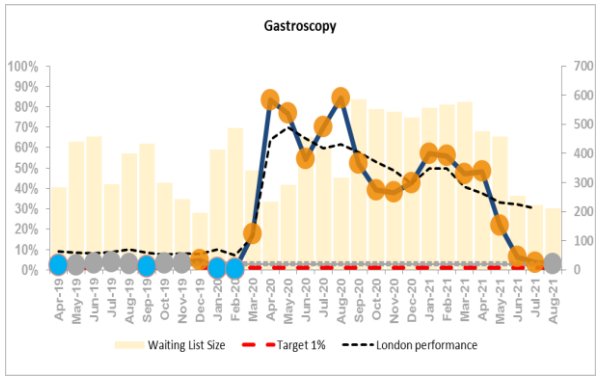






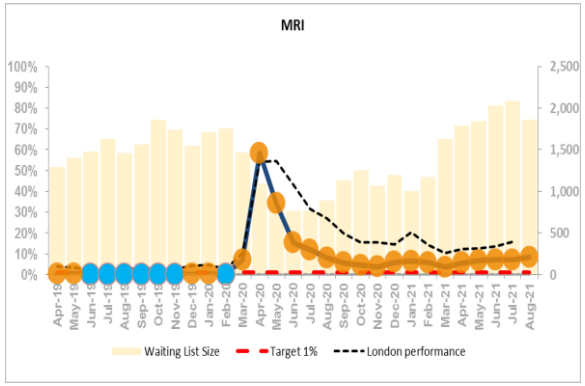


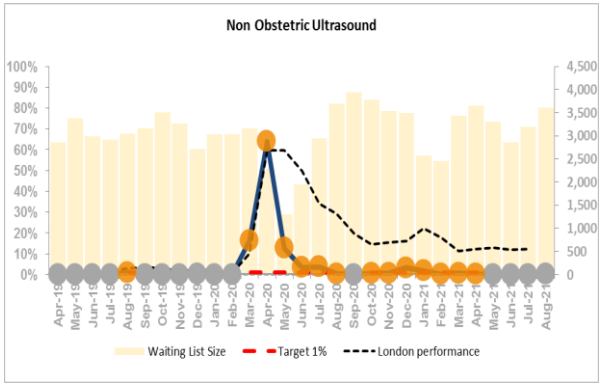


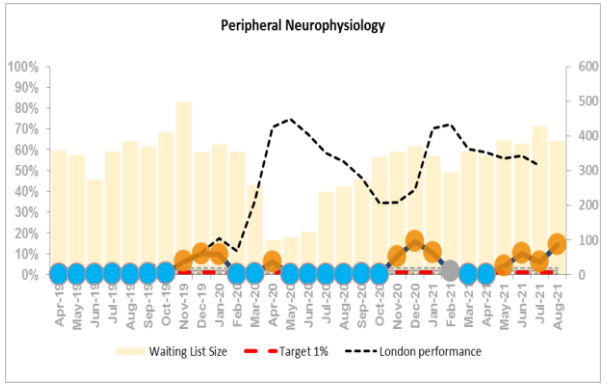


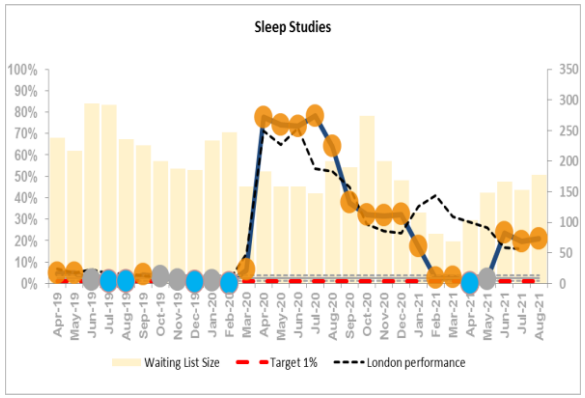
Diagnostics

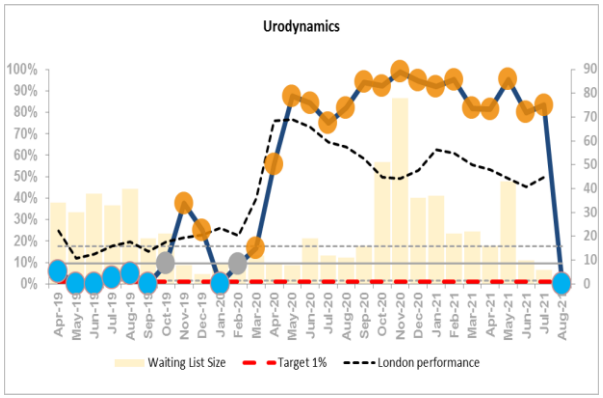
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance



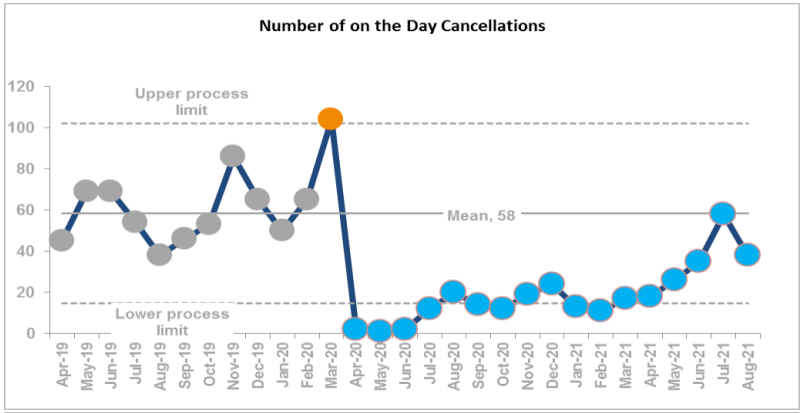


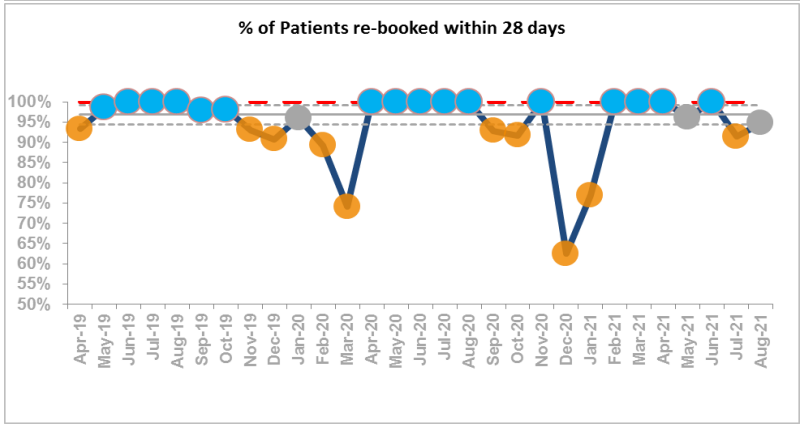


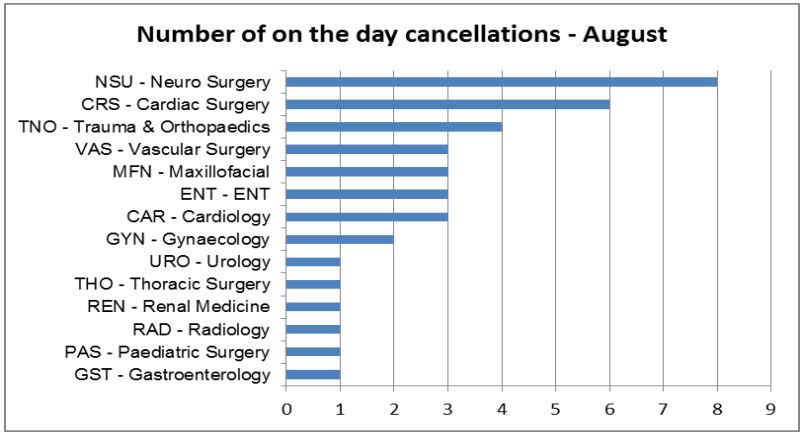




On the Day Cancellations for Non Clinical Reasons







What the information tells us

In August the Trust cancelled 38 patients due for elective treatment on the day of their operation for non-clinical reasons, a decrease compared to 58 patients cancelled in July. Compared to the 2019 baseline, cancellations remain below the mean. Of the 38 patients cancelled, two patients were not offered a re-booking date within 28 days due to staffing availability (Max Fax and Neuro), reporting a performance 94.7% against a target of 100%. Performance is within the upper and lower control limits showing only common cause variation.

Neurosurgery and Cardiac Surgery had the largest proportion of on-the-day cancellations in the month with critical care bed availability being the main contributor.

Cancellation reasons for the month are broken down as follows:

Bed - No Critical Care bed available – 10
Timing – Emergency case took priority – 7
Timing – List over booked – 7
Timing – Complication - previous cases – 6
Timing - Surgeon / Anaesthetist late start – 2
Bed - No Ward bed available – 2
Staffing – 1
Equipment – 1
Other – 2

Actions and Quality Improvement Projects

Processes – Timing

- SNCT are re-introducing the Golden Patient process which will help to reduce late starts, and cancellations caused by related overruns.
- Better communications between site, surgical bed managers and ITU are also being introduced to improve timely starts/ reduce overruns.

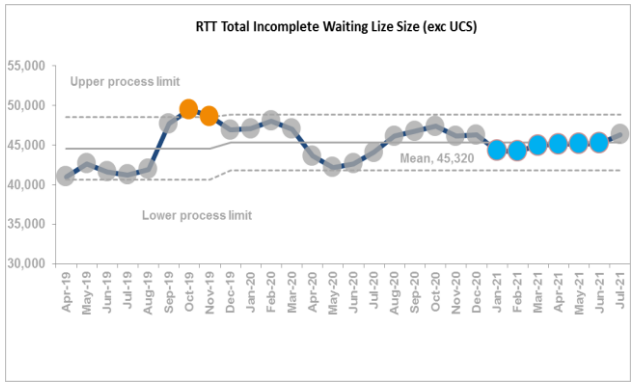
Staffing

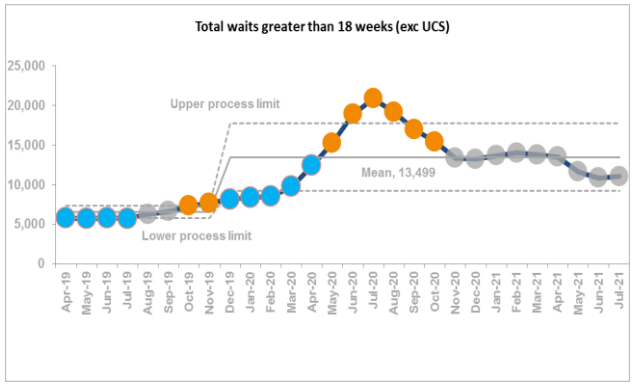
- Anaesthetic staffing remains a significant risk.
- A recruitment drive is currently underway, advertising 16 anaesthetic consultant roles as well as nursing and ODP roles.

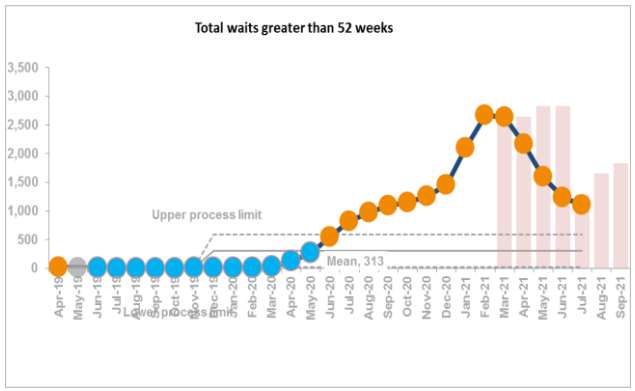
Scheduling

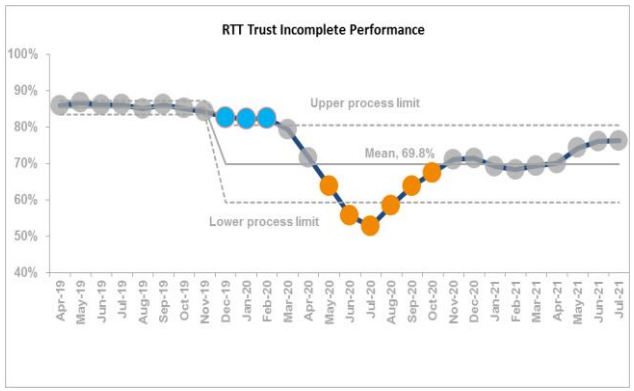
- New management and monitoring processes have been put in place to manage PPCs against targets and tighten up list-planning processes.
- This has resulted in more advance bookings in September, which will help to improve POA, equipment booking, ‘re-booking within 28 days’ compliance and ‘over-booking’ issues.

Referral to Treatment — July 2021









Note: Unknown Clock Starts (UCS) have been excluded from the above metrics. For context the number of UCS in July was 303, an decrease from 512 in June. Compared to the same month last year this is a 57% lower.

Actions and Quality Improvement Projects

July clock stop information shows that we treated fewer non admitted patients in July per day compared to every month this financial year, with an average of 404 clock stops per day. However this is expected as activity levels were broadly in line with planned activity in July and we achieved over 100% of 2019/20 activity levels consistently throughout the month. Admitted clock stops remained broadly on trend, with clock stops performing better than plan despite a planned reduction in activity. An increase in available theatre capacity in July (compared to 19/20) allowed continued improvements in DC/EL activity.

Current metrics:

- The reduction in 104 weeks, continues to be a focus. Whilst there are still some patients waiting over this time frame, these are patient choice delays or specific clinical reasons for delay.
- The number of +78 weeks waits has risen, however a revised trajectory is being drafted. It is expected that there will continue to be risk within Cardiology, ENT, General Surgery and Plastics. A more detailed plan will be shared once available.

What the information tells us

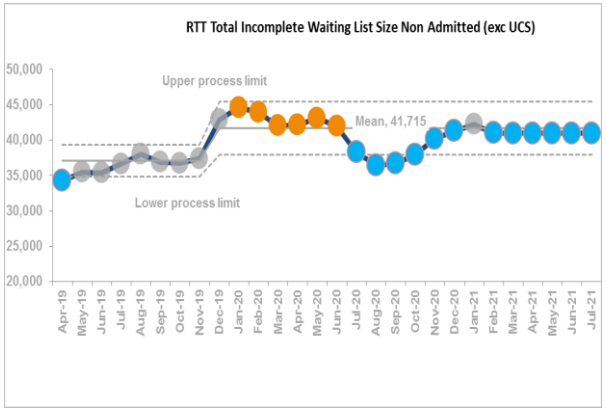
In July, 46,319 patients were waiting for treatment on the Patient Tracking List (PTL), an increase of 2.4% (1,077 patients) compared to the previous month. The PTL size moves above the mean for the first time in six months. Compared to the same month last year, the PTL size is 5% higher. At Trust level, the number of patients waiting for more than 18 weeks has increased by 2.4%. The number of patients waiting for more than 52 weeks continues to show improvement with a favourable position against our trajectory. In July there were 1,106 patents above 52 weeks compared to 1,240 patients in June.

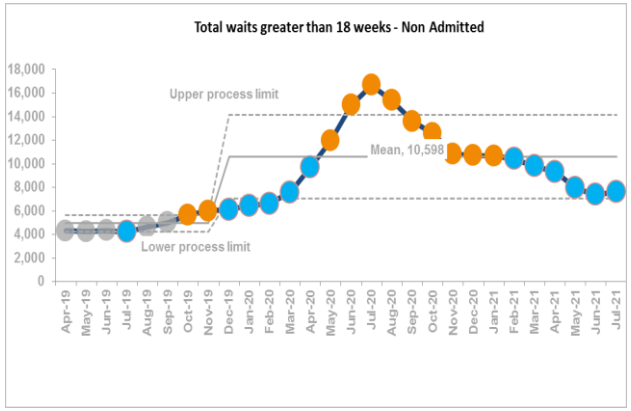
The number of patients on the non-admitted PTL has been below the mean for the past six months, showing a stable trend. In July, the number of patients waiting for more than 18 weeks increased by 3.5%% (255 patients), spread across a number of specialties. General Surgery continues to see 18 week waiters decrease with a reduction of 7.7% compared to the previous month. The number of non admitted patients waiting for more than 52 weeks fell by 8.6% (31 patients) with the largest proportions within Audiology, ENT and General Surgery.

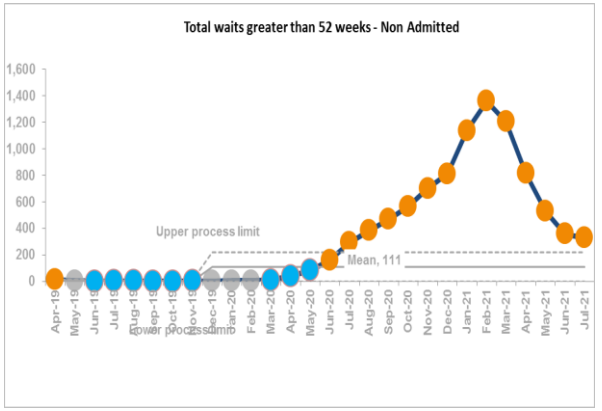
The total waiting list size for admitted patients remains above the mean and continues to show special cause variation, however showing a decrease throughout July. In total 6,619 patients are on the waiting list compared to 6,809 In June. Within the admitted pathway, the number of patients waiting for treatment beyond 18 weeks decreased by 1.8%. The highest proportion of admitted pathway waits over 18 weeks is in Cardiology and General Surgery. Compared to the previous month, the number of patients waiting for more than 52 weeks has reduced by 11.7% with a total of 777 patients. Specialties with the highest proportion of 52 week waits are within General Surgery, Cardiology and ENT, all three specialties seeing a reduction compared to the previous month.

Referral to Treatment — July 2021

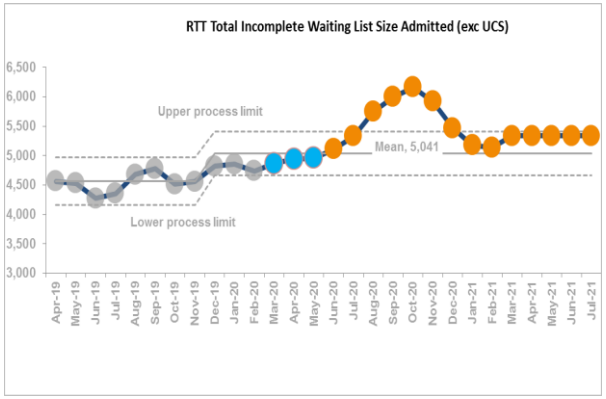
Non Admitted PTL

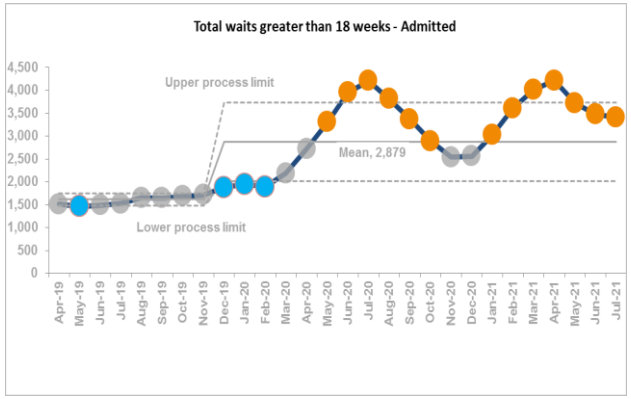


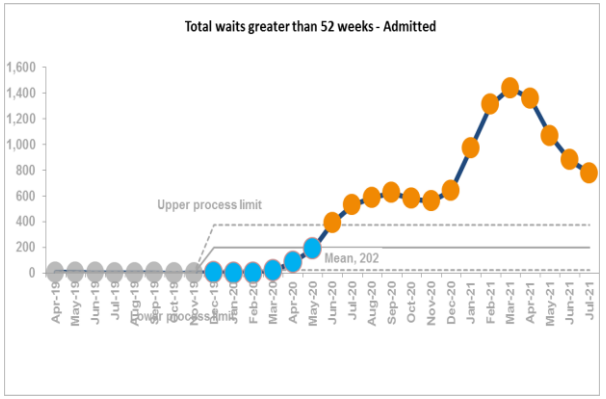




Admitted PTL







Balanced Scorecard Approach

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

Key

Current Month

A Previous Month

Scorecard RAG rating based on PreCOVID-19 plan

Workforce

Indicator Description	Target	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
Trust Level Sickness Rate	3.2%	3.4%	3.6%	3.3%	3.3%	3.9%	4.2%	3.6%	3.1%	3.4%	3.6%	3.7%	3.9%	4.1%
Trust Vacancy Rate	10%	8.2%	9.1%	9.4%	9.1%	8.5%	7.8%	8.6%	8.2%	9.6%	9.2%	8.6%	9.5%	8.9%
Trust Turnover Rate* Excludes Junior Doctors	13%	15.2%	15.4%	15.3%	15.3%	15.0%	15.0%	14.7%	14.4%	14.5%	14.6%	14.8%	15.2%	15.1%
Total Funded Establishment		9,263	9,265	9,320	9,331	9,336	9,330	9,451	9,454	9,568	9,695	9,684	9,709	9,698
IPR Appraisal Rate - Medical Staff	90%						63.8%	66.6%	72.3%	75.3%	76.5%	78.4%	77.5%	77.4%
IPR Appraisal Rate - Non Medical Staff	90%	74.6%	72.4%	71.7%	70.6%	69.6%	65.8%	65.6%	70.5%	75.3%	76.8%	74.6%	73.9%	72.9%
Overall MAST Compliance %	85%	89.9%	89.9%	90.5%	90.0%	89.4%	88.9%	88.2%	88.7%	89.4%	90.2%	90.4%	90.0%	88.6%
Ward Staffing Unfilled Duty Hours	10%	3.7%	5.4%	6.3%	10.4%	15.8%	19.9%	16.6%	11.8%	7.0%	8.6%	6.8%	9.9%	13.8%
Trust Stability Index	85%	86.3%	86.1%	85.8%	87.0%	88.5%	87.7%	88.0%	88.5%	88.2%	87.7%	87.3%	86.6%	86.7%
Number of **Formal** Employee Relations Cases													37	45
Number of **Informal** Employee Relations Cases													15	13
Employee Relation Cases (Formal and Informal)				44	42	34	26	26	47	52	42	54	52	58
COVID Risk Assessment completed				87%	86%	85.1%	84.6%	83.8%	82.7%	82.1%	79.9%	79.4%	78.9%	77.2%

What the information tells us

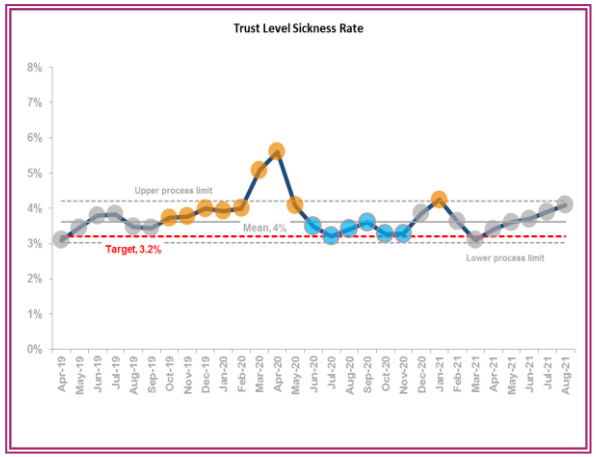
- The Trust's sickness absence rate at 4.1% has shown a month-on-month increase since April 2021.
- Vacancy Rate at 8.9% is below the set target of 10%, maintaining good performance.
- The Trust turnover rate remains above set target – a new approach to completing exit questionnaire was implemented on 2 November and will provide useful and timely information to help with putting in place required strategies.
- Medical Appraisal rates shows special cause deterioration.

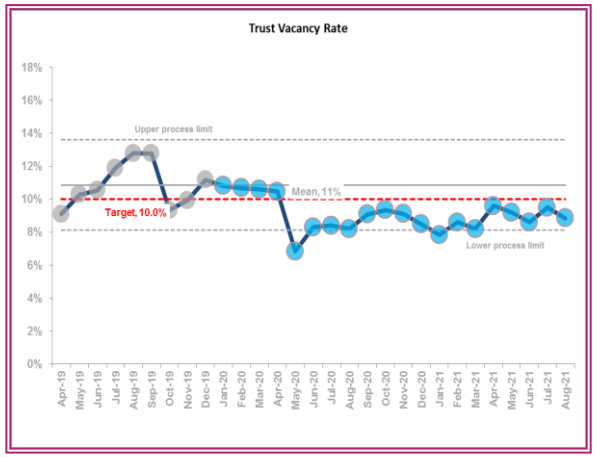
Actions and Quality Improvement Project

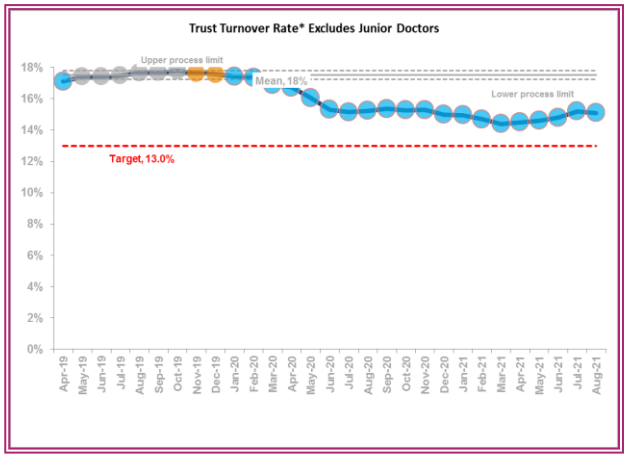
- The Employee Relations (ER) team is working closely with managers to ensure timely referral to Occupational Health and management.
- Focus on management of sickness absence continues with the Employee Relations team providing a monthly report on progress on the cases being managed. The Chief Nurse meets with Divisional Directors of Nursing bi-weekly for an update on sickness absence management. Human Resources Business Partners (HRBPs) share the reports with Divisions.
- Completion of appraisals for non-medical staff continues to be encouraged with HRBPs providing trajectories accordingly.
- Completion of appraisals for non-medical staff continues to be encouraged

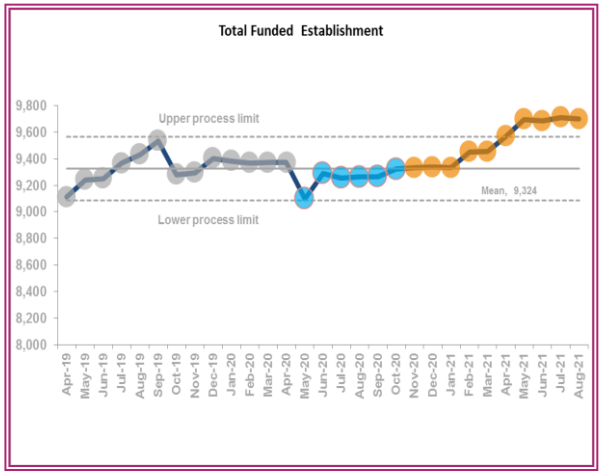
Workforce

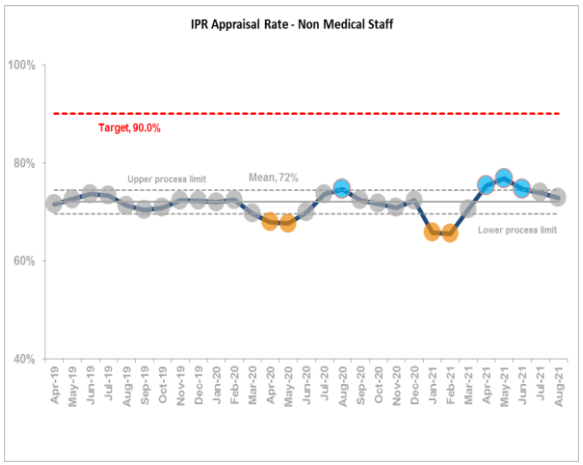
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

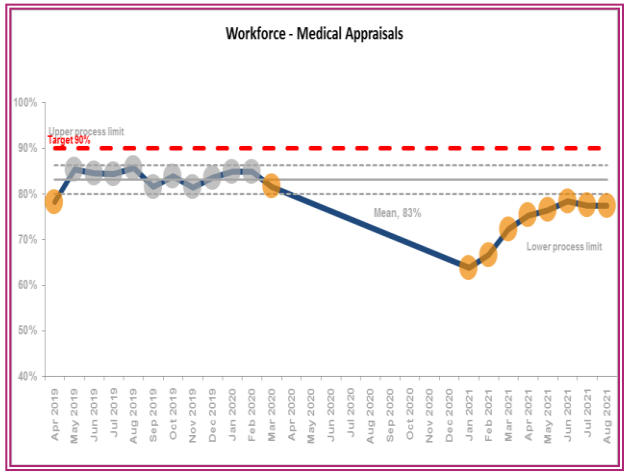








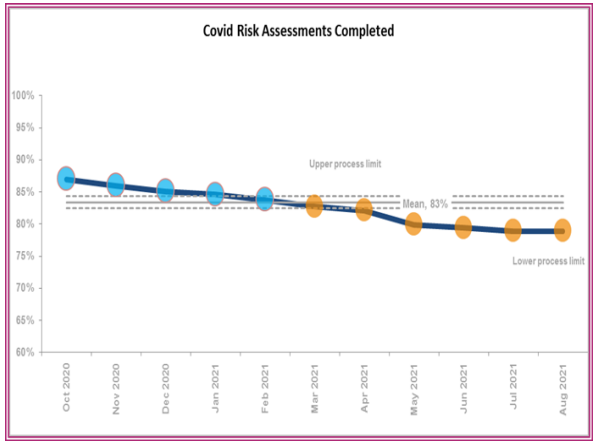




2.2

Our People Perspective

Workforce – August COVID-19 Risk Assessment



Division	Number of forms completed	Number of staff	% completed
Children and Women's Diagnostic and Therapy Services Division	2,537	3,258	77.9%
Medicine and Cardiovascular Division	1,655	2,213	74.8%
Surgery & Neurosciences Division	1,627	2,046	79.5%
Corporate Division	547	714	76.6%
SWL Pathology Division	447	653	68.5%
Estates and Facilities Division	302	340	88.8%
Research & Development Division	63	78	80.8%
Trust Total	**7178**	**9302**	**77.2%**

Staff Group	Number of forms completed	Number of staff	% completed
Nursing and Midwifery Registered	2264	2680	84.5%
Administrative and Clerical	1541	1889	81.6%
Medical and Dental	747	1424	52.5%
Additional Clinical Services	922	1272	72.5%
Allied Health Professionals	576	689	83.6%
Add Prof Scientific and Technic	567	656	86.4%
Healthcare Scientists	312	416	75.0%
Estates and Ancillary	249	276	90.20%
Trust Total	**7178**	**9302**	**77.2%**

Ethnicity	No of forms completed	Total number of staff	% completed
Black Asian and Minority Ethnic Group	3,490	4,530	77.0%
White	3,494	4,497	77.7%
Unknown	194	275	70.5%
Trust Total	**7178**	**9302**	**77.2%**

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

What the information tells us

- The table shows completion of COVID Risk Assessment as at 31 August 2021 and show special cause variation with a deteriorating position.
- The Trust completion rate is at 77.2%. Completion rate for BAME staff stands at 77.0% and White staff 77.7%.

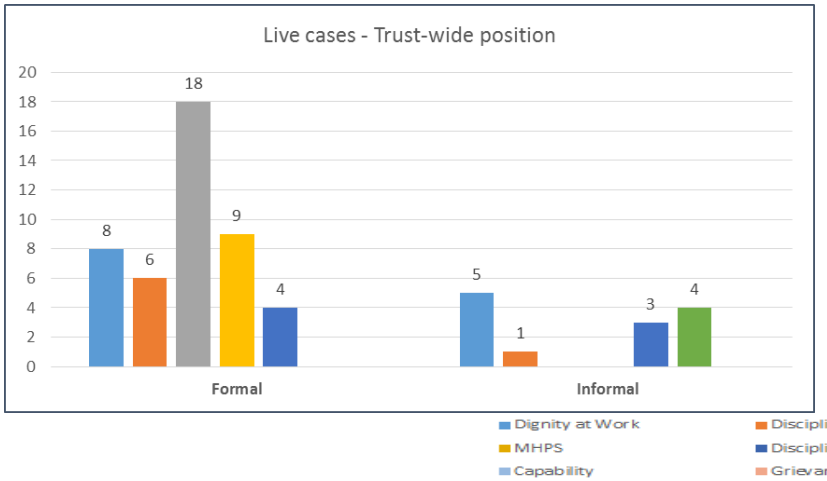
Actions and Quality Improvement Project

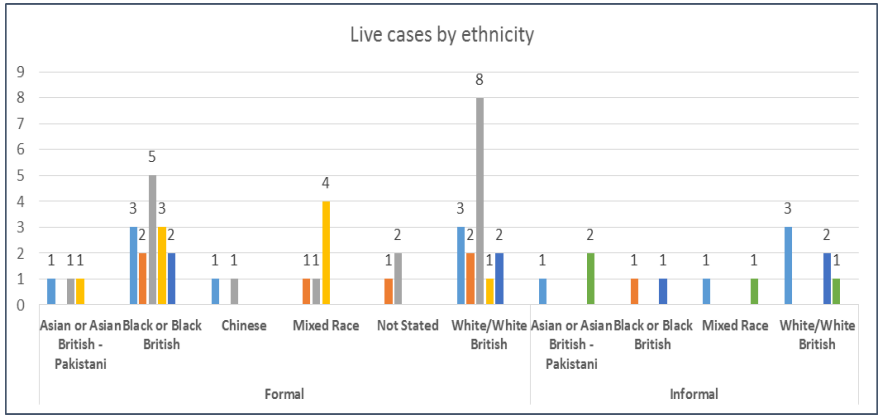
All new starters are given the COVID Risk Assessment form to complete with their line managers inside their first week in the Trust. The Director of Medical Education (DME) and Chief Medical Officer supported by the HR team have sent reminders to junior doctors to ensure completion of COVID Risk Assessments for the junior doctors who recently joined the Trust.

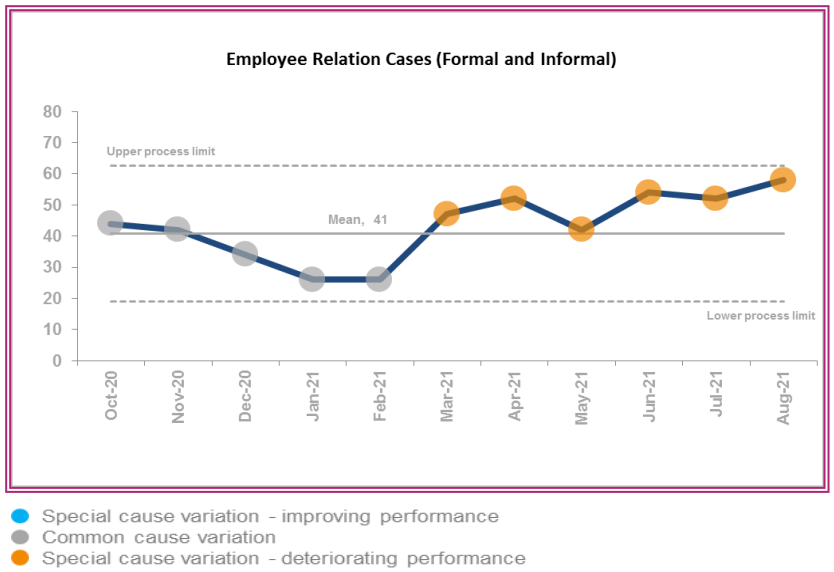
2.2

Our People Perspective

Workforce - Employee Relations Cases as of 31 August 2021







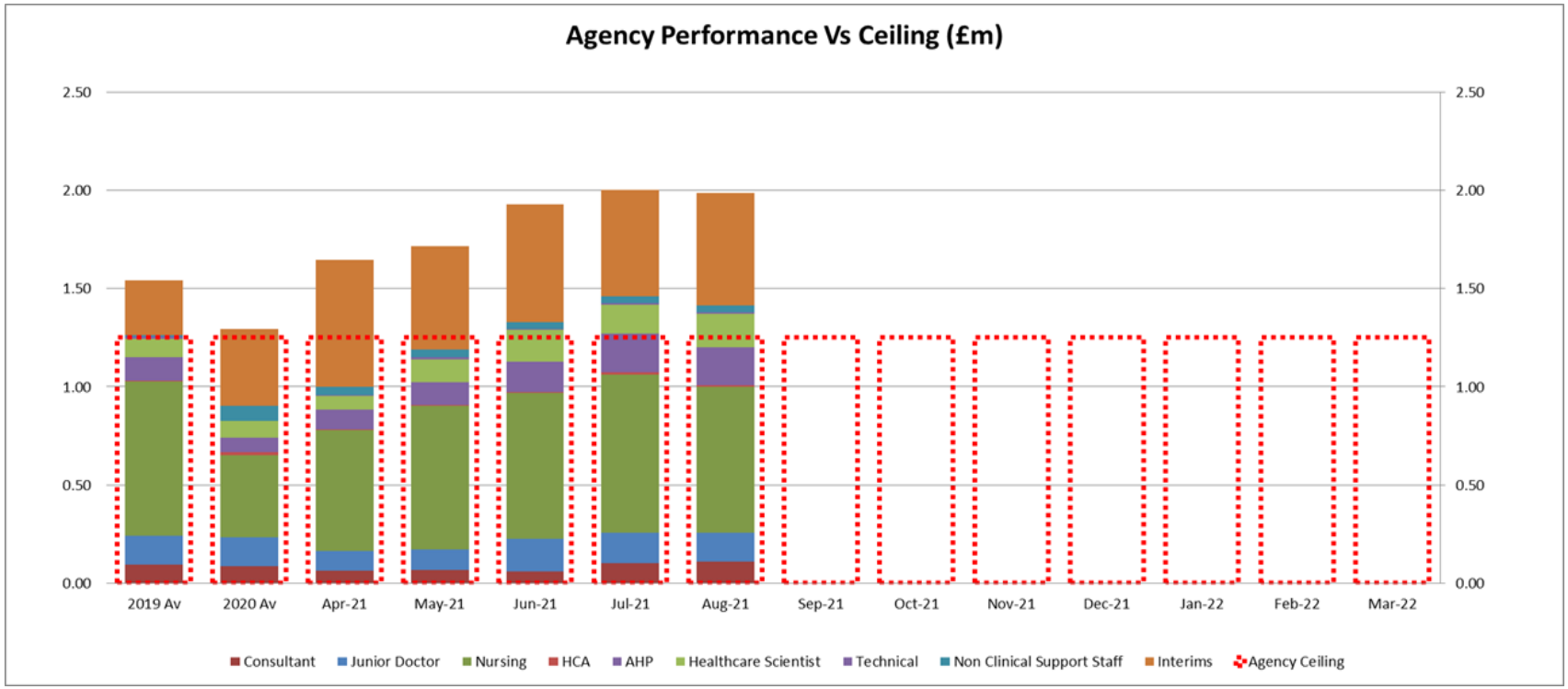
What the information tells us

- Cases have now increased to a total of 58 from 52 live cases reported as at 31 July 2021 – 45 formal cases and 13 informal cases. The increase is mainly due to 4 additional disciplinary cases approved. Performance show special cause variation with a deterioration position
- For formal cases only, Disciplinary remains the highest case type at 18. This is followed by 9 Employment Tribunal (ET) cases and 8 Capability cases.
- By division, Corporate Services & CWDT have the highest number of cases at 26 and 15 respectively. These numbers include Informal cases.
- For disciplinary cases, BAME staff account for 8 of the 18 cases, and white staff also account for 8 of the 18 cases. The staff that account for the remaining 2 cases did not wish to disclose their ethnicity.

Actions and Quality Improvement Project

HR Surgeries are now run twice every week to met the needs and demand of managers. Twilight sessions will be run one Friday of every month to capture managers on night shift, who may otherwise not have the availability to attend. The purpose of the Surgery is to equip managers with knowledge and skills to manage HR related matters and consistently apply HR policies and procedures

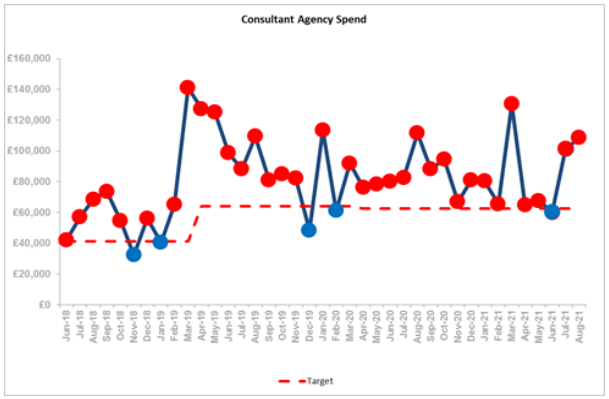
Agency use

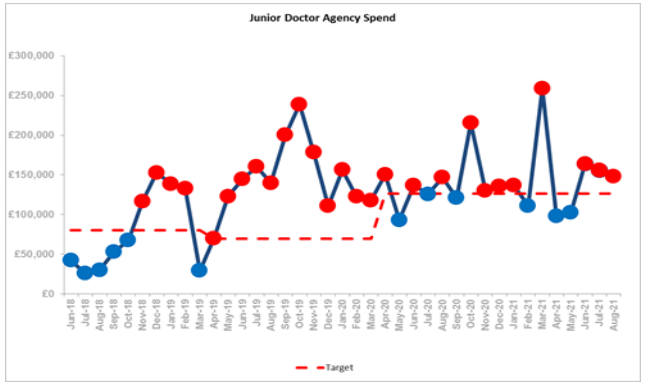


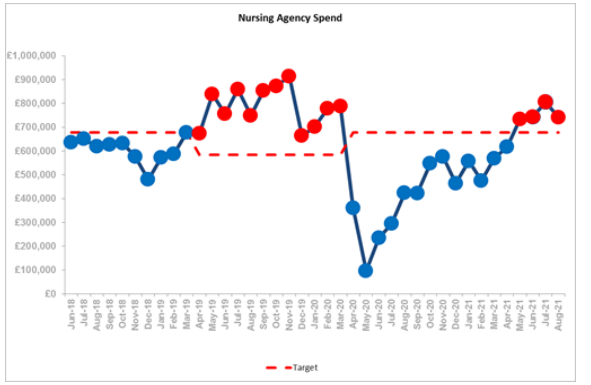
- The Trust's total pay for August was £48.86m. This is £0.32m adverse to a plan of £48.54m
- There is an internal annual agency target of £15.00m
- Agency cost was £1.99m or 4.1% of the total pay costs. For 2020/21, the average agency cost was 2.5% of total pay costs
- For August, the monthly target set is £1.25m. The total agency cost is worse than the target by £0.74m
- The biggest areas of overspend were Interims (£0.40m) , Healthcare Scientists (£0.09m) and AHP (£0.09m)

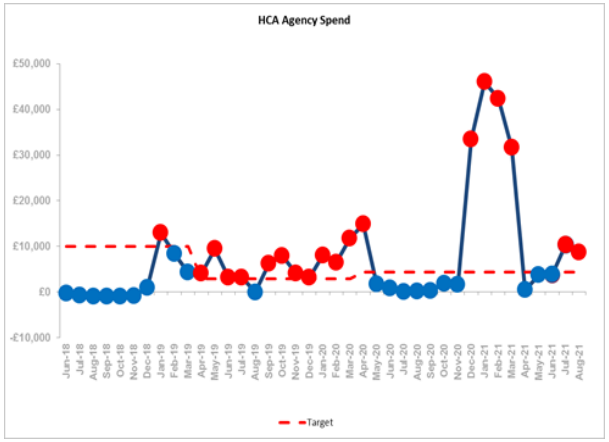
Agency use

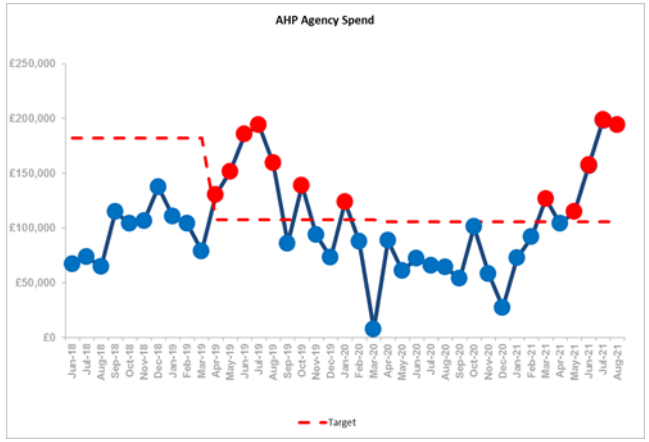

Below cap
Above cap

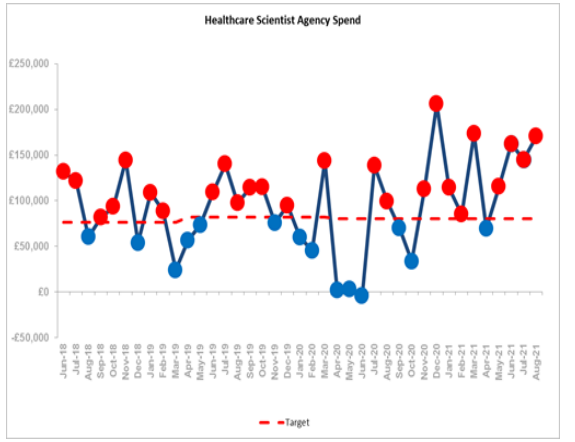

Consultant Agency Spend
Target

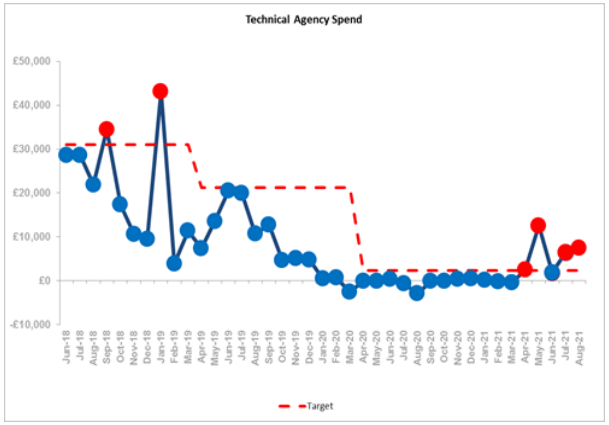

Junior Doctor Agency Spend
Target

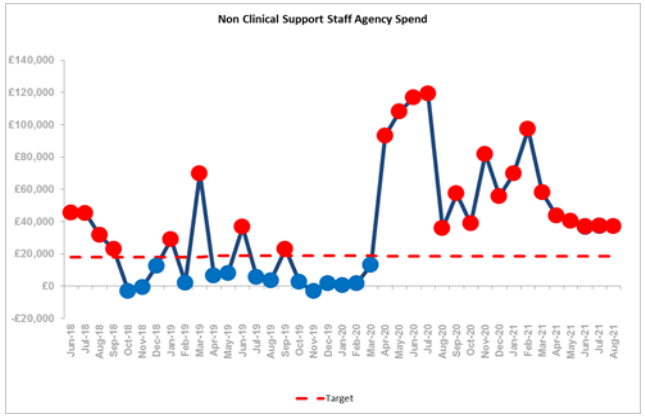

Nursing Agency Spend
Target

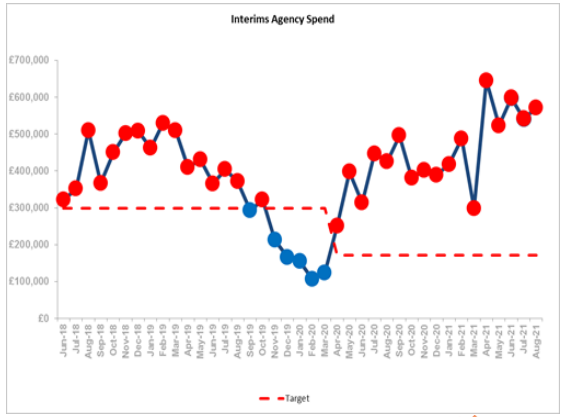

HCA Agency Spend
Target


AHP Agency Spend
Target


Healthcare Scientist Agency Spend
Target

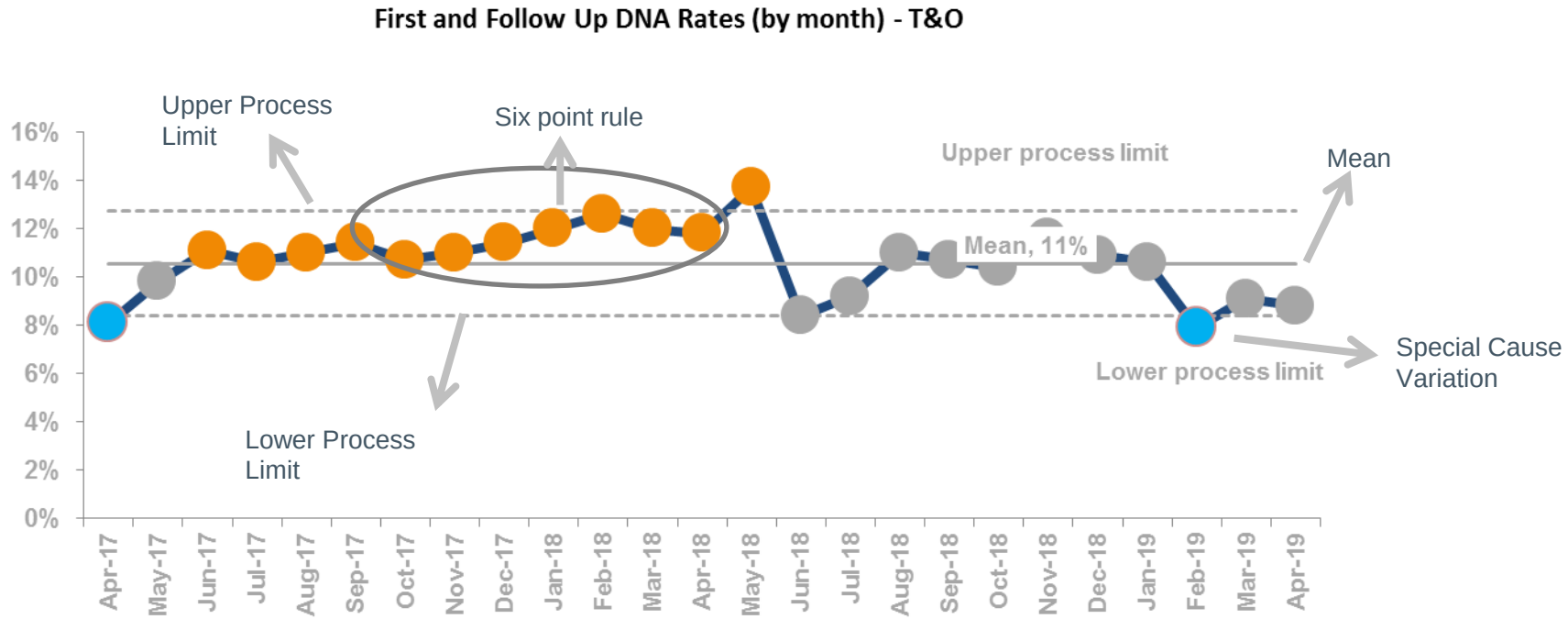

Technical Agency Spend
Target


Non Clinical Support Staff Agency Spend
Target


Interims Agency Spend
Target

Appendix
Additional Information

Interpreting SPC (Statistical Process Control) Charts



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

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

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

RTT Performance – July 2021

Indicator Description	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21
RTT Trust Incomplete Performance	52.7%	58.4%	63.7%	67.4%	71.0%	71.4%	69.1%	68.3%	69.3%	70.0%	74.2%	76.0%	76.2%
RTT Total Incomplete Waiting Lize Size (exc UCS)	44,117	46,139	46,755	47,399	46,142	46,290	44,291	44,236	44,960	45,109	45,156	45,242	46,319
Total waits greater than 18 weeks (exc UCS)	20,863	19,177	16,974	15,443	13,365	13,251	13,695	14,027	13,801	13,522	11,662	10,850	11,044
Total waits greater than 52 weeks	825	972	1,097	1,146	1,261	1,456	2,108	2,671	2,644	2,174	1,597	1,240	1,106
Total waits greater than 52 weeks Trajectory									2,742	2,645	2,832	2,828	1,288
RTT Incomplete Performance - Admitted	31.8%	35.6%	38.3%	44.2%	50.6%	51.9%	49.2%	45.6%	45.1%	41.4%	47.1%	48.9%	48.4%
Total waits - Admitted	6,165	5,923	5,470	5,178	5,141	5,335	5,950	6,634	7,301	7,193	7,045	6,809	6,619
Total waits greater than 18 weeks - Admitted	4,207	3,816	3,373	2,891	2,541	2,564	3,025	3,608	4,013	4,213	3,724	3,476	3,415
Total waits greater than 52 weeks - Admitted	529	588	626	579	559	643	971	1,310	1,439	1,359	1,067	880	777
RTT Incomplete Performance -Non Admitted	56.1%	61.8%	67.1%	70.3%	73.6%	73.9%	72.2%	72.3%	74.0%	75.4%	79.2%	80.8%	80.8%
Total waits - Non Admitted	37,952	40,216	41,285	42,221	41,001	40,955	38,341	37,602	37,651	37,916	38,111	38,433	39,700
Total waits greater than 18 weeks - Non Admitted	16,656	15,361	13,601	12,552	10,824	10,687	10,670	10,419	9,788	9,309	7,938	7,374	7,629
Total waits greater than 52 weeks - Non Admitted	296	384	471	567	702	813	1,137	1,361	1,205	815	530	360	329

Note: Unknown Clock Starts (UCS) have been excluded from the above metrics. For context the number of UCS in July was 303, an decrease from 512 in June. Compared to the same month last year this is a 57% lower.

RTT Performance – July 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 Service	604	24.2%	888	75.3%	815	677	1,492	54.6%	126	142
Urology Service	475	49.3%	1,431	90.4%	1,528	378	1,906	80.2%	25	65
Trauma and Orthopaedics Service	307	57.7%	2,028	81.4%	1,827	508	2,335	78.2%	38	18
Ear Nose and Throat Service	697	40.5%	3,988	69.4%	3,051	1,634	4,685	65.1%	173	193
Ophthalmology Service			288	27.8%	80	208	288	27.8%	21	12
Oral Surgery Service	219	28.3%	799	79.8%	700	318	1,018	68.8%	19	33
Neurosurgical Service	211	57.3%	1,817	73.0%	1,448	580	2,028	71.4%	58	33
Plastic Surgery Service	589	51.3%	667	86.7%	880	376	1,256	70.1%	41	84
Cardiothoracic Surgery Service	72	1	157	1	209	20	229	91.3%	0	0
General Internal Medicine Service			20	85.0%	17	3	20	85.0%	0	0
Gastroenterology Service	506	93.7%	2,874	78.4%	2,728	652	3,380	80.7%	12	5
Cardiology Service	1,348	47.8%	2,343	82.4%	2,574	1,117	3,691	69.7%	106	219
Dermatology Service	7	100.0%	2,233	90.6%	2,030	210	2,240	90.6%	16	11
Respiratory Medicine Service	3	100.0%	1,194	92.0%	1,101	96	1,197	92.0%	0	0
Neurology Service	16	81.3%	1,856	89.8%	1,679	193	1,872	89.7%	2	0
Rheumatology Service			890	82.2%	732	158	890	82.2%	2	0
Elderly Medicine Service			62	96.8%	60	2	62	96.8%	0	0
Gynaecology Service	199	48.7%	1,963	82.2%	1,710	452	2,162	79.1%	33	12
Other – Medical Services	115	80.0%	6,444	85.2%	5,580	979	6,559	85.1%	83	45
Other – Paediatric Services	685	49.6%	1,950	89.1%	2,077	558	2,635	78.8%	53	51
Other – Surgical Services	680	34.7%	3,303	75.1%	2,718	1,265	3,983	68.2%	154	246
Other – Other Services	76	50.0%	1,238	65.4%	848	466	1,314	64.5%	44	71
Grand Total	**6,809**	**48.9%**	**38,433**	**80.8%**	**34,392**	**10,850**	**45,242**	**76.0%**	**1,006**	**1,240**

The numbers reported above exclude Unknown Clock Starts(UCS)

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

Early Warning Score

Indicator Description	Threshold	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
Compliance with appropriate response to EWS (Adults)	100%	78.2%	84.8%	92.4%	94.1%	93.7%	95.3%	92.8%	89.9%	88.0%	88.0%	91.0%	92.3%	91.6%
Number of EWS Patients (Adults)		634	465	474	426	478	235	360	553	483	581	443	531	429

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

3.1

Meeting Title:	**Trust Board**		
Date:	30th September 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 12th August and 16th September. 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. However, it was clear from the discussion and reporting at our August meeting that the Trust is not experiencing the more usual step-down in activity during August, as the holiday season arrives. What was reported to us was of a service under pressure, with high levels of A&E attendances and underlying demand at 'winter' levels, exacerbated by staff absence due to sickness and catch-up holiday. Hospital staff are responding well to the situation and we took assurance from the way that executive team was managing what was clearly a pressured situation. However, the lack of downtime for staff and continued working at capacity presents a risk that, if not managed extremely well, could have significant adverse consequences as we move into the autumn. The September meeting had a significant focus on progress on culture, diversity and inclusion and there was a strong element of the Committee being brought up to date on some solid progress over the summer, and good momentum being maintained. The individual components are summarised below. However, it is worth drawing attention here to the confirmation of funding that has been received for the culture programme as a whole. This gives confidence and assurance about the Trust's ability to deliver on what is an ambitious implementation plan. The Committee noted the proposed allocation of the funding, and the prioritisation and phasing of delivery activity. Overall, the culture programme is developing good momentum, and we were assured by the way that the project management of what is a very broadly-based set of activities is being managed. The confirmation of funding for the Culture Programme creates the resourcing base that will help secure delivery. The proposed targets and success indicators for the Programme have been revised and re-calibrated. Whilst stretching, they represent the scale of the Trust's ambition in this area.		
Recommendation:	The Board is asked to note this report.		
Supports			
Trust Strategic Objective:	Valuing our staff		
CQC Theme:	Are services at this Trust well-led		
Single Oversight Framework Theme:	Board Assurance, Risk management		

Workforce and Education Committee Report

Trust Board, 30 September 2021

1. Committee Chair's Overview

Since my last report to Board in July we have had two further meetings of the Committee, in August and September. August was more a review of a number of operational areas, and September was focussed more on the Culture programme. No new risks at Trust level were identified.

2. Key points:-

Internal Operations and Supply

HR Operations Dashboard - we reviewed the Trust's operational HR dashboard and noted a number of points. The new Performance Development Review programme (which replaces appraisals) will be the subject of a poster campaign in the autumn. We will want to review progress here at the turn of the calendar year.

Covid vaccination rates amongst staff had risen to 86% / 77% (first jab / second jab) although within our Black staff the rates were 66% / 53%. Trust management confirmed it would continue to influence all staff who have not had the vaccinations to take them, and was shifting focus to conversation with a clinician in support of this.

The pre-disciplinary review process continued, and was typically moving 20% of cases reviewed into informal resolution. The process for managing internal investigations in disciplinary cases had been improved, with the average now running at 53 days (down from over 200).

People Management Group Report. The PMG is the executive committee that oversees all HR and culture issues within the Trust. We had a helpful update on its activities. We noted the ambitious targets that Trust management had set in its management of agency spend, and the level of challenge that delivering these would require. We also received an update on a Trust-wide initiative to update all policies, including HR policies. This work had been held over during the pandemic, and was being re-initiated. A process for executive and then Committee review had been agreed. This is work in progress. Progress was being made on the HR policies in line with the revised timescale. There is a separate issue arising on whether individual HR policies are contractual or non-contractual but no immediate risk arises from this.

South-West London Partnership Workforce Initiatives – we had a helpful update on a number of important, and potentially very helpful, initiatives which continue to be progressed on a joint basis across south west London Trusts. Of particular relevance are the initiatives relating to: single recruitment hub; a shared bank; a potential shared occupational health service; and a common-form Positive Action Programme. The latter particularly is critical to us at St George's as we look to deliver on a number of the actions within the Delivery phase of our culture programme (see below).

Workforce Planning

Nursing Establishment Review - Rob Bleasdale (our Chief Nurse) updated us on this year's Nursing Establishment review, and the re-set of that establishment at 666 Whole Time Equivalents, up 3.5% on last year's 644. The service logic of the increase, the changes of service configuration at individual ward and unit level, and the granular nature of the review undertaken were noted. The Committee took strong assurance from the robust nature of the process followed.

Culture, Diversity and Inclusion

Culture Programme Update – Humaira Ashraf and Dan Scott provided us with a general update and then reported on two important steps for the Culture Programme, as it moves into its Delivery phase. First, and of critical importance, is the fact that a budget has been agreed and allocated to enable the Delivery phase to be executed as planned. The significance is that this will allow the whole of the planned programme to be moved forward on a collected and integrated basis, and hopefully amplify its impact. We reviewed the individual budget lines to appreciate the programme that was being supported financially. Second, the headline targets and milestones to evaluate the success of the programme implementation have been further reviewed and refined, and a final set of targets has now been agreed. These range across: staff survey results; workforce metrics; and the penetration by BAME staff of more senior AfC bands (notably bands 7 and above) and the VSM group. The targets set are unquestionably challenging, yet achievable. If delivered on, they will contribute a material change to the culture of the Trust and the working environment of our staff. Those targets, and more importantly the processes and actions to secure their delivery, have the full support of the Committee. Recruitment of a programme manager is well under way.

The Culture programme had been progressed over the summer by two sub-groups ('*Teamwork Development*' and '*Values/Behaviours*') and we received assurance that the programme continued to be on track. Within this update, the Committee was updated on the review being undertaken of the Diversity and Inclusion Action Plan, in the light of certain potential gaps identified as a result of the Discovery phase of the culture programme. St George's organisational values are being refreshed (and not re-written) and good progress was reported. The design principles of this activity were set out, and their relevance to the wider culture programme noted. Progress being made by the Teamwork Development subgroup was noted.

Overall, the Committee took assurance from the reports and the level of continuing activity being undertaken. It was clear that there would be a broadening of the people involved in moving the culture programme and its individual components forward. There is a clear need to ensure that, as delivery moves from a small and highly committed programme board and the culture champions to a wider staff group including senior and middle managers, momentum and commitment is maintained. Whilst this raised a potential risk to delivery, the Committee took assurance from the way the executive was approaching the broadening of responsibility for this.

Workforce Race Equality Report – Joseph Pavett-Downer, the Trust's D&I Lead, summarised the results that would be contained within the Trust's WRES Report, that would in due course be published on the Trust's website. At the time of the meeting, comparator results from other London Trusts were not available and therefore the Trust's performance against similar organisations was not yet possible. Joseph's overall assessment was that the results were broadly as expected in that whilst generally steady progress continued to be made, certain areas required more focus and work if we were to deliver further progress. It was clear that the executive had identified the next steps needed, and was keen to progress them. The Committee made a number of helpful suggestions about particular analyses and deep dives that might assist the overall analysis, and these would be taken forward. As a summary of the Trust's progress over the last 12 months, of the 9 key indicators: 5 had moved forward; 2 were broadly static; and two had gone backwards. A copy of the summary slide is attached as Annex 1. The level of objective analysis, self-evaluation, and clarity on further action required in the draft Report was appreciated by the Committee.

People Pulse Report – Rhia Gohel and Chloe Miller presented the results of this new, more detailed, rolling quarterly survey. Whilst the survey is intended to replace the Friends and Family test, it helpfully retains a question on each of 'place to work' and 'place to be treated' so we can continue to monitor longer-range trend data on what are important barometers of the internal mood. Rhia and Chloe noted that there were some limitations to the new Pulse Survey

(sample size, response rate, range of questions, lack of comparable trend data) but equally it represents a much more current 'in-the-moment' evaluation of staff opinion - and the initial results demonstrated this very clearly. It will not, and is not intended to, displace the Annual Staff Survey but does allow for rapid assessment of staff opinion and sentiment on a range of issues. Over time, and as we begin to accumulate quarterly results, this will be a really useful diagnostic resource to the Trust. The first run of the survey had taken place in August across a selected sample of 2,500 staff, of whom 570 had responded. Rather than try to survey the whole organisation, a decision had been taken to sample a group of staff who were demographically and professionally representative of the organisation. The key finding was that staff engagement had fallen since the 2020 National Survey, but remained materially higher than the average of other NHS acute Trusts. A copy of the survey summary is set out in Annex 2. The Committee had been updated on the detail of the survey and whilst there were areas of further focus identified, the initial results had not raised any new risks to the Trust. We look forward to further reports as this survey gains traction.

Strategy and Risk

Workforce Strategy – the Trust's Workforce Strategy was set in 2018, for the period 2019-2024. This was based on a number of operational assumptions and these are being checked against the more detailed findings of the Discovery phase of the Culture Programme, and against the changed environment as a result of the introduction of the south-west London ICS. It was emphasised that the broad objectives set out in the original strategy remain the priorities.

Trust Governance and Compliance

Q1 Report from Guardian of Safe Working – We were joined by Serena Haywood, the Trust's Guardian. There were two elements to Serena's report. First, an update on the April – June status of exception reporting by our junior doctors. The position had been more settled compared to prior year as the Trust came through the second wave of the pandemic. Exception reports had reduced overall, although there were still significant pressures – particularly as a result of (a) rota gaps in some specialties, and (b) premises and IT failures (which were to be discussed further outside the Committee). There were two exception reports which had raised an immediate patient safety concern, both of which had been addressed at the time. In addition, and something the Committee felt was sensible and appropriate, the 230+ non-contracted doctors and fellows were to be brought within the scope of the Guardian. This would clearly add to the Guardian's workload and we asked that the time allocation for Guardian duties be kept under review. The second part of Serena's report was an update on the changeover of junior doctors at the start of August, and its impact on what was already an exceptionally busy period for the Trust. There was some sense that the immediate service pressures were not being expressed in exception reports. Serena would investigate and work with the CMO, Richard Jennings, to address any issues identified.

Internal Audit Report – Recruitment to band 8D+. We had an initial discussion in August of an internal audit report addressing the Trusts recruitment processes for Band 8D and above. Management accepted substantially all of its findings and recommendations and so it was agreed that management would work up a more detailed response and work plan which would come back to the Committee for review. Although a number of changes were required, there were no immediate material risks to service delivery in the matters identified by the Internal Auditor. At the September meeting the Committee reviewed an updated management response to the Internal Audit Report, which had examined the Trust's procedures and processes in its recruitment of more senior staff. A number of criticisms had been made, which management generally accepted. It was pointed out to the Committee that these arose largely from non-compliance with processes, rather than defective procedures. As a result, the remediation would be based on recruiter and staff practice and behaviour. The individual remediations steps proposed were reviewed and discussed, and the Committee concluded that

they were appropriate and would if implemented successfully address the underlying issues. The Committee also asked for an update in March 2022 on progress on their implementation.

Medical Revalidation – we received a helpful update on revalidation from Luci Etheridge, the Trust's GMC Responsible Officer and Deputy CMO. The key point that Luci made was that following the suspension by the GMC of the revalidation process (including appraisal) during Covid, there was now a material backlog. This, coupled with the revalidation workload arising in the normal course, had meant a decrease in compliance with annual appraisal. This was being addressed but would take time to bring back to more usual levels. Luci also reported that the recommendations of the last High Level Responsible Officer Quality Review (undertaken in early 2020) continued to be implemented. It is clear that much positive work is being done and whilst it will take time to get back on to a normal footing, we are under way with that. In the margins of the Committee discussion on revalidation, we received an informal briefing on the re-set of job planning for consultants. There is clearly much work to be done here as the Trust steps down from its Covid-response and a number of complex challenges to be managed. We will monitor progress at future meetings.

Nursing Revalidation – we received a helpful and comprehensive report from Sharon Suggett (our Head of Nursing – Workforce and Professional Standards) on the monitoring and governance mechanisms in place at the Trust. The conclusion we reached was that the Trust operates a robust and effective system for monitoring nursing, midwifery and nursing associate registration and revalidation. We noted that the NMC's Covid Temporary Register remains open.

Bank Staff Holiday Pay – Paul DaGama briefed the Committee on decisions made in relation to certain staff who had worked for the Trust via the South West London Bank in the year 2019-2020.

Gender Pay Gap Report (19-20) – As previously indicated, the revised text is being checked and once this has been done an updated version will be circulated for wider comment.

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

Stephen J Collier

Committee Chair, 22nd September 2021

Appendix 1

No	Indicator	London average 2020	St George's 2020	St George's 2021	2021 Position vs. 2020
1.	Percentage of BAME Staff in organisation	45.2%	46.4%	47.7%	↑
2.	Relative likelihood of White applicants being appointed from shortlisting compared BAME applicants	1.59	1.47	1.47	→
3.	Relative likelihood of BAME staff entering the formal disciplinary process, compared to that of White staff	1.95	2.54	1.82	↓
4.	Relative likelihood of White staff accessing non-mandatory training and CPD compared to BAME staff	0.97	1.05	1.03	↓
5.	% of BAME staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months.	31.9%	27.4%	27.3%	↓
6.	% of BAME staff experiencing harassment bullying or abuse from staff in the last 12 months	29.3%	30.8%	30.1%	↓
7.	% of BAME staff believing that organisation provides equal opportunities for career progression or promotion	67.1%	63.0%	63.0%	→
8.	% of BAME staff personally experiencing discrimination at work from manager/leader/ or other colleagues.	15.1	16.2%	18.0%	↑
9.	Percentage difference between the organisations' board voting membership and its overall workforce	TBC	-28.2%	-34.9%	↓

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Appendix 2

Summary of results
Summarising the data

As this is the first time the organisation has taken part in the Pulse Survey, there is no previous data to compare this quarter's survey to, nevertheless, some useful information can be gathered to drive forward future work.

Supporting our staff: Health and Wellbeing

7

Key points of interest

Staff engagement at the Trust is higher than the reported average for Acute Trusts but has fallen since the 2020 staff survey

- The Trust in recent years has made huge strides in engaging with staff. This is likely due to the establishment of the Staff Networks, the Culture Champions, the Health and Wellbeing Champions and through further supporting the improvement of the line manager/employee relationship (e.g. Wellness Action Plans; improved appraisals process); however, since the 2020 survey, engagement figures have fallen. Though this may mean that engagement is not as strong as in 2020, a smaller sample within the Pulse Survey has been taken and so scores may not be as accurate as depicted within the 2020 survey results

Colleague mental health and wellbeing is better than the reported average for Acute Trusts

- This is likely due to an enhanced health and wellbeing programme that has been effectively communicated throughout the pandemic, as well as increasing staff resource in wellbeing services

The Trust has more to do on…

- Improving access to childcare provision for staff
- Improving access to financial information and support for staff
- Improving staff engagement
- Improving practical support and opportunities to staff that helps them to do their role (e.g. improving IT, flexible working opportunities)
- Showing staff they are cared for and valued (e.g. by improving safety guidelines, thanking staff for their efforts)

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St George's University Hospitals NHS Foundation Trust

3.1

Meeting Title:	**Trust Board**		
Date:	30 September 2021	**Agenda No**	**3.1.1**
Report Title:	**Workforce Race Equality Standard (WRES) 2021 Report**		
Lead Director/ Manager:	Paul da Gama, Chief People Officer		
Report Author:	Joseph Pavett-Downer, D&I Workforce Lead Humaira Ashraf, Director of Education, Culture and OD		
Presented for:	Endorse		
Executive Summary:	All NHS providers are required to complete an annual Workforce Race Equality Standard Report (WRES). The report is based on a snapshot of data from 31st March each year and aims to highlight progress against a number of key indicators of workforce equality, including a specific indicator to address the low numbers of Black, Asian and Minority Ethnic board members across NHS organisations. In line with national requirements this report has been should be reviewed internally and approved at Board before being published on the organisations website. The deadline for publication is 30th September 2021. The key findings and metrics for this report submission are outlined below. Each point is compared to the previous reporting period in 2020: • Overall, the BAME staff population at St George's continues to increase year on year • BAME staff are over-represented in lower bands • BAME staff are under-represented in higher bands • BAME staff are under-represented at Executive and Board level, both in voting and non-voting. • Most notably across the AFC Bands, we see an increase in BAME representation at Band 6 which brings us to 55% representation. This is the first recorded leadership and management AFC band to tip the scale in favour of Black, Asian and ME staff. • The relative likelihood of white applicants being appointed from shortlisting compared to BAME applicants remain the same (as the previous reporting period) at 1.47 • The relative likelihood of BAME staff entering the formal disciplinary process compared to white staff has reduced from 2.54 to 1.87 • Relative likelihood of white staff accessing non–mandatory training and CPD (compared to BAME staff) has reduced from 1.05 in 2020 to 1.03 in 2021 • Overall we see a 10% reduction in staff accessing non-mandatory training and CPD (compared to 2020) • We see a slight reduction in the levels of BAME staff reporting experiencing bullying, harassment or abuse from patient, relatives and visitors. • BAME staff reported experiencing slightly increased levels of bullying, harassment and abuse a manager, team leader or colleague.		
Recommendation:	The Board is asked to note the report and approve the publication of the WRES 2021 report and narrative on the Trust's website.		

Supports			
Trust Strategic Objective:	Culture		
CQC Theme:	Safe, Effective, Responsive, Well-Led		
Single Oversight Framework Theme:			
Implications			
Risk:	Our staff do not feel safe to raise concerns and are not empowered to deliver to their best because we fail to build an open and inclusive culture across the organisation which celebrates and embraces our diversity.		
Legal/Regulatory:			
Resources:			
Equality and Diversity:	The D&I Action Plan is designed to close the gap in workplace inequalities.		
Previously Considered by:	Workforce and Education Committee	**Date**	16 September 2021
Appendices:	WRES report		

St George's University Hospitals NHS
NHS Foundation Trust

National Workforce Race Equality Standard (WRES)

St George's 20-21 Report

St George's University Hospitals NHS
NHS Foundation Trust

St George's University Hospitals NHS
NHS Foundation Trust

1. Executive Summary:

All NHS providers are required to complete an annual Workforce Race Equality Standard Report (WRES). The report is based on a snapshot of data from 31st March each year and aims to highlight progress against a number of key indicators of workforce equality, including a specific indicator to address the low numbers of Black, Asian and Minority Ethnic board members across NHS organisations.

In line with national requirements this report should be reviewed internally and approved at Board before being published on the organisations website. The deadline for publication is 30th September 2021.

The key findings and metrics for this report submission are outlined below. Each point is compared to the previous reporting period in 2020:

- Overall, the BAME staff population at St George's continues to increase year on year
- BAME staff are over-represented in lower bands
- BAME staff are under-represented in higher bands
- BAME staff are under-represented at Executive and Board level, both in voting and non-voting.
- Most notably across the AFC Bands, we see an increase in BAME representation at Band 6 which brings us to 55% representation. This is the first recorded leadership and management AFC band to tip the scale in favour of Black, Asian and ME staff.
- The relative likelihood of white applicants being appointed from shortlisting compared to BAME applicants remain the same (as the previous reporting period) at 1.47
- The relative likelihood of BAME staff entering the formal disciplinary process compared to white staff has reduced from 2.54 to 1.87
- Relative likelihood of white staff accessing non–mandatory training and CPD (compared to BAME staff) has reduced from 1.05 in 2020 to 1.03 in 2021
- Overall we see a 10% reduction in staff accessing non-mandatory training and CPD (compared to 2020)
- We see a slight reduction in the levels of BAME staff reporting experiencing bullying, harassment or abuse from patient, relatives and visitors.
- BAME staff reported experiencing slightly increased levels of bullying, harassment and abuse a manager, team leader or colleague.

St George's University Hospitals NHS
NHS Foundation Trust

2. Purpose

- This paper provides a summary of the 2021 Workforce Race Equality Standard (WRES) findings.
- This report will be published on our website, alongside the D&I action plan.
- The Board is asked to receive this report for information and approve for publication.

3. Background

- In April 2015, NHS England introduced the WRES in response to consistent findings that BAME applicants and staff consistently fared worse in employment outcomes and satisfaction surveys. The WRES was designed to enable NHS organisations to demonstrate progress against a number of key indicators of workforce equality, including a specific indicator to address the low levels of BAME Board representation.
- Since April 2015, the WRES has been included in the full length NHS Standard Contract and requires all providers of NHS services to address the issue of workforce race inequality by implementing and using the WRES.
- There are nine WRES indicators. Four of the indicators focus on workforce data, four are based on data from national NHS Staff Survey questions, and one indicator focuses upon BME board representation. The WRES highlights differences between the experience and treatment of White staff and BAME staff in the NHS with a view to organisations closing those gaps through the development and implementation of action plans focused upon continuous improvement over time.
- The WRES is produced in line with Technical Guidance issued by NHS England.
- Indicators 1-3 and 9 are produced via the Electronic Staff Record (ESR) from a snapshot of data taken on 31st March 2021. All other indicators are from the 2020 staff survey

4. Key Staff Metrics

	2021	2020	2019
Total number of staff in organisation	9154	8,873	8,884
% of *BAME* Staff	47.7%	46.1%	44.6%
% of staff who self-reported ethnicity	96.1%	96.7%	97.22%

St George's University Hospitals NHS
NHS Foundation Trust

5. Indicator Overview

No	Indicator	London average 2020	St George's 2021	Position vs. 2020
1.	Percentage of BAME Staff in organisation	45.2%	47.7%	↑
2.	Relative likelihood of White applicants being appointed from shortlisting compared BAME applicants	1.59	1.47	→
3.	Relative likelihood of BAME staff entering the formal disciplinary process, compared to that of White staff	1.95	1.82	↓
4.	Relative likelihood of White staff accessing non-mandatory training and CPD compared to BAME staff	0.97	1.3	↓
5.	% of BAME staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months.	31.9%	27.3%	↓
6.	% of BAME staff experiencing harassment bullying or abuse from staff in the last 12 months	29.3%	30.1%	↓
7.	% of BAME staff believing that organisation provides equal opportunities for career progression or promotion	67.1%	63.0%	→
8.	% of BAME staff personally experiencing discrimination at work from manager/leader/ or other colleagues.	15.1	18.0%	↑
9.	Percentage difference between the organisations' board voting membership and its overall workforce	TBC	-34.9%	↓

*The WRES London data for 2021 is not due for publication until later this year so our performance in 2021 is compared to the London average for the previous reporting period (2020).

6. INDICATOR 1: '*Percentage staff by AfC pay band and ethnicity'*

As with previous reporting years, we continue to see a small increase year on year across our Black, Asian and Minority Ethnic workforce. For this reporting year, we see an increase of +1.3% on our 2020 report, this equates to around +238 'BAME' full time equivalent members of staff employed at the organisation.

Whilst we see a pattern of increase, overall, across the workforce, our workforce data still highlights that Black, Asian and Minority Ethnic (BAME) staff are over-represented in lower bands and under-represented in higher bands. This is not unique to St George's and mirrors what we see across London NHS trusts (see table A and B).

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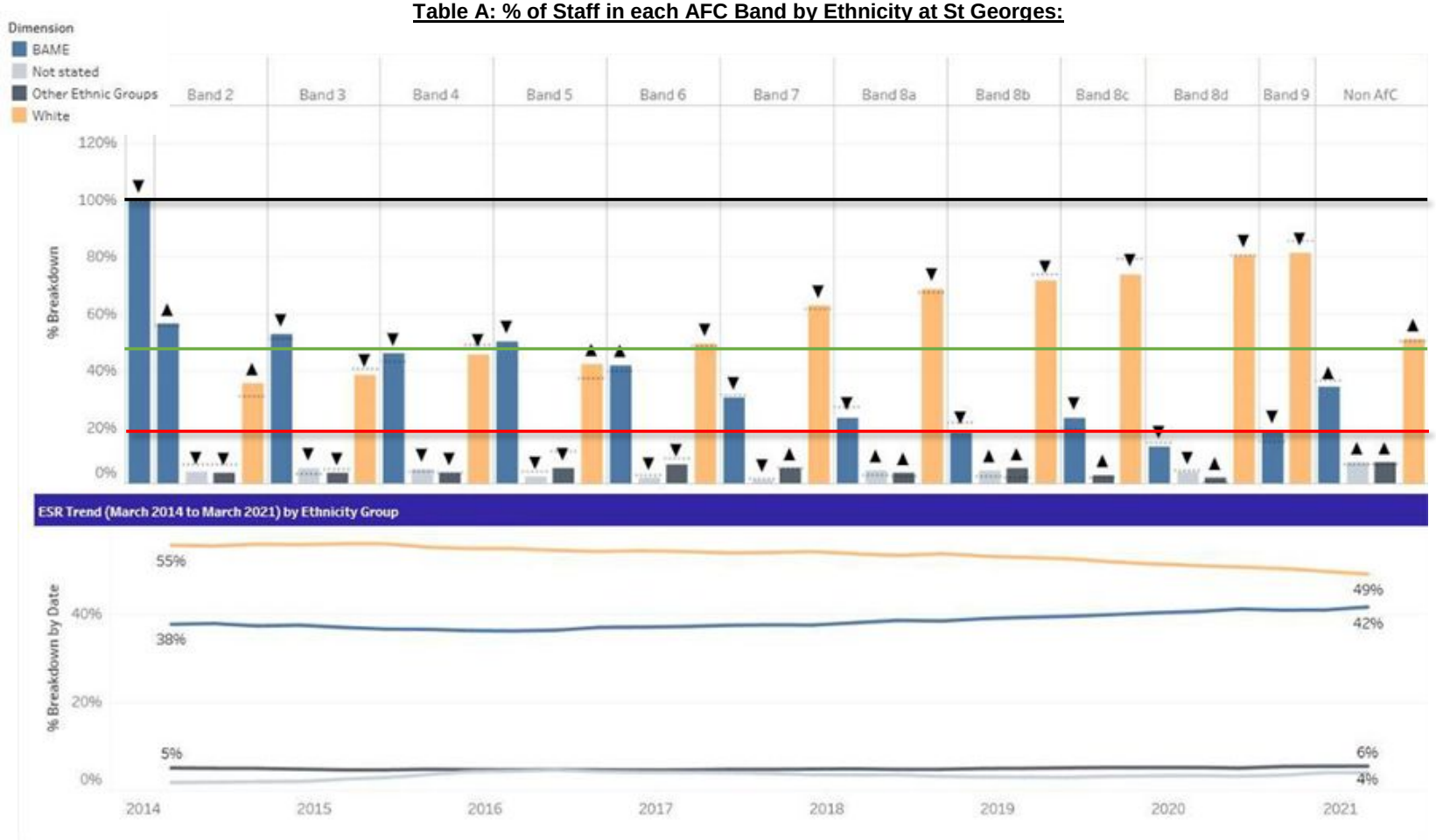
Table A: % of Staff in each AFC Band by Ethnicity at St Georges:

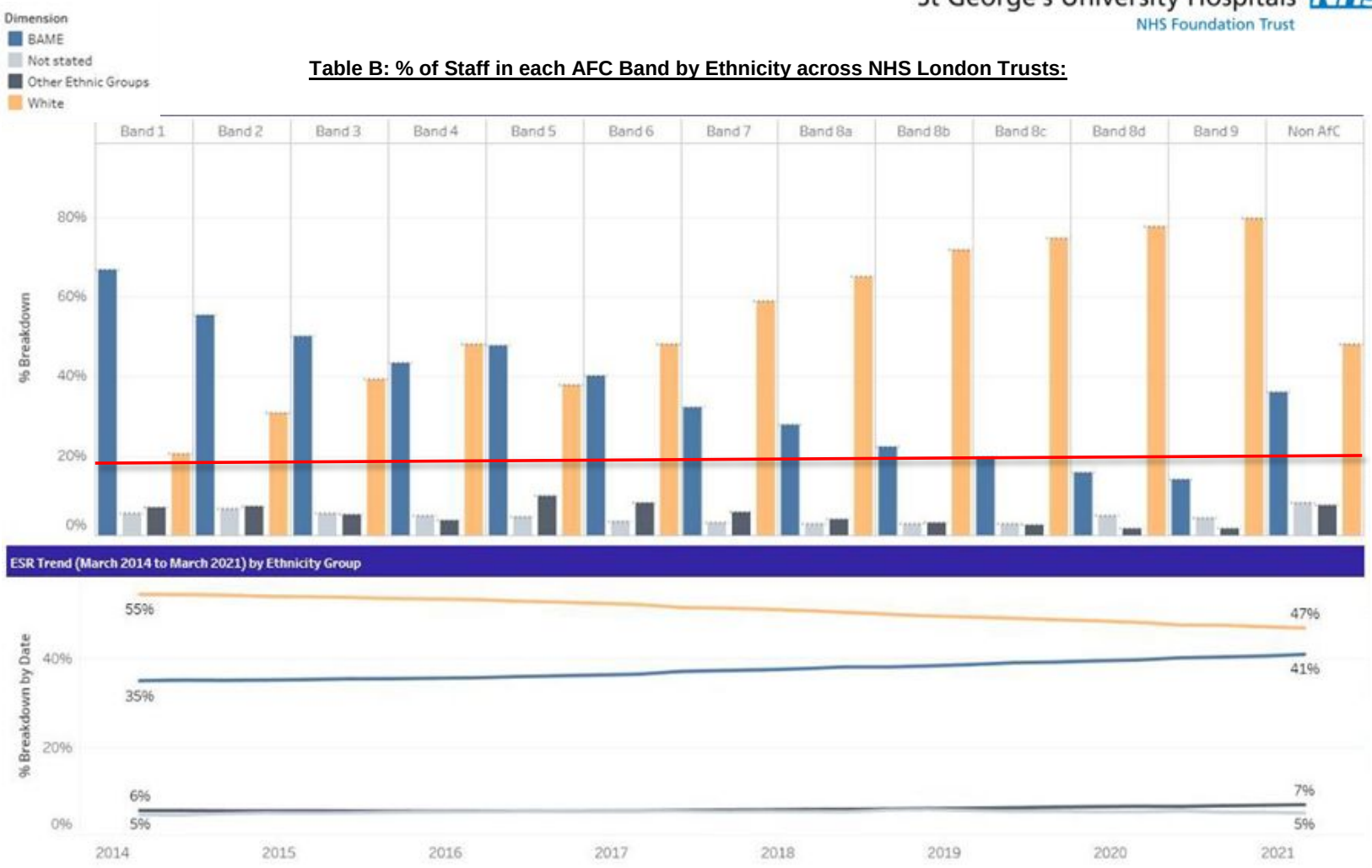


Note: The solid red line indicates NHE/I target of 19% Black, Asian and ME staff in each AFC pay band.
The solid green line indicates the target for St George's to be representative across all AFC pay bands.

St George's University Hospitals NHS
NHS Foundation Trust

3.1

Table B: % of Staff in each AFC Band by Ethnicity across NHS London Trusts:



Note: The solid red line indicates the national target of a at least 19% Black, Asian and ME staff in each AFC pay band

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Clinical Staff

For Clinical staff (table C), we see an increase (vs. the previous reporting year) in the percentage of Black, Asian and Minority Ethnic staff across 7 of the 12 AFC bands. Most notably in band 4 where we see an increase of 11% (*+47*). We have seen a decrease in representation across 3 of the AFC bands, most notably in AFC band 9 where we see a significant reduction (-13%) in Black, Asian and Minority Ethnic representation, from 33% in 2020 to 20% in 2021. The number of White staff in AFC band 9 reduced in 2020 to 67%, this is back up at 80% this reporting year, which is consistent with the previous two reporting years (2019 and 2018). It is worth noting however, that this change in representation is due to two additional band 9 roles that have been introduced in this reporting year. This shifts representation in this banding from 2 White:1 BAME (3 posts in total) to 4 White:1 BAME (5 posts in total) member of staff at Band 9.

Overall, across the Clinical workforce we see an increase of 131 Black, Asian and ME members of staff, this equates to 4.8%. We see a reduction of 2 FTE members of staff recorded as ''Ethnicity Unknown'. For White Staff we see a reduction by 49 members of staff (-1.8%).

Table C: % of BAME vs. White Clinical Staff in each AFC Band at St George's:

	Banding	2021 Headcount	BAME +/- vs. PRP*	2021 (%)**	2020 (%)**	2019 (%)**	2018 (%)**
Clinical Staff	Band 2	733	+2%	70/26	72/25	69/27	53/44
	Band 3	307	-1%	63/35	64/33	60/38	41/57
	Band 4	203	+11%	60/37	49/49	51/48	42/55
	Band 5	1288	+5%	58/40	53/45	50/48	44/54
	Band 6	1369	+1%	48/50	47/51	45/53	48/50
	Band 7	1094	+3%	35/63	32/66	31/67	30/68
	Band 8a	319	0%	25/72	25/72	24/74	24/74
	Band 8b	79	+2%	23/76	21/78	22/76	22/77
	Band 8c	32	-4%	16/84	20/80	17/83	11/89
	Band 8d	11	+3%	18/82	15/85	8/92	6/94
	Band 9	5	-13%	20/80	33/67	17/83	20/80
	VSM	1	0%	0/100	0/100	100/0	100/0

*% increase or decrease in the number of Black, Asian and Minority Ethnic Staff in the current reporting period vs. the previous reporting period

** In these columns the first % figure indicates BAME representation and the second figure indicates White Representation i.e. 70% BAME / 25% White

Non-Clinical Staff:

For Non- Clinical staff (table D), we see an increase (vs. the previous reporting year) in the percentage of Black, Asian and Minority Ethnic staff across 6 of the 13 AFC bands. Most notably in band 6, where we see an increase of 8% *(+14),* this increase brings us to 55% BAME representation at this level. Though early days, this is the first recorded leadership and management AFC band increase to tip the scale in favour of Black, Asian and ME staff.

We have seen a decrease in representation across 5 of the AFC bands, most notably at Very Senior Manager (VSM) level, where we see a reduction of -14% *(-3)* in Black, Asian and Minority Ethnic representation, from 21% in 2020 to 7% in 2021. The percentage of White staff at VSM level has increased by +14% from 79% in 2020 to 93% in 2021. However, in terms of headcount it is a reduction of White Staff at VSM level as this was 16 in 2020 to 14 in 2021. Black, Asian and ME staff at VSM has gone from 4 in 2020 to 1 in 2021.

Overall, Black, Asian and Minority Ethnic representation across leadership and management roles has increased, this is across AFC bands 6, 8A, 8B, 8D and 9. We see a slight reduction in representation, in terms of percentage, at AFC bands 7 (-1%) and 8c (-2%). Within these two AFC bands the number of White staff has increased at a similar percentage, +1% and +3% respectively. Whilst both of these bands see a percentage reduction, it is not because the number of BAME staff have decreased, the number of BAME staff has actually increased in both AFC bands 7 and 8c, however the number of White staff in these bandings has increased at a higher rate, which results in a reduction in representation overall in these bands.

Overall, across the Non-Clinical workforce we see an increase of 47 Black, Asian and ME members of staff, this equates to 5.17%. We also see an increase of 50 FTE members of staff recorded as ''Ethnicity Unknown'. For White Staff we see a reduction by 21 headcount (1.2%).

Whilst these numbers are modest improvements on 2020 and there is still a long way to go, they represent a further step in the right direction, particularly towards a more representative non-clinical management structure in the organisation. BAME representation for 8A+, including board and non-executive directors, is still particularly low and will need to be driven as part of our D&I strategy. Table D (below) give a breakdown of figures across four years, this details the % of BAME vs. % of White employees.

Table D: % of BAME vs. White Non-Clinical Staff by Grade at St George's:

	Banding	2021 Headcount	BAME +/- vs. PRP*	2021 (%)**	2020 (%)**	2019 (%)**	2018 (%)**
Non-Clinical Staff	Band 1	1	0%	100/0	100/0	100/0	67/14
	Band 2	515	+1%	48/48	47/50	47/49	62/34
	Band 3	305	-2%	50/41	52/44	52/45	55/43
	Band 4	472	0%	45/49	45/51	46/52	42/54
	Band 5	202	-1%	42/52	43/54	40/58	40/56
	Band 6	134	+8%	55/39	47/51	41/57	42/56
	Band 7	148	-1%	43/57	44/56	34/66	32/67
	Band 8a	96	+3%	33/57	30/67	28/70	34/65
	Band 8b	52	+1%	28/62	27/69	26/70	23/73
	Band 8c	32	-2%	38/63	40/60	28/72	14/86
	Band 8d	32	+5%	15/79	10/85	7/93	13/88
	Band 9	11	+5%	27/73	22/78	0/100	0/100
	VSM	15	-14%	7/93	21/79	9/91	5/95

*% increase or decrease in the number of Black, Asian and Minority Ethnic Staff in the current reporting period vs. the previous reporting period

** In these columns the first % figure indicates BAME representation and the second figure indicates White Representation i.e. 70% BAME / 25% White

Medical Staff:

For completeness we have included data on Medical staff (see table E) however this is not required as part of the organisation's annual WRES submission. This year, NHS England and Improvement's National WRES Team have introduced the Medical Workforce Race Equality Standard Report (MWRES).

The 2020 MRES Report was published in August 2021 so further analysis and review will take in partnership with the Chief Medical Officers Office. Click here to view a copy of the 2020 MWRES Report.

Table E: % of BAME vs. White Medical Staff by Grade at St George's:

		BAME +/- vs. PY*	2021	2020	2019	2018
Medical Staff **	Consultant	+1%	37/56	36/56	36/57	34/58
	Trust Grade	+10%	60/36	50/39	59/38	47/41
	Trainee Grade	+4%	43/48	39/53	38/57	38/57

Action taken and planned:

In 2020, following the appointment of our substantive Diversity and Inclusion Workforce Lead, we invested a significant amount of time in re-developing our action plan to ensure it reflects the needs of our workforce, particularly in regards to equal opportunities for our Black, Asian and Minority Ethnic staff. This action plan was approved in October 2020.

To support the organisation in becoming a more responsible, more inclusive employer, we have focused on delivering on the commitments made within each of our six work streams. The six work streams are outlined below, along with the 'action' taken within each.

1. *Improving the Career Progression of "BAME" Staff*
   - Launched the Recruitment Inclusion Specialist process
   - Trained 100 members of staff to support recruitment panels and champion inclusive, unbiased recruitment
   - This is now a mandatory process for all AFC Band 7+ roles and consultant recruitment panels
   - Supported the development of a 1 day bespoke SWL Inclusive Recruitment and Selection Training. Following the current phased introduction period, this will be a mandatory requirement for all recruiting managers and panel members.
   - Formalised feedback and careers coaching for those that are unsuccessful at interview

2. *Improving development opportunities and ensuring equal access for staff*
   - Refreshed our PDR Process
   - Introduced a CPD Application Review Panel

3. *Building awareness and understanding*
   - Developed and launched our *Let's Talk about Race and Inclusion: A toolkit for leaders in starting a team dialogue about tackling racism*

- Piloted Exploring our Bias' and Building Inclusion Workshops.
- Delivered tailored D&I Awareness Sessions to over 300 staff members
- Developed and published the Diversity and Inclusion Intranet Hub
- Supported departmental led D&I initiatives, action plan development and working groups

4. *London Workforce Race Equality Strategy Recommendations*
   - Our Diversity and Inclusion Lead and one of our Heads of Nursing have joined the London WRES Experts Programme.

5. *Leadership Commitment*
   - Monthly review and monitor of progress via our D&I Impact Tracker
   - Monthly Progress Updates provided to Executive Team
   - D&I Module added to all internal leadership development programmes
   - Successfully secured places on the NHSE/I White Allies Programme for six senior white leaders at the organisation
   - Developing Leadership Capabilities:
     - An Inclusive Leadership Module added to (and inclusion elements added throughout) our King's Fund Advanced Leadership Development Programme
     - Existing and new management and leadership development programmes are now being designed (or redesigned) with Equity and Inclusion as an integral 'golden thread' throughout each. Each programme will now closely reflect (i) our ambitions within our D&I action plan, (ii) clear expectations of leaders to tackle inequities and build inclusive cultures, and (iii) affective and skills development in fulfilling these expectations.
     - This includes two new leadership programmes for (i) Matrons, Senior Therapists & Midwives and (ii) Ward Managers and AHPs

6. *Listening and responding to concerns raised by BAME staff*
   - Introduced HR Decision Tree (Grievance management process)
   - Introduced Free2Speak Up Champions (with training and protected time)

7. *Organisation-wide Culture Development Programme*
   - Alongside and closely aligned with the organisational D&I Action Plan, St George's continues with its culture improvement programme, guided by the NHSE/I Culture and Leadership Programme. Together, these 2 areas of work make up the Culture, Equity and Inclusion Programme.
   - Central to this culture improvement programme is the need to build a more inclusive culture. Ambitious targets for measuring our culture have been set, using indicators from the staff survey, workforce data and staff ethnicity composition at all levels. Measuring diversity and inclusion features heavily in how we are measuring cultural change.
   - A new Culture, Equity and Inclusion Programme Board has been established to oversee delivery and success of this organisation-wide programme. The Board is chaired by our CEO, and includes representatives from all Divisions, as well as leaders of our 4 D&I staff networks.

7. **INDICATOR 2: '*Relative likelihood of white applicants being appointed from shortlisting compared to BAME applicants'***

2021	2020	2019
1.47	1.47	1.57

Whilst the relative likelihood of appointment remains at 1.47 for the second consecutive year, the numbers of staff being appointed across all bands has increased. 34.36% of white shortlisted applicants were appointed, compared to 31.21% in 2020. 23.41% of shortlisted Black, Asian and Minority Ethnic applicants were appointed, compared to 21.25% in 2020. Whilst these are both increases (3% and 2% respectively), it is important to keep the focus on the relative likelihood of appointment of over BAME staff as this indicates any success in shifting the dial to a fairer, more representative organisation. As long as we see an increased likelihood of appointment for White Staff we have to challenge whether our processes and systems are equitable.

For applicants that did not record an ethnicity we saw a lift of 6% on 2020's data to 74% of applicants appointed from shortlisting. This translates to 837 applicants in 2021 vs. 654 in 2020. Interestingly, 74% of undisclosed applicants were shortlisted compared to 34% for White and 23% for BAME. Does this indicate that those that do not disclose an ethnicity are high calibre candidates concerned about disclosure and the possible impact on successfully securing an interview?

Action taken and planned:
Two of our AP work steams (noted above) will support improving career progression and development opportunities for BAME staff.

This includes:

- Introduced trained Recruitment Inclusion Specialist on all interview panels for AFC Band 7+ and consultant recruitment panels.
- We are currently scoping extending this to include B6+ (including all internal acting up and secondment opportunities)
- Mandatory Inclusive Recruitment and Selection Training for all recruiting managers, with a challenging bias module included
- Formalised feedback and careers coaching for those that are unsuccessful at interview
- Interview Skills Training for staff
- New significant funding has been secured to investment in our Organisational Development function. This will include staff to lead on Leadership Development and Inclusive talent Management, both which will align with and support our D&I agenda.
- Developing a D&I training and learning framework that will include developing D&I competencies for staff and leaders, updating the mandatory trust wide Equality & Diversity Module, and introducing challenging bias workshops

8. **INDICATOR 3: '*Relative likelihood of BAME staff entering the formal disciplinary process compared to white staff'***

2021	2020	2019
1.82	**2.54**	**1.82**

2021's data show a notable improvement (on 2020) in this indicator, with BAME staff 1.82 times more likely (relative to white staff) to enter a formal disciplinary process. This is down from 2.54 in the previous year. Whilst this is notable improvement, it is still higher than that of White staff. There is work still to be done to ensure responsible and fair decision within the disciplinary process at the organisation. In terms of the numbers of BAME staff entering the disciplinary process, this is down from 73 in 2020 to 57 in 2021. The number of White staff remains similar at 34 in 2020 to 32 in 2021.

Action taken and planned:
This is being addressed as part of our D&I Action Plan which has been redeveloped into a set of deliverables and actions. Work stream 3 - 'Listening, Supporting and Responding to Concerns Raised by our Staff' features 5 key deliverables that aim to create an environment where staff feel supported to raise concerns and confident that the processes we have in place are fair and effective. The measure of success for this particular work stream is a decreased likelihood of BAME staff entering the formal disciplinary process.

In addition, in late 2020 we introduced a central repository for employee relations activity. We hope this will continue to support us in identifying hotspots and trends to enable us to target interventions with regards to disciplinary cases that involve staff from BAME backgrounds

9. **INDICATOR 4: '*Relative likelihood of white staff accessing non–mandatory training and CPD compared to BAME staff'***

	2020			2021		
	White	**BAME**	**Unknown**	**White**	**BAME**	**Unknown**
Number of staff in workforce	4538	4098	294	4464	4336	354
Number of staff accessing non-mandatory training and CPD	1675	1444	84	1142	1076	60
Likelihood of staff accessing non-mandatory training and CPD	36.91%	35.24%	28.57%	25.58%	24.82%	16.96%
Relative likelihood of white staff accessing compared to BAME staff	1.05			1.03		

This year we see a decrease in all staff accessing non-mandatory training and CPD. For BAME staff, the likelihood of accessing non-mandatory training and CPD is 24.82%, this is down from 35.24% in 2020.

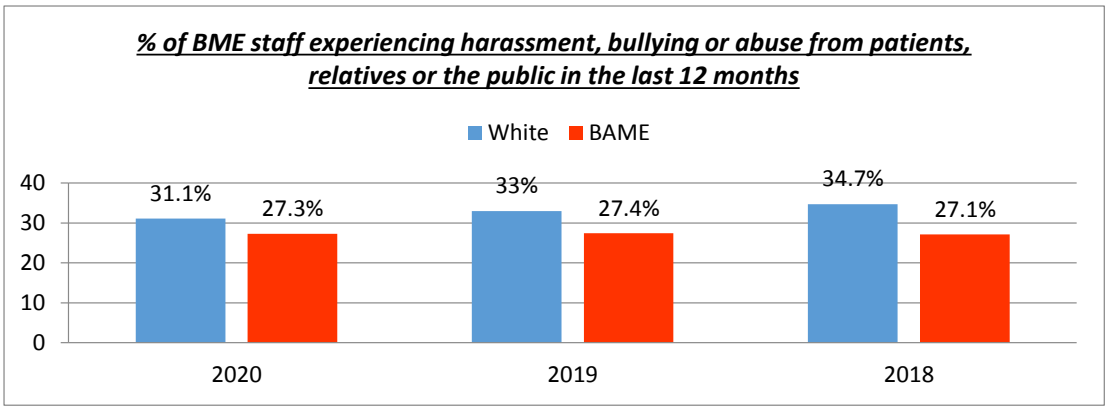
For White staff, the likelihood of accessing non-mandatory training and CPD is 25.58%, this is down from 36.91% in 2020.

Overall, across all ethnic groups, including 'unknown', we see roughly a 10% reduction in staff accessing non-mandatory training and CPD. As this is across all groups it may suggest a trust wide barrier that could be attributed to the COVID pandemic.

Action taken and planned:

Our action plan (work stream 2) includes the introduction of a panel process to review applications for higher value CPD programmes as well a trust wide review of the process and application for general training and development opportunities.

10. Indicator 5: *'% of BME staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months'*

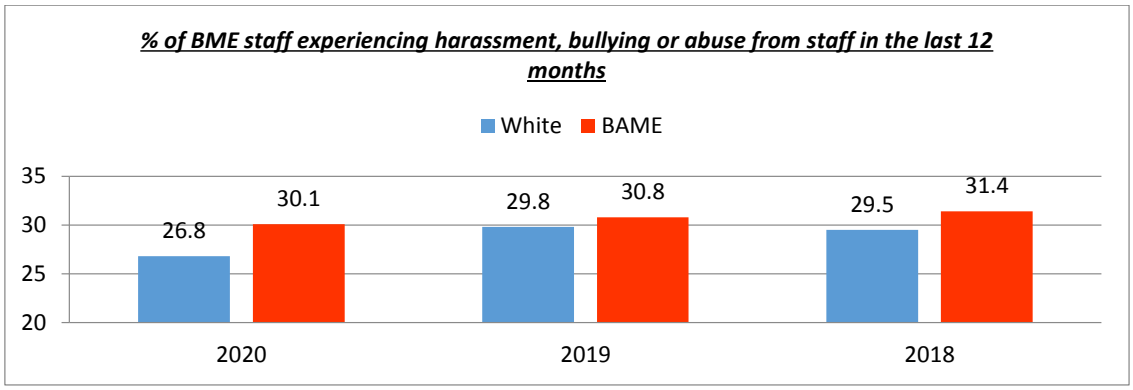


Source: NHS Staff Survey 2020

The results for 2020 and 2019 remain fairly consistent for BAME Staff, with a slight reduction of 0.1% in 2020. For White Staff we see a greater increase, however this is still relatively small at just -1.9% compared to 2019.

Compared to the benchmark group, White Staff at St George's reported higher instances (31.1%) of harassment, bullying or abuse (from patients, relatives) compare to the White Staff within the average benchmark group (25.4%). BAME Staff at St George's reported slightly lower (27.3%) instances compared to the BAME average benchmark group (28.0%).

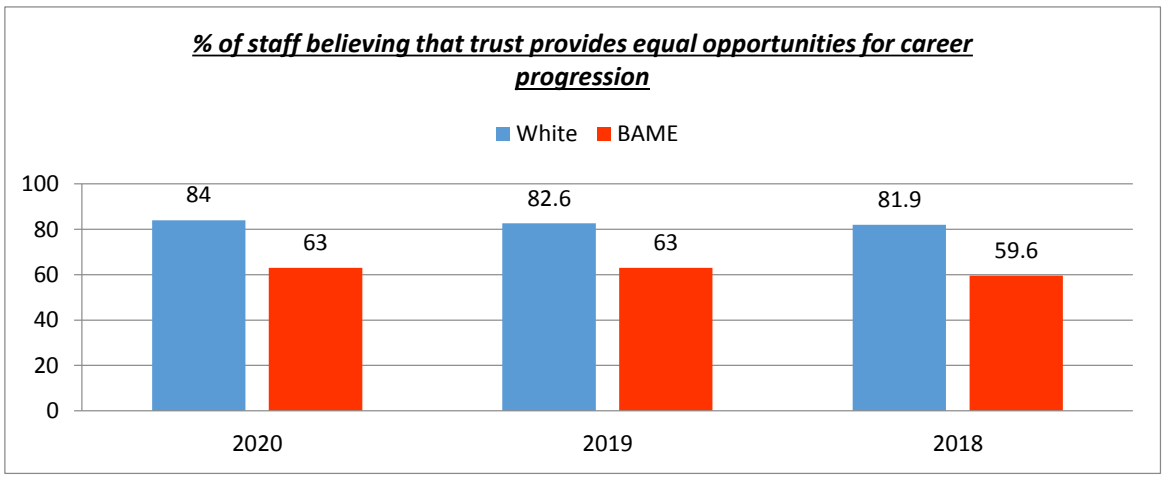
11. Indicator 6: *'% of BAME staff experiencing harassment, bullying or abuse from staff in the last 12 months'*



Source: NHS Staff Survey 2020

In 2020 30.1% of BAME Staff reporting experiencing harassment, bullying or abuse from staff in the 12 month reporting period, this follows a downward trend from 2018 and is a slight reduction compared to 30.8% in 2019. For White Staff there is a greater reduction from 29.8% in 2019 to 26.8% in 2020. This a difference of 3.3% between White and BAME Staff in 2020. Both White and BAME staff report higher instances harassment, bullying or abuse (from staff) compare to the national average for both groups.

12. Indicator 7: *'% of staff believing that trust provides equal opportunities for career progression'*



Source: NHS Staff Survey 2020

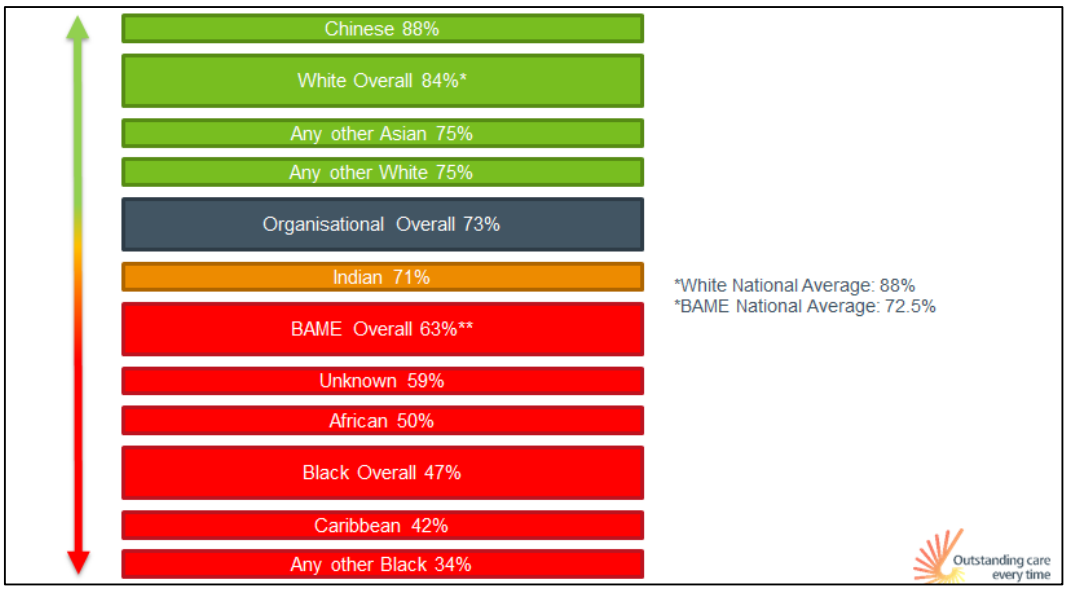
We see a slight increase (+1.4%) for White staff whilst the result remains the same for staff categorised under the *'BAME'* umbrella (63%). Nationally, we have dropped from 73.4% in 2019 to 73.2% in 2020. Whilst this is not a significant reduction this is one of the staff survey

indicators where we see greatest difference (11.5%). between the current trust position and the national average benchmark group.

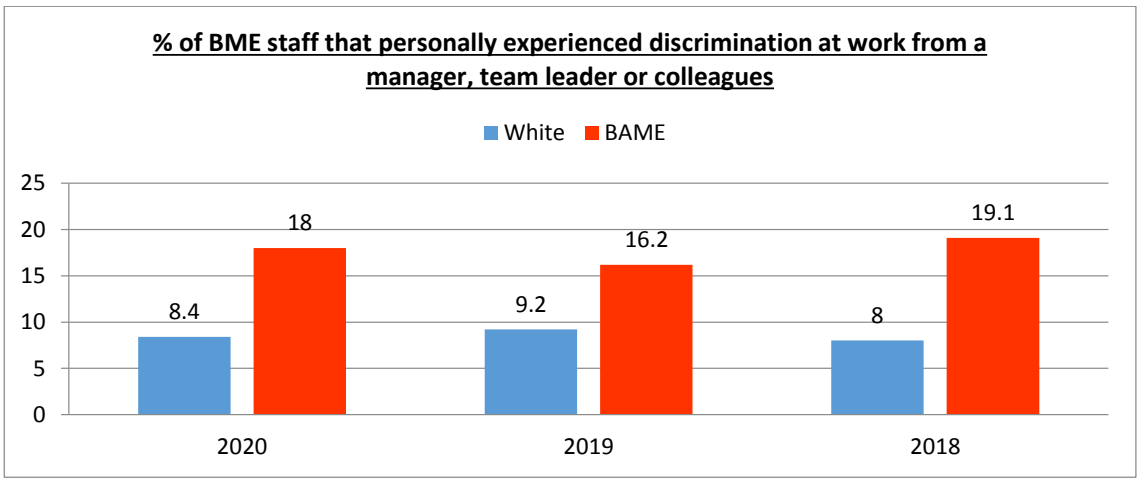
At St George's, there are significant variances in how staff from different ethnic backgrounds perceive fairness with regards to career progression – particularly when looking at the difference ethnicities within the '*BAME*' umbrella (see table F). These variances reinforce the importance of recognising the varied experiences of individual minority ethnic groups, and the importance of responding with appropriately tailored interventions to improve the experiences of staff from different ethnic backgrounds.

In particular, the experience of black staff appears significantly different to that of the wider BAME category. Overall, only 47% of Black respondents believe the organisation acts fairly with regards to career progression, a sharp contrast to the 63% of '*BAME Overall'*, the 84% of White respondents and the 73% for '*Organisational Overall'.*

Table F: % of staff that believe the organisation acts fairly with regards to career progression split by ethnicity:



13. Indicator 8: '% of BAME staff that personally experienced discrimination at work from a manager, team leader or colleagues'



Source: NHS Staff Survey 2020

In 2020, 67% of staff that reported experiencing discrimination indicated that it was based on ethnicity. This suggests there were at least 640 individual instances of racial discrimination in the 12 month period covered by the 2020 Staff Survey. As an organisation (for all ethnicities including white) we are closer to the 'worst' performing acute Trust than we are to the 'average' nationally.

If we look specifically at White compared to BAME staff, we see that White staff reported a slight reduction (-0.8%) in instances of discrimination from a manager, team leader or colleague. Staff categorised under the *'BAME'* umbrella reported an increase (+1.8%) of instances of discrimination from these sources.

As with other WRES staff survey indicators the experience of black staff appears notably poorer compared to that of the wider BAME category. Overall, 25% of Black staff reported experiencing instances of discrimination; this is in contrast to 18% of *'BAME Overall'*, 13% for '*Organisational Overall'* and 8% for '*White Overall'.* These findings strongly suggest that a more focus and individualised approach is required to understand the experiences and barriers to different minority ethnic groups within the 'BAME' umbrella.

St George's University Hospitals NHS
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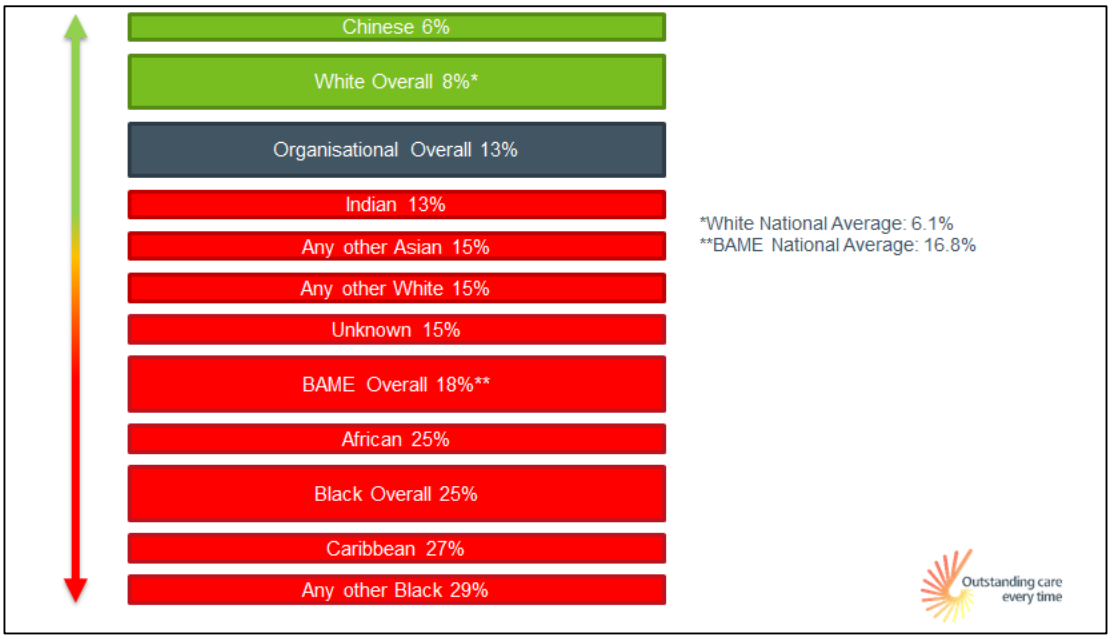
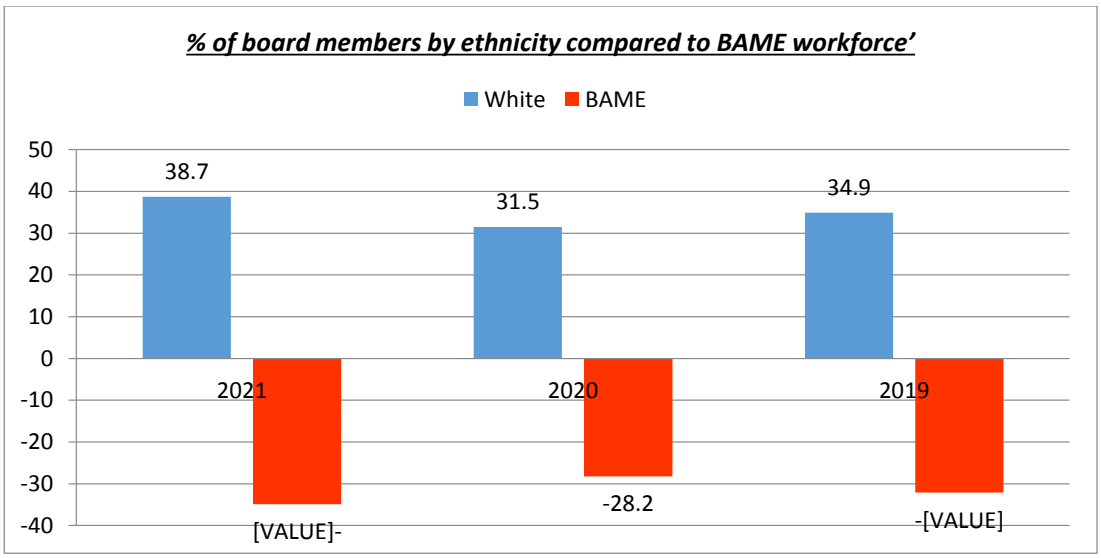
Table G: '% of BAME staff that personally experienced discrimination at work from a manager, team leader or colleagues':



14. **INDICATOR 9: *'Percentage of board members by ethnicity compared to BME workforce'***



As at 31 March 2021, the Trust Board comprised of 16 substantive and 1 interim member, two of whom were from a *BAME* background (one Non-Executive Director and one Associate Non-Executive Director). Of this, among the 11 voting members of the Board there was one *BAME* member (a Non-Executive Director). For the purpose of this report and consistency, the interim member has not been included in the workforce data or the graphs featured in this report.

In terms of the total Board composition in 2021, as representatives of the total workforce, white people are 38.7% *over*-represented, and *BAME* people are 34.9% *under*-represented.

This is a regretful reduction from 2020, where white people were 31.5% over-represented, and BAME people were 28.2% under-represented, at board level. BAME people are now 6.7% more underrepresented than they were in 2020.

This shift was due to two BAME Board members leaving the organisation in 2020. The number of White Board members remained the same as 2020. In 2020, the composition of the Board included four *BAME* members out of a total Board of 17 members (one NED, one associate NED, the Chief Operating Officer and the Chief People Officer).

Due to the relatively small number of Board members, even a small shift in board level composition can reflect significant changes in percentages of the Board over or under representation compared with the total workforce.

Action taken and planned:

In January 2020, one new Non-Executive Director and one Associate NED joined the Trust Board, both of whom are from a BAME background. This followed an external appointments process, which had sought to attract candidates from a diverse range of applicants.

Building on this, in autumn 2020, following a comprehensive procurement exercise, we commissioned an executive search company to help us to recruit BAME candidates to 4 Very Senior Management (VSM) posts, two of which were at executive directorate level. Despite the rigour of our recruitment search, the composition of our Board and senior

management team is predominately made up of non-BAME leaders. One of the reasons given for this unsatisfactory executive search outcome is that the talent pool with regards to the recruitment of experienced and appropriately qualified BAME leaders is limited. As the Trust remains fully committed to increasing the diversity of our Board and senior management team we are taking following actions to address the 'perceived' lack of 'talented' BAME senior leaders:

Increasing our internal pipeline of high quality BAME candidates for senior level positions through the introduction and implementation of the 'Positive Action Talent Development Programme'

We are currently in the process of putting plans in place to develop and implement a CEO led positive action programme aimed at band 8c and above BAME colleagues. The objectives of the programme is to:

- Support AFC Band 8c colleagues from Black, Asian and Minority communities to progress into AFC Band 8d or 9 roles within 24-36 months of completing the programme;
- Support AFC Band 8d – AFC Band 9 colleagues from Black, Asian and Minority communities to progress into executive level roles within 24-36 months of completing the programme.

Removing barriers and supporting our BAME Leaders to not only survive but thrive within our Trust

We are holding a series of focus group sessions with our BAME leaders both from the medical and non-medical functions. The purpose of the focus groups will be to:

- Understand the lived experience of BAME leaders at St George's – what helps and hinders them to perform to their full potential;
- Understand what the Trust needs to do to improve retention and career progression of our existing BAME leadership.

It is our intention to analyse data from the focus groups and to develop a series of recommendations that will improve retention and the career progression of all BAME leaders within the Trust.

Remove bias from our recruitment processes

We are taking a range of steps to ensure that our recruitment and selection process is fair and equitable, for example:

- Trained 120 recruitment inclusion representatives (RIS) to sit on all interview panels for band 7 and above posts;
- Working with our recruitment partners to introduce unconscious bias as a core element of recruitment and selection training. It is our intention to also make attendance at recruitment and selection training a mandatory requirement for all recruiting managers.

Are there any other factors or data which should be taken into consideration in assessing progress?

We have established a Culture, Equity and Inclusion (CEI) Programme Board. This board meets monthly and is chaired by the Chief Executive Officer. The primary aim of the CEI

Programme Board is to lead the implementation of a culture change programme that promotes inclusion and where diversity of the workforce is celebrated. The membership of the Board includes a number of BAME leaders and staff including the BAME Network Chair. Many of our culture change measures of success include improvement in our WRES data.

St George's University Hospitals NHS
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APPENDIX 1: WRES 2020/21 Raw Data Submission:

Answer Required
Auto Populated
N/A

INDICATOR		DATA ITEM		MEASURE	2020 WHITE	2020 BME	2020 ETHNICITY UNKNOWN/NULL	2021 WHITE	2021 BME	2021 ETHNICITY UNKNOWN/NULL	Notes
			1a) Non Clinical workforce		Verified figures	Verified figures	Verified figures	Verified figures	Verified figures	Verified figures	
1	Percentage of staff in each of the AfC Bands 1-9 OR Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce	1	Under Band 1	Headcount	0	0	0	0	0	0	
		2	Band 1	Headcount	0	1	0	0	1	0	
		3	Band 2	Headcount	271	254	20	258	257	21	
		4	Band 3	Headcount	143	167	13	137	168	30	
		5	Band 4	Headcount	246	216	18	247	225	29	
		6	Band 5	Headcount	107	85	7	112	90	12	
		7	Band 6	Headcount	69	64	3	56	78	8	
		8	Band 7	Headcount	76	59	0	84	64	0	
		9	Band 8A	Headcount	63	28	3	61	35	11	
		10	Band 8B	Headcount	35	14	2	36	16	6	
		11	Band 8C	Headcount	15	10	0	20	12	0	
		12	Band 8D	Headcount	33	4	2	27	5	2	
		13	Band 9	Headcount	7	2	0	8	3	0	
		14	VSM	Headcount	16	4	1	14	1	0	
			1b) Clinical workforce of which Non Medical								
		15	Under Band 1	Headcount	0	0	0	0	0	0	
		16	Band 1	Headcount	0	0	0	0	0	0	
		17	Band 2	Headcount	193	564	30	201	532	30	
		18	Band 3	Headcount	107	207	7	110	197	6	
		19	Band 4	Headcount	77	78	3	78	125	7	
		20	Band 5	Headcount	596	706	24	530	758	23	
		21	Band 6	Headcount	699	650	24	694	675	24	
		22	Band 7	Headcount	701	347	20	702	392	16	
		23	Band 8A	Headcount	229	79	9	236	83	9	
		24	Band 8B	Headcount	62	17	1	61	18	1	
		25	Band 8C	Headcount	24	6	0	27	5	0	
		26	Band 8D	Headcount	11	2	0	9	2	0	
		27	Band 9	Headcount	2	1	0	4	1	0	
		28	VSM	Headcount	1	0	0	1	0	0	
			Of which Medical & Dental								
		29	Consultants	Headcount	359	235	50	366	240	44	
		30	*of which Senior medical manager*	Headcount	0	0	0	0	0	0	
		31	Non-consultant career grade	Headcount	11	14	3	9	15	1	
		32	Trainee grades	Headcount	385	284	54	376	338	74	
		33	Other	Headcount	0	0	0	0	0	0	
2	Relative likelihood of staff being appointed from shortlisting across all posts	34	Number of shortlisted applicants	Headcount	4057	6598	970	4235	5990	1130	
		35	Number appointed from shortlisting	Headcount	1266	1402	654	1455	1402	837	
		36	Relative likelihood of appointment from shortlisting	Auto calculated	31.21%	21.25%	67.42%	34.36%	23.41%	74.07%	
		37	Relative likelihood of White staff being appointed from shortlisting compared to BME staff	Auto calculated	1.47			1.47			
3	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation Note: This indicator will be based on data from a two year rolling average of the current year and the previous year	38	Number of staff in workforce	Auto calculated	4538	4098	294	4464	4336	354	
		39	Number of staff entering the formal disciplinary process	Headcount	34	73	4	32.5	57.5	6.5	
		40	Likelihood of staff entering the formal disciplinary process	Auto calculated	0.75%	1.78%	1.36%	0.73%	1.33%	1.84%	
		41	Relative likelihood of BME staff entering the formal disciplinary process compared to White staff	Auto calculated		2.38			1.82		

4	**Relative likelihood of staff accessing non-mandatory training and CPD**	42	Number of staff in workforce	Auto calculated	4538	4098	294	4464	4336	354	
		43	Number of staff accessing non-mandatory training and CPD:	Headcount	1675	1444	84	1142	1076	60	
		44	Likelihood of staff accessing non-mandatory training and CPD	Auto calculated	36.91%	35.24%	28.57%	25.58%	24.82%	16.95%	
		45	Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff	Auto calculated	1.05			1.03			
9	**Percentage difference between the organisations' Board voting membership and its overall workforce** **Note: Only voting members of the Board should be included when considering this indicator**	46	Total Board members	Headcount	12	4	0	12	2	0	
		47	*of which: Voting Board members*	Headcount	8	2	0	8	1	0	
		48	*: Non Voting Board members*	Auto calculated	4	2	0	4	1	0	
		49	Total Board members	Auto calculated	12	4	0	12	2	0	
		50	*of which: Exec Board members*	Headcount	8	2	0	8	0	0	
		51	*: Non Executive Board members*	Auto calculated	4	2	0	4	2	0	
		52	Number of staff in overall workforce	Auto calculated	4538	4098	294	4464	4336	354	
		53	Total Board members - % by Ethnicity	Auto calculated	75.0%	25.0%	0.0%	85.7%	14.3%	0.0%	
		54	Voting Board Member - % by Ethnicity	Auto calculated	80.0%	20.0%	0.0%	88.9%	11.1%	0.0%	
		55	Non Voting Board Member - % by Ethnicity	Auto calculated	66.7%	33.3%	0.0%	80.0%	20.0%	0.0%	
		56	Executive Board Member - % by Ethnicity	Auto calculated	80.0%	20.0%	0.0%	100.0%	0.0%	0.0%	
		57	Non Executive Board Member - % by Ethnicity	Auto calculated	66.7%	33.3%	0.0%	66.7%	33.3%	0.0%	
		58	Overall workforce - % by Ethnicity	Auto calculated	50.8%	45.9%	3.3%	48.8%	47.4%	3.9%	
		59	Difference (Total Board -Overall workforce)	Auto calculated	24.2%	-20.9%	-3.3%	36.9%	-33.1%	-3.9%	

APPENDIX 2: Diversity and Inclusion Action Plan

Diversity & Inclusion Action Plan

Our Organisational Commitment to Tackling Discrimination and Building an Inclusive Culture

Outstanding care every time

Introduction

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

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

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

Development of the D&I Action Plan

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

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

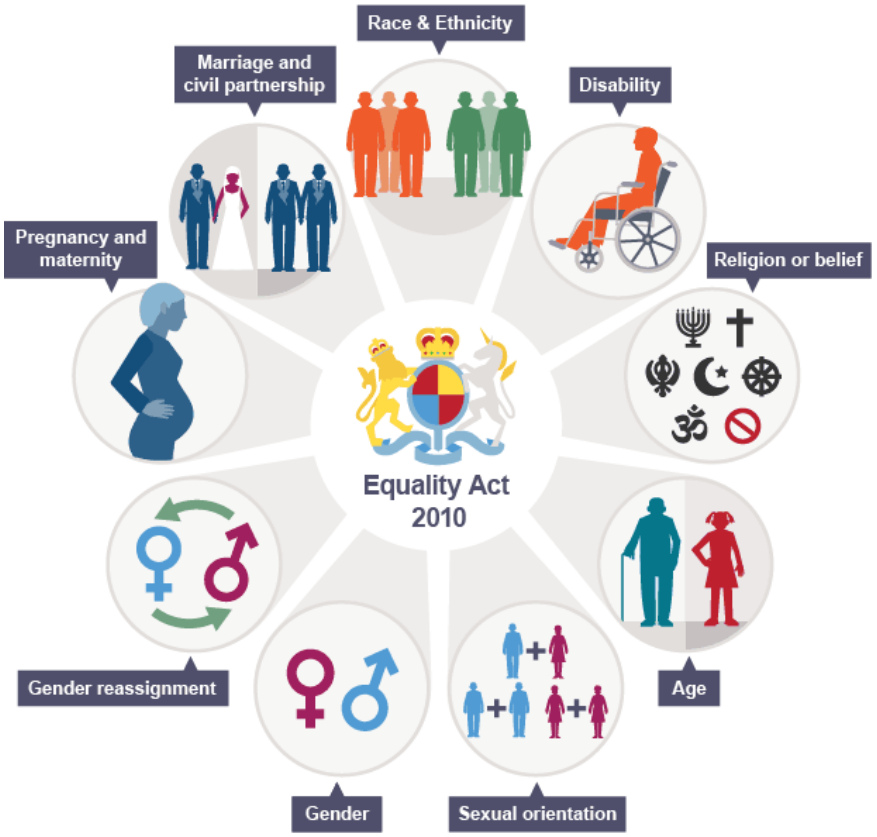


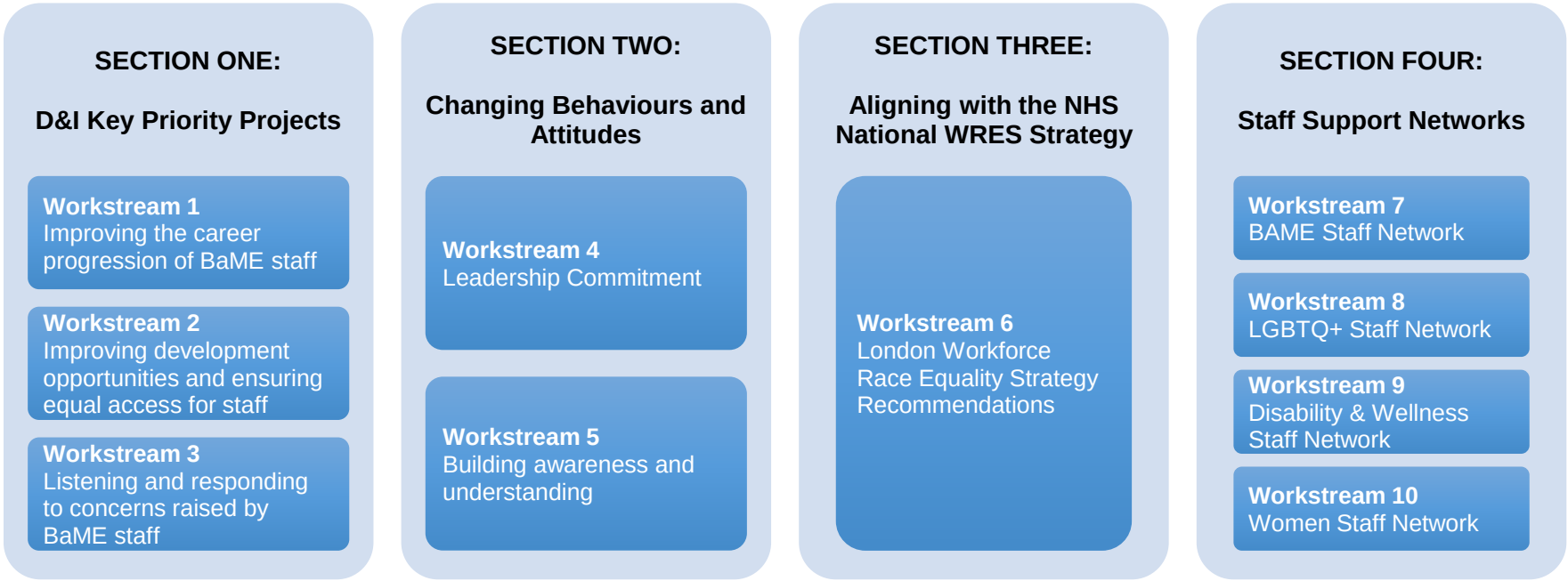
Figure 1The 9 Protected characteristics enshrined in the Equality Act 2010

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

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

Structure of the Action Plan

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



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

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

Roles and Responsibilities

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

Targets and Success Measures

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

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

SECTION ONE: Diversity & Inclusion Key Priority Projects

WORKSTREAM 1: Improving the Career Progression of BAME Staff

Executive Sponsor: Chief Strategy Officer

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

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

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

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

Workstream Risks and Dependencies:

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

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

Executive Sponsor: Chief People Officer

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

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

Deliverable	Actions	Prof. Lead	Project Manager	Delivery Date	Measure / Target
2.1 Equal access to training and development opportunities for all staff	2.1.1 Review and revise all policies, processes and procedures related to application and attendance for training and development to ensure selection is equitable.	ACPO(C)	Education Centre Leads	30/09/20	Relative likelihood of White staff accessing non-mandatory training /CPD compared to BAME is **1.0**
2.2 Transparent, fair and equal access panel-based decision making process for selection on high value development programmes	2.2.1 Develop panel process for HEE CPD higher value development programmes (including specification of high value programmes, clear criteria, panel composition requirements, assessment techniques etc.)	Head of Corporate Nursing/ ACPO(C)	Head of Prof Dev	30/09/20	By the end of 2021, **100%** of high value programme selection processes will involve BAME represented panels
2.3 BAME staff have greater access to career coaching and mentoring	*Equivalent to deliverable 1.4 in Workstream 1 above*				By end of 2021, **50** BAME staff are in coaching/mentoring relationships
2.4 Improved personal development and career planning for employees	2.4.1 Clarify line manager expectations and responsibilities (as part of a future 'management charter') in relation to supporting staff to develop meaningful PDPs as a part of the annual appraisal process (including updating appraisal training)	ACPO(C)/ ACPO(W)	HRBPs, HofCT	31/03/21	By the end of 2021, **60%** of PDR records include evidence of career focused conversations (beyond the usual 'development conversation') *[Measurement will*
	2.4.2 Revise Performance Development Review Process to ensure that there is a structured career development section in place	ACPO(C)	HoCT, OD Lead	31/03/21	
	2.4.3 Develop guidance and training module for managers to conduct career planning discussions (which may be part of the performance	ACPO(C)	HoCT, OD Lead	31/12/20	

	review discussion, but not exclusively)				*require new LMS functionality]*
2.5 An talent management approach that is inclusive in assessing, developing and retaining talent to improve representation of BAME groups	2.5.1 Develop an Inclusive Talent Management Process that is integrated into the succession planning and performance development review process	ACPO(C)	OD Lead	31/12/21	TBC with design of the talent management approach
	2.5.2 Establish Inclusive Talent Management moderation processes and panels	ACPO(C)	HRBPs OD Lead	31/12/21	
	2.5.3 Implement and embed the talent management processes using a phased approach	ACPO(C)	HRBPs OD Lead	31/12/21	
2.6 A succession planning process that is inclusive, to improve representation of BAME groups	2.6.1 Develop a succession planning approach, policies and processes for the Trust and trial the process	ACPO(C)/ ACPO(W)	HRBP/ OD Lead	31/12/21	TBC with design of the succession planning approach
	2.6.2 Implement the succession planning process across the Trust	ACPO(C)/ ACPO(W)	HRBP/ OD Lead	31/12/21	

Workstream Risks and Dependencies:

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

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

Executive Sponsor: Chief Corporate Affairs Officer

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

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

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

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

Workstream Risks and Dependencies:

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

SECTION TWO: Changing Attitudes and Behaviour

WORKSTREAM 4: Leadership Commitment

Executive Sponsor: Chief Executive Officer

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

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

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

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

Workstream Risks and Dependencies:

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

WORKSTREAM 5: Building Awareness and Understanding

Executive Sponsor: Chief People Officer

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

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

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

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

Workstream Risks and Dependencies:

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

SECTION THREE: Aligning With the NHS National WRES Strategy

WORKSTREAM 6: London Workforce Race Equality Strategy Recommendations

Executive Sponsor: Chief People Officer

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

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

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

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

Appendix A: Overview of Roles and Responsibilities

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

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

Appendix B: Workforce Race Equality Standard (WRES) 2019

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

St George's University Hospitals NHS
NHS Foundation Trust

National Workforce Race Equality Standard (WRES)

St George's 20-21 Report

St George's University Hospitals NHS
NHS Foundation Trust

St George's University Hospitals NHS
NHS Foundation Trust

1. Executive Summary:

All NHS providers are required to complete an annual Workforce Race Equality Standard Report (WRES). The report is based on a snapshot of data from 31st March each year and aims to highlight progress against a number of key indicators of workforce equality, including a specific indicator to address the low numbers of Black, Asian and Minority Ethnic board members across NHS organisations.

In line with national requirements this report should be reviewed internally and approved at Board before being published on the organisations website. The deadline for publication is 30th September 2021.

The key findings and metrics for this report submission are outlined below. Each point is compared to the previous reporting period in 2020:

- Overall, the BAME staff population at St George's continues to increase year on year
- BAME staff are over-represented in lower bands
- BAME staff are under-represented in higher bands
- BAME staff are under-represented at Executive and Board level, both in voting and non-voting.
- Most notably across the AFC Bands, we see an increase in BAME representation at Band 6 which brings us to 55% representation. This is the first recorded leadership and management AFC band to tip the scale in favour of Black, Asian and ME staff.
- The relative likelihood of white applicants being appointed from shortlisting compared to BAME applicants remain the same (as the previous reporting period) at 1.47
- The relative likelihood of BAME staff entering the formal disciplinary process compared to white staff has reduced from 2.54 to 1.87
- Relative likelihood of white staff accessing non–mandatory training and CPD (compared to BAME staff) has reduced from 1.05 in 2020 to 1.03 in 2021
- Overall we see a 10% reduction in staff accessing non-mandatory training and CPD (compared to 2020)
- We see a slight reduction in the levels of BAME staff reporting experiencing bullying, harassment or abuse from patient, relatives and visitors.
- BAME staff reported experiencing slightly increased levels of bullying, harassment and abuse a manager, team leader or colleague.

In October 2020 the organisation introduced its D&I Action Plan (see appendix 2). This multi-year action plan was based on the organisational needs, with a number of the key deliverables which were subject to the introduction of additional resources, including a Talent Management Lead and Leadership Development Lead. Due to the pandemic and increased pressures across the organisation a number of these workstreams were delayed and have since been rescheduled for delivery in early 2022. Further details can be found in appendix 2.

Our Action Plan will undergo an annual review this October 2021 to review progress and ensure the action plan is still aligned to the needs of the organisation. In addition to the deliverables outlined in the action plan, there a number of other initiatives/projects that have been introduced, these include Active Bystander training for leaders, a SWL Positive Action Programme for future BAME leaders. These will be added to the action plan as part of the annual review.

St George's University Hospitals NHS
NHS Foundation Trust

2. Purpose

- This paper provides a summary of the 2021 Workforce Race Equality Standard (WRES) findings.
- This report will be published on our website, alongside the D&I action plan.
- The Board is asked to receive this report for information and approve for publication.

3. Background

- In April 2015, NHS England introduced the WRES in response to consistent findings that BAME applicants and staff consistently fared worse in employment outcomes and satisfaction surveys. The WRES was designed to enable NHS organisations to demonstrate progress against a number of key indicators of workforce equality, including a specific indicator to address the low levels of BAME Board representation.
- Since April 2015, the WRES has been included in the full length NHS Standard Contract and requires all providers of NHS services to address the issue of workforce race inequality by implementing and using the WRES.
- There are nine WRES indicators. Four of the indicators focus on workforce data, four are based on data from national NHS Staff Survey questions, and one indicator focuses upon BME board representation. The WRES highlights differences between the experience and treatment of White staff and BAME staff in the NHS with a view to organisations closing those gaps through the development and implementation of action plans focused upon continuous improvement over time.
- The WRES is produced in line with Technical Guidance issued by NHS England.
- Indicators 1-3 and 9 are produced via the Electronic Staff Record (ESR) from a snapshot of data taken on 31st March 2021. All other indicators are from the 2020 staff survey

4. Key Staff Metrics

	2021	2020	2019
Total number of staff in organisation	9154	8,873	8,884
% of *BAME* Staff	47.7%	46.1%	44.6%
% of staff who self-reported ethnicity	96.1%	96.7%	97.22%

St George's University Hospitals NHS
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5. Indicator Overview

No	Indicator	London average 2020	St George's 2020	St George's 2021	Position vs. 2020
1.	Percentage of BAME Staff in organisation	45.2%	46.4%	47.7%	↑
2.	Relative likelihood of White applicants being appointed from shortlisting compared BAME applicants	1.59	1.47	1.47	→
3.	Relative likelihood of BAME staff entering the formal disciplinary process, compared to that of White staff	1.95	2.54	1.82	↓
4.	Relative likelihood of White staff accessing non-mandatory training and CPD compared to BAME staff	0.97	1.05	1.03	↓
5.	% of BAME staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months.	31.9%	27.4%	27.3%	↓
6.	% of BAME staff experiencing harassment bullying or abuse from staff in the last 12 months	29.3%	30.8%	30.1%	↓
7.	% of BAME staff believing that organisation provides equal opportunities for career progression or promotion	67.1%	63.0%	63.0%	→
8.	% of BAME staff personally experiencing discrimination at work from manager/leader/ or other colleagues.	15.1	16.2%	18.0%	↑
9.	Percentage difference between the organisations' board voting membership and its overall workforce	TBC	-28.2%	-34.9%	↓

*The WRES London data for 2021 is not due for publication until later this year so our performance in 2021 is compared to the London average for the previous reporting period (2020).

6. INDICATOR 1: '*Percentage staff by AfC pay band and ethnicity'*

As with previous reporting years, we continue to see a small increase year on year across our Black, Asian and Minority Ethnic workforce. For this reporting year, we see an increase of +1.3% on our 2020 report, this equates to around +238 'BAME' full time equivalent members of staff employed at the organisation.

Whilst we see a pattern of increase, overall, across the workforce, our workforce data still highlights that Black, Asian and Minority Ethnic (BAME) staff are over-represented in lower bands and under-represented in higher bands. This is not unique to St George's and mirrors what we see across London NHS trusts (see table A and B).

St George's University Hospitals NHS
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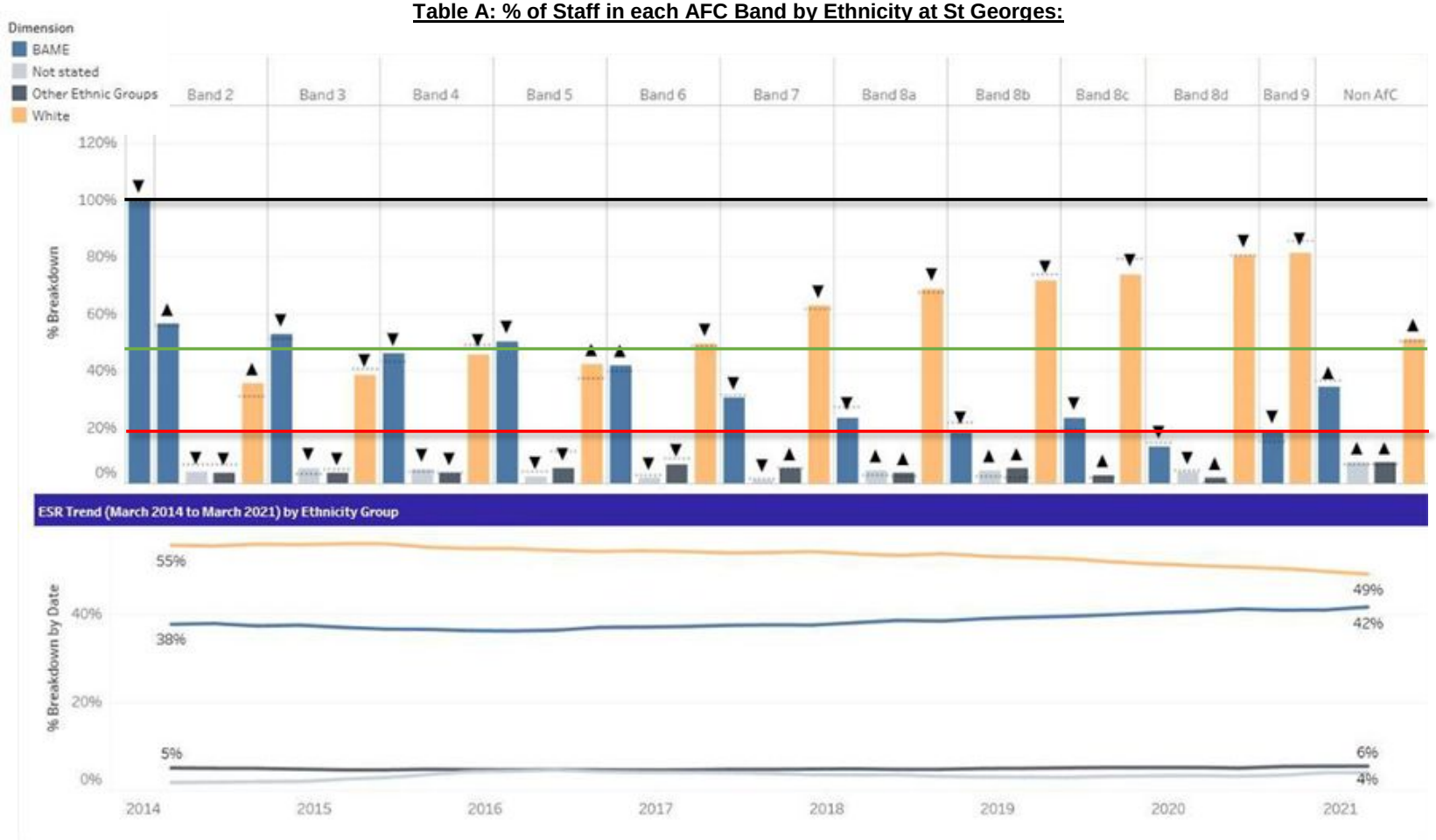
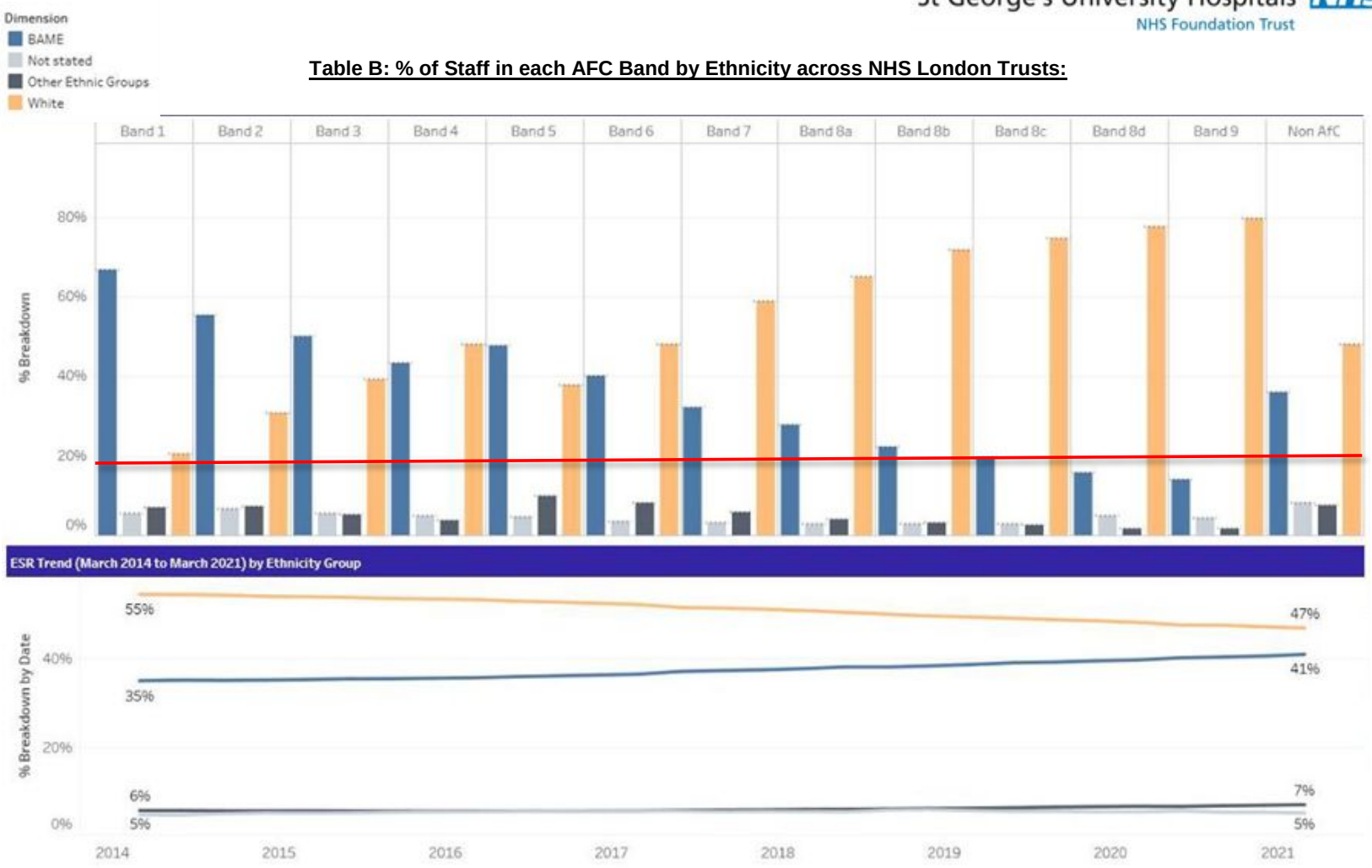
Table A: % of Staff in each AFC Band by Ethnicity at St Georges:



Note: The solid red line indicates NHE/I target of 19% Black, Asian and ME staff in each AFC pay band.
The solid green line indicates the target for St George's to be representative across all AFC pay bands.

Table B: % of Staff in each AFC Band by Ethnicity across NHS London Trusts:



Note: The solid red line indicates the national target of a at least 19% Black, Asian and ME staff in each AFC pay band

Clinical Staff

For Clinical staff (table C), we see an increase (vs. the previous reporting year) in the percentage of Black, Asian and Minority Ethnic staff across 7 of the 12 AFC bands. Most notably in band 4 where we see an increase of 11% (*+47*). We have seen a decrease in representation across 3 of the AFC bands, most notably in AFC band 9 where we see a significant reduction (-13%) in Black, Asian and Minority Ethnic representation, from 33% in 2020 to 20% in 2021. The number of White staff in AFC band 9 reduced in 2020 to 67%, this is back up at 80% this reporting year, which is consistent with the previous two reporting years (2019 and 2018). It is worth noting however, that this change in representation is due to two additional band 9 roles that have been introduced in this reporting year. This shifts representation in this banding from 2 White:1 BAME (3 posts in total) to 4 White:1 BAME (5 posts in total) member of staff at Band 9.

Overall, across the Clinical workforce we see an increase of 131 Black, Asian and ME members of staff, this equates to 4.8%. We see a reduction of 2 FTE members of staff recorded as ''Ethnicity Unknown'. For White Staff we see a reduction by 49 members of staff (-1.8%).

Table C: % of BAME vs. White Clinical Staff in each AFC Band at St George's:

	Banding	2021 Headcount	BAME +/- vs. PRP*	2021 (%)**	2020 (%)**	2019 (%)**	2018 (%)**
Clinical Staff	Band 2	733	+2%	70/26	72/25	69/27	53/44
	Band 3	307	-1%	63/35	64/33	60/38	41/57
	Band 4	203	+11%	60/37	49/49	51/48	42/55
	Band 5	1288	+5%	58/40	53/45	50/48	44/54
	Band 6	1369	+1%	48/50	47/51	45/53	48/50
	Band 7	1094	+3%	35/63	32/66	31/67	30/68
	Band 8a	319	0%	25/72	25/72	24/74	24/74
	Band 8b	79	+2%	23/76	21/78	22/76	22/77
	Band 8c	32	-4%	16/84	20/80	17/83	11/89
	Band 8d	11	+3%	18/82	15/85	8/92	6/94
	Band 9	5	-13%	20/80	33/67	17/83	20/80
	VSM	1	0%	0/100	0/100	100/0	100/0

*% increase or decrease in the number of Black, Asian and Minority Ethnic Staff in the current reporting period vs. the previous reporting period

** In these columns the first % figure indicates BAME representation and the second figure indicates White Representation i.e. 70% BAME / 25% White

Non-Clinical Staff:

For Non- Clinical staff (table D), we see an increase (vs. the previous reporting year) in the percentage of Black, Asian and Minority Ethnic staff across 6 of the 13 AFC bands. Most notably in band 6, where we see an increase of 8% *(+14),* this increase brings us to 55% BAME representation at this level. Though early days, this is the first recorded leadership and management AFC band increase to tip the scale in favour of Black, Asian and ME staff.

We have seen a decrease in representation across 5 of the AFC bands, most notably at Very Senior Manager (VSM) level, where we see a reduction of -14% *(-3)* in Black, Asian and Minority Ethnic representation, from 21% in 2020 to 7% in 2021. The percentage of White staff at VSM level has increased by +14% from 79% in 2020 to 93% in 2021. However, in terms of headcount it is a reduction of White Staff at VSM level as this was 16 in 2020 to 14 in 2021. Black, Asian and ME staff at VSM has gone from 4 in 2020 to 1 in 2021.

Overall, Black, Asian and Minority Ethnic representation across leadership and management roles has increased, this is across AFC bands 6, 8A, 8B, 8D and 9. We see a slight reduction in representation, in terms of percentage, at AFC bands 7 (-1%) and 8c (-2%). Within these two AFC bands the number of White staff has increased at a similar percentage, +1% and +3% respectively. Whilst both of these bands see a percentage reduction, it is not because the number of BAME staff have decreased, the number of BAME staff has actually increased in both AFC bands 7 and 8c, however the number of White staff in these bandings has increased at a higher rate, which results in a reduction in representation overall in these bands.

Overall, across the Non-Clinical workforce we see an increase of 47 Black, Asian and ME members of staff, this equates to 5.17%. We also see an increase of 50 FTE members of staff recorded as ''Ethnicity Unknown'. For White Staff we see a reduction by 21 headcount (1.2%).

Whilst these numbers are modest improvements on 2020 and there is still a long way to go, they represent a further step in the right direction, particularly towards a more representative non-clinical management structure in the organisation. BAME representation for 8A+, including board and non-executive directors, is still particularly low and will need to be driven as part of our D&I strategy. Table D (below) give a breakdown of figures across four years, this details the % of BAME vs. % of White employees.

Table D: % of BAME vs. White Non-Clinical Staff by Grade at St George's:

	Banding	2021 Headcount	BAME +/- vs. PRP*	2021 (%)**	2020 (%)**	2019 (%)**	2018 (%)**
Non-Clinical Staff	Band 1	1	0%	100/0	100/0	100/0	67/14
	Band 2	515	+1%	48/48	47/50	47/49	62/34
	Band 3	305	-2%	50/41	52/44	52/45	55/43
	Band 4	472	0%	45/49	45/51	46/52	42/54
	Band 5	202	-1%	42/52	43/54	40/58	40/56
	Band 6	134	+8%	55/39	47/51	41/57	42/56
	Band 7	148	-1%	43/57	44/56	34/66	32/67
	Band 8a	96	+3%	33/57	30/67	28/70	34/65
	Band 8b	52	+1%	28/62	27/69	26/70	23/73
	Band 8c	32	-2%	38/63	40/60	28/72	14/86
	Band 8d	32	+5%	15/79	10/85	7/93	13/88
	Band 9	11	+5%	27/73	22/78	0/100	0/100
	VSM	15	-14%	7/93	21/79	9/91	5/95

*% increase or decrease in the number of Black, Asian and Minority Ethnic Staff in the current reporting period vs. the previous reporting period

** In these columns the first % figure indicates BAME representation and the second figure indicates White Representation i.e. 70% BAME / 25% White

Medical Staff:

For completeness we have included data on Medical staff (see table E) however this is not required as part of the organisation's annual WRES submission. This year, NHS England and Improvement's National WRES Team have introduced the Medical Workforce Race Equality Standard Report (MWRES).

The 2020 MRES Report was published in August 2021 so further analysis and review will take in partnership with the Chief Medical Officers Office. Click here to view a copy of the 2020 MWRES Report.

Table E: % of BAME vs. White Medical Staff by Grade at St George's:

		BAME +/- vs. PY*	2021	2020	2019	2018
Medical Staff **	Consultant	+1%	37/56	36/56	36/57	34/58
	Trust Grade	+10%	60/36	50/39	59/38	47/41
	Trainee Grade	+4%	43/48	39/53	38/57	38/57

Action taken and planned:

In 2020, following the appointment of our substantive Diversity and Inclusion Workforce Lead, we invested a significant amount of time in re-developing our action plan to ensure it reflects the needs of our workforce, particularly in regards to equal opportunities for our Black, Asian and Minority Ethnic staff. This action plan was approved in October 2020.

To support the organisation in becoming a more responsible, more inclusive employer, we have focused on delivering on the commitments made within each of our six work streams. The six work streams are outlined below, along with the 'action' taken within each.

1. *Improving the Career Progression of "BAME" Staff*
   - Launched the Recruitment Inclusion Specialist process
   - Trained 100 members of staff to support recruitment panels and champion inclusive, unbiased recruitment
   - This is now a mandatory process for all AFC Band 7+ roles and consultant recruitment panels
   - Supported the development of a 1 day bespoke SWL Inclusive Recruitment and Selection Training. Following the current phased introduction period, this will be a mandatory requirement for all recruiting managers and panel members.
   - Formalised feedback and careers coaching for those that are unsuccessful at interview

2. *Improving development opportunities and ensuring equal access for staff*
   - Refreshed our PDR Process
   - Introduced a CPD Application Review Panel

3. *Building awareness and understanding*
   - Developed and launched our *Let's Talk about Race and Inclusion: A toolkit for leaders in starting a team dialogue about tackling racism*

- Piloted Exploring our Bias' and Building Inclusion Workshops.
- Delivered tailored D&I Awareness Sessions to over 300 staff members
- Developed and published the Diversity and Inclusion Intranet Hub
- Supported departmental led D&I initiatives, action plan development and working groups

4. *London Workforce Race Equality Strategy Recommendations*
   - Our Diversity and Inclusion Lead and one of our Heads of Nursing have joined the London WRES Experts Programme.

5. *Leadership Commitment*
   - Monthly review and monitor of progress via our D&I Impact Tracker
   - Monthly Progress Updates provided to Executive Team
   - D&I Module added to all internal leadership development programmes
   - Successfully secured places on the NHSE/I White Allies Programme for six senior white leaders at the organisation
   - Developing Leadership Capabilities:
     - An Inclusive Leadership Module added to (and inclusion elements added throughout) our King's Fund Advanced Leadership Development Programme
     - Existing and new management and leadership development programmes are now being designed (or redesigned) with Equity and Inclusion as an integral 'golden thread' throughout each. Each programme will now closely reflect (i) our ambitions within our D&I action plan, (ii) clear expectations of leaders to tackle inequities and build inclusive cultures, and (iii) affective and skills development in fulfilling these expectations.
     - This includes two new leadership programmes for (i) Matrons, Senior Therapists & Midwives and (ii) Ward Managers and AHPs

6. *Listening and responding to concerns raised by BAME staff*
   - Introduced HR Decision Tree (Grievance management process)
   - Introduced Free2Speak Up Champions (with training and protected time)

7. *Organisation-wide Culture Development Programme*
   - Alongside and closely aligned with the organisational D&I Action Plan, St George's continues with its culture improvement programme, guided by the NHSE/I Culture and Leadership Programme. Together, these 2 areas of work make up the Culture, Equity and Inclusion Programme.
   - Central to this culture improvement programme is the need to build a more inclusive culture. Ambitious targets for measuring our culture have been set, using indicators from the staff survey, workforce data and staff ethnicity composition at all levels. Measuring diversity and inclusion features heavily in how we are measuring cultural change.
   - A new Culture, Equity and Inclusion Programme Board has been established to oversee delivery and success of this organisation-wide programme. The Board is chaired by our CEO, and includes representatives from all Divisions, as well as leaders of our 4 D&I staff networks.

7. **INDICATOR 2: '*Relative likelihood of white applicants being appointed from shortlisting compared to BAME applicants'***

2021	2020	2019
1.47	**1.47**	**1.57**

Whilst the relative likelihood of appointment remains at 1.47 for the second consecutive year, the numbers of staff being appointed across all bands has increased. 34.36% of white shortlisted applicants were appointed, compared to 31.21% in 2020. 23.41% of shortlisted Black, Asian and Minority Ethnic applicants were appointed, compared to 21.25% in 2020. Whilst these are both increases (3% and 2% respectively), it is important to keep the focus on the relative likelihood of appointment of over BAME staff as this indicates any success in shifting the dial to a fairer, more representative organisation. As long as we see an increased likelihood of appointment for White Staff we have to challenge whether our processes and systems are equitable.

For applicants that did not record an ethnicity we saw a lift of 6% on 2020's data to 74% of applicants appointed from shortlisting. This translates to 837 applicants in 2021 vs. 654 in 2020. Interestingly, 74% of undisclosed applicants were shortlisted compared to 34% for White and 23% for BAME. Does this indicate that those that do not disclose an ethnicity are high calibre candidates concerned about disclosure and the possible impact on successfully securing an interview?

Action taken and planned:
Two of our AP work steams (noted above) will support improving career progression and development opportunities for BAME staff.

This includes:

- Introduced trained Recruitment Inclusion Specialist on all interview panels for AFC Band 7+ and consultant recruitment panels.
- We are currently scoping extending this to include B6+ (including all internal acting up and secondment opportunities)
- Mandatory Inclusive Recruitment and Selection Training for all recruiting managers, with a challenging bias module included
- Formalised feedback and careers coaching for those that are unsuccessful at interview
- Interview Skills Training for staff
- New significant funding has been secured to investment in our Organisational Development function. This will include staff to lead on Leadership Development and Inclusive talent Management, both which will align with and support our D&I agenda.
- Developing a D&I training and learning framework that will include developing D&I competencies for staff and leaders, updating the mandatory trust wide Equality & Diversity Module, and introducing challenging bias workshops

8. INDICATOR 3: '*Relative likelihood of BAME staff entering the formal disciplinary process compared to white staff'*

2021	2020	2019
1.82	**2.54**	**1.82**

2021's data show a notable improvement (on 2020) in this indicator, with BAME staff 1.82 times more likely (relative to white staff) to enter a formal disciplinary process. This is down from 2.54 in the previous year. Whilst this is notable improvement, it is still higher than that of White staff. There is work still to be done to ensure responsible and fair decision within the disciplinary process at the organisation. In terms of the numbers of BAME staff entering the disciplinary process, this is down from 73 in 2020 to 57 in 2021. The number of White staff remains similar at 34 in 2020 to 32 in 2021.

Action taken and planned:
This is being addressed as part of our D&I Action Plan which has been redeveloped into a set of deliverables and actions. Work stream 3 - 'Listening, Supporting and Responding to Concerns Raised by our Staff' features 5 key deliverables that aim to create an environment where staff feel supported to raise concerns and confident that the processes we have in place are fair and effective. The measure of success for this particular work stream is a decreased likelihood of BAME staff entering the formal disciplinary process.

In addition, in late 2020 we introduced a central repository for employee relations activity. We hope this will continue to support us in identifying hotspots and trends to enable us to target interventions with regards to disciplinary cases that involve staff from BAME backgrounds

9. INDICATOR 4: '*Relative likelihood of white staff accessing non–mandatory training and CPD compared to BAME staff'*

	2020			2021		
	White	**BAME**	**Unknown**	**White**	**BAME**	**Unknown**
Number of staff in workforce	4538	4098	294	4464	4336	354
Number of staff accessing non-mandatory training and CPD	1675	1444	84	1142	1076	60
Likelihood of staff accessing non-mandatory training and CPD	36.91%	35.24%	28.57%	25.58%	24.82%	16.96%
Relative likelihood of white staff accessing compared to BAME staff	1.05			1.03		

This year we see a decrease in all staff accessing non-mandatory training and CPD. For BAME staff, the likelihood of accessing non-mandatory training and CPD is 24.82%, this is down from 35.24% in 2020.

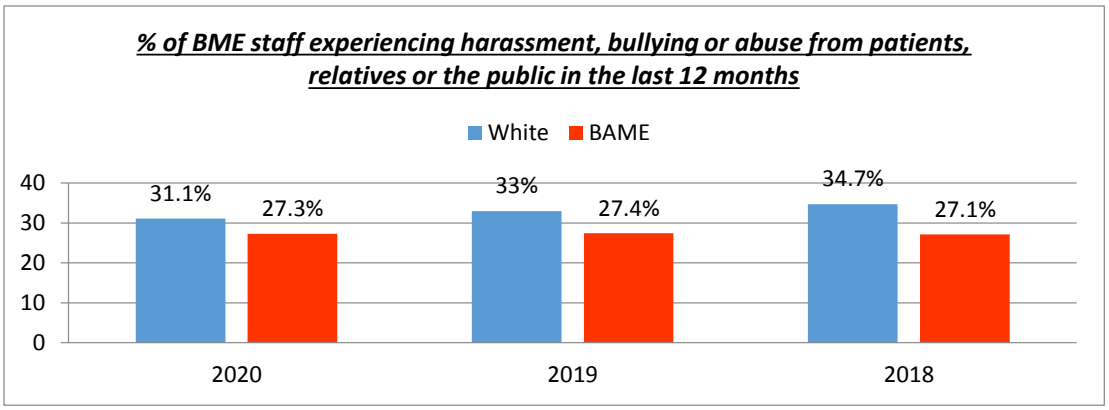
For White staff, the likelihood of accessing non-mandatory training and CPD is 25.58%, this is down from 36.91% in 2020.

Overall, across all ethnic groups, including 'unknown', we see roughly a 10% reduction in staff accessing non-mandatory training and CPD. As this is across all groups it may suggest a trust wide barrier that could be attributed to the COVID pandemic.

Action taken and planned:

Our action plan (work stream 2) includes the introduction of a panel process to review applications for higher value CPD programmes as well a trust wide review of the process and application for general training and development opportunities.

10. Indicator 5: *'% of BME staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months'*

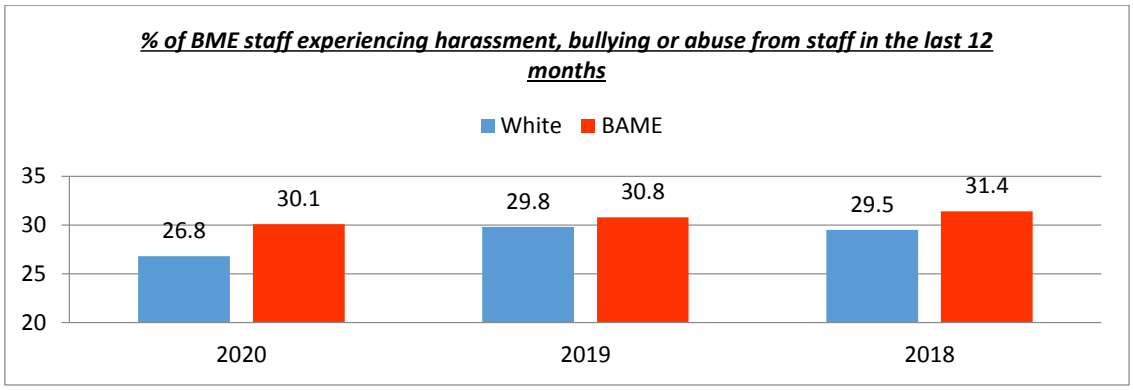


Source: NHS Staff Survey 2020

The results for 2020 and 2019 remain fairly consistent for BAME Staff, with a slight reduction of 0.1% in 2020. For White Staff we see a greater increase, however this is still relatively small at just -1.9% compared to 2019.

Compared to the benchmark group, White Staff at St George's reported higher instances (31.1%) of harassment, bullying or abuse (from patients, relatives) compare to the White Staff within the average benchmark group (25.4%). BAME Staff at St George's reported slightly lower (27.3%) instances compared to the BAME average benchmark group (28.0%).

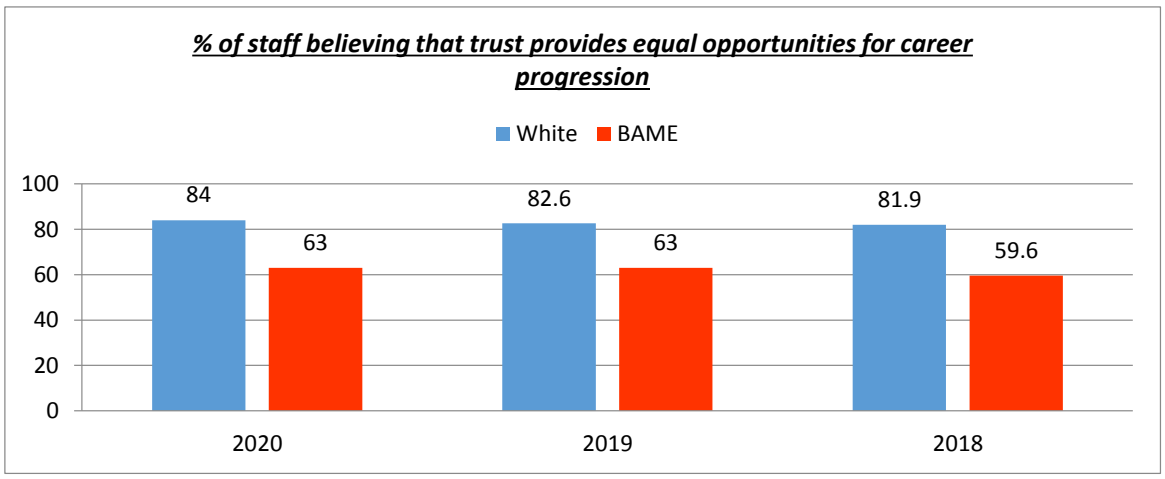
11. Indicator 6: *'% of BAME staff experiencing harassment, bullying or abuse from staff in the last 12 months'*



Source: NHS Staff Survey 2020

In 2020 30.1% of BAME Staff reporting experiencing harassment, bullying or abuse from staff in the 12 month reporting period, this follows a downward trend from 2018 and is a slight reduction compared to 30.8% in 2019. For White Staff there is a greater reduction from 29.8% in 2019 to 26.8% in 2020. This a difference of 3.3% between White and BAME Staff in 2020. Both White and BAME staff report higher instances harassment, bullying or abuse (from staff) compare to the national average for both groups.

12. Indicator 7: *'% of staff believing that trust provides equal opportunities for career progression'*



Source: NHS Staff Survey 2020

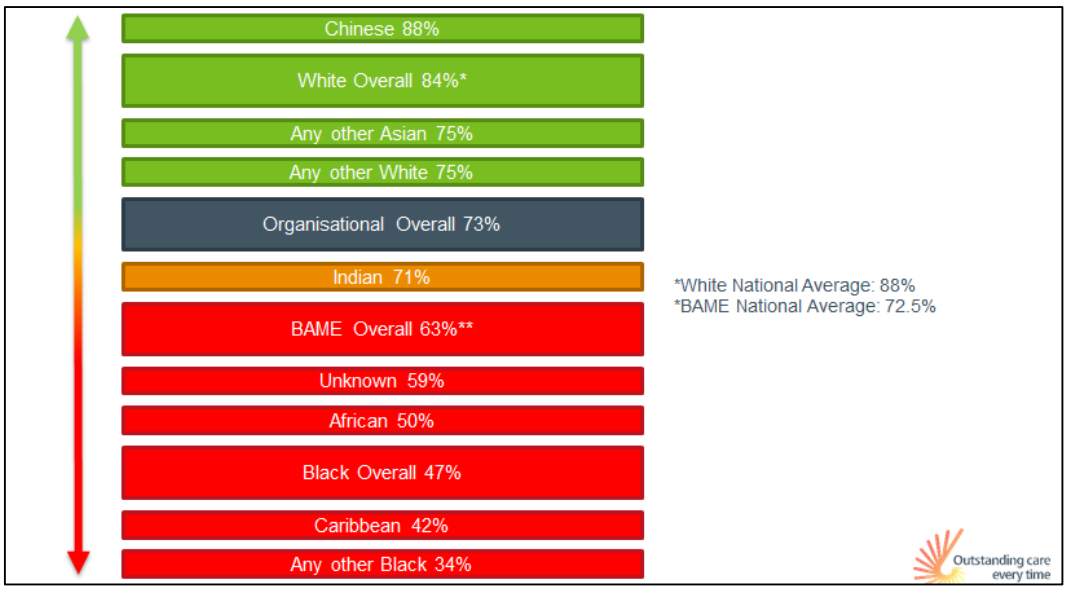
We see a slight increase (+1.4%) for White staff whilst the result remains the same for staff categorised under the *'BAME'* umbrella (63%). Nationally, we have dropped from 73.4% in 2019 to 73.2% in 2020. Whilst this is not a significant reduction this is one of the staff survey

indicators where we see greatest difference (11.5%). between the current trust position and the national average benchmark group.

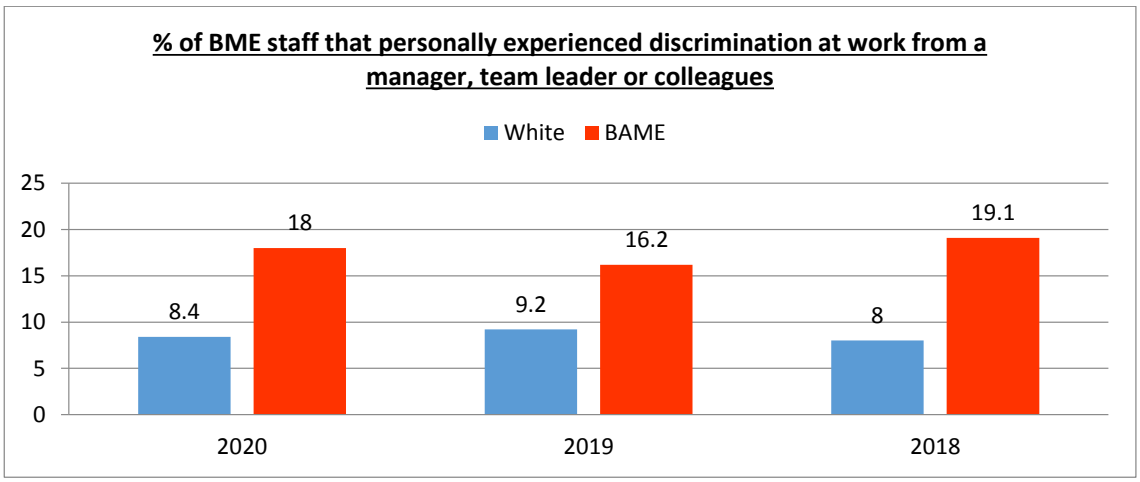
At St George's, there are significant variances in how staff from different ethnic backgrounds perceive fairness with regards to career progression – particularly when looking at the difference ethnicities within the '*BAME*' umbrella (see table F). These variances reinforce the importance of recognising the varied experiences of individual minority ethnic groups, and the importance of responding with appropriately tailored interventions to improve the experiences of staff from different ethnic backgrounds.

In particular, the experience of black staff appears significantly different to that of the wider BAME category. Overall, only 47% of Black respondents believe the organisation acts fairly with regards to career progression, a sharp contrast to the 63% of '*BAME Overall'*, the 84% of White respondents and the 73% for '*Organisational Overall'.*

Table F: % of staff that believe the organisation acts fairly with regards to career progression split by ethnicity:



13. Indicator 8: '% of BAME staff that personally experienced discrimination at work from a manager, team leader or colleagues'



Source: NHS Staff Survey 2020

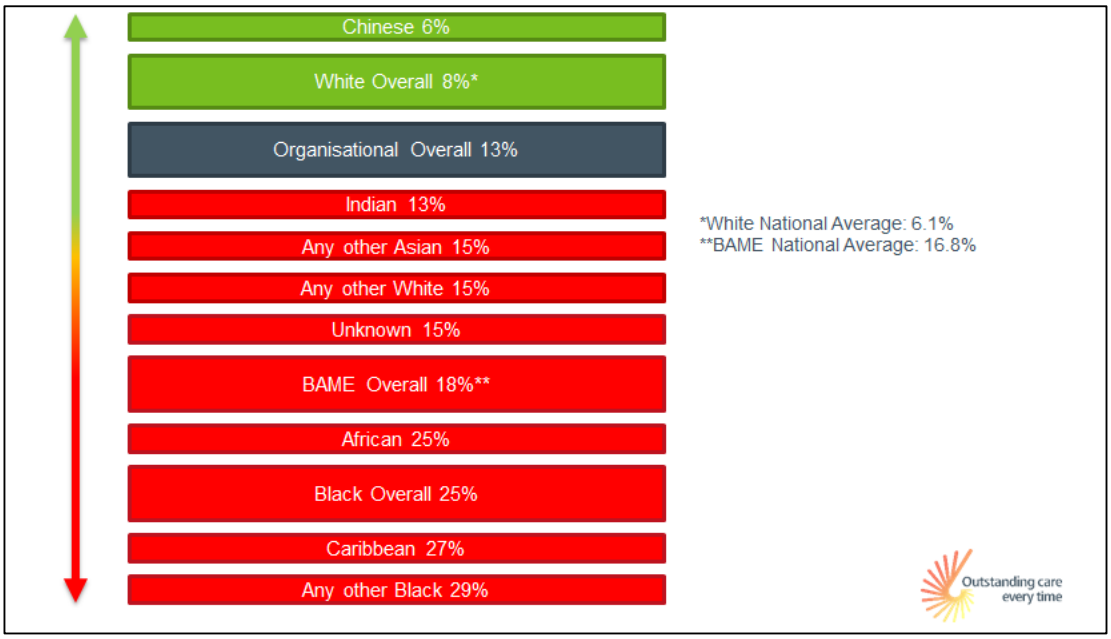
In 2020, 67% of staff that reported experiencing discrimination indicated that it was based on ethnicity. This suggests there were at least 640 individual instances of racial discrimination in the 12 month period covered by the 2020 Staff Survey. As an organisation (for all ethnicities including white) we are closer to the 'worst' performing acute Trust than we are to the 'average' nationally.

If we look specifically at White compared to BAME staff, we see that White staff reported a slight reduction (-0.8%) in instances of discrimination from a manager, team leader or colleague. Staff categorised under the *'BAME'* umbrella reported an increase (+1.8%) of instances of discrimination from these sources.

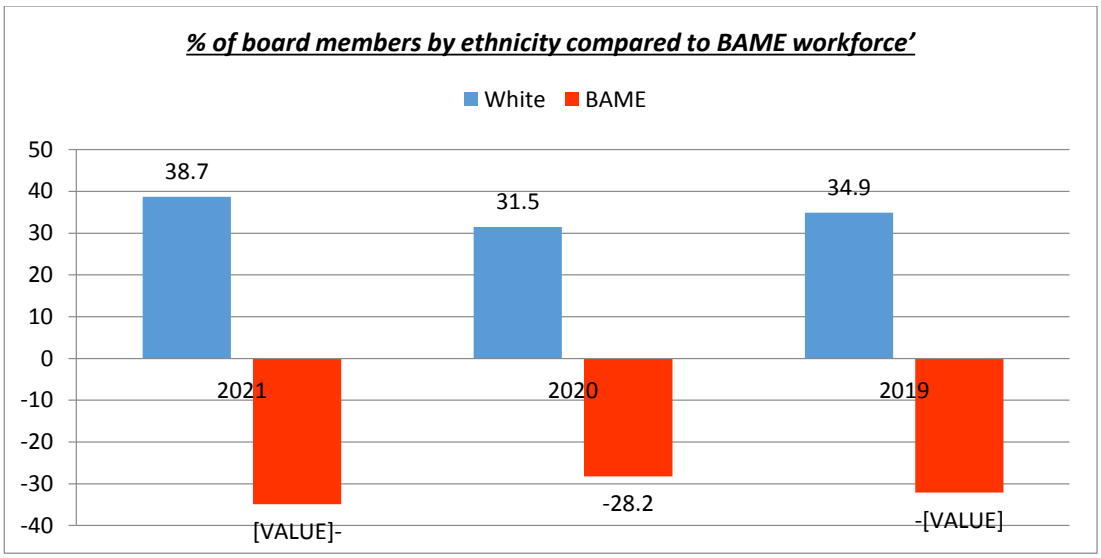
As with other WRES staff survey indicators the experience of black staff appears notably poorer compared to that of the wider BAME category. Overall, 25% of Black staff reported experiencing instances of discrimination; this is in contrast to 18% of *'BAME Overall'*, 13% for '*Organisational Overall'* and 8% for '*White Overall'.* These findings strongly suggest that a more focus and individualised approach is required to understand the experiences and barriers to different minority ethnic groups within the 'BAME' umbrella.

St George's University Hospitals NHS
NHS Foundation Trust

Table G: '% of BAME staff that personally experienced discrimination at work from a manager, team leader or colleagues':



14. **INDICATOR 9: *'Percentage of board members by ethnicity compared to BME workforce'***



As at 31 March 2021, the Trust Board comprised of 16 substantive and 1 interim member, two of whom were from a *BAME* background (one Non-Executive Director and one Associate Non-Executive Director). Of this, among the 11 voting members of the Board there was one *BAME* member (a Non-Executive Director). For the purpose of this report and consistency, the interim member has not been included in the workforce data or the graphs featured in this report.

In terms of the total Board composition in 2021, as representatives of the total workforce, white people are 38.7% *over*-represented, and *BAME* people are 34.9% *under*-represented.

This is a regretful reduction from 2020, where white people were 31.5% over-represented, and BAME people were 28.2% under-represented, at board level. BAME people are now 6.7% more underrepresented than they were in 2020.

This shift was due to two BAME Board members leaving the organisation in 2020. The number of White Board members remained the same as 2020. In 2020, the composition of the Board included four *BAME* members out of a total Board of 17 members (one NED, one associate NED, the Chief Operating Officer and the Chief People Officer).

Due to the relatively small number of Board members, even a small shift in board level composition can reflect significant changes in percentages of the Board over or under representation compared with the total workforce.

Action taken and planned:

In January 2020, one new Non-Executive Director and one Associate NED joined the Trust Board, both of whom are from a BAME background. This followed an external appointments process, which had sought to attract candidates from a diverse range of applicants.

Building on this, in autumn 2020, following a comprehensive procurement exercise, we commissioned an executive search company to help us to recruit BAME candidates to 4 Very Senior Management (VSM) posts, two of which were at executive directorate level. Despite the rigour of our recruitment search, the composition of our Board and senior

management team is predominately made up of non-BAME leaders. One of the reasons given for this unsatisfactory executive search outcome is that the talent pool with regards to the recruitment of experienced and appropriately qualified BAME leaders is limited. As the Trust remains fully committed to increasing the diversity of our Board and senior management team we are taking following actions to address the 'perceived' lack of 'talented' BAME senior leaders:

Increasing our internal pipeline of high quality BAME candidates for senior level positions through the introduction and implementation of the 'Positive Action Talent Development Programme'

We are currently in the process of putting plans in place to develop and implement a CEO led positive action programme aimed at band 8c and above BAME colleagues. The objectives of the programme is to:

- Support AFC Band 8c colleagues from Black, Asian and Minority communities to progress into AFC Band 8d or 9 roles within 24-36 months of completing the programme;
- Support AFC Band 8d – AFC Band 9 colleagues from Black, Asian and Minority communities to progress into executive level roles within 24-36 months of completing the programme.

Removing barriers and supporting our BAME Leaders to not only survive but thrive within our Trust

We are holding a series of focus group sessions with our BAME leaders both from the medical and non-medical functions. The purpose of the focus groups will be to:

- Understand the lived experience of BAME leaders at St George's – what helps and hinders them to perform to their full potential;
- Understand what the Trust needs to do to improve retention and career progression of our existing BAME leadership.

It is our intention to analyse data from the focus groups and to develop a series of recommendations that will improve retention and the career progression of all BAME leaders within the Trust.

Remove bias from our recruitment processes

We are taking a range of steps to ensure that our recruitment and selection process is fair and equitable, for example:

- Trained 120 recruitment inclusion representatives (RIS) to sit on all interview panels for band 7 and above posts;
- Working with our recruitment partners to introduce unconscious bias as a core element of recruitment and selection training. It is our intention to also make attendance at recruitment and selection training a mandatory requirement for all recruiting managers.

Are there any other factors or data which should be taken into consideration in assessing progress?

We have established a Culture, Equity and Inclusion (CEI) Programme Board. This board meets monthly and is chaired by the Chief Executive Officer. The primary aim of the CEI

Programme Board is to lead the implementation of a culture change programme that promotes inclusion and where diversity of the workforce is celebrated. The membership of the Board includes a number of BAME leaders and staff including the BAME Network Chair. Many of our culture change measures of success include improvement in our WRES data.

St George's University Hospitals NHS
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APPENDIX 1: WRES 2020/21 Raw Data Submission:

Answer Required
Auto Populated
N/A

INDICATOR		DATA ITEM		MEASURE	2020 WHITE	2020 BME	2020 ETHNICITY UNKNOWN/NULL	2021 WHITE	2021 BME	2021 ETHNICITY UNKNOWN/NULL	Notes
			1a) Non Clinical workforce		Verified figures	Verified figures	Verified figures	Verified figures	Verified figures	Verified figures	
1	Percentage of staff in each of the AfC Bands 1-9 OR Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce	1	Under Band 1	Headcount	0	0	0	0	0	0	
		2	Band 1	Headcount	0	1	0	0	1	0	
		3	Band 2	Headcount	271	254	20	258	257	21	
		4	Band 3	Headcount	143	167	13	137	168	30	
		5	Band 4	Headcount	246	216	18	247	225	29	
		6	Band 5	Headcount	107	85	7	112	90	12	
		7	Band 6	Headcount	69	64	3	56	78	8	
		8	Band 7	Headcount	76	59	0	84	64	0	
		9	Band 8A	Headcount	63	28	3	61	35	11	
		10	Band 8B	Headcount	35	14	2	36	16	6	
		11	Band 8C	Headcount	15	10	0	20	12	0	
		12	Band 8D	Headcount	33	4	2	27	5	2	
		13	Band 9	Headcount	7	2	0	8	3	0	
		14	VSM	Headcount	16	4	1	14	1	0	
			1b) Clinical workforce of which Non Medical								
		15	Under Band 1	Headcount	0	0	0	0	0	0	
		16	Band 1	Headcount	0	0	0	0	0	0	
		17	Band 2	Headcount	193	564	30	201	532	30	
		18	Band 3	Headcount	107	207	7	110	197	6	
		19	Band 4	Headcount	77	78	3	78	125	7	
		20	Band 5	Headcount	596	706	24	530	758	23	
		21	Band 6	Headcount	699	650	24	694	675	24	
		22	Band 7	Headcount	701	347	20	702	392	16	
		23	Band 8A	Headcount	229	79	9	236	83	9	
		24	Band 8B	Headcount	62	17	1	61	18	1	
		25	Band 8C	Headcount	24	6	0	27	5	0	
		26	Band 8D	Headcount	11	2	0	9	2	0	
		27	Band 9	Headcount	2	1	0	4	1	0	
		28	VSM	Headcount	1	0	0	1	0	0	
			Of which Medical & Dental								
		29	Consultants	Headcount	359	235	50	366	240	44	
		30	*of which Senior medical manager*	Headcount	0	0	0	0	0	0	
		31	Non-consultant career grade	Headcount	11	14	3	9	15	1	
		32	Trainee grades	Headcount	385	284	54	376	338	74	
		33	Other	Headcount	0	0	0	0	0	0	
2	Relative likelihood of staff being appointed from shortlisting across all posts	34	Number of shortlisted applicants	Headcount	4057	6598	970	4235	5990	1130	
		35	Number appointed from shortlisting	Headcount	1266	1402	654	1455	1402	837	
		36	Relative likelihood of appointment from shortlisting	Auto calculated	31.21%	21.25%	67.42%	34.36%	23.41%	74.07%	
		37	Relative likelihood of White staff being appointed from shortlisting compared to BME staff	Auto calculated	1.47			1.47			
3	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation Note: This indicator will be based on data from a two year rolling average of the current year and the previous year	38	Number of staff in workforce	Auto calculated	4538	4098	294	4464	4336	354	
		39	Number of staff entering the formal disciplinary process	Headcount	34	73	4	32.5	57.5	6.5	
		40	Likelihood of staff entering the formal disciplinary process	Auto calculated	0.75%	1.78%	1.36%	0.73%	1.33%	1.84%	
		41	Relative likelihood of BME staff entering the formal disciplinary process compared to White staff	Auto calculated		2.38			1.82		

4	**Relative likelihood of staff accessing non-mandatory training and CPD**	42	Number of staff in workforce	Auto calculated	4538	4098	294	4464	4336	354	
		43	Number of staff accessing non-mandatory training and CPD:	Headcount	1675	1444	84	1142	1076	60	
		44	Likelihood of staff accessing non-mandatory training and CPD	Auto calculated	36.91%	35.24%	28.57%	25.58%	24.82%	16.95%	
		45	Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff	Auto calculated	1.05			1.03			
9	**Percentage difference between the organisations' Board voting membership and its overall workforce** **Note: Only voting members of the Board should be included when considering this indicator**	46	Total Board members	Headcount	12	4	0	12	2	0	
		47	*of which: Voting Board members*	Headcount	8	2	0	8	1	0	
		48	*: Non Voting Board members*	Auto calculated	4	2	0	4	1	0	
		49	Total Board members	Auto calculated	12	4	0	12	2	0	
		50	*of which: Exec Board members*	Headcount	8	2	0	8	0	0	
		51	*: Non Executive Board members*	Auto calculated	4	2	0	4	2	0	
		52	Number of staff in overall workforce	Auto calculated	4538	4098	294	4464	4336	354	
		53	Total Board members - % by Ethnicity	Auto calculated	75.0%	25.0%	0.0%	85.7%	14.3%	0.0%	
		54	Voting Board Member - % by Ethnicity	Auto calculated	80.0%	20.0%	0.0%	88.9%	11.1%	0.0%	
		55	Non Voting Board Member - % by Ethnicity	Auto calculated	66.7%	33.3%	0.0%	80.0%	20.0%	0.0%	
		56	Executive Board Member - % by Ethnicity	Auto calculated	80.0%	20.0%	0.0%	100.0%	0.0%	0.0%	
		57	Non Executive Board Member - % by Ethnicity	Auto calculated	66.7%	33.3%	0.0%	66.7%	33.3%	0.0%	
		58	Overall workforce - % by Ethnicity	Auto calculated	50.8%	45.9%	3.3%	48.8%	47.4%	3.9%	
		59	Difference (Total Board -Overall workforce)	Auto calculated	24.2%	-20.9%	-3.3%	36.9%	-33.1%	-3.9%	

APPENDIX 2: Diversity and Inclusion Action Plan

Diversity & Inclusion Action Plan

Our Organisational Commitment to Tackling Discrimination and Building an Inclusive Culture

Outstanding care every time

Introduction

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

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

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

Development of the D&I Action Plan

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

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

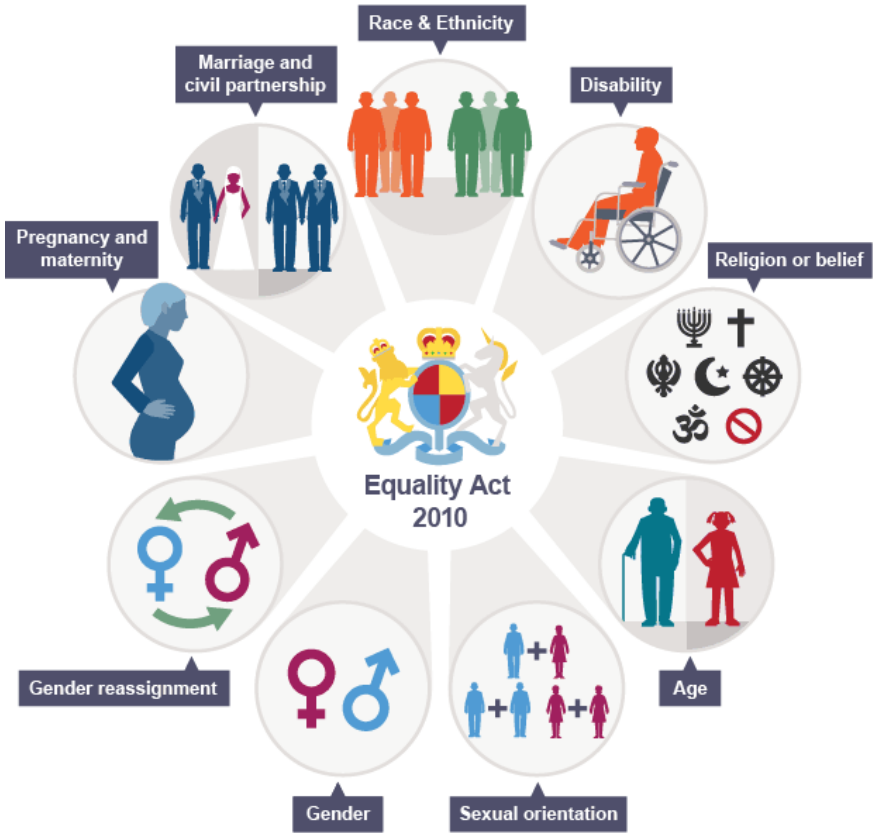


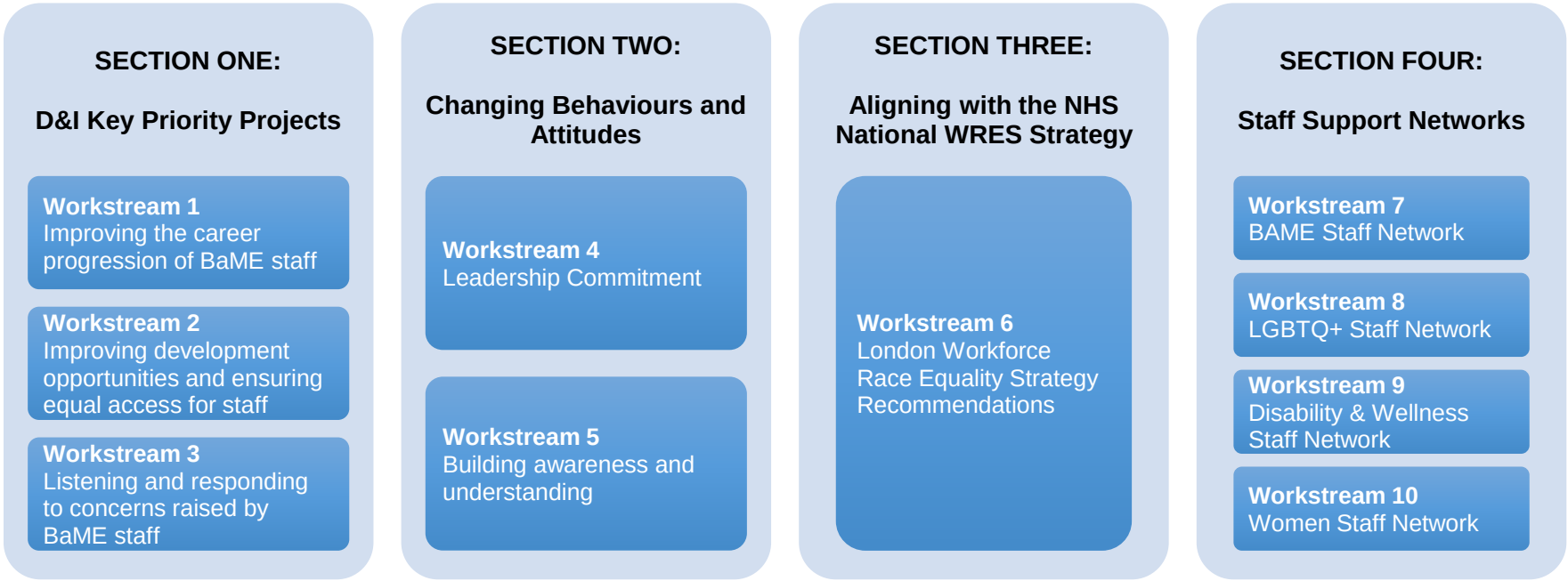
Figure 1The 9 Protected characteristics enshrined in the Equality Act 2010

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

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

Structure of the Action Plan

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



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

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

Roles and Responsibilities

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

Targets and Success Measures

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

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

SECTION ONE: Diversity & Inclusion Key Priority Projects

WORKSTREAM 1: Improving the Career Progression of BAME Staff

Executive Sponsor: Chief Strategy Officer

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

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

Deliverable	Actions	Delivery Date	Measure / Target	Progress Update 2021
1.1 All recruitment panels are ethnically balanced / representative (to be mandated for band 8A and above)	1.1.1 Design and schedule 2-3 half day trainings for approx 30 BAME recruitment reps who have already been recruited and received some basic initial training	31/08/20	1. By end of 2021, we will have a pool of **120** trained BAME recruitment reps (Recruitment Inclusion Specialists) 2. By end of 2021, **100%** of recruitment panels will include a BAME inclusion representative (Recruitment Inclusion Specialist)	All actions as specified in the action plan has been delivered/completed. Measure 1 – completed Measure 2 – our current compliance averages 63%
	1.1.2 Assess the necessary number of BAME recruitment reps to recruit, train and retain, based on average number of recruitment panels per year • For bands 8A and above, initially • For band 7 also	31/08/20		
	1.1.3 Define and implement an organisation-wide process for ensuring that: • trained BAME recruitment reps are invited to sit on recruitment panels in a reasonable timeframe after completing their training • All 8A and above recruitment panels include a trained recruitment rep	31/07/20		
	1.1.4 Train additional BAME staff to sit on recruitment panels, and establish an ongoing training offer to retain enough representatives	31/01/21		
1.2 All recruiting managers and recruitment panel members are trained in recruitment and selection (including countering unconscious bias in recruitment)	1.2.1 Develop and implement a training offer in recruitment and selection (R&S) for all recruiting managers and recruitment panel members, that includes unconscious bias.	31/01/21	In Q4 of 2021, **60%** of all panel members have been trained in R&S. By end of 2021, **500** total will be trained.	Training offer has been developed and launched in collaboration with the SWL Recruitment Hub. Due to the complexities and number of stakeholders involved this action was delayed by several months,
	1.2.2 Develop and implement a process to make R&S training (which includes bias) mandatory for all staff participating on a recruitment panel	31/03/21		
1.3 All BAME staff who are not successful at interview	1.3.1 Develop and implement a process and proforma in line with positive action that managers will complete to record a career conversation if a BAME staff member is	~~31/08/20~~	By end of 2021, **90%** of BAME staff not	Process and guidance has been developed and approved

are offered feedback and a career coaching conversation	not successful at interview for a role at Band 6 or above (and encouraged for all other bands)	31/01/22	successful after interview are offered a career coaching conversation	via the necessary channels. Due to staff changeover this has not been launched.
	1.3.2 Develop supportive guidance for recruitment panel chairs offering feedback and a coaching conversation for BAME staff who are not successful at interview	~~31/08/20~~ 31/01/22		
1.4 BAME staff have greater access to coaching and mentoring	1.4.1 Develop and implement a career coaching and mentoring offer (including policies and processes) that is connected to the performance appraisal process, to be made available for BAME staff (includes creating a communication plan to launch the offer to staff)	~~31/01/21~~ 31/01/22	By end of 2021, **50** BAME staff are in coaching/mentoring relationships	This deliverable and associated actions were dependant on additional resource being secured. Our business case has recently been approved and we are in the early stages of the recruitment process for a Talent Management lead.
	1.4.2 Create and build up list/bank of internal career coaches/mentors, and train new/existing coaches/mentors as necessary	~~30/09/20~~ 31/03/22		
1.5 BAME staff have access to interview training to boost their performance when applying for roles	1.5.1 Develop a short course and supporting written guidance on 'preparing for job interviews' and ensure it is routinely offered year round	30/09/21	By end of 2021, **80** BAME staff attend interview preparation training	Action as specified in the action plan has been delivered/completed.
1.6 All interviews at all levels include D&I questions and decision making criteria	1.6.1 Make D&I questions mandatory in all selection interviews, and use the candidate's response as a criteria to make recruitment decisions.	~~31/01/21~~ 31/12/21	By end of 2021 **100%** of interviews will include a D&I question (measured by the presence of a BAME Recruitment Rep)	Example questions have been developed and approved by relevant stakeholders. Individuals are using the documents and they are part of our Recruitment Inclusion Specialist Guide for recruitment managers. However, this process has yet to be formalised (mandated) within the recruitment and selection policy.

Workstream Risks and Dependencies:

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

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

Executive Sponsor: Chief People Officer

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

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

Deliverable	Actions	Delivery Date	Measure / Target	Progress Update 2021
2.1 Equal access to training and development opportunities for all staff	2.1.1 Review and revise all policies, processes and procedures related to application and attendance for training and development to ensure selection is equitable.	30/09/20	Relative likelihood of White staff accessing non-mandatory training /CPD compared to BAME is **1.0**	Action as specified in the action plan has been delivered/completed. Measure – relative likelihood is currently 1.03.
2.2 Transparent, fair and equal access panel-based decision making process for selection on high value development programmes	2.2.1 Develop panel process for HEE CPD higher value development programmes (including specification of high value programmes, clear criteria, panel composition requirements, assessment techniques etc.)	30/09/20	By the end of 2021, **100%** of high value programme selection processes will be held via panel review	Action as specified in the action plan has been delivered/completed. Measure – on track
2.3 BAME staff have greater access to career coaching and mentoring	*Equivalent to deliverable 1.4 in Workstream 1 above*	N/A	By end of 2021, **50** BAME staff are in coaching/mentoring relationships	See deliverable 1.4 in Workstream 1 above. In addition, encourage career conversations and line managers as part of our Big 5 Fairer Career Progression Month.
2.4 Improved personal development and career planning for employees	2.4.1 Clarify line manager expectations and responsibilities (as part of a future 'management charter') in relation to supporting staff to develop meaningful PDPs as a part of the annual appraisal process (including updating appraisal training)	31/03/21	By the end of 2021, **60%** of PDR records include evidence of career focused conversations (beyond the usual	Actions 2.4.1 and 2.4.2 as specified in the action plan have been delivered/completed. Due to significant upgrades
	2.4.2 Revise Performance Development Review Process to ensure that there is a structured career development section in place	31/03/21		

	2.4.3 Develop guidance and training module for managers to conduct career planning discussions (which may be part of the performance review discussion, but not exclusively)	31/12/20	'development conversation') *[Measurement will require new LMS functionality]*	to the Trust's learning management system, iLearn, in 2021, we were unable to introduced new modules across the platform, including a reasonable adjustments and disability awareness module. The upgrade has been completed and we will be able to launch these modules by the end of 2021. This will see action 2.4.3 completed.
2.5 An talent management approach that is inclusive in assessing, developing and retaining talent to improve representation of BAME groups	2.5.1 Develop an Inclusive Talent Management Process that is integrated into the succession planning and performance development review process	~~31/12/21~~ 31/03/22	Introduced talent management process across the organisation.	This deliverable and associated actions were dependant on additional resource being secured. Our business case has recently been approved and we are in the early stages of the recruitment process for a Talent Management Lead.
	2.5.2 Establish Inclusive Talent Management moderation processes and panels	~~31/12/21~~ 31/03/22		
	2.5.3 Implement and embed the talent management processes using a phased approach	31/12/21		
2.6 A succession planning process that is inclusive, to improve representation of BAME groups	2.6.1 Develop a succession planning approach, policies and processes for the Trust and trial the process	31/12/21	Introduced succession planning approach across the organisation.	This deliverable and associated actions were dependant on additional resource being secured. Our business case has recently been approved and we are in the early stages of the recruitment process of Talent Management Lead
	2.6.2 Implement the succession planning process across the Trust	31/12/21		

Workstream Risks and Dependencies:

- Introducing new processes around selection for CPD (deliverables 2.1 and 2.2) may attract resistance as they will require more time and paperwork. Strong role modelling and commitment from senior leaders will be required to fully embed these new selection procedures
- Conducting a career conversation relies on the level of skill and confidence of the manager to initiate the conversation, so the risk is that the benefits will be very patchy from team to team

- Whether a career conversation has been held is fairly subjective. Clarity will need to be provided around a standard development conversation, and a truly forward looking career conversation
- Introducing talent management and succession planning methodologies requires allocating resources in time to participate in the relevant assessment and decision making processes from leaders, so resistance may be experienced and participation levels may be affected
- Assessing latent talent (or potential) can be particularly open to bias due its limitations on objectivity
- Sustainable talent management systems may benefit from some IT infrastructure to manage them which may attract necessary investment

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

Executive Sponsor: Chief Corporate Affairs Officer

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

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

Deliverable	Actions	Delivery Date	Measure / Target	Progress Update 2021
3.1 Staff are offered and encouraged to raise concerns through highly accessible routes	3.1.1 Clarify and/or develop and communicate opportunities for concerns around discrimination and exclusion to be raised through a variety of routes, including Acting CPO structure, D&I Lead, FTSUG, HR, other	01/01/21	Continuous feedback from the BAME network that channels to raise issues are adequate and effective	Action as specified in the action plan has been delivered/completed. Raising Concerns policy has been revised in line with National Guidelines.
	3.1.2 Communicate and review the grievance/raising concerns processes with BAME network colleagues	30/09/20		
3.2 Teams are supported with focused OD interventions to assess and respond to team or departmental issues around diversity and inclusion	3.2.1 Work with BAME Network Chair and other key stakeholders (HRBPs, F2SU, HR) to identify BAME staff raising issues 'hot spots' (an area where there are a number of issues being raised by BAME staff around inappropriate behaviour, discrimination and bullying and harassment)	31/12/21	Measures and targets will be determined for each local issue addressed.	The actions as specified in the action plan has been delivered/completed. This piece of work is going/live.
	3.2.2 In conjunction with key stakeholders (managers responsible for 'hot spot' areas devise an OD plan to identify, address and resolve issues as raised	07/08/20		
3.3 Recommendations from the culture change diagnostic project around inclusion are implemented	3.3.1 Review culture change diagnostic data and incorporate improvement actions	31/12/21	Culture, Equity and Inclusion Programme Plans are developed to fully incorporate D&I Action Plan	The actions as specified in the action plan has been delivered/completed.
3.4 Real experiences of exclusion are sensitively recorded and communicated so they are	3.4.1 Follow up Gillian's and Jacqueline's communication piece with a lived experience story from BME staff members that bring out real examples of what has been said to them at SGH and how it feels	31/12/21	By end of 2021, we will have captured **8** personal stories of lived experience at	Communications regarding D&I are regualry shared, however they have not specifically focused on a

clearly and effectively heard across the Trust			SGH	Staff Story.
3.5 Team leaders are supported to initiate meaningful dialogues around inclusion with their teams	3.5.1 Provide structured support in the form of techniques, guidelines and where possible facilitation for Team leaders to have meaningful conversations about diversity and inclusion	31/08/20	Number of team level discussions conducted around Race and Inclusion	Action as specified in the action plan has been delivered/completed. D&I Workforce Lead and Head of OD continue to work with a number of services offering support and intervention as required

Workstream Risks and Dependencies:

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

SECTION TWO: Changing Attitudes and Behaviour

WORKSTREAM 4: Leadership Commitment

Executive Sponsor: Chief Executive Officer

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

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

Deliverable	Actions	Delivery Date	Measure / Target	Progress Update 2021
4.1 The expectation of all staff to be involved in tackling exclusion and discrimination is role modelled	4.1.1 Executive Team and Board members to come up with one personal action which they will take to improve the working lives of the BAME workforce (e.g., I am being reverse-mentored by a BAME colleague) and cascade to all employees	31/08/20	**100%** of Exec team comply	Action as specified in the action plan has been delivered/completed. These will be communicated/published by the end of 2021.
4.2 D&I networks are actively and visibly supported by an Executive Sponsor	4.2.1 Review and clarify the role of the Executive Sponsor in providing focused support for each D&I Network, including specifically, supporting the implementation of each network's action plan	31/08/20	Each network has an action plan with active endorsement from Exec sponsor	Due to a number of changes/vacancies within our Network Leadership Teams and a revision of our Terms of Reference the action (as stated) has not progressed. Measure – 3 of the 4 networks have an action plan that was agreed by members. Following successful appointment to our Network Chair roles these action plans will be updated and include agreeing review of the role of the executive sponsor.

4.3 Leadership competencies specific to inclusion are defined and integrated in all leadership development initiatives	4.3.1 Develop competency framework for leaders/senior managers, specifying building the capability to promote D&I as a core management and leadership competency	31/12/21	By the end of 2021, all existing and new management and leadership programmes explicitly focus on D&I competencies as a core requirement of good leadership and management	Actions as specified in the action plan have been delivered/completed. Measure – on track
	4.3.2 The Advanced Leadership Programme aimed at Deputy General Managers and Service Managers to include the development of inclusive leadership capabilities.	01/11/21		
	4.3.3 Ensure that all existing general programmes, and future Leadership Development programmes commissioned for functional directorates contain inclusive leadership capabilities as a core part of the programme	31/01/21		
4.4 Leadership position successors are required to demonstrate a strong commitment to inclusion	4.4.1 Succession planning to include D&I as a gateway; The Trust can only promote (or nominate to promote) an individual if they have an excellent track record of promoting D&I **NB Connection to Deliverable 2.6 on succession planning*	~~31/12/21~~ 29/04/22	Introduced succession planning approach across the organisation.	This deliverable and associated actions were dependant on additional resource being secured. Our business case has recently been approved and we are in the early stages of the recruitment process for Leadership Development Lead.
4.5 Each Division and Directorate has a D&I action plan in place that translates organisational D&I initiatives locally and focuses on local D&I priorities	4.5.1 Divisions and Directorates are supported to produce local D&I action plans which consider: What are we going to do as a division/directorate to improve diversity and inclusion within our function? To include a toolkit/template for identifying priorities and formulating an action plan.	~~31/01/21~~ 28/03/22	Evidence of local D&I action plans	Work is underway and a number of divisions have action plans that are in review/draft. Due to the pandemic and operational pressures further work is require to delivery on this action
4.6 St George's D&I strategy and action plan (and its measurable outcomes) are comparable to and continually learning from the D&I successes (and challenges) of other Trusts, organisations and sectors	4.6.1 Introduce an annual benchmarking exercise with other Trusts (link to WRES data)	31/01/21	Participation in relevant networks, annual benchmarking, and adoption of best practice from other organisations	Agree at the SWL D&I Committee meeting that this benchmarking exercise was to be placed on hold due to operational pressures across the sector.
	4.6.2 Build and/or connect with a network of D&I Leads in other	ongoing		Action as specified in the

	comparable Trusts with similar challenges, to offer a forum for continuous learning, and improvement (including visits to other Trusts)			action plan has been delivered/completed
	4.6.3 Learning from other organisations and sectors country wide through networking and other relationship building efforts	ongoing		Action as specified in the action plan has been delivered/completed.
4.7 D&I is systematically considered in all leadership and governance discussions and decision making forums/processes at Board and Exec levels	4.7.1 To ensure that D&I features in our discussions and decision making processes we will: • Wherever possible include D&I issues as a discussion agenda item; • Review our meetings in relation to how effective we were in considering D&I • Include a section on our paper submission template that explicitly outlines the impact of decisions/plans on D&I	31/08/20	Continuous explicit focus on D&I in all Board and Exec level meetings	Action as specified in the action plan has been delivered/completed.
4.8 Board level meetings regularly include reviewing patient and staff stories and monitoring WRES data	4.8.1 Agree as part of our Patient and staff story at Trust Board we will also consider a D&I staff or patient story	31/01/21	Staff and Patient stories featured twice a year at board	Action as specified in the action plan has been delivered/completed.
	4.8.2 Use the WRES and survey data to make a simple dashboard to track progress at each Board meeting	31/01/21		Action as specified in the action plan has been delivered/completed.
4.9 All staff communications will regularly feature updates, successes and stories that promote the agenda for building a culture of inclusion	4.9.1 Regular communications on D&I are developed and disseminated to all staff from the CEO/Chair/Exec team	ongoing	Quarterly communications reflecting D&I specific content	Picking up again - Action as specified in the action plan has been delivered/completed
4.10 The D&I action plan is fully aligned with the organisational culture change programme	4.10.1 Align all D&I leadership work with the culture change programme and ensure all recommendations are integrated	31/01/21	Culture, Equity and Inclusion Programme Plans are developed to fully incorporate D&I Action Plan	The actions as specified in the action plan has been delivered/completed.

Workstream Risks and Dependencies:

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

WORKSTREAM 5: Building Awareness and Understanding

Executive Sponsor: Chief People Officer

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

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

Deliverable	Actions	Delivery Date	Measure / Target	Progress Update 2021
5.1 The workforce has renewed and strengthened connection and meaning with our organisational values	5.1.1 Plan, launch and implement the 'Values Into Action' project, to refresh our values Trust-wide. Likely to involve a range of facilitated team discussions, learning experiences, revised values and behaviours policy, and provision of tools and resources. Likely to involve 3 main phases of work: • Compiling and shaping • Testing and development • Embedding and reinforcing	~~31/01/21~~ (throughout 2021-2022)	Staff survey and workforce data measures (as per the culture programme impact indicators)	Currently under development This initiative was held back due to operational pressures and organisational 'readiness'
5.2. Different minority groups are recognised and celebrated across St George's	5.2.1 Plan and deliver a sustainable range of diversity and faith awareness and celebration events throughout the year.	ongoing	A range of Diversity and faith awareness/ celebration events are held across the year	The action as specified in the action plan has been delivered/completed. This piece of work is

				going/live.
5.3 The D&I action plan is fully aligned with the organisational culture change programme	5.3.1 Align the D&I Action Plan with the culture change programme	31/01/21	Culture, Equity and Inclusion Programme Plans are developed to fully incorporate D&I Action Plan	The actions as specified in the action plan has been delivered/completed.
5.4 All staff build an awareness of unconscious bias at work as a basis to continue building more inclusive team and organisational cultures	5.4.1 Specify and develop a bespoke training workshop ‘	30/09/20	By the end of 2021, **2000** individuals in the Trust will have completed the F2F or online module.	Action 5.4.1 and 5.4.2 have been completed/delivered. Action 5.4.2 has not been delivered /completed Action 5.4.4 has been delayed to the urgade to the orgs. learning management system. Content is under review and planned to introduced by end of 2021. Measure – unable to meet
	5.4.2 Pilot and launch a short online workshop	31/10/20		
	5.4.3 Make the workshop widely available as both an online or in-person experience, sourcing the help of external providers as needed	31/12/20		
	5.4.4 Develop a self-directed online e-learning module reflecting the same content	31/12/20		
5.5. All staff have highly accessible access to the full range of D&I resources, trainings, contacts, policies and other information via the intranet	5.5.1 Develop a D&I intranet page that integrates all existing and future resources, trainings, contacts, policies, and networks information etc.	31/12/20	Intranet pages are live, accessible to all staff and regularly updated.	The action as specified in the action plan has been delivered/completed.

Workstream Risks and Dependencies:

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

SECTION THREE: Aligning With the NHS National WRES Strategy

WORKSTREAM 6: London Workforce Race Equality Strategy Recommendations

Executive Sponsor: Chief People Officer

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

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

Deliverable	Actions	Delivery Date	Measure / Target	Progress Update 2021
6.1 Authoritarian managerial processes are replaced with person centred learning processes	6.1.1 Develop a new approach and process to respond to serious or chronic performance issues, thus reducing our dependency on formal disciplinaries (to be used only for extreme cases, e.g. theft, violence and patient safety breaches)	30/11/20	**25%** reduction in number of formal disciplinaries by end of 2021.	The action as specified in the action plan has been delivered/completed. New disciplinary process has been developed and implemented. Achievement of measures to be assessed by end of 2021.
	6.1.2 Implement new approach and processes as designed	30/11/20		
6.2 An executive on each board has completed the WRES Advisor programme	6.2.1 Executive level advisor to be nominated	30/09/20	Evidence of completion	Director of Culture and OD is part of the WRES Experts Sponsors Programme. We are awaiting further information /launch of the WRES Advisor programme.
	6.2.2 Nominated executive level advisor to attend the WRES Advisor Programme	31/03/21		
6.3 An organisational culture transformation programme is in place to strengthen racial inclusion	6.3.1 Align the D&I Action Plan with the culture change programme	31/01/21	Culture, Equity and Inclusion Programme plans in place, and Programme Board	The action as specified in the action plan has been delivered/completed.

			established.	
6.4 Increased BAME representation among Freedom to Speak Up Guardians and champions	6.4.1 Align the D&I Action Plan with the organisational FSUG strategy	31/12/20	By end of 2021, % of FSUGs is **equivalent** to the BAME staff %	The action as specified in the action plan has been delivered/completed. Measures to be assessed by end of 2021.
6.5 Independent STP/ICS WRE oversight panels are in place	FOR INFORMATION ONLY (implemented outside of the Trust)			
6.6 Commissioners are working with providers in enhancing their performance against indicators of race inequality	FOR INFORMATION ONLY (implemented outside of the Trust)			
6.7 CQC Assessments include specific race related key lines of enquiry	FOR INFORMATION ONLY (implemented outside of the Trust)			
6.8 Competency Frameworks and Development Programmes for supervisors and line managers	*Covered by deliverable 4.3 in Workstream 4 above*			
6.9 White Allies Programme is in place and supported to more effectively distribute responsibility for equality and inclusion	6.9.1 Research best practice among white ally programmes in NHS and other organisations	31/12/20	Programme has been implemented and staff are supporting to attend.	Action has been delivered/completed via successful application to NHSE/I's White Allies Programme. Six of our leaders commenced on the programme in September 2021.
	6.9.2 Develop and agree a proposal to establish and support a white allies programme/network, in collaboration with the BAME network Chair and Workforce D&I Lead	31/01/21		
	6.9.3 Implement the proposal	31/03/21		
6.10 A Frontline Staff Forum is established to enable more feedback on the success of this action plan, and other aspects of working life in the NHS	6.9.1 Research best practice among Frontline Staff Forums in NHS and other organisations	30/04/21	Programme has been implemented and staff are supporting to attend.	Awaiting further information/direction from NHSE/I
	6.9.2 Develop and agree a proposal to establish and support a Frontline Staff Forum	31/05/21		
	6.9.3 Implement the proposal	31/07/21		
6.11 A London-specific WRES experts	FOR INFORMATION ONLY (implemented outside of the Trust)			

cohort is established				
6.12 Recruitment and secondment processes are debiased	*Recruitment aspect is covered by Workstream 1 above*			
	6.12.1 Develop a process for applying for and awarding secondments that is transparent, unbiased and equally accessible	31/10/20 31/03/22	Clear and transparent process for secondments and other opportunities. Appointment of Staff Engagement Lead	In collaboration with the SWL Recruitment Hub, an Inclusion Recruitment and Selection training offer have been developed and launched. Further work required with the SWL Recruitment Hub Staff Engagement Lead has been appointment and started in September 2021.
	6.12.2 Implement new processes, including effective staff engagement and communications	31/12/20		
6.13 Identification and closure of the gap in experience for agency, bank and temporary staff	FOR INFORMATION ONLY (to be implemented initially by London-wide intervention, and may require future organisational level actions)			
6.14 Improved understanding of the experience of staff in primary care	FOR INFORMATION ONLY (implemented outside of the Trust)			
6.15 Implemented key recommendations from the London Nursing and LAS priority plan	FOR INFORMATION ONLY (implemented outside of the Trust)			

Appendix A: Overview of Roles and Responsibilities

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

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

Appendix B: Workforce Race Equality Standard (WRES) 2019

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

Meeting Title:	**Trust Board**		
Date:	30 September 2021	**Agenda No**	3.1.2a
Report Title:	**Trust Responsible Officer Annual report to the Board of Directors**		
Lead Director/ Manager:	Dr Luci Etheridge, Responsible Officer and Deputy Medical Director (Workforce)		
Report Authors:	Dr Luci Etheridge, Responsible Officer and Deputy Medical Director (Workforce) Nicola McDonald, Revalidation Support Officer		
Presented for:	Assurance		
Executive Summary:	The Responsible Officer (RO) reports to the Board annually on progress in medical appraisal and revalidation of licensed doctors. In normal times the Trust makes a self-assessment return to NHS England and NHS Improvement for the Annual Organisational Audit (AOA) in June. This is used to benchmark our processes and performance against other Designated Bodies. In March 2020, at the onset of the Covid-19 pandemic, medical appraisal and all associated activities were paused. As a result, there has been no AOA in 2020 or 2021, so there is no requirement to take a report to the Board or for a statement of compliance to be signed. However, in December 2020 a new Responsible Officer (RO) was appointed, medical appraisal has been resumed and revalidation recommendations are being made. Therefore, the RO wishes to share the ongoing progress towards the Higher level RO quality review visit (HLROQRV) that took place in early 2020 and seek support for further planned improvements. This report was reviewed and endorsed by the Workforce and Education Committee at its meeting on 12 August 2021.		
Recommendation:	The Board is asked to: • Note the Designated Body Annual Board Report; • Note that appraisal and revalidation is fully resumed following the disruption of the pandemic but that appraisal rates have been affected; • Note the planned actions for the upcoming year.		
Supports			
Trust Strategic Objective:	• Right care, right place, right time • Champion team St Georges		
CQC Theme:	Effectiveness and Well Led		
NHS Oversight Framework Theme:	Workforce support and development		
Implications			

Risk:	Failure to ensure high quality appraisal for our Doctors risks disengagement from the Trust.		
Legal/Regulatory:	Failure to respond to feedback and reach an appropriate level of compliance risks scrutiny by NHSEI. Medical appraisal compliance informs the well led domain of the CQC.		
Resources:	N/A		
Previously Considered by:	People Management Group Workforce and Education Committee	**Date**	21 July 2021 12 August 2021
Equality Impact Assessment:	N/A		
Appendices:	A. Designated Body annual report to the board B. HLRO quality review visit action plan progress update		

1. PURPOSE

1.1. The purpose of this paper is:

- to present the RO Annual Board report to the board via WEC
- to describe the context for the 2021 report
- to highlight progress against previous actions, where these have been delayed by COVID-19, and areas for improvements in 2021/22

2. BACKGROUND

2.1. It is a regulatory and contractual requirement of Doctors that they participate in annual appraisal of the full scope of their practice in order to maintain their licence to practise.

2.2. In March 2020 the requirement for appraisal and all associated activities was paused by the Chief Medical Officer of NHSEI and the GMC deferred revalidation for all doctors until 2021.

2.3. In normal years the designated report to the board would contain the results of the Annual Organisational Audit submitted by the Trust in June. This enables benchmarking against other designated bodies. There has been no requirement to submit the AOA this year.

2.4. A new RO was appointed in December 2020. The new team wish to ensure the board remains sighted on the actions and progress made since the High Level Responsible Officer Quality Review visit in early 2020 and during the transition period between ROs.

3. PROGRESS

3.1. Three Divisional Appraisal Leads have been appointed and started in post in April 2021. They are building relationships within Divisions and beginning to work more closely with Divisional Management Boards to review progress with medical appraisal rates.

3.2. We meet monthly as the Appraisal and Revalidation group and are starting to triangulate information relevant to medical appraisal.

3.3. A large scale quality assurance exercise has been undertaken and reported back to stakeholders. Changes have been made to the appraiser database based on the results of this exercise. The draft Medical Appraisal Policy is also being reviewed to ensure key findings are reflected, and this will be submitted for ratification this year.

3.4. Appraiser refresher training has been developed based on the results of the QA exercise and all appraisers have been invited to attend this.

3.5. The processes for making revalidation recommendations to the GMC are streamlined with a three-month lead in time to reduce the number of deferrals for missing information

3.6. The Responsible Officer Advisory Group meets quarterly and includes major stakeholder representation to hold the RO to account and support effective decision making about doctors connected to the organisation. The next step is to recruit a lay representative to this group.

3.7. On March 4th 2020 we had a HLRO quality review visit. The action plan arising from this is found at Appendix B. Progress on actions was initially delayed due to the pandemic but is now in progress again.

4. COMPLIANCE

4.1. Compliance with annual appraisal had improved from 63% (699 connections) in 2014/15 to 83% (899 connections) in 2018/19. However, we consistently benchmarked approximately 5% lower than similar sized designated bodies. In 2020 compliance dropped to less than 50% due to the impact of the pandemic. It is now 76.3% (947 connections).

4.2. Monthly reports are produced for each Division and discussed by the Divisional Appraisal Leads quarterly at Divisional Management Board. The Divisional Appraisal Leads will start working proactively with Care Group Leads to address areas where compliance is low and identify contributory factors.

4.3. There continue to be areas of the organisation where annual appraisal is not prioritised. Over the next year, as we emerge from the impact of the pandemic, the RO aims to better understand this and work to engage appraisers and appraises to ensure that there is a robust system of flagging this at an early stage to allow direct intervention.

5. ACTIONS FOR THE COMING YEAR

5.1. To ensure the Medical Appraisal Policy reflects the recommendations of the HLRO QRV and the findings of the internal QA and seek to have this ratified and shared widely.

5.2. To embed appraiser training and support for medical appraisers to improve appraisal quality across the organisation.

5.3. To establish ongoing quality assurance of medical appraisal and feed this back through the Divisions to enhance compliance.

5.4. To embed processes for the review of performance through the Responsible Officer Advisory Group, to recruit a lay representative to this group, and use the forum to ensure robust systems of governance and feedback around the performance of doctors.

5.5. To review the administrative support required to ensure the governance functions of appraisal and revalidation can be routinely met.

6. IMPLICATIONS

Risks

6.1. There is a risk that if the Trust consistently fails to benchmark at or above the compliance rate for similar sized same sector designated bodies this will draw scrutiny from NHSEI.

6.2. Compliance rates with annual appraisal inform the well led domain of the CQC.

6.3. Failure to ensure high quality appraisal for our Doctors risks disengagement from the Trust.

7. RECOMMENDATIONS

7.1. WEC is asked to approve the Designated Body annual report (Appendix A)

7.2. WEC is asked to note and approve the actions planned to improve our appraisal processes, compliance and the quality of appraisals.

Luci Etheridge, Responsible Officer

Appendices
A. Designated Body annual report to the board
B. HLRO quality review visit action plan progress update

Outstanding care every time

St George's University Hospitals NHS Foundation Trust

APPENDIX A: Designated Body Annual Board Report

Section 1 – General:

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

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

Date of AOA submission: N/A. Cancelled by NHS England and Improvement (NHSEI) due to Covid-19. **Action from last year:** Improve the overall % of completed appraisals, particularly in our non-Consultant groups. The Appraisal Leads will work with their divisions to support appraisal. Appraisal rate review is a part of the regular divisional performance review. **Comments:** Three Divisional Appraisal leads are now in post and have begun working with Divisions to review and address appraisal rates directly. They have started reporting back through Divisional Management Board on a quarterly basis. Overdue appraisals and doctors with potential non-engagement are reviewed monthly by the Appraisal and Revalidation team. Overall for the year March 20-March 21 67.6% of appraisals were completed in accordance with category 1 of the AOA. Prior to the pandemic, the Trust achieved 83.4% overall, 90% for consultant medical staff. Although this had improved from previous years it remained about 5% below peer designated bodies. There were 947 doctors connected to the Trust in March 2021, compared with 899 in 2018/19. Since March 21 rates have improved further, with 76.3% compliance achieved in June 2021. **Action for next year:** Improve the overall % of completed appraisals to achieve 90% category 1 completion by 2023, in line with the average for same sector designated bodies.

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

Action from last year: No action from last year. **Comments:** Dr Luci Etheridge replaced Ms Karen Daly as RO in December 2020. She has previously been a Divisional Appraisal Lead and completed RO training in 2020. **Action for next year:** No action required.

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

Action from last year: Appoint an additional Divisional Appraisal Lead and review if/what additional administration support is required.

Comments: Three Divisional Appraisal Leads are now in post and working effectively with the RO and Revalidation Support Officer. As we emerge from the pandemic and normal systems resume, the RO is reviewing processes to ensure robust governance around the conduct and performance of doctors in the organisation and will work with medical staffing to review if/what additional administrative support is required. A key recommendation from the High Level Responsible Officer Quality Review Visit (HLROQRV) was to review the level of administrative support required for the number of connections we have.

Action for next year: Review administrative support required to ensure governance functions can be routinely met and integrated effectively with doctor engagement and development.

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

Action from last year: No action from last year.

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

Action for next year: No action required.

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

Action from last year:. Finalise the Medical Appraisal policy and put forward for authorisation (end of September 2020) so the policy can be published/circulated asap after that.

Comments: The draft policy was reviewed as part of a routine Higher Level Responsible Officer Quality Review Visit (NHSEI) in March 2020, who suggested amendments. This was put on hold due to Covid-19. The policy was redrafted at the start of 2021 and now needs to be reviewed by the LNC and ratified.

Action for next year: Ensure all doctors are able to access the Medical Appraisal Policy and resources to support appraisal and revalidation through the new intranet. Review the policy annually at the Responsible Officer Advisory Group.

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

Action from last year: No action from last year.

Comments: The Trust took part in the Higher Level Responsible Officer Quality Review Visit (NHSEI) in March 2020. The new RO has had further contact with the HLRO team since taking up post to ensure progress against the recommendations in the action plan.

Action for next year: No action required.

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

Action from last year: No action from last year

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

Action for next year: No action required.

Section 2 – Effective Appraisal

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

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

Comments: All doctors are required to declare their full scope of work in their appraisal and should include supporting information that is proportionate to that, including information from all organisations in which they work, of any complaints and significant events they have been named in (or that they have not been named). The findings from an internal quality assurance exercise in 2020 demonstrated that this requirement is not being consistently met. Since then, the Medical Appraisal Policy has been updated and this need has been addressed at Medical Appraiser training. The AaRG meet monthly and review information about doctors of concern or where additional support will be needed to ensure they meet requirements for revalidation.

Action for next year: Embed Appraiser refresher training to ensure all appraisers challenge supporting information.

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

Action from last year: Improve quality of appraisal inputs.

Comments: The Divisional Appraisal Leads are regularly carrying out Appraiser update training which addresses the minimum requirements and supports Appraisers to seek and challenge this. Further QA will take place in 2021 to assess the impact of this.

Action for next year: Reassess quality in 2021/22 through annual QA exercise.

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

Action from last year: Publish/circulate updated Medical Appraisal Policy.

Comments: The draft policy was reviewed as part of a routine Higher Level Responsible Officer Quality Review Visit (NHSEI) in March 2020, who suggested amendments. This was put on hold due to Covid-19. The policy was redrafted at the start of 2021 and will now be reviewed by the LNC and ratified.

Action for next year: Carry forward from last year.

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

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

Comments: Following an internal quality assurance exercise, low performing appraisers and those with poor quality appraisal were identified. This group have since been written to and invited to training and several have stepped down from their appraiser role. Several new doctors have expressed interest in taking on medical appraisal and will be invited to undergo training and selection in 2022 to refresh and diversify the pool of appraisers. A process of allocation of appraisers has begun (a HLROQRV recommendation), beginning with senior doctors and doctors in difficulty. The aim is to phase in complete allocation by 2023 but this will be partially dependent on resource within the Revalidation Support team.

Action for next year: Embed allocation of appraisers for all doctors and train new appraisers.

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

Action from last year: Implement an enhanced quality assurance process and introduce appraiser forums. This is an item in the HLROQRV action plan.

Comments: A QA of 83 appraisers (166 appraisals) was carried out in Sept 2020 using the NHSE quality assurance tool, the ASPAT, by the Divisional Appraisal Leads. The results of this have been fed back to all appraisers, to the Divisional leadership and to other stakeholders via the ROAG. Appraiser update training has been developed based around this and all appraisers have been invited to attend. In future years, participation in annual updates will be a requirement to continue in role as a Medical Appraiser.

[1] http://www.england.nhs.uk/revalidation/ro/app-syst/

Action for next year: Annual QA and review of Appraiser training attendance.

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

Action from last year: Report to WEC annually.

Comments: See above.

Action for next year: Report back on annual QA in the RO report to the board.

Section 3 – Recommendations to the GMC

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

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

Comments: Revalidation was suspended by the GMC between March 2020 and 2021 and any doctor with a revalidation date during this time had that date deferred for 12 months. The Trust suspended all medical appraisal between March 2020 and October 2020 as part of the recognition of the increased workload on medical staff. However, in October 2020 the RO wrote to all doctors encouraging them to re-engage with medical appraisal in preparation for revalidation restarting in 2021. There are now a high number of doctors due to revalidate, either following deferral from 2020 or because they were due to revalidate in 2021. However, the process has been established for the Divisional Appraisal Leads and RO meet monthly with the Revalidation Support Officer to routinely review all upcoming revalidations 3 months in advance. This allows time for any issues to be addressed.

The number of revalidation recommendations between April 2020 and March 2021 totalled 40. All were submitted on time.

The number of recommendations to revalidate totalled 40.

The number of recommendations to defer totalled 1.
.
There were no recommendations of non-engagement.

Action for next year: No further action required

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

Action from last year: No action from last year. **Comments:** The Revalidation Support Officer will inform each doctor of what recommendation has been submitted. In the majority of cases where a deferral is necessary, the Revalidation Support Officer will communicate this to the doctor beforehand and the Divisional Appraisal Lead will give the doctor a clear action plan and timeframe to achieve by the next due date. The RO contacts the doctor directly in cases where they are deferred because they are subject to an ongoing process or where they are failing to meet the requirements of an action plan and are at risk of non-engagement. **Action for next year:** No action required.

Section 4 – Medical governance

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

Action from last year: An external report in April 2019 highlighted some inconsistencies in process and conduct of our systems for Clinical Governance. There is a clear action plan arising which is to be implemented in the coming year. **Comments:** Work towards the action plan is ongoing and several factors have already been implemented, despite interruptions due to the pandemic. **Action for next year:** Continue implementation of the action plan arising from the clinical governance review.

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

Action from last year: Implement process to log complaints directly to appraisal. **Comments:** The electronic appraisal system enables incidents and significant events known to be logged on the appraisal page for inclusion in the next appraisal. The Revalidation Support Officer has established an effective system with one of the Divisions to share information about doctors named in Serious or Adverse Incidents. However, this has not been fully established with the other two Divisions due to vacancies at Divisional Governance Manager level. A record is received quarterly of doctors who have been named in complaints and this will be logged. However, this information is not always reliable. Work is underway to establish a process whereby Divisional Chairs oversee all complaints where the practice of a doctor has been directly questioned, in order that the quality of complaint response

and associated reflection can be improved. The RO will be notified of all of these directly in order that they can be attached to appraisal. The Responsible Officer Advisory Group is now established and has stakeholder representation from all key areas, except for a lay member representing the public. It meets quarterly to review areas and/or practitioners of concern and advise the RO accordingly.

Action for next year: Embed processes for review of performance of doctors through the Responsible Officer Advisory Group and recruit a lay representative to this group.

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

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

Comments: The Responding to Concerns (RtC) meeting takes place weekly and considers all concerns raised internally and externally and tracks progress to resolve these. The terms of reference and membership of this group have been reviewed and the group's role is being considered as part of the Trust MHPS policy. We ensure that appropriate support including Occupational Health and staff support is available for all doctors in difficulty.

Action for next year: Review MHPS policy to include the RtC group and ensure clarity about its remit and function within the organisation.

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

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

Comments: Significant concerns about Medical Staff at St George's are managed under the Maintaining High Professional Standards policy, the disciplinary policy for Medical and Dental Staff. In addition to this policy, there is a weekly Responding to concerns meeting attended by the Chief Medical Officer, the Chief People Officer, Responsible Officer, Medical HR Manager and Employee Relations Manager, whereby all cases are reviewed and those in a formal process are monitored to ensure sufficient progress. The RO meets regularly with Liaison Officers from the GMC and PPAS. The progress of MHPS cases is reported to Trust Board.

2This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

Action for next year: Finalise MHPS policy to include RtC group and agree and standardise steps and support for informal action within Divisions. Audit referrals to the RtC group, including for the impact of diversity and inclusion policies on referrals and outcomes.

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

Action from last year: No action from last year.

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

Action for next year: No action required.

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

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

Comments: See above

Action for next year: See above

Section 5 – Employment Checks

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

Action from last year: No action from last year.

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

Action for next year: No action required.

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

Section 6 – Summary of comments, and overall conclusion

General review of last year's actions

- The Covid-19 pandemic continues to cause disruption to appraisal and revalidation, however good progress has been made against the HLROQRV action plan from 2020.
- Three Divisional Appraisal Leads are now in post and are supporting the RO to develop processes and training.
- A large quality assurance exercise has been completed and has led to some changes in the Medical Appraiser pool, with ongoing intention to maintain diversity within the Appraiser group.
- Review of the MHPS policy and role of the Responding to Concerns group is ongoing.

Actions still outstanding

- Improve the overall % of completed appraisals to achieve 90% category 1 completion, in line with the average for same sector designated bodies.
- Review and publish the updated Medical Appraisal Policy.

New Actions:

- Ensure all doctors are able to access the Medical Appraisal Policy and resources to support appraisal and revalidation through the new intranet. Review the policy annually at the Responsible Officer Advisory Group.
- Review administrative support required to ensure governance functions can be routinely met and integrated effectively with doctor engagement and development.
- Embed Appraiser refresher training to ensure all appraisers challenge supporting information.
- Reassess quality of appraisal in 2021/22 through an annual QA exercise.
- Report back on annual QA in the RO report to the board.
- Embed allocation of appraisers for all doctors and train new appraisers.
- Embed processes for review of performance through the Responsible Officer Advisory Group and recruit a lay representative to this group.
- Review MHPS policy to include the RtC group and ensure clarity about its remit and function within the organisation.
- Audit referrals to the RtC group, including for the impact of diversity and inclusion policies on referrals and outcomes.

Overall conclusion:

A new RO is in post and has appointed and inducted three Divisional Appraisal Leads. The new team is now building working relationships within Divisions. Over the next year we aim to finalise the Medical Appraisal Policy, establish and embed processes for regular quality assurance and training and work more closely with the Divisions to achieve higher appraisal compliance.

Section 7 – Statement of Compliance:

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

Signed on behalf of the designated body:

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

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

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

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

APPENDIX B: HLROQRV Action plan progress report

Area/concern/issue identified at Review Visit	Action	Update on progress
Deputy RO	JD for RO to include arrangements for deputising by appraisal leads	Completed
Quality review of appraisals	Identify scope, process , timeline and tool (most likely ASPAT) and process for feeding back to appraisers Identify minimum standards in line with local and national appraisal policy	Completed
TNA for appraisers	Identify training needs from quality review and appraiser engagement and set up regular training events for existing appraisers	Completed
Ensure sufficient number of well-trained appraisers Match appraiser number with demand	Review database of appraisers, number of appraisals conducted and ensure sufficient number of annual appraisals. Establish process for allocation of appraisers.	Completed. Plan for allocation is to start with senior leaders and Drs in difficulty.
Communication/regular meetings with appraisers	Evaluate options for efficient communications with Trust appraisers at a Divisional level.	Refresher training underway Webpage being set up for regular comms
Reduce numbers of missed appraisals	Divisional leads to establish regular liaison with Care Group Leads to promote ownership of Care Group appraisal compliance rates	Regular reports sent to CGLs. Div Leads presenting quarterly at DMB
Change MSF to earlier in the appraisal cycle	MSF opens 2 years before revalidation, change to L2P to communicate this to appraisers and appraisees	Completed
Set up ROAG	TOR, meeting calendar, etc	Completed
Review and update policies in line with changes above	Update policy	Need LNC input and ratification
Revalidation Process	Send doctors notification that revalidation is due in line with being	All reviewed 3 months in

	under notice to include deadline for all documents provided i.e. 2 weeks in advance.	advance at monthly AARG.
Policies and Procedures	Update terminology, check hyperlinks, emphasis on scope of work, reference L2P, clearly set out RO expectations. Managing Concerns.	Medical appraisal policy updated and covered in training. SOP for DALs. Triangulating concerns at ROAG.
HR	Update self-declaration (new starter paperwork) to include scope of work and to place onus on doctors to self-declare if new concerns arise	Completed

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3.1

Meeting Title:	**Trust Board**		
Date:	30 September 2021	**Agenda No**	3.2.1b
Report Title:	**Annual Nursing and Midwifery Registration and Revalidation Report**		
Lead Director/ Manager:	Robert Bleasdale - Chief Nurse & Director of Infection Prevention and Control		
Report Author:	Sharon Suggett, Head of Nursing – Workforce and Professional Standards		
Presented for:	Assurance		
Executive Summary:	This report provides assurance to the Trust Board on the monitoring and governance mechanisms for the continuing registration and revalidation of nurses; nursing associates and midwives by the trust. For the period 1 July 2020 to 31 July 2021, the Trust had zero cases of Nursing, Midwifery or Nursing Associate staff members suspended due to either a failure to register or revalidate.		
Recommendation:	The Board is asked to note the report.		
Supports			
Trust Strategic Objective:	Treat the patient, Treat the person Build a better St George's		
CQC Theme:	Safe, Well-led, Responsive, Caring, Effective		
NHS Oversight Framework Theme:	Workforce support and development		
Implications			
Risk:	N/A		
Legal / Regulatory:	N/A		
Resources:	N/A		
Equality and Diversity Implications	N/A		
Previously Considered by:	Workforce and Education Committee	**Date**	12 August 2021
Appendices:	N/A		

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3.1

Annual Nursing and Midwifery Registration and Revalidation Report
Trust Board, 30 September 2021

1. Introduction

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

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

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

2. Revalidation Requirements

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

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

3. Trust Monitoring of Revalidation Compliance

Individuals are responsible for ensuring that they maintain their registration for each statement of entry relating to each part of the NMC register, including recordable

entries, in line with the requirements for the role for which they are employed.

The Workforce Information team will, on a monthly basis, access the on-line registration checking system of the professional body (NMC) to verify that the

employee has renewed their registration, and a new expiry date is inputted on ESR.

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

The Trust Workforce Information team will run a set of reports each month that will check all employees who have an expiring registration that have not yet been renewed. The reports are automatically run 10 days prior to the end of the month.

4. Failure to maintain NMC registration

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

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

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

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

If an individual fails to meet the requirements of their professional body to re-register or revalidate at the required time for all relevant parts of the register required, they will not be eligible for continued employment as a registered practitioner. In addition, they will not be protected by either their professional indemnity insurance or the Trust's Public Liability insurance. They will not be allowed to work as a registered nurse, nursing associate or midwife until this is rectified. They will be placed upon unpaid suspension until their registration is renewed. Their salary will be affected as they will not receive pay during this time. Staff who are knowingly working without registration are in breach of their contract of employment of the trust and this will lead to disciplinary action.

Where a nurse, nursing associate or midwife is unable to fulfil the requirements of

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

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

For the Period 01 July 2020 to 31 July 2021, the Trust did not have any Midwife, Nurse or Nurse associate suspended due to lapsed registration.

Bank Registered Staff

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

5. Current Revalidation position

NMC Covid Temporary Register

The emergency legislation introduced by the Government enables temporarily registered, fit, and suitably experienced professionals to practice and support the Covid-9 emergency situation. These professionals include;

- Nurses and midwives who left the NMC register within the last 3-5 years
- Overseas applicants (nurses and midwives) who have completed all parts of the NMC registration process except for the OSCE (18 staff in the trust currently).

The NMC have confirmed with the individuals above as to who meets the criteria and are on the temporary register which will close when the Secretary of State confirms that the emergency situation has ended.

Covid extension by NMC

As a result of the covid response, the NMC has automatically extended revalidation application dates by 8 weeks for anyone who was due to revalidate in April 2021.

For the Period 01 July 2020 to 31 July 2021, the Trust did not have any Midwife, Nurse or Nurse associate suspended due to a failure to revalidate.

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

Meetings are held every 3 months with the NMC to ensure that the relevant action has been taken on a case by case basis; to determine how the case is progressing and if there is further information that the NMC require.

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

6. Future Actions

The HR Workforce Information Team has been instructed to maintain monthly information on revalidation and NMC pin expiry as this information currently gets overridden as the system is updated. This will allow the provision of accurate monthly reporting.

Sharon Suggett
Head of Nursing Workforce and Professional Standards
August 2021

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4.1

Meeting Title:	**Trust Board**		
Date:	30 September 2021	**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:	Approval		
Executive Summary:	The report sets out the key issues discussed and agreed by the Committee at its meeting on 6 September 2021.		
Recommendation:	**The Board is asked to:** • **Receive the Value for Money report 2020/21 from the Trust's External Auditor; and** • **Receive and note the completion of the annual audit and receipt of the Audit certificate for 2020/21.**		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	Well Led		
Single Oversight Framework Theme:	Finance and use of resources, Leadership and Improvement capability (Well Led)		
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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Audit Committee Report
Report of meeting held on 6 September 2021

Matters for the Board's attention

The Audit Committee met on 6 September 2021 to consider the Value for Money Report from the Trust's External Auditor. This reports provides an overview of the Committee's scrutiny of the Report and recommends that the Board formally receive both the Report and the audit certificate for 2020/21.

External Audit Value for Money Report

The focus of the Committee meeting in September was the Value for Money Report prepared by the Trust's External Auditor, Grant Thornton. The discussion followed the Committee's consideration of the Auditor's Annual Report and Opinion on the Trust's financial statements at its meeting in June 2021 and its consideration of an early draft of the Value for Money Report at its meeting in July 2021.

The Committee noted that the requirement for the External Auditors to prepare a Value for Money Report was new for 2020/21 and followed the introduction by the National Audit Office of a new Code of Practice, which introduced a revised approach to the audit of value for money. The Code required the Trust's Auditors to consider whether the Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in the use of its resources.

The External Auditor presented the report to the Committee, and explained that they had assessed the Trust's value for money arrangements across the three metrics of: financial sustainability; governance; and improving economy, efficiency and effectiveness. This assessment had been undertaken between May and June 2021 and focused on the financial year 2020/21. The Auditor had found no significant weaknesses in the Trust's value for money arrangements, and as a result the Committee was pleased to hear that the Auditor had not made any key recommendations.

In relation to financial sustainability, the Committee heard that the Audit had identified no significant weaknesses, despite the considerable uncertainty in relation to NHS funding in the second half of the financial year 2021/22. The Auditor acknowledged the improvements that had been made by the Trust in relation to financial governance, financial planning and risk management which had culminated in the Trust successfully exiting financial special measures in December 2020. At the same time, the report observed that there were underlying structural issues that could pose a challenge were it not for the current system funding arrangements, and that the Trust's ability to plan to achieve its control total was a potential weakness albeit that this was beyond the Trust's control given the absence of national financial planning guidance.

The Committee heard that Auditor had found that there was no evidence or indication of significant weakness regarding the Trust's governance arrangements. Having earlier in the year endorsed a new approach to the Board Assurance Framework, the Committee was pleased to note the Auditor's positive findings that the BAF format was clear, understandable and based on good system practice, with appropriate oversight by Board Committees, and that the Auditor had found that the Trust's approach to tracking the impact of Covid-19 on the BAF was appropriate in light of multi-faceted nature of the impact of the pandemic. The Auditor found that the Trust's arrangements for internal audit enabled it to receive sufficient assurance to enable the Trust to assess whether internal controls had operated as expected.

In relation to improving economy, efficiency and effectiveness, the Committee heard that the Auditor had that the Trust used performance information appropriately in identifying areas for improvement, and that the Trust was working collaboratively with partners to improve performance at Trust and system level.

Although the Auditor had not made any key recommendations, the Committee noted and considered a number of improvement recommendations that the Auditor had presented. These were not material the Auditor's Opinion, and were offered for the Trust to reflect upon as part of ongoing improvement work. The Committee asked the respective Executive leads to comment on these recommendations. During this discussion, the Committee noted that:

- the Executive had accepted the recommendation from the Auditor that the Trust should re-establish its previous approach to monitoring the delivery of savings and efficiencies in order to bring back some of the rigour that had been in evidence during the time at which the Trust had been in financial special measures, and this work was in progress.

- The Trust had accepted the Auditor's recommendation to complete a review of 'unintended' cost savings to identify efficiencies to carry forward into a post Covid-19 operating environment.

- The Trust would respond to the Auditor's findings by making clear in reporting when clarity was expected in relation to financial arrangements and where estimates were made to the best of limited knowledge.

- The Trust would respond to the Auditor's recommendations by making clear in reporting – as far as possible – which elements of financial performance were dependent on the Integrated Care System or on NHS England and NHS Improvement.

- The Trust would take forward the recommendations in relation to the BAF as part of the refresh of the Framework which was scheduled to take place following the agreement by the Board of a new set of corporate objectives in late September 2021.

The Committee, however, expressed some reservations regarding the proposed recommendations in relation to improving economy, efficiency and effectiveness, noting that in a number of areas the proposed improvement actions had already been completed. During its discussions, the Committee noted that:

- In the relation to the recommendation on Emergency Department performance, the Trust had previously undertaken a detailed review of its performance with the assistance of the Emergency Care Improvement Support Team (ECIST), which in November 2020 had reported that the processes, clinical leadership and focus, and culture of learning were 'exemplary'. The Committee agreed with the management suggestion that this action had already been implemented.

- In relation to elective recovery and cancer waiting times, the Committee recognised that the Trust already had in place a comprehensive elective recovery programme with recovery trajectories agreed for diagnostics, outpatients and elective treatments. The Trust was already ahead of its trajectory on patients waiting more than 52 weeks for treatment and on track on recover performance against both the 31-day and 62-day cancer targets across all specialties. Close oversight of this was maintained in the weekly Access Committee which looked at all clinical, operational and management oversight, which would remain in place until the backlog was addressed.

- Similarly, the Trust was already working collaboratively with other hospitals across south west London to provide mutual aid to manage waiting times collectively across the system. The Trust recognised that this carried a risk that reporting of waiting times data could be distorted, the collaboration was proving effective and the Trust was implementing mutual aid arrangements in accordance with the requirements of NHS England and NHS Improvement.

The Committee asked the Auditor to reflect on the wording of the recommendations in relation to improving economy, efficiency and effectiveness and to hold further discussions with the Executive. Minor amendments were made and subsequently the report was received by the Committee on email circulation.

More broadly, the Committee discussed and reflected on the completion of the first value for money audit and the value added through the process, noting that a focus on value for money was welcome and that the first cycle of undertaking this work had highlighted areas of learning to pick up the following year.

Recommendation

The Board is asked to:

- **Receive the Value for Money report 2020/21 from the Trust's External Auditor; and**
- **Receive and note the completion of the annual audit and receipt of the Audit certificate for 2020/21.**

Grant Thornton

Auditor's Annual Report on St George's University Hospitals NHS Foundation Trust

For the period 2020/2021

September 2021

Contents

We are required under Schedule 10 paragraph 1(d) of the National Health Service Act 2006 to satisfy ourselves that the Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice issued by the National Audit Office (NAO) requires us to report to you our commentary relating to proper arrangements.

We report if significant matters have come to our attention. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Value for Money arrangements

Revised approach to Value for Money work for 2020/21

On 1 April 2020, the National Audit Office introduced a new Code of Audit Practice which comes into effect from audit year 2020/21. The Code introduced a revised approach to the audit of Value for Money. (VFM)

There are three main changes arising from the NAO's new approach:

- A new set of key criteria, covering financial sustainability, governance and improvements in economy, efficiency and effectiveness
- More extensive reporting, with a requirement on the auditor to produce a commentary on arrangements across all of the key criteria.
- Auditors undertaking sufficient analysis on the Trust's VFM arrangements to arrive at far more sophisticated judgements on performance, as well as key recommendations on any significant weaknesses in arrangements identified during the audit.

The Code require auditors to consider whether the body has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources. When reporting on these arrangements, the Code requires auditors to structure their commentary on arrangements under the three specified reporting criteria.

Improving economy, efficiency and effectiveness

Arrangements for improving the way the body delivers its services. This includes arrangements for understanding costs and delivering efficiencies and improving outcomes for service users.

Financial Sustainability

Arrangements for ensuring the body can continue to deliver services. This includes planning resources to ensure adequate finances and maintain sustainable levels of spending over the medium term (3-5 years)

Governance

Arrangements for ensuring that the body makes appropriate decisions in the right way. This includes arrangements for budget setting and management, risk management, and ensuring the body makes decisions based on appropriate information

Potential types of recommendations

A range of different recommendations could be made following the completion of work on the body's arrangements to secure economy, efficiency and effectiveness in its use of resources, which are as follows:

Statutory recommendation

Written recommendations to the body under Section 24 (Schedule 7) of the Local Audit and Accountability Act 2014. A recommendation under schedule 7 requires the body to discuss and respond publicly to the report.

Key recommendation

The Code of Audit Practice requires that where auditors identify significant weaknesses in arrangements to secure value for money they should make recommendations setting out the actions that should be taken by the body. We have defined these recommendations as 'key recommendations'.

Improvement recommendation

These recommendations, if implemented should improve the arrangements in place at the body, but are not made as a result of identifying significant weaknesses in the body's arrangements

Executive summary

Value for money arrangements and key recommendation(s)

We have assessed the Trust's Value for Money arrangements across the 3 metrics of:

- Financial Sustainability;
- Governance;
- Improving economy, efficiency and effectiveness;

For 2020/21 we have also assessed arrangements concerning Covid-19.

This assessment has been completed between May and June 2021 with the data available in this timeframe in relation to the financial year 20/21 and 21/22 in respects of planning for future periods. Note has also been given to longer term plans (i.e Capital) where these are available.

We have conducted this assessment through;

- Interviewing senior leadership and other key personnel;
- Reviewing financial documents such as budgets, outturn reports and capital plans;
- Reviewing non-financial documents such as CQC reports, staff surveys, workforce and business plans; and
- Incorporating sector, regulator and other market knowledge and experience

At this stage no significant weaknesses have been confirmed and thus no key recommendations have been made. However several improvement recommendations have been included.

Financial sustainability

We assessed the arrangements concerning Financial Sustainability and raised no indications of potential significant weaknesses. However this assessment is made in the knowledge there is uncertainty regarding

This assessment is made despite the uncertainty that exists in relation to NHS funding for second half of 2021/22 and beyond. Despite the improvements the Trust has made in relation to financial governance as reflected by it exiting special measures during the year there are still underlying structural issues that would pose a challenge were it not for current system funding.

Governance

We assessed the arrangements concerning Governance and raised no indications of potential significant weaknesses.

We did not conduct further risk based work on Governance arrangements. Therefore whilst we have raised improvement recommendations, we have raised no key recommendations.

Improving economy, efficiency and effectiveness

We assessed the arrangements concerning the 3e's and raised no indications of potential significant weaknesses.

We did not conduct further risk based work on the 3e's arrangements. Therefore whilst we have raised improvement recommendations, we have raised no key recommendations.

Opinion on the financial statements

We have audited the financial statements of St George's University Hospitals NHS Foundation Trust (the 'Trust') for the year ended 31 March 2021, which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 7 of the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2021 and of its expenditure and income for the year then ended; and
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Commentary on the arrangements to secure economy, efficiency and effectiveness in its use of resources

All Foundation Trusts are responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness from their resources. This includes taking properly informed decisions and managing key operational and financial risks so that they can deliver their objectives and safeguard public money. The Trust's responsibilities are set out in Appendix A.

Foundation Trusts report on their arrangements, and the effectiveness of these arrangements as part of their annual governance statement.

Under Schedule 10 of the National Health Service Act 2006, we are required to be satisfied whether the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

The National Audit Office's Auditor Guidance Note (AGN) 3, requires us to assess arrangements under three areas:

Financial Sustainability

Arrangements for ensuring the Trust can continue to deliver services. This includes planning resources to ensure adequate finances and maintain sustainable levels of spending over the medium term (3-5 years).

Governance

Arrangements for ensuring that the Trust makes appropriate decisions in the right way. This includes arrangements for budget setting and management, risk management, and ensuring the Foundation Trust makes decisions based on appropriate information.

Improving economy, efficiency and effectiveness

Arrangements for improving the way the Trust delivers its services. This includes arrangements for understanding costs and delivering efficiencies and improving outcomes for service users.

Our commentary on each of these three areas, as well as the impact of Covid-19, is set out on pages 6 to 16. Further detail on how we approached our work is included in Appendix B.

Financial sustainability

We considered how the Foundation Trust:

1. identifies all the significant financial pressures it is facing and builds these into its plans.
2. plans to bridge its funding gaps and identify achievable savings.
3. plans its finances to support the sustainable delivery of services in accordance with strategic and statutory priorities.
4. ensures its financial plan is consistent with other plans such as workforce, capital, investment and other operational planning.
5. identifies and manages risk to financial resilience, such as unplanned changes in demand and assumptions underlying its plans.

1. identifies all the significant financial pressures it is facing and builds these into its plans

The Trust delivered a surplus of £1.3m from continued operations before control total adjustments with an actual deficit of £3.1m. 20/21 has been an exceptional year with Covid-19 impacting the Trust's priorities and plans as well as funding arrangements which will continue into 21/22. Looking forward, the Trust has had to plan for 21/22 with a degree of uncertainty with funding arrangements only confirmed for the first six months of the year. Historically, the Trust has been financially challenged with continued reliance on non-recurrent funding and whilst there is a track record of achieving savings targets it has still consistently delivered deficit financial plans. The Trust and the Integrated Care System (ICS)'s longer term financial plan is focussed around considerable capital investment in shared facilities and elective recovery, some of which are already in operation.

COVID funding for 2020/21 has masked a historic underlying deficit run rate although the Trust left special measures during 2020 due to ability to demonstrate it has made improvements in its financial performance and governance. The delay in the Department of Health and Social Care (DHSC) confirmation of funding for 2021/22 has meant the Trust has only been able to issue a six month budget (expanded into a annual month budget for the purposes of comparison but this is not a formal agreement). There is no evidence to suggest the budget is based on unrealistic expectations or that there is a degree of short-termism in thinking of the management.

The Trust has included in its' planning considerable detail in regards to cost pressures/expectations and a prudent approach to additional income streams such as private patient income. It has appropriately drawn on available data such as expected inflation, population statistics and the revenue costs of proposed capital expenditure. It has identified its' funding gap and thus required savings in line with its' cohort of ICS bodies.

However, the Trust is beholden to funding agreements set out by the DHSC, which at present is delayed. The ability for the Trust to realistically and sensibly plan to achieve its control total is therefore a potential significant weakness. This situation will be monitored and reported on further in the late Summer when there is additional clarity around finding agreements.

2. plans to bridge its funding gaps and identify achievable savings

For 2021/22 the Trust has set a business plan with a £1.2m deficit which complies with guidance on what the Trust will receive in terms of block income and additional income for exceptional items such as Covid-19 testing and High Cost Drugs and Devices. With the other components of the ICS this will be a balanced position for the system.

Due to Covid-19 impacted operations savings plans have not been monitored or upkept, this is reasonable and in line with expectations of the regulators. However it is realistic to expect new saving plans to be required in the near future at levels similar to pre-pandemic levels. The Trust has identified areas for making these savings, but not defined programmes within these areas.

Improvement Recommendation A – the Trust bring back some of the rigour and established tracking programmes as were operated during financial special measures. This high-touch approach has a proven track record and will be effective at re-establishing good practice after this break in budget and savings monitoring.

The Trust plans to harness some of the savings achieved as a result of Covid-19 impacted operations. It is evident the Trust is assessing the positive and negative impacts of these operations, i.e. digitalised outpatient forms, including their impact on health outcomes as well as their financial impact. This includes liaising with the ICS members so that practises become more, not less aligned.

Financial sustainability

Improvement Recommendation B –The Trust should complete a review of 'unintended' cost reductions to identify efficiencies to carry forwards into a post Covid-19 operating environment. As part of this exercise the Trust will also need to ensure clinical outcomes are given equal focus alongside the consideration of potential financial savings.

3. plans its finances to support the sustainable delivery of services in accordance with strategic and statutory priorities

The Trust has continued to invest in its infrastructure as a result of several internal and external reviews which indicated the negative impact on clinical outcomes. The MTFS and short term budgets and plans rely on this infrastructure being in place, a priority which is clear within the Trusts' reporting and operations. Therefore the improvement of infrastructure is both a strategic and statutory priority.

These plans are appropriately linked to the wider ICS plans and contribute sufficiently. As noted in the Governance section of this report the business plan designed to link corporate plans and budgets was not in place for 20/21 and is not for 21/22. This has been identified as an improvement recommendation.

In September 2020 the board approved a strategy framework constructed around 'Care, Culture and Collaboration' and we can see that the H1 and H2 plans are linked to this framework.

We are satisfied The Trust plans its' finances to support sustainable delivery of its' priorities.

4. ensures its financial plan is consistent with other plans such as workforce, capital, investment and other operational planning

The workforce plan is intrinsically interlinked with the short and medium term budgets, and is appropriately presented as complimentary reports to support decision making. In common with the rest of the sector, the Trust has accumulated significant annual leave balances for its staff. Decisions on how to manage this staffing risk are ongoing, but the financial impact of this is factored into the budgets.

Capital spend requirements per the plan are currently in excess of the capital funding available to the Trust. This is due to increased cost expectation of existing projects and unexpected maintenance costs of current infrastructure. The intention was that £60.3m of funds would be available in 21/22 to fund the capital programme. Since then the ICS have withdrawn £6.5m. Additionally, the Trust has subsequently identified further critical infrastructure capital costs which moves the position from a £60.8m capital expenditure requirement and matching capital departmental spending limit (CDEL), to a capital expenditure requirement of £67.9m with a CEDL of £54.3mil. The 5 year capital plan shows clearly the gap in available funding from internal sources.

Given the importance of the capital planning to the clinical safety of the Trust this is an area the Trust will need to undertake work in once there is greater clarity later in the year regarding funding.

It is evident from Board and Finance and Investment Committee (FIC) reporting the mismatch between capital spending limits and capital spending requirements are highlighted for consideration and scrutiny.

Improvement Recommendation C –We recommend an estimation to when further information will become available to aide decision making be included in the papers. This would provide a trigger point for decisions made based on currently uncertain data to be reviewed. For example providing a date at which funding or information on funding will become available to assist with decision making and scrutiny.

5. identifies and manages risk to financial resilience, such as unplanned changes in demand and assumptions underlying its plans

The Trust appropriately incorporates risks into its planning and budgeting and presents these risks clearly to the Board where there is quantifiable impact. Where the impact is not yet known and thus not quantifiable it is still presented but with TBC status. These are RAG rated for prioritisation. This is in line with the reporting we see elsewhere in the NHS and is good practise.

This is particularly evident in the current budgeting scenario which states 'assume H2 funding is equal to H1 funding'. This is a considerable assumption, but is clearly the current best guess at funding yet to be confirmed by DHSC. The cashflow impact is also assessed based on the assumption of continued block type funding and the 'bulky' receipt of this income.

Financial sustainability

Mitigation planning is completed and factors in ICS-wide considerations such as; delaying ITU infrastructure spend at the Trust will have capacity impacts at ICS partnership Trusts who will then have to absorb patients. It is particularly good practise to see these considerations being reported, this is an advanced state compared to some other ICS operations.

The ICS has a reported elective recovery plan which factors in the potential of further Covid-19 patient waves. This plan considers where elective recovery is going to be prioritised in the system and therefore where ITU beds are needed to treat COVID patients.

Conclusion

We found no evidence or indication of potential significant weakness regarding the financial sustainability of the Trust, as such, no further risk-based work has been performed on this criteria for assessing the arrangements for securing value for money. This assessment is made despite the uncertainty that exists in relation to NHS funding for second half of 2021/22 and beyond. Despite the improvements the Trust has made in relation to financial governance as reflected by it exiting special measures during the year there are still underlying structural issues that would pose a challenge were it not for current system funding.

As part of our 2021/22 VFM audit we will consider whether a risk around financial sustainability has emerged subsequent to confirmation of the revenue and capital funding available to the Trust. Should the funding be insufficient we may determine there is a significant VFM weakness in relation to financial sustainability.

Governance

We considered how the Foundation Trust:

1. monitors and assesses risk and gains assurance over the effective operation of internal controls, including arrangements to prevent and detect fraud
2. approaches and carries out its annual budget setting process
3. ensures effectiveness processes and systems are in place to ensure budgetary control
4. ensures it makes properly informed decisions, supported by appropriate evidence and allowing for challenge and transparency
5. monitors and ensures appropriate standards.

1. monitors and assesses risk and gains assurance over the effective operation of internal controls, including arrangements to prevent and detect fraud

The BAF format is clear, understandable and based on sector good practice. Assurance levels are listed in the BAF such that governance functions are aware of the reliability of the current position. The structure of the specialised scrutiny committees (i.e. finance & investment, quality and safety, estates and assurance etc) is designed to enable oversight by appropriately experienced and qualified members and attendees. We note from our attendance at designated committees and through our review of minutes and agendas that sufficient time and prominence is given to identifying, discussing and challenging risk at the Trust.

The BAF is sufficiently detailed. Accountability is further enhanced by the fact each risk has a named individual as risk owner. The BAF has a clear scoring system on a matrix system, and it is good practice to have a target score and actual score so a comparison can be made to demonstrate the level of action required to mitigate risks. The Trust has no individual Covid-19 risk. This is due to the multiarea impact of Covid-19. Instead there is a summary section on each risk which outlines where and if Covid-19 impacts this risk area. This to be an appropriate way to manage the risk.

As at Mar 2021 the BAF has ten risks. Accepted practice in the sector is a Trust the size of St George's would expect anything from five to 15 risks in its BAF. Any more or less might be indicative of an organisation not scoring its key strategic risks appropriately.

Improvement Recommendation D – review scoring to understand stagnation: three of ten BAF risks and also 20+ linked corporate risks have the same gross and net risk scores. In most cases these are not new risks. A scenario with scores not improving or even worsening implies the controls in place are having little to no effect on likelihood or impact. Although it is more likely an issue with scoring and the review of challenge process. Resources are finite so if it determined the scoring is correct the Trust may wish to consider whether its prioritisation of actions is appropriate e.g. if time and effort are being ineffectively applied to some risk areas could resources be better directed to other risks where actions would have more impact.

Improvement Recommendation E – expand the remit of SR4 regarding the SWL ICS to encompass financial restraints explicitly: We would expect SR4 to encompass financial and governance considerations, which it does not explicitly do. The risks detailed note 'capacity' without reference to whether or not this is financial. However considerable detail has been input to the controls of making a success of the ICS. Currently the risk is sufficient but could further benefit from including the financial constraints of the system and how those might be agreed and offset between the individual organisations.

The Trust has an outsourced Internal Audit function provided by TIAA to monitor and assess the effective operation of internal controls. From our attendance at Audit Committee and our review of documentation the Audit Committee appears to receives sufficient assurance to enable it to assess whether internal controls have operated as expected. Appropriate time and prominence is given to the reporting presented by TIAA, with good challenge offered by the members of the committee.

The Local Counter Fraud Specialist (LCFS) holds regular update meetings with the Director of Finance where both reactive and proactive work are discussed and reviewed. Sufficient focus is given to the counter fraud service and working arrangements with them. There is a clear and direct line to audit committee and thus board if required.

Governance

2. approaches and carries out its annual budget setting process

Risks are shown alongside their uncertain monetary impact where this can be measured. Where values are uncertain the Trust use trends and existing data to extrapolate and thus support decision making. Reporting through FIC and the Board is done on a timely basis to allow them to challenge management's actions.

We found evidence of alternative proposals and scenarios going to FIC before final decisions are made, for example regarding the circumstances of the capital expenditure programme for 2021/22.

The substance of this assessment is whether you are considering more than one way of doing something, or more than one possible budgetary outcome The evidence we have seen indicates that this is occurring and you are considering a variety of 'what-ifs' whilst operating in an income restrained environment and a highly regulated and prescribed set of priorities.

Through discussions with staff and reviews of your budgets we can see priorities are aligned with the MTFS, however these priorities are often not written down and fully evidenced against the MTFS. This plan also dates back to 2019 before the impact of Covid-19. There is currently no business plan which joins financial budgets, workforce plans, capital plans and ICS priorities due to the uncertainties arising from Covid-19. There is therefore a risk that these strategic plans are not fully aligned and are incongruent.

Improvement Recommendation F – refresh business plan to encapsulate existing financial and non-financial strategic plans including where the priorities have changed in light of Covid.

The Trust effectively consults internally and externally during the budget setting process. The main consultation is with those responsible for delivery. Medical, Nursing and Operational lead of each area must sign off this plan before it becomes part of the CIP program. This ensures there are no preventative clinical impacts of the savings plans.

There is evidence of regular consultation via the ICS and directly with NHSI. Throughout the year the Trust engages with their local NHSE/I representative around budgetary matters, discussing trends and possibilities. As a Trust in financial special measures, a strong financial governance protocol was assigned and adopted by the Trust. Despite the fact the Trust has exited special measures this structure still exists and supports your financial governance arrangements.

It is clear that consultation has occurred for capital expenditure planning, both internally from a clinical need perspective and in the 'wider internal' of the ICS where the capital expenditure impacts the group objects such as ITU space. Externally consultation has considered CQC action plans and expectations.

Improvement Recommendation G – for the clarity of its reporting to board, stating where decisions are able to be made by you in isolation and which budgetary lines are decided more centrally i.e. within the ICS, or as a non-negotiable value from NHSE/I. This would give the executive and the governance a better understanding of what you are able to impact and whether you need to impact this in an organisational or system wide basis.

3. ensures effectiveness processes and systems are in place to ensure budgetary control

The Trust engage with budget holders to review financial performance and identify actions to resolve adverse variances on a regular and established basis. This is completed between the finance function and the DDO (budget holder) on a monthly basis. The process is weekly in relation to salaries and agency costs as there has been a pressure on both of these areas during the Covid-19 pandemic.

The Board receives and notes the Integrated quality and performance report, which has been scrutinised at both the Finance and Investment and the Quality and Safety Committees first. Relevant non-financial information is presented alongside but not as part of the financial reporting. We note from a review of the detailed H1 plan and accompanying paper that the workforce plan and corporate objectives are drawn in to the same briefing note.

4. ensures it makes properly informed decisions, supported by appropriate evidence and allowing for challenge and transparency

Budgets are discussed within the Committee structure with approval from the Board. This provides appropriate opportunity for challenge and revisions where necessary.

Strategic decisions are being made with the SWL ICS in mind with wider consultation and sharing of information. The ICS action plan includes a plan for regular updates from ICS leadership to individual bodies, allowing for Trust-level decision making and challenge.

Governance

The CEO, CFO and COO, Medical Director and Chief Nurse are present at appropriate committee meetings. This sets the tone from the top re accountability to scrutiny. It is of additional note that directors of specific areas i.e. estates, information, infection control etc are executives of the committee and are thus called upon to attend where a paper requires or would benefit from their input.

We take assurance by the additional supervision provided over these plans by NHSI regional groups. There is a defined pathway and so the establishment of the ICS is more supported than some of the other, looser arrangements for joint working within the NHS.

A review of the breaches and waivers papers presented to Audit Committee show no indication of due process being avoided which might result in illegal actions or actions which would damage the reputation of the Trust.

5. monitors and ensures appropriate standards

You have arrangements in place to monitor compliance with legislation and regulatory standards, having a standing item section in the Audit Committee titled 'internal compliance and assurance' and includes papers from the counter fraud team, the freedom to speak up champion and the ITCG lead.

Website content includes explanations on what is fraud, what is bribery, the do's and don'ts and how to report it. Details of the upcoming fraud initiative have also been a budget holder group who regularly allowed or at least failed to stop overpayments. An action plan has been created following this work to ensue that these budget holders are trained and held to account.

We have viewed FIC reporting which demonstrates how budgets are reported both in their original position and then variations to this as the year progresses. Under Covid-19 this budget was displayed as a *baseline* and *baseline + Covid-19* budget, to ensure clarity on financial performance. included.

An anti-bribery and corruption statement from your CEO has been uploaded. This shows your commitment to highlighting how to act appropriately in its legal and regulatory environment from a different lens than just clinical safety.

The Trust has a code of conduct which all staff sign up to on employment, this ensures that they are aware of their responsibilities re legislation and regulation and the ICS plan also includes a section on culture and how this should be communicated to staff at each NHS body. This aligns with the NHS strategic care priorities.

Arrangements for making a declaration of interest are in place at the beginning of all Board or committee meetings and a link on the website contains a compiled list of these. The secretary collects the annual declarations which contain instructions to update in-year if circumstances change. Members of the board and other staff classified as 'decision-makers' are required to complete an annual declaration. Board members are also asked to declare any interests they have before the start of each board meeting. What constitutes an interest and how to declare this are easily searchable online, circa 50% of decision makers have made a declaration. We would not expect this number to be at 100% as many decision makers are not acting in a role which would result in them having an interest.

Improvement Recommendation H – There is an inconsistency in the reporting on the website which can be rectified with some changes in language. Currently the disclosure online appears that only 50% of staff have followed the policy that they must make a declaration. It is not clear to a reader whether this means only 50% of decision makers have complied or whether 50% of decision makers have an interest. We recommend that nil responses should still be submitted so that it is clear that all staff have understood that they have to consider their interests.

Conclusion

We found no evidence or indication of potential significant weakness regarding the governance arrangements at the Trust, as such, no further risk-based work has been performed on this criteria for assessing the arrangements for securing value for money.

Improving economy, efficiency and effectiveness

We considered how the Foundation Trust:

1. uses financial and performance information to assess performance to identify areas for improvement
2. evaluates the services it provides to assess performance and identify areas for improvement
3. ensures it delivers its role within significant partnerships, engages with stakeholders, monitors performance against expectations and ensures action is taken where necessary to improve
4. ensures that it commissions or procures services in accordance with relevant legislation, professional standards and internal policies, and assesses whether it is realising the expected benefits.

1. uses financial and performance information to assess performance to identify areas for improvement

An integrated quality and performance report (IQPR) presented to the Board includes performance, safety and financial matters and contains notation to contextualise and analyse the results. This analytic often compares performance with and without Covid-19 data to allow for meaningful discussions and decision making. Comparisons are appropriately drawn from other Trusts, especially those which operate within the SWL ICS, for which greater data is available.

The performance indicators are presented across the categories of : outcomes, finance and productivity, patient perspective, process perspective and people perspective. These are appropriate groupings and cover the core operations of the Trust. Much is presented graphically with accompanying 'what the information tells us' box and an 'action and quality improvement project' box clarifying the current position and direction of travel.

The Trust is assured of the accuracy of financial and performance data reported to the Board both from a review perspective and from the integrity of the collection and analysis methods. Most of the comparative data comes from nationally available datasets and tools.

As a national model hospital ambassador the Trust is active in using this data to quantify potential savings or performance improvements of suggested programmes. However the Trust recognises there is a time lag in the model hospital data and so the true potential may be overstated compared to live Trust level data. The outcome of these exercises is the Plan, Do, Study, Act programmes, the notable prompt of which is a PDSA poster. This ensures that there is a recognised plan for improvement across the Trust. These PDSA posters are displayed in areas where teams will be impacted by the change.

Our review of performance information indicates the Trust has appropriate arrangements in place to monitor KPIs and use this to instruct improvement programmes. Additionally Trust can demonstrate arrangements in place to learn from other NHS organisations to improve performance.

2. evaluates the services it provides to assess performance and identify areas for improvement

There is no evidence of consistent failure to meet minimum service standards in core areas; there is however a moving picture in regards to the NHSI metrics required for quality reporting. Traditionally the Trust has struggled to meet the A&E targets, however during COVID the Trust's Four Hour Operating Standard performance was 94.8% increasing from 92.1% reported in February 21. Performance here continues to exceed the London average.

Improvement Recommendation I – Given the improvements in A&E performance the Trust should investigate what changes arising due to Covid-19 have improved performance that could continue when services return to business as usual.

The impact on various cancer targets however is more variable. February 2021 RTT performance was 68.3% against a National target of 92% with 2,671 patients waiting longer than 52 weeks and the volume of patients awaiting treatment increased. This poses a wider issue for the health economy as long term illnesses undergo delays to treatment and diagnosis.

Improving economy, efficiency and effectiveness

Improvement Recommendation J - The Trust forward plans for cancer treatment should also factor in how backlogs will be managed and what the operational and cost implications of this will be.

We found no evidence the Trust has failed to review and challenge strategic priorities, the cost-effectiveness of existing activities or to identify where they do not contribute sufficient value. In working with the ICS there are already some established cost and efficiency savings, i.e. the procurement hub, with potential for more to be realised as the ICS develops.

The ICS in SWL is more advanced than others, with official designation, established plans and governance structures and aligned strategic aims. The Trust is monitoring shared programmes for EEE's from a Trust and system perspective.

There are several areas where patient capacity requirements have been moved around the ICS, for example audiology and endoscopy. The additional ITU space being constructed at the Trust will serve all members of the ICS rather than the Trust alone. There are, as aforementioned, ICS level plans to achieve elective recovery targets and manage a potential third Covid-19 wave across the ICS rather than on an individual Trust basis.

These areas indicate the Trust is performing well in achieving EEE in relation to partnership working.

3. ensures it delivers its role within significant partnerships, engages with stakeholders, monitors performance against expectations and ensures action is taken where necessary to improve

There is evidence strategies developed at a partnership level are translated into meaningful actions to be delivered by the Trust. Examples of this include ITU space, movement of specialist treatments within the ICS and shared resource pooling with Epsom and St Helier.

The Trusts actions indicate a commitment to supporting the ICS in delivering its system wide plans.

Improvement Recommendation K – Consider where it is pertinent to factor in performance of the other Trusts when reporting against KPIs. Without this context it is difficult for stakeholders to understand the trade-offs made between Trusts.

The Trust monitors the implications or impact of spending reductions leading to, for example, a detrimental effect on service quality and performance in priority areas. As a system, the ICS must set a balanced budget and the Trust needs to deliver its own financial targets to support this objective.

There is no evidence of significant financial loss or failure to deliver expected efficiency/performance improvements when working through significant partnerships. The provider collaborative, the ICS, the procurement hub, the recruitment hub and the pathology shared services as examples where savings and efficiencies have been made.

The Trust has engages and consults with key stakeholders, where appropriate, to determine local priorities for resources or opportunities for savings.

4. ensures that it commissions or procures services in accordance with relevant legislation, professional standards and internal policies, and assesses whether it is realising the expected benefits.

The Trust has an established procurement strategy. The includes the hosting of the SWL procurement hub, designed to make efficiency savings on back office services in SWL. There is no evidence of the Trust failing to operate a fair procurement exercise for a significant contract; the rules and protocols established within the hub prevent this.

The procurement hub is an appropriate use of resources and does not indicate a risk of a significant weakness, each Trust has gained a 1-3% saving on being part of the hub.

Where required, the Trust appropriately sources external expert guidance on procuring services, including legal advice. A review of breaches and waivers shows no indication of contracts being rolled forwards without due process being followed.

Conclusion

We found no evidence or indication of potential significant weakness regarding the economy, efficiency and effectiveness arrangements at the Trust, as such, no further risk-based work has been performed on this criteria for assessing the arrangements for securing value for money.

COVID-19 arrangements

Since March 2020 Covid-19 has had a significant impact on the population as a whole and how NHS services are delivered.

We have considered how the Trust's arrangements have adapted to respond to the new risks they are facing.

Financial sustainability

Arrangements are in place to identify and monitor additional costs arising from responding to the Covid-19 pandemic. This includes operational level initial coding and reporting covid costs separately at scrutiny level.

The Trust also has arrangements in place to compile and monitor returns to NHSI/NHSE relating to Covid-19 costs and to assess whether Covid-19 related spend is appropriate to be incurred.

Governance

The Trust's arrangements have adapted to respond to the new risks its face from 2020-21 onwards in respect of Covid-19. This includes factoring COVID into the BAF and having the director of infection control lead on Covid-19 programme areas.

The Trust's governance and internal control systems were adapted to take account of the impact of Covid-19 on the body's operations. However with a Trust of your size with considerably digitised support functions (i.e. finance) controls were not significantly impacted. Where changes were required to financial or other control processes as a result of Covid-19 these have these been assessed by the internal audit function and by management to confirm they are appropriate. There has been no marked decrease in assurance gradings in 20/21.

Improving economy, efficiency and effectiveness

The Trust has maintained effective controls around expenditure and procurement during the pandemic by maintaining good practise on breaches and waivers and utilising the SWL procurement hub. We have no concerns to highlight around COVID procurement.

The Trust has arrangements in place for capturing and monitoring the impact of Covid-19 on quality and safety through the committee and through the integrated performance reporting.

Conclusion

We have no concerns to raise in relation to the arrangements in response to Covid-19.

Improvement recommendations

Financial Sustainability

	Recommendation A	Recommendation B	Recommendation C
Auditor judgement	The Trust needs to restart its previously thorough and effective savings monitoring procedures that have not been required whilst temporary COVID-19 funding is in place. The Trust has continued to identify areas for making savings, but has not defined programmes within these areas. This therefore is the responsibility of those impacted budget holders to find these savings. To this end additional support will be required by the budget holders to ensure savings are realised.	The Trust implemented various actions as a response to Covid-19 that have led to cost reductions in some areas. There is a risk that a return to business as usual practices could see these savings opportunities disappear.	It is evident from Board and FIC reporting that the mismatch between capital spending limits and capital spending requirements are highlighted for consideration and scrutiny. Some of the reasoning given for this mismatch is delays in agreed funding however there is a lack of clarity of when these delays are likely to be resolved.
Summary recommendation	We recommend the Trust bring back some of the rigour and established tracking schemes as were operated during financial special measures but have not been required whilst COVID-19 funding has been in place. This high-touch approach has a proven track record and will be effective at re-establishing good practice after this break in budget and savings monitoring.	The Trust should complete a review of 'unintended' cost savings to identify efficiencies to carry forwards into a post Covid-19 operating environment. As part of this exercise the Trust will also need to ensure clinical outcomes are given equal focus alongside the consideration of potential financial savings.	We recommend Committee papers which require decisions include an estimate for when greater clarity is expected on funding arrangements. This will help the Board and Committees understand the timescales relating to the decisions they are making. These decisions should also be tracked to ensure they are revisited once greater information is available to the Trust.
Management comment	Agreed and this is in progress. Target attainment date: October 2021 Executive Lead: Andrew Grimshaw	Agreed and this is in progress. Target attainment date: October 2021 Executive Lead: Andrew Grimshaw	Agreed – Whilst future financial frameworks and regimes are unknown due to the exceptional environment the NHS is in as a result of the pandemic, an estimation of timescales will be included in future papers for decision, where exact clarity is not available. It will be made clear that these estimations are made to the best of limited current knowledge on future funding arrangements. Target attainment date: October 2021 Executive Lead: Andrew Grimshaw

The range of recommendations that external auditors can make is explained in Appendix C.

Improvement recommendations

Governance

	Recommendation D	Recommendation E	Recommendation F
Auditor judgement	3 of 10 BAF risks and also 20+ linked corporate risks have the same gross and net risk score, additionally these are often not new risks. The impact of this is that time and effort might be being applied to these risks without benefit. A scenario with scores not improving or even worsening implies the controls in place are having little to no effect on likelihood or impact. Another interpretation is that there an issue with the scoring that needs reviewing and challenge. Resources are finite so it is possible resources and effort are being ineffectively applied to these risk areas and could be better directed in achieving other things that would benefit the Trust.	The remit of Strategic Risk 4 (SR4) regarding the South West London ICS does not include financial restraints explicitly. We would expect SR4 to encompass financial and governance considerations. The risks detailed note 'capacity' without reference to whether or not this is financial. However considerable detail has been input to the controls of making a success of the ICS.	Through discussions with staff and reviews of your budgets we can see that your priorities are aligned with your MTFS, however these priorities are often not written down and fully evidenced against the MTFS. This plan also dates back to 2019 before the impact of Covid-19. There is therefore a risk that these strategic plans are not fully aligned and are incongruent
Summary recommendation	There is a possibility Corporate risk (and to a lesser extent BAF risk) scores are either not being appropriately adjusted, or that controls in place are doing little to impact the scoring outcome. The Trust may wish to consider whether its prioritisation of actions is appropriate e.g. if time and effort are being ineffectively applied to some risk areas could resources be better directed to other risks where actions would have more impact.	Currently the risk is sufficient but could further benefit from including the financial constraints of the system and how those might be agreed and offset between the individual organisations.	We recommend the Trust refreshes business plans to encapsulate existing financial and non-financial strategic plans including where the priorities have changed in light of Covid-19.
Management comment	The Trust will consider the scoring of BAF and corporate risks as work is ongoing regarding the structure of the BAF. There will be instances where scores remain static due to scale of work required to implement actions. Target attainment date: December 2021 Executive Lead: Stephen Jones	The Trust will consider the framing of the risks and whether there is sufficient focus on financial risks to the ICS reflected in the BAF. Target attainment date: December 2021 Executive Lead: Stephen Jones	Agreed. Business plans will be refreshed in line with national timelines, and priorities once these are published. Target attainment date: November 2021 Executive Lead: Andrew Grimshaw

The range of recommendations that external auditors can make is explained in Appendix C.

Improvement recommendations

Governance

	Recommendation G	Recommendation H
Auditor judgement	It would improve decision making and scrutiny if for the clarity of reporting to Board, the Trust stated where decisions are able to be made by Board in isolation and are interdependent with the wider health system e.g. within ICS led plans.	The Trust's website includes information about declaration of interest compliance. 'Decision making staff' are required to make either positive or nil declarations, aligned to each financial year. Currently the disclosure online suggest for 2020/21 24% of 'decision makers have made a declaration and the remaining 76% have not. It is not clear whether nil returns are factored into the 24%
Summary recommendation	We recommend Board reporting makes a distinction between what is within the control of the Trust and what is either part of wider ICS plans or decisions made by NHSI/E that are not negotiable.	The performance data as per the Trust website suggests declaration of interest compliance is poor. If this information is accurate the Trust needs to consider how it can ensure better compliance.
Management comment	Agreed. Future reports will made clear which elements of performance and decision making are dependent on the ICS/NHSIE. Target attainment date: October 2021 Executive Lead: Andrew Grimshaw	The Trust is working towards higher disclosure levels and as part of this will consider how the results are framed and presented for public consumption. Target attainment date: March 2022 Executive Lead: Stephen Jones

The range of recommendations that external auditors can make is explained in Appendix C.

Improvement recommendations

Improving economy, efficiency and effectiveness

	Recommendation I	Recommendation J
Auditor judgement	The Trust has improved A&E performance under Covid-19 operating procedures. It is likely the main contribution to this improvement relates to the volume, complexity and type of A&E attendance during the pandemic. However it is also likely some improvements have arisen from changes in arrangements and protocols.	The Trust has had to delay some treatments due to Covid-19 operating procedures, as such some performance metrics are showing slippage against the target, i.e. cancer diagnostic and treatment waiting times. Whilst it is clearly not the intention, this has had a short term positive financial impact but will have far wider reaching clinical and financial impacts in the future. The trust should consider the impact actioning a backlog will have on capacity and treatment targets.
Summary recommendation	We note A&E performance has improved due to a number of actions made by the Trust both before (as reflected on by Emergency Care Improvement Support Team (ECIST) Review Report in 2019) and during the pandemic. This will continue to be challenge especially over winter when there is a natural increase in A&E attendance. The Trust will therefore need to keep arrangements under constant review as new challenges emerge.	The Trust forward plans for cancer treatment should also factor in how backlogs will be managed and what the operational and cost implications of this will be. We note the elective recovery programme in place but these will likely require continued refinement particularly if there is any further rises in COVID-19 demand leading to constraints on capacity or issues with finances once funding arrangements are confirmed.
Management comment	The Trust's ED performance improved across the last surge, with the Trust achieving 95% standard in March 2021. Since then, ED performance has fluctuated reflecting periods when the NHS has experienced higher than ever previously recorded ED attendances. Despite this, the Trust is consistently in the top 4 performers in London and the top 10 for England. ED performance has been significantly improved by the clinical leadership in ED using Quality improvement techniques to tackle the issues raised in the Emergency Care Improvement Support Team (ECIST) Review Report, following a review of the ED in autumn 2019. ECIST revisited the Trust in November 2020, and reported that the processes, clinical leadership and focus and culture of earning were 'exemplary'. The Trust continues to support our ED to learn and adapt to the changing operating environment to sustain timely and effective care for all patients accessing emergency and urgent care. Target attainment date: Complete to date noting ongoing process of review is required within the ED Team. Executive Lead: Anne Brierley	Across the covid surges the Trust, along with all other NHS trusts has had to delay elective treatments with a commensurate increase in the size and duration of waiting lists and times. Addressing elective waiting lists and recovering required performance targets will take considerable planning and resources. The Trust has a comprehensive elective recovery programme, with recovery trajectories agreed with each care group for diagnostics, outpatients and elective treatments. The Trust has also invested in 4 daycase theatres to support elective recovery. This trajectory includes cancer and non-cancer pathways, and focuses on sustaining timely treatment for priority 1 (within 72 hours) and priority 2 (within 28 days) for cancer and non-cancer as referral rates return to and exceed pre-COVID referral rates. To date the Trust is ahead of its trajectory to remove all patients waiting 52+ weeks, and on track to recover cancer 31 and 62 day targets across all specialities. Elective recovery is monitored in the weekly Access Committee which looks at ensure all clinical, operational and financial implications are effectively managed. Target attainment date: Complete but trajectories in place and management oversight will remain in place while the backlog is addressed in the long-term. Executive Lead: Anne Brierley

The range of recommendations that external auditors can make is explained in Appendix C.

Improvement recommendations

Improving economy, efficiency and effectiveness

Recommendation K

Auditor judgement	The Trust is committed to being a key component in ensuring the SWL ICS succeeds in delivering its objectives. Some patients are being moved from the Trust' waiting lists o the waiting lists at other Trusts, i.e. for Audiology. Without the context that this is an intentional move, the Audiology performance at the Trust looks poor and there could be other KPIs equally distorted by ICS collaboration.
Summary recommendation	The Trust should consider where it is pertinent to factor in performance of the other Trusts when reporting against KPIs. Without this context it is difficult for stakeholders to understand the trade-offs made between Trusts.
Management comment	The Trust is proactively working with the other acute hospitals in SWL ICS. As part of this the SWL Acute Provider Collaborative (APC) has created a system of mutual aid to collectively manage waiting times across the system. As this involves and more patients are moved between hospitals there is a risk this distorts waiting times reporting. Delivery of mutual aid to support effective elective treatment pre-existed in SWL before COVID. SWL has also made good progress in implementing high volume / low complexity clinical speciality hubs (for example urology), where the three DGHs support the St George's by treating long waiters. There is effective governance and reporting between the Trusts, overseen by the Elective Recovery Board in SWL at which all CEOs are members, and reviewed weekly at an operational level. Patients treated in DGHs are removed from the Trust's PTL to the treating Trust – thus ensuring accuracy on numbers treated, size of waiting list and length of waiters for each Trust, in accordance with the NHSE regulations on elective mutual aid. Reporting to NHSE for SWL comprises of SWL in aggregate and individual Trust performance, with detail on mutual aid and the impact of speciality hubs reported in the quarterly 'deep dives' with NHSE on SWL elective recovery performance. Trust oversight will remain in place and will align with SWL systems and processes. Target attainment date: Complete Executive Lead: Anne Brierley

The range of recommendations that external auditors can make is explained in Appendix C.

Opinion on the financial statements

Audit opinion on the financial statements

We gave an unqualified opinion on the financial statements in June 2021.

We also concluded the other information to be published with the financial statements, was consistent with our knowledge of the Trust and the financial statements we audited.

Audit Findings Report

More detailed findings can be found in our AFR, which was reported to the Trust's Audit Committee in June 2021.

We did not identify any material adjustments to the financial statements which impacted on the Trust's surplus position.

We have also raised one medium priority recommendation and followed up the delivery of prior year recommendations. We found one prior recommendation was only partially implemented during the year but note the Trust has an appropriate plan in place to implement the action in 2021/22,

Whole of Government Accounts

To support the audit of Consolidated NHS Provider Accounts, the Department of Health and Social Care group accounts, and the Whole of Government Accounts, we are required to examine and report on the consistency of the Trust's consolidation schedules with their audited financial statements. This work includes performing specified procedures under group audit instructions issued by the National Audit Office (NAO).

We were able to certify and report to the NAO that the figures reported in the consolidation schedules were consistent with the audited financial statements.

Appendices

Appendix A - Responsibilities of the Foundation Trust

The accounting officer is responsible for:

- Preparation of the statement of accounts
- Ensuring that income and expenditure is in line with relevant laws and regulations
- Assessing the Trust's ability to continue to operate as a going concern

Public bodies spending taxpayers' money are accountable for their stewardship of the resources entrusted to them. They should account properly for their use of resources and manage themselves well so that the public can be confident.

Financial statements are the main way in which local public bodies account for how they use their resources. Local public bodies are required to prepare and publish financial statements setting out their financial performance for the year. To do this, bodies need to maintain proper accounting records and ensure they have effective systems of internal control.

All local public bodies are responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness from their resources. This includes taking properly informed decisions and managing key operational and financial risks so that they can deliver their objectives and safeguard public money. Local public bodies report on their arrangements, and the effectiveness with which the arrangements are operating, as part of their annual governance statement.

The accounting officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the accounting officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error. The Accountable Officer is also responsible for ensuring the regularity of expenditure and income.

The accounting officer is required to comply with the NHS foundation trust annual reporting manual and the Department of Health & Social Care group Accounting Manual and prepare the financial statements on a going concern basis, unless the Trust is informed of the intention for dissolution without transfer of services or function to another entity. An organisation prepares accounts as a 'going concern' when it can reasonably expect to continue to function for the foreseeable future, usually regarded as at least the next 12 months.

The Trust is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

Appendix B - Risks of significant weaknesses - our procedures and conclusions

As part of our planning and assessment work, we considered whether there were any risks of significant weakness in the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources that we needed to perform further procedures on. The risks we identified are detailed in the table below, along with the further procedures we performed, the conclusions we have drawn and the final outcome of our work:

Risk of significant weakness	Procedures undertaken	Conclusion	Outcome
Financial sustainability was identified as a potential significant weakness, see page 6 onwards for more details.	We have reviewed the Trust's annual and medium term financial plans and assess the robustness of the plan for addressing the financial position assessed the effectiveness of the plan in supporting ongoing financial stability for the Trust. We also reviewed the capital plan and the available capital funding Considered H2 funding arrangements as they become available to the Trust Considered further capital injections (or lack thereof) and the implications for the long term sustainability of the Trust estate to deliver increased demand for healthcare services.	We have concluded there is no indicator of significant weakness. However we note there is still uncertainty regarding revenue funding for the second half of 2021/22 and beyond. There could also be implications for the long term sustainability of the Trust estate to deliver increased demand for healthcare services should it not be able to access sufficient capital funding. As part of our 2021/22 VFM audit we will consider whether a risk around financial sustainability has emerged subsequent to confirmation of the revenue and capital funding available to the Trust. Should the funding be insufficient we may determine there is a significant VFM weakness in relation to financial sustainability.	Currently no significant weakness has bee confirmed and as such no key recommendations are being raised.

Appendix C - An explanatory note on recommendations

The recommendations that can be raised by the Trust's auditors are as follows:

Type of recommendation	Background	Raised within this report
Key	The NAO Code of Audit Practice requires that where auditors identify significant weaknesses as part of their arrangements to secure value for money they should make recommendations setting out the actions that should be taken by the Trust. We have defined these recommendations as 'key recommendations'.	None at this stage
Improvement	These recommendations, if implemented should improve the arrangements in place at the Trust, but are not a result of identifying significant weaknesses in the Trust's arrangements.	Several recommendations

Appendix D - Use of formal auditor's powers

We bring the following matters to your attention:

Public Interest Report Under Schedule 10 of the National Health Service Act 2006, auditors of foundation trusts have a responsibility to make a report in the public interest if they consider a matter is sufficiently important to be brought to the attention of the audited body or the public as a matter of urgency, including matters which may already be known to the public, but where it is in the public interest for the auditor to publish their independent view.	Not applicable
Referral to NHS Regulator Under Schedule 10 of the National Health Service Act 2006 auditors of foundation trusts have the responsibility to report to the relevant NHS regulatory body if the auditor has reason to believe that the foundation trust (or director or officer of the foundation trust) is: • about to make, or has made a decision which involves or would involve unlawful expenditure; • About to take, or has taken, a course of action which, if pursued to its conclusion, would be unlawful and likely to cause a loss of deficiency.	Not applicable

Appendix E – information used to prepare this assessment

Many sources of information were used to facilitate this assessment, below is a series of examples of sources used to conclude on the value for money, please note that due to reporting deadlines there now may be more recent versions of these reports:

NHS Staff Survey

FREEDOM TO SPEAK UP INDEX REPORT 2021

Care Quality Commission

Modality	Jan-21	Feb-21	Mar-21	Variance last month	% Variance last month
Audiology - Audiology Assessments	70	95	124	29	31%
Cardiology - echocardiography	216	154	99	-55	-36%
Cardiology - electrophysiology	3	4	4	0	0%
Colonoscopy	68	90	32	-58	-64%
Computed Tomography	4	4	4	0	0%
Cystoscopy	29	22	25	3	14%
Flexi sigmoidoscopy	20	36	21	-15	-42%
Gastroscopy	132	163	142	-21	-13%
Magnetic Resonance Imaging	18	19	21	2	11%
Respiratory physiology - sleep studies	10	2	1	-1	-50%
Urodynamics - pressures & flows	25	12	13	1	8%
Grand Total	595	601	486	-115	-19%

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Independent auditor's report to the Council of Governors of St George's University Hospitals NHS Foundation Trust

In our auditor's report issued on 25 June 2021, we explained that we could not formally conclude the audit and issue an audit certificate for the Trust for the year ended 31 March 2021, in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice, until we had:

Completed our work on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources.

We have now completed this work, and the results of our work are set out below.

Opinion on the financial statements

In our auditor's report for the year ended 31 March 2021 issued on 25 June 2021 we reported that, in our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2021 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

No matters have come to our attention since that date that would have a material impact on the financial statements on which we gave this opinion.

Report on other legal and regulatory requirements - the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception – the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2021.

We have nothing to report in respect of the above matter.

Responsibilities of the Accounting Officer

The Chief Executive, as Accounting Officer, is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under paragraph 1 of Schedule 10 of the National Health Service Act 2006 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in April 2021. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the Trust plans and manages its resources to ensure it can continue to deliver its services;

- Governance: how the Trust ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the Trust uses information about its costs and performance to improve the way it manages and delivers its services.

We have documented our understanding of the arrangements the Trust has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we have considered whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Audit certificate

We certify that we have completed the audit of Camden and Islington NHS Foundation Trust for the year ended 31 March 2021 in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

Use of our report

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Trust's Council of Governors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Council of Governors, as a body, for our audit work, for this report, or for the opinions we have formed.

Paul Dossett

Paul Dossett, Key Audit Partner
for and on behalf of Grant Thornton UK LLP, Local Auditor

London

2 September 2021

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St George's University Hospitals NHS Foundation Trust

4.2

Meeting Title:	**Trust Board**		
Date:	30 September 2021	**Agenda No**	**4.1**
Report Title:	**Finance and Investment Committee report**		
Lead Director/ Manager:	Ann Beasley, Chairman of the Finance and Investment Committee		
Report Author:	Ann Beasley, Chairman of the Finance and Investment Committee		
Presented for:	Assurance		
Executive Summary:	The report sets out the key issues discussed and agreed by the Committee at its meetings on the 23rd September 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 – September 2021

The Committee met on 23rd September. In addition to the regular items on strategic risks, operational performance and financial performance, it also considered papers on:

- Winter Planning;
- Planning and forecast update for 2021/22;
- The Investment Strategy; and
- An SWLP Report,

Committee members discussed the Board Assurance Framework (BAF) risks on Finance through its 'deep dive' as well as ICT, Estates and Operations on an exceptions basis. The Committee noted the challenges of operational performance and increased observation of OPEL 3 status at the Trust in August. The Committee discussed current financial performance, cash management and capital expenditure as the Trust reported the M5 YTD financial performance of 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) and the Chief Information Officer (CIO) gave updates on their respective BAF risks. The committee discussed the ICT Risks including the challenges of the proposed EPR upgrade. Finance risks were proposed to remain unchanged, in the deep dive update, although it was noted that formal planning guidance has yet to be received for H2. The Operational Risk was briefly discussed, with the challenges of staff wellbeing noted as a key consideration in the coming months.

1.2 Estates Report –the Deputy Director of Estates & Facilities (DDE&F) introduced the normal monthly update, and the committee discussed the implications of the proposed approach to the Non-Emergency Patient Transport (NEPT) contract.

1.3 Activity Performance – the Deputy Chief Operations Officer (DCOO) noted the expected performance against activity trajectories in August, where Daycase/Elective is expected to be slightly below (at 92% compared to 95% target) and Outpatient performance is expected to be ahead (at 104% compared to 95%).

1.4 Emergency Department (ED) Update – the performance of the Emergency Care Operating Standard was recorded at 81.5% in August. The Committee noted the challenges in August, and discussed the challenges of filling junior doctor gaps caused by the scheduled rotation, and the prominence of OPEL 3 in the month.

1.5 Diagnostics Performance – the DCOO noted that the six-week diagnostic standard performance was 3.5% in August compared to 4.3% in July.

1.6 Cancer Performance – the DCOO noted Cancer performance in July where 3 of the 7 targets were met.

1.7 Referral to Treatment (RTT) Update – the performance against the RTT target was discussed, where performance in July of 76.2% had improved against the previous month's value of 76.0%, with the number of 52 week waits of 1,106 being less than the previous month's 1,240. The size of the waiting list (including QMH patients) was 46,319 patients.

1.8 Winter Update – the DCOO introduced a paper on the Winter plan for 2021/22, including the operational and workforce risks that exist. The Committee welcomed the work undertaken in challenging circumstances.

1.9 Financial Performance– the DCFO noted performance at M5 YTD for 2021/22, where a £0.1m surplus was in line with the phased plan submitted on 21st June. This included the income and expenditure impact associated with the Elective Recovery Fund (ERF). The Committee discussed the challenges facing South West London ICS, including ERF and the H2 settlement.

He noted the cash balance as at 31st August 2021 was £50.9m (higher than at year end), including additional receipts where payments will be made in the future (such as for annual leave carry forward), and payments made in advance at year end which have since returned to normal payment dates.

1.10 Planning 21-22 – the DCFO noted the progress being made on planning for H2 2021/22, albeit without formal planning guidance. The Committee noted the importance of the capital programme and endorsed the spending at risk proposed in the paper, noting that this risk was low.

1.11 Investment Strategy – the DCFO introduced the paper re-approving the investment strategy for Trust cashflow, which had no changes from the previous year.

1.12 SWLP Report – the DCFO introduced the quarterly financial report for SWLP, noting the incorporation of Epsom & St Helier into the four trust partnership. He also noted the progress on the implementation of LIMS (Laboratory Information Management System).

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,
September 2021

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4.3

Meeting Title:	**Trust Board**		
Date:	30 September 2021	**Agenda No**	**4.3**
Report Title:	**Financial Performance (Month 5)**		
Lead Director/ Manager:	Andrew Grimshaw, Chief Finance Officer		
Report Author:	Tom Shearer, Deputy Chief Finance Officer		
Presented for:	Update		
Executive Summary:	The Trust is reporting a surplus of £0.1m at the end of August, which is on plan. This includes £14.3m of ERF income and £9.3m of ERF costs, both of which are £7.6m higher than plan (and so offset). Excluding ERF, income is reported at £1.4m adverse to plan at Month 5. This is due to a shortfall in COVID testing income, which is offset in non-pay. Excluding ERF, expenditure is reported at £1.3m favourable to plan at Month 5. This is due to lower COVID testing and Commercial Pharmacy costs, partially offset by higher staffing costs related to COVID. Capital expenditure of £19.6m has been incurred year to date. This is to £0.4m favourable to a plan of £20.0m. At the end of Month 5, the Trust's cash balance was £50.9m, which is £47.9m higher than the £3m minimum cash balance required by NHSE&I. The Trust is actively ensuring suppliers are paid in good time.		
Recommendation:	The Trust Board notes the M5 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.		
Previously Considered by:	Finance & Investment Committee	**Date**	23/09/21
Appendices:	N/A		

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Financial Report Month 5 (August 2021)

4.3

Andrew Grimshaw
Chief Financial Officer

30th September 2021

Executive Summary – Month 5 (August)

Area	Key Issues	Current Month (YTD)	Previous Month (YTD)
Financial Position	The Trust is reporting a surplus of £0.1m at the end of August, which is on plan. This includes £14.3m of ERF income and £9.3m of ERF costs, both of which are £7.6m higher than plan (and so offset).	On Plan	On Plan
Income	Excluding ERF, income is reported at £1.4m adverse to plan at Month 5. This is due to a shortfall in COVID testing income, which is offset in non-pay.	£1.4m Adv to plan	£0.3m Adv to plan
Expenditure	Excluding ERF, expenditure is reported at £1.3m favourable to plan at Month 5. This is due to lower COVID testing and Commercial Pharmacy costs, partially offset by higher staffing costs related to COVID.	£1.3m Fav to plan	£0.4m Fav to plan
ERF	The Trust has received £14.3m of ERF income, which is £7.6m over plan. The Trust has incurred £9.3m of associated costs, which is £7.6m under plan.	On Plan	On Plan
Capital	Capital expenditure of £19.6m has been incurred year to date. This is to £0.4m favourable to a plan of £20.0m.	£0.4m Fav to plan	£0.4m Fav to plan
Cash	At the end of Month 5, the Trust's cash balance was £50.9m, which is £47.9m higher than the £3m minimum cash balance required by NHSE&I. The Trust is actively ensuring suppliers are paid in good time.	£47.9m Fav to plan	£49.9m Fav to plan

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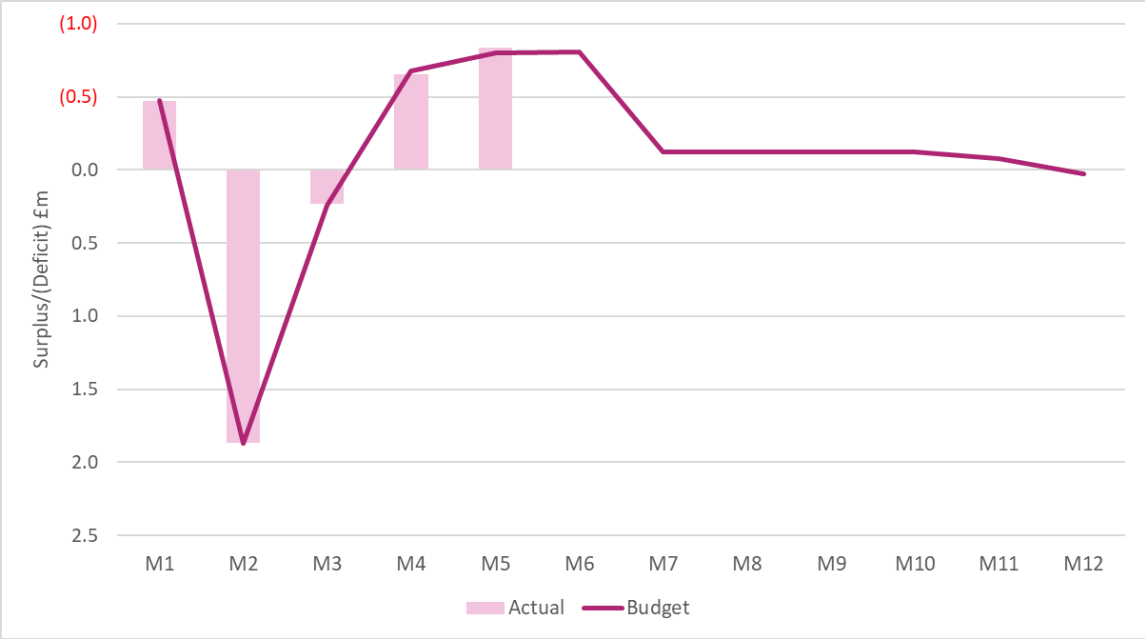
Contents

1. Month 5 Financial Performance

			Full Year Budget (£m)	M5 Budget (£m)	M5 Actual (£m)	M5 Variance (£m)	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)
Excluding ERF	Income	SLA Income	848.3	70.6	70.0	(0.5)	354.2	352.4	(1.8)
		Other Income	135.8	11.4	10.9	(0.5)	55.8	56.3	0.5
	Income Total		**984.1**	**82.0**	**81.0**	**(1.0)**	**410.0**	**408.7**	**(1.4)**
	Expenditure	Pay	(582.5)	(48.5)	(48.9)	(0.3)	(242.7)	(243.9)	(1.2)
		Non Pay	(366.1)	(31.2)	(29.9)	1.3	(154.7)	(152.1)	2.6
	Expenditure Total		**(948.6)**	**(79.7)**	**(78.7)**	**1.0**	**(397.4)**	**(396.0)**	**1.3**
	Post Ebitda		(44.1)	(3.5)	(3.5)	0.0	(17.5)	(17.5)	0.0
	Grand Total		**(8.6)**	**(1.2)**	**(1.3)**	**(0.0)**	**(4.9)**	**(4.9)**	**(0.0)**
ERF	**Income**		14.8	0.6	2.3	1.7	6.7	14.3	7.6
	Expenditure		(7.4)	(0.2)	(1.9)	(1.7)	(1.7)	(9.3)	(7.6)
	Total		**7.4**	**0.4**	**0.4**	**0.0**	**5.0**	**5.0**	**0.0**
	Reported Position		**(1.2)**	**(0.8)**	**(0.8)**	**(0.0)**	**0.2**	**0.1**	**(0.0)**



Trust Overview

The in month reported position at **M5 is a £0.8m deficit, which is on plan. The YTD position is a £0.1m surplus, which is on plan**.

Excluding ERF income and costs:

- **Income** is £1.4m under plan, due to a shortfall in COVID testing income.
- **Pay** is £1.2m overspent across Junior Doctor and Nursing staff groups due to additional costs related to COVID, such as sickness.
- **Non-pay** is £2.6m underspent due to lower COVID testing costs and Commercial Pharmacy.

The Trust has received £14.3m of ERF income, which is £7.6m over plan. The Trust has incurred £9.3m of associated costs, which is £7.6m over plan.

2. Balance Sheet as at 31st August 2021

Statement of Financial Position	M12 March-21 FY 20-21 Actual Audited (£m)	M05 August-21 FY21-22 YTD Actual (£m)	Movement YTD Aug-21 (£m)
Fixed assets	**470.7**	**478.9**	**8.2**
Current assets			
Stock	**13.2**	15.1	1.9
Debtors	**83.3**	77.6	(5.7)
Cash	**36.6**	50.9	14.3
Total Current Assets	**133.1**	**143.6**	**10.5**
Current liabilities			
Creditors	**(110.8)**	(144.1)	(33.3)
Capital creditors	**(36.0)**	(17.2)	18.8
PDC div creditor	**0.0**	(5.1)	(5.1)
Provision<1 Year	**(0.9)**	(0.9)	0.0
Borrowings< 1 year	**(5.1)**	(4.8)	0.3
Int payable creditor	**(0.1)**	(0.1)	0.0
Total current liabilities	**(152.9)**	**(172.2)**	**(19.3)**
Net current assets/-liabilities	**(19.8)**	**(28.6)**	**(8.8)**
Provisions> 1 year	**(3.3)**	(3.2)	0.1
Borrowings> 1 year	**(57.4)**	(57.1)	0.3
Total Long-term liabilities	**(60.7)**	(60.3)	0.4
Net assets	**390.2**	**390.0**	**(0.2)**
Taxpayer's equity			
Public Dividend Capital	**531.9**	531.9	(0.0)
Income & Expenditure Reserve	**(225.2)**	(225.5)	(0.3)
Revaluation Reserve	**82.4**	82.4	0.0
Other reserves	**1.2**	1.2	0.1
Total taxpayer's equity	**390.2**	**390.0**	**(0.2)**

M05 FY21-22 YTD Statement of Financial Position

Fixed assets increased by £8.2m since March-21. This includes the impact of depreciation (£11.5m), capital expenditure (£19.6m) and Grove reversionary interest of £82k.

Inventory value has increased by £1.9m compared to Mar-21. This is due to increases in central store stock, pharmacy, cardiac catheter and cardiac pacing stocks (shown on slide 10h).

Debtors has decreased by £5.7m since March 2021, and this is due to high accounts receivables turnover by the Trust from NHS debtors. There has been significant reduction in SGUL, Smartway, NHS CCG and NHS FT receivables.

The cash position is £14.3m higher than reported at year-end in March-21. The increase in cash is due to £3.7m of VAT refund for June-21 and July-21 in August-21. Trust also received £0.6m from Smartway and received £1m from NHS Kingston Trust for SWL pathology and other invoices.

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

Creditors are £33.3m higher than the figures reported at year-end in March-21. There is a significant increase in NHS and Non-NHS accruals since March-21. March-21 creditors were low due to HMRC, and NHS Pension liability was paid in advance in August-21.

Capital creditors are £18.8m lower than March-21. This decrease is due to FY 20-21 capital creditors paid in FY21-22.

Provisions has decreased by £0.1m which is due to the utilisation of the early retirement provision.

No new borrowing has occurred since March-21, except an increase in capital finance lease borrowing of £2.4m M05 YTD.

PDC creditors has increased to £5.1m since March-21. This is due to M05 YTD accrued PDC of £12.2m for the full FY21-22 which is calculated based on forecasted M12 FY21-22 net assets. No PDC has been received between April-21 and August-21.

There has been no significant movement in taxpayers equity except the M05 YTD I&E reserve of £0.3m which is due to the YTD M05 I&E deficit including finance and dividend charges.

3. Month 5 Cash Flow Statement

Statement of Cash Flow	M05 YTD FY 21-22 Actual £m
Opening Cash balance	**36.6**
Income and expenditure deficit	(0.2)
Depreciation	11.5
Impairment	0.0
Interest payable	1.3
PDC dividend	5.1
Other non-cash items	(0.1)
Operating surplus/(deficit)	**17.6**
Change in stock	(1.9)
Change in debtors	5.7
Change in creditors	33.3
Change in provisions	(0.1)
Net change in working capital	**37.0**
Capital spend	(19.6)
Capital Creditors	(18.8)
Capital additions Finance leases	2.4
Interest paid	(1.4)
PDC dividend charge paid	0.0
Interest Received	0.0
Net change in investing activities	**(37.4)**
PDC Capital Received	0.0
Accrued Interest YTD (DH & LEEF)	0.0
DH Capital £14.747m Loan repaid	(0.3)
LEEF Loan (Other Loan)	(0.7)
PFI	(0.5)
Finance lease payments	(1.3)
Net change in financing activities	**(2.9)**
Cash balance as at 31.08.2021	**50.9**

M05 FY21-22 YTD cash movement

- The cumulative M05 21-22 I&E deficit is £0.2m. (*NB this includes the impact of donated grants and depreciation which is excluded from the NHSI performance total).
- Within the I&E deficit of £0.2m, depreciation (£11.5m) does not impact cash. The charges for interest payable (£1.3m) and PDC dividend (£5.1m) are added back and the amounts actually paid for these expenses shown lower down for presentational purposes. This generates a YTD cash "operating surplus" of 17.6m.
- The net change in working capital has increased to £37m in August-21 compared to March-21. This is due to major movement in creditors of £33.3m, which is due to increased NHS and Non-NHS accruals, HMRC and NHS Pension liability in August-21.
- The stock value has increased by £1.9m in August-21 compared to March-21. This is due to significant increase in central stores stock.
- The Trust paid a DH Capital loan repayment of £0.3m in May-21, and a LEEF loan payment of £0.7m was made in June-21. In addition, as at M05, the Trust has made repayments of £0.5m and £1.3m for PFI and Finance leases, respectively.
- Capital creditors reduced by £18.8m compared to March-21 and a new capital finance lease addition of £2.4m has been made YTD to August-21.
- There has been no capital or revenue support PDC received between April-21 and August-21.

August-21 cash position

- The Trust achieved a cash balance of £50.9m on 31st August-21, £47.9m higher than the £3m minimum cash balance required by NHSI. This is due to the June -21 and July-21 VAT refund of £2.3m and £1.5m respectively received from HMRC in August-21.

4. M4 Capital

- The Trust is planning to spend £56.579m on capital expenditure this financial year, including £3.5m on finance leases.
- This spend is to be funded by Internal capital of £20.497m, leases of £3.5m and new PDC allocation of £32.582m.
- The spend is planned to cover a number of spending initiatives this year covering IT Medical Equipment and estate infrastructure.
- The Trust has spent £19.639m YTD as at M05.
- Trust continues to exert tight control over capital expenditure, approving requisitions for all projects.

Spend category	FY Budget £000	YTD budget £000	YTD exp £000	*YTD var £000*
MRI	8,700	8,250	7,290	960
Cath Labs	6,300	5,580	4,526	1,054
Estates	7,800	1,535	3,812	-2,277
IT	6,600	1,710	2,133	-423
Lease Renewals	3,500	2,915	1,806	1,109
SWLP BAU Capital	500	0	72	-72
SWLP 4TTP	700	0	0	0
Total St George's Schemes	**34,100**	**19,990**	**19,639**	**351**
SWL Schemes				
Critical Care Expansion	27,400	0	0	0
SGH Emergency Floor	3,070	0	0	0
SWL LCHR (host TBC)	2,000	0	0	0
SWL PACs	1,300	0	0	0
Community Diagnostics Hub	2,000	0	0	0
Total SWL Schemes	**35,770**	**0**	**0**	**0**
Total Expenditure	**69,870**	**19,990**	**19,639**	**351**
Mitigations required in year	-15,691	0	0	0
SWL contingency held at STG	2,400	0	0	0
Expenditure as per PFR	**56,579**	**19,990**	**19,639**	**351**