Outstanding care every time

St George's University Hospitals NHS Foundation Trust

Trust Board Meeting (Part 1) Agenda

Date and Time: Thursday, 25 November 2021, 09:00-12:00
Venue: MS Teams

Time	Item	Subject	Lead	Action	Format
1.0 OPENING ADMINISTRATION					
09:00	1.1	Welcome and apologies	Chairman	Note	Verbal
	1.2	Declarations of interest	All	Assure	Verbal
	1.3	Minutes of meeting – 30 September 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 Q2 2021/22*	CMO	Assure	Report
	2.1.2	Mental Capacity Act and Deprivation of Liberty Standards Annual Report 2020/21*	CN	Assure	Report
	2.1.3	Duty of Candour Annual Report*	CN / CMO	Assure	Report
09:35	2.2	Integrated Quality and Performance Report*	COO	Assure	Report
09:55	2.3	Winter Plan	COO	Assure	Report
10:05	2.4	Duty of Candour for Patients with Nosocomial Covid-19	CMO	Assure	Report
3.0 CULTURE					
10:10	3.1	Workforce and Education Committee Report	Committee Chair	Assure	Report
	3.1.1	Workforce Disability Equality Standard Report 2021 and Action Plan*	CPO	Note	Report
	3.1.2	Freedom to Speak Up Report Q2 2021/22*	CCAO	Assure	Report
4.0 COLLABORATION					
10:30	4.1	Audit Committee Report	Committee Chair	Assure	Report
10:40	4.2	Finance and Investment Committee Report	Committee Chair	Assure	Report
10:50	4.3	Finance Report (Month 7)*	CFO	Update	Report
11:00	4.4	St George's Hospital Charity Report	CSO	Update	Report
11:10	4.5	Horizon Scanning Reports • Policy, regulatory, legislative • Local and Regional	CCAO / CSO	Note	Report
11:20	4.6	Board Assurance Framework Q2 (2021/22) Review	CCAO	Note	Report
5.0 CLOSING ADMINISTRATION					
11:35	5.1	Questions from Governors and the Public	Chairman	Note	Verbal
	5.2	Any new risks or issues identified	All	Note	
	5.3	Any Other Business	All	Note	
11:45	5.4	Patient Story	CN	Note	Verbal
12:00 CLOSE					

Date of Next Meeting: Thursday 27 January 2022, 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 Attendees		
Members	**Designation**	**Abbreviation**
Gillian Norton	Chairman	Chairman
Jacqueline Totterdell	Chief Executive Officer	CEO
Ann Beasley	Non-Executive Director/Vice Chairman	AB
Robert Bleasdale	Acting Chief Nurse & Director of Infection, Prevention & Control	ACN
Anne Brierley*	Chief Operating Officer	COO
Stephen Collier	Non-Executive Director	SC
Paul da Gama*	Chief People Officer	CPO
Andrew Grimshaw	Chief Finance Officer and Deputy Chief Executive Officer	CFO/DCEO
Jenny Higham	Non-Executive Director St George's University Representative)	JH
Richard Jennings	Chief Medical Officer	CMO
Stephen Jones*	Chief Corporate Affairs Officer	CCAO
Peter Kane	Non-Executive Director	PKa
Dame Parveen Kumar	Non-Executive Director	NED
Pui-Ling Li*	Associate Non-Executive Director	ANED
Suzanne Marsello*	Chief Strategy Officer	CSO
Tim Wright	Non-Executive Director	NED
In Attendance		
Geoff Stokes	Head of Corporate Governance	HoCG
Apologies		
Quorum:	*The quorum of this meeting is a third of the voting members of the Board which must include one non-executive director and one executive director.*	

* *Non-voting member of the Board*

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Minutes of the St George's University Hospitals NHS Foundation Trust Board Meeting in Public

Thursday 30 September 2021

Held virtually via Microsoft Teams

PRESENT		
Gillian Norton	Chairman	Chairman
Jacqueline Totterdell	Group Chief Executive Officer	GCEO
Ann Beasley	Non-Executive Director	AB
Robert Bleasdale	Chief Nurse & Director of Infection Prevention & Control	CN
Stephen Collier	Non-Executive Director	SC
Paul Da Gama*	Chief People Officer	CPO
Andrew Grimshaw	Chief Finance Officer and Deputy Chief Executive Officer	CFO
Prof Jenny Higham	Non-Executive Director	JH
Dr Richard Jennings	Chief Medical Officer	CMO
Stephen Jones*	Chief Corporate Affairs Officer	CCAO
Prof Parveen Kumar	Non-Executive Director	NED
Dr Pui-Ling Li*	Associate Non-Executive Director	PL
Suzanne Marsello*	Chief Strategy Officer	CSO
Tim Wright	Non-Executive Director	TW
IN ATTENDANCE		
Anna Clough	Deputy Chief Operating Officer	DCOO
Peter Kane	Non-Executive Director designate	PK
APOLOGIES		
Elizabeth Bishop	Non-Executive Director	NED
Anne Brierley*	Chief Operating Officer	COO
SECRETARIAT		
Geoff Stokes	Head of Corporate Governance/Board Secretary (minutes)	HoCG

** Non-voting members of the Board*

		Action
1.0	**OPENING ADMINISTRATION**	
1.1	**Welcome, introductions and apologies** The Chairman welcomed everyone to the meeting and noted apologies from Elizabeth Bishop and Anne Brierley. The Chairman specifically welcomed: • Peter Kane who had been appointed as a non-executive director and chair of the Audit Committee and was observing the meeting. He would formally commence his term of office the following day, replacing Elizabeth Bishop; • the Care Quality Commission (CQC) inspector, Abu Suleiman, who was expected to join the meeting; • Geoff Stokes, Interim Head of Corporate Governance, who was providing secretariat support to the Board; • Anna Clough who was covering as Acting Chief Operating Officer due to the unfortunate absence of Anne Brierley; • Anna Macarthur, Director of Communications and Engagement who has recently joined the Trust and who was observing the meeting. • Governors John Hallmark and Shalu Kanal, public governors for the Wandsworth constituency.	
1.2	**Declarations of Interest** The Chairman reminded the Board of previously declared interests for herself and Anne Beasley as Chairman-in-Common and non-executive director respectively at Epsom and St Helier University Hospitals NHS Trust (ESTH). The GCEO also declared her interest as Group Chief Executive Officer for both the Trust and Epsom and St Helier University Hospitals, having taken up her new role on 16 August 2021.	
1.3	**Minutes of the Previous Meeting** The minutes of the meeting held on 29 July 2021 were approved as a true and accurate record.	
1.4	**Action Log and Matters Arising** The Board reviewed and noted the action log. The CPO gave a verbal update on action **TB27.05 21/01 – Gender Pay Gap** and commented that the data analysis had been reviewed at the Workforce and Education Committee (WEC) which was assured that the issues identified had been addressed. It was hoped that the action would be completed by the following week. It was agreed that this action would be kept open and that an update on the completion of the action would be provided at the next Board meeting.	
1.5	**Chief Executive's Officer (CEO) Report** The Board received the report from the GCEO, who made the following points: • Emergency care performance had struggled in recent weeks and this was being investigated as attendances had not increased significantly. The	

		Action
	problem was not unique to the Trust but other trusts were doing relatively better. These challenges had followed a sustained period of high performance in emergency care in previous months. • Since taking up the position of Group Chief Executive at the Trust and ESTH, further opportunities had emerged for joined up patient care and research between ESTH and St Georges' (SGUH). • Consultation with executive colleagues has started on a revised executive structure for the new group model and it was hoped that the new group executive team would be in place by January 2022. The new structure would strengthen the leadership capacity across both organisations, both strategically and operationally. • The South West London Acute Provider Collaborative (SWL APC) was well established and had led to a number of joint working initiatives, including pathology, procurement and recruitment. • Millie Banerjee had been confirmed as the Chair designate of the Integrated Care Board for South West London, the establishment of which was being established on a statutory basis through the Health and Care Bill currently before Parliament, and an appointment of Chief Executive was expected to be made in the coming weeks. • Professor Peter Mortensen, President of the Royal College of Surgeons (RCS) and Stephen Hammond MP had visited the Trust's Surgical Treatment Centre at Queen Mary's Hospital in Roehampton and were impressed with the facility. The Centre had been established to address the backlog of elective work at the Trust and beyond which had developed as a result of the impact of the Covid-19 pandemic, and was an innovative solution to ensure patients were treated in a timely way. • The Trust had been put forward for a number of awards as set out in the paper. This was encouraging and a testament to the great work being undertaken by staff across the organisation. • Louise Ludgrove, had joined the Trust as Interim Director of Workforce, succeeding Elizabeth Nyawade. Elizabeth and Mitchell Fernandez, Assistant Chief Nurse, who had also let the Trust on promotion, were thanked for their service. The Board noted the Chief Executive's 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 August and September 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. The key matters of note from the Committee related to: • Resuscitation training had improved and basic life support (BLS) training had now reached the target of 80%, with intermediate and advanced life support training both on track to reach their targets by December 2021.	

		Action
	• There had been an increase in the number of patients for cardiology MRI scanning. Two new cardiac catheter laboratories were expected to open shortly which would see performance improve. • There had been issues with the Birth Centre having to close due to staffing challenges in August. The service had remained midwife-led. • There continued to be challenges with on-the-day cancellations of treatment, with 58 such cancellations recorded in July and 38 in August. • Diagnostics performance was improving and it was encouraging that there had been a reduction in patients awaiting a booked appointment. It was noted that the CQC insight report the Committee received was based on information held about the Trust nationally but due to the Covid-19 pandemic some of the data was out of date. The Insight report would be taken to the Committee quarterly, with commentary where performance had been updated. The Board noted the updates from the August and September 2021 Committee meetings.	
2.1.1	**Learning from Deaths Q1 2021/22** The Board received and considered the report for quarter 1 of 2021/22. It was noted that as the pandemic had progressed, more information and knowledge about treating patients had emerged which had resulted in better outcomes. A question was raised about a patient being unable to be taken through the cardiac catheterisation laboratory (cath lab) and it was explained that following this unfortunate event, processes had been changed to address this issue and ensure patients were in the correct bed and treated by the correct specialist. The Board: • noted and supported progress against the relevant aspects of the Quality and Safety Strategy which had been achieved through the implementation of the Mortality and Morbidity team; • noted that the Trust was fully compliant with all Clinical Negligence Scheme for Trusts (CNST) requirements in this quarter and continued to use this work to drive improvement; • was assured that current outlier alerts were being investigated robustly and that there was a granular understanding of the Trust's mortality data; and • noted the analysis of data available regarding waves 1 and 2 of the Covid 19 pandemic that could be used to assist understanding of the Trust's outcomes.	
2.1.2	**Infection Prevention and Control Annual Report** The Board received and considered the infection prevention and control annual report for 2020/21, which had been considered in detail by the Quality and Safety Committee at its meeting in August 2021, and noted the reduction in *c.difficile* infections from eight in 2019/20 to four in 2020/21.	

		Action
	The Board noted and received assurance from the infection prevention and control annual report for 2020/21.	
2.1.3	**Learning from Disabilities Report** The Board received and considered the learning disabilities report, which had been considered in detail by the Quality and Safety Committee at its meeting in September 2021, and noted the following key points: • There had been a reduction in referrals but this was likely to have been due to the pandemic and patients shielding. • The service performed well against national benchmarks. • Technology had been used to improve processes. The Board acknowledged that the team should be celebrated as providing an excellent service for patients. It was noted that the patient story due to be heard later on the agenda, which related to a patient with learning disabilities, had, unfortunately, needed to be postponed. The Board noted the report.	
2.2	**Integrated Quality and Performance Report (IQPR)** The Board received and noted the IQPR for month 5 (August 2021), which had been scrutinised at both the Finance and Investment and the Quality and Safety Committees the previous week. Operational highlights were as follows: • ED performance had deteriorated disproportionately compared with other trusts in the rest of London and across England and this had impacted morale. 'Normal' winter activity levels were already being seen and the situation was likely to become more challenged in the coming months. • Staffing levels had been a challenge in August, with additional sessions not being picked up but this has improved in recent weeks. • The number of patients experiencing long waits for elective treatment remained a concern but it was hoped that by the end of November 2021, the only waits longer than 104 weeks would be through patient choice. • Two week waits (2ww) for suspected breast cancer remained problematic with a growth in the number of referrals and pressures on capacity. The 62 day position was also an issue, partly affected by delays in diagnostics in other trusts leading to late referrals.	
	A question was raised about theatre utilisation and productivity and whether recent guidance would help to improve this. It was felt that this was unlikely in the short term as the Trust remained concerned about avoiding post-operative infection.	
	'Do not attend' (DNA) numbers remained a concern and it was confirmed that all DNAs were followed up. It was acknowledged that the Trust's outpatient communication was not as good as it could be, which may contribute to high DNA numbers.	

		Action
	The 2ww position was also questioned and it was confirmed that most cases were seen shortly after the two week target and most resulted in negative diagnoses. An action plan was being put in place to increase capacity. It was noted that the Board at its meeting in July had agreed that a paper reviewing breast screening and the 2ww pathway would be brought to the Quality and Safety Committee ahead of the next Board meeting.	
	The following points were made about the patient care aspects of the IQPR: • Further to the report from QSC, BLS training has met the target of 85% as of today. Intermediate life support (ILS) and advanced life support (ALS) were on track to achieve their targets by the end of December 2021. There had been an impressive use of technology to deliver BLS training. • To address maternity suite difficulties, there had been changes in the workforce model to maintain a midwife-led service through the labour ward rather than the delivery suite. • There had been an increase in hospital acquired Covid-19 and a paper on this would be discussed in the private board meeting. The Trust planned to publish its data on nosocomial Covid-19 infection in November 2021.	
	There was a brief discussion about the number of unfilled duty hours and the impact this had on outcomes. It was explained that triangulation took place between the number of staffing 'red flags' that were raised, incidents reported through Datix and feedback from the friends and family test (FFT) and no correlation has been shown. The gaps were caused by sickness, pre-planned leave and fewer staff willing to fill additional shifts. International and newly qualified staff were due to start at the Trust shortly so substantive staffing levels were expected to improve.	
	A summary of the key workforce performance was provided and it was noted that many indicators would be affected by the general pressure on the Trust. • There was a worrying trend in staff sickness levels, although this was not out of line with other London trusts. There was a need to understand hotspots and the nature of absences as well as to target early intervention, as evidence showed that this had a significant impact on reducing the length of sickness absence. • There was a healthy pipeline to fill vacancies, and the 'time to hire' had reduced to 53 days from 71 due to changed processes, such as contacting managers at the start of a recruitment process.	
	The Board noted the IQPR report.	
3.0	**CULTURE**	
3.1	**Workforce and Education Committee Report** Stephen Collier, Chair of the Committee, presented the report of the meetings held in August and September 2021, which highlighted the following key issues:	

		Action
	• The pressure on staff had been acknowledged and was being addressed by executive management, albeit that pressures would continue to be felt acutely over the coming months. • It was encouraging to see the culture programme moving forward, including an allocation of funding to support the delivery of this work. • There was a detailed update on staff planning and the Committee was assured about the processes employed. • A 'pulse' survey had been initiated which would provide more timely feedback on the views of staff. • The workforce race equality standard (WRES) report showed some interesting analysis, especially in the wide variation of experience of staff from different backgrounds that were grouped together as BAME staff. More analysis was being undertaken and a further report would be brought back to the Committee as a deep dive.	
	The Board noted the updates from the August and September 2021 Committee meetings.	
3.1.1	**Workforce Race Equality Standards Report** The Board considered the workforce race equality standards (WRES) report, which had been considered previously by the Workforce and Education Committee, and the following points were made: • Five of the nine indicators in the WRES had improved, two had stayed the same and two had deteriorated. • WRES indicators 1 and 9 (focussing on the makeup of the organisation) showed a good overall picture, with diversity improving at senior levels. Unfortunately, the picture at executive level was not so encouraging. The sizable percentage change in the number of BAME Executive Directors related to two roles that had changed over the past year. • The likelihood of BAME staff being subjected to disciplinary action had improved and this was partly due to the implementation of the Harding principles, which included a panel deciding if disciplinary action was needed. • Work was being undertaken with senior BAME staff to understand the issues BAME staff were encountering and to enable the Trust to become more sophisticated and mature in addressing these. • The WRES action plan had been incorporated into the wider strengthening culture action plan and demonstrated a clear focus on these important issues.	
	The Board noted the report and approved the publication of the WRES 2020/21 report and narrative on the Trust's website.	
3.1.2	**Revalidation Reports** The Board considered the annual report from the Responsible Officer in respect of medical revalidation and noted that while medical appraisal had improved to 76.3%, this was not yet where it needed to be. Appraisal leads	

		Action
	were in place across each division and this was expected to help provide greater focus. The Board then considered the annual nursing and midwifery registration and revalidation report and noted that controls were in place to ensure substantive and temporary staff did not treat patients if their registration with the Nursing and Midwifery Council had lapsed. The Board noted the reports and: • that appraisal and revalidation was fully resumed following the disruption of the Covid-19 pandemic but that appraisal rates have been affected; and • the planned actions for the upcoming year.	
4.0	**COLLABORATION**	
4.1	**Audit Committee Report (Including value for money)**	
4.1.1	**External Audit Value for Money Audit Report** In the absence of Elizabeth Bishop, Ann Beasley provided an update on behalf of the Committee on the additional meeting held on 6 September 2021 and made the following points: • The value for money (VfM) report was a new process and looked at three areas – financial sustainability, governance and economy, efficiency and effectiveness. There were no key recommendations in these areas, and the Committee had welcomed this. • Some minor improvement recommendations were made which had been accepted by management, even though some are already being addressed, particularly those in relation to operational performance. • On balance, the Committee had queried the added value the report had provided, but it was encouraging that no concerns were raised and there was an opportunity to consider learning from the process to inform next year's report. The Board: • received the Value for Money report 2020/21 from the Trust's External Auditor; and • received and noted the completion of the annual audit and receipt of the audit certificate for 2020/21.	
4.2	**Finance and Investment Committee Report** Ann Beasley, Chair of the Committee, provided an update on the meetings held in August and September 2021 and highlighted the following: • A discussion on risk had taken place as usual, which had focused in particular on ICT risks. This had not resulted in the Committee proposing a change in risk scores on the BAF. For example, in terms of ICT there is a constant need to stay vigilant and address new challenges as they arise.	

		Action
	• Financially, the Trust was where it needed to be at this stage but there was concern that planning guidance for the second half of the year (H2) had not yet been issued. • The Committee had noted the importance of the capital programme and had endorsed the spending at risk that had been proposed by management, noting that the risk was low.	
	The Board noted the updates from the August and September 2021 Committee meetings.	
4.3	**Finance Report Month 5** The Board received and noted the Trust's financial performance at month 5 and the following points were made: • The Trust was on plan at the end of month 5, and this period had been relatively uneventful. However, the key focus was on H2 and it was disappointing that planning guidance had not been received which made planning for the second part of the year more challenging. This also highlighted the challenges faced by colleagues at NHS England and NHS Improvement (NHSE&I). • The Trust was planning to spend £56.6m on capital expenditure in the current financial year, including £3.5m on finance leases. This spend was being funded through internal capital of £20.5m, leases on £3.5m and new public dividend capital of £32.6m. The Trust is able to continue to invest in the estates infrastructure and medical equipment. The Board noted the month 5 financial position.	
5.0	**CLOSING ADMINISTRATION**	
5.1	**Questions from Governors and the public** No questions were received from the public. John Hallmark, Public Governor for Wandsworth, asked for an explanation of OPEL, how OPEL levels were determined and their impact. It was explained that the operational pressures escalation levels (OPEL) framework used a number of triggers to determine the level of operational pressure the Trust was facing, and at OPEL 4 additional measures, such as standing down of non-urgent meetings, increasing the number of ward rounds and other measures were taken to improve discharge and flow through the hospital.	
	The Board thanked Governors for their feedback and input.	
5.2	**Any new risks or issues identified** There were no other risks or issues identified.	
5.3	**Any Other Business** No other business was raised.	
5.4	**Patient Story** The planned patient story was unfortunately deferred.	
Date of next meeting: Thursday, 25 November 2021, MS Teams		

The meeting closed at 10:15.

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ACTION LOG - TRUST BOARD (PART 1)

ACTION REF	MEETING DATE	ITEM NO.	ITEM	ACTION	WHEN	WHO	UPDATE	STATUS
PUBLIC210527.1	27 May 2021	3.11	Gender Pay Gap	The Board noted and endorsed the report subject to Stephen Collier and Ann Beasley agreeing the final data analysis.	25 Nov 2021	CPO Ann Beasley Stephen Collier	Report has been agreed	PROPOSED FOR CLOSURE
PUBLIC210729.1	29 Jul 2021	2.2	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 Nov 2021	COO	On QSC agenda 25 Nov 2021	PROPOSED FOR CLOSURE

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Meeting Title:	**Trust Board**		
Date:	25 November 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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NHS
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Chief Executive's report to the Trust Board
Trust Board, 25 November 2021

It has been two months since my last board report and - like the rest of London - we are feeling some pressure across our Trust. We are however performing well in many areas. Less than 200 people are now waiting more than six weeks for routine diagnostics – just 2.3% of the waiting list compared with 24.6% this time last year. And we continue to manage ambulance hand overs in a timely way.

But as the media reports, there is a great deal of pressure in the NHS - felt most keenly in our emergency pathways. The achievement against the four-hour standard in our Emergency Department (ED) is directly affected by patient flow through the hospital. We are working closely with our local health and social care partners to expand community capacity to support people at home, and ensure we discharge patients with ongoing needs in a timely way.

This month we worked with print and broadcast media to highlight the challenges we face, encourage take up of the vaccine, recognise the efforts of our staff and signpost people to alternatives to ED. I was pleased to see St George's featured on the front page of the Daily Express and on Channel 5 News.

We know winter will be challenging as we respond to Covid-19, flu and children's respiratory viruses all while sustaining our elective recovery and supporting our tired teams. Our Winter Plan update to the Board this month sets out the additional actions we have taken to maximise clinical capacity and support our NHS people through the coming months.

H2 finance

NHS England and NHS Improvement (NHSE&I) has published its updated planning guidance for the second half of the year with the six areas set out in March remaining as priorities. Whilst many of the additional funding streams available to the Trust continue in to H2, such as the Elective Care Recovery Fund, and continued funding for the cost of Covid-19, overall funding is slightly reduced, with the Trust requiring to review its current level of spend, step back up financial control, and seek opportunities to improve productivity and efficiency where available. It is expected that 22/23 will see a continuation, and an increase of this financial challenge. The Trust has submitted a plan for H2 alongside the ICS which. While it includes a small deficit position, this is expected to be acceptable to NHS London.

Corporate Objectives 2021/22

With my thanks to the Board and all those who gave feedback, our corporate objectives for the second half of the 21/22 financial year have been approved and shared with senior leaders across the Trust. These objectives will support delivery of improvements in our service to patients and the health and wellbeing of all our staff. They have been simplified and they link to our themes: Care, Culture & Collaboration. Executive leads are in place for all and we will be held to account by our Board for delivery in H2.

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NHS
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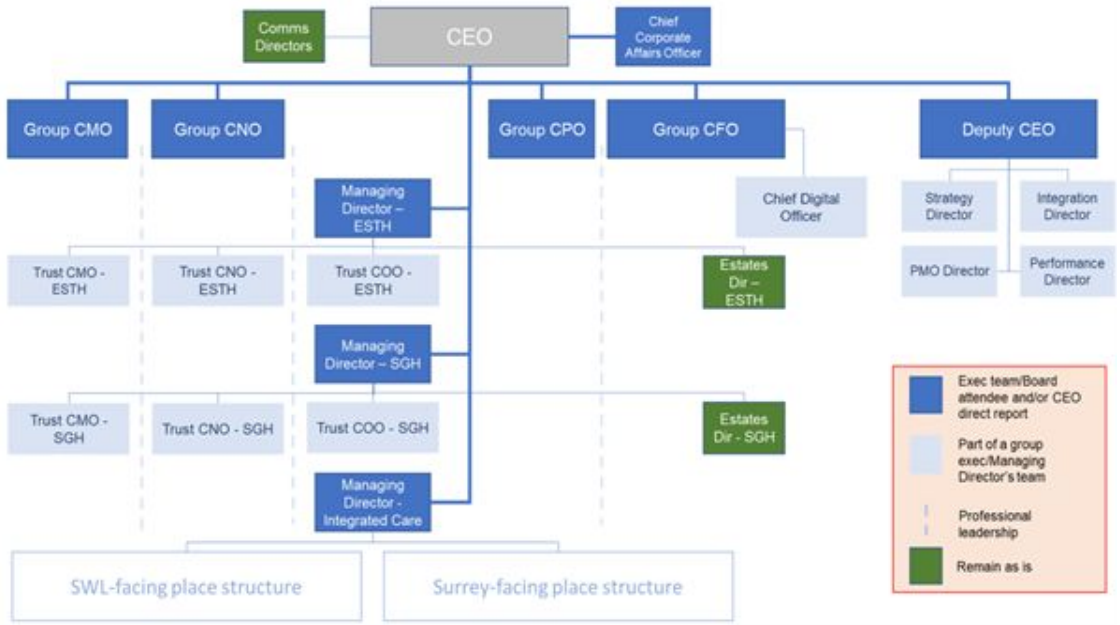
NHS Foundation Trust

Developing our hospital group with Epsom and St Helier

This week marks my 100th day as Group Chief Executive of St George's and Epsom and St Helier hospitals. Our hospitals are now formally working together to improve patient care, bolster our workforce and share our expertise.

The next phase in us working together as a hospital group is to create a single executive team to provide leadership for both organisations as well as the operational management of our hospitals and community services.

Following a consultation process, I am pleased to announce our new structure, which creates a number of group executive posts as well as site-based managing director and clinical roles. The diagram below explains what that will look like.



My new blended executive team will be made up of directors across both hospitals and will reflect the wealth of knowledge, expertise and skills of both leadership teams. A transparent and competitive recruitment process has begun to appoint to these roles and I expect most directors will be in post by early January.

We continue to work with our partners in southwest London

We have shown throughout the pandemic that collaboration with our partners gives us the best outcomes for patients. This is evident in our sustained reduction in people waiting a long time for routine surgery, which is ahead of our plan, and SWL is an exemplar in London. Work continues to develop a new statutory Integrated Care System for SWL which will be made up of three parts: SWL ICS (South West London Integrated Care System) places; SWL ICS Provider Collaboratives; and SWL level ICS.

Both the Chairman and I attended listening events in October 2021 to help design an ICS that works for us in SWL and delivers health and care improvements for local people. The

ICS will be producing proposals for the SWL Integrated Care Partnership and Place-based Partnerships and they hope to share this with us in the next few weeks.

Senior appointments to the ICS have also been made since my last update to the Board. Our congratulations to Millie Banerjee who has been confirmed as the ICB (Integrated Care Board) Chair and Sarah Blow who has been appointed Chief Executive Officer.

Children's cancer services

Earlier in the month NHS England and NHS Improvement published its national specification for Paediatric Treatment Centres - as well as the linked specification for Paediatric Oncology Shared Care Units - in response to the review by Sir Mike Richards. The specification makes co-location with level 3 paediatric critical care a mandatory requirement.

Everyone at George's is proud of the joint PTC that we have delivered with the Royal Marsden for over 20 years. Our children's services - rated Outstanding by the CQC - has provided the complex medical, surgical, neurosurgical and intensive care for children with cancer in South London, Kent, Sussex and Surrey. But, with significant advances in NHS cancer treatments, we welcome this new national standard. St George's is the only provider of children's cancer surgery in south London and is the only site where all aspects of cancer care for children with haematological, solid tumour and neurological tumours can be provided from one site. When I met paediatric teams last week, it was clear they hope to continue to provide children and their families with the best possible cancer care. We will now work with our partners in south London to develop a model that offers the best possible care to children and their families.

International Climate Change Conference COP 26

Staff at St George's are not only passionate about patient care but also the environment and we continue to take steps to be more sustainable. St George's, which aims to be carbon neutral by 2040, is the first Trust in England to introduce a carbon neutral patient menu which has helped us cut 23 tonnes of carbon, the equivalent of planting 30 acres of forests. Healthcare Assistant Marsha Lord was one of just nine NHS workers chosen to appear in a photographic exhibition at the climate change conference taking sustainable action to help achieve net zero carbon emissions. The exhibition, entitled "Care for the future: delivering the world's first net zero health service", celebrated the NHS staff who are supporting the transformation to greener healthcare. We have already introduced a range of recycling, energy saving, and carbon reduction programmes and I shall continue to update the Board on our efforts to become carbon neutral.

#ThankYouGeorges

The last two years has tested staff at St George's and taken a toll on families and our local communities. I am so proud of everyone who works at our Trust and who has kept going, putting patients and colleagues first, despite being tired and worn down. Their response continues to be phenomenal.

To show our appreciation for everything staff have given throughout the pandemic, we started a three-month season of thanks on 1 October - 'Thank You George's'. Every

member of staff has been given a £40 gift voucher to treat themselves, their families, or their colleagues. We ran a weeklong food festival where every member of staff was given a free hot meal and we have other great events planned, as well as a chance to learn, reflect, and share their experiences of responding to Covid-19.

I'm pleased to report that Thank You George's has been a big hit with staff and we have received lots of emails and comments from colleagues who say they appreciate that all their hard work is being recognised.

Staff survey

We are having a final push to encourage as many staff as possible to complete the NHS Staff Survey before it closes tomorrow (26 November). We have stepped up our efforts this year to encourage staff to tell us what they think so we can again make improvements to their working lives and improve patient care. From pop up banners at the hospital sites to posters, flyers, presentations, an offer of free tea and cake and some protected time to complete the survey, we continue to do everything possible to encourage staff feedback.

Maternity Memorial Garden and VIP visits

We continue to welcome high profile visitors to St George's. Her Royal Highness Princess Michael of Kent officially opened a new Maternity Memorial Garden at St George's Hospital in October. The garden, which will serve as a quiet place for reflection for anyone affected by pregnancy or baby loss, as well as a permanent memorial to those mothers who have died during and after pregnancy, was opened to coincide with Baby Loss Awareness Week.
The maternity service employs a team of three midwives to provide dedicated bereavement care, and with support from a psychotherapist to provide counselling for anyone affected by pregnancy loss, or who lost a partner during pregnancy.

B&Q funded the garden which was built by St George's head gardener, John Greco, as well as volunteers from B&Q, and supported by St George's Hospital Charity.

I was also pleased to welcome the Chief People Officer, Prerana Issar, and the Chief Operating Officer, Mark Cubbon, of NHS England to St George's recently. They both visited our surgical hub at Queen Mary's while Prerana also spent time in ED and on the wards at St George's. When leaving Prerana said she felt 'energised' and that she will take learning back with her, not least, the practical steps the Trust has taken to help support staff.

Black History Month

We celebrated the achievements of our Black staff in October and hosted a series of events to mark Black History Month. The Trust's Black Asian and Minority Ethnic staff network and the hospital charity teamed up to create a month-long celebration which kick started with African drummers performing outside the Grosvenor and Atkinson Morley wing entrances of St George's Hospital.

The Chairman and I wrote to everyone working at the hospital reaffirming our commitment to create an inclusive culture at St George's where all staff can thrive and deliver outstanding care every time.

Like many organisations, St George's was forced to take a long hard look at itself following the death of George Floyd last year. This much needed review was guided by many of our staff sharing their realities of what it feels like to work at St George's, particularly when from a minority or marginalised group. Their feedback helped changed the way we work.

Awards

In the last month, I was delighted to hear about a number of our staff who have been recognised for their outstanding work with award nominations.

Sheron King, Clinical Nurse Specialist for children with neurodisability, has won a Royal College of Nursing Rising Star Award.As part of Black History Month celebrations, RCN London held a Rising Star awards ceremony which recognises nurses and healthcare support workers from London's Black, Asian, and Minority Ethnic (BAME) nursing community who have made an outstanding contribution to the capital's health and care system. Sheron is a highly experienced paediatric nurse who has been working at St George's since 1997, providing care and support to children with complex medical conditions. Congratulations Sheron.

At the Nursing Times awards, our teams were nominated for four awards across a range of categories, from infection prevention and control to cancer nursing. Unfortunately, they missed out on the top prizes on the night, but nevertheless it is wonderful that our teams are being nominated for their innovative way of delivering care to our patients.

Padraic Costello, Clinical Nurse Specialist, was also nominated at the recent National Learning Disability and Autism Awards, which celebrate excellence in support for people with learning disabilities. Padraic and his team work across the Trust to make adjustments for adult patients with learning disabilities, and we are extremely proud of the fact he was nominated for this national award.

Finally, a team in our Emergency Department were shortlisted for an HSJ Award for their involvement in a project aiming to reduce waiting times for emergency patients needing a Covid PCR test. This project has reduced waiting times for test results from approximately 90 minutes down to 12 minutes and means patients can get the right care, in the right place, much more quickly.

Well done to all our staff who have been recognised with these prestigious award nominations.

Dr Roger Adlard

And finally, it was with great sadness that we announced the loss of our friend and colleague Roger Adlard who passed away suddenly on 5 October. Roger was a consultant plastic surgeon and joined St George's in 2015 having been a trainee here previously. His death came as a huge shock to his team and the wider St George's family – he was universally loved and will be sorely missed. We offered support to his colleagues and I'm sure I speak on behalf of the Board when I say our thoughts remain with his wife Julie and his family at this difficult time.

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Meeting Title:	**Trust Board**		
Date:	25 November 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, Chair of the Quality and Safety Committee		
Presented for:	Assurance		
Executive Summary:	The report sets out the key issues covered by the Committee at its meetings in October and November 2021.		
Recommendation:	The Board is asked to note the updates from the October and November 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		

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Quality and Safety Committee Report

Matters for the Board's attention

The Quality and Safety Committee met on 21 October 2021 and 18 November 2021 and considered the following matters of business at these meetings:

October 2021	November 2021
• Surgical Safety – Never Events Gap Analysis • Board Assurance Framework Q2 Report • Strategic Risk 10 Deep Dive • Integrated Quality & Performance Report (M6) • Serious Incident Monthly Report • Update on Covid-19 outbreak on Amyand Ward and IPC measures • National Patient Surveys - Urgent and Emergency Care Survey • Patient Safety & Quality Group Monthly Report • Gender Identity Service • Duty of Candour Annual Report* • Mental Capacity Act Report/Deprivation of Liberty Annual Report* • Human Tissue Authority Report (Designated Individual) (NHS Returns)	• Integrated Quality & Performance Report (M7) • Winter Plan • Serious Incidents Monthly Report • Mortality Monitoring Committee and Learning from Patient Deaths Q2* • Quality Improvement and Transformation Programme Update • Nurse Staffing Report • Breast Services Recovery • Mortuary/Body Store Assurance • Clinical Governance Reviews - Phase 1/2/3 • Clinical Audit Annual Plan • Patient Safety & Quality Group Monthly Report • Quality Strategy Implementation Updates (Quarterly) • Board Assurance Framework -SR 2 Deep Dive • CQC Statement of Purpose

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

The report covers the key issues that the Committee would like to bring to the attention of the Board.

1. Never Events Gap Analysis

The Committee received a deep dive report on never events gap analysis. The review covered never events from 2010 onwards but particularly focussed on never events in the period 1 April 2018 to 31 March 2021, during which time, 13 were reported. Two of these were classified as 'moderate harm'.

There was some indication that learning had been adopted in relation to 'retaining foreign objects post procedure' where these cases had reduced compared to the previous three year period.

2. Strategic Risk 10

A report on the deep dive undertaken in relation to strategic risk 10 (SR10 – research) was presented to the Committee. The establishment of the Translational and Clinical Research

Institute and the clinical academic groups in conjunction with St George's University of London had a positive impact on the risk. However, SR10 was also impacted by a risk to income due to a change in the basis of Clinical Research Network funding.

3. Integrated Quality and Performance Report (IQPR)

The Committee considered the key areas of quality and safety performance in months 6 and 7 (2021/22) and would like to highlight the following issues, conscious that the Board will discuss the month 7 performance data later on the agenda:

- Areas of good or improving performance:
  - Basic life support training is above the target of 85% and improvements continue to be seen for intermediate and advanced life support training. Advanced life support (ALS) training is on plan to achieve the target by the end of December and stands at 81% as of the date of the meeting.
  - Duty of candour compliance is at 100%
- Areas of challenge:
  - There was a case of MRSA bacteraemia reported in September 2021.
  - Staffing challenges have remained a concern in maternity services with the birth centre being closed over 50% of the time.
  - Achieving the target for immediate life support (ILS) is at risk, due to operational pressures.
  - Attendance at the emergency department is still high but higher acuity is being seen impacting on length of stay and therefore flow.

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

4. Winter Plan

The Committee heard an update on the winter plan, with a potential shortfall of 80 general and acute beds across the Trust. A dedicated discharge team has been established and the creation of a 'virtual frailty ward' (which will be known as Hospital at Home) is planned to provide support to patients at home who would otherwise be admitted or have longer lengths of stay whilst care packages are put in place.

5. Serious Incident Reporting

The Committee considered and noted the serious incident reports which covered September and October 2021. During these periods:

- 10 serious incidents were declared (7 in September, 3 in October);
- 7 serious incident investigations were concluded (3 in August, 4 in September).

The Committee focussed on a patient with interstitial ling disease who had not been reviewed face-to-face between February 2020 and July 2021 during which their condition deteriorated, limiting treatment options. The Committee also heard an update on the Covid outbreak that had occurred on Amyand Ward in August 2021.

An information governance incident was reported which related to the theft of a briefcase. Courier arrangements are being established prior to an IT solution being implemented to reduce this risk.

The Committee heard of a sad case of a patient dying whilst waiting for cardiac surgery. Changes have been made to increase the availability of sessions and there are also more regular reviews of waiting lists to manage risk.

A 4 year old child underwent the insertion of a Portacath and suffered damage to a major artery and had a cardiac arrest. The patient was resuscitated but it is possible that there may have been neurological damage. Changes have been made to increase oversight and supervision.

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

6. National Patient Surveys – Urgent and Emergency Care

The Committee received feedback on a patient survey that showed the Trust performed significantly better in the 2020 survey that the one two years earlier. This involved seeking views from over 1,200 patients (of which 25% responded) and showed the Trust was rated 14th out of 126 trusts.

7. Gender Identity Service

A proposal to introduce a new service at the Trust was presented. This service will see male to female surgery carried out and the Trust being developed as a centre of excellence for training staff from other trusts across England. Queen Mary Hospital will provide the base for the service and will involve two experienced consultants and specialist nurses.

8. Duty of Candour Annual Report

The Committee heard that duty of candour compliance had reduced in 2020/21 from the previous year but that during the early part of 2021, compliance has improved significantly.

9. Mental Capacity Act/Deprivation of Liberty Annual Report

The annual report on the application of the Mental Capacity Act and deprivation of liberty was presented to the Committee and it was noted that take up of training had declined during the pandemic. The team is now fully staffed, although previous staff shortages meant that the team operated at 50% capacity for about half the year.

10. Human Tissue Authority Report

The Committee heard that the Trust is compliant with Human Application, Organ Donation & Transplantation and Post-Mortem licenses. Transplant activity reduced during the pandemic and although there had been 13 incidents reported. Not met the threshold to be declared as serious incidents.

11. Mortality Monitoring Committee (MMG) and Learning from Patient Deaths Q2

The work of the MMG and the Learning from Deaths in Q2 2021/22 report was reviewed by the Committee. All mortality and morbidity meetings across the Trust are now supported by a member of the team and we are now formulating templates and guidance to support flexible standardisation which will promote improved learning.

Initial work to expand the Medical Examiner service through a collaborative approach with colleagues in primary care was discussed. This is in line with national recommendations to build an effective service through an iterative approach.

12. Quality Improvement and Transformation Programme Update

The Committee received an update on the activities of the Quality Improvement Academy and the Transformation teams which has largely been dedicated to supporting the recovery of elective services and other issues arising from the Covid-19 pandemic.

The expectation of leaders in driving quality improvement was flagged and needs to run alongside organisational and management development.

The current and anticipated pressures on the Trust are also driving the work of the team and changes are planned to relocate some staff members closer to the services they support.

13. Nursing Staffing Report

The nursing staffing report was received and it was noted no patient safety alerts occurred during 'red flag' events (when staffing was not at the level needed for the acuity of patients).

There are 40 overseas nurses due to start between now and February 2021 and it was reported that there is a full package of support to help those nurses settle, for example, putting them in touch with nurses from their own country, being shown around the area etc. The move towards more flexible working is also being explored, in order to persuade agency nurses to return to working through the Trust's bank.

14. Breast Services

Both breast screening and symptomatic services suffered challenges during the pandemic, leading to a backlog of cases. There have also been some staff shortages due to some staff relocating back to their home countries. Performance for symptomatic services has deteriorated with the '2 week wait' target being missed with patients being seen on average after 17 days. Innovative routes to improve capacity are being explored but workforce is a challenge and difficult to solve in the short term. Risk reviews are taking place on patients diagnosed with cancer that breach the 2-week wait target.

A 'consultant of the day' model has been introduced and this supports a managed diagnostic pathway to avoid multiple visits by patients.

Some scheduling and planning improvements have been made which have led to more patients being managed through the pathway. At present it is anticipated that performance will not recover until at least March 2022.

15. Mortuary

The Committee received an update following the letter sent by NHS England and NHS Improvement on 3 November 2021 asking for assurance on security and access to mortuaries and body stores. Some improvements have been identified as being needed and these are being implemented rapidly.

16. Clinical Audit Programme 2021/22 Update

An update on the clinical audit programme was received, which had also been reported to the Audit Committee. The governance of the programme has been reviewed and has been supported by some useful recommendations arising from an internal audit review, which are being implemented.

17. Quality Strategy Implementation Update

Positive news relating to the implementation of the quality strategy was reported. In particular, treatment escalation plans have been reviewed to provide greater transparency for clinical teams.

The ambition of the strategy was questioned and it was confirmed that challenging targets have been set and demonstrates that good progress has been made.

18. CQC Statement of Purpose

The Committee approved the Trust's Statement of Purpose as part of its registration with the Care Quality Commission. This sets out the services and locations the Trust provides.

19. Recommendation

The Board is asked to note the updates from the October and November 2021 meetings.

Dame Parveen Kumar
Committee Chair
November 2021

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Meeting Title:	**Trust Board**		
Date:	25 November 2021	**Agenda No**	2.1.1
Report Title:	Learning from Deaths and Mortality Monitoring Group (MMG) Report – Quarter 2 2021/22 (July – September 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:	Assure		
Executive Summary:	The paper provides an overview of the work of the MMG and Learning from Deaths in Q2 2021/22. An outline of progress against the Quality and Safety Strategy priority related to the implementation of Mortality & Morbidity Coordinators Team is included. All M&M meetings across the Trust are now supported by a member of the team and we are now formulating templates and guidance to support flexible standardisation which will promote improved learning. Initial work to expand the Medical Examiner service to scrutinise non-coronial non-acute deaths is detailed. Our collaborative approach with colleagues in primary care to develop processes during the non-statutory phase is explained. This is in-line with national recommendations to build an effective service through an iterative approach. 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 specific learning and actions derived from mortality review. Organisational improvement requirements in the perinatal mortality review process are also noted. Established local mortality review processes and associated outcomes are reported, alongside developments nationally in the Learning from Deaths agenda. The extension of the Learning Disability Mortality Review Programme to include autistic people is noted, alongside our initial plans for participation which will ensure that we are able to report cases as soon as the national system allows. To demonstrate processes in relation to monitoring and investigating mortality outlier alerts, a brief update on the current status of the improvement work related to major trauma is presented. A new investigation of clinical coding in relation to cardiology is also introduced. National mortality measures are also reported. Both our SHMI and HSMR remain lower than expected.		
Recommendation:	• To note and support progress against Quality and Safety Strategy through implementation of the M&M team. • To note the expansion of the ME service to begin scrutinising non-acute deaths, in line with the NHS Patient Safety Strategy. • To note that the Trust is fully compliant with all CNST requirements in this quarter and continues to use this work to drive improvement. • To note and support plans to participate in the extension of the Learning Disability Mortality Review Programme (LeDeR) to include autistic people.		

	• To consider the assurance provided that current outlier alerts are being investigated robustly and that there is a granular understanding of our mortality data.		
Committee Assurance:	The Committee is also asked that in considering contents of this report, its supporting documents and the discussion at the meeting which of the following assurance rating it would provide to the Trust Board. • **Substantial Assurance:** The report and discussions assured the Committee that there are robust systems of internal controls operating effectively to ensure that quality and safety risks are managed to deliver high quality services and care to patients. • **Reasonable Assurance:** The report and discussions assured the Committee that the system of internal controls is generally adequate and operating effectively but some improvements are required to ensure that quality and safety risks are managed to deliver high quality services and care to patients. • **Limited Assurance:** The report and discussions supported the Committee's conclusion that that the system of internal controls is generally inadequate or not operating effectively and significant improvements were required to ensure that the quality and safety risks are managed effectively to improve the position and ensure that high quality services and care is provided to patients. • **No Assurance:** The report and discussions led the Committee to conclude that there was a fundamental breakdown or absence of core internal controls and systems to enable the Trust to deliver high quality services and care to its patients.		
Supports			
Trust Strategic Objective:	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 progressing but is not fully mature. Finalising 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**	18 Nov 21
Equality Impact Assessment:	N/A This is in line with the principles of the Accessible Information Standard		

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1.0 **PURPOSE**

The purpose of this paper is to provide the Board with an update on the work of the Mortality Monitoring Group (MMG) and progress against the Learning from Deaths agenda. The paper also summarises the activity of the Medical Examiner office and details the expansion of the service to non-coronial deaths in the non-acute sector.

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 Mortality & Morbidity Team**

The new Mortality & Morbidity (M&M) team, introduced in Q1 of this year, are in place to support the introduction of consistent processes which are focussed on learning. This underpins the Trust's strategic priority to improve patient safety by minimising avoidable harm and 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. Strengthening mortality governance processes will support improvements in patient safety through learning from deaths, which is one of the quality priorities described in the Quality Account 2021-22.

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 & essential elements of meetings • Implement standardised agenda & supporting documentation (pilot) • Highlight and share the learning	 Met In progress In progress Ongoing
	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 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	

This quarter the Team Leader completed the mapping of all M&M meetings across the Trust. A summary of the current position is provided in Appendix 1. Each clinical team now has an allocated coordinator who is facilitating the meetings and supporting mortality governance. Cover arrangements within the team have also been defined to ensure that effective support can be maintained in all circumstances. The coordinators are beginning to support the sharing of learning through enabling liaison between teams where M&M discussion identifies consideration of the case is required within another service.

Engagement with Clinical Governance Leads continues through the forum chaired by the Deputy Chief Medical Officer for Innovation. In September the Learning from Deaths Lead and Head of Mortality Services attended the forum to discuss the design of a core data set and supporting templates. Following the meeting, the Learning from Deaths Lead is drafting a template and best practice guidelines which will be presented for comment to the forum in November. Once the content and format are agreed this will be piloted in several M&Ms and refined following evaluation.

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. These data are presented to the Regional ME team prior to submission to the National ME.

Below is a summary of the key data submitted by St George's ME office. During this quarter the ME service scrutinised all in-hospital deaths. There were two medical certificates of cause of death were rejected by the registrar and the ME spoke to all but 36 families. Timeliness of processes related to death continues to be good, with only 28 certificates not completed within three calendar days of death.

A key function of the ME service is to support the appropriate referral of deaths to the coroner. This quarter 88 deaths were referred. In half of these cases the coroner felt no further investigation was required and gave the doctor permission to issue the medical certificate of cause of death. This is associated with the coroner issuing a Form 100A, which denotes to the registrar that the coroner is aware of the death and that the death can be registered without any further investigation. In the remaining 50 percent of deaths referred this quarter, the coroner felt that further investigation, such as a post-mortem or inquest was required.

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 Patient Safety Team or to the clinical team involved with the patient's care. These cases are included in section 3 of this report.

DEATHS OCCURING AT THE ME OFFICE SITE THAT HAVE BEEN SCRUTINISED BY THE ME	
Number of in-hospital deaths scrutinised	**358**
Number of adult cases not notified to the Coroner	261
Number of adult cases notified to the Coroner and a form 100A issued	44
Number of adult cases taken by the Coroner for investigation	44
Number of child deaths not notified to the Coroner	8
Number of child deaths notified to the Coroner and a form 100A issued	0
Number of child deaths taken by the Coroner for investigation	1
TIMELINESS AND REGISTRATION REJECTIONS	
Number of MCCDs not completed within 3 calendar days	28

(NB: no account of BH or weekend and requirement is 5 days)		
Number of MCCDs rejected by registrar after ME scrutiny		2
Number of cases where urgent release of body is requested and achieved within requested time		23
Number of cases where urgent release of body is requested and NOT achieved within requested time		0
ACHIEVING COMMUNICATION WITH BEREAVED		
Number of deaths in which communication did not take place		**36**
Reasons for no communication:	Declined	4
	No response	18
	No NOK	8
	Not documented	6
DETECTION OF ISSUES AND ACTIONS		
ME referred for structured judgement review		23
ME referred to other clinical governance processes		2
ME referred to external organisation		1
Families referred to PALS		10

In August the Lead ME and Head of Mortality Services met with senior colleagues from primary care services in Wandsworth and Merton. The St George's ME office will be expected to expand scrutiny to include non-acute non-coronial deaths that occur in these boroughs. This represents a significant change and the number of deaths considered by the office will more than double.

It is not possible to predict with accuracy when the statutory ME system will be implemented; however, the intention to put MEs on a statutory footing is confirmed in the government's white paper *Integration and innovation: working together to improve health and social care for all*. We now have opportunity to prepare in advance for the statutory system, which we anticipate will be in place in Summer 2022.

We are working with leaders from GP services within both boroughs to codesign and pilot the expansion of the service. We are keen to adopt a constructive and developmental approach, respectful of the professional status of colleagues who provided care to deceased patients in their final illness. As nationally recommended, we will follow an incremental approach which allows capacity and skills to grow over a realistic period. Importantly, this allows us to learn and refine the system together.

The National ME has established the legal basis for providers to share records and with the support the Information Governance Team the ME service has completed a data sharing assurance statement that can be shared with colleagues in the non-acute sector. Work is underway to further define data sharing requirements and processes and a number of practices have volunteered to work with us to pilot this. Collaboration will continue in quarter 3.

The introduction of Medical Examiner Officers (MEO) will be essential for the successful expansion of the service. MEOs provide support to MEs in their role in scrutinising the circumstances and causes of death. They are a point of contact and source of expert advice for the bereaved, healthcare

professionals and coroner and registration services. We have received funding that will allow us to recruit a team of three MEOs. Recruitment is currently underway, and we anticipate the team will be in post early in 2022.

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 from 11/01/2021 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 89%
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 21/12/2020-20/03/2021 and the actions and learning arising from them. In this quarter four of the seven completed reviews were

graded as having no issues or issues which would not have made a difference to the outcome. The three cases where issues were identified are summarised below.

There was one stillbirth case in which issues were identified that the review group considered may have made a difference to the outcome for the baby. The case was declared and investigated as a serious incident (ref STEIS 2021/5322). The findings, including the root cause and conclusion, and actions were reported in the Serious Incidents report to QSC in August 2021. The investigation found that the mother met the criteria for screening for gestational diabetes, but this was not offered. Additionally, when she developed an indication for a glucose tolerance test this was not offered. The investigation report recommended a standard operating procedure be introduced for all urinalysis samples taken at antenatal appointments. It also recommended an audit of the diabetes referral process, and for all referrals to be completed electronically. Each of these actions have been completed.

There was also a case where the panel felt care following delivery at a referring Trust had impacted on the outcome of the baby. The baby was allowed to get cold prior to transfer to St George's Hospital. The neonatal risk lead consultant has provided feed back to the transferring Trust of the importance of using the correct equipment to maintain optimum temperature during transfers and to inform their internal risk management process. As the issues of care occurred at another Trust it was not necessary to report an incident at St George's. (PMRT ref 71285).

In the final case the panel noted that the test results to confirm Down's Syndrome in a baby following birth, took longer than is usual. In this instance the laboratory did not process the sample immediately as they noted that antenatal genetic testing had been done. The review group felt that although it would have been preferable to have the results more quickly, it would not have changed the outcome.

There were several care themes noted which did not directly impact outcome. This included lack of face-to-face booking appointments due the COVID-19 pandemic and instances of late booking due to the mother being non-resident in this country and hospital commitments with other children. It was found that for one mother who had little/no English there was a failure to use translation services to interpret during the first 24 hours that her baby was on the neonatal unit. Staff have been reminded of the importance of using translation services and this has been incorporated in training curriculum. Lack of documentation around bereavement care and poor communication were also identified as themes, which are being addressed through actions previously reported such as investment in the bereavement team, revision of the pathway to meet national standards and streamline documentation processes for clinicians. Revision of bereavement literature for parents, alongside the training and education of staff to improve support have also been implemented to strengthen this aspect of care.

The report also highlights an organisational issue which has previously been reported and is ongoing. Increasing the number of PMRT panels that include an external member continues to be 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, but it has proved very difficult to get external panel members due to staffing and acuity levels in the region and issues relating to the COVID-19 pandemic.

3.0 MONTHLY INDEPENDENT REVIEW OF MORTALITY

3.1 During this quarter, independent reviews, using the structured judgement review (SJR), have been completed for 26 deaths, of which 23 were referred to the Learning from Deaths Lead by the Medical Examiner Office. These deaths comprise patients with confirmed learning disabilities (n=4), severe

mental health diagnosis (n=8), those in which the ME has detected a potential issue with care or identified possible learning (n=5), deaths following elective admission (n=5), areas subject to enhanced oversight (1), family concerns (1), and governance concerns flagged by clinical teams (2).

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 Patient Safety Team and therefore the judgements reached at the initial review, and documented here, may not constitute final conclusions about treatment and care.

SJRs may be used as one element of a full portfolio of information considered in the evaluation of patient safety incidents at the weekly Serious Incident Declaration Meeting (SIDM). During Q1 and Q2 there have been a total of 12 serious incidents (SIs) where the patients involved had died at the point of SI declaration, with five and seven SIs respectively.

These cases are reported to Quality and Safety Committee (QSC) monthly, both at the point of declaration and again once the investigation is complete. Through this mechanism QSC are informed of immediate risk mitigation actions and the findings of completed investigations, including the root cause, conclusion, and improvement actions.

Collaborative working between the Learning from Deaths team and the Patient Safety Team to identify any issues of concern and share learning is well established. Work is underway to make this more robust, including highlighting mortality within the annual SI thematic analysis and codesign of a new integrated claims, litigation, incident and patient experience report. The Learning from Deaths team will also begin reviewing all completed SI investigations where a patient has died to ensure that they are aware of the outcome of the investigation of deaths they have reviewed and of learning that has been generated. It will also allow the team to be vigilant to any emerging themes.

3.2 **Overview of July 2021 to September 2021**

Between July and September 2021 there were 358 deaths. Members of the Mortality Review Team (MRT) reviewed 26 deaths, representing 7.3% 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 26 deaths reviewed this quarter problems were identified in relation to 7 (26.9%) of the patients reviewed, with each experiencing one problem.

Problem in healthcare	No harm	Possible harm	Harm	TOTAL
Assessment	1	1	0	2
Medication	0	0	0	0
Treatment	0	0	1	1
Infection control	0	1	0	1
Procedure	0	1	0	1
Monitoring	0	0	0	0
Resuscitation	1	0	0	1
Communication	1	0	0	1
Other	0	0	0	0
TOTAL	3	3	1	7

In one instance it was thought that a treatment-related problem led to harm, whereby a patient received anticoagulants as part of treatment for Covid-19 and subsequently died following a large bleed. Although this death was not felt to be avoidable, it was referred by the Learning from Deaths team for a specialist opinion. It was found that the patient was managed according to hospital protocol and unfortunately died from a complication of their treatment. An incident (DW158607) had been reported for this case, which was reviewed by the service and specialist opinion sought from Clinical Haematology and Pharmacy. Following this review the incident was classified as low harm.

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

- 24 of 26 (92.3%) deaths reviewed were assessed as definitely not avoidable
- 1 of 26 (3.8%) deaths reviewed were assessed as slight evidence of avoidability
- 1 of 26 (3.8%) deaths reviewed were assessed as possibly avoidable

No deaths were judged to be probably or definitely avoidable.

Avoidability of death judgement	Number	Percentage
Definitely not avoidable	24	92.3
Slight evidence of avoidability	1	3.8
Possibly avoidable but not very likely (less than 50:50)	1	3.8
Probably avoidable (more than 50:50)	0	
Strong evidence of avoidability	0	
Definitely avoidable	0	
Total	**26**	

An assessment of overall care is also provided for each death reviewed: In 22 deaths (84.6%) the care provided was observed as being good; for 2 patients (7.7%) care was felt to have been adequate. In 2 death (7.7%), the care provided was observed as being poor.

Overall care judgement	Number	Percentage
Excellent care	0	0
Good care	22	84.6%
Adequate care	2	7.7%
Poor care	2	7.7%
Very poor care	0	0
Total	**26**	

In the death that was felt to be possibly avoidable a problem related to assessment was noted, which may have led to harm. In this case care was judged to be poor. Although the cause of death was uncertain the reviewer questioned whether hypoglycaemia, which appeared treatable, could have contributed. A referral was made to the coroner and the Patient Safety team are liaising with the ward team regarding a review of the death and any subsequent learning.

In the second case where poor care was observed, the death was judged to have been definitely not avoidable. In terms of clinical care this patient received the appropriate level of care for her diagnosis. However, there were areas for improvement, including communication with family. Potential issues of concern were identified by the clinical team in relation to a large patient transfer which had occurred earlier in the day and regarding resuscitation decisions. This death has been declared as a serious incident and is currently being investigated (ref DW157503 2021/18324).

3.3 **Learning disabilities**

All deaths that occur in patients with learning disabilities (aged 4 and over) 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 SJR 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 55 deaths, with reviews completed for each. This quarter there have been four deaths in patients with a learning disability. Overall care was judged to be good for all the patients and none of the deaths were felt to be avoidable.

LD DEATHS Avoidability of death judgement score	**2018/19**	**2019/20**	**2020/21**				**2021/22**	
			Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**
TOTAL DEATHS	**9**	**16**	**4**	**4**	**7**	**7**	**4**	**4**
REVIEWS COMPLETED	**9**	**16**	**4**	**4**	**7**	**7**	**4**	**4**
Definitely not avoidable	9	16	4	4	7	7	2	4
Slight evidence of avoidability	0	0	0	0	0	0	2	0
Possibly avoidable (< 50:50)	0	0	0	0	0	0	0	0
Probably avoidable (> 50:50)	0	0	0	0	0	0	0	0
Strong evidence of avoidability	0	0	0	0	0	0	0	0
Definitely avoidable	0	0	0	0	0	0	0	0

It should be noted that there has been a retrospective correction to the information in this table, relating to a death that occurred in Q3 2020/21. Previously one death was reported for that period as having slight evidence of avoidability; however, additional clinical input and subsequent review resolved any concerns, and the death was found to be definitely not avoidable.

At the end of March 2021, the NHS published the first policy related to the LeDeR programme, *Learning from lives and deaths – People with a learning disability and autistic people (LeDeR) policy 2021*. This policy sets out the core aims and values of the LeDeR programme and explains the expectations of development of the service from June 2021. Central to this evolution of the programme is the inclusion of deaths of autistic people. Further advice is expected in the coming months, but it is understood that every adult with a diagnosis of autism will be eligible for LeDeR review.

Although notification of the deaths of people with a learning disability or autistic people to the LeDeR programme is not mandated, there is a strong expectation supported by the CQC that providers will do so. Since the programme was first introduced the Trust has been committed to full participation and has plans in place to ensure that we notify all deaths of autistic people as soon as the system is live. A standard operating procedure (SOP) will be defined; however, it is anticipated that participation will be facilitated through the Mortality Services team. MEOs will identify appropriate deaths and will refer to the Learning from Deaths team to make the notification. The SOP will be submitted to the Mortality Monitoring Group for ratification in November 2021. At the present time the national system does not allow reporting for autistic people; however, we are monitoring this and will begin to report deaths as soon as required.

4.0 LEARNING FROM MORTALITY

The following summaries provide an overview of mortality investigations that are currently underway. The alert related to trauma has been reported extensively in previous versions of this report.

4.1 Trauma Audit & Research Network (TARN)

In 2020 the Trust was informed by the Trauma Audit & Research Network (TARN) that it appeared to be an outlier for case-mix adjusted mortality outcomes for the period July 2017 to June 2019, 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 following 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.

The investigation to date has considered both data quality and completeness and clinical care. Both strands of work have been reported in full in previous versions of this report and concluded that improvements are required.

To identify potential improvements to the clinical pathway a multidisciplinary team recently visited Royal London Hospital's major trauma centre to observe their practice and learn from their experiences of developing and strengthening their trauma service. The visit was very informative and the generosity of the host site in sharing their improvement journey provided a range of ideas and possibilities for positive change. The Lead for Major Trauma is preparing a report for MMG which will summarise the learning gathered and proposals for improvement. It is anticipated that this will be considered by MMG before year end and progress will continue to be reported in this paper.

4.2 Acute Myocardial Infarction

The August publication of the Summary Hospital-level mortality indicator (SHMI), covering the period April 2020 – March 2021, showed that mortality was higher than expected in the Acute Myocardial Infarction (AMI) diagnosis group.

The Mortality Monitoring Group noted that the cardiology care group recently completed a comprehensive clinical review and are currently implementing several improvement actions, as previously reported in this paper (Q4 2020/21). It was therefore decided that this alert should first be investigated through a review of clinical coding. This work is currently underway and is drawing on the expertise of the clinical team, the clinical coding team and the Strategic Business Intelligence Team. The progress of this work will be monitored through MMG with an update scheduled for December 2021. The outcome of this investigation will be reported in this paper subsequently.

It should be noted that in the two subsequent SHMI publications mortality for this diagnosis group is no longer higher than expected; however, the investigation will be completed to better under the alert and ascertain whether improvement actions are required.

5.0 LATEST NATIONAL PUBLISHED RISK-ADJUSTED MORTALITY

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

The latest SHMI data, covering discharges from June 2020 to May 2021, was published on 14th October 2021. The Trust's overall mortality is categorised as 'lower than expected' at 0.85. We were one of 14 Trusts in the category, and one of 11 trusts in the same category for the same period last year.

During the 12-month period there were 66,360 inpatient spells at the Trust, with 1,440 deaths observed, compared to 1,700 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. 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	1.07	As expected
Acute myocardial infarction	1.24	As expected
Cancer of bronchus; lung	0.47	Lower than expected
Fluid and electrolyte disorders	0.63	Lower than expected
Fracture of neck of femur (hip)	1.10	As expected
Gastrointestinal haemorrhage	0.93	As expected
Pneumonia (excluding TB/STD)	0.77	Lower than expected
Secondary malignancies	0.86	As expected
Septicaemia (except in labour), shock	0.98	As expected
Urinary tract infections	0.79	As expected

5.2 **Hospital Standardised Mortality Ratio (HSMR)** [source: Dr Foster]
For the most recent 12 months of data reported by Dr Foster (July 2020 to June 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: July 2020 – June 2021	Value	Banding
HSMR (all admission methods)	86.0	Lower than expected
HSMR: Weekday emergency admissions	80.6	Lower than expected
HSMR: Weekend emergency admissions	108.0	As expected

Unfortunately, over the last few months there has been severe disruption to the service provided by Telstra, the organisation that provides Dr Foster data and consequently the Mortality Monitoring Group has not been able to evaluate risk-adjusted mortality at diagnosis and procedure group level. The service has very recently been restored and we therefore anticipate that in the next quarter the consideration of a mortality at a granular level will be possible. The Trust is exploring the use of an additional platform (Healthcare Evaluation Data) to monitor mortality 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 most recent SHMI diagnosis level data available through NHS Digital do not suggest any areas of concern.

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Appendix 1

Division: Children and Women, Diagnostics, Therapeutics and Critical Care			
Care Group	**Status**	**Frequency of Meetings**	**Additional Information**
Gynaecology	Fully Established	Monthly	
Acute Paediatrics	Fully Established	Bi-Monthly (2 months)	Quarterly joint meetings with Paeds ED and PICU + Joint meeting with Neonatal Unit 2 times a year
Specialist Paediatrics	Integrated within Acute Paediatrics	Integrated with Acute Paediatrics	Ad-hoc meeting due to low volume of cases. Cases are usually discussed through the Acute Paediatrics M&M
Paediatric Surgery	Fully Established	Quarterly	
PICU	Partially Established	Monthly	Recent change over in clinical governance lead. M&M team yet to attend a meeting – First meeting to be attended 15/11/2021.
Paediatric Surgery	Fully Established	Quarterly	The Clinical Governance lead for paediatric surgery also supports an additional M&M meeting for 'Paediatric Anaesthesia' which takes place 2 times a year.
Diagnostic Radiology	Fully Established	6 times a year	
Interventional Radiology	Fully Established	Monthly	
Cardiac ICU	Fully Established	Weekly	
General ICU	Fully Established	Weekly	
Neuro ICU	Fully Established	Weekly	
CWDTCC Notes: The following care groups do not have meetings due to no/minimal mortality & morbidity activity – Breast Screening and Clinical Genetics. The Team Leader has met with all Clinical Governance Leads for these care groups and informed them of the M&M team service should a need for administrative support with M&M meetings arise in the future. The Obstetric and Neonatal care groups have multiple meetings throughout the month. The M&M team are currently working with the governance leads for each care group to clearly define which meetings the M&M team can provide administrative support to.			

Division: Medicine and Cardiovascular Services			
Care Group	**Status**	**Frequency of Meetings**	**Additional Information**
Emergency Medicine	Fully Established	Monthly	
Acute Medicine	Fully Established	Monthly	
Senior Health	Fully Established	Bi-Monthly (2 Months)	The senior health team have imminent plans to change to monthly meetings.
Cardiology	Fully Established	Monthly	Meetings alternate between Morbidity and Mortality cases

			each month to accommodate the volume of cases and facilitate adequate discussion time.
Cardiac Surgery	Fully Established	Monthly	
Thoracic Surgery	Fully Established	Monthly	
Vascular Surgery	Fully Established	Monthly	
Haematology	Fully Established	Bi-Monthly (2 Months)	
Oncology & Palliative	Fully Established	Monthly (2 times a month)	
Renal	Fully Established	Monthly	Renal Transplantation (quarterly) & Vascular Access (4 times a year) are additional M&M Meetings under the Renal care group.
Chest Medicine	Fully Established	Bi-Monthly (2 Months)	
Clinical Infection Unit	Fully Established	Monthly	
Dermatology & Lymphoedema			
Diabetes & Endocrinology	Fully Established	Monthly	
Gastroenterology & Endoscopy	Fully Established	Monthly	
Rheumatology	Fully Established	Ad-Hoc	Low/ Minimal M&M activity. There has been one meeting in 2021 on 29/09/2021.
Medicine & Cardiovascular Services Notes: The following care groups do not have meetings due to no/minimal mortality & morbidity activity – Dermatology & Lymphoedema. The Team Leader has met with all Clinical Governance Leads for these care groups and informed them of the M&M team service should a need for administrative support with M&M meetings arise in the future.			

Division: Surgery, Theatres, Neurosciences & Cancer			
Care Group	**Status**	**Frequency of Meetings**	**Additional Information**
Neurology	Fully Established	Quarterly	
Interventional Neuroradiology	Fully Established	Monthly	
Neurosurgery	Fully Established	Bi-Monthly (2 Months)	
Stroke	Fully Established	Monthly	
Trauma & Orthopaedics	Fully Established	Bi-Monthly (2 Months)	
ENT & Audiology	Fully Established	Quarterly	
General Surgery	Fully Established	Monthly	
Maxillofacial	Fully Established	Monthly	
Plastic Surgery	Partially Established	Ad-Hoc	Low/ Minimal M&M activity. First meeting in 2021 scheduled for 26/11/2021.

Urology	Fully Established	Monthly (2 times a month)	
Cancer	Integrated within other care groups	-	
STNC Notes: The following care groups do not have meetings due to no/minimal mortality & morbidity activity – Anaesthetics, Neurorehab, Pain Clinic, Dentistry, and SWL Pathology. The Team Leader has met with all Clinical Governance Leads for these care groups and informed them of the M&M team service should a need for administrative support with M&M meetings arise in the future.			

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Appendix 2: National Quality Board Dashboard – data to 30th September 2021

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

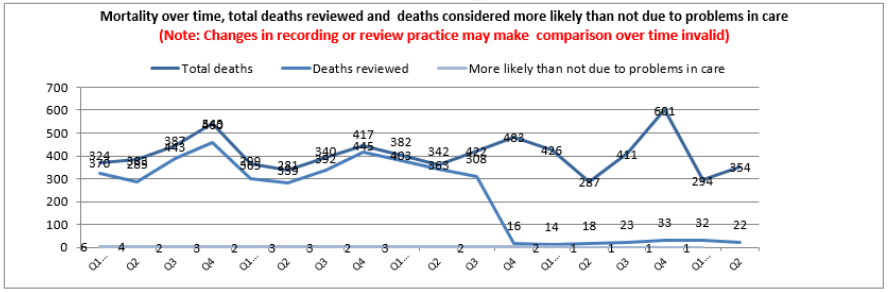
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

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
132	121	5	10	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
354	294	22	32	0	1
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
648	1725	54	88	1	5

Time Series: Start date 2017-18 Q1 — End date 2021-22 Q2



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	0	0.0%	This Month	5	100.0%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	1	4.5%	This Quarter (QTD)	1	4.5%	This Quarter (QTD	20	90.9%
This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	1	1.9%	This Year (YTD)	3	5.6%	This Year (YTD)	5	9.3%	This Year (YTD)	45	83.3%

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

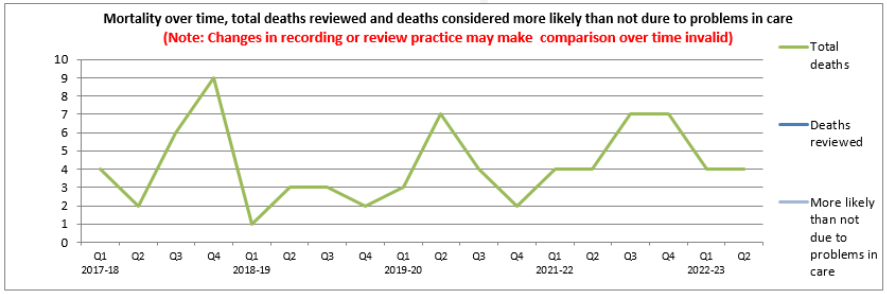
Summary of total number of learning disability deaths and total number reviewed under the LeDeR methodology. Please note that all LD deaths are reviewed using our standard approach, pending reviews as directed by the LeDeR process. The outcome of these local reviews is displayed in the second data grouping 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
2	1			0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
4	4			0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
8	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	4	4	4	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
8	22	8	22	0	0

Time Series:	Start date	2017-18	Q1	End date	2021-22	Q2



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Meeting Title:	**Trust Board**		
Date:	25 November 2021	**Agenda No**	2.1.2
Report Title:	Mental Capacity Act and Deprivation of Liberty – Annual Report (2020-21)		
Lead Director/ Manager:	Robert Bleasdale – Chief Nurse and Director of Infection Prevention and Control		
Report Author:	James Godber, MCA and DoLS Lead Practitioner		
Presented for:	Assurance		
Executive Summary:	This report highlights some of the key achievements of, and areas of challenge relating to effective application of the Mental Capacity Act (MCA) across the Trust. Good practice in this area protects human rights and champions patient centred care. Supporting teams, patients and family members with often-complex issues relating to the MCA and DoLS remains the main body of work covered by the team. In addition, the team provide assurance to the SGH Trust Board around compliance with the MCA. Work in both areas is achieved via; direct clinical support, the on-going development of guidance, support and resources, engagement in audit and assurance activities, and comprehensive approaches to Trust-wide education and awareness raising. The pressures of COVID and movement of staff into new roles presented a challenge for the team. COVID Guides and amended consent form to support COVID vaccinations were created by the team to encourage and support the use of MCA in practice. Clinical support to the teams moved at pace in line with the rapidly changing governance around the MCA during COVID. We provided an increasing amount of telephone support and disseminating new guidelines as they arose. The challenges of providing this information and support increased due to the situational and personal stressors experienced by the wider clinical teams. There were 379 MCA / DoLS related referrals in 2020/21 a 5% increase on the previous year and the fourth consecutive year of growth in referrals received. Training provisions decreased due to the clinical pressures experienced across the Trust. Online training provision was sustained and has been well attended. Face to face training was suspended and is only now restarting. Audits were broadly encouraging, staff were engaged and appear keen to understand and apply the MCA in practice. There are clear areas for development around documentation; with the upcoming Liberty		

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	Protection Safeguards (LPS) standards this is an increasingly urgent priority. The team is now fully staffed according to budget however due to challenges within the team, operated on half staffing a significant portion of the year. With LPS on the horizon, with implications for the Trust and our legal, reputational and clinical responsibility, there is a need to review staffing and skill mix to ensure we are able to be fully compliant.		
Recommendation:	The Trust Board is asked to receive the report and content, noting the pending changes to Mental Capacity Act in April 2022 with the commencement of LPS.		
Supports			
Trust Strategic Objective:	- Treat the patient – treat the person - Right care, right place, right time		
CQC Theme:	Safe / Caring / Well Led		
Single Oversight Framework Theme:	N/A		
Implications			
Risk:			
Legal/Regulatory:	The Annual Report references the Trust's legal and regulatory duties in this area		
Resources:	The Annual Report references the currently available resources.		
Previously Considered by:	Quality and Safety Committee Patient Safety and Quality Group	**Date:**	21 October 2021 20 October 2021
Appendices:	Nil		

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MCA and DoLS Annual Report 2020-21

1.0 Introduction:

The Mental Capacity Act 2005 (MCA) derives from Human Rights legislation. It provides a statutory framework to empower and protect people of 16 years and above who may not be able to make their own decisions, and details when and how decisions can be legally and proportionately made on behalf of others. It also enables people to protect their approach to decision making in case they lose capacity in the future.

Deprivation of Liberty Safeguards (DoLS)[1] is an amendment to the MCA. It provides a system of legal safeguards, covering both the patient and the relevant organisation, in circumstances whereby someone who lacks capacity is being 'kept' in a particular setting in their 'best interests', for the purposes of delivering care or treatment.

The core aim of the MCA team at St George's University Hospitals Foundation Trust (SGH) is to support teams in embedding the understanding and use of the MCA into all aspects of care and treatment. Doing this ensures that some of our most vulnerable patients are having their voices heard and wishes followed when using SGH services. This approach protects the human rights of patients and can provide assurance that the serious personal and organisational risks of not following this primary legislation are avoided.

Working pan-Trust, St George's University Hospitals MCA team started life as a single fixed term post in 2016, but has subsequently grown to encompass 2 substantive posts (since April 2020) both staffed by registered healthcare professionals. The development of this resource has coincided with increased

[1] This scheme is due to change to the Liberty Protection Safeguard's in 2022. This change will substantially increase the trust's role and responsibilities in this area and require cross-divisional support and additional resources to ensure that patient's human rights are maintained and that the organisation is legally compliant.

training, audit and resource development in relation to the MCA, in addition to providing direct clinical support for a continually increasing number of referrers.

The period has seen a positive progression away from inadequate practice identified by the CQC in 2016, but there remains work to do. The following report provides further detail on the MCA Teams key areas or work, progress and challenges, throughout 2020-21.

1.1 A Challenging Year:

This year has seen the workforce at St George's and healthcare settings worldwide working to adjust to the challenge of responding effectively to the global pandemic. In such circumstances, there were multiple challenges to maintaining business as usual. Securing the divisional support needed to steer on-going behavioural change, and support training and audit development in relation to the MCA and DOLS, has been more challenging due to clinical staff facing unprecedented competing demands.

Providing care to patients with Covid-19 was hugely challenging with patients making difficult decisions and the staff looking after them with sub-optimal access to family members and friends. Anecdotally, this at times caused a breakdown in discussions with patients and families around care, treatment and discharge decisions.

The development of a more streamlined approach to discharge during the pandemic, re-allocation of staff, and changing remit of multiple wards, necessary to manage the huge influx of Covid positive patients, at times appeared to constrain the time and resource available for patient and family involvement in decision-making and fulfilment of other obligations under the MCA.

This national issue was recognised by the Department of Health and Social Care. They released multiple documents over this period reminding all who worked in healthcare that the MCA still applied. They also provided guidance on several topics

for safe and legal care of patients who may lack capacity, including vaccination & treatment for covid, DNACPR, and discharge decision making [2]

In this challenging context there was, understandably, reduced face to face training activity during this period, and some ward based audits were also suspended at times (in part, due to the additional challenge of reduced staffing). Resource development and awareness raising continued however, with the MCA team releasing documentation templates with embedded guidance for optimising supported decision making, capacity assessment and Best Interests Decision Making. The MCA team were also among the first to upload content for staff to the Trust's new intranet site and provided specific guidance on how to approach the MCA during the pandemic as part of this.

The Team contributed substantially to a Trust wide audit on consent, and the re-drafting of consent forms for in-patient covid vaccinations to include patients who might lack capacity. A large-scale audit of staff knowledge of the MCA was also piloted, capturing response from 526 Trust staff.

Other initiatives included; the provisional design of an MCA Champions Programme and the piloting of a train the trainer package integral to this programme, and on-going work with stakeholders across health and social care to develop training significantly targeted at using the MCA appropriately and effectively when making discharge decisions.

This year saw another increase in referral activity, supporting the idea that, even in such a challenging time, staff awareness of the MCA and where to get support continues to increase.

2.0 Governance and Structure:

Since February 2020, a Band 8a MCA Lead Practitioner has been in place. This left a staffing gap in the Band 7 MCA Practitioner role, which was filled in May 2020. This core team of two clinicians (Please see Fig 1.1 overleaf) was adversely affected

[2] https://www.gov.uk/government/publications/coronavirus-covid-19-looking-after-people-who-lack-mental-capacity

by long-term sickness within the team, meaning actual capacity was substantially reduced for much of the reporting year in question. In addition, the Head of Safeguarding role was unfilled for several months during this reporting year, impacting on the accessibility and availability of senior support.

The performance and activity of the MCA team is monitored through the Trust Safeguarding Committee, which meets every quarter and includes representation from the Adult Safeguarding Lead from the CCG. IQPR monthly reports also provide a barometer for practice across key areas.

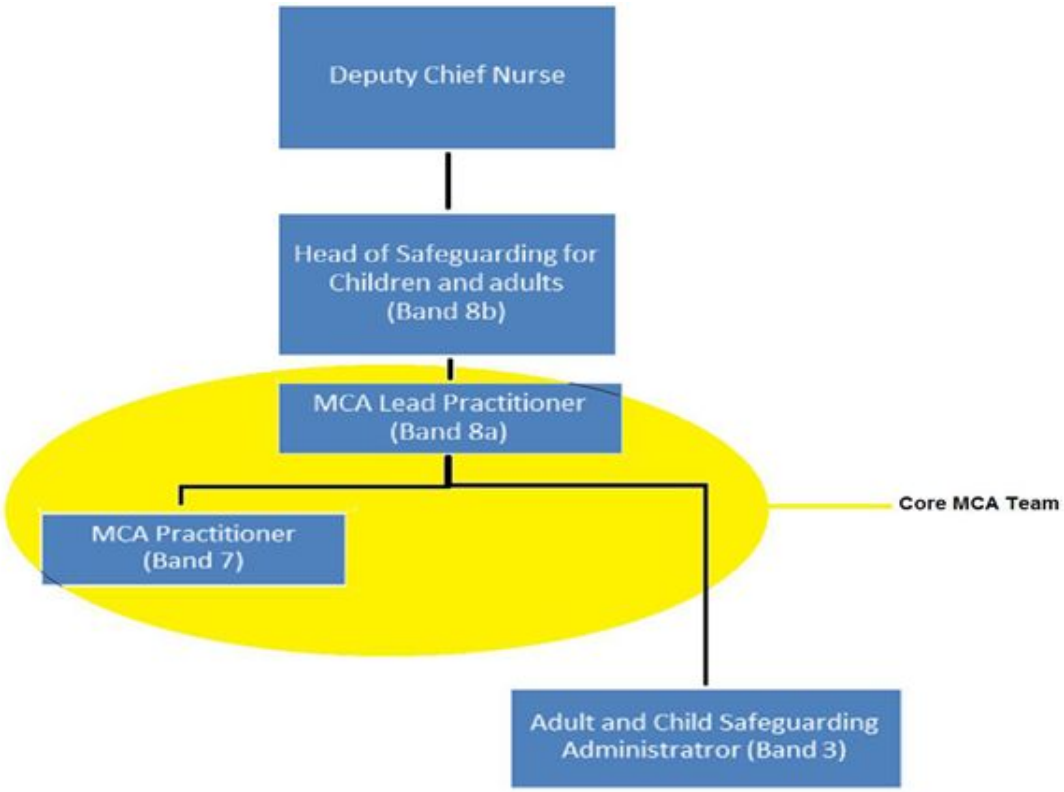
Organisational resources supporting good governance around the MCA include:

- direct support from MCA team members
- The MCA & DoLS Policy
- The Restrictions & Restraints Policy
- The MCA Intranet site and Supported Decision making / Capacity assessment /Best Interests Proformas on iClip alongside a number of intranet resources
- The Safeguarding team, the Head of Nursing for Mental Health, Trust's legal team, liaison psychiatry and discharge teams also provide invaluable support in responding to complex cases effectively

Nationally, key guidance and governance sources relating to the MCA include:

- The Mental Capacity Act (MCA), MCA code of Practice
- The Deprivation of Liberty Safeguards codes of Practice
- The Mental Capacity Amendment Act (2019) guidance on Supported Decision Making and Mental Capacity
- The Care Act and (for practice relating to 16 and 17-year-olds, The Children's Act)
- CQC guidance on Best Practice in relation to the MCA and DOLS also provides a framework against which some aspects of practice can be reviewed as does Royal College of Surgeons and General Medical Council guidance on consent and supported decision-making.

Fig 1.1 MCA Core team and reporting structures



2.1 Challenges and Areas for Development

Plans to re-launch the MCA steering group this year have not materialised, mostly due to the interface between the demands placed on the workforce by the pandemic and local staffing issues. This is likely to be negatively impacting on the consistency, frequency, and review of strategic level processes and structures to enable Trust wide buy-in to, and support for, embedding the MCA and providing effective governance in this area.

The recent creation of the Head of Nursing for Mental Health post provides opportunities for joint working and partnership, with the aim of improving the care and treatment of patient groups who may face barriers to accessing optimal care and treatment, via the newly established Mental Health and Complex Decisions Group.

2.2 Key Next steps:

- Re-launch MCA Steering Group and part of improving divisional engagement with and local ownership of the MCA agenda.
- Engage with Mental Health and Complex Decisions Group and work closely with HoN for Mental Health and associated stakeholders.

3.0 MCA Training

3.1 Mandatory and statutory training programmes specifically covering the MCA and DoLS

Following the launch of two e-learning packages in 2018 covering essential (Level 1) and intermediate (level 2) Practice around the MCA and DOLS, patient facing staff working with adults and children over 16 years of age continue to be auto- enrolled onto high quality training that they should complete as part of their mandatory and statutory training requirements. It is acknowledged however that this will require review in light of the changing landscape that is Liberty Protection Safeguards.

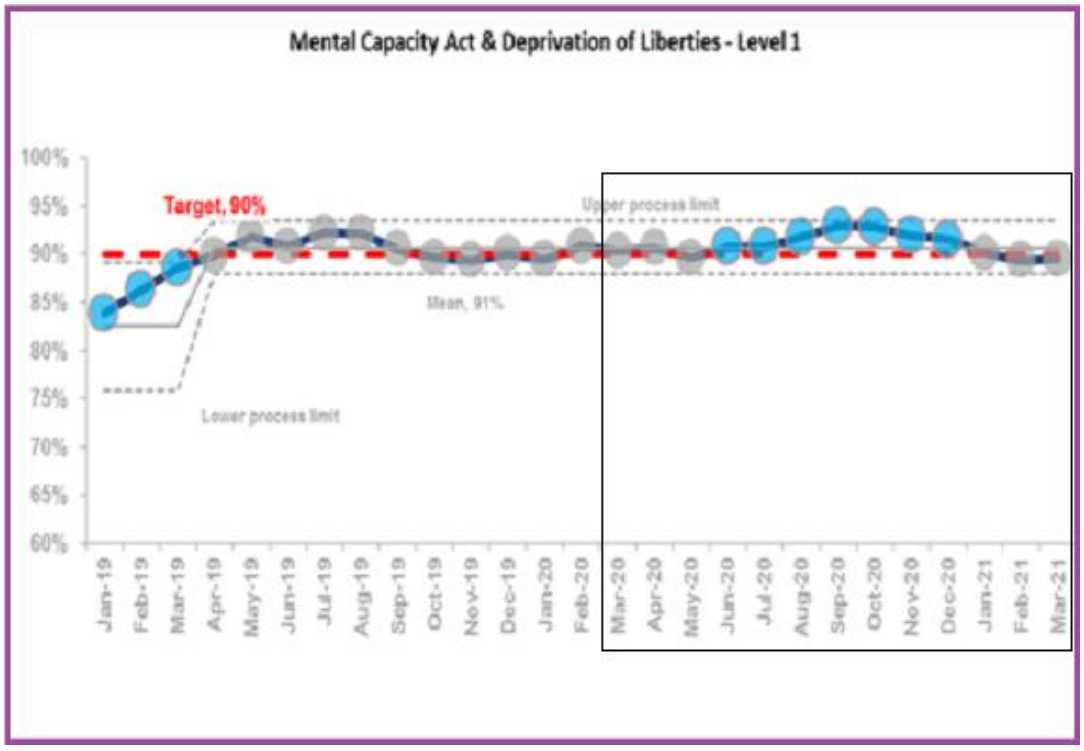
3.2 Face to Face Training:

The number of face-to-face training was well below previous years, in the context of Covid 19, with approximately 20 face to sessions delivered over the 2020/21 financial year, to an estimated 200 staff. These sessions were typically delivered to key areas where additional needs are identified, on request of Practice Educators or other clinical educational co-ordinators, or to 'difficult to reach' groups. Examples include sessions for medical and nursing staff rotating through the emergency department, HCAs undertaking Trust induction, and Site Leads at the Trust.

3.3 Headline Training Figures:

For Level 1 training, training compliance has typically met or exceeded the target of 90%, across the year as a whole (see fig 1.2, below, for reference).

Fig 1.2 MCA E –learning Level 1 (Essential) training compliance 2019-20

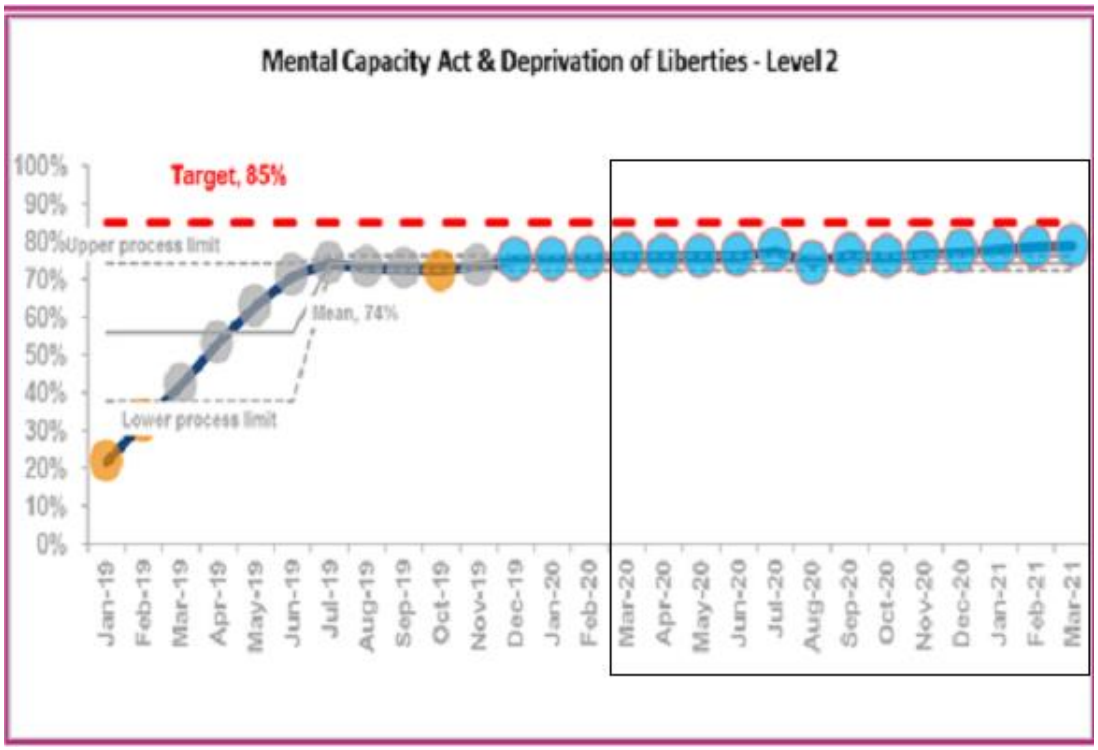


Compliance for Level 2 MCA /DoLS training continues to sit at around 75-80%, below the target of 85% (see fig 1.3, below, for reference)

For context, at the time of writing current level of compliance for the 3 largest staff groups trained at Level 2 stands as follows:

- Allied Health Professionals 90% (338/376 staff)
- Nursing and Midwifery: 92% (1151 / 1259 staff)
- Medical and Dental: 63% (747 /1188 staff).

Fig 1.3 MCA E –learning Level 2 (Intermediate) training compliance 2020/21



3.4 Train the Trainer Pilot:

During the year covered by this report, An advanced level of MCA Training (level 3) was developed and used to pilot a Train the Trainer scheme with key staff from the Trust's renal team (who had requested increased ownership of the training session). The programme is still being evaluated at the time of writing but has potential to form an integral part of an MCA Champions Programme, which aims to partly devolve expertise on the MCA to local teams.

3.5 Challenges and Areas for Development:

Changes will need to be made to e-learning modules to:

- Ensure staff refreshing their competencies for the first time have the opportunity to complete a brief but high quality and scenario-based quiz.
- Review content related to DOLS and remove this when the Liberty Protection Safeguards comes into place (and supersedes DOLS).
- Ensure staff have access to high quality, standalone training, in adequate time to support knowledge and practice relating to the Liberty Protection Safeguards.

Staff working with young people (16/17) are not currently auto enrolled onto Mandatory MCA Training. This is a gap in provision that is likely to become more problematic, particularly with the introduction of LPS, which includes 16/17 year olds.

Feedback from senior members of the Trust's Discharge Hub and from external partners in the local authority have suggested that there may be a training need in relation to discharge planning end documentation for patients who may lack capacity.

3.6 Key Next Steps:

- Work with Training and education team to update current E-learning.
- Lobby for divisional support and local managerial ownership of training compliance in relation to the MCA to drive up the level of compliance. The re-introduction of the MCA Steering group is likely to be instrumental in achieving buy in for this approach.
- Work in partnership with Child Safeguarding Team and key clinical staff in paediatrics to design deliver and evaluate mandatory training programme (including updating training needs analysis to draw in appropriate staff).
- Work with the Discharge Hub and community partners to review discharge paperwork in cases where capacity around discharge in doubt. Use this process to inform design and delivery of training in this area to key stakeholders.

4.0 MCA Audit

4.1 Background Context and Summary of Work

Effective and clinically meaningful audit of the Mental Capacity Act is a challenging and resource intensive task. The MCA and DOLS Codes of Practice and NICE Guidelines provide a huge pool of information relating to best practice but the narrative and broad nature of legislative based guidance, and its constant evolution

via case law, does not lend itself well to neat, binary or quantitate measurement by delegated local assessors[3].

In this context the MCA team continually tries to take an innovative and resource sensitive approach to audit, working alongside other stakeholders to audit areas of common interest and extracting relevant data from assurance activates already in place. During this year, the monthly barometer of MCA related knowledge and practice continued to be covered by key questions integrated into The Trust's Ward Accreditation Programme. The MCA team also launched a Trust-wide staff knowledge questionnaire (developed collaboratively with staff healthcare partners across South West London) and contributed to a Trust-wide audit of consent to serious medical/surgical treatments with the Trust's consent and audit leads.

4.2 Ward Accreditation: Staff knowledge and use of the MCA

As part of an on-going ward accreditation process, three questions directly relate to use of the MCA. One relates to staff knowledge of the legislation and two relate to applied practice.

Reduced staffing and challenges related to the pandemic resulted in ward accreditation not taking place as intensively or regularly over the past year so some gaps in data are present.

[3] Some organisations try to overcome this by focusing on organisational markers such as the presence or absence of policies and subject matter experts, but this does not, in itself, provide assurance on wider knowledge or practice. Some review capacity assessments completed to see if they contain words or phrases that suggest evidence of key stages of good practice guidance are present. This can provide limited assurance in relation to cases where a need to use the MCA has been identified. Unfortunately, it provides no information about cases where a need to apply the MCA has been overlooked, or perhaps even circumvented.

Fig 1.4 MCA Ward accreditation (staff knowledge) question

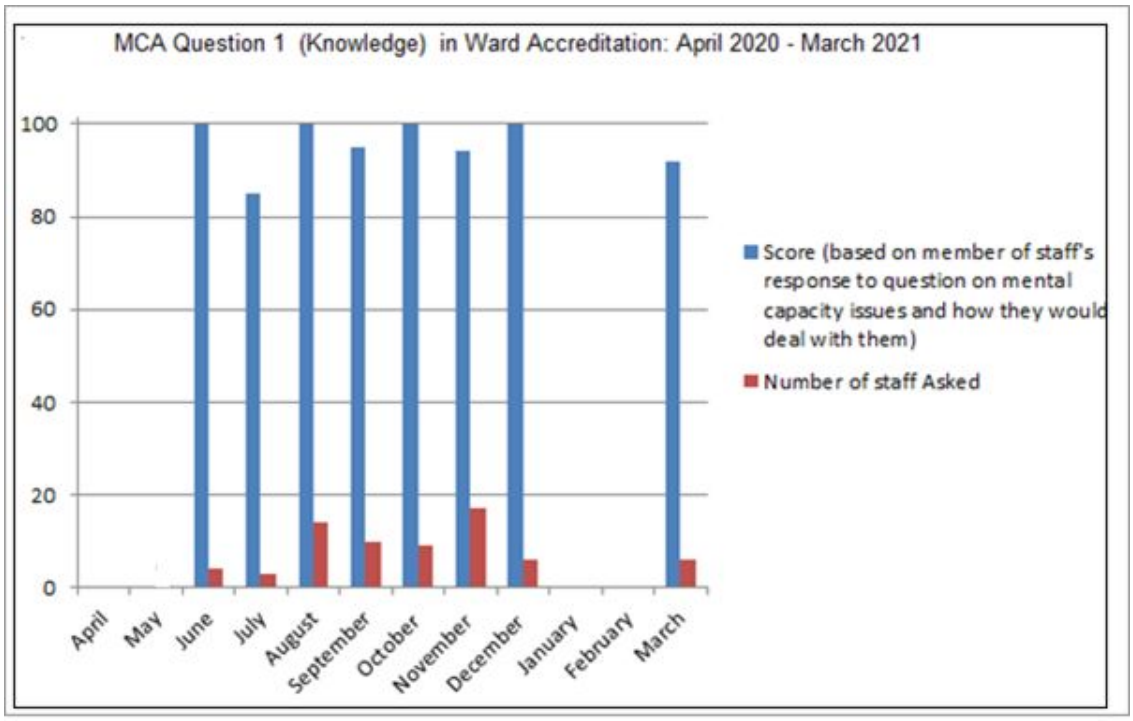


Fig 1.5 MCA Ward accreditation applied Practice question 1

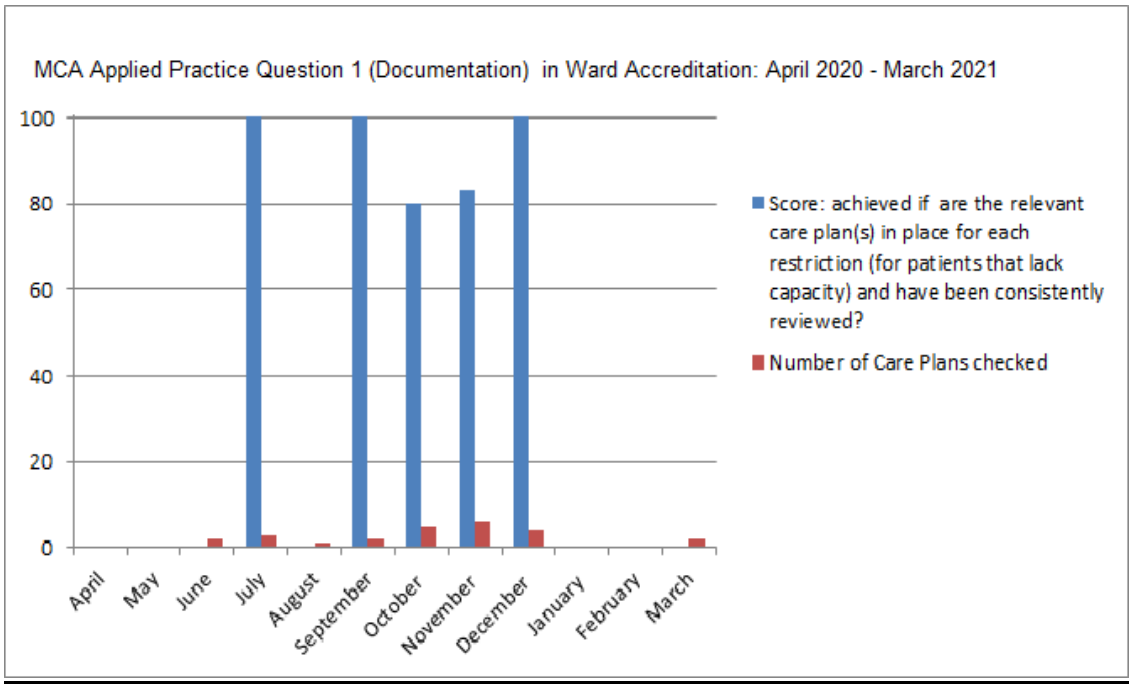
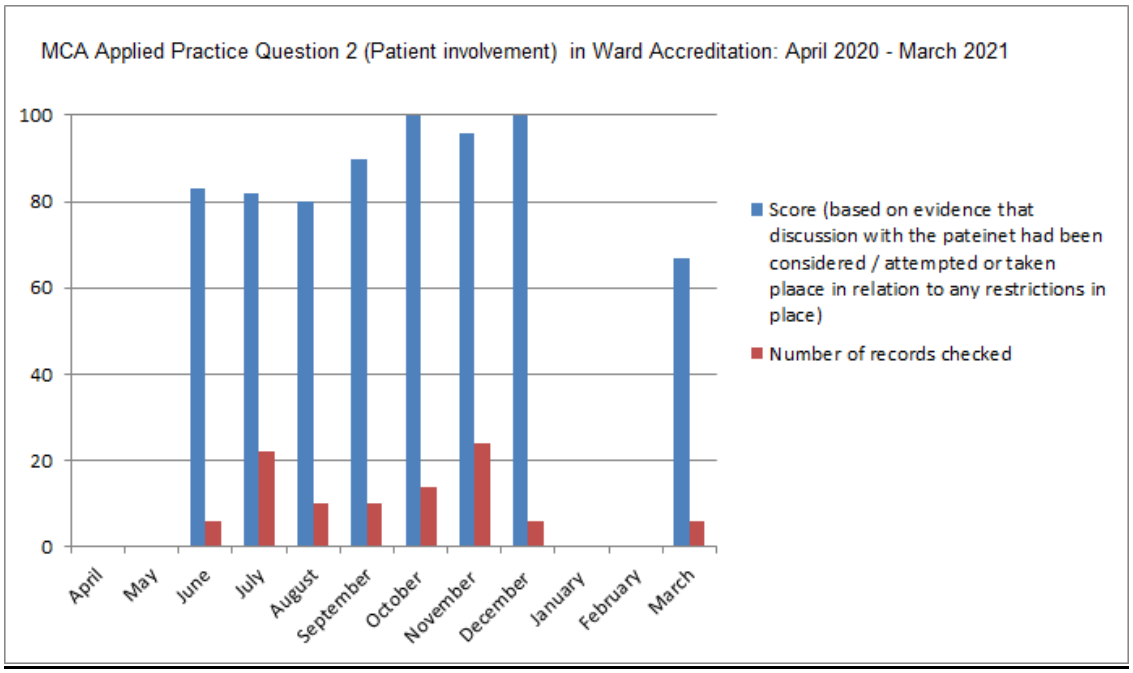


Fig 1.6 MCA Applied MCA Ward accreditation applied Practice question 2



Summary of findings: Whilst ward accreditation data relating to staff knowledge and applied practice around the MCA generally shows good performance, sample sizes are small which limits the assurance that can be given, and there are still a small number of staff who need support to integrate the MCA into a patient's care plan when required to do so.

4.3 Staff Knowledge Audit

Following work in the previous year to develop an MCA staff knowledge audit with healthcare providers across South West London, staff across the Trust were emailed a questionnaire relating to their understanding and use of the Mental Capacity Act (MCA) to provide assurance and identify and gaps in staff knowledge to inform future teaching and resource development. Data was collected between November 2020 and January 2021. 526 staff completed the questionnaire which covered questions covering areas relating to the MCA including:

- Understanding when a capacity might be in doubt.

- Supported Decision making
- The role and nature of independent advocacy and advanced decision making.
- Scenarios relating to serious medical treatments and discharges against advice when Capacity May be in doubt
- Best Interests Decision Making

There is a standalone report for this audit but, in summary, results were broadly encouraging uptake was good. There was some evidence that knowledge gaps existed around proxy decision making, external advocacy, decision makers, the nature and extent of support indicated. The majority of staff were able to identify where to seek support and demonstrated good working knowledge of; when capacity might be in doubt, the core principles of supported decision-making, key considerations when faced with scenarios relating to serious medical treatment decisions, and patients wishing to discharge against medical advice.

There was some evidence that there may be knowledge gaps relating to:

- Advanced decision making
- Lasting powers of attorney
- When an Independent Mental Capacity Advocate is indicated
- The role of next of kin in decision making
- The Decision specific nature of Capacity Assessment
- Detailed understanding of what all-practicable steps entails when supporting someone who may lack capacity to try and make their own decision.

4.4 Trust wide Consent Audit

Without capacity, there cannot be valid consent, so the MCA team were glad to be an integral part of the design, delivery and evaluation of a Trust-wide audit of consent in 2020-21, alongside the interim Trust lead for consent, Trust Audit Lead, Patient Records Team, and Assistant Deputy Chief Nurse.

This audit was undertaken in response to CQC findings in 2019 that questioned record keeping and process in relation to consent at The Trust. 400 simple form audits were reviewed following education by clinician’s in their local area. The MCA and Consent Leads then audited a cross section of their work, looking specifically at

the quality of documentation in a cross section of medical records. . A key theme from this audit related to poor evidence of effective supported decision making and two-way discussion with patients who may lack capacity.

A related outcome was the production of supplementary documentation for those patients who may lack the capacity to consent to invasive/semi-invasive procedures, providing a resource to help enable and record consent, which incorporates key aspects of supported decision-making in patients with complex needs. The audit also made a strong case for further work in this area and for the creation of a substantive position to lead on consent related issues in future.

4.5 Challenges and Next Steps:

- Annual repetition of staff knowledge audit with optimisation of question design and scoring, and the inclusion of anonymised feedback to provide education for all participants.
- Continue participation in Patient Records / consent working group to ensure patients who may lack capacity are represented in any areas considered, future audits and any plans to change systems and processes relating to supported decision making and consent.
- Activation of automatic data collection embedded in new Trust proforma covering supported decision-making, Capacity Assessment and Best Interests Decision Making (see awareness raising and resource Development).

5.0 MCA Awareness Raising and Resource Development

Awareness raising is predominantly provided through face-to-face training, e-learning programmes and via MCA direct clinical support including support in complex cases and in-direct support via remote reviews and advice accessible via bleep, email and phone. Policies relating to the Mental Capacity Act and the use of restrictions and restraints under the MCA provide further in-depth guidance. An Intranet homepage for MCA and DoLS also provides information and advice on key aspects of practice and signposts further help.

Key activity undertaken by the MCA team in this area included:

- The launch of Trust-wide electronic templates for capturing supported decision-making, capacity assessments and Best Interests decisions.
- Leading the review and updating of the Restrictions and Restraints Policy in conjunction with the Head of Nursing for Mental Health.
- Re-working Covid 19 vaccination consent form for in patients to ensure patients lacking capacity could be considered.
- Designing and populating content for the MCA pages on the new Trust Intranet site
- Providing updated guidance on application of the MCA during the Covid 19 pandemic

5.1 Challenges and Next Steps (planned within the current financial year):

- Continue development of an MCA Champions programme to provide quality augmentation of awareness raising and feedback across the Trust in relation to the MCA. While this could not be undertaken in 2020-21, work is being planned in conjunction with the LPS. This will require buy-in across Division's with protected time for staff.
- Review and update of the Trust's MCA Policy, to align it more closely with the Trust's consent policy.
- Source and develop resources to inform and educate staff about additional roles and responsibilities associated with the introduction of the Liberty Protection Safeguards (LPS)
- Make increased use and increase frequency of review of intranet-based content relating to the MCA and LPS.

6.0 Clinical Support: MCA and DoLS referrals 2020-21

There are clear duties under the Mental Capacity Act (2005) that staff have to all patients. Patients who may have difficulty making decisions should be adequately supported to make their own decisions whenever possible. When a patient lacks

capacity, decisions made for them, must have regard for the principles laid out in the MCA.

Not doing so carries the risk of litigation, loss of reputation and infringement of human rights. In addition, the hospital, as a 'managing authority' has a responsibility to ensure that all those patients who could potentially meet the criteria of deprivation have the appropriate safeguards triggered, are referred to the 'supervisory authority' (the appropriate local authority) for independent assessments, and that any such assessment or authorisation is reported to the Care Quality Commission.

To meet these requirements and to obtain support for working within the MCA in clinical cases, teams can currently refer to the MCA team for information, advice, and direct support.

The range of issues the MCA team deal with is large, and can include the following:

- Phone advice on a particular aspect of applying the MCA
- Helping someone complete a DoLS form correctly / completing it for them.
- Reviewing cases from admission to the point of referral to unpick advice relating to the MCA from other issues such as disagreements over clinical reasoning and approach, or a breakdown in communication between the treating team and other stakeholders
- Escalating to and co-ordinating with others when their input is needed (e.g. psychiatry, psychology, the discharge team, social services, speech and language therapy)
- Supporting/reviewing capacity assessments and Best Interests processes led by others
- Leading capacity assessments and chairing Best Interests discussions
- Providing longitudinal support, stakeholder co-ordination, documentation and legal escalation (of required) around complex and at times contentious cases relating to multiple treatment episodes or complex discharge decisions

During 2020/21 there were 379 referrals relating to the Mental Capacity act and DoLs (see fig 1.7), a 5% increase on the 2019/20 figure of 361. This is the third consecutive annual increase in referrals.

Of the 379 referrals received by team at St George's, 221 of these (compared with 173 the previous year) resulted in an urgent DoLS being put in place (see fig 1.) and a request being sent to the local authority to grant a Standard Authorisation. Of the authorisations that were applied for 10 were granted which represents 5 % of the authorisations submitted.

As staff and service user knowledge and understanding of this legislation continues to grow, as LPS is introduced, and as more cases relating to hospital care and treatment are overseen by The Court of Protection, there is a very high chance that referrals to the MCA team will continue to grow.

Fig 1.7 : DoLS and MCA Referrals covering period 2020-2021

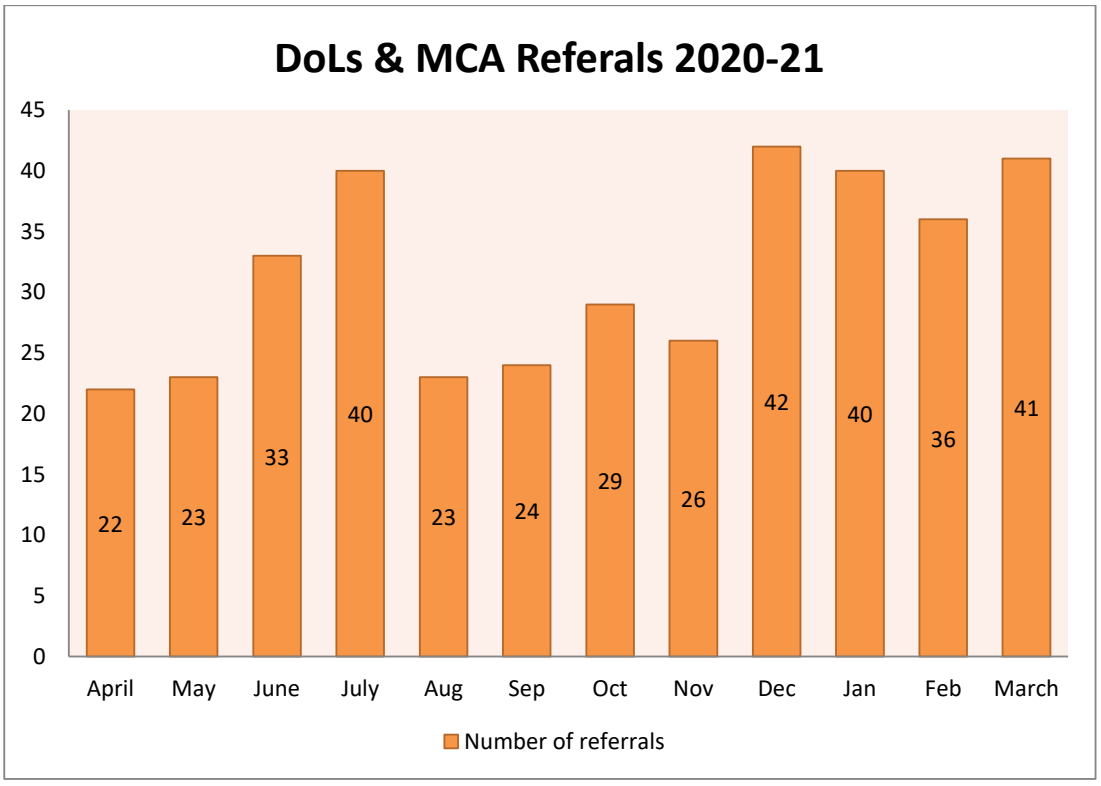
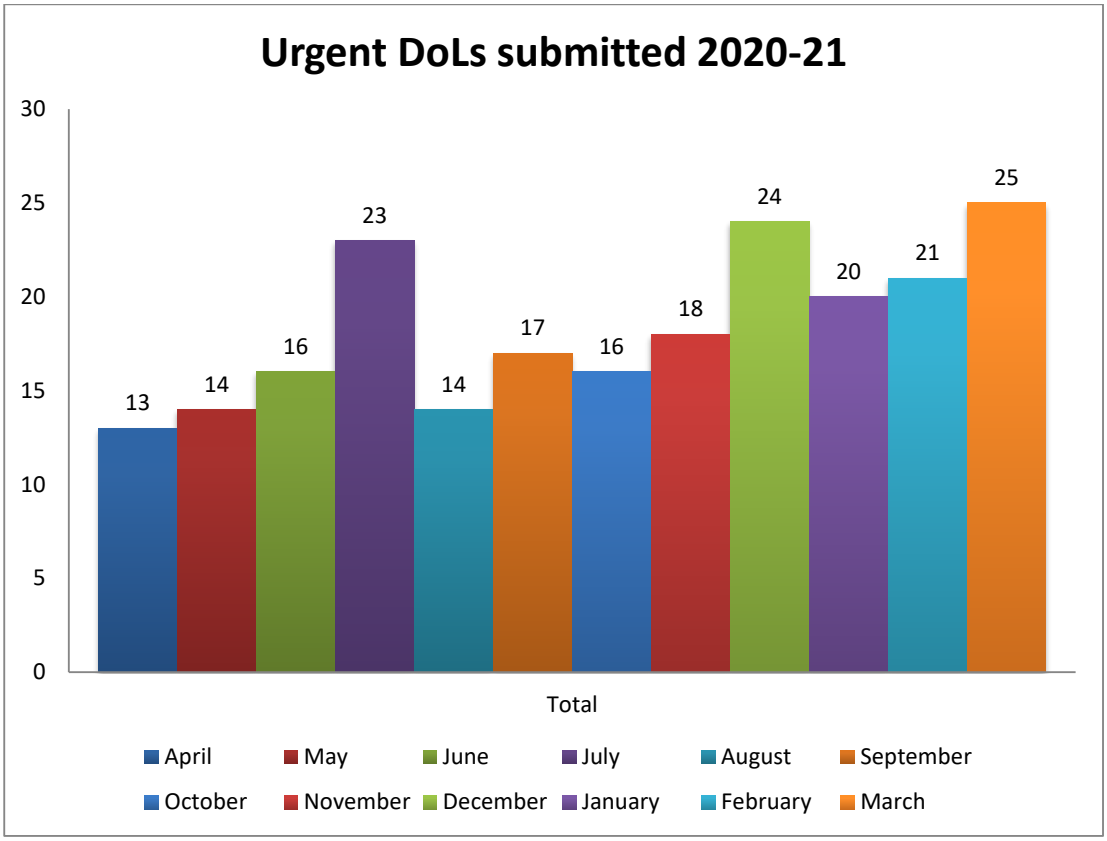


Fig 1.8: Urgent DoLs sent to the local authority to grant a Standard Authorisation each month.

2020-2021;



8.0 Collaborative Working

During 2020-21, the MCA team were involved in multiple partnership working projects both within and outside The Trust including:

- On-going membership of the London-wide MCA and DoLS network
- Attendance at the Weekly Dementia and Delirium Team Multidisciplinary Meeting (MDM)
- Working with external stakeholders across health and social care in South West London to prepare for change from DoLS to LPS
- Joint working with head of nursing for mental health on review of restrictions and restraints policy
- On-going involvement with the Trust Patient Record Group on issues relating to supported Decision-making and consent
- Supporting clinical staff with capacity assessments and Best Interests Meetings

- Helping design documentation and guidance for teams to ensure it is MCA compliant.

9.0 Challenges for 2021-22

9.1 Managing change from the Deprivation of Liberty Safeguards to the Liberty Protection Safeguards (LPS):

The Liberty Protection Safeguards (LPS) will replace the Deprivation of Liberty Safeguards (DoLS) system. The aim of LPS is to provide protection for people aged 16 and above who are or who need to be deprived of their liberty in order to enable their care or treatment and lack the mental capacity to consent to their arrangements.

People who might have a Liberty Protection Safeguards authorisation include those with dementia, autism and learning disabilities who lack the relevant capacity to consent to their admission to hospital and care plan. They have been designed to put the rights and wishes of those people at the centre of all decision-making on deprivation of liberty.

The Liberty Protection Safeguards are planned to come into force in April 2022 when the Trust will need to be compliant with them. Compared to DoLS, LPS significantly increases the role of hospital staff in responding to Deprivations of Liberty with substantial implications for training, oversight, reputation and legal compliance. LPS is likely to create a substantial new work stream for the MCA team and increase the role of patient facing staff. Additional resources, divisional support and an openness, at all levels, to adapting systems, processes and documentation to assimilate LPS will be essential if the trust is to succeed in this area.

9.2 Launching and Maintaining and MCA / LPS Champions Programme

Carried over from last year due to the impact of the pandemic and staffing constraints, there remains a need to devolve expertise around the MCA and develop

local support structures to support teams to apply the MCA effectively in practice (and meet the new responsibilities that will accompany the introduction of LPS).

A meaningful MCA Champions programme is likely to require Champions who have influence across the MDT, who are being released from clinical duties for study time, and who receive high quality resources, education and advice from the MCA team.

Divisional support and buy in is likely to be crucial in supporting recruitment, and balancing the time required to develop Champions, with increasing operational demands being placed on MCA team.

9.3 Senior and Divisional Support for the MCA agenda

The MCA team's work with multiple teams over the last year suggests an ongoing increase in the number of staff who are aware of the need to challenge ways of practising and approaching patient care, that may fail to incorporate supported decision making and use of the MCA. Some of these staff may be in a consultative and psychologically safe MDT environment where they feel able to support a better approach, or challenge poor or variable practice. However, feedback to our team over the last year continues to suggest that further behavioural change is needed to move towards a truly consultative patient centred model of care.

The MCA team continue to get some queries from a small number of staff, suggesting a substantial lack of understanding of the principles of the MCA and the need to apply them. There is pushback at times on making changes to patient pathway documentation and processes that might support optimal recognition of patients needing support to make decisions about their admission, care and treatment.

Supporting all staff and continuing to drive changes to behaviour and documentation relating to supported decision making, consent and capacity, can only be achieved if the small central team and patient facing staff alike has senior and cross divisional support.

A potentially crucial tool in mitigating the (reputational, legal, financial and human rights based) risks relating to senior/divisional support of the MCA agenda (including

LPS) relate to the re-launch of the MCA / LPS steering group, and ensuring that there is adequate and targeted representation within this group from senior decision makers and staff working on the 'shop floor' across divisions and clinical specialties

9.4 Project Management Support

As per last year's annual report, there remains a requirement for project management support to drive key aspects of the development plan in respect of MCA and DoLs. The core members of the team do their utmost to maintain the necessary expertise to support clinicians and patients and provide advice to the Trust on what is needed to provide a high-quality approach in relation to the MCA. Without additional support, delivery on to some of the trust wide projects relating to the MCA is likely to be slower or in some cases, not achieved.

10. Conclusion

In spite of some very real challenges over the past year, the MCA team has worked incredibly hard to continue to improve the voice of some of our most vulnerable patients being heard. There has been delayed progress with the transition away from DOLs towards the LPS as government deadlines have been pushed back, however during this time, we have continued to ensure that the legal rights of our patients are upheld and that we support our colleagues to apply the principles of the MCA. Clear areas of excellence have been identified alongside areas for development and learning.

Looking towards next year, the LPS is due to come into force in April 2022. This places a statutory duty on the Trust as Managing Authority, which impacts at patient, individual clinician, ward and MCA team level. There is limited current guidance which is delaying our detailed planning; however, workforce planning and scoping are underway. As we move away from crisis management and pandemic practice, the team are developing training, improving links with internal and external partners, to support excellence in the MCA which will support our eventual compliance with our statutory duty under LPS.

Looking forward the team aim to continue with the development of resources and support for staff, with increased MCA presence on the wards. LPS is due to be launched in April 2022 which will provide significant challenges for the team and wider trust. Support will be required from the organisation to ensure compliance, education, and resource development.

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	**25 November 2021**	**Agenda No**	**2.1.3**
Report Title:	**Duty of Candour – Annual Report 2020/21**		
Lead Director/ Manager:	**Robert Bleasdale, Chief Nurse and Director of Infection Prevention and Control**		
Report Author:	**Jenny Miles, Patient Safety Manager**		
Presented for:	**Assurance**		
Executive Summary:	The purpose of this report is to provide an overview of the regulatory requirements, monitoring and reporting arrangements and compliance for Duty of Candour for all qualifying incidents reported in 2020/21 (1 April 2020 to 31 March 2021). 458 qualifying incidents were reported (moderate and above severity). There was evidence of Duty of Candour having been completed in all cases. 90% (410) where Duty of Candour was undertaken were completed within 20 working days of the incident being identified. This showed a slight reduction in performance when compared with 2019/20 where 93% (379) of the 409 qualifying incidents had Duty of Candour completed within 20 working days. During 2021/22 (April – July) there has been a significant improvement with Duty of Candour compliance. In April, May and July 2021, there was 100% compliance with Duty of Candour within 20 working days.		
Recommendation:	The Committee is asked to: 1. Note the contents of the report 2. Note that compliance and any improvement actions is monitored at the Patient Safety and Quality Group		
Supports			
Trust Strategic Objective:	Treat the patient treat the person Right care, right place, right time		
CQC Theme:	Safe, Effective, Caring and Well led		
Single Oversight Framework Theme:	N/A		
Implications			
Risk:	None		
Legal/Regulatory:	Enforcement undertakings applicable to SGUH Compliance with the Health & Social care Act 2008 (Regulations 2014): Regulation 20 and CQC Registration Regulations		
Resources:	N/A		
Equality and Diversity:	No issues to consider		
Previously Considered by:	Quality and Safety Committee	**Date**	21/10/21
Appendices:	N/A		

Outstanding care every time

St George's University Hospitals NHS Foundation Trust

Duty of Candour Annual Report 2020/21

1.0 Purpose

The purpose of this report is to provide an overview of the regulatory requirements, monitoring and reporting arrangements and compliance for Duty of Candour for all qualifying incidents reported in 2020/21 (1 April 2020 to 31 March 2021).

2.0 Policy and Regulatory Requirements

The Department of Health introduced a contractual Duty of Candour on NHS organisations which came into force in November 2014. The contractual duty strengthened the existing National Patient Safety Agency (NPSA) Being Open Framework and outlined deadlines for the provision of verbal and written communication with patients, relatives and/carers. The statutory duty was also reinforced by a joint professional statement from the General Medical Council (GMC) and Nursing and Midwifery Council (NMC).

The Trust's current Duty of Candour Policy is based on the updated Being Open Framework and aims to give clear guidance to those staff involved in patient safety incidents to ensure timely and effective communication with patients or next of kin where appropriate (NOK). If a patient is harmed as a result of a mistake or error in their care, they, their family or those who care for them, should receive an apology, be kept fully informed as to what has happened, have their questions answered and know what is being done in response. This is defined as *Being open* and the Duty of Candour policy sets out the Trust's commitment to patients to:

- apologise for the harm caused;
- explain, openly and honestly, what has gone wrong;
- describe what we are doing in response to the mistake;
- offer support and counselling services that might be able to help;
- provide the name of a person to speak to;
- give updates on the results of any investigation(s).

The statutory regulations and contractual requirements for Duty of Candour mandate the implementation of Being Open discussions for all patients or NOK who have suffered moderate, severe harm or death as a result of an incident. These discussions are to be clearly documented in a letter to the patient or NOK and in the patient's health records. Commissioners are able to impose financial sanctions where documented being open discussions are not carried out in line with regulations.

The technical guidance included in the NHS standard contract (NHS England, 2013) and the statutory regulations (November 2014) state that Duty of Candour applies to all patient safety incidents that result in moderate harm, severe harm or death. Although Duty of Candour does not apply to low/no harm incidents, the technical guidance recommends that these incidents should still be reported to the patient and the Trust's incident reporting process should still be followed with actions taken to prevent similar occurrences.

On occasions where moderate or severe harm is the result of a recognised complication of a treatment/procedure/operation a Being Open conversation with the patient or NOK is undertaken and documented clearly in the health records. However, if the patient was consented appropriately and no failings in care were identified then statutory Duty of Candour does not apply. Therefore, it is important that the consent process is robust and the patient is fully informed and aware of the risks of a planned treatment/ procedure.

3.0 Resources

The Trust has a Duty of Candour Policy and training was provided to all new staff at Trust induction. Further training was provided on an ad-hoc basis where indicated. Information leaflets were also provided for patients and staff.

4.0 Duty of Candour: The Trust Process and Timelines

In summary the overall process for Being Open and the actions to be taken when a moderate, high or extreme severity incident is identified is as follows:

1. **Immediate action to be taken on the day of incident detection**

   - Incident identified and reported on the Trust's adverse incident reporting system (Datix)

2. **Action to be taken as soon as possible, but no later than 10 days of incident detection**

   - A verbal apology and explanation of the incident provided to the patient or NOK as soon as feasible, but no later than 10 days of incident detection.
   - The verbal communication to be followed up by a letter, including an apology, acknowledgement and explanation of the facts known so far. The letter is to be sent no later than 10 days after the initial conversation. Both initial conversation and written follow-up to be recorded on Datix and within the patient's health records.
   - If the patient or NOK decline a written response this is recorded in the patient's health records.
   - Contact throughout the investigation should be agreed with the patient or NOK.

3. **Within 60 days for Serious Incidents (SIs) and on Completion of Investigations for other incidents**

   A full written explanation to be provided to the patient or NOK with a written apology. Where a serious incident investigation has taken place the patient or NOK is provided a copy of the serious incident investigation report and covering letter.

5.0 Monitoring and Reporting arrangements

Duty of Candour compliance is monitored at the Patient Safety and Quality Group (PSQG) on a monthly basis. Compliance is also reported in the Integrated Quality and Performance Report (IQPR) on a monthly basis to Quality and Safety Committee and the Trust Board.

In order to evidence compliance with Duty of Candour for all moderate and above severity incidents (including serious incidents) compliance was reported on a monthly basis both at divisional level at divisional governance groups and Trust wide at PSQG. To aim to meet 100% overall compliance the monthly report to PSQG included a two month look back to capture performance not completed within the initial 20-day timeframe.

To inform the Trust's position on compliance information was extracted from Datix as to whether a verbal discussion was held with patients or NOK and whether this was followed up in writing within 20 days of the incident in line with the regulatory requirements.

6.0 Duty of Candour (DoC) compliance for 2020/21

Table 1 below comprises data for moderate and above severity incidents reported between 1 April 2020 to 31 March 2021.

458 qualifying incidents (moderate and above severity) were reported and Duty of Candour was completed for all cases. 90% (410) of Duty of Candour were completed within 20 working days of the incident being identified. This showed a slight reduction in performance when compared with 2019/20 where 93% (379) of the 409 qualifying incidents had Duty of Candour completed within 20 working days, see Tables 1 and 2 below.

Table 1: Data for moderate and above severity incidents 2020/21

Date Incident Reported (Month-Year)	Total No. of incidents	Total No. of incidents DoC completed	DoC completed (%)	Total No. of incidents with DoC completed within 20 working days	DoC completed within 20 working days (%)
Apr-20	41	41	100%	36	88%
May-20	34	34	100%	29	85%
Jun-20	38	38	100%	34	89%
Jul-20	30	30	100%	26	87%
Aug-20	29	29	100%	27	93%
Sep-20	49	49	100%	46	94%
Oct-20	28	28	100%	25	89%
Nov-20	57	57	100%	55	96%
Dec-20	47	47	100%	45	96%
Jan-21	52	52	100%	44	85%
Feb-21	32	32	100%	24	75%
Mar-21	21	21	100%	19	90%
Total	**458**	**458**	**100%**	**410**	**90%**

Table 2: Data for moderate and above severity incidents 2019/20

Date Incident Reported (Month-Year)	Total No. of incidents	Total No. of incidents DoC completed	DoC completed (%)	Total No. of incidents with DoC completed within 20 working days	DoC completed within 20 working days (%)
Apr-19	29	29	100%	29	100%
May-19	35	35	100%	31	91%
Jun-19	15	15	100%	14	93%
Jul-19	31	31	100%	30	97%
Aug-19	30	30	100%	28	93%
Sep-19	34	34	100%	34	100%
Oct-19	42	42	100%	41	98%
Nov-19	41	41	100%	37	90%
Dec-19	37	37	100%	33	89%
Jan-20	49	49	100%	47	96%
Feb-20	38	38	100%	31	82%
Mar-20	28	28	100%	24	86%
Total	**409**	**409**	**100%**	**379**	**93%**

6.1 Current performance 2021/22

During 2021/22 (April to July) there has been a significant improvement with Duty of Candour compliance, as shown in Table 3. In April, May and July 2021, there was 100% compliance with Duty of Candour within 20 working days.

Table 3: Data for moderate and above severity incidents 2021/22 (April-July)

Date Incident Reported (Month-Year)	Total No. of incidents	Total No. of incidents DoC completed	DoC completed (%)	Total No. of incidents with DoC completed within 20 working days	DoC completed within 20 working days (%)
Apr-21	21	21	100%	21	100%
May-21	16	16	100%	16	100%
Jun-21	27	27	100%	26	96%
Jul-21	18	18	100%	18	100%

7.0 Next steps and sustaining current performance

The Duty of Candour Policy is scheduled to be reviewed once the updated national guidance regarding the Patient Safety Incident Response Framework (PSIRF) is issued to the Trust. The Trust is anticipating receiving that guidance in Q4 2021/22.

Weekly divisional meetings led by the Patient Safety team will continue to be held with the relevant divisional governance teams where indicated. The purpose of these meetings is to maintain the focus on improved performance.

Outstanding care every time

St George's University Hospitals NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	25 November 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:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify)		
Executive Summary:	This report consolidates the latest management information and improvement actions across our productivity, quality, performance and workforce for the month of October 2021. **Our Finance & Productivity** Outpatient activity in October 2021 is currently at 90% of the activity reported in October 2019. This is expected to rise to 94% once data catch up is completed which is 7% higher than trajectory. Elective and Daycase performance is expected to be behind trajectory (after estimated catch up), with a percentage of 84%, lower than the 87% trajectory submitted for October. Theatre specialties are at 90%, with non-Theatre specialties at 82%. Activity levels have been impacted in October due to annual leave. Non-elective Length of Stay (LOS) remains above the mean of the 2019 baseline. On average non-elective inpatients stayed in a hospital bed for a total of 6.2 days. Focus remains on early discharge, increase use of discharge lounge and continuing to work with external partners particularly for Merton and Wandsworth concentrating on discharge, maximising community capacity and virtual frailty ward. **Our Patient Perspective** Targeted work by the Chief Nurse and the Chief Medical Officer to increase Resuscitation training continues to show improvements. Basic Life Support (BLS) and Advance Life Support (ALS) show improvement with performance at 85.3% and 78% respectively this month. Immediate Life Saving (ILS) rates have declined with performance at 65.9%. There were four COVID-19 Hospital Onset Healthcare Associated infections and one MRSA bacteraemia reported in October. Significant staffing challenges and clusters of high activity and acuity continues to affect staffing ratios in Maternity Services, impacting on the Birth Centre closure which was 21% this month and a supernumerary Labour Ward coordinator at available on ward 88.7% of the time. Improvement continues with antenatal bookings with 95% of women referred being booked by 12 weeks and 6 days. Inpatient, Maternity (Postnatal) and Outpatient services achieved FFT targets where patients rated the services as "Good" or "Very Good". Emergency Department (ED) services were under difficult operational pressures throughout the month and performance for ED FFT experienced a further drop in performance to 71.3% from 73.6% compared to the previous month **Our Process Perspective** In October 73.8% of patients were admitted, discharged or transferred within four hours of their arrival. Flow and capacity remain challenged across the		

Trust with an increase in the acuity of admitted patients and higher numbers of long staying patients that has an impact on front end capacity. The Trust escalated to OPEL 4 for fourteen days in the month, the highest escalation. Fifty-two patients breached the 12-hour ED target where no patient should wait longer than 12 hours before they are admitted to a ward.

For September, 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 continues to see an increase in Two Week Rule (TWR) referrals; the Trust received 1,646 TWR referrals in September 2021, compared to 1,514 in September 2019. The 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.

It was the expectation that the numbers of patients over 63 days would continue to rise through September, related to increasing referrals from other Trusts in Head & Neck, issues within the breast service and in Lower GI. The Trust has agreed a trajectory to reach no more than 141 patients over day 62 by the end of March 2022.

The Trust reported a continued improvement in performance against the six-week diagnostic standard in October 2021 with a performance of 2.3% compared to 3.2% in September 2021. Cardiac MRI capacity remains challenged with additional capacity being added over the next two months to recover the position.

September's 2021's RTT performance was 76.3% against a National target of 92% with 1,005 patients waiting longer than 52 weeks which is ahead of trajectory. The number of 78+ week waits has decreased are ahead of trajectory in all services. Focus continues on reducing 104+ week waits.

Our Workforce Perspective

The Workforce Perspective section, has a new format and a series of Diversity & Inclusion and Culture metrics to monitor the Trust's programmes and key corporate objectives. New metrics are Internal hire rate, BAME staff recruitment and representation in senior bandings and COVID-19 staff vaccination rates (both jabs). Further developments will follow.

The Trust's sickness absence rate increased for the seventh consecutive month to 4.5% against a target of 3.2%. The Surgical Directorate has seen the largest increase in the month with a sickness rate of 5.12%.

Appraisal rates for non-medical staff and medical staff was 73.6% and 75.8% respectively remaining below the Trust target of 90%.

In October, the Trust's internal hire rate was 32.4%. Of the senior substantive staff (Band 8 and above) employed in the trust, Black and Minority Ethnic staff represent 28%. The completion rate for COVID-19 Risk Assessments was 74% and our COVID-19 vaccination rate was, 86% first dose, 84% second dose and 34% booster.

The Trust's total pay for October was £58.19m. This is £0.31m adverse to a plan of £57.88m. Agency spend was £1.98m against a target of £1.25m which is an adverse variance of £0.73m. The largest areas of agency overspend were Interims (£0.42m), Healthcare Scientists (£0.10m) and AHP (£0.11m).

Recommendation:	The Committee is requested to note the report		
Committee Assurance:	The Committee is also asked that in considering contents of this report, its supporting documents and the discussion at the meeting which of the following assurance rating it would provide to the Trust Board. • **Substantial Assurance:** The report and discussions assured the Committee that there are robust systems of internal controls operating effectively to ensure that quality and safety risks are managed to deliver high quality services and care to patients. • **Reasonable Assurance:** The report and discussions assured the Committee that the system of internal controls is generally adequate and operating effectively but some improvements are required to ensure that quality and safety risks are managed to deliver high quality services and care to patients. • **Limited Assurance:** The report and discussions supported the Committee's conclusion that that the system of internal controls is generally inadequate or not operating effectively and significant improvements were required to ensure that the quality and safety risks are managed effectively to improve the position and ensure that high quality services and care is provided to patients. • **No Assurance:** The report and discussions led the Committee to conclude that there was a fundamental breakdown or absence of core internal controls and systems to enable the Trust to deliver high quality services and care to its patients.		
Supports			
Trust Strategic Objective:	Treat the Patient Treat the Person Right Care Right Place Right Time		
CQC Theme:	Safe, Caring, Responsive, Effective, Well Led		
Single Oversight Framework Theme:			
Implications			
Risk:	NHS Constitutional Access Standards are not being consistently delivered and risk remains that planned improvement actions fail to have sustained impact		
Legal/Regulatory:			
Resources:	Clinical and operational resources are actively prioritised to maximise quality and performance		
Equality and Diversity:			
Previously Considered by:	Executive Management Team Finance & Investment Committee Quality & Safety Committee	**Date**	15 Nov 2021 18 Nov 2021 18 Nov 2021
Appendices:			

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NHS
St George's University Hospitals
NHS Foundation Trust

Integrated Quality and Performance Report

For Trust Board
Meeting Date – 25 November 2021

Andrew Grimshaw - Deputy Chief Executive Officer

12 November 2021

Our Outcomes

How Are We Doing?

October 2021

Daycase and Elective Surgery operations

Actual: 4,461

2019 Actual: 5,790

6 Week Diagnostic Performance

Actual: 2.3% Target: 1%

Four Hour Emergency Standard

Actual: 73.8%

Plan: 95%

Whole Trust Inpatient Friends and Family Test

Actual 98.9%

Target 95%

Outpatient First Attendance

Actual 17,908

2019 Actual: 19,652

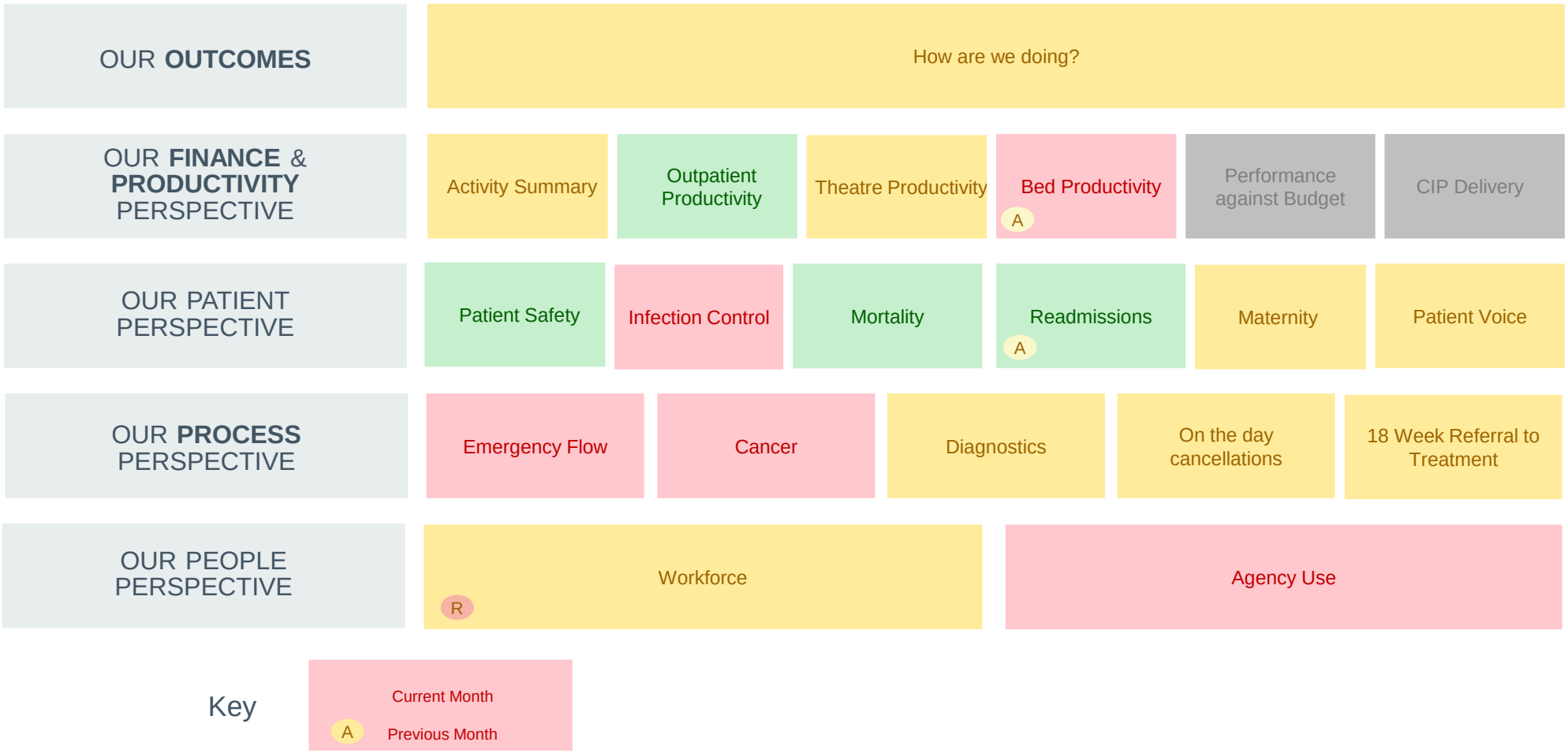
September 2021

Referral to Treatment Standard - Number of 52 Week Breaches

1,005

Outstanding care every time

Balanced Scorecard Approach



Executive Summary – October 2021 (1 of 2)

	What the Information tells us	Actions and Quality Improvement Projects

Finance & Productivity Perspective	• Outpatient activity was 90% of October 2019 activity and is expected to be 94% after catch-up
	• Elective and Daycase performance was 77% of October 2019 activity and is expected at 84% with Theatre specialties at 90% and non-Theatre specialties at 82%.
	• Non-Elective Lengths of Stay (LOS) show special cause deterioration at 6.2 days which is significantly above the 2019 mean of 4.4 days.
	• Elective LOS also shows special cause deterioration at 4.6 days; in 2019, patients stayed on average 3.8 days.
		• Outpatients – Work on Patient Initiated Follow-ups and Advice & Guidance uptake is being undertaken to improve overall performance
		• Daycase & Elective activity
		  • Large underperformance in endoscopy is driven by low uptake of population Bowel Cancer Screening; the service is working with the London Screening Hub to increase invitation rates to expand reach and improve attendance rates.
		  • DSU23 launches in late November, with new Breast, ENT and Plastics lists moving from IP into DSU; this will significantly increase capacity and productivity.
		  • Focus on Recovery Flow undertaken which aims to improve productivity in Tooting theatres using real-time monitoring on performance which informs appropriate actions and escalations.
		• Length of Stay
		  • Flow work programme established
		  • Early Bird Pilot programme focussing on discharges before 10 am will be tested on key wards
		  • Focussed work on increasing use of departure lounge underway
		  • Positive engagement from all local Age UK services to provide support with discharge and delivery of practical services

Patient Perspective	• Immediate Life Support (ILS) training rate has fallen to 66%; the target is 85% • Advanced Life Support (ALS) training rate has remained steady at 78%, breaking its seven month consecutive increase run • MCA & DoLs training level 1 completion rates at 83.7% shows special cause deterioration; the target is 90%. • All patient safety indicators showed either common cause variation or special cause improvement. • There was one MRSA bactaeremia reported in October and four Hospital Onset Healthcare Associated COVID-19 infection • In maternity, staffing challenges, clusters of high activity and acuity continued which impacted on staffing ratios; the birth centre was closed over 21% of the time and supernumerary midwife was available 88.7%. • Inpatient, Maternity (Postnatal Ward) and Outpatient services achieved FFT targets where patients rated the services as "Good" or "Very Good“.	• ILS - As the Critical care Outreach team is now fully established consideration is being given to re-categorising some staff groups to BLS level 2; this will be discussed at the Trust wide Resus Group • ALS - Resus Team attended medical staff induction • Face to face training is being reviewed to support teams with practical application of the Mental Capacity Act and improve quality of documentation, alongside encouragement to complete required Level 1 & 2 training. • Full root cause analysis is in progress with respect to the MRSA bactaeremia; the Infection Control Group continues to monitor and support staff to ensure high quality care • Maternity has successfully filled all band 5 and band 6 midwifery vacancies; The team have successfully won a bid for an additional £50K to introduce a Band 7 leadership role • FFT ED – following on from investigations, movement to the Trust’s collection system has resulted in a response rate drop and the position has also been impacted by current operational pressures. Posters with QR codes have been set up in high traffic areas to provide opportunities to participate in FFT survey

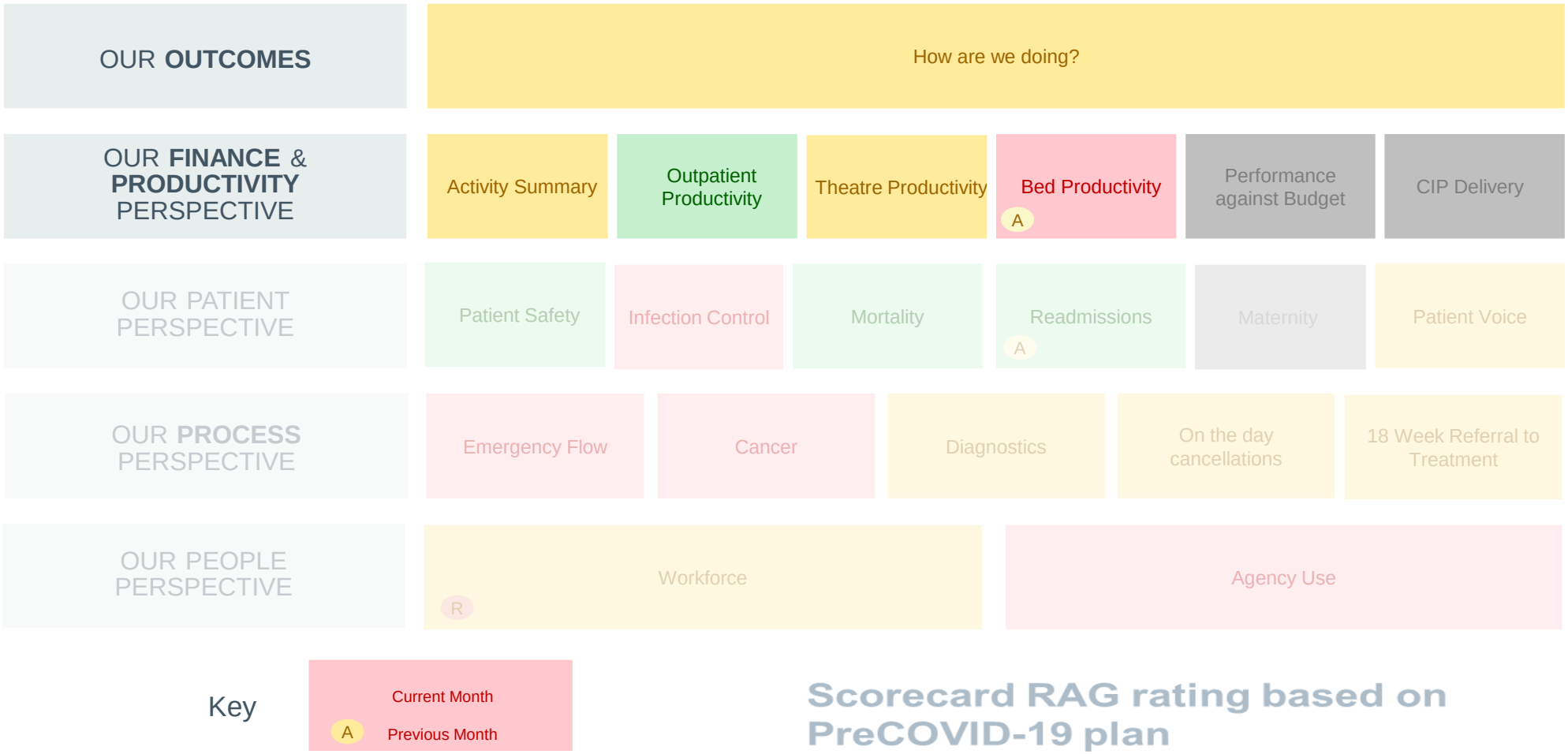
Executive Summary – October 2021 (2 of 2)

	What the Information tells us	Actions and Quality Improvement Projects

Process Perspective	• Four Hour Operating Standards
	  • 73.8% of patients either admitted, discharged or transferred within four hours of their arrival; the target is 95%
	  • 52 patients breached the 12-hour ED target; no patient should wait longer than 12 hours before they are admitted to a ward.
	• September 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 80.4% decreasing from 81.3% reported in August
	  • 62 Day Performance was 68.4% with a target of 85%
	• Six week diagnostic standard improved to 2.3% from 3.2%
	  • Capacity challenges remain in Cardiac MRI with 120 patients waiting more than 6 weeks.
	• Referral to Treatment for September:
	  • Waiting list has remained stable though the list has been growing slowly for the past six month
	  • 1,005 patients have been waiting over 52 weeks since referral compared to the June plan number of 1,106.
		• Four Hour Operating Standards actions
		  • LIAT point of care testing being introduced into the department for COVID -19 and Flu during November.
		  • The Homelessness Inclusion Team has begun work in November and will be based in ED supporting homeless patients presenting there. The team, funded by a central grant from DHSC, will also assist on wards in the rest of the Trust.
		• Cancer
		  • The Trust is seeking mutual aid from other SWL providers to ensure patients are seen in a timely manner for Breast referrals and a Harms review process is in place
		  • Key tumour groups are working with theatres and diagnostics to address capacity and flow issues
		• Diagnostics
		  • Additional Cardiac MRI capacity is now provided via the new MRI Community Diagnostic Centre at the Wilson and additional sessions on the St. James' Wing mobile unit. November capacity is fully booked with the expectation that performance improvement will be seen in December
		• Referral to Treatment
		  • Optimisation of the Surgical Treatment Centre at QMH (improving utilisation and throughput)
		  • Development of 23 hour DSU pathway
		  • Continued use of the JRU, extended to inpatient pathways at Kingston

People Perspective	• Trust sickness absence rate increased for the seventh consecutive month and was at 4.5%
	• Medical and non-Medical appraisal rates remain below their target of 90% at 75.7% and 73.7% respectively
	• Trust turnover rate is 15.4% against a target of 13%
	• The proportion of senior BAME substantive staff is 28% compared to the 2019 mean of 25%
	• The internal hire rate was 32.4% against a target of 40%
	• Agency cost was £1.98m which is £0.73m adverse to the monthly target of £1.25m, however total October Trust pay is £0.31m adverse to plan
		• Sickness rate
		  • The Winter Workforce Wellbeing Plan has been designed to address the Trust Level Sickness and Vacancy rate
		  • Projects within the Winter Workforce Plan have been re-prioritised and will be reviewed regularly with the People Management Group
		• Communications sent to staff reminding them to completed the Personal Development Review (PDR); Trust Employee Relations team discussions taking place on incorporating pay progression into the PDR process.
		• A turnover deep dive was undertaken finding the main cause for turnover is due to fatigue and stress. The Trust has a suite of measures to support staff and minimise the number of those struggling before they go on leave
		• Debiasing recruitment is a key programme in the Trust's Diversity & Inclusion Plan with a wide variety of training programmes, Recruitment Inclusion Specialists and CPD Application panels.
		• Internal opportunities policy available along with job advertisements that are "Internal First"

Balanced Scorecard Approach



Activity Summary

		Activity compared to 2019/20			Activity compared to previous year			Activity compared to 2020/21		
		Oct-19	Oct-21	Variance	YTD 19/20	YTD 20/21	Variance	Oct-20	Oct-21	Variance
ED	ED Attendances	14,308	13,454	-5.97%	99,701	90,991	-8.74%	10,010	13,454	34.41%
Inpatient	Non Elective	4,178	3,380	-19.10%	27,864	23,485	-15.72%	3,346	3,380	1.02%
	Elective & Daycase	5,790	4,461	-22.95%	37,851	34,040	-10.07%	4,989	4,461	-10.58%
Outpatient	OP Attendances	54,899	49,293	-10.21%	352,268	347,102	-1.47%	48,472	49,293	1.69%

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

Note: Figures quoted are as at 08/11/2021 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 October 2021 have been shown against activity levels reported in October 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).

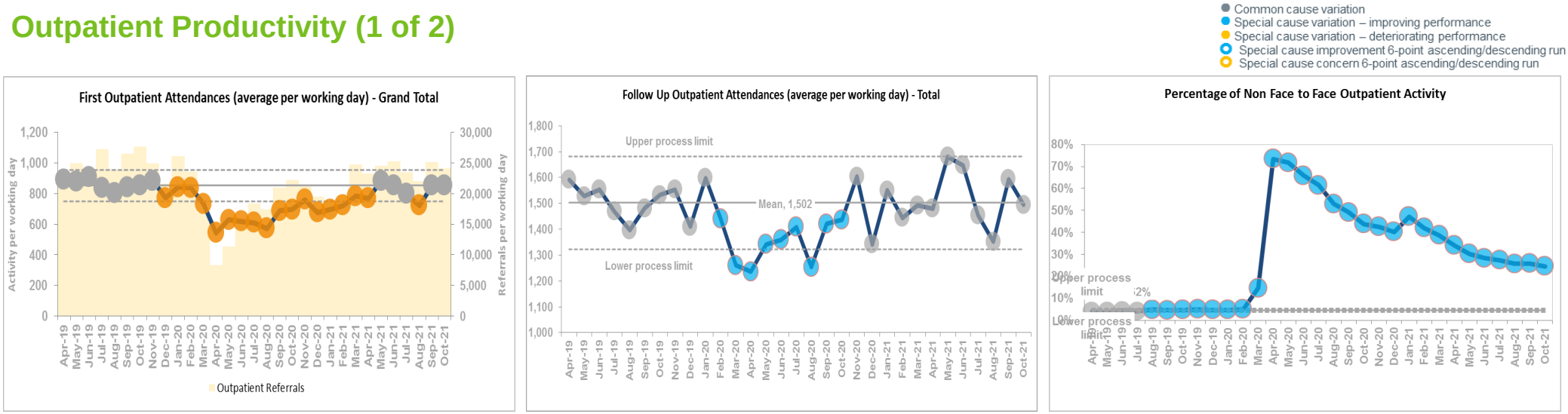
October Activity Performance v Trajectories – Elective, Daycase & Outpatients

The Trust has submitted final activity trajectories for H2, which forecast activity at 95% of 2019/20 levels adjusted for working days. In October, there are only 21 working days compared to 23 in 2019/20, hence the target for October is 87%. The Trust no longer receives ERF payments based on activity trajectory performance, as it now factors in activity clock stop data. This is not available as yet for October.
Note: The below activity information is shown in 'SLAM' currency, as this is the currency the Trust is used to seeing and reporting.

	ACTIVITY QUANTUMS					ACTIVITY %s				
Specialty	Oct Trajectory	Oct Activity	Oct catch up estimate	Oct Activity after catch up	variance activity	Oct Trajectory	Oct Actual	Oct catch up estimate	Oct Activity after catch up	variance activity
Cardiac Surgery (172)	42	31	1	32	-10	105%	78%	1%	79%	-26%
Colorectal Surgery (104)	26	50	4	54	28	55%	106%	8%	115%	59%
Ear, Nose & Throat	197	127	13	140	-57	102%	66%	7%	73%	-29%
General Surgery (100)	57	50	4	54	-3	69%	61%	5%	66%	-4%
Gynaecology (502)	193	171	15	186	-7	84%	75%	6%	81%	-3%
Neurosurgery (150)	98	138	8	146	48	55%	78%	5%	82%	27%
Trauma & Orthopaedics (110)	48	99	11	110	62	41%	84%	9%	93%	52%
Urology (101)	380	333	35	368	-12	119%	104%	11%	115%	-4%
Total Theatre Specialties	**1,040**	**999**	**89**	**1,088**	**48**	**83%**	**83%**	**7%**	**90%**	**7%**
Gastroenterology (301)	1,254	1,045	152	1,197	-57	81%	67%	10%	77%	-4%
Cardiology (320)	229	201	6	207	-22	77%	67%	2%	69%	-7%
Dermatology (330)	16	0	0	0	-16	92%	0%	0%	0%	-92%
Neurology (400)	771	581	27	608	-163	98%	74%	3%	77%	-21%
Paediatrics (420)	14	37	3	40	26	77%	206%	16%	221%	144%
Paed Surgery (171)	90	100	5	105	14	84%	93%	4%	98%	14%
Clinical Haematology (303)	178	139	47	186	8	183%	143%	48%	191%	8%
Medical Oncology (370)	108	97	2	99	-10	104%	93%	2%	95%	-9%
All Other Specialties	1,357	1,248	62	1,311	-46	85%	78%	4%	82%	-3%
All Other	**4,017**	**3,448**	**303**	**3,751**	**-266**	**88%**	**75%**	**7%**	**82%**	**-6%**
Total Daycase / Elective	**5,058**	**4,447**	**392**	**4,839**	**-218**	**87%**	**77%**	**7%**	**84%**	**-3%**
Outpatients	**47,619**	**49,269**	**2,463**	**51,733**	**4,114**	**87%**	**90%**	**4%**	**94%**	**7%**

- 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 84%, lower than the 87% trajectory submitted for October. Theatre specialties are at 90%, with non-Theatre specialties at 82%.
- Outpatient performance is expected to be 94% after catch-up, which is higher than the 87% trajectory by 7%.

Outpatient Productivity (1 of 2)



What the information tells us

First outpatient activity throughout October increased slightly compared to the previous month with performance continuing to show common cause variation. On average, there were 853 attendances daily with a daily increase in the number of referrals received. First outpatient activity reported in October 2021 was 91% of activity reported in October 2019, this is expected to increase once coding is completed. Activity levels within Surgery have continued to see a steady increase with October levels being above the mean of 2019, Women's services have seen activity levels increase to above the upper control limit.

At Trust level, follow-up activity continues to show common cause variation with activity levels in line with the mean of 2019. In the month, the daily average attendance was 1,495 compared to 1,593 patients in September.

All outpatient activity in October 2021 was 90% of the activity reported in October 2019, this is expected to increase to 94% once data catch up is completed which is higher than the 87% trajectory by 7%.

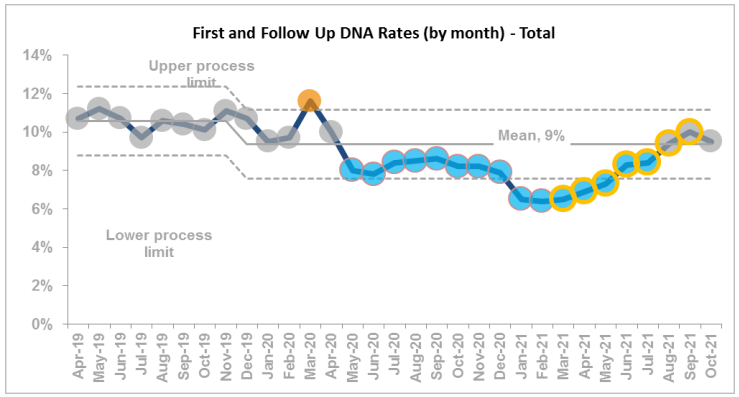
In October, 24.6% of our outpatient attendances were undertaken in a virtual setting, showing a continued decline. The largest proportion of virtual appointments were reported within Cardiology, Respiratory Medicine and Gastroenterology.

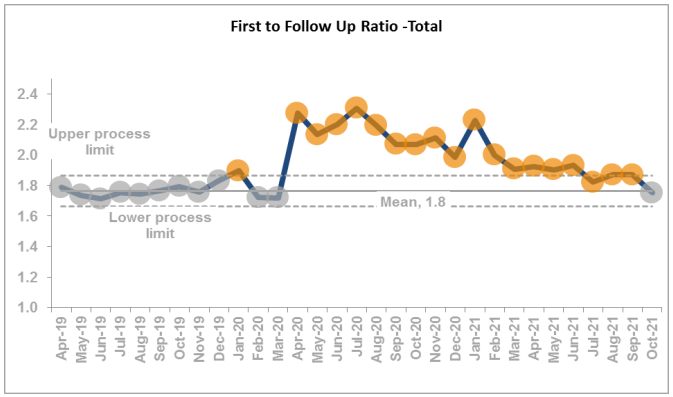
Please note that COVID-19 related OP activity has been excluded from the charts.

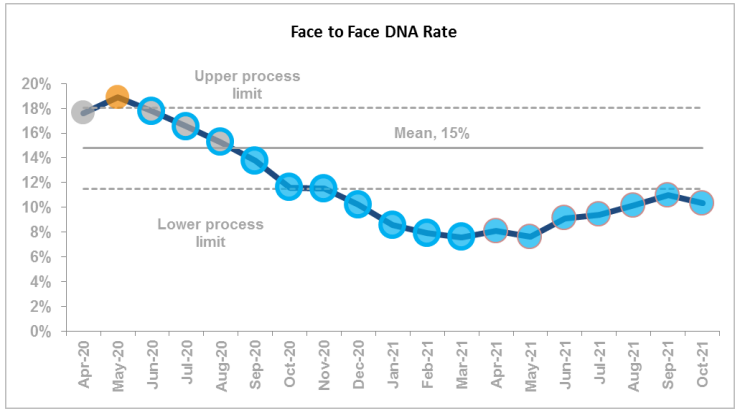
Actions and Quality Improvement Projects

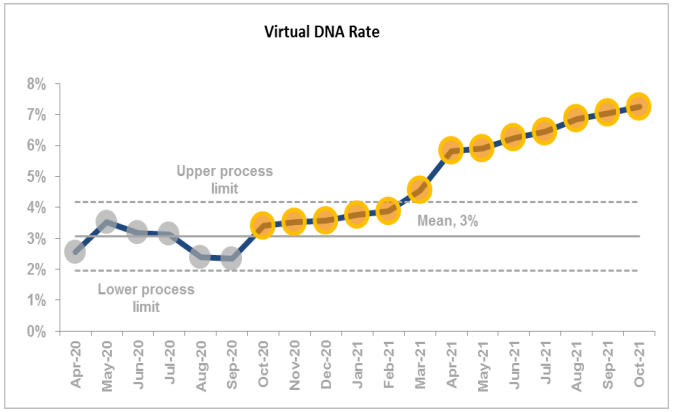
- As part of the Elective care recovery programme, we are treating a large volume of patients who have waited a long time for their appointments and therefore there is a higher proportion requiring an appointment in a face-to-face setting. It is anticipated that we will see a lower volume of virtual 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. Many services now have mixed media clinics and this may well become the norm. 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 has oversight of all key Outpatient KPIs and transformation work streams. This reports into the Elective Care Recovery Programme Board.
- I.T. are bidding for some monies to support virtual outpatient activity and Outpatients have assisted with this bid.
- Work is on-going both within the Trust and at SWL level to improve both PIFU and A&G both of which should support an improvement in our overall performance.

Outpatient Productivity (2 of 2)









Common cause variation
Special cause variation – improving performance
Special cause variation – deteriorating performance
Special cause improvement 6-point ascending/descending run
Special cause concern 6-point ascending/descending run

What the information tells us

The proportion of patients not attending their outpatient appointment in October was 9.5%, slightly below levels seen in the previous month and in line with the mean of 2019.

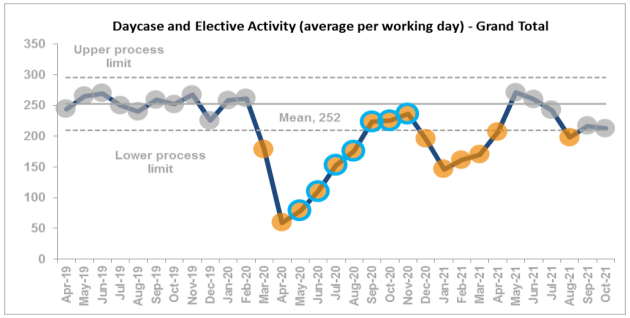
The first to follow-up ratio has continued to see a steady reduction over recent months falling returning to within 2019 common cause levels.

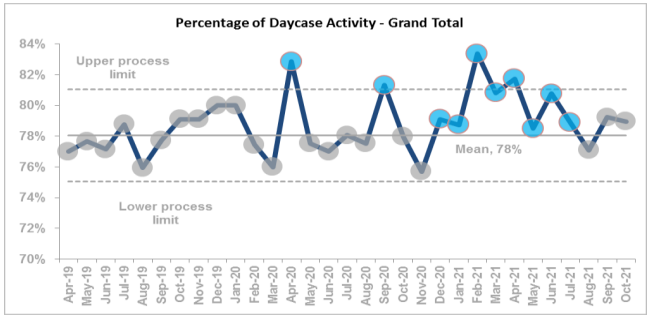
The Trust continues to see a higher DNA rate for those patients being seen in a face-to-face environment compared with a virtual setting.

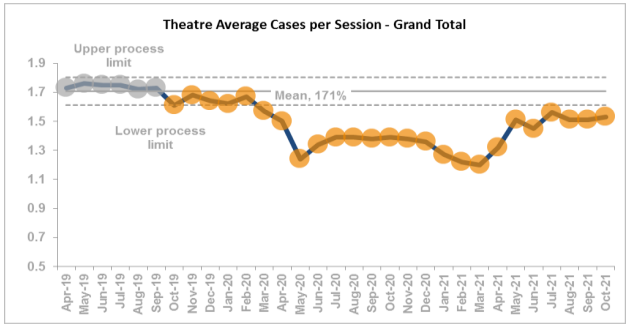
Actions and Quality Improvement Projects

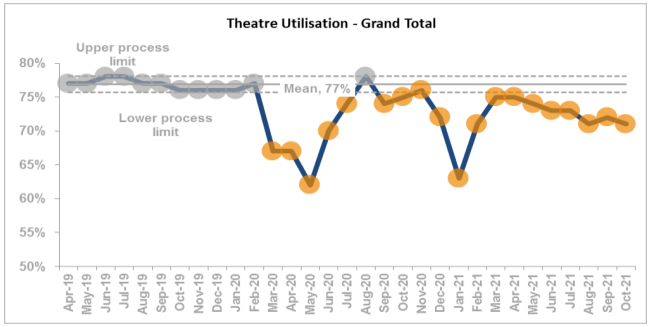
- Services are undertaking clinic reviews to reflect the needs of their backlog. Some clinics may have additional new appointments depending on where the demand lies.
- We are also looking at how Patient Initiated Follow ups (PIFU) may be able to assist with reducing our DNA rates and ensuring that our appointment slots are offered to those who need and want an appointment.
- Work continues with services to review communications to patients which we believe is impacting the DNA rates.

Elective Activity & Theatre Productivity









What the information tells us

In October, the number of elective treatments fell compared to September. Although levels are show common cause variation, activity throughout the month is below the mean of 2019 baseline.

On average, 212 patients were treated per day compared to 217 in September. Overall elective activity was 77% of that reported in October 2019 and is expected to rise to 84% once data catch up is completed, this is below the trajectory of 87% submitted for October.

Several specialties continue to see activity levels within 2019 common cause limits although many are below the mean of 2019 including ENT, General Surgery, Max Fax, Vascular and Endoscopy. The reduction in Endoscopy activity has largely been impacted due to the low uptake of Bowel cancer screening .

In October, Theatres ran 950 theatre sessions, compared to 1,101 in the same period in 2019. The average cases per session and theatre utilisation, although below the lower control limit, remains stable.

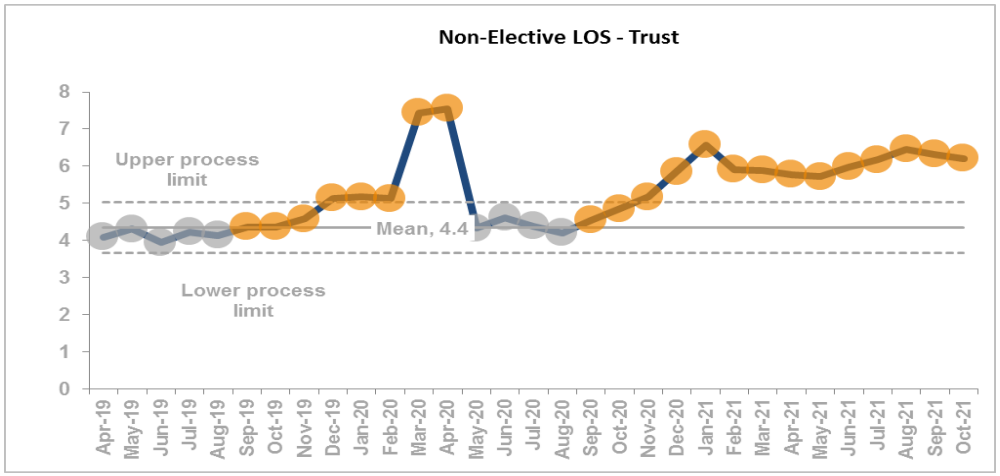
- Common cause variation
- Special cause variation – improving performance
- Special cause variation – deteriorating performance
- Special cause improvement 6-point ascending/descending run
- Special cause concern 6-point ascending/descending run

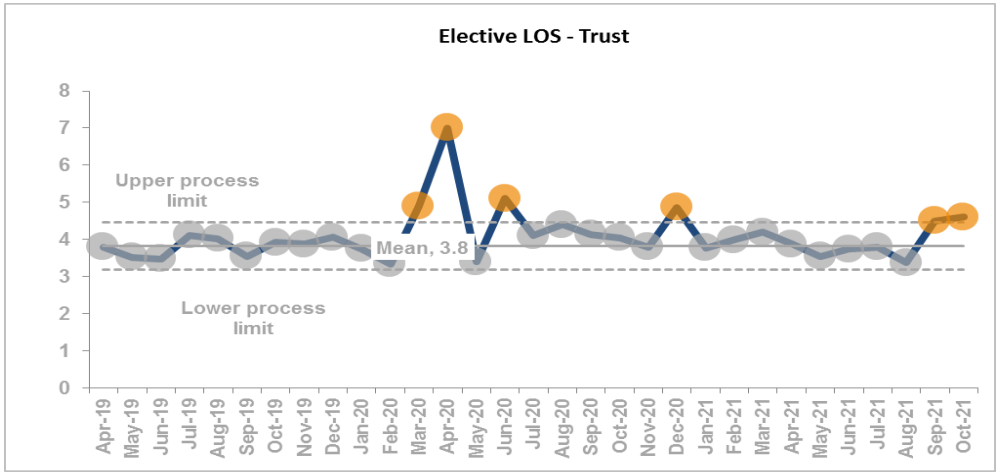
Actions and Quality Improvement Projects

Activity levels have been impacted in October due to annual leave. October saw both private and state school half-terms which led to increased leave for staff. This is compounded by higher levels Annual Leave allowances due to COVID-19, which means fewer staff are available to work. Improvement projects focusing on DSU, POA, Flow, Scheduling and Recruitment are underway:

- **DSU 23 hour/ Extended Recovery:** DSU23 launches in late November, with new Breast, ENT and Plastics lists moving from IP into DSU. This scheme will significantly increase DSU capacity and productivity.
- **POA:** 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', avoiding unnecessary POA, improving patient experience and increase capacity. Required changes to iClip eTCI have been actioned. A pilot in T&O commences in late November.
- **Recovery flow:** A new dashboard was launched in September, providing a live picture of all theatre recovery areas. This is supported by three daily meetings and a system of internal KPIs and 'breach criteria' linked to recovery occupancy, which trigger a range of escalations. This innovation is aimed at improving list sequencing and minimising blockages which cause overruns and cancellations.
- **Scheduling:** List Planning has been re-vamped. 'Daily dash' huddles with Patient Pathway Coordinators (PPCs) and individual team targets have been introduced to monitor and drive performance.
- **Recruitment:** A recruitment drive is underway to increase numbers of anaesthetists (14 posts out, 5 recruited to, interviewing for 6 more posts in November), nurses (10 new nurses starting at QMH in Q3) and ODPs (10 recruited to an ODP training programme which commences in Q4).
- **Endoscopy**. The low uptake of Bowel Cancer Screening is out of SGH direct line of influence, the service has been entirely engaged with the London Screening Hub, who have increased their invitation rates for SWL by a further 630 invites per month to expand reach and probability to improve uptake. Invitations were sent out at beginning of Oct – and are therefore likely to convert to colonoscopy activity in 6 weeks time.

Length of Stay





Common cause variation
Special cause variation – improving performance
Special cause variation – deteriorating performance
Special cause improvement 6-point ascending/descending run
Special cause concern 6-point ascending/descending run

What the information tells us

Non-elective Length of Stay (LOS) remains above the mean of the 2019 baseline with a decrease in October. On average non-elective inpatients stayed in a hospital bed for a total of 6.2 days. Recent increases continue to be driven by an increase in the acuity of patients being admitted, the number of outer borough admissions and a continued high number of patients with a delayed discharge due to external dependencies, e.g. placement, care support and equipment. There has been an increase in the specialties of Senior Health and Acute Medicine.

Patients staying in excess of 7, 14 and 21 day has continued to increase impacting on flow throughout the Trust. Capacity throughout the hospital has been challenged with occupancy continuing to increase. The Trust was on its highest OPEL status on 14 days in October.

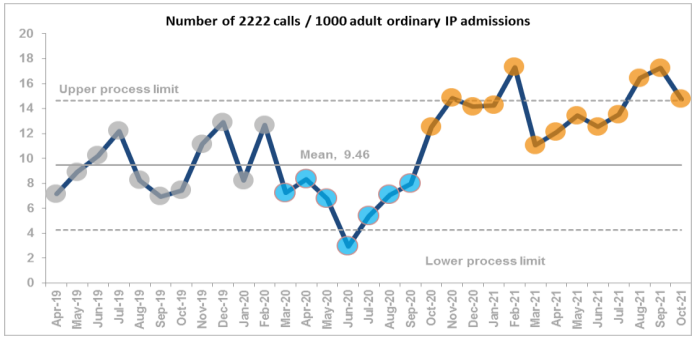
Elective length of stay has continued above the upper control limit through October. On average, patients stayed in a hospital bed for 4.6 days compared to 4.5 days in September with increases seen within Neurosciences.

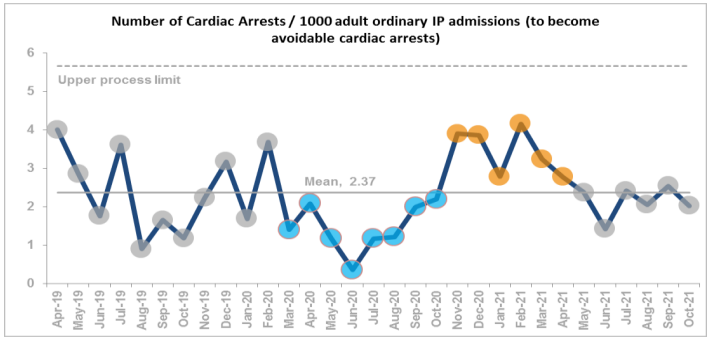
Actions and Quality Improvement Projects

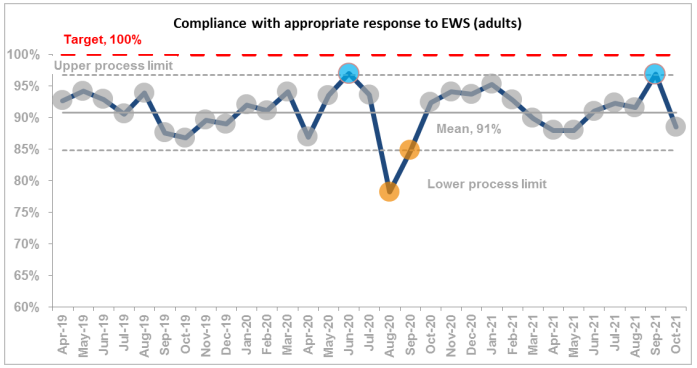
- Early Bird pilot programme focusing on discharges before 10am to support flow from ED to the wards developing further based on early success with this, further refinement of the process required.
- Increasing the use of the departure lounge where appropriate, a review of the capacity of the lounge, particularly for number of available beds required.
- Establishment of SGUH flow programme
- External interface flow work which includes three focal areas for Merton and Wandsworth: discharge, maximising community capacity and virtual frailty ward
- Focus on referring patients to the bed bureau for patients no longer meeting the criteria to reside and awaiting rehabilitation or placement
- Positive engagement from all local Age UK services to provide support with discharge and delivery of practical services, for example key safe installation, furniture removal

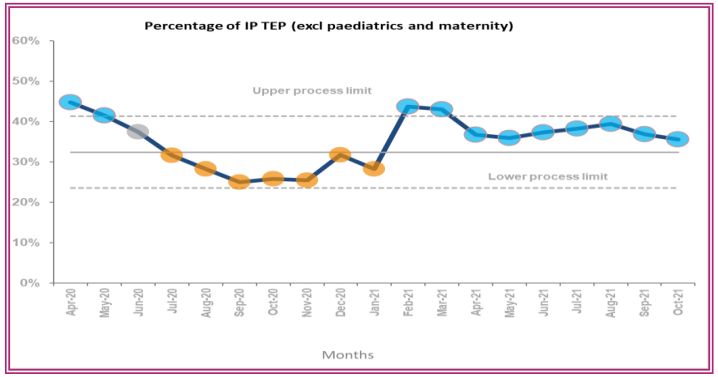
Balanced Scorecard Approach

Quality Priorities – Treatment Escalation Plan









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 89% this month and shows common cause variation.
- Performance against our Treatment Escalation Plans has plateaued in recent months and continues to show special cause variation.

Common cause variation
Special cause variation – improving performance
Special cause variation – deteriorating performance
Special cause improvement 6-point ascending/descending run
Special cause concern 6-point ascending/descending run

Actions and Quality Improvement Projects

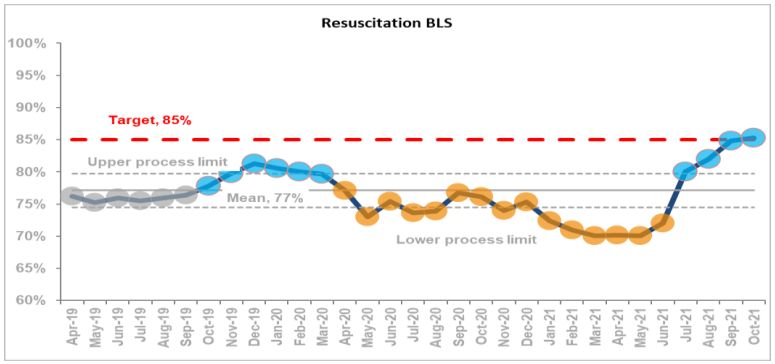
In order to continue to improve Treatment Escalation Plan (TEP) completion rates the following developments are now in place:

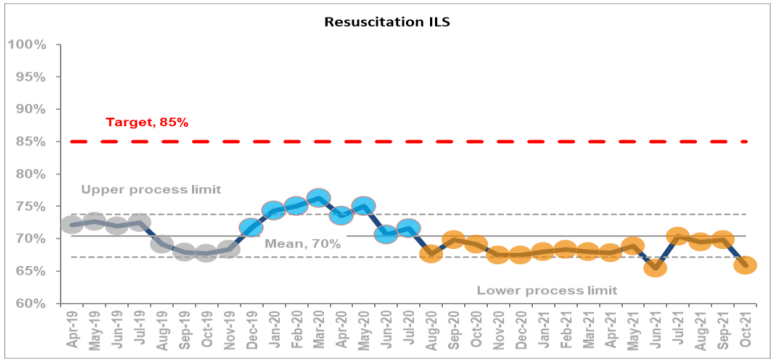
- Electronic dashboard to see how many patients in any clinical area have not had a TEP completed
- Reporting at ward level in divisional performance reports.

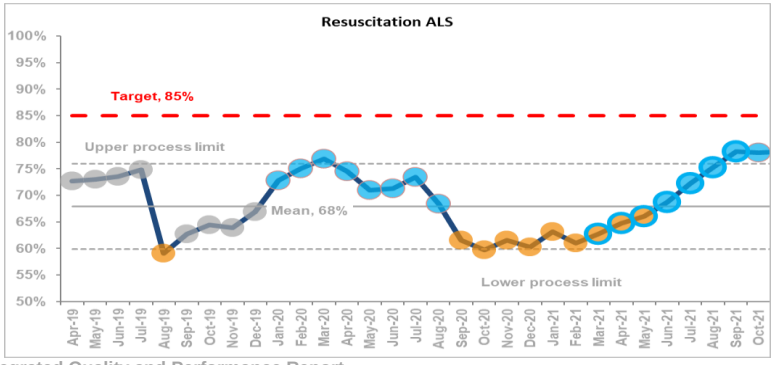
The following initiatives are in development for implementation by 31 March 2022:

- Easy electronic link to TEP from CERNER iCLIP to promote completion
- Simulation sessions to help clinicians to have conversations with patients about treatment escalation planning

Quality Priorities – Deteriorating Patients







What the information tells us

- BLS (Basic Life Support) training performance continues to shows special cause improvement with a steady increase in performance which is now 85%, and achievement of the target.
- ILS (Immediate Life Support) shows special cause variation, with performance at 66% for this month.
- ALS (Advanced Life Support) training performance continues to be maintained with performance at 78%
- BLS and ALS continues to show improvement with BLS being achieved following targeted work internally. ILS rates have not met the Trust target.

Common cause variation
Special cause variation – improving performance
Special cause variation – deteriorating performance
Special cause improvement 6-point ascending/descending run
Special cause concern 6-point ascending/descending run

Actions and Quality Improvement Projects

BLS - To maintain current performance the Self Assessment Pod is now open Monday to Friday 08:00 to 18:00

ILS – ILS Monday has commenced. At least 30 ILS places offered weekly although DNA rates remain high at 40% exacerbated by current operational pressures. Resus team scoping the development of eILS recertification course – ILS equivalent is 2.5 hours face-to-face with on-line learning

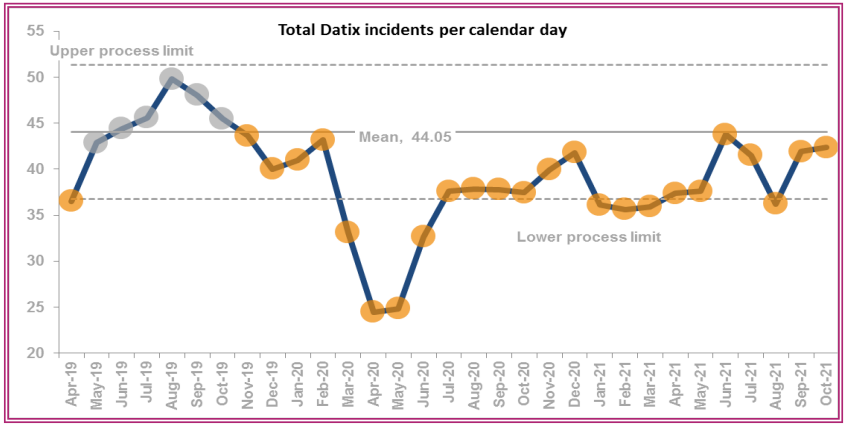
A further review of the training needs analysis will be undertaken. As the Critical care Outreach team is now fully in place consideration should be given to re-categorising some groups of staff to BLS level 2. This will be further discussed at the next Trust wide Resus Group

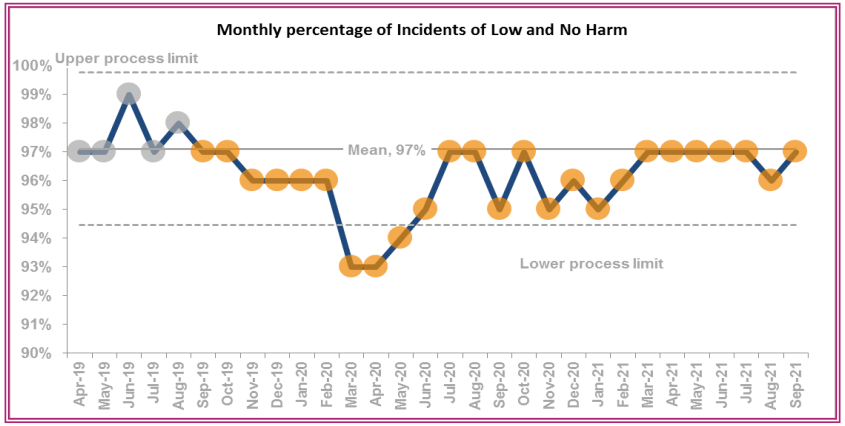
ALS – Resus Team attended medical staff induction – ALS certificates requested and available courses highlighted

Quality Priorities – Learning from Incidents

Common cause variation
Special cause variation – improving performance
Special cause variation – deteriorating performance
Special cause improvement 6-point ascending/descending run
Special cause concern 6-point ascending/descending run

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





What the information tells us

- Open Serious Incident (SI) investigations are being completed in line with external deadlines, 60 working days.
- All incidents at moderate harm and above have had a Duty of Candour completed within 20 working days for 2 consecutive months.

Actions and Quality Improvement Projects

Duty of Candour (DoC) - There were 28 qualifying incidents reported in August 2021 and DoC was completed for all 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 sustain compliance.

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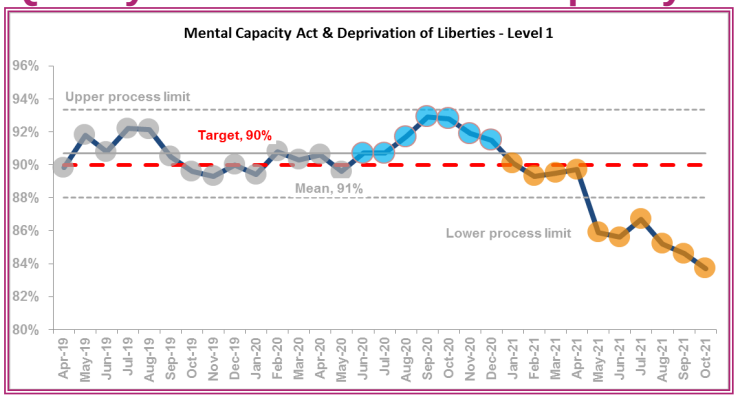
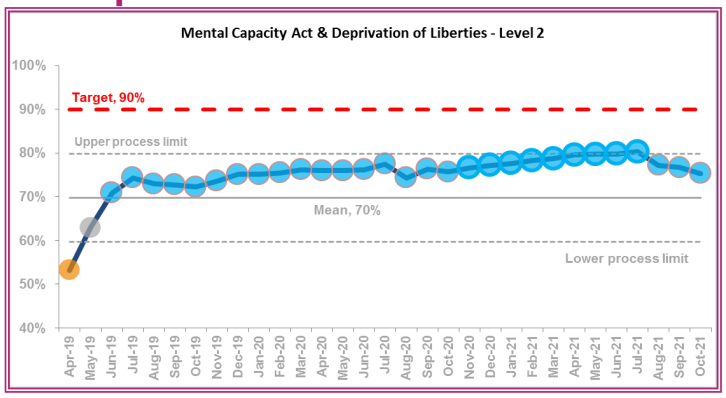
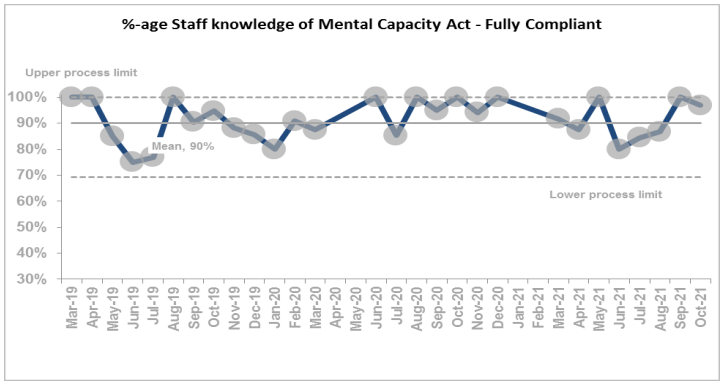
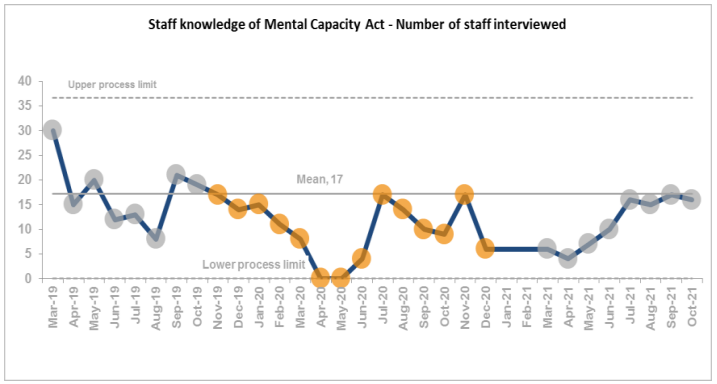
Our Patient Perspective

Quality Priorities – Mental Capacity Act & Deprivation of Liberties









- Common cause variation
- Special cause variation – improving performance
- Special cause variation – deteriorating performance
- Special cause improvement 6-point ascending/descending run
- Special cause concern 6-point ascending/descending run

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 ten months below the 2019/20 average. Performance in October was 83.7%
- Overall Level 2 compliance was 75% this month.
- Metrics showing the number of staff interviewed and their level of knowledge was suspended in January and February 2021 and interviews resumed in March. Performance against both metrics shows commons cause variation.

Actions and Quality Improvement Projects

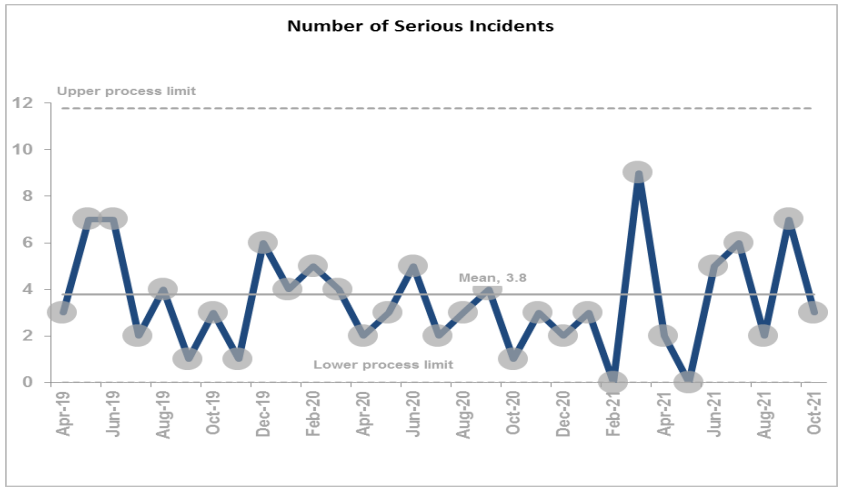
Our new Mental Capacity Act (MCA) Lead commenced in September 2021 and is working with colleagues to review our current systems and processes as part of our preparation for the implementation of the Deprivation of Liberty Safeguards (LPS). The LPS will require increased competence and confidence with capacity assessments at clinician level as well as significant new responsibility for the Trust as we take over from the Local Authority as Responsible Body (replacing 'supervisory body).

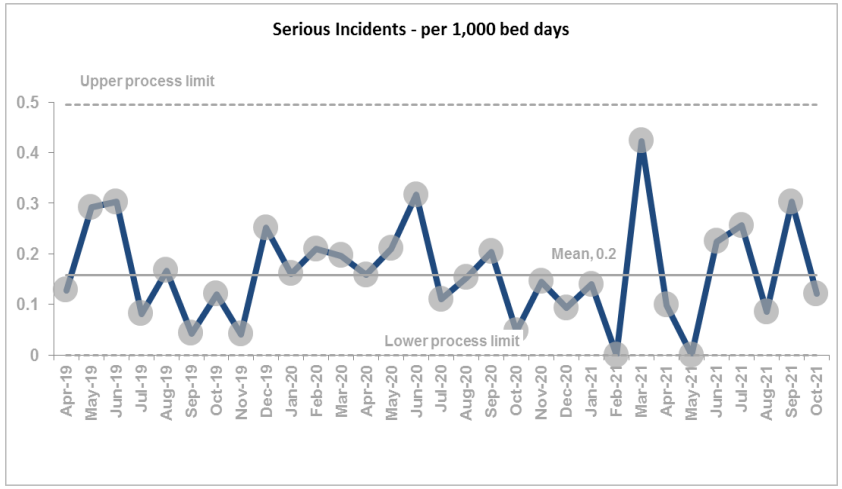
Face to face training is being reviewed to support teams with practical application of the Mental Capacity Act and improve quality of documentation, alongside encouragement to complete required Level 1 & 2 training. As part of the preparation period, the MCA CNS has protected clinical time to provide active role modelling and problem solving with ward teams.

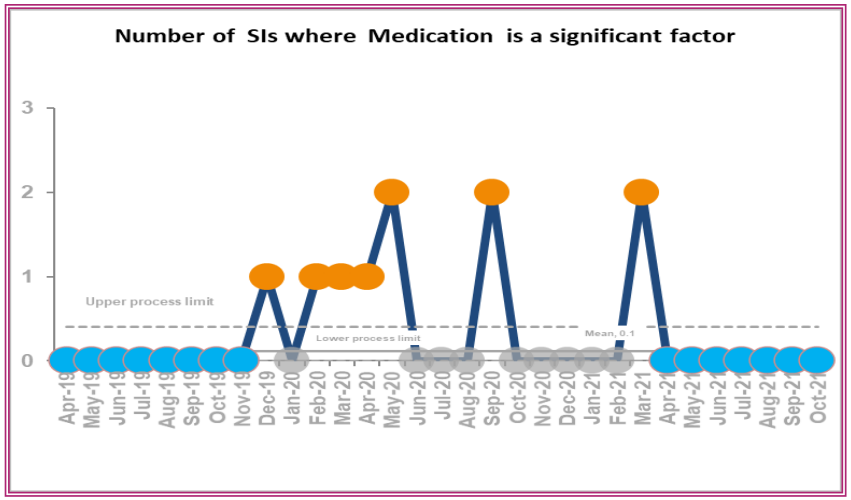
The MCA Steering Group has been reconvened to support and lead the continued embedding of MCA processes and LPS implementation.

Patient Safety- Serious Incidents

Common cause variation
Special cause variation – improving performance
Special cause variation – deteriorating performance
Special cause improvement 6-point ascending/descending run
Special cause concern 6-point ascending/descending run







What the information tells us

- Common cause variation is seen in the number of Serious Incidents and the number of Serious Incidents per 1,000 bed days.

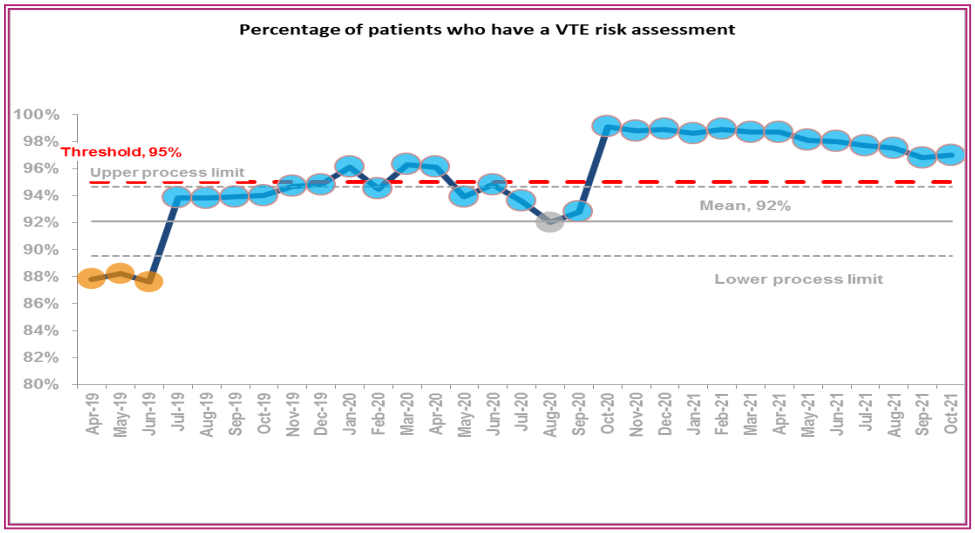
Actions and Quality Improvement Projects

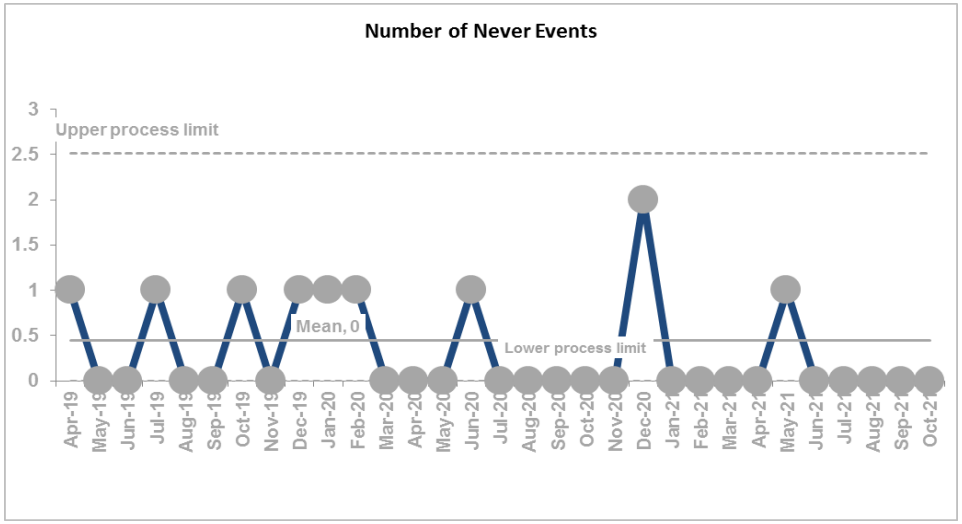
- Serious Incident (SI) investigations are being completed in line with external deadlines, 60 working days.

Our Patient Perspective

Patient Safety- VTE and Never Events

Common cause variation
Special cause variation – improving performance
Special cause variation – deteriorating performance
Special cause improvement 6-point ascending/descending run
Special cause concern 6-point ascending/descending run





What the information tells us

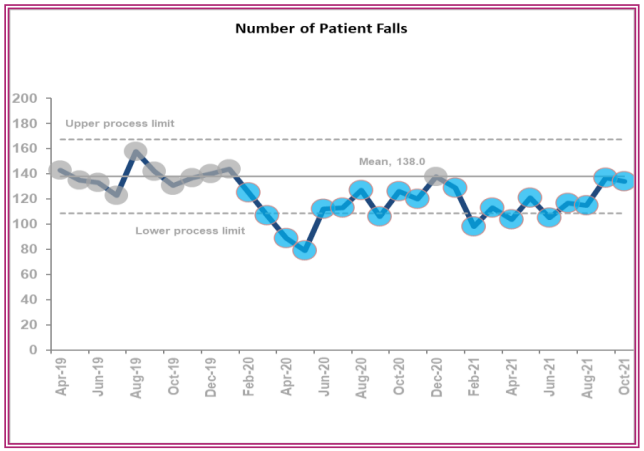
- The percentage of patients who have had a VTE risk assessment was 97% against a target of 95%.
- There were no Never Events declared in October 2021.

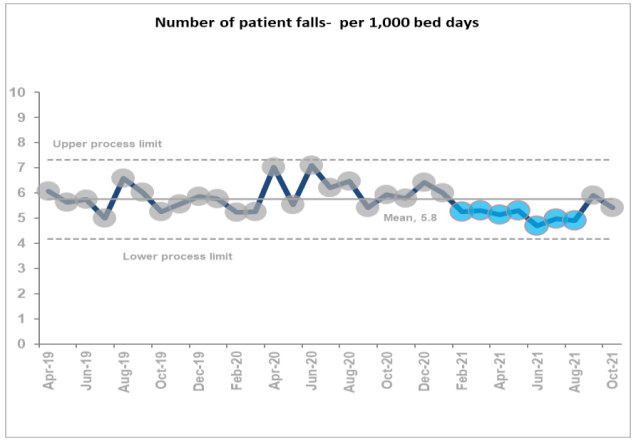
Actions and Quality Improvement Projects

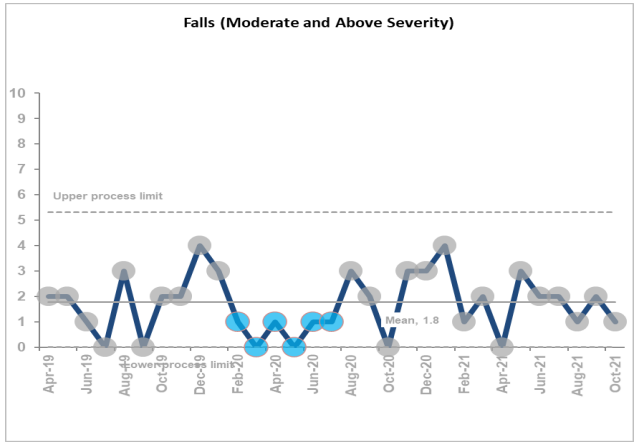
- The Hospital Thrombosis Group (HTG) continue to monitor VTE performance through Tableau reporting, the pharmacy VTE audit and hospital acquired thrombosis root cause analysis. The COVID-19 VTE prophylaxis policy has also been updated based on NICE guidance published in September 2021.

Our Patient Perspective

Patient Safety- Falls







Common cause variation
Special cause variation – improving performance
Special cause variation – deteriorating performance
Special cause improvement 6-point ascending/descending run
Special cause concern 6-point ascending/descending run

What the information tells us

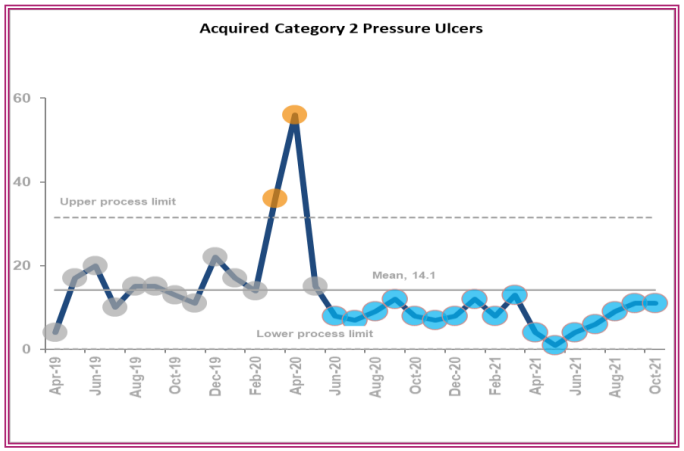
- The number of patients falls show special cause variation with an improving position and the number of Patient Falls per 1,000 bed days has returned to common cause variation.
- One patients had a fall in month with a severity of moderate or above showing common cause variation.

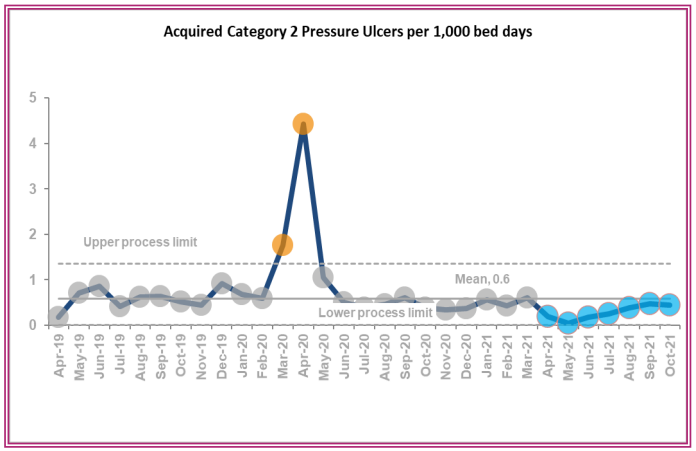
Actions and Quality Improvement Projects

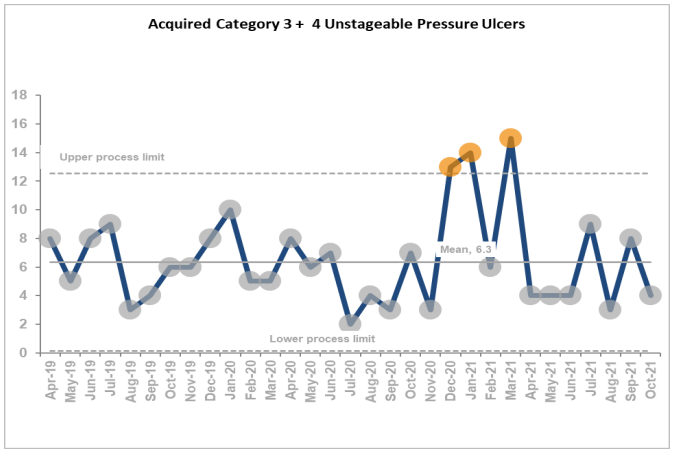
- Falls prevention measures continue to be implemented across inpatient wards
- Falls incidents continue to be monitored and reviewed locally by senior nursing teams with any learning identified and improvement actions implemented as appropriate.

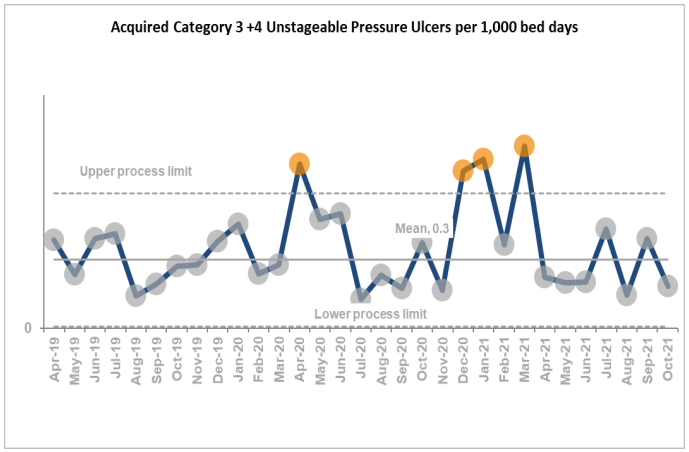
Our Patient Perspective

Patient Safety- Pressure Ulcers









Common cause variation
Special cause variation – improving performance
Special cause variation – deteriorating performance
Special cause improvement 6-point ascending/descending run
Special cause concern 6-point ascending/descending run

What the information tells us

- There were 11 Category 2 Pressure ulcers this month. Category 2 PUs and rate per 1,000 bed days shows special cause variation with an improving position.
- The number of Category 3 & 4 Unstageable Pressure and the rate per 1,000 bed days continue to show common cause variation.

Actions and Quality Improvement Projects

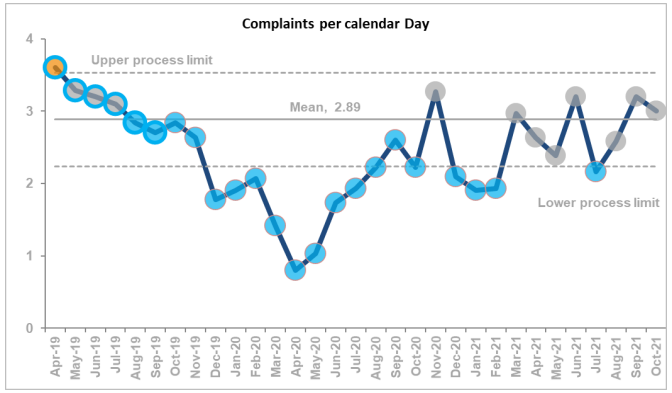
The Tissue Viability Nurses validate all category 2 and above pressure ulcers.

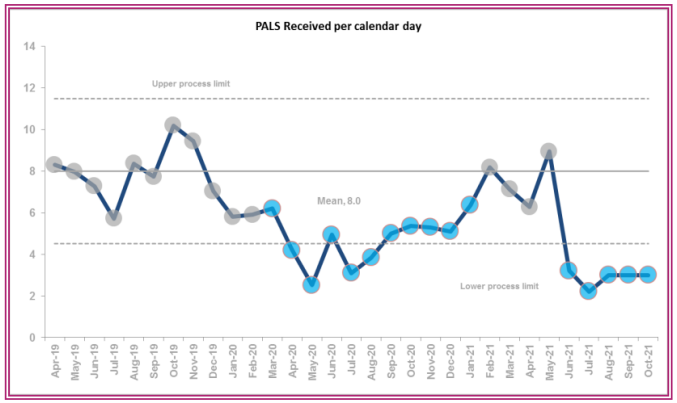
All category 3 and above pressure ulcers undergo root cause analysis to identify any learning.

Our Patient Perspective

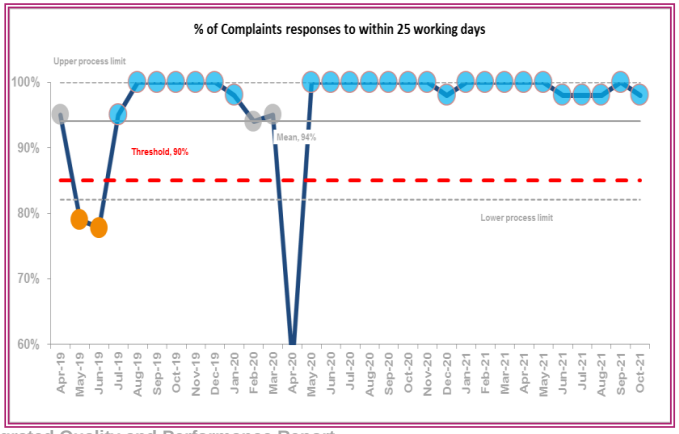
Complaints

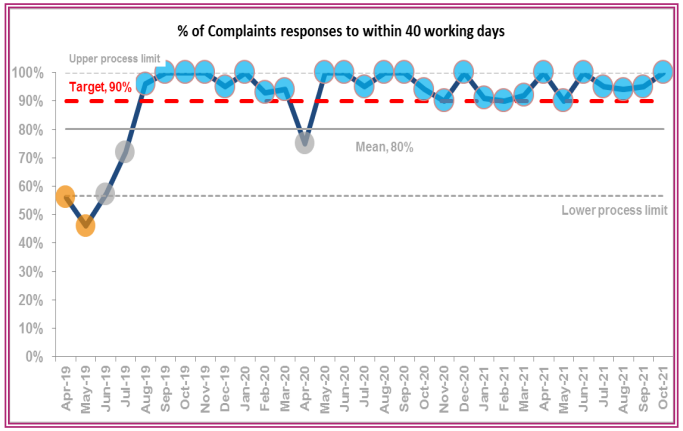
Indicator Description	Target	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
% of Complaints responses to within 25 working days	85%	100%	100%	98%	100%	100%	100%	100%	100%	98%	98%	98%	100%	98%
% of Complaints responses to within 40 working days	90%	94%	90%	100.0%	91%	90%	92%	100%	90%	100%	95%	94%	95%	100%
% of Complaints responses to within 60 working days	100%	N/A	N/A	100%	100%	100%	100%	N/A	100%	50.0%	N/A	N/A	100%	N/A
Number of Complaints breaching 6 months Response Time	0	0	0	0	0	0	0	0	0	0	0	0	0	0





Common cause variation
Special cause variation – improving performance
Special cause variation – deteriorating performance
Special cause improvement 6-point ascending/descending run
Special cause concern 6-point ascending/descending run





What the information tells us

- The number of complaints per calendar day shows common cause variation.
- All response categories continue to be achieved and remain within target.
- PALS received per calendar day has been consistently below the lower control limits for the past five months.

Actions and Quality Improvement Projects

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

Our Patient Perspective

Infection Control

Indicator Description	Threshold 2021-2022	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	YTD Actual
MRSA	0	0	0	0	0	0	0	0	0	0	0	0	1	1	2
C.diff Hospital Acquired Infections	52	0	5	5	1	3	2	2	2	2	0	3	4	4	22
C.diff Community Associated Infection		0	0	3	1	0	1	1	0	0	0	2	1	1	
MSAA	25	3	5	4	8	5	5	5	3	3	3	3	0	3	20
E.Coli	111	6	3	9	6	6	6	7	6	5	6	5	4	5	38
Covid-19: Hospital Onset Healthcare Associated (>14 days) HOHA	NA	7	28	62	59	24	0	2	0	0	0	18	2	7	29
Covid-19: Hospital Onset Probable Associated (8-14 days) HOPA	NA	0	28	76	56	35	4	0	1	1	0	10	1	4	17

What the information tells us :

There was one MRSA bacteraemia reported on 1 October 2021 in a patient admitted on 25 July 2021.The patient had a history of previous MRSA colonisation since March 2020 when they were an in-patient in St Thomas' Hospital. A Peripheral central (PICC) line was inserted on 23 September 2021 and was removed on 28 September 2021. Blood cultures taken on 1 October 2021 were positive for MRSA. A full Root Cause Analysis is in progress to establish any learning and implement appropriate improvement actions.

There were 5 incidents of patients with C. *difficile* infection during October 2021. This consisted of 4 Hospital Onset Healthcare Associated, where the specimen was taken beyond admission day plus one day and 1 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, for example in antimicrobial prescribing, patient isolation or environmental or medical device cleanliness. Since April 2021 there have been a total of 22 cases consisting of 17 HOHA and 5 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 October 2021, the Trust had 22 cases against a trajectory of no more than 26 for this point in the year. The Trust is therefore under this trajectory.

There were 3 patients with Trust apportioned MSSA cases in October 2021 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 38 cases, against a trajectory of no more than 55 for this point in the year. The Trust is therefore under this trajectory. Trajectories have also been set *for Pseudomonas aeruginosa* and *Klebsiella* bacteraemia which are being monitored at the Infection Control Group. These organisms are at or near (but not exceeding) their set trajectories.

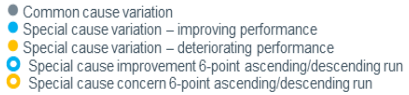
There were 7 Hospital Onset Healthcare Associated cases (HOHA) of Covid-19 during October 2021, where the sample was taken >14 days after admission and 4 Hospital Onset Probable Associated (HOPA) case where the specimen was taken 8-14 days after admission.

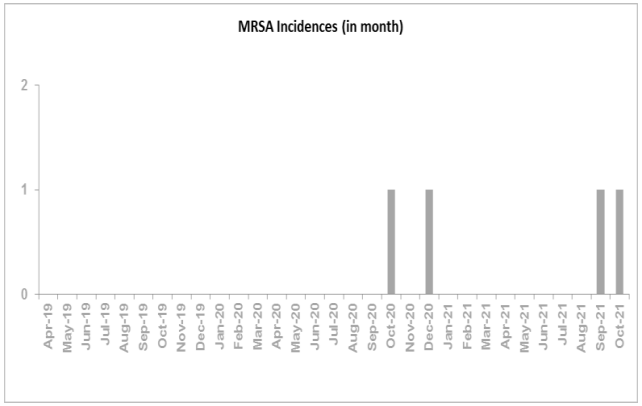
Actions and Quality Improvement Projects

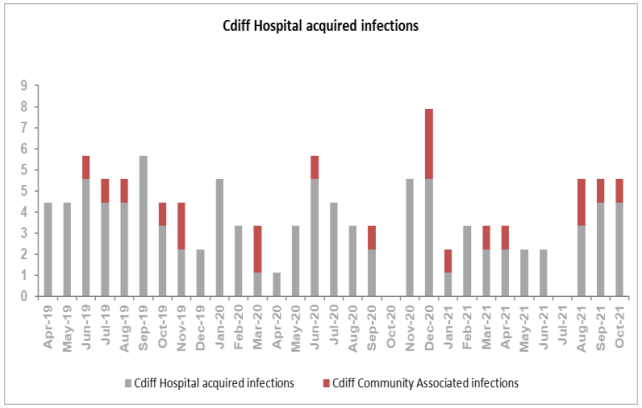
National COVID-19 data submissions continue to be validated daily and signed off by the Chief Nurse and Director of Infection Prevention and Control. The Infection Prevention and Control Team has been involved in winter planning discussions.

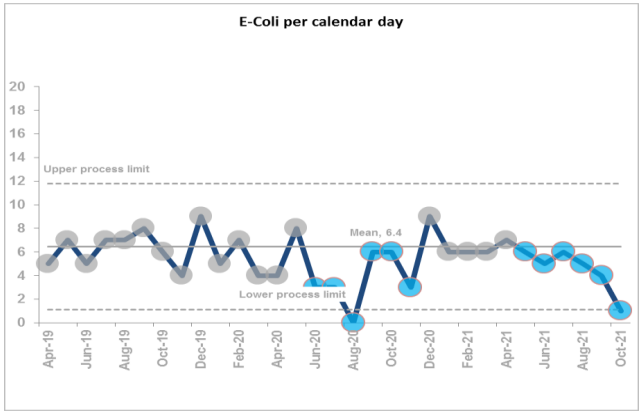
Our Patient Perspective

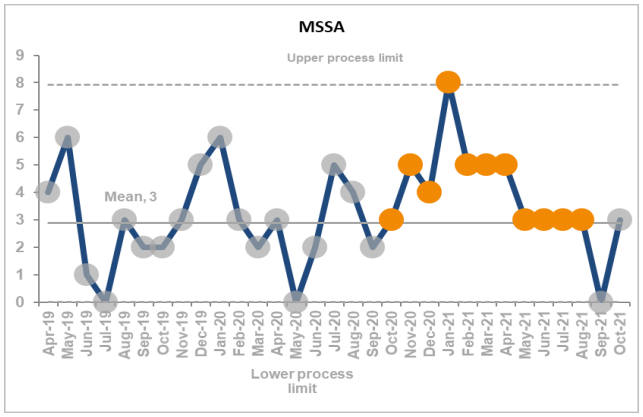
Infection Control

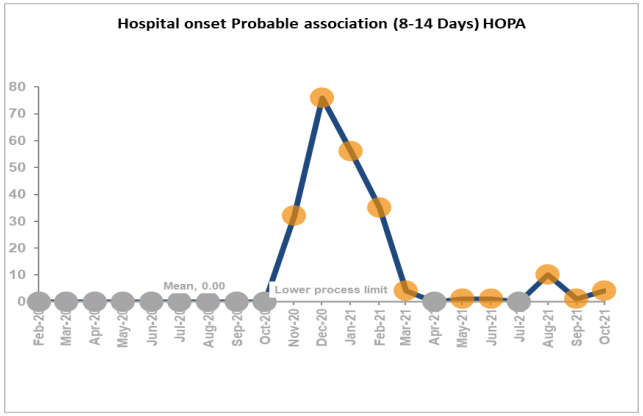


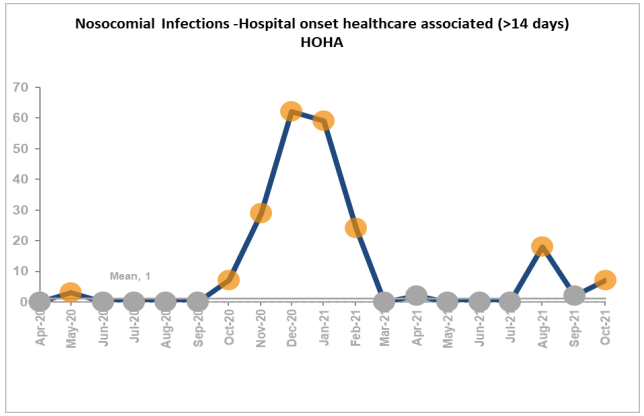












Our Patient Perspective

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	Jun-21	Jul-21	Jul 2020 to June 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	63.7	63.7	86.0
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	84.7	84.7	108
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	76.6	76.6	80.6

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	May-20-Apr-21	June-20-May-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	0.82	0.85

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	Aug-21	Sep-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%	9.8%	10.3%	10.3%	10.1%	9.3%	9.0%

Note: HSMR data reflective of period July 2020– June 2021 based on a monthly published position. As a result of problems with Dr Foster there is no update to the data previously reported showing discharges for March, April and May 2021. SHMI data is based on a rolling 12 month period and reflective of period May 2020 to Apr 2021 published (August 2021).
Readmission data excludes CDU, AAA and all ambulatory areas where there are design pathways

Mortality data not updated- update from Dr Foster due 18th Nov 21

What the information tells us

Mortality as measured by the summary hospital-level mortality indicator (SHMI) is lower than expected for the year June 2020 – May 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. Telstra, formerly Dr Foster, has not been able to provide updated outcomes data; therefore, the HSMR data reported here remains unchanged from last month.

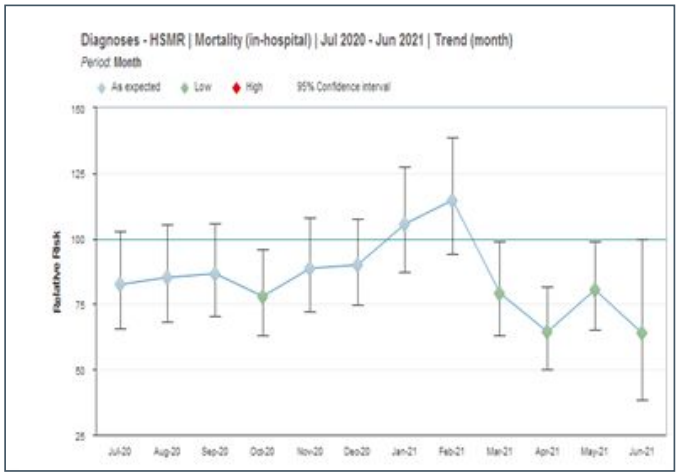
Our latest HSMR, for the 12 months from July 2020 to June 2021 shows our mortality to be lower than expected. Looking specifically at emergency admissions, mortality is lower than expected for those patients admitted during the week and as expected for those admitted at the weekend. SHMI and HSMR have taken differing approaches to managing the impact of Covid-19, which is now included in the periods reported. Telstra (Dr Foster), who produce the HSMR, include Covid-19 activity; whereas NHS Digital who are responsible for SHMI have excluded all Covid-19 activity.

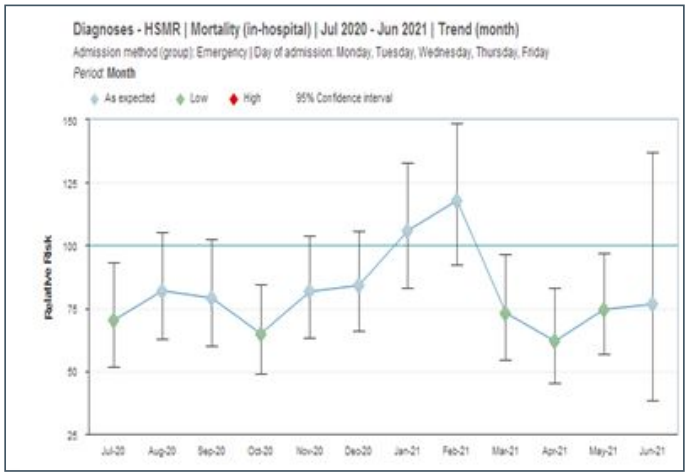
Actions and Quality Improvement Projects

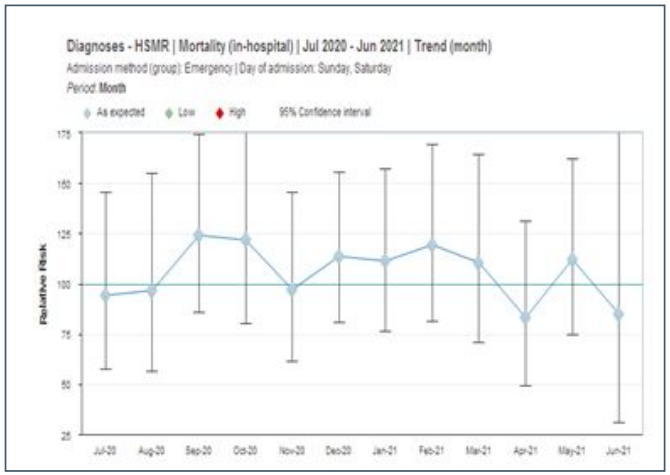
We monitor and investigate mortality through the Mortality Monitoring Group (MMG). MMG is continuing to oversee the investigation of TARN (Trauma Audit and Research Network) mortality data. We are no longer a mortality outlier; however, a number of strands of improvement work related to data quality and clinical pathways are underway. In October the Clinical Lead for Major Trauma attended MMG to provide an update from the peer visit to the Royal London Hospital major trauma unit and a proposal paper will be presented to the group for consideration in November. Additionally, an investigation of coding related to acute myocardial infarction is underway and will be discussed at MMG in November.

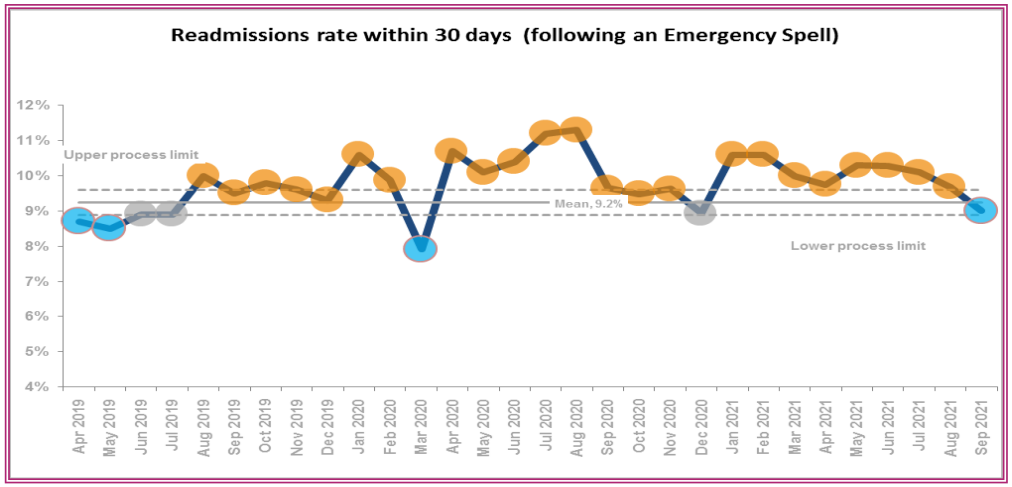
Mortality and Readmissions (Hospital Standardized Mortality Rate)

Common cause variation
Special cause variation – improving performance
Special cause variation – deteriorating performance
Special cause improvement 6-point ascending/descending run
Special cause concern 6-point ascending/descending run







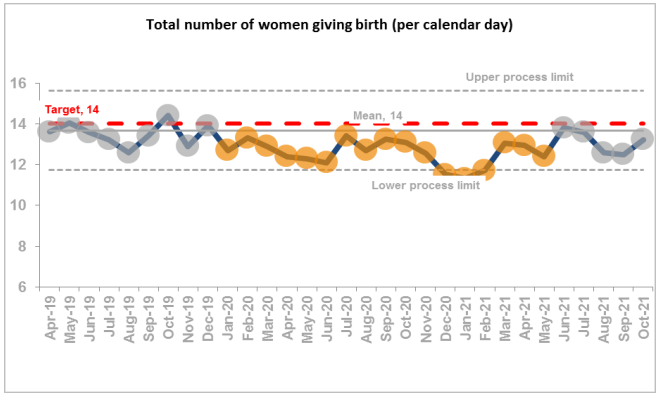


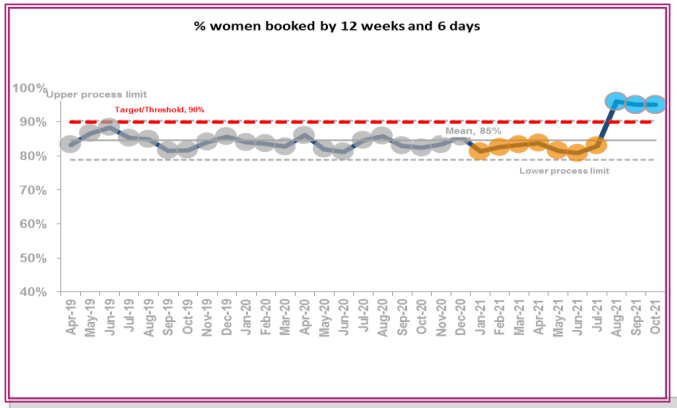
Mortality data shows previous month- update from Dr Foster available 18th Nov 21

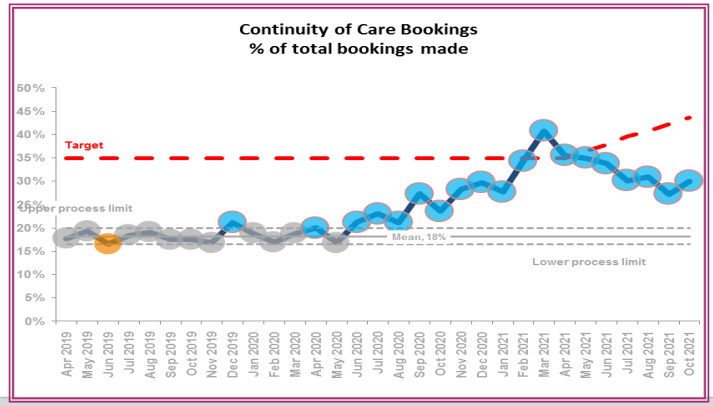
Our Patient Perspective

Maternity

Common cause variation
Special cause variation – improving performance
Special cause variation – deteriorating performance
Special cause improvement 6-point ascending/descending run
Special cause concern 6-point ascending/descending run







What the information tells us

- The clinical acuity and complexity remained high in October 2021. Staffing challenges and clusters of high activity and acuity continued which impacted on staffing ratios.
- In response Birth Centre staff and office based midwives were diverted to the Delivery Suite and inpatient areas when required although the overall staffing profile improved from the end of September 2021. Subsequently Birth Centre closure was 21% in month which is an improvement from the position in September of 56%. A lower than expected rate of supernumerary status of the Labour Ward coordinator at 88.7% reflects the midwifery staffing, activity and acuity during peak times. This also reflected high short term sickness challenges and remaining vacancies.
- There was a significant improvement in antenatal bookings with 95% of women referred being booked by 12 weeks and 6 days

Actions and Quality Improvement Projects

The planned launch of the centralised Maternity Telephone Helpline has been delayed again until mid December 2021 due to an unexpected delay in the completion of enabling works. Once launched the Helpline will enable direct access to the service for advice and information and will support consistent advice as well as clinically appropriate signposting.

Work continues with our Maternity Voice partnership service user group, including women with additional needs to co-produce innovations and improvements to care pathways. As per the OCKENDEN immediate and essential requirements, Quality Improvement projects are underway to support the Induction of labour process and caesarean section process, to reduce post partum haemorrhage rates (which have risen slightly to 2.6% in month) and to strengthen Personalised Care. Recruitment has continued for the additional 15.6WTE midwives and 0.5WTE Obstetric Consultant secured from the Ockenden Workforce bid. Recruitment has successfully filled all band 5 and band 6 midwifery vacancies and the positive impact will be seen over the coming months dependant on start dates.

The team have successfully won a bid for an additional £50K to introduce a Band 7 leadership role to support new and preceptorship midwives in clinical practice throughout their transition period as new registrants and our recruitment of International Midwives has commenced with great success. Maternity Services (in parallel with South West London Local Maternity and Neonatal System (SWL LMNS) submitted a bid to NHS Digital (NHSX) on 13 November 2021 for Digital funding to support transformation, including an end to end digital maternity information system that if successful will provide a single health records solution by the addition of a maternity module to our enterprise wide electronic patient record.

Stillbirths will be reviewed through our governance frameworks and any contributing or causal factors identified for learning, A rapid review has been undertaken with no initial immediate care concerns identified.

The data relating to Continuity of Care (CoC) bookings is not yet available, but a similar picture to that presented in September 2021 is anticipated, which is a reflection on redistribution of staff to support inpatient services during July, August and September alongside national changes in how CoC is measured. Reconfiguration of our community service is underway to also improve the CoC position along with directed recruitment to these teams.

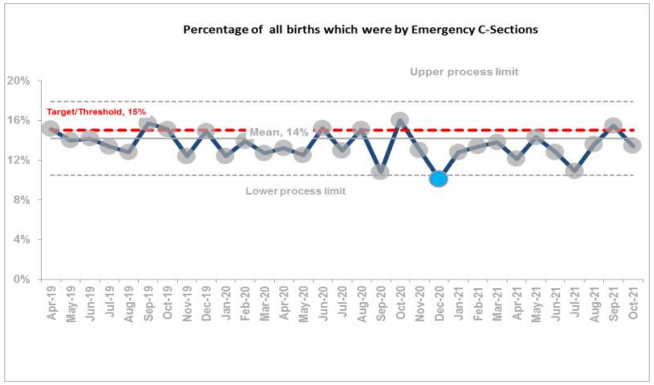
Maternity

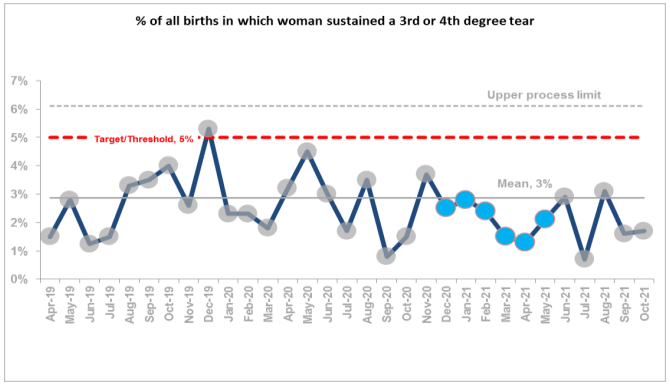
Maternity Dashboard

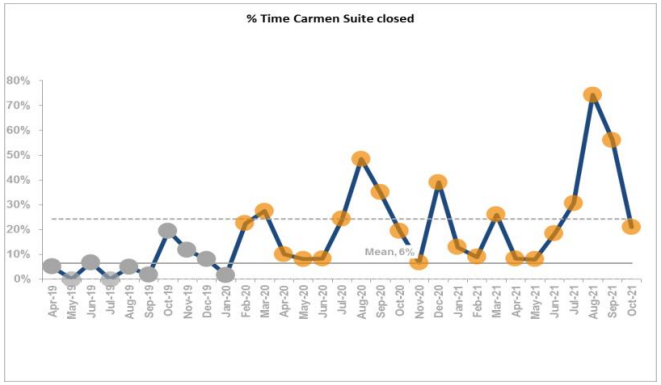
Definitions	Target	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
Total number of women giving birth (per calendar day)	14 per day	13.1	12.6	11.5	11.3	11.7	13.1	12.9	12.4	13.8	13.6	12.6	12.5	13.2
Caesarean sections (Total Emergency and Elective by Delivery date)	<28%	30.9%	27.3%	23.8%	28.5%	28.0%	29.1%	25.5%	27.6%	24.6%	24.7%	27.2%	28.3%	27.3%
% deliveries with Emergency C Section (including no Labour)	<8%	3.7%	2.9%	3.4%	2.3%	3.4%	4.0%	3.4%	3.9%	1.9%	3.6%	2.6%	4.5%	4.4%
% Time Carmen Suite closed	0%	19.4%	6.7%	39.0%	12.9%	9.0%	26.0%	8.3%	8.0%	18.3%	30.6%	74.2%	56.0%	21.0%
% of all births in which woman sustained a 3rd or 4th degree tear	<5%	1.5%	3.7%	2.5%	2.8%	2.4%	1.5%	1.3%	2.1%	2.9%	0.7%	3.1%	1.6%	1.7%
% of all births where women had a Life Threatening Post Partum Haemorrhage >1.5 L	<4%	2.5%	2.9%	2.5%	3.1%	1.2%	3.2%	2.8%	4.2%	2.4%	3.6%	2.3%	1.3%	2.9%
Number of term babies (37+ weeks), with unplanned admission to Neonatal Unit		20	16	11	13	9	11	8	13	14	13	16	13	12
Supernumerary Midwife in Labour Ward	>95%	100.0%	98.3%	91.9%	100.0%	94.6%	98.4%	98.3%	98.4%	97.0%	88.7%	90.3%	90.0%	88.7%
Babies born with Hypoxic Ischaemic Encephalopathy / (1000 babies)		0.0	0.0	8.4	5.7	0.0	2.5	0.8 (Qtr1)			2.4 (Qtr2)			
Still Births per 1000 Births	<3	7.4	8.0	5.6	2.8	9.1	4.9	2.6	5.2	2.4	7.1	0.0	2.7	9.8
Neonatal Deaths (KPI 72) per 1000 Births	<3	12.3	2.7	5.6	0.0	3.0	2.5	2.6	0.0	0.0	0.0	2.6	0.0	0.0
Continuity of Care Bookings- % of total bookings made (Target increases monthly by 1.5% towards a 51% target in Mar 22)	43.7%	23.6%	28.3%	29.7%	27.7%	34.3%	40.1%	35.2%	35.0%	33.8%	30.1%	30.6%	27.2%	30.0%
Percentage of all births which were by Emergency C-Sections (KP25+26)	15%	16.0%	13.0%	10.1%	12.8%	13.4%	13.8%	12.1%	14.3%	12.8%	10.9%	13.6%	15.5%	13.4%
% women booked by 12 weeks and 6 days	90%	82.4%	83.4%	85.6%	81.3%	82.6%	83.3%	83.8%	81.5%	80.8%	83.0%	96.0%	95.0%	95.0%
Number of term babies (37+ weeks), with unplanned admission to Neonatal Unit as a percentage of deliveries	6%	5.1%	4.1%	2.8%	3.3%	2.3%	2.8%	2.0%	3.3%	3.5%	3.3%	4.1%	3.3%	3.0%

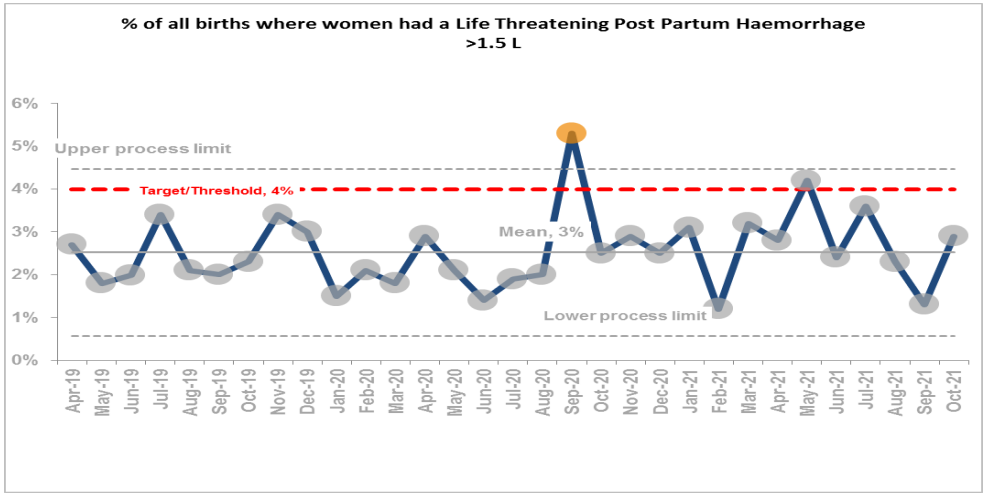
Maternity

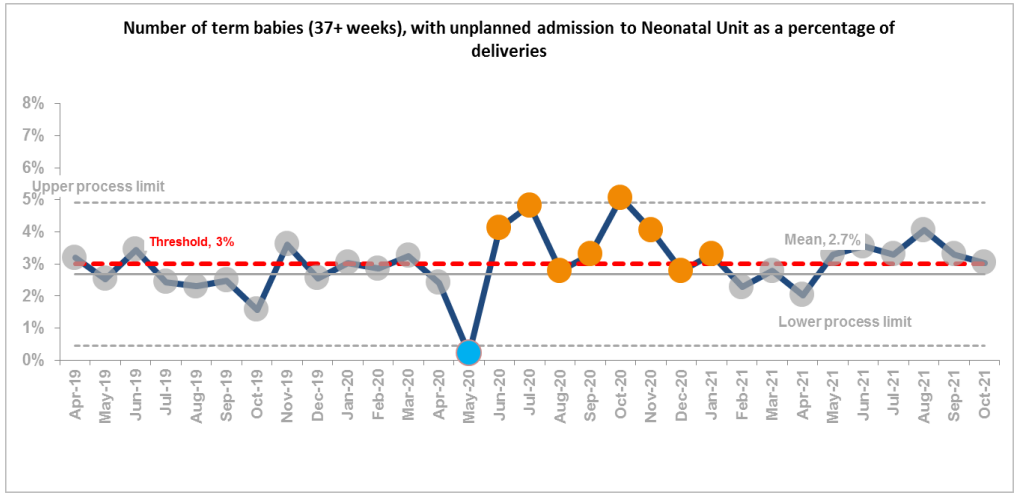
Common cause variation
Special cause variation – improving performance
Special cause variation – deteriorating performance
Special cause improvement 6-point ascending/descending run
Special cause concern 6-point ascending/descending run











Friends & Family Survey

Indicator Description	Target	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
Emergency Department FFT - % positive responses	90%	89.7%	89.2%	84.9%	92.1%	90.8%	88.8%	86.4%	83.4%	79.8%	81.6%	78.0%	73.6%	71.3%
Inpatient FFT - % positive responses	95%	97.1%	98.6%	97.9%	99.0%	98.3%	99.3%	98.2%	97.1%	97.5%	97.2%	98.4%	97.9%	98.9%
Maternity FFT - Antenatal - % positive responses	90%	N/A	N/A	N/A	N/A	N/A	50.0%	N/A	N/A	N/A	100.0%	50.0%	N/A	N/A
Maternity FFT - Delivery - % positive responses	90%	N/A	94.6%	100.0%	90.4%	93.0%	91.6%	88.9%	100.0%	90.0%	100.0%	N/A	100.0%	84.0%
Maternity FFT - Postnatal Ward - % positive responses	90%	100.0%	0.0%	100.0%	N/A	N/A	81.8%	100.0%	95.8%	91.9%	100.0%	0.0%	N/A	94.4%
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%	91.7%	87.5%	91.7%	100.0%	100.0%	92.9%	89.5%
Outpatient FFT - % positive responses	90%	89.1%	89.5%	90.3%	96.9%	90.4%	95.2%	88.7%	91.3%	90.7%	91.0%	89.8%	90.2%	90.3%

What the information tells us

- Inpatient, Maternity (Postnatal Ward) and Outpatient services achieved FFT targets where patients rated the services as "Good" or "Very Good“. Performance for Emergency Department FFT experienced a further drop in performance to 71.3% this month showing special cause deterioration. Maternity Delivery and Community FFT also saw a fall in performance and shows special cause variation with a deteriorating position.
- Inpatient services response rate saw a marked increase this month showing special cause improvement with performance at 60% compared to 23% last month

Actions and Quality Improvement Projects

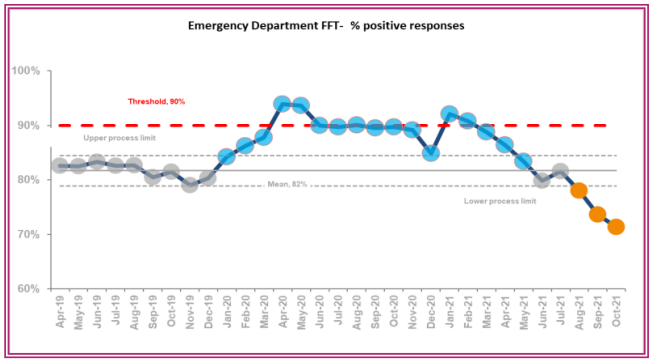
For the Emergency Department, the service moved from an external provider to the Trust’s FFT collection system in January 2021, since then there has been a significant drop in reported response rate. However, the FFT positive responses are also impacted by the current operational pressures in the department and increased waiting times.

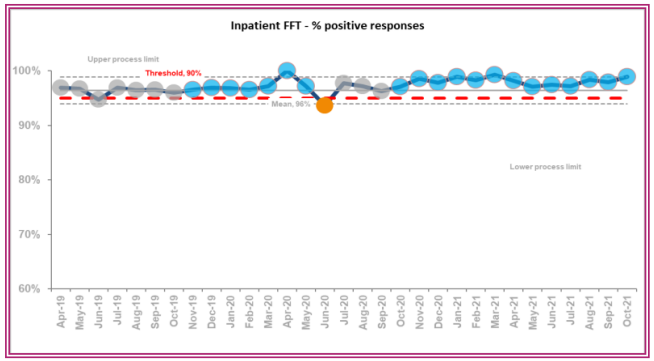
Feedback request posters with a QR code have been created within the department and exit areas to give patients and visitors further opportunity to feedback at the time of discharge from the Emergency Department.

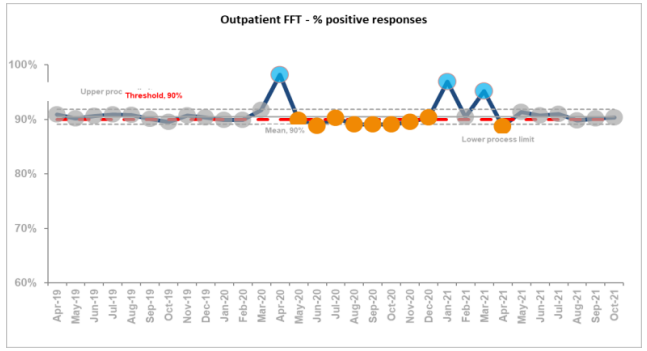
For Midwifery Services delivery, October was again a busy month with a number of high risk deliveries which may have influenced waiting times in triage and bed allocation, although there were no reported delays in pain relief.

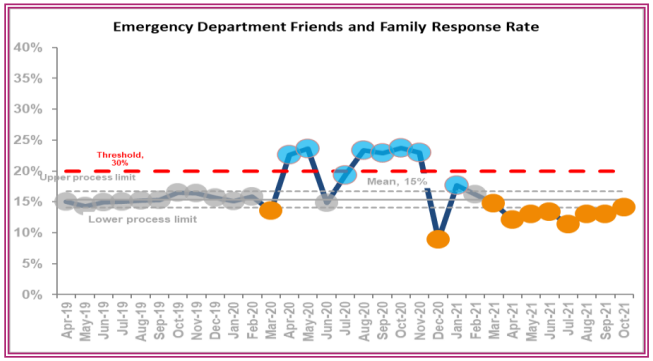
For the Community Services, a review is underway to establish the reasons for this change in performance.

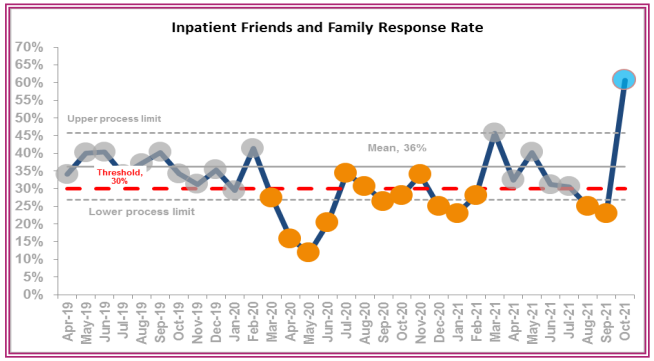
Friends and Family Test

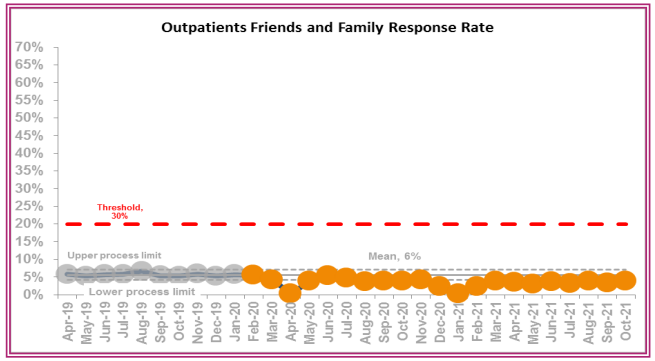








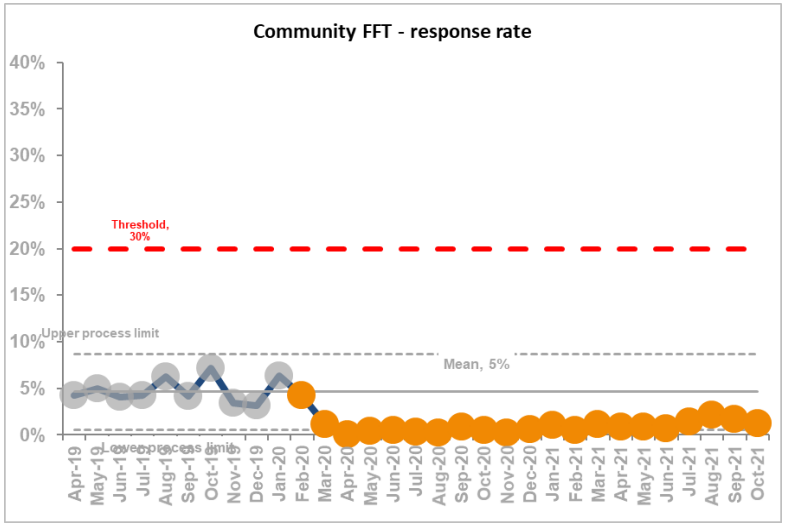


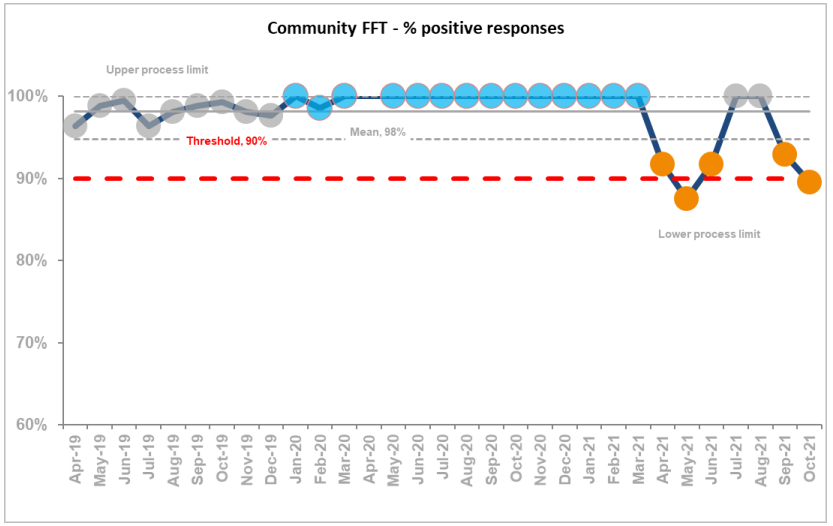


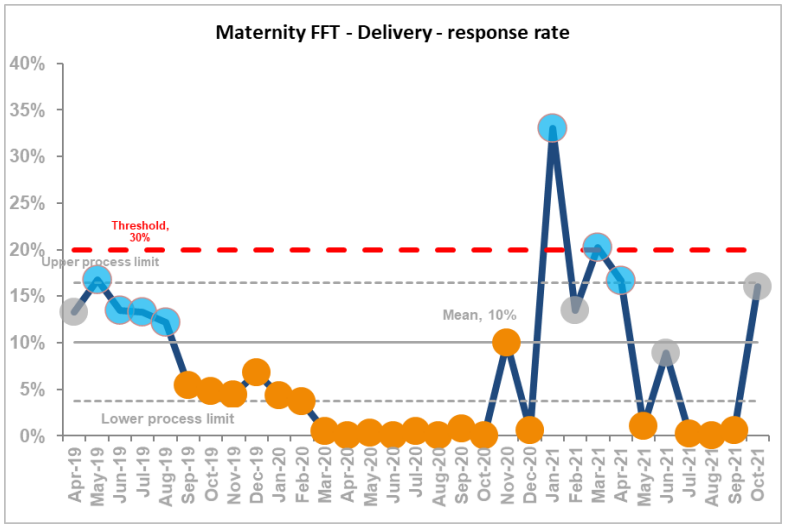
- Common cause variation
- Special cause variation – improving performance
- Special cause variation – deteriorating performance
- Special cause improvement 6-point ascending/descending run
- Special cause concern 6-point ascending/descending run

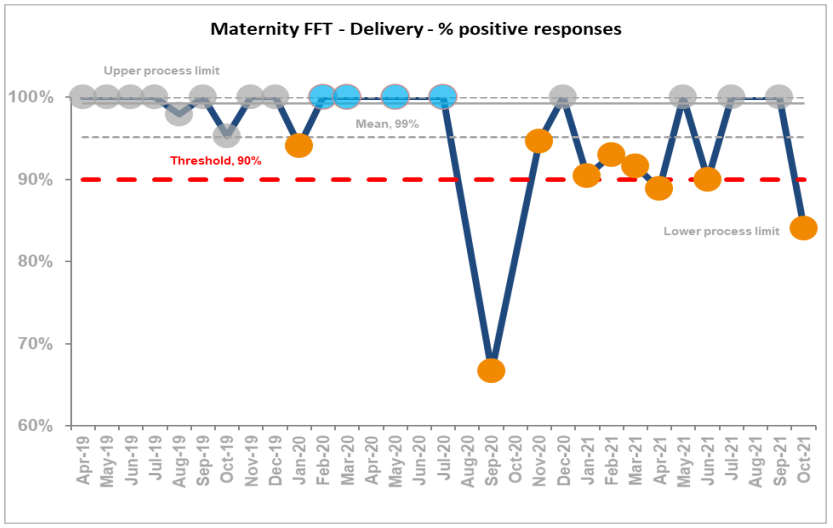
Our Patient Perspective

Friends and Family Test







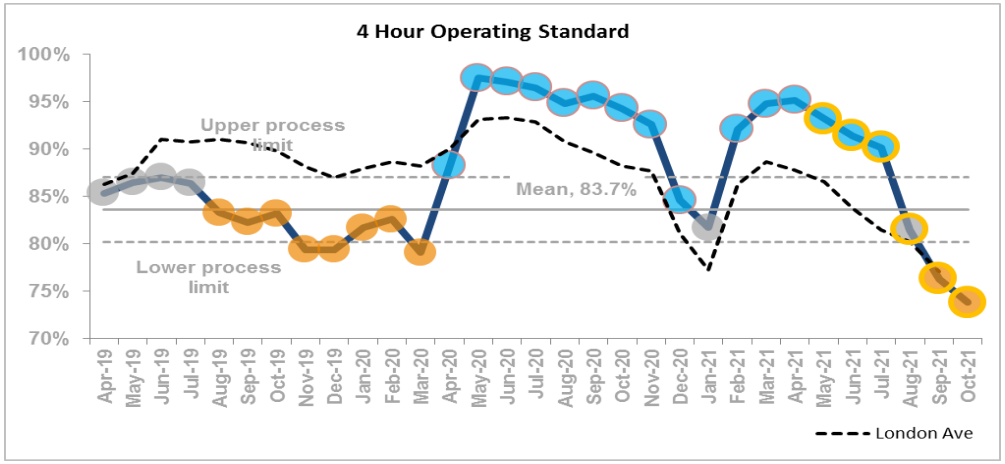


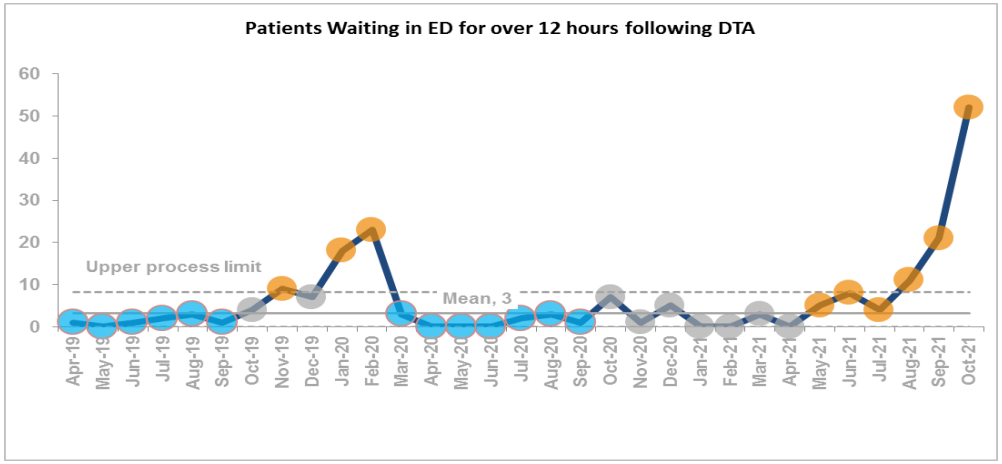
Common cause variation
Special cause variation – improving performance
Special cause variation – deteriorating performance
Special cause improvement 6-point ascending/descending run
Special cause concern 6-point ascending/descending run

Our Patient Perspective

Balanced Scorecard Approach

Emergency Flow





What the information tells us

Performance against the Four-Hour Operating Standard has fallen significantly over the past three months, performing below the lower control limit. Performance throughout October reported that 73.8% of patients attending the Emergency Department (ED) either discharged, admitted or transferred within 4 hours of their arrival with challenges both in the admitted and non admitted pathway. Attendance numbers through the month averaged 434 patients per day with some days reaching 518 attendances. The acuity of the patients requiring treatment increased compared to September with 48% of patients with a Manchester Triage Score of between 1 and 3 whereas pre-COVID, 41% of patients had acuity scores 1-3; this varies day to day reaching up to 59% on same days throughout the month. Capacity and flow throughout the Trust has been challenged and discharges have struggled to keep pace with the number of patients requiring admissions consistently. The Trust were escalated to Internal OPEL 4 status for 14 days of the month Both Trust occupancy and capacity on AMU continues to show high capacity coupled with increasing patients staying in excess of 7, 14 and 21 days has impacted flow. Therefore, patients are delayed in finding a hospital bed and remain unplaced in ED impacting front end capacity. Teams throughout the Trust continue to work hard to maintain flow and recover daily.

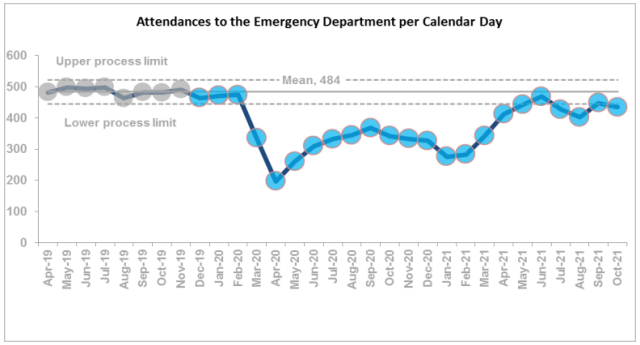
In October, 52 patients breached the 12-hour ED target where no patient should wait longer than 12 hours before they are admitted to a ward.

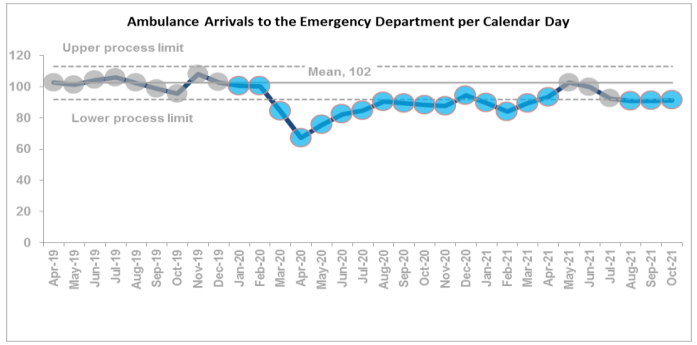
- Common Cause
- Special Cause Improvement
- Special Cause Concern
- Special cause concern 6-point ascending/descending run
- Special cause improvement 6-point ascending/descending run

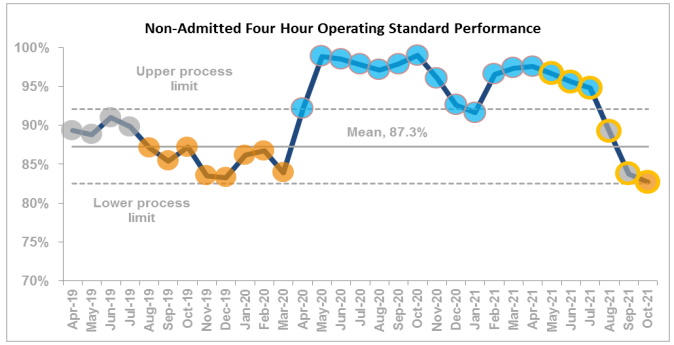
Actions and Quality Improvement Projects

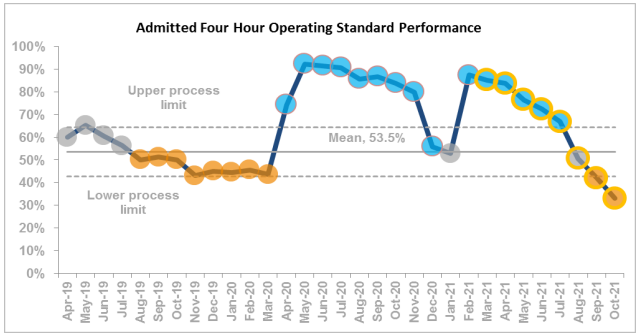
- In-Hours GP service has increased the productivity of the GP provision and the consistency of session availability.
- The ED Winter Capacity Plan has been implemented within the department; this has involved repurposing a number of spaces to support cohorting of DTAs and has the result of increasing trolley space by 4 and an offers an additional 8 chairs. The new arrangements have been funded by the Trust although it is still proving difficult to fully fill all of the shifts.
- On a wider level the Trust is working closely with system to improve the capacity and process for discharging patients to the community who have on-going care needs. The flow this could create within the hospital will be the biggest contributing factor in returning to previous performance levels within the Emergency Department.
- 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.
- LIAT point of care testing being introduced into the department for COVID -19 and Flu during November.
- The Homelessness Inclusion Team has begun work in November and will be having a launch event on the 18th. It consists of a GP, Specialist Nurse, 2 housing workers and a care navigator. The team has ben funded via a central grant from DHSC and will be based in ED supporting homeless patients presenting there and also those who are on the wards across the rest of the Trust.

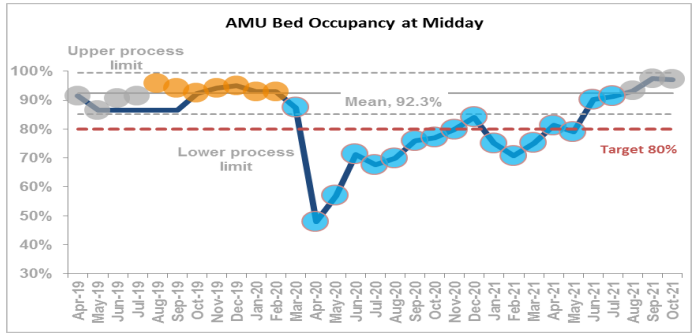
Emergency Flow

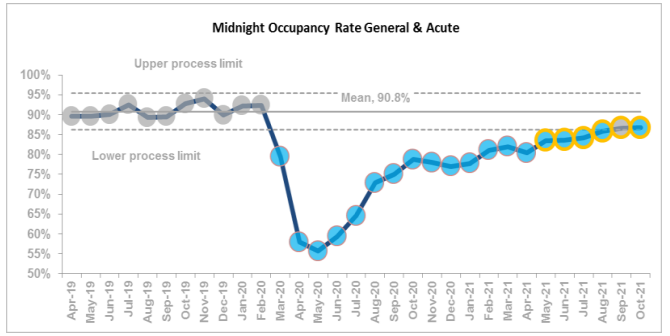


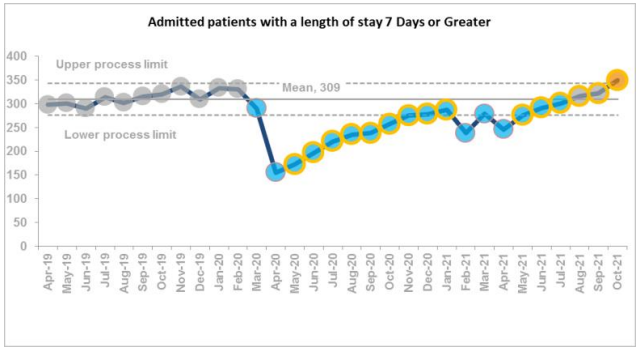


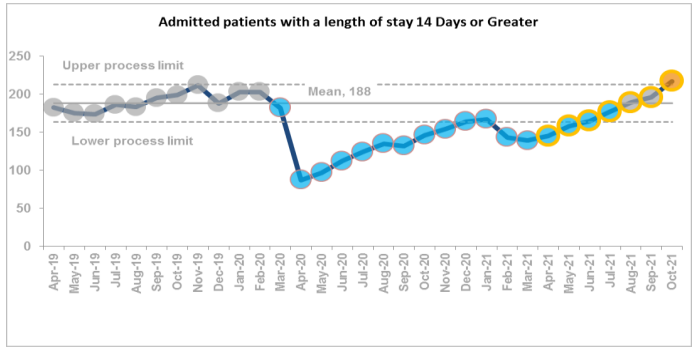


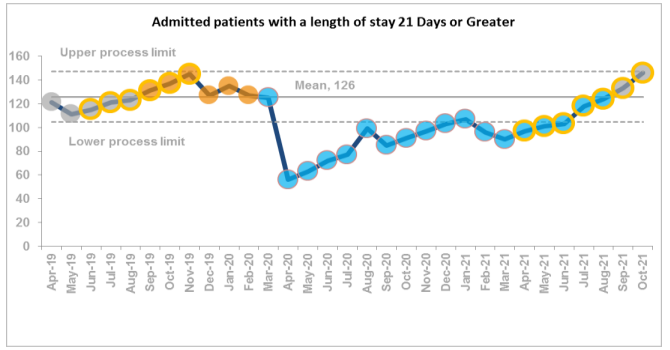






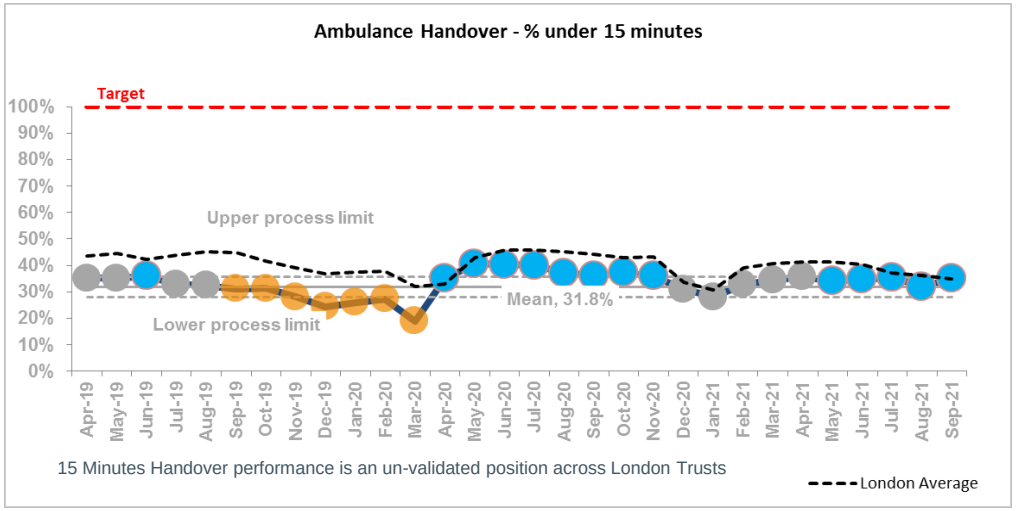


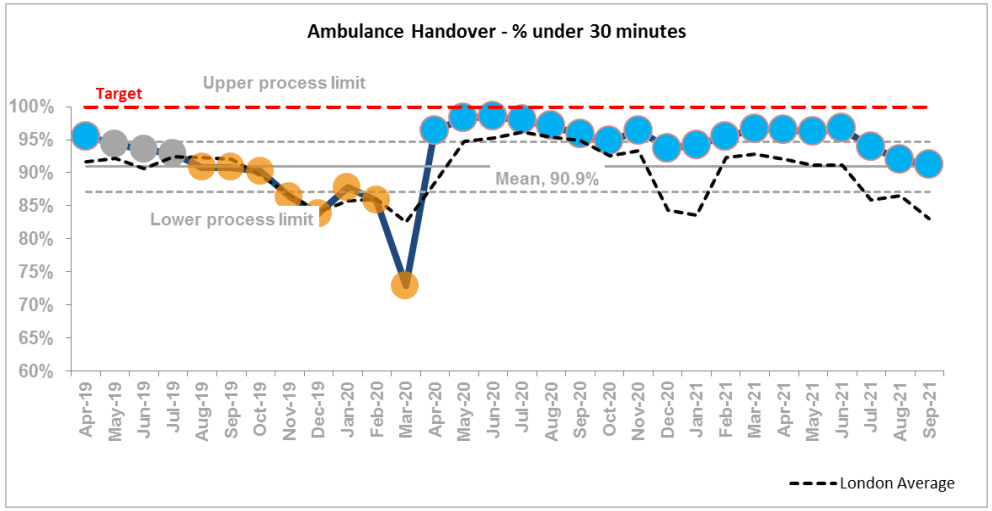


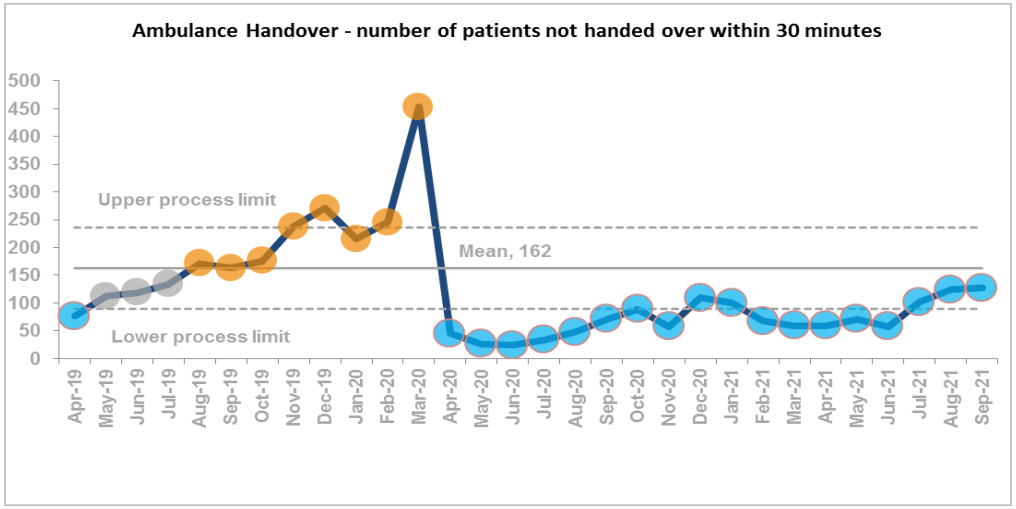


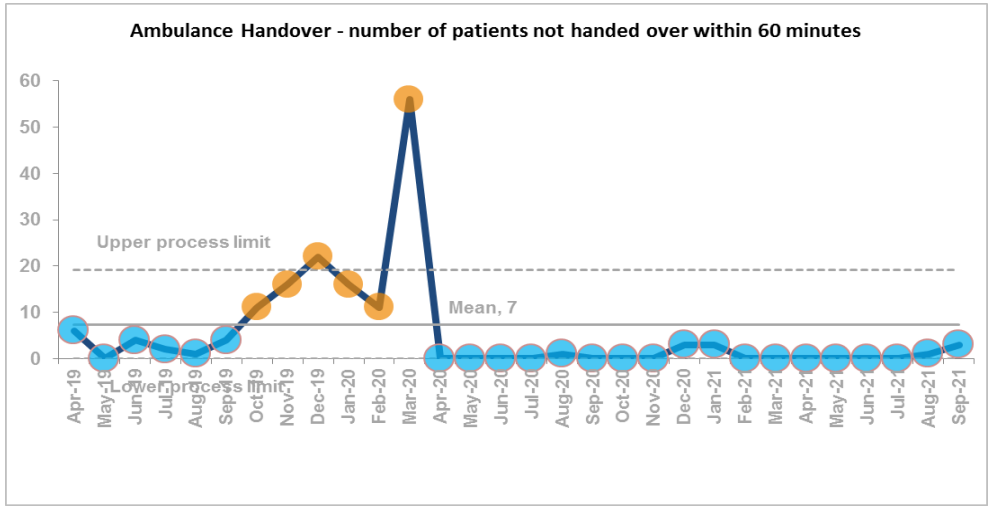
Our Process Perspective

Emergency Flow





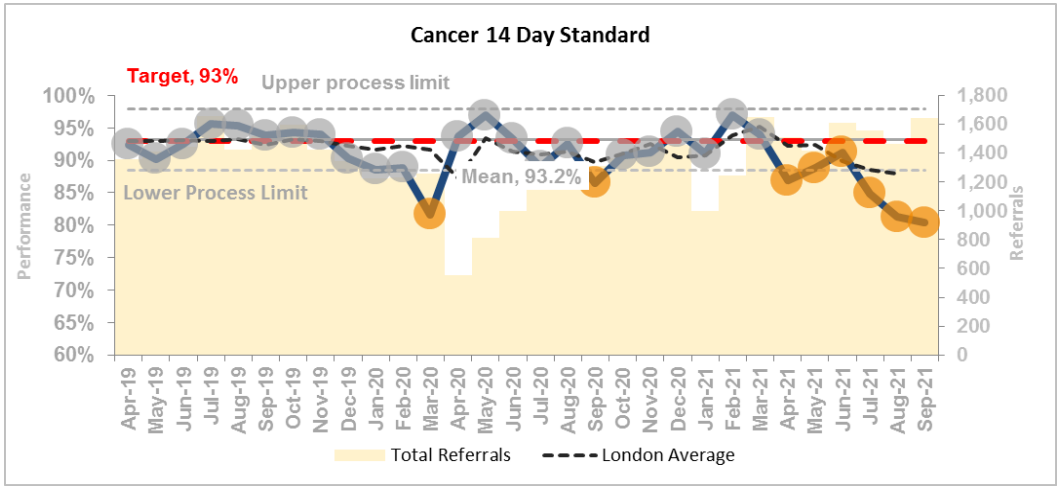


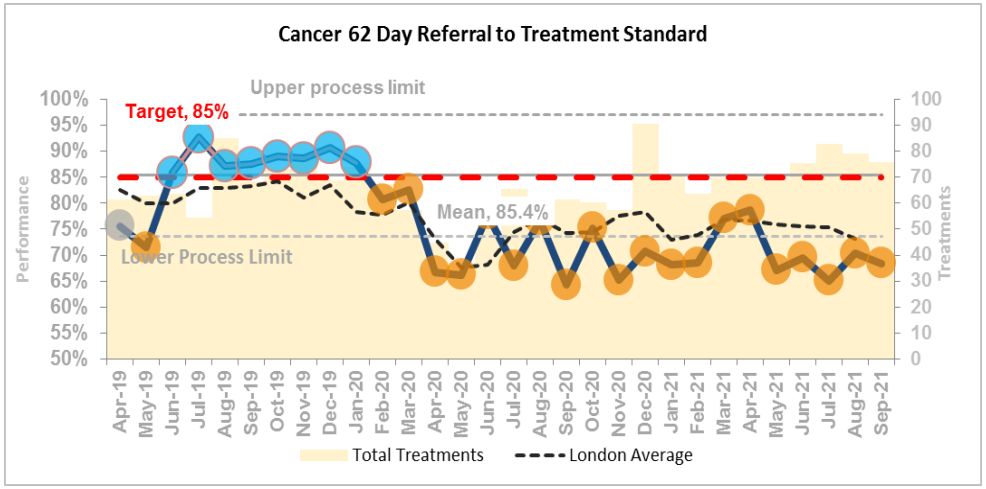


Ambulance handover data is one month in arrears

Our Process Perspective

Cancer





What the information tells us

In September, 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.

The Trust continues to see an increase in two-week rule referrals; receiving 1,646 TWR referrals in September compared to 1514 in September 2019, an increase of 8.7%. Performance decreased in September with 80.4% of patients seen within 14 days compared to 81.3% in August. In September, three of the eleven tumour groups were compliant against the 93% target.

Performance against the 31-day treatment standard continues to be achieved. The number of first definitive treatments in September 2021 was 12% higher compared to the same month in 2019. All tumour groups apart from Urology (performance of 92.9%) were compliant against the 96% standard.

There were 76 accountable treatments on the 62-day GP pathway, of which 52 patients received treatment within 62 days. Monthly performance remains below the lower control limit showing special cause variation. In September, 68.4% of patients received treatments within 62 days of referral against the national target of 85%, a decrease compared to the previous month; similar performance was seen within London. There were 24 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. Seven tumour groups were non-compliant in month; Breast 81.3%, Gynae 66.7%, Head & Neck 58.3%, Lower GI 70.6%, Lung 66.7%, Upper GI 0% and Urology 58.1%

At the end of September, there were 166 patients on the 63 day plus patient tracking list, against a trajectory of 160 of which 25 were waiting for more than 104 days.

Actions and Quality Improvement Projects

14 Day Standard

- The Trust is not expecting to report compliance against 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 for Quarter 3 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.

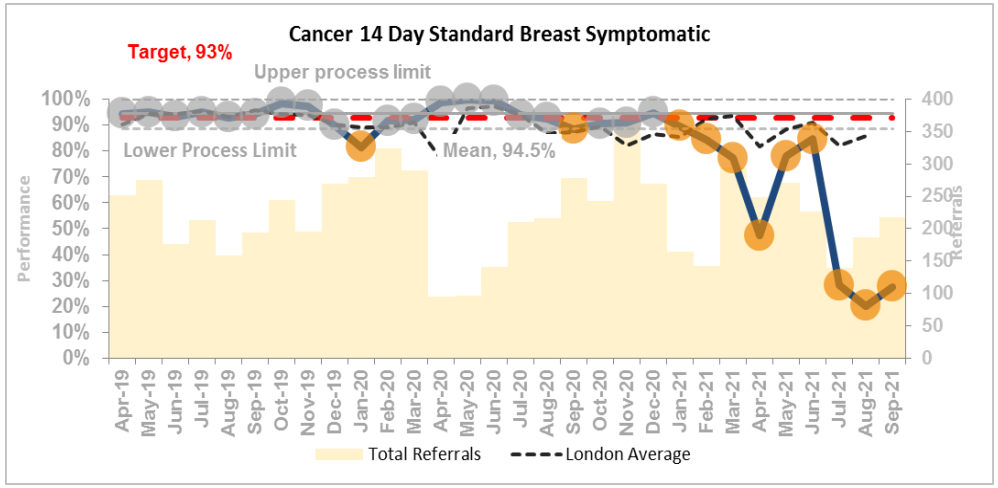
63+ Days

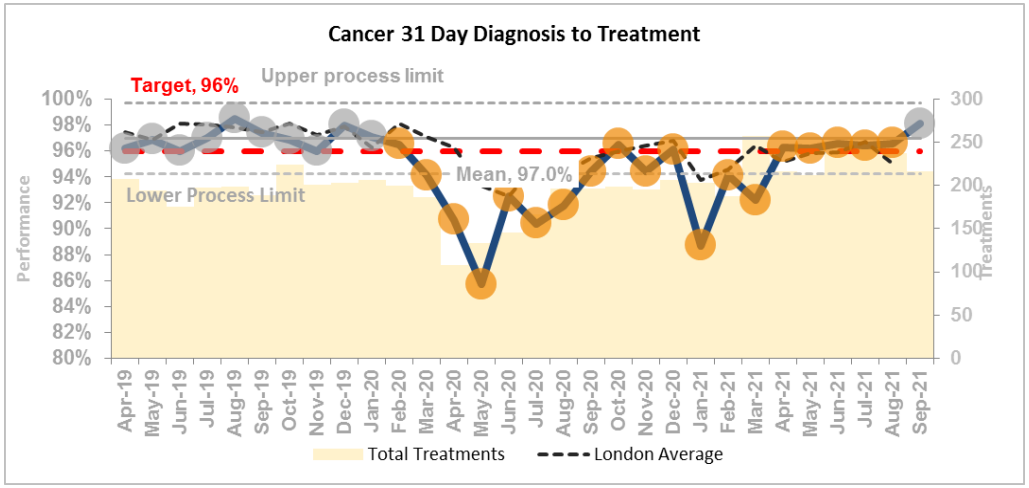
- It was the expectation that the numbers of patients over 63 days would continue to rise through September, related to increasing referrals from other Trusts in Head and Neck, issues within the breast service and in Lower GI, where previous diagnostic delays have lengthened pathways. The Trust has agreed a trajectory to have no more than 160 patients over day 62 on the PTL by the end of March 2022

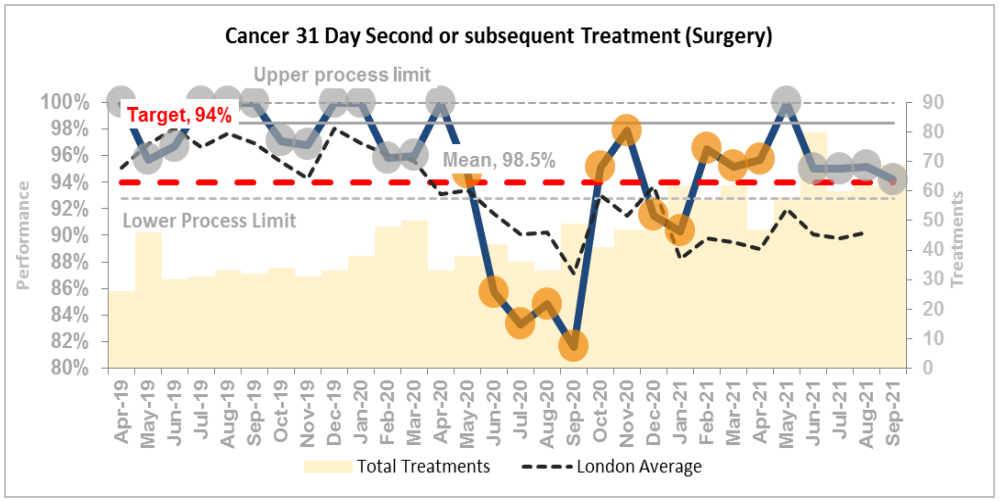
Common Cause
Special Cause Improvement
Special Cause Concern
Special cause concern 6-point ascending/descending run
Special cause improvement 6-point ascending/descending run

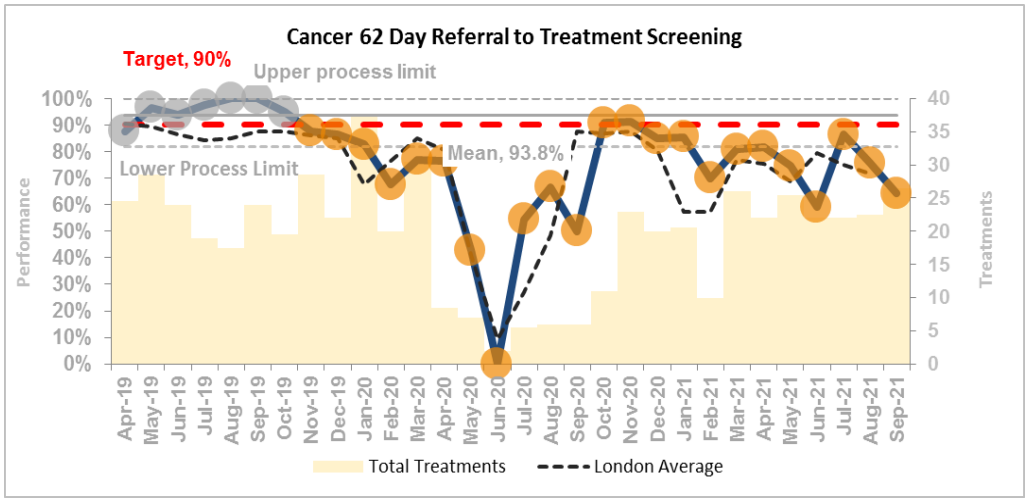
Our Process Perspective

Cancer









Our Process Perspective

Cancer

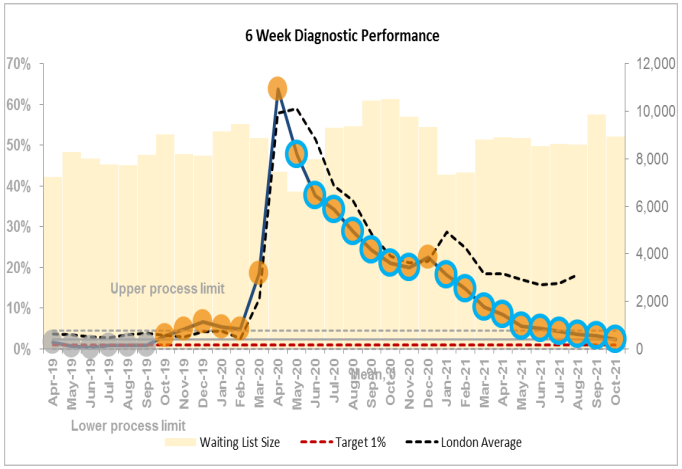
14 Day Standard Performance by Tumour Site - Target 93%

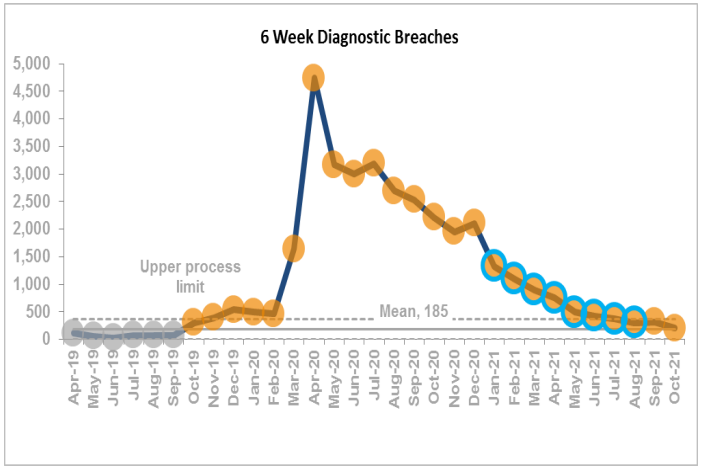
Tumour Site	Target	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	No of Patients
Brain	93%	-	-	-	-	-	-	-	-	-	-	-	-	-	
Breast	93%	88.6%	92.0%	91.6%	95.0%	86.6%	92.5%	82.9%	54.5%	78.7%	86.1%	26.9%	17.5%	30.1%	302
Children's	93%	100.0%	75.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	50.0%	50.0%	2
Gynaecology	93%	91.6%	91.9%	94.3%	91.6%	79.3%	94.9%	94.9%	87.2%	92.6%	91.7%	95.0%	94.5%	85.4%	103
Haematology	93%	96.0%	96.2%	96.2%	96.2%	95.5%	100.0%	90.0%	96.4%	100.0%	95.5%	79.3%	90.9%	100.0%	26
Head & Neck	93%	84.1%	93.7%	96.0%	98.8%	91.6%	96.4%	94.6%	95.7%	96.9%	93.4%	95.5%	88.1%	92.4%	184
Lower Gastrointestinal	93%	61.8%	83.1%	76.4%	92.2%	99.3%	98.6%	98.2%	95.9%	67.6%	82.2%	96.7%	95.7%	98.3%	235
Lung	93%	90.5%	100.0%	94.4%	76.5%	90.0%	100.0%	94.4%	91.9%	97.5%	93.9%	74.3%	68.2%	82.6%	46
Skin	93%	95.4%	93.7%	95.1%	93.0%	90.7%	98.7%	98.0%	93.6%	97.5%	94.5%	91.4%	94.8%	91.0%	509
Upper Gastrointestinal	93%	93.0%	94.8%	90.6%	98.0%	95.3%	100.0%	95.4%	98.1%	96.9%	97.4%	96.6%	97.2%	95.2%	105
Urology (Suspected testicular cancer)	93%	85.6%	83.3%	93.3%	98.2%	95.3%	98.9%	97.1%	89.6%	97.0%	98.3%	98.1%	88.6%	86.6%	134

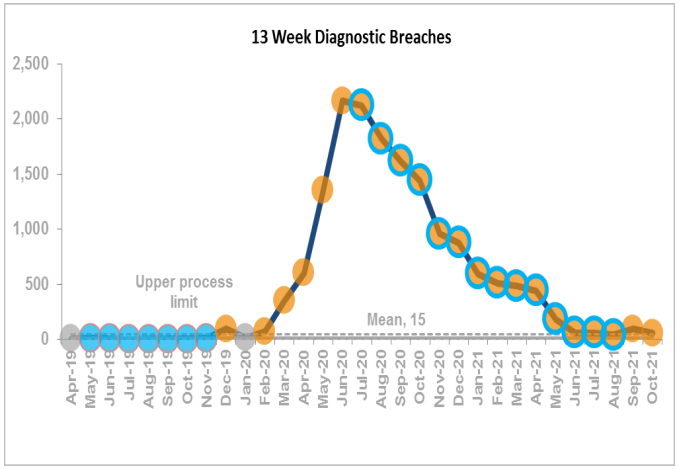
62 Day Standard Performance by Tumour Site - Target 85%

Tumour Site	Target	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	No of Treatments
Brain	85%	-	-	-	-	-	-	100.0%	-	-	-	-	-	-	
Breast	85%	92.3%	83.3%	84.6%	84.6%	75.0%	62.5%	100.0%	91.7%	78.6%	80.0%	83.3%	66.7%	81.3%	16.0
Children's	85%	-	-	-	-	-	-	-	-	-	-	-	-	-	0
Gynaecology	85%	71.4%	33.3%	100.0%	0.0%	50.0%	-	50.0%	75.0%	40.0%	60.0%	50.0%	100.0%	66.7%	3.0
Haematology	85%	100.0%	100.0%	77.8%	87.5%	100.0%	88.9%	100.0%	100.0%	66.7%	50.0%	80.0%	80.0%	100.0%	1.5
Head & Neck	85%	25.0%	60.0%	61.5%	57.1%	52.9%	57.9%	83.3%	90.9%	46.7%	70.6%	50.0%	86.7%	58.3%	6.0
Lower Gastrointestinal	85%	22.2%	25.0%	42.9%	38.5%	60.0%	33.3%	33.3%	75.0%	46.2%	66.7%	18.2%	61.5%	70.6%	9
Lung	85%	77.8%	55.6%	33.3%	100.0%	50.0%	73.3%	100.0%	90.9%	100.0%	62.5%	25.0%	100.0%	66.7%	6.0
Skin	85%	100.0%	100.0%	50.0%	81.5%	87.1%	88.9%	92.6%	78.8%	87.9%	78.8%	76.5%	74.1%	89.5%	9.5
Upper Gastrointestinal	85%	28.6%	100.0%	100.0%	53.8%	50.0%	71.4%	33.3%	60.0%	-	100.0%	100.0%	25.0%	0.0%	3
Urology	85%	55.6%	71.4%	57.1%	78.4%	57.6%	73.3%	70.8%	56.5%	45.8%	47.8%	69.2%	55.6%	58.1%	21.5
Other	85%	0.0%	100.0%	100.0%	-	-	57.1%	100.0%	100.0%	-	100.0%	50.0%	100.0%	100.0%	1

Diagnostics







What the information tells us

At the end of October 2.3% of patients on the Diagnostic Patient Tracking List were waiting for more than six weeks, this is an improved position against the 3.2% of patients waiting at the end of September and better than the London average. In total, 207 patients were waiting for more than six weeks for a diagnostic test, 111 less patients compared to the previous month, the total waiting list size has seen a reduction overall compared to September. The decreases over the month have largely been impacted by increased capacity through additional sessions within Sleep Studies and Echo, this has reduced the number of long waiting patients particularly within the 13+ cohort.

Capacity challenges remain within Cardiac MRII. In total at the end of October 120 patients were waiting for more than six weeks, this represents 58% of the total number of breaches. Additional capacity has supported the reduction of long waiting patients compared to September and the recovery plan will continue through November and December

A number of modalities are now complaint against the national standard of 1% including the return to compliance within Neurophysiology which was previously achieved in May 2021.

Actions and Quality Improvement Projects

Weekly performance meetings continue with Divisional Director of Operations (DDO) support where areas are challenged.

Echocardiography - Additional capacity including ad hoc independent sector sessions at weekends has supported the decrease in the number of long waiting patients, this results in a cost pressure. Intensive Support Team (IST) Demand and Capacity work completed and shared with Directorate.

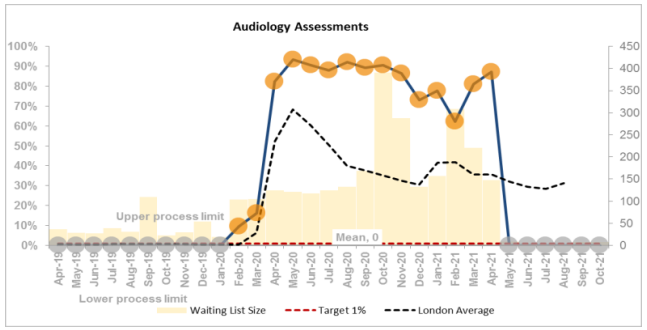
Sleep Studies - Recovery plan has seen improvement throughout the month with extra clinics for the sleep pulse ox tests provided externally for breaching patients via Community Diagnostic Hub (CDH) funding.

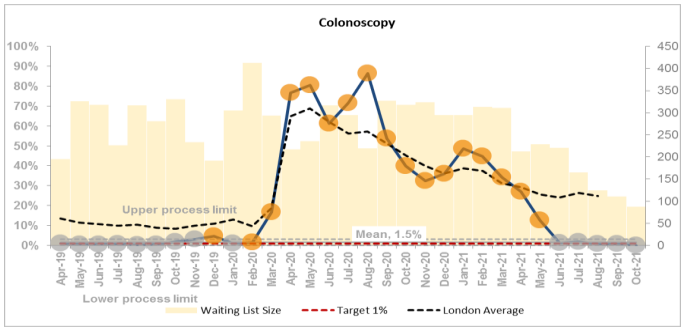
Cardiac MRI - The first additional Cardiac MRI day on the St James's Wing (SJW) mobile unit was on the 27 September with 14 additional 3-session days booked between October to December. This is possible by 'lift & shifting' work to the new MRI Community Diagnostic Centre at The Wilson. November capacity is already fully booked however not likely to see a significant shift in performance until December.

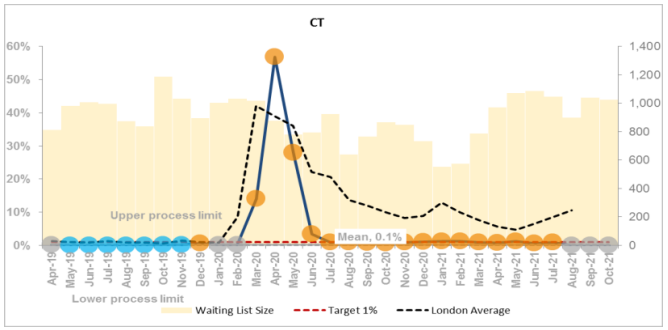
Common Cause
Special Cause Improvement
Special Cause Concern
Special cause concern 6-point ascending/descending run
Special cause improvement 6-point ascending/descending run

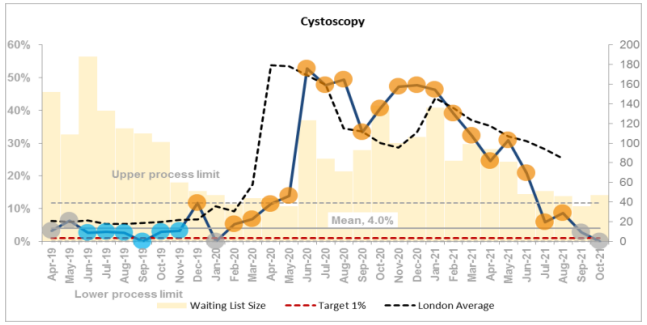
Our Process Perspective

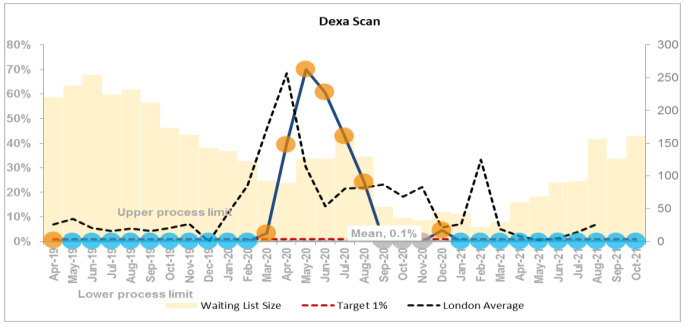
Diagnostics

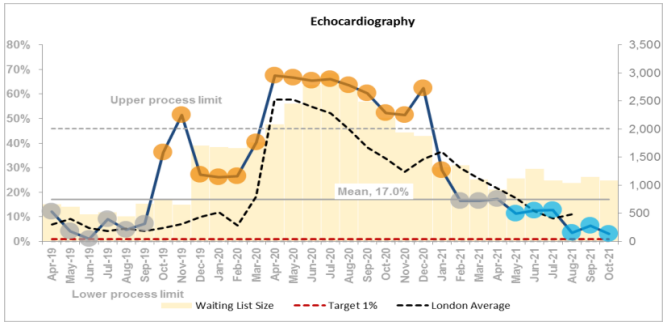


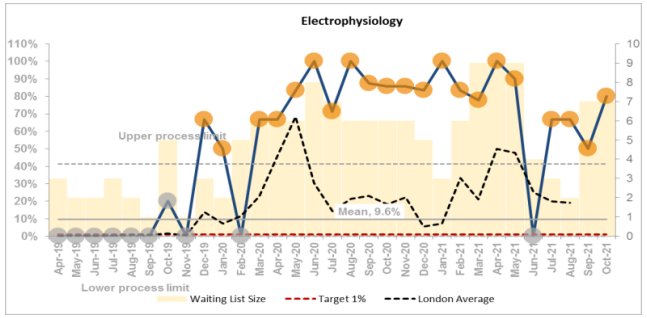


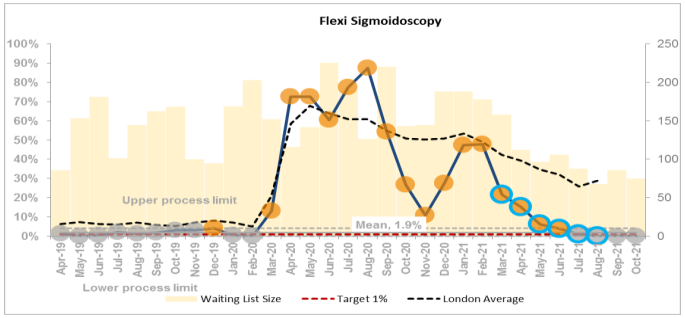


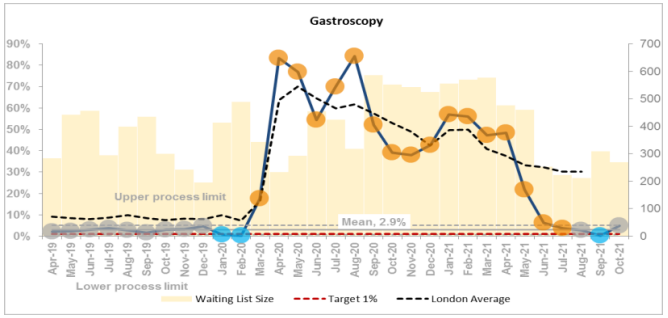






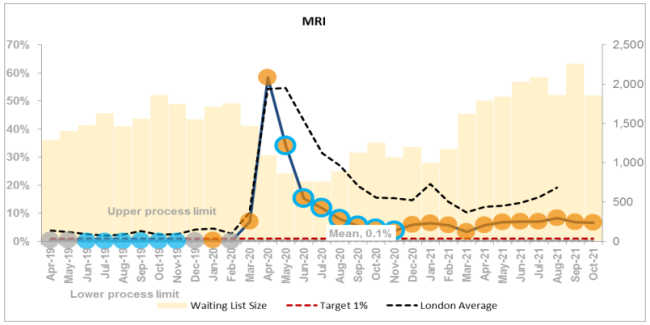


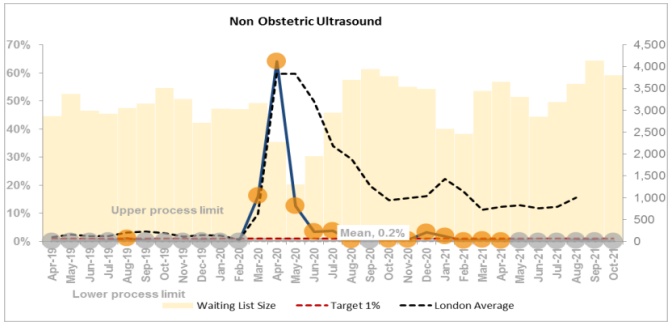


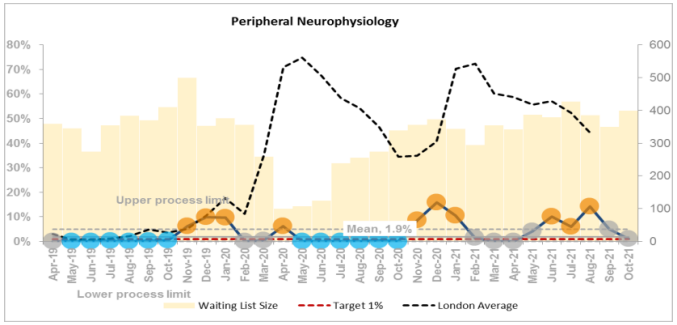


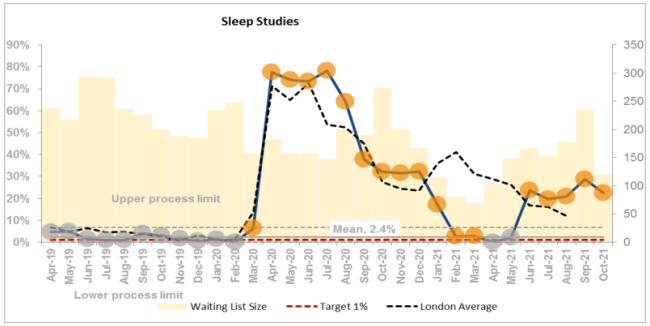
Our Process Perspective

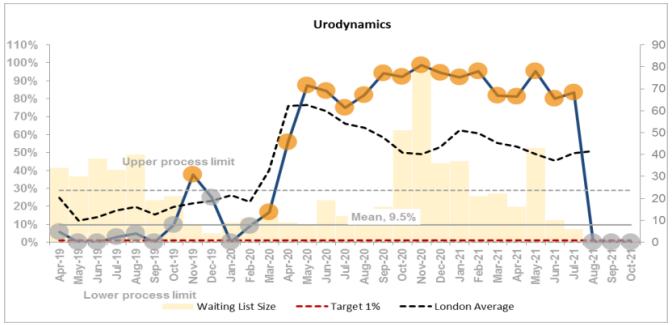
Diagnostics







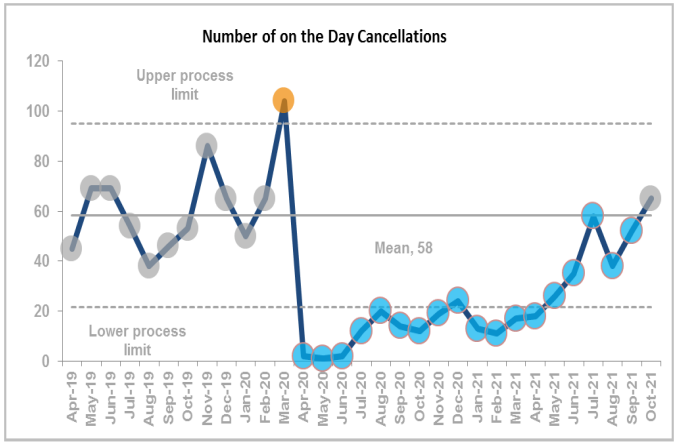


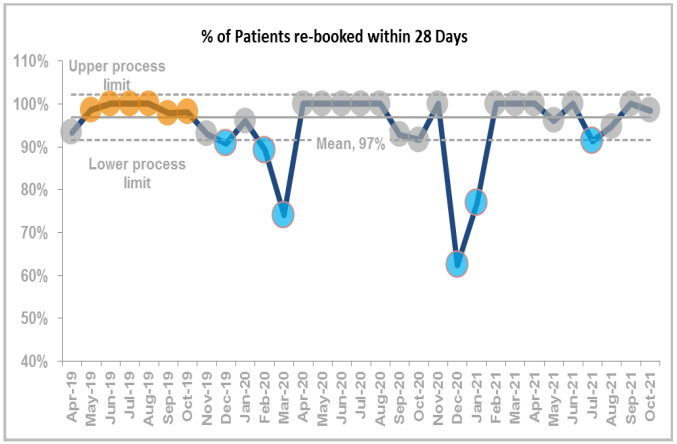


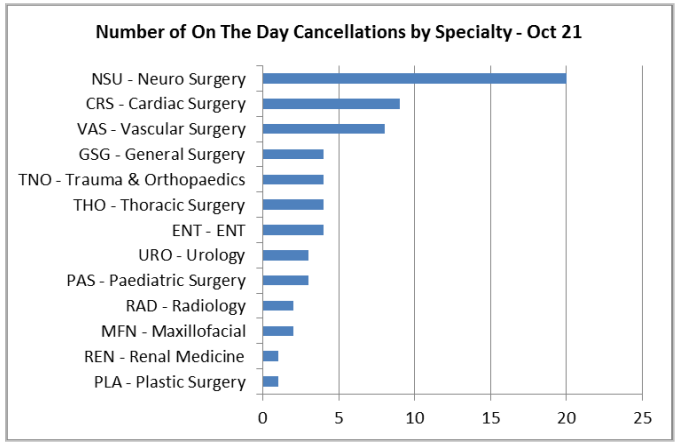
Our Process Perspective

On the Day Cancellations for Non Clinical Reasons(OTD)

Common cause variation
Special cause variation – improving performance
Special cause variation – deteriorating performance
Special cause improvement 6-point ascending/descending run
Special cause concern 6-point ascending/descending run







What the information tells us

The Trust saw an increase in on-the-day cancellations for non-clinical reasons. The Trust cancelled 65 patients due for elective treatment on the day of their operation compared to 52 patients in September. The number of cancellations is showing common cause variation.

Of the 65 patients cancelled, 98% were offered a re-booking date within 28 days. One patient was unable to be booked within the target timeframe due to capacity.

Neurosurgery had the largest proportion of on-the-day cancellations in the month with 20 patients cancelled 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 – 14
- Timing – Emergency case took priority – 9
- Timing – List over booked – 7
- Bed - No Ward bed available – 6
- Staffing – Surgeon unavailable – 5
- Equipment/Theatre - Equipment Issues – 5
- Timing – Complication - previous cases – 4
- Bed - Recovery full – 3
- Staffing Other – 3
- Staffing - Anaesthetist unavailable – 2
- Other – 3

Actions and Quality Improvement Projects

Processes – Beds/ Flow

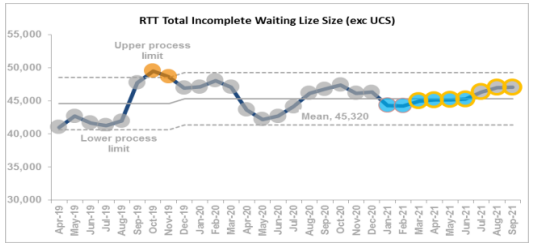
- Theatres launched a new Recovery Flow dashboard in late September, which provides a live picture of all theatre recovery areas across Tooting site.
- This is supported by 3 daily meetings and a system of internal KPIs and 'breach criteria' linked to recovery occupancy, which trigger a range of escalations.
- These new processes have improved communication and issues are being escalated earlier in the day which is leading to faster actions and resolution of recovery flow issues. The wider team are confident that this change has avoided cancellations and improved flow by speeding up the transfer of patients from Recovery on to SAL/SDL or the wards.
- However, the significant site pressures (in particular ITU capacity) and regular OPEL4 status has meant that more OTD cancellations occurred in October compared with September.
- The plans to create a two bedded Neuro PACU will help to ease the strain on NITU capacity.

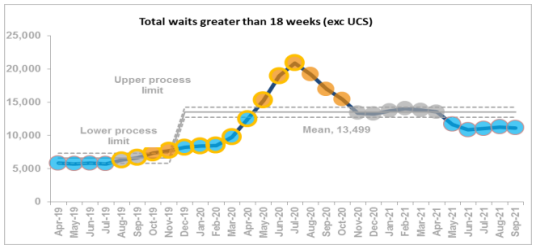
Scheduling

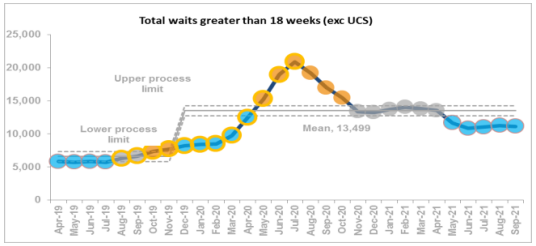
- New management and monitoring processes have been put in place to manage PPCs against targets and tighten up list-planning processes.
- This has resulted in more advance bookings (most specialties are now booked 3 weeks in advance), which will help to improve POA, equipment booking, 're-booking within 28 days' compliance and 'over-booking' issues.
- The ASA1 Streaming pilot in T&O will also help to free up POA nursing capacity to enable POAs to take place further form TCI date.

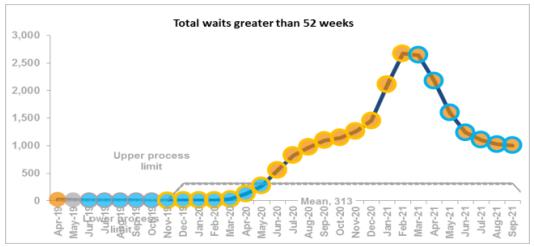
Our Process Perspective

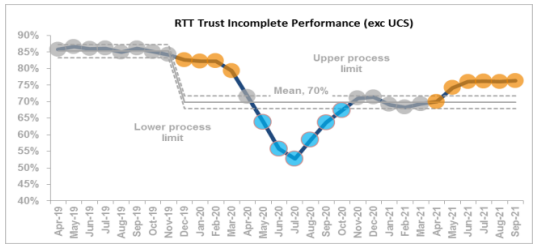
Referral to Treatment — September 2021

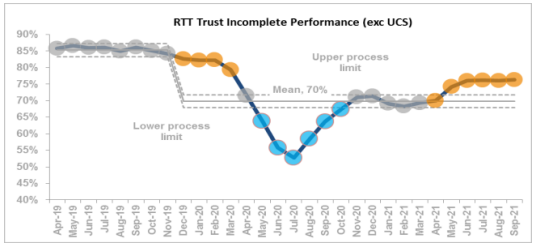












Note: Unknown Clock Starts (UCS) have been excluded from the above metrics. For context the number of UCS in September was 374, a decrease from 403 in August. Compared to the same month last year this is a 48% lower.

Actions and Quality Improvement Projects

- The reduction in 104 week waits continues to be a focus. Our trajectory target of zero patients after November is at risk due to delays with the cath lab refurbishment program. Alternative provision is being investigated but there is a risk to delivery.
- The number of +78 week waits has decreased steadily throughout September and we are ahead of trajectory in all services.

The most significant challenges remain in General Surgery, ENT, Plastics and Cardiology due to demand and capacity challenges. To support these services there are on-going changes to the Theatre template to optimise capacity, including the below:

- Optimisation of the Surgical Treatment Centre at QMH (improving utilisation and throughput)
- Development of 23 hour DSU pathway
- Continued use of the Joint Referral Unit (JRU), extended to inpatient pathways at Kingston

What the information tells us

At the end of September, 47,104 patients were waiting for treatment on the Patient Tracking List (PTL), a small increase of 0.1% (37 patients) compared to the previous month. The PTL size has increased for seven consecutive months showing special cause vconcern. Although the total PTL size has increased, the number of patients waiting for more than 18 weeks has seen a decrease by 1.3% remaining below the lower control limit. The number of patients waiting for more than 52 weeks continues to show a favourable position against our trajectory. In September there were 1,005 patents above 52 weeks compared to 1,028 patients in August.

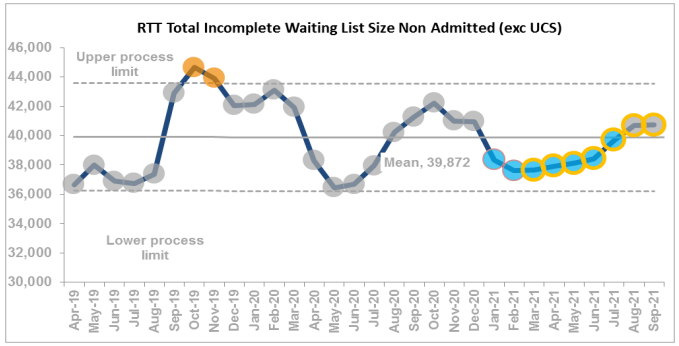
The number of patients on the non-admitted PTL continues below the mean, showing a stable trend. In September, the number of patients waiting for more than 18 weeks decreased by 2.1% (169 patients). There were 342 patients who, at the end of September, have waited over 52 weeks - an increase of 16 patients compared to August, most patients were in Audiology (27%), ENT (22% and General Surgery (21%).

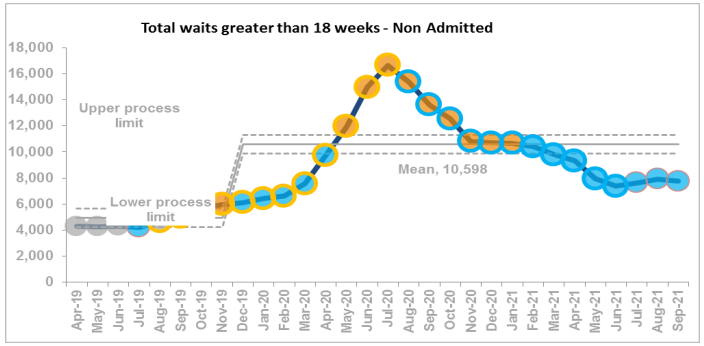
The total waiting list size for admitted patients remains above the mean and continues to show a comparable trend to recent months. In total 6,293 patients are on the waiting list. The number of patients waiting for treatment beyond 18 weeks increased by 27 patients compared to August. The highest proportion of admitted pathway waits over 18 weeks is within Cardiology and General Surgery. Compared to the previous month, the number of patients waiting for more than 52 weeks has further reduced by 5.6% with a total of 663 patients.

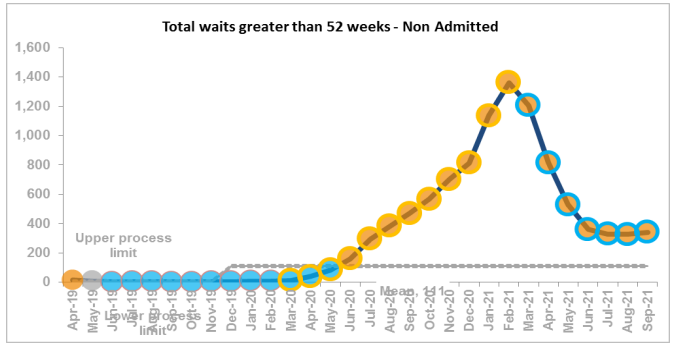
Our Process Perspective

Referral to Treatment — September 2021

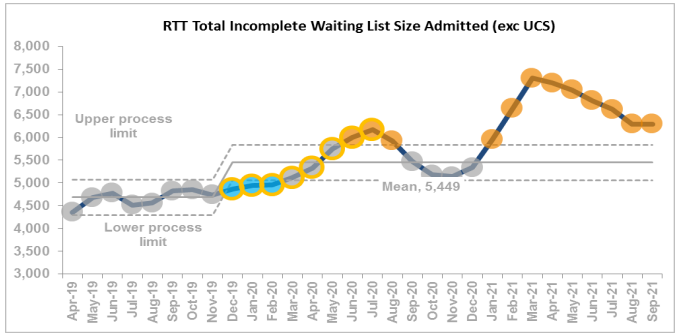
Non Admitted PTL

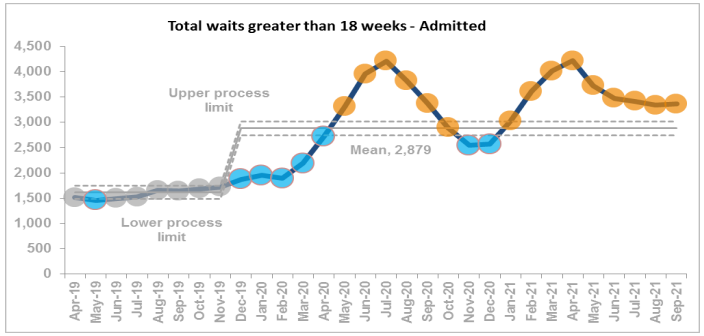


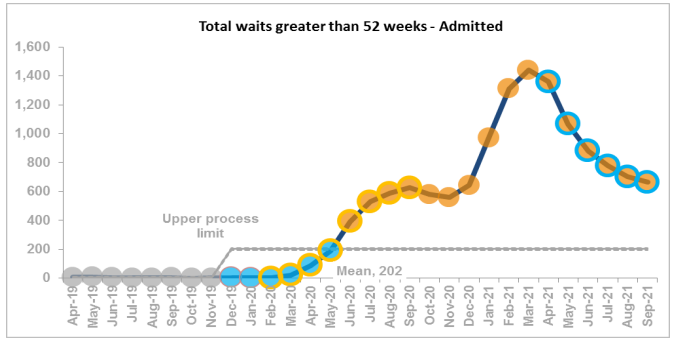




Admitted PTL







Our Process Perspective

Balanced Scorecard Approach

Workforce

Metric	Benchmark Average	Performance 12 months ago	Performance 3 months ago	Current Performance	Target	Distance to target	Current RAG Rating
Sickness	4.0%	3.3%	3.9%	4.5%	3.2%	1.3%	✖
Vacancy	10.8%	9.4%	9.5%	7.3%	10.0%	-2.7%	✓
Turnover		15.3%	15.2%	15.4%	13.0%	2.4%	!
Medical Appraisal			77.5%	75.8%	90.0%	-14.2%	!
Non-Medical Appraisal	72.0%	71.7%	73.9%	73.7%	90.0%	-16.3%	!
MAST	85.7%	90.5%	90.0%	86.3%	85.0%	1.3%	✓
Stability		85.8%	86.6%	87.5%	85.0%	2.5%	✓

* Benchmark info is taken from Guy's & St Thomas', King's, Lewisham & Greenwich, Imperial, and UCLH

* Turnover benchmarking isn't available as different Trusts calculate turnover in different ways

Overall Summary	!

What the information tells us

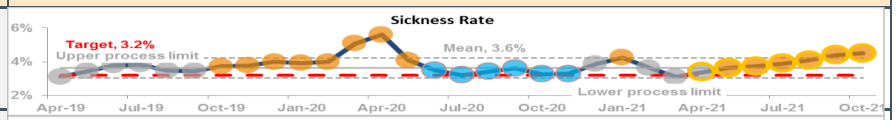
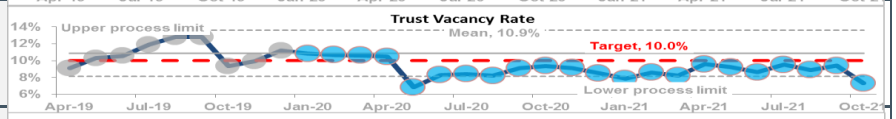
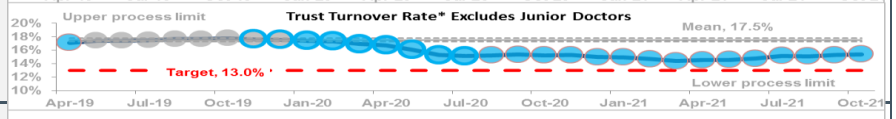
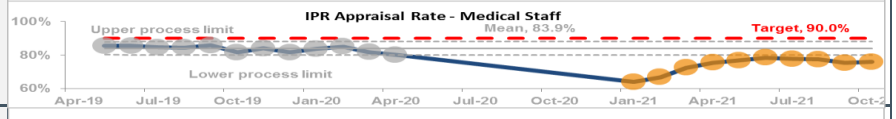
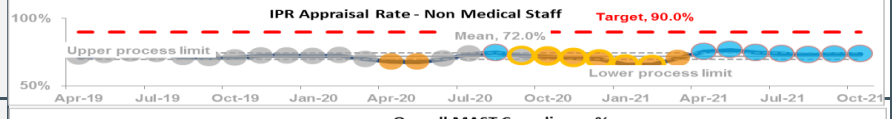
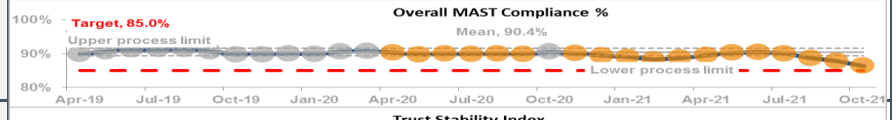
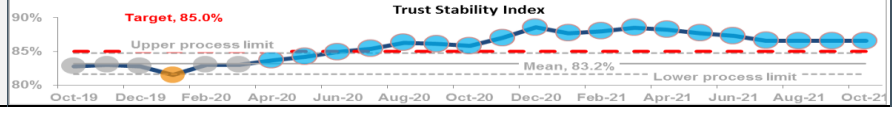
- The Trust's sickness absence rate has risen for the sixth consecutive month showing special cause deterioration. The rate is currently 4.5% and the target is to not exceed 3.2%.
- Vacancy Rate has fallen this month to 7.3% this is within the target of less than10%.
- The Trust turnover rate in October was 15.39% and remains above the target of 13% – On the 2 November 2020, a new approach to completing exit questionnaire was implemented and will provide useful and timely information to help with putting in place required strategies.
- Medical Appraisal rates is consistently below 2019/20 mean whereas non-medical appraisal rates continues to remain above the 2019/20 mean.

Actions and Quality Improvement Project

- All related projects have been re-prioritised within the Winter Workforce Plan and will be frequently reviewed and addressed. The Winter Workforce Wellbeing Plan has been designed to address the Trust Level Sickness and Vacancy rate.
- Retention of staff is a key focus within both the Diversity and Inclusion programme as well as the Culture Programme. A deep dive was held at the Workforce Education Committee meeting focusing on Turnover Rates, the numbers are significantly increasing now. The main cause for turnover is due to fatigue and stress. We have a suite of support measures to support staff and minimise the number of those struggling before they go on leave
- Communications has been issued to staff reminding them to complete the Personal Development Review (PDR) process. Further discussions are taking place with the Trust Employee Relations team to incorporate the pay progression onto the PDR process. A paper on PDR completion plus a communications plan is being presented at PMG meeting. Work planned with the new group model in the new financial year to develop a Communications Strategy and to develop a shared approach to pay progression.
- MAST training expected to fall by around 1.5 % to 2% at this time of year due to junior doctors rotation and new staff joining; HR intend to sustain MAST training numbers during the challenging operational winter pressures

Workforce Metrics

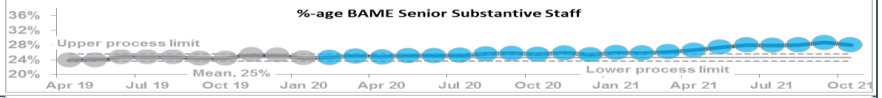
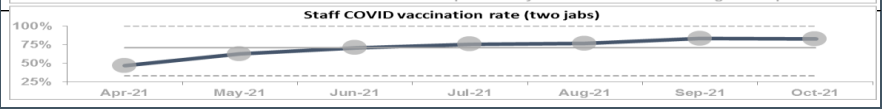
Common cause variation
Special cause variation – improving performance
Special cause variation – deteriorating performance
Special cause improvement 6-point ascending/descending run
Special cause concern 6-point ascending/descending run

	Oct-21	Target	Var to target	Trend
Trust Level Sickness Rate	4.5%	3.2%	-1.3%	
Trust Vacancy Rate	7.3%	10%	2.7%	
Trust Turnover Rate* Excludes Junior Doctors	15.4%	13%	-2.4%	
IPR Appraisal Rate - Medical Staff	75.8%	90%	14.2%	
IPR Appraisal Rate - Non Medical Staff	73.7%	90%	16.3%	
Overall MAST Compliance %	86.3%	85%	-1.3%	
Trust Stability Index	87.5%	85%	-2.5%	

Our People Perspective

Diversity & Inclusion, Culture Metrics

- Common cause variation
- Special cause variation – improving performance
- Special cause variation – deteriorating performance
- Special cause improvement 6-point ascending/descending run
- Special cause concern 6-point ascending/descending run

	Oct-21	Target	Var to target	Trend
! Internal Hire Rate (all bands)	32.4%	40%	7.6%	
NA %-age BAME Senior Substantive Staff (Band 8 and up)	28.0%	N/A		
NA Senior BAME Recruitment rate (Band 8 and up)	16.0%	N/A		
! COVID-19 Risk Assessment Completion rate	74.0%	90%	16.0%	
! COVID-19 Staff vaccination rate (both Jabs) (This is as at the 1st day of the month)	76.6%	90%	13.4%	

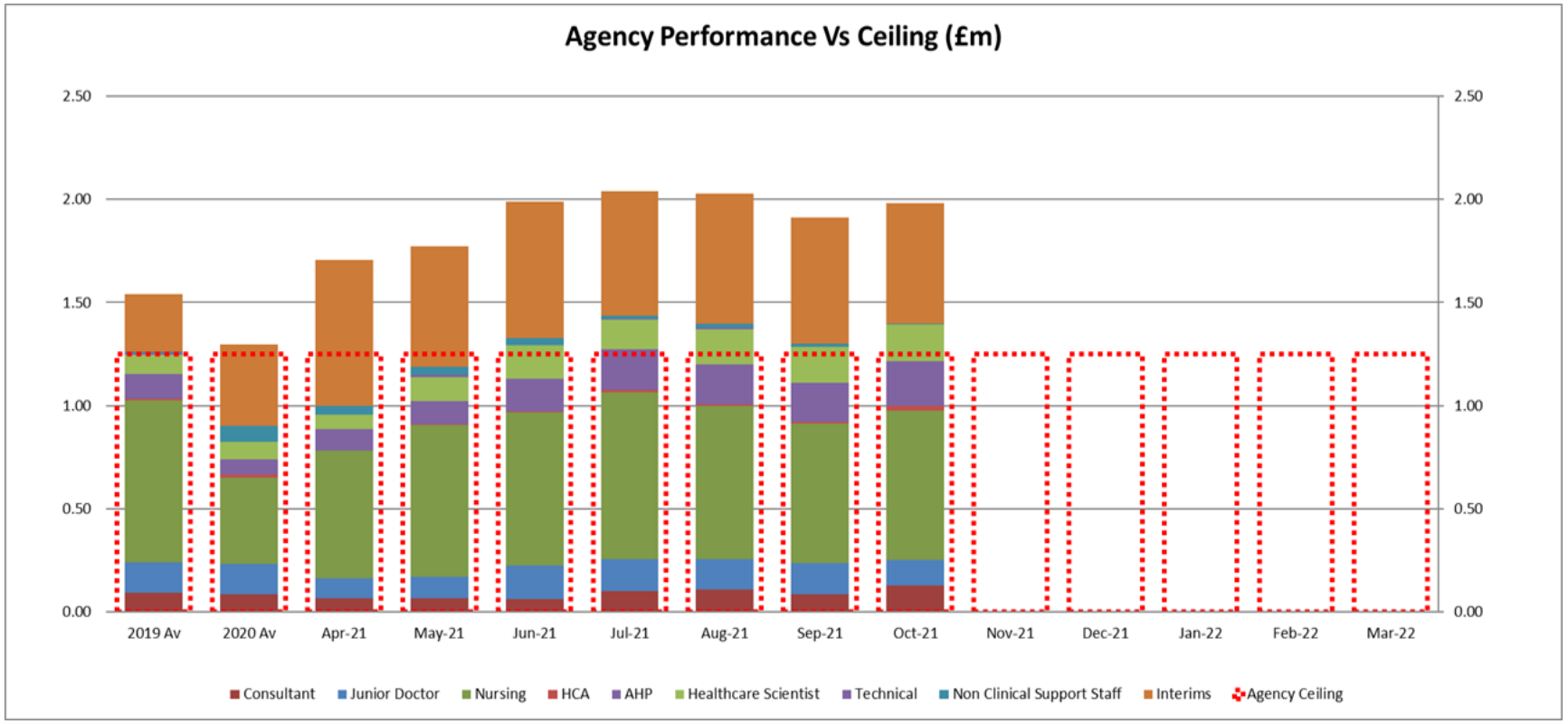
What the information tells us

- In October, the internal hire rate was 32.4% showing common cause variation.
- Of the Senior substantive staff (Band 8 and above) employed in the trust, Black and Minority Ethnic staff represent 28% of that group which above the 2019/20 mean of 25%.
- The completion rate for COVID-19 Risk Assessments was 74% in October against a target of 90% showing special cause variation with a deteriorating performance.
- At time of writing, the COVID-19 vaccination rate was, 86% first dose, 84% second dose, 34% booster.

Actions and Quality Improvement Project

- As part of our Diversity & Inclusion plan we are focusing on debiasing recruitment. Projects include Recruitment Inclusion Specialists, training courses and programmes such as White Allies Programme.
- To encourage Inclusive Recruitment we working towards Active career Conversations (for all unsuccessful internal applicants), posting job adverts – 'Internal First' and an Internal Opportunities policy.
- All existing staff have had a COVID-19 risk assessment and all new staff complete one when they join the Trust.
- We run walk in COVID-19 vaccination drop-in sessions, a letter from the Chief Nurse is being sent to all unvaccinated members of staff. COVID-19 jab FAQ is available for any questions raised. We are accessing and recording COVID-19 vaccinations which were received by staff whilst abroad.

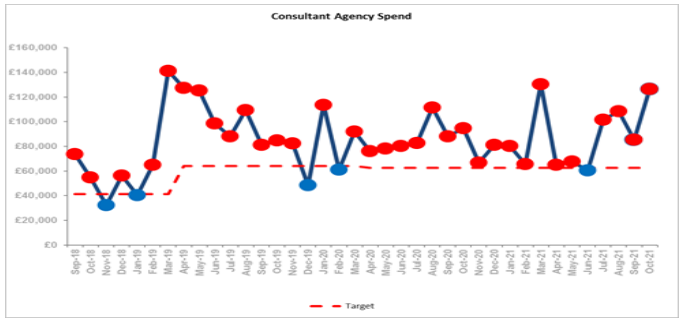
Agency use

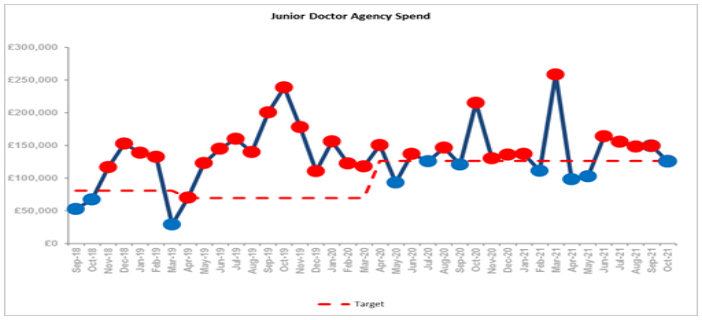


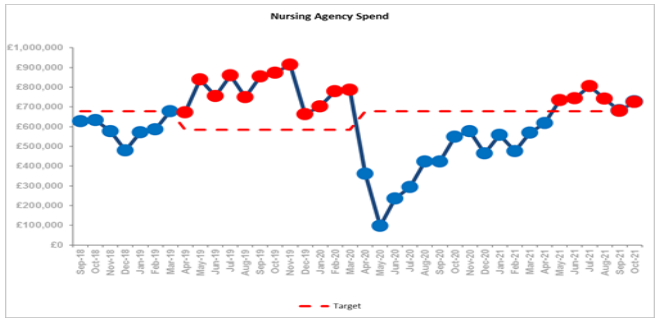
- The Trust's total pay for October was £58.19m. This is £0.31m adverse to a plan of £57.88m
- There is an internal annual agency target of £15.00m
- Agency cost was £1.98m or 3.4% of the total pay costs. For 2020/21, the average agency cost was 2.5% of total pay costs
- For October, the monthly target set is £1.25m. The total agency cost is worse than the target by £0.73m
- The biggest areas of overspend were Interims (£0.42m) , Healthcare Scientists (£0.10m) and AHP (£0.11m)

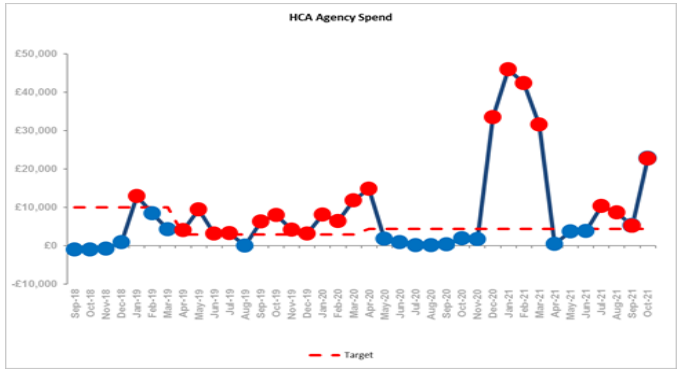
Agency use

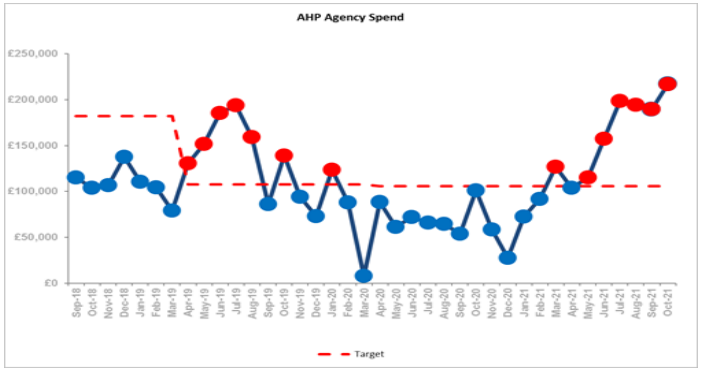
Below cap
Above cap

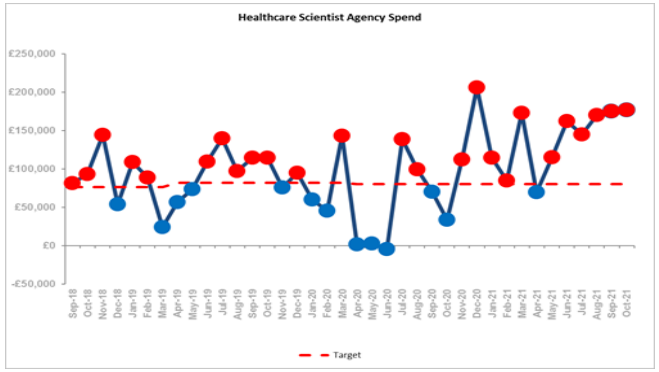


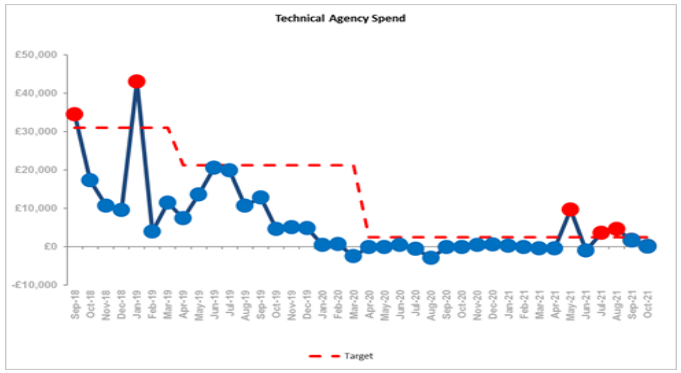


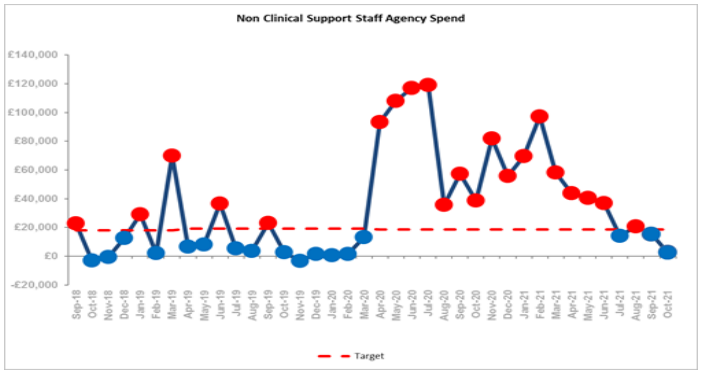


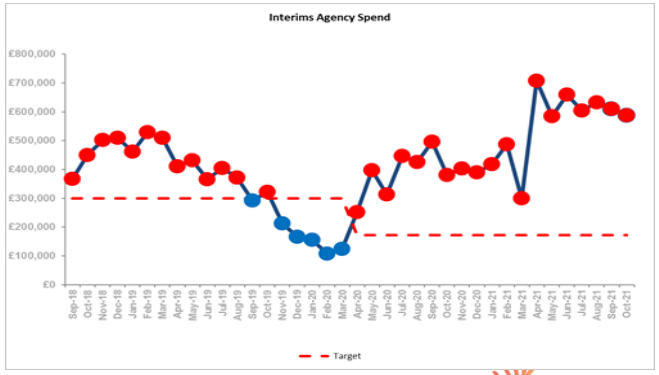








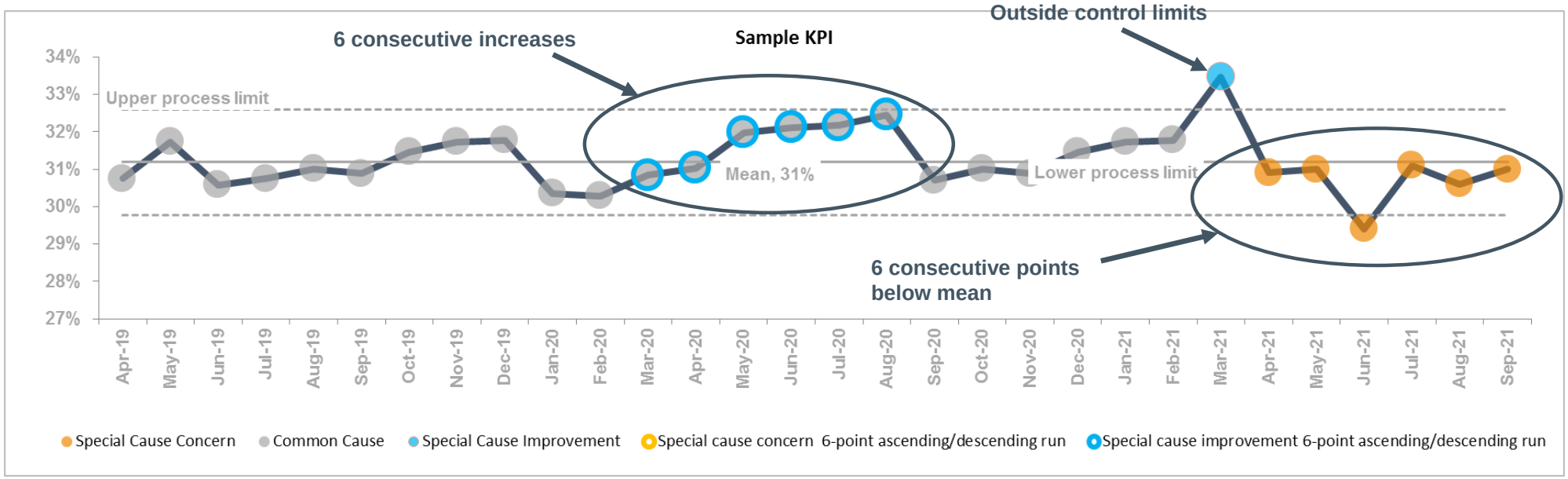




Our People Perspective

Appendix
Additional Information

Interpreting SPC (Statistical Process Control) Charts



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

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

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

Outstanding care every time

RTT Performance – September 2021

Indicator Description	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
RTT Trust Incomplete Performance (exc UCS)	63.7%	67.4%	71.0%	71.4%	69.1%	68.3%	69.3%	70.0%	74.2%	76.0%	76.2%	76.0%	76.3%
RTT Total Incomplete Waiting Lize Size (exc UCS)	46,755	47,399	46,142	46,290	44,291	44,236	44,960	45,109	45,156	45,242	46,319	46,977	47,014
Total waits greater than 18 weeks (exc UCS)	16,974	15,443	13,365	13,251	13,695	14,027	13,801	13,522	11,662	10,850	11,044	11,263	11,121
Total waits greater than 52 weeks	1,097	1,146	1,261	1,456	2,108	2,671	2,644	2,174	1,597	1,240	1,106	1,028	1,005
Total waits greater than 52 weeks Trajectory							2,742	2,645	2,832	2,828	1,288	1,659	1,836
RTT Incomplete Performance - Admitted	38.3%	44.2%	50.6%	51.9%	49.2%	45.6%	45.1%	41.4%	47.1%	48.9%	48.4%	47.0%	46.6%
Total waits - Admitted	5,470	5,178	5,141	5,335	5,950	6,634	7,301	7,193	7,045	6,809	6,619	6,291	6,293
Total waits greater than 18 weeks - Admitted	3,373	2,891	2,541	2,564	3,025	3,608	4,013	4,213	3,724	3,476	3,415	3,335	3,362
Total waits greater than 52 weeks - Admitted	626	579	559	643	971	1,310	1,439	1,359	1,067	880	777	702	663
RTT Incomplete Performance -Non Admitted	67.1%	70.3%	73.6%	73.9%	72.2%	72.3%	74.0%	75.4%	79.2%	80.8%	80.8%	80.5%	80.9%
Total waits - Non Admitted	41,285	42,221	41,001	40,955	38,341	37,602	37,651	37,916	38,111	38,433	39,700	40,686	40,721
Total waits greater than 18 weeks - Non Admitted	13,601	12,552	10,824	10,687	10,670	10,419	9,788	9,309	7,938	7,374	7,629	7,928	7,759
Total waits greater than 52 weeks - Non Admitted	471	567	702	813	1,137	1,361	1,205	815	530	360	329	326	342

Note: Unknown Clock Starts (UCS) have been excluded from the above metrics. For context the number of UCS in September was 374, a decrease from 403 in August. Compared to the same month last year this is a 48% lower.

RTT Performance – September 2021

Specialty	Admitted		Non Admitted	
	Total	% within 18 weeks	Total	% within 18 weeks
General Surgery Service	507	16.8%	912	78.4%
Urology Service	436	61.7%	1,684	91.8%
Trauma and Orthopaedics Service	263	52.1%	1,919	81.1%
Ear Nose and Throat Service	529	36.9%	4,046	65.0%
Ophthalmology Service			183	46.4%
Oral Surgery Service	232	37.5%	768	81.0%
Neurosurgical Service	199	57.8%	2,167	78.6%
Plastic Surgery Service	610	46.4%	970	90.4%
Cardiothoracic Surgery Service	64	1	178	1
General Internal Medicine Service	6	1	61	90.2%
Gastroenterology Service	304	89.1%	3,152	77.2%
Cardiology Service	1,383	44.8%	2,597	80.7%
Dermatology Service	3	100.0%	2,496	91.6%
Respiratory Medicine Service	2	100.0%	1,097	87.3%
Neurology Service	24	91.7%	2,434	88.6%
Rheumatology Service	1	1	911	74.6%
Elderly Medicine Service			96	84.4%
Gynaecology Service	238	60.1%	1,605	84.7%
Other – Medical Services	127	85.0%	6,902	83.0%
Other – Paediatric Services	571	43.6%	2,184	87.2%
Other – Surgical Services	709	32.4%	2,892	80.2%
Other – Other Services	85	49.4%	1,467	69.0%
Grand Total	**6,293**	**46.6%**	**40,721**	**80.9%**

Incomplete Pathway					
Within 18 weeks	Over 18 weeks	Total	% within 18 weeks	Over 42 weeks	Over 52 weeks
800	619	1,419	56.4%	129	176
1,815	305	2,120	85.6%	27	29
1,694	488	2,182	77.6%	37	12
2,823	1,752	4,575	61.7%	221	130
85	98	183	46.4%	43	8
709	291	1,000	70.9%	28	17
1,818	548	2,366	76.8%	55	19
1,160	420	1,580	73.4%	64	61
225	17	242	93.0%	0	0
61	6	67	91.0%	1	0
2,704	752	3,456	78.2%	14	6
2,715	1,265	3,980	68.2%	153	198
2,290	209	2,499	91.6%	11	1
960	139	1,099	87.4%	1	0
2,178	280	2,458	88.6%	15	0
681	231	912	74.7%	13	2
81	15	96	84.4%	0	0
1,503	340	1,843	81.6%	32	10
5,834	1,195	7,029	83.0%	71	61
2,153	602	2,755	78.1%	43	25
2,550	1,051	3,601	70.8%	188	201
1,054	498	1,552	67.9%	134	49
35,893	**11,121**	**47,014**	**76.3%**	**1,280**	**1,005**

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.

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Early Warning Score

Indicator Description	Threshold	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
Compliance with appropriate response to EWS (Adults)	100%	92.4%	94.1%	93.7%	95.3%	92.8%	89.9%	88.0%	88.0%	91.0%	92.3%	91.6%	96.9%	88.5%
Number of EWS Patients (Adults)		474	426	478	235	360	553	483	581	443	531	429	479	532

Meeting Title:	Trust Board		
Date:	25 November 2021	**Agenda No**	**2.3**
Report Title:	Updated 2021 Trust Operational Winter Plan		
Lead Director/ Manager:	Anne Brierley Chief Operating Officer		
Report Author:	Trust Planning Team		
Presented for:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify)		
Executive Summary:	This is the Trust's Winter 2021 Plan, updated from the version reviewed by Board in September. The previous Plan highlighted a potential significant risk in capacity (modelling suggesting that the Trust could be 40-80 acute G&A beds short compared to patient demand at peak periods of this winter). It was agreed that the updated Plan - including work in progress with local partners to ensure there was sufficient community capacity to enable timely discharge of patients from acute settings - would be presented to November Board. As demonstrated in the Trust's ED performance in recent weeks, flow through the emergency pathways is critical to meeting the 4-hour access standard; ensuring there is sufficient clinical capacity on the emergency floor to off-load ambulances quickly and assess and treat those patients with acute or critical presentations. Since the September Board update, there have been the following developments: • Significant partnership working with primary, community and social care in Merton and Wandsworth to agree and commence implementation of community capacity to meet patient need this winter • Winter funding agreed to expand SDEC (same day emergency care) capacity and increase ED staffing to meet the increased numbers in ED • Pan-SWL collaboration to develop clinical network to support place-based 'virtual wards', where acute, primary, community and social care support post-acute / sub-acute patients to recover in their usual place of residence • Place-based and pan-SWL agreements (with capacity being sourced) to manage Transfers of Care (from acute to community settings) 7 days a week • Flow programme underway within the Trust to enable our teams to work smarter and optimise timely discharges 7/7 These developments should offer the Board a good degree of assurance that the Trust is doing everything within its gift to safely manage the combination of winter, children's respiratory, elective recovery and COVID patient demands this winter. However, as indicated in the principal risks (slide 5), this reduces but does not mitigate fully the operational risks faced by the NHS (including this Trust) this winter. Material risks remain, and the Trust will need to flex its resources proactively to best manage clinical risk across patient cohorts, especially at times where there is most likely to be a mismatch between capacity (acute and community) and patient demand, for example the first 2 weeks in January.		

Recommendation:	The Committee is asked to note the following updates: • Progress on internal actions to deliver safe care during winter pressures, and support staff well-being • Progress on place-based actions with partners to increase community-based capacity to enable timely and safe discharge from acute settings, and sustain flow through the emergency pathways • [Together with the H2 Plan] to note the triangulation between this Winter Plan, the Winter Workforce Plan and the Trust's H2 Plan The Committee is also asked to note that despite these actions, the residual risks remain high due to the combination of multiple patient demand pressures that will occur during this winter. However, the Trust's commitment remains: • To meet the need of all our patients, proactively managing resources to mitigate clinical risk across all patient cohorts • To support staff well-being
Committee Assurance:	The Committee is also asked that in considering contents of this report, its supporting documents and the discussion at the meeting which of the following assurance rating it would provide to the Trust Board. • **Substantial Assurance:** The report and discussions assured the Committee that there are robust systems of internal controls operating effectively to ensure that quality and safety risks are managed to deliver high quality services and care to patients. • **Reasonable Assurance:** The report and discussions assured the Committee that the system of internal controls is generally adequate and operating effectively but some improvements are required to ensure that quality and safety risks are managed to deliver high quality services and care to patients. • **Limited Assurance:** The report and discussions supported the Committee's conclusion that that the system of internal controls is generally inadequate or not operating effectively and significant improvements were required to ensure that the quality and safety risks are managed effectively to improve the position and ensure that high quality services and care is provided to patients. • **No Assurance:** The report and discussions led the Committee to conclude that there was a fundamental breakdown or absence of core internal controls and systems to enable the Trust to deliver high quality services and care to its patients.
Supports	
Trust Strategic Objective:	Care, Culture, Collaboration
CQC Theme:	Safe, Caring, Responsive, Effective, Well-led
Single Oversight Framework Theme:	
Implications	
Risk:	The principal risks to the Trust with regards to the delivery of safe and timely care during this winter are set out in Slide 5 of this paper. Risks relating to use of resources (workforce and finance) are detailed in the H2 Plan and Winter Workforce Plan – which have been triangulated with this Plan.

Legal/Regulatory:	The Trust is currently not meeting the Constitutional Standard for Emergency Care (4-hour access target). This reflects demand pressures and workforce challenges currently felt widely. The Plan details what the Trust is doing to improve internal flow; and actions in place with partners to increase community capacity (enabling safe and timely discharge). However, it is likely that recovering and sustaining the 4-hour ED access standard will remain challenging through this winter.		
Resources:	Significant resources are committed to the delivery of this Plan, both in the Trust's H2 operational Plan, and through short-term winter / elective recovery monies which are being made available in the NHS and social care.		
Equality and Diversity:	Resilience of service delivery across all elective and non-elective pathways during this winter is essential to • tackle health inequalities that differentially affect populations, and • to address residual inequalities caused over the last 18 months due to reduction in elective capacity and patient reluctance to seek emergency care during peaks of the COVID pandemic.		
Previously Considered by:	Verbal update to FIC, 18th November QSC, 18th November	**Date**	
Appendices:			

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NHS
St George's University Hospitals
NHS Foundation Trust

Our Plan for Winter - 2021/22

Including COVID-19, Flu, Elective Recovery, Children's Respiratory Conditions

Anne Brierley – Chief Operating Officer
Robert Bleasdale – Chief Nursing Officer
Dr Richard Jennings – Chief Medical Officer

November 2021

Version 8

Contents

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Chief Executive Officer's Introduction

There is little doubt that the NHS has another tough winter ahead. With seasonal demand, flu and children's reparatory conditions on the rise and COVID still darkening our doorsteps, all while we continue to maintain our elective recovery, we will be asking our staff to once again dig deep this winter.
Despite the pressure, we have learnt a lot over the last 18 months and we continue to be innovative and agile as we respond to the challenges. By adapting and working in new ways with our partners, we are able to ease some of the expected pressure so we can continue to provide safe and timely care to our patients.

The winter challenge faces all sectors of the NHS and social care and across our South West London region we have 12 clinical networks in place. Over 1,200 patients have been treated through mutual aid this year so far, reducing the number of elective long waiters and helping us hit our plan for treating those patients who have waited over 52 weeks. We will once again use our critical care network to manage clinical pressures across our ITUs.
We have learnt from the excellent team working which has developed over the last year and will continue to build on these innovations. Alongside local partners, the COVID virtual ward will be expanded, discharges will be better co-ordinated and supported within the hospital and we will make good use of new technology such as combined COVID and flu POCT. By simplifying processes we will make it easier for staff to discharge patients safely.

Our innovative newly built surgical centre at Queen Mary's has meant we were able to continue to offer day surgery to over 1200 patients whose treatment had been delayed by the pandemic and it will continue to run throughout winter.

We have invested in our workforce and now have over 100 nurses joining our team in the next month. We have recruited ITU nurses to support the extra 14 ITU beds we expect to need this winter, will continue to work as a clinical network in South West London to provide critical care this winter.

But we won't just be caring for our patients this winter, we will also continue to look after our staff. From wellbeing rooms and psychological counselling to ensuring they have their rest breaks and easy access to vaccinations, our staff and keeping them staff well remain a continued focus of this winter plan.
I want to thank all our staff at Team Georges who have given so much over the last 18 months and are gearing up again for another tough winter. Their efforts have not gone unnoticed by me, my executive team or members of the Trust Board.

Thank you
Jacqueline Totterdell,
Chief Executive

Executive Summary

Our Plan for Winter 2021/22 aims to ensure that we continue to provide safe and timely care for all patients throughout this winter. During this year, we have sought feedback from teams, partners and patients about has what worked well in our pandemic response, and what we can improve as we continue to provide care to all our patients as well as treating COVID. This plan incorporates those lessons, in particular continuing to focus on our staff's health and well being.

We absolutely recognise the skill, professionalism and commitment that all of our staff continue to demonstrate, across emergency, cancer and elective pathways. Keeping our staff well and supported continues to be key and, in planning for this winter, we have invested in our workforce in key areas to minimise clinical risk and to reduce – as far as possible – the pressures felt by teams.

For this winter, we have looked at a 'most likely' scenario and developed a plan to help us deliver safe and timely care. We are not expecting to need to open as many ITU beds as last winter, which means less redeployment and more continuity for staff, and a better ability to continue with routine elective care for our patients. In line with GIRFT recommendations, we plan to do more elective care as day cases, to enable elective recovery to continue.

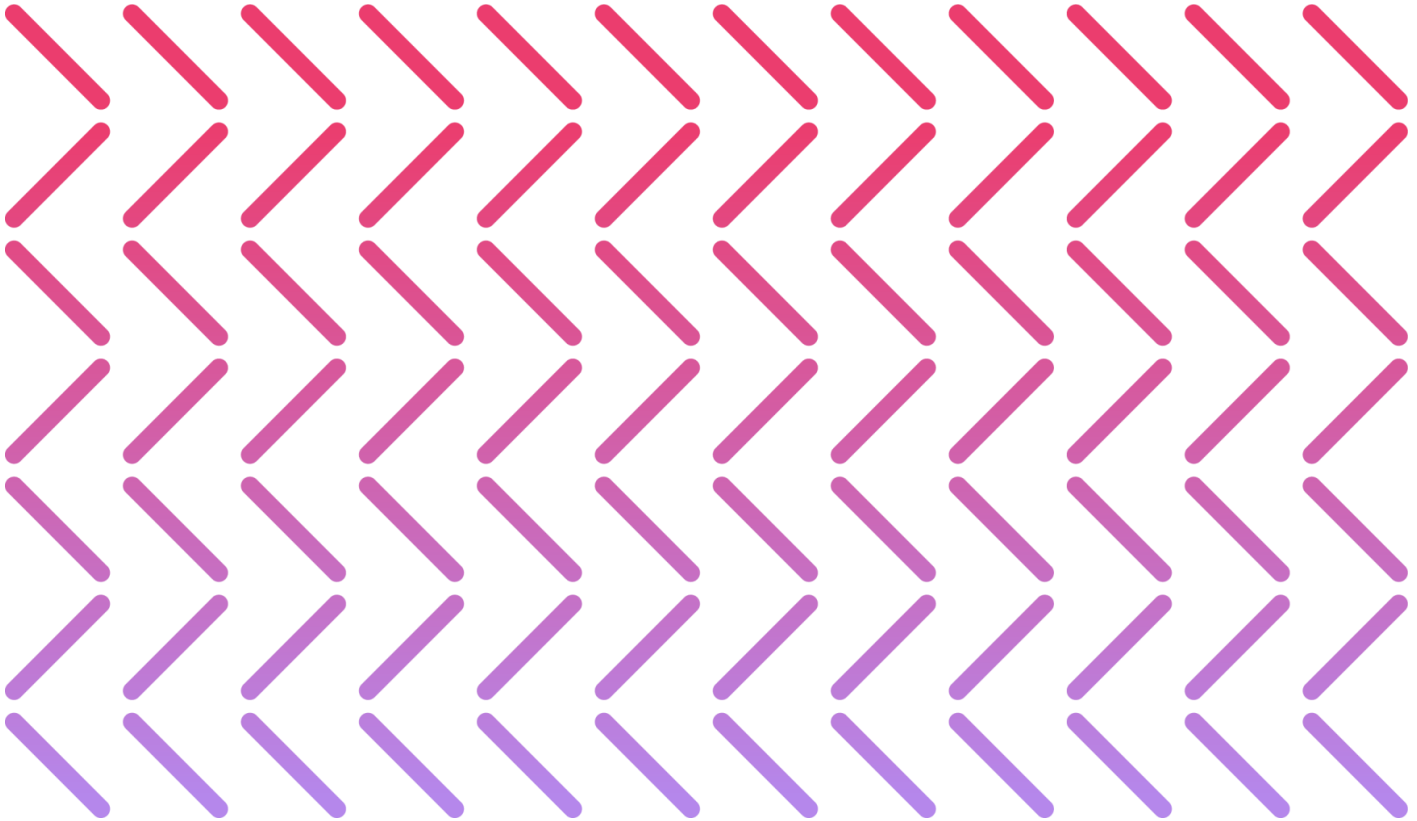
The plan describes how and when we will use our finite resources to gain the most from them, improving our internal processes to support staff in working smarter, not harder, and identifying specific areas where increases in demand are expected, such as a surge in children's respiratory conditions. In addition, our plans do not depend on repurposing our day surgery unit and endoscopy suites for COVID this winter. We have the benefit of our Elective Care Centre and Diagnostic Hub at QMH to protect our elective pathways, which have been running since this summer and we will take advantage of our strong partnership working in Merton and Wandsworth to develop a virtual frailty ward and MDT Transfer of Care hub to sustain flow, helping us to manage the clinical risk between patients arriving at the Emergency Department and patients ready for discharge on wards.

These innovations will help us to make best use of our acute capacity to treat patients across all care pathways as we continue to focus on balancing the clinical risk across all these patient cohorts.

Patient safety, staff welfare and wellbeing are clear priorities for us in delivering this plan. This winter plan aims to keep us all protected from flu and COVID, with our flu vaccination programme's ambition to offer all frontline staff the flu vaccine, aiming for 95% of frontline staff being vaccinated by 1 December 2021; our COVID vaccination and booster programme, which continues in line with national guidelines. It also includes our winter planning, which sets out how we will manage services throughout this period – with patient safety and staff welfare as our top priorities.

We continue to be active partners in the Merton and Wandsworth and the South West London Integrated Care System Winter Plans in facing and responding to the unique challenges that this winter will bring, collaborating to best provide care to the patients we are here to serve.

SECTION 1
Summary Winter Plan



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Winter Plan – Principal Risks

Principal Risk	Mitigations	Controls	Original Risk	Mitigated Risk
Non-elective patient need and demand will outstrip Trust capacity	• 6 additional ITU beds open to protect elective work • Additional 9 trolleys and 12 chairs in Majors ED (winter funding to staff) • Improving supported discharges to optimise inpatient capacity (7/7 transfer of care hub) • Pan-SWL plans for managing ITU COVID surge (if required) • Use of SWL winter bed bureau (additional 'step-down' bedded capacity)	Trust and pan-SWL operational and clinical oversight, linking to Trust governance processes	Original risk - 4 likelihood, 5 consequences = 20	Current (residual) risk - 4 likelihood, 4 consequences = 16
Staff morale and capacity is reduced following pandemic	• Targeted recruitment and investment in key staff groups - HCAs, RNs, ITU, theatres staff, anaesthetists • Investment in safer staffing to give ward manager supernumerary time for supervision and support of ward teams • Ongoing staff support • Promoted catch up of annual leave over the summer • Effective rostering to minimise gaps in staffing levels	Monitoring of staff welfare through line management, staff engagement and feedback channels	Original risk - 4 likelihood, 4 consequences = 16	Current risk - 4 likelihood, 3 consequences = 12
Elective recovery will be stalled by winter pressures	• 4 additional theatres at QMH • DSU and Jungle move to 23 hours, increasing operating hours • Mutual aid in place for high volume / low complexity procedures where there are long waiters • Green wards protected, and supported with dedicated PACU and ITU capacity • Investment in areas of clinical risk on recovery - endoscopy and cardiology • ITU staff investment (and reduced expected ITU COVID surge demands) will significantly reduce redeployment of staff from all clinical areas, enabling BAU to continue more strongly than in previous winter	Weekly review of activity against trajectory at care group level, scrutiny at SWL and regional levels	Original risk - 4 likelihood, 4 consequences = 16	Current risk - 4 likelihood, 3 consequences = 12
Insufficient community capacity to meet increased population needs **Merton and Wandsworth winter plan**	• Community partners provision of a virtual frailty ward (with clinical support from us) • Winter investment in same day emergency care pathways (SDEC) in Trust • Increased local GP telephone and home visiting capacity • Shared M&W community capacity plan (domiciliary care, residential care, community therapies, virtual ward staff), with additional contracting in place to increase capacity	Trust and pan-SWL operational and clinical oversight, linking to Trust governance processes	Original risk - 4 likelihood, 5 consequences = 20	Current (residual) risk - 4 likelihood, 4 consequences = 16*

* go-live is due in Early December - once established, should be able to reduce risk to 3x4=12)

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Winter Plan 2021/22
A Flexible Modular Approach

The scope, operating constraints and available options to mitigate patient need and demand in aggregate are expected to be greater than the available clinical and social care resources to meet all our patients' needs. Continuing to do more of the same will not be possible, nor will it be sufficient.

We will need to flex and adapt our care pathways, ways of working and our 'real-time' clinical prioritisation and oversight across all our patient cohorts to ensure that we:

- **effectively manage clinical risk across all clinical pathways; and are**
- **nimble and proactive in meeting changing challenges as they unfold over this Winter.**

There are 3 inter-dependent components driving this approach;

1) Scale and range of likely demand – usual winter pressures, plus COVID, plus flu, plus children's respiratory surge, plus on-going elective recovery

2) Workforce resilience and capacity – for staff within the Trust, and across system partners in primary, community, social care and mental health.

3) Limited additional mitigations to provide additional acute inpatient 'winter' capacity – the Trust (as with all SWL acute Trusts) has yet to close winter inpatient capacity, and hospital occupancy continues to run 'hot'; this position is replicated across all healthcare settings.

The Trust's Winter Plan is modular and dynamic, outlining multiple inter-dependent scenarios and actions to address, which we will use flexibly to meet changes in demand and capacity as winter unfolds. We will continue with executive flow huddles to make conscious and proactive decisions about patient flow.

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Winter – as part of business as usual

- Our plan puts patient safety, staff welfare and staff wellbeing at the heart of everything we do
- We have listened to our staff, patients and their carers to learn lessons from last year, and included the NHS planning priorities for H2, in this year's winter plan
- In response we have maintained our 3 corporate themes which form the key principles that will guide us through the period of this plan as follows:
    - **Care** – patients and staff feel cared for when accessing and providing high quality, timely care at St George's; in how the Trust starts to recover from COVID-19 and in how we respond to any future wave
    - **Culture** – we will transform our culture to create an inclusive, compassionate and enabling place to work where staff feel respected and understand their role in the delivery of high quality clinical care for our patients and service users
    - **Collaboration** – we will engender an ethos of collaborative working across our teams within St George's, and with our system partners, to achieve the best outcomes for patients, building on the spirit of collaboration developed internally and externally through the COVID-19 response
- We have also agreed our 6 corporate objectives for H2, which are set out below, to support delivery of our 3 corporate themes above, which provides the context for our winter plan priorities:

Theme	CARE			CULTURE		COLLABORATION
Objective	1	2	3	4	5	6
Exec Lead	CNO	COO	CMO	CPO	CPO	CFO
Corporate Objective Description	**Improve patient safety by reducing avoidable harm in relation to:** **a) Learning from all local/ SWL nosocomial Covid cases** **b) TEPs agreed within 24 hours of admission** **c) Improving the practice of consent.** **d) Improve discharge processes.** **e) Equality of access and outcome for BAME patients**	**Improve the clinical effectiveness and efficiency of all patient pathways.**	**Embed a quality, safety and learning culture through monthly patient safety, mortality and morbidity meetings for every speciality.**	**Deliver on our Health and Well Being (HWB) promises to all staff by investing in:** **a) Physical and mental health staff services** **b) Flexible working** **c) Well Being guardian appointment**	**Taking action on our culture to ensure we are more inclusive and diverse, where discrimination, violence and bullying is not tolerated – improving the experience of BAME staff in particular.**	**Make best use of our resources at St. Georges and across South West London ICS, for the benefit of patients and the welfare of our staff.**
Improvement Measures	• Reduction in the number of Covid nosocomial cases compared to 2020/21. • 90% of adult admissions have Treatment Escalation Plans (TEPs) agreed with a reduction in the number of cardiac arrests compared to 2020/21. • Improvement in consent audit performance compared to December 2020. • Improve discharge planning and delivery to help maintain flow within the hospital. • Identify areas of differential outcome for BAME patients and agree actions to improve within Maternity.	• Improved GIRFT performance for all specialities. • Delivery of 7 day clinical services (with CMO and CNO) • Deliver 4 hour A&E, cancer, RTT and diagnostics pathway trajectories. • Deliver agreed elective recovery trajectories. • Deliver Covid and winter plans in collaboration with APC and ICS partners.	• All specialities run, record and act upon learning (including Trust wide) from monthly patient safety, mortality and morbidity meetings. • Maintain SHMI at "below expected" level • Improvement in safety culture score compared to 2020/21.	• Deliver Covid and flu vaccination programme for all staff. • Appoint a HWB guardian. • HWB assessments for all staff completed and implemented. • Flexibility by default recommendations implemented. • Improvement in HWB staff survey score compared to 2020/21.	• Implement the priorities agreed in our Culture, Equity and Inclusion Programme plans. • Improvement in our engagement, diversity and inclusion staff survey scores compared to 2020/21. • Further improvement in representation of BAME staff and the local community in our leadership (Bands 7 and above).	• Implement the staff passport to promote best use of ICS/ APC capacity and staff expertise. • Support ESTH EPR replacement programme. • Financial balance achieved (Trust & SWL ICS) within the resource envelope agreed.

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Operational Capacity Safety Plan

- Our winter plan is based on a Clinical Safety Strategy, developed by the Chief Medical Officer, Chief Nursing Officer, Chief Operating Officer, Divisional Management and Care Group leadership teams, the aim being to help us safely navigate winter by being proactive.
- The key elements are set out in the diagram below, balancing the needs of COVID, flu, elective recovery and the forecast increase in children's respiratory conditions. Put simply, we are planning to run as many services as possible at St. George's, across South West London NHS and independent sector - so that all patients can access the care they need, when they need it.
- This Operational Capacity Safety Plan is supported by care group risk assessments of patients and their needs, with treatment plans agreed and communicated with every patient and their GP where clinically appropriate.

COVID-19

- Designated COVID-19 ward(s) allocated, flexing with need
- Extra 6-14 ICU beds at peak demand
- Staff redeployed in teams
- Counsellors available to support staff in need and promote resilience
- Vaccination programme to continue
- Booster shots to be offered to all frontline staff

Flu

- Vaccination programme underway
- Staffed by peer vaccinators
- Availability of clinics – Mon-Fri
- Weekend and pop-up clinics to be advertised
- Aim for 100% flu vaccinations
- Flu patients allocated to side rooms, then bays, then a ward to be allocated according to demand
- Virus strains to be separated where possible

Emergency Floor

- Effective use of escalation
- Mental Health support 7/7
- POCT for COVID and Flu

New actions:

- Increased majors by 9 trolleys and 12 chairs
- POCT - joint testing for flu and COVID with winter funding to staff
- Expand same day emergency care pathways (SDEC), reflecting learning from ECIST visit

Elective Recovery

- Protect beds from surge
- Appropriately staff theatres
- Mega rota for outliers to protect patient flow

New actions:

- 4 QMH theatres with insourced theatres support
- Day Surgery Unit for adult and children (DSU and Jungle) move to 23 hours recovery to extend operating sessions
- Dedicated and protected green wards, ITU and PACU capacity
- Investment made in pre-operative team and training on outpatient EPR administration

Children's Respiratory

- Beds reallocated flexing with need
- Viral admissions in cubicles
- Increase ITU/HDU beds using PICU
- Place-based partners working together to optimise capacity

New actions:

- Incremental increase to a maximum **above** BAU of
  - 10 ITU
  - 6 Enhanced Care
  - 3 Ward
- Virtual respiratory ward in place with partners

Our Plan for Winter 2021/22

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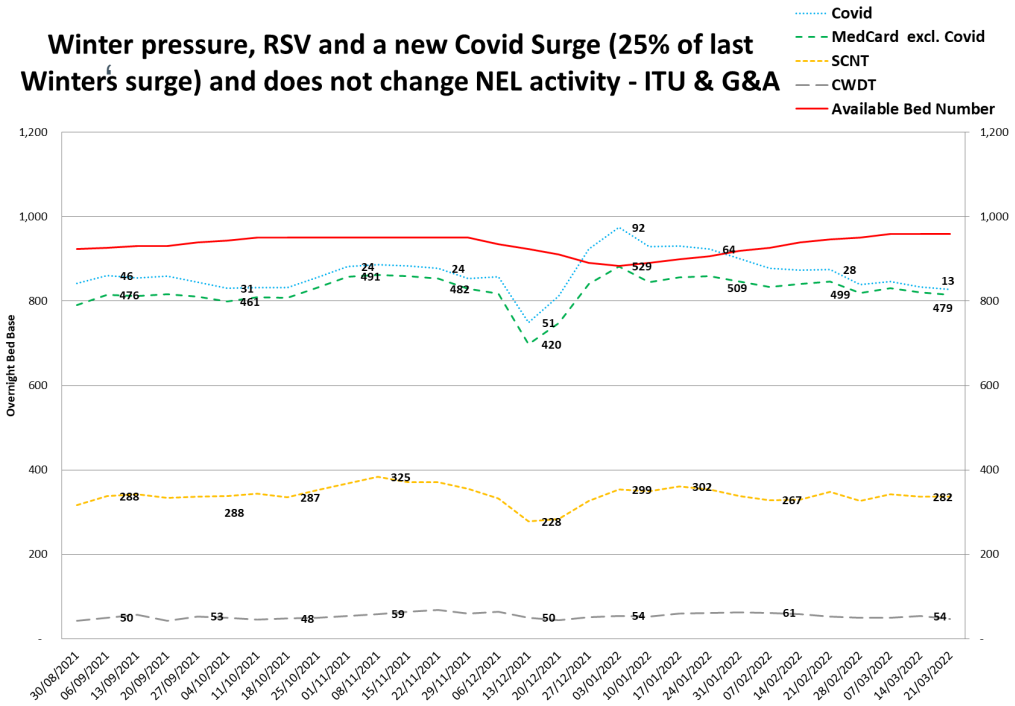
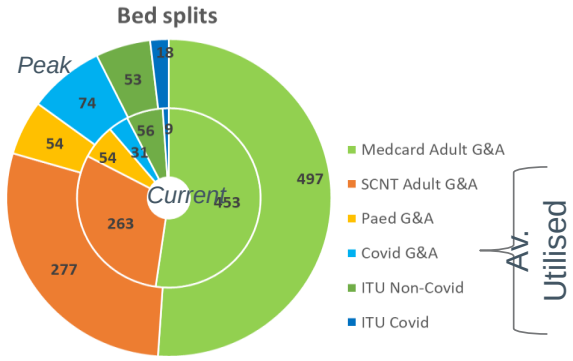
Scenario A – Likelv Case



- **Suggested Scenario to plan for** – some COVID-19 activity, routine winter unplanned care activity, planned care including inpatient, day case, outpatient and imaging. Maintain elective recovery efforts, whilst planning for a Christmas surge.

- **Bed Capacity** – we will need to flex our capacity in line with profiled demand, we will be under pressure (as per normal Winter) for 8 weeks or so between December and the end of January 2022, and dependent upon COVID volumes, if we cannot manage down further our DTOC patient groups (target level = <25) we will likely need to anticipate elective activity pauses:
  - **ICU** – A baseline of 66 beds, with up to an additional 14 ICU beds for peak period COVID patients
  - **MedCard** – peak availability of 530 G&A medical beds on the Tooting and QMH sites, with a risk of COVID requiring an additional 60 beds.
  - **SCNT** – peak of 325 beds, prior to Christmas, and for as long as practicable during November.
  - **CWDT** – no change to bed base
- **Theatre, Day Surgery, Endoscopy and Outpatients**, including new capacity through our Elective Care Centre and Diagnostic Hub at QMH, is available to run clinical services in line with our forecast activity, including delivery of our trajectories for the NHS Constitution Standards.

- **Workforce** – Taking the average bed position, throughout the Winter, we are short-staffed in nearly all categories due to our vacancy levels. We have assumed a ratio of 1:1 in Critical Care in the below. This further stretches if we look at the peak period, more so in the gap for Qualified Nurses covering general G&A capacity. Overall, we are not as short staffed as last winter due to the investments we have made in key areas and aim to staff gaps through continuing recruitment and the use of our staff bank – see workforce plan.



	Ward Type	Beds
Covid	Covid ITU	6
	G&A - Covid	36
Non-Covid	General ITU	55
	G&A - Non-Covid	720
	Paeds, Maternity & Neonatal	183
All	Total Beds	1082

	Staff Group	Gap (WTE)
All	Critical Care Nurses (CCN)	-44
	Registered Nurses (RN)	-202
	Health Support Workers (HCA)	-141
	Pharmacists	4
	Therapists	13
	Admin & Clerical	-44

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St. George's Winter Plan Assumptions and Mitigating Actions at Times of Peak Demand

Likely Scenario

- Winter Pressure
- RSV
- COVID surge ~25% of last winter
- No reduction in NEL
- No. flu and COVID cases small proportion of overall NEL demand

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- 20-60 general and acute medical beds short at times of peak demand
- 6-14 ITU beds short at times of peak demand
- Staffing challenges in junior doctors, RN's, HCAs, B5, RMNs

Actions – St George's

- Designate COVID wards
- Designate a flu ward
- Increase ITU capacity
- Redeploy staff (in teams)
- Reduce inpatient elective throughput
- Trigger mega rota for outlier assessment and for AHPs
- Continue recruitment and use of bank/agency and WLI shifts
- Utilise Independent Sector where possible
- Reduce areas of care e.g. elective surgery, priority 3 & 4

Action – SWL Partners

- Working as SWL on
  - ITU capacity
  - Supporting ED pressures
  - Mutual aid for elective recovery
  - Developing pan-SWL clinical network to support place-based virtual frailty wards
- Winter plan with Merton and Wandsworth incorporates
  - 7/7 MDT and multi-partner discharge hub
  - Frailty virtual ward
  - Additional community capacity (primary care, domiciliary care, residential care, social care)

Winter Workforce Plan

We are committed to supporting our workforce through the predicted winter pressures. Winter commonly causes additional pressures on our workforce through increased staff sickness due to illness and increased working pressure, staff vacancies and annual leave during festive periods. This year an additional pressure is expected due to the COVID 19 pandemic, this brings unpredictable challenges and means we need to be better prepared for all possible challenges.

Our focus is to:

- build upon our existing workforce plans as opposed to trying to create a raft of new initiatives. The key is to try to prioritise those activities which we believe will help us most in having good, healthy and affordable staffing levels this winter.
- move at pace and where we're introducing something new, the focus should be upon what we can do quickly (within a month or so).
- have a clear focus; understand the key questions we are trying to answer within the context of the overall objective.
- join system levels where we believe there are likely to be synergies, and this won't cause undue delays.

Our five workstreams are:

Staff Support Team

- Staff support on a normal basis do not have any contact with the managers of the staff receiving counselling. However, I feel that they could actually advise on staff readiness to return to or remain in the workplace. We are re-working our intranet pages so staff can easily find the staff support service.
- We maintain immediate contact on the day of contact, with sessions offered to staff within 5 working days (most often much sooner than that)
- We will continue our visits to clinical areas (sometimes daily when needed). At least weekly. We are offering regular support groups at QMH and ST Johns too.
- We will contact all care group leads and service managers to emphasise our support for serious untoward incidents and our immediate availability for debriefing.
- We want to encourage managers to attend Manager Support Sessions (individual sessions for managers to access support about work psychological issues such as difficult conversations) and we will work up some comms on these.
- We are designing groups for staff who have been through personal loss during covid and how this affects their work.
- We have designed 5 minute brief interventions on developing compassion in teams that we take around the wards (Random acts of kindness -often accompanied with a chocolate)
- We want to re-advertise the bullying and harassment helpline which does not get many calls.

Occupational Health

- A need for OH information to be more accessible on the intranet
- Managers/staff unable to find the information they need – large call volumes and emails due to this
- Managers need to be aware of services that are available
- Long Covid consultations are available for staff
- Physiotherapy available for staff – no self referrals
- I triage all referrals and allocate accordingly
- I am in discussions with Teresa Mulvena to send some referrals directly to staff support

Staff Health & Wellbeing

- As part of the plan for the Thank You Festival we will be running a week of reflective practice at the beginning of November. We hope to liaise with the art department to produce something that all staff can express how they have been affected by covid. This reflective week will be offered to all staff: clinical and admin staff, and to ensure coverage we will stop all other business that week.
- Booking onto REACT Wellbeing Conversations training
- Ensuring managers are all completing Wellness Action Plans, not only for themselves, but also with each of their team members, and that these are being reviewed/amended regularly and accordingly
- Ensuring that teams are making space for wellbeing within their huddles/team meetings
- Ensuring that line managers are aware of where to find more information to signpost staff to (we can absolutely produce more information sheets to support this)
- Creating a culture of wellbeing by putting it at the heart of what they do, e.g. ensuring staff have scheduled breaks, ensuring that wellbeing is discussed and thought about, ensuring staff are taking annual leave throughout the winter season
- Providing staff with an opportunity to develop their wellbeing learning (e.g. through accessing training like Mental Health Awareness)
- Encouraging teams to take part in the Thank You George's events that will be run in Q3
- Engaging with all of the mental health and supportive interventions Teresa's team is facilitating

Recruitment

- Plot the current vacancy rates for each division
- Map the current nurses in the pipeline to include all international recruitment , against the vacancies for each division
- Clear Trajectory of the position through winter pressures - till April 2022
- Establish from the above where the shortfalls are
- Include a 10% uplift for staff absences over the winter pressures
- Liaise with Staff Bank on how we can work together to address shortfalls and where they will need to support the divisions.
- Continue with International recruitment via the capital nurse programme
- Continue with domestic recruitment, holding regular open days and webinars
- IEN's in the pipeline - expecting 28 October- no issues, 40 in November and in December- there is an accommodation problem that may be a barrier

Absence Management

- Plot additional support at Ward level to support the recording of sickness. Particularly around short-term absence concerns
- Support for managers to manage sickness effectively.
- Produce presentation of sickness hotspot data and support managers to interpret data to better manage absence
- Renew templates for staff letters relating to absence
- Produce and issue a 'Return to Work' Manager's guide, with focus on RTW meetings
- Review data and sickness processes for clinicians
- HR surgeries to manage sickness absence
- Fast track of urgent mental health referrals

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Staff Health and Wellbeing

The Current Picture

Increase in workload
NHS staff over the last 18 months have experienced an increase in workload due to COVID-19, winter pressures and a pressure to deliver elective procedures that have been delayed.

Staff burnout
An increase in workload has resulted in many staff experiencing an increase in stress levels, exhaustion and burnout. If left unsupported, this can lead to a risk in delivering safe and effective patient care.

Staff sickness
Stress and burnout, coupled with the risk of contracting COVID-19 has also led to an increase in sickness levels across all staff within the Trust.

Staff vacancy rates
As a result of Brexit and other issues, staff vacancy rates have increased in this timeframe too, and so the Trust vacancy rate is higher than it was a year ago.

Redeployment
During the last 18 months, some staff have been redeployed to work in other areas that are not their speciality, and without the safety network that their team provides. This can lead to staff feeling under skilled and may lead to a negative impact on their wellbeing.

Rates of pay
Though there has been a 3% uplift of pay for NHS staff, recent announcements by the treasury regarding an increase to NI contributions and inflation mean that for many staff, their take home pay will be less than the pay award increase.

Condition of estates
The current condition of our estates has been shown to negatively impact the wellbeing of staff. Staff have experienced issues with leaks, heating, lack of water and broken toilets. This all leads to an undesirable workspace and may contribute to disengagement.

Our Current Offer

Working with local organisations to set up wellbeing hubs

Providing food to staff on wards

Encouraging staff to take adequate rest breaks/annual leave

Increasing provision of wellbeing information to staff

Creating training and resources to support managers

Creating a culture that places wellbeing at its heart

Providing training on wellbeing to staff

Increasing capacity of Staff Support Service to provide specialist groups

Mediation

Facilitating specialist interventions

Health promotion to at risk groups

Reinforcement of messaging 'its ok to not be ok'

Providing cover on wards at times of significant pressure

Increasing capacity of Staff Support Service

Promoting national specialist services

Supporting staff until they return back to work

Referring staff into external services if required

Providing line managers with guidance & support on how to manage distressed staff

Facilitating trauma debrief groups

Additional winter pressure support offer

Scheduled Rest Breaks

Developing localised wellbeing plans by care group

Improving the Wellbeing Hub rest spaces

Targeted health and wellbeing relationship building with line managers

Liaising with line managers to identify at risk staff

Regular reporting of key themes

Fast tracking managers to access coaching support

Providing line managers with targeted wellbeing resources

Supporting Practice Educators in facilitating groups and mentoring

Targeting at risk groups

Peer to peer support groups

We will:

Communicate health and wellbeing services, develop localised wellbeing plans by care group. And support staff during the festive season

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Workforce Investment and Priorities

Item	Description	£m	WTE	Mitigation for H2
Acute Medicine Capacity	Capacity to support flow	2.0	69.4	LoS imporvements
ITU Capacity	Pandemic ongoing impact	4.0	61.0	Commissioner funding
Anaesthetics Additional Sessions	Elective Recovery / Pandemic ongoing impact	1.0		Elective recovery
PACU	Elective recovery	0.4	7.8	Elective recovery
Lung Function Recovery	Elective recovery	0.1		Elective recovery
Breast Screening Backlog	Elective recovery	0.4		Elective recovery
Cath Lab Recovery	Elective recovery	1.2	33.4	Elective recovery
Endoscopy Recovery	Elective recovery	1.1	29.3	Elective recovery
ED Expanded Footprint	Following on from expanded ITU	0.3	11.1	Commissioner funding
Jungle Weekend working	Elective recovery	0.1	2.0	Elective recovery
Linden lodge nursing	Pandemic ongoing impact	0.2	3.0	Reduce COVID Expenditure
Infection Consultant	Pandemic ongoing impact	0.1	1.0	Other CIP
Chest Consultant (COVID)	Pandemic ongoing impact	0.1	0.5	Commissioner funding
Oncology Chemo Activity Increase	Elective recovery	0.3	5.0	Reduce COVID Expenditure
Palliative Care	Pandemic ongoing impact	0.1	3.0	Other CIP
Dialysis additional capacity	Pandemic ongoing impact	0.1	2.5	Commissioner funding
Other COVID Staffing (Occ Health, Sickness)		2.4		Reduce COVID Expenditure
Improvement/Culture/OD Work		0.8		Other CIP
Total		**14.7**	**228.9**	

In the past year, our staff have gone above and beyond what could reasonably be expected in response to the COVID-19 demands we faced, to make sure that every COVID-19 patient that needed our support could access it, whilst continuing to run our 'retained' services. This required many staff to work in different roles and different services as we were asked to prioritise these patients during the pandemic, resulting in many other services being paused as we did not have the staff to keep them going.

Learning from this, we have invested significantly in extra staff (see table above), to make sure we can run the services for all of the patients that need us, while looking after our own frontline staff's welfare and wellbeing, by making sure they are not stretched too far this winter.

Decisions to redeploy staff to support delivery of this plan at the expense of pausing other services will only be taken in extremis and as a last resort.

Our Workforce plan identifies several important priorities and areas of focus:

- Recruitment - manage vacancies and over recruit in areas of pressure
- Sickness - support managers to help their staff take the time to get well and return to work
- Occupational Health Service and Staff Support Team - visit clinical areas; improve intranet page
- Rostering / Annual Leave Management - run rostering clinics and to support this, increase staffing levels on roster helpdesk
- Temporary Staffing - auto enrolment of new staff onto our staff bank, with earlier advertising of shifts to help staff plan ahead
- Health and Wellbeing - use of Wellness Action Plans, support for taking of breaks and ensuring staff can take annual leave through the winter plan period

All these areas aim to improve the working environment for our staff by increasing the number of staff who are available to take on the many tasks needed and looking after those staff who are already in post.

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ICU Bed Surge Plan

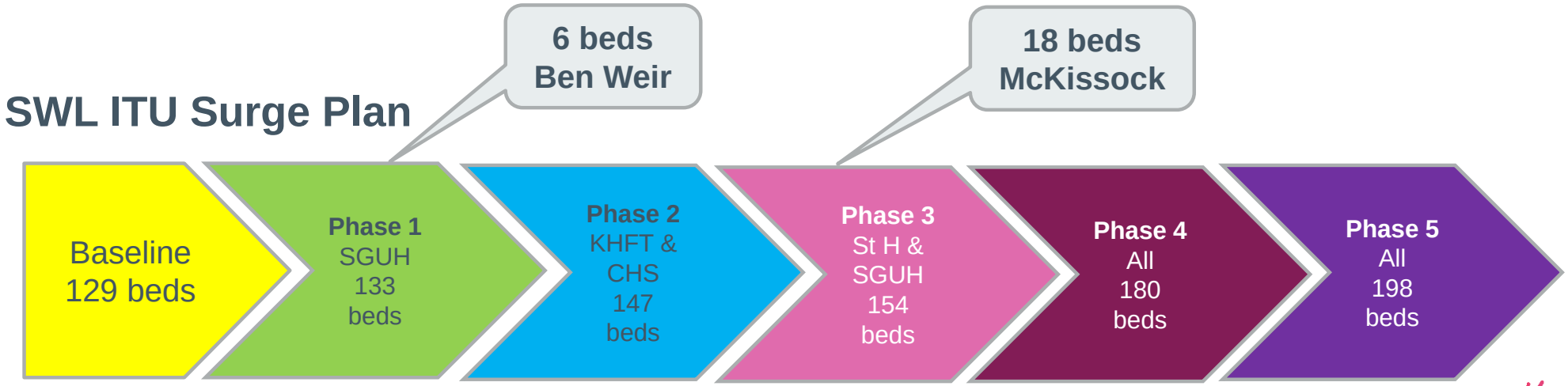
Current ITU Configuration

CTICU AMW 1	CTCUA AMW 1	Neuro ICU AMW 2	NDU AMW 2	GICU STJ 1	PACU	Ben Weir AMW 1		
15	6	17	4	18	6	6	**Total**	**72**

SGH has multiple small ITUs enabling a flexible approach to their use.

The role of each unit will flex between COVID, elective and emergency capacity depending on the type of patient presenting.

SWL ITU Surge Plan



Our Plan for Winter 2021/22

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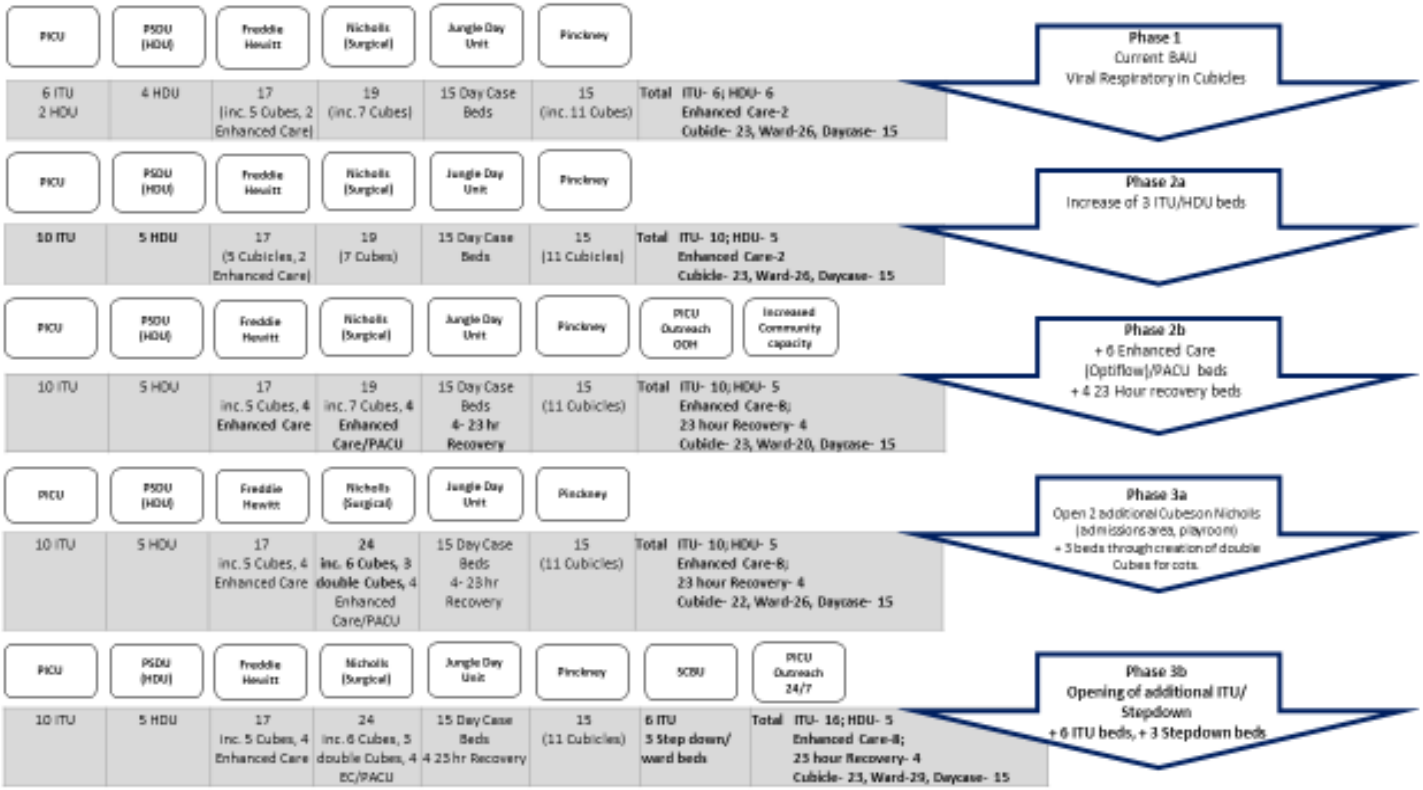
Children's Elective and Non-Elective Plan (including respiratory surge)

The Children's respiratory surge plan for the Trust is detailed here.

The Plan is based on Public Health England estimates for respiratory surge for children this winter, and co-ordinated with other acute providers in SWL, and place-based partners to optimise capacity and ensure effective clinical pathways.

The Plan has been funded at risk by the Trust, with detailed operational planning underpinning this to ensure that phases are stepped up and down in a timely and effective way.

St Georges Children's Respiratory Surge Plan



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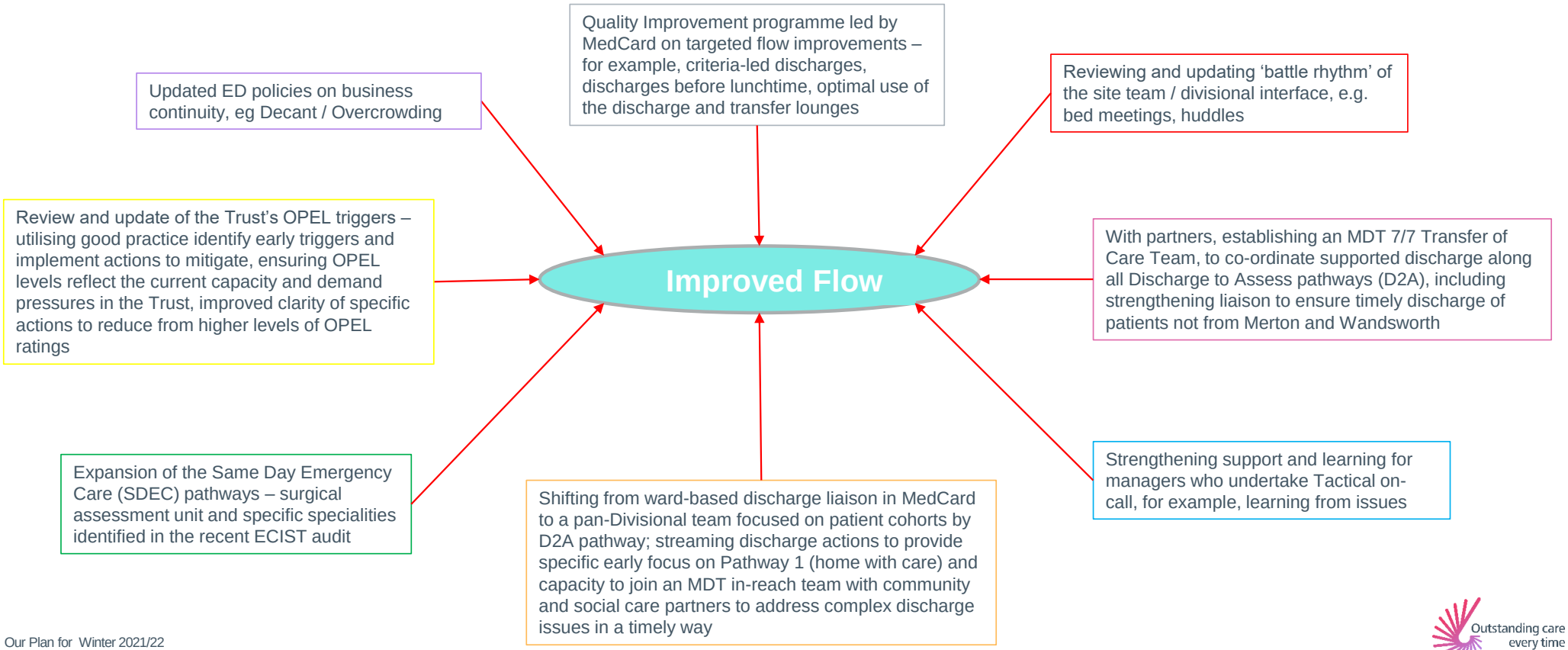
Improving Flow within the Trust

It is crucial when bed pressures are high that the Trust's Flow processes are consistent and effective to minimise clinical risk across the emergency floor and inpatient areas. Whilst we have significantly improved cross-divisional working (a key enabler), there are still areas where we can simplify processes to make it easier for staff to discharge patients safely, requiring support on discharge. Staff are working extremely hard – we need to embed our internal learning processes to ensure that our processes are smart and effective. Key areas we are currently working on include:



Increasing post-discharge community capacity

A key risk for the Trust this winter is ensuring we have sufficient inpatient capacity to meet the patient need and demand that presents through our emergency pathways. Our modelling suggests that the combination of winter, flu and COVID means that there are points during winter where the Trust could be circa 80 inpatient G&A beds short to meet this demand, with very limited physical capacity to increase bed numbers except very short-term to meet immediate demand pressures.

We have worked very closely with our local health and social care partners to increase community (post-discharge) capacity in patients' own homes and residential care, and have secured winter funding to implement these. These initiatives will start during early December, and we expect to continue to increase capacity and scope over the winter months. Beyond this winter, there are commissioning plans to embed these as Business As Usual, key to the ongoing sustainable delivery of the wider emergency / urgent care pathways in Merton and Wandsworth. These include:

- Pan-SWL bed bureau providing additional residential, nursing and specialist rehab capacity, including for patients who are COVID positive
- Merton and Wandsworth virtual frailty ward, led by our community partner with support from social care and the Trust. The aim is to support timely discharge of patients with both complex and specific long term conditions (diabetes, heart failure and respiratory) from AMU and Cavell (our short stay ward)
- Increased contracting of domiciliary care and reablement capacity for Merton and Wandsworth residents
- Improved pan-agency forward planning of community support to facilitate timely discharge from acute beds, streamed by D2A pathway (as described in the Internal Flow slide previously)

We will also benefit from (and contribute to) the implementation of a pan-SWL clinical network supporting the development of the SWL Virtual Hospital. This will enable sharing of good practice and learning, give consistent oversight on how clinical risk is managed, and support timely flow of patients whose place of residence is different to the acute hospital which has provided inpatient care. It will also enable pan-SWL consistency around specific clinical protocols, for example IV antibiotics prescribing and administration in domiciliary settings.

Communications

Our key communications' objectives are:

- Signpost alternatives to attending our Emergency Department, helping people 'Choose Well' and make the right choices when it comes to accessing care – in line with the regional south west London campaign, **we will encourage adults to seek advice for minor health concerns from their local pharmac**y, and to contact NHS 111 first (online in the first instance)

- Ensure local residents are staying well and healthy this winter via **COVID-19 and influenza vaccination campaigns** (for Trust staff and the wider public) and infection control measures

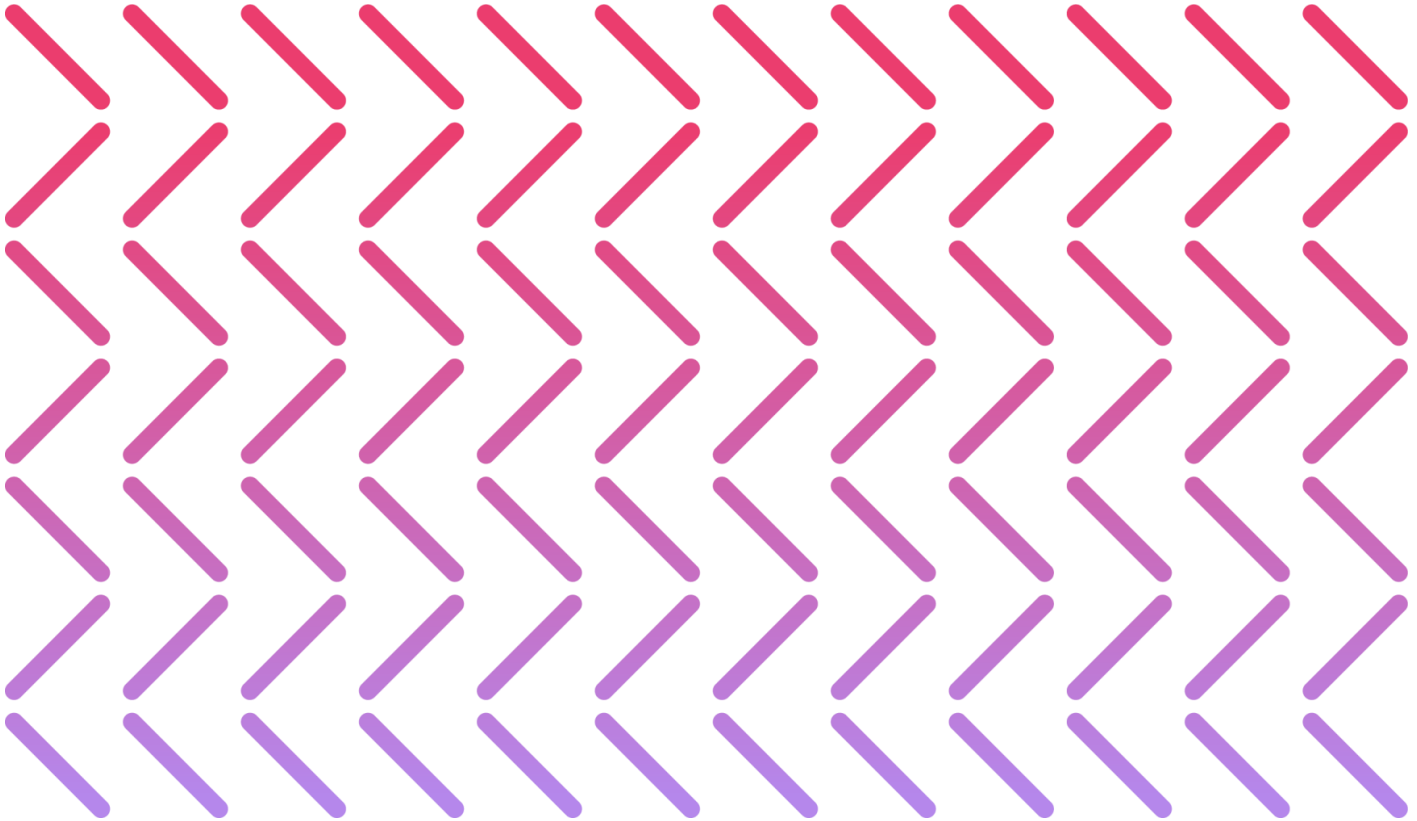
- **Celebrate staff and make them feel appreciated for their work** during this challenging period, and also ensure they are aware of the health and wellbeing support available to them.

Our objectives are also important priorities for the wider NHS in south west London, and we will work with South West London Health and Care Partnership to share content and key messages. **We have consulted with communications colleagues at SWL,** who have approved of our approach and our plan to collaborate closely on this work.

The winter months coincide with the existing 'Thank You George's' campaign, so we plan to align with existing events, activities and gifts to ensure that staff feel that their efforts are recognised and health and wellbeing programmes are promoted.

The Trust will also be collaborating with Transport for London on a campaign to encourage travellers to wear face masks. Featuring images of our staff, the campaign will help to reinforce our public message around infection control.

Appendix 1
Supporting Plans



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Summary - Supporting Plans

- Our Plan for winter is more ambitious, as we aim to run all of our services throughout the season, only pausing some during significant surges in demand and then re-starting them as quickly and safely as possible. This is backed up by a significant investment in extra staff to make this possible.

- It will take the same Team St. George's spirit that delivered such positive results last year, this time with more patients benefiting from the full range of care we are here to provide, with many supporting plans to make it all possible.

- Below are listed some of our key supporting plans:

Patient Safety and Quality	Workforce	Operational	Corporate/ Policy
Quality and Safety Strategy 2019/24	Workforce Strategy 2019/24	ICU Capacity Phasing	H2 and Winter Plan Triangulation Analysis
Patient Safety & Quality Plan 2021/22	Staff Health and Well Being Plan	Ward Plan - G&A Adult Bed Capacity Phasing	Communications Plan
Infection Prevention and Control Policy	Workforce Investment Plan	Children's Elective and Non-Elective Plan (incl. Respiratory)	SW London Pathology Plan
Non Invasive Ventilation for Level 2 Patients	ICU Staff Investment Plan	Cancer Recovery Plan	Estates and Facilities and Visiting Plan
COVID Treatment Guidelines and Protocols	Workforce Risks and Mitigation by Profession	Elective Recovery Plan	Key NHS Constitution Standards Forecasts
COVID Vaccination and Booster Programme	Workforce Risks and Mitigation by Key Clinical Area	General Medical Mega Rota	Demand and Capacity Plan
Flu Vaccination Programme	Planned Preventive Equipment	Therapies Service Plan	Financial Management this Winter
	COVID Vaccination and Booster Programme	Mental Health Service Plan	
	Flu Vaccination Programme		

- These supporting plans were included in last years winter plan and are available upon request from the relevant lead executive director.

Flu Vaccination Plan

- Patricia Beckford will be the Flu Lead responsible for planning and delivering the Flu Campaign
- Flu campaign will run from **27th September 2021 – 28th February 2022** but preparation for the Campaign commenced July 2021
- Flu jab to be offered to all Trust staff members, clinical or non-clinical and health care university students.
- The Flu Clinic is a walk-in clinic with opening hours **Monday to Friday 8am – 6pm**. Location on the ground floor of the Atkinson Morley. Weekend clinics and pop up clinics will be advertised a week in advance giving date, time and location.
- NIVS is the choice of recording staff who have been vaccinated
- Details of the staff vaccinated will be uploaded to an excel data base recorded under the appropriate directorate broken down by staffing groups and divisions. This will enable clarity of compliance.
- A weekly update will be emailed to CEO, Head Of Nursing, Head of HR, Comms and various other persons as is appropriate.
- Previous year 2020/21 the peer vaccinators that we had recruited were unable to deliver effectively as was planned due to COVID restrictions. This year we are experiencing a similar issue due to staff shortage and the pressures of the service staff express exhaustion as a reason for not wanting to train to vaccinate
- Projected percentage of vaccination achievement **85% by 30th November 2021**

COVID Vaccination Plan

COVID-19 vaccination and booster

- Any staff not vaccinated to continue to be offered the vaccination
- All staff to be offered the COVID-19 booster
- Clinics began 27 September Monday – Sunday
- Clinics to continue from 18 October 2021 Thursday – Sunday
- Booking via the National Booking System, email or by calling 0208 7253100
- National announcement mandating NHS frontline staff to be double vaccinated by April 2022

Site Management – As Is

St. George's has a well-developed and tested Escalation Surge Capacity Management Plan which clearly outlines what actions are required at each level. It sets out how St. George's University Hospitals NHS Foundation Trust will achieve the requirements to manage safely surges in demand in winter 2021/22. In addition, St. George's has a Standard Operating Procedure (SOP) for the management of day-to-day operations. This plan incorporates the planning for winter weather and the implementation of the 'Winter Watch' system which operates from 1 November 2021 to 31 March 2022 and comprises four response levels; 0 through to 4.

The 'surge capacity' element of the Standard Operating Procedure, can be activated at any time within or outside of the 'Winter Watch' season. This will be led by the Clinical Site Management team with the support of the on-call management team in response to "front door" pressures, and the Trust may choose to initiate certain actions or parts of the plan, in the event of capacity issues, to assist with the management of vulnerable patients.

The winter and cold weather element of the plan will be activated by pager alerts or email received from the Department of Health (DH), NHS England (London) or the Met Office, either in or out of hours. Operational implementation of the winter plan will be the responsibility of the Clinical Site Management Team, on-call management team and CWDT division winter coordinators.

The Escalation Surge Capacity Management Plan will be placed on the intranet in the Major Incident Section of the St. George's Universities Hospitals NHS Foundation Trust intranet and in the On Call Managers and Directors folder on the L Drive. **An up to date paper copy will be available in the**:

- Hospital Incident Coordination Centre (ICC), room G2.099 in St. George's Hospital
- EPLO's office, Room G2.45
- Clinical Site Management "grab box", Clinical Site Management, St. George's Hospital, room G2.072
- Room 2007, 2nd floor, Queen Mary's Hospital, Roehampton (which has the potential to act as The Community Services Coordination Centre)
- Strategic On-call equipment
- Tactical On-call equipment
- On-call Community Service Manager's equipment

Site Management (in & out of hours)

	IN HOURS	OUT OF HOURS
Executive Level	Chief Operating Officer	Strategic on-call: 08448 222 888 SG202 07717 158601
Management Level	Surge Capacity Escalation Group inc. - Head of Ops - HoN - GMs - Lead Clinicians - Service leads	CSW On-call (until end of November 2018) 08448 222 888 CSW1 Tactical On-call -SGH 08448 222 888 SG236 07876 475145
Communications on-call Always available 24/7: 08448 222 888 SG548 07824 3472677		
Operational Level	Clinical Site Manager 020 8672 3570 Option 2 bleep 6007 All ward managers, discharge co-ordinators, Service Managers	Clinical Site Manager 020 8672 3570 Option 2 bleep 6007 Or 07584 610036

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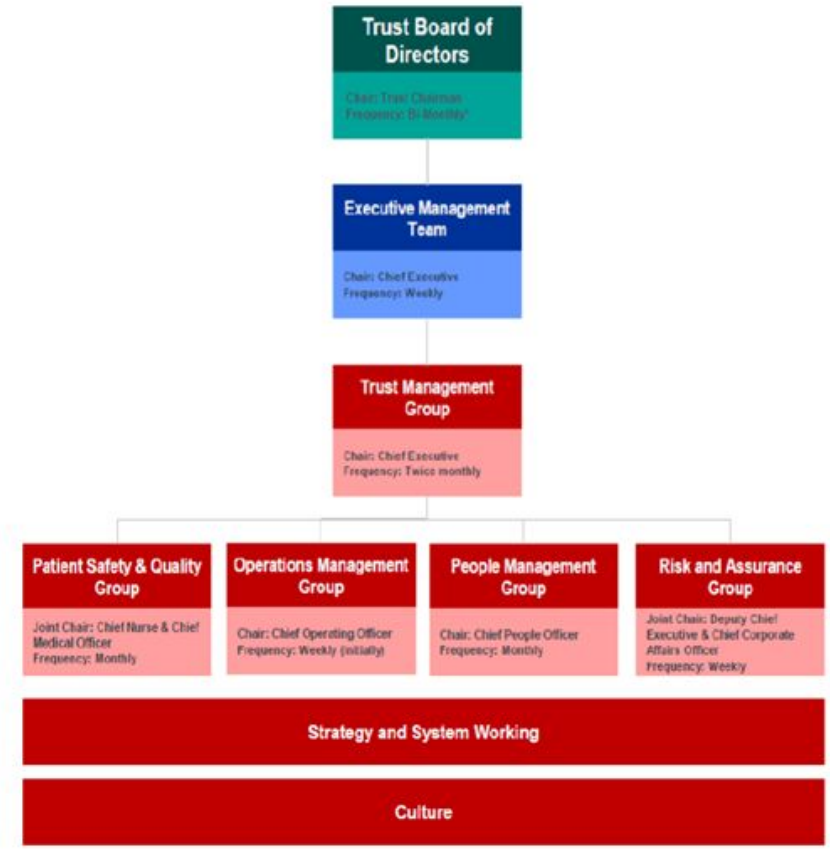
Governance



Our Plan for Winter 2021/22

- The Trust will lead and manage delivery of this plan through its existing management structures.
- The Operations Management Group will lead the operational response for the Trust, with support from the Patient Safety & Quality Group (Clinical Safety Strategy) and People Management Group (workforce, staff welfare and wellbeing plans).
- The Risk and Assurance Group will seek assurance that this plan is being effectively and economically delivered, with associated risks sufficiently mitigated to maintain patient, staff and site operations safety at all times.
- When needed, Gold command will be the Executive Management Team led by the CEO or DCEO, with routine updates and assurance reports provided to the Trust board. Silver Command will be the Operational Management Group, led by the COO (or CNO/ CMO in their absence), with routine updates and assurance reports provided to the Executive Management Team, Trust Management Group and then to sub-committees of the Trust Board. Bronze Command will be the clinical site operations team, led by the Head of Clinical Site Operations.
- We will follow NHSEI guidance in delivering our clinical and operational response this winter, using our tried and tested escalation policies to run our services, within the operating framework set by our Winter Plan 2021/22 and associated NHSEI and South West London guidance.
- Learning from phase 1 - we will communicate through multiple channels, including face to face and virtual via Teams, with care group leads (CMO/ DCEO led); matrons and AHPs (CNO led); and general managers (COO led).
- During OPEL 4 periods, we will communicate face to face 3 times a week (Mon, Wed, Fri) through the care group leads meeting with the ‘triumvirates’ (lead doctor, nurse/ AHP and manager), from 0815 to 0900. We will agree joint expectations with regards to cascade and feedback arrangements, to improve our communication and teamwork at every level across St. George’s.

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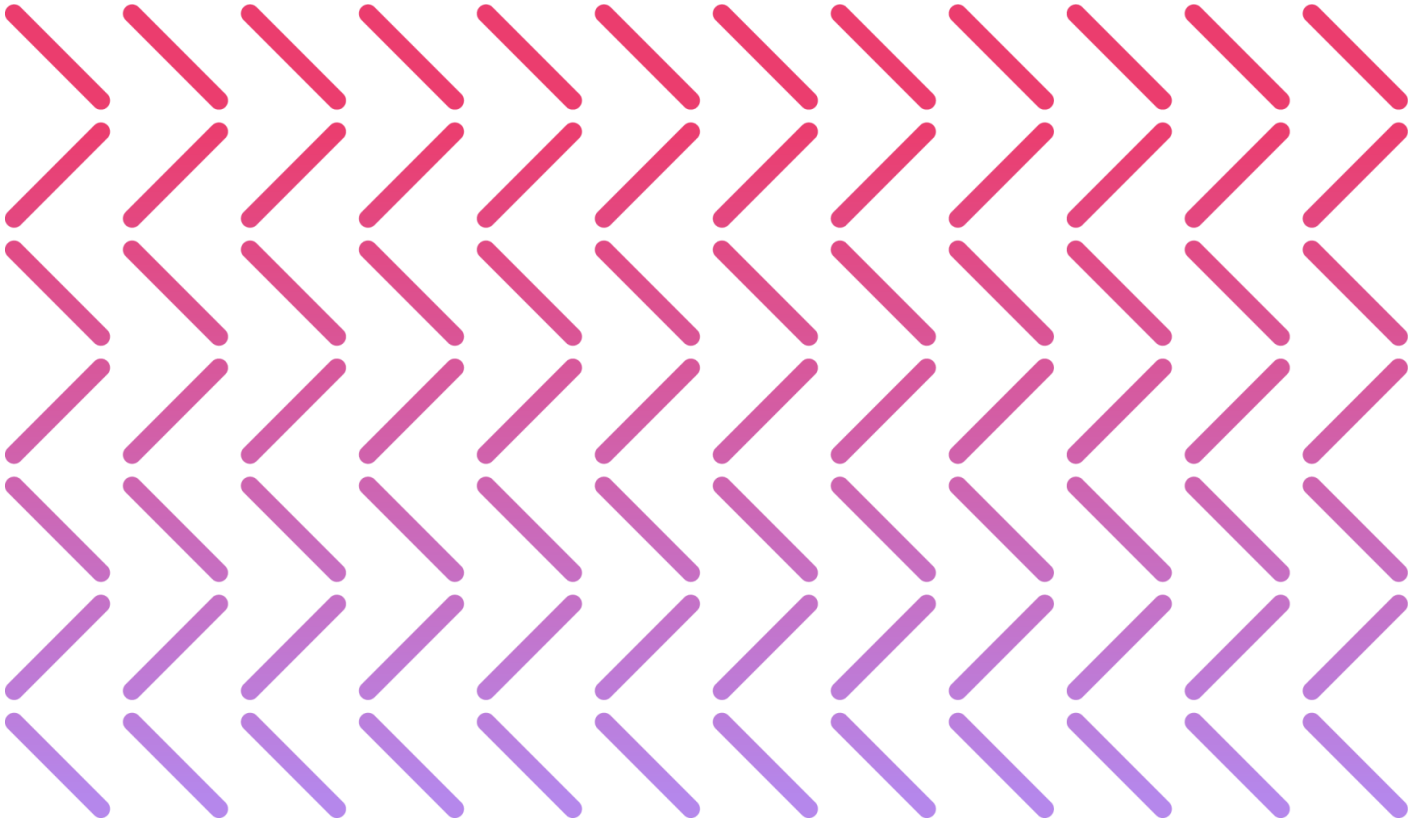
Appendix 2
Summary Winter Communications Plan



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Communications channels

We plan to utilise our public-facing channels from November 2021-February 2022 for this campaign, ensuring key messages are shared with patients and the public throughout.

Engagement with both print and broadcast media will help amplify our messages, so we will continue to work proactively with outlets during winter.

We will also keep staff informed about how busy our services are via a new daily intranet update which will be available to all staff.

Established campaigns around encouraging staff to get their COVID-19 and flu vaccines will continue to run throughout the winter and the Communications team will support this through all our relevant channels.

External communications

External communications activity will include:

CHANNEL	CONTENT	AUDIENCE
Trust website	Standing article on home page and banner for high traffic pages related to emergency care	Patients/public
Press release and proactive engagement with media	Press release on how local residents can help the NHS, issued during topical times of year (e.g. Black Friday, NYE)	Local/national media
Social media	Regular reminders via our Facebook, Twitter and Instagram accounts on pharmacy campaign, NHS 111 online and vaccines	Patients/public
Posters and flyers in ED	Choose Well – information on alternatives to attending ED. Poster and flyers at main entrances	Patients
The Brief	Link to above web content	Members/stakeholders

Internal communications

Internal communications activity will include:

CHANNEL	CONTENT	AUDIENCE
Trust intranet	Consider updates on the intranet which would allow staff to access information such as live OPEL status; ED attendances and bed capacity	All staff
Staff bulletins	Regular items on staff wellbeing programmes	All staff
Senior leaders' briefings	Standing operational and winter pressure updates	Band 8a and above staff
All staff briefings	As above	All staff

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St George's University Hospitals NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	25 November 2021	**Agenda No**	2.4
Report Title:	Discharging Duty of Candour for Nosocomial Covid-19		
Lead Director/ Manager:	Robert Bleasdale – Chief Nurse and Director of Infection Prevention and Control		
Report Author:	Robert Bleasdale – Chief Nurse and Director of Infection Prevention and Control Alison Benincasa – Director of Quality Governance and Compliance		
Presented for:	Assurance		
Executive Summary:	From the start of the Covid-19 pandemic, it was recognised throughout the NHS that there was a risk that patients would acquire Covid-19 while in hospital, as a hospital-associated infection. This was a significant risk issue throughout the first and second waves, and continues to be a risk, although the risk was significantly reduced as facilities for rapid Covid-19 inpatient testing were developed and strengthened. Despite the Trust responding to national guidance and rapidly deploying infection prevention and control measures, sadly a number of patients developed a nosocomial infection. Given the evolving understanding of the nature of the Covid-19 virus, its incubation period and testing regimes throughout the pandemic, clear national definitions were published in June 2021. Whilst these definitions were in place from June 2021 to facilitate a transparent and complete picture for South West London of nosocomial Covid-19 cases and provide an overview position, the national definitions set out below have been retrospectively applied to nosocomial Covid-19 cases since the start of the pandemic in March 2020: • Hospital Onset Healthcare Associated (HOHA): a case where the first positive sample was taken 15 days or more after the date of admission • Hospital Onset Probable Associated (HOPA): a case where the first positive sample is taken between day 8 to 14 from hospital admission • Hospital Onset Indeterminate Association (HOIA): a case where the first positive sample is taken between day 3 to 7 from hospital admission • Community Onset, Community Associated (COCA): a case where the first positive sample is taken <=2 days of admission Sadly between March 2020 and 31 June 2021, there have been 154 patients who tested positive post admission to the Trust for nosocomial Covid-19 and sadly died, 74 of these patients definitely acquired Covid-19 (HOHA) whilst an inpatient at St George's Hospital and 80 probably		

	acquired Covid-19 (HOPA) whilst an inpatient at St George's Hospital. In all of these cases, an independent review has been completed by the Medical Examiners office and a discussion has taken place following this with the patients next of kin. In addition to the learning from each of the waves of the pandemic which is summarised in this paper a detailed mortality review was completed and presented to the Quality and Safety Committee in August 2021. The Trust has coordinated the approach to the discharging of Duty of Candour to the next of kin for each of these patients across Trusts in South West London. This paper provides details of the approach being taken by St Georges and the establishing of a dedicated phone line should any next of kin wish to contact the Trust. The monitoring and coordination of this is being completed through the corporate nursing office, with a letter being sent from the Chief Nurse and Director of Infection Prevention and Control and Chief Medical Officer. Currently 36 letters have been sent to individual next of kin, with a further 117 next of kin currently being contacted prior to a duty of candour letter being sent to them. From 1 September 2021 DoC has also been discharged for patients who had either HOHA or HOPA nosocomial Covid-19 infection whilst an inpatient and have since been discharged from hospital. A further report will be provided to Quality and Safety Committee in January 2022 on this position.		
Recommendation:	The Board is asked to note the content of the report and the Trust approach to supporting next of kin and the discharging of duty of candour.		
Supports			
Trust Strategic Objective:	- Treat the patient – treat the person - Right care, right place, right time		
CQC Theme:	Safe / Caring / Well Led		
Single Oversight Framework Theme:	N/A		
Implications			
Risk:			
Legal/Regulatory:	Enforcement undertakings applicable to SGUH Compliance with the Health & Social care Act 2008 (Regulations 2014): Regulation 20 and CQC Registration Regulations		
Resources:			
Previously Considered by:	Executive Meeting	**Date:**	22/11/21
Appendices:	Appendix 1 – HOHA wave 2 letter Appendix 2 – HOHA and HOPA wave 1 letter Appendix 3 – HOHA and HOPA letters after September 2021		

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NHS
St George's University Hospitals
NHS Foundation Trust

Trust Board
25 November 2021

Duty of Candour for patients with Nosocomial Covid-19

1.0 Background and classification of nosocomial Covid-19

From the start of the Covid-19 pandemic, it was recognised throughout the NHS that there was a risk that patients would acquire Covid-19 while in hospital, as a hospital-associated infection. This was a significant risk issue throughout the first and second waves, and continues to be a risk, although the risk was significantly reduced as facilities for rapid Covid-19 inpatient testing were developed and strengthened.

When the Covid-19 pandemic began, and when Covid-19 testing facilities were not available, or were not well-developed, there were no agreed national definitions for what constituted probably or definitely hospital-associated Covid-19 infection. These definitions were produced nationally in June 2020.

National guidance has been produced by NHSIE to guide Trusts in approaching the discharge of Statutory Duty of Candour when patients have been either moderately or severely harmed by acquiring Covid-19 in hospital, although this guidance is not mandatory[1].

While there are no current arrangements for national benchmarking, it is clearly important for individual Trusts to understand their own numbers and outcomes for patients who have acquired Covid-19 in hospital. This enables appropriate consideration and weight to be given to current and future mitigations to minimise harm from hospital-acquired Covid-19 in the future. A detailed review was undertaken by the Medical Examiner's office and Trust Mortality lead for cases of nosocomial infections where patients have sadly died, which was presented to the Quality and Safety Committee in August 2021.

In September 2021 a collective decision was taken by South West London Trusts to discharge retrospective Duty of Candour (DoC) for Hospital Onset Healthcare Associated nosocomial Covid-19 cases where patients sadly died during Wave 2. The timeframe for Wave 2 was confirmed as 1 September 2020 to 30 June 2021 due to the national definition of nosocomial Covid-19 cases only being published in June 2020. It was also agreed that further discussions would be held to extend retrospective DoC to all nosocomial Covid-19 cases where patients sadly died in Waves 1 and 2.

To facilitate a transparent and complete picture for South West London of nosocomial Covid-19 cases and provide an overview position, the national definitions set out below have been retrospectively applied to nosocomial Covid-19 cases:

- Hospital Onset Healthcare Associated (HOHA): a case where the first positive sample was taken 15 days or more after the date of admission

[1] 'Reporting and responding to hospital onset COVID-19 cases' 2020; this guidance was created by NHSE/I and the National Patient Safety Team, in consultation with the NHSE/I Nursing Directorate

- Hospital Onset Probable Associated (HOPA): a case where the first positive sample is taken between day 8 to 14 from hospital admission
- Hospital Onset Indeterminate Association (HOIA): a case where the first positive sample is taken between day 3 to 7 from hospital admission
- Community Onset, Community Associated (COCA): a case where the first positive sample is taken <=2 days of admission

As agreed with South West London Trusts from 4 October 2021 retrospective DoC was discharged for HOHA Covid-19 cases where patients sadly died during Wave 2. In addition, further to recent discussions retrospective DoC has now been extended to all nosocomial Covid-19 cases where patients sadly died in Waves 1 and 2 and has now commenced.

2.0 Identification of nosocomial Covid-19 cases

Since March 2020 the Trust has maintained a central record of all Covid-19 deaths managed by the Head of Mortality Services. For patients who had nosocomial Covid-19 and sadly died, and prior to the reporting of the death on the central portal for national reporting (CPNS), the Medical Examiner's office conducted an independent review of all deaths to establish if the patient had a positive covid-19 test within 28 days of death. This included a review of information on the Medical Certificate of Cause of Death (MCCD) for all of these patients and noted whether the patient had Covid-19 recorded on part 1 of the MCCD [1a, 1b or 1c – disease or condition leading to death], or on part 2 of the MCCD [significant conditions contributing to death].

The independent medical review confirmed that from the beginning of the pandemic on 1 March 2020 until 31 June 2021 (wave 1/3/20 – 31/08/20, wave 2 – 1/9/20-30/6/21) there were:

- 154 patients who had nosocomial Covid-19 and sadly died
- 74 of these patients definitely acquired Covid-19 (HOHA) whilst an inpatient at St George's Hospital
- 80 probably acquired Covid-19 (HOPA) whilst an inpatient at St George's Hospital

There are 35 cases that are recorded by the Medical Examiners office where a patient has sadly died and Covid-19 is stated on the death certificate that do not appear on the Trust microbiology report and therefore the point of acquisition has been unable to be classified at the time of writing this paper. Medical Microbiology and Infection Prevention and Control teams are working together to classify these remaining cases through a detailed review of the clinical record. However initial reviews of the data recorded at the time of reporting suggests that in none of these cases was the infection associated with an inpatient stay at the Trust:

  - In 4 cases patients were transferred from another acute trust with a positive test
  - In 4 cases there was evidence of a positive point of care test in the Emergency Department
  - In 15 cases there was evidence in the record of a positive test prior to admission
  - In 12 cases there was not a positive test within 28 days but there was a clinical diagnosis of covid-19 and this was documented on the medical certificate of cause of death

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Table 1: Total numbers of Covid-19 cases classified according to hospital or community acquisition for the period 1 March 2020 – 31 September 2021

		HOHA					HOPA					HOIA					Not associated with SGH inpt stay					Not on micro spreadsheet				
Month	TOTAL	MCCD 1	MCCD 2	Not on MCCD	HMC	Total	MCCD 1	MCCD 2	Not on MCCD	HMC	Total	MCCD 1	MCCD 2	Not on MCCD	HMC	Total	MCCD 1	MCCD 2	Not on MCCD	HMC	Total	MCCD 1	MCCD 2	Not on MCCD	HMC	Total
Mar-20	82	11	2	0	2	15	8	0	0	0	8	9	1	0	0	10	47	1	1	0	49	0	0	0	0	0
Apr-20	190	10	3	0	0	13	13	2	0	1	16	9	2	1	0	12	139	4	1	1	145	4	0	0	0	4
May-20	23	1	0	0	0	1	2	0	0	0	2	0	0	0	0	0	13	2	0	1	16	3	1	0	0	4
Jun-20	4	0	2	0	0	2	0	1	0	0	1	0	0	0	0	0	0	0	1	0	1	0	0	0	0	0
Jul-20	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Aug-20	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1
Sep-20	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Oct-20	7	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1	6	0	0	0	6	0	0	0	0	0
Nov-20	17	1	1	1	0	3	2	1	0	0	3	2	1	0	0	3	7	0	1	0	8	0	0	0	0	0
Dec-20	91	7	6	1	0	14	12	6	1	2	21	6	1	1	1	9	37	2	1	3	43	4	0	0	0	4
Jan-21	221	7	2	1	0	10	9	4	1	0	14	16	1	1	0	18	156	3	1	2	162	15	2	0	0	17
Feb-21	95	11	2	0	0	13	9	3	1	0	13	5	1	0	0	6	49	12	0	0	61	0	0	1	1	2
Mar-21	18	0	1	0	1	2	1	0	0	1	2	2	0	0	0	2	8	1	0	2	11	1	0	0	0	1
Apr-21	4	0	0	1	0	1	0	0	0	0	0	1	0	0	0	1	1	0	1	0	2	0	0	0	0	0
May-21	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1	0	0	0	0	0
Jun-21	5	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1	3	0	0	0	3	1	0	0	0	1
Jul-21	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4	0	0	0	4	0	0	0	0	0
Aug-21	15	2	2	0	0	4	2	0	0	0	2	1	0	0	0	1	5	1	0	1	7	0	1	0	0	1
Sep-21	21	2	0	1	0	3	1	0	0	0	1	2	0	0	0	2	13	1	1	0	15	0	0	0	0	0
	799					81					83					66					534					35

MCCD1 – Medical Certificate Cause of Death Part 1, MCCD2- Medical Certificate Cause of Death Part 2, HMC – Referral to Her Majesties Coroner

3.0 Context

When considering the number of patients who have come to harm, or who have died, as a result of acquiring (or probably acquiring) Covid-19 in hospital, it is important to remember the context in which these events happened.

- Between July 2020 and March 2021 (i.e. the second wave) 1332 patients got Covid in South-West London hospitals between July and March;
- This represents 20% of the 6951 hospital inpatients with Covid-19 in South-West London (SWL) during this period;
- This represents 1.5% of all SWL diagnosed cases of Covid-19 in the same time period (N = 85,969);
- In this Trust, less than 2.5% of 15765 emergency admission patients acquired Covid during the second wave;
- In this Trust only 0.3% of (approximately) 1700 elective admissions acquired Covid in hospital during the second wave.

4.0 Statutory Duty of Candour

The statutory duty of candour came into force in November 2014 and outlines the requirements for registered providers (registered persons) to be open and transparent with patients receiving care or treatment and deadlines within which verbal and written communication should be undertaken. The statutory duty is enshrined in a joint professional statement from the General Medical Council (GMC) and Nursing & Midwifery Council (NMC).

The duty mandates us, if a patient is harmed as a result of a mistake or error in their care, they, their family or those who care for them, should receive an apology, be kept fully informed as to what has happened, have their questions answered and know what is being done in response, setting out the commitment to patients to:

- apologise for the harm caused;
- explain, openly and honestly, what has gone wrong;
- describe what we are doing in response to the mistake;
- offer support and counselling services that might be able to help;
- provide the name of a person to speak to;
- give updates on the results of any investigation.

The statutory requirements mandate Trusts to implement being open discussions for all patients who have suffered moderate, severe harm or death as a result of an incident. These discussions need to be clearly documented in letters to the patient or next of kin and in the health records.

5.0 Discharging Duty of Candour for Wave 2 HOHA nosocomial Covid-19

To fulfil the retrospective DoC requirements a standard letter template from the Chief Nurse was created and was adapted to reflect each individual case, see Appendix 1. A single point of contact to provide support for relatives was also put in place coordinated by the Corporate Nursing team, this consisted of a dedicated mobile phone number and email address, should any next of kin have any further questions, need support or wish to meet with members of the clinical team.

In discharging the DoC, dedicated staff from within Corporate Nursing have reviewed the patients clinical records to establish the next of kin details and individual circumstances, to facilitate adaptation of the letter and minimise additional distress to next of kin, recognising significant events such as birthdays and anniversaries of the patient death. In doing so a large number of next of kin details held only contain a telephone number. Therefore, a telephone discussion takes place with each of the listed next of kin to establish their address and provide a discussion on the letter prior to this being sent.

From 4 October 2021 as outlined above, the Trust commenced discharged retrospective DoC for 43 patients who sadly died from or with HOHA nosocomial Covid-19 during Wave 2. Currently DoC has been completed for 36 patients; for 1 patient there was no next of kin, and for 6 patients telephone contact with the next of kin to obtain their address has not been successful. Corporate Nursing will continue to attempt to make telephone contact with the 6 relatives.

Corporate Nursing has currently been contacted by 2 next of kin, 1 to express their thanks for receiving the letter and the helpful information, and 1 next of kin indicated that they would like to meet with the clinicians involved in their relative's care which is in the process of being arranged.

6.0 Extending Duty of Candour for nosocomial Covid-19

Following a meeting with the South West London Trust Chief Nurses it was agreed to complete DoC for all cases of nosocomial Covid-19 (HOHA and HOPA) where patients have sadly died in Wave 1 and Wave 2 from the 8 November 2021, and as outlined in Table 2 this relates to a further 110 patients for the Trust. This letter is sent jointly from the Chief Nursing Officer and the Chief Medical Officer, see Appendix 2. The corporate nursing team are currently confirming next of kin addresses for all of these cases and conducting telephone calls where required. It is proposed that the DoC process will be paused for a 2 week period

over Christmas and New Year to minimise any distress associated with receiving the letters over this period.

Table 2: HOHA and HOPA nosocomial Covid-19 cases by Wave 1 and Wave 2

Timeframe	HOHA	HOPA	Total
Wave 1: 1 March 2020 to 31 August 2020	31	27	**58**
Wave 2: 1 September 2020 to 30 June 2021	43 (36/43 DoC discharged)	53	**96**
Total	**74**	**80**	**154**

It should also be noted that from 1 July 2021 DoC has been discharged for patients who sadly died from or with HOHA and HOPA nosocomial Covid-19 infection. From 1 September 2021 DoC has also been discharged for patients who had either HOHA or HOPA nosocomial Covid-19 infection whilst an inpatient and have since been discharged from hospital, see Appendix 3 for Wave 3 letters.

7.0 Learning from Wave 1 and 2

When considering the degree to which the risk of hospital-acquired Covid can be mitigated, it is important to recognise the constraints of NHS estates and buildings, and the constraints of accurate rapid diagnostic testing. Some of the key challenges, which are common to some, if not all NHS Trusts, are;

- NHS buildings have not historically been designed to prevent the spread of airborne infections;
- Most patients are in bays of 4 – 8 beds;
- These beds are often less than 2m apart;
- There is often poor ventilation;
- Most existing NHS hospitals have too few single rooms;
- Hygiene, masks & hand washing will help reduce spread, but cannot stop airborne spread;
- 1/3 – 1/2 of Covid cases are asymptomatic;
- Diagnostic tests are not 100% accurate and do not give immediate results.

This evolving nature of the pandemic should also be considered when interpreting the figures, and considering any future learning. It is for this reason the first and second waves should be considered separately. As the pandemic evolved and there was greater understanding of the disease, its features, routes of transmission and advances in diagnostic testing, this led to additional measures being implemented in wave two when contrasted with wave one. To illustrate this in the first wave testing for Covid-19 was not readily available and restricted to patients with a positive travel history and or clinical symptoms. In the absence of these criteria patients were managed on a normal pathway. With the increase in testing capacity and understanding of other clinical presentations, it became apparent that a large number of patients could be asymptomatic with Covid-19.

The rapid response to changing guidance and implementation of mitigations was managed by the executive through the operational meetings and infection control committee. These measures were significant in both waves and continue to be reviewed as part of the SWL system learning into Covid-19. As an illustration the following measures were implemented across wave one and two:

Wave 1 – steps taken to mitigate nosocomial infection

- Rapid development of Covid-19 Infection Prevention and Control (IPC) and Personal Protective Equipment (PPE) Guidance, including donning and doffing, published on Trust intranet, based on national guidance issued from PHE which was updated as guidance evolved
- Rapid training and education for staff, including redeployed staff and medical students. This included key IPC principles and Covid management
- 'Boot camps' for the re-training of staff to enhance their competencies for redeployment in both established and newly created critical care areas
- Hand hygiene training was increased and conducted on wards, with an increased frequency of audits undertaken by Divisions in ward areas
- Due to the changing guidance and need to track patients the IPC nurse team was extended to cover 7 day service
- The Trust POD for patient and staff PCR testing was established initially for patients with a positive travel history or confirmed symptoms attending ED. This was later expended to support community testing with a medical outreach team to undertake community testing with the London Ambulance Service to prevent patients attending hospital
- To ensure resources were accessible to staff a dedicated Trust intranet page with staff health resources and Covid-19 clinical guidance published on intranet
- Initially there was limited screening available for patients, this was initially via PHE and samples sent to an external lab. This was later expanded to onsite lab capacity; assessment was initially based on clinical presentation or travel history early in wave 1. This later moved to the testing of all patients
- Wards were colour coded to support segregation of patients, including dedicated Covid-19 Wards (blue), amber (status not known), yellow (screened negative), green (screened negative and isolated)
- The Emergency Department and Acute Medical Unit established dedicated pathways including amber (possible/suspected) and blue (confirmed) to minimise cross infection. However, patients were held here until result returned which increased the risk of infection
- Social distancing introduced with beds closed to support this, which was supported through reduced bed occupancy in the Trust in wave one
- Staff were encouraged to work flexibly to reduce footfall on the site, and outpatient activity utilised virtual appointments to protect vulnerable patients and minimise hospital attendance
- Discharge to Care Homes pathway was later implemented which required a negative swab within 48 hours of discharge needing to be completed
- FFP3 mask fit testing programme for all staff identified as undertaking or assisting with Aerosol Generating Procedure, with key at risk staff prioritised based on areas of work and task undertaken
- Enhanced cleaning using chlorine agent and increased frequency of cleaning Trust wide including communal areas, and a specific focus on touch points

- Signage at all Trust entrances regarding Covid symptoms and restrictions in place, with some entrances fully closed to support a one-way system.
- Additional hand hygiene station procured and in place across Trust
- Moved to use virtual outpatients, and closure of none essential services to limit foot fall on site
- Open entrances had dedicated security staff to monitor mask compliance and prevent unnecessary access
- Restriction of visiting in line with national guidance
- An electronic system was implemented to monitor PPE supply in clinical areas daily

Wave 2 – Additional steps taken on top of Wave1 actions to further mitigate nosocomial infection and in response to national guidance

- Trust IPC guidance and standards were benchmarked against NHSE/I COVID-19 Board Assurance Framework issued in May 2020. The Trust assessed itself as compliant against all sections with partial compliance in relation to FFP3 mask fit testing due to variability in supply of the masks from the NHS national supply
- The Trust assess itself against the ten key principles of prevention of nosocomial spread of SARS CoV-2 published by NHSE/I. The Trust declares full compliance with 8 of the ten principles and two areas of partial compliance namely:
    - Beds are maintained at 2 metre distance -this was not achievable in all areas and mitigations were put in place i.e. mask wearing of staff and patients
    - Consider testing COVID negative patients daily – the Trust implemented day 0,3&7 testing. In addition, there was increased testing for patients and staff for any area with an outbreak.
- Estates work was completed to enclose all resus cubicles in ED and majors cubicles, allowing ED majors to be single cubicles
- The ED waiting area was upgraded as part of this work to ensure the chairs are divided by Perspex screens
- Trust local Covid-19 Protocol based on PHE national guidance, including cleaning and decontamination was regularly reviewed and updated as guidance evolved
- Ongoing updates to Trust PPE guide based on updated PHE guidance, published on intranet
- Social distancing and mask wearing for all staff introduced Trust wide as per national guidance; with posters, floor markings and associated communications
- Introduction of facemasks for inpatients
- Liaison between Microbiology Laboratory and site team to provide PCR results to manage patient placement and to offer rapid testing, in order to minimise the time patients Covid status was unknown
- Introduction of ‘Point of Care’ rapid testing in the ED to facilitate pathway management, this was followed by PCR confirmatory test (Day 0), followed by repeat PCR at Day 3 and 7 as per national guidance
- An electronic dashboard of swabbing was implemented on Tableau with daily email to remind matrons any patients who have not been swabbed at day 0 (admission), day 3 & 7
- Step down guidance published on Trust intranet to support the safe placement of patients post Covid infection from ICU and minimise the risk of infection

- Screening protocol was implemented for elective surgery and guidance for recovered patients being screened and assessed for elective procedure implemented and patient information leaflet produced for elective patients
- Theatre pathways in place e.g. green pathway for shielded patients; blue patient pathway with recovery in theatre, to limit risk of infection across the elective pathway
- Dedicated risk assessment in place for patients being discharged to segregate green pathways
- Risk assessment in place to ensure green pathway patients and those who are clinically extremely vulnerable needing hospital transport are transported by themselves in an ambulance
- During the peak of wave two a dedicated team to clean medical devices in Covid-19 critical care areas was implemented to minimise the risk of other infections
- Introduction of Lateral Flow testing for all staff, followed by PCR confirmatory test if symptomatic
- Staff working in high risk pathways such as Oncology, ICU and Renal are screened weekly with a PCR test
- Daily meetings with Occupational Health and IPC implemented to review cases and monitor potential outbreaks
- Formal outbreak meetings for both staff only, and other ward area outbreaks affecting patients and staff, with bay and ward closures where necessary to prevent unnecessary movement of patients and staff
- Outbreak (staff and patient) summaries to infection control committee for shared learning
- Daily validation by IPC case numbers of patients admitted to ensure accurate monitoring to support reporting, patient movement and early escalation with increasing numbers
- Trust process for ‘learning lessons from the second wave’
- The Trust was one of the first 50 sites to launch the vaccination programme
- Phased introduction of visiting, with PCR testing for parents/relatives attending NNU, lateral flow testing for maternity and key at risk areas such as green pathway and screening questions in place

A South West London review of the learning from wave 1 and wave 2 has also been completed and discussed with the Chief Medical Officers, Chief Nursing Officer and Directors of Infection Prevention and Control and Infection Control Leads. The key learning was shared at the Clinical Leaders and Acute Cell for South West London, and continues to be discussed through the South West London Infection Control forum.

A review of nosocomial Covid-19 cases where patients sadly died was undertaken with the Trust Medical Examiner’s office and discussed at the Trust’s Mortality Monitoring Group in August 2021, and was presented to the Quality and Safety Committee in September 2021.

8.0 Reporting requirements: Process for new nosocomial Covid-19 cases

Serious Incidents are identified, investigated and learned from in line with national best practise and guidelines, most notably the Serious Incident Framework March 2015 which supports learning to prevent recurrence.

As described in the Serious Incident Framework, a serious incident requiring investigation is defined as an incident that has occurred in relation to NHS-funded services and care including acts and/or omissions occurring as part of NHS-funded healthcare (including in the community) that result in:

- Unexpected or avoidable death of one or more patients, staff, visitors or members of the public
- Unexpected or avoidable injury to one or more people that has resulted in serious harm
- Unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional in order to prevent death or serious harm

The severity of harm must be related to the incident rather than to the natural course of the patient's illness or underlying condition:

- Moderate - Any patient safety incident that resulted in a moderate increase in treatment and that caused significant but not permanent harm to one or more patients
- High / Severe - Any patient safety incident that resulted in permanent harm to one or more patients
- Extreme - Any patient safety incident that directly results in the death of one or more patients

It should be noted that all Never Events are defined as serious incidents although not all Never Events necessarily result in serious harm or death.

Due to the pandemic the Serious Incident Investigation Framework has recently been revised and all Trusts are now required to declare HOHA and HOPA Covid-19 nosocomial infection as a serious incident in cases where a patient has sadly died. These cases will be discussed at the weekly executive led Serious Incident Decision Meeting prior to declaration to establish any immediate learning and for assurance that DoC has been completed.

In cases where there is an outbreak of Hospital Acquired Covid-19 Infections that sadly result in patient death, these cases will be investigated as a cluster serious incident and whilst the investigation will review the individual outbreak, it will include individual case reviews of any patients that have sadly died.

In addition, for HOHA and HOPA nosocomial Covid-19 cases that do not meet the criteria for a Serious Incident as outlined above, all cases are reported on Datix, the Trust's electronic incident reporting system. The Trust is required to upload patient safety incidents at least monthly to the National Reporting and Learning System (NRLS), the central database of patient safety incident reports. In these cases, as detailed previously DoC is discharged by the individual clinical team using the template letter as outlined in appendix 3.

9.0 Conclusion

The Trust remains committed to learning from cases of nosocomial infection and responding to the changing guidance regarding the treatment and management of Covid-19. Any cases of hospital acquired Covid-19 will undergo a rapid review and be discussed through the infection prevention and control committee. Any cases that meet the threshold for a

declaration of a serious incident will be investigated in line with the national framework and be reported to the Quality and Safety committee in line with the Trusts established governance structure.

In line with national guidance and the agreement with South West London, the Chief Nurse has established a central process for the discharging of DoC for all cases of nosocomial infection where a patient has sadly died, retrospectively applying the definitions to the start of the pandemic. This process in currently underway with 36 next of kin of patients who have sadly died of Hospital Onset Healthcare Acquired Covid-19 in wave 2 being contacted. The corporate nursing team are currently in the process of completing DoC through contacting and writing to the remaining 117 next of kin. From the 1 July 2021 DoC has been discharged for patients who sadly died from or with HOHA and HOPA nosocomial Covid-19 infection. From 1 September 2021 DoC has also been discharged for patients who had either HOHA or HOPA nosocomial Covid-19 infection whilst an inpatient and have since been discharged from hospital.

The Trust position on the discharging of Duty of Candour for the sad deaths from wave 1 and 2 will be monitored and reported to the Quality and Safety Committee in January 2022.

St George's University Hospitals NHS
NHS Foundation Trust

Private and Confidential

Corporate Nursing Office
Room 1.033
First Floor Grosvenor Wing
St George's Hospital
Blackshaw Road
London
SW17 0QT

Re Hospital Onset Covid-19 Infections - Duty of Candour

I am writing to you regarding the sad death of your RELATIVE, name following his/ her admission to St George's Hospital during the Covid-19 Pandemic. I appreciate that it will have been an extremely difficult time for you and I would like to extend my deepest sympathies.

I am writing to advise you that a review has been undertaken of all patients who were admitted to hospital during the pandemic and later tested positive for Covid-19 during their stay. This type of infection is called a 'nosocomial infection' or 'hospital on-set infection' which means where a patient catches Covid-19 whilst they are in hospital.

The Trust did attempt to minimise nosocomial Covid-19 infections from the start of the pandemic by ensuring that National Infection Prevention and Control guidance was implemented which included;

- Ensuring staff, patients and visitors (once allowed) used appropriate personal protective equipment at all times
- Checking staff, patients and visitors were all following infection prevention and control guidance such as regularly washing their hands
- Ensuring that patients were cared for in groups dependent on their Covid-19 status and clinical risk (this means grouping patients of similar Covid-19 status in different wards or bays to reduce the risk of cross infection)
- Looking into what happened to identify what we could do differently to improve our care and protect our patients from infection
- Undertaking rapid Covid-19 testing (PCR swabs) at the point of admission from late October 2020

Whilst these measures were implemented to minimise the risk of nosocomial Covid-19 sadly we were not able to protect all patients from a nosocomial Covid-19 infection whilst they were in our care.

From reviewing your RELATIVE's medical records, it was identified that he/ she tested positive for Covid-19, 15 or more days after his/ her admission, which is defined as a 'definite nosocomial infection', and was therefore directly attributable to the admission when he/ she

was cared for at St George's Hospital. I am very sorry that we were unable to prevent your RELATIVE from catching Covid-19 during his/ her admission and in line with national guidance his/ her death has been considered as a Covid-19 hospital death.

Whilst I recognise it may be of little comfort to you, I would like to confirm that at the time your RELATIVE's nosocomial infection was identified a full investigation was undertaken to determine the causes and to implement and share any lessons identified. The understanding of the Covid-19 virus has deepened over the last 18-months and the learning obtained from the pandemic will enable the Trust to reduce the risk of nosocomial Covid-19 infection for our future patients and their families.

I recognise that receiving this letter now may be upsetting, for which I would like to apologise. I believe it is important to be open and honest with you with regard to your RELATIVE's care and treatment.

I understand that this letter may prompt questions. If you would like to discuss this letter further, please telephone 07425 635051 and a member of the Corporate Nursing team will take your details and ensure you are contacted by the appropriate person at the Trust. You can telephone Monday to Friday 9am to 5pm (however if you leave a message outside of these hours we will contact you the following working day).

Alternatively, you can email me at: corporate.nursing@stgeorges.nhs.uk or write to me at:

Corporate Nursing Office
Room 1.033
First Floor Grosvenor Wing
St George's Hospital
Blackshaw Road
London
SW17 0QT

If you would like to make contact by telephone, email or letter please can I request that you do so before 30 November 2021 to ensure that the Trust can respond to any questions you may have in a timely way.

Whilst I appreciate this will have been a difficult letter to receive, I hope that you will feel reassured by the actions that the Trust has taken to prevent and investigate nosocomial Covid-19 infection, and please once again accept my sincere condolences.

Yours sincerely,

Robert Bleasdale
Chief Nursing Officer
and Director of Infection Prevention and Control

St George's University Hospitals NHS
NHS Foundation Trust

Wave 1: HOHA - Duty of Candour letter
(following a death that occurred between 1 March 2020 and 31 August 2020, Hospital onset, hospital acquired)

Corporate Nursing Office
Room 1.033
First Floor Grosvenor Wing
St George's Hospital
Blackshaw Road
London
SW17 0QT

Dear Next of Kin

Re Hospital Onset Covid-19 Infections - Duty of Candour

We are writing to you regarding the sad death of your RELATIVE, name following HIS/ HER admission to St George's Hospital during the Covid-19 Pandemic. We appreciate that it will have been an extremely difficult time for you and we would like to extend our deepest sympathies.

We would like to advise you, that a review has been undertaken of patients who were admitted to hospital during the pandemic, and later tested positive for Covid-19 during their stay. This type of infection is called a 'nosocomial infection' or 'hospital on-set infection' and in this case would mean where a patient catches Covid-19 whilst they are in hospital.

We are very sorry to tell you that it is now clear that your RELATIVE caught the Covid-19 infection in our hospital, after being admitted for other reasons. From reviewing your RELATIVE'S medical records, it was identified that HE/ SHE tested positive for Covid-19, 15 or more days after HIS/ HER admission, which is defined as a 'definite nosocomial infection', and was therefore directly attributable to the admission when HE/ SHE was cared for at St George's Hospital. We are very sorry that we were unable to prevent your RELATIVE from catching Covid-19 during HIS/ HER admission.

The Trust made every effort to try to prevent any of our patients catching Covid-19 in our hospital, and we put many measures in place, in line with national guidance, to try to minimise the chance of this happening. Unfortunately, we were not able to prevent all of our patients from catching this infection while they were in our hospital. Some of the measures that the Trust was able to put in place at the time included:

- Enhanced cleaning measures for all wards and departments throughout the hospital
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- Checking staff, patients and visitors were all following infection prevention and control guidance such as regularly washing their hands
- Ensuring that patients were cared for in groups dependent on their Covid-19 status and clinical risk (this means grouping patients of similar Covid-19 status in different wards or bays to reduce the risk of cross infection)

We appreciate the fact that receiving this letter now may cause further distress to you, and we are very sorry if that is the case. The Trust does however have a duty to be open and honest with you about the fact that your RELATIVE caught Covid-19 in our hospital.

While we appreciate that it may be of little comfort to you, we would like you to know that the Trust has investigated cases of Covid-19 infection that occurred in our hospital, in order that we can learn any lessons about ways in which our care can be improved to try to minimise the risk of this happening to other patients in the future. In addition the Trust introduced onsite rapid testing facilities for Covid-19.

We understand that this letter may prompt a number of questions. If you would like more information about the findings of the review or to discuss this letter further, please telephone 07425 635051 and a member of the Corporate Nursing team will take your details and ensure you are contacted by the appropriate person at the Trust. You can telephone Monday to Friday 9am to 5pm (however if you leave a message outside of these hours we will contact you the following working day).

Alternatively, you can email me at: corporate.nursing@stgeorges.nhs.uk or write to me at:

Corporate Nursing Office
Room 1.033
First Floor Grosvenor Wing
St George's Hospital
Blackshaw Road
London
SW17 0QT

If you would like to make contact by telephone, email or letter please can we request that you do so as soon as possible to ensure that the Trust can respond to any questions you may have in a timely way.

Whilst we appreciate this will have been a difficult letter to receive, we hope that you will feel reassured by the actions that the Trust has taken to prevent and investigate nosocomial infections, and please once again accept my sincere condolences to you.

Yours sincerely,

Robert Bleasdale
Chief Nursing Officer
and Director of Infection Prevention and Control

Richard Jennings
Chief Medical Officer

St George's University Hospitals NHS
NHS Foundation Trust

Wave 1: HOPA - Duty of Candour letter
(following a death that occurred between 1 March 2020 and 31 August 2020, Hospital onset, probably acquired)

Corporate Nursing Office
Room 1.033
First Floor Grosvenor Wing
St George's Hospital
Blackshaw Road
London
SW17 0QT

Dear Next of Kin

Re Hospital Onset Covid-19 Infections - Duty of Candour

We are writing to you regarding the sad death of your RELATIVE, name following HIS/ HER admission to St George's Hospital during the Covid-19 Pandemic. We appreciate that it will have been an extremely difficult time for you and we would like to extend our deepest sympathies.

We would like to advise you, that a review has been undertaken of patients who were admitted to hospital during the pandemic, and later tested positive for Covid-19 during their stay. This type of infection is called a 'nosocomial infection' or 'hospital on-set infection' and in this case would mean where a patient catches Covid-19 whilst they are in hospital.

We are very sorry to tell you that it is now clear that your RELATIVE probably caught the Covid-19 infection in our hospital, after being admitted for other reasons. From reviewing your RELATIVE'S medical records, it was identified that HE/ SHE tested positive for Covid-19, between 8 and 14 days after HIS/ HER admission, which is defined as a 'probable nosocomial infection', and was therefore probably attributable to the admission when HE/ SHE was cared for at St George's Hospital. We are very sorry that we were unable to prevent your RELATIVE from probably catching Covid-19 during HIS/ HER admission.

The Trust made every effort to try to prevent any of our patients catching Covid-19 in our hospital, and we put many measures in place, in line with national guidance, to try to minimise the chance of this happening. Unfortunately, we were not able to prevent all of our patients from catching this infection while they were in our hospital. Some of the measures that the Trust was able to put in place at the time included:

- Enhanced cleaning measures for all wards and departments throughout the hospital
- Ensuring staff, patients and visitors (once allowed) used appropriate personal protective equipment at all times
- Checking staff, patients and visitors were all following infection prevention and control guidance such as regularly washing their hands
- Ensuring that patients were cared for in groups dependent on their Covid-19 status and clinical risk (this means grouping patients of similar Covid-19 status in different wards or bays to reduce the risk of cross infection)

We appreciate the fact that receiving this letter now may cause further distress to you, and we are very sorry if that is the case. The Trust does however have a duty to be open and honest with you about the fact that your RELATIVE probably caught Covid-19 in our hospital.

While we appreciate that it may be of little comfort to you, we would like you to know that the Trust has investigated cases of Covid-19 infection that occurred in our hospital, in order that we can learn any lessons about ways in which our care can be improved to try to minimise the risk of this happening to other patients in the future. In addition, the Trust introduced onsite rapid testing facilities for Covid-19.

We understand that this letter may prompt a number of questions. If you would like more information about the findings of the review or to discuss this letter further, please telephone 07425 635051 and a member of the Corporate Nursing team will take your details and ensure you are contacted by the appropriate person at the Trust. You can telephone Monday to Friday 9am to 5pm (however if you leave a message outside of these hours we will contact you the following working day).

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Whilst we appreciate this will have been a difficult letter to receive, we hope that you will feel reassured by the actions that the Trust has taken to prevent and investigate nosocomial infections, and please once again accept my sincere condolences to you.

Yours sincerely,

Robert Bleasdale
Chief Nursing Officer
and Director of Infection Prevention and Control

Richard Jennings
Chief Medical Officer

St George's University Hospitals NHS
NHS Foundation Trust

Wave 2: HOPA – Duty of Candour letter: From CNO/CMO
(following a death that occurred between 1 September 2020 and 30 June 2021, Hospital onset, probably acquired)

Corporate Nursing Office
Room 1.033
First Floor Grosvenor Wing
St George's Hospital
Blackshaw Road
London
SW17 0QT

Dear Next of Kin

Re Hospital Onset Covid-19 Infections - Duty of Candour

We are writing to you regarding the sad death of your RELATIVE, name following HIS/ HER admission to St George's Hospital during the Covid-19 Pandemic. We appreciate that it will have been an extremely difficult time for you and we would like to extend our deepest sympathies.

We would like to advise you, that a review has been undertaken of all patients who were admitted to hospital during the pandemic, and later tested positive for Covid-19 during their stay. This type of infection is called a 'nosocomial infection' or 'hospital on-set infection' and in this case would mean where a patient catches Covid-19 whilst they are in hospital.

We are very sorry to tell you that it is now clear that your RELATIVE probably caught the Covid-19 infection in our hospital, after being admitted for other reasons. From reviewing your RELATIVE'S medical records, it was identified that HE/ SHE tested positive for Covid-19, between 8 and 14 days after HIS/ HER admission, which is defined as a 'probable nosocomial infection', and was therefore probably attributable to the admission when HE/ SHE was cared for at St George's Hospital. We are very sorry that we were unable to prevent your RELATIVE from probably catching Covid-19 during HIS/ HER admission.

The Trust made every effort to try to prevent any of our patients catching Covid-19 in our hospital, and we put many measures in place, in line with national guidance, to try to minimise the chance of this happening. Unfortunately, we were not able to prevent all of our patients from catching this infection while they were in our hospital. Some of the measures that the Trust was able to put in place at the time included:

- Enhanced cleaning measures for all wards and departments throughout the hospital
- Ensuring staff, patients and visitors (once allowed) used appropriate personal protective equipment at all times
- Checking staff, patients and visitors were all following infection prevention and control guidance such as regularly washing their hands
- Ensuring that patients were cared for in groups dependent on their Covid-19 status and clinical risk (this means grouping patients of similar Covid-19 status in different wards or bays to reduce the risk of cross infection)
- Looking into what happened to identify what we could do differently to improve our care and protect our patients from infection

- Introduced Covid-19 PCR tests for patients on the day of admission, day 3 and day 7

While we appreciate that it may be of little comfort to you, we would like you to know that the Trust has investigated cases of Covid-19 infection that occurred in our hospital, in order that we can learn any lessons about ways in which our care can be improved to try to minimise the risk of this happening to other patients in the future. In addition, the Trust introduced onsite rapid testing facilities for Covid-19.

We understand that this letter may prompt a number of questions. If you would like more information about the findings of the review or to discuss this letter further, please telephone 07425 635051 and a member of the Corporate Nursing team will take your details and ensure you are contacted by the appropriate person at the Trust. You can telephone Monday to Friday 9am to 5pm (however if you leave a message outside of these hours we will contact you the following working day).

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Whilst we appreciate this will have been a difficult letter to receive, we hope that you will feel reassured by the actions that the Trust has taken to prevent and investigate nosocomial infections, and please once again accept my sincere condolences to you.

Yours sincerely,

Robert Bleasdale
Chief Nursing Officer
and Director of Infection Prevention and Control

Richard Jennings
Chief Medical Officer

St George's University Hospitals NHS
NHS Foundation Trust

Wave 3: Duty of Candour letter: from the service: From 1 September 2021 onwards

HOHA: Patient who definitely acquired Covid-19: inpatient/ discharged

Dear (Name of Patient)

Re Definite Hospital Onset Covid-19 Infections - Duty of Candour

Further our discussion on DATE, I am writing to you in line with NHS England and Improvement guidance to fulfil Duty of Candour and to be open and honest with you with regard to the care are treatment you received.

I want to confirm that you tested positive for Covid-19 15 or more days after your admission to hospital. This type of infection is called a 'nosocomial infection' or 'hospital on set infection' and means where a patient catches Covid-19 whilst they are admitted to hospital. I am sincerely sorry that the Trust was unable to prevent you from catching Covid-19 during your admission.

The Trust made every effort to try to prevent any of our patients catching Covid-19 in our hospital, and we put many measures in place, in line with national guidance, to try to minimise the chance of this happening. Unfortunately, we were not able to prevent all of our patients from catching this infection while they were in our hospital. Some of the measures that the Trust was able to put in place at the time included:

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- Looking into what happened to identify what we could do differently to improve our care and protect our patients from infection
- Introduced Covid-19 PCR tests for patients on the day of admission, day 3 and day 7

While I appreciate that it may be of little comfort to you, I would like you to know that the Trust has investigated cases of Covid-19 infection that occurred in our hospital, in order that we can learn any lessons about ways in which our care can be improved to try to minimise the risk of this happening to other patients in the future.

If you would like to speak to me or a member of the ward team following receipt of this letter, please contact NAME on TELEPHONE NUMBER or via email at EMAIL ADDRESS and they will organise this for you.

Whilst I appreciate this will have been a difficult letter to receive, I hope that you will feel reassured by the actions the Trust has taken to prevent and investigate nosocomial infections. Once again please accept my sincere apologies and I hope that you have made a good recovery following your admission and wish you continued good health.

Yours sincerely,

NAME
TITLE

St George's University Hospitals NHS
NHS Foundation Trust

Wave 3: Duty of Candour letter: from the service: From 1 September 2021 onwards

HOPA: Patient who probably acquired Covid-19: inpatient/ discharged

Dear (Name of Patient)

Re Definite Hospital Onset Covid-19 Infections - Duty of Candour

Further our discussion on DATE, I am writing to you in line with NHS England and Improvement guidance to fulfil Duty of Candour and to be open and honest with you with regard to the care are treatment you received.

I want to confirm that you tested positive for Covid-19 between 8 and 14 days after your admission to hospital. This type of infection is called a 'nosocomial infection' or 'hospital on set infection' and means where a patient probably caught Covid-19 whilst admitted to hospital for other reason. I am sincerely sorry that the Trust was unable to prevent you from probably catching Covid-19 during your admission.

The Trust made every effort to try to prevent any of our patients catching Covid-19 in our hospital, and we put many measures in place, in line with national guidance, to try to minimise the chance of this happening. Unfortunately, we were not able to prevent all of our patients from catching this infection while they were in our hospital. Some of the measures that the Trust was able to put in place at the time included:

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- Looking into what happened to identify what we could do differently to improve our care and protect our patients from infection
- Introduced Covid-19 PCR tests for patients on the day of admission, day 3 and day 7

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Yours sincerely,

NAME
TITLE

St George's University Hospitals NHS
NHS Foundation Trust

Wave 3: HOHA – Duty of Candour letter: From CNO
(following a death that occurred between 1 September 2021 Hospital onset, hospital acquired)

Corporate Nursing Office
Room 1.033
First Floor Grosvenor Wing
St George's Hospital
Blackshaw Road
London
SW17 0QT

Dear Next of Kin

Re Hospital Onset Covid-19 Infections - Duty of Candour

I am writing to you regarding the sad death of your RELATIVE, name following HIS/ HER admission to St George's Hospital during the Covid-19 Pandemic. I appreciate that it will have been an extremely difficult time for you and I would like to extend my deepest sympathies.

I would like to advise you, that a review has been undertaken of patients who were admitted to hospital during the pandemic, and later tested positive for Covid-19 during their stay. This type of infection is called a 'nosocomial infection' or 'hospital on-set infection' and in this case would mean where a patient catches Covid-19 whilst they are in hospital.

I am very sorry to tell you that it is now clear that your RELATIVE caught the Covid-19 infection in our hospital, after being admitted for other reasons. From reviewing your RELATIVE'S medical records, it was identified that HE/ SHE tested positive for Covid-19, 15 or more days after HIS/ HER admission, which is defined as a 'definite nosocomial infection', and was therefore directly attributable to the admission when HE/ SHE was cared for at St George's Hospital. I am very sorry that we were unable to prevent your RELATIVE from catching Covid-19 during HIS/ HER admission.

The Trust made every effort to try to prevent any of our patients catching Covid-19 in our hospital, and we put many measures in place, in line with national guidance, to try to minimise the chance of this happening. Unfortunately, we were not able to prevent all of our patients from catching this infection while they were in our hospital. Some of the measures that the Trust was able to put in place at the time included:

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- Introduced Covid-19 PCR tests for patients on the day of admission, day 3 and day 7

I appreciate the fact that receiving this letter now may cause further distress to you, and I am very sorry if that is the case. The Trust does however have a duty to be open and honest with you about the fact that your RELATIVE caught Covid-19 in our hospital, and that (as indicated on his/her death certificate) this Covid-19 infection probably caused or contributed to his/her death.

While I appreciate that it may be of little comfort to you, I would like you to know that the Trust has investigated cases of Covid-19 infection that occurred in our hospital, in order that we can learn any lessons about ways in which our care can be improved to try to minimise the risk of this happening to other patients in the future. In addition, the Trust introduced onsite rapid testing facilities for Covid-19.

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Yours sincerely,

Robert Bleasdale
Chief Nursing Officer
and Director of Infection Prevention and Control

St George's University Hospitals NHS
NHS Foundation Trust

Wave 3: HOPA – Duty of Candour letter: From CNO
(following a death that occurred between 1 September 2021 Hospital onset, probably hospital acquired)

Corporate Nursing Office
Room 1.033
First Floor Grosvenor Wing
St George's Hospital
Blackshaw Road
London
SW17 0QT

Dear Next of Kin

Re Hospital Onset Covid-19 Infections - Duty of Candour

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Yours sincerely,

Robert Bleasdale
Chief Nursing Officer
and Director of Infection Prevention and Control

Meeting Title:	**Trust Board**		
Date:	25 November 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:	Assurance		
Executive Summary:	This Report sets out a summary of the matters reviewed by the Committee at its meetings on 15th October and 11th November. 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. Looking forward, the Committee anticipates the potential for a change in the overall risk ratings by the end of the financial year, assuming that current progress is maintained. However, it is very clear that the pressure is firmly on the Trust and its staff – the twin challenges of Covid and elective recovery, especially when allied to 'normal' winter pressures are generating real stretch for staff across the Trust and this came through starkly in a number of the reports received. The October meeting spent time discussing two important reports to the Committee, each of which looked at different aspects of the way that the second wave of the pandemic had impacted the Trust, and the learning and remedial actions being adopted as a result. The first of these was the Q2 report from our Guardian of Safe Working, Serena Haywood. This will also be coming to Board, so I will not comment further here, although there is a short summary below. The second was a report back to WEC in response to a request we had made on the Trust's experience in and the learning from the Covid pandemic. This was an interesting and highly informative report, and went some way to capturing the harrowing experience that this generated for some of our staff. It gave real context to the critical importance of the current wellness initiatives and the need for individual decompression as we start to exit the pandemic.		
Recommendation:	The Board is asked to note this report.		
Supports			
Trust Strategic Objective:	Champion Team St George's (Culture)		
CQC Theme:	Well-led		
NHS Oversight Framework Theme:	Board Assurance, Risk management		
Implications			
Risk:	As set out in the report.		
Resources:	N/A		
Previously considered by:	N/A	**Date:**	N/A
Appendices:	N/A		

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Workforce and Education Committee Report
Board of Directors – 25 November 2021

1. Committee Chair's Overview

Since my last report to Board in September we have had two further meetings of the Committee, in October and November. No new risks at Trust level were identified. The Trust is clearly working under significant operational pressures, and we took assurance from the way in which the executive was managing this, whilst maintaining adherence to standard operating protocols. That pressure is however having an impact on staff and their wellbeing, which the Trust is attempting to address.

2. Key points:-

Internal Operations and Supply

Deep Dive - Employee Relations. The Committee had previously asked for a deep dive review of the employee relations function and Theresa Ekendu, the Trust's Head of Operations and HR, reported back with a helpful summary paper. We took assurance from the focus that this area has been receiving, and the clear progress being made. The number of cases being opened continues to be actively managed down, as did the time to close. However, operational pressures had meant that the trend in closing cases had slowed over the last four months, as managers had been pulled back into operational delivery. As a consequence, the proportion of cases being managed within their target timescale had fallen. In response, the executive is considering using HR resource (internal or external) to manage some of these cases directly and secure timely resolution – something which the Committee supported. Work has begun on devising a new 'Day 1' management process in cases where stress / anxiety / depression was given as the reason for absence. The anticipation was that rapid intervention would help stop cases becoming intractable.

Learning from Covid - The Committee received an interesting and reflective report on the initial learning from Covid, assessing what had worked well and what had not. This was an initial assessment and further evaluation was being undertaken. However, what the report clearly communicated was the harrowing nature to some staff of their experience on the front line during a surging pandemic, and the near-traumatic experience for some. It was clear that in future staff would benefit from access to continuing psychological support and that in organisational planning for future activity surges the health and wellbeing of the staff would be a priority.

The report also assessed, in the light of the Trust's experience of its pandemic response, the future opportunities for improvements and - for a number of the changes implemented - whether the Trust was minded to Restore, Retain or Reinvent the change in question. One important area of learning related to the lack of trained nurses for ITU beds in the event of a pandemic surge, and the way that step-up training had been swiftly planned and delivered to allow other staff to transition into ITU. It was noted that the Trust had since trained nurses to be able to support ITU beds, as part of its contingency planning for any winter surge. The Committee took assurance from the report – both in terms of the Trust's immediate response to the pandemic and the reflective way in which it was evaluating the lessons learned.

HR Operations Dashboard - we reviewed the Trust's operational HR dashboard and noted a number of points. The new Assurance Framework dashboard was discussed, and seen as extremely helpful in setting out the current key workforce issues facing the Trust. The total funded establishment had increased by almost 5% (435 FTEs – 9,698, up from 9,263 12 months ago). It was not clear where this additional resource had been deployed, so we have asked for a report back. Trust sickness rates had been increasing steadily since the low point in March (3.1%) and now stood at 4.1%. The data showed Ward Staffing Unfilled Duty Hours at 13.8% in August, and whilst the figure is potentially over-stated there is an unmistakeable rising trend here, linked to a tightening staffing market.

We have asked for a deep dive review of our bank and agency utilisation, in order to assess whether we are looking at something which is potentially indicating a significant shortfall in available nursing staff in south London. If so, the situation could tighten further during the winter. Covid vaccination rates amongst staff had moved slightly, with 86% / 83% (first jab / second jab) compared to 86% / 77% two months ago, although within our black staff the rates remain materially lower at 69% / 64%. Flu jab uptake was marginally behind expectations, but we were left in no doubt that the team responsible was not intending to allow this situation to continue. A 'jab-athon' approach was being adopted, which all staff would be actively encouraged to support.

Deep Dive, Turnover and Leavers Report – we had asked for a deep dive on the data relating to staff who leave the Trust, and received a comprehensive analysis and, importantly, an outline of the strategies being adopted to improve retention rates. Overall Trust turnover (on a rolling 12 month basis) had bottomed in April at 14.4% (as against a Trust target of 13%, and a rate of 18.7% in August 2017), but had begun to notch up more recently. Turnover by staff group and function was reviewed. The highest turnover was seen in HR and Therapies In relation to leavers, some 51% of those who leave have been with the Trust less than two years, although this figure rose to 62% of Non-Qualified Nurse leavers. The principle reasons for leaving were summarised, and attention was drawn to certain limitations on how internal data was collected. The Committee were made aware of the steps taken to improve the collection of exit data through the use of a new external partner. The key message from their research was that whilst there was a slight increase in leavers, the majority were 'happy' leavers i.e. moving for positive reasons such as promotion. 77% stated that they would work for the organisation again and 76% would recommend SGUH as a place to work. This is higher than for other NHS comparator organisations. The Committee welcomed this analysis and asked that further updates be brought to future meetings.

People Management Group Report. We received comprehensive summaries of the activities and focus areas of the executive, which we continue to find helpful in providing us with a perspective on issues arising.

Workforce Planning

Winter Workforce Plan – at our November meeting we reviewed a detailed paper setting out the workforce planning process being undertaken by the Trust, and explored a number of the assumptions underpinning this – notably those relating to sickness absence rates, leaver rates, and the availability of bank and agency resources. We took assurance from the approach being adopted, and the thinking that was going into maximising the Trust's ability to continue to deliver a full range of services across the winter months.

Culture, Diversity and Inclusion

Culture Programme Update – The Committee received a report from Daniel Scott, Associate Director of Leadership & Organisational Development on behalf of the Culture, Diversity and Inclusion Programme Board (CDIPB) at both the October and November meetings. In October we noted the updates on local culture intervention that were taking place in Cardiac surgery, Obstetrics & Gynaecology departments and on the Trust values refresh programme. At the November meeting we received an update on Programme Management and the generally solid progress being made. This led us on to a related discussion of the Trust's Staff Thank-You Initiative, which was sensibly pitched at reflecting staff contribution during the pandemic, and also linked to the learning from that experience. We appreciated the thought and sensitivity which had gone into this.

Workforce Disability Equality Report – Joseph Pavett-Downer, the Trust's D&I Lead, summarised the results that would be contained within the Trust's WDES Report, that would in due course be published on the Trust's website. A concerning increase in the proportion of staff with a disability experiencing harassment, bullying or abuse from other colleagues was noted, with a wide gap between the experiences of disabled and non-disabled staff. The executive confirmed that they were attempting to

address this. However, the report also reflected on the positive change to the number and proportion of disabled staff being satisfied with the extent to which the Trust values their work. Key action points were to address the harassment, bullying or abuse report; increase the rate of self-declaration of disability; and to create greater awareness amongst staff of disabilities which may not be clearly visible.

Improving Career Progression for BAME Staff – At our November meeting Joseph Pavett-Downer, the Trust's D&I Lead, summarised the actions being taken to ensure fairness and transparency within Trust recruitment processes – covering external recruitment and internal promotion. A key part of this debiasing of recruitment involved the use of Recruitment Inclusion Specialists (RIS) in the panel interview process. These were Trust staff who had received specialist training, and 110 had been trained since the initiative began in September 2020. The use of a RIS was being progressively rolled out: 79% of Band 8a interviews now included a RIS, and 45% of Band 7. The roll-out would continue across a wider range of band appointments, with the objective of all panels having a RIS participant. On the basis of the first year's experience, a number of improvements had been identified and were to be made to the RIS process.

Black History Month – the Committee received a report on the various events which had been put on to mark Black History Month, and noted that these had been well received.

Strategy and Risk

Education Strategy Update – we received a very helpful update on the implementation of the Education Strategy and noted that due to wider operational pressures some elements of this had been deferred into 2022.

Review of Strategic Risks 8 (culture) and 9 (workforce) – at its November meeting the Committee reviewed the risk scores and assurance ratings for each of the two Trust Strategic risks which it oversees. Whilst no change is recommended at this stage, the Committee recognised the solid progress being made by the executive in managing and mitigating these risks. As such, the Committee is minded to reduce the risk rating for these risks later in the year, provided continuing progress is made.

Trust Governance and Compliance

Q2 Report from Guardian of Safe Working – We were joined by Serena Haywood, the Trust's Guardian, who reported on Q2. As GOSWH, Serena had raised an alarm with our CMO, Richard Jennings, about the cumulative impact of COVID and increasing pressure within the Trust and its impact on our trainee doctors. Serena acknowledged that this was being taken seriously by the Trust and a set of remediations were under active discussion. In Q2 there had been a considerable increase in exception reports, with 101 in the quarter. The nature, causes and responses to these were discussed in some detail. In addition, the Committee reviewed the current position in a small number of specialties where trainees had raised issues relating to: culture, staff relations and behaviour, and the adverse impact on training and development. Certain of these had involved trainees raising concerns outside the Trust and those concerns were being addressed with vigour. The Deputy Chief Medical Officer, Lucinda Etheridge and the CMO Richard Jennings endorsed the conclusions reached by Dr Haywood and we took assurance from the agreed approach. We will continue to monitor the follow-on actions.

A pilot was being finalised to assess the implications of bringing (non-trainee) non-consultant doctors into the Safe Working regime. The Committee encouraged this, if achievable.

Freedom to Speak Up Guardian, Q2 Report – We were joined by our Guardian, Karyn Richards-Wright who summarised the very comprehensive paper that she had prepared for the Committee summarising activity during Q2. As this Report will be within the papers for the Board meeting, it is not further summarised here. What was however clear was that the number of concerns raised

continued to grow, although it should be noted that these are almost entirely related to staff on staff concerns, such as behaviours, team working and relations with colleagues, as opposed to patient safety issues. The Trust was therefore planning a focused piece of engagement to encourage staff to raise safety issues, building on the experience of other trusts. However, as the Guardian had gained further traction and support from the Trust, so the proportion of concerns raised that had been resolved informally continued to grow. The Committee noted the success of the initiative to get additional staff to take on the role of FTSU Champions and that the 19 new Champions represented a broad cross section of staff. In addition, the Committee welcomed the decision of the Trust Management Group in November to incorporate training on raising concerns as part of the Trust's Mandatory and Statutory Training programme.

Junior Doctor Medical Education – at our November meeting we reviewed three very comprehensive papers focussed on medical education, a critical part of the Trust's activities and one which had a real financial significance. The first two related to recent evaluations (external and internal) of our undergraduate and postgraduate medical education, and the actions now needed. The GMC's enhanced monitoring of two services was noted. The third paper set out the principle areas of concern, the actions proposed, and drew a number of conclusions and reflections from these. In summary, there were clear issues with the way medical education had been delivered in some specialties (albeit not known to the Trust until external parties had notified it) and corrective action was promptly required. The Board had at an earlier meeting received a private briefing on a number of the issues identified.

A co-ordinated response to this situation had since been agreed by our senior medical leadership[1] and was to be implemented by them. The Committee probed a number of the operational assumptions underpinning the proposed action plan, and concluded that it was addressing the right issues in the right order. The Committee also took assurance from the broadly-based approach being adopted (rather than one confining itself to individual specialties), and the way that the action plan was being developed within the Trust's wider culture programme, an element being led by Humaira Ashraf on the HR side. The timescale for full impact of the Action Plan was noted and accepted as realistic, but it was also agreed that an interim update would be provided to the Committee in six months time – so that progress could be assessed. We will report back to the Board at that point.

Bank Staff Holiday Pay – Paul Da Gama briefed the Committee on further developments in relation to certain staff who had worked for the Trust via the South West London Bank.

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

Stephen J Collier
Committee Chair
19 November 2021

[1] Richard Jennings, our Chief Medical Officer; Indranil Chakravarty, our Director of Medical Education; Joyce Popoola, our Clinical Sub-Dean; Luci Etheridge, our Deputy Chief Medical Officer; and Mo Amaran, our new Chief Registrar.

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St George's University Hospitals NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	25 November 2021	**Agenda No**	**3.11**
Report Title:	Workforce Disability Equality Standard (WDES) 2021 Report		
Lead Director/ Manager:	Paul Da Gama, Chief People Officer		
Report Author:	Joseph Pavett-Downer, D&I Workforce Lead		
Presented for:	Approve		
Executive Summary:	All NHS providers are required to complete an annual Workforce Disability Equality Standard Report (WDES). 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 for staff with a disability. In line with national requirements this report should be reviewed internally and approved at Board before being published on the organisation's website. The deadline for publication is 31st October 2021. The key findings and metrics for this report submission are outlined below - each point is compared to the previous reporting period in 2020; **Workforce Numbers and Declaration** • There is an increase in the number of staff that have declared a disability (+28) however this still remains only 2% of the workforce. • There is a higher number of Disabled staff in lower bands however the headcount percentage remains fairly consistent across all bands. • There is an increase in the number of staff that did not declare a disability, from 744 in 2019 to 769 in 2020. • Disabled staff within the Medical workforce remains very low, particularly the Consultant grade (0.3%) and the Non-Consultant Career grade (0%). • Disabled staff are under-represented at Executive and Board level, both in voting and non-voting. **Recruitment** • Non-Disabled applicants are 1.08 times more likely to be appointed compared to Disabled applicants, this is down 0.01% compared to 2019. Disciplinary • Disabled staff have not entered the Disciplinary process since 2018. **Harassment, Bullying and Abuse** • The gap between the experience of Disabled and Non-Disabled staff has reduced across three of the four indicators in this area. • Compared to 2019, harassment, bullying or abuse towards disabled staff, from; o Patients/service users is down -2.6% o Managers is down -4.8% o Colleagues is up +0.9% • Reporting rates at St George's, for both disabled and non-disabled staff, has increased for the second year and is higher than the national average.		

	Beliefs about equal opportunities, career progression and promotion • The percentage of Disabled staff believing that the Trust provides them with equal opportunities has increased by 2.2%, compared to 2019. • The gap between the experience of Disabled and Non-Disabled staff has reduced by 2.3%. **Feeling pressure to go to work when unwell** • A higher number of Disabled staff compared to non-Disabled staff reported feeling pressure to come into work despite not feeling well enough to carry out their duties. This was reported in years 2018, 2019 and 2020. • The gap between both groups has increased for the second year, with a difference of 9.3%. • Both groups report feeling slightly more pressured compared to 2019. **Feeling that work is undervalued** • Disabled staff at the Trust are much less likely to feel that their work is valued by the organisation. • In 2020, 34.9% of Disabled staff who responded to the Staff Survey said they felt the organisations valued their work - compared to 49.1% of Non-Disabled staff. This is difference of 14.2% between the two groups. **Adjustments in the workplace** • Only 71.5% of Disabled staff felt that adequate adjustments had been made in their work place. This is an increase of 5.6% compared to 2019.
Recommendation:	The Board is asked to note the Workforce Disability Equality Standard Report 2021 and Action Plan which has been published 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** 15 October 2021
Appendices:	WDES report

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NHS Workforce Disability Equality Standard (WDES)

Annual Report 2021

Our organisational commitment to advancing the equality and experience of disabled people at work

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Executive Summary

All NHS providers are required to complete an annual Workforce Disability Equality Standard Report (WDES). 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 for staff with a disability.

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 31st October 2021.

The key findings and metrics for this report submission are outlined below - each point is compared to the previous reporting period in 2020;

Workforce Numbers and Declaration

- There is an increase in the number of staff that have declared a disability (+28) however this still remains only 2% of the workforce.
- There is a higher number of Disabled staff in lower bands however the headcount percentage remains fairly consistent across all bands.
- There is an increase in the number of staff that did not declare a disability, from 744 in 2019 to 769 in 2020.
- Disabled staff within the Medical workforce remains very low, particularly the Consultant grade (0.3%) and the Non-Consultant Career grade (0%).
- Disabled staff are under-represented at Executive and Board level, both in voting and non-voting.

Recruitment

- Non-Disabled applicants are 1.08 times more likely to be appointed compared to Disabled applicants, this is down from 1.09 in 2019.

Disciplinary

- Disabled staff have not entered the Disciplinary process since 2018.

Harassment, Bullying and Abuse

- The gap between the experience of Disabled and Non-Disabled staff has reduced across three of the four indicators in this area.
- Compared to 2019, harassment, bullying or abuse towards disabled staff, from;
    - Patients/service users is down -2.6 percentage points
    - Managers is down -4.8 percentage points
    - Colleagues is up +0.9 percentage points
- Reporting rates at St George's, for both disabled and non-disabled staff, has increased for the second year and is higher than the national average.

Beliefs about equal opportunities, career progression and promotion

- The percentage of Disabled staff believing that the Trust provides them with equal opportunities has increased by 2.2 percentage points, compared to 2019.
- The gap between the experience of Disabled and Non-Disabled staff has reduced by 2.3 percentage points.

Feeling pressure to go to work when unwell

- A higher number of Disabled staff compared to non-Disabled staff reported feeling pressure to come into work despite not feeling well enough to carry out their duties. This was reported in years 2018, 2019 and 2020.
- The gap between both groups has increased for the second year, with a difference of 9.3 percentage points.
- Both groups report feeling slightly *more pressured* compared to 2019.

Feeling that work is undervalued

- Disabled staff at the Trust are much less likely to feel that their work is valued by the organisation.
- In 2020, 34.9% of Disabled staff who responded to the Staff Survey said they felt the organisations valued their work - compared to 49.1% of Non-Disabled staff. This is difference of 14.2 percentage points between the two groups.

Adjustments in the workplace

- Only 71.5% of Disabled staff felt that adequate adjustments had been made in their work place. This is an increase of 5.6 percentage points compared to 2019.

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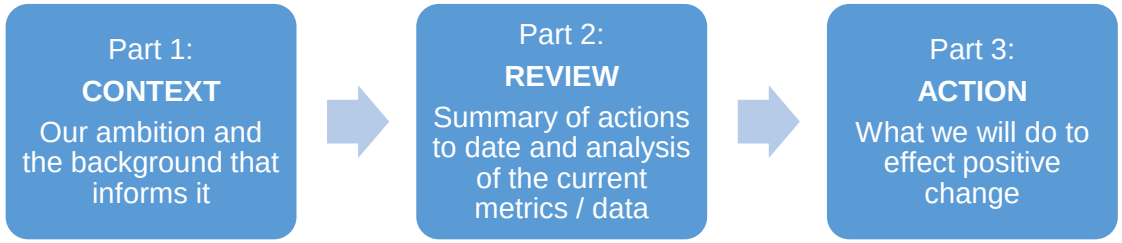
Aims and Structure of This Document

This document has been developed to serve two main purposes:

- To set out the organisation's ambition and action plan for supporting the diversity and inclusion of Disabled people in our organisation; and
- To provide the data, updates and planned actions required for our 2021 annual report to the Workforce Disability Equality Standard (WDES).

To fulfil these aims, the document has been arranged into three parts:



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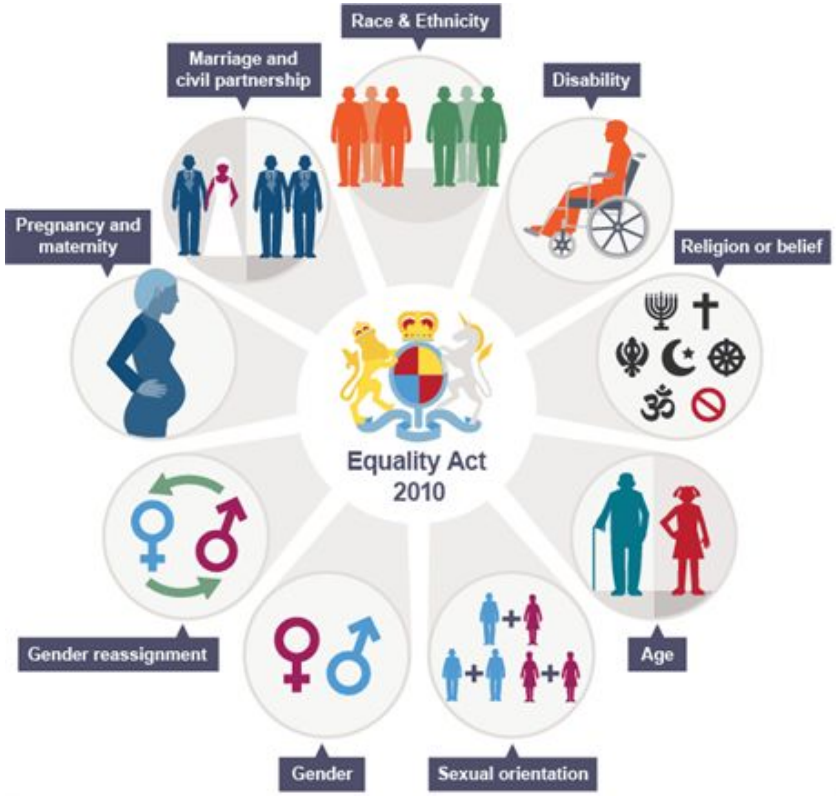
Disability is a Core Strand of Our D&I Agenda

Everyone who works at St George's, or applies to work in the Trust, should expect to be treated fairly and valued equally irrespective of age, disability, race, ethnicity, gender, gender identity, religion or belief, sexual orientation, marital status, or pregnancy and maternity status. These are known as protected characteristics. The Trust is committed to enabling everyone in the Trust to achieve their full potential in an environment characterised by dignity and mutual respect.

In August 2020, St George's developed a wider organisational Diversity and Inclusion Action Plan that aims to support and strengthen the equality and experience of our staff who represent any and all of the protected characteristics. While many of the outcomes and deliverables set out in this plan will also benefit Disabled staff, it is deemed important to have a connected but separate action plan that specifically focuses on disability.

We hope that the action plan we set out below, nested within our wider organisational D&I action plan, reflects the extent and authenticity of this ambition.



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Our Ambition

Serving a diverse population of 1.3 million and with over 9000 employees, St George's University Hospitals Trust is the largest healthcare provider in South West London. It is crucial that the diversity of our workforce reflects the diversity of the communities we serve, and that Disabled people are statistically well represented at all levels in our organisation. However, equally important to strong diversity and representation is authentic inclusion.

St George's is committed to building a workforce in which each employee can enjoy a strong sense of belonging and where diversity, difference and uniqueness are truly valued. As well as being well-represented across all levels, we must ensure that people from marginalised groups, including Disabled people, are actively and always included, and that this inclusion is felt *authentically* at a personal level. Lip-service will not suffice.

Achieving strong diversity and inclusion of Disabled people at St George's will offer significant benefits for our organisation:

- Delivery of better patient care, because…
    - Staff who feel included, engaged and supported have greater personal resources and resilience to offer thorough and compassionate care
    - Staff who are differently-abled may offer enhanced empathy and support to patients due to their lived-experience of disability
    - Patients with disabilities may be more able to identify with and relate to our Disabled staff
- Stronger team performance by maximising our blend of skills, talents, knowledge and professional experience
- Stronger individual performance by enabling Disabled staff to use their disability at work as advantage instead of a disadvantage
- Improved retention of our staff, especially our Disabled staff (including staff who may become Disabled)
- A reduction in bullying, harassment, discrimination and other forms of exclusion by building greater understanding, appreciation and respect for people with disabilities
- Supporting our organisational journey towards adopting a more compassionate and inclusive culture

Our ambition is to create an organisation - and a reinforcing culture - that not only offers equality and a positive experience for all of our Disabled colleagues, but one that actively nurtures and celebrates our physical and mental differences in ability. We strive for this in the certainty that our rich diversity and a universal sense of belonging will be integral to our success as a healthcare organisation.

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Background

The Workforce Disability Equality Standard (WDES)

The WDES was introduced in 2019 and is designed to improve the experiences of Disabled people working in, or seeking employment within the NHS. This mandated collection of evidence-based metrics helps an organisation understand more about the experiences of its staff. The 10 metrics on which we report against each year are included in the table opposite.

The WDES report compares data between Disabled and non-Disabled staff in order to identify disparities and barriers in the workplace. These findings inform the organisation's WDES Action Plan, which aims to directly address inequalities faced by Disabled members of staff.

We are pleased that the NHS, our parent organisation, is currently the only UK employer that mandates its member organisations to report annually on its representation and inclusion of Disabled people. However, our ambition is to go far beyond what is mandated, and to become a truly great employer of Disabled people, and an exemplar for other NHS Trusts.

Metric 1	% Disabled staff in AfC pay-bands (or medical and dental subgroups and VSMs) compared with the percentage of staff in the overall workforce (for both clinical and non-clinical groups)
Metric 2	Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts
Metric 3	Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure
Metric 4	Staff Survey Q13: % Disabled staff compared to non-disabled staff: a) experiencing harassment, bullying or abuse from different groups b) saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it
Metric 5	Staff Survey Q14: % Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion
Metric 6	Staff Survey Q11: % Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties
Metric 7	Staff Survey Q5: % Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work
Metric 8	Staff Survey Q28b: % Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work
Metric 9	a) The staff engagement score for Disabled staff, compared to non-disabled staff b) Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard?
Metric 10	% difference between the organisation's Board voting membership and its organisation's overall workforce

What is 'Disability'?

Defining 'disability' is not always straightforward. The Equality Act 2010 defines a Disabled person as:

> *"someone who has a mental or physical impairment that has a substantial and long-term adverse effect on the person's ability to carry out normal day-to-day activities."*

Some of the terms in this definition are open to interpretation, and further guidance is found in Appendix C. However, instead of trying to judge whether a person falls within the statutory definition of disability, we should focus on meeting the needs of the worker (or job applicant). In supporting a Disabled member of staff, it is almost always more important to understand and support the *effects* of a disability rather than the cause.

It is important to note that the definition of disability regards the person as they are *without* aids, support or medication (the exception being visual impairment where it can be addressed by use of wearing prescription spectacles). This is particularly relevant for those with mental health conditions who are able to control their condition with medication, and also for those with conditions such as epilepsy and diabetes that are otherwise controlled by medication.

Additional information on the definition of disability is attached in Appendix C, taken directly from guidance produced and published by NHS Employers. This guidance was published in 2014. We will continue to closely monitor best practice and guidance and communicates updates as necessary.

Legal Obligations of Employers and Reasonable Adjustments

Protection against disability-based discrimination is enshrined in the Equality Act 2010. Due to the additional barriers faced by Disabled people, it is permitted to treat Disabled *more* favourably than their non-Disabled colleagues. Understanding this, and the reasons for it, is crucial to removing the barriers that continue to deny Disabled people equality of *outcome* in work and more broadly.

The Equality Act 2010 protects employees, and covers areas including recruitment, assessment and selection, terms of employment, promotion and training opportunities, dismissal or redundancy, and discipline and grievances.

The Equality Act 2010 also requires that *reasonable adjustments* are made to working conditions, policies and practices that put a Disabled member of staff at a disadvantage. A reasonable adjustment could include any of the following:

- making adjustments to premises or acquiring/modifying equipment
- providing a reader or interpreter, or employing a support worker
- reallocating a Disabled employee's duties to another person
- providing supervision, training, mentoring or other support
- transferring a person to fill an existing suitable vacancy without competitive interview
- altering working hours or the place of work
- allowing someone to be absent during working hours for rehabilitation, assessment or treatment
- modifying procedures for testing or assessment

Useful checklists and further detail on the legal obligations can be found in the Guidance relating to disability for the NHS document, published by NHS Employers. This guidance document also sets out examples of good practice (when not legally obligated), particularly around the supporting carers and disability related absence from work.

While St George's is mandated and committed to meet its legal obligations in protecting Disabled people, our ambitions to support the equality and experience of Disabled people go far beyond this

Progress Updates 2020/21

Over the last year, the Trust has taken the following steps to help improve the experiences and wellbeing of staff with a disability (or long-term health condition)

Project Search

Project Search is a supported internship for local young adults with a learning disability and/or autism. This initiative was launched at St George's in 2012 and aims to provide work experience leading to employment, either in the host organisation or elsewhere. Unfortunately, the pandemic has had a significant impact on many organisations ability to safely host the 2020/21 cohort and the programme was placed on hold. During the last 12 months many of the young adults in the programme have reported increased rates of low moods, loneliness and reduced confidence. Support teams at Cricket Green (our partnering school) have been working with these individuals to support and prepare them for coming into the workplace again. In July 2021, we welcomed back our 2019/20 cohort to host their final graduation ceremony with colleagues and leadership teams across the hospital. We are pleased to report the programme will re-launch this October 2021 and now forms part of our Widening Participation Programme. Refer to Appendix B for further details.

Disability and Wellbeing Staff Network

Our Disability and Wellness Network (DAWN) launched in late 2019 and membership has grown steadily to over 50 members across the organisation. Activity has unfortunately stalled in the last 12 months due to the pandemic and increased pressures across the organisation. The pandemic has also presented additional health risks for a number of key members which has left our network leadership posts vacant. This period was used to collectively review the Terms of references (TOR) across our four staff networks. Following a review and consultation with members, a number of additions and points of clarify were made to the TOR – these updates focused largely on formalising election processes, establishing a clear Network Leadership Committee and introducing a 'package of support' for each staff network. The updated TOR was signed off by members in August 2021 and the election process for the Network Leadership Committee launched in October 2021.

Wellness Action Plan

Our We have developed and launched the Wellness Action Plan was in May 2021. This plan provides a structured framework to support line managers in facilitating effective wellbeing conversations with their staff members. By introducing these plans, the Trust aims to facilitate a more inclusive culture that puts staff wellbeing and health at the heart of everything we do. The plans focus on both individual physical and mental health needs and encourages discussion about how these needs can be met, which may include reasonable adjustments being made to support individuals to carry out their roles.

REACT Training and Guidance

To supplement the Wellness Action Plan, all line managers have been invited to take part in *'Wellbeing Conversations Training'* to support

them in having effective wellbeing conversations with their team members. This training provides managers with the essential tools such as how to identify the level of support someone might require, how to signpost if appropriate, and how to facilitate conversations around making reasonable adjustments. Guidance has also been developed and is available on the intranet for managers supporting staff, both at work and those working remotely (as evidence shows that their wellbeing needs may differ).

Menopause Policy

In September 2021 our Health and Wellbeing Service, in collaboration with our Women's Staff Network, introduced a Menopause Policy that takes into account the specific needs individuals may face when experiencing the menopause. This policy provides much needed support for staff, as well as clarity for managers, particularly around reasonable adjustments. Though the Menopause is not a disability or long-term health condition, it does impact the health and well-being of staff across the organisation, and can have additional implications for those already living with a disability or long term health condition.

Menopause Café

In addition to the Menopause policy, our Health and Wellbeing service host monthly menopause cafés to support individuals experiencing the menopause. These sessions provide a free, safe and inclusive space to learn more about the menopause, it's impact on staff and to share experiences.

Wellbeing Hubs

In May 2020, following feedback from staff, the Trust created 3 temporary wellbeing hubs for staff. These much needed hubs were introduced as staff reported limited access to adequate rest spaces away from the pressures of their clinical/work environments. These hubs were received very positively and were well used in this period. Due to the success and clear need, it was agreed in November 2020 that this would be a permanent Wellbeing space for staff.

Organisational Culture Change programme

Since completing the culture diagnostic exercise in 2020, St George's has been continuing its organisation-wide culture programme by structuring, designing and resourcing a broad ranging set of solutions and interventions. We have started to deliver on much of the plan, with a lot more to come. A large component of this culture programme focuses specifically on building a more inclusive culture – as reflected in our comprehensive multi-year D&I Action plan. Some of these elements that will positively impact on our disabled staff are likely to include:

- Development of new leadership and management development offer that includes D&I aspects in all of the training programmes within it
- Establishing an inclusive approach to talent management
- A 'values refresh' that will clarify behaviours expected of all staff. This will also entail learning opportunities that will support greater awareness and understanding of inequality and how to tackle it.
- Establishing new policies and ways of working that better enable remote and homeworking.

Calibre Leadership Programme

This innovative leadership development programme has been designed by and for leaders with a disability or long-term health condition. Following a successful application process, we have been awarded 10 funded places for members of staff at St George's. Following an internal application process, the successful 10 staff members will start the programme in February 2022. The programme aims to;

- Transforms how disabled staff think about themselves and their disabilities.
- Help boost confidence and self-worth.
- Provide a peer network across London.
- Help explore conversations with managers/leaders about disability in the workplace.
- Demonstrates how disability and neuro-diversity can be can be an asset to employers.
- Help transform the perspective and approach taken by employers regarding support and development of employees with disabilities.

Access to new eLearning

Due to significant upgrades 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. Two of the key benefits of the upgrade are;

- iLearn can now connect to the national learning content provided by *E-Learning for Healthcare* (e-learning content provider for Health Education England). This provides access to content from eLfH, such as the Disability Matters programme.
- iLearn can now be accessed from outside the Trust's network directly which supports accessibility for those working from home or shielding. It also features improved software for screen reading and speech recognition.
- iLearn will be accessible from PC, laptop and personal mobile devices (phones tablets) so should improve ease and speed of access to Trust learning content and mandatory/statutory training for all staff.

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REVIEW: Indicator Overview

At the time of writing, St George's Hospital employs 9,162 staff, 209 of these staff members (2%) have formally declared themselves as living with a disability, while 769 (8%) did not disclose. In contrast, our 2020 Staff Survey results indicate that 11.7% of respondents consider themselves to have a disability.

Data collected via the staff survey, Electronic Staff Records (ESR) and recruitment records have been compiled and used to report against the 10 WDES metrics below. The full set of data responses are set out in Appendix A.

Metric	Description	Disabled Staff 2020	Disabled Staff 2021	Vs. 2020	Non-Disabled Staff 2021	Vs. ND Staff
1.	% Disabled staff in AfC pay-bands (or medical and dental subgroups and VSMs) compared with the percentage of staff in the overall workforce (for both clinical and non-clinical groups)	2%	2%	→	90%	→
2.	Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts	1.09	1.08	↓	N/A	N/A
3.	Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure	0	0	→	N/A	N/A
4a.	Staff Survey Q13: % of staff experiencing harassment, bullying or abuse from patients/ service users	38.4%	35.8%	↓	28.4%	↑
4b.	Staff Survey Q13: % of staff experiencing harassment, bullying or abuse from managers	28.3%	23.5%	↓	13.1%	↑
4c.	Staff Survey Q13: % of staff experiencing harassment, bullying or abuse from other colleagues	33.5%	34.4%	↑	20.9%	↑

4.d	Staff Survey Q13: % of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	47.1%	49.2%	↑	47.7%	↑
5.	Staff Survey Q14: % of staff believing that the Trust provides equal opportunities for career progression or promotion	64.6%	66.8%	↑	75.2%	↓
6.	Staff Survey Q11: % of staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	34.0%	35.1%	↑	25.8%	↑
7.	Staff Survey Q5: % of staff saying that they are satisfied with the extent to which their organisation values their work	32.0%	34.9%	↑	49.1%	↓
8.	Staff Survey Q28b: % of staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work	65.9%	71.5%	↑	N/A	N/A
9.	The staff engagement score for Disabled staff, compared to non-disabled staff	6.3	6.6	↑	7.1	↓
10.	% difference between the organisation's Board voting membership and its organisation's overall workforce with a declared disability	-2%	-2%	→	100%	↓

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Disability Equality and Experience Action Plan 2020/21

Identifying Priority Themes

Based on our experiences of delivering our WDES actions during 2020/2021 as outlined above, and the analysis of our WDES metrics (refer to appendix A below), we recognise that for Disabled staff to thrive in the workplace, an improved understanding of their needs is required. In addition, we appreciate that improved resource, dedicated time and increased visibility of this community will be critical to success in working towards workplace equality and a better experience of working at St George's.

Though our Disabled staff are recognised as a community that empowers and enriches our workforce, they often feel overlooked and misunderstood. Maintaining a dialogue with our Disabled staff, responding appropriately and taking action, will ensure that progress is meaningful and these staff members feel valued.

In order to better understand and tackle the workplace inequalities experience by our Disabled staff, we must work with key stakeholders to examine policies, training and provisions that affect them.

Enhanced by an Organisational Diversity & Inclusion Action Plan

We must also recognise the wider context of Equality, Diversity and Inclusion across the organisation and how improvements can be made for all staff with protected characteristics. To enable this, a Diversity and Inclusion Action Plan has been developed following discussions at Executive Management and Trust Management Group meetings, and in response to issues raised by staff, Diversity & Inclusion steering group meetings and on an individual basis to the CEO. This action plan is a 'living document' that will be further developed and refined to reflect and integrate what we learn about the impact of our interventions, and through additional input from stakeholders around the Trust. It is intended that this Diversity & Inclusion Action Plan will incorporate the Staff Networks' own individual action plans as well as the actions identified in this paper and outlined below.

4 Key Areas of Focus

As progress has been limited, the four areas of focus remain as outlined in our 2019/20 WDES Report;

1. A rigorous approach to exploring and providing guidance to managers through training and additional resources
2. Review core line management processes and documents that affect Disabled Staff
3. Increase forms of engagement and declaration rates amongst Disabled Staff
4. Raise awareness amongst staff and build on the understanding of disability and how this impacts staff affected by or living with a disability

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WDES Action Plan - 2020/21 Update

Links to	Deliverable	Action/s	Timescale	Lead/s	2021 Update
N/A	Improved understanding and awareness of the types of disabilities and how these impact members of staff across the organisation	1. Work with OH & H&W to develop a series of posters and hand-outs to raise awareness of common disabilities and what staff and managers can do to support their colleagues in the workplace 2. Work with the staff network to identity and promote a series of staff stories to further the learning of non-Disabled staff and help raise awareness of disabilities in the workplace.	Feb 2021	D&I Lead	• Introduced the Wellness Action Plan and REACT Training. This includes guidance to line managers on conducting annual wellness conversations with every member of staff. • Due to vacancies within the network this action has not been delivered in full. Staff stories and experiences have been shared within our network meetings as well as on a 121 basis with our D&I Lead.
Metric 1	Increase staff declaration rates	3. Encourage staff to validate their ESR 4. Work with Staff Engagement Lead to promote importance of declaration as part of the staff survey 5. Work with Recruitment to review on-boarding information/process regarding disability and declaration	March 2021	SE Lead & D&I Lead	• Guidance on validating ESR has been created and issued to staff across the organisation. • The LIA role has been replaced with a Staff Engagement Lead. Our new Staff Engagement Lead started in September 2021 and will be including this message in our upcoming Staff Survey communications strategy. • We have seen an increase in declaration rates which may be due to the Introduction and focus on our Culture Change programme which has been designed to help create an environment that values diversity and promotes inclusion.
Metric 4	Reduced number of Disabled staff experiencing harassment, bullying or abuse from managers and colleagues.	6. Mandatory online disability awareness training including neuro-diversity and ableism to be rolled out for all staff. 7. Disability Awareness Section on the Intranet – signposting for staff as well as guidance and support for managers	May 2021	HoCT & D&I Lead	• New Diversity and Inclusion Intranet hub went live in February 2021, this includes information on Disability and our Disability Staff Network. • See update on page 12 - due to significant upgrades 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

Metric 4	Increase the numbers of Disabled staff reporting incidents of harassment, bullying or abuse at work	8. Work with F2SU Guardian to develop a targeted approach and support mechanism for Disabled Staff 9. Mandatory line manager training sessions on reporting abuse relating to protected characteristics	May 2021	HoCT & D&I Lead	• In line with National Guidance our F2SU policy has been revised and will be launched in October 2021. In addition, our F2SU Guardian attends our bi-monthly staff network meetings to ensure staff are aware of the service and to hear of our concerns being raised by members. • See update on page 12 - due to significant upgrades 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
Metric 8	Improve staff satisfaction with the level of reasonable adjustment(s) implemented to support them to carry out their work	10. Finalise and roll out Reasonable Adjustments guidance and mandatory e-learning resource	Jan 2021	HoCT	• See update on page 12 - due to significant upgrades 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

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APPENDIX A: WDES Metrics Report

Detailed below is the organisation's WDES data which was submitted on 31st August 2021, covering data available in March 2021. (Please note, Staff banding and role is categorised into 4 'clusters' as outlined in the table below)

Metric 1: % of staff in AfC pay bands, medical subgroups and VSM (incl. executive board members) compared with the % of staff in the overall workforce

Non-clinical workforce

	Disabled staff in 2020	Disabled staff in 2021	Disabled staff in 2020/2021	Non-disabled staff in 2020	Non-disabled staff in 2021	Non-disabled staff in 2020/21	Unknown/ null staff in 2020	Unknown/ null staff in 2021	Unknown/ null staff in 2020/21	Total staff in 2020	Total staff in 2021
	(%)	(%)	(+/-)	(%)	(%)	(+/-)	(%)	(%)	(+/-)	Headcount	Headcount
Cluster 1 (B1 - 4)	4.1%	4.2%	+0.05	85.6%	84.6%	-1.04	10.3%	11.3%	+0.99	1349	1373
Cluster 2 (B5 - 7)	2.6%	2.8%	+0.18	90.4%	88.3%	-2.11	7%	8.9%	+1.93	470	504
Cluster 3 (B8a - 8b)	1.4%	1.2%	-0.19	85.5%	78.2%	-7.32	13.1%	20.6%	+7.51	145	165
Cluster 4 (B 8c – VSM)	0%	0%	0.0	94.7%	95.7%	+0.95	5.3%	4.3%	-0.95	94	92

(Data source: ESR)

Disabled staff in non-clinical roles

- There has been very little change in the numbers of Disabled staff across all clusters (less than 0.5 percentage points +/-)
- There is still 0 members of non-clinical staff in cluster 4 with a declared disability
- For non-Disabled staff, we see a reduction of -2.11 percentage points in Cluster 2 and -7.32 percentage points in Cluster 3 from 2020 to 2021.

Declaring disability

- The number of staff that did not declare a disability ('unknown') has increased in all clusters except cluster 4 where it has decreased (-0.95 percentage points).
- Most notably, in cluster 3, there is an increase of +7.51 percentage points. This may indicate a decrease in confidence amongst staff from in the Trust's ability to understand and support them to carry out their jobs.

Clinical workforce

	Disabled staff in 2020	Disabled staff in 2021	Disabled staff in 2020/2021	Non-disabled staff in 2020	Non-disabled staff in 2021	Non-disabled staff in 2020/2021	Unknown/ null staff in 2020	Unknown/ null staff in 2021	Unknown/ null staff in 2020/2021	Total staff in 2020	Total staff in 2021
	(%)	(%)	(+/-)	(%)	(%)	(+/-)	(%)	(%)	(+/-)	Headcount	Headcount
Cluster 1 (1 - 4)	2.05%	2.3%	+0.28	91.63%	91.6%	-0.03	6.32%	6.1%	-0.25	1266	1286
Cluster 2 (B5 - 7)	1.96%	2.4%	+0.45	92.06%	92.4%	+0.36	5.97%	5.2%	-0.8	3767	3814
Cluster 3 (B8a - 8b)	0.5%	0.7%	+0.24	91.18%	90.9%	-0.25	8.31%	8.3%	+0.02	397	408
Cluster 4 (B8c – VSM)	4.26%	4.1%	-0.18	91.49%	93.9%	+2.39	4.26%	2%	-2.22	47	49
Cluster 5 (Consultants)	0.31%	0.3%	0	73.83%	75.2%	+1.4	25.86%	24.5%	-1.4	642	650
Cluster 6 (Non-consultant career grade)	0%	0%	0	67.86%	72%	+4.14	32.14%	28%	-4.14	28	25
Cluster 7 (Med, Dental & trainee grades)	0.83%	0.9%	0.06	94.6%	92.1%	-2.47	4.5%	7%	+2.48	722	788

(Data source: ESR)

Disabled staff in clinical roles

- The number of Disabled people working in clinical roles has increased in clusters 1, 2 and 3. It has decreased in cluster 4.
- There has been no change within the consultant workforce (cluster 5) which is still at 0.3% of the workforce.
- Cluster 6 remains at 0% for the third year running. Non-disabled staff in this cluster has increased by +4.14 percentage points.
- In comparison, the number of non- Disabled staff has increased across 4 of the 7 clusters.
- The data strongly demonstrates that addressing employment inequalities in clinical work at the Trust must form part of the wider plan for equal access to opportunities for Disabled staff.

Declaring disability

- There is a reduction in the number of 'unknown' in 5 of the 7 clusters.
- There is an increase of +2.48 percentage points in 'unknown' for cluster 7 (Medical and Dental Training Grades)

Metric 2: Relative likelihood of Disabled staff compared to non-disabled staff being appointed from shortlisting across all posts

	Relative likelihood in 2020	Relative likelihood in 2021	Relative likelihood difference (+-)
Relative likelihood of non-disabled staff being appointed from shortlisting compared to Disabled staff	1.09	1.08	-0.01

(Data source: Trust's recruitment data)

- A small reduction (-0.01 percentage points) compared to the previous year however Non-Disabled staff are still more likely (than Disabled staff) to be appointed from shortlisting.

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Metric 3: Relative likelihood of Disabled staff compared to non-Disabled staff entering the formal capability process, as measured by entry into the formal capability procedure

	Relative likelihood in 2020	Relative likelihood in 2021	Relative likelihood difference (+-)
Relative likelihood of Disabled staff entering formal capability process compared to non-disabled staff	0	0	0

(Data source: Trust's HR data)

- Disabled staff have not entered the formal capability process at the Trust since 2018. There are a number of possible reasons for this, including:
  - Disabled staff being more than capable of performing their role and delivering to a high standard
  - Disabled staff being appropriately supported by their managers so that they are effectively able to carry out their job roles
  - A very low proportion (2%) of self-declared Disabled staff compared to non-Disabled (90%) and 'unknown' staff (8%)

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Metric 4: Percentage of Disabled staff compared to non-Disabled staff experiencing harassment, bullying or abuse (HBA).

	Disabled staff responses to 2019 NHS Staff Survey	Non-disabled staff responses to 2019 NHS Staff Survey	Difference between Disabled staff and non-disabled staff responses 2019	Disabled staff responses to 2020 NHS Staff Survey	Non-disabled staff responses to 2020 NHS Staff Survey	Difference between Disabled staff and non-disabled staff responses 2020
	(%)	(%)	(+/-)	(%)	(%)	(+/-)
4a. Staff experiencing harassment, bullying or abuse from patients/ service users	38.4%	29.6%	+8.8	35.8%	28.4%	+7.4
4b. Staff experiencing harassment, bullying or abuse from managers	28.3%	15.4%	+12.9	23.5%	13.1%	+10.4
4c. Staff experiencing harassment, bullying or abuse from other colleagues	33.5%	21.6%	+11.9	34.4%	20.9%	+13.5
4d. Staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	47.1%	45.2%	-1.9	49.2%	47.7%	+1.5

(Data source: Question 13, NHS Staff Survey

- The gap between the experience of Disabled and non-disabled staff has reduced in indicators 4a, 4b and 4d, compared to 2019.
- Compared to 2019, HBA, towards disabled staff, from;
    - Patients/service users (4a) is down -2.6 percentage points
    - Managers (4b) is down -4.8 percentage points
    - Colleagues (4c) is up +0.9 percentage points
- Disabled staff reported high rates of HBA from other colleagues, compared to 2019. In contrast non-disabled staff reported lower rates compared to 2019.
- The number of Disabled staff who felt able to report harassment, bulling or abuse has increased from the second year.
- Reporting rates at St George's, for both disabled and non-disabled staff, are higher than the average nationally

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Metrics 5 to 8

	Disabled staff responses to 2019 NHS Staff Survey	Non-Disabled staff responses to 2019 NHS Staff Survey	Difference between Disabled staff and non-disabled staff responses 2019	Disabled staff responses to 2020 NHS Staff Survey	Non-Disabled staff responses to 2020 NHS Staff Survey	Difference between Disabled staff and non-disabled staff responses 2020
	(%)	(%)	(% Points)	(%)	(%)	(% Points)
Metric 5 - Percentage of staff believing that the trust provides equal opportunities for career progression or promotion.	64.6%	75.3%	-10.7	66.8%	75.2%	-8.4
Metric 6 - Percentage of saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	34.0%	25.3%	-8.7	35.1%	25.8%	-9.3
Metric 7 - Percentage of staff saying that they are satisfied with the extent to which their organisation values their work.	32%	46.9%	-14.9	34.9%	49.1%	-14.2
Metric 8 - Percentage of staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.	65.9%	N/A	N/A	71.5%	N/A	N/A

(Data source: Questions 14, 11, 5, 28b, NHS Staff Survey)

Beliefs about equal opportunities, career progression and promotion

- Disabled staff felt notably less confident about the Trust providing equal opportunities with regards to carer progression and promotion.
- The percentage of Disabled staff believing that the Trust provides them with equal opportunities has increased by 2.2 percentage points, compared to 2019.
- The gap between the experience of Disabled and Non-Disabled staff has reduced by 2.3 percentage points.

Feeling pressure to go to work when unwell

- A higher number of Disabled staff compared to non-Disabled staff reported feeling pressure to come into work despite not feeling able to carry out their duties. This was reported in years 2018, 2019 and 2020.

- The gap between both groups has increased for the second year, with a difference of 9.3 percentage points.
- Both groups report feeling slightly *more pressured* compared to 2019.

Feeling that work is undervalued

- Disabled staff at the Trust are much less likely to feel that their work is valued by the organisation. In 2020, 34.9% of Disabled staff who responded to the Staff Survey said they felt the organisations valued their work - compares to 49.1% of Non-Disabled staff.

Adjustments in the workplace

- Only 71.5% of Disabled employees felt that adequate adjustments had been made in their work place. This is an increase of 5.6 percentage points compared to 2019.

Metric 9: Disabled staff engagement

	Disabled staff engagement score for 2019 NHS Staff Survey	Non-Disabled staff engagement score for 2019 NHS Staff Survey	Difference between Disabled and non-Disabled staff engagement 2019	Disabled staff engagement score for 2020 NHS Staff Survey	Non-Disabled staff engagement score for 2020 NHS Staff Survey	Difference between Disabled and non-Disabled staff engagement 2020
Staff engagement score for Disabled, compared to non-Disabled staff.	6.3	7	-0.7	6.6	7.1	-0.5

(Data source: NHS Staff Survey)

- Staff engagement is higher for non-Disabled staff compared to Disabled staff.
- Staff engagement has increase for both groups compared to 2019.

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Metric 10: Percentage difference between the organisation's board voting membership and its organisation's overall workforce

(Data source: NHS ESR and/or trust's local data

	Disabled Board members in 2020	Non-Disabled Board members in 2020	Board members with disability status unknown in 2020	Difference between Disabled Board members and Disabled staff in overall workforce	Disabled Board members in 2021	Non-Disabled Board members in 2021	Board members with disability status unknown in 2021	Difference Between Disabled and non-Disabled Board members in 2021
% difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated by Exec/non-exec and Voting/non-voting.	(%)	(%)	(%)	(+/-)	(%)	(%)		(+/-)
	Exec = 0 Non-exec = 0 Voting = 0 Non-voting = 0	Exec = 100 Non-exec = 100 Voting = 100 Non-voting = 100	Exec = 0 Non-exec = 0 Voting = 0 Non-voting = 0	Total Board = 0 Overall workforce = 181 Difference = -2%	Exec = 0 Non-exec = 0 Voting = 0 Non-voting = 0	Exec = 100 Non-exec = 100 Voting = 100 Non-voting = 100	Exec = 0 Non-exec = 0 Voting = 0 Non-voting = 0	Total Board = 0 Overall workforce = 209 Difference = -2%

- 2% of the Trust's workforce have declared themselves as having a disability. In contrast, at board level is this 0%. Highlighting an underrepresentation at board level.

APPENDIX B: Project Search

Project SEARCH is an international trademarked and copyrighted programme model, which requires a licensing agreement with their national office based at Cincinnati Children's Hospital Medical Centre. DFN Project Search holds the licence for Europe and the UK.

The model is a supported internship for local young adults with a learning disability and / or autism. It is a collaboration between a host business (St Georges University Hospitals NHS Foundation Trust), an education provider (Cricket Green School in Mitcham), a supported employment provider (Kaleidoscope) and the intern's family. On-site support is provided by the tutors and job coaches and funding for these posts is provided by the intern's home Local Authority and Access to Work funding. Interns must have an existing Education Health and Care Plan in order for funding to be agreed. Project Search at St Georges has been running for 8 years, in which we have achieved some fantastic employment outcomes both within the hospital and externally.

Our aim is to develop the young people's employability skills through total immersion in the workplace: the internships run from September to August with interns attending the Trust every day, Monday to Friday, for a mix of classroom based teaching and work experience placements across the trust. As the year progresses the interns spend less time in the classroom and more in the departments hosting the work experience placement (hours in the final term are from 9.30am to 3.30pm).

The interns undertake real work, rather than shadowing and they learn these work skills from staff and managers hosting a placement. These staff are called Project SEARCH mentors and they take on this role on a voluntary basis. Mentors and managers receive practical advice and support from the job coach and tutors. Any 'reasonable adjustments' needed to enable the interns to do the work are developed with the placement mentor/s manager and Project SEARCH job coach and tutors. Systematic instruction is one of the methods used to teach work skills. Placement staff have access to group training sessions and the team deliver training in departments too.

We aim to place interns in 3 different departments over the year, 1 placement per academic term. However, some interns may stay in one department for the whole year if it is obvious they have found their career niche. Increasingly interns may have 2 concurrent placements where a department is unable to accommodate an intern 'full time'.

Together with St Georges, we have developed an employability skills rubric with a grant from the South West London Academic Health and Social Care System. We routinely use this to assess the employability skills of each intern at the start of their year and at the end of each placement. Progress reports are shared with placement mentors and managers and managers are invited to discuss these at the mentor's performance appraisal. The interns and their next of kind also receive the reports and end of year employability skills profiles are given to each intern to assist with the job applications.

Success is achieved when the interns secure paid employment of at least 16 hours a week. This international measure of success is not always relevant or achievable for each of our interns, however we deem it to be as much of a success when an intern secures the hours of employment they are looking for, or voluntary work where they prefer, or another form of personal and professional development programme.

Since 2012 our interns have achieved 75% employment compared to the national average of 7%. We have had a total 14 interns secure employment across many different departments within St Georges Hospital.

Three interns have secured full time employment with Theatre Porters, two interns in Catering and one intern in each of the following: General

Porters, Sterile Services, Outpatients, Medical Records, Student Union Shop, Marks and Spencer's. One intern secured an apprenticeship with the St Georges Advanced Patient Simulation Centre (GAPS).

We have also had interns secure paid employment, by gaining valuable work experience through completing Project Search at St Georges, with external companies such as Next, Pret, Starbucks, and local nurseries, leisure centres and theatres.

Project SEARCH @ St Georges has been assessed by an external inspector twice and at our last assessment in 2017 our 'quality of provision' was rated as *'outstanding'*.

Over the years the interns at Project Search have received so much support from various departments in St Georges providing placements within; Pharmacy Pre Pack, Medical Staffing, HR-Recruitment, the Education Centre: Haematology Services, Atkinson Morley Reception, the Playroom, the University Library, Macmillan Cancer Support Services and Gardening. The Project Search Team are incredibly grateful for so many departments being involved in our programme and mentoring our interns through their rotations.

APPENDIX C: Additional Information on the Definition of Disability

The meaning of disability

In order to avoid discrimination, it is recommended that instead of trying to make a judgement as to whether a person falls within the statutory definition of disability, we focus on meeting the needs of each worker and job applicant.

When is a person Disabled?

A person has a disability if he/she/they have a physical or mental impairment, which has a substantial and long-term adverse effect on his/her ability to carry out normal day-to-day activities.

What about people who have recovered from a disability?

In most circumstances, people who have had a disability within the definition in the past are protected from discrimination even if they have since recovered.

What does 'impairment' cover?

It covers physical or mental impairments; this includes sensory impairments, such as those affecting sight or hearing.

Are all mental impairments covered?

The term 'mental impairment' is intended to cover a wide range of impairments relating to mental functioning, including what are often known as learning disabilities. Hidden impairments such as mental illness, mental health conditions, diabetes and epilepsy may count as disabilities where they meet the definition in the Act.

What is a 'substantial' adverse effect?

A substantial adverse effect is something which is more than a minor or trivial effect. The requirement that an effect must be substantial reflects the general understanding of disability as a limitation going beyond the normal differences in ability which might exist among people.

Account should also be taken of where a person avoids doing things which, for example, cause pain, fatigue or substantial social embarrassment; or because of a loss of energy and motivation. An impairment may not directly prevent someone from carrying out one or more normal day-today activities, but it may still have a substantial adverse long-term effect on how they carry out

those activities. For example, where an impairment causes pain or fatigue in performing normal day-to-day activities, the person may have the capacity to do something but suffer pain in doing so; or the impairment might make the activity more than usually fatiguing so that the person might not be able to repeat the task over a sustained period of time.

What is a 'long-term' effect?

A long-term effect of an impairment is one: (i) which has lasted at least 12 months, or (ii) where the total period for which it lasts is likely to be at least 12 months, or (iii) which is likely to last for the rest of the life of the person affected.

Effects which are not long-term would therefore include loss of mobility due to a broken limb which is likely to heal within 12 months, and the effects of temporary infections, from which a person would be likely to recover within 12 months.

What if a person has no medical diagnosis?

There is no need for a person to establish a medically diagnosed cause for their impairment. What it is important to consider is the effect of the impairment, not the cause.

What if the effects come and go over a period of time?

If an impairment has had a substantial adverse effect on normal day-to-day activities but that effect ceases, the substantial effect is treated as continuing if it is likely to recur; that is if it is more probable than not that the effect will recur.

What are 'normal day-to-day activities'?

They are activities which are carried out by most people on a fairly regular and frequent basis. The term is not intended to include activities which are normal only for a particular person or group of people, such as playing a musical instrument or a sport to a professional standard or performing a skilled or specialised task at work. However, someone who is affected in such a specialised way but is also affected in normal day-to-day activities would be covered by this part of the definition. Day-to-day activities thus include – but are not limited to – activities such as walking, driving, using public transport, cooking, eating, lifting and carrying everyday objects, typing, writing (and taking exams), going to the toilet, talking, listening to conversations or music, reading, taking part in normal social interaction or forming social relationships, nourishing and caring for one's self. Normal day-to-day activities also encompass the activities which are relevant to working life.

What about treatment?

Someone with an impairment may be receiving medical or other treatment which alleviates or removes the effects (though not the impairment). In such cases, the treatment is ignored and the impairment is taken to have the effect it would have had without such treatment. This does not apply if substantial adverse effects are not likely to recur even if the treatment stops (i.e. the impairment has been cured).

Members of staff requiring treatment for an impairment must be allowed time off work to attend. This must be recorded as disability related absence and not counted as sickness absence. For more information, see absence management policy.

Does this include people who wear spectacles?

No. The sole exception to the rule about ignoring the effects of treatment is the wearing of spectacles or contact lenses. In this case, the effect while the person is wearing spectacles or contact lenses should be considered.

Are people who have disfigurements covered?

People with severe disfigurements are covered by the Act and are automatically treated as this having a substantial adverse effect on their ability to carry out normal day-to-day activities. However, they do need to meet the long-term requirement.

Are there any other people who are automatically treated as Disabled under the Act?

Anyone who has HIV infection, cancer or Multiple Sclerosis is automatically treated as Disabled under the Act. In addition, people who are registered as blind or partially sighted, or who are certified as being blind or partially sighted by a consultant ophthalmologist, are automatically treated under the Act as being Disabled. People who are not registered or certified as blind or partially sighted will be covered by the Act if they can establish that they meet the Act's definition of disability.

What about people who know their condition is going to get worse over time?

Progressive conditions are conditions which are likely to change and develop over time. Where a person has a progressive condition he/she/they will be covered by the Act from the moment the condition leads to an impairment which has some effect on ability to carry out normal day-to-day activities, even though not a substantial effect, if that

impairment is likely eventually to have a substantial adverse effect on such ability in the future. This applies provided that the effect meets the long-term requirement of the definition.

Are people with genetic conditions covered?

If a genetic condition has no effect on ability to carry out normal day-to-day activities, the person is not covered. Diagnosis does not in itself bring someone within the definition. If the condition is progressive, then the rule about progressive conditions applies.

Are any conditions specifically excluded from the coverage of the Act?

Yes. Certain conditions are to be regarded as not amounting to impairments for the purposes of the Act. These are:

- addiction to or dependency on alcohol, nicotine, or any other substance (other than as a result of the substance being medically prescribed)
- seasonal allergic rhinitis (e.g. hay fever), except where it aggravates the effect of another condition
- tendency to set fires
- tendency to steal
- tendency to physical or sexual abuse of other persons
- exhibitionism
- voyeurism.

Also, disfigurements which consist of a tattoo (which has not been removed), non-medical body piercing, or something attached through such piercing, are to be treated as not having a substantial adverse effect on the person's ability to carry out normal day-to-day activities (from The Equality Act 2010, Employment statutory code of practice).

This information is not definitive. Further guidance on matters to be taken into account in determining questions relating to the definition of disability is also available from the Office for Disability Issues.

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NHS
St George's University Hospitals
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	25 November 2021	**Agenda No**	**3.1.2**
Report Title:	**Freedom to Speak Up Report: Q2 2021/22**		
Lead Director/ Manager:	Stephen Jones, Chief Corporate Affairs Officer & Executive Lead for Freedom to Speak Up		
Report Authors:	Karyn Richards-Wright, Freedom to Speak Up Guardian		
Presented for:	Assurance		
Executive Summary:	This report provides an update from the Freedom to Speak Up Guardian on raising concerns cases received during Q2 2021/22. It sets out current activity and themes emerging and areas in which concerns are being raised. Although a small proportion of the total cases, the report provides an update on current formal investigations / reviews, all of which relate to 2020/21 cases. The report also provides an update on progress in implementing our FTSU strategy.		
Recommendation:	Trust Board is asked to: • Note the number of concerns raised with the FTSU Guardian in Quarter 2 2021/22 and the themes which emerge from this; • Note the appointment and training of 19 new FTSU Champions across the Trust, the first cohort of the new Champions to be recruited. • Note the progress in implementing the Trust's FTSU strategy.		
Supports			
Trust Strategic Objective:	Champion Team St George's		
CQC Theme:	Well Led		
NHS Oversight Framework Theme:	Leadership and Improvement Capability (Well Led)		
Implications			
Risk:	Failure to comply with the requirements around Freedom to Speak Up, a regulatory requirement, risks undermining staff confidence in the leadership of the Trust and would be a reputational risk to the organisation.		
Legal/Regulatory:	NHSI, Freedom to Speak Up: Raising Concerns (Whistleblowing) Policy for the NHS, April 2016. Sir Robert Francis QC, Freedom to Speak Up: An independent report into creating an open and honest reporting culture in the NHS, 2015.		
Resources:	As set out in the report.		
Equality and Diversity:	As set out in the report.		
Previously Considered by:	People Management Group Risk and Assurance Group Workforce and Education Committee	**Date**	3 November 2021 3 November 2021 11 November 2021
Appendices:	N/A		

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NHS
St George's University Hospitals
NHS Foundation Trust

Freedom to Speak Up

Freedom to Speak Up Report Q2 2021/2022

Report author:
Karyn Richards-Wright
Freedom to Speak Up Guardian

Executive Lead:
Stephen Jones
Chief Corporate Affairs Officer

24 November 2021

1. Executive Summary

Purpose

This reports provides an update from the Freedom to Speak Up Guardian on raising concerns cases received during Q2 2021/22. It sets out current activity and themes emerging and areas in which concerns are being raised. Although a small proportion of the total cases, the report provides an update on current formal investigations / reviews.

The report also provides an update on the implementation of the Trust's Freedom to Speak Up Vision and Strategy, which was approved by the Trust Board at its meeting on 24 September 2020.

Background

The Trust Board approved the Trust's new Freedom to Speak Up Vision and Strategy at its meeting on 24 September 2020.

As part of this, a new approach to reporting through the Workforce and Education Committee (WEC) and Board was agreed; quarterly reports on Freedom to Speak Up are now presented to the WEC and to the Board. The Board received the Q1 2021/22 Freedom to Speak Up report at its meeting in July 2021.

As part of its response to the 2020 NHS Staff Survey, the Trust has launched its Big 5, which focuses on the key themes and feedback provided by staff in their responses to the survey. In June, the focus of the Big 5 was on raising concerns. In October 2021, the Trust marked national FTSU month with a number of activities and events and used the occasion to introduce our new cohort of 19 new FTSU Champions to the organisation.

Key themes in Q2 2021/22

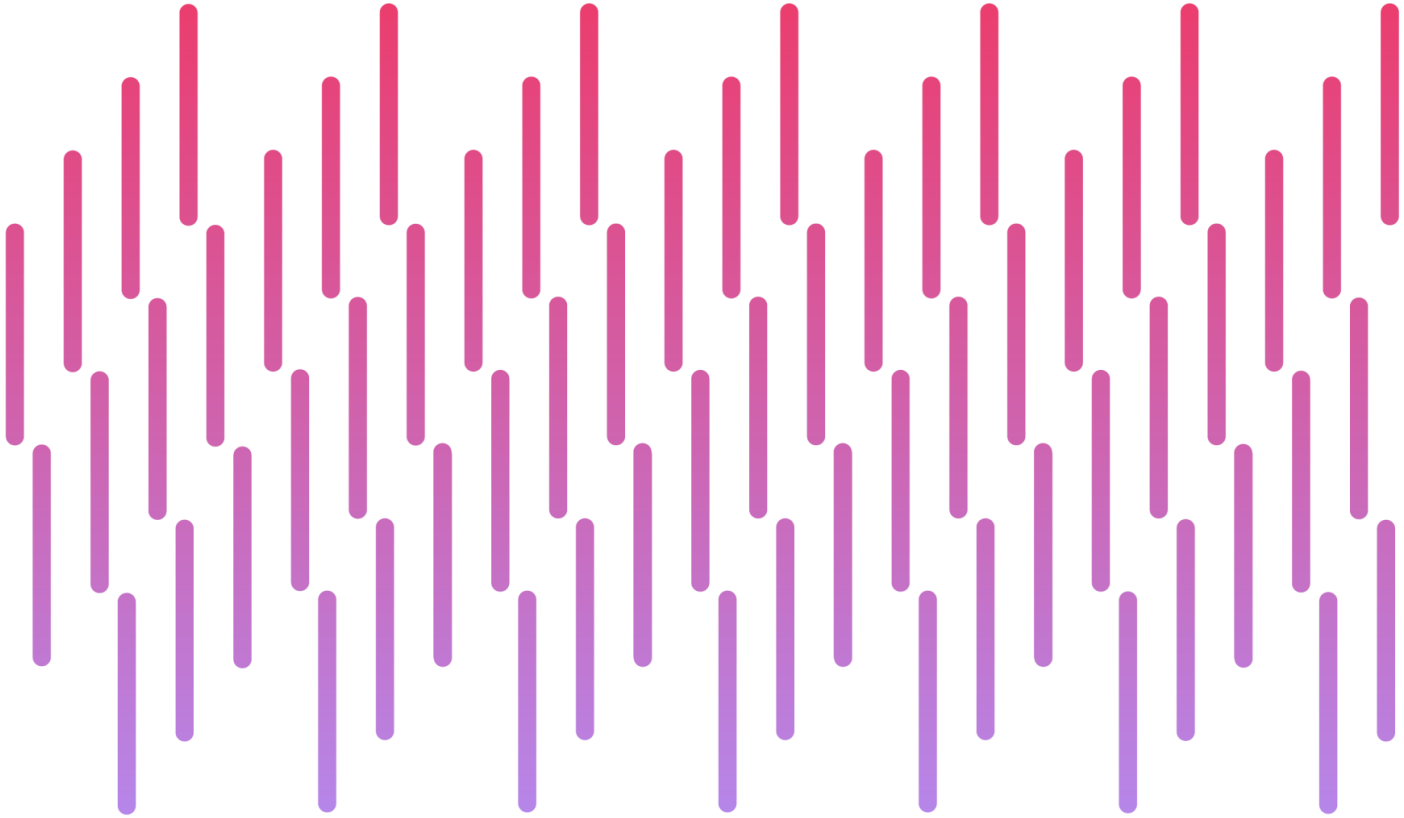
- A total of 31 concerns have been raised with the Trust's Freedom to Speak Up Guardian in Q2 2021/22, and a total of 48 concerns in the year-to-date.
- In Q2 2021/22, administrative and clerical staff were the staff group which had raised the most concerns. In Q1, nursing staff had raised the highest number of concerns.
- The vast majority of concerns related to concerns about leadership and team functioning, bullying and harassment, and concerns about Trust processes. Leadership and team functioning concerns related in particular to issues around staff not feeling supported by managers, feeling that managers are not present for advice and / or assistance, and that support after returning to work from sickness is an issue. 2% of the concerns raised had a patient safety dimension to them.
- Of the 31 of concerns raised to the Guardian in Q2 2021/22, all except one have been resolved informally. Two appreciative inquiries were launched as a result of concerns raised to the FTSU Guardian in 2020/21 and these are ongoing and are being managed separately from the FTSU process.

Recommendation

The Workforce and Education Committee is asked to:

- Note the number of concerns raised with the FTSU Guardian in Quarter 2 2021/22 and the themes which emerge from this;
- Note the appointment and training of 19 new FTSU Champions across the Trust, the first cohort of the new Champions to be recruited.
- Note the update on the progress in the implementation of the Trust's FTSU strategy.

2. Current Freedom to Speak Up activity and themes



Freedom to Speak Up

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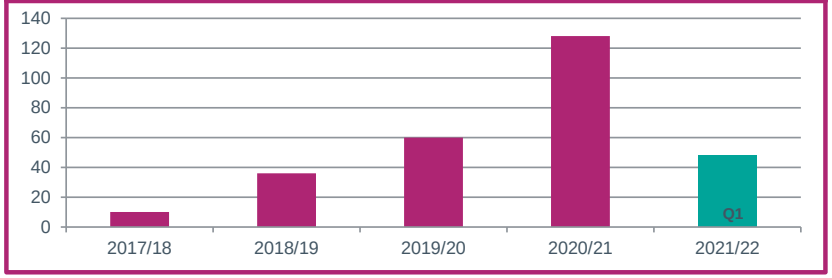
2. Current activity and themes

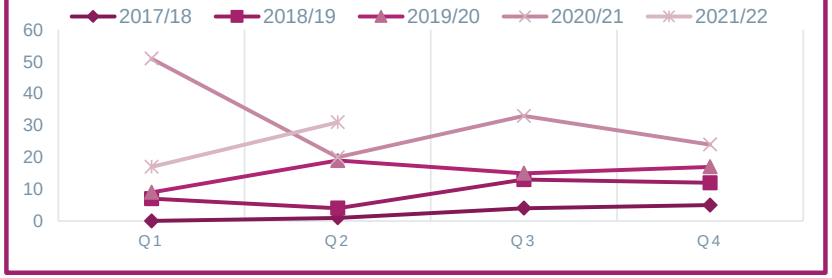
Number of concerns raised with FTSU Guardian 2021/22

Quarter (2021/22)	Number of concerns raised with the FTSU Guardian
Q1	17
Q2	31
Q3	-
Q4	-
Year-to-date	48

Total number of concerns raised to the FTSU Guardian 2017/18 – Present



Total number of concerns raised to the FTSU Guardian 2017/18 – Present: Quarter by Quarter comparison



- A total of 31 concerns have been raised with the Trust's Freedom to Speak Up Guardian in Q2 2021/22. This brings the total number of concerns raised with the Guardian to 48 in the year-to-date.
- The number of concerns raised in Q2 2021/22 represents the highest number of concerns raised in the corresponding period over the previous four years, and 50% higher than the number of concerns raised in Q2 last year. The current year has also seen the second highest number of concerns raised with the Guardian at this point in the year (the highest being 2020/21). It should, however, be noted that one concern raised comprises of a collective concern from 7 staff members.

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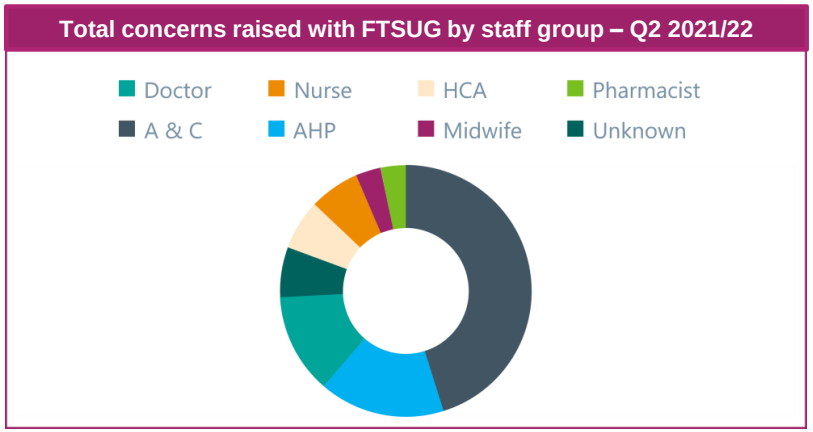
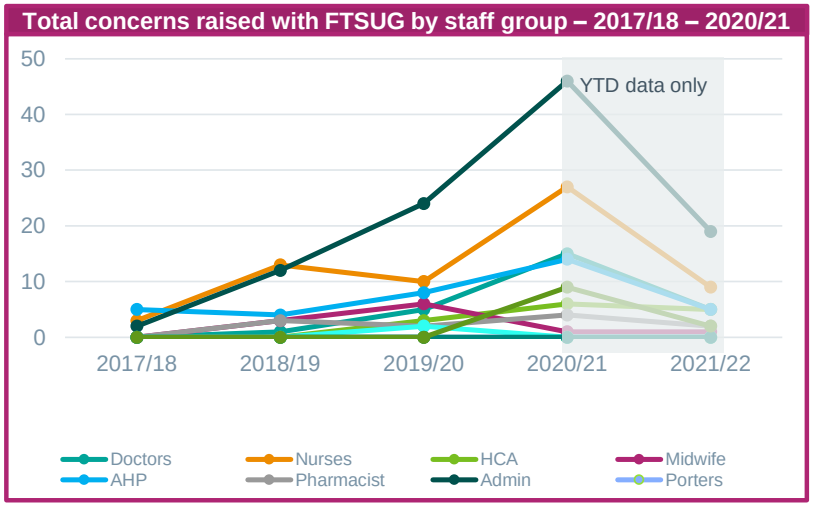
2. Current activity and themes
Concerns raised by staff groups





- A & C staff are the staff group raising the most concerns in Q2 2021/22 with 14 concerns coming from A & C staff. In the same quarter 2020/2021 A & C staff raised 12 concerns out of the 20 concerns raised in Q1 2020/21.
- The themes coming from A & C staff are conflict with colleagues, conflict with managers, concerns regarding the application of a process.
- It is to be noted however that 7 of the concerns fall within a collective concern from staff within the same area. This related to concerns relating to career progression, conflict with a new manager within the area and resources. The team are currently working with their manager informally on how these concerns will be addressed following advice from the Guardian and discussions with management and HR.
- From the 31 concerns raised in Q2, 2 of the staff members declared to the Guardian that they had a declared hidden disability and they were of the view that the lack of understanding from their manager in relation to their disability and how to best support them within their role was impacting on the psychological safety. The Guardian will be working with our D & I Lead on this arising theme and how best as an organisation we can ensure that our managers are able to support staff who declare a disability effectively. The Guardian will keep the board updated in this regard.

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2. Current activity and themes

Concerns by Division and themes Q1 2021/22

Concerns by Division 2021/22						
Division	**Q1**	**Q2**	**Q3**	**Q4**	**YTD**	**Themes in concerns**
CWDT (3,265 staff)	3	14			**17**	Bullying and harassment Conflict within teams Conflict with line manager/Leadership
MedCard (2,194 staff)	8	11			**19**	Bullying and harassment Conflict within teams Leadership concerns Process Concerns
SNCT (2,016 staff)	5	4			**9**	Bullying and harassment Leadership
Corporate (inc Estates & Facilities) (1,036 staff)	1	2			**3**	Process Leadership
Total concerns	**17**	**31**			**48**	

- The Division with the most concerns raised in Q2 is CWDT with 14 concerns raised.
- Medcard then have 11 concerns
- SNCT with 4 concerns
- Corporate had 2 concern raised
- It is to be noted that there were **no direct patient safety concerns raised during Q2** .
- The Guardian continues to work closely with line managers, HR and OD to discuss themes and provide support support to divisions moving forward as to how to address some of the issues being raised to ensure that learning from concerns is reflected throughout divisions. The Guardian whilst working with line managers actively encourages managers to support their staff to complete the Speak up, Listen up e-learning module to further enhance our organisational understanding of raising concerns, how to address concerns raised and how to learn from concerns.

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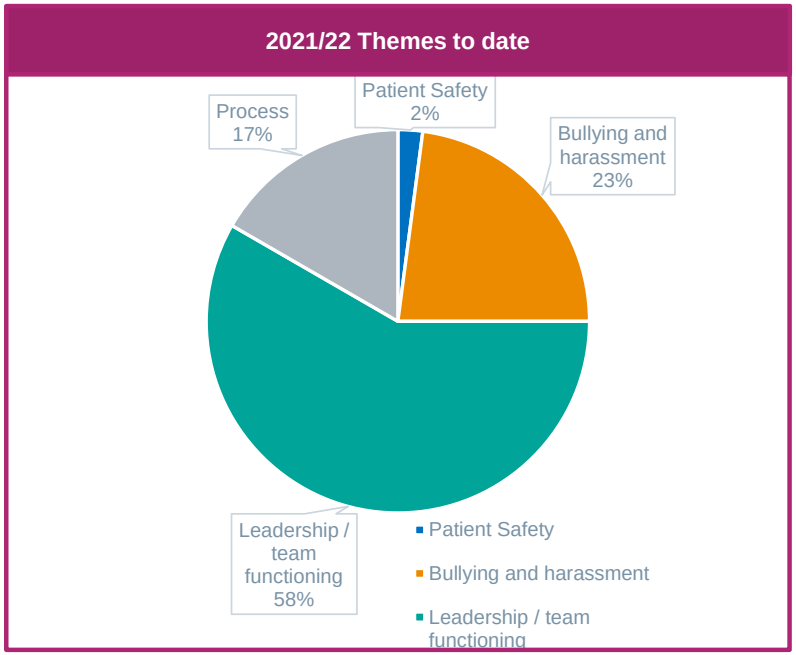
2. Current activity and themes

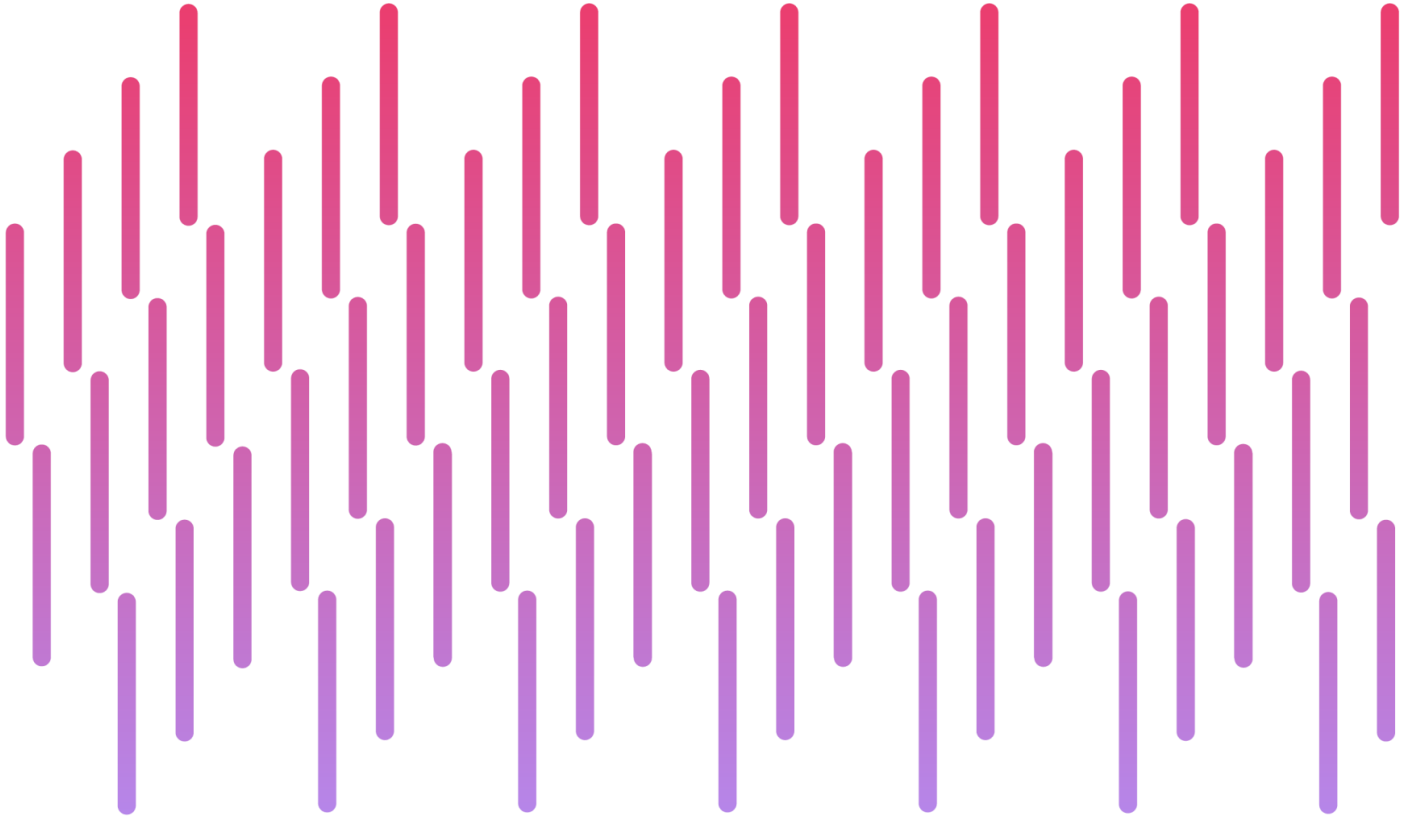
Concerns by Division and themes arising 2020/21 (2 of 2)



** "Other" category includes principally what might be termed pure signposting – where a staff member has sought advice from the FTSU Guardian but which does not fall within these categories*

- **Leadership concerns during Q2 continue as in Q1, to constitute the greatest proportion of concerns. Staff are continuing to report feelings of not being supported by managers, feeling that managers are unsure of correct processes or fail to follow correct processes and that support after returning to work from sickness is an issue.**
  - Bullying and harassment still remains a recurrent theme in concerns being raised to the Guardian across all divisions, both clinical and non-clinical.
  - Broader behavioural and leadership issues are also prevalent – for example, conflict with line managers, conflict within teams.
- The Guardian is working closely with our managers, HR and OD teams to support the organisation in addressing and learning from the themes coming through.

3. Current Freedom to Speak Up investigations / reviews



Freedom to Speak Up

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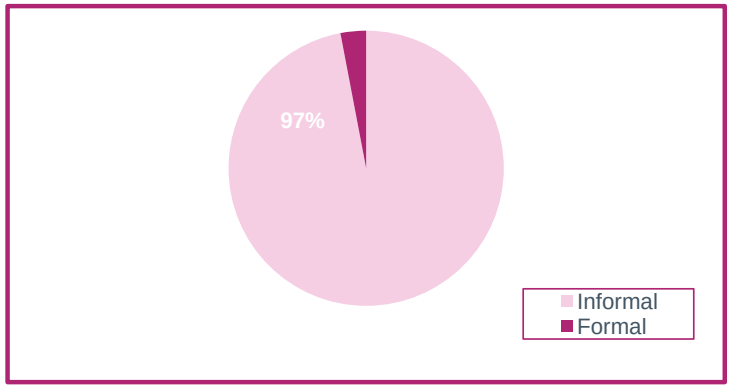
3. Current FTSU investigations / reviews

Current investigations – 2021/22 (1 of 2)



Division	Q 1	Q 2	Q 3	Q 4	YT D	Resolution
CWDT	3	14				11 resolved informally 1 – informal case (7person collective concern) – still ongoing facilitated discussions underway 2 investigations underway
MedCard	8	11				19 resolved informally
SNCT	5	4				9 resolved informally
Corporate (inc. Estates & Facilities)	1	2				3 resolved informally

- **The vast majority of concerns raised with the FTSU Guardian are resolved informally and rapidly; concerns raised with the Guardian that are formally investigated are a very small proportion of the total number of concerns raised.**
  - Out of the 31 concerns raised in Q2, 97 % have been resolved informally.
  - The Guardian is able to resolve the majority of concerns informally and rapidly, typically through signposting to the appropriate route for handling the issue (e.g. a relevant HR process) or through raising with the relevant team to enable prompt action to be taken to address the concern raised.
  - The Guardian works closely with Staff Support and is also a trust mediator so is also able to facilitate resolution of concerns.
- **Timeliness of formal investigations and / or responses remains an issue.**
  - The Guardian and exec lead still have concerns regarding the length of time it takes to commission some investigations and get them underway to keep inside of our own good practise guidelines and are working with the organisation on a case by case basis. We are exploring the feasibility developing a cohort of trained FTSU investigators who are trained in the specifics of how to undertake a FTSU investigation (which is by its nature different from other types of investigation) and the timescales for delivery.
  - Some of the challenges with perceptions of the speed of FTSU cases is linked to work being undertaken in full or in part as a result of FTSU concerns but outside the remit of FTSU itself – e.g. the appreciative enquiries.

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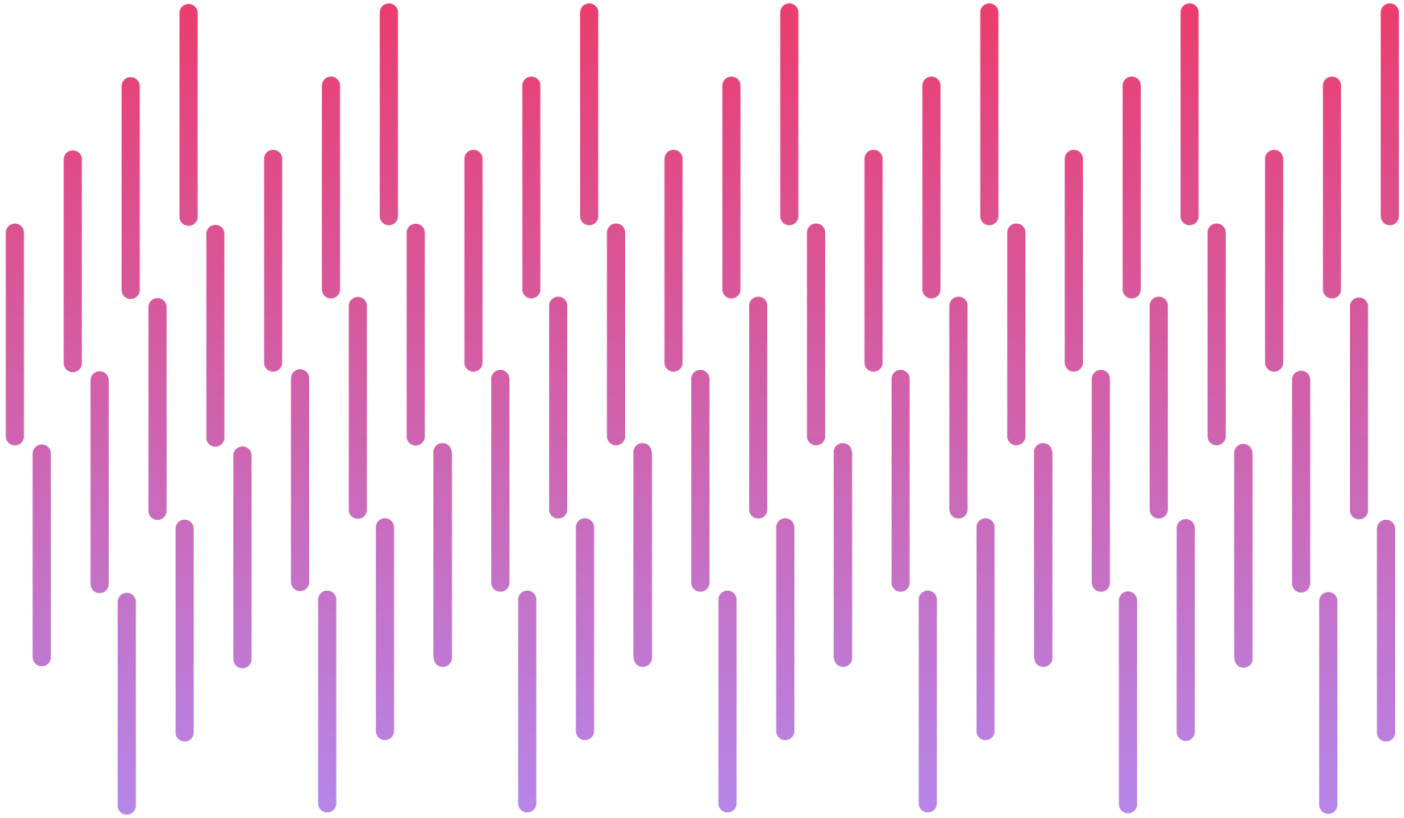
3. Current FTSU investigations / reviews

Current investigations – 2020/21 (2 of 2)

Division	Area	Status
CWDT	Pharmacy	Appreciative enquiry underway (prompted in part by FTSU concerns, but undertaken outside FTSU process)
MedCard	Haematology	Appreciative enquiry underway (prompted in part by FTSU concerns, but undertaken outside FTSU process)
CWDT	Maternity	Investigation underway
CWDT	OBS & Gynae	Investigation underway

- There are currently two formal FTSU investigations underway.
- The table opposite sets out the processes underway following the raising of issues with the FTSU Guardian. The appreciative inquiries were launched as a result of concerns raised to the Guardian, but are being managed separately from the FTSU process.
- Due to the confidentiality of the concerns raised, the table sets out the areas, divisions and the status of the investigations / reviews only.
- Cases are maintained on the FTSU Guardian case management tool. High level summaries of the cases are shared with the Executive Lead for Raising Concerns, the Non-Executive Lead for Raising Concerns and the Chief Executive.
- Investigations / reviews which risk or breach the 12-week timeline set out for the investigation of concerns are escalated to the Executive Lead for Raising Concerns.

4. Freedom to Speak up Month



Freedom to Speak Up

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4. Freedom to Speak up Month Oct 2021

October was National Freedom to Speak up month and the month was used to introduce our 19 new champions to the organisation and further promote the HEE/National Guardian's Office e-learning programme which will soon be available as part of our mandatory training programme following approval.

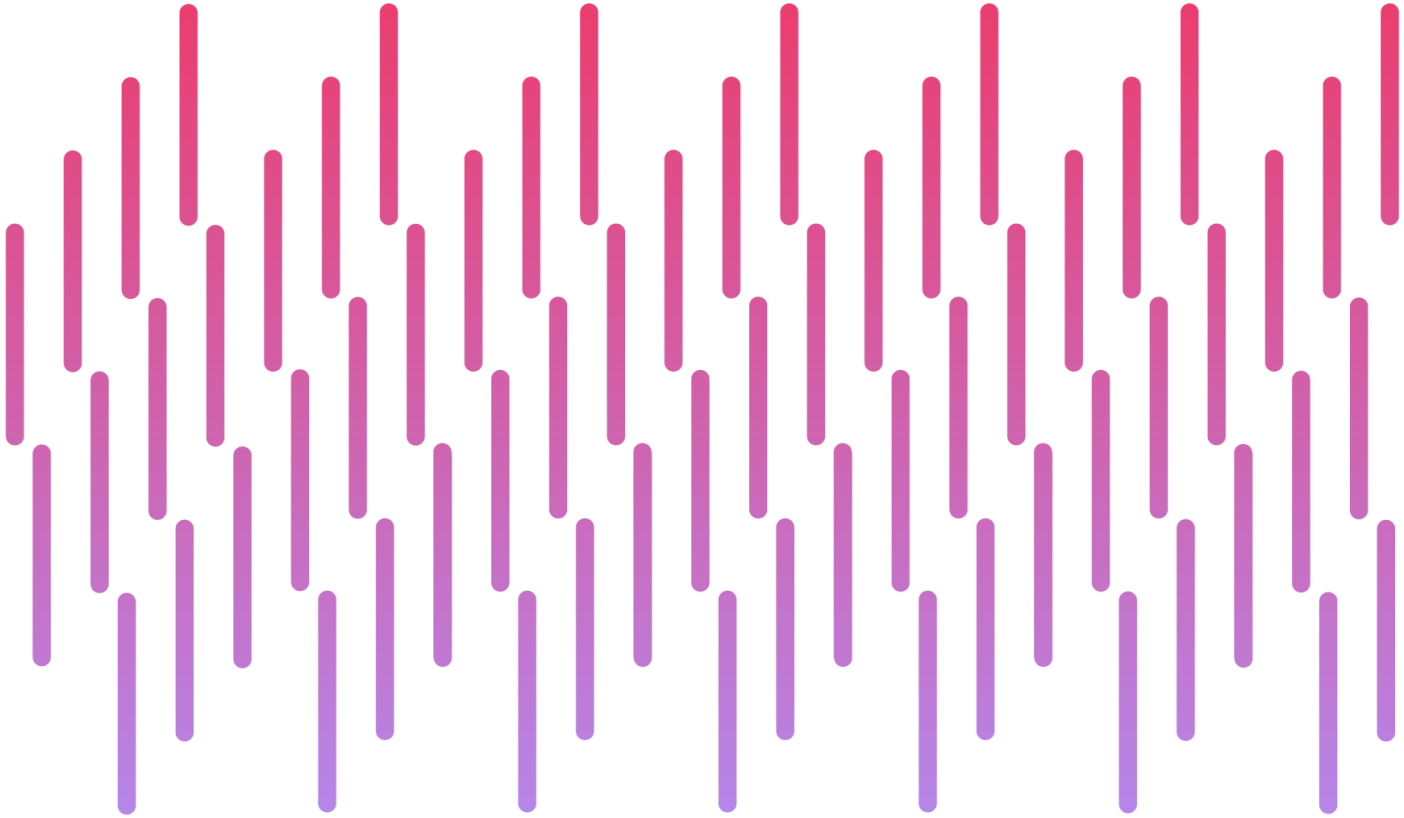
Our champions are listed below and come from a variety of different staff groups. Whilst staff can contact any of the champions for advice and signposting, champions will also be supporting individual teams dependant upon where the organisational need is.

Louisa Odura Bechie – Clinical Coding Officer
Jayne Box – AMW Receptionist
Roberta Brambilla – Renal Consultant
Alex Cheshire – Endoscopy Nurse Team Lead
Princess Cole – Specialist Biomedical Scientist
Jessica Costan – Health & Safety Administrator
Elaine Hoilett – Receptionist NNU
Khalid Khan – Biomedical Engineer
Sara La Bouchardiere – ED Nurse
Ediscyll Lorusso – Senior Thrombosis SNP
Rachel Maddick – Renal Transport Co-ordinator
Naomi Priestly - Clinical Research Nurse
Mark Quarrel – Clinical Trials Assistant
Mridula Sharma – Senior Nurse (Theatres)
Claire Fraser Taylor – Consultant Transplant Urologist
Marina Timofeeva – MTO (Pharmacy)
Jeanette Turner – Advanced Audiologist
Andrew Vernell – Nurse (Theatres)
Mary Ward – Iclip Champion User

Our Freedom to Speak up Champions are also be supporting our staff networks by attending network meetings and each network will be supported by a named champion who will work closely with the network chair and Guardian to ensure all staff network members have access to a FTSU champion.

Womens Network – Princess Cole & Guardian
BAME Network – Khalid Khan & Guardian
LGBTQ+ Network – Elaine Hoilett & Guardian
Disability Network – Mark Quarrel & Guardian

5. FTSU Strategy progress update



Freedom to Speak Up

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5. FTSU Strategy Update

Progress in implementing the FTSU vision and strategy

FTSU Vision
(as approved by Trust Board, Sept 2020)

"We aim to create a culture of safety and learning in which all staff feel safe, supported and confident to raise concerns without fear or detriment, and where speaking up is visibly championed as a core part of providing outstanding care every time to our patients, staff and the communities we serve.

"We aim to become a leader in establishing a positive speaking up culture by encouraging and supporting our staff to speak up, listening to their concerns and acting on them. Staff will not fear speaking up and will be thanked for doing so."

FTSU Strategic Objectives
(as approved by Trust Board, Sept 2020)

- **We will support our staff to feel confident about speaking up**
- **We will make it safe for our staff to speak up**
- **We will investigate concerns promptly, fully and fairly**
- **We will ensure that speaking up makes a difference**
- **We will support the positive development of our organisational culture**

The Trust Board considered and approved the Trust's first Freedom to Speak Up Vision and Strategy at its meeting on 24 September 2021. As part of this, the Board agreed both the overall vision of the FTSU culture we are seeking to achieve, and five strategic objectives to support the delivery of that vision (see opposite). In addition, the Board agreed a year one plan to support improvements and the establishment of strengthened FTSU structures and processes.

To further embed progress, and to highlight the importance we attach to speaking up, raising concerns has been established as one of the Trust's "breakthrough" corporate objectives for the second half of 2021/22.

Since the approval of the strategy in September 2020, we have focused on delivering the year-one plan for strengthening the fundamentals of FTSU at the Trust – building the structures and processes for the function; rolling out the new e-learning programme to new starters and seeking approval for the incorporation of this into the Trust's MAST programme; and establishing a new network of FTSU Champions across the Trust. Significant progress has been made in building up the fundamentals of the function (see table on the following pages).

Measuring the impact of these changes on staff perceptions about and confidence in speaking up is harder to measure. The most recent FTSU Index shows that the Trust has improved its FTSU Index position in each of the last two years (from 211th of 230 Trust in 2019, to 204th in 2020, to 195th in 2021). The most recent position, however reflects the returns in the autumn 2020 NHS Staff Survey. The current staff survey results will give a sense of the extent to which confidence has improved. We are also planning to incorporate a question on FTSU in the new quarterly pulse surveys so that we have a tool for tracking staff perceptions and feedback in a more real-time way.

With the support of our workflow system, we are tracking the timescales for the completion of FTSU investigations.

The FTSU Guardian is a member of the Culture, Diversity and Inclusion Programme Board, which is helping to ensure that the work on strengthening culture and raising concerns is mutually supportive. Likewise, the FTSU Guardian is actively involved in working with the OD team in local culture initiatives across the Trust.

5. FTSU Strategy Update

Progress in implementing the FTSU year one plan

Commitment	RAG	Progress to date	Next steps
Strengthen the FTSU function		• Established a dedicated senior FTSU Guardian role focused solely on FTSU. Role appointed to at Band 8a level. • Resources for the establishment of a new Deputy FTSU Guardian identified and secured. • Resources for administrative support to the FTSU function identified and secured. • Dedicated FTSU budget established and FTSU cost centre created. • Dedicated workflow tool in place for tracking FTSU cases.	• Recruiting to the Deputy FTSU Guardian position in Q3 2021/22. • Recruiting to the administrative support post in Q3 2021/22. • Consider opportunities for mutual learning and shared support between the Trust's FTSU function and the function at Epsom & St Helier (from Q4 2021/22 onwards)
Refresh the FTSU Champions Network		• Developed new FTSU Champions role description and secured sign off through People Management Group and Trust Management Group. • Recruitment campaign launched and significant interest generated. • 19 new FTSU Champions recruited and trained to date representing a broad cross-section of staff – different professional backgrounds, varying levels of seniority, across the clinical and non-clinical divisions.	• Recruitment and training of additional FTSU Champions during Q3 and Q4 2021/22.
Develop a FTSU Charter		• Draft FTSU Charter developed based on best practice and national guidance. • Engagement activities planned for securing feedback on the draft Charter.	• Complete engagement process and finalise the Charter, then take through Trust governance processes for approval. • Developing training for staff in undertaking FTSU investigations to help ensure that investigations are completed within established timescales.
Refresh the FTSU Policy		• FTSU policy in place, which is fit for purpose. The policy was extended while the Trust awaited the publication of a new national FTSU policy during calendar year 2021. • New training programme in raising concerns to support staff in understanding the Trust policy and how to raise concerns has been incorporated into the induction programme for new staff (with 647 new staff trained since May 2021). • Trust Management Group is scheduled to consider a proposal (which has been endorsed by the People Management Group and MAST Steering Group) to incorporate this raising concerns training package into the Trust's established MAST programme (TMG to consider proposal on 10 November 2021).	• A new national policy was planned for launch during calendar year 2021, after which a revision to the Trust policy was planned. However, the new national policy has not been published, so the Trust will now revised and update its FTSU policy based on local needs and feedback. • Subject to TMG approval, incorporate FTSU training programme into Trust MAST programme and e-learning platform.

5. FTSU Strategy Update

Progress in implementing the FTSU year one plan

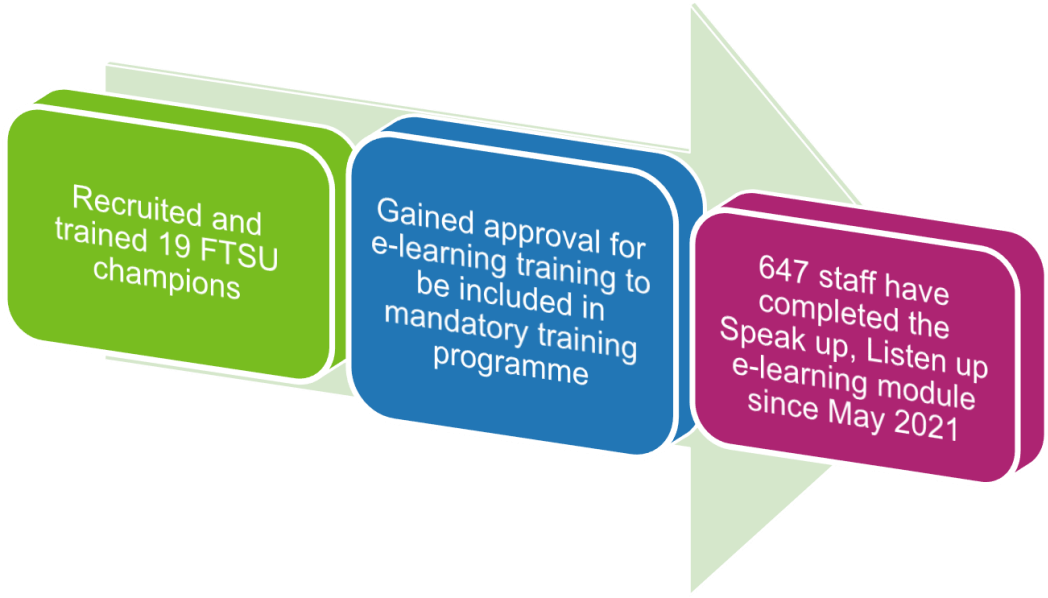
Commitment	RAG	Progress to date	Next steps
Establish a FTSU Summit		• Draft Terms of Reference for a new FTSU / Raising Concerns Group prepared.	• Seek feedback and engage with a view to finalising the ToR and commencing the Group from Q4 2021/22.
Develop a communications plan and activities to support speaking up		• Full range of communications channels used to promote awareness of FTSU (e.g. CEO weekly message, eG, video clips, Senior Leaders briefings) • Detailed communications plan developed and delivered to support the delivery of the “Let’s Talk” FTSU month in June 2021 and national FTSU month in October 2021.	• Campaign around the raising of safety concerns is currently being developed. • Subject to TMG’s approval of the incorporation of raising concerns training into the MAST programme, a communications plan around the launch of the e-learning module for all staff is being planned.
Develop effective assurance reporting to the Trust Board and Committees		• New style and format of Board reporting developed and delivered. • Quarterly reports submitted to the Workforce and Education Committee and the Trust Board, with the FTSU Guardian presenting these reports.	• FTSU annual report to the Board planned for year-end 2021/22. • Further Board-level FTSU training to be undertaken following the finalising of the new national FTSU Board training package.

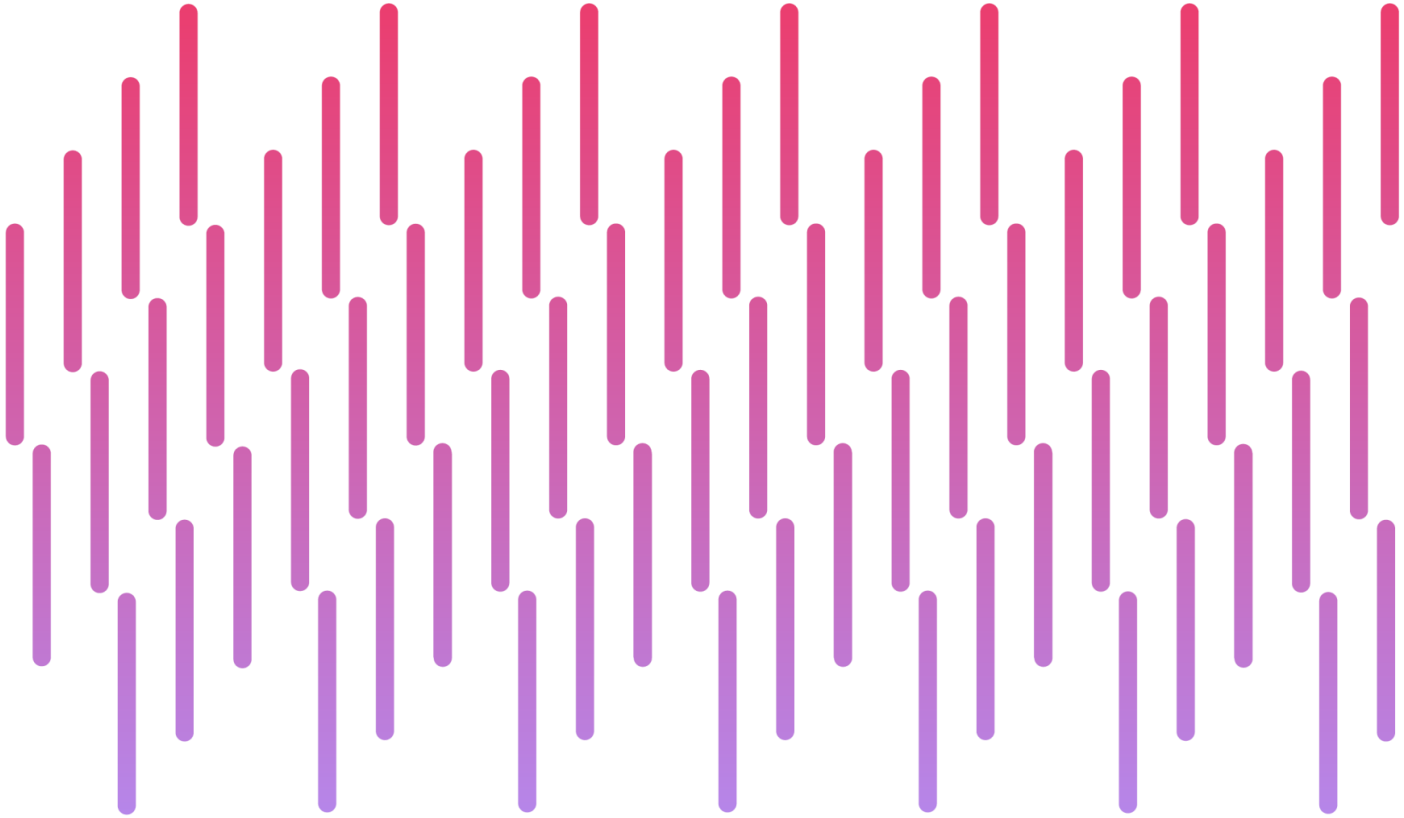
5. Focus of FTSU activities over the next 3 months

There has been much progress since the approval of the strategy.

Over the next quarter we will be focussing on

- Communications Poster campaign for specific staff groups
- Continuing champion recruitment campaign
- Updating the Raising Concerns Policy
- Continue Divisional Reporting
- Work with D & I team regarding themes from staff with invisible disabilities





Freedom to Speak Up: Q2 2021/22 Report
St George's University Hospitals NHS Foundation Trust

Freedom to Speak Up

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NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	25 November 2021	**Agenda No**	**4.1**
Report Title:	**Audit Committee Report**		
Lead Director/ Manager:	Peter Kane, Chair of the Audit Committee		
Report Author:	Peter Kane, 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 11 November 2021.		
Recommendation:	The Board is asked to note the report from the Audit Committee.		
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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St George's University Hospitals NHS Foundation Trust

Audit Committee Report

Report of meeting held on 11 November 2021

Matters for the Board's attention

The Audit Committee met on 11 November 2021 and this report provides assurance to the Board of the areas covered at the meeting.

The items covered at the meeting were as follows:

- External Audit Progress Report
- Internal Audit Progress Report
- Internal Audit Recommendation Tracker
- Final Internal Audit Review Reports
    - Estate Capital Projects - Reasonable Assurance
    - Patient Engagement - Reasonable Assurance
    - Clinical Audit - Limited Assurance
- Client Briefing Notes from TIAA
- Counter Fraud Update
- Losses & Special Payments
- Aged Debt
- IFRS 16 (Leases) Update on Implementation and Preparations
- Annual Review of the Trust's Clinical Audit Programme

Issues of note arising from the report are shown below;

1. Matter Arising - Review of Board Assurance Framework

It was noted that a previous action to review the Board Assurance Framework (BAF) will be deferred until group governance arrangements have been established to enable a new BAF to reflect a common approach between the Trust and Epsom and St Helier University Hospitals NHS Trust (ESTH). The intention is that this will be in place for 1 April 2022.

2. External Audit

The Committee discussed the outline timetable for the year-end audit and requested that the external auditors produce a 'lessons learnt' report for the next meeting to be considered alongside the year end audit plan, particularly in light of the completion of the first value for money report for 2020/21.

3. Internal Audit – Progress Report

The Committee heard of some concern about securing the engagement of senior management with two internal audits and that this could put the programme at risk of not completing on time.

It was also noted that there are a number of actions to address recommendations from previous audits that remain outstanding and have passed their target dates. It was emphasised that due dates are agreed with management when audits are completed so more care is needed to ensure they are realistic to ensure they are achieved. Trust Management Group are reviewing outstanding actions and the Committee will expect attendance from chief officers responsible for overdue actions.

4. Internal Audit

The Committee was pleased to receive two internal audit reports which had received 'reasonable assurance'. The estates capital projects audit found that controls on capital projects had improved in recent years. On patient engagement, the audit identified the impact of the pandemic on the Trust's patient engagement activity but found that the system of controls reviewed was generally adequate and operating effectively.

The Committee discussing in greater detail the review on clinical audit, which had received a 'limited assurance' rating. The Committee heard that there were no surprises among the findings and many constructive points had been identified which will help make the clinical audit programme more mature, particularly in relation to consistency in following up on the outcome of clinical audits, and improved engagement with the programme. Many of the identified actions from the audit would be addressed through the development of a new standard operating procedure which was scheduled to be approved by the Patient Safety and Quality Group in December. The Committee also enquired about the extent to which the Trust worked collaboratively with the clinical audit lead at Epsom and St Helier, and heard that early discussions were taking place to share learning and best practice. Following its discussion of the audit report, the Committee considered a review of the Trust's clinical audit programme and were assured that processes were in place to enable accurate monitoring and escalation of issues when required.

During the review of internal audit reports the question of the current meeting arrangements were discussed It was felt that some benefits in terms of traveling time and flexibility had been noted when meeting virtually, although other opportunities are missed, such as the ability to triangulate information through on site visits etc.

It is likely the current arrangements will remain for at least the next few months, not least because rooms previously used for committee meetings have been repurposed to provide more direct support to staff.

Recommendation

The Board is asked to receive assurance from the report of the Audit Committee.

Peter Kane

Chair, Audit Committee

November 2021

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	25 November 2021	**Agenda No**	**4.2**
Report Title:	**Finance and Investment Committee report**		
Lead Director/ Manager:	Ann Beasley, Chair of Finance and Investment Committee (October meeting) and Tim Wright, Acting Chairman of the Finance and Investment Committee (November meeting)		
Report Author:	Ann Beasley, Chair of FIC, October meeting Tim Wright, Acting Chairman of FIC, November meeting		
Presented for:	Assurance		
Executive Summary:	The report sets out the key issues discussed and agreed by the Committee at its meetings on the 21 October and 18 November 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		

St George's University Hospitals NHS
NHS Foundation Trust

Finance and Investment Committee – October & November 2021

The Committee met on 21st October and 18th November. In addition to the regular items on strategic risks, operational performance and financial performance, it also considered papers on:

- Costing, SLR and PLICS
- Planning and forecast update for 2021/22;
- A Procurement Report;
- An SWLP Report,

As is its usual practice, the Committee discussed the Board Assurance Framework (BAF) risks on a rotating basis by deep dives, with consideration by exception in intervening months. In October members undertook a deep dive into the estates and operational risks. Issues raised in discussion covered the ICT reorganisation, and potential water ingress to the data centre. Members were assured that mitigations were receiving sufficient executive focus. The Committee noted the challenges of operational performance and increased occurrence of OPEL 3 and 4 at the Trust. Members considered the three key issues underpinning operational performance, namely domiciliary care capacity, site capacity and workforce fatigue. At the November meeting, members also heard that further delays in the refurbishment of the Cardiac Cath Labs were a risk. The Committee discussed current financial performance, cash management and capital expenditure as the Trust reported the M6 (in October) and M7 (in November) 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 Operations Officer (COO) gave updates on their respective BAF risks. In the absence of the Chief Information Officer (CIO), her deputy and the Deputy Chief Executive Officer (DCEO) updated the committee on the ICT BAF risk. The committee discussed the ICT Risk, focussing on the estates challenges being experienced with the data centre. Finance risks were proposed to remain unchanged, following confirmation of the H2 planning guidance. The Operational Risk discussion was predominantly regarding domiciliary care capacity and how that supports hospital discharge.

1.2 Estates Report –the Director of Estates & Facilities (DE&F) introduced the normal monthly update, noting the actions taken to ensure that the lifts in St James's Wing were able to continue in use but Committee members expressed some concern that matters had not been dealt with pro-actively and asked for lessons to be learnt.

1.3 Activity Performance – the Chief Operations Officer (COO) noted the expected performance against activity trajectories in October, where Daycase/Elective is expected to be slightly below (at 84% compared to 87% target) and Outpatient performance is expected to be ahead (at 94% compared to 87%).

1.4 Emergency Department (ED) Update – the performance of the Emergency Care Operating Standard was recorded at 73.8% in October. The Committee noted the current emphasis on ambulance handover and the challenges in recent months, related to workforce and domiciliary care capacity.

1.5 Diagnostics Performance – the COO noted that the six-week diagnostic standard performance was 2.3 % in October compared to 3.2% in September. Members acknowledged the significant improvement over the last few months.

St George's University Hospitals NHS
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1.6 Cancer Performance – the COO noted Cancer performance in September where 3 of the 7 targets were met, along with expectations on when the remaining metrics would be delivered by the Trust.

1.7 Referral to Treatment (RTT) Update – the performance against the RTT target was discussed, where performance in September of 76.3% had improved against the previous month's value of 76.0%, with the number of 52 week waits of 1,005 being less than the previous month's 1,028. The size of the waiting list (including QMH patients) was 47,014 patients. It was noted at the November meeting that all 104 week waits should be cleared by 4 December.

1.8 Winter Update – the COO gave a verbal update 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 M7 YTD for 2021/22, where a £2.6m deficit is in line with the phased plan for H2 submitted on November 16th. This included the income and expenditure impact associated with the Elective Recovery Fund (ERF).

He noted the cash balance as at 31st October 2021 was £70.9m (which is 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 Costing, SLR and PLICS – the DFP introduced a paper on Costing, SLR and PLICS, noting the submission of the annual return, which shows the impact of COVID on annual Trust costs. The Committee noted the update.

1.11 Planning 21-22 – the DCFO noted the progress being made on planning for H2 2021/22, including plans to mitigate the risks expected following the submission of the H2 financial plan.

1.12 Procurement Report – the AD-P noted latest performance against breaches and waivers targets and progress on delivering Procurement CIPs.

1.13 SWLP Report – the DCFO introduced the Q2 quarterly financial report for SWLP, where the division is on plan to date. He also noted the progress on the implementation of LIMS (Laboratory Information Management System), which is requiring careful management amongst SWL partners.

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,
Chair FIC (October meeting); and

Tim Wright
Acting Finance & Investment Committee Chair (November meeting)

Meeting Title:	**TRUST BOARD**		
Date:	**25 November 2021**	**Agenda No**	**4.3**
Report Title:	**M7 Financial Performance**		
Lead Director/ Manager:	Tom Shearer		
Report Author:	Tom Shearer		
Presented for:	Update		
Executive Summary:	Please note plan figures in this report are work in progress and subject to change ahead of the H2 financial plan submission on 16th November. However, the Trust will be on plan in M7. The Trust is reporting a deficit of £2.6m at the end of October, which is on plan. This includes £16.3m of ERF income and £11.4m of ERF costs, both of which are £7.7m higher than plan (and so offset). Excluding ERF, income is reported at £1.4m adverse to plan at Month 7. This is due to a shortfall in COVID testing income, which is offset in non-pay. Excluding ERF, expenditure is reported at £1.4m favourable to plan at Month 7. This is due to lower COVID testing and Commercial Pharmacy costs, partially offset by higher staffing costs related to COVID. Capital expenditure of £28.8m has been incurred year to date. This is to £0.5m favourable to a plan of £29.2m. At the end of Month 7, the Trust's cash balance was £70.9m, which is £67.9m 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 M7 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**	18/11/21
Appendices:	N/A		

Meeting Title:	Trust Board		
Date:	25 November 2021	**Agenda No**	4.4
Report Title:	**St. George's Hospital Charity: Update November 2020 to October 2021**		
Lead Director	Suzanne Marsello, Chief Strategy Officer (Director sponsor for St George's Charity)		
Report Author:	Amerjit Chohan, CEO, St George's Hospital Charity Vivien Gunn, Head of Grants, St George's Hospital Charity Sarah McCullough, Fundraising and Communications Director Clem Brohier, Finance and Operations Director Helena Copsey, Arts Manager		
Presented for:	Approval Decision Ratification Assurance Discussion **Update** Steer Review Other (specify)		
Executive Summary:	The last 11 months has in the main been dominated by Covid and our response in supporting our incredible NHS colleagues here at the Trust. We know our hospital colleagues rose to the challenge, transforming services at pace to deal with the rapidly spreading virus, saving countless lives, whilst continuing to provide excellent care for patients needing treatment for other reasons. The compassion, dedication and kindness shown by staff at this hugely challenging time continues to inspire us. The response from our local community and the outpouring of generosity and donations recognised the remarkable treatment and outstanding care given at our hospitals. As a result, we are very proud that we have had our most successful year to date (20/21) raising £4.2m, double our previous record, and awarding £3,137,373 in grants, another record. This was to a great extent due to £1.1m funding from NHS Charities Together and £603,000 from the Charity's own COVID Appeal. Going forward the Charity cannot rely on the same funding opportunities which it was afforded as an NHS Charity during the COVID pandemic. The charity has delivered thousands of care packages to our NHS staff (including cleaning, catering, clinical and clerical staff). We also installed five staff wellbeing hubs, funded a Wellbeing Garden (outside AMW) and used donations to buy iPads for COVID-19 patients to connect with loved ones. Using COVID Appeal funds the Charity will be supporting the Trust's Thank You series of events for staff by contributing towards the staff Lunch on Us week in November 2021 and in December 2021providing Christmas meals and pizzas for staff working Christmas Eve, Christmas Day and New Year's Day. With the support of NHS Charities Together and in partnership with the Trust, the Charity has secured funding for a staff shower block, cycle storage, staff room improvements, staff wellbeing activities and a staff outdoor gym. We are delighted the new Wudu Wash Facilities to support Muslim patients and their family and friends have been opened. Of note we are pleased to be funding both the renewal of the Trust's patient and visitor WiFi and the upgrade of the existing 1gb line to 10Gb line to enable enhanced usage of the service for patients and visitors.		

	The Charity is particularly excited to have launched The Children's Appeal, by working in close partnership with the Trust. The appeal is aiming to raise over the next four years net income after estimated costs of £4 million towards the cost of the expansion of PICU (Paediatric Intensive Care Unit) and transforming the children's wards (Nicholls, Pinckney and Frederick Hewitt) and an associated arts strategy.		
Recommendation:	The Trust Board is asked to: ➢ Note the report, and the investment that has been awarded by the Charity in support of Trust projects.		
Supports			
Trust Strategic Objective:	1. Treat the patient, treat the person 2. Right care, right place, right time 3. Balance the books, invest in our future 4. Build a better St. George's 5. Champion Team St. George's 6. Develop tomorrow's treatments today		
CQC Theme:	1. **Safe**: you are protected from abuse and avoidable harm. 2. **Effective**: your care, treatment and support achieve good outcomes, helps you to maintain quality of life and is based on the best available evidence. 3. **Well-Led**		
Single Oversight Framework Theme:	▪ Strategic Change		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	Executive Management Group	**Date:**	15 November 2021
Appendices:	None		

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St. George's Hospital Charity May 2020 to November 2020 Update

1.0 Purpose

1.1 The report is provided to give the Trust Board an update regarding the activities of the Charity since November 2020 and highlight future plans.

2.0 Introduction: St George's Hospital Charity Activity Update

This report covers the period from November 2020 to October 2021.

Since our November 2020 report the COVID outbreak has continued, with further virus variants and a lengthy lockdown which was finally lifted in June 2021 as the national vaccination programme began to reap results. The Charity has published its 20/21 Annual Report. The year of the global pandemic 20/21 has been an exceptional one. Despite the economic and operational challenges that the pandemic has brought, the Charity has delivered sound performance from operational activities. In the year to 31 March 2021 total income from fundraising and the investment portfolio was £4.2m (2019/20: £2.1m). Total income has increased 50% from £2.8m to £4.2m, over the three-year period ending 31 March 2021. The Charity was proactive and agile in its fundraising efforts with the pandemic causing a switch to a focus to a COVID-19 Appeal and fundraising through digital platforms. This contributed to a large increase in income of £1.1m from NHS Charities Together, £603,000 from the COVID-19 Appeal and £465,000 from gifts in kind. Total expenditure for the year was £4.2m (2019/20: £2.8m). Of this, £3.6m (2019/20: £2.1m) has been spent, or committed to, charitable activities. The total cost of raising funds is £0.6m (2019/20: £0.7m) a decrease of £0.1m mainly due to the cancellation of fundraising events which have resulted in no associated costs.

Formal Board of Trustee meetings took place on 19 March 2021, 29 July 2021, 21 May 2021 and 24 September 2021.

2.1 Charity Capital Projects Update

The Charity is working with the Trust Capital Team with which it meets on a monthly basis.

Of note:

- To support Muslim patients and their family and friends, the Charity has funded female and male Wudu Wash facilities close to the Spiritual Care Centre. This was funded by the local community who came together donating and fundraising over £16,000 for this project as well as other improvements to the Prayer Facilities.
- The Charity is looking forward to the opening of the staff shower block and the completion of the staff outdoor gym.

2.2 General grants update

Apart from the Covid Appeal, the business of normal grant-making continued. Highlights include: saving sight in premature babies by funding new technology to identify retinal damage, central monitoring equipment for the high dependency maternity unit, equipment for new surgery for unborn babies with congenital diaphragmatic hernia, strengthening links between research and clinical support by joint funding of two postdoctoral fellowships at St George's, University of London, equipment for use in Neurology Theatres which included a state of the art

microscope and a Stealth Station for image guided neurosurgical procedures as well as funding the renewal of the Trust's patient and visitor WiFi and the upgrade of the existing 1gb line to 10Gb line to enable enhanced usage of the service for patients and visitors.

The Charity is working closely with the Trust to put its portfolio of c. 230 Special Purpose Funds to good use which in total represents c £5.1 m. It will do this by meeting quarterly with the Trust's divisional teams and clinical directorates to highlight this particular source of funding available to the Trust.

2.3 The Charity's COVID-19 Appeal

As a result of the second COVID wave the Charity reopened the COVID Appeal in January 2021 and closed it again in March 2021. The Charity's income raised from the total COVID Appeal in 20/21 was £603,000. This excludes funding from NHS Charities Together which is detailed below. We have worked closely with hospital colleagues to identify areas of greatest needs awarding grants and distributing donations across a broad range of requirements using COVID Appeal and NHS Charities Together funding. All of which was only made possible also by our wonderful teams of volunteers.

As a snapshot we supported staff with 50,000 hot meals, 12,000 individual staff care packages, 4,000 staff wellbeing boxes, 5 staff wellbeing hubs, 95 Team Thank You awards, distributed 150 iPads used by patients for contacting loved ones, 9,000 face coverings,1,000 scrubs for hospital staff and awarded 73 Covid grants to staff totalling £112,000 across a variety of categories to benefit staff and patients. Additionally we supported St George's, University of London by funding a £20,000 safety cabinet for COVID 19 Research and an additional £40,000 for 2 COVID pump priming research grants. We intend shortly to be using further Covid Appeal funds to support the Trust's Thank You series of events for staff by contributing towards the staff Lunch on Us week and in December providing Christmas meals and pizzas for staff working Christmas Eve, Christmas Day and New Year's Day.

2.4 NHS Charities Together Funding

The membership organisation for NHS Charities, NHS Charities Together raised over £150m (this includes the £30m raised by Sir Captain Tom) to distribute to its members. In partnership with the Trust, the Charity successfully bid for £1.1m as follows:

- Stage 1 Urgent Response: £98,000 spent on wellbeing hubs, wellbeing space, wellbeing garden and iPad programme
- Stage 1 Urgent Response: £50,000 community project supporting BAME communities
- Stage 2 Community Partnerships: £757,406 to support 5 community projects across Croydon, Kingston and Richmond, Merton, Sutton and Wandsworth, an area which has a total population of 1.7 million.
- Stage 3 Staff Recovery: £198,000 was secured to provide a staff shower block, cycle storage, staff
  room improvements and staff wellbeing activities
- Stage 4 Second Wave Urgent Response: £50,000 to provide a staff outdoor gym.

3.0 Fundraising Update

The last ten months have seen the fundraising team respond to the demands of the fundraising environment to ensure that money for the hospitals could be raised in as safe and appropriate way. This included a virtual auction at Christmas and a gift giving ask to supporters through the Clause for the Cause campaign. Community fundraisers continued to amaze us with their commitment to the charity and we supported them in their bike rides, triathlons, sky dives and Captain Tom 100 challenges.

Organised challenge events have been slow to recover post COVID however participants supporting St George's Hospital Charity have taken part in the virtual Royal Parks Half marathon and the London Marathon walk. Most recently, the Vitality 10K and the London Landmarks Half Marathon marked the return of running events in the City. We are looking forward to a busy autumn of events.

Corporate and philanthropic giving has been largely centred on support for staff during COVID and to say thank you for the wonderful care their friends and family have received. A group of contractors working at Battersea Power Station gifted the value of their Christmas lunch to the charity whilst a group of employees from Martins Estate Agents have recently completed a 35 mile cycling and walking challenge.

4.0 The Charity's Arts Programme:

Art's St George's

- In June we organised music performances for the Vaccine Clinic, bringing the participatory arts programme back into the hospital for the first time since the start of the pandemic. We received very positive feedback from people queuing for their vaccine including: *"The harp was beautiful and eased my nerves coming in, being someone who is very afraid of needles"*
- St George's Arts Week took place for the first time in outside spaces across St George's and Queen Mary's from 19-23 July. 18 events took place, with 14 artists and 6 cultural organisations, engaging with 443 people, including patients, their families and staff members. We hope this will become an annual event.
- Our Summer Series of creative activities and music performances in outpatients waiting areas continues every Wednesday until 15 September.
- Staff Arts Club now has 450 members, offering staff the chance to improve their work-life balance through free ticket offers and creative activities.
- We have begun to highlight artworks in the hospital art collection through our Artwork of the Month feature on our website and social channels.
- New artworks have recently been installed in the Rose Centre, Gynaecology Outpatients, and Courtyard Clinic staff support areas.
- Looking forward:
    - COVID-19 Commemorative Art Commission steering group invitations to be sent to key staff stakeholders following formal sign-off of the grant award. The Trust is fully involved in the commissioning process.
    - We will be recruiting 3 new resident artists in the autumn who will help us to bring arts and culture into the hospital in a more long-term sustainable way, delivering creative sessions across the Trust.

5.0 Looking Forward

As our attention moves away from emergency response and we learn to live with coronavirus, we are looking forward to more transformational projects for the Trust, including launching our exciting new Children's Appeal, expanding our arts programme, and developing our community connections. The Children's Appeal is to be formally launched on November 9th 2021, aiming to raise over the next four years net income after estimated costs of £4 million towards the cost of the expansion of PICU (Paediatric Intensive Care Unit) and transforming the children's wards (Nicholls, Pinckney and Frederick Hewitt) and an associated arts strategy.

To help support this expansion the Charity is investing in its head count both in terms of fundraising but also the grant giving function. Our most recent key appointment includes a Director of Fundraising and Communications and Director of Finance and Operations.

END

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Meeting Title:	**Trust Board**		
Date:	25 November 2021	**Agenda No**	**4.5.1**
Report Title:	**Horizon Scanning Report, August – November 2021: Emerging Policy, Legislative and Regulatory Issues**		
Lead:	Stephen Jones, Chief Corporate Affairs Officer		
Report Author:	Stephen Jones, Chief Corporate Affairs Officer		
Presented for:	Note		
Executive Summary:	This report provides a quarterly update to the Trust Board on emerging political, legislative, policy and regulatory issues that have relevance to the Trust. This report focuses on key developments between August 2021 and November 2021, highlighting particular developments relating to: the political and legislative environment; developments in the NHS policy and institutional landscape; system and professional regulation; reports from key stakeholders; and key appointments. The report is intended to support the Board in providing a regular and systematic review of national political, policy and regulatory developments. It is distinct from the local and regional horizon scanning work which is reported in a separate report on the agenda. Key issues to highlight in the period August to November 2021 • The Health and Care Bill, which represents the biggest reform of the NHS in the past decade, has now completed its Report Stage in the House of Commons. The Bill is expected to move the House of Lords in the coming days to start its passage through the Upper Chamber, where the potential for amendment is somewhat higher than during the Commons stages. Royal Assent is anticipated in Q4 2021/22. Among the most significant elements of what is a wide-ranging piece of legislation, the Bill will place Integrated Care Systems on a statutory footing and give the Secretary of State for Health enhanced powers over the NHS. In October, the Government set out amendments to the Bill giving the CQC oversight of ICSs. • The Government has announced the introduction of mandatory Covid-19 vaccinations for all frontline NHS and social care staff, from April 2022, to protect colleagues, patients and visitors from Covid-19. Enforcement would come into effect from 1 April, subject to Parliamentary approval. The potential impact on staffing is currently being worked through by the Trust. • The Government's *Build Back Better* plan, which was announced in September 2021 and set out its plans for tackling Covid-19 backlogs, reforms to adult social care, and plans for bringing the health and social care system together on a long-term basis, pledged a £36 billion investment in the health and care system over the next three years. The autumn Budget and Spending Review committed a further £5.9bn in capital to support elective recovery and digital transformation. • The CQC's September 2021 report into maternity services in England identified ongoing concerns about leadership and oversight of risk, team working and culture, and the extent to which services are		

	engaging with and listening to the needs of their local populations, and pointed to the pressing need to address the inequalities in outcomes for Black and minority ethic women and babies, which have been further exacerbated during the Covid-19 pandemic. The report identified four areas of improvement for maternity services. • A new review of healthcare leadership has been launched by the Department of Health and Social Care, led by former Vice Chief of the Defence Staff, General Sir Gordon Messenger. The review is expected to report to the Secretary of State in early 2022. The stated purpose of the Health and Social Care Leadership Review is to improve processes and strengthen the leadership of health and social care in England. Terms of reference for the review were published on 23 November 2021. • Health Education England, NHSX and NHS Digital are all to be merged into NHS England and NHS Improvement. The merger of HEE into NHSE&I aligns finance and workforce planning, and brings education and training spending within the NHSE&I funding allocation which has been ring-fenced from any reductions in spending in recent years • A report by the Royal College of Emergency Medicine has found that there were 4,519 excess deaths as a result of overcrowding and 12-hour stays in emergency departments in England in 2021/22, and that one in 67 patients staying in ED for 12 hours comes to excess harm.
Recommendation:	The Board is asked to note the update.
Supports	
Trust Strategic Objective:	All
CQC Theme:	Well-led
NHS Oversight Framework Theme:	Leadership and Improvement Capability (Well-led)
Implications	
Risk:	Horizon scanning is a key element in assisting the Board to understand emerging risks that could impact on the Trust's strategy and its operation.
Legal/Regulatory:	N/A
Equality, Diversity and Inclusion	N/A
Resources:	N/A
Previously Considered by:	N/A **Date** N/A
Appendices:	N/A

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NHS
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Horizon Scanning report

Emerging policy, political, legislative and regulatory issues, August – November 2021

Stephen Jones
Chief Corporate Affairs Officer

25 November 2021

1. Executive Summary

This report provides a quarterly update to the Trust Board on emerging political, legislative, policy and regulatory issues that have relevance to the Trust. This report focuses on key developments between August 2021 and November 2021, highlighting particular developments relating to: the political and legislative environment; developments in the NHS policy and institutional landscape; system and professional regulation; reports from key stakeholders; and key appointments. The report is intended to support the Board in providing a regular and systematic review of national political, policy and regulatory developments. It is distinct from the local and regional horizon scanning work which is reported in a separate report on the agenda.

Key issues to highlight in the period August to November 2021

- The Health and Care Bill, which represents the biggest reform of the NHS in the past decade, has now completed its Report Stage in the House of Commons. The Bill is expected to move the House of Lords in the coming days to start its passage through the Upper Chamber, where the potential for amendment is somewhat higher than during the Commons stages. Royal Assent is anticipated in Q4 2021/22. Among the most significant elements of what is a wide-ranging piece of legislation, the Bill will place Integrated Care Systems on a statutory footing and give the Secretary of State for Health enhanced powers over the NHS. In October, the Government set out amendments to the Bill giving the CQC oversight of ICSs.

- The Government has announced the introduction of mandatory Covid-19 vaccinations for all frontline NHS and social care staff, from April 2022, to protect colleagues, patients and visitors from Covid-19. Enforcement would come into effect from 1 April, subject to Parliamentary approval. The potential impact on staffing is currently being worked through by the Trust.

- The Government's *Build Back Better* plan, which was announced in September 2021 and set out its plans for tackling Covid-19 backlogs, reforms to adult social care, and plans for bringing the health and social care system together on a long term basis, pledged a £36 billion investment in the health and care system over the next three years. The autumn Budget and Spending Review committed a further £5.9bn in capital to support elective recovery and digital transformation.

- The CQC's September 2021 report into maternity services in England identified ongoing concerns about leadership and oversight of risk, team working and culture, and the extent to which services are engaging with and listening to the needs of their local populations, and pointed to the pressing need to address the inequalities in outcomes for Black and minority ethic women and babies, which have been further exacerbated during the Covid-19 pandemic. The report identified four areas of improvement for maternity services.

- A new review of healthcare leadership has been launched by the Department of Health and Social Care, led by former Vice Chief of the Defence Staff, General Sir Gordon Messenger. The review is expected to report to the Secretary of State in early 2022. The stated purpose of the Health and Social Care Leadership Review is to improve processes and strengthen the leadership of health and social care in England. Terms of reference for the review were published on 23 November 2021.

- Health Education England, NHSX and NHS Digital are all to be merged into NHS England and NHS Improvement. The merger of HEE into NHSE&I aligns finance and workforce planning, and brings education and training spending within the NHSE&I funding allocation which has been ring-fenced from any reductions in spending in recent years

- A report by the Royal College of Emergency Medicine has found that there were 4,519 excess deaths as a result of overcrowding and 12-hour stays in emergency departments in England in 2021/22, and that one in 67 patients staying in ED for 12 hours comes to excess harm.

2. Purpose

The NHS Leadership Academy identifies three essential 'building blocks' in helping NHS boards to exercise their roles of formulating strategy, ensuring accountability and shaping a healthy culture effectively. Effective boards are informed by the external context within which they operate. They are informed by and shape the intelligence on understanding local needs, trends and comparative information on organisational performance, and give priority to engagement with stakeholders and opinion formers. This report provides the Board with a regular update on key developments in the Trust's external environment at the national level, particularly in relation to:

- **Political and legislative developments**: Current and emerging political and parliamentary developments at a national level with direct or indirect implications, or potential implications, for the Trust; key changes, or potential future changes, to primary legislation and regulations.
- **NHS policy and institutional landscape**: Changes and developments in relation to significant new national policy as determined by the central NHS organisations, and changes to the national architecture and structures of the NHS and those organisations with which the Trust interacts.
- **System and professional regulation**: Changes and prospective changes to the regulatory landscape, of both system regulators and relevant professional regulators with potential relevance to the Trust.
- **Reports and updates from key stakeholders**: Topical reports from key national bodies and other stakeholders of relevance to the Trust, and highlights of recent Board meetings of key system partners.
- **Current inquiries**: Summary of key inquiries that are underway.
- **Appointments**: Key appointments to national bodies and other key stakeholders.

This report is intended to help ensure the Board receives a comprehensive quarterly update on key issues relating to these areas. It is distinct from the strategy horizon scanning report which focuses on regional and local issues.

3. Political and legislative developments

Health and Care Bill

- On 6 July 2021, the new Health and Care Bill was introduced to Parliament and has since completed its First and Second Readings (on 6 and 14 July respectively) and Committee Stage in the House of Commons. As at 23 November, the Bill has completed the first of two days of Parliamentary debate at Report Stage. The Bill would then receive a Third Reading in the House of Commons before moving to review by the House of Lords. Royal Assent is anticipated in Q4 2021/22.
- The Health and Care Bill builds on the proposals for legislative change set out by NHS England in its Long Term Plan, while also incorporating lessons learnt from the pandemic that will benefit both staff and patients. The Bill is intended to build on the proposals for reform from NHS England and NHS Improvement to make the NHS less bureaucratic, more accountable, and more integrated in the wake of Covid-19. The Bill provides that each part of England will have an Integrated Care Board and an Integrated Care Partnership responsible for bringing together local NHS and local government, such as social care, mental health services and public health advice, to deliver joined up care for its local population. The majority of the Bill is focused on developing system working, with integrated care systems (ICSs) being put on a statutory footing. It also formally merges NHS England and NHS Improvement, and gives the secretary of state a range of powers of direction over the national NHS bodies and local systems and trusts. Other measures proposed include putting the Healthcare Safety Investigation Branch (HSIB) on a statutory footing; a new legal power to make payments directly to social care providers; the development of a new procurement regime for the NHS; and a new duty on the secretary of state to report on workforce responsibilities. The bill, which is structured in six parts, focuses largely on the detail on how a new health and care system based on integration rather than competition will be structured. This includes specifications on how integrated care systems (ICSs) are to be set up and the distinct statutory functions for the integrated care board (ICB) and integrated care partnership.
- On 20 October 2021, the Government set out an amendment to the Bill which provides for the Care Quality Commission to have oversight of Integrated Care Systems (ICSs). The CQC has stated that the amendment “supports health and care systems to be held accountable and encourages the shift towards more integrated and improved outcomes for people”. The change is intended to provide for meaningful independent assurance to the public and Parliament about how ICSs deliver safe, high quality care to their local populations. The CQC’s role is expected to focus on assessing leadership, integration of services and care pathways, as well as quality and safety. It is intended to complement rather than duplicate the oversight role of NHS England and NHS Improvement.
- The most high profile issue in the Bill’s Parliamentary passage to date has been the Report Stage debate on the Government’s plans to cap the costs of social care. In a vote on 22 November 2021, MPs endorsed plans to exclude means-tested council support payments from a new £86,000 lifetime limit on costs.
- The new legislative framework, particularly as it relates to the creation of the new ICS architecture, relates to Strategic Risk 4 (system working) on the Trust’s Board Assurance Framework.

3. Political and legislative developments

House of Commons Health and Social Care Committee Report – Coronavirus: Lessons learned to date

- On 12 October 2021, the House of Commons Health and Social Care Committee published the report of its inquiry into lessons learnt from Covid-19. The inquiry was undertaken jointly with the Commons Science and Technology Committee, and examined the initial UK response to the Covid-19 pandemic.

- The joint inquiry, which began in October 2020, examined six key areas of the response to covid-19: the country's preparedness for a pandemic; the use of non-pharmaceutical interventions such as border controls, social distancing and lockdowns to control the pandemic; the use of test, trace and isolate strategies; the impact of the pandemic on social care; the impact of the pandemic on specific communities; and the procurement and roll-out of covid-19 vaccines. The inquiry concluded that some initiatives were examples of global best practice but others represented mistakes. The Committee concluded that both must be reflected on to ensure that lessons are applied to better inform future responses to emergencies. In particular, the Committee concluded that:
    - "The forward-planning, agility and decisive organisation of the vaccine development and deployment effort will save millions of lives globally and should be a guide to future Government practice";
    - "The delays in establishing an adequate test, trace and isolate system hampered efforts to understand and contain the outbreak and it failed in its stated purpose to avoid lockdowns";
    - "The initial decision to delay a comprehensive lockdown—despite practice elsewhere in the world—reflected a fatalism about the spread of covid that should have been robustly challenged at the time";
    - "Social care was not given sufficient priority in the early stages of the pandemic";
    - "The experience of the covid pandemic underlines the need for an urgent and long term strategy to tackle health inequalities"; and
    - "The UK's preparedness for a pandemic had been widely acclaimed in advance, but performed less well than many other countries in practice".

New Inquiries launched by the House of Commons Health and Social Care Committee

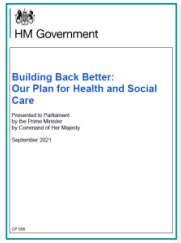
- The Health and Social Care Committee has recently launched three new inquiries:

    - On 16 November 2021, the Committee announced an inquiry into the future of General Practice. The Committee will examine challenges facing general practice in the NHS over the next five years. The inquiry will consider access to services and the impact of changes introduced during the pandemic such as online or virtual consultations. Barriers to accessing services and the extent to which the Government and NHS England's plans will address these issues will also be considered.

    - On 5 November, the Committee announced an inquiry into regional disparities in cancer outcomes. The inquiry will seek to understand why certain areas have better access to clinical trials, more curative treatment options, and more advanced services than others and will examine why survival rates are lower for more deprived socio-economic groups. The Committee is also expected to consider how less survivable and less common cancers fit into the NHS's long-term cancer plan. This includes how effectively the Government's investment in new community diagnostic hubs will improve diagnosis of less common and less survivable cancers.

    - On 22 September, the Committee announced an inquiry into examine the case for the reform of NHS litigation against a background of a significant increase in costs, and concerns that the clinical negligence process fails to do enough to encourage lessons being learnt which promote future patient safety.

3. Political and legislative developments



"Build Back Better: Our Plan for Health and Social Care"

- On 7 September 2021, the Government published its *Build Back Better: Out Plan for Health and Social Care*, which set out its plans for tackling Covid-19 backlogs, reforms to adult social care, and plans for bringing the health and social care system together on a long term basis.
- As part of the plans, the Government announced a £36 billion investment in the health and care system over the next three years. This is in addition to the settlement for the NHS reached in 2018, which will see its budget rise by £33.9 billion a year by 2023/24.
- From April 2022, the Government will introduce a new, UK-wide 1.25 per cent Health and Social Care Levy, ringfenced for health and social care. This will be based on National Insurance contributions (NICs) and from 2023 will be legislatively separate. All working adults, including those over the state pension age, will pay the levy and the rates of dividend tax will also increase by 1.25% to help fund this package.
- The Government has said that the new funding is expected to fund an extra 9 million checks, scans, and operations. The NHS long term plan committed to increasing activity year on year. In recognition of pressures from Covid, the Government has said this will now increase to 110% of the planned activity levels by 2023/24.
- Relates to Strategic Risk 5 (financial sustainability) and Strategic Risk 6 (capital) on the Trust's Board Assurance Framework.

HM Treasury

Autumn Budget and Spending Review 2021

- On 27 October 2021, the Chancellor of the Exchequer delivered an autumn Budget and Spending Review that was billed as focusing on post-Covid recovery. Key features of the Budget and Spending Review:
    - The DHSC revenue budget will grow by 4.1% per year from £147.1bn in 2021/22 to £177.4bn in 2024/25. Within this, the NHSE&I budget will grow from £136.1bn in 2021/22 to £162.6bn in 2024/25, an average real terms increase of 3.8%. These funding increases are supported by the 1.25% Health and Social Care Levy announced in September 2021.
    - The DHSC capital budget will grow by 3.8% per year from £9.4bn in 2021/22 to £11.2bn in 2024/25. Within this, it was announced that the NHS would receive £5.9bn over the next three years to support elective recovery and improve digital technology: £2.3bn for the transformation of diagnostic services; £1.5bn for new surgical hubs; and £2.1bn for innovative use of technology. A further £150m was announced over the next three years to invest in mental health facilities linked to emergency departments and to enhance patient safety in mental health units. The Government's commitment to invest £3.1bn in the New Hospital Programme and £1.1bn in the Hospital Upgrade Programme between 2022/23 and 2024/25 was also reaffirmed.
    - The Government pledged "hundreds of millions of pounds in additional funding over the SR21 period (2021/22 to 2024/25)" to develop the NHS workforce, but there was no confirmation of the size and nature of the Health Education England (HEE) budget for 2022/23.
- Relates to Strategic Risk 5 (financial sustainability) and Strategic Risk 6 (capital) on the Trust's Board Assurance Framework.

3. Political and legislative developments

Review of health and social care leadership

- On 2 October 2021, the Government launched a review of leadership in health and social care. The review is being led by former Vice Chief of the Defence Staff, General Sir Gordon Messenger, and will report back to the Secretary of State for Health and Social Care in early 2022. The stated purpose of the Health and Social Care Leadership Review is to look to improve processes and strengthen the leadership of health and social care in England. Working with the health and care systems, the Review Lead will have a team from DHSC and the NHS to support him led by Dame Linda Pollard, chair of Leeds Teaching Hospital. Terms of reference for the review were published on 23 November 2021.

- The government has said that “strengthening leadership, including clinical leadership, and spreading the best examples of outstanding management is vital in ensuring that every pound of investment is spent well, by driving up innovation and more efficient ways of working”. The Government has also said that the review will help to reduce regional disparities in efficiency and health outcomes. The review will consider what is needed to improve how health and social care is led and managed in England, such as:
    - the drivers of performance and the standards expected of good leaders and leadership teams
    - what further powers may be needed to drive real and sustained change, including effective systems for intervention and recovery in both providers and integrated care systems
    - how to help health and care leaders collaborate for more integrated care for citizens
    - proposals for ensuring the right incentives for the best leaders and leadership teams to take on the most difficult leadership challenge
    - how to more rapidly foster and replicate the best of examples of leadership
    - how to support and improve the skills of all leaders and managers throughout their careers and encourage the best leaders within the system to rise
    - how to draw new expertise and talent into leadership roles in the health and care systems (including the NHS Management Graduate Trainee Scheme)
    - how to ensure the right training, opportunities and support for clinicians to take on management roles throughout their careers
    - whether the right pay and incentives are in place to foster good and excellent performance and recruit and retain the best leaders from start of career to retirement
    - driving up efficiency – to support leaders, managers, clinicians and wider staff, creating the space and time for them to focus as much time as possible on delivering for patients and care users
- As part of its work, the Review will also look at how to deliver the findings of proposals and commitments made in previous reports on improving healthcare leadership, such as the report by Lord Rose in June 2015.

Establishment of new Office for Health Improvement and Disparities (OHID)

- On 3 September 2021, the Department of Health and Social Care announced that the new Office for Health Improvement and Disparities (OHID) would officially launch on 1 October 2021. The aim of the new body is to tackle health inequalities across the country, and will be co-led by the newly appointed Deputy Chief Medical Officer, Dr Jeanelle de Gruchy. The OHID is part of the Department of Health and Social Care and has a role in working across Government to reduce health disparities. The body will tackle the top preventable risk factors for poor health, including obesity caused by unhealthy diets and lack of physical activity, smoking and alcohol consumption. According to the Department, it will work across the health system to drive forward action on health disparities, including improving access to health services across the country, and coordinate with government departments to address the wider drivers of good health, from employment to housing, education and the environment.

3. Political and legislative developments

Secretary of State for Health and Social Care – Open letter to all NHS trusts in England on COP26

- On 10 November 2021, the Rt Hon Savid Javid MP, Secretary of State for Health and Social Care wrote to all NHS trusts in England regarding the role of the NHS in achieving the UK's commitments to tackle climate change.
- The letter reminds NHS trusts of the requirement, set out in NHS England's 2020 *Delivering a 'Net Zero' National Health Service*, to produce a 3-year Green Plan that is approved by the Board. It encouraged trusts to use available capital funding to mitigate emissions. It also encouraged NHS trusts to consider building in biodiversity plans into this work and to consider how best to use, manage and enhance their green spaces for the benefit of people and wildlife. In particular, it highlighted the NHS Forest initiative which has led to over 77,000 trees being planted across 200 different NHS organisations' estates, as well as individual trusts' initiatives such as the 1 hectare of wildflowers planted by the University of Birmingham NHS Foundation Trust and the rooftop honey bees project by Manchester NHS Foundation Trust. The letter also outlined the requirements that will be placed on all public bodies, including NHS England, to report publicly on key environmental outcomes via the forthcoming Environment Bill.

UK health services – Net Zero pledge

- On 9 November 2021, it was announced that the four health services across the United Kingdom have committed to achieve net zero carbon emissions as part of the UK's commitment to become net carbon zero by 2050:
    - In England, there are plans to embed the net zero commitment as well as wider commitments to biodiversity and climate resilience within the NHS Constitution, with a formal review of the NHS Constitution expected to take place in 2022. All NHS suppliers will be expected to publish a carbon reduction plan. A new net zero healthcare building standard will be published and applied to the existing new hospitals building programme previously announced by the Government.
    - In Scotland, there is a commitment to deliver a net zero carbon emissions health service by 2045, with the ambition to bring this forward to 2040. All NHS buildings in Scotland will be required to use renewable heat by 2038 and must work towards zero emissions of medical nitrous oxide by 2027. All NHS Scotland small and medium sized vehicles must be net zero by 2025, and all Scottish health boards will be required to prepare net zero route maps by the end of 2022.
    - In Wales, NHS Wales and social care is committed to the ambition for the public sector in Wales to be collectively net zero by 2030. By 2025, all lighting across the NHS Wales estate must be LED based, and reducing emissions will be part new procurement contracts for major suppliers to NHS Wales. The ambition is that by 2030, all Welsh Ambulance Services new vehicles will be plug-in electric or low carbon fuel, and all new build NHS Wales buildings must use low carbon heating.
    - In Northern Ireland, there are commitments to develop a sustainable low carbon health system to help meet Northern Ireland's emissions targets, developing an emissions reduction action plan, and influencing supply chains to reduce their carbon emissions in supplying health and social care.

Review of the health impact of potential bias in medical devices

- The Government has announced a review into the health impact of potential bias in medical devices. An independent review will look at potential bias in items such as oxygen measuring devices and the impact on patients from different ethnic groups. It follows concerns that the way medical devices and technologies are designed and used could mean a patient's diagnosis and treatment is affected by their gender or ethnic background, exacerbating existing inequalities in healthcare. The review is expected to begin work shortly and report its initial findings by late January 2022.

4. NHS policy and institutional landscape

Mandatory vaccines for frontline NHS staff

- On 9 November, the Government announced that Covid-19 vaccinations would be made mandatory for all frontline health and social care workers.
- The regulations will apply to health and social care workers who have direct, face-to-face contact with people while providing care – such as doctors, nurses, dentists and domiciliary care workers, unless they are exempt. They will also apply to ancillary staff such as porters and receptionists who may have social contact with patients but are not directly involved in their care. This will apply across the CQC regulated health and social care sector. The requirements will come into force in the spring, subject to the passage of the regulations through Parliament. There will be a 12-week grace period between the regulations being made and coming into force to allow those who have not yet been vaccinated to have both doses. Enforcement would begin from 1 April, subject to Parliamentary approval.
- Relates to Strategic Risk 1 (patient safety), Strategic Risk 3 (operational performance) and Strategic Risk 9 (workforce), but has potentially wide-ranging impact across all risks on the Trust's Board Assurance Framework.

Health Education England and NHSX merged into NHS England and NHS Improvement

- On 22 November 2021, the Department of Health and Social Care announced that Health Education England, NHSX and NHS Digital will be merged into NHS England and NHS Improvement. HEE is currently an executive non-departmental public body of the DHSC, responsible for coordination of education and training within the health and public health workforce within England, including the training of doctors and nurses. NHS Digital is a non-departmental public body responsible for the information, data and IT systems for commissioners, analysts and clinicians in health and social care in England. NHSX is a joint unit of NHS England and the Department of Health and Social Care, supporting local NHS and care organisations to digitise their services, connect the health and social care systems through technology and transform the way patients' care is delivered at home, in the community and in hospital. NHS Digital and NHSX will form part of the new Transformation Directorate within NHSE alongside Improvement, and Innovation, Research and Life Sciences.
- The merger of HEE into NHS England and NHS Improvement has been anticipated for some time, and particularly so following the Government's most recent Budget where future funding for HEE had not been agreed. It had been reported that the funding settlement HEE had sought was considered by HMT to be unaffordable, and this has been reported as a factor leading to the effective end of the independent education body. HEE's 2020/21 budget was £3.96bn. The merger of HEE into NHSE&I aligns finance and workforce planning, and brings education and training spending within the NHSE&I funding allocation which has been ring-fenced from any reductions in spending in recent years. It is anticipated that the merger will clarify responsibility for workforce planning and facilitate the development of a national workforce strategy to meet future demand for services.
- Relates principally to Strategic Risk 3 (operational performance), Strategic Risk 5 (financial sustainability), Strategic Risk 8 (culture) and Strategic Risk 9 (workforce) on the Trust's Board Assurance Framework, though has wider implications across all strategic risks.

4. NHS policy and institutional landscape

Consultation on Changes to the NHS Transaction Guidance

- On 9 November 2021, NHS England and NHS Improvement launched a consultation on proposed changes to its *NHS transactions guidance for trusts undertaking transactions, including mergers and acquisitions.* The guidance governs the way NHSE/I assures and grants proposed transactions involving trusts. This includes reviewing transactions it considers could expose trusts, and the systems they are part of, to significant risk. The proposed changes reflect the increasing role of systems and collaboration between providers in the period leading up to a transaction, and put a greater emphasis on the opportunities to deliver patient and population benefits. NHSE/I intends the updated guidance to offer reduced regulatory burden and reduced costs to trusts, while ensuring proposed transactions meet the needs of patients and the public.

- Some of the key features on which NHSE&I are consulting include:
    - NHSE/I sets out a new overall test that proposals for a transaction should meet: Do the deliverable benefits to patients and the wider public materially outweigh the costs and risks in the medium to long term? Trusts will be asked to demonstrate ambition for patients and the public, and show mitigation strategies for short term financial risks
    - NHSE/I intends to retain aspects of the Competition and Markets Authority's (CMA) regulatory process, given the decreased role for the CMA in future transactions.
    - The reporting threshold for capital proposals from foundation trusts not in distress/financial difficulty will be set at £50 million, or £30 million for digital cases.
    - The proposals acknowledge that the existing guidance operates under the premise of a financially strong acquirer taking over an unsustainable trust, but this is now often not the case as many acquiring trusts have limited financial headroom (and/or the business case for the transaction carries broader benefits than the financials).
    - A new risk assessment framework will place an increased emphasis on success factors, including culture, staff engagement, digital integration and readiness for transformational change.
    - ICSs will not be given a 'final say' in whether a transaction can go ahead, but system support will be a key factor in determining whether a strategic case should progress to a full business case, and whether the transaction offer benefits to patients in the wider system, rather than just the transacting trusts

- NHSE/I draws similarities between the inherent risks associated with bringing together two or more organisations via mergers and acquisitions and those associated with some types of collaboration. It therefore proposes to capture a limited number of collaborative arrangements within its revised guidance, to encourage 'the right level of strategic thinking' before decisions that may give rise to material risk for the parties involved or may be difficult to unwind in the future. The proposals may be iterated further as the models associated with provider collaboratives develop. In practice NHSE/I proposes to ask trusts to engage with it if they have proposals for:

    - Significant joint working at board level – Particularly where it involves core roles such as chair, chief executive, deputy chief executive, chief operating officer, medical director, nursing director and the chief financial officer.

    - The development of committees in common – Where a significant proportion of strategy formulation and/or operational management of services has been delegated from the trust boards.

Public Health England – Transfer of functions

- Reforms to the public health system which were announced in March 2021 came into effect from 1 October 2021. On this date, Public Health England transferred all of its health protection functions into the UK Health Security Agency (UKHSA) and health improvement / healthcare public health functions into the Office for Health Improvement and Disparities (OHID), NHS England and NHS Improvement, and NHS Digital (prior to the latter's merger into NHSEI). NHS Test and Trace functions also became part of UKHSA.

5. System and professional regulation

Care Quality Commission State of Care Report 2020/21

- On 22 October 2021, the CQC published its annual State of Care Report for 2021/22. The report provides an annual assessment of the state of health and social care in England and looks at the quality of care provided across the NHS and social care over the past year. The report concludes that: “The system has not collapsed – but the system is composed of individuals who deliver and receive care, and the toll taken on many of these individuals has been heavy. As we approach winter, the workforce who face the challenges ahead are drained in terms of both resilience and capacity, which has the potential to impact on the quality of care they deliver.”
- Key findings of the report:
    - People’s experience of care:
        - The impact of the pandemic on many who use health and social care services has been intensely damaging. The pandemic has further exposed and exacerbated pre-existing inequalities. People with a learning disability have faced increased challenges as a result of the pandemic. The need for mental health care has increased, with children and young people particularly badly affected.
        - Health and social care staff are exhausted and the workforce is depleted. People across all professions, and carers and volunteers, have worked tirelessly to help those who needed care. The negative impact of working under this sustained pressure, including anxiety, stress and burnout, cannot be underestimated.
        - Surveys have shown that, when people were able to access the care they needed, they were often positive about that care.
    - Flexibility to respond to the pandemic:
        - Of the NHS acute areas examined (cancer, cardiovascular, A&E, and mental health services), cancer services have achieved the best response and recovery.
        - The NHS was able to expand its critical care capacity to respond to the needs of the patient population at a time of crisis.
        - The CQC has serious concerns about ambulance handover delays at hospitals, which puts the safety of patients at risk.
        - The ‘discharge to assess’ model for managing transfers of care has helped to support services in both health and social care.
        - Urgent action is needed to tackle staffing issues in adult social care and the increased pressures and stresses caused by staff shortages.
    - Ongoing quality concerns:
        - Improvements in maternity care are far too slow, with continuing issues around staff not having the right skills or knowledge, poor working relationships, and not learning from when things go wrong. Other concerns include a lack of engagement with local women by maternity services and limited action taken by these services to improve equitable access.
        - While services have largely maintained levels of Deprivation of Liberty Safeguards during 2020/21, they need to have a continued focus on people subject to a deprivation of liberty. The CQC continue to have concerns about delays in authorisations, which mean that individuals are deprived of their liberty longer than necessary, or without the appropriate legal authority and safeguards in place.
    - Challenges for systems:
        - Collaborative working was varied among the local systems reviewed. There was a lack of integration of adult social care providers into system-level planning and decision-making. Most systems had some understanding that inequalities in care that existed in their areas before the pandemic, as well as how they had worsened or changed due to the pandemic. But tackling these inequalities was often not a main priority for them.
        - Workforce planning is a major priority and challenge for local systems and providers. Recruitment and staff retention continue to be severe problems. In adult social care, the situation is serious and deteriorating. There must be a sharp focus on developing a clearly defined career pathway and training, supported by consistent investment that will enable employers to attract and retain the right people.

5. System and professional regulation

Care Quality Commission report on Safety, Equity and Engagement in Maternity Services

- On 20 September 2021, the CQC published a new report on maternity services in England. The report presents an analysis of the key issues persisting in some maternity services and highlights where action is still needed to support essential improvements, and highlights continued concern about the variation in the quality and safety of maternity services. The report draws on the findings from a sample of nine focused maternity safety inspections carried out between March and June 2021, along with insight gathered from interviews and direct engagement with organisations representing women and their families.

- While recognising that many maternity units across the country are providing good care, the report reveals ongoing concerns about leadership and oversight of risk, team working and culture, and the extent to which services are engaging with and listening to the needs of their local population. It also points to the pressing need to address the inequalities in outcomes for Black and minority ethic women and babies, which have been further exacerbated during the Covid-19 pandemic.

- In 2020, the CQC's 'Getting safer faster' maternity briefing made a number of recommendations for action. It also set out CQC's intention to retain a strong focus on the safety and quality of maternity services going forward. Following that briefing, CQC launched a programme of focused maternity safety inspections, targeting those services where monitoring of data and information from people working in and using maternity services indicated an increased safety risk.

- In its 2021 report the CQC notes a variation in the consistency and stability of leadership teams in the services they inspected and, in some services, that a shared purpose and sense of a united "maternity team" was lacking. Inspectors saw some positive examples of multidisciplinary team training and learning. However, the extent to which staff were fully engaged with that training varied, and in some services, there was a lack of support for staff to maintain and develop their skills and individual competencies. Poor incident reporting was a further theme and staff did not always recognise what constituted an incident or how to grade incidents correctly.

- The CQC has set out the following recommended next steps for maternity services and wider system partners to help address the issues identified in the 2021 maternity services report and support improvements for those using and working in maternity services across the country:

    - **Leadership**: In line with essential action 2 of the Ockenden review, Boards must take effective ownership of the safety of maternity services. This includes ensuring that they have high quality, multidisciplinary leadership and positive learning cultures. They must seek assurance that staff feel free to raise concerns, that their concerns and adverse events lead to learning and improvement and that individual maternity staff competencies are assured.

    - **Voices and choices**: In line with the Cumberlege review 'First do no harm', maternity services must ensure that all women and their families have information and support that allows them to make choices about their care. This includes listening to individual women and fully explaining choices, in an accessible way throughout the pregnancy journey - for example, working effectively with interpreters.

    - **Engagement**: As supported by the findings of Better Births and First do no harm, local maternity systems need to improve how they engage with, learn from and listen to the needs of women, particularly women from Black and minority ethnic groups. They also need to make sure that targeted engagement work is appropriately resourced.

    - **Data and risk**: Services and systems should use ethnicity data they collect to review safety outcomes for women from Black and minority ethnic groups and take action in response to risk factors. This includes working with Black and minority ethnic women to personalise care and reduce inequality of outcomes.

- Links to Strategic Risk 1 (patient safety), Strategic Risk 2 (clinical governance), Strategic Risk 8 (culture) and Strategic Risk 9 (workforce) on the Board Assurance Framework.

5. System and professional regulation

Future Standards for Physician Associates and Anaesthesia Associates

- On 21 October 2021, the General Medical Council (GMC) published future professional standards for Physician Associates (PAs) and Anaesthesia Associates (AAs), which was developed with the Faculty of Physician Associates, Royal College of Physicians, Association and Anaesthesia Associates, and Royal College of Anaesthetists.
- The guidance has been made available now to give PAs, AAs, and students time to familiarise themselves with the GMC's requirements. It will also help the public, employers and other members of the healthcare team to better understand these important roles and the contribution that PAs and AAs make to patient care across the UK. In 2019 the Department of Health and Social Care, with the support of the four UK governments, asked the GMC to regulate PAs and AAs. The guidance has been developed as part of the GMC's programme of work to prepare for future regulation. It will come into effect once legislation to implement broader reforms to healthcare professional regulation has been passed by the UK parliament.
- Links to Strategic Risk 1 (patient safety) and Strategic Risk 9 (workforce) on the Board Assurance Framework.

General Medical Council survey of reasons why doctors have stopped practising in the UK

- On 6 October, the GMC published a report analysing the reasons why doctors have stopped working in the UK and what stopped them returning to UK practise. The GMC undertook a survey of doctors who stopped practising in the UK between 2014 and 2019 and found that dissatisfaction with their jobs and burnout were among the main reasons given for leaving their jobs.
- Doctors were asked to select and rank factors which played a part in their decision to leave. Many cited personal reasons, such as retirement (27%) or returning to their home country (32%). But workplace issues were given by many including dissatisfaction (36%) and burnout (27%). Bullying was included as a reason by 5.5% of respondents. When analysing respondents' top three reasons for leaving, lifestyle factors were cited more often than workplace issues. Doctors with some protected characteristics were more likely to include certain negative reasons for leaving. For example, disabled doctors were more likely to report bullying as a factor, while BME doctors, and some religious groups, reported higher levels of bullying and harassment. LGBT doctors more commonly reported mental health issues.
- Links to Strategic Risk 8 (culture) and Strategic Risk 9 (workforce) on the Board Assurance Framework.

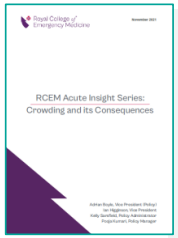
New Nursing and Midwifery Test of Competence

- The NMC's new Test of Competence (ToC) was launched on 2 August 2021. The ToC seeks to make sure professionals who trained overseas, and some professionals who want to re-join the register after time away from practice, have the right skills and knowledge to practise safely. The new ToC reflect the NMC's new Future Nurse and Future Midwife standards, ensuring that all those delivering care in the UK will meet the same high standards, regardless of where they are trained or how long they have been out of practice. Other changes the NMC are introducing include: Splitting the computer-based test (CBT) into two parts - Part A will cover numeracy and Part B will cover nursing or midwifery theory. The new practical part of the test, the objective structured clinical examination (OSCE) will have ten stations rather than six. It will assess additional skills as well as the candidate's values and behaviours, and evidence-based practice.
- Links to Strategic Risk 1 (patient safety) and Strategic Risk 9 (workforce) on the Board Assurance Framework.

6. Reports from key stakeholders

NHS Providers – *State of the Provider Sector 2021*

- On 16 November 2021, NHS Providers published its annual *State of the Provider Sector* report. The report is based on a survey of trusts, and asked for trust leaders' views across several areas such as capacity to meet rising demand, quality of care, workforce priorities, NHS funding and system working. 172 trust leaders from 114 separate trusts responded to the survey, accounting for 54% of the provider sector across all regions and trust types in England.
- Key issues highlighted in the report included:
    - A large majority (87%) of trust leaders said they were extremely concerned about the impact of seasonal pressures over winter on their trust and local area
    - Trust leaders highlighted staff availability leading to workforce shortages as one of the biggest risks to services over winter. Almost all (94%) trust leaders were extremely or moderately concerned about the current level of burnout across their workforce.
    - 84% of trust leaders were very worried or worried about their trust having the capacity to meet demand for services
    - Just over half (51%) of trust leaders rated the current quality of healthcare provided by their local area as very high or high.
    - A large number (85%) of trust leaders were very worried or worried about sufficient investment being made in social care in their local area.
    - 43% of trust leaders were confident or very confident that plans to embed system working, via statutory ICSs, will support better collaboration between local partners and improve mutual aid. 41% were confident or very confident that these plans will support better outcomes for patients.
- Links to all Strategic Risks on the Board Assurance Framework



Royal College of Emergency Medicine (RCEM) Report – *Crowding and its Consequences*

- A report published by the RCEM on 18 November 2021 found that at least 4,519 patients have died as a result of overcrowding and 12 hour stays in Emergency Departments in England in 2020/21. The report investigated the extent of harm that crowding causes and applied NHSEI's findings from the Getting It Right First Time programme which found that one in 67 patients staying in the ED for 12 hours comes to excess harm.
- In the context of 7,059 12-hour stays in EDs across England in October 2021, the highest number ever recorded, the report highlights the risks to patient safety of overcrowding in ED and the risks going into winter. The College stated that: "if performance continues to fall this winter: more and more patients will come to avoidable harm in the Emergency Department; staff will face moral injury; and the urgent and emergency care system will be deep into the worst crisis it has faced."
- In a related report, also published in November 2021, the Association of Ambulance Chief Executives, found that as many as 160,000 patients annually may be coming to harm as a result of delayed ambulance handovers.
- Links to all Strategic Risk 1 (patient safety), Strategic Risk 3 (operational performance) on the Board Assurance Framework

Outstanding care every time

7. Key appointments

Appointment of new NHS England Chief Executive

- On 28 July 2021, Amanda Pritchard was appointed as the new Chief Executive of NHS England and formally took on the role from 1 August 2021. Prior to her appointment, Amanda Pritchard had served as Chief Operating Officer of NHS England for two years. Prior to this, she was Chief Executive of Guy's and St Thomas' NHS Foundation Trust and Deputy Chief Executive of Chelsea and Westminster NHS Foundation Trust. Mark Cubbon was subsequently appointed interim Chief Operating Officer of NHS England while recruitment for a substantive appointment is undertaken, and an outcome of this process is expected shortly.

New Deputy Chief Medical Officer and Head of Office for Health Improvement and Disparities

- Dr Jeanelle de Gruchy has been appointed as Deputy Chief Medical Officer at the Department of Health and Social Care and Head of the new Office for Health Improvement and Disparities (see earlier in report for further details about OHID). Dr de Gruchy previously served as President of the Association of Directors of Public Health, the Director of Population Health at Tameside Metropolitan Borough Council, and Chair of the Greater Manchester Association of Directors of Public Health. Other previous roles included being Director of Public Health and the London Borough of Harringay and Chair of the London Association of Directors of Public Health.

Sir James Mackey appointed as adviser to NHS England on elective recovery

- On 10 September 2021, Sir James Mackey, Chief Executive of Northumbria Healthcare NHS Foundation Trust and former Chief Executive of NHS Improvement, was appointed as an adviser to NHS England on elective recovery, looking at new ways of addressing the elective backlog following the Covid-19 pandemic. He is expected to spend two-days a week working for NHS England supporting the national team.

CQC Chief Inspector of Hospitals to retire in 2022

- On 14 September, the CQC announced that its Chief Inspector of Hospitals, Ted Baker, will retire in March 2022. Ted Baker has served as Chief Inspector since July 2017, having previously served as Deputy Chief Inspector of Hospitals under Sir Mike Richards. The CQC is currently undertaking a recruitment for Ted Baker's successor.

Appointments to roles of Chair-designate and Chief Executive-designate of South West London Integrated Care Board

- Sarah Blow has been appointed as the new Designate Chief Executive and Millie Banerjee as Chair Designate of the new NHS Integrated Care Board for South West London. Both will take up their roles as soon as the Health and Care Bill receives Royal Assent. The next step will be for the SWL ICB to recruit Non-Executive Directors and Executive Directors. Subject to the legislation, the NHS South West London Integrated Care Board will become a statutory body on 1 April 2022.

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	25 November 2021	**Agenda No**	4.5
Report Title:	Horizon Scanning Q2, 2020-21 Report		
Lead Director/ Manager:	Suzanne Marsello, Chief Strategy Officer		
Report Author:	Laura Carberry, Strategy and Partnership Manager		
Presented for:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify)		
Executive Summary:	This Horizon Scanning Quarterly Report is intended for Trust Board; apprising the Board of the latest Local and Regional Updates, based on CCG Governing Body and Health and Wellbeing Board papers in south west London. It should be considered alongside the Corporate Office's Horizon Scanning Q2, 2020-21 Report on National Policy. Areas of interest/ particular relevance to the Trust, include: • COVID-19; • The evolving Integrated Care System (ICS), Place-based Partnerships and Provider Collaboratives in SWL; • Mental Health; and, • Renal Services in SWL and Surrey.		
Recommendation:	Trust Board is asked to: • Note the latest Local and Regional Updates.		
Supports			
Trust Strategic Objective:	1. Treat the patient, treat the person 2. Right care, right place, right time 3. Balance the books, invest in our future 4. Build a better St. George's 5. Champion Team St. George's 6. Develop tomorrow's treatments today		
CQC Theme:	1. **Safe**: you are protected from abuse and avoidable harm. 2. **Effective**: your care, treatment and support achieves good outcomes, helps you to maintain quality of life and is based on the best available evidence. 3. **Responsive**: services are organised so that they meet your needs. 4. **Caring**: staff involve and treat you with compassion, kindness, dignity and respect. 5. **Well Led**: the leadership, management and governance of the organisation make sure it's providing high-quality care that's based around your individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.		
Single Oversight Framework Theme:	▪ Leadership and Improvement Capability (well-led)		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Equality and Diversity:	N/A		

Previously Considered by:	Executive Management Team	**Date**	15 November 2021
Appendices:	N/A		

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Horizon Scanning Report Q2, 2021- 22

Local and Regional Updates

This Horizon Scanning Quarterly Report is intended for Trust Board; apprising the Board of the latest Local and Regional Updates, based on CCG Governing Body and Health and Wellbeing Board papers in south west London.

It should be considered alongside the Corporate Office's Horizon Scanning Q2, 2021- 22 Report on National Policy.

Suzanne Marsello, Chief Strategy Officer

Laura Carberry, Strategy and Partnership Manager

November 2021

CONTENTS

HIGHLIGHTS

Below are the Headlines/ Highlights that are of particular relevance to the Trust.
NB: Areas covered in the Main Body of this Report are not fully replicated or summarised in this Table.

Item	Notes	Likely to be of particular interest to…
COVID-19	Agendas for the CCG Governing Body and also the Health and Wellbeing Boards all covered COVID-19 with an emphasis and focus on learning and plans in relation to: • Children's and Adolescent Mental Health Services (CAMHS) • Communications and Engagement • Health and Care Plans • Health Inequalities • Impact and Learning from the 1st, 2nd and 3rd Waves • Joint Strategic Needs Assessments (JSNAs) • Mental Health • NHS Operating Plans (including H1 and H2) • Operational Performance • Outbreak Management • Post-COVID Syndrome • Public Health • Test and Trace Programmes • Vaccination Programmes • Variants of Concern (VoCs)	• Executive Management Team
The evolving Integrated Care System (ICS), Place-based Partnerships and Provider Collaboratives in SWL	Agendas for the CCG Governing Body and also the Health and Wellbeing Boards all covered the evolving Integrated Care System and particularly, Place-based Partnerships in SWL. The CCG Governing Body emphasis/ focus incl.: • Annual Accounts and Reporting and its Annual General Meeting • Communications and Engagement • ICS Transition including Organisational Development and System Development Plans • NHS Operating Plans (including H1 and H2) Health and Wellbeing Boards emphasis/ focus incl.: • Borough-level Estates Strategies • Borough-level Health and Care Plans • Joint Strategic Needs Assessments (JSNAs) • NHS Operating Plans (including H1 and H2) • Place-based Partnership Transition	• Chief Executive • Chief Operating Officer • Chief Strategy Officer • Deputy Chief Executive/ Chief Finance Officer • Executive Management Team

Item	Notes	Likely to be of particular interest to…
Mental Health	Agendas for the CCG Governing Body and also the Health and Wellbeing Boards all covered/ identified Mental Health as a particular priority in SWL. Children and Adolescent Mental Health Services (CAHMS) is an identified and ongoing operational pressure and risk in SWL. CAHMS demand has increased with further investment needed and plans recognising and reflecting this in SWL.	• Executive Management Team
Renal Services in SWL and Surrey	Agendas for the CCG Governing Body in July and in October 2021, covered progress on the reconfiguration of Renal Services in SWL and Surrey. The CCG Committees in Common (CiC) endorsed and fed back in June 2021 on the Pre-Consultation Business Case (PCBC) and a discussion in July 2021 with the Joint Health Overview and Scrutiny Committee (JHOSC) for South West London and Surrey was progressed. Communication and Engagement (July- September 2021) on the proposed reconfiguration of Renal Services in SWL and Surrey was reviewed in October 2021; feedback focused in particular on: Continuity of Care, Investment, and Transport and Travel. The Decision-Making Business Case (DMBC) and Engagement Outcome Report are expected to be finalised in November 2021.	• Executive Management Team

SOUTH WEST LONDON CCG: Q2, 2021- 22

GOVERNING BODY MEETING PAPERS SUMMARY

CCG Governing Body Meeting: 7 July 2021

Bi-Monthly Meetings

- The **Accountable Officer and Chair Report** covered the Community Engagement Steering Group; ICS Transition; and, the reconfiguration of Renal Services in SWL and Surrey.
  - Community Engagement Steering Group: chaired by Susan Gibbon (Lay Member, Patient and Public Involvement) and including CVS and Healthwatch as Members. The Community Engagement Steering Group convened in May 2021 and discussed 2021-22 Annual Planning and Priorities- at Place and SWL-level; NHS 111; and, the reconfiguration of Renal Services in SWL and Surrey.
  - ICS Transition: it is anticipated that there will be detailed guidance on ICS's imminently from NHS England but the development of an ICS Organisational Development Plan, System Development Plan (SDP) and Transition Plans are in progress in SWL; engagement is ongoing in parallel with partners in the SWL System with events planned in the Autumn 2021.
  - Renal Services in SWL and Surrey: the development of a Joint Renal Unit is being led by Epsom and St Helier University Hospitals NHS Trust and St George's University Hospitals NHS Foundation Trust and the location proposed is St George's Hospital in Tooting.
  - Commissioners (Frimley CCG, NHS England Specialised Commissioning, South West London CCG and Surrey Heartlands CCG) have developed, with feedback incorporated from the Joint Clinical Senates (London and South East Regions), a Pre-Consultation Business Case (PCBC) with support from the Trusts.
  - The Committees in Common (CiC) endorsed and fed back in June 2021 on the PCBC and a discussion in July 2021 with the Joint Health Overview and Scrutiny Committee (JHOSC) for South West London and Surrey is planned.
- The **2020/21 Annual Accounts and Report** were covered by the Governing Body; these were agreed with Auditors, approved by the Audit Committee with delegated responsibility and submitted in June 2021; Auditors will complete the ongoing and outstanding reporting on Value for Money (VfM) in September 2021.
- The **Annual General Meeting** was discussed by the Governing Body; the agenda for agreement included: 2020/21 achievements and challenges including COVID-19 as well as 2021/22 areas of emphasis/ focus and forward look with identified presenters; the Meeting via MS Teams is scheduled for 29 September 2021.
- There was a discussion on the f**inal H1 Plan (1 April- 30 September 2021)** by the Governing Body; it was acknowledged that ambitions/ aspirations locally were not prioritised or reflected with the expectation/ focus on National Priorities (Community Services, COVID-19, Elective Care, Finance, Maternity Services, Mental Health, Primary Care, Recovery/ Restart of Services, Urgent and Emergency Care, Vaccination, Workforce, etc.) in the plan submitted in June 2021.

  Activity aligned to BAU levels and a commitment to deliver the following KPIs was signed-off by SWL ICS;

  - 80% A&E, including an assumption that NHS 111 reduces Walk-ins;
  - 88% Bed Occupancy (G&A);
  - 100% of Diagnostics;
  - 100% Electives, including Independent Sector support and Queen Mary's Hospital;
  - 100% Non-Elective, including a 5% admission assumption for COVID-19; and,
  - 99% Outpatients, including 28% Virtual.

  Additional Elective Recovery funding is contingent on delivering these KPIs.

SOUTH WEST LONDON CCG: Q2, 2021- 22

GOVERNING BODY MEETING PAPERS SUMMARY

- Approval from the Governing Body for the **Croydon Memorandum of Understanding for the Place-based System**, between Croydon Health Services NHS Trust and NHS SWL CCG and effective from July 2021 to March 2022, was requested.

  This aims for alignment and collaboration to continue in the delivery of the Health and Care Plan and integrated Health and Social Care led by the One Croydon Alliance (Age UK, Croydon Council, Croydon GP Collaborative, Croydon Health Services NHS Trust, South London and Maudsley NHS Foundation Trust (SLaM) and other Stakeholders) and, a commitment to the MoU for the Place-based System to be reaffirmed and restated by SWL CCG.

  It also aims for the allocation of the Borough-level Budget to be delegated* and for a continuation of the Executive and Leadership Teams that have been shared since 2019. * *In 2019-20, £225.8m for Acute and Community Services was delegated by Croydon CCG and Croydon Health Services NHS Trust to the One Croydon Alliance.*

  The Borough-based Committee in the first instance is proposed as the representative of SWL CCG.

- Approval to commission a **Digital Pan-London Shared Care Plan** as lead for London was requested from SWL CCG; with the decision on a Development Partner to be delegated to the Pan-London Collaborative Commissioning Group and finalised by September 2021.

  The approach to commissioning a Digital Pan-London Shared Care Plan includes:

  - the coordination and delivery of an Implementation Programme led by SWL ICS; and,
  - the development of an IT Solution led by OneLondon Digital Transformation Team.

  The Contract for 'Coordinate My Care', currently provided by the Royal Marsden NHS Foundation Trust, is due to expire on 30 March 2022.

  Consultation has identified improvements and influenced and informed the draft IT Service Specification as well as the Outline Business Case (OBC) which has been ratified by the SWL CCG Finance Committee.

- **Committee Reports** were covered by the Governing Body including:
  - Audit Committee;
  - Finance Committee;
  - Finance Report;
  - Performance Report; and,
  - Primary Care Commissioning Committee.
  - Oversight, Performance and Quality Committee.

Board Papers can be found at: https://swlondonccg.nhs.uk/previous-governing-body-meetings/july-2021-governing-body-meeting/

DONM: 6 October 2021

SOUTH WEST LONDON CCG: Q2, 2021- 22

GOVERNING BODY MEETING PAPERS SUMMARY

CCG Governing Body Meeting: 6 October 2021

Bi-Monthly Meetings

- The **Accountable Officer and Chair Report** covered the 2020-21 CCG Self-Assessment, the 2021 GP Patient Survey, Blood Tubes, the Integrated Care System (ICS) and Refugee Support in SWL.
  - 2020- 21 CCG Self Assessment: with the advent of COVID-19, the annual assessment of CCGs by NHSE was simplified. The approach included the CCG completing a Self-Assessment and consideration of the experiences/ interactions with NHSE London Region as well as feedback from the Health and Wellbeing Boards in Merton, Richmond and Wandsworth. The areas of assurance covered: Finance, Governance and Leadership, Health Inequalities, Public Involvement and the Quality of Services; a confirmation letter from NHSE was received in response.
  - 2021 GP Patient Survey: administered annually in England by Ipsos MORI and issued to c2m Patients; data on the experiences (at GP Practice level) of Patients was reported and published in July 2021.

    It was advised that the CCG, with a 31% response rate in SWL: achieved better than average in almost all areas and compared favourably with its London Peers.
  - Blood Tubes: it was advised that the availability of Beckton Dickinson (BD) Blood Tubes was improving, following recent shortages in the UK.
  - Integrated Care System (ICS): it is anticipated that further information on Integrated Care Systems (ICS) will be issued by NHSE shortly; development and engagement on the future ICS is ongoing with Partners and Stakeholders in SWL.
  - Refugee Support in SWL: 300 Refugees are being cared for in Croydon by the Rainbow Health Centre with further input, resources and support from SWL.
- The approach to Communication and Engagement (July- September 2021) on the proposed **reconfiguration of Renal Services in SWL and Surrey** was reviewed; feedback focused in particular on: Continuity of Care, Investment, and Transport and Travel.

  The Decision-Making Business Case (DMBC) and Engagement Outcome Report are expected to be finalised in November 2021.
- The **Board Assurance Framework (BAF)** and **Corporate Risk Register** were reviewed. Discussion focused on Blood Tubes, changes to Coordinate My Care (CMC), the COVID-19 Vaccination Programme, Estates and increasing Hospital-acquired Infections, the Financial Position, Mental Health, the NHS Constitutional Standards, Oversight of Providers/ Quality, Planned Care and Urgent Care as the risks that scored over 15 or, were of significance.
- The **2021-22 Children's Mental Health Programme in SWL** was considered and discussed by the Governing Body.

  CAHMS demand has increased with further investment planned and progressed in SWL, e.g. additional Attention Deficit Hyperactivity Disorder (ADHD) and Autism Spectrum Disorder (ASD) Services, Dialectical Behaviour Therapy (DBT), the extension of the iThrive Model to Kingston, Richmond and Sutton and later on to Wandsworth (implementation in Merton is progressing); Mental Health in Schools, and; the prevention of Self-Harm and Suicide.
- There was a discussion on the **Independent Review of Health Inequalities in Merton and Sutton** (in particular East Merton and North Sutton) led by the King's Fund; it found that the **Improving Healthcare Together (IHT) Programme's** plans and proposals in response should be sustained, with further recommendations to be reviewed by the system as a whole.

SOUTH WEST LONDON CCG: Q2, 2021- 22

GOVERNING BODY MEETING PAPERS SUMMARY

Bi-Monthly Meetings

- There was a discussion on the issues and latest position in relation to **Workforce**.

  Approval for the annual Staff Survey Action Plan and the Grievance and, Recruitment and Selection Policies was requested and, Key Performance Indicators (KPIs) were reviewed.
- **Committee Reports** were covered by the Governing Body including:
  - Audit Committee;
  - Finance Committee;
  - Finance Report;
  - Performance Report; and,
  - Oversight, Performance and Quality Committee.

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

DONM: 3 November 2021

HEALTH AND WELLBEING BOARDS: Q2, 2021- 22

BOARD PAPERS SUMMARY

Quarterly Meetings

Croydon HWB: No Meetings planned in Q2, 2021-22

Board Papers can be found at:
https://democracy.croydon.gov.uk/ieListMeetings.aspx?CommitteeId=172&utm_source=mod-gov&utm_medium=taxonomy&utm_campaign=%20committee-calendar-healthwellbeing

DONM: 20 October 2021

Kingston HWB: 22 July (CANCELLED) and 8 September 2021

- The **2019- 21 Health and Care Plan for Kingston** was discussed and progress reflected on and reviewed; Age Well, Live Well and Start Well, Carers and Prevention, as well as COVID-19 latterly, were the identified priorities for these years.

  The **2021- 24 Health and Care Plan for Kingston** was also discussed and is expected to be finalised by October 2021. It is anticipated that there will be continued emphasis/ focus on Age Well, Live Well and Start Well alongside COVID- 19, Health Inequalities, Mental Health and Obesity as planned priorities.
- The **2021/22 NHS Operating Plan for SWL** was discussed; Community Services, COVID-19 Programmes, Elective Care and Elective Care Recovery, Health Inequalities, Primary Care, Population Health, Urgent and Emergency Care and Workforce are identified Integrated Care System (ICS) priorities for SWL.
- Approval of the annual **Better Care Fund (BCF) Plan** was requested; the 2021/22 BCF Plan- conditional on Health and Wellbeing Board review and sign-off- was submitted in May 2021.
- The **Borough-level Health and Care Estates Strategy for Kingston** was discussed; it was acknowledged that additional engagement with the Health and Care System and alignment with the evolving Models of Care as well as Population Health is needed and consequently, the development of the Estates Strategy for Kingston is 'live' with the ongoing prioritisation of Projects/ Schemes regularly reviewed.
- The Chair led a discussion on the evolving **Integrated Care System and Place-based Partnerships** verbally.
- **Partners' Updates** covered the Adult Social Care, Children's Services including Education, Housing and Public Health Portfolios as well as the Financial Position, Healthwatch's latest Meeting, Kingston Hospital's latest operational performance and position and a Kington Voluntary Action's latest progress on its projects/ programmes.

Board Papers can be found at:
https://moderngov.kingston.gov.uk/ieListDocuments.aspx?CId=488&MId=9231&Ver=4

DONM: 17 November 2021

HEALTH AND WELLBEING BOARDS: Q2, 2021- 22

BOARD PAPERS SUMMARY

Quarterly Meetings

Merton HWB: 28 September 2021

- Agreement for the **Community Subgroup** of the Health and Wellbeing Board to be extended to March 2022 was requested; the aim/ purpose of the Community Subgroup is to coordinate the COVID-19 response for those disproportionately impacted and to focus on Health Inequalities in partnership. It will assist in delivering the future and ongoing Post-COVID Syndrome and the Vaccination Programmes.
- Approval of the **2021 Joint Strategic Needs Assessment (JSNA)/ Merton Story** was requested; this is an annual assessment that covers the demographics and details the local needs of the population and the priorities proposed for that year and it is a duty on the Health and Wellbeing Board to produce it statutorily.

  There is a continued emphasis/ focus on Age Well, Live Well and Start Well as well as on COVID-19, Health Inequalities and Place.
- There was a discussion on the evolving **Integrated Care System, Place-based Partnerships and Provider Collaboratives in SWL.**

  Place-based Partnership- the agreed approach is to be a Committee of the Integrated Care Board (ICB) by April 2022. Currently, discussion and engagement on the existing and future **Health and Care Plan for Merton** is ongoing and the implementation of the Organisational Development Plan for the Place-based Partnership is progressing well.

  An abridged **Borough-level Estates Strategy for Merton** is expected to be published shortly by SWL CCG; the final draft was reviewed and signed-off in April 2021. A **Health and Wellbeing Hub has been established in Mitcham** with locations, options and opportunities being reviewed by the Programme Team.

  Community Diagnostic Hubs were discussed and the plans shared for SWL; the aim is for 3 Community Diagnostic Hubs to be established in Croydon (location TBC), at Queen Mary's Hospital and at St Helier Hospital with further planned Satellites e.g. at Kingston Hospital, The Nelson Health Centre, St Johns' Health Centre, etc.

Board Papers can be found at:
https://democracy.merton.gov.uk/ieListDocuments.aspx?CId=184&MId=3965&Ver=4

DONM: 23 November 2021

HEALTH AND WELLBEING BOARDS: Q2, 2021- 22

BOARD PAPERS SUMMARY

Richmond HWB: 15 July (ADJOURNED) and 5 August 2021

Quarterly Meetings

- The **2019- 2021 Health and Care Plan for Richmond** was considered and progress reflected on and reviewed; the **2021- 23 Health and Care Plan for Richmond** was discussed and is expected to be finalised by November 2021. It is anticipated that there will be continued emphasis/ focus on Age Well, Live Well and Start Well alongside COVID- 19 and Health Inequalities as planned priorities in Richmond.
- The **2021/22 NHS Operating Plan for SWL** was discussed; Community Services, COVID-19 Programmes, Diagnostics and Diagnostic Recovery, Elective Care and Elective Care Recovery, Equality, Diversity and Inclusion (EDI), Health Inequalities, Mental Health, Primary Care, Population Health, Urgent and Emergency Care and Workforce are identified Integrated Care System (ICS) priorities for SWL.
- The **2021 Joint Strategic Needs Assessment (JSNA) for Richmond** was discussed and feedback requested; this is an annual assessment that covers the demographics and details the local needs of the population and the priorities proposed for that year and it is a duty on the Health and Wellbeing Board to produce it statutorily.

  Approval to delegate to the Director of Public Health for final publication review and sign-off was sought.

  There is a continued emphasis/ focus on Age Well, Live Well and Start Well as well as on Carers, Community Voice, COVID-19, People, Place and Vulnerable Groups.
- Approval of the **Borough-level Health and Care Estates Strategy for Richmond** was requested; it was acknowledged that additional engagement with the Health and Care System and alignment with the evolving Models is needed and consequently, the development of the Estates Strategy is iterative and 'live' with the ongoing prioritisation of Projects/ Schemes in Richmond.
- The centrality of **Children and Young People** was considered by the Health and Wellbeing Board; a Children and Young People's Plan will be developed in partnership and it was confirmed that the Health and Wellbeing Board will focus in the forward plan on the issues and, oversee and own the plan and priorities in Richmond for Start Well.
- The **Children's and Adolescent Mental Health Services (CAMHS)** latest performance and position was presented.

  It was acknowledged that Children and Young People's Mental Health is an identified and ongoing operational pressure and risk for Richmond as well as SWL.

  CAHMS demand has increased with further investment needed and recognised in SWL.

  In 2022, Adolescent to Adulthood Transition will be a focus and the launch of the iThrive Model is a planned priority in Richmond. There will also be an emphasis on Neurodevelopment issues e.g. Attention Deficit Hyperactivity Disorder (ADHD) and Autism.
- Approval of the **COVID-19 Local Outbreak Management Plan for Richmond** was requested; approaches to Communication and Engagement, COVID-19 NHS Test and Trace and Vaccination Programmes, the detection and identification of Variants of Concern (VoCs) and Health Inequalities, etc. are detailed in the plan.
- The **Health and Wellbeing Board's Terms of Reference** were reviewed.

Board Papers can be found at:
https://cabnet.richmond.gov.uk/ieListDocuments.aspx?CId=643&MId=5106&Ver=4

DONM: 25 October 2021

HEALTH AND WELLBEING BOARDS: Q2, 2021- 22

BOARD PAPERS SUMMARY

Quarterly Meetings

Sutton HWB: 27 September 2021

- The **2021- 23 Health and Care Plan for Sutton** was discussed and is expected to be finalised by December 2021. It is anticipated that there will be continued emphasis/ focus on Age Well, Live Well and Start Well alongside COVID- 19, Health Inequalities and Population Health as planned priorities in Sutton.
- **COVID-19 and Mental Health** was discussed including: Adult and Children and Adolescent Mental Health Services (CAHMS) demand increasing, the experiences of local people in Sutton, the impact on Mental Health Services and the response in Sutton.
- There was a discussion on the evolving **Integrated Care System, Place-based Partnerships and Provider Collaboratives in Sutton and SWL.**

  The emphasis/ focus of the **Place-based Partnership in Sutton** is presently: the Alliance Agreement and arrangements around the Place-based Leadership Transition Team and Programme Management Office (PMO), discussion and engagement on the existing and future Health and Care Plan as well as Digital/ IT Systems, Integrated Care, Organisational Development and Population Health.

  Population Health Management- the development of a framework for Population Health Management is being progressed by NHSE and Optum; leadership and participation in this Population Health Management Programme has been supported in Sutton by SWL.

Board Papers can be found at:
https://moderngov.sutton.gov.uk/ieListDocuments.aspx?CId=471&MId=5437&Ver=4

DONM: 6 December 2021

HEALTH AND WELLBEING BOARDS: Q2, 2021- 22

BOARD PAPERS SUMMARY

Quarterly Meetings

Wandsworth HWB: 30 September 2021

- The **2021 Health and Care Plan for Wandsworth** was discussed and is expected to be finalised by November 2021. It is anticipated that there will be continued emphasis/ focus on Age Well, Live Well and Start Well alongside COVID- 19, Health Inequalities and Mental Health as planned priorities in Wandsworth.
- The **2020-2021 Public Health Board (Richmond and Wandsworth) Report** was received**;** addressing Health Inequalities, coordinating the COVID-19 Public Health response, the creation of a Community Action Group, delivering Immunisation Programmes e.g. for Measles and supporting the Workforce, were part of the reflection and review for Wandsworth.
- The approach to **Child Death Reviews** was discussed including the latest position and processes, responsibilities and roles in Wandsworth and SWL.

  In 2021-22 there will be emphasis/ focus on: appropriate arrangements re Child Death Review Meetings and continuing to embed the processes, responsibilities and roles at St George's Hospital.
- The **Children's and Adolescent Mental Health Services (CAMHS)** latest performance and position was presented.

  It was acknowledged that Children and Young People's Mental Health is an identified priority for SWL and Wandsworth.

  CAHMS demand has increased with a commensurate increase in Mental Health Services e.g. in the Community and in Schools. Investment in Neurodevelopment Services has been positive with a reduction seen in the Waiting List.

  Discussions re implementing the iThrive Model are ongoing with further initiatives planned e.g. in Adolescent to Adulthood Transition, for Autism Spectrum Disorder and, for BAME Communities, etc.

Board Papers can be found at:
https://democracy.wandsworth.gov.uk/ieListDocuments.aspx?CId=508&MId=7068&Ver=4

DONM: 25 November 2021

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St George's University Hospitals NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	25 November 2021	**Agenda No**	**4.6**
Report Title:	**Board Assurance Framework (BAF) Quarter 2 2020/21 Review**		
Lead Director/ Manager:	Stephen Jones, Chief Corporate Affairs Officer		
Report Author:	Alison Benincasa, Director of Quality Governance and Compliance James Brind, Head of Risk		
Presented for:	**Assurance**		
Executive Summary:	This paper presents the Trust Board with the Board Assurance Framework as at Q2 2021/22 and sets out the proposed risk scores and assurance ratings, as well as the actions being taken to address identified gaps in control and assurance. With the exception of Strategic Risk 4, which is reserved to the Board, the information set out for each strategic risk has been reviewed by the relevant Board Committee, following review by the responsible sub-Group of the Trust Management Group and by the Trust Management Group and Executive Management Team.		
	The Board is asked: a) For the Strategic Risk (system working) reserved to itself (SR4): • Agree the proposed score of 12 (4c x 3l) (no change) • Agree the proposed assurance rating of 'good' (no change) b) For the 9 risks assigned to its assuring Committees to: • Agree the proposed risk scores, assurance ratings and statements from the relevant assuring committee • Note the progress achieved in year in mitigating identified gaps in control and assurance c) To note that the BAF is being reviewed in the context of the corporate objectives agreed by the Board in September 2021 and the formation of the hospital group with Epsom and St Helier University Hospitals, and updates will be brought back to the Board.		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	Well led		
Single Oversight Framework Theme:	Quality of Care Leadership and Improvement Capability		
Implications			
Risk:	The strategic risk profile		
Legal/Regulatory:	Compliance with Heath and Social Care Act (2008), Care Quality Commission (Registration Regulations) 2014, the NHS Act 2006, NHSI Single Oversight Framework, Foundation Trust Licence		
Resources:	N/A		

Previously Considered by:	Quality and Safety Committee Finance and Investment Committee Workforce and Education Committee Trust Management Group	**Date**	18.11.2021 18.11.2021 11.11.2021 10.11.2021
Equality and diversity:	The BAF reflects agreed risks in relation to quality and diversity and the actions being taken to address these.		
Appendices:	• Board Assurance Framework Q1 2021/22 (Executive Summary) • BAF Full Report • Aligned Risks on the Corporate Risk Register • Scoring matrix for the BAF		

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NHS
St George's University Hospitals
NHS Foundation Trust

Board Assurance Framework 2021/22

Trust Board
Q2 2021/22 Update

Stephen Jones
Chief Corporate Affairs Officer

25 November 2021

Executive Summary

1. Purpose

This paper presents the strategic risks on the Board Assurance Framework assigned to the Quality and Safety Committee as at the end of October 2021 and sets out the risk scores and assurance ratings, as well as the actions being taken to address identified gaps in control and assurance.

2. Background

The Board Assurance Framework (BAF) brings together in one place all of the relevant information on the risks to the delivery of the Board's strategic objectives as set out in its five-year clinical strategy, Delivering Outstanding Care, Every Time. The BAF acts as the source of evidence the Board can rely on to be confident that risks are being managed and controlled effectively. The BAF provides a structured approach for identifying and mapping the main sources of assurance and coordinating them to best effect. It also highlights where there are gaps in assurance and / or ineffective controls that need to be addressed. The BAF provides a framework through which the Board can understand the sources and levels of assurance relevant to the management of its strategic risks, and it provides an evidence-base of effective oversight of risks to the organisation and its strategic objectives.

The Board approved the new Strategic Risks on the Board Assurance Framework (BAF) at its meeting in May 2020. In July 2021, the Board reviewed the year-end target risk scores, which had been proposed by the Executive Director responsible for each individual strategic risk and endorsed by the relevant Board Committee. The Board Committees are assigned the Strategic Risks as follows, with Strategic Risk 4 (system working) reserved to the Board:

- Quality and Safety Committee: Strategic Risks 1 (patient safety and learning), 2 (clinical governance), and 10 (research)
- Finance and Investment Committee: Strategic Risks 3 (operational performance and access), 5 (financial sustainability), 6 (capital), and 7 (estates)
- Workforce and Education Committee: Strategic Risks 8 (culture) and 9 (workforce)

At Executive level, the sub-groups of the Trust Management Group oversee the following risks:

- Patient Safety and Quality Group: SR1, SR2, SR10
- Operations Management Group: SR3, SR5, SR6
- People Management Group: SR8, SR9
- Risk and Assurance Group: SR4, SR7

In line with the decision of the Board in May 2020, the impact of Covid-19 has been measured against each strategic risk on the BAF. The Board considered including a stand alone Covid-19 strategic risk, but considered that given that the pandemic had implications across the BAF it would be more appropriate to track the impact of the pandemic against the existing strategic risks. Defined Covid-19 risks are set out on the Corporate Risk Register.

Executive Summary

3. Update BAF position at Q2 2021/22:

- **Risk scores:** There are seven extreme risks, two high risks and 1 moderate risk. There are no proposed changes to the headline risk scores at Q2 2021/22. The most recent changes to the strategic risk scores were made as follows:
  - The Board agreed to reduce the risk score for SR5 (financial sustainability) from 25 to 20 at its meeting in January 2021 following review by FIC.
  - The Board agreed to reduce the risk score for SR8 (culture) from 20 to 16 at its meeting in May 2021, following review by the WEC.
- **Assurance ratings:** Six of the ten strategic risks currently have a 'partial' assurance rating; one has a 'limited' assurance rating; and three have a 'good' assurance rating. The most recent changes to the assurance ratings were made as follows:
  - The Board agreed to increase the assurance rating for SR8 (culture) from "partial" to "good" at its meeting in July 2021, following review by WEC.
  - The Board agreed to increase the assurance rating for SR4 (system working) from "partial" to "good" at its meeting in May 2021.
- **Target risk scores:** Board Committees have reviewed and endorsed the target risk scores for the strategic risks assigned to them.
- **Supporting risks:** A review of the supporting risks on the corporate and divisional risk registers is regularly undertaken, and these are considered by the relevant Sub-Groups of the Trust Management Group. This process identified that a number of supporting risks documented on the BAF are not documented in datix. This compromises the integrity of the BAF as the information from datix should populate the BAF. Risk owners are in the process of updating these risks. A detailed review of HR risks on the Corporate Risk Register is currently being undertaken.
- **Progress in mitigating risks:** Included in the summaries of each strategic risk are overviews of the actions completed in-year to address identified gaps in control and assurance. This is intended to demonstrate the progress achieved in mitigating the strategic risk even where this has not progressed to the point where a change in the risk score can be recommended. Since the Board reviewed the BAF at quarter 1 in July 2021, a number of gaps in control have been addressed across the BAF but are not considered sufficiently material at this point to justify a change in the headline risk score.
- **Strategic Risk 4 (system working) is reserved to the Board:** The Board is asked to review and agree the risk score and assurance level for this risk. In July 2021, the Board endorsed the risk score at 12 (4 consequence x 3 likelihood), with an increased assurance rating of 'good' from 'partial' on the basis of the progress achieved in-year. When the Board reviewed the risk score at Q1, it considered that while the Trust had made significant progress in working as part of the SWL ICS, the inherent risks around system working that went beyond the Trust's control warranted the risk score being maintained at 12. At Q2, a risk score of 12 and assurance rating of "good" is also proposed. Progress to continues to be made in working collaboratively with system partners and the Trust has made significant progress in its collaboration with Epsom and St Helier having announced the formation of a hospital group in August 2021. At the same time, there remains ongoing uncertainty around the final form of the Government's health reforms, including those around Integrated Care Systems, which are currently going through Parliament, and the way in which specialised commissioning delegation will work, which means that there is ongoing uncertainty and risk in relation to this.

4. Recommendation:

- For Strategic Risk 4 (system working) which is reserved to the Board, the Board is asked to agree the proposed risk score of 12 (4x4) and assurance rating of 'good' (no change);
- For the nine Strategic Risks assigned to Board Committees, the Board is asked to:
  - Agree the proposed risk scores, assurance ratings and statements from the relevant assuring committee
  - Note the progress being made in mitigating identified gaps in control and assurance
  - Note that the BAF is being reviewed in the context of the new Corporate Objectives agreed by the Board in September 2021 and the formation of the hospital group with ESTH and updates will be brought back to the Board.

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Overveiw

Strategic Risk 1: Our patients do not receive safe and effective care built around their needs because we fail to build and embed a culture of quality and learning across the organisation.

SR1 position at Q2 2021/22: Summary		
Proposed risk score at Q2 21/22:	**16** (4 consequence x 4 likelihood)	The current risk score for SR1 of 16 continues to reflect the level of risk around patient and staff exposure to the SARS-CoV-2 virus and delays in patient treatment and the elective backlog due to Covid-19. Reviewed and endorsed by Quality and Safety Committee on 18 November 2021.
Year-end target risk score	**12** (4 consequence x 3 likelihood)	Following review, the Board agreed to carry forward the year-end target risk score of 12 for 2021/22. Absent Covid, our calculation is that the risk score would be 12 (4x3).
Initial risk score – July 2020 (unmitigated score)	**20** (4 consequence x 5 likelihood)	The Board recognised the initial (unmitigated) risk score of 20 for SR1 at its meeting in July 2020.
Assurance rating at Q2:	**Partial**	An assurance rating of partial is proposed. The assurance rating reflects the fact that there are five actions identified to increase assurance which are not yet completed. There also continue to be significant unknowns related to the future development of the pandemic, and controls the Trust can put in place either individually or together with partners can only go some way to addressing the level of risk associated with Covid-19.
Change from last quarter:	⟷ **No change**	No changes are proposed to the overall risk score or to the assurance rating at October 2021. Risk score: Given the level of risk in relation to Covid-19, the impact on waiting times and elective care, it is not considered possible to reduce this risk further at this stage. Assurance rating: The assurance rating remains partial but may be revised upwards in Q3 with the completion of actions to address gaps in control.
SR1 In year-risk mitigation – actions taken to address gaps in control and assurance		
In year progress in mitigating risks	**Gaps in assurance and control closed in-year to date**	There are six actions to address identified gaps in control and assurance in relation to SR1. One of the six actions was completed in Q2 2021/22; the Trust has successful appointment all new posts within the Governance structure. This will support the implementation of the Quality and Safety strategy.. A new gap in control was identified in relation to achieving the 85% target for staff trained in life support training for ALS and ILS, and a corresponding action has been added, agreed trajectories in place.

Overview

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

SR2 position at Q2 2021/22: Summary		
Proposed risk score at Q2 21/22:	**12** (4 consequence x 3 likelihood)	The current risk score for SR2 of 12 continues to reflect the level of risk around our clinical governance in the context of the continuing implementation of integrated clinical governance improvement plan, which is scheduled for implementation by March 2022. Reviewed and endorsed by Quality and Safety Committee on 18 November 2021.
Year-end target risk score	**8** (4 consequence x 2 likelihood)	Following review, the Board agreed to carry forward the target risk score of 8 for 2021/22 on the basis that full implementation of the clinical governance improvement plan is scheduled for completion by March 2022, which is expected to materially mitigate the risk and enable a lowering of the risk score. A Quality and Safety Committee deep dive into SR2 is scheduled for November 2021 along with a review of progress in the implementation of the clinical governance improvement plan.
Initial risk score – July 2020 (unmitigated score)	**16** (4 consequence x 4 likelihood)	The Board recognised an initial (unmitigated) risk score of 16 for SR2 at its meeting in July 2020.
Assurance rating at Q2:	**Partial**	The assurance rating of partial is proposed. Further implementation of the clinical governance improvement plan will be material to increasing the assurance rating. Subject to this, it is expected that an increase in the assurance rating may be possible in Q3 2021/22.
Change from last quarter:	⟷ **No change**	No changes are proposed to the overall risk score or to the assurance rating at October 2021. Risk score: Unchanged due to ongoing actions to mitigate risk and address gaps. Assurance rating: Unchanged due to slippage in actions to address gaps
SR2 In year-risk mitigation – actions taken to address gaps in control and assurance		
In year progress in mitigating risks	**Gaps in assurance and control closed in-year to date**	The recommendations from the third phase clinical governance review have been considered and an action plan to address these has been developed, integrated with the wider clinical governance improvement plan, and has been presented to the Board. Delivery of all aspects of the clinical governance improvement plan is scheduled for March 2022 as part of the year 2 Quality and Safety Strategy implementation plan. There are six actions to address gaps in control and assurance, none of which were scheduled for completion in Q2. An update report on progress against the Clinical Governance Improvement Plan 2021/22 was provided to Quality and Safety Committee at its meeting in November 2021 which demonstrated all actions will be delivered by March 2022

Overview

Strategic Risk 3: Our patients do not receive timely access to the care they need due to delays in treatment and the inability of our technology and transformation programmes to provide accessible care built around our patients' lives

SR3 position at Q2 2021/22: Summary		
Proposed risk score at Q2 2021/22:	**20** (5 consequence x 4 likelihood)	It is proposed that a risk score of 20 continues to reflect the level of risk in relation to both access to treatment and ICT. Reviewed by the Finance and Investment Committee on 18 November 2021.
Year end target risk score	**15** (5 consequence x 3 likelihood)	The Board agreed a target risk score of 15 at year-end 2020/21 and the Finance and Investment Committee agreed to roll forward this target risk into 2021/22.
Initial risk score – July 2020 (unmitigated score)	**25** (5 consequence x 5 likelihood)	Absent the mitigations currently in place, the risk score would be 25.
Proposed assurance rating at Q2 2021/22:	**Limited**	It is proposed that this remains unchanged until the following controls are fully in place and reporting – external audit of RTT validation processes; audit of non-RTT and DM01 waiting lists. These actions are expected to be completed by September 2021
Change from last month:	⟷ **No change**	The change from 20 to 16 is proposed to the overall risk score. No change is proposed for the assurance rating at Q2 2021/22. Risk score: Small change due to ongoing actions to mitigate risk and address gaps due for completion later in the year. Assurance rating: There has been a slippage in actions.
SR3 In year-risk mitigation – actions taken to address gaps in control and assurance		
In year progress in mitigating risks	**Gaps in assurance and control closed in-year to date**	No new controls have been delivered in Q2. However, the Trust has continued to demonstrate consistent delivery for Priority 1 patients (cancer and non-cancer, treat within 72 hours) and Priority 2 patients (cancer and non-cancer, treat within 28 days) and in Q2 has moved to treat lower priority patients. This means that we are treating patients with urgent clinical needs in a timely way. We are ahead of our trajectory to reduce the number of long waiting patients waiting over 52 weeks and should have treated all patients unavoidably waiting over 104 weeks by the end of November. Additional theatres have been built at QMH to increased elective activity.

Overview

Strategic Risk 4: As part of our local Integrated Care System, we fail to deliver the fundamental changes necessary to transform and integrate services for patients in South West London

SR4 position at Q2 2021/22: Summary		
Proposed risk score at Q2 2021/22:	**12** (4 consequence x 3 likelihood)	The current risk score for SR4 of 12 continues to reflect the significance and importance of system working, and attendant risks. Last reviewed by the Board on 29 July 2021.
Year end target risk score	**8** (4 consequence x 2 likelihood)	The target risk of 8 was set on the basis that the Trust is making good progress in working collaboratively with system partners and specifically in its collaboration with Epsom and St Helier.
Initial risk score – July 2020 (unmitigated score)	**16** (4 consequence x 4 likelihood)	Absent the mitigations currently in place, the risk score would be 16.
Proposed assurance rating at Q2 2021/22:	**Good**	The Board increased its assurance rating for SR4 from "partial" to "good" at Q4 2020/21, and a continuation of this position is proposed.
Change from last month:	⟺ **No change**	No changes are proposed to the overall risk score or to the assurance rating at Q2 2021/22 Risk score: Unchanged due to strategy long term plan for implementation of all mitigations Assurance rating: There has been slippage in actions.
SR4 In year-risk mitigation – actions taken to address gaps in control and assurance		
In year progress in mitigating risks	**Gaps in assurance and control closed in-year to date**	During 2021/22, this risk has been mitigated by the establishment of new controls : ➢ The opening of the new modular surgery unit at Queen Mary Hospital as a centre for elective surgery which will assist the Trust and the wider SWL system reduce the elective backlog. ➢ The appointment of the Trust Chief Executive as Lead CEO for the SWL Acute Provider Collaborative ➢ Further progress in collaboration with Epsom and St Helier

Overview

Strategic Risk 5: We do not achieve financial sustainability due to under delivery of cost improvement plans and failure to realise wider efficiency opportunities

SR5 position at Q2 2021/22: Summary		
Proposed risk score at Q2 2021/22:	**20** (5 consequence x 4 likelihood)	The current risk score for SR5 of 20 continues to reflect the level of financial uncertainty and risk the Trust faces in year, particularly in relation to the H2 position. The Trust is still not in receipt of financial envelopes, or confirmed financial planning guidance for H2 of 21/22. What is known is that there will be more challenging targets around ERF income, and more challenging efficiency ask, and operational pressures requiring investment that are to create a material financial challenge for 21/22. Reviewed and endorsed by Finance and Investment Committee on 18 November 2021.
Year end target risk score	**12** (4 consequence x 3 likelihood)	The Board agreed a target risk score of 12 at year-end 2020/21 and the Finance and Investment Committee agreed to roll forward this target risk into 2021/22.
Initial risk score – July 2020 (unmitigated score)	**25** (5 consequence x 5 likelihood)	Absent the mitigations currently in place, the risk score would be 25.
Proposed assurance rating at Q2 2021/22:	**Partial**	The Finance and Investment Committee endorsed an assurance rating of "partial" at its meeting on 23 September 2021.
Change from last month:	⟷ **No Change**	No changes are proposed to the overall risk score or to the assurance rating at Q2 21/22. Risk score: Unchanged due to ongoing actions to mitigate risk and address gaps. Assurance rating: Unchanged due to slippage in actions to address gaps
SR5 In year-risk mitigation – actions taken to address gaps in control and assurance		
In year progress in mitigating risks	**Gaps in assurance and control closed in-year to date**	This risk has been mitigated by the completion of actions to address identified gaps in control and assurance: ➢ Plan in place for financial balance in 21/22, or in line with NHSI/E control total and the plan has been submitted to NHSE/I Further actions to address gaps in control and assurance are being implemented.

Overview

Strategic Risk 6: We are unable to invest in the transformation of our services and infrastructure, and address areas of material risk to our staff and patients, due to our inability to source sufficient capital funds

SR6 position at Q2 2021/22: Summary		
Proposed risk score at Q2 2021/22:	**20** (4 consequence x 5 likelihood)	The current risk score of 20 reflects the challenges the Trust faces in relation to capital funding, which remains materially short of requirements in 2021/22 while the capital funding position beyond the current year is uncertain. The SWL capital plan remains over-subscribed vs. capital allocations (CDEL, by c£20m. The Trust has not yet been able to confirm funding to address all key risks in 21/22, and doesn't currently have funding confirmed for the 5 year capital from 22/23 and beyond. Reviewed and endorsed by Finance and Investment Committee on 18 November 2021.
Year end target risk score	**12** (4 consequence x 3 likelihood)	The Board agreed a target risk score of 12 at year-end 2020/21 and the Finance and Investment Committee agreed to roll forward this target risk into 2021/22.
Initial risk score – July 2020 (unmitigated score)	**25** (5 consequence x 5 likelihood)	Absent the mitigations currently in place, the risk score would be 25.
Proposed assurance rating at Q2 2021/22:	**Partial**	The Finance and Investment Committee endorsed an assurance rating of "partial" at its meeting on 23 September 2021.
Change from last month:	⟷ **No change**	No changes are proposed to the overall risk score or to the assurance rating at Q2 21/22. Risk score: Unchanged due to ongoing actions to mitigate risk and address gaps. Assurance rating: There has been a slippage in the completion of actions.
SR6 In year-risk mitigation – actions taken to address gaps in control and assurance		
In year progress in mitigating risks	**Gaps in assurance and control closed in-year to date**	No new controls have been put in place to date, but the Trust is pursuing emergency funding through the ICS to NHSEI and alternative methods of financing the current programme are being developed by the DCFO.

Executive Summary

Strategic Risk 7: We are unable provide a safe environment for our patients and staff and to support the transformation of services due to the poor condition of our estates infrastructure

SR7 position at Q2 202122: Summary		
Proposed risk score at September 2021:	**20** (4 consequence x 5 likelihood)	The current risk score for SR7 of 20 reflects the current level of risk in relation to the Trust's estate. It is anticipated that a reduction in the risk score to 16 will be achievable in Q2 2021/22 following the approval of the estates strategy, strengthening of estates governance groups, and the updating of the Premises Assurance Model. Reviewed and endorsed by Finance and Investment Committee on 18 November 2021.
Year end target risk score	**16** (4 consequence x 4 likelihood)	Following review, the Board agreed to carry forward the year-end target risk score of 16 for 2021/22. A number of key gaps remain, particularly in relation to capital planning and the need for a more sustainable approach for year-on-year investment for the long term. This will be mitigated by the approval of a new estate strategy There has been a slight slippage in the originally identified timetable due to COVID pressures such as oxygen supply to the Trust which has been largely successful and offered opportunities for shared learning across other compliance areas.
Initial risk score – July 2020 (unmitigated score)	**25** (5 consequence x 5 likelihood)	Absent the mitigations currently in place, the risk score would be 25.
Proposed assurance rating at Q2:	**Partial**	The Finance and Investment Committee endorsed an assurance rating of "partial" at its meeting on 22 July 2021.
Change from last month:	⟷ **No change**	No changes are proposed to the overall risk score or to the assurance rating at September 2021. Risk score: Unchanged pending agreement of estates strategy, green plan, and PAM review Assurance rating: the assurance rating will be re-assessed once actions to close gaps in control are completed
SR7 In year-risk mitigation – actions taken to address gaps in control and assurance		
In year progress in mitigating risks	**Gaps in assurance and control closed in-year to date**	All actions from Q1 have been completed in relation to the Trust Estates Strategy leading to these actions being closed. The delivery of the Estates Strategy is to be actioned separately. Estates Assurance Group – CNO and Director E&F have agreed a way forward; ToR prepared and meetings being planned. Improvements in the PAM regarding systems and processes but further work on action plans due to approved Estates Strategy Resourcing still a concern re, Systems, Capital Funding, Supply Chain delays.

Executive Summary

Strategic Risk 8: We fail to build an open and inclusive culture across the organisation which celebrates and embraces our diversity because our staff are not empowered to deliver to their best and do not feel safe to raise concerns

SR8 position at Q2 2021/22: Summary		
Proposed risk score at Q2 2021/22:	**16** (4 consequence x 4 likelihood)	The current risk score for SR8 of 16 reflects the level of risk in relation to culture across the organisation. The strengthening culture action plan has been developed and implementation has begun, but until this progresses further the Trust continues to face challenges around culture, diversity and inclusion, and raising concerns. Reviewed and endorsed by Workforce and Education Committee on 11 November 2021.
Proposed year-end target risk score	**12** (4 consequence x 4 likelihood)	Notwithstanding the lead-time required for actions designed to impact on the culture of any organisation, the WEC provisionally endorsed a proposal to set a stretching year-end target risk score of 12 (4 x 3) on the basis that the culture action plan, D&I action plan, and FTSU action plan are scheduled to make significant progress over the next year.
Initial risk score – July 2020 (unmitigated score)	**20** (4 consequence x 5 likelihood)	The Board set an initial risk score of 20 for SR8 at its meeting in July 2020.
Proposed assurance rating at Q2 2021/22:	**Good**	An increase in the assurance rating from "partial" to "good" was approved in Q1 2021/22. This is based on the following: • A clear strengthening culture action plan was agreed by the Board in May 2021, and a delivery governance structure is in place • Progress has been made in delivering the D&I action plan to date • Progress has been made in implementing the FTSU strategy to date • Leadership development programmes are being put into place • There is clear governance and reporting around this work through the Culture Diversity and Inclusion Programme Board, which has commenced its meetings.
Change from last quarter:	**No change**	Risk score: No change proposed (4 consequence x 4 likelihood) Assurance rating: No Change proposed remaining "good"
SR8 In year-risk mitigation – actions taken to address gaps in control and assurance		
In year progress in mitigating risks	**Gaps in assurance and control closed in-year to date**	During Q2 2021/22 to date, this risk has been mitigated by the completion of a number of identified gaps in controls: • Plans to ensure all interview panels include a RIS for Band 8a and above implemented and extended to B7 interviews • D&I network ToRs approved and recruitment commenced • Culture change programme business case approved • Staff survey 2020 priorities developed into Big 5 programme has been implemented • Quarterly pulse survey implemented in Q2 • New IT system in place for recording PDRs

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Executive Summary

Strategic Risk 9: We are unable to meet the changing needs of our patients and the wider system because we do not recruit, educate, develop and retain a modern and flexible workforce and build the leadership we need at all levels

SR9 position at Q2 2021/22: Summary		
Proposed risk score at Q2 2021/22:	**16** (4 consequence x 4 likelihood)	The current risk score for SR9 of 16 continues to reflect the current level of risk in relation to recruitment, retention, education and development. Reviewed and endorsed by Workforce and Education Committee on 11 November 2021.
Proposed year-end target risk score	**12** (4 consequence x 3 likelihood)	A target risk score of 12 at year-end is proposed on the basis that significant progress has already been made in mitigating this risk, and a number of supporting risks have been closed. Further progress is envisaged in the coming months, potentially with a reduction of the risk to 12 in Q4 2021/22, so on balance a year end position of 12 is considered appropriate.
Initial risk score – July 2020 (unmitigated score)	**20** (4 consequence x 5 likelihood)	Without the mitigations in place, the risk score would be 20.
Proposed assurance rating at Q2 2021/22:	**Partial**	An assurance rating of 'partial' was agreed by WEC for Q1 2021/22.
Change from last quarter:	⟷ **No change**	No changes are proposed to the overall risk score or to the assurance rating at Q2 2021. Risk score: Unchanged due to complexity in completion of actions to mitigate risk and address gaps Assurance rating: Given that a significant number of gaps in control and assurance remain, and the complexity in completion of actions, it is not considered the appropriate time to increase the assurance rating.
SR10 In year-risk mitigation – actions taken to address gaps in control and assurance		
In year progress in mitigating risks	**Gaps in assurance and control closed in-year to date**	During Q2 2021/22 to date, this risk has been mitigated by the completion of a number of identified gaps in controls: • Workforce strategy reviewed and refreshed • Workforce strategy implementation plan reviewed and communicated to PMG and WEC • Implemented King's Fund leadership programme • Delivered the matron and senior clinical leaders programme • Delivered of general clinical leaders • New IT system in place for recording PDRs Completion of a number of actions to address identified gaps in control and assurance have been deferred to later in the financial year partially due to change in the staffing. It is considered that should these be delivered as planned, it will be possible at that point to revisit the risk score and assurance rating.

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Overview

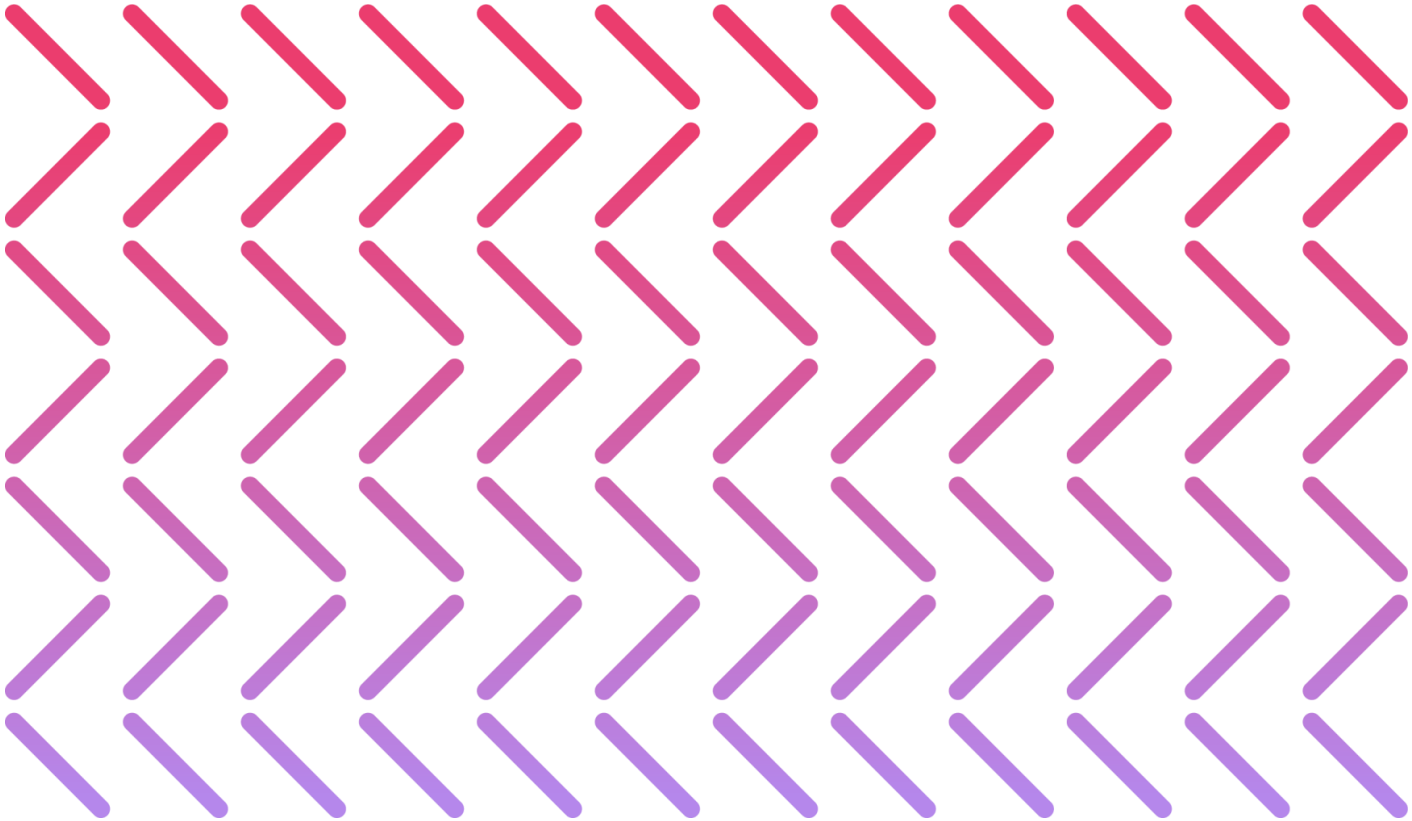
Strategic Risk 10: Research is not embedded as a core activity which impacts on our ability to attract high calibre staff, secure research funding and detracts from our reputation for clinical innovation

SR10 position at Q2 2021/22: Summary		
Proposed risk score at Q2 21/22:	**9** (3 consequence x 3 likelihood)	The current risk score for SR10 of 9 continues to reflect the level of risk in relation to research, which balances the strong progress on Covid research against the impact of the pandemic on non-Covid research and the continuing absence of clarity on funding. Reviewed and endorsed by Quality and Safety Committee on 18 November 2021.
Year-end target risk score	**6** (3 consequence x 2 likelihood)	Following review, the Board agreed to carry forward the target risk score of 6 for year end 2021/22 on the basis that the actions to address remaining gaps in control are scheduled to be delivered by December 2021.
Initial risk score – July 2020 (unmitigated score)	**12** (3 consequence x 4 likelihood)	Absent the mitigations currently in place, the risk score would be 12.
Assurance rating at Q2:	**Good**	We have considered whether the assurance rating can be upgraded. While the assurance rating is "good", it is not considered to yet meet the requirements of "substantial" given the impact of Covid and the limitations on the Trust's control environment to mitigate to the risk to non-Covid research.
Change from last month:	⟷ **No change**	No changes are proposed to the overall risk score or to the assurance rating at October 2021. Risk score: Unchanged due to ongoing actions to mitigate risk and address gaps due for completion later in the year. Assurance rating: Actions to address gaps on track but not yet due. There has been no slippage in actions.
SR10 In year-risk mitigation – actions taken to address gaps in control and assurance		
In year progress in mitigating risks	**Gaps in assurance and control closed in-year to date**	No actions to address identified gaps in control and assurance were due for completion in Q2 2021/22. All remaining actions are due for completion in December 2021. It is proposed that the risk score be revisited at the December QSC meeting.

Strategic Risks: High Level Summary – Assurance Rating and Risk Score

Strategic Objective	Corporate Objective	Risk Reference	2021/22 Strategic Risks	Assurance Rating	Risk Score Q2 2021/22	Target Risk Score for 21/22
1. Treat the patient, treat the person	Care	SR1	Our patients do not receive safe and effective care built around their needs because we fail to build and embed a culture of quality improvement and learning across the organisation	Partial	Extreme - 16	High - 12
	Care	SR2	We are unable to provide outstanding care as a result of weaknesses in our clinical governance	Partial	High - 12	Moderate - 8
2. Right care, right place, right time	Care	SR3	Our patients do not receive timely access to the care they need due to delays in treatment and the inability of our technology and transformation programmes to provide accessible care built around our patients' lives	Limited	Extreme - 20	Extreme - 16
	Collaboration	SR4	As part of our local Integrated Care System, we fail to deliver the fundamental changes necessary to transform and integrate services for patients in South West London	Good	High-12	High-12
3. Balance the books, invest in our future	Collaboration	SR5	We do not achieve financial sustainability due to under delivery of cost improvement plans and failure to realise wider efficiency opportunities	Partial	Extreme - 20	High-12
	Collaboration	SR6	We are unable to invest in the transformation of our services and infrastructure, and address areas of material risk to our staff and patients, due to our inability to source sufficient capital funds	Partial	Extreme - 20	High-12
4. Build a better St George's	Care	SR7	We are unable provide a safe environment for our patients and staff and to support the transformation of services due to the poor condition of our estates infrastructure	Partial	Extreme - 20	Extreme - 16
5. Champion team St George's	Culture	SR8	We fail to build an open and inclusive culture across the organisation which celebrates and embraces our diversity because our staff do not feel safe to raise concerns and are not empowered to deliver to their best	Good	Extreme - 16	High - 12
	Culture	SR9	We are unable to meet the changing needs of our patients and the wider system because we do not recruit, educate, develop and retain a modern and flexible workforce and build the leadership we need at all levels	Partial	Extreme - 16	High - 12
6. Develop tomorrow's treatments today	Collaboration	SR10	Research is not embedded as a core activity which impacts on our ability to attract high calibre staff, secure research funding and detracts from our reputation for clinical innovation.	Good	Moderate - 9	Low - 6

Board Assurance Framework

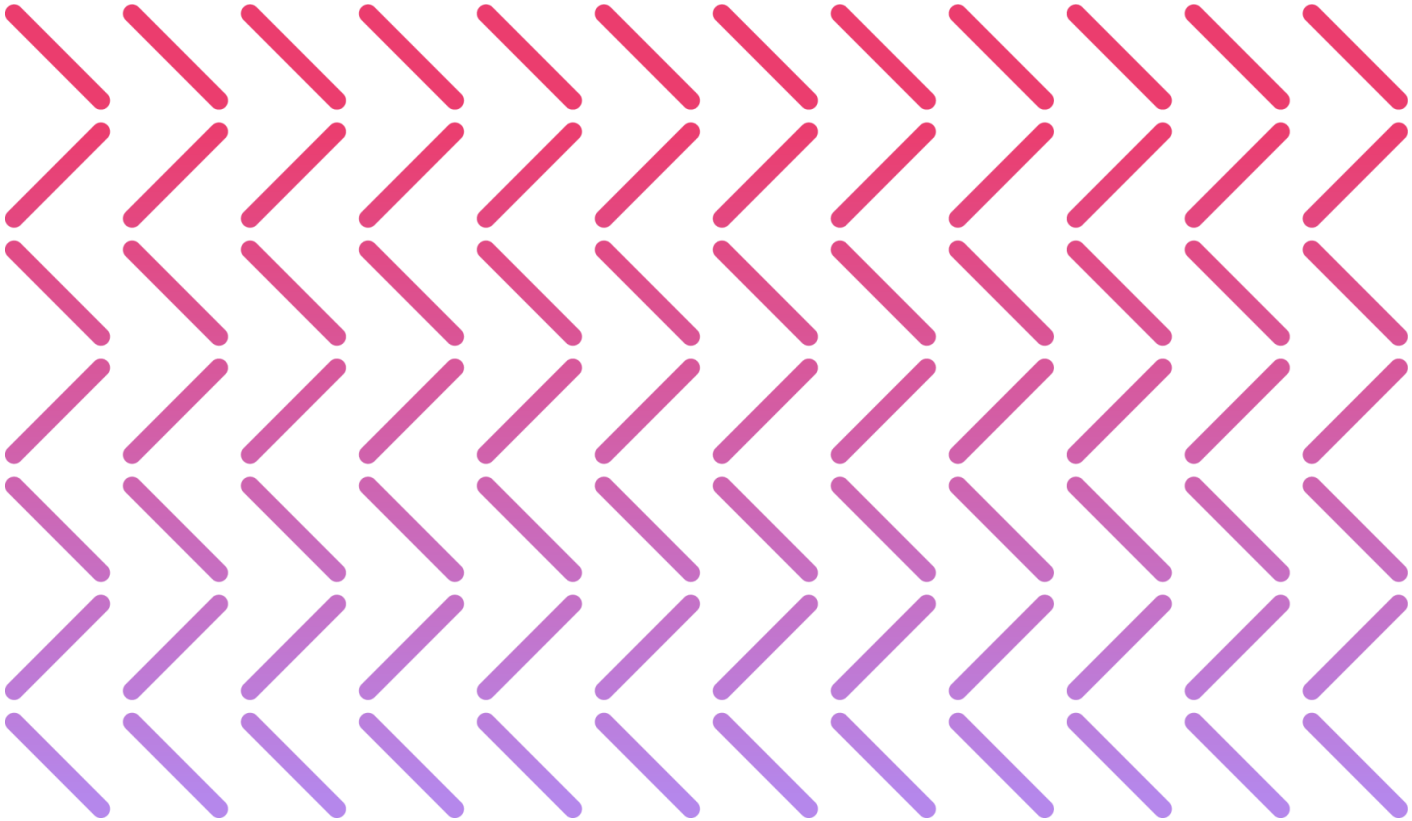


Outstanding care every time

Strategic Objective 1: Treat the Patient, Treat the Person
Strategic Risks SR1 and SR2

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

SR2:
We are unable to provide outstanding care as a result of weaknesses in our clinical governance



Outstanding care every time

Strategic Objective	Treat the patient, treat the person	*Corporate Objective 2021/22:*	*Care*

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

Risk Appetite / Tolerance	**LOW**	Patient safety is our highest priority and we have a **low appetite** for risks that impact on patient safety. Our appetite for risks affecting patient experience is also low, but is higher than for risks impacting on patient safety. If patient experience conflicts with patient safety, the safety of services will always be our highest priority.	**Assurance Committee**	**Quality and Safety Committee**
			Executive Group	Patient Safety and Quality Group
			Executive Lead(s)	Chief Nurse & DIPC Chief Medical Officer
			Date last Reviewed	20 October 2021

Current risk and assurance assessment

Strategic Risk 1 sets out the risk to the delivery of the Trust's clinical strategy of a failure to ensure that patients receive safe and effective care due to a failure to build and embed a culture of quality improvement and learning across the Trust. Key contributing elements to this risk are risks on the Corporate Risk Register relating to Covid-19, waiting times, infection prevention and control, treatment escalation, and learning from deaths.

During Q2 2021/22, the risk has been mitigated by the

- Successful appointment all new posts within the Governance structure. This will support the implementation of the Quality and Safety strategy.

The current risk score of 16 (Extreme) highlights the level of risk the Trust is balancing with particular reference to infection control and avoidable harm across nine supporting risks (five of which relate to Covid-19). The assurance strength is rated as partial to reflect the gaps in controls and the sources of assurance outlined above and overleaf which means there are weaknesses related to controlling this strategic risk.

Overall SR Rating – Quarterly Scores

Period 2021/ 2022	Risk Score	Assurance Strength	Change (last reporting period)	Inherent Risk Score	Target Risk Score For 2021/22
Q1	Extreme 16 = 4(C) x 4(L)	Partial		20 = 4(C) x 5(L)	12 = 4(C) x 3(L)
Q2	Extreme 16 = 4(C) x 4(L)	Partial			
Q3					
Q4					

Summary COVID-19 Impact

The Covid-19 pandemic has had a significant impact on this strategic risk, in terms of both the overall risk score and the risk profile. Mapped against this strategic risk are five risks on the Corporate Risk Register related to Covid-19 (risk of exposure to Covid-19; risk of non-Covid patients – both those know and those not known to the Trust – waiting too long for treatment; risk of availability of personal protective equipment; risk of lack of fit testing for FFP3 masks). Absent the pandemic, and the associated risks on the Corporate Risk Register, a risk score of 12 would be possible.

The Trust is developing the new Covid-winter and Flu plan, planned with partners in SWL. Infection Prevention and Control guidance continues to be implemented and revised as and when required directed by Public Health England.

Strategic Objective	Treat the patient, treat the person	*Corporate Objectives 2021/22:*	*Care*
SR1	**Our patients do not receive safe and effective care built around their needs because we fail to build and embed a culture of quality improvement and learning across the organisation**		

Key risk controls in place	Control effectiveness				Key sources of assurance	Lines of assurance (positive/ negative)		
	Q1	Q2	Q3	Q4		1	2	3
Quality and Safety Strategy in place and approved by the Trust Board (January 2020) supported by an implementation plan	S	S			• Trust removed from Quality Special Measures in March 2020 following improvements documented in CQC inspection report published in Dec 2019 • Quarterly update reports to QSC re delivery against Quality and Safety Strategy year 2 implementation plan		X X	X
Serious Incident reporting and Investigation Policy including electronic incident reporting system (Datix) in place	S	S			• Weekly review of serious incidents at serious incident declaration meeting and monthly report to PSQG and QSC (Note the Trust is currently awaiting the new - Patient Safety Incident Reporting Framework) • Internal Audit report/internal management action plan: rated substantial assurance		X X	X X
Complaints Policy in place	G	G			• Quarterly complaints report to Patient Safety Quality Group identifying emerging themes and learning • Internal Audit report including internal management action plan: rated reasonable assurance • Learning from complaints included in divisional governance reports		X X X	X
Friends and Family Test – *SMS feedback method in place for virtual and face to face outpatient appointments* - Text messaging – SMS surveys for inpatient surveys setup	G	G			• Friends and Family Test: Monthly performance reports to QSC via IQPR		X	X
Infection Control Policy including Root Cause Analysis (RCA) for all C. Diff cases to ensure learning in place	S	S			• Infection control audit reports identifying emerging themes and improvement actions • Ward round monitoring to ascertain that infection control requirements are in place and followed and periods of increased Surveillance and Assessment (PISA)	X X	X X	
Early Warning Score training in place	G	R			• nEWS assurance audit completed over August/September 2020: Complete set 83%; Correctly scored 88%; Appropriate response 60%; Frequency 82%	X	X	
Sepsis tool live on iClip	G	G			• Sepsis tool on iClip in place	X		
COVID-19 measures: patient testing, masks, and facilities	G	R			• Covid testing carried out on day 0, 3 and 7 of admission; Masks wearing for in-patients; Emergency floor development increased number of single isolation facilities • Daily compliance performance report for PCR testing	XX		
Governance structure – new positions all recruited to	R	R				X		
Life support training - Programme to increase the numbers of staff who have undertaken required life support training is in place	N/A	R			• BLS target performance of 85% achieved by 30 September 2021. Agreed trajectories in place to achieve 85% training performance for ALS and ILS	XX		

Strategic Objective	Treat the patient, treat the person	*Corporate Objectives 2021/22:*	*Care*
SR1	**Our patients do not receive safe and effective care built around their needs because we fail to build and embed a culture of quality improvement and learning across the organisation**		

Gaps in controls and assurances	Actions to address gaps in controls and assurances	Complete by (date)	Progress
Newly recruited staff in corporate governance to embed a culture of quality improvement and learning	• Embed new posts within the corporate and divisional teams supported by individually agreed objectives • Ensure consistent application of standardised processes for incident reporting	Mar 2022	
Seven day clinical services standards (also see SR3)	**Implementation of Divisional action plans to achieve seven day clinical service standards compliance.** All Care Groups have updated their risk assessment. Directorates have defined plans to address all non- compliance. Capital works to install 2 static MRIs has commenced, with the equipment was expected to go-live in January 2022, however it has now been deferred to February 2022. Budget setting and job planning for 2021/22 will address a number of gaps in 7 day services. Further assurance sought of residual non-compliance areas due end of July 2021.	Feb 2022	
Critical Care Outreach team not recruited to full establishment	**Deliver recruitment plan to Critical Care** *Critical Care recruitment plan reviewed and revised as partial recruitment only achieved due to Covid-19. The multidisciplinary make-up of the team is being reassessed which may involve recruiting more senior nurses B7. Re-costing models currently being finalised*	Dec 2021	
Early Warning Score electronic devices not reliable due to IT issues as patient observations are not visible by the bedside. Lack of handheld devices to facilitate nurses' awareness of vital signs	**Improve Early Warning Score electronic device availability in the wards through Wi-Fi and address cold spot** *Wi-Fi will be addressed through the ICT Network improvement Project which is expected to run until the end of 2021*	Dec 2021	
Divisional reporting by ward to PSQG on the number of Treatment Escalation Plans in place for all non-elective adult patients within 24 hours of admission	**Commencement of divisional reporting on TEPs** The divisional reporting has commenced and TEP is part of the reporting template. Divisions working towards making the information available at ward level	Dec 2021	
Life support training is in place for advanced, intermediate and basis levels.	Programme to increase the numbers of staff who have undertaken required basic life support training and the target is scheduled to be met in (or potentially before) September 2021.	Complete	

Strategic Objective	Treat the patient, treat the person	*Corporate Objectives 2021/22:*	*Care*
SR1	**Our patients do not receive safe and effective care built around their needs because we fail to build and embed a culture of quality improvement and learning across the organisation**		

Lead indicators	RAG Rating Q1	Q2	Q3	Q4	Lead indicators: Progress update
All adult inpatients to have a Treatment Escalation Plan in place within 24 hours of admission					October 2021 - TEP Performance against our Treatment Escalation Plans has plateaued in recent months at around 35% and continues to show common cause variation with an improving position
Compliance with appropriate response to Early Warning Score (adult)					October 2021 - Compliance with appropriate response to EWS (adults) was 92%
Severity of reported incidents					October 2021 - Severity of adverse incidents – 97% No harm/ Low harm
Number of declared serious incidents					3 serious incidents were declared in October 2021
Open serious incident investigations > 60 days					All serious incident investigations continue to be completed within the 60 day timeframe
Number of declared Never Events per month (0)					No Never Event declared in October 2021
Infection Control (MRSA, C. Diff, MSSA, E-Coli)					MRSA 1, Hospital Acquired CDiff 1; MSSA 1; and E-Coli 1 reported in October 2021
Number of hospital acquired pressure ulcer category 3 and above					4 category 3 pressures ulcers in October 2021
Safety Thermometer percentage of patients with Harm Free Care (new harm)	N/A	N/A			National reporting paused since April 2020
Friends and Family Test					In October 2021 3 service did not meet their target for positive FFT response: Emergency Department; Maternity Delivery: and Community
ALS training attainment					78% performance in October 2021 against the 85% trajectory
ILS training attainment					66% performance in October 2021 against the 85% trajectory
BLS training attainment					85% performance target maintained in October 2021

Emergent / future risks	Future opportunities
• Culture shift to embed quality improvement and learning does not happen, or does not happen quickly enough • Reputation of speciality services and impact on business • System working related to hospital specific clinical pathways may mean that we cannot manage our own activity • Impact of any future surge of Covid-19 on the Trust's ability to provide care to all patients in a timely way and on its capacity to learn from incidents • Risk of potential workforce gaps associated with Covid vaccine mandate • Unable to ensure effective patient engagement as a result of the impact of Covid-19 • Quality Improvement Academy does not have traction to effectively promote a culture of learning across the Trust	• We can utilise the data we hold related to our patients and the activity across our services to improve our learning in the organisation and how we plan and/ or deliver our services. We can also develop, adopt and promote key safety measurement principles and use culture metrics to better understand how safe our care is • The new National Patient Safety Incident Reporting Framework with its enhanced focus on learning will enable us to work together with our patients and their families to improve our investigation of incidents • Covid-19 provides opportunities to think differently about how we engage with patients, service users and their families

Strategic Objective	Treat the patient, treat the person		Corporate Objectives 2021/22:	Care
SR2	**We are unable to provide outstanding care as a result of weaknesses in our clinical governance**			
Risk Appetite / Tolerance	**LOW**	We have a **low appetite** for risks that affect the robustness of our clinical governance structures, systems and processes as these can impact directly on the quality of care patients receive.	**Assurance Committee**	**Quality and Safety Committee**
			Executive Group	Patient Safety and Quality Group
			Executive Lead(s)	Chief Nurse & DIPC Chief Medical Officer
			Date last Reviewed	20 October 2021

Current risk and assurance assessment

Improving clinical governance is a key priority in the Trust's Quality and safety Strategy 2019-24. The independent governance reviews undertaken in 2019 show that there is a need for significant strengthening of clinical governance. The Trust is in the process of implementing the recommendations from the reviews, but progress has been impacted by Covid-19.

Following the publication of the Independent Mortality Panel's Review and Independent Scrutiny Panel's Review on 26 March 2020 Trust Board reviewed the comprehensive sources of assurance that the cardiac surgery service at St George's is safe, and the Trust Board also reviewed the assurance that all the recommendations of these reports had been or were being acted upon. The CMO and the Associate Medical Directors continue to progress improvement actions and drive engagement.

The Trust has key controls and sources of assurance in place, for example the implemented Medical Examiner service and weekly care Group Leads meeting led by the Chief Medical Officer. There are a number of gaps in controls and sources of assurance in particular the work to strengthen clinical governance as highlighted above by reducing variation in our processes for Mortality and Morbidity monitoring at care group level. The current risk score of 12 (High) highlights the level of risk the Trust is balancing across seven supporting risks including failure to act on diagnostic findings, to comply with the Mental Capacity Act and to improve clinical governance. The assurance strength is rated as partial to reflect the gaps in the controls and sources of assurance outlined and above overleaf which means there are weaknesses related to controlling this strategic risk.

An update report on progress against the Clinical Governance Improvement Plan 2021/22 was provided to Quality and Safety Committee at its meeting in November 2021 which demonstrated progress to date and that all outstanding actions will be delivered by March 2022. As such it is recommended that the strategic risk score is reduced to 8 (4x3).

Overall SR Rating – Quarterly Scores

Period 2021/ 2022	Risk Score	Assurance Strength	Change (last reporting period)	Inherent Risk Score	Target Risk Score For 2021/22
Q1	High 12= 4(C) x 3(L)	Partial		20 = 4(C) x 5(L)	8 = 4(C) x 2(L)
Q2	High 12= 4(C) x 3(L)	Partial			
Q3					
Q4					

Summary COVID-19 Impact

Covid-19 resulted in a temporary suspension of improvement work in particular relating to the Must and Should do actions within the Trust CQC action plan and the actions associated with the phase 1 and 2 governance reviews. The CNO and CMO reviewed and revised the delivery dates for the improvement actions in the integrated clinical governance improvement plan with the agreement of the CQC. The CQC action plan was closed in April 2021. Other plans have also been delayed due to resources being diverted to other Covid-19 priorities.

Strategic Objective	Treat the patient, treat the person	*Corporate Objectives 2021/22:*	*Care*
SR2	**We are unable to provide outstanding care as a result of weaknesses in our clinical governance**		

Key risk controls in place	Control effectiveness				Key sources of assurance	Lines of assurance (positive/ negative)		
	Q1	Q2	Q3	Q4		1	2	3
Action plan to deliver improvements identified by the CQC	S	S			• CQC action plan close report to QSC in May 2021 • One should do action remained open and monitored on an exception basis in PSQG (measures to avoid mixed sex breaches in children's services). Close report approved at PSQG in September 2021 and all actions completed	X	X	X X X
Board agreement to invest in identified improvements to clinical governance	S	S			• Phase 1 and phase 2 external governance reviews • Phase 3 report and Board approved analysis of outstanding recommendations • Actions from the external governance reviews integrated into the year 2 implementation plan for the Quality and Safety Strategy with quarterly updates reports to QSC		X	X X
Improvement plan for Cardiac Surgery services	S	S			• Independent external mortality review • CQC inspection report December 2019: recognised improvements in Cardiac Surgery governance processes • NICOR: The Trust is out of alert and is within the expected mortality range	X	X	X X X
Risk management framework in place	R	R			• CQC inspection report December 2019: negative references to documentation of risks on risk registers • Internal audit report 2021 gives reasonable assurance		X X	X X
Mental Capacity Act (MCA) and Depravation of Liberty Standards strategy in place	S	G			• MCA Steering Group reports to PSQG demonstrating progress against MCA strategy. MCA Steering Group to be re-launched in October 2021 due to changes in leadership		XX	
MCA level 1 and level 2 training programme in place	R	R			• MCA level 1 and 2 training levels across all staff groups reported	X X	X X	
Electronic templates for the recording of Capacity Assessment and best interest decisions	G	G			• Electronic templates for the recording of Capacity Assessment launched on 2 November 2020	X		
Medical Examiner System in place	S	S			• Medical Examiner office reviewed all non-coronial inpatient deaths in May 2020		X	X
Mortality Monitoring Committee and Learning from Deaths lead in place	G	G			• Learning from Deaths report including SHMI and sources of individual mortality alerts e.g. NICOR		X	
Updated IT technical system to support eDischarge summary	R	R			• Trust does not comply with NHSE Standard Contract for Discharge Summary			X
Governance structure – new appointed recruited to	R	R				X		
Agreed methodology for Consent and Trust lead in place	R	R			• Bi-annual Consent audit included in Audit Committee agreed Clinical Audit Programme 2021/22	X	X	

Strategic Objective	Treat the patient, treat the person	*Corporate Objectives 2021/22:*	*Care*
SR2	**We are unable to provide outstanding care as a result of weaknesses in our clinical governance**		

Gaps in controls and assurances	Actions to address gaps in controls and assurances	Complete by (date)	Progress
Areas for improvement identified by the three phases of the external clinical governance review	Delivery of the Clinical Governance Improvement Programme 2021/22, which incorporates all agreed recommendations from the three phases of the external clinical governance review. Papers presented Quarterly to PSQG and QSC	Mar 2022	
Full implementation of the Cardiac Surgery action plan to address all recommendations from the reviews	**Implement the Cardiac Surgery action plan** *Full implementation of the remaining two recommendations from the reports published by NHSEI in March 2020.*	Oct 2021	
MCA level 3 training module not developed	**Develop and implement MCA level 3 training module. Level 3 / Champions programme** *The development of a level 3 MCA training programme has been paused for the recruitment of a new MCA Lead. The new MCA Lead commenced employment this month (September). The programme will be developed as part of the preparation for the implementation of the Liberty Protection Safeguards.*	April 2022	
OrderComms catalogue not kept up to date therefore not all results are reported via Cerner	**Update Cerner OrderComms catalogue:** *Delayed as resources diverted to set up COVID vaccine hub* The SWLP LIMS project is working through each discipline in terms of order comms and completing end to end testing of the orders between Clinisys WinPath Enterprise and all of the order comms systems in the sector including SGH's iCLIP. The project is aiming to complete by December 2021.	Dec 2021	
eDischarge Summary Form not available on iClip	**Finalise the eDischarge form to be included onto iClip:** *Awaiting Cerner solution. The Trust is mitigating this risk by sending discharge documentation electronically via DOCMAN* *Discharge Workflow Project kick-off is imminent. This project will implement the discharge workflow which is the precursor to implementing a structured discharge summary in the new required format.*	June 2022	
Liberty Protection Safeguards (LPS) process as not yet issued by DoH	*Trust to implement LPS from April 2022 following DoH guidance*	Apr 2022	

Strategic Objective	Treat the patient, treat the person	*Corporate Objectives 2021/22:*	*Care*
SR2	**We are unable to provide outstanding care as a result of weaknesses in our clinical governance**		

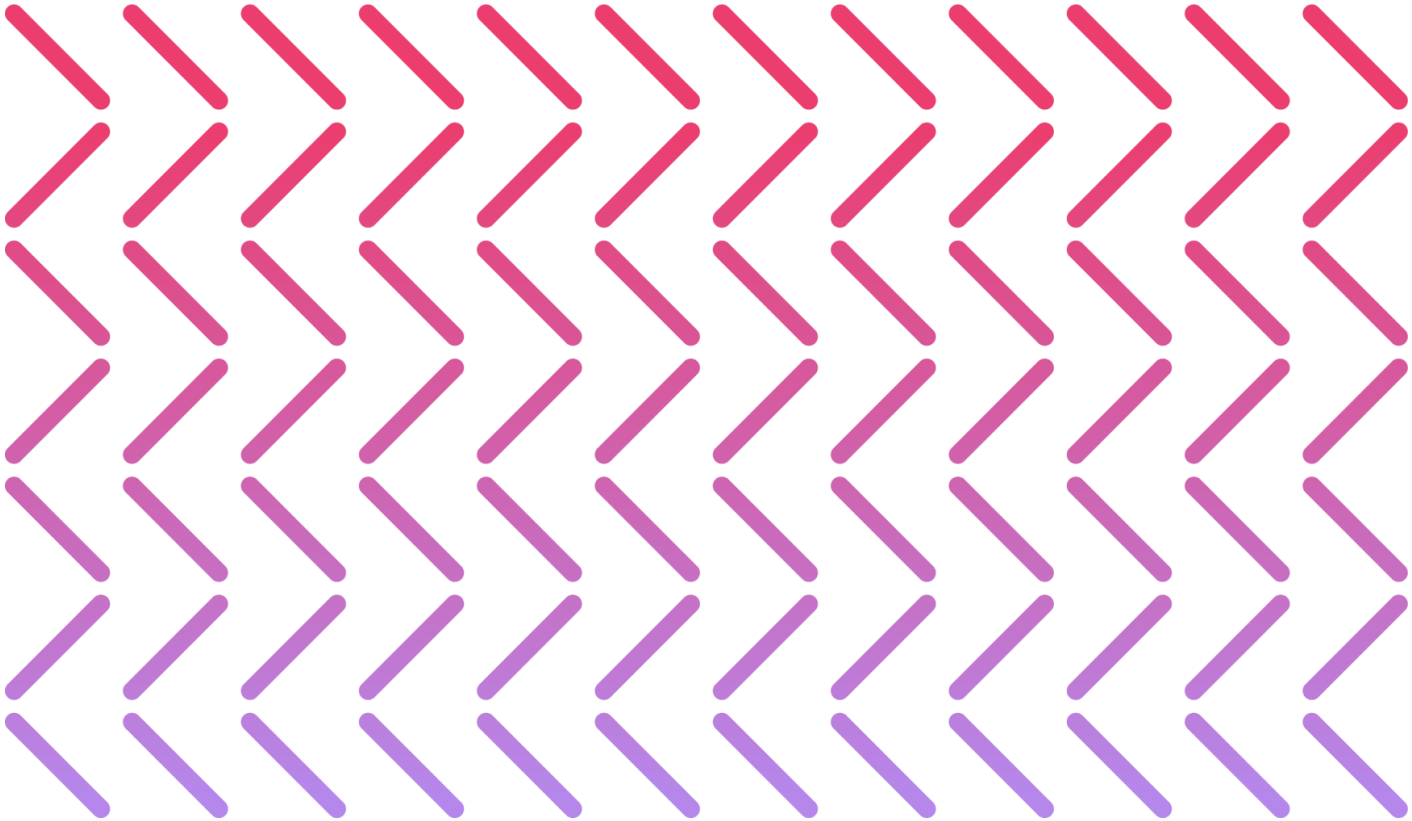
Lead indicators	RAG Rating Q1	Q2	Q3	Q4	Lead indicators: Progress update
Progress against phase 1 and phase 2 governance reviews					Learning from Deaths lead in place. Successful recruitment to all 14 posts in the original business case Progress report on actions in the Clinical Governance Improvement Plan 2021/22 reported to Quality and safety Committee at its November 2021 meeting
Maintaining the SHIMI within the confidence level (<0.1)					SHMI is 0.85 for the year June 2020 – May 2021
Open serious incident investigations > 60 days					All serious incident investigations continue to be completed within the 60 day timeframe
Readmission within 30 days (linked to failure in discharge planning)					9.0% readmission rate in August 2021, compared with 9.3% in August 2021
Number of open actions on CQC Trust wide action plan (2 Must dos: 44 should dos)					All actions completed, 5 actions to be carried forward as business as usual in the Trust's Operational Recovery Plan and Capital Programme for 2021/22
MCA level 1 and level 2 training performance					October 2021 - Level 1 MCA training compliance is 83.7%, level 2 compliance is 75% against the performance target of 85%
Diagnostic indicators – DM01					In October 2021 performance against the six-week diagnostic standard was 2.3% compared to 3.2% in September with a total of 207 patients waiting for more than six weeks, an improvement of 25%. Capacity challenges remain within Cardiac MRI - additional capacity through November and December will help support recovery..

Emergent / future risks	Future opportunities
• A further surge in summer 2021 may impact on the delivery of the Integrated Clinical Governance review action plan	• Implementation of the integrated clinical governance improvement programme is expected to deliver significant improvements in the Trust's clinical governance from ward to Board. • IT developments to support new ways of working e.g.care group meetings and communication

Strategic Objective 2: Right Care, Right Place, Right Time
Strategic Risks SR3 and SR4

SR3:
Our patients do not receive timely access to the care they need due to delays in treatment and the inability of our technology and transformation programmes to provide accessible care built around our patients' lives

SR4:
As part of our local Integrated Care System, we fail to deliver the fundamental changes necessary to transform and integrate services for patients in South West London



Strategic Objective	Right care, right place, right time	*Corporate Objectives 2021/22:*	Care
SR3	**Our patients do not receive timely access to the care they need due to delays in treatment and the inability of our technology and transformation programmes to provide accessible care built around our patients' lives**		

Risk Appetite / Tolerance	**LOW**	We have a low appetite for risks that impact on operational performance as this can impact on patient safety, but our appetite here is higher than for risks that directly affect the safety of our services	**Assurance Committee**	**Finance and Investment Committee**
			Executive Lead(s)	Chief Operating Officer
			Date last Reviewed	21 October 2021

Current risk and assurance assessment

Improvements have been made in our technology and the Trust has key controls and sources of assurance in place, for example the continued roll out of Windows10 and Microsoft teams has facilitated the provision of virtual clinical services and the video conferencing system for patients (Attend Anywhere) is now in use with supporting laptops, webcams and headsets installed.

However, there are a number of gaps in controls and sources of assurance as given the significant increase in the number of virtual users, the existing infrastructure now requires significant investment to ensure its stability and functionality.

In addition, although some progress has been made the Trust has not achieved the clinical standards for seven day services.

The Trust has continued to demonstrate consistent delivery for Priority 1 patients (cancer and non-cancer, treat within 72 hours) and Priority 2 patients (cancer and non-cancer, treat within 28 days) and in Q2 has moved to treat lower priority patients. This means that we are treating patients with urgent clinical needs in a timely way. We are ahead of our trajectory to reduce the number of long waiting patients waiting over 52 weeks and should have treated all patients unavoidably waiting over 104 weeks by the end of November. Additional theatres have been built at QMH to increased elective activity.

The assurance strength is rated as limited to reflect the impact of Covid-19 and the gaps in controls and the sources of assurance outlined above and overleaf which means there are weaknesses related to the control of this strategic risk.

Overall SR Rating – Quarterly Scores

Period 2021/ 2022	Risk Score	Assurance Strength	Change (last reporting period)	Inherent Risk Score	Target Risk Score For 2021/22
Q1	**Extreme 20= 5(C) x 4(L)**	**Limited**	N/A	**25 = 5(C) x 5(L)**	**15= 5(C) x 3(L)**
Q2	**Extreme 20= 5(C) x 4(L)**	**Limited**	N/A		
Q3					
Q4					

Summary COVID-19 Impact

Although Q2 has seen less of a direct impact from Covid, there are still constraints to our services as a result. The green elective pathway has been protected through ringfenced green surgical beds and four additional theatres have opened on the QMH site. The treatment of elective patients under all priorities has continued and volumes of priority 3 and 4 patients increased and those waiting over 52 weeks decreased. The four hour standard for emergency patients has dropped in recent months and the Trust has seen several days of Opel 4 with patients waiting extended periods of time in ED. This is multifactorial but has been influenced by IPC pathways reducing flexibility of the hospital bed base, as well as increased attendances up to 19/20 winter levels in September, and staffing shortages.
All services had high sickness and absence rates over the summer months, some due to covid isolation rules and actual covid sickness, and some due to the need for staff to take annual leave and time off over the summer. This led to a lower uptake of additional shifts, but since September this has seen an improvement.

Strategic Objective	Right care, right place, right time	*Corporate Objectives 2021/22:*	Care
SR3	**Our patients do not receive timely access to the care they need due to delays in treatment and the inability of our technology and transformation programmes to provide accessible care built around our patients' lives**		

Key risk controls in place	Control effectiveness				Key sources of assurance	Lines of assurance (positive/ negative)		
	Q1	Q2	Q3	Q4		1	2	3
Clinical Safety Strategy	S	S			Clinically driven plan agreed at Operational Management Group and approved at Quality and Safety Committee		X	
Insourced company to manage adult and paediatric ECHO.	R	R			Performance included in Integrated Quality and Performance Report (IQPR)	X	X	
Digital strategy - ICT Work plan aligned to Digital strategy	G	G			Digital strategy aligned to clinical strategy and outpatient strategy			XX
VDI	G	G			Improvement noticed by users Q4 of 2019/20 and reported to IGG but then Covid-19 pandemic increased homeworking/remote working and further improvements are now necessary to meet the 'new normal' with the improvement project in flight	XX		
Virtual clinics – video conferencing system with patients (Attend Anywhere) in use with supporting laptops, webcams and headsets installed; operational management by Corp OPD	R	R			Informatics Governance Group		X	
New workflow in iClip for Referral Assessment Service clinics as part of Covid19 changes	S	S			ICT Outpatient Project Steering Group and the Trust Communications news story published in Staff Bulletin 26 June 2020	X		
Provision of iCLIP clinic documentation for physical or virtual OPA available.	S	S			Trust Communications news story published in Staff Bulletin 26 June 2020	X		
Provision of Office365 and Microsoft Teams to support MDT cancer and orthopaedic meetings and further roll out in progress	S	S			ICT Covid-19 Service Management Report presented to IGG in April 2020 10,000 staff migrated to Office 365 with access to teams presented to IGG Oct 2020		X X	
ED rapid assessment and triage process in place	G	G			Clinical pathway and Standard Operating Procedure (SOP)	X		
Direct access pathways	G	G			Clinical Pathway and SOP	X		
Partnership working between ED and local Mental Health organisations to improve care and waiting time for patients attending the ED with mental health needs	R	R			Clinical Pathway, Memorandum of Understanding/ COMPACT, and local service performance metrics	X		
UCC direct pathways	G	G			Clinical Pathway and SOP	X		
Clinical Decision Outcome Form (CDOF) incorporated within iClip	R	R			eCDOF tableu	XX		

Strategic Objective	Right care, right place, right time	*Corporate Objectives 2020/21:*	Care
SR3	**Our patients do not receive timely access to the care they need due to delays in treatment and the inability of our technology and transformation programmes to provide accessible care built around our patients' lives**		

Gaps in controls and assurances	Actions to address gaps in controls and assurances	Complete by (date)	Progress
Availability of paediatric trained physiologist / ECHO technicians to carry out ECHO	Recruitment of vacant post within the new cardiac physiology structure Band 7 with experience in paeds ECHO however no accreditation. Recruitment process continues for band 8a lead with accreditations	Dec 2021	
Seven day clinical services standards	Implementation of Divisional action plans to achieve seven day clinical service standards compliance. All Care Groups have updated their risk assessment. Directorates have defined plans to address all non-compliance. Capital works to install 2 static MRIs has commenced, with the equipment was expected to go-live in January 2022, however it has now been deferred to February 2022. Budget setting and job planning for 2021/22 will address a number of gaps in 7 day services. Further assurance sought of residual non-compliance areas due end of July 2021. Care groups have reported their position, and this has been reviewed by both divisions, PSQG and QSC. There is a review process through the divisional governance boards to give assurance of the safety of non-compliant services. Directorates have changed highlighted areas of focus for recruitment and service change. Proposals to expand existing MRI services to 7 days to extend coverage for non-emergency inpatient scanning over 7 days are pending a funding proposal submitted to OMG. New MRI capacity will come online by Feb 2022, and can provide 24/7 cover for emergency imaging dependant on funding for 1 extra member of staff.	~~Sep 2020~~ Feb 2022	
Cyber security	Implement recommendation to improve cyber security - 2020/21 Project Plan – completed after penetration test. The network is segmented via VLAN, migration from N3 to HSCN done, password policy implemented. Forcepoint and IPS in place. Cyber Essentials Plus task and finish group underway to provide assurance for end December 2021. It is envisaged that this will not meet the standards as Agresso not updated until April 2022	~~Mar 2021~~ ~~Dec 2021~~ April 2022	
ICT disaster recovery (DR) plan – require solution for 2nd data centre	Design ICT disaster recovery (DR) plan to include provision for second data centre Draft plan for hybrid model approved by IGG in Dec 2020; Site for a 2nd physical onsite data centre will be longer term depending on internal build such a renal unit, or availability in community or sites in SW London. Cloud solution for partial DR now purchased and being configured. Current phase is implementation, moving suitable systems across to cloud solution with view to reducing score when complete so due date modified but awaiting high speed VPN - delays due to licensing	~~Mar 2021~~ Mar 2022	

Strategic Objective	Right care, right place, right time	*Corporate Objectives 2020/21:*	Care
SR3	**Our patients do not receive timely access to the care they need due to delays in treatment and the inability of our technology and transformation programmes to provide accessible care built around our patients' lives**		

Gaps in controls and assurances	Actions to address gaps in controls and assurances	Complete by (date)	Progress
Outpatient virtual clinic, RAS and Attend Anywhere projects not fully implemented yet	Complete the ICT outpatient projects that are in flight - project re-scoped with COS post-Covid and re-prioritised. Virtual clinics and Attend anywhere implemented for all the services that were in scope around July 2021. Some services remained as DBS services (minority) but those were approved at the time at steering group. In the processes of transitioning this into BAU	~~Sep 2020~~ ~~Sep 2021~~ Dec 2021	
MDT teleconferencing for SWLP, equipment not yet provisioned; workflows changed due to Covid-19	ICT Project Plan 2020/21 to improve hardware and workflow for MDT teleconferencing. 4 rooms out of the original requirement for 6 rooms have been delivered. Outstanding tasks: • Train the Trainer potentially to be started in November • Additional ceiling mounted microphone for the Jenner Seminar Room 1	~~Sep 2020~~ ~~Sep 2021~~ Dec 2021	
Data warehouse capacity - not built to deal with current volume of data / continue use of paper based records. Cerner nightly extracts being terminated.	Project to improve data warehouse in capital plan 20/21 delayed due to Covid and now in 21/22 plan. Improvement project identifying alternative models of data management, with requirements developed to consider other organisations in SW London. Implementation following selection.	~~Mar 2021~~ Apr 2022	
Multiple clinical systems which do not interoperate leading to fragmented clinical records (use of standalone systems not using patient MRN as single identifier)	Projects for Outpatients and Theatres in 2020/21 ICT Project plan - DSU has gone live with updated content; QMH DCU and STG Obstetric theatres now live. Project paused due to Covid19 surge but expected to complete during 2021/22, Covid-permitting. New project manager appointed	~~Dec 2020~~ Dec 2021	
Sufficient availability of VDI upgrade to support remote working	VDI Horizon upgrade to Win10 piloted and for Sept/Oct roll out; hardware replacement programme for outpatient areas; new remote access solution (Swivel) being rolled out – expect to complete Q3 21/22	~~Oct 2020~~ Dec 2021	
ICT network infrastructure is old and not sufficiently resilient or able to meet today's demands for Wi-Fi and video-conferencing	Replacement of network core completed in Q2; additional requirements to implement DMZ being resourced; followed by campus network and Wi-Fi completing Q4 2022/23. Phased improvement over this time period.	Mar 2022	

Strategic Objective	Right care, right place, right time	*Corporate Objectives 2021/22:*	Care
SR3	**Our patients do not receive timely access to the care they need due to delays in treatment and the inability of our technology and transformation programmes to provide accessible care built around our patients' lives**		

Lead indicators	RAG Rating				Lead indicators: Progress update
	Q1	Q2	Q3	Q4	
ED attendances					August 2021 – 12,464 ED Attendances. 10% lower than August 2019. Acuity levels remain high with 5% more patients scoring between 1-3 against Manchester Triage System compared to August 2019
Inpatient – non elective					August 2021 – 3,340 Non Elective Spells. 12% lower than August 2019
Inpatient – elective and day case					August 2021– 4,133 Day case / Elective activity. 18% lower than August 2019. 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.
Outpatient attendances					August 2021 – 45,903 Attendances. 0.5% higher than August 2019. Outpatient performance is expected to be 104% after catch-up, which is higher than the 95% trajectory by 9%.
RTT					July 2021 the Trust reported 1,106 patients waiting for more than 52 weeks to receive treatment. This is a decrease of 134 patients compared to June and ahead of trajectory.
6 week Diagnostic Performance					August 2021 performance against the six-week diagnostic standard was 3.5% compared to 4.3% in July 2021
ED 4hr operating standard					August 2021 performance was 81.5%. impact of COVID 19 still widely evident, high acuity of patients , capacity and flow throughout the Trust has been challenged.
Cancer 14 Day Standard					July 2021 Performance against the 14 day standard was below the target of 93% reporting 84.9% compared to 91.2% in June 2021. 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
Cancer 62 Day referral to Treatment Standard					July 2021 Performance was at 65.1% against the 85% target. 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.

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

Strategic Objective	Right care, right place, right time			*Corporate Objectives 2021/22:*	Collaboration
SR4	**As part of our local Integrated Care System, we fail to deliver the fundamental changes necessary to transform and integrate services for patients in South West London**				
Risk Appetite / Tolerance	**MODERATE**	Because we recognise that significant changes are necessary across the South West London system, we have a moderate appetite for risks that impact on system transformation and cross-system working in order to facilitate changes that will improve care for patients across South West London.	**Assurance Committee**	**Trust Board**	
			Executive Lead(s)	Chief Strategy Officer	
			Date last Reviewed	29 July 2021	

Current risk and assurance assessment

The SWL Integrated Care System's five year plan sets out how it will deliver the priorities within the NHS Long Term Plan. The Trust is a member of the SWL ICS and contributed to developing the five year plan. As the Trust works towards SWL system priorities there is a risk that these may not directly link with St George's. The Trust is an active member of the various forums across the SWL ICS and has opportunity to influence the future direction which also provides opportunity for the Trust to better understand its role in delivery. The Trust's CEO is a chair of the Acute Provider Collaborative which has a focus on developing standardised clinical pathways. The Trust is also represented on the SWL 'enabler' workstreams such as workforce, digital , estates and finance. The Trust's workforce strategy which was approved by Trust Board in November 2019 will support the Trust to develop the future workforce models required to deliver the ambitions. The management and clinical capacity within the Trust does pose a challenge going forward to enable sufficient engagement with the clinical priorities at SWL and Borough level.

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

An in-year target risk score of 12(4x3) was considered by the Board to be a realistic year end position for this risk to reflect the significant and impact of system working changes. There remains an inherent tension between the statutory framework which places accountability on individual organisations and the move to greater system working, and this tension will continue pending legislative change.

Overall SR Rating – Quarterly Scores

Period 2020/ 2021	Risk Score	Assurance Strength	Change (last reporting period)	Inherent Risk Score	Target Risk Score For 21/22
Q1	High 12= 4(C)x3(L)	Good	N/A	16 = 4(C) x 4(L)	12= 4(C)x3(L)
Q2	High 12= 4(C)x3(L)	Good	N/A		
Q3					
Q4					

Summary COVID-19 Impact

There is a risk to delivery of pre-Covid strategic priorities due to the required focus on Covid recovery plans. The Trust is continuing to work with system partners to integrate Covid recovery activity / governance arrangements with pre-existing plans/governance structures. The SWL ICS has established a Covid-19 Recovery Board which has overseen the development of, and will oversee delivery of, the SWL ICS Covid-19 recovery plan. The Trust CEO is a member of the SWL ICS Covid-19 Recovery Board. The collaborative approach adopted across SWL in the response to Covid-19 has accelerated cross boundary working and the integration and transformation of services albeit barriers to further integration exist due to existing legal/ statutory frameworks.

Outstanding care every time

Strategic Objective	Right care, right place, right time	*Corporate Objectives 2021/22:*	Collaboration
SR4	**As part of our local Integrated Care System, we fail to deliver the fundamental changes necessary to transform and integrate services for patients in South West London**		

Key risk controls in place	Control effectiveness				Key sources of assurance	Lines of Assurance (positive / negative)		
	Q1	Q2	Q3	Q4		1	2	3
The SWL ICS Programme Board on which the Trust CEO is a member	R	R			• CEO representation on the Board • Quarterly SWL ICS Updates to Trust Board		X	X
The Trust is a member of the SWL Acute Provider Collaborative	S	S			• The APC is chaired by the Trust CEO and has a focus on clinical pathway standardisation		X	X
SWL Covid-19 Recovery Structure has been established	R	R			• Trust representation on key workstreams • CEO is a member of the Recovery Board and chair of the Elective Recovery Programme		X	X
SWL Clinical Senate - set the clinical priorities for SWL	R	R			• The Trust is represented on the Clinical Senate by the CMO		X	X
SWL ICS Five Year Plan - the Trust contributed to developing the five year plan which set the priorities for SWL	R	R			• The Trust is represented at all SWL Integrated Care System meetings • The SWL ICS and Acute Provider Collaborative Forums allow general oversight of commissioner and provider plans to develop relationships outside the sector • The Trust is an active contributor to the key 'enabling' workstreams across the SWL ICS e.g. Workforce, Digital, Finance		X	X
A Wandsworth and Merton Provider Partnership Board is in place	R	R			• The Trust is represented on this Board and is a forum for agreeing the approach to place-based transformation		X	X
SWL Covid-19 Recovery Plan - driving greater collaboration	R	R			• The Trust CEO is a member of the SWL ICS Covid-19 Recovery Board , Steering Group and is chair of the Acute Cell		X	X
The Trust Workforce Strategy approved by Trust Board in November 2019 – a key driver being delivery of the SWL five year plan as well as the Trust's clinical strategy	R	R			• Implementation plans are in place and being delivered against		X	
Annual review of Trust Strategy	S	S			• The review of Trust strategy undertook in June confirmed that the priorities are still relevant taking account the changes in the external environment.		X	
Trust contribution to the Wandsworth and Merton Local Health and Care Plans	R	R			• The CSO is a member on both of the Borough Health and Care Partnership Boards • The CSO chairs the Wandsworth Borough Estates Strategy Working Group which will reflect any changes in clinical priorities		X	X
Exploration of opportunities for closer collaboration between St George's and Epsom and St Heliers Hospitals	S	S			• Programme Board established and Strategic Committees in Common set up, with ToR approved by both Boards		X	

Strategic Objective	Right care, right place, right time	*Corporate Objectives 2021/22*	Collaboration
SR4	**As part of our local Integrated Care System, we fail to deliver the fundamental changes necessary to transform and integrate services for patients in South West London**		

Gaps in controls and assurances	Actions to address gaps in controls and assurances	Complete by (date)	Progress
Limited clinical and management capacity within the Trust to engage with and deliver the clinical priorities for Wandsworth and Merton as set out in their respective Local Health and Care Plans	Both Wandsworth and Merton Health and Care Partnership Boards have reviewed the priorities in the LCHP in light of Covid-19 and this will provide an opportunity to re-assess the Trust's role in delivering these (The Trust is represented on both Boards) Future business planning activities to take account of the Trust's contribution to delivering the key priorities in the LHCP. NHSE/I have delayed business planning due to COVID, so this will be completed later than March 2021	March 2021	
With Covid-19 recovery being planned at SWL ICS level there is potential for Wandsworth and Merton Borough level priorities to be over-looked	Wandsworth and Merton Provider Board meetings which are attended by the Trust CEO are to identify any particular issues and so to act as the bridge between borough and system level planning	Complete	
Arrangements for reducing collectively the elective backlog in SWL	Construction of modular theatres in QMH to provide elective day case procedures to assist in reducing elective backlog for the Trust and wider SWL.	Complete	
Impact of specialised commissioning devolution on the Trust's clinical service income	Engagement with the SWL system to shape arrangements for spec com devolution in SWL.	March 2022	

Strategic Objective	Right care, right place, right time	*Corporate Objectives 2021/22:*	Collaboration
SR4	**As part of our local Integrated Care System, we fail to deliver the fundamental changes necessary to transform and integrate services for patients in South West London**		

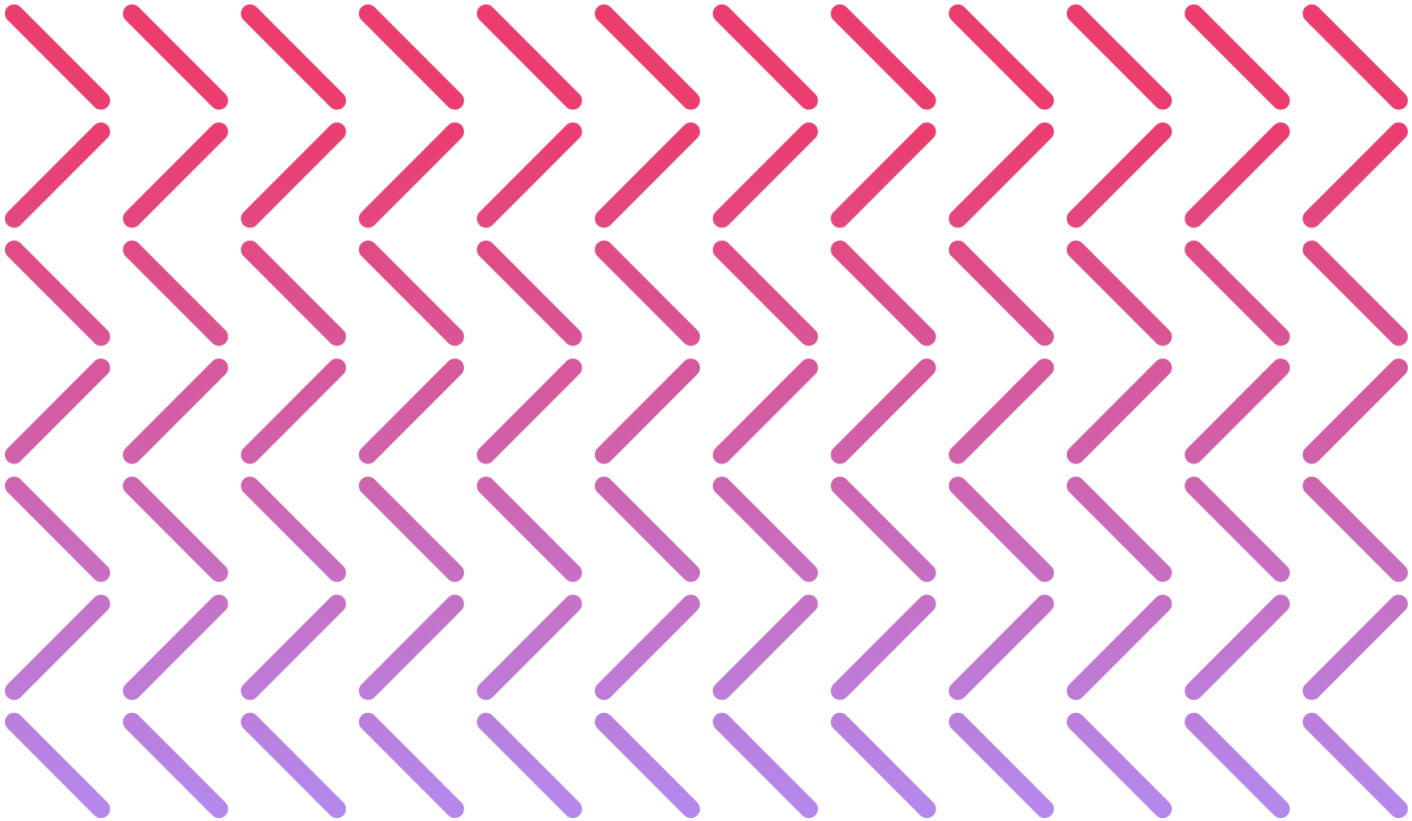
Lead indicators	RAG Rating Q1	Q2	Q3	Q4	Lead indicators: Progress update
A SWL Covid19 recovery plan in place					The Trust is represented on the SWL Recovery Board and associated workstreams leading the development of the Covid-19 recovery plan, which has now been agreed.
Clinical Safety Strategy in place and has identified revised clinical pathways across SWL					14 SWL clinical networks have now been established – though some elements of their work programmes have been paused due to COVID
The number of clinical networks which are fully established for which SGUH is the lead provider					SGUH clinicians have leadership roles in 8 of the 14 networks
The number of key SWL meetings that have appropriate representation from SGUH					The CEO is a member of the SWL ICS Programme Board and SWL Recovery Board , chair of the Elective Recovery Programme and APC. Borough level meetings are represented by the Chief Strategy Officer.
Delivery of Clinical Strategy implementation plans					Plans have been revised during Q2 to reflect any implications of Covid-19 and first progress report was presented to Trust Board in September 2020
Delivery of Corporate Support Strategy implementations plans					Implementation plans have been developed and approved during Q2. First progress report was presented to Trust Board September 2020

Emergent / future risks	Future opportunities
The continued focus on the response to Covid-19 may put additional pressure on the clinical and management capacity within the Trust to focus on SWL five year plan priorities The outcome of the Building Your Future Hospitals (BYFH, previously Improving Healthcare Together or IHT) programme may present some risks to the Trust's ability to manage the potential increase in demand. The Trust has set out the capital investment it would require from the programme, as well as enabling investment in ED required from other sources, but these have not yet been confirmed.	The SWL Covid-19 Recovery Programme Board and associated recovery plan will provide an opportunity for enhanced collaborative working to achieve greater integration and transformation of services The outcome of the Improving Healthcare Together programme may provide an opportunity for greater collaboration between St George's, Epsom and St Helier and the Royal Marsden The consultation on the future of Integrated Care Systems may support closed system working and provide a statutory framework on which to build closer collaboration and integration.

Strategic Objective 3: Balance the books, invest in our future
Strategic Risks SR5 and SR6

SR5:
We do not achieve financial sustainability due to under-delivery of cost improvement plans and failure to realise wider efficiency opportunities

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



Strategic Objective	Balance the books, invest in our future	*Corporate Objective 2021/22:*	Collaboration
SR5	**We do not achieve financial sustainability due to under delivery of cost improvement plans and failure to realise wider efficiency opportunities**		

Risk Appetite / Tolerance	**LOW**	We have a low appetite for risks that will threaten the Trust's ability to deliver services within our financial resources	**Assurance Committee**	**Finance and Investment Committee**
			Executive Lead(s)	Chief Finance Officer
			Date last Reviewed	21 October 2021

Current risk and assurance assessment

- Financial planning for within the NHS is currently operating to revised timetables and frameworks due to the pandemic. A financial plan is due to be submitted through the ICS, to NHSI, in November, and it is expected that there will remain a material financial challenge due to operational pressures during winter, efficiency requirements nationally, and elective recovery funding being more challenging to earn.
- Elective Recovery Fund income is required for the Trust to achieve financial balance, based on activity trajectories produced by the Trust. It is anticipated that the ERF ask in H2 will be materially more challenging than in H1. Therefore, the Trust is very unlikely to be able to achieve the level of contribution from this activity required to fund the financial gap it has.
- It is expected that delivery of c2%-3%% CIP will be required in the second six months. Engagement has been challenging due to operational and clinical focus on the response to COVID 19, elective recovery and emergency activity pressures.
- Operational pressures associated with the continued management of COVID, activity recovery, and dealing with a surge in emergency activity (eg. Paeds RSV) are causing significant financial challenge in H2.
- There is no provision in the plan for a 3rd COVID surge, as per guidance.
- Divisional financial performance is being picked up through the Operational Management Group, through to Trust Management Group.
- Divisions are being met on a monthly basis by the Deputy CFO to review overspends, and underspends. Equal attention is being given to both as ensuring underspends on areas of lower activity due to the pandemic will form a material part of the financial recovery plan.
- Increased financial governance is being introduced through Thursday afternoon focussed sessions aimed at delivering financial improvement.

Overall SR Rating – Quarterly Scores

Period 2021/ 2022	Risk Score	Assurance Strength	Change (last reporting period)	Inherent Risk Score	Target Risk Score For 2021/22
Q1	Extreme 20 = 5(c) x 4(L)	Partial	N/A	25= 5(c) x 5(L)	12= 5(c)x3(L)
Q2	Extreme 20 = 5(c) x 4(L)	Partial	N/A		
Q3					
Q4					

Summary COVID-19 Impact

- New financial framework in place for 21/22 aimed at addressing elective recovery following COVID 19, as well as managing business as usual demand.
- Monthly reporting will review spend to ensure costs are stepped down where expected, and cost increases due to COVID are reasonable and justified.
- An interim block arrangement for NHS income continued through M1-6 of 21/22, and is expected to continue through H2.

Strategic Objective	Balance the books, invest in our future	*Corporate Objective 2021/22:*	Collaboration
SR5	**We do not achieve financial sustainability due to under delivery of cost improvement plans and failure to realise wider efficiency opportunities**		

Key risk controls in place	Control effectiveness				Key sources of assurance	Lines of Assurance (positive / negative)		
	Q1	Q2	Q3	Q4		1	2	3
Monthly divisional finance meetings with in place with DCFO to discuss areas for escalation (underspends/overspends)	S	S			Monthly divisional finance reports	xx	xx	
Monthly reporting of financial issues through to OMG, TMG, FIC and Trust Board	S	S			Monthly Trust finance reports	xx	xx	
Monthly external review of Trust position by NHSE/I as part of monthly top-up payment review	S	S			Top up payment made to Trust		x	x
Financial plan in place, with monthly performance being scrutinised vs budget	S	S			Monthly report to Finance and Investment Committee	x	x	
South West London FAC continued to develop system financial management processes in support of delivery of control totals.	G	G			SWL Monthly Finance Report			x
Plan in place for financial balance in 21/22 , or in line with NHSI/E control total	P	P			Plan agreed as part of SWL for financial balance in 21/22. New financial frameworks expected to provide increased risk in H2			x

Strategic Objective	Balance the books, invest in our future	*Corporate Objective 2021/22:*	Collaboration
SR5	**We do not achieve financial sustainability due to under delivery of cost improvement plans and failure to realise wider efficiency opportunities**		

Gaps in controls and assurances	Actions to address gaps in controls and assurances	Complete by (date)	Progress
South West London financial performance management structure in place to drive and ensure financial performance and best practise within sector	- Trust to lead development of financial governance with SWL ICS - Framework agreed by CFOs and CEOs - Further work required to ensure full benefit realised from SWL working.	Sept 20	
Capacity plan not fully developed inline with new working environment post COVID	- Capacity plan to be agreed in line with financial forecasts and performance trajectories through OMG - Capacity plan agreed as part of activity trajectory's. Still a work in progress - Whilst complete for theatres and inpatient beds, further work required on outpatients.	~~Sept 20~~ Nov 21	
Lack of accountability within services for financial performance and delivery	- Finance to be included within objectives of all leadership posts with financial responsibility within the organisation	~~Nov 20~~ Nov 21	
Plan for 21/22 currently year still in infancy, with no clarity in level of income the Trust will be in receipt of for H2	- Work up plans for H2, as much as practically possible with no planning guidance. - Await planning guidance for H2, and funding enveloped so scale of challenge, and action required can be confirmed.	~~Mar 21~~ Mar 22	

Strategic Objective	Balance the books, invest in our future	*Corporate Objective 2021/22:*	Collaboration
SR5	**We do not achieve financial sustainability due to under delivery of cost improvement plans and failure to realise wider efficiency opportunities**		

Lead indicators	RAG Rating Q1	Q2	Q3	Q4	Lead indicators: Progress update
Financial balance achieved YTD					Financial balance reported at M2
Financial balance forecast through to year end					Significant uncertainty remains around H2, and risk around ERF remains for H1.
CIP/improvement plan to be agreed and delivered					Further work required on stepping back up recurrent efficiency programme for 21/22 required.
SWL plan to be developed to remain within control total					SWL position remains balanced, although risks in some providers being offset by favourable positions in others, with a sector risk around ERF remaining.

Emergent / future risks	Future opportunities
- Financial envelopes for 21/22 risk not being at the level the Trusts needs for recovery. - Non-NHS income recovery will continue to be challenged. - Competing priorities within divisions meaning finance isn't prioritised	- Financial improvement/mitigation through further collaboration within the SWL ICS

Strategic Objective	Balance the books, invest in our future			*Corporate Objective 2021/22:*	Collaboration					
SR6	**We are unable to invest in the transformation of our services and infrastructure, and address areas of material risk to our staff and patients, due to our inability to source sufficient capital funds**									
Risk Appetite / Tolerance	**LOW**	Due to the importance of securing investment in the Trust's ageing estates infrastructure, we have a low appetite for risks that could impact on the availability of capital	**Assurance Committee**	**Finance and Investment Committee**						
			Executive Lead(s)	Chief Finance Officer						
			Date last Reviewed	21 October 2021						
Current risk and assurance assessment	• Current capital funding available (CDEL) to SWL remains materially short of requirements (c£20m) for 21/22. • Weekly reviews taking place with DCFO to ensure limited funds are prioritised and risks articulated from funding shortfalls. • Mitigations currently being worked through including reviewing timings of projects between years, as well as revenue funding sources for some projects. • In addition, Trusts capital plans for 22/23 and beyond do not have sources of funding confirmed against them. • SWL prioritisation continues for 21/22 schemes. • Significant shortfall currently in existence across South West London when comparing essentially plans to CDEL allocation. Mitigation being worked through in the ICS, but has a material impact on St George's.		**Overall SR Rating – Quarterly Scores**	**Period 2021/ 2022**	**Risk Score**	**Assurance Strength**	**Change (last reporting period)**	**Inherent Risk Score**	**Target Risk Score For 2021/22**
				Q1	**Extreme – 20 4(c) x 5(L)**	**Partial**	**N/A**	**20 = 4(c) x 5(L)**	**12= 4(c)x3(L)**
				Q2	**Extreme – 20 4(c) x 5(L)**	**Partial**	**N/A**		
				Q3					
				Q4					
			Summary COVID-19 Impact						

Strategic Objective	Balance the books, invest in our future	*Corporate Objective 2021/22:*	Collaboration
SR6	**We are unable to invest in the transformation of our services and infrastructure, and address areas of material risk to our staff and patients, due to our inability to source sufficient capital funds**		

Key risk controls in place	Control effectiveness				Key sources of assurance	Lines of Assurance (positive / negative)		
	Q1	Q2	Q3	Q4		1	2	3
Monthly reporting to FIC and Trust Board on key areas of risk, both financially, and due to non-investment.	S	S			Monthly finance reports		X	
Weekly Capital funding update and discussion, to review clinical urgency of requests.	S	S			Weekly update to OMG on status of COVID capital bids		X	
Evolution and development of capital prioritisation at SWL level through CFO meeting (FAC)	S	S			SWL Capital Plan report		X	

Strategic Objective	Balance the books, invest in our future	*Corporate Objective 2021/22:*	Collaboration
SR6	**We are unable to invest in the transformation of our services and infrastructure, and address areas of material risk to our staff and patients, due to our inability to source sufficient capital funds**		

Gaps in controls and assurances	Actions to address gaps in controls and assurances	Complete by (date)	Progress
Confirmation of emergency financing to fund essential programme of capital works within CDEL allocation	Pursue emergency funding through the ICS through to NHSI/E London through CFO Emergency funding application submitted and with national team Additional CDEL allocation pursued to mitigate critical infrastructure risk with NHS London	Aug 21	
No alternative means of financing identified to fund programme	Alternative methods of financing current programme to be developed by DCFO Further work is ongoing to ensure all options are explored between now and the end of the year.	Mar 22	
Confirmation of funding for 21/22 programme in place	Further work required through ICS to ensure funding for 21/22 in place.	Mar 21	
Confirmation of funding for 22/23 programme and beyond in place	Further work required through ICS to ensure funding for 22/23 in place.	Mar 22	

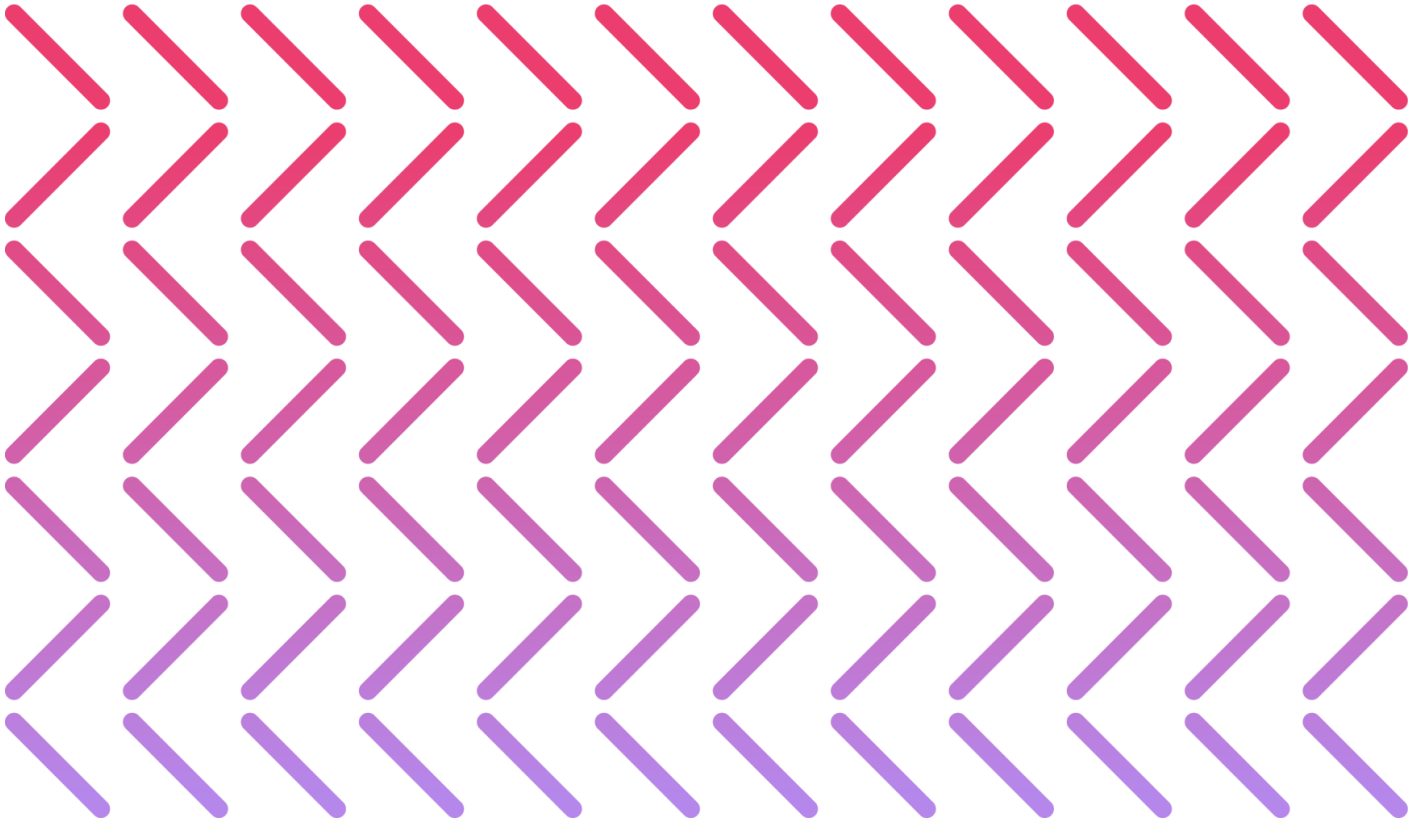
Strategic Objective	Balance the books, invest in our future	*Corporate Objectives 2021/22:*	Collaboration
SR6	**We are unable to invest in the transformation of our services and infrastructure, and address areas of material risk to our staff and patients, due to our inability to source sufficient capital funds**		

Lead indicators	RAG Rating				Lead indicators: Progress update
	Q1	Q2	Q3	Q4	
Funding confirmed for full 21/22 capital programme					Funding confirmed for 21/22 plan.
Funding confirmed for 5 year capital plan					No further clarification on additional sources of finance for 21/22 and beyond.
Reduction of clinical risk resulting from old equipment estate infrastructure and IT					Additional risks emerging due to COVID. Spending continuing at risk to mitigate risks.,
Capital spend at full value of plan in 21/22					Full spend forecast, although risks and mitigations in place for higher spend forecast in Q4

Emergent / future risks	Future opportunities
- Funding for 21/22 BAU and projects still to be identified/confirmed. - Funding relating to the Trusts key strategic priorities, and the estates strategy is still to be confirmed	- Emergency capital funding made available from NHSE/I - Further prioritisation within SWL to move money to address material and urgent risk at St George's, as well as ITU expansion.

Strategic Objective 4: Build a better St George's
Strategic Risk SR7

SR7:
We are unable to provide a safe environment for our patients and staff and to support the transformation of services due to the poor condition of our estates infrastructure



Strategic Objective	Build a better St George's	*Corporate Objective 2021/22*	*Care*

SR7	We are unable provide a safe environment for our patients and staff and to support the transformation of services due to the poor condition of our estates infrastructure

Risk Appetite / Tolerance	LOW	We have a low appetite for risks that affect the safety of our patients and staff

Assurance Committee	**Finance and Investment Committee**
Executive Group	Risk and Assurance Group
Executive Lead(s)	Chief Finance Officer
Date last Reviewed	21 October 2021

Current risk and assurance assessment

Our current risk assessments indicate that this continues to be an extreme risk for the Trust.

We are currently going through a process of reassessing our strategic risks with the relevant strategic compliance groups to agree a number of areas where risk ratings can be reduced, as was presented and agreed at previous Risk and Assurance Group and Finance and Investment Committee meetings. We are also using the opportunity to look at streamlining governance processes for estates reporting and assurance groups.

In Q2 2021/22, the final Estate Strategy and Green Plan was presented and approved by the Trust Board in August 21.

The Trust Board approved the Hospital Infrastructure Programme (HIP) application in relation to the redevelopment of the Tooting site and the delivery of the Trust's Estates strategy. The outcome will not be known until Spring 2022.

A wider communications plan is being prepared for all stakeholders.

Our 2021/22 capital plan has been set and is heavily constrained by available funding. We have used a risk based approach to prioritise capital projects, to ensure our risk assessments align with clinical risks we are beginning to meet monthly with clinical governance leads.

Overall SR Rating – Quarterly Scores

Period 2021/ 2022	Risk Score	Assurance Strength	Change (last reporting period)	Inherent Risk Score	Target Risk Score For 2021/22
Q1	**Extreme 20 = 4(c) x 5(L)**	Partial	N/A	**25 = 5(c) x 5(L)**	**16 = 4(c) x 4(L)**
Q2	**Extreme 20 = 4(c) x 5(L)**	Partial	N/A		
Q3					
Q4					

Summary COVID-19 Impact

- Our operational teams are well versed in dealing with COVID-19 and are prepared for future requirements
- There are two potential impacts on capital project delivery:
  - Availability of spaces within the Trust to deliver capital projects
  - Impact on construction industry with increased lead times, resource constraints etc.
  - Resourcing for Project Management

Strategic Objective	Build a better St George's	*Corporate Objective 2021/22*	*Care*
SR7	**We are unable provide a safe environment for our patients and staff and to support the transformation of services due to the poor condition of our estates infrastructure**		

Key risk controls in place	Control effectiveness				Key sources of assurance	Lines of Assurance (positive / negative)		
	Q1	Q2	Q3	Q4		1	2	3
Risk adjusted backlog maintenance programme informed by Authorised Engineer reports and independent condition surveys	S	S			Independent surveys and AE reports provide assurance on key issues but their renewal has been delayed due to COVID Safety working groups have been postponed during COVID, but are now running again PAM now provides enhanced assurance, this has now been assessed externally and improvements being implemented.. CQC report 2019 - technical assurance has been provided on the key areas of concern where reactive maintenance could potentially impact patient care		X X X X	
Investment profile provides plans to manage backlog maintenance investment	W	w			The capital plan provides additional funding to undertake work on high risk maintenance backlog areas and will prioritise the key corporate estates risk however the current resources do not meet the requirements,		X	
Governance systems in place to provide oversight on critical estates issues	P	P			The PAM has been submitted for 20-21 and actions are being monitored. Costed action plans need further development due to the changes with the Estates strategy.			X
Estate Assurance Group to review all key assurance and activities	P	P			The Group will review PAM data together with assurance reports prepared for working groups.		XX	
Green Plan		S			Approved at Board at the end of August 2021 – road map in place for delivery		X	X
Estates Strategy		S			Estates strategy approved by Trust Board		X	

Strategic Objective	Build a better St George's	*Corporate Objectives 2021/22:*	Care
SR7	**We are unable provide a safe environment for our patients and staff and to support the transformation of services due to the poor condition of our estates infrastructure**		

Gaps in controls and assurances	Actions to address gaps in controls and assurances	Complete by (date)	Progress
Lack of an estates strategy for the Trust's sites	Develop Estates Strategy and present to Trust Board Estates Strategy completed and approved by the Trust Board in July 2021	Close	
Absence of a Green Plan for the site	Develop Green Plan and present to Trust Board Green Plan completed and approved by the Trust Board in July 2021	Close	
Premises Assurance Model requires updating	Delivery of plan to update PAM PAM updated and submitted annually (20-21 submitted on plan)	Close	
No centralised data management system in place to ensure all required information is available and coordinated	Data and Systems review within E&F to be undertaken, Identified resource to undertake the work. Work will be commencing in November 2021	~~Jan 2021~~ Jan 2022	
Governance groups are not aligned with new wider assurance arrangements	All groups are meeting, but a review of governance arrangements is now being undertaken to improve effectiveness. Meeting has been held between Director E&F and CNO and principles of assurance group; ToR drafted = meeting dates to be planned.	~~Feb 2021~~ Dec 2022	

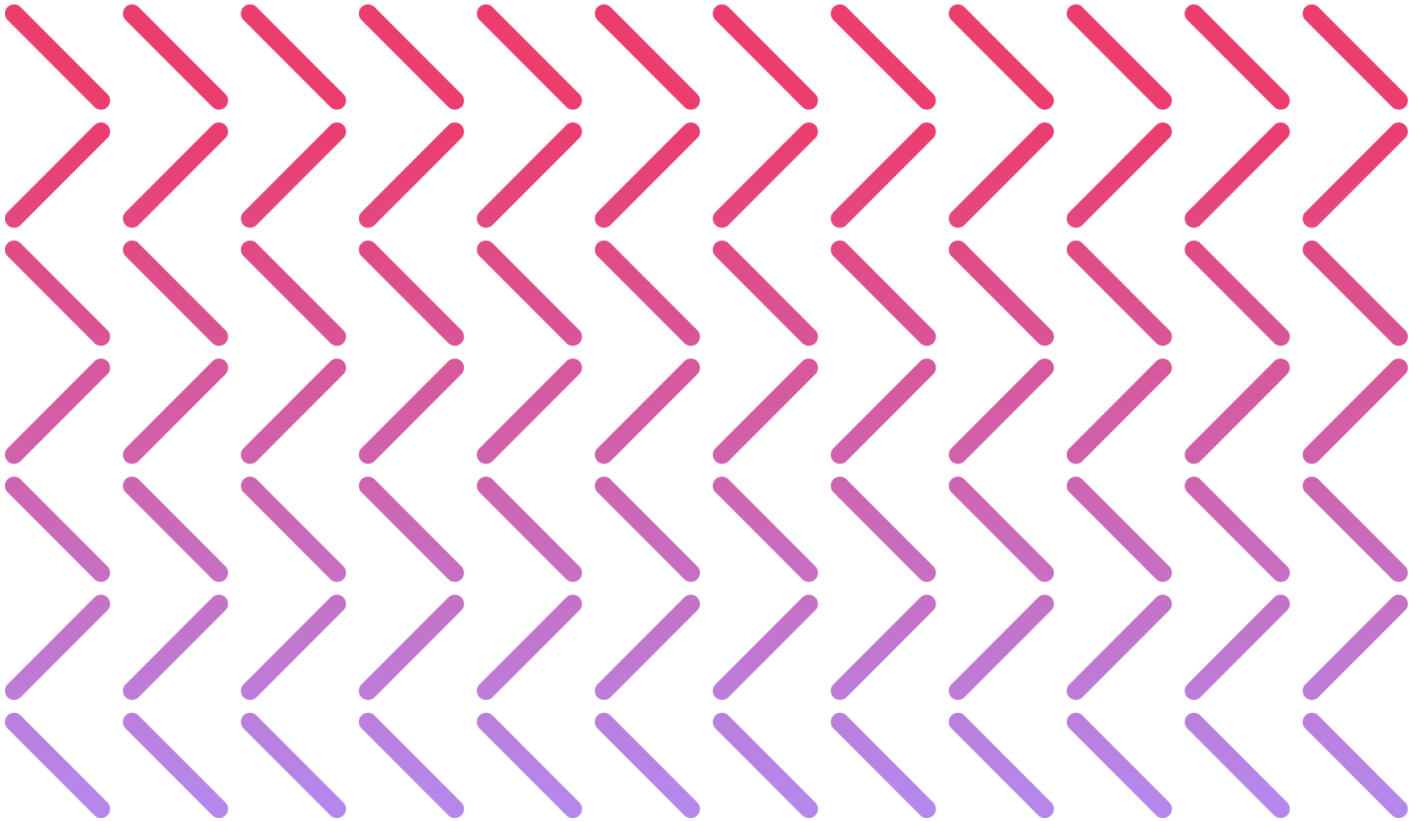
Strategic Objective	Build a better St George's	*Corporate Objectives 2021/22:*	Care
SR7	**We are unable provide a safe environment for our patients and staff and to support the transformation of services due to the poor condition of our estates infrastructure**		

Lead indicators	RAG Rating				Lead indicators: Progress update
	Q1	Q2	Q3	Q4	
% of reports on items of statutory compliance completed to required timescales					Current progress good in completing statutory compliance works
% of backlog maintenance tasks (reactive / planned) undertaken in line with plan					Currently over 80% of planned works being undertaken
Capital expenditure spend profile against agreed plan					Some delays due to prolonged time to agree plan, but will be caught up over year
% of PAM compliance					PAM reporting will need to be updated significantly to reflect progress

Emergent / future risks	Future opportunities
Lack of sustainable investment leads to further deterioration, therefore Trust is unable to deliver its wider strategic objectives Failure to secure HIP funding as first building block of estate strategy Relationship with University blocks future development of the site	HIP application now submitted Improving relationship with University may unlock future development opportunities Identification of development sites provide commercial opportunities for alternative capital investment

Strategic Objective 6: Develop tomorrow's treatments today
Strategic Risk SR10

SR10:
Research is not embedded as a core activity which impacts on our ability to attract high calibre staff, secure research funding and detracts from our reputation for clinical innovation



Strategic Objective	Develop tomorrow's treatments today			Corporate Objectives 2021/22:	Collaboration
SR10	**Research is not embedded as a core activity which impacts on our ability to attract high calibre staff, secure research funding and detracts from our reputation for clinical innovation**				
Risk Appetite / Tolerance	**HIGH**	We have a high appetite for risks in this area in order to pursue research and innovation	**Assurance Committee**	**Quality and Safety Committee**	
			Executive Group	Patient Safety and Quality Group	
			Executive Lead(s)	Chief Medical Officer	
			Date last Reviewed	20 October 2021	

Current risk and assurance assessment

There has been a significant boost to the research profile in the Trust due to a 100% increase in patient recruitment to clinical trials over the previous three years. The Trust is remains highly active in Covid-19 research studies and is implementing the approved Research Strategy 2019-24, in particular the set up of the Translational and Clinical Research Institute (TACRI) and the four Clinical Academic Groups (CAGs), although implementation has been slower than anticipated in some areas due to Covid-19.

The Trust has a number of key controls and sources of assurance in place, for example regular research resource and portfolio review meetings with research teams and documented progress reports, and identified funding for the research portfolio.

The current risk score of 9 (Moderate) highlights the strong progress of research in the Trust including in Covid research, whilst recognising that Covid has caused the suspension of most of our clinical research in the Spring of 2020 and Winter of 2021 and delayed part of the strategy implementation. We are now progressing well in our strategy implementation, and anticipate substantial progress in 2021/22, however we have not yet had the outcome of the £500K Trust investment for strategy implementation we have sought for 2021/22 so cannot proceed with research staff initiatives until we have this.

The assurance strength is now rated as good to reflect the sources of assurance and completed actions to address the previously identified gaps in controls. Governance and risk management arrangements provide a good level of assurance that the risks identified are managed effectively. Evidence is available to demonstrate that systems and processes are generally being applied and implemented though with delays in some areas due to Covid.

Overall SR Rating – Quarterly Scores

Period 2021/ 2022	Risk Score	Assurance Strength	Change (last reporting period)	Inherent Risk Score	Target Risk Score For 2021/22
Q1	Moderate 9= 3(c) x 3(L)	Good	N/A	16 = 4(c) x 4(L)	6 = 3(c) x 2(L)
Q2	Moderate 9=3(c) x 3(L)	Good			
Q3					
Q4					

Summary COVID-19 Impact

Most non-Covid-19 clinical research studies were suspended in March 2020. Though many studies were able to resume in the Summer and Autumn of 2020, in January 2021 we had to suspend most studies again due to the second wave of Covid. We have now begun the process of re-starting studies. The Trust has successfully participated in a large number Covid-19 clinical research studies and has currently recruited over 6,000 patients to 39 Covid-19 studies. We are one of two South London Covid vaccine hubs and Prof Paul Health of St Georges is the UK lead for the Novavax Covid vaccine trial. The implementation of the Research Strategy was impacted by Covid-19 but is now progressing well. We have sought £500K Trust investment to support implementation in 2021/22.

Strategic Objective	Develop tomorrow's treatments today	*Corporate Objectives 2021/22:*	Collaboration
SR10	**Research is not embedded as a core activity which impacts on our ability to attract high calibre staff, secure research funding and detracts from our reputation for clinical innovation**		

Key risk controls in place	Control effectiveness				Key sources of assurance	Lines of Assurance (positive / negative)		
	Q1	Q2	Q3	Q4		1	2	3
Research Strategy 2019-24 : approved by the Trust Board in December 2019 and supported by an implementation plan for the research strategy	S	S			• Increased numbers of clinical research studies led from St George's	x		
Partnership between St George's and St George's University London	G	G			• Partnership in place. TACRI and all four Clinical Academic Groups, which are joint Trust/University structures, have been set up	x	x	
Key role in south London Clinical Research Network (chaired by CEO)	S	S			• Leadership positions in the Clinical Research Network St George's CEO now chairs the CRN Partnership Board and Prof Paul Heath of St George's co-chairs the South London Vaccine Task Force.		x	x
Implementation of process of horizon scanning clinical studies, including 'easy win' studies to balance portfolio against lower recruiting more intensive studies	S	S			• We have increased the numbers of patients recruited to clinical trials, which doubled over 3 years.	x	x	
Regular research resource and portfolio review meetings with research teams	S	S			• JRES holds regular meetings with research teams to review patient recruitment and troubleshoot any problems.	x		
Joint Research and Enterprise Services review and ratify (with researchers) all study targets and resources required	S	S			• There is annual target setting process for patient recruitment which is monitored and supported by JRES	x	x	x
Translational and Clinical Research Institute (TACRI) Steering Committee set up	S	S			• Steering Committee in place and reports to Patient Safety Quality Group and QSC	x	x	
Funding to implement 2019-24 research strategy approved for 2020/21	S	S			• £200K initial funding to implement the research strategy agreed. Statistical support for TACRI commenced. We await the outcome of the 2021/22 funding request.		x	
TACRI Steering Committee set up	S	S			• Bi-monthly meetings		x	
Four Clinical Academic Groups formerly established	S	S			• Four CAGs have been established, and a CAG Director has been appointed for each.		x	

Strategic Objective	Develop tomorrow's treatments today	*Corporate Objectives 2021/22:*	Collaboration
SR10	**Research is not embedded as a core activity which impacts on our ability to attract high calibre staff, secure research funding and detracts from our reputation for clinical innovation**		

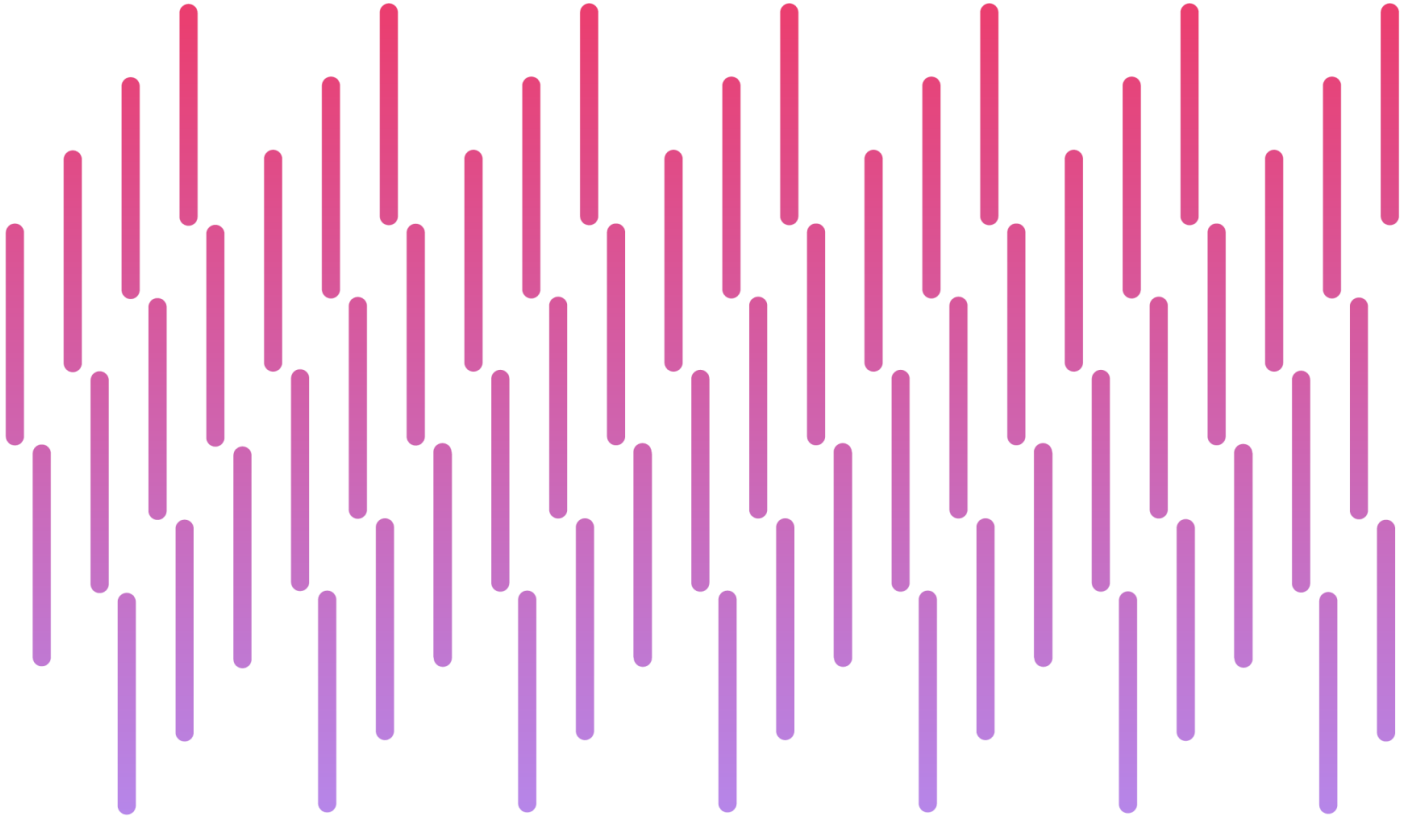
Gaps in controls and assurances	Actions to address gaps in controls and assurances	Complete by (date)	Progress
Few clinical academics - Many areas of Trust activity are not reflected in St George's University London research	**Seek investment to allow more clinical academic appointments** TACRI will help to mitigate this. Longer term, investment will be needed from both the Trust and SGUL if new clinical academic posts are to be appointed. Investment of £500K sought for 21/22.	December 2021	
Poor research IT infrastructure	**Seek investment /work with IT to set up research data warehouse** We have established interest in a data warehousing project from both Trust and SGUL researchers and have held initial discussions with Trust IT and IT companies to look at options to establish a research data warehouse	December 2021	
Translational and Clinical Research Institute (TACRI) fully functioning	**Establish functional TACRI** Administrator started in January 2021. TACRI launch event December 2020.Membership to be established February 2021; website to be launched Spring 2021; Statistical support to commence February 2021; seminar series and training to commence Spring 2021.	December 2021	

Strategic Objective	Develop tomorrow's treatments today	*Corporate Objectives 2021/22:*	Collaboration
SR10	**Research is not embedded as a core activity which impacts on our ability to attract high calibre staff, secure research funding and detracts from our reputation for clinical innovation**		

Lead indicators	RAG Rating Q1	Q2	Q3	Q4	Lead indicators: Progress update
Percentage of patients recruitment in south London Clinical Research Network at St George's					17% (final figure, 2019/20) NIHR have advised prioritisation of Covid research for the past year. The 2020/21 figure will not impact CRN funding.
Patient recruitment numbers					10,538 (final figure, 2019/20). NIHR have advised prioritisation of Covid research for the past year, with most non-Covid research suspended during the first and second waves of Covid.
Number of clinical research studies led from St George's					59 (current St George's Trust/ University sponsored clinical research studies on National Institute for Health Research portfolio). Recently awarded major Covid pregnancy vaccine trial, to be led by St George's.

Emergent / future risks	Future opportunities
• Restrictions on funding/ investment to extend research activities, with consequent inability to exploit research opportunities in full • Alignment of St George's and St George's University research priorities recognised as a risk in the Research Strategy • Reduced availability of National Institute for Health research funding	• National Institute for Health Research call for core Clinical Research Facility funding • Opportunity for a greater research leadership role in SW London / partnership with other Acute Provider Collaborative Trusts • Build on current profile related to Covid-19 research activity/ studies • Develop closer collaboration between St George's and St George's University

Appendix 1: Individual risks contributing to strategic risks
Linked risks on the Corporate Risk Register



Outstanding care every time

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

Risk short form title	CRR Ref	Description	Open Date	Inherent Score	Current Score Sep 2021
Strategic Risk 1	Our patients do not receive safe and effective care built around their needs because we fail to build and embed a culture of quality improvement and learning across the organisation			20	16
Covid-19-wait too long (2)	COVID-2105	Non Covid-19 patients not known to the Trust wait too long for treatment (patients group B) (also see SR3)	Apr 2020	20 (4x5)	16 (4x4)
Covid-19-wait too long (1)	COVID-2104	Non Covid-19 patients, known to the Trust, wait too long for treatment (patient group A) (also see SR3)	Apr 2020	20 (4x5)	16 (4x4)
Covid-19 - exposure	COVID-2051	Risk of exposure to Covid-19 virus	Feb 2020	20 (5x4)	15 (5x3)
7 Day Service Standards	MD1118	Failure to comply with 4 standards of the Seven day Service due to resource limitation and/or lack of defined operating model	Nov 2016	12 (3x4)	12 (3x4)
Infection control	CN2050	C Diff; MRSA; MSSA; E.Coli	Mar 2020	12 (3x4)	12 (3x4)
Covid-19-Fit test	COVID-2106	Lack of fit test for FFP3 masks	Apr 2020	12 (4x3)	12 (4x3)
Covid-19-PPE	COVID-2107	Lack of PPE to effectively manage exposure to Covid-19 virus	Apr 2020	20 (4x5)	8 (4x2)
Learning from incidents	CN1166	Failure to learn from incidents	Nov 2016	15 (5x3)	8 (4x2)
Deteriorating patients	MD1527	Staff fail to recognise, escalate and respond appropriately to the signs of a deteriorating patient. This may happen because the Early Warning Score is inaccurately recorded or the escalation process is not applied correctly	Dec 2016	20 (5x4)	8 (4x2)
Learning from complaints	CN2009	Failure to learn from complaints	Dec 2019	15 (3x5)	6 (3x2)

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

Risk short form title	CRR Ref	Description	Open Date	Inherent Score	Current Score Sep 2021
Strategic Risk 2	**We are unable to provide outstanding care as a result of weaknesses in our clinical governance**			20	12
Compliance with the CQC regulatory framework	CN-1179	Failure to comply with the CQC regulatory framework and deliver actions in response to CQC inspections may prevent the Trust achieving an improved rating at our next inspection	Jan 2017	**20 (5x4)**	**12 (4x3)**
Diagnostic findings	MD1526	Acting on diagnostic findings	Jul 2016	**16 (4x4)**	**12 (4x3)**
Mental capacity Act	CN751	Failure to comply with Mental Capacity Act (MCA)	Jun 2016	**16 (4x4)**	**12 (4x3)**
Improving the quality of clinical governance	CN-2056	There is a risk that we may not improve the quality of clinical governance following the external reviews of mortality monitoring & MDT and clinical governance in a timely manner which may have an adverse impact on patient care	Sep 2019	**12 (4x3)**	**12 (4x3)**
Cardiac surgery service – patient safety impact	CVT-1661	There is a risk that we may not make effective improvements to patient safety following the second NICOR mortality alert for cardiac surgery	Sep 2018	**16 (4x4)**	**8 (4x2)**
Discharge	MD2052	Non-compliance with the eDischarge Summary Standard	Mar 2020	**16 (4x4)**	**TBC**
HealthCare Record (accuracy)		Healthcare Record (accuracy)	TBC	**TBC**	**TBC**
Learning from deaths	MD1119	Variation in practice in M&M / MDT meetings may mean we fail to learning from deaths and fail to make improvement actions to prevent harm to patients	Nov 2016	**TBC**	**TBC**
Strategic Risk 3	**Our patients do not receive timely access to the care they need due to delays in treatment and the inability of our technology and transformation programmes to provide accessible care built around our patients' lives**			**20**	**20**
Network outage	CRR-1395	Infrastructure - Risk of further major network outages due to out-dated, unreliable, and prone to failure network, as a result of a lack of investment and maintenance in the Trust's ICT Network Infrastructure	Sec 2017	**25 (5x5)**	**20 (5x4)**
ICT Disaster Recovery Plan	CRR-803	In the event of an ICT disaster, there is a RISK this would result in delays or a complete failure in the Trust's ability to recover its ICT systems.	Feb 2011	**20 (5x4)**	**20 (5x4)**
Covid-19-wait too long (2)	COVID-2105	Non Covid-19 patients not known to the Trust wait too long for treatment (patients group B) (also see SR1)	Apr 2020	**20 (4x5)**	**20 (4x5)**
Paediatric ECHO delivery	CCAG-1980	Inability of safely provide a paediatric ECHO service at St Georges Hospital	Nov 2019	**20 (4x5)**	**16 (4x4)**

Individual Risks contributing to Strategic Risks

Linked risks on the Corporate Risk Register

Risk short form title	CRR Ref	Description	Open Date	Inherent Score	Current Score Sep 2021
Strategic Risk 3 (continue)	**Our patients do not receive timely access to the care they need due to delays in treatment and the inability of our technology and transformation programmes to provide accessible care built around our patients' lives**			**25**	**20**
ECHO Service Delivery	CCAG-1950	Risk of delay in delivery of planned ECHOs in favour of delivering ECHO in patients who are on a 6 week diagnostic pathway, (DM01)	Oct 2019	**20 (4x5)**	**16 (4x4)**
Virtual by Design	IT-2157	There is a risk that IT Audiovisual/infrastructure are not met by IT resources, impacting on patient care	Sep 2020	**20 (4x5)**	**16 (4x4)**
Telephony	CRR-1292	Infrastructure - Potential failure of the Trust's central telecoms system (ISDX) (1), radio tower system (DDI) (2), and/or VoIP platform (500 handsets) (3) due to aged telecoms infrastructure	Jul 2017	**20 (5x4)**	**16 (4x4)**
Data Warehouse/ Information Management Fragmentation	CRR-1312	Information - Risk of poor daily operational performance reporting due to difficulties to retrieve data stored on multiple storage	Aug 2017	**20 (4x5)**	**16 (4x4)**
Covid-19-wait too long (1)	COVID-2104	Non Covid-19 patients, known to the Trust, wait too long for treatment (patient group A) (also see SR1)	Apr 2020	**20 (4x5)**	**16 (4x4)**
Wrong blood in tube	RHO-1626	Misidentification of patient or of the blood sample at venepuncture for transfusion samples, leading to wrong blood in tube (WBIT).leading to ABO incompatible blood transfusion	Aug 2018	**20 (5x4)**	**15 (5x3)**
Patient flow		Risk of inadequate patient flow in the Trust (and across the health care system) for emergency admission	TBC	**20**	**12**
Management of RTT		Risk that patient pathways and waiting times (RTT) are not accurately monitored or managed due to poor data quality and lack of management process	July 2020	**20**	**12**
Exposure to Cyber or Malware attack	CRR-0013	Infrastructure - Risk of potential successful malware / cyber attack due to weakness in the ICT infrastructure. This could lead to loss of data and operational disruption	Apr 2016	**20 (4x5)**	**12 (4x3)**
Fragmented Clinical Records	CRR-1398	Unavailability of all the correct and up to date clinical information at point of care due to fragmented patient records as a consequence of: Cerner implementation, multiple clinical system running in parallel but separate from Cerner,	Dec 2017	**20 (4x5)**	**12 (4x3)**
Diagnostic findings	MD1526	Acting on diagnostic findings	Jul 2016	**16 (4x4)**	**12 (4x3)**
7 day services	MD1118	Failure to be compliant with 4 of the Seven Day Services clinical standards	Nov 2016	**12 (3x4)**	**12 (3x4)**

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

Risk short form title	CRR Ref	Description	Open Date	Inherent Score	Current Score Sep 2021
Strategic Risk 3 (continue)	**Our patients do not receive timely access to the care they need due to delays in treatment and the inability of our technology and transformation programmes to provide accessible care built around our patients' lives**				
Clinical Decision Outcome Form	S2030	There is an on-going risk that patients on any elective pathway could be lost to follow up. This can be caused by the incorrect outcome being recorded on the Clinical Decision Outcome	Mar 2020	**12**	**12**
VDI Sub-optimal	IT- 1717	Sub-optimal Virtual Desktop Infrastructure (VDI) due to insufficient licenses, insufficient compute power, and upgrade to Win10.	Nov 2018	**12 (3x4)**	**12 (3x4)**
Diagnostics within 6 weeks		Failure to comply with 6 week diagnostic standard which may result in poor quality of care for patients	TBC	**20**	**9**
Electronic document management solution	CRR-1592	There is a risk of no access to clinical records if the EDM software fails impacting on delivery of patient care based on lack of recent/historical information stored	Jul 2018	**16 (4x4)**	**Closed**
Emergency care 4hr operating standard	ED-1514 ED-852	Failure to deliver and sustain the 95% Emergency Care Operating Standard	May 2014	**20 (4x5)**	**Closed**
Strategic Risk 4	**As part of our local Integrated Care System, we fail to deliver the fundamental changes necessary to transform and integrate services for patients in South West London**			**16**	**12**
Other providers' strategies conflicting with Trust Strategy	CRR-1899	There is a risk that other acute providers in SWL will pursue clinical/commercial relationships with other tertiary providers that pose a strategic threat to SGUH		**15 (5x3)**	**TBC**
Devolution of specialised commissioning	STR-2220	There is a risk that the devolution of NHSE specialised commissioning is effected in a way that conflicts with the Trust's strategy to be the tertiary centre for SWL and Surrey	Feb 2021	**12 (4x3)**	**12 (4x3)**
Lack of collaboration across SWL Acute Providers	STR1496	There is a risk that the Trust and system partners (CCG, Kingston) are unable to agree on future use of QMH	Oct 2018	**12 (4x3)**	**8 (4x2)**

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

Risk short form title	CRR Ref	Description	Open Date	Inherent Score	Current Score Sep 2021
Strategic Risk 5	We do not achieve financial sustainability due to under delivery of cost improvement plans and failure to realise wider efficiency opportunities			25	20
Managing Income & Expenditure in line with budget	CRR-1411	Risk the Trust is not able to manage income and expenditure against agreed budgets to delivery the financial plan.	Dec 2017	25 (5x5)	20 (5x4)
Managing an effective financial control environment	CRR-0028	Risk of not meeting statutory obligations, prevent fraud, mismanagement of funds or inappropriate decision making by Trust officers due to ineffective financial systems and processes	Oct 2016	20 (4x5)	20 (4x5)
Identifying and delivering CIPs	CRR-1865	Risk that the Trust doesn't have sufficient capacity and capability to deliver CIPs at the level required to hit the financial plan.	Apr 2019	20 (5x4)	20 (5x4)
Future cash requirements are understood	CRR-1416	Risk that future cash requirements are not understood	Dec 2017	20 (5x4)	15 (5x3)
Manage commercial relation with non-NHS organisations	Fin-1856	Risk that the Trust does not have sufficient capacity, or skills to manage commercial relationships with non-NHS organisations procuring services from the Trust.	May 2019	12 (4x3)	12 (4x3)
Processes to manage cash and working capital	CRR-1417	Risk that the Trust does not have up to date processes to manage cash and working capital	Dec 2017	20 (5x4)	12 (4x3)
Understanding cost structures	Fin-1372	A risk that we do not understand our current cost and performance baseline and structures, or benchmark ourselves against others in this area to identify efficiencies and improvements.	Nov 2017	15 (5x3)	9 (3x3)
Maintaining a five year forward view	CRR-1413	The Trust has insufficient capacity to develop a five year long term financial plan that is aligned to an agreed clinical strategy.	Dec 2017	16 (4x4)	9 (3x3)
Maintaining an effective procurement environnent	Fin-1083	Risk the Trust has insufficient capacity and capability to ensure best value is achieved on all procurement.	Oct 2016	15 (3x5)	9 (3x3)
Managing within new contract forms (block contracts)	Fin- 1858	There is a risk that the Trust could be financially impacted by a failure to manage performance inline with new contract models, specifically a block contract.	May 2019	9 (3x3)	9 (3x3)
Risk that the Trust could be financially penalised due to non-delivery of control totals within South West London	Fin-1857	Risk that the Trust could be financially penalised due to non-delivery of control totals within South West London. It is unclear within planning guidance what the impact of other organisations within the South West London patch not hitting control totals will be on the organisations.	May 2019	9 (3x3)	9 (3x3)
Unsupported finance and procurement system		A risk that the Trust has an unsupported finance and procurement system.	TBC	8	8

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

Risk short form title	CRR Ref	Description	Open Date	Inherent Score	Current Score Sep 2021
Strategic Risk 6	**We are unable to invest in the transformation of our services and infrastructure, and address areas of material risk to our staff and patients, due to our inability to source sufficient capital funds**			20	20
Funding for 5 year capital plan		The Trusts does not have funding sources confirmed to deliver years 2 through to 5 of the 5 year capital plan.	TBC	20 (5x4)	20 (5x4)
Funding for current year capital plan		The Trusts does not have funding sources confirmed to deliver the next 1 year of the capital plan	TBC	12 (3x4)	15 (3x5)
Strategic Risk 7	**We are unable provide a safe environment for our patients and staff and to support the transformation of services due to the poor condition of our estates infrastructure**			**20**	**20**
Bacterial contamination of water supply	CRR-0016	Risk from exposure to potential pathogenic bacteria in water	May 2014	**20 (5x4)**	**20 (5x4)**
Inability to address infrastructure backlog maintenance to maintain safe site	CRR-0008	Inability to address infrastructure backlog maintenance to maintain safe site due to lack of capital	Jul 2016	**20 (4x5)**	**20 (4x5)**
Risk of fire starting in Lanesborough Wing developing into a major fire	EF2036	Risk that an undetected and immediately extinguished fire could develop into a major fire resulting in area evacuation	Feb 2020	**20 (5x4)**	**20 (5x4)**
Cardiac Catheter Labs breakdowns	CCAG-1025	Cardiac Catheter Labs breakdown /failure due to old equipment/ infrastructure	Sep 2016	**20 (4x5)**	**20 (4x5)**
Electrical Infrastructure - Risk of non-compliance	CRR-1311	Risk of electrical non-compliance with Electricity at Work Regulations and BS7671 due to lack of regular testing	Aug 2017	**16 (4x4)**	**16 (4x4)**
Lack of UPS/IPS power supplies	EF2061	Lack of UPS/IPS power supplies	Mar 2020	**20 (5x4)**	**15 5x3)**
Data Centre	CRR-810	Risk that a fire, flood, power failure in the Data Centre could cause loss of data due to having a single data centre hosting all on-site critical systems	Mar 2014	**20 (5x4)**	**15 (5x3)**

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

Risk short form title	CRR Ref	Description	Open Date	Inherent Score	Current Score Sep 2021
Strategic Risk 8	**Our staff are not empowered to deliver to their best and do not feel safe to raise concerns because we fail to build an open and inclusive culture across the organisation which celebrates and embraces our diversity**			**20 (4x5)**	**16 (4x5)**
Organisational culture	HR-2178	There is a risk that we fail to achieve a significant shift in culture to support the delivery of the Trust strategic objectives	Sep 2020	**20 (4x5)**	**16 (4x5)**
Diversity and Inclusion	HR-1967	There is a risk that we are unable to deliver our Diversity and Inclusion Strategy or that it does not have the required impact	Jul 2019	**20 (4x5)**	**16 (4x4)**
Raising Concerns	HR-1978	There is a risk that our staff a) don't know how to raise concerns at work b) don't know who to raise concerns with c) are not confident the concerns will be properly address and d) don't feel safe in raising concerns	Nov 2019	**20 (4x5)**	**16 (4x4)**
Bullying and Harassment	HR-881	There is a risk that our staff continue to report high levels of bullying and harassment compared with peers and that we have not taken adequate measures to address this	May 2010	**20 (4x5)**	**16 (4x4)**
Effective Engagement	HR-1364	There is a risk that we fail to engage effectively with our staff	Apr 2016	**15 (3x5)**	**12 (3x4)**
Organisational Development	HR-1360	There is a risk that we do not ensure that our senior managers are developed to have the right leadership skills to be able to deliver our vision of outstanding care every time	Nov 2017	**12 (3x4)**	**12 (3x4)**
Recognise good practice	HR-1361	A risk that we do not recognise success or good practice amongst our workforce.	Nov 2017	**12 (3x4)**	**12 (3x4)**

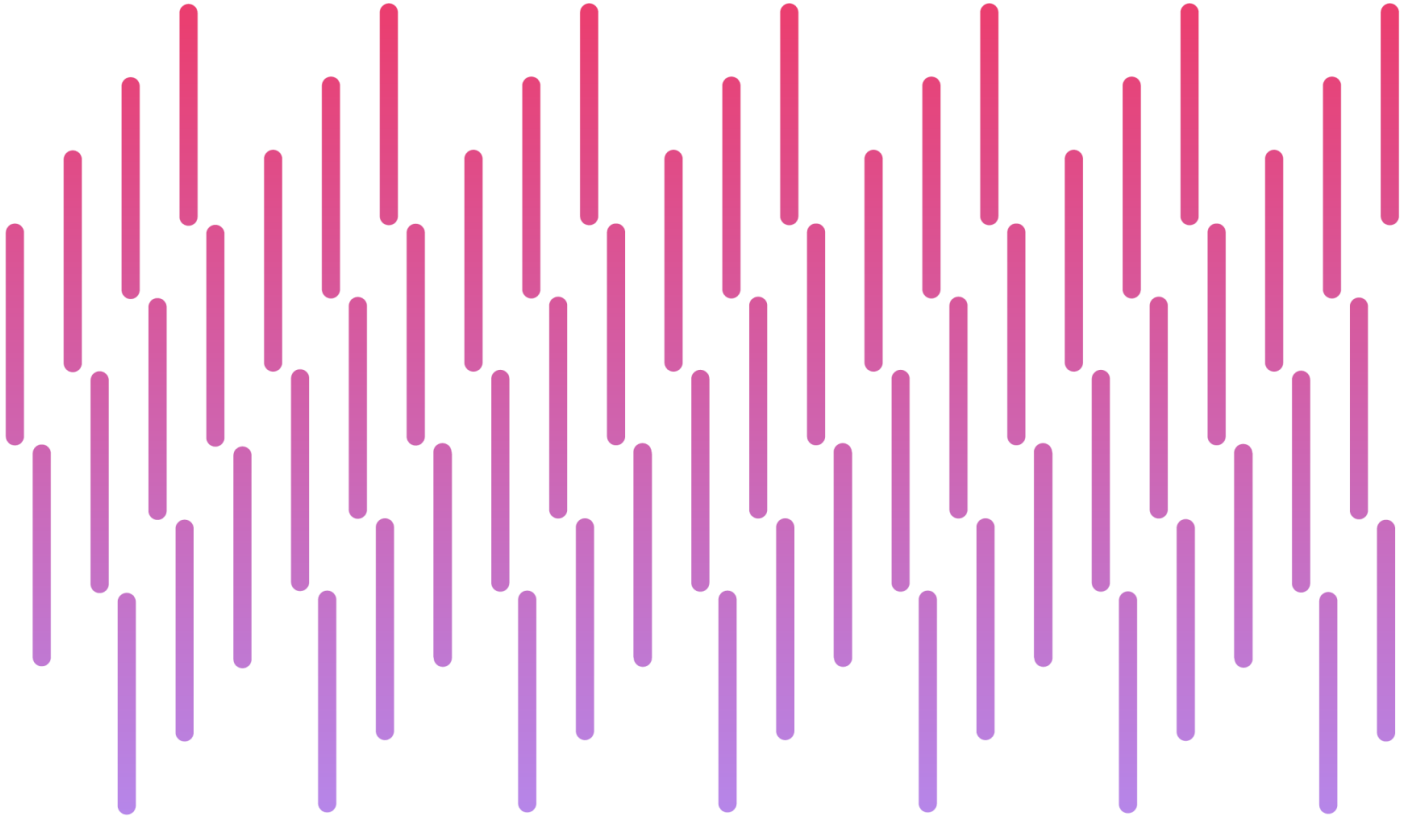
Individual Risks contributing to Strategic Risks
Linked risks on the Corporate Risk Register

Risk short form title	CRR Ref	Description	Open Date	Inherent Score	Current Score Sep 2021
Strategic Risk 9	We are unable to meet the changing needs of our patients and the wider system because we do not recruit, educate, develop and retain a modern and flexible workforce and build the leadership we need at all levels			20	16
Junior Doctors vacancies	CRR-1684	There is a risk that we are unable to fill Junior Doctor rota vacancies, leading to rota gaps which may impact on patient safety	Oct 2018	20 (4x5)	16 (4x4)
Recruitment and Retention	CRR-0025	There is a risk that we fail to recruit and retain sufficient and suitable workforce with the right skills to provide quality of care and service at appropriate cost	Jan 2015	16 (4x4)	16 (4x4)
High quality appraisals	HR-1363	Risk that we do not ensure all of our staff have a high quality appraisal.	Nov 2017	12 (3x4)	12 (3x4)
Health and Wellbeing	HR-2242	There is a risk that health and wellbeing is not embedded in the organisation.	Apr 2021	12 (3x4)	9 (3x3)
Education Strategy	HR-2179	Failure to deliver the Education Strategy due to potential lack of organisational engagement and financial constraints	Oct 2020	9 (3x3)	9 (3x3)
Workforce Strategy	HR-2038	There is a risk that the identified priorities in the Workforce Strategy do not produce the improvements or changes desired.	Feb 2020	9 (3x3)	9 (3x3)
Impact on pension tax on the NHS	CRR-1884	Pension tax impacting on the Trust. There are two elements to this risk. 1. Senior members of staff choose to leave the NHS as they have reached their Life Time Allowance (LTA) pension cap. 2. The impact of the annual allowance, where consultants are taking early retirement, reducing their hours, turning down additional work which is having an operation impact on the Trust. This leaves gaps in service cover	Jul 2019	16 (4x4)	Closed
Risk posed by a 'no deal' exit from the EU	CRR-1824	There is a risk that we are unable to retain our EU staff post EU exit	Apr 2019	16 (4x4)	Closed
Compliance with section 1 of the Employment Rights Act (1996)	HR-2164	Failure to comply with changes to the Section 1 of the Employment Rights Act (1996) statement come into effect on 6 April 2020	Sep 2020	16 (4x4)	Closed
Employee relations activities	HR-2163	Inability to provide historical data on Employee relations activity	Sep 2020	20 (4x5)	Closed
Disciplinary process	HR-2165	Risk that fair, effective, independent and objective disciplinary actions are not taken changed from 10(5x2) to 5(5x1)	Sep 2020	20 (5x4)	Closed
Administration of honorary contracts staff	HR-2166	Risk that Trust does not comply with the training/legal requirement for medical staff on honorary contract	Sep 2020	12 (4x3)	Closed

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

Risk short form title	CRR Ref	Description	Open Date	Inherent Score	Current Score Sep 2021
Strategic Risk 10	**Research is not embedded as a core activity which impacts on our ability to attract high calibre staff, secure research funding and detracts from our reputation for clinical innovation**			**16**	**9**
The profile of research in SGHT being low	MD-1133	There is a risk that insufficient focus is given to research in SGHT. This could lead to a lack of investment in research, impacting on research delivery, income, reputation and ability to recruit and retain high calibre staff	Nov 2016	**12 (3x4)**	**9 (3x3)**
Research partnership with St George's University	MD-1495	There is a risk that if research priorities are not aligned across SGUH and SGUL we will miss opportunities to translate academic research in to improved patient outcomes	Mar 2018	**12 (3x4)**	**6 (3x2)**
MHRA accreditation of the research department	MD-1405	There is a risk that the research department does not retain its MHRA accreditation due to poor infrastructure/ compliance	Dec 2017	**16 (4x4)**	**8 (4x2)**
Clinical Research recruitment reduction	MD-1132	Risk of Clinical Research recruitment reduction. could result in a significant shortfall in overall (CRN and Commercial) recruitment and therefore reduction in research funding and income	Nov 2016	**12 (3x4)**	**9 (3x3)**

Appendix 2: Scoring the Board Assurance Framework
Risk Assessment & Assurance sources and descriptors



Outstanding care every time

Scoring the Board Assurance Framework

Risk Assessment and tracking of actions to address gaps in controls

Calculating Risk Scores

Risk Grading (Scoring)

CONSEQUENCE INDEX			LIKELIHOOD INDEX*		
5	Catastrophic	Multiple deaths caused by an event; ≥£5m loss; May result in Special Administration or Suspension of CQC Registration; Hospital closure due to enforcement action; Total loss of public confidence	5	Almost Certain	No effective control; or ≥ 1 in 5 chance within 12 months
4	Major	Severe permanent harm or death caused by an event; £1m - £5m loss; Prolonged adverse publicity; Prolonged disruption to one or more Divisions; Extended service closure	4	Likely	Weak control; or ≥1 in 10 chance within 12 months
3	Moderate	Moderate harm – medical treatment required up to 1 year; £100K - £1m loss; Temporary disruption to one or more Divisions; Service closure	3	Possible	Limited effective control; or ≥ 1 in 100 chance within 12 months
2	Minor	Minor harm – first aid treatment required up to 1 month; £50K - £100K loss; or Temporary service restriction	2	Unlikely	Good control; or ≥ 1 in 1000 chance within 12 months
1	Insignificant	No harm; 0 - £50K loss; or No disruption – service continues without impact	1	Rare	Very good control; or <1 in 1000 chance (or less) within 12 months

*Use of relative frequency can be helpful in quantifying risk, but a judgment may be needed in circumstances where relative frequency measurement is not appropriate or limited by data.

Risk scoring matrix

L/C	1	2	3	4	5
5					
4					
3					
2					
1					

Calculating Strength of Controls

Strength of controls

Control Strength	Description
Substantial	The identified control provides a strong mechanism for helping to control the risk
Good	The identified control provides a reasonable mechanism for helping to control the risk
Reasonable	The identified control provides a partial mechanism for controlling the risk but there are weaknesses in this
Weak	The identified control does not provide an effective mechanism for controlling the risk

Scoring the Board Assurance Framework
Assurance sources and descriptors

Sources of Assurance

Sources of Assurance

Line of Assurance	First Line Assurance	Second Line Assurance	Third Line Assurance
Description	Care Group / Operational level	Corporate Level	Independent and external
Examples	Service delivery / day-to-day management Care Group level oversight Divisional level oversight	Board and Board Committee oversight Executive oversight Specialist support (e.g. finance, corporate governance)	Internal audit External audit Care Quality Commission NHSE&I Independent review Other independent challenge

Progress on actions to address gaps in control / assurance

Delivered	
On track to deliver to agreed timescale	
Slippage against agreed timescales (non-material)	
Progress materially off track	
Action not delivered to agreed timescale	

Calculating Levels of Assurance

Assurance Levels

Level of Assurance	Description
Substantial	Governance and risk management arrangements provide substantial assurance that the risks identified are managed effectively. Evidence provided to demonstrate that systems and processes are being consistently applied and implemented across relevant services. Outcomes are consistently achieved across all relevant areas
Good	Governance and risk management arrangements provide a good level of assurance that the risks identified are managed effectively. Evidence is available to demonstrate that systems and processes are generally being applied and implemented but not across all relevant services. Outcomes are generally achieved but with inconsistencies in some areas
Partial	Governance and risk management arrangements provide reasonable assurance that the risks identified are managed effectively. Evidence is available to demonstrate that systems and processes are being applied but insufficient to demonstrate implementation widely across services. Some evidence that outcomes are being achieved but this is inconsistent across areas and / or there are identified risks to current performance
Limited	Governance and risk management arrangements provide limited assurance that the risks identified are managed effectively. Little or no evidence is available that systems and processes are being consistently applied or implemented within relevant services. Little or no evidence that outcomes are being achieved and / or there are significant risks identified to current performance