Outstanding care every time

St George's University Hospitals NHS Foundation Trust

Trust Board Meeting in Public – Agenda

Date and Time: Thursday 27 January 2022, 09:00 – 11:10
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	Approve	Verbal
	1.3	Minutes of meeting held on 25 November 2022	Chairman	Approve	Report
	1.4	Action log and matters arising	All	Review	Report
09:05	1.5	Chief Executive Officer's Update	CEO	Inform	Verbal
2.0 CARE					
09:15	2.1	Quality and Safety Committee Report	Committee Chair	Assure	Report
09:25	2.2	Covid-19 and Operational Update*	CNO, CMO, COO	Assure	Report
09:35	2.3	Integrated Quality and Performance Report*	COO	Assure	Report
3.0 CULTURE					
09:50	3.1	Workforce and Education Committee Report	Committee Chair	Assure	Report
10:00	3.2	Vaccination as a Condition of Deployment	CPO	Assure	Report
4.0 COLLABORATION					
10:10	4.1	Finance and Investment Committee Report	Committee Chair	Assure	Report
10:20	4.2	Finance Report (Month 9)*	CFO	Note	Report
10:30	4.3	Emergency Preparedness, Resilience and Response Assurance Report* (to follow)	COO	Assure	Report
10:40	4.4	Board Assurance Framework Q3 Report	CCAO	Review	Report
10:50	4.5	Changes to Executive Membership of Committees	CCAO	Approve	Report
10:55	4.6	Trust Non-Executive Director Lead Roles	CCAO	Approve	Report
5.0 CLOSING ADMINISTRATION					
11:00	5.1	Questions from Governors and Public	All	Note	Verbal
	5.2	Any new risks or issues identified	All	Note	
	5.3	Any Other Business	All	Note	
	5.4	Draft Agenda for Next Meeting	Chairman	Note	Report
11:10	**CLOSE**				

Date of Next Meeting: Thursday 31 March 2022, 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.

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Trust Board
Purpose, Meetings and Membership

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

Membership and Attendees		
Members	**Designation**	**Abbreviation**
Gillian Norton	Chairman	Chairman
Jacqueline Totterdell	Group Chief Executive Officer	GCEO
Ann Beasley	Non-Executive Director/Vice Chairman	AB
Robert Bleasdale	Chief Nurse & Director of Infection, Prevention & Control	CN
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
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	PKu
Pui-Ling Li	Associate Non-Executive Director	PLL
Tim Wright	Non-Executive Director	TW
In Attendance		
Geoff Stokes	Head of Corporate Governance (minutes)	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.*	

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.

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	27 January 2022	**Agenda No.**	**1.2**
Report Title:	**Declarations of Interest: New Group Executive Directors**		
Lead Director/ Manager:	Stephen Jones, Chief Corporate Affairs Officer		
Report Author:	Stephen Jones, Chief Corporate Affairs Officer		
Presented for:	Approval		
Executive Summary:	This paper sets out proposals for the Trust Board to authorise conflicts of interest arising from the appointment of new Group Executive Directors from 1 February 2022 following the establishment of a hospital group between the Trust and Epsom and St Helier University Hospitals NHS Trust. The Trust's Constitution, reflecting the provisions of the NHS Act 2006, permits the Board of Directors to authorise a conflict of interest of a director. It can do so by determining that the conflict, or potential conflict, arises from a permitted cause, and it is for the Board to determine what constitutes a permitted cause. This paper sets out the considerations the Board needs to consider in determining whether to authorise the conflicts.		
Recommendation:	The Board is asked to authorise the conflicts of interest that arises from the appointment of a Group Executive across St George's University Hospitals NHS Foundation Trust and Epsom St Helier NHS Trust for the reasons set out in this paper.		
Supports			
Trust Strategic Objective:	Build a Better St George's		
CQC Theme:	Well Led		
Single Oversight Framework Theme:	Leadership and improvement capability (well-led)		
Implications			
Risk:	As set out in the paper.		
Legal/Regulatory:	National Health Service Act 2006 (Schedule 7) as amended by the Health and Social Care Act 2012 NHS Foundation Trust Code of Governance (Sections A.1.9, B.1.1) St George's University Hospitals NHS Foundation Trust Constitution (Paragraph 34)		
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

Declarations of Interest: New Group Executive Directors
Trust Board, 27 January 2022

1.0 PURPOSE

1.1 This paper sets out proposals for the Trust Board to authorise conflicts of interest arising from the appointment of new Group Executive Directors from 1 February 2022 following the establishment of a hospital group between the Trust and Epsom and St Helier University Hospitals NHS Trust.

2.0 BACKGROUND

2.1 The Trust Board approved proposals to establish a hospital group with Epsom and St Helier University Hospitals NHS Trust (ESTH) in June 2021. Jacqueline Totterdell was appointed as Group Chief Executive Officer from 16 August 2021 and, following a robust appointments process, a new Group Executive has been appointed with Group Executive Directors formally taking up their roles from 1 February 2022. In addition to the establishment of a single Group Executive, the two Trusts already share a number of joint appointments at Board level. NHS England and NHS Improvement appointed the Trust Chairman as Chairman of ESTH from 1 October 2019 and Gillian Norton has since served as Chairman-in-Common across both Trusts. Ann Beasley was appointed as a Non-Executive Director at ESTH from 1 June 2021, and Peter Kane was appointed as NED at both Trusts from 1 October 2021. Prior to Peter Kane's appointment, Elizabeth Bishop had served as a NED at both Trusts. The appointments of the Chairman, two NEDs, and the Group Chief Executive to the Board of ESTH alongside their appointments at St George's have previously been considered and authorised by the Board.

3.0 GROUP EXECUTIVE APPOINTMENTS

3.1 Following the Board's approval of the formation of a hospital group with ESTH and the appointment of a Group Chief Executive, a process was undertaken to define the structure for a new Group Executive. The appointments process was undertaken in the autumn and an announcement of the new Group Executive roles was made in December 2021. The appointments are:

- Dr James Marsh, Group Deputy Chief Executive
- Dr Richard Jennings, Group Chief Medical Officer
- Arlene Wellman, Group Chief Nursing Officer
- Andrew Grimshaw, Group Chief Finance Officer
- Paul da Gama, Group Chief People Officer
- Stephen Jones, Group Chief Corporate Affairs Officer
- Kate Slemeck, Managing Director for St George's
- James Blythe, Managing Director for Epsom and St Helier
- Thirza Sawtell, Managing Director for Integrated Care

3.2 All of the Group Executive Directors listed above, with the exception of the Managing Director for Epsom and St Helier (MD-ESTH), will be members of the St George's University Hospitals NHS Foundation Trust (SGUH) Board of Directors. Likewise, all of the Group Executive Directors listed above, with the exception of the Managing Director of St George's (MD-SGUH), will be members of the Board of Epsom and St Helier University Hospitals NHS Trust. The MD-ESTH would be an invited attendee of the SGUH Board, and the MD-SGUH would be an invited attendee of the ESTH Board.

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

4.0 LEGAL AND REGULATORY POSITION

4.1 The Trust's Constitution, the NHS Foundation Trust Code of Governance and the NHS Act 2006, as amended by the Health and Social Care Act 2012, set out provisions that are relevant to the duties and responsibilities of Directors of the Trust and how conflicts of interest, actual or perceived, are managed:

- In terms of the duties of directors, the NHS Foundation Trust Code of Governance ("the Code") states that: "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 organisation so as to maximise the benefits for the members of the trust as a whole and for the public" (Section A.1.b). This reflects the duties on directors of NHS foundation trusts set out in the NHS Act 2006, as amended by the Health and Social Care Act 2012.

- In relation to factors that could impact on the discharge of the responsibilities of directors, the Code states that "The board should determine whether the director is independent in character and judgement and whether there are relationships or circumstances which are likely to affect, or could appear to affect, the director's judgement. The board of directors should state its reasons if it determines that a director is independent despite the existence of relationships or circumstances which may appear relevant to its determination".

- The NHS Act 2006, as amended by the Health and Social Care Act 2012, provides that each director of an NHS Foundation Trust has "a duty to avoid a situation in which the director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the corporation". It further states that this duty is "not infringed if…the matter has been authorised in accordance with the [Trust's] constitution".

- The Trust's Constitution makes two relevant provisions in relation to authorising a conflict of interest:

    - First, it says that the Board of Directors by majority decision may disapply the provision of the Trust's Constitution which would otherwise prevent a director from being counted as participating in the decision-making process;

    - Second, it says that the Board of Directors may determine that the director's conflict of interest arises from a permitted cause – and it is for the Board to determine this.

4.2 In summary, the legal and regulatory position is, therefore, that the Board can decide to authorise a conflict of interest of one of its directors if it considers it appropriate to do so. If it chooses to do so, it must set out its reasons for deciding this.

5.0 PROPOSED APPROACH

5.1 All of the newly appointed Group Executive Directors who are members of both the SGUH Trust Board and the ESTH Trust Board have simultaneous duties to promote the success of SGUH and ESTH respectively (as do those NEDs who serve on both Boards and the Group Chief Executive). These dual responsibilities mean that there are relationships and circumstances that are relevant to the directors' independence and could affect, or be seen to affect, the director's judgement. Clearly, with the establishment of a Group model between SGUH and ESTH and the creation of a single Group Executive, it is not possible for each director to "avoid a situation in which the director has (or can have) a direct or indirect interest (or possibly may conflict) with the interests of the corporation". The existence of the interest is inherent in the role.

5.3 The Board is entitled to authorise these conflicts of interests to exist if it judges the conflict of interest to arise from a permitted cause. There are a number of reasons why the Board may consider authorising the Group Executives' conflict of interest. The establishment of the group – and thereby the existence of the interest – will assist closer collaboration between two major hospitals in South West London which will be of potentially significant benefit to patients of both organisations. The group model strengthens the scope for joint working between clinical teams across the two organisations, enables more effective and coordinated engagement with the South West London Integrated Care System, and provides a framework for greater harmonisation of strategy across the two organisations. All of this means that the services provided by both trusts to their patients and local populations is enhanced. Should the Board approve the authorisation of these conflicts of interest, the Directors would be permitted to participate in discussions on which the interest was relevant.

5.4 The Senior Independent Director (Stephen Collier) is a member of the St George's Board only and is not a member of ESTH. As a result, any Board members or Governors who have concerns regarding the management of conflicts of interest may raise these with the SID.

6.0 RECOMMENDATION

6.1 The Board is asked to authorise the conflicts of interest that arises from the appointment of a Group Executive across St George's University Hospitals NHS Foundation Trust and Epsom St Helier NHS Trust for the reasons set out in this paper.

Author: **Stephen Jones, Chief Corporate Affairs Officer**
Date: **25 January 2022**

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 25 November 2021

Held virtually via Microsoft Teams

PRESENT		
Gillian Norton	Chairman	Chairman
Jacqueline Totterdell	Group Chief Executive Officer (from item 2.3)	GCEO
Ann Beasley	Non-Executive Director	AB
Robert Bleasdale	Chief Nurse & Director of Infection Prevention & Control	CN
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
Prof Jenny Higham	Non-Executive Director	JH
Dr Richard Jennings	Chief Medical Officer	CMO
Stephen Jones*	Chief Corporate Affairs Officer	CCAO
Peter Kane	Non-Executive Director	PKa
Prof Parveen Kumar	Non-Executive Director	PKu
Dr Pui-Ling Li*	Associate Non-Executive Director	PL
Suzanne Marsello*	Chief Strategy Officer	CSO
Tim Wright	Non-Executive Director	TW
IN ATTENDANCE		
Professor Heather Jarman	Consultant Nurse in Emergency Care (item 5.4)	HJ
Karyn Richards-Wright	Freedom to Speak up Guardian (for item 3.1.2)	FTSUG
Geoff Stokes	Head of Corporate Governance/Board Secretary (minutes)	HoCG
APOLOGIES		

** Non-voting members of the Board*

Items recorded in the order they were taken.

		Action
1.0 OPENING ADMINISTRATION		
1.1	**Welcome, introductions and apologies** The Chairman welcomed everyone to the meeting and noted that there were no apologies.	
1.2	**Declarations of Interest** The Chairman reminded the Board of previously declared interests for herself and Ann Beasley as Chairman-in-Common and non-executive director respectively at Epsom and St Helier University Hospitals NHS Trust (ESTH). Jacqueline Totterdell also declared her interest as Group Chief Executive Officer (GCEO) for both the Trust and ESTH, as did Peter Kane, who is a non-executive director at both trusts.	
	Stephen Jones, Chief Corporate Affairs Officer (CCAO), explained that although conflicts of interest existed from the joint appointments with ESTH, the Trust's Constitution and NHS Foundation Trust Code of Governance provided that the Board can authorise these conflicts if the reasons given are acceptable. As with previous such authorisations, the Board was asked to approve the conflicts of interest for the Group CEO and Peter Kane on the basis that closer collaboration between the Trust and ESTH, which was fostered through these appointments, was in the interests of the patients served by the two organisations.	
	The Board authorised the conflict.	
1.3	**Minutes of the Previous Meeting** The minutes of the meeting held on 30 September 2021 were approved as a true and accurate record.	
1.4	**Action Log and Matters Arising** The Board reviewed and noted the action log and agreed to close both outstanding actions as these had been completed.	
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 October and November 2021, which set out the key matters raised and discussed. Some of the reports discussed by the Committee also feature later on the Board agenda. The key matters of note from the Committee were as follows. • The never events gap analysis focussed on the last few years to ensure learning has been implemented. • Compliance with life support training continues to improve, although the Trust was not yet at the required levels. • Staffing challenges in some areas of the Trust remain, and these had especially affected the birth centre. The Committee Chair has visited maternity services and through this and the reporting to the Committee	

		Action
	was assured that the services provided remained safe despite these challenges. • Winter planning has taken into account the anticipated impact of Covid-19, elective recovery and the normal winter pressures on emergency services. • The Trust will be establishing a new gender identity service. AB asked about the serious incidents reported and wondered whether they could be attributed to Covid-19. Richard Jennings, Chief Medical Officer (CMO), explained that since the pandemic began there have been a small number of serious incidents that have been directly related to Covid-19 and this had been highlighted in the reports to the Committee. The most recent cases included in the Committee report, however, were not related to the impact of Covid-19. Suzanne Marsello, Chief Strategy Officer (CSO), provided an update on the gender reassignment service, explaining that NHS England and NHS Improvement (NHSE/I) have approved the service. The Chairman noted the positive impact this service will have on this cohort of people. The Board noted the updates from the October and November 2021 Committee meetings.	
2.1.1	**Learning from Deaths Q2 2021/22** The Learning from Deaths report for quarter 2 had been considered in detail by the Quality and Safety Committee at its meeting in November 2021. AB commented that the report was very thorough and thoughtful. The Board: • Noted and supported progress against the Quality and Safety Strategy through the implementation of the Mortality and Morbidity Team. • Noted the expansion of the medical examiner service to begin scrutinising non-acute deaths, in line with the NHS Patient Safety Strategy. • Noted that the Trust is fully compliant with all CNST requirements in the previous quarter and continues to use this work to drive improvement. • Noted and supported plans to participate in the extension of the Learning Disability Mortality Review Programme (LeDeR) to include autistic people. • Considered the assurance provided that current outlier alerts are being investigated robustly and that there is a granular understanding of the Trust's mortality data.	
2.1.2	**Mental Capacity Act and Deprivation of Liberty Annual Report** Robert Bleasdale, Chief Nurse, introduced the annual report on the application of the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) for 2020/21, which had been considered in detail by the Quality and Safety Committee at its meeting in October 2021. The following points were highlighted.	

		Action
	• Under the forthcoming Liberty Protection Safeguards (LPS), the local authority responsibility for the application of DoLS will transfer to providers from April 2022, although guidance is still awaited. • A Mental Capacity Act steering group has been established. • There has been an increase in the application of the MCA and adult safeguarding issues have also increased. In response to a question from the Chairman, the CN confirmed that the transfer of the responsibility for applying DoLS is on the risk register. The Board noted and received assurance from the Mental Capacity Act and Deprivation of Liberty Safeguards annual report for 2020/21.	
2.1.3	**Duty of Candour Annual Report** The duty of candour annual report had been considered in detail by the Quality and Safety Committee at its meeting in October 2021. The Board noted the report and received assurance that improvement actions are monitored at the Patient Safety and Quality Group.	
2.2	**Integrated Quality and Performance Report (IQPR)** The Board received and noted the IQPR for month 7 (October 2021), which was scrutinised at both Finance and Investment Committee and the Quality and Safety Committee the previous week. Operational highlights were as follows: • Elective performance: ○ Trajectory on the admitted pathway is slightly behind plan, although endoscopy productivity is improving which will support further progress. ○ Of the 2,000 lower complexity procedures transferred to private providers as part of a pan-London initiative, 1,200 came from south west London, which was seen as positive by NHS London. ○ Breast screening performance continues to improve and although patients are being seen on average at day 17 (rather than the target of day 14) there is a minimal impact on safety. ○ Pathways have changed to enable patients to have multiple tests carried out on the same day. ○ Concerns have been raised about outpatient letters and texts not aligning, so a review is being conducted in each care group to understand and rectify the issue. ○ The 'cashing up' process (to ensure clinic records are kept updated) is a historic problem and is being addressed. The backlog has reduced from 18,000 records in March 2021 to approximately 5,000 in November 2021. In the four services where there have been particular issues, a 'perfect week' will be held in December to improve the process. Current performance shows that once the backlog is eliminated performance can be maintained.	

		Action
	○ There has been a massive improvement in the 6-week diagnostic performance, which is now 2.3% against a target of 1%. Approximately 12 months ago, this stood at over 24%. • Emergency performance: ○ A visit from the Emergency Care Improvement Support Team (ECIST) took place but they did not find anything significant for the Trust to improve. ○ Although the emergency department feels busy, numbers are as expected, however the acuity of patients presenting is much higher. This time of year would normally see the Trust at about 41 on the Manchester triage scale, but recently this has been at about 48 and occasionally over 50. ○ There is assurance that the Trust is safe, but flow needs to be addressed to alleviate pressure. Peter Kane, Non-Executive Director, asked if the publicised pressures on the London Ambulance Service NHS Trust (LAS) affected SGUH. Anne Brierley, Chief Operating Officer (COO), explained that the Trust focuses on quick and timely ambulance handover to reduce the level of unknown risk. Therefore, the Trust has generally not had the same issues as other trusts in London. There is a pilot study being carried out by LAS to review the number of ambulances compared to the size of emergency departments, but this isn't affecting SGUH yet. In response to questions raised, it was noted that there are a large number of variables affecting performance, including collaboration with system partners. The Chairman noted the improved performance in diagnostics and asked for her thanks be passed on to the diagnostics teams. The following points were made about the patient care aspects of the IQPR: • There has been a difficult MRSA case, but no learning is relevant due to the specific circumstances of the patient. • In response to an earlier question, it was noted that the serious incidents section includes a process control chart to provide assurance about the number of SIs being reported and they are within the expected range. A summary of the key workforce performance was provided, and it was noted that: • The format of the report is being improved to include benchmarks. • Sickness is still a concern at 4.5% compared to the target of 4%, but this is a problem across many trusts. • The vacancy rate is 7.3%, although turnover is increasing. This is not surprising as staff start to look for career development opportunities following the second wave of the pandemic. • Work has started with a new provider for exit interviews. Their analysis shows that 77% of leavers are 'happy', which is high compared to other trusts.	

		Action
	• 86% of staff have had their first Covid-19 vaccination and 84% have had their second. Guidance is awaited on implementing compulsory vaccination for front line staff. Tm Wright (TW), Non-Executive Director, supported the changed formatting and noted that the wellbeing indicators could also benefit from a refresh. Paul de Gama, Chief People Officer (CPO) agreed, explaining that he is about halfway through the review. He also noted the need to make the document more useful for forecasting. PKu noted that agency use always seems to be high and above the local ceiling and asked if there were other ways of addressing this, especially through winter. The CPO explained that a number of approaches are being used to reduce agency spending. These include reviewing resource, ensuring that rotas are working as well as they should and improving the recruitment process, for example, by speeding up pre-employment checks. The Chairman added that at the last junior doctors' forum she had attended there were comments about lack of resources for effective rotas. The CFO explained that budgets are set to reflect the junior doctors' cohort, but this is an area of overspend, so more controls are needed. The CMO added that it is not likely to be a resource issue as such, but a need to ensure the e-rostering tools the Trust has invested in are used consistently. The Board noted the IQPR report.	
2.3	**Winter Plan** Anne Brierley, Chief Operating Officer (COO), introduced the winter plan and made the following key points. • Modelling shows that, during the winter, capacity will be exceeded by demand by between 40 and 80 general and acute beds. • Additional funding to cover winter pressures has been allocated and is fairly generous. This has been used to increase the availability of trolleys and chairs in the emergency department (ED) as well as additional staff. • There has been an investment in the same day emergency care surgical pathway to speed up flow. • In partnership with local authority colleagues from Merton and Wandsworth, additional domiciliary and residential care places have been commissioned. • Arrangements are in place across south west London to ensure an equitable allocation of intermediate care beds. • Changes are being made to the transfer of care hub (discharge lounge) focussing on individual patients to track their discharge or transfer of care. • Merton and Wandsworth community colleagues are returning on site to help with supported discharge. • A 'virtual ward' is being established which will enable a 'hospital at home' service to begin in December with the intention of growing that service in the coming months.	

		Action
	• There is an enhanced primary care model with investment to prevent acute conveyances. PKa commented positively on the level of detail in the plan and asked about confidence in its resilience. The COO explained that she gains confidence as the numbers at the Trust are similar to previous years, unlike other trusts. There is a focus on ensuring that specialist intervention is obtained quickly to speed up decision making. PKa also asked if messages to the community can be disseminated more effectively about the need to get vaccinated. It was suggested that publicising data, such as the fact that unvaccinated patients with Covid-19 are eight times more likely to be hospitalised, might be useful. The GCEO added that she has approached the Mayor of London's office about the lack of compliance of mask wearing on public transport. The Mayor's office is working with the Trust's Director of Communications and Engagement on a publicity campaign, featuring some of our staff. PKu noted the stress on staff and asked if they have been told about the winter plan. The COO explained that communications with care groups have started and added that the plan highlights wellbeing measures for staff that are being put in place. The Board noted: • 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, and • the triangulation between this Winter Plan, the Winter Workforce Plan and the Trust's H2 Plan. The Board also noted that despite these actions, the residual risks remain high due to the combination of multiple patient demand pressures that will occur during this winter. Finally, the Board noted the Trust's commitment: • to meet the needs of all our patients, proactively managing resources to mitigate clinical risk across all patient cohorts, and • to support staff well-being.	
2.4	**Duty of Candour for Patients with Nosocomial Covid-19**	
	Robert Bleasdale, Chief Nurse, introduced the report on duty of candour (DOC) for patients who definitely or probably contracted Covid-19 at the Trust. He explained that it is a sad paper to present and made the following points: • Although a wide range of risk mitigations were put in place from the start of the pandemic in line with national guidance, some patients contracted Covid-19 during their inpatient stays at the Trust. • The Trust is now testing at day 0, day 3 and day 7, whereas earlier in the pandemic, testing was only carried out on symptomatic patients or based on travel history.	

		Action
	• There have been 154 nosocomial deaths, of which 74 have been classified as definite, and 80 as probable. The current definitions have been applied retrospectively for cases since the start of the pandemic. • All cases have been reviewed and families of all 154 patients have been contacted by the Trust. • The trusts across south west London are taking a collective approach to discharging DOC. • To date, letters have been sent to 36 of the 43 cases of 'hospital onset hospital acquired' (HOHA) infection occurring in wave 2 of the pandemic. • The Trust is in the process of contacting relatives for the remaining patients so that up-to-date addresses are used. This is taking more time than would be desired as contact details are not always up to date. • Two responses have been received so far, one thanking the Trust for the letter and the other asking for a meeting. • The DOC process will be paused over Christmas to avoid causing further distress and the process should be completed by the end January 2022.	
	The Chairman thanked the CN for the report, which was sad one, but was nevertheless both comprehensive and sensitive.	
	Stephen Collier (SC), Non-Executive Director, suggested reflecting on the approach following patient feedback when the process has been completed.	
	The Board noted the content of the report and the Trust approach to supporting next of kin and discharging its duty of candour.	
1.5	**Group Chief Executive's Officer (CEO) Report** Jacqueline Totterdell, Group Chief Executive Officer, presented her report to the Board and made the following points. • She has published the new Group structure to both SGUH and ESTH staff and given details about the areas covered by the new group chief officer portfolios. The recruitment process is underway for the senior teams below Group Executive level. • As part of the 'Thank You Georges' initiative, letters are being sent to partner organisations thanking them for their support during the pandemic. The £40 gift vouchers which have been provided to every member of Trust staff have been well received, as has the 'lunch on us' scheme. • There have been visits from Princess Michael of Kent to open the new maternity memorial garden and Prerana Issar, Chief People Officer, NHS England and NHS Improvement.	
	The CMO endorsed the comment in the report about the sad loss of Roger Adlard who died suddenly in October. He was a popular member of staff and will be dearly missed.	
	The Board noted the Group Chief Executive's report.	

		Action
3.0 CULTURE		
3.1	**Workforce and Education Committee Report** Stephen Collier, Chair of the Committee, presented the report of the meetings held in October and November 2021, which highlighted the following key issues: • The Committee has heard with concern about the pressure staff at the Trust are feeling. Executives are thinking clearly about that pressure and how it can be alleviated, and staff are being supported by a number of wellbeing initiatives. • There has been focussed work in relation to junior doctors and medical education. There were three reports that collectively gave assurance that the issues that had emerged are now being addressed, though these also highlighted the current challenges. • There have been 345 new staff recruited which represents a 4.5% increase in established staff. • The workforce implications of the winter plan have been discussed. • The implementation of the culture plan continues. The CMO commented that the learning from Covid-19 work will be a significant part of the Thank You Georges programme. The Board noted the updates from the October and November 2021 Committee meetings.	
3.1.1	**Workforce Disability Equality Standards Report 2021 and Action Plan** The workforce disability equality standards (WDES) report had been considered previously by the Workforce and Education Committee.	
	The Chairman emphasised the need to support staff so they can talk about their reality, taking into consideration their disability, even if hidden. The Board noted the Workforce Disability Equality Standard Report 2021 and action plan which has been published on the Trust's website.	

		Action
3.1.2	**Freedom to Speak Up Report Q2 2021/22** Karyn Richards-Wright, the Freedom to Speak up Guardian (FTSUG), introduced the report and pointed out the following. • Since the last report there have been 31 concerns raised, 7 of which were from same area as a collective concern. Some concerns have also been raised externally with the Care Quality Commission (CQC). • The themes are consistent with recent reports, and continue to be around bullying and harassment, team functioning, poor working relations between colleagues, and issues with line managers. • Two cases related to hidden disabilities, with the Trust not putting in place reasonable adjustments. The FTSUG is working with the Diversity and Inclusion Lead to address this. • The FTSUG is working with the learning and development team to support obstetrics and gynaecology, and cardiac teams. • Over 700 staff have completed the online training that has been made available. • There are 19 champions who have been trained and are being deployed across the Trust to support the raising concerns agenda. The CCAO added that good progress is being made on the strategy approved over a year ago, but there is still more to do. He commented that; • Core processes have improved and it will be interesting to see if the staff survey shows any progress from last year. • Adding freedom to speak up as part of the mandatory and statutory training (MAST) programme and the introduction of champions will help. • A charter is being developed which will be rolled out early next year. • The introduction of pulse surveys will provide a snapshot of staff perceptions. The CMO commented on the origins of speaking up and noted that there were no patient safety concerns raised and wondered if more publicity was needed. The FTSUG explained that she has spoken at the junior doctors' forum and will be focussing on work with junior doctors, alongside the Guardian of Safe Working to provide an environment where concerns can be raised. The Chairman added that across the country freedom to speak up concerns tended not to focus on patient safety concerns directly. The GCEO felt there was still an issue about how staff interact with their co-workers and managers. It would be helpful to understand the segmentation of where this occurs to know where focus is needed. The FTSUG agreed and noted that some junior staff are managers but may not have had the appropriate training.. She added that the organisation needs to know how concerns will be responded to, in order to encourage staff to raise concerns. It is positive that patient safety concerns are raised locally, but these may not be captured through the freedom to speak up route. The CCAO explained that a campaign is planned to encourage patient safety concerns to be raised. Similar targeted campaigns had been used at other trusts which had experienced similarly low levels of safety concerns being	

		Action
	raised through freedom to speak up. The Trust was aware that safety concerns were, however, raised through various other routes and the key was being confident that where staff had a safety concern these were raised, and the campaign would assist with this. He added that sometimes bullying and harassment and behavioural issues may have patient safety implications now or in the future. AB noted that it would be as useful to identify the areas where no concerns have been made as those where there have been. The Board noted: • The number of concerns raised with the FTSU Guardian in Quarter 2 2021/22 and the themes which emerge from these. • The appointment and training of 19 new FTSU Champions across the Trust, the first cohort of the new Champions to be recruited. • The progress made in implementing the Trust's FTSU strategy.	
4.0	**COLLABORATION**	
4.1	**Audit Committee Report** Peter Kane, Chair of the Audit Committee, introduced the report from the meeting held on 11 November 2021 and made the following points: • External audit provided a paper identifying lessons learned from the year end audit and gave assurance that the value for money audit will be integrated into the year-end audit for 2021/22. • The experience at ESTH of the value for money audit is also being reviewed to share learning. • There are two internal audit reviews on the programme that have not yet started due to a lack of senior engagement, and these are being followed up. • It is important that actions agreed in response to recommendations are implemented and at present too many are overdue. The Trust Management Group is focussing on this, but the Committee will need to review and follow up if there is no improvement. The Board noted the report from the Audit Committee from the November meeting.	
4.2	**Finance and Investment Committee Report** Ann Beasley, Chair of the Committee, provided an update on the meetings held in October and November 2021, supported by Tim Wright, who chaired the November 2021 meeting. She complimented the COO for her ability to explain and clarify complex issues which helps the discussion at committee. The following points were also made: • The elective recovery fund needs proper management of clock stops to maximise cost recovery. • There has been an issue with lift maintenance and lessons need to be learned to ensure proactive intervention.	

		Action
	• It was disappointing that the financial envelope details for the second half of the year (H2) were only recently announced and some details are still being clarified. • There was a good example of triangulating risks between estates and ICT to minimise flood risk issue at the data centre.	
	The Chairman commended the finance team for their work in making sense of H2.	
	The Board noted the updates from the October and November 2021 Committee meetings.	
4.3	**Finance Report (Month 7)** Andrew Grimshaw, Chief Financial Officer and Deputy Chief Executive (CFO), presented the Trust's financial performance at month 7 and made the following points: • Concerns raised by AB about lack of detail for planning for H2 were reiterated • Although there is more funding available than the pre-pandemic position it represents a reduction in funding with some Covid-19 funding being withdrawn or reduced. • The Trust reported a £2.6m deficit in month 7.	
	The Board noted the month 7 financial position.	
4.4	**St. George's Hospital Charity: Update November 2020 to October 2021**	
	Suzanne Marsello, Chief Strategy Officer (CSO), introduced the report and Tim Wright, Non-Executive Director (TW) as a trustee of the charity, gave his thanks for her support to the charity especially in relation to the children's appeal.	
	TW added that there are challenges ahead in persuading donors not to put restrictions on their donations. Understandably, large donors often want to fund something specific, but this may not align to the Trust's priorities.	
	PKa added that there would be benefit in liaising with ESTH charity, notwithstanding that there are different governance arrangements. He also asked about the investment policies of the charity. TW explained that there is currently £14m-£15m invested and there is a strong policy on investing with ethical and environmental concerns in mind. The CSO added that the charity is keen to work more closely with ESTH charity.	
	It was confirmed that the Trust invests in research in conjunction with the university.	
	The Chairman reiterated that the Trust's Charity was an independent organisation unlike ESTH's and it was important to remember this important difference. She endorsed TW's thanks to the CSO and the particularly impressive launch of the children's appeal.	
	The Board noted the report, and the investment that has been awarded by the Charity in support of Trust projects.	
4.5	**Horizon Scanning**	

		Action
	Stephen Jones, Chief Corporate Affairs Officer (CCAO), referenced the policy, regulatory and legislative aspects of the report and highlighted the following: • The business continuity challenge due to the introduction of compulsory vaccinations needs to be emphasised. • The Health and Care Bill has now completed its Commons stages and will be introduce to the House of Lords. It now includes a provision for the CQC to oversee integrated care systems. • NHS England and NHS Improvement (NHSE/I) is currently consulting on its transactions guidance, which contains provisions relevant to joint and collaborative arrangements between trusts. • The terms of reference for the Messenger review of NHS leadership have been published, albeit at a high level. • The Royal College of Emergency Medicine (RCEM) and the Association of Ambulance Chief Executives have published reviews of patient harm due to overcrowding in emergency departments and delayed ambulance handovers respectively . The RCEM report shows that there have been 4,519 excess deaths as a result of overcrowding in emergency departments across England.	
	SC said it was a helpful report but asked about the publication of the elective recovery plan which was not covered. The GCEO explained that it is likely to include much of what London already does, and South West London Integrated Care System is well thought of compared to other systems in the country.	
	The CSO referenced the report covering local and regional issues which focussed on the integrated care system and the development of place-based partnership and provider collaboratives.	
	The Board noted the updates.	
4.6	**Board Assurance Framework**	
	Stephen Jones, Chief Corporate Affairs Officer (CCAO), introduced the Board Assurance Framework and noted the following: • There is no proposal to change the scores of any of the strategic risks at this stage. • There has been movement in the corporate risk register to mitigate risks and address gaps in control. • A deep dive into strategic risk 7 (SR7 - estates) will take place at the Risk Assurance Group in January 2022 to see if there is scope to reduce the risk score. • All clinical governance actions are scheduled to finish by the end of March 2021 and there may be an opportunity then to revise the risk score for strategic risk 2 (SR2 – clinical governance). • Strategic risk 4 (SR4 – system working) is proposed to remain at a risk score of 12. This is in spite of the progress the Trust has made, with collaboration with Epsom and St Helier and the wider system, but as the Health and Care Bill is still making its way through parliament, the level	

		Action
	of uncertainty means it would not be prudent to change the score at this stage.	
	PKa noted the assumption across a number of risks that there will be a move from red to amber by the end of financial year and asked how realistic this is. The CCAO explained that the Board set what it considered to be stretching but achievable target scores. However, while there was a realistic prospect that some of the target risk scores would be met, there is a possibility that some will not.	
	For the Strategic Risk (system working) reserved to itself (SR4), the Board: • Agreed the proposed score of 12 (4c x 3l) (no change). • Agreed the proposed assurance rating of 'good' (no change). For the 9 risks assigned to its assuring Committees, the Board: • Agreed the proposed risk scores, assurance ratings and statements from the relevant assuring committee. • Noted the progress achieved in year in mitigating identified gaps in control and assurance. The Board further noted 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 in due course.	
5.0	**CLOSING ADMINISTRATION**	
5.1	**Questions from Governors and the public** No questions were received from the public. Richard Mycroft, Public Governor – South West Lambeth (RM), noted the impressive planning for winter, but asked if more could be done in collaboration with primary care. The COO commented that, unlike other trusts in London, the number of patients that attend the emergency department who should have been seen in primary care is relatively low. The key issue is to enable GPs to contact specialists to gain advice to avoid referring patients to the Trust. The GCEO added that there is effective collaboration with GPs and the key is to co-design pathways. RM noted that governor visits have re-started, and he was particularly impressed with the recent visit to the emergency department. 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	**Staff Story**	
	This story was provided by a staff member about their experience. Professor Heather Jarman is a Consultant Nurse in Emergency Care and she presented	

		Action
	on developing nursing, midwifery and AHP (NMAHP) research careers at St George's. She made the following points: • 1 in 40 doctors participate in research compared to 1 in 1,000 nurses • NMAHPs now have different aspirations and expect research opportunities to be funded and time made available. • Barriers include a perceived lack of skills; research not being seen as part of the job role and limited opportunities. • The Chief Nursing Officer for NHS England and NHS Improvement (NHSE/I) is committed to creating a people centred research environment. • A chief nurse research fellowship pilot has been developed and has been extended through charity funding. • Two staff currently have research in their job plans.	
	In response to questions, HJ clarified that service pressures play a part in enabling NMAHPs to be released for research. She added that she is also looking at ways that sabbaticals can be arranged to provide time to prepare grant applications or research activities. The Translational and Clinical Research Institute which has been set up as a partnership with St Georges, University of London (SGUL) will be a great help in creating new opportunities for NMAHPs to get involved in research.	
	The GCEO said she is proud of the work that HJ has done and also thanked the Chief Nurse who has championed research. She emphasised the need for the 'bench to ward' time to be shortened to ensure that research can have real benefits for our patients.	
	There was recognition that the pandemic has led to a greater level of awareness of research, especially on the wards, which has helped to encourage participation.	
	In response to a question raised, the CSO proposed picking up with St George's Charity the provision of a seed corn fund. She also added that the Charity has a Medical Advisory Group and maybe a change of title would help to shift the emphasis.	
	The Board thanked Professor Jarman for her fascinating presentation.	
Date of next meeting: Thursday, 27 January 2022, MS Teams		

The meeting closed at 11:55

ACTION LOG - TRUST BOARD (PART 1)

ACTION REF	MEETING DATE	ITEM NO.	ITEM	ACTION	WHEN	WHO	UPDATE	STATUS

There are no outstanding actions for public Board

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	27 January 2022	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

1

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Chief Executive's report to the Trust Board

Trust Board, 27 January 2022

It has been two months since the last Trust Board meeting and it has continued to be a challenging period for the Trust with the emergence of the Omicron variant, increasing staff absences and a busy emergency department with a higher acuity of patients.

At the start of the new year, we reached a peak of 21 Covid-positive patients being treated on our intensive care unit and 170 on our wards. In response, we opened seven Covid wards and expanded our intensive care unit to 79 beds from the previous level of 66.

Thanks to our hugely successful vaccination programme, these numbers aren't as high as January 2021 - the peak of wave 2 - when there were more than 260 Covid-positive patients on our wards and more than 90 in intensive care.

While responding to the third wave of Covid, our Emergency Department continued to see high numbers of patients. An average of 367 people a day attended the department and we have seen patients with a higher acuity requiring care. We took a number of actions to help maximise clinical capacity during this period such as creating additional space for more trolleys and chairs in our emergency department, establishing a dedicated discharge team and creating 'virtual frailty wards' to support patients at home who would otherwise be admitted or have longer lengths of stay whilst care packages are put in place.

We were also supported by our system partners, and I would like to put on record my thanks to the primary care teams in both Wandsworth and Merton for extending their evening clinic capacity which helped reduce the number of people walking into our urgent treatment centre.

My thanks also to all the St George's staff who chose to cancel their annual leave during this busy period - putting their patients' needs before their own. We will be supporting our colleagues to rest and take their leave over the next three months.

Covid related staff absences

Staff absences because of isolation or covid related sickness increased in December, peaking at over 440 just before Christmas. In response the Trust implemented the new national guidance around self-isolation which allowed staff to return to work provided they have negative lateral flow test results on days six and seven of their isolation period and meet strict criteria such as not displaying symptoms and continuing to take daily lateral flow tests. Urgent PCR tests for staff were made available through our testing pod at St George's.

While the increase in covid related staff absences were in line with other hospitals, we are thankfully starting to see absence due to Covid-19 decrease.

Vaccine update

To support the national drive to deliver booster doses to the public, our vaccine clinic at St George's extended its opening hours in December offering appointments to local people 12 hours a day, seven days a week, and vaccinating around 1,000 people each day. By mid-January, the clinic has administered over 120,000 vaccines to staff, patients, and the public.

Vaccination as a condition of employment (VCOD)

Following the introduction of new legislation, it will be against the law for any CQC-regulated provider to employ unvaccinated patient-facing staff from 1 April 2022. As set out in guidance issued by NHS England on 15 January, regulations apply to almost all members of

staff and, in order to be double jabbed by 1 April, all staff will need to have their first dose by 3 February.

The Trust was already working hard to encourage all staff to take up offers of the vaccine and more than nine in ten staff have had the first dose. But we have recently stepped up our efforts to help all our staff make an informed decision. We have written to everyone who we do not have a vaccine record for while also running Q&As, publishing information on the intranet, setting up face to face meetings with managers and utilising staff networks.

We will explore opportunities for redeployment, but given the scope of the regulations, these opportunities are likely to be extremely limited. We are therefore working at pace to identify staff who have had their vaccine elsewhere, which we anticipate will reduce the numbers of staff that this policy will affect. Our vaccine clinic at St George's is also extending its hours in the coming weeks to create more capacity.

This week there has been speculation in the media that this deadline could be pushed back so we will watch with interest but continue to work towards the 1 April target date.

Nightingale surge hub at St George's

In preparation for a potential surge in people needing hospital care, NHS England and NHS Improvement asked us to identify additional non-clinical space where a new Nightingale surge hub could be built. This Nightingale capacity was planned to be in addition to our existing surge plans, and would be based on a different clinical model, validated nationally, for patients with low levels of medical and care needs.

Work to construct a structure at our Tooting site began at the end of December 2021 with a hope that it would never be needed. I am pleased to report that, thanks to everyone who followed guidance and the hard work of NHS staff, this project at St George's has now been paused.

2022/23 Planning guidance

NHS England published its planning guidance on Christmas eve, setting out ten priorities for the NHS including investing in workforce, improving urgent and emergency care, using data to redesign care pathways and expanding the use of community services to support out of hospital care through anticipatory care models and virtual wards.

We are working with our system partners in South West London who are developing a 22/23 planning submission setting out how we can deliver on these priorities - while also looking at what we need to provide locally for our community in South West London.

Integrated Care Boards

It was announced in December that the statutory go-live date for Integrated Care Systems would be delayed until July with further guidance to be issued in January 2022. Current statutory arrangements of the NHS South West London Clinical Commissioning Group as the accountable decision-making body will remain in place until then. The Integrated Care Board (ICB) plans to operate where it can in shadow form from April 2021.

Following Millie Banerjee's appointment as the ICB Chair Designate, and Sarah Blow as Designate Chief Executive, responsible for NHS budgets and functions, work is ongoing to recruit Non-Executive Members and Executive Directors to the ICB.

The ICB constitution is also in development through engagement with all system partners. We will continue to work with the ICB and our local health partners and communities to improve services and the health of those we all serve in South West London.

Elective recovery

NHS England planning guidance published on Christmas Eve set out a requirement to deliver “significantly more elective care to tackle the elective backlog” and trusts are being asked to deliver 110% of elective capacity and 120% of diagnostic activity against our pre-pandemic activity.

In spite of the increased demand for our services, we have continued to carry out the most urgent and emergency operations and procedures as well as diagnostic testing and continue to undertake as many Priority 3 and 4 elective surgery cases as we are able. We continue to reduce the number of patients waiting over 52 weeks and now have 938 patients waiting more than a year for treatment. At the time of our last Board meeting in November 2021, this figure was 1,041.

We now need to look again at how we continue to prioritise urgent and long waiting elective patients while also tackling the backlog of patients who have been waiting as a result of previous capacity challenges.

Secretary of State for Health visits St George’s new Covid Medicines Delivery Unit

In December, St George’s became one of the first hospitals in the country to offer new antiviral treatments to people with Covid-19 who are at highest risk of going to hospital and becoming seriously ill. These treatments help manage the symptoms of the virus and reduce the risk of hospitalisation or death.

The Covid Medicines Delivery Unit (CMDU) treats immunosuppressed Covid-19 patients with Sotrovimab, a monoclonal antibody infusion, given to patients via a drip in the Unit at St George’s, or Molnupiravir, an anti-viral Covid-19 pill that is delivered to the patient at home. The treatments are available to eligible patients who are contacted via our CMDU team directly.

On 22 December, we were pleased to welcome Sajid Javid, Secretary of State for Health and Social Care, to the CMDU at St George’s to meet with staff and patients receiving the treatment. He praised the efforts of the CMDU team and of our vaccine clinic team, which he visited on the day.

The St George’s, Epsom and St Helier University Hospitals and Health Group

Since my last update to the board, I am pleased to report that I have now appointed to my executive team for our new hospital group. The group executives will bring together a wealth of knowledge, expertise, and skills from the leadership teams of both St George’s and Epsom and St Helier hospitals, as well as external organisations.

They will take up their new posts on 1 February and a full list of the new group executive team along with their biographies, is available on our website.

St George’s intensive care staff feature in TfL mask wearing campaign

Thanks to a collaboration with the Mayor of London, St George’s staff have featured in a London-wide campaign to encourage TfL users to wear their masks or face coverings on public transport – something I am personally passionate about. The campaign features some of our intensive care doctors and nurses wearing PPE and members of the public wearing masks on the Tube with the message ‘I save lives, you can too’. The campaign continues in January and the Mayor has confirmed that he will continue to encourage mask wearing on public transport despite the end of Plan B.

Outstanding care every time

St George's University Hospitals NHS Foundation Trust

Rob Bleasdale, Chief Nursing Officer and Director of Infection Prevention and Control is leaving the Trust in April to take up a new role as Chief Nurse for Chelsea and Westminster Hospital. Rob held a number of senior nursing leadership roles at the Trust and was appointed interim Chief Nurse in February 2020. Rob led the vaccination programme at St George's with our hospital being one of the first in the country to set up a clinic. We have since gone on to jab well over 120,000 people and have no doubt saved hundreds of lives as a result. My huge and heartfelt thanks to Rob for everything he has done for staff, patients, and our community over the last seven years.

My thanks and congratulations also to Suzanne Marsello, our Chief Strategy Officer, who is leaving us at the end of the month to take up a new role as Director of Strategy and Provider Collaboration at Surrey Heartlands Integrated Care System. Under Suzanne's leadership St George's launched its five-year strategy 'Delivering Outstanding Care, Every Time' – designed to give everyone connected with St George's clarity about our ambitions for the future. Suzanne also played a key role in supporting collaboration with our local partners, and was instrumental in securing £12m of funding for the community diagnostic centre at Queen Mary's Hospital.

We are currently appointing to vacant posts.

Jacqueline Totterdell

Group Chief Executive Officer

January 2022

Meeting Title:	Trust Board		
Date:	27 January 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 December and January 2022.		
Recommendation:	The agendas of both meetings were reviewed in the context of the impact of Covid-19 and focussed on business-critical issues in recognition of the operational pressures on the Trust.		
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		
Equality and Diversity:	N/A		
Previously Considered by:	N/A		
Appendices:	All		

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Quality and Safety Committee Report

Matters for the Board's attention

The Quality and Safety Committee met on 16 December 2021 and 20 January 2022 and considered the following matters of business at these meetings:

December 2021	January 2022
• Surgical Site Safety Deep Dive Follow-up • Integrated Quality and Performance Report (M8) • Serious Incidents Report • Maternity Service Update • Mortuary and Body Store Assurance Update • Research & Development Annual Report and Strategy Implementation Update • Patient Safety & Quality Group Report • Strategic Risk 2 Deep Dive • Board Assurance Framework Monthly Update	• Covid-19 Update • Integrated Quality and Performance Report (M9) • Nurse Staffing Report • Serious Incidents Report • Cardiac Surgery Q3 Report • Quality Strategy Implementation Updates • Patient Safety & Quality Group Report • Board Assurance Framework Monthly Update • Annual Review of Committee Effectiveness (Plan)

*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.

Surgical Site Safety Deep Dive

The Committee received assurance from a follow-up on the surgical site safety deep dive which had taken place. It was noted that the World Health Organisation (WHO) checklist is applied robustly and that there is a focus at divisional level on compliance with the Local Safety Standards for Invasive Procedures (LocSSIPs).

Theatre audits are carried out irrespective of the pressures in the Trust unless there are extreme staff shortages.

Integrated Quality and Performance Report (IQPR) Months 8 and 9

The Committee considered the key areas of quality and safety performance in months 8 and 9 (2021/22) and would like to highlight the following issues, conscious that the Board will discuss the month 9 performance data later on the agenda:

- Areas of good or improving performance:
  - Basic life support training (BLS) is above the target of 85% and advanced life support (ALS) training has not yet reached the target of 85%. But it is anticipated this will be achieved by the end of January 2022. Immediate life support (ILS) training had declined and has not me the target. The training needs analysis is being reviewed to make sure that only staff that need ILS training are included The Committee were assured that all new starters undertake ILS as part of their induction.
  - Duty of candour compliance has been maintained at 100%

  - Up to and including November, there were no cases of falls in the previous three months. There were two falls in December
  - The staffing position in maternity has improved
  - The deployment of staff from the Royal Air Force has had a positive impact on operations and morale
- Areas of challenge:
  - The Mental Capacity Act (MCA) level one position has deteriorated and is below target
  - There has been an increase in category 3 pressure ulcers
  - In November there were five still births of which four were referred to the Health Service Investigation Branch
  - The Trust has had three 'never events' over November and December
  - There are challenges in achieving cancer and breast screening targets
  - The complaints performance is struggling and there have been two breaches of the Trust's 60-day targets.

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

Serious Incident Reporting

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

- 11 serious incidents were declared (5 in November, 6 in December);
- 9 serious incident investigations were concluded (5 in October, 4 in November).

The Committee head of a sad case of a patient who committed suicide after being discharged from the Emergency Department.

In November, there were a number of maternity incidents reported including three stillbirths and a baby born with hypoxic ischaemic encephalopathy (HIE) which means that the baby will have continued developmental problems. There were no common themes identified in the cases. A further stillbirth occurred in December, and this has prompted a retrospective review of stillbirths over the last three years to ensure there are no common themes that may have been missed.

The closed investigations included a case involving a patient with HIV discharged from the Emergency Department and following this case, collaborative work has been undertaken to trigger an automatic alert to the HIV team when a patient with HIV attends the Emergency Department.

Two 'never events' were reported, one relating to a wrong site surgery, where an error occurred on a mole removal procedure, the other relating to the mis-administration of insulin.

Maternity Service Update

The quarter 2 report described the serious incidents that had taken place during the quarter

In response to the significant staffing pressures affecting maternity, plans were described to increase recruitment at local, national and international level, partly in response to Ockenden funding, which should see a significant increase in January 2022.

An action plan to improve the experience of trainees in Obstetrics and Gynaecology was described and the response from Health Education England is awaited.

Mortuary and Body Store Assurance Update

Following an incident at a hospital trust in Kent, the Committee received a report addressing issues for the Trust that had been highlighted by that incident. Additional access controls are required for some entry points and these are being put in place.

A separate issue in compliance with DBS checks is being reviewed by Workforce and Education Committee.

Research and Development Annual Report and Strategy Implementation Update

The Committee heard the financial challenges being faced by research due to the Trust not being able to invest in staff due to the Covi-19 pandemic.

A significant proportion of the research carried has been on Covid-19 including leading a national vaccine study looking the RNA vaccines and Omicron sequencing.

A bid for £3.5m over five years has been submitted to the National Institute for Health Research (NIHR) Clinical Research Facility (CRF) with the outcome expected in January 2022.

Patient Safety and Quality Group (PSQG) Update

The PSQG update was received with highlights from the November report including an update on the implementation of NICE guidance and on strengthening escalation processes. The December report included issues relating to staff dealing with 'end of life' care, and the impact this has on staff not used to treating patients who subsequently die. Further updates on NICE guidance were given.

Strategic Risk 2 Deep Dive

The Committee reviewed the deep dive paper into strategic risk 2 (SR2) which relates to clinical governance. It noted that there were no proposals to change the risk score although there had been significant movement in the corporate risks aligned to SR2. Many of the actions to reduce the risk are expected to be completed by the end of March 2022 and the risk scores will be reviewed then.

The Risk and Assurance Group will review the risk assurance template so that the risk description is more accurate to help the members understand the risks in a better way and make decisions based on it.

Board Assurance Framework Monthly Update

There were no proposed changes to risk scores, but changes are expected once actions are completed in quarter 4.

Covid-19 Update

The Committee heard a comprehensive report about Covid-19 including encouraging news that the number of inpatients testing positive for Covid-19 (including the Omicron virus) is reducing. There was also an update on the 'vaccination of a condition of deployment' requirements and following the latest contact approximately 100 staff have been in touch, with many of them providing evidence of having had a vaccination elsewhere.

The impact of the pandemic on staff was discussed with concern being raised about the continuing pressure on staff.

Nurse Staffing Report

An extensive recruitment campaign has been underway (mostly internationally) and over 120 nurses have started at the Trust since September. A further 50 offers have been made with another 100 to be interviewed.

Cardiac Surgery Q3 Report

The latest update on cardiac surgery was received and the Committee noted that there has been some encouraging signs of greater engagement with consultants in the unit. Succession planning is underway to ensure strong leadership continues.

Activity levels for the team remain low which could start to affect the skill levels in the department. This has been caused in part by Covid with theatre and critical care capacity having been diverted. Nevertheless, there still remains a reputational risk.

Quality Strategy Implementation Updates

The Committee received progress on implementing the Quality Strategy which covered the following highlights;

- The trajectory to have treatment escalation plans in place for 40% of all adult in-patient admissions was not met; performance was 39.5%
- The Trust wide audit of consent re-scheduled from Q2 to January 2021 was not undertaken due to the recent appointment to the role of medical lead for consent. The audit will be undertaken in February 2022
- The complaints process for Children and Young People was not presented to the Patient Partnership and Engagement Group (PPEG) and therefore not incorporated into the Complaints Policy due to OPEL 4 and the cancellation of PPEG. This will be presented to PPEG March 2022
- The improvement plan in response to the national benchmarking audit of Learning Disability Services was not implemented due to staff shortages in this specialist team

Recommendation

The Board is asked to note the updates from the December 2021 and January 2022 meetings.

Dame Parveen Kumar

Committee Chair

January 2022

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	27 January 2022	**Agenda No**	**2.3**
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) (select using highlight)		
Executive Summary:	This report consolidates the latest management information and improvement actions across our productivity, quality, performance, and workforce for the month of December 2021. **Our Finance & Productivity** Outpatient activity in December 2021 is expected to be 111% after catch-up, which is higher than the 100% trajectory by 11%. 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. Elective and Daycase performance is expected to be behind trajectory (after estimated catch up), with a percentage of 96%, lower than the 100% trajectory submitted for December. Theatre specialties are at 89%, with non-Theatre specialties at 98%. DSU Extended Recovery was launched for across three specialties in November (ENT; Breast; Plastics). This scheme will significantly increase DSU capacity and productivity as well as alleviate recovery flow issues in SJW in particular 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 6.9 days. Higher length of stay continues to be driven by high acuity in the patients admitted. Daily, an average of 61 patients await discharge due to external dependencies, e.g., placement, care support and equipment. **Our Patient Perspective** Immediate Life Saving (ILS) training rates were at performance at 66.5% and Advanced Life Support (ALS) training rate has remained steady at 81.4%; the target is 85% There were two Never Events in December and one Serious Incident where Medication was a Significant Factor There were 61 Hospital Onset Health Associated (HOHA) COVID-19 infections and 30 Hospital Onset Probably Associated (HOPA) COVID-19 infections. In Maternity services, the Carmen delivery suit was closed for 27.4% of time however a supernumerary midwife was staffed for 98.3% of shift time. The rate of neonatal deaths per 1000 births was 13.2 in December however the Trust is not identified as an outlier. Inpatient, Maternity (Postnatal Ward), Community and Outpatient services achieved FFT targets where patients rated the services as "Good" or "Very Good **Our Process Perspective** In December, 72.1% of patients were admitted, discharged or transferred within four hours of their arrival. Flow and capacity remain challenged across		

	the Trust. The Trust is working closely with system partners 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. 158 patients breached the 12-hour ED target where no patient should wait longer than 12 hours before they are admitted to a ward. In November, Cancer performance remained challenged, and six of the seven cancer standards were not achieved. The 14 Day Standard performance was at 76.4% with five tumour groups non-compliant. Challenges continue to be seen within breast where performance fell to 10.3%. The Trust is not expecting to report compliance against the 14 Day Standard until issues within the breast services are resolved. There is a recovery plan in place and a portion of referrals are on divert to SWL providers The 62 Day Standard performance was 60.1% against a target of 85%. 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. This Trajectory was met in November, however December will be challenged. In November, Cancer Faster Diagnosis Standard (FDS) performance fell to 60.1% which was below trajectory. Breast and GI services continues to be the lowest performers. At the end of December, the Trust reported that 3.3% of patients were waiting to have a diagnostic test, with a decrease in the number of patients waiting for more than six weeks and a decreasing waiting list size. Capacity challenges remain within Cardiac MRI and Echocardiography with recovery plans in place for Q4. November's 2021's RTT performance was 74.2% against a National target of 92% with 959 patients waiting longer than 52 weeks which is ahead of trajectory and a further improvement on October's performance. Clock stop performance in November was excellent, achieving better than forecast with over 100% of 19/20 clock stop levels. This is because of new ways of working within the RTT team and a focus on the timely cashing up of clock stops **Our Workforce Perspective** In December the Trust's sickness absence rate increased to 5.6% against a target of 3.2% Appraisal rates for non-medical staff and medical staff was 74.8% and 73.1% respectively remaining below the Trust target of 90%. The Staff COVID-19 vaccination rate was 87% in December, an improvement of 0.6% on last month. The Trust's total pay for December was £52.08m which is £0.30m adverse to a plan of £51.78m. Agency spend was £1.75m against a target of £1.25m which is an adverse variance of £0.50m. The largest areas of agency overspend were Interims (£0.54m), Healthcare Scientists (£0.07m) and Consultants (£0.02m).
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**	17 Jan 2022 20 Jan 2022 20 Jan 2022
Appendices:			

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Integrated Quality and Performance Report

For Trust Board
Meeting Date – 27 January 2022

Andrew Grimshaw - Deputy Chief Executive Officer

14 January 2022

Our Outcomes

How Are We Doing?

December 2021

Daycase and Elective Surgery operations

Actual: 3,980
2019 Actual: 4,500

6 Week Diagnostic Performance

Actual: 3.3% **Target:** 1%

Four Hour Emergency Standard

Actual: 72.1%
Plan: 95%

Whole Trust Inpatient Friends and Family Test

Actual 96%
Target 95%

Outpatient First Attendance

Actual 16,609
2019 Actual: 15,403

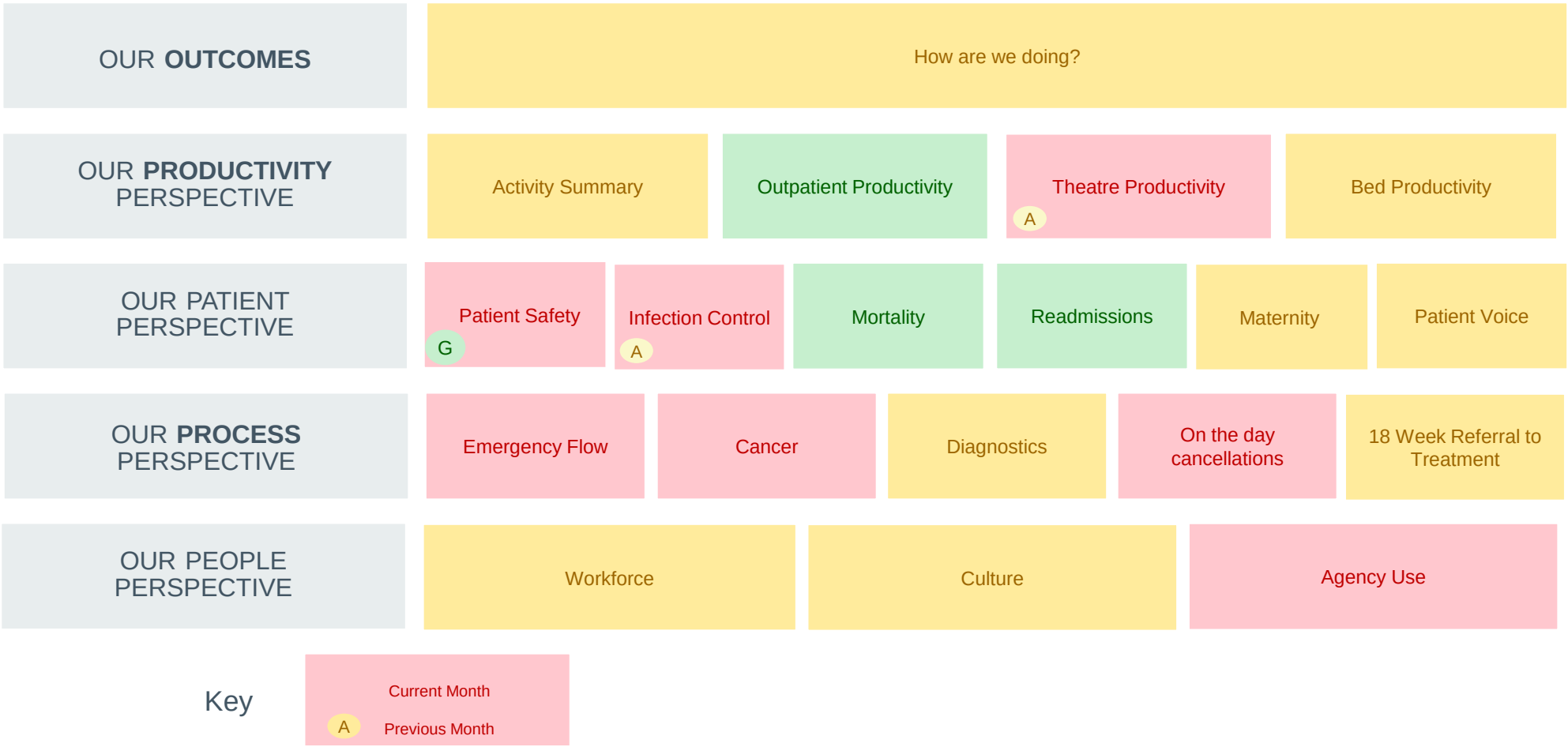
November 2021

Referral to Treatment Standard - Number of 52 Week Breaches

959

Outstanding care every time

Balanced Scorecard Approach



Executive Summary – December 2021 (1 of 2)

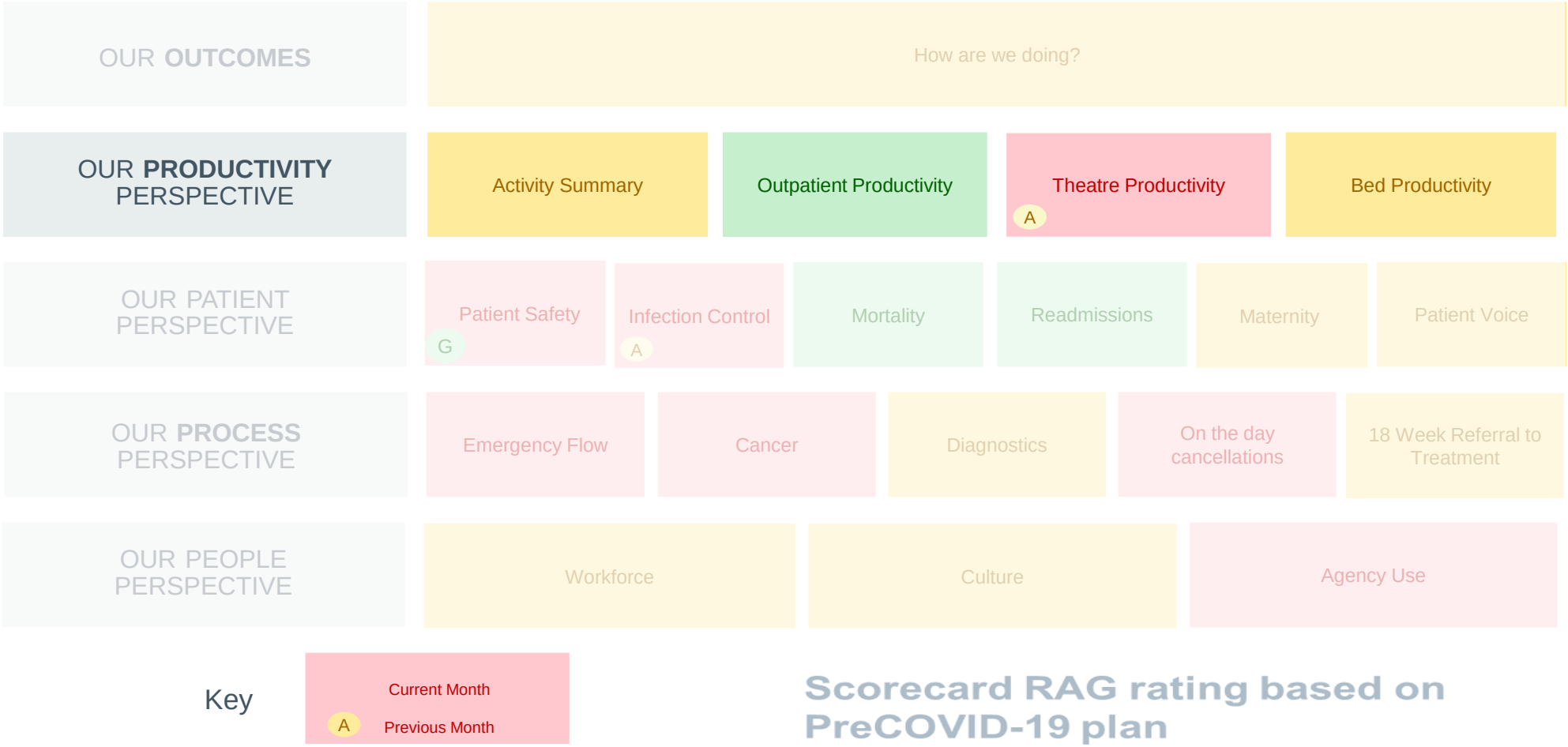
	What the Information tells us	Actions and Quality Improvement Projects
Finance & Productivity Perspective	• December's outpatient activity was 105.4% of December 2019's level and is expected to reach 111% • Elective and Daycase activity levels in December was 11.56% less than the same period in 2019 and is expected to reach 96% after coding catch-up; the submitted trajectory was 100% • Non-Elective Lengths of Stay (LOS) show special cause deterioration at 6.9 days which is a slight decrease compared to the previous month's 7.1. • Elective LOS was 3.8 days which is the same as 2019's average.	Outpatients – Work on Patient Initiated Follow-ups and Advice & Guidance uptake is being undertaken to improve overall performance; Perfect Weeks are being undertaken in key specialties Daycase & Elective activity • DSU Extended Recovery launched with two lists will have patients staying overnight in the last week of January • Pre-Operative Assessment will be streamlined with the reduction of HCA appointments for fit and healthy patients; pilot is on track to launch • Recruitment continues at pace with 9 recruited so far however staffing remains challenging with leavers and retirements Length of Stay • Weekly Multi-Agency Discharge Events (MADE) are being held throughout January • Early Bird Pilot programme focussing on discharges before 10 am will be rolled out across Adult wards in January • Focussed work on increasing use of departure lounge underway

Patient Perspective	• Immediate Life Support (ILS) training rate was 66.5%; the target is 85%
	• Advanced Life Support (ALS) training rate has remained steady at 81.4%; the target is 85%
	• There were two Never Events in December and one Serious Incident where Medication was a Significant Factor
	• There were 61 Hospital Onset Health Associated (HOHA) COVID-19 infections and 30 Hospital Onset Probably Associated (HOPA) COVID-19 infections
	• Maternity
	  • The Carmen delivery suit was closed for 27.4% of time however a supernumerary midwife was staffed for 98.3% of shift time
	  • The rate of neonatal deaths per 1000 births was 13.2 in December
	• Inpatient, Maternity (Postnatal Ward), Community and Outpatient services achieved FFT targets where patients rated the services as "Good" or "Very Good".
		• ILS – Training needs analysis complete and recommendations to actioned in January 2022
		• ALS – Individual staff certification is now being followed up
		• Never Events actions and mitigations in place including review and updating of protocols
		• Thematic and individual reviews are taking place for nosocomial COVID-19 cases to ascertain learning and outcomes reported to the Infection Control Group
		• Maternity
		  • Staffing - overall substantive staffing profile improving and diverting community and office based midwives to Delivery Suite and other acute inpatient areas
		  • The neonatal death rate does identify the Trust as an outlier. All cases have been reviewed by the Midwifery Risk and Governance Multidisciplinary team and no immediate learning was identified.
		• 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. To increase response rates volunteers and the current military deployment are assisting patients with completion of FFT and, additional electronic handheld devices have been made available for patients

Executive Summary – December 2021 (2 of 2)

	What the Information tells us	Actions and Quality Improvement Projects
Process Perspective	Four Hour Operating Standards for December • 72.1% of patients either admitted, discharged or transferred within four hours of their arrival; the target is 95% • 158 patients breached the 12-hour ED target November Cancer performance • the Trust met the 31-Day Second or subsequent Treatment (Drug) • 14 Day Performance decreased to 76.4% compared to October's 80.4% • 62 Day Performance decreased to 60.1% from 66.5% in October; the target of 85% • Faster Diagnosis Standard (FDS) was 60.1% which is below the trajectory 67.9%; the Trust aims to reach 75% by March 2022 Six week diagnostic standard for December • 3.3% of patients were waiting for more than six weeks for their diagnostic test or procedure; and increase from 3.1%; the target is 1% • 278 patients were waiting for more than six weeks and only 20 patients were waiting for more than 13 weeks Referral to Treatment for November: • 959 patients have been waiting over 52 weeks since referral compared to the October's number of 1,023. • The Trust had 13,112 clock stops against a trajectory of 11,911. A clock stop generally means a patient has received their first definitive treatment. The Trust achieved its clock stop target for admitted pathways but did not achieve it for non-admitted pathways. • Clock stop performance in November was excellent, achieving better than forecast and over 100% of 19/20 clock stop levels.	Four Hour Operating Standards actions • Additional clinical support has been secured - 15 medical students, 4 RAF medics and 8 technicians) • New Assistant General Manager role introduced to improve patient flow across the Emergency floor Cancer • Breast Cancer - additional slots and clinics confirmed Jan 22 with further additions planned for Feb. • Weekly PTL assurance meetings and Access Committee is actively monitoring and supporting a clear communications and management plan for patients with benign results Diagnostics • Echocardiography – capacity remains challenged however additional weekday lists are available after successful recruitment through January. • Sleep Studies – continuing to maintain improved performance with additional lists • Neurophysiology – due to retirement, January resource will be limited and managed with using ad hoc sessions, however set to improve in February with Consultant starting Referral to Treatment • On track to deliver zero patients waiting greater than 104 weeks by the end of January. • New ways of working introduced within the RTT team with a focus on the timely cashing up of clock stops. • Trust was identified as an outlier with respect to Data Quality however after investigations, errors corrected and now within tolerance.
People Perspective	• Trust sickness absence rate increased for the ninth consecutive month and was at 5.6% • Medical and non-Medical appraisal rates remain below their target of 90% at 73.1% and 74.8% respectively • Trust turnover rate remained unchanged at 16.0% against a target of 13% • COVID staff vaccination rate (second dose) was 87% at time of writing • Agency cost was £1.75m which is £0.5m adverse to the monthly target of £1.25m, however total December Trust pay is £0.30m adverse to plan	• Bank staff incentive and holiday accommodation programme stood up to encourage the uptake of bank shifts as, across London, Trusts were competing for a small pool of staff. • Monthly Divisional Sickness Meeting Reviews have been stood up with Employee Relations (ER)/HR Business Partners (HRBP) and divisional senior team (Divisional Directors of Operations and senior team) to provide overview and seek support for any cases with significant lapse times and review any ER hotspots. • Appraisal rates – HRBPs are providing trajectories and working with teams to encourage uptake and promoting understanding of the importance of appraising staff. • Inclusive recruitment practices was soft launched in Corporate Division (workforce pressures dependant). • The Trust is working on contacting and validating records for staff with missing vaccination records to ensure completeness and accuracy of reporting.

Balanced Scorecard Approach



Activity Summary

		Activity compared to 2019/20			Activity compared to previous year			Activity compared to 2020/21		
		Dec-19	Dec-21	Variance	YTD 19/20	YTD 20/21	Variance	Dec-20	Dec-21	Variance
ED	ED Attendances	13,799	11,391	-17.45%	127,679	115,166	-9.80%	9,579	11,391	18.92%
Inpatient	Non Elective	4,205	3,160	-24.85%	36,161	29,902	-17.31%	3,275	3,160	-3.51%
	Elective & Daycase	4,500	3,980	-11.56%	47,965	43,348	-9.63%	4,111	3,980	-3.19%
Outpatient	OP Attendances	43,605	45,961	5.40%	447,056	447,859	0.18%	45,025	45,961	2.08%

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

Note: Figures quoted are as at 11/01/2022 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 December 2021 have been shown against activity levels reported in December 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).

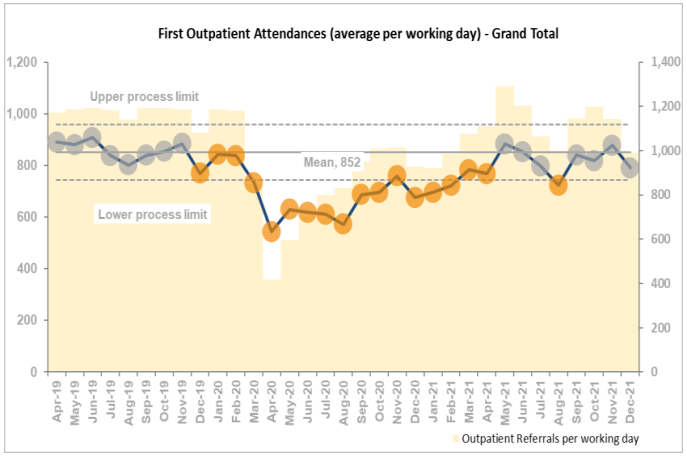
December Activity Performance v Trajectories – Elective, Daycase & Outpatients

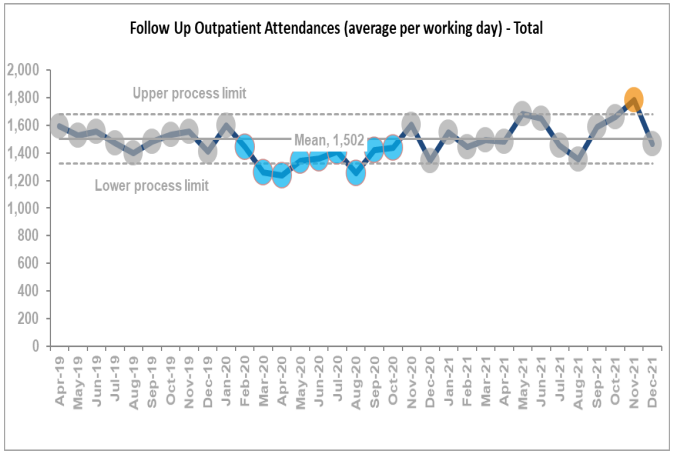
The Trust has submitted final activity trajectories for H2, which forecast activity at 95% of 2019/20 levels adjusted for working days. In December, there are 21 working days compared to 20 in 2019/20, hence the target for December is 100%. The Trust no longer receives ERF payments based on activity trajectory performance, as it now factors in activity clock stop data. Note: The below activity information is shown in 'SLAM' currency, as this is the currency the Trust is used to seeing and reporting.

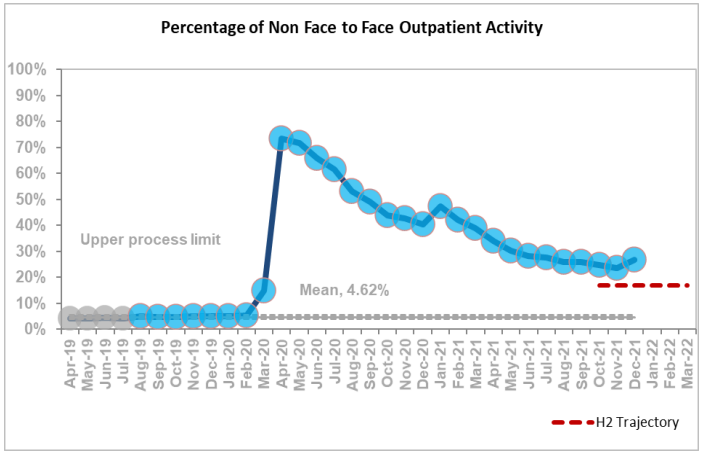
	ACTIVITY QUANTUMS					ACTIVITY %s				
Specialty	Dec Trajectory	Dec Activity	Dec catch up estimate	Dec Activity after catch up	variance activity	Dec Trajectory	Dec Actual	Dec catch up estimate	Dec Activity after catch up	variance activity
Cardiac Surgery (172)	34	12	0	12	-21	120%	43%	1%	44%	-77%
Colorectal Surgery (104)	13	35	3	38	24	64%	167%	13%	180%	116%
Ear, Nose & Throat	166	113	12	125	-42	117%	80%	8%	88%	-29%
General Surgery (100)	52	46	4	50	-2	80%	71%	6%	76%	-3%
Gynaecology (502)	180	131	11	142	-38	97%	70%	6%	76%	-20%
Neurosurgery (150)	90	105	6	111	21	64%	74%	4%	78%	15%
Trauma & Orthopaedics (110)	59	67	7	74	15	47%	53%	6%	59%	12%
Urology (101)	315	256	27	283	-32	137%	111%	12%	123%	-14%
Total Theatre Specialties	**909**	**765**	**69**	**834**	**-75**	**96%**	**81%**	**7%**	**89%**	**-7%**
Gastroenterology (301)	1,190	881	128	1,009	-181	93%	69%	10%	79%	-14%
Cardiology (320)	184	190	6	196	12	88%	91%	3%	94%	6%
Dermatology (330)	0	7	1	8	8	105%				
Neurology (400)	577	555	26	581	4	113%	109%	5%	114%	1%
Paediatrics (420)	26	26	2	28	2	89%	90%	7%	97%	8%
Paed Surgery (171)	74	62	3	65	-9	97%	82%	4%	85%	-11%
Clinical Haematology (303)	181	122	41	163	-18	211%	142%	48%	190%	-21%
Medical Oncology (370)	83	111	2	113	30	120%	161%	3%	164%	44%
All Other Specialties	1,264	1,251	63	1,314	50	98%	97%	5%	101%	4%
All Other	**3,578**	**3,205**	**270**	**3,475**	**-103**	**101%**	**90%**	**8%**	**98%**	**-3%**
Total Daycase / Elective	**4,488**	**3,970**	**340**	**4,310**	**-178**	**100%**	**88%**	**8%**	**96%**	**-4%**
Outpatients	**43,478**	**45,930**	**2,297**	**48,227**	**4,749**	**100%**	**105%**	**5%**	**111%**	**11%**

- 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 96%, lower than the 100% trajectory submitted for December. Theatre specialties are at 89%, with non-Theatre specialties at 98%.
- Outpatient performance is expected to be 111% after catch-up, which is higher than the 100% trajectory by 11%.

Outpatient Productivity (1 of 2)







What the information tells us

On average through December, there were 791 first outpatients attendances daily compared to 877 per day the previous month; activity levels saw a decline as typically seen in December with performance continuing to show common cause variation within the upper and lower control limits. First outpatient activity reported in December 2021 was 108% of activity reported in December 2019, this is expected to increase once coding is completed. Specialist Medicine has continued to see an improved position with an increase in activity over the past three-month period; its performance has returned to within the upper and lower control limit.

At Trust level, follow-up activity shows common cause variation with activity levels in line with the mean of 2019. In month, the daily average attendance was 1,465 compared to a high of 1,718 patients in November.

All outpatient activity in December 2021 was 105% of the activity reported in December 2019, this is expected to increase once data catch up is completed with a trajectory of 100%

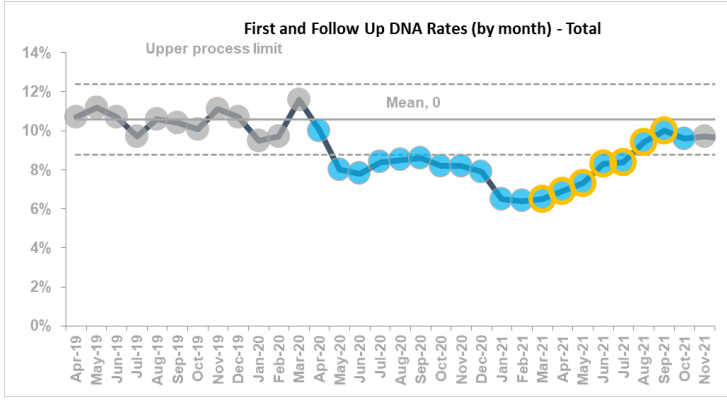
In December, 26.7% of our outpatient attendances were undertaken in a virtual setting, showing an increase compared to November and above trajectory of 17%. The largest proportion of virtual appointments were reported within Cardiology, Respiratory Medicine and Gastroenterology.

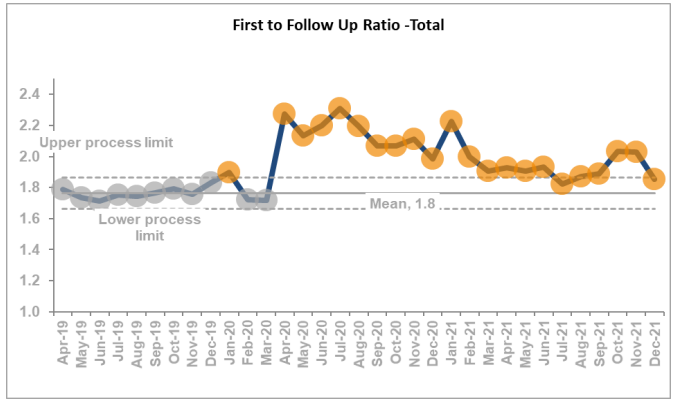
Please note that COVID-19 related OP activity has been excluded from the charts.

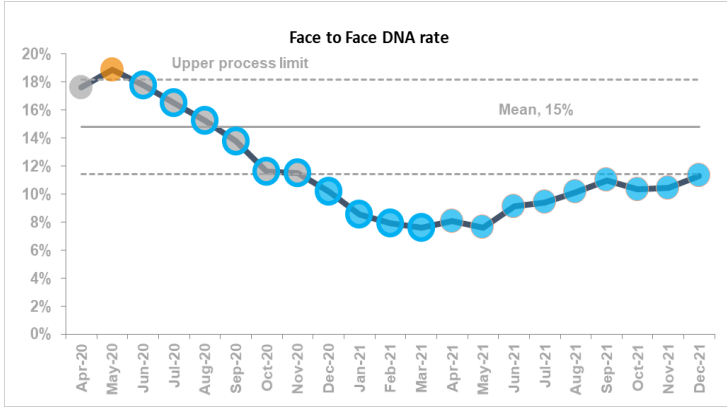
Actions and Quality Improvement Projects

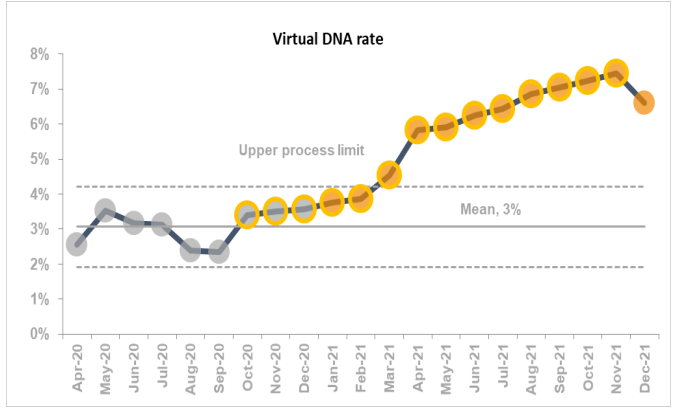
- As part of the Elective care recovery programme, the Trust is treating a large volume of patients who have waited a long time for their appointments and therefore there is a higher proportion requiring an appointment in a face-to-face setting. It is anticipated that there will be a lower volume of virtual activity as backlog is worked through 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.
- Unfortunately monies that I.T were bidding for to support virtual outpatient activity was unsuccessful on this occasion, however, there is an intention to resubmit when monies become available in the new Financial Year
- Work is on-going both within the Trust and at SWL level to improve both Patient Initiated Follow-up (PIFU) and Advice and Guidance (A&G) both of which should support an improvement in our overall performance. New services have been identified to go live with PIFU and should be live before the end of March '22.

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 December was 9.6%, performance has been consistent over the last three-month period and is below the mean of 2019

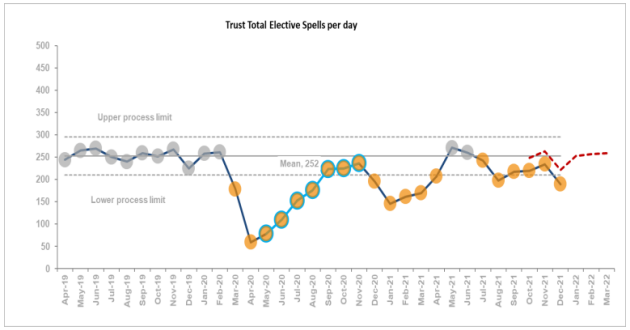
The new to follow-up ratio has decreased in December, returning to within the upper and lower control limits. Women's services is a particular higher outlier with, on average, four follow-ups per first appointment; this is in line with an increase in follow-up appointments over the last three months.

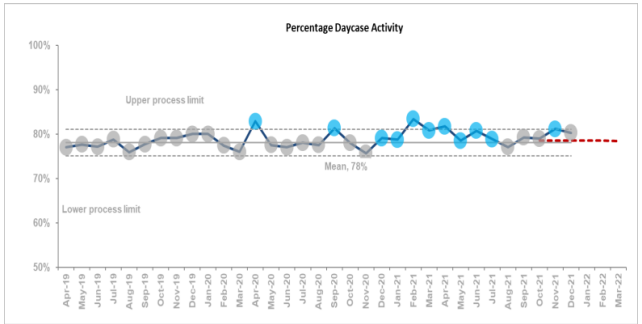
The Trust continues to see a higher DNA rate for those patients being seen in a face-to-face environment compared with a virtual setting. In December, the rate of patients not attending a virtual appointment has improved.

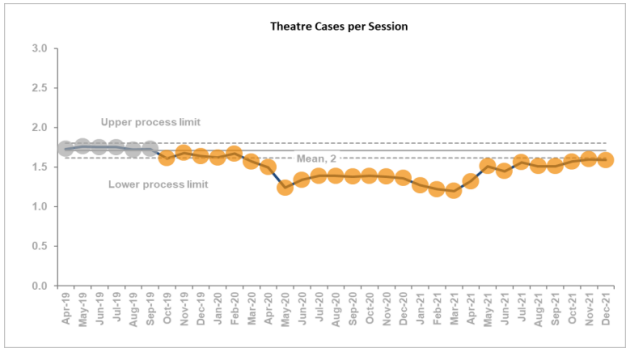
Actions and Quality Improvement Projects

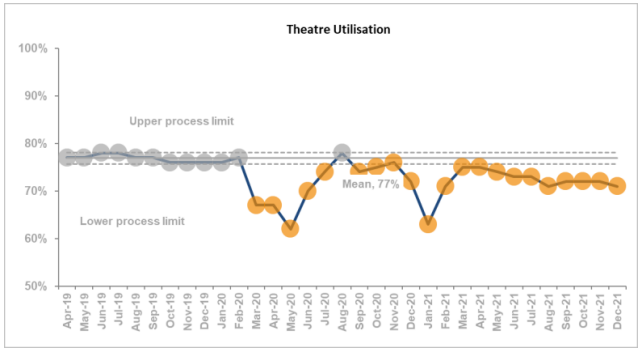
- Services are undertaking clinic reviews to reflect the needs of their backlog. Some clinics may have additional new appointments depending on where the demand lies.
- Patient Initiated Follow ups (PIFU) are being looked at and may be able to assist with reducing DNA rates and ensuring that appointment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

Elective Activity & Theatre Productivity









What the information tells us

On average throughout December, 189 patients were treated per day compared to 234 in November. Overall elective activity was 88% of that reported in December 2019 and, although expected to rise once data catch up is completed to 96%, this is below trajectory of 100%. Theatre specialties are at 89%, with non-Theatre specialties at 98%. Endoscopy activity remains blow plan by 14%, ENT below by 29% whereas Colorectal Surgery and T&O are above plan with activity levels above 2019 baseline.
In December, Theatres ran 782 theatre sessions, compared to 909 in the same period in 2019. The number of 4-hour sessions available and utilised for day case procedures has increased by 22% however inpatient sessions have reduced.

Both the average cases per session and theatre utilisation fell slightly in December.

- 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

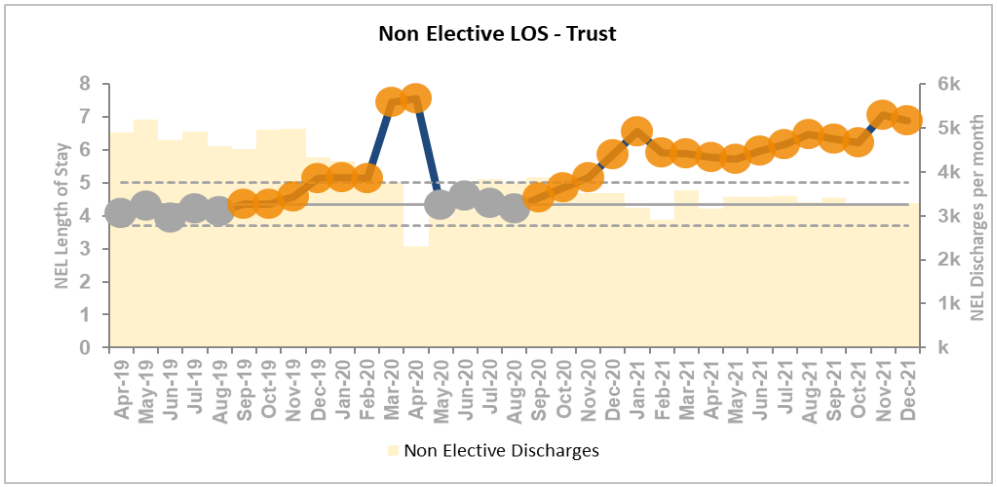
- **DSU 23 hour/ Extended Recovery:** DSU Extended Recovery was launched for across three specialties in November (ENT; Breast; Plastics). This scheme will significantly increase DSU capacity and productivity as well as alleviate recovery flow issues in SJW in particular. Due to a six week delay in completion of the lift refurbishment, DSU 23 hour overnight stays have been delayed until January. Two lists will see patients staying overnight in the last week of January.

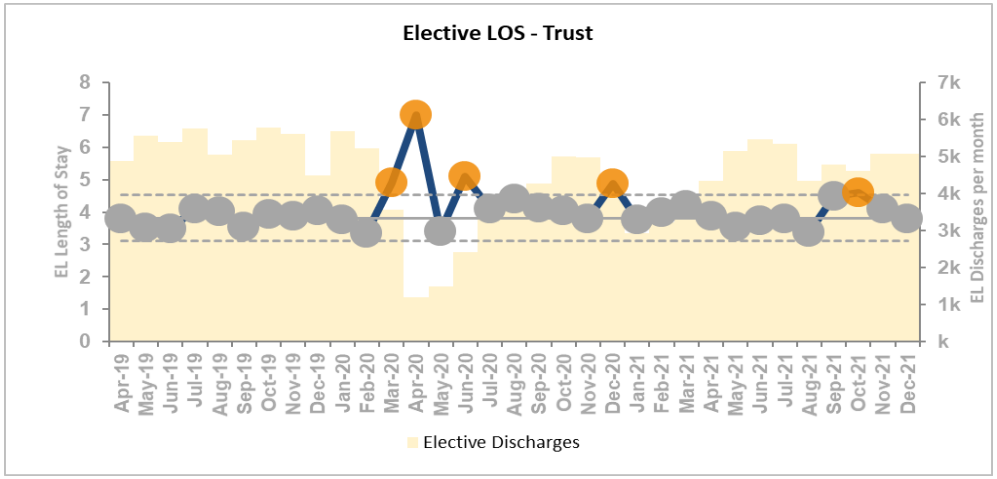
- **POA:** 35% of SGH patients are ASA1 and otherwise fit and healthy. An 'ASA1 Streaming' project has been launched to enable safe streaming of these patients 'straight to swab', avoiding unnecessary POA, improving patient experience and increase capacity. Required changes to iClip eTCI have been signed off, enabling a full pilot in T&O and Urology to commence in mid-February. A soft roll-out is being launched Monday 17th January in POA to test the new proforma ahead of full pilot. This test will reduce the number of HCA appointments. Full pilot will reduce both nursing and HCA appointment requirements.

- **Recovery flow:** Following launch of the new Recovery Flow project in October, the time elapsed between patients in General beds being 'ready to leave' recovery, and the patient actually leaving recovery has more than halved. Both PACU, SJW Recovery and Neuro Recovery have also seen substantial reductions in the Length of Stay for patients 'Ready to Leave' (R2L) recovery. This has improved flow and reduced avoidable admissions and cancellations caused by bed blocking. A further intervention is being launched on Monday 17th January to open up a 'Yellow' SDL Discharge pathway from SJW to DSU to relieve pressure on SJW Recovery, improve flow, maximise SDLs and minimise failed SDLs. This is linked to both short term tactics and a longer term strategy to increase PACU capacity.

- **Recruitment:** The anaesthetic recruitment drive continues at pace. 23 posts have been advertised, with 9 recruited to so far. However, this is in the context of 17 staff leaving (or soon to leave) since August 2021, so staffing remains extremely stretched. Interviews for 5 more posts are taking place in the next month.

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

Throughout December, patients admitted through the non-elective pathways stayed in a hospital bed for 6.9 days on average. This a slight decrease of 0.2 days compared to the previous month.

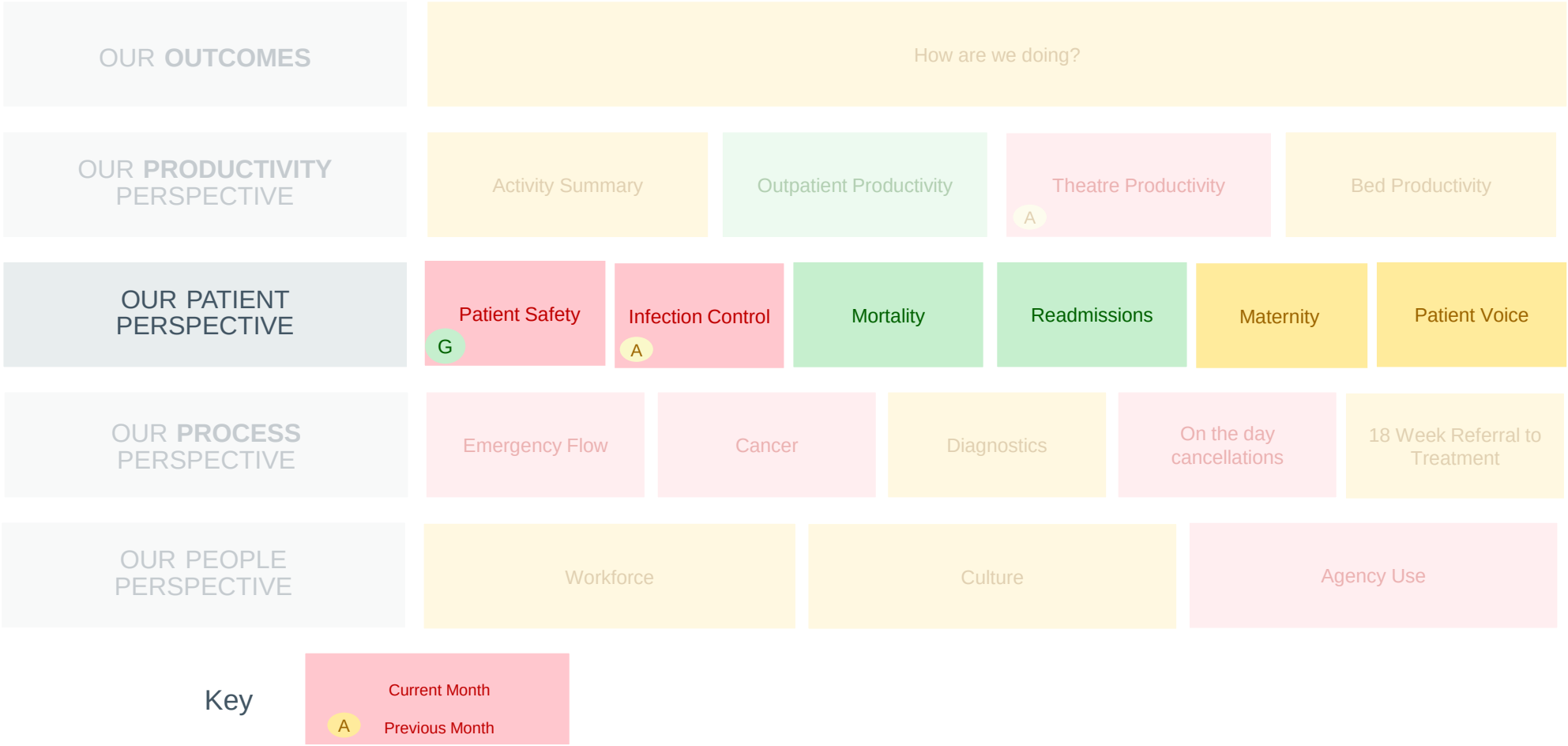
Higher length of stay continues to be driven by high acuity in the patients admitted. Daily, an average of 61 patients await discharge due to external dependencies, e.g., placement, care support and equipment. Patients staying more than 7, 14 and 21 day is still above the upper control limit which continues to impact bed flow across the Trust, however through December teams worked extremely hard to reduce this with all cohorts reducing.

Elective length of stay reduced and is showing only common cause variation. On average, patients stayed in a hospital bed for 3.8 days compared to 4.1 days in November.

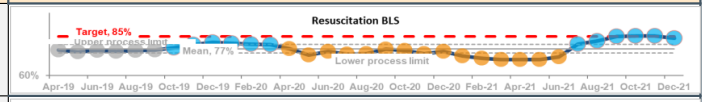
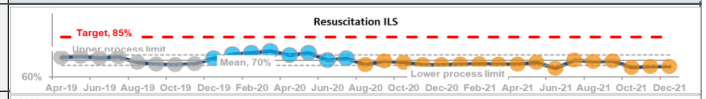
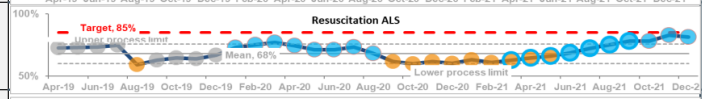
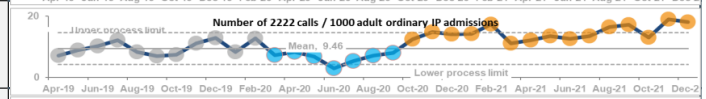
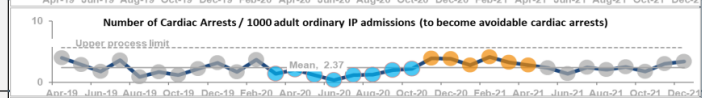
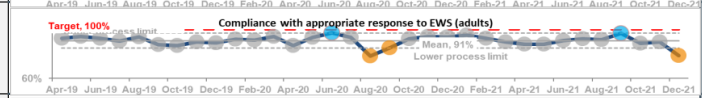
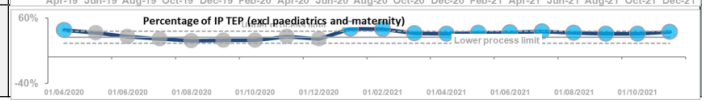
Actions and Quality Improvement Projects

- Work to optimise Discharge to Assess process with Merton and Wandsworth underway to ensure appropriate / essential information at the point of referral and to develop more efficient communication channels between organisations.
- Weekly Multi-Agency Discharge Events (MADE) are being held throughout January
- Early Bird pilot programme, focusing on discharges before 10am to support flow from ED, is operational in all Surgical wards and will be implemented across all Adult Medical Wards in January
- Increasing the use of the departure lounge where appropriate, a review of the use of and capacity of the lounge, particularly for number of available beds required.
- 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
- Discharge Hub secondment opportunities advertised to support discharges and flow, particularly over winter

Balanced Scorecard Approach



Quality Priorities – Deteriorating Patients

	Target	Dec21	Var to target	Trend
Basic Life Support Training (BLS)	85.0%	83.8%	-1.5%	
Intermediate Life Support Training (ILS)	85%	66.5%	-18.5%	
Advanced Life Support Training (ALS)	85%	81.4%	-3.6%	
Number of 2222 Calls/1000 adult ordinary IP admissions	N/A	18.1	-	
Number of Cardiac Arrests/ 1000 adult ordinary IP admissions (to become avoidable cardiac arrests	N/A	3.4	-	
Compliance with appropriate response to Early Warning Scores (Adults)	100%	78.5%	-21.5%	
Percentage of Inpatient Treatment Escalation Plans (excl paediatrics and maternity)	40%	39.5%	-0.5%	

What the information tells us

- BLS (Basic Life Support) training performance continues to shows special cause improvement with performance at 83.8%.
- ILS (Immediate Life Support) shows special cause deterioration, with performance at 66% for this month.
- ALS (Advanced Life Support) training performance continues to be maintained with performance at 81.4%
- 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 78.5% this month and shows common cause variation.
- Performance against our Treatment Escalation Plans has plateaued in recent months however continues to be above the long-term mean.

Actions and Quality Improvement Projects

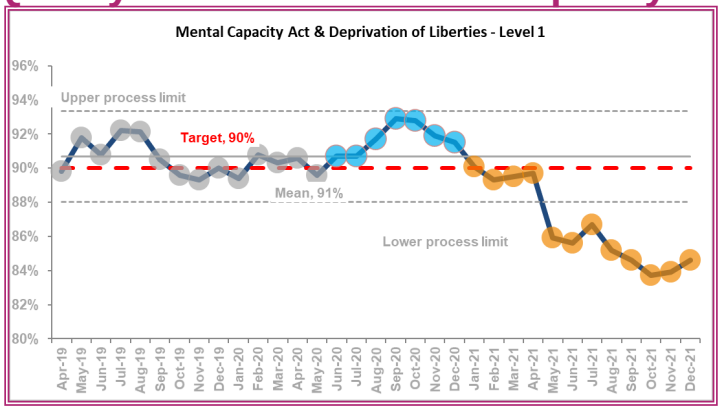
BLS - To improve and sustain performance the Self Assessment Pod is now open Monday to Friday 08:00 to 18:00 with additional 'drop-in' sessions planned for community areas

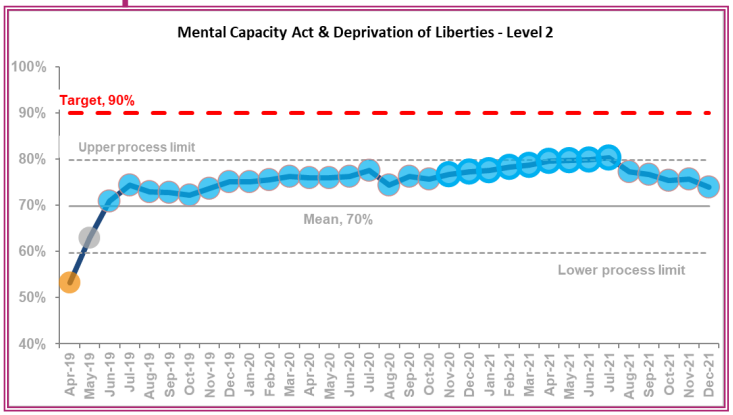
ILS – A minimum of 30 training places are offered weekly although DNA rates remain high at 25 - 40% exacerbated by current operational pressures. eILS recertification course will be available from April 2022. The further review of the training needs analysis has been completed and the report together with the recommendations was presented at the Resuscitation Meeting on 12 January 2022. Further discussion and agreement as to the next steps will be taken at the Patient Safety and Quality Group on 19 January 2022

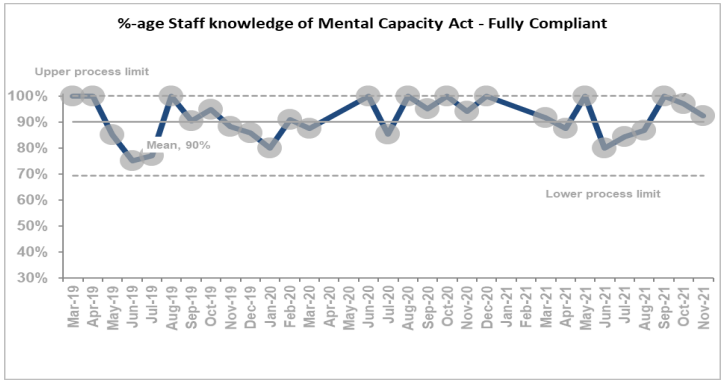
ALS - The Deep Dive into ALS records has identified those that have not yet provided certificates and this has been followed up on an individual staff basis. ALS dates are also being offered to non-compliant staff.

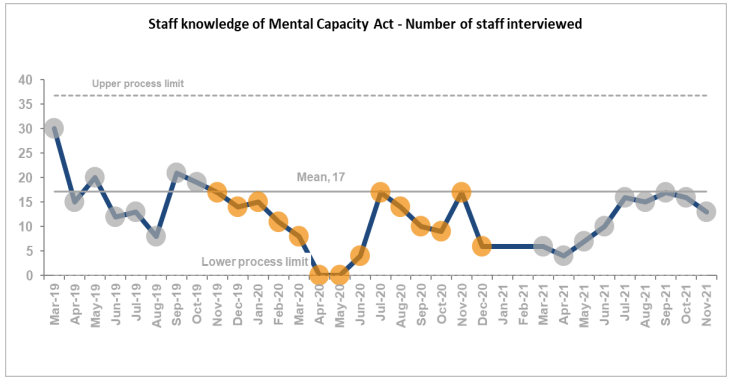
TEP - In order to continue to improve Treatment Escalation Plan (TEP) completion rates the following developments are now in place: Electronic dashboard to see how many patients in any clinical area have not had a TEP completed and Reporting at ward level in divisional performance reports. The following initiatives are in development for implementation by 31 March 2022: Easy electronic link to TEP from CERNER iCLIP to promote completion and Simulation sessions to help clinicians to have conversations with patients about treatment escalation planning

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 eleven months below the 2019/20 average. Performance in December showing a slight improvement at 84.6%.
- Overall Level 2 compliance was 74% this month and show special cause variation.
- Metrics showing the number of staff interviewed and their level of knowledge was suspended in January and February 2021 and interviews resumed in March 2021. Performance against both metrics shows common cause variation. Staff interview were suspended in December 2021 and will be recommenced towards the end of January 2022.

Action and Quality Improvement Projects

The implementation of the new Liberty Protection Safeguards has been further delayed. The Code of Practice is due to be released for consultation in coming months. There is no new proposed implementation date and no new detail on how implementation will be funded. Provider advice in the interim is to improve staff knowledge and implementation of the MCA. All staff non-compliant at Level 2 from the training needs analysis are being contacted directly in order to undertake the training

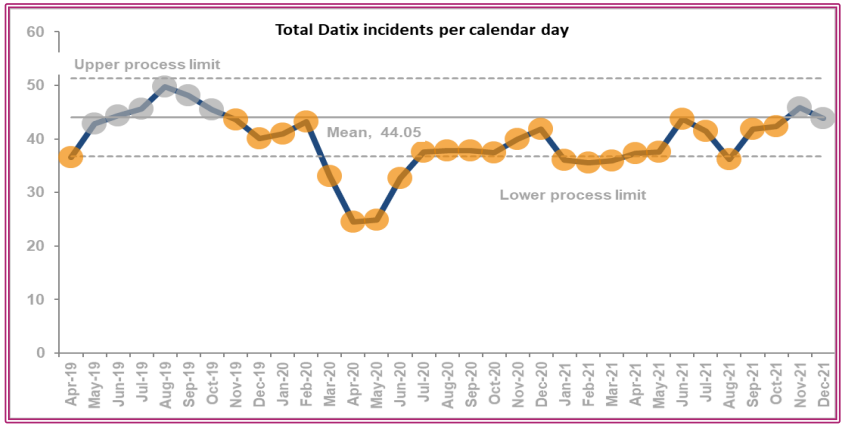
The MCA team have noted an increase in referrals to the team when treatment decisions are being made for adults lacking capacity to make the specific decision. In response to this the MCA and best interests flowcharts will be reviewed to ensure a consistent message and to support the clinician in appropriate documentation of the decision made on behalf of the patient.

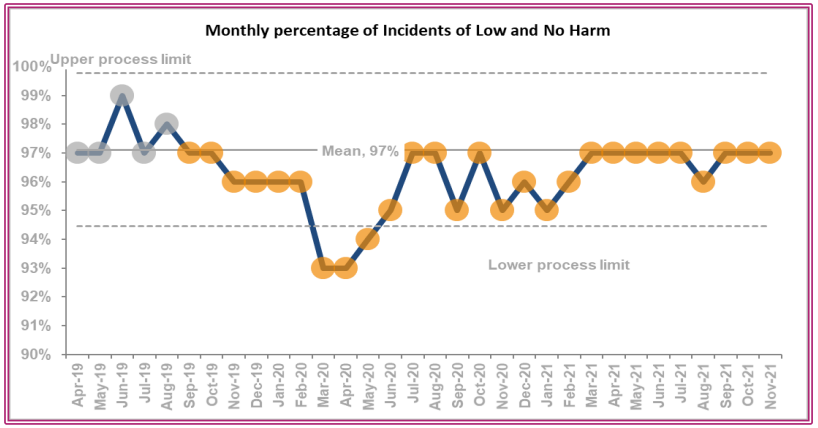
Discharge Coordinator and Discharge to Assess Mental Capacity Act Workshops will be launched by the end of January 2022. To promote awareness and support the development of MCA knowledge the existing twice weekly MCA drop in sessions have been transferred to a virtual platform via Microsoft teams.

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	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Monthly percentage of Incidents of Low and No Harm		96.0%	95.0%	96.0%	97.0%	97.0%	97.0%	97.0%	97.0%	96.0%	97.0%	97.0%	97.0%	data one months in arrears
Open SI investigations >60 days	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Duty of Candour completed within 20 working days, for all incidents at moderate harm and above	100%	96.0%	85.0%	75.0%	90.0%	100.0%	100.0%	96.0%	100.0%	100.0%	100.0%	100.0%	data two months in arrears	
Total Datix incidents per calendar day		42	36	36	36	37	38	44	42	36	42	42	46	44





What the information tells us

- All Open Serious Incident (SI) investigations are being completed in line with external deadlines of 60 working days.
- All incidents of moderate harm and above have had a Duty of Candour completed within 20 working days for 4 consecutive months.

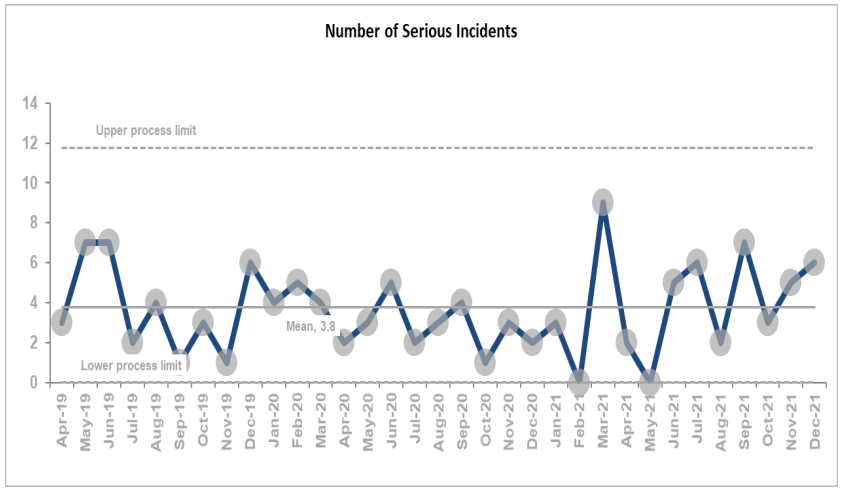
Actions and Quality Improvement Projects

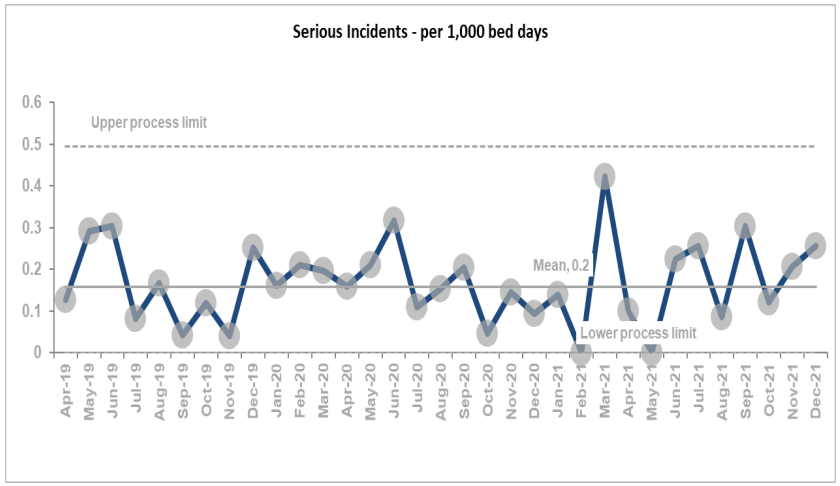
Duty of Candour (DoC) - There were 17 qualifying incidents reported in October 2021 and DoC was completed for all incidents within 20 working days.

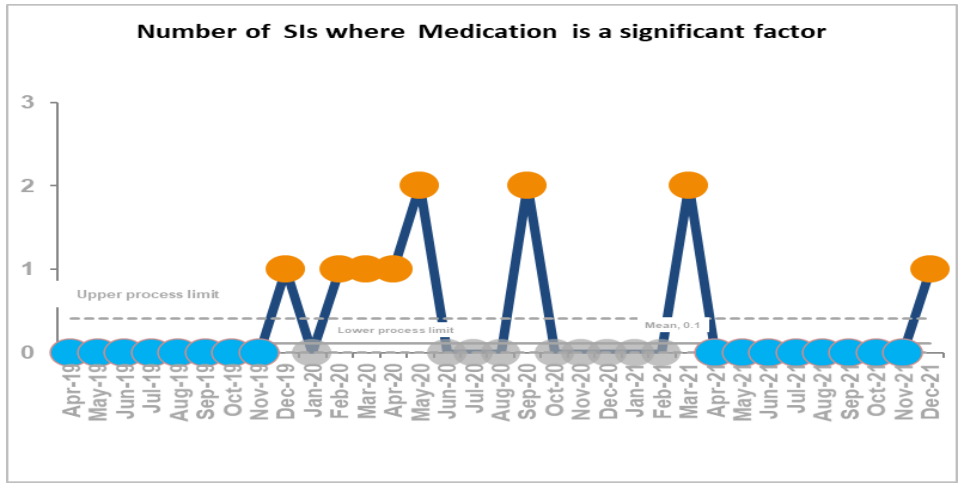
Significant improvement has been noted with DoC compliance. This continues to be monitored and support provided to the relevant departments in order to continually sustain compliance.

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



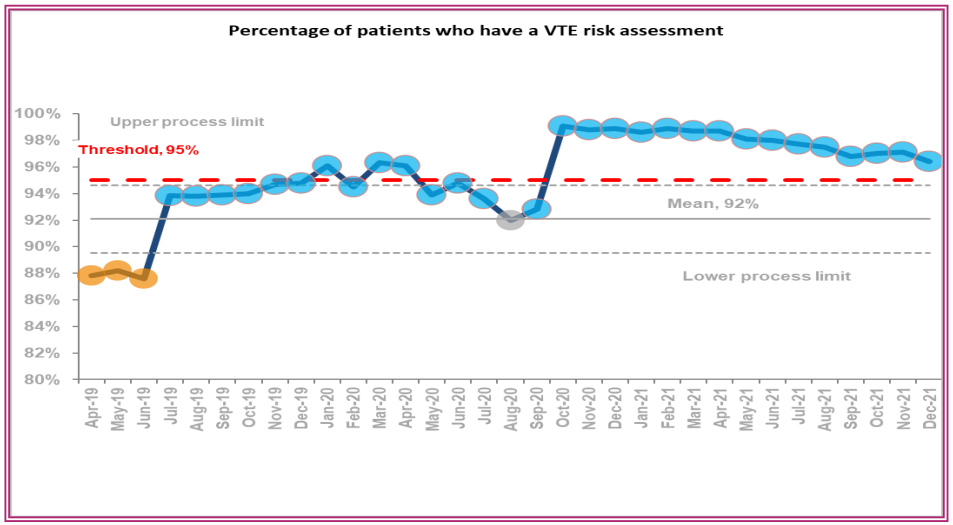


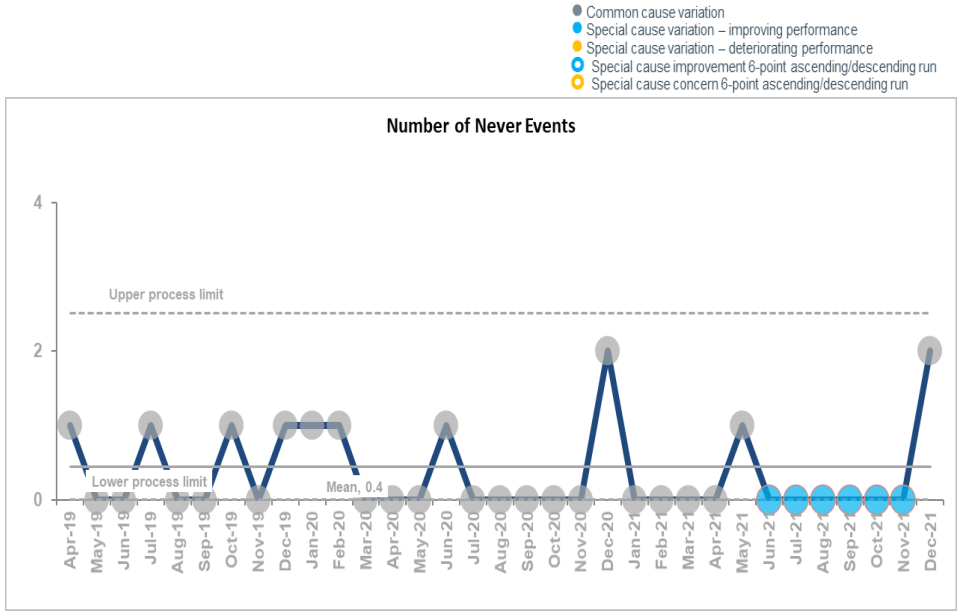


What the information tells us

- Common cause variation is seen in the number of Serious Incidents and the number of Serious Incidents per 1,000 bed days.
- One Serious Incidents where Medication is a significant factor was recorded in December the first seen since March 2021. This was an overdose of insulin Never Event (see details on slide 6).

Patient Safety- VTE and Never Events





What the information tells us

- The percentage of patients who have had a VTE risk assessment was 96.4% against a target of 95%.
- There were two Never Events declared in December 2021:
  - Overdose of insulin due to the use of an incorrect device. The patient came to no harm as a result
  - Wrong site surgery involving a patient who underwent an excision of the wrong scar. They subsequently underwent excision of the correct scar without complication

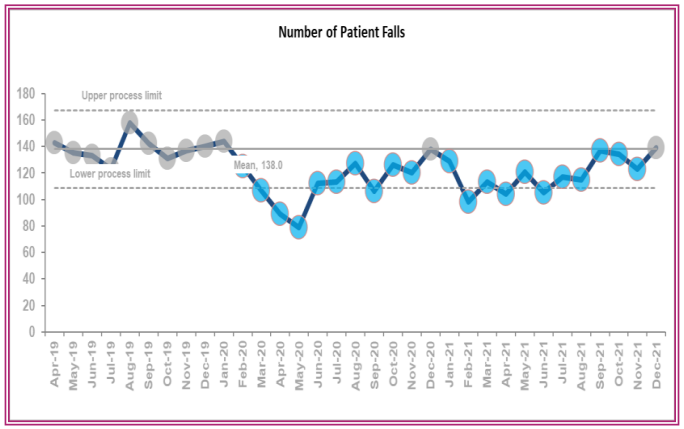
Actions and Quality Improvement Projects

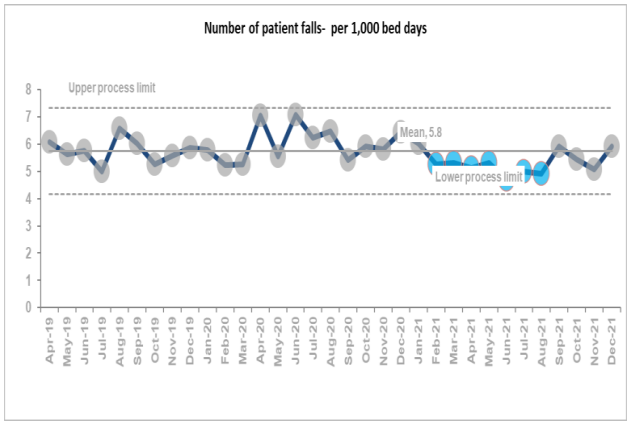
Never Event - Overdose of insulin: The storage of insulin syringes and 1ml syringes has been segregated with clear labelling and updated signage regarding the administration of insulin using insulin syringes only. Teaching sessions for all ward staff will be provided in January 2022 to raise awareness following this incident.

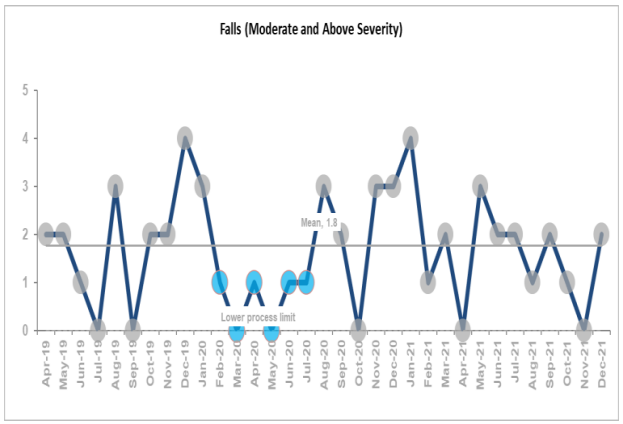
Never Event - Wrong site surgery: Protocols have been updated to include confirming the intended site to be excised using photographic evidence and prior to commencement of the procedure confirming with patients that the correct site has been identified. Local Safety Standards for Invasive Procedures (LocSSIPs) are currently being reviewed to reflect these changes.

VTE : 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.

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

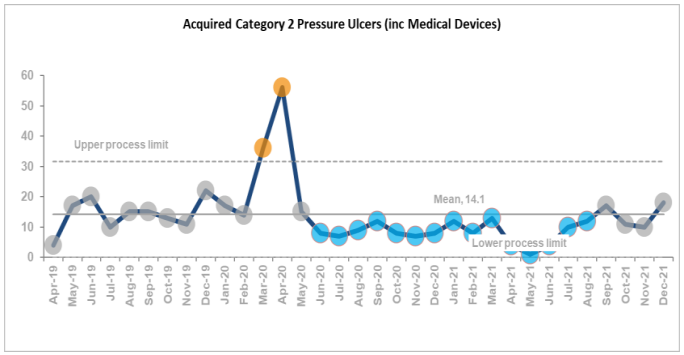
What the information tells us

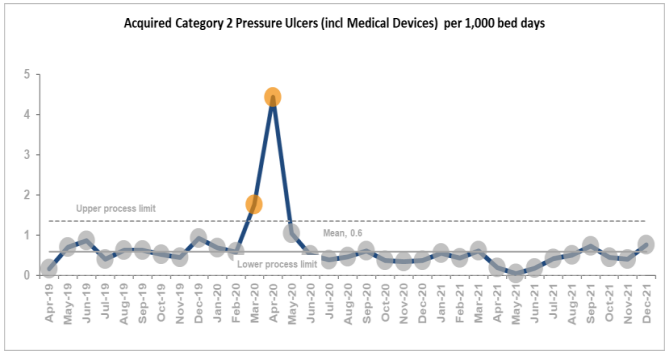
- The number of patients falls now shows common cause variation; Patient Falls per 1,000 bed days also shows common cause variation.
- Two patients had a fall in month with a severity of moderate harm or above.

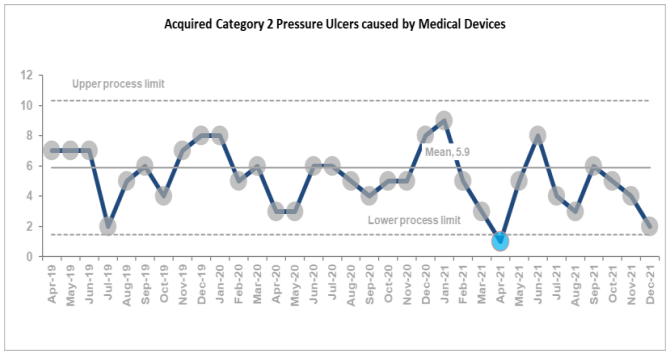
Actions and Quality Improvement Projects

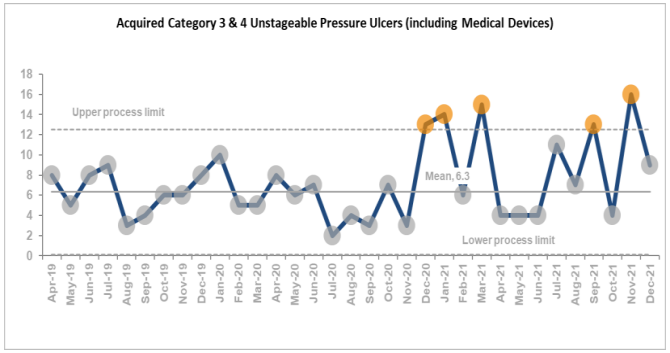
- Falls prevention measures continue to be implemented across inpatient wards
- Falls incidents continue to be monitored and reviewed locally by senior nursing teams with any learning identified and improvement actions implemented as appropriate.

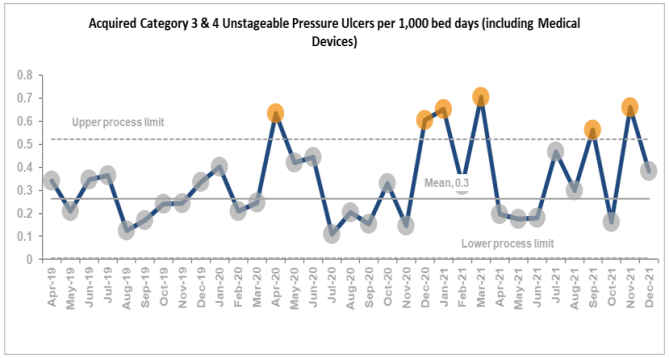
Patient Safety- Pressure Ulcers

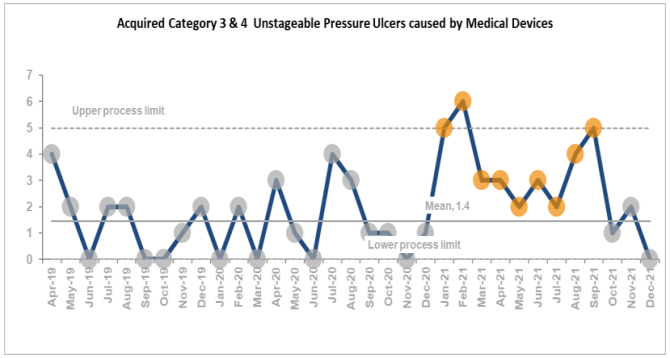












What the information tells us

- There were 18 Category 2 Pressure ulcers this month. Category 2 PUs and rate per 1,000 bed days shows common cause variation.
- The number of Category 3 & 4 Unstageable Pressure and the rate per 1,000 bed shows common cause variation

Actions and Quality Improvement Projects

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

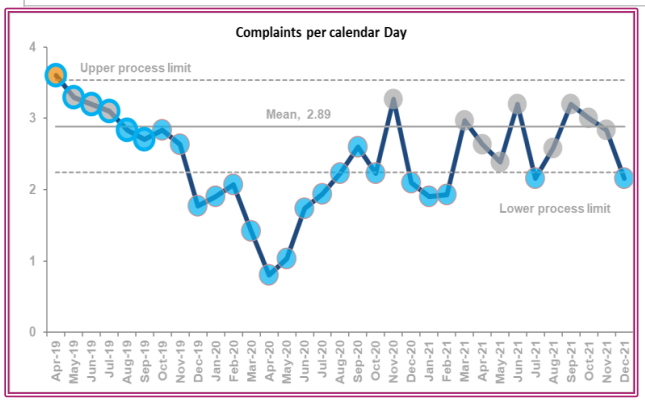
All category 3 and above pressure ulcers undergo root cause analysis to identify any learning.

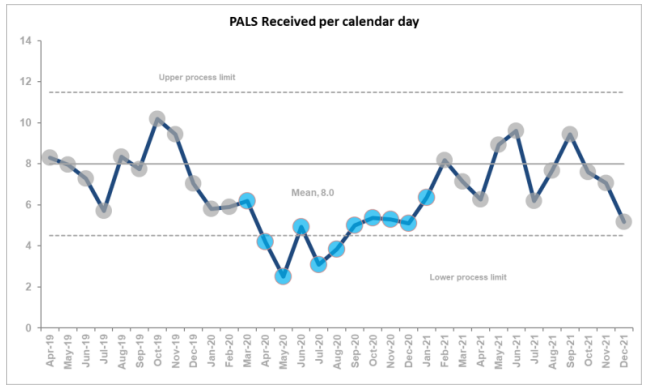
- Common cause variation
- Special cause variation – improving performance
- Special cause variation – deteriorating performance
- Special cause improvement 6-point ascending/descending run
- Special cause concern 6-point ascending/descending run

Our Patient Perspective

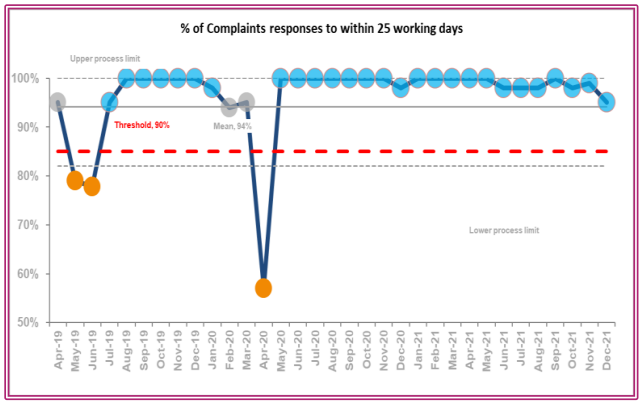
Complaints

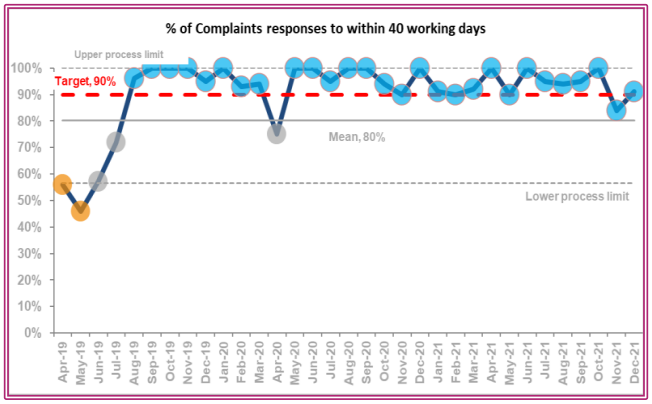
Indicator Description	Target	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Complaints Received per calendar day		2.1	1.9	1.9	3.0	2.6	2.4	3.2	2.2	3	3	3	2.8	2
% of Complaints responses to within 25 working days	85%	98%	100%	100%	100%	100%	100%	98%	98%	98%	100%	98%	99%	95%
% of Complaints responses to within 40 working days	90%	100.0%	91%	90%	92%	100%	90%	100%	95%	94%	95%	100%	84%	91%
% of Complaints responses to within 60 working days	100%	100%	100%	100%	100%	N/A	100%	50.0%	N/A	N/A	100%	N/A	N/A	67.0%
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 special cause variation with a reduction in the number of complaints from 85 to 67 formal complaints received in December
- Percentage of complaints responded to within 40 working days was achieved with performance at 91%. Two complaints in the 40 day response category breached out of the total of 23 Performance is still above early 2019 average.
- Percentage of Complaints responded to within 60 working days was not achieved. A total of 6 complaints were received, 2 of which were not responded to within the allotted time.
- PALS received per calendar shows common cause variation.

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	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	YTD Actual
MRSA Incidences (in month)	0	0	0	0	0	0	0	0	0	0	1	1	0	0	2
Cdiff Hospital acquired infections	52	5	1	3	2	2	2	2	0	3	4	4	5	5	33
Cdiff Community Associated infections		3	1	0	1	1	0	0	0	2	1	1	1	0	
MSSA	25	4	8	5	5	5	3	3	3	3	0	3	10	2	32
E-Coli	111	9	6	6	6	7	6	5	6	5	4	5	7	6	51
Covid-19 Nosocomial Infections Hospital Onset healthcare associated (>14 days) HOHA	N/A	62	59	24	0	2	0	0	0	18	2	7	4	69	102
Covid-19:Nosocomial Infections Hospital Onset Probable associated (8-14 days) HOPA	N/A	76	56	35	4	0	1	1	0	10	1	4	1	31	49

What the information tells us :T

here were 5 incidents of patients with C. difficile infection during December 2021 all of which were classified as Hospital Onset Healthcare Associated, where the specimen was taken beyond admission day plus one day. No cases were classified as Community Onset Healthcare Associated (COHA), where the specimen is taken within admission day plus one day (and where the patient had also been an inpatient in the previous 4 weeks). Each case is reviewed to identify if there were any lapses in care, for example in antimicrobial prescribing, patient isolation or environmental or medical device cleanliness. NHSI/E set a trajectory of no more than 52 cases for 2021-22 or no more than 4.3 cases per month. Since April 2021, there have been a total of 33 cases, against a trajectory of no more than 39 for this point in the year. The Trust is therefore under this trajectory.

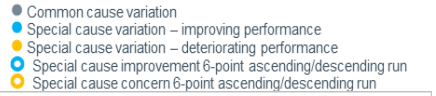
There were 2 patients with Trust apportioned MSSA cases during December 2021 and 6 cases of Trust apportioned E. coli bacteraemia. A new NHSI/E trajectory has been set for E.coli bacteraemia of no more than 111 cases for 2021-2022 or no more than 9.25 cases per month. Since April 2021, there have been a total of 51 cases, against a trajectory of no more than 83.25 for this point in the year. The Trust is therefore under this trajectory.

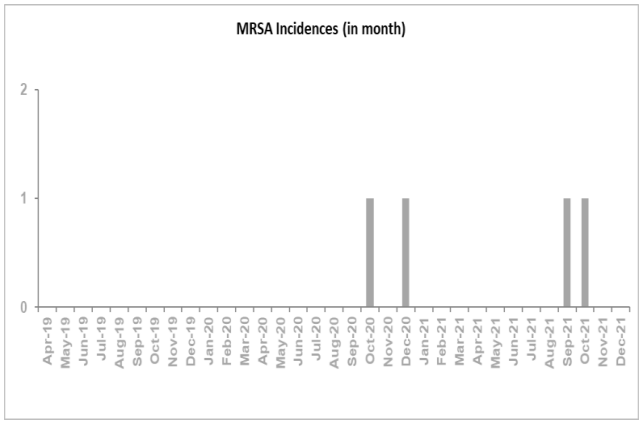
There were 69 Hospital Onset Healthcare Associated cases (HOHA) of Covid-19 during December 2021, where the sample was taken >14 days after admission and 31 Hospital Onset Probable Associated (HOPA) cases where the specimen was taken 8-14 days after admission. Thematic and individual reviews are taking place for cases to ascertain learning and outcomes reported to the Infection Control Group.

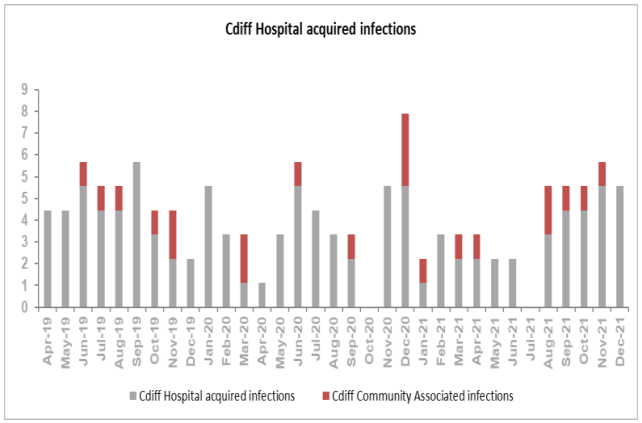
Actions and Quality Improvement Projects

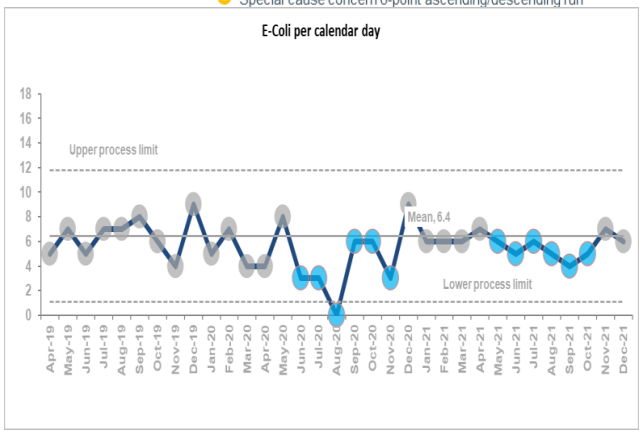
National COVID-19 data submissions continue to be validated daily and signed off by the Chief Nurse and Director of Infection Prevention and Control. The Infection Prevention and Control Team has been involved in winter planning discussions.

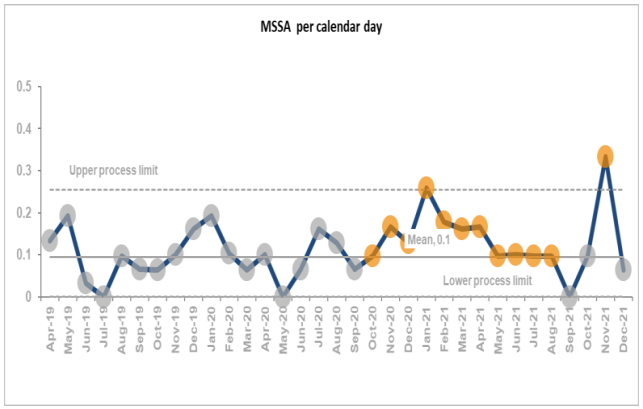
Infection Control

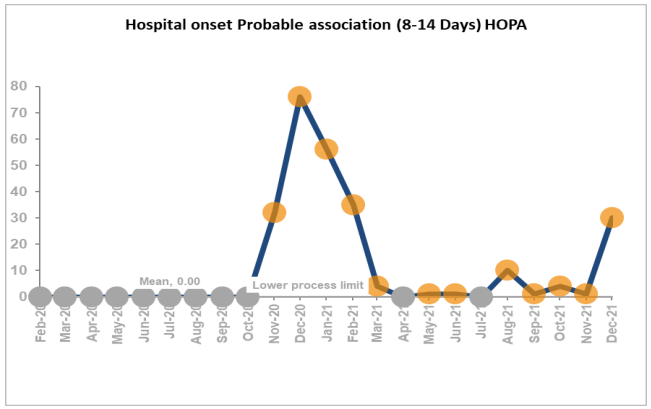


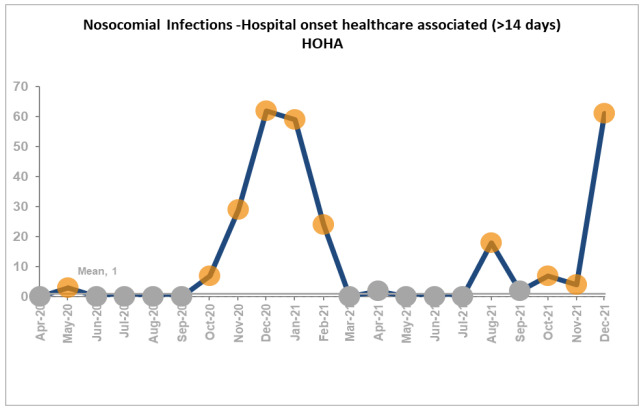












Our Patient Perspective

Mortality and Readmissions

Indicator Description	Oct-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	Sep-21	Oct 2020 to Sept 2021
Hospital Standardised Mortality Ratio (HSMR)	95	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	86.8	86.0
Hospital Standardised Mortality Ratio Weekend Emergency	80.6	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	105.5	109
Hospital Standardised Mortality Ratio Weekday Emergency	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	83.6	76.7

Indicator Description	Nov18-Oct19	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	July-20-June-21	Aug-20-July-21
Summary Hospital Mortality Indicator (SHMI)	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	0.86	0.88

Indicator Description	Jun-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	Oct-21	Nov-21
Emergency Readmissions within 30 days following non elective spell (reporting one month in arrears)	10.4%	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%	8.3%	7.2%

Note: HSMR data reflective of period October 2020– Sept 2021 based on a rolling monthly published position.. SHMI data is based on a rolling 12 month period and reflective of period August 2020 to July 2021 published (October 2021). Readmission data excludes CDU, AAA and all ambulatory areas where there are design pathways

What the information tells us

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

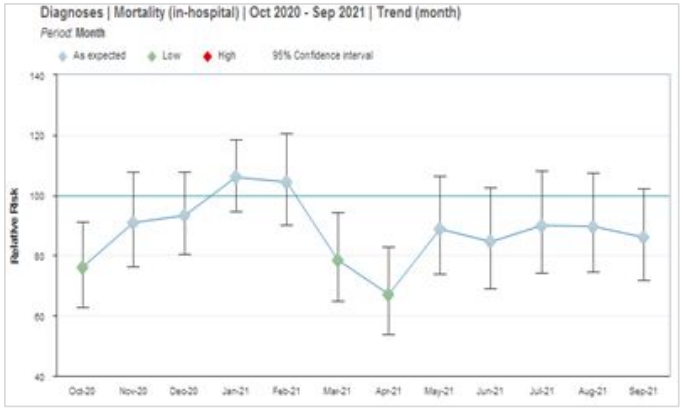
The percentage of patients readmitted within 30 days following an Emergency admission was 8.3% in November. In the last 4 months there has been a steady decline in readmissions and performance now shows special cause variation with an improving position.

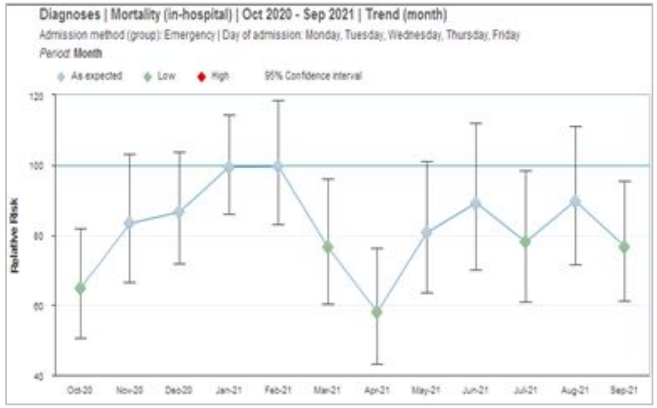
Actions and Quality Improvement Projects

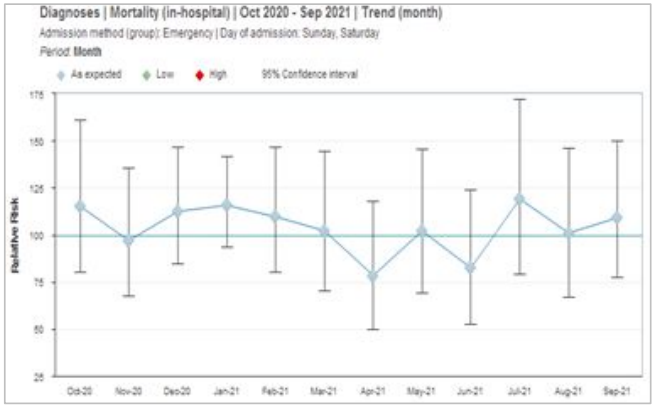
We continue to monitor and investigate mortality signals in discrete diagnostic and procedure codes from Dr Foster through the Mortality Monitoring Group (MMG). The group are currently overseeing an investigation of mortality in the diagnosis group Acute Myocardial Infarction, as higher than expected mortality is indicated by analysis of both the HSMR and SHMI. This enquiry will incorporate an investigation of clinical coding as well as a clinical review of cases. The Cardiology Clinical Governance Lead will provide an update on the investigation to MMG in February.

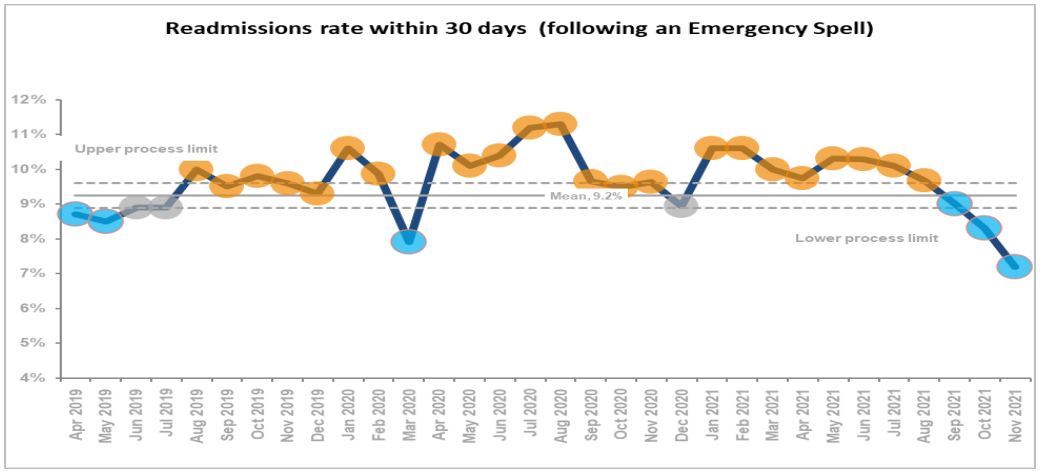
Mortality and Readmissions (Hospital Standardized Mortality Rate)

- 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



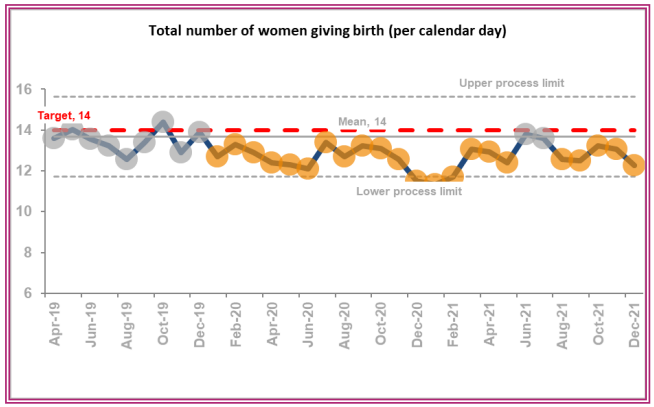


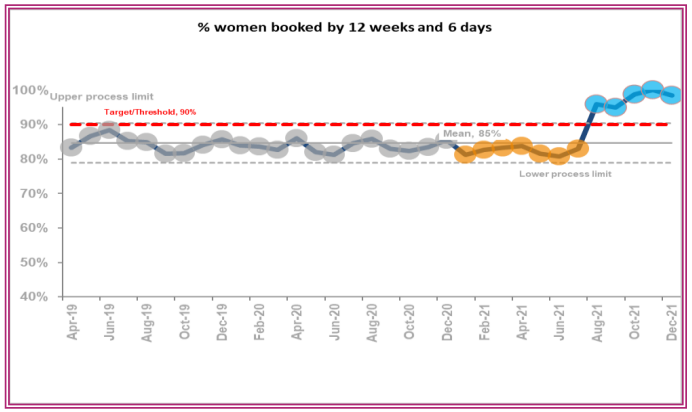


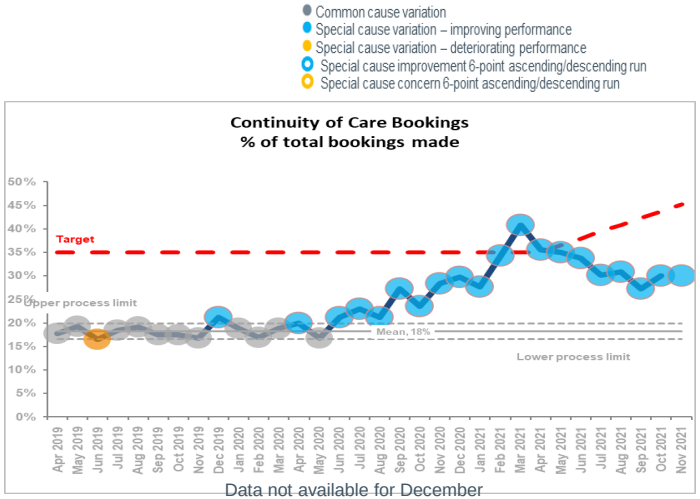


Our Patient Perspective

Maternity







Data not available for December

What the information tells us

- The clinical acuity and complexity remained high in December 2021. Staffing challenges continued which impacted on staffing ratios
- Part of the response continues to include diverting community and office based midwives to Delivery Suite and other acute inpatient areas. The overall substantive staffing profile continued to improve throughout December 2021 although short term sickness and covid absences remain. Birth Centre closure was 27.4 % in month which has deteriorated from the position in November of 15%. There was also a sustained rate of supernumerary status of the Labour Ward coordinator at 98.4%
- In December 2021 there were 2.6 still births per 1000 births and 13.2 neonatal deaths per 1000 births. The neonatal death figure does not reflect the Trust as an outlier. All cases have been reviewed by the Midwifery Risk and Governance Multidisciplinary team and no immediate learning was identified. All cases are on the Perinatal Mortality Tool pathway and have been uploaded within the required 7 working days.
- There was a continued performance in antenatal bookings with 100% of women referred being booked by 12 weeks and 6 days

Actions and Quality Improvement Projects

We have secured the £1.8M in bid for funding to support Digital Transformation and provide a single health records solution by the addition of a maternity module to our enterprise wide EPR (electronic patient record). Once in place, Women will be able to access their own maternity care record and complete documentation via the Trust's patient portal and receive curated healthcare information pertinent to their circumstances.

There has been a further delay to the completion of enabling works for the centralised Maternity Telephone Helpline will now be launched in mid February 2022. 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.

Following confirmation of over 90% compliance for the OCKENDEN immediate and essential requirements we are currently planning for a site visit from the Regional teams. The remaining and outstanding elements pertain to SWL Local Midwifery Network shared actions for the Perinatal Quality Surveillance model along with local training needs analysis and training requirements for the year.

We have launched the QI programme to improve clinical triage processes on the Delivery Suite and this includes increasing and improving the environmental capacity to conduct clinical triage assessment.

Maternity Transformation Programmes have been paused for at least three months in response to national staffing challenges. However, work continues to scope out staffing models for increasing Continuity of Care (CoC) teams to improve and expand CoC along with directed recruitment to these teams.

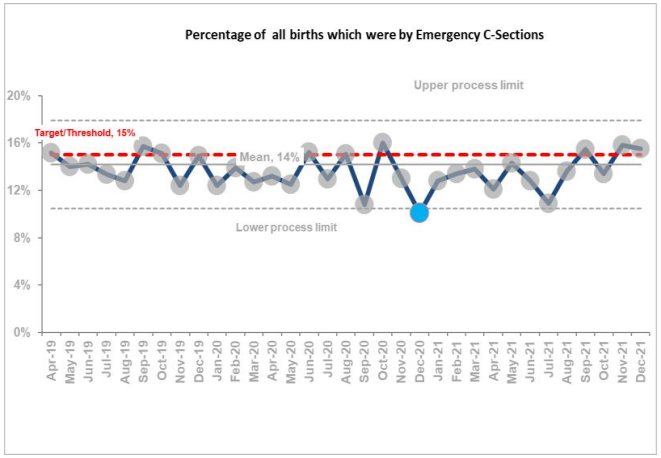
Maternity

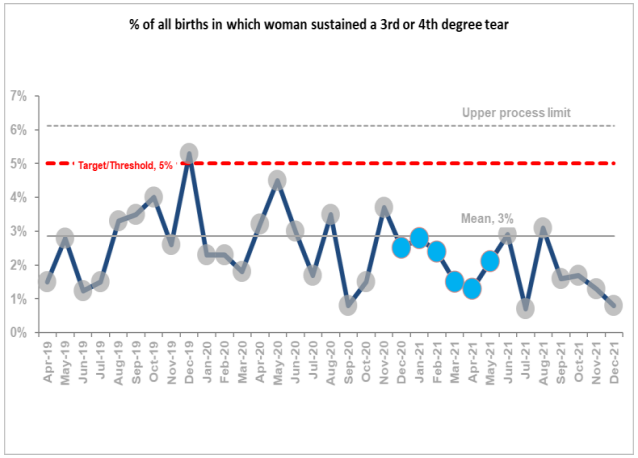
Maternity Dashboard

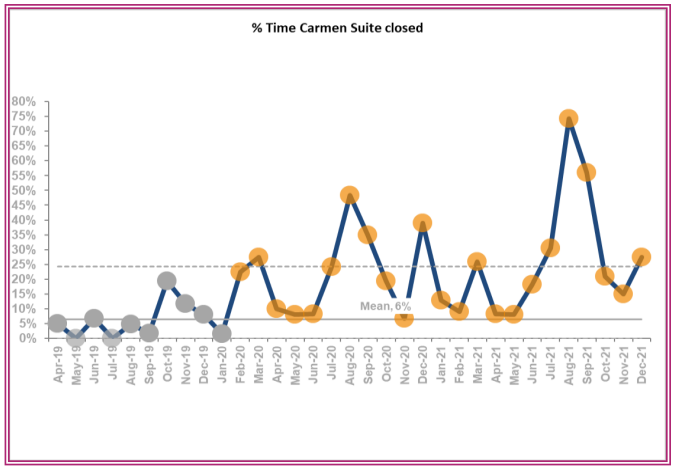
Definitions	Target	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Total number of women giving birth (per calendar day)	14 per day	11.5	11.3	11.7	13.1	12.9	12.4	13.8	13.6	12.6	12.5	13.2	13.1	12.3
Caesarean sections (Total Emergency and Elective by Delivery date)	<28%	23.8%	28.5%	28.0%	29.1%	25.5%	27.6%	24.6%	24.7%	27.2%	28.3%	27.3%	31.4%	31.3%
% deliveries with Emergency C Section (including no Labour)	<8%	3.4%	2.3%	3.4%	4.0%	3.4%	3.9%	1.9%	3.6%	2.6%	4.5%	4.4%	5.4%	4.4%
% Time Carmen Suite closed	0%	39.0%	12.9%	9.0%	26.0%	8.3%	8.0%	18.3%	30.6%	74.2%	56.0%	21.0%	15.0%	27.4%
% of all births in which woman sustained a 3rd or 4th degree tear	<5%	2.5%	2.8%	2.4%	1.5%	1.3%	2.1%	2.9%	0.7%	3.1%	1.6%	1.7%	1.3%	0.8%
% of all births where women had a Life Threatening Post Partum Haemorrhage >1.5 L	<4%	2.5%	3.1%	1.2%	3.2%	2.8%	4.2%	2.4%	3.6%	2.3%	1.3%	2.9%	3.6%	2.4%
Number of term babies (37+ weeks), with unplanned admission to Neonatal Unit		11	13	9	11	8	13	14	13	16	13	12	12	10
Number of term babies (37+ weeks), with unplanned admission to Neonatal Unit as a percentage of deliveries	6%	2.8%	3.3%	2.3%	2.8%	2.0%	3.3%	3.5%	3.3%	4.1%	3.3%	3.0%	3.0%	2.5%
Supernumerary Midwife in Labour Ward	>95%	91.9%	100.0%	94.6%	98.4%	98.3%	98.4%	97.0%	88.7%	90.3%	90.0%	88.7%	98.4%	98.3%
Babies born with Hypoxic Ischaemic Encephalopathy / (1000 babies)		8.4	5.7	0.0	2.5	0.8 (Qtr1)			2.4 (Qtr2)			Not yet available		
Still Births per 1000 Births	<3	5.6	2.8	9.1	4.9	2.6	5.2	2.4	7.1	0.0	2.7	9.8	10.2	2.6
Neonatal Deaths (KPI 72) per 1000 Births	<3	5.6	0.0	3.0	2.5	2.6	0.0	0.0	0.0	2.6	0.0	0.0	0.0	13.2
Continuity of Care Bookings- % of total bookings made (Target increases monthly by 1.5% towards a 51% target in Mar 22)	43.7%	29.7%	27.7%	34.3%	40.1%	35.2%	35.0%	33.8%	30.1%	30.6%	27.2%	30.0%	30.0%	
Percentage of all births which were by Emergency C-Sections (KP25+26)	15%	10.1%	12.8%	13.4%	13.8%	12.1%	14.3%	12.8%	10.9%	13.6%	15.5%	13.4%	15.8%	15.5%
% women booked by 12 weeks and 6 days	90%	85.6%	81.3%	82.6%	83.3%	83.8%	81.5%	80.8%	83.0%	96.0%	95.0%	98.8%	100.0%	98.4%

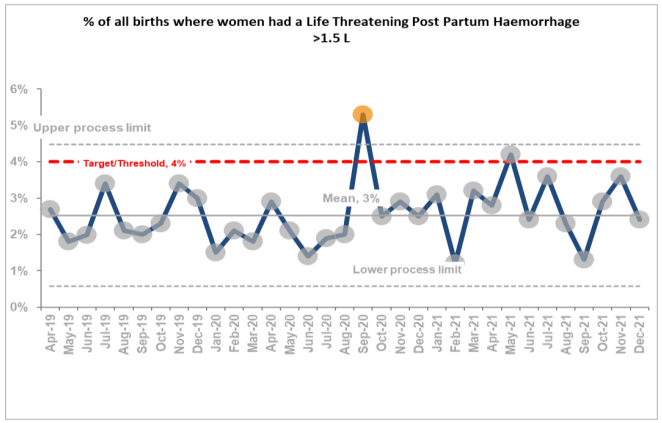
Maternity

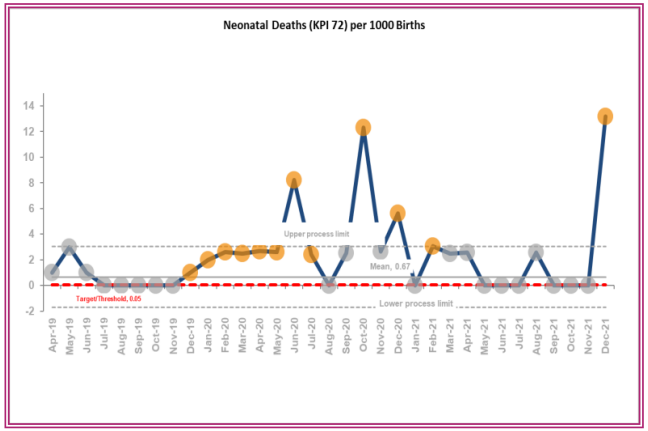
- Common cause variation
- Special cause variation – improving performance
- Special cause variation – deteriorating performance
- Special cause improvement 6-point ascending/descending run
- Special cause concern 6-point ascending/descending run

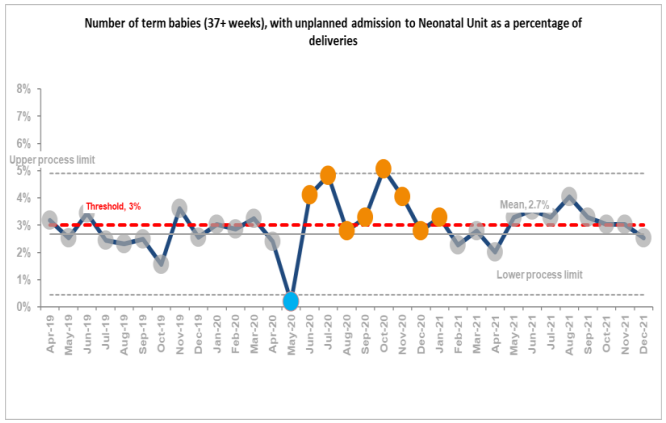












Friends & Family Survey

Indicator Description	Target	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Emergency Department FFT - % positive responses	90%	84.9%	92.1%	90.8%	88.8%	86.4%	83.4%	79.8%	81.6%	78.0%	73.6%	71.3%	75.5%	77.4%
Inpatient FFT - % positive responses	95%	97.9%	99.0%	98.3%	99.3%	98.2%	97.1%	97.5%	97.2%	98.4%	97.9%	98.9%	98.3%	96.0%
Maternity FFT - Antenatal - % positive responses	90%	N/A	N/A	N/A	50.0%	N/A	N/A	N/A	100.0%	50.0%	N/A	N/A	N/A	100.0%
Maternity FFT - Delivery - % positive responses	90%	100.0%	90.4%	93.0%	91.6%	88.9%	100.0%	90.0%	100.0%	N/A	100.0%	84.0%	86.8%	87.9%
Maternity FFT - Postnatal Ward - % positive responses	90%	100.0%	N/A	N/A	81.8%	100.0%	95.8%	91.9%	100.0%	0.0%	N/A	94.4%	100.0%	90.5%
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%	91.7%	87.5%	91.7%	100.0%	100.0%	92.9%	89.5%	94.1%	94.4%
Outpatient FFT - % positive responses	90%	90.3%	96.9%	90.4%	95.2%	88.7%	91.3%	90.7%	91.0%	89.8%	90.2%	90.3%	91.7%	91.9%

What the information tells us

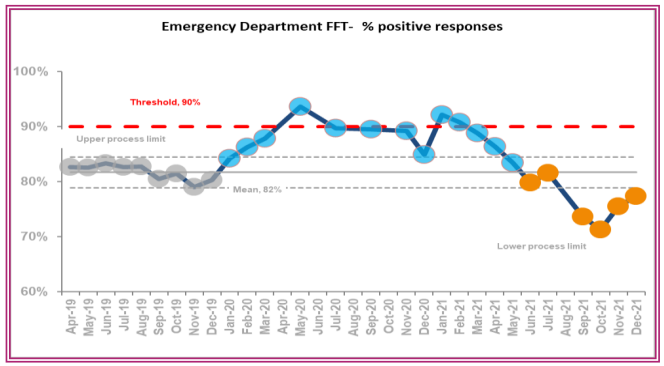
- Inpatient, Maternity (Postnatal Ward), Community and Outpatient services achieved FFT targets where patients rated the services as "Good" or "Very Good".
- Performance for Emergency Department and Maternity Delivery saw an increase in performance at 77.4% and 87.9% respectively this month though the services show special cause variation with a deteriorating position.

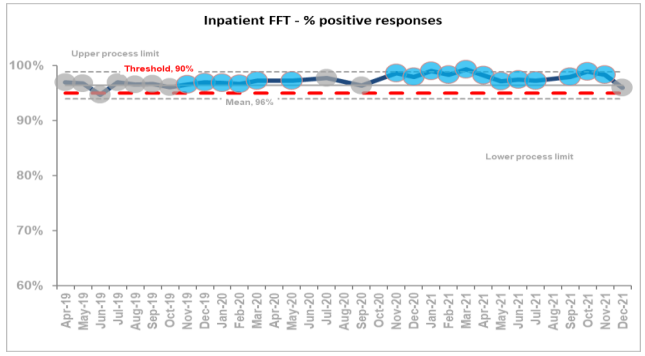
Actions and Quality Improvement Projects

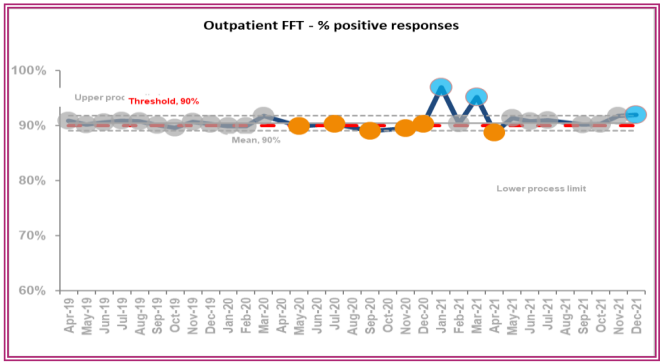
For the Emergency Department, the service moved from an external provider to the Trust's FFT collection system in January 2021, since then there has continued to be a reduction in reported response rate. The data accuracy has been confirmed and the process checked to ensure that reminder texts are being sent and received. The FFT positive responses continue to be impacted by the current operational pressures in the department and increased waiting times. Action being taken to improve the response rate is to utilise the volunteers and the current military deployment to assist patients with completion of FFT. In addition, additional electronic handheld devices have been made available for patients to complete the questions whilst in the department.

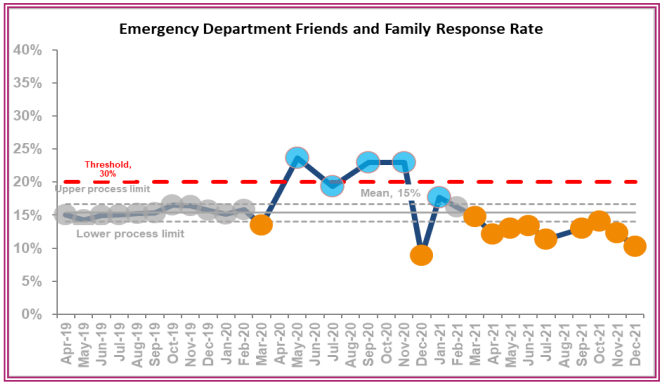
Midwifery Services in December were again busy with a number of high risk deliveries and staffing challenges which may have influenced waiting times and bed allocation, although there were no reported delays in pain relief. The team have revised the current questions set for relaunch in February 2022.

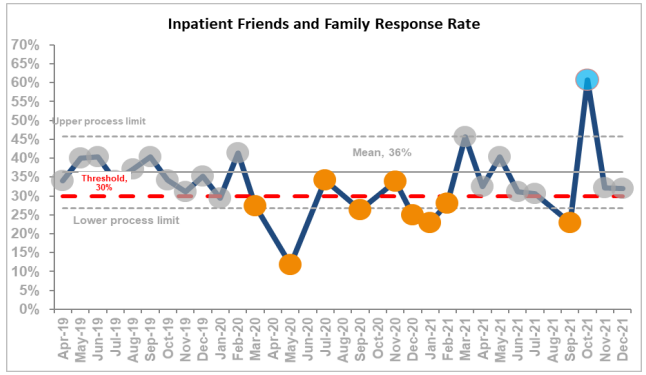
Friends and Family Test

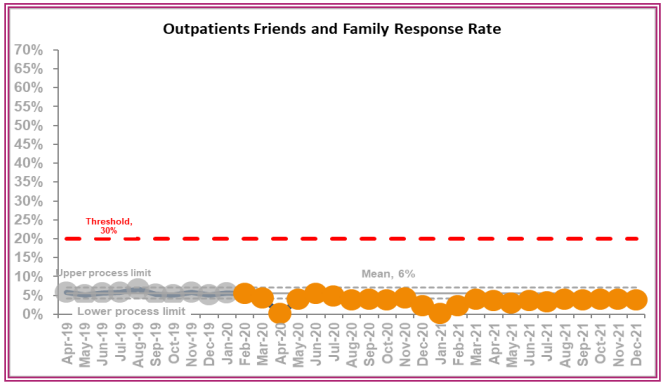








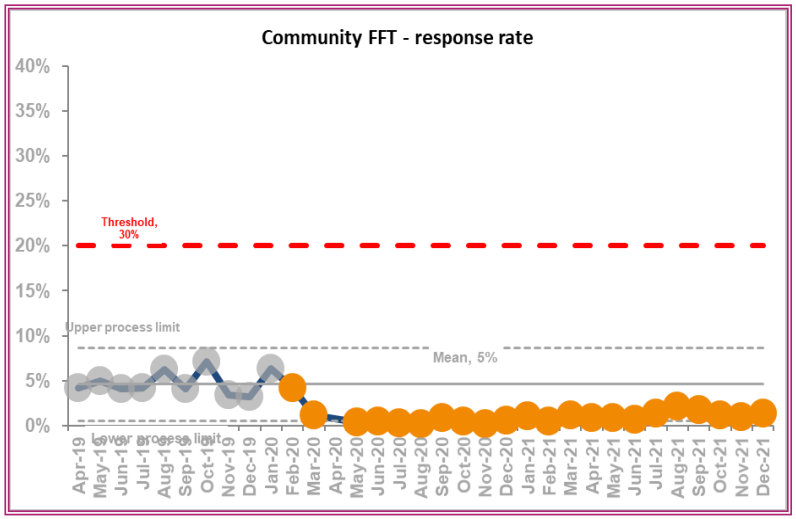


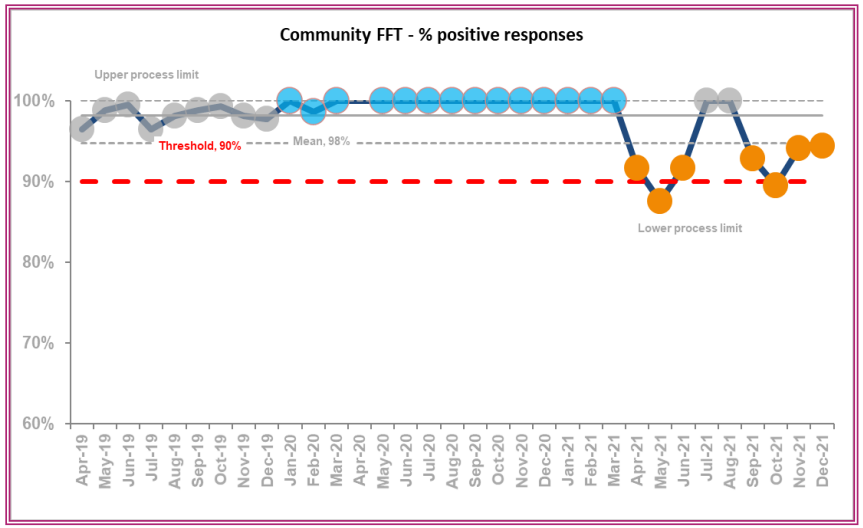


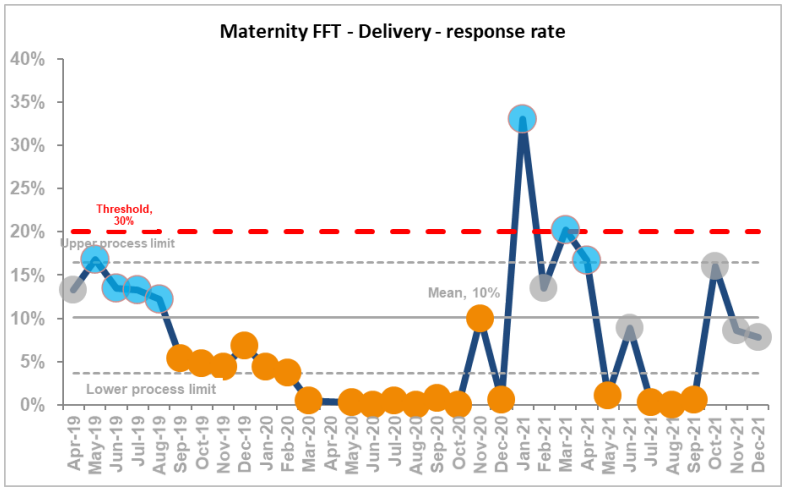
- Common cause variation
- Special cause variation – improving performance
- Special cause variation – deteriorating performance
- Special cause improvement 6-point ascending/descending run
- Special cause concern 6-point ascending/descending run

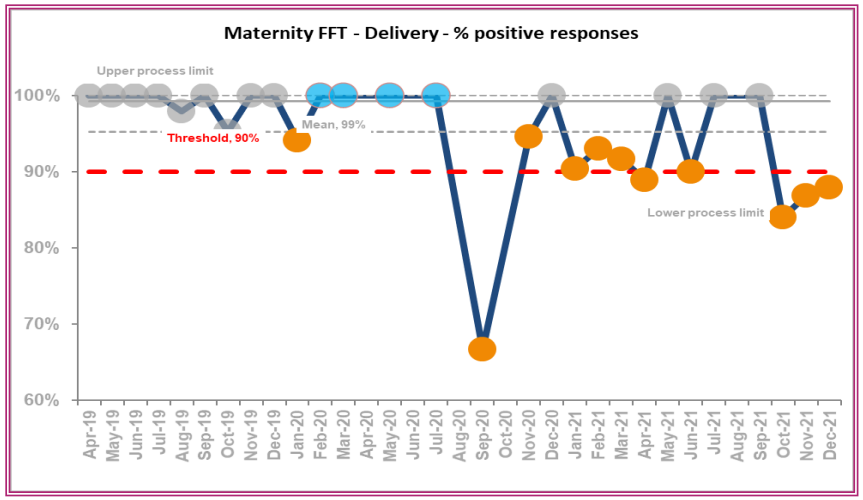
Our Patient Perspective

Friends and Family Test





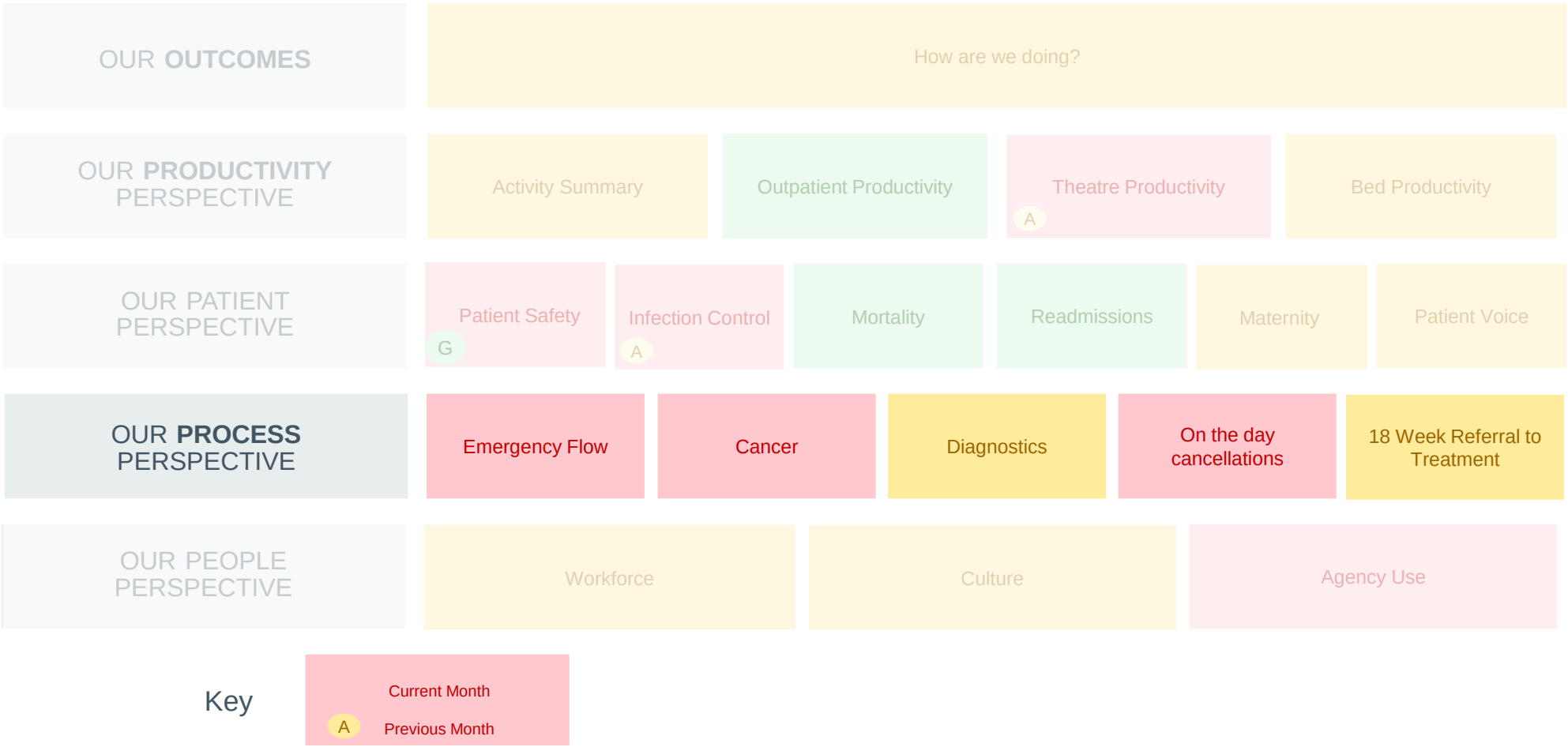




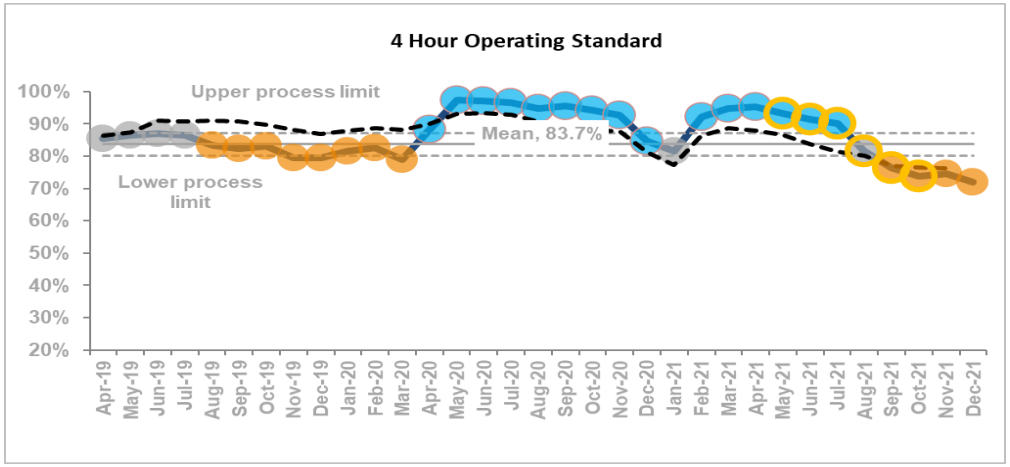
Common cause variation
Special cause variation – improving performance
Special cause variation – deteriorating performance
Special cause improvement 6-point ascending/descending run
Special cause concern 6-point ascending/descending run

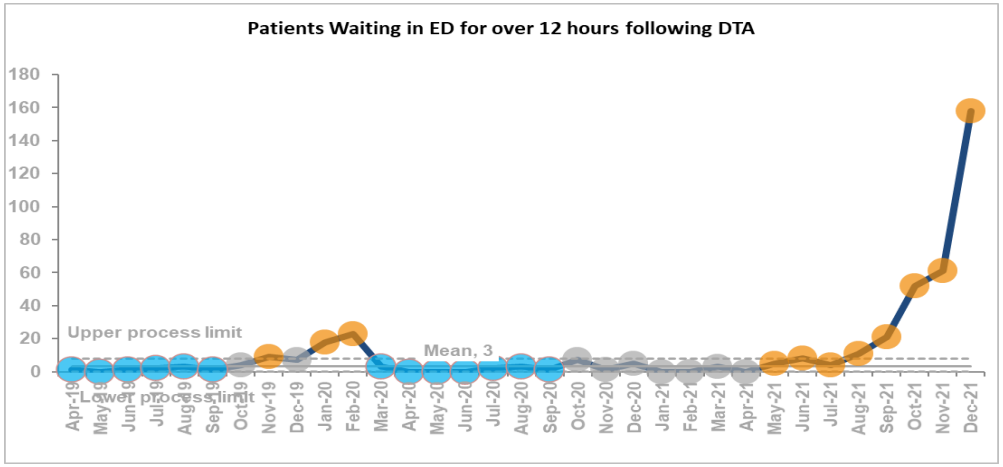
Our Patient Perspective

Balanced Scorecard Approach



Emergency Flow





What the information tells us

Performance against the Four-Hour Operating Standard has shown a steady decline with the past four months performing below the lower control limit. Performance throughout December reported that 72.1% of patients attending the Emergency Department (ED) were either discharged, admitted or transferred within 4 hours of their arrival, similar performance is seen across London. Attendance numbers through the month averaged 367 patients per day with on average 88 daily ambulance arrivals showing a decrease compared to the previous month.

The acuity of the patients requiring treatment remains high with 49% of patients with a Manchester Triage Score of between 1 and 3 whereas pre-COVID, 41% of patients had acuity scores 1-3. The proportion of admissions increased compared to November with 29% of patients attending requiring admission. AMU midday occupancy continues to show high capacity and the number of patients staying more than 7, 14 and 21 days, although decreased remains above the mean of 2019 - this impacts the admitted pathway performance and creates front end capacity issues where the number of patients awaiting admission has been high throughout the month.

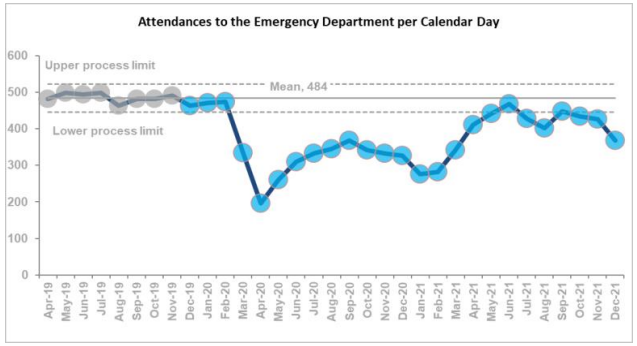
In December, 158 patients breached the 12-hour ED target where no patient should wait longer than 12 hours before they are admitted to a ward; this is a significant increase whilst also seeing an increase in the number of patients waiting for more than 30 minutes for ambulance handover.

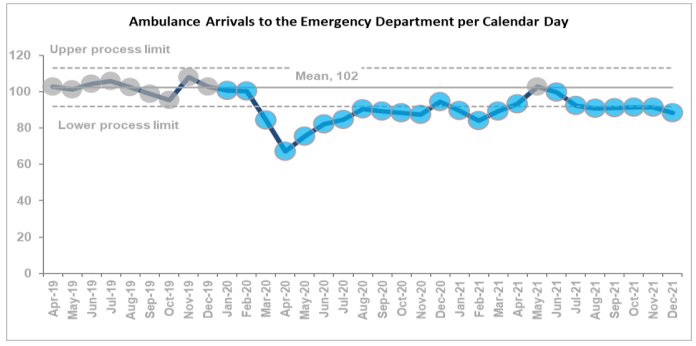
- Common Cause
- Special Cause Improvement
- Special Cause Concern
- Special cause concern 6-point ascending/descending run
- Special cause improvement 6-point ascending/descending run

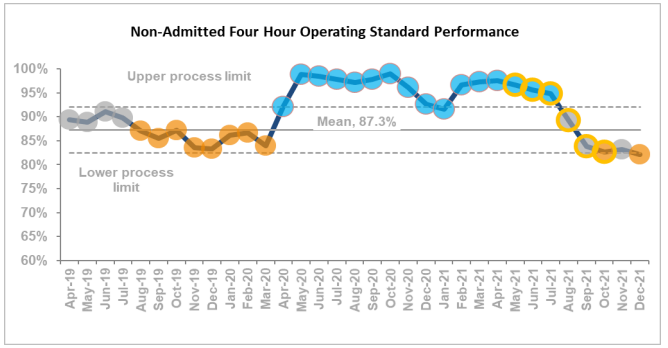
Actions and Quality Improvement Projects

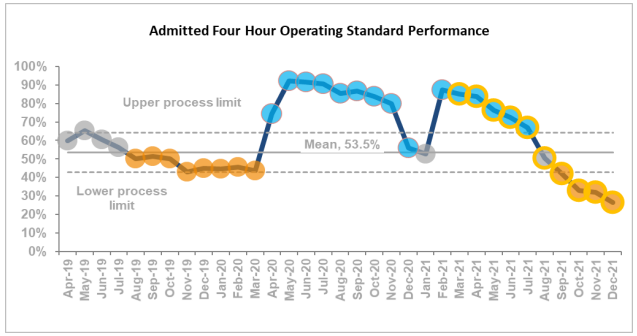
- In-Hours GP service has increased the productivity of the GP provision and the consistency of session availability.
- 15 medical students have been employed to work as medical assistants to help cover the sickness and isolation gaps
- 4 RAF medics and 8 technicians are temporarily supporting the department
- The ED Winter Capacity Plan has been implemented within the department; this has involved repurposing a number of spaces to support cohorting of Decision To Admits (DTAs) and has the result of increasing trolley space by 4 and 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.
- New Assistant General Manager role introduced to wok on patient flow across the emergency floor

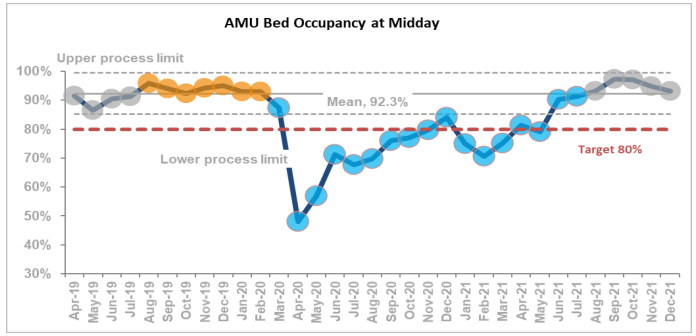
Emergency Flow

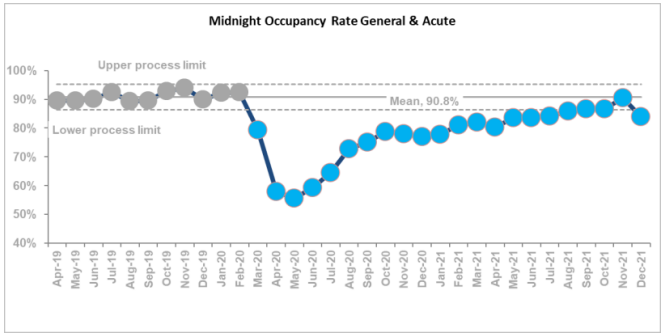


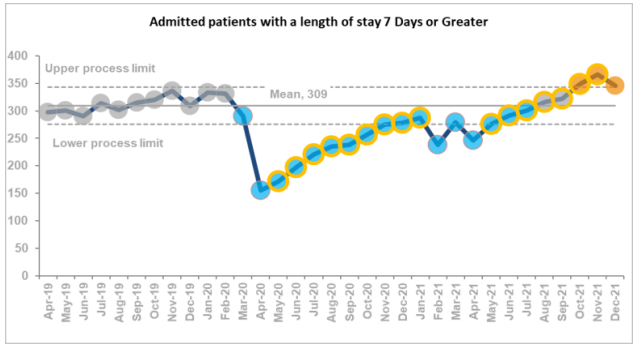


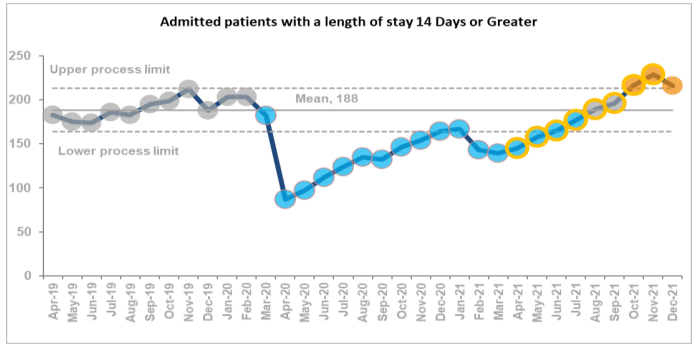


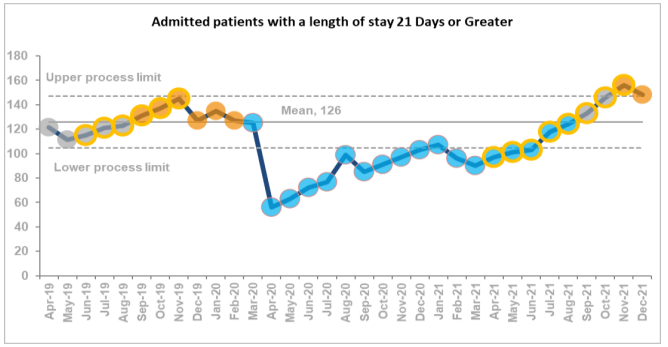






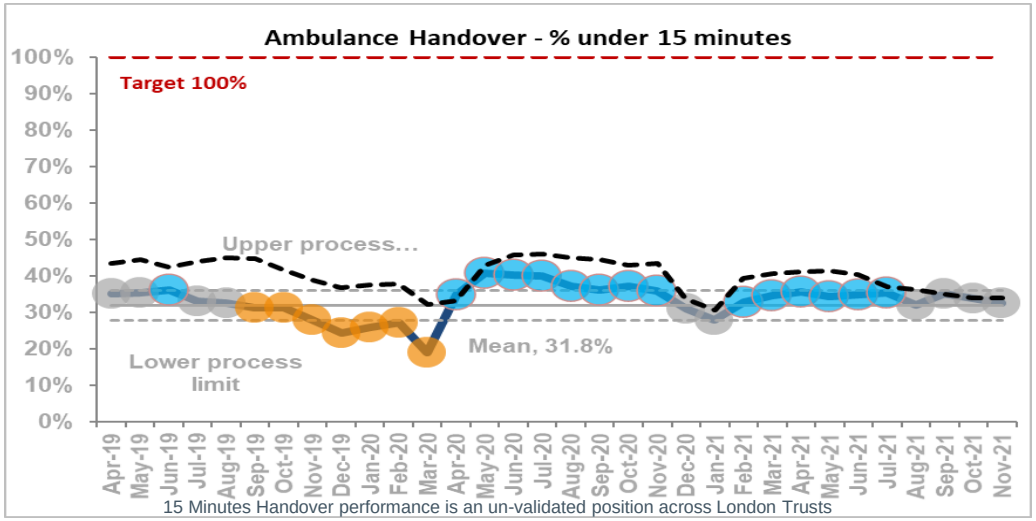




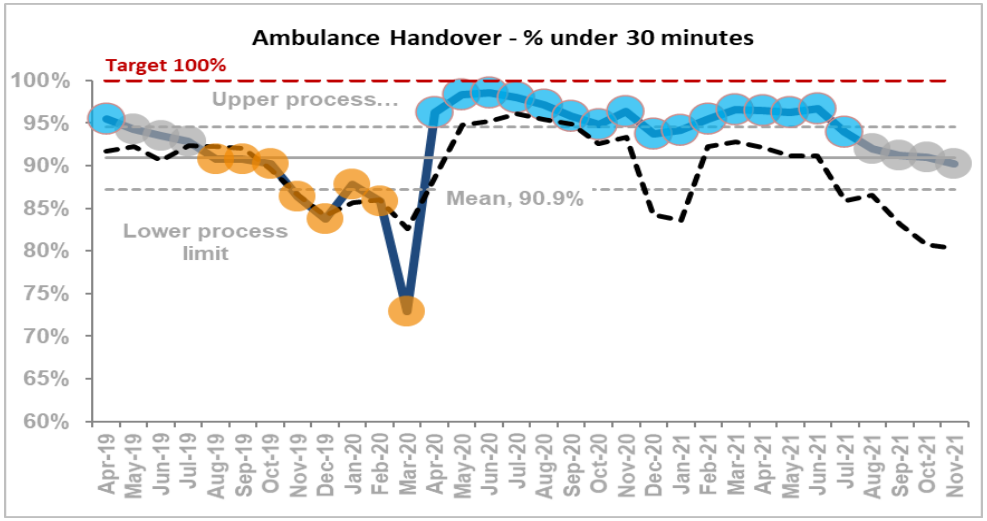


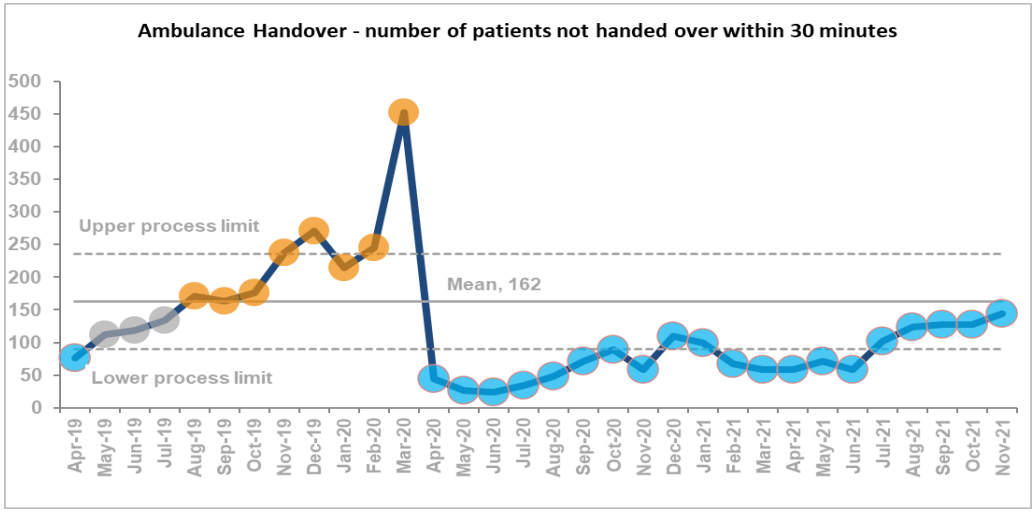
Our Process Perspective

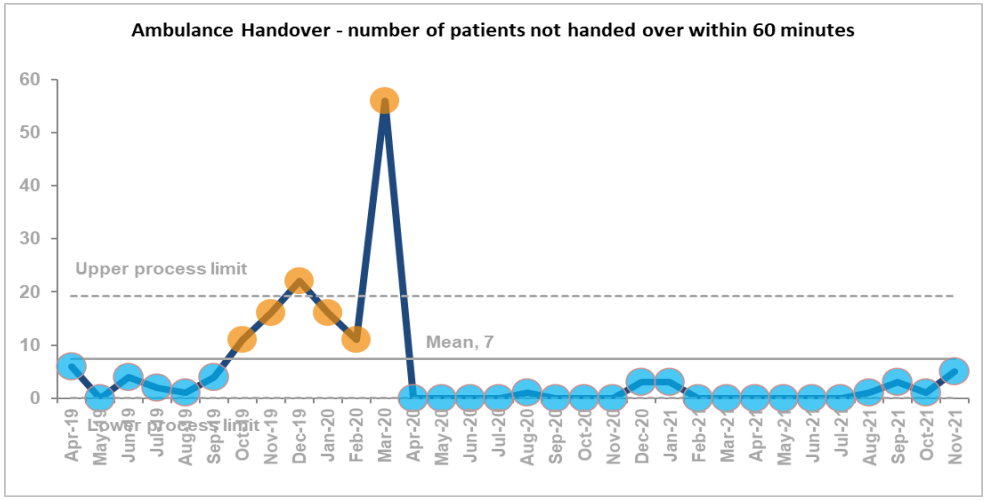
Emergency Flow



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



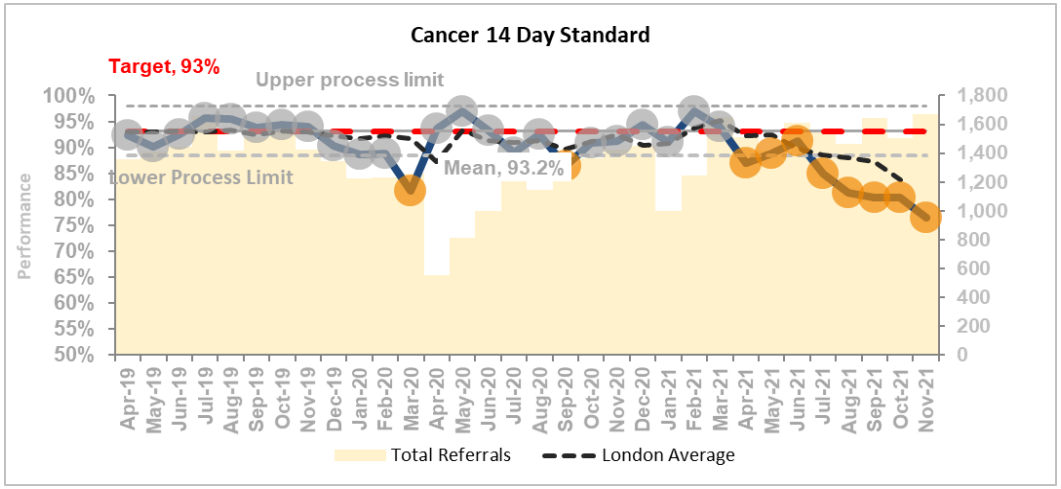


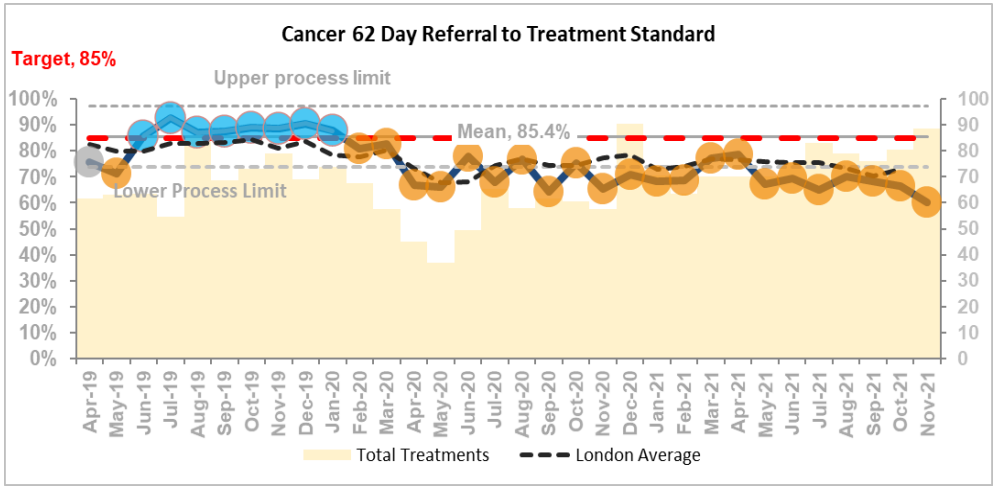


Ambulance handover data is one month in arrears

Our Process Perspective

Cancer





What the information tells us

Cancer performance in the month of November remained challenged achieving only the Cancer 31 Day Second or subsequent Treatment (Drug) standard.

In November, the Trust received 1,671 Two-Week-Rule (TWR) referrals, an increase of 11% compared to the previous month, referral numbers remain above the mean of 2019. Performance has fallen further below the lower control limit with 76.4% of referred patients seen within 14 days; the target is 93%. Five tumour groups were not compliant including Breast , Gynaecology, Head & Neck , Lung and Skin.

Performance against the 31-day treatment standard achieved 91.8% against a target of 96%. There were 220 treatments in month, compared to 188 in October.

There were 86.5 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. In November, 60.1% of patients received treatments within 62 days of referral against the national target of 85%, a decrease compared to the previous month. There were 34.5 breaches of the 62 Day standard, attributed to radiology, pathology, clinical complexity, patient choice and late inter-trust transfers affecting H&N and urology. All tumour groups were non-compliant. At the end of November, there were 159 patients on the 63 day plus patient tracking list, against a trajectory of 160 of which 46 were waiting for more than 104 days, this is an improvement compared to the previous month

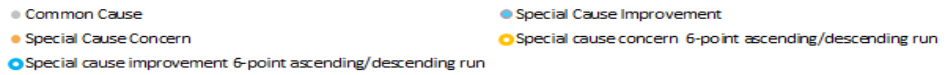
Actions and Quality Improvement Projects

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. There is a recovery plan in place and a portion of referrals are on divert to SWL providers.

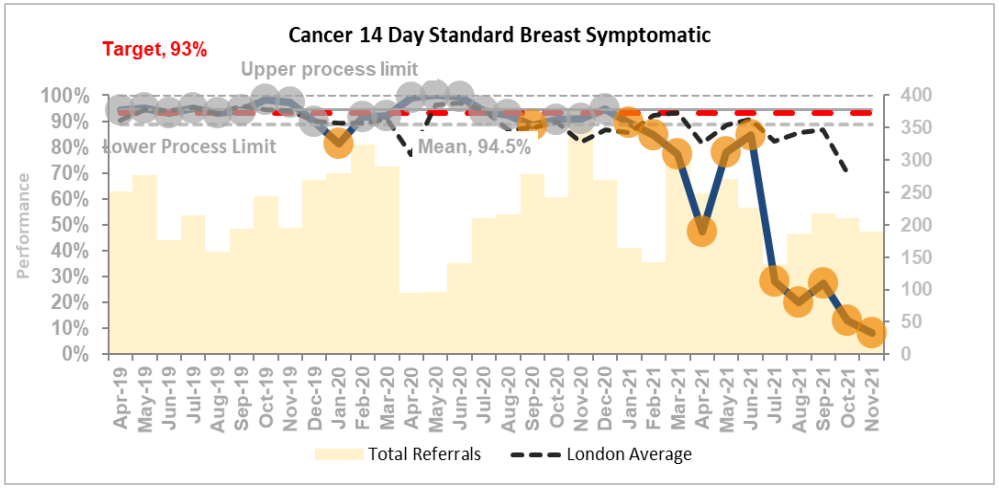
63+ Days

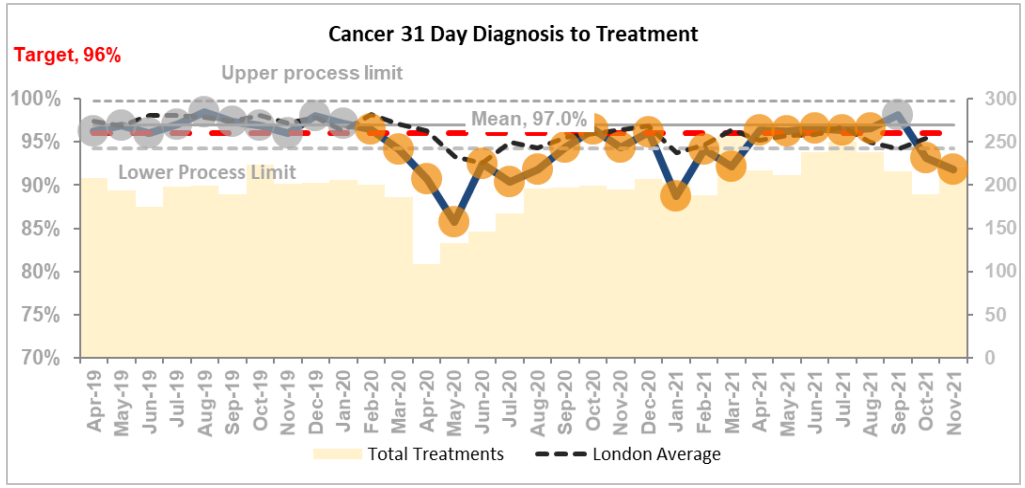
- The Trust has agreed a trajectory to have no more than 160 patients over day 62 on the PTL by the end of March 2022. This Trajectory was met in November.
- The number of patients over 63 days increased through December; the increase in this cohort is driven by challenges in radiology affecting CTC and GI services, Breast and Skin due to front end challenges, Covid and patient choice. There is also some patient choice, complex pathways and later inter trust transfers affecting H&N and Urology.

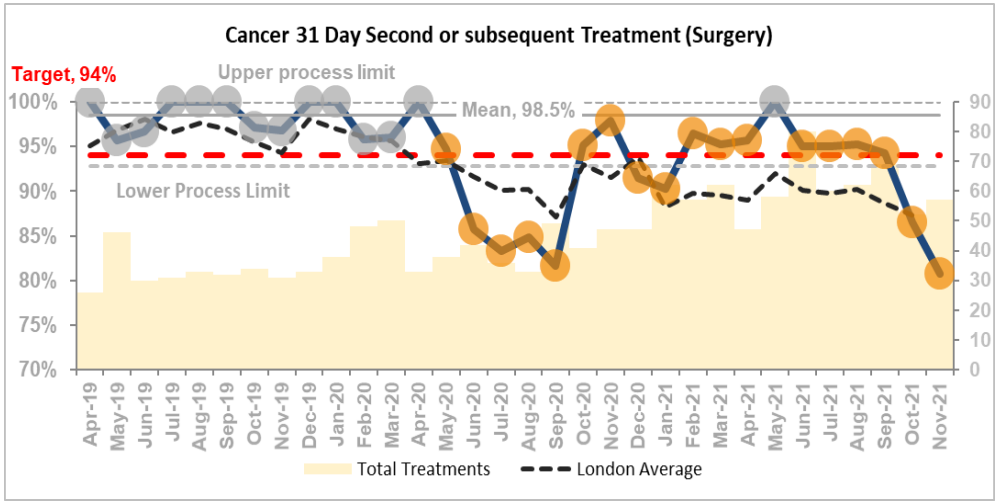


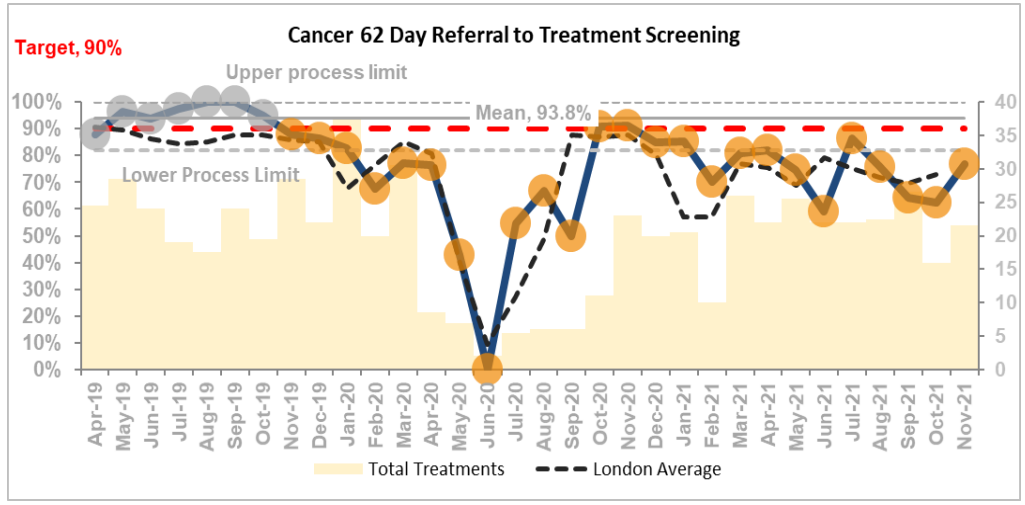
Our Process Perspective

Cancer









Our Process Perspective

Cancer

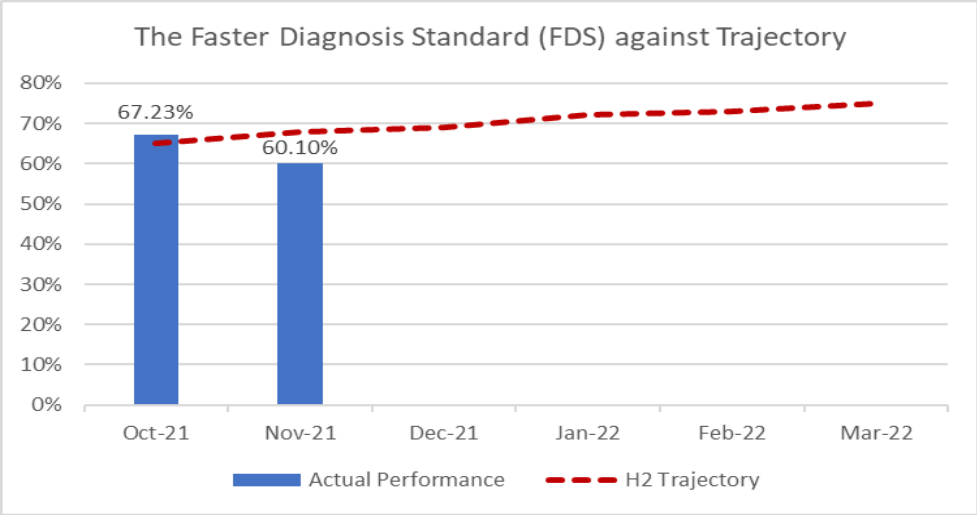
14 Day Standard Performance by Tumour Site - Target 93%

Tumour Site	Target	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	No of Patients
Brain	93%	-	-	-	-	-	-	-	-	-	-	-	-	-	
Breast	93%	91.6%	95.0%	86.6%	92.5%	82.9%	54.5%	78.7%	86.1%	26.9%	17.5%	30.1%	14.5%	10.3%	331
Children's	93%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	50.0%	50.0%	90.0%	100.0%	2
Gynaecology	93%	94.3%	91.6%	79.3%	94.9%	94.9%	87.2%	92.6%	91.7%	95.0%	94.5%	85.4%	88.7%	88.1%	126
Haematology	93%	96.2%	96.2%	95.5%	100.0%	90.0%	96.4%	100.0%	95.5%	79.3%	90.9%	100.0%	100.0%	95.8%	24
Head & Neck	93%	96.0%	98.8%	91.6%	96.4%	94.6%	95.7%	96.9%	93.4%	95.5%	88.1%	92.4%	93.8%	91.9%	160
Lower Gastrointestinal	93%	76.4%	92.2%	99.3%	98.6%	98.2%	95.9%	67.6%	82.2%	96.7%	95.7%	98.3%	98.3%	99.6%	245
Lung	93%	94.4%	76.5%	90.0%	100.0%	94.4%	91.9%	97.5%	93.9%	74.3%	68.2%	82.6%	85.7%	74.3%	35
Skin	93%	95.1%	93.0%	90.7%	98.7%	98.0%	93.6%	97.5%	94.5%	91.4%	94.8%	91.0%	93.7%	90.4%	479
Upper Gastrointestinal	93%	90.6%	98.0%	95.3%	100.0%	95.4%	98.1%	96.9%	97.4%	96.6%	97.2%	95.2%	96.8%	96.6%	116
Urology (Suspected testicular cancer)	93%	93.3%	98.2%	95.3%	98.9%	97.1%	89.6%	97.0%	98.3%	98.1%	88.6%	86.6%	94.4%	94.7%	153

62 Day Standard Performance by Tumour Site - Target 85%

Tumour Site	Target	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	No of Treatments
Brain	85%	-	-	-	-	100.0%	-	-	-	-	-	-	-	-	
Breast	85%	84.6%	84.6%	75.0%	62.5%	100.0%	91.7%	78.6%	80.0%	83.3%	66.7%	81.3%	66.7%	54.5%	11.0
Children's	85%	-	-	-	-	-	-	-	-	-	-	-	-	-	0
Gynaecology	85%	100.0%	0.0%	50.0%	-	50.0%	75.0%	40.0%	60.0%	50.0%	100.0%	66.7%	40.0%	55.6%	4.5
Haematology	85%	77.8%	87.5%	100.0%	88.9%	100.0%	100.0%	66.7%	50.0%	80.0%	80.0%	100.0%	50.0%	42.9%	7.0
Head & Neck	85%	61.5%	57.1%	52.9%	57.9%	83.3%	90.9%	46.7%	70.6%	50.0%	86.7%	58.3%	36.4%	56.5%	11.5
Lower Gastrointestinal	85%	42.9%	38.5%	60.0%	33.3%	33.3%	75.0%	46.2%	66.7%	18.2%	61.5%	70.6%	75.0%	75.0%	4
Lung	85%	33.3%	100.0%	50.0%	73.3%	100.0%	90.9%	100.0%	62.5%	25.0%	100.0%	66.7%	70.6%	70.0%	5
Skin	85%	50.0%	81.5%	87.1%	88.9%	92.6%	78.8%	87.9%	78.8%	76.5%	74.1%	89.5%	72.7%	77.5%	20
Upper Gastrointestinal	85%	100.0%	53.8%	50.0%	71.4%	33.3%	60.0%	-	100.0%	100.0%	25.0%	0.0%	50.0%	0.0%	2.5
Urology	85%	57.1%	78.4%	57.6%	73.3%	70.8%	56.5%	45.8%	47.8%	69.2%	55.6%	58.1%	81.3%	54.1%	18.5
Other	85%	100.0%	-	-	57.1%	100.0%	100.0%	-	100.0%	50.0%	100.0%	100.0%	100.0%	66.7%	1.5

Cancer – Faster Diagnosis Standard (FDS)



What the information tells us

The Faster Diagnosis Standard (FDS) is a new performance standard being introduced to ensure patients who are referred for suspected cancer have a timely diagnosis.

Rapid Diagnostic Centre (RDC) pathways and the Faster Diagnostic Standard (FDS) are designed to speed up cancer diagnosis and improve patient experience. They will also provide a mechanism to monitor and support the NHS Long Term Plan ambitions. Rapid Diagnostic Centre pathways ensures everyone with suspected cancer gets the right tests at the right time in as few visits as possible.

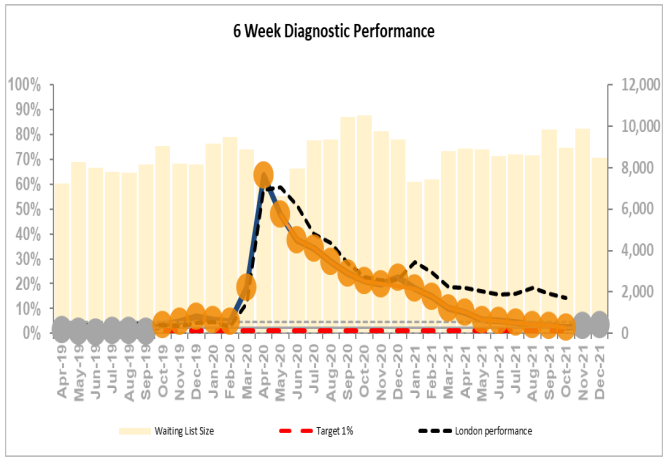
The 28-Day FDS data was published from April 2021 in a shadowing format. Systems will be expected to meet the new FDS (for all routes urgent suspected cancer, urgent breast symptomatic, and urgent screening referrals in aggregate) from Q3 2021/22, to be introduced initially at a level of 75%. The Trust has agreed an initial trajectory of 65% increasing to 75% by March 2022.

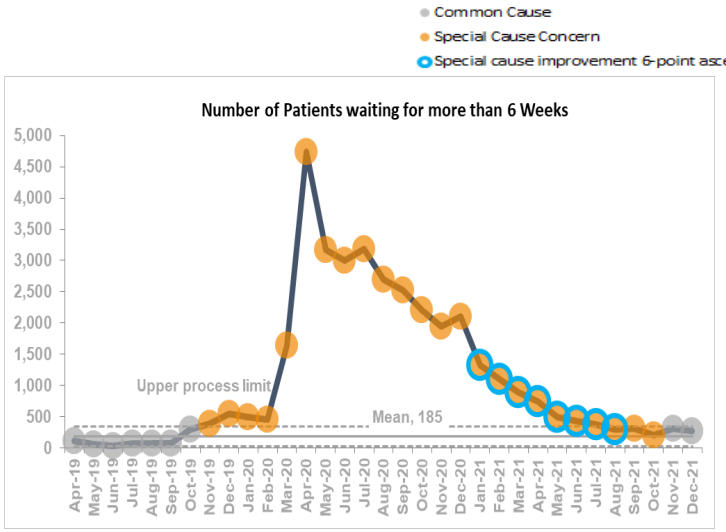
In November 60.1% of patient's received a communication of diagnosis for cancer or a ruling out of cancer, or a decision to treat if made before a communication of diagnosis within 28 days following referral. Performance was below the trajectory of 67.9%.

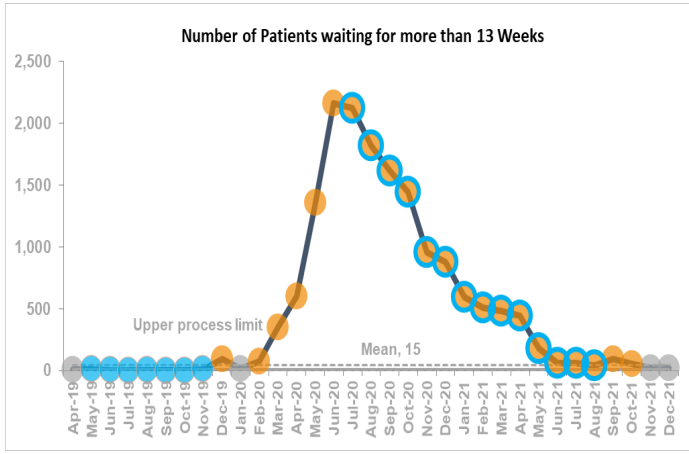
Actions and Quality Improvement Projects

- **Breast and GI services** – continues to be the lowest performers, the trust will not return to compliance in the view of the current Breast challenges which is being managed as part of the Breast Recovery Plan.
- **Clear communication** and management of patients awaiting an FDS communication with benign results awaiting a FU or clinic letter is under way via weekly PTL assurance meetings and Access Committee. **This has seen a reduction from > 1000 to 600 patients**. Further work is planned with services to reduce this to support FDS clock stop completion.
- **Live Data** – All services and Operations managers receive a daily FDS Tableau report with real time data on FDS performance, and tools to forward plan FDS completion
- **Daily validation** and data quality checks are completed by the cancer data team to ensure accurate data is recorded and uploaded to Cancer wait times
- **FDS champion** – A Band 8a post is under recruitment with the aim to drive changes and pathway design to support FDS
- **Clinical engagement** is under way to improve clinic letters to support FDS completion

Diagnostics







What the information tells us

At the end of December, there was a reduction of 9% (28 patients) in the number of patients waiting for more than six weeks on the Diagnostic Patient Tracking List compared to the previous month. Performance showed that in total 3.3% of patients were waiting beyond six weeks for their procedure with a decrease in the overall waiting list size. Performance remains better then the London average.

In total, 278 patients were waiting for more than six weeks with continuing capacity and staffing challenges within Cardiac MRI and Echo, both modalities seeing an increase in long waiters through December. Gynae Ultrasound who had reported a spike in six week breaches in November, mainly due to staffing issues, have reduced breaches by 75% enabling the Trust to maintain performance overall, further additional capacity is needed through January to return to compliance.

The Trust continues to see a reduction in the number of patients waiting over thirteen weeks. At the end of December there were 20 patients reported within this cohort, the majority within Cardiac MRI, all patients have been booked.

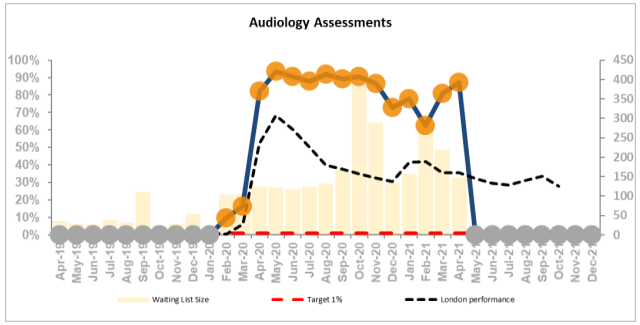
Activity levels reduced across the majorities of modalities throughout December, whilst continuing to prioritise long waiting patients, there is an increase in the number of patients waiting between four and five weeks, particularly within Radiology services, this was anticipated and capacity allows for performance to be maintained though January.

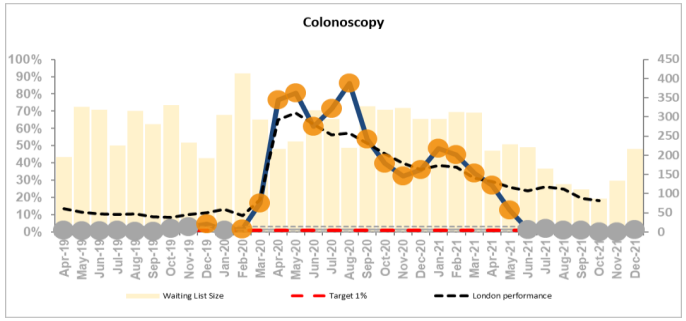
Actions and Quality Improvement Projects

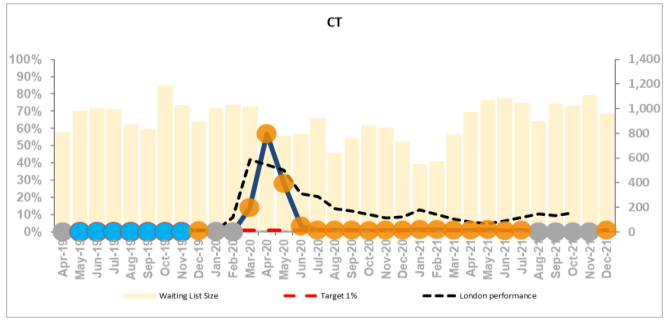
- Weekly performance meetings continue with particular focus on patients waiting for more than ten weeks. Divisional Director of Operations (DDO) support where areas are challenged.
- Echocardiography - staffing shortages have continued due to high sickness levels and annual leave resulting in cancelled lists. Capacity remains challenged however additional weekday list available through January after successful recruitment. This will help reduce long waiters however impact may not be seen until February. Many of the patients waiting for more than six weeks are within Stress Echo where a specialist skill set is required with two operators – additional internal staff being trained with a weekend list added this month however more capacity needed to improve and maintain better performance.
- Cardiac MRI - Additional capacity throughout January has been fully booked into. Awaiting confirmation of further capacity in February using mobile van with the aim of bringing forward the longest waiting patients once capacity opens
- Gynaecological Ultrasound - Increasing capacity with additional clinics using bank and agency staff.. Furthermore, recruiting 1.2 WTE Sonographers to substantively increase capacity
- Neurophysiology - Due to consultant retirement– ad hoc sessions are being relied upon through January to help minimise long waiting patients.. January resource will be limited however set to improve in February with Consultant starting

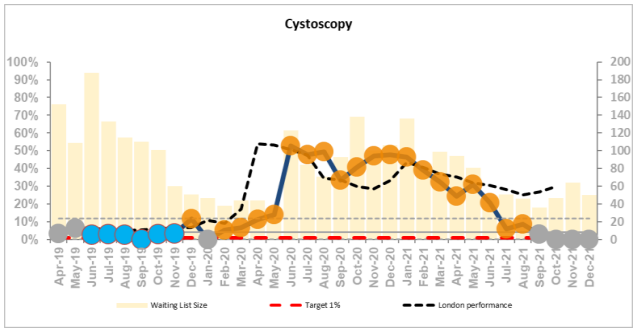
Our Process Perspective

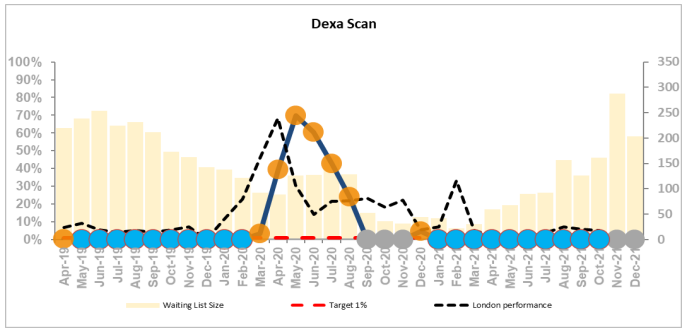
Diagnostics

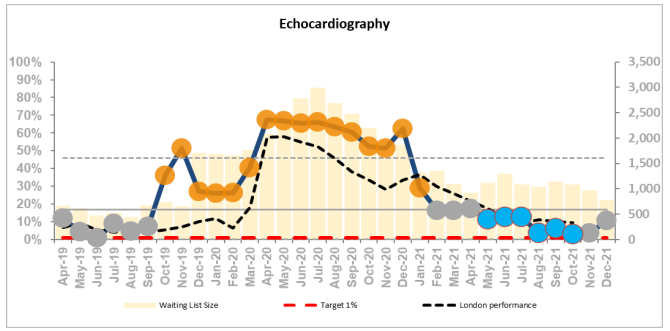


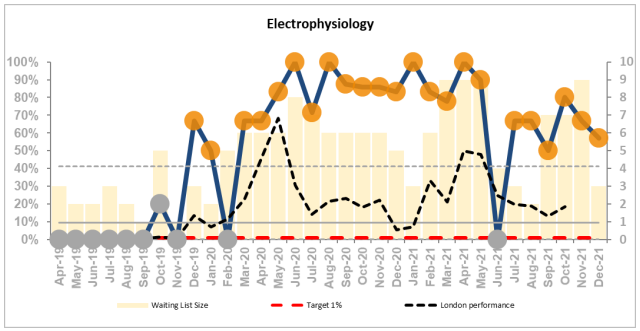


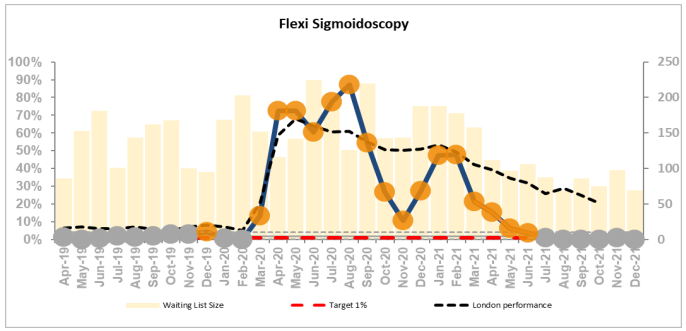


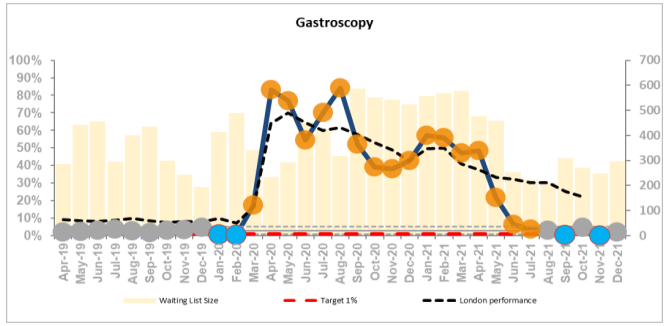






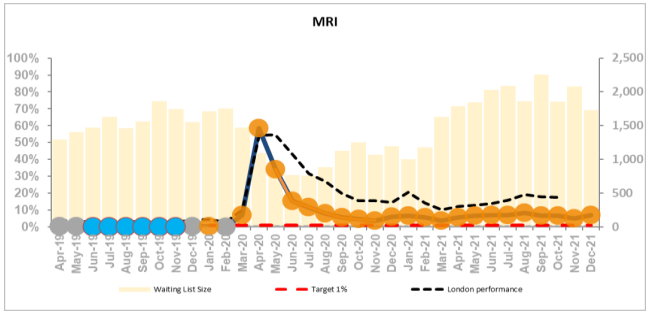


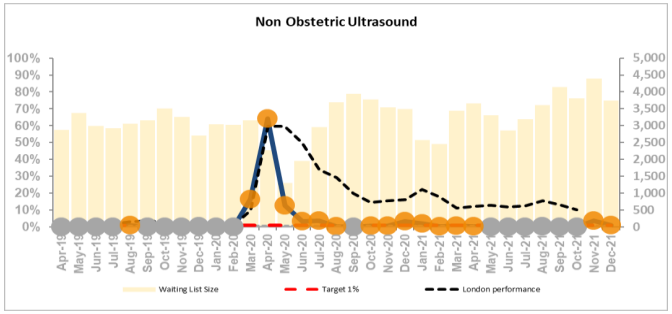


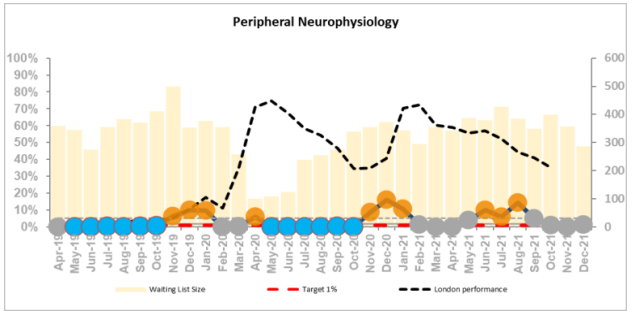


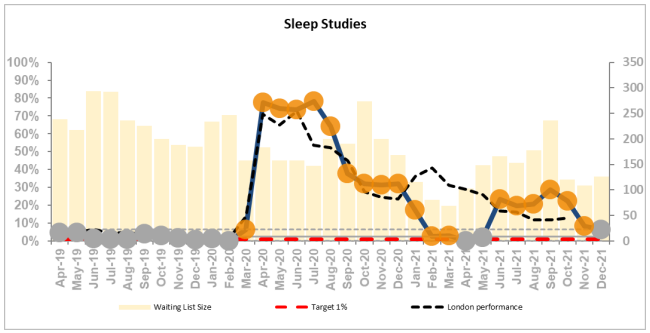
Our Process Perspective

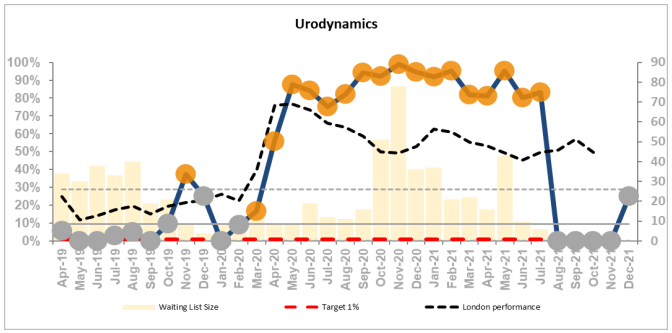
Diagnostics





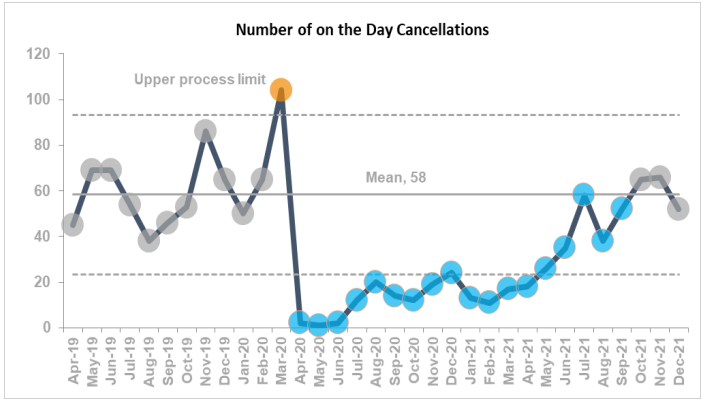


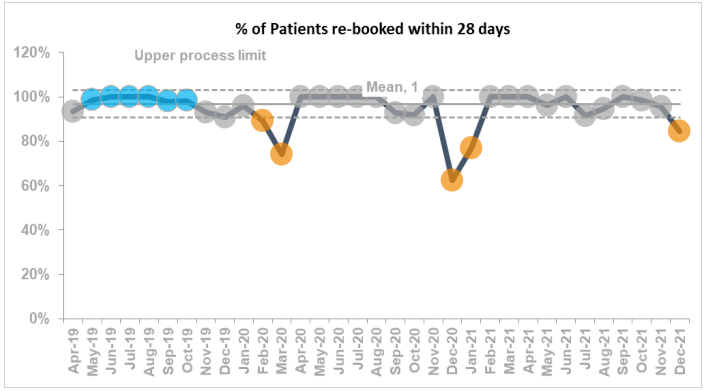


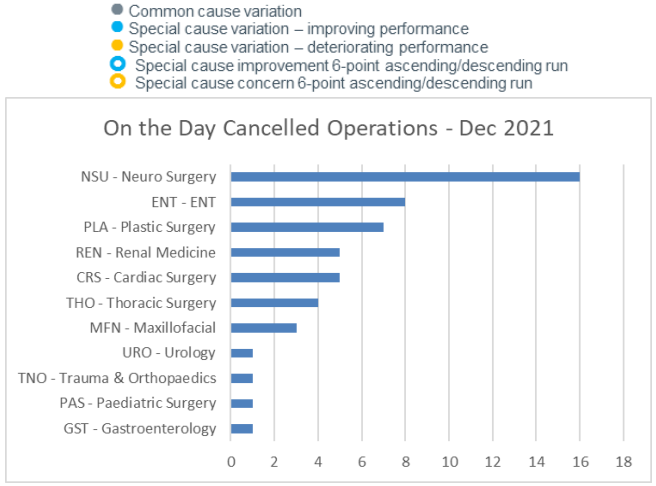


Our Process Perspective

On the Day Cancellations for Non Clinical Reasons(OTD)







What the information tells us

In December, 52 patients had their procedure cancelled on the day for non-clinical reasons, due to bed and staffing availability. Due to on-going challenges with both staffing and Covid measures, specialties have not had the available capacity to re-schedule all patients within 28 days. Eight patients therefore were not re-booked within the required time frame meaning that 85% of patients were re-booked however the target is100%.

Neurosurgery continues to be impacted by on-the-day cancellations with, again, the largest proportion of on-the-day cancellations in the month; in total16 patients were cancelled with critical care bed availability being the main contributor as well as staffing availability.

Cancellation reasons for the month are broken down as follows:

- Bed Availability – 18
- Staffing Availability – 11
- Timing - Emergency case took priority – 7
- Timing - List over booked - 7
- Timing - List Cancelled - 3
- Equipment/Theatre - Equipment Issues – 2
- Timing - Complication - previous case/-s – 2
- Other – 2

Actions and Quality Improvement Projects

The main challenge remains flow and bed capacity. A number of interventions were launched in October to improve flow and reduce *avoidable* On the day cancellations which have had a positive impact, namely:

- New Daily meetings (taking place at 9.30am, 1pm and 3.30pm) between key staff, to improve the early identification of issues and communication around the early resolution of flow challenges.
- Launch of a Recovery Flow dashboard to improve 'live' visibility of the status of all Tooting site recovery areas, track the reasons for recovery blockages and delays and provide a guide to staff around when and how to escalate.
- Regular project meetings to discuss Recovery flow.

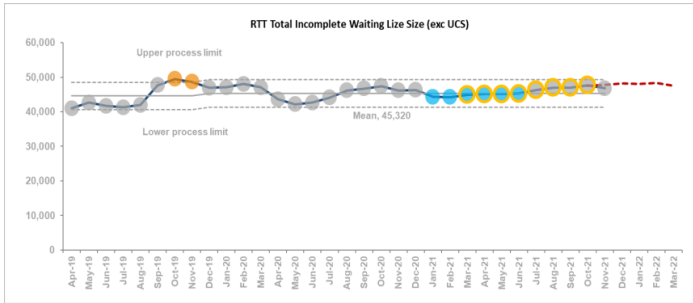
Following a review of the data after three months, the initial signs are encouraging:

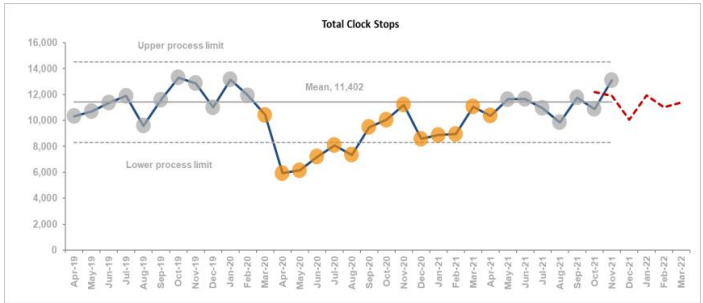
- The time elapsed between patients in General beds being 'ready to leave' recovery, and the patient actually leaving recovery has more than halved.
- Both PACU and SJW Recovery have seen substantial reductions in the Length of Stay for patients 'Ready to Leave' (R2L) recovery.
- Cardiac has seen a small reduction and Neuro a substantial reduction in the Length of stay for R2L patients.
- The top reasons recorded for delays in Recovery flow will come as no surprise:
  1. Lack of Green Beds.
  2. Lack of ICU Beds.
  3. Flow delayed due to patients staying overnight in recovery.

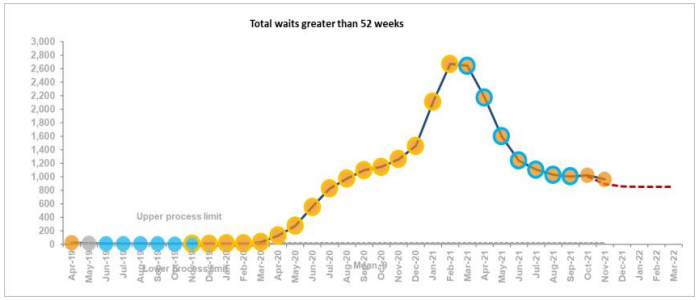
A further intervention is being launched on Monday 17th January to open up a 'Yellow' SDL Discharge pathway from SJW to DSU to improve flow in SJW Recovery, maximise SDLs and minimise failed SDLs. This is linked to both short term tactics and a longer term strategy to increase PACU capacity.

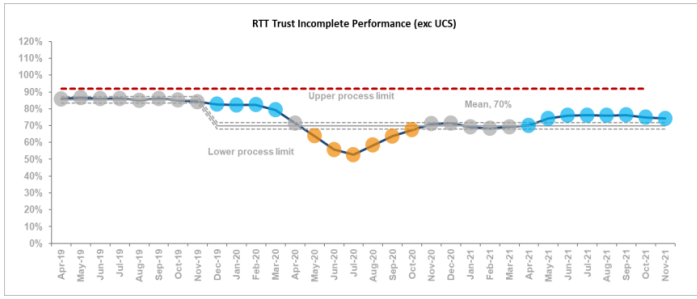
Our Process Perspective

Referral to Treatment — November 2021









Note: Unknown Clock Starts (UCS) have been excluded from the above metrics. For context the number of UCS in November was 632, an increase from 538 in October. Compared to the same month last year this is a 9% lower.

Actions and Quality Improvement Projects

- Total 104 week wait focus has continued, with 4 patients breaching this target at the end of November. We are on track to deliver zero patients waiting greater than 104 weeks by the end of January.
- The number of +78 week waits and 52 week waits has decreased steadily throughout November and we are ahead of trajectory in all services. We are committed to eliminate all 52 week waits in most specialties other than General Surgery, ENT, Plastics and Cardiology.
- Clock stop performance in November was excellent, achieving better than forecast and over 100% of 19/20 clock stop levels. This is as a result of new ways of working within the RTT team and a focus on the timely cashing up of clock stops.

Data Quality

The national minimum dataset submission marked St George's as an outlier across London in terms of data quality. After investigation the cause of the DQ issues were identified and circa 50% of the errors corrected as they were submission errors rather than true DQ issues. There has been a huge amount of hard work to correct the remaining reporting errors and we are now below the expected 15% tolerance and expect to further improve this position.

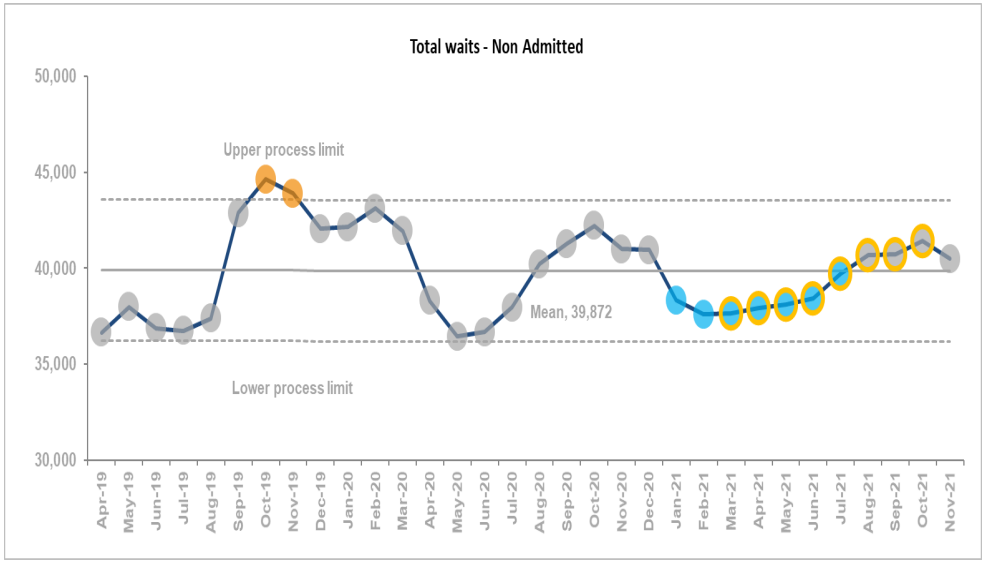
What the information tells us

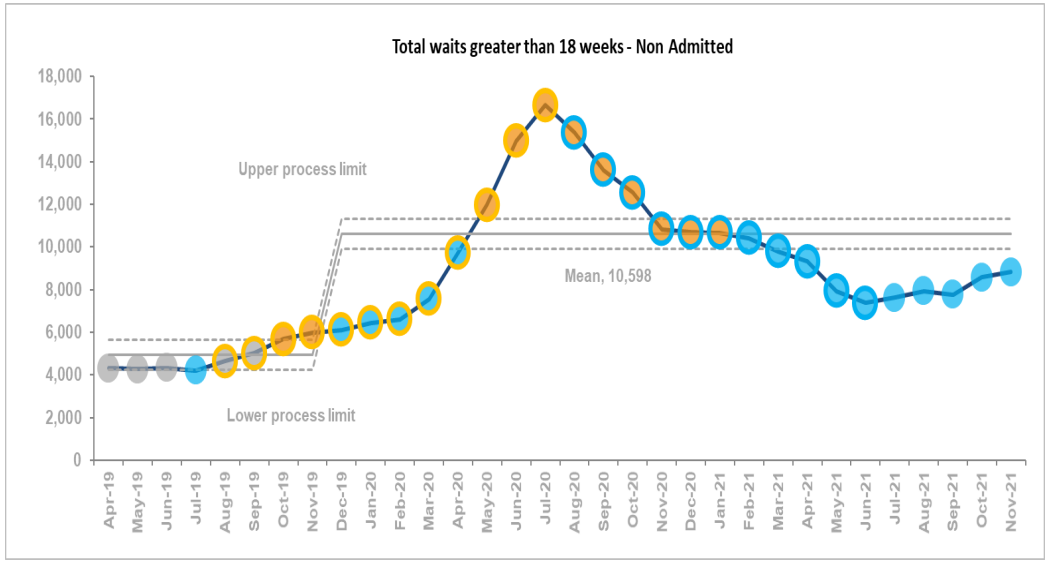
At the end of November, 46,802 patients were waiting for treatment on the Patient Tracking List (PTL), this is a decrease of 1.8% (865 patients) compared to the previous month, which is a great achievement and better than forecast and the national objectives to keep total PTL size steady at September levels. 74.5% of patients were waiting for less than 18 weeks. The PTL size continues to show a steady trend and in line with trajectory, although remains above the mean of 2019. At the end of the month, 12,070 patients were waiting for more than 18 weeks, the largest proportion of waiters within ENT and Cardiology.

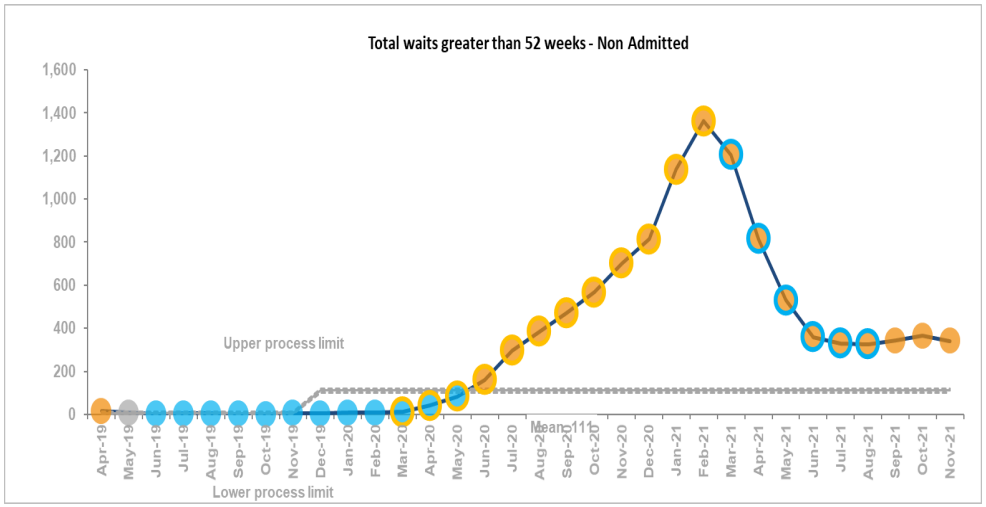
The number of patients waiting for more than 52 weeks continues to show a favourable position against our trajectory with 959 patents above 52 weeks compared to 1,023 patients in October. The number of clock stops in the month were above H2 trajectory, seeing a significant improvement. This is partially due to an increased effort in the cashing up of outcomes throughout the month enabling the identification of clock stops more quickly.

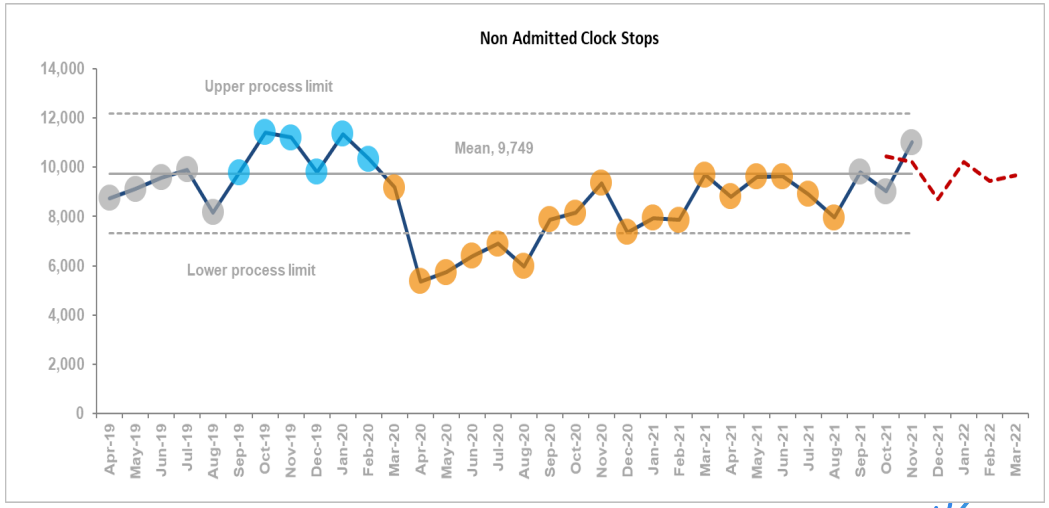
The number of patients on the non-admitted PTL remains above the mean although decreasing by 2.2% compared to the previous month. The number of patients waiting for more than 18 weeks remains below the lower control limit however an increasing trend is observed. The largest increase is within Gastroenterology where the percentage of patients waiting for more than 18 weeks has increased by 22%. Several specialties have had a decrease in the month including Trauma & Orthopaedics and Gynaecology. There were 340 patients who, at the end of November, have waited over 52 weeks – a decrease of 6%.
The total waiting list size for admitted patients remains above the upper control limit with 6,299 patients on the waiting list. The number of patients waiting for treatment beyond 18 weeks decreased by 138 patients compared to October. The largest 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 with a total of 340 patients within the admitted pathway.

Referral to Treatment Non-Admitted Pathway — November 2021



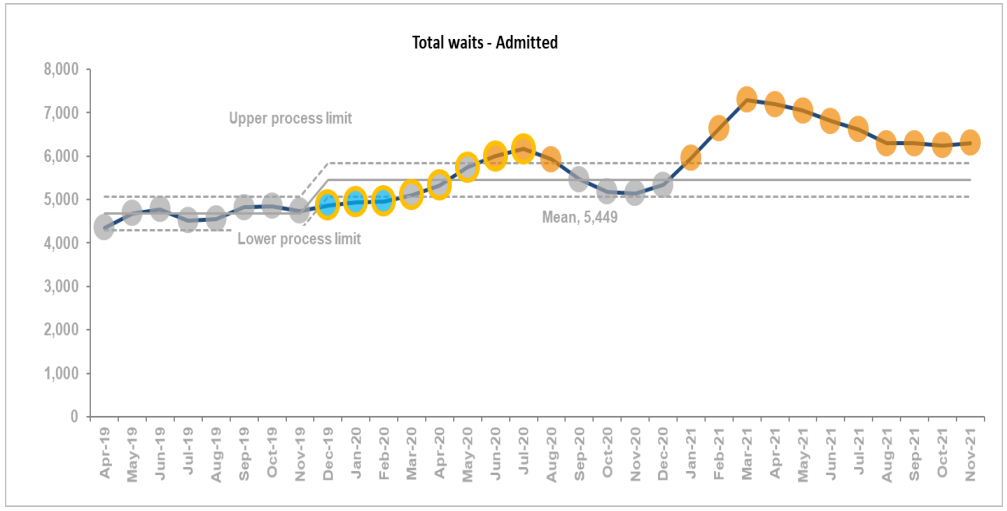


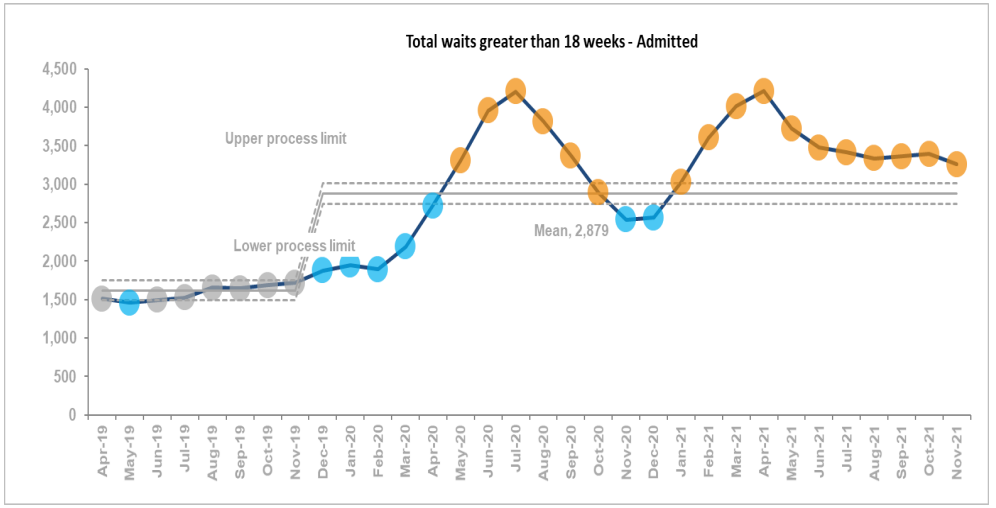


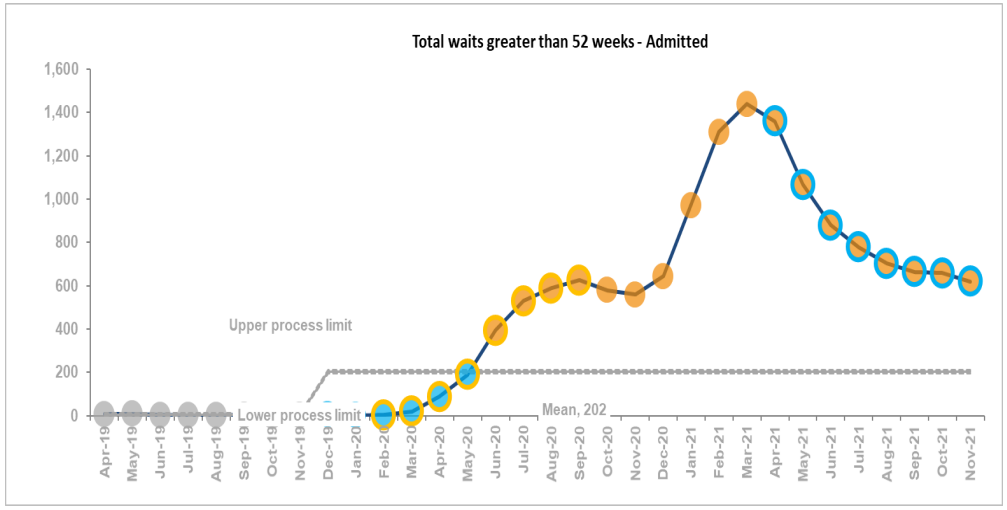


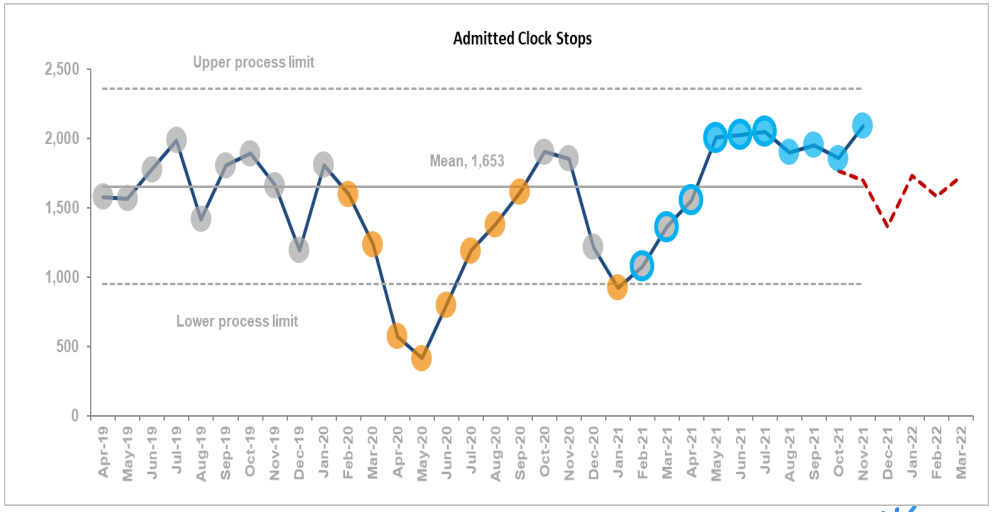
Our Process Perspective

Referral to Treatment Admitted Pathway — November 2021



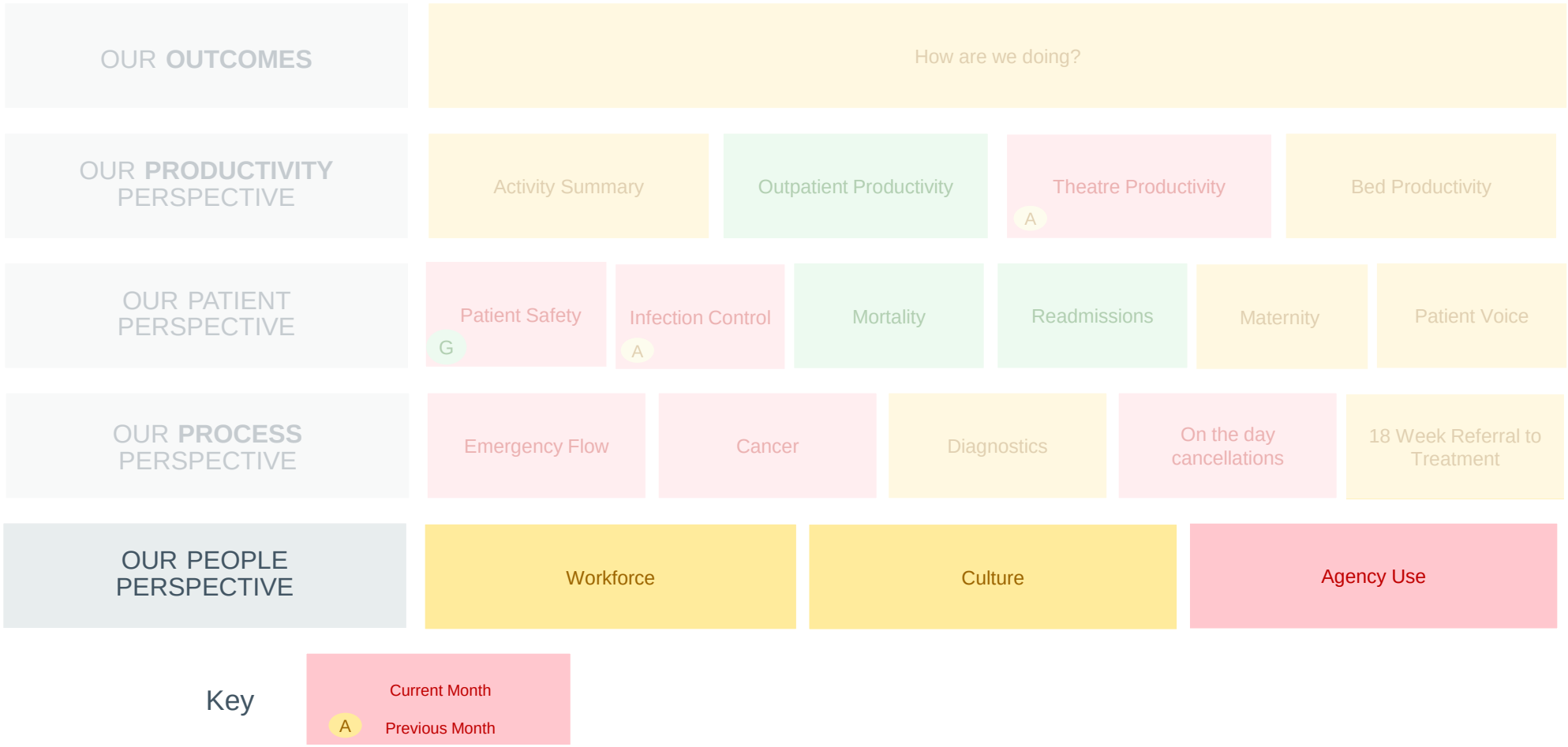






Our Process Perspective

Balanced Scorecard Approach



Workforce

Metric	Benchmark Average	Performance 12 months ago	Performance 3 months ago Sep-21	Current Performance Dec-21	Target	Distance to target	Current RAG Rating
Sickness	4%	3.9%	4.4%	5.6%	3.2%	-2.4%	✗
Vacancy	10.8%	8.5%	9.4%	10.1%	10%	-0.1%	!
Turnover		15.0%	15.3%	16.0%	13%	-3.0%	!
Medical Appraisal			75.2%	73.1%	90%	-16.9%	!
Non-Medical Appraisal	72%	69.6%	73.4%	74.8%	90%	-15.2%	!
MAST	85.7%	90.0%	87.7%	88.7%	85%	+3.7%	✓
Stability		87.7%	87.3%	86.9%	85%	+1.9%	✓

What the information tells us

- The Trust's sickness absence rate has risen for the ninth consecutive month showing special cause deterioration. The rate is currently 5.6% and the target is to not exceed 3.2%.
- Vacancy Rate has increased this month to 10.1% exceeding the target of less than 10% for the first time since May 2020.
- The Trust turnover rate in December was 16% and was adverse to target of 13%.
- Medical Appraisal rates and non-medical appraisal rates continues to be non-compliant against the 90% target.
- MAST and Stability are both being achieved with performance at 88.7% and 86.9% respectively against a target of 85%

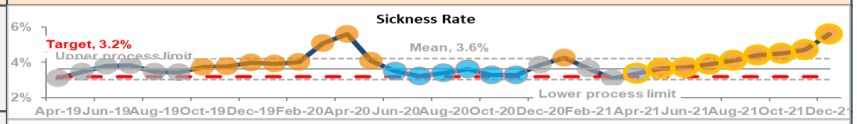
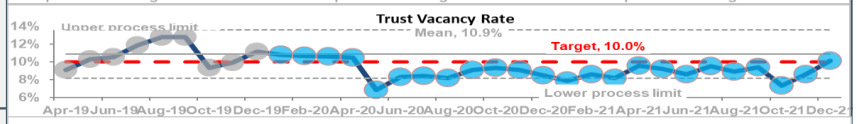
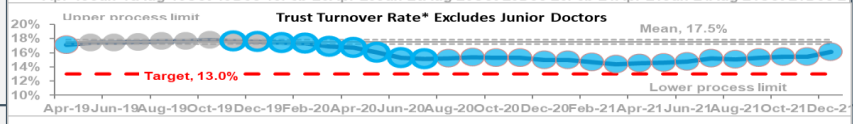
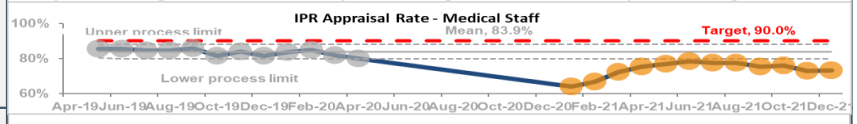
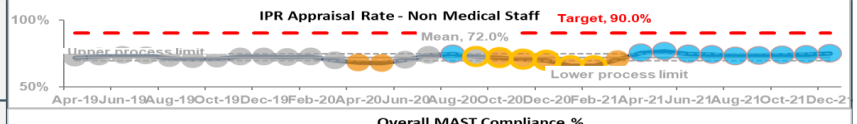
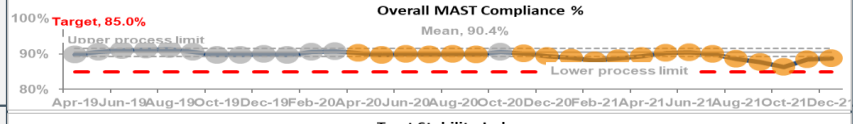
* Benchmark info is taken from Guy's & St Thomas', King's, Lewisham & Greenwich, Imperial, and UCLH.
* Turnover benchmarking isn't available as different Trusts calculate turnover in different ways

Actions and Quality Improvement Project

- The Trust sickness rate remains above average owing to the impact of both winter and Covid/self-isolation. Teams were challenged over Christmas and a bank staff incentive and holiday accommodation programme was stood up to encourage the uptake of bank shifts as, across London, Trusts were competing for a small pool of staff. Covid absences peaked in the first week of January 2022 and we are seeing these numbers decline daily. All areas are impacted with the main hotspots being Emergency Department, Estate & Facilities, Outpatients, Critical Care, Children's and Cancer. Monthly Divisional Sickness Meeting Reviews have been stood up with Employee Relations (ER)/HR Business Partners (HRBP) and divisional senior team (Divisional Directors of Operations and senior team) to provide overview and seek support for any cases with significant lapse times and review any ER hotspots.
- The vacancy factor remains a significant issue for the Trust with several areas impacted particularly Midwifery, Acute Medicine, Critical Care, Major Trauma and Surgical. Monthly Divisional Recruitment Management Meetings have been stood up with the recruitment hub including hiring managers and senior team to improve time to hire rates, review recruitment pipeline with the aim of speeding up the process.
- Turnover is an ongoing challenge reflective of the national NHS landscape with teams continuing to be impacted by the knock-on effects of both Brexit, Covid and what is being termed the 'great resignation' with staff members making lifestyle choices e.g. relocation, early retirement. The HRBP team continue to support teams looking at workforce re-design, skill mix and strategies to combat hard to recruit posts.
- The appraisal rates have plateaued and dipped given the operational challenges and remain below the Trust's target of 90%. The HRBPs are providing trajectories and working with teams to encourage uptake and promoting understanding of the importance of appraising staff.
- MAST Compliance – Focus for the first quarter 2022 will be on reviewing Training Needs Assessments for safeguarding Adults which will be split into 4 levels to come into line with national directives.
- Stability – The Trust is developing the Values Into Action project which will refresh our values and introduce a behavioural framework for all staff. The first embargoed set of 2021 staff survey results are now being analysed and a full approach to communicating the results at all levels is being planned (the 'Big 5' Campaign), which will this year include reports for all Care Groups to enable a more tailored approach to action planning.

Workforce Metrics

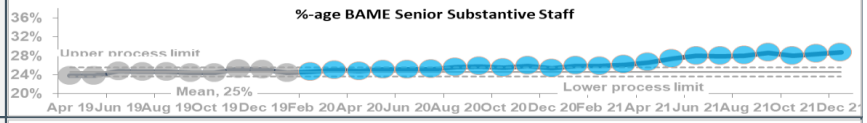
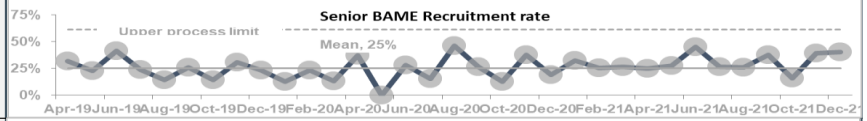
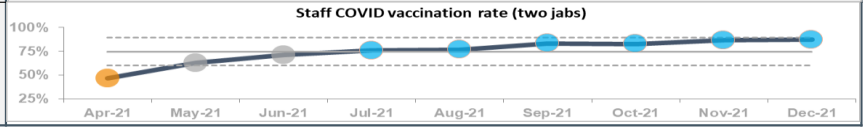
Common cause variation
Special cause variation – improving performance
Special cause variation – deteriorating performance
Special cause improvement 6-point ascending/descending run
Special cause concern 6-point ascending/descending run

	Dec-21	Target	Var to target	Trend
Trust Level Sickness Rate	5.6%	3.2%	-2.4%	
Trust Vacancy Rate	10.1%	10%	-0.1%	
Trust Turnover Rate* Excludes Junior Doctors	16.1%	13%	-3.0%	
IPR Appraisal Rate - Medical Staff	73.1%	90%	-16.9%	
IPR Appraisal Rate - Non Medical Staff	74.8%	90%	-15.2%	
Overall MAST Compliance %	88.7%	85%	+3.7%	
Trust Stability Index	86.9%	85%	+1.9%	

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

	Dec-21	Target	Var to target	Trend
Internal Hire Rate (all bands)	53.7%	40%	+13.7%	
%-age BAME Senior Substantive Staff (Band 8 and up)	28.7%	N/A		
Senior BAME Recruitment rate (Band 8 and up)	40.3%	N/A		
COVID-19 Staff vaccination rate (both Jabs)	87.0%	90%	-3.0%	

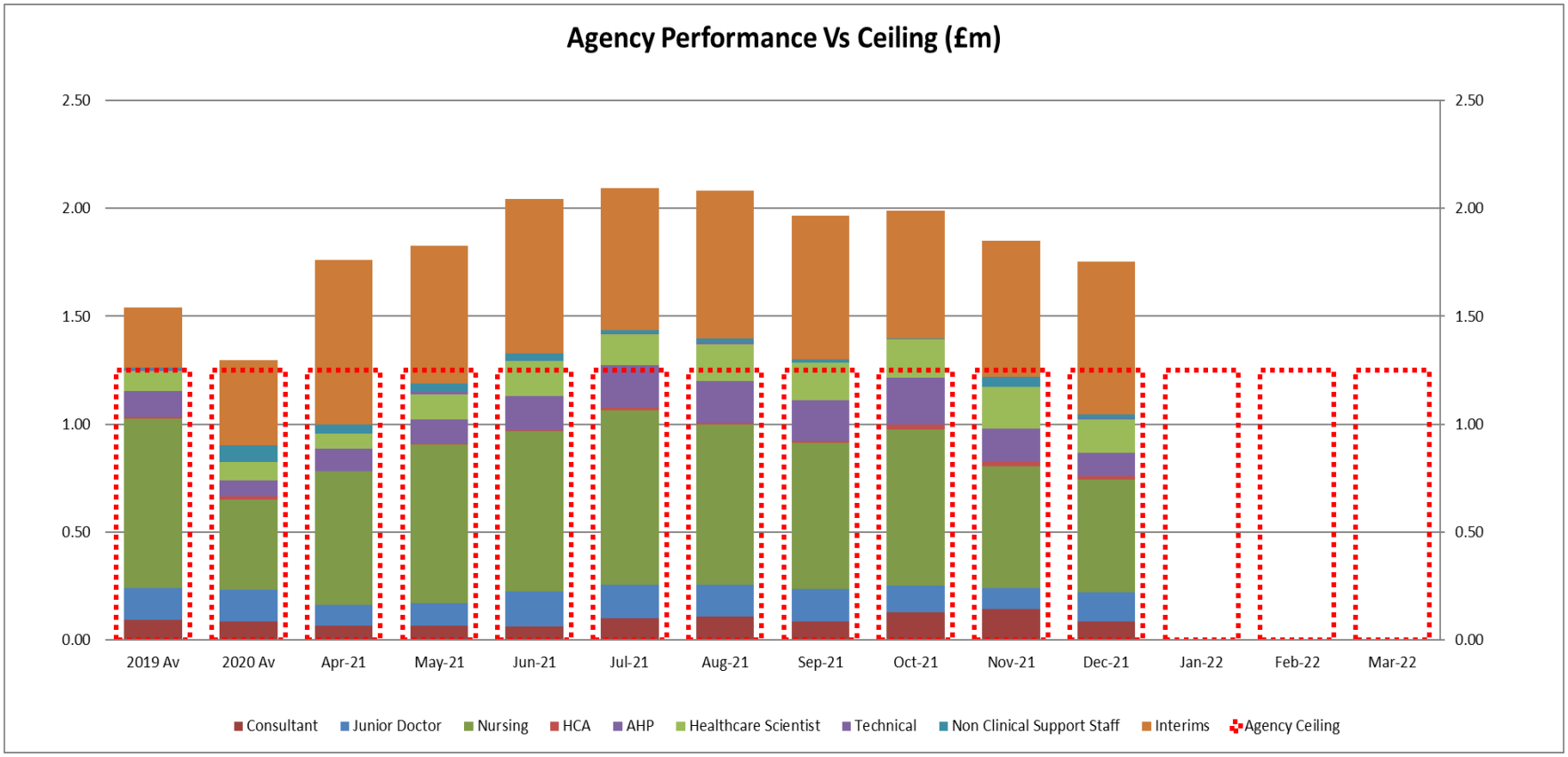
What the information tells us

- In December, the internal hire rate was 53.7% showing common cause variation.
- Of the Senior substantive staff (Band 8 and above) employed in the trust, Black and Minority Ethnic staff represent 28.7% of that group which is above the 2019/20 mean of 25%.
- At time of writing, the COVID-19 vaccination rate was 87%.

Actions and Quality Improvement Project

- The recruitment team are working closely with Capital Nurse. 37 overseas nurses arrived in November. 45 Health Care Support Workers are currently going through pre-employment checks. Virtual webinar held 17th December. 14 newly qualified nurses joined the Trust in November. The campaign is being relaunched late Dec/early Jan for 2022 qualifiers.
- Soft launch of inclusive recruitment practices in Corporate Division (workforce pressures dependant).Review of Recruitment Inclusion Specialist (RIS) process with hub and trained RISs.
- There is an active communication plan promoting vaccinations for all staff including highlighting National requirements for NHS employment. The Trust is working on contacting and validating records for staff with missing vaccination records to ensure completeness and accuracy of reporting.

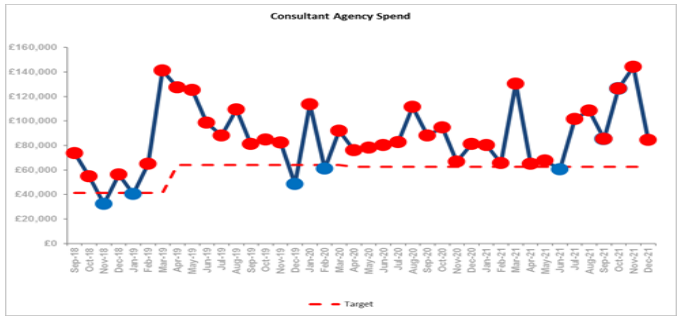
Agency use

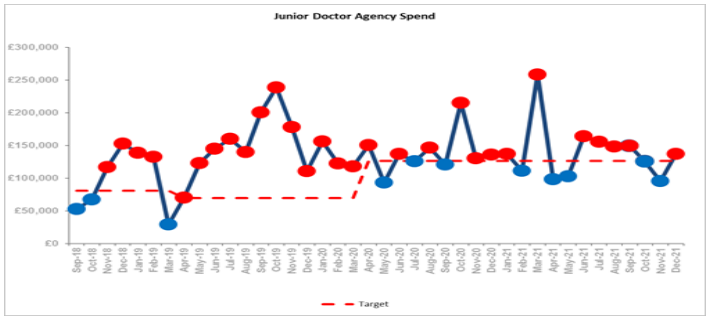


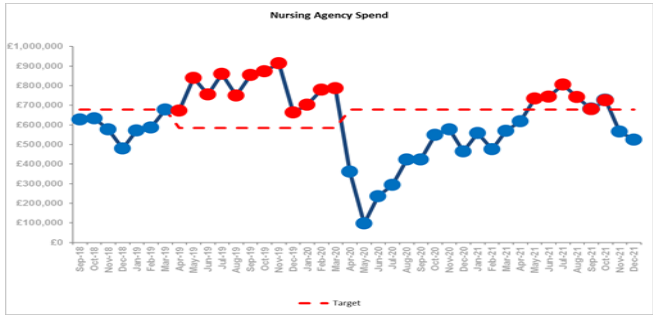
- The Trust's total pay for December was £52.08m. This is £0.30m adverse to plan of £51.78m
- There is an internal annual agency target of £15.00m
- Agency cost was £1.75m or 3.4% of the total pay costs. For 2020/21, the average agency cost was 2.5% of total pay costs
- For December, the monthly target set is £1.25m. The total agency cost is worse than the target by £0.50m
- The biggest areas of overspend were Interims (£0.54m) , Healthcare Scientists (£0.07m) and Consultants (£0.02m)

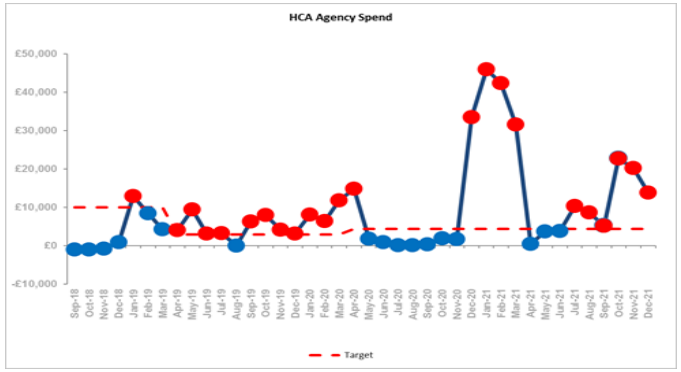
Agency use

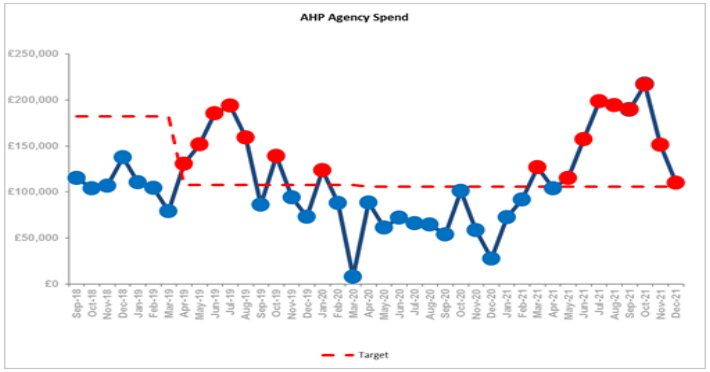
Below cap
Above cap

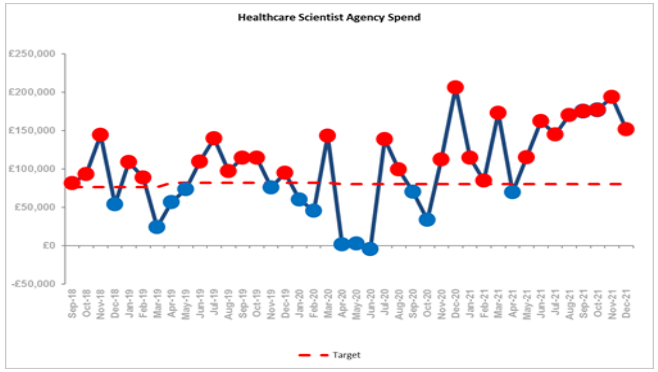


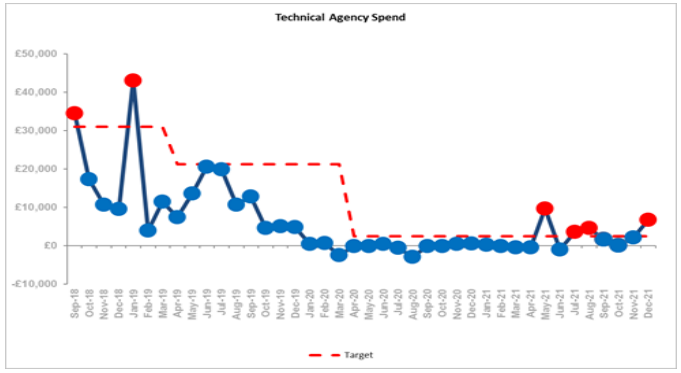


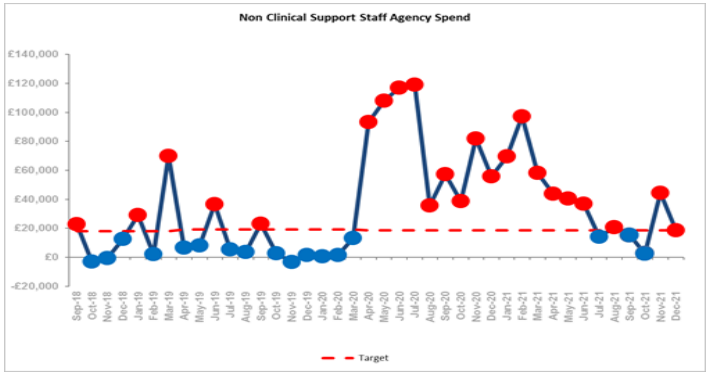


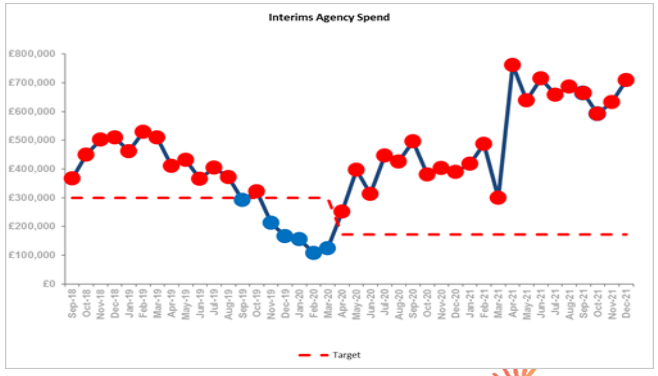








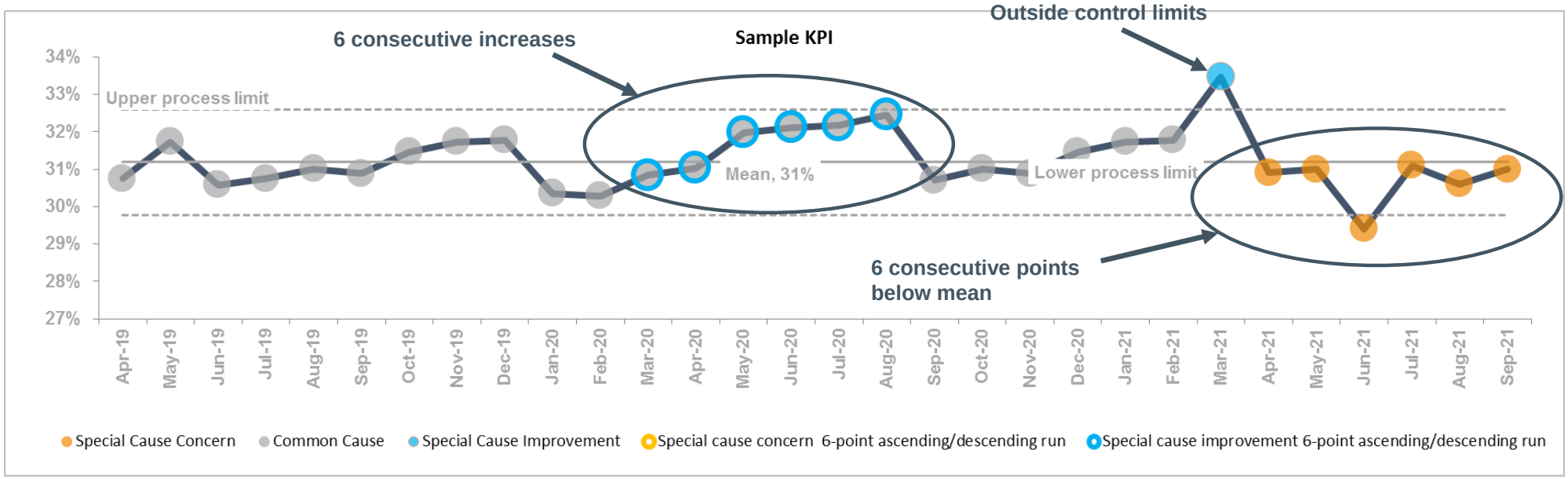




Our People Perspective

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

RTT Performance – November 2021

Indicator Description	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21
RTT Trust Incomplete Performance (exc UCS)	71.0%	71.4%	69.1%	68.3%	69.3%	70.0%	74.2%	76.0%	76.2%	76.0%	76.3%	74.9%	74.2%
RTT Total Incomplete Waiting Lize Size (exc UCS)	46,142	46,290	44,291	44,236	44,960	45,109	45,156	45,242	46,319	46,977	47,014	47,667	46,802
Total waits greater than 18 weeks (exc UCS)	13,365	13,251	13,695	14,027	13,801	13,522	11,662	10,850	11,044	11,263	11,121	11,969	12,070
Total waits greater than 52 weeks	1,261	1,456	2,108	2,671	2,644	2,174	1,597	1,240	1,106	1,028	1,005	1,023	959
RTT Incomplete Performance - Admitted	50.6%	51.9%	49.2%	45.6%	45.1%	41.4%	47.1%	48.9%	48.4%	47.0%	46.6%	45.7%	48.3%
Total waits - Admitted	5,141	5,335	5,950	6,634	7,301	7,193	7,045	6,809	6,619	6,291	6,293	6,250	6,299
Total waits greater than 18 weeks - Admitted	2,541	2,564	3,025	3,608	4,013	4,213	3,724	3,476	3,415	3,335	3,362	3,396	3,258
Total waits greater than 52 weeks - Admitted	559	643	971	1,310	1,439	1,359	1,067	880	777	702	663	658	619
RTT Incomplete Performance -Non Admitted	73.6%	73.9%	72.2%	72.3%	74.0%	75.4%	79.2%	80.8%	80.8%	80.5%	80.9%	79.3%	78.2%
Total waits - Non Admitted	41,001	40,955	38,341	37,602	37,651	37,916	38,111	38,433	39,700	40,686	40,721	41,417	40,503
Total waits greater than 18 weeks - Non Admitted	10,824	10,687	10,670	10,419	9,788	9,309	7,938	7,374	7,629	7,928	7,759	8,573	8,812
Total waits greater than 52 weeks - Non Admitted	702	813	1,137	1,361	1,205	815	530	360	329	326	342	365	340

Note: Unknown Clock Starts (UCS) have been excluded from the above metrics. For context the number of UCS in November was 632, an increase from 538 in October. Compared to the same month last year this is a 9% lower.

RTT Performance – November 2021

Specialty	Admitted		Non Admitted		Incomplete Pathway					
	Total	% within 18 weeks	Total	% within 18 weeks	Within 18 weeks	Over 18 weeks	Total	% within 18 weeks	Over 42 weeks	Over 52 weeks
General Surgery Service	464	18.1%	1,026	75.1%	855	635	1,490	57.4%	84	170
Urology Service	459	63.2%	1,590	91.8%	1,750	299	2,049	85.4%	32	36
Trauma and Orthopaedics Service	252	56.3%	1,578	79.9%	1,403	427	1,830	76.7%	12	9
Ear Nose and Throat Service	501	43.7%	4,089	64.2%	2,845	1,745	4,590	62.0%	166	160
Ophthalmology Service			165	76.4%	126	39	165	76.4%	6	16
Oral Surgery Service	229	37.1%	706	80.6%	654	281	935	69.9%	32	18
Neurosurgical Service	189	61.4%	2,116	74.1%	1,684	621	2,305	73.1%	56	16
Plastic Surgery Service	651	48.4%	709	83.2%	905	455	1,360	66.5%	44	67
Cardiothoracic Surgery Service	48	1	195	1	212	31	243	87.2%	0	0
General Internal Medicine Service	1	1	36	83.3%	31	6	37	83.8%	0	0
Gastroenterology Service	312	80.8%	3,316	68.4%	2,521	1,107	3,628	69.5%	9	3
Cardiology Service	1,455	42.9%	2,796	80.0%	2,860	1,391	4,251	67.3%	117	191
Dermatology Service	9	88.9%	2,429	86.2%	2,103	335	2,438	86.3%	3	2
Respiratory Medicine Service			1,223	91.6%	1,120	103	1,223	91.6%	0	0
Neurology Service	20	75.0%	2,457	82.4%	2,040	437	2,477	82.4%	26	0
Rheumatology Service			844	71.9%	607	237	844	71.9%	5	0
Elderly Medicine Service			84	85.7%	72	12	84	85.7%	0	0
Gynaecology Service	235	63.8%	1,505	90.9%	1,518	222	1,740	87.2%	9	4
Other – Medical Services	161	78.9%	7,320	79.1%	5,915	1,566	7,481	79.1%	28	37
Other – Paediatric Services	543	49.5%	2,312	84.0%	2,210	645	2,855	77.4%	60	14
Other – Surgical Services	696	37.1%	2,888	77.8%	2,505	1,079	3,584	69.9%	104	169
Other – Other Services	74	52.7%	1,119	67.6%	796	397	1,193	66.7%	25	47
Grand Total	**6,299**	**48.3%**	**40,503**	**78.2%**	**34,732**	**12,070**	**46,802**	**74.2%**	**818**	**959**

The numbers reported above exclude Unknown Clock Starts(UCS)

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

Early Warning Score

Indicator Description	Threshold	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Compliance with appropriate response to EWS (Adults)	100%	93.7%	95.3%	92.8%	89.9%	88.0%	88.0%	91.0%	92.3%	91.6%	96.9%	88.5%	89.7%	78.5%
Number of EWS Patients (Adults)		478	235	360	553	483	581	443	531	429	479	532	507	480

Meeting Title:	Trust Board Meeting		
Date:	27 January 2022	**Agenda No.**	**3.1**
Report Title:	Workforce and Education Committee Report		
Lead Director/ Manager:	Stephen Collier, Chair of Workforce and Education Committee		
Report Author:	Stephen Collier, Chair of Workforce and Education Committee		
Presented for:	Information		
Executive Summary:	This Report sets out a summary of the matters reviewed by the Committee at its meetings on 10th December and 13th January. Generally, the Trust continues to make progress on a range of HR-related issues albeit that this has been impacted more recently by the effects of the Omicron surge. The executive had planned for this potential and we took assurance from the way they had responded to it. A change in one area of Trust-wide risk requires to be brought to the attention of the Board. In relation to risk SR9 (workforce) there is a material and imminent risk arising from the mandating (effective from the end of March) of Covid vaccinations for those staff deployed into patient-facing environments. Given the significance of the risk to service delivery associated with this and the assessment of the impact of this risk as 25, the position is set out in some detail below. It is important to say that these risks are fully recognised and being acted upon by the executive and we took assurance from the way that they are addressing this. Nonetheless, the outturn is currently uncertain and the potential impact significant. There is also a new risk within SR9 relating to DBS checks, and specifically the Trust's previous policy in relation to updating these. The consequence of these risks, and notably the potential impact of mandatory vaccination, is such that the Committee is recommending an increase in the risk rating for corporate risk SR9 from the present 16 to 20. We would ask the Board to support that recommendation.		
Recommendation:	The Board is asked to note this report.		
Supports			
Trust Strategic Objective:	Valuing our staff		
CQC Theme:	Are services at this Trust well-led		
Single Oversight Framework Theme:	Board Assurance, Risk management		

Internal Operations and Supply

Covid – Omicron surge and mandatory vaccination. At the December meeting we were updated on the surge in community infection levels with Omicron, and the impact on the Trust – both in terms of patient demand and staff sickness and self-isolation. It was clear then that the pressure was on, and staff absences peaked on 23rd December at around 8% of the on-site workforce. They have since fallen back though remain high. At the January meeting it was clear that we had passed the peak – but Omicron self-isolation was still having a strong adverse impact on normal operations. A number of areas of routine hospital service had been and remain affected by the current Covid surge, but it is clear that the executive is working creatively and sensibly to reduce that impact.

As at the end of December almost 90% of Trust staff had received both vaccines and a robust process was in place to verify the vaccination status of individual staff members. The corollary is that, as at the end of December, almost 1,000 of our staff had not been verified as having been vaccinated. Within this is a material number of doctors and nurses (at all levels of seniority).

At the January meeting we had a helpful and informative update on the Trust's planning for the consequences of the NHS mandating vaccines for staff whose deployment might bring them into contact with patients (Vaccination as a Condition of Deployment, or 'VCOD'). The practical reality is that staff who are not vaccinated (and not otherwise exempt) may well be at risk of termination of their employment. The scale of this potential loss of staff creates a risk to the Trust in terms of maintaining service, and to staff of becoming unemployed (particularly given that the vaccination mandate applies across all CQC regulated activities, and therefore working in other health settings is unlikely to be an option). There is also a risk of the workplace culture being adversely affected, as this is a divisive issue amongst staff with strong views on all sides.

The timescale requires that relevant staff have had their first vaccination by 3 February, and their second by 31 March. The approach being taken by the Trust, as it has been over the last 12 months, is to encourage and persuade staff to be vaccinated. There were some indications that staff continued to come forward for vaccination, but the numbers are modest. There were also indications that some staff had been vaccinated but that status had not yet been verified. Again the numbers are probably modest. Therefore the planning assumption that the executive has adopted, which we endorsed, was of a significant number of staff remaining unvaccinated. Planning for this scenario had been undertaken and a steering group established to assess the impact within individual directorates and workplaces, and manage the Trust's response. This is jointly chaired by the Chief People Officer and the Chief Nurse, and incudes staff side representatives in its membership. The Committee was also provided with assurance that Staff Side representatives have also been engaged on this issue outside of the steering group.

The position facing the Trust, and the individual members of staff affected, is stark. Staff shortages nationally suggest that the Trust will not find it easy to recruit alternative staff, and so the loss of experienced staff would represent a real loss to the Trust. Given the immediacy of the risk, the executive has agreed to provide regular reports on a private basis to the Committee so we can monitor the situation. Since the meeting at which this was discussed, NHSE has issued guidance to NHS employers on managing the process. This is still being reviewed in detail, although initial indications are that there is nothing in this which requires the Trust to adopt a different approach to the issue.

Workforce Report – at our December meeting we reviewed the report, which summarises the status of a number of areas and provides us with a set of KPIs. We had raised an issue at a previous meeting of where the c450 additional employed staff (Oct 20 vs Sept 21) being reported by the Trust had been deployed. The answer was that: c250 represented additions to the payroll as a result of the TUPE transfer in of staff working within south west London pathology (150) and south west London procurement (c100). Of the remainder (193) these represented net new staff, who had been deployed across the Trust but in particular to MedCard, ITU, and Caesar Hawkins. The Committee regarded this as a positive result from the recent recruitment campaign. It was noted that some staff

who had been deployed on a temporary basis to ITU had enjoyed the work and opted to remain there on a continuing basis.

We also reviewed trends in (a) bank, and (b) agency usage and noted an overall increase in bank usage and a decline in agency usage. This was an encouraging trend, particularly as market rates for agency staff were hardening significantly. It was reported that there had been no further developments in the Trust's resolution of historic bank staff holiday pay issues, and the indications were that this might therefore be assessed as a closed matter by financial year-end.

The staff survey had achieved a 52% completion rate, down from 59% the previous year. Given the operating environment during which the survey had been completed, there was some concern that pressure on staff might adversely affect their perceptions of the workplace.

We received a report on the results of the Staff Thank-You campaign (£40 voucher). At the time of the report, over 6,000 staff had downloaded their voucher. It was reported that the recognition of contribution was as important as the voucher itself.

Winter Workforce Action Plan – we reviewed the workforce plan to address pressures across the winter months. This built upon existing initiatives, was operationally focussed, and was for a limited term. A tighter approach to absence management was noted. The plan also included a set of success measures, and we will at a future meeting assess how far these have been achieved. In parallel, a Health and Wellbeing plan had been developed which would provide relevant support to staff. The importance of clinical staff taking breaks was being emphasised, and non-clinical staff were being asked to volunteer to support wards for short periods whilst staff took their breaks. Food and drink for staff working on Covid wards was also being prioritised.

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.

Staff Health and Wellbeing

Q3 Report – at our January meeting Teresa Mulvena summarised the staff support initiatives undertaken by the Trust in Q3. There had been high levels of staff distress – the combination of sickness due to Covid and a less-tolerant response from patients whose treatment or care had been delayed had resulted in a challenging operating environment. New referrals for talking therapies continued to increase. Additional funding had been received from the local CCG to support staff wellbeing initiatives, and this had been very welcome. Initial concern from staff at being deployed into the Nightingale step-down unit had subsided, once the function of that unit had been made clear.

Culture, Diversity and Inclusion

Culture Programme Update – At the January meeting, the Committee received a short report from Daniel Scott, the Trust's Head of OD, summarising the impact of the Omicron surge on the culture programme. There had been a deferral of certain activities, but overall strong support from staff for continuing with the programme. The consequence was that slippage was limited, and the overall effect would be measured in weeks rather than months.

Workforce Strategy – Implementation Plan. Paul Da Gama reported to the January meeting on the status of implementation. Operational pressures had led to a short holding-back of some initiatives, and it was hoped that these could be re-initiated shortly. A particular focus would be the implementation of the shared bank between the Trust and Epsom and St Helier.

Diversity and Equality – Joseph Pavett-Downer, the Trust's D&I Lead, updated us at the December meeting on progress in this area. An appointment had been made to the role of D&I Officer, and we welcomed Renee Barrett who joined the Trust from Great Ormond Street Hospital. The senior leadership team had attended an Active Bystanders programme. Elections were taking place to a number of staff networks. The Trust's participation in UK Disability History month was noted. Ethnic

Diversity statistics across senior pay bands were reviewed, and some progress noted. Bands 9 and VSM remained an area of focus.

Strategy and Risk

Review of Strategic Risks 8 (culture) and 9 (workforce) – There are no matters which require re-assessment of the risks related to culture (SR8).

In relation to risk SR9 (workforce) there is a material and imminent risk arising from the mandating of Covid vaccinations for those staff deployed into patient-facing environments, which is effective from the end of March. The executive assessed the potential impact of this risk as 25 and the Committee accepted that judgement. The Committee also accepted that these risks are fully recognised by the executive and we took assurance from the way that they are addressing this.

Nonetheless, the outturn is currently uncertain and the potential impact significant. We therefore draw specific attention to it. There is also a new risk within SR9 relating to DBS checks (see below), and specifically the Trust's previous policy in relation to updating these. The consequence of these risks, and notably the potential impact of mandatory vaccination, is such that the Committee is recommending an increase in the risk rating for corporate risk SR9 from the present 16 to 20. We would ask the Board to support that recommendation.

Trust Governance and Compliance

Q3 Report from Guardian of Safe Working – We were joined by Serena Haywood, the Trust's Guardian, who reported on Q3. The key point that Serena made was the rapid rise in Q3 (Oct – Dec) in the number of exception reports by trainees (117, up from 101 in Q2) driven largely by the operational and staffing pressures arising from the surge in Omicron variant cases. Serena's assessment was that the Trust's senior doctors had been responded supportively to pressures on junior doctors. However, Serena also noted that the continuing pressure on the juniors had led to an increasing caution by them about being redeployed due to concern about reduced structured training. Disruption to medical education had been with the Trust (and the wider NHS) for almost two years, and there were indications that juniors were now seriously concerned about the continuing impact, and therefore expressing concerns.

The Junior Doctors Forum had been revitalised. The work of Lucinda Etheridge and Mo Amaran in this was noted. Attendance was improving. IT related issues appeared to be being brought back under control, although there was still work to do. There was an apparent comparative under-reporting of exception reports in surgical divisions, and this would be reviewed offline between Serena and Richard Jennings, the Trust's CMO. The inclusion within exception reporting of Trust-employed non-consultant doctors had been deferred to January, and will therefore now have started. The Trust was shortly to launch a programme emphasising to all staff (including doctors in training) the need to take their work breaks.

DBS compliance and record-keeping – we received a detailed report at the December meeting on gaps in the recording of the DBS status of a significant number of staff, and the plans to address these. This was an issue for staff in post at the point when DBS checks had been introduced in 2002; those who had TUPE'd into the Trust; and certain staff groups where DBS checks had not been undertaken. An admin task force had been established and a 12 week programme established to secure full compliance by the end of February. The Committee noted the position, and will review progress at its February meeting.

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

Stephen J Collier

Committee Chair, 19 January 2022

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	27 January 2022	**Agenda No**	**3.2**
Report Title:	Update on Vaccination as a Condition of Deployment (VCOD)		
Lead Director/ Manager:	Paul da Gama, Chief People Officer		
Report Author:	Nicola Taylor		
Presented for:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify) (select using highlight)		
Executive Summary:	No NHS staff member is legally allowed to be employed in direct face-to-face patient care unless fully vaccinated, or exempt, after 31 March 2022. This paper outlines the progress made in implementing this policy. The purpose of this paper is provide an overview to the Board of the approach being undertaken by the Trust in relation to new regulations recently introduced and commonly known as Vaccination as a Condition of Deployment (VCOD). These regulations explain that, from 1 April 2022, all NHS staff, health and social care workers, and volunteers working in England who have face-to-face contact with service users, will need to provide evidence that they have been fully vaccinated against COVID-19, unless they are exempt. The paper highlights the approach being taken, which is broadly to provide advice and guidance and to support all staff to be vaccinated. To achieve full vaccination by 31 March 2022, all staff must have received their first vaccine by 3 February 2022, and we aim to ensure that staff fully understand the potential impact that this decision will have upon their future employment both within St George's and, also the wider health sector.		
Recommendation:	The Board is asked to; • note the work that has been achieved on the VCOD policy and further to note the next steps being undertaken. • recognise the risks that have been outlined, and to support the VCOD steering group in its work to mitigate those risks.		
Committee Assurance:	VCOD is a fast-evolving issue, which the Trust is doing its best to manage, but given the nature of the regulations and its very significant potential impact, this paper is only able to offer reasonable Assurance.		
Supports			
Trust Strategic Objective:	Valuing our staff		
CQC Theme:	Well led		
Implications			
Risk:	VCOD represents a considerable risk to the Trust, and this has been reflected by both the individual risk rating applied to this matter and also the impact that it has upon Strategic Risk number 9 as part of the Trust's BAF.		
Resources:	The management of VCOD will require the Trust to invest in a number of areas, particularly in relation to its Employee Relations function, to help manage redeployment and potential dismissals.		
Equality and Diversity:	A national impact assessment has been undertaken and the Trust is in the process of undertaking a more local assessment. It is likely that these		

	regulations will impact more heavily upon certain BAME groups where take up rates of the vaccine are lower.		
Previously Considered by:	A verbal update on this issue was provided to the Workforce and Education Committee.	**Date**	

Outstanding care every time

St George's University Hospitals NHS Foundation Trust

Agenda Item: ***To be left blank***

Trust Board – TBC

Agenda item – Overview of the Trust's approach to Introduction of Vaccination as a Condition of Deployment Regulations

Presented by: Paul da Gama, Chief People Officer

1.0 PURPOSE

1.1 The purpose of this paper is to provide an overview to the Board of the approach being undertaken by the Trust in relation to new regulations recently introduced and commonly known as Vaccination as a Condition of Deployment (VCOD). These regulations explain that, from 1 April 2022, all NHS staff, health and social care workers, and volunteers working in England who have face-to-face contact with service users, will need to provide evidence that they have been fully vaccinated against COVID-19, unless they are exempt.

1.2 The paper highlights the approach being taken, which is broadly to provide advice and guidance and to support all staff to be vaccinated. To achieve full vaccination by 31 March 2022, all staff must have received their first vaccine by 3 February 2022, and we aim to ensure that staff fully understand the potential impact that this decision will have upon their future employment both within St George's and, also the wider health sector.

2.0 CONTEXT

2.1 Like many NHS organisations St George's has worked hard over the last year to ensure that its staff have the COVID vaccine and currently circa 90% of its staff have had a first vaccination.

On 6 January 2022 legislation was passed by Parliament requiring all NHS staff with direct patient contact to be fully vaccinated, unless exempt, by 1 April 2022. If a member of staff has not had both vaccines by 1 April 2022, it will be against the law to employ them after this date, and they are likely to be dismissed with notice.

2.2 St George's Hospital has determined that, in the first instance, all staff who work at the Trust are considered to be in scope of the legislation. This was agreed to ensure communications could go out quickly giving staff as much time as possible to inform themselves of the changes and act upon it if they wished. It is recognised that once a proper evaluation of scope is undertaken that many posts will ultimately be considered out of scope.

2.3 Led by Paul da Gama, Chief People Officer, and Robert Bleasdale, Chief Nurse and Director for Infection, Prevention and Control, a steering group has been set up, meeting twice weekly. This has representatives from Human Resources, Communications, Staff Side, Occupational

Health, Estates and Facilities, Bank and Agency, Information Governance, Workforce Intelligence and project support. This group has identified key areas of work that need to be delivered and an outline of these areas, and progress made, is described below.

3.0 Workstreams

Information Governance/Data Protection

3.1 The vaccination status of an individual is medical information which needs to be treated with care. The legislation allows SGH to access this and use it in line with the purpose of delivering compliance. The steering group has ensured that such information is shared solely with people who need to know, identifying those people and keeping them to a minimum. The privacy notice has been updated and shared with staff via the Trust's intranet, to provide assurance of our being allowed to access this data and of our protection of that data.

3.2 Significant care is being taken over the storage of data, with secure servers being set up to manage this sensitive information.

Communications

3.3 It is imperative that information on this legislative change is shared as widely as possible, giving everyone an opportunity to understand the requirements and have a chance to meet them. As such many different avenues have been utilised:

1) A dedicated VCOD page has been set up on the intranet containing all related VCOD documentation, and is accessible to all staff.
2) Staff whose current vaccination status is not confirmed have been written to, via post and email, by the Chief Nurse and Chief People Officer, outlining the need to be fully vaccinated by 31 March 2022, the consequences of choosing not to and where further information or vaccination clinics can be accessed. A copy of this letter is also available on the intranet.
3) A further letter has been sent showing support for those individuals where vaccination status is not confirmed, encouraging them to update their details or be vaccinated if not already.
4) Webinars have been held for all staff, attended by a panel of experts including nurses and doctors, where the regulations have been described and interactive Q&A sessions have been run. These will continue to run through February and March to continue to inform staff.
5) Briefing sessions for managers have been held to support them in holding meetings with staff whose vaccination status remains unconfirmed.
6) Flyers have been designed and printed to be distributed around the hospital sites
7) Large posters and banners have been designed to get the attention of staff around the hospital sites.
8) New intranet pages have been designed which offer staff and managers advice and guidance.

1:1 Staff support

3.4 The most important element in this whole process is our staff. Those whose vaccination status remains unconfirmed need support whether they are already vaccinated, wish to be vaccinated or do not want the vaccination. For those staff who are vaccinated a dedicated email address has been set up for evidence of vaccination to be provided and this has already received many emails.

3.5 Staff who have not yet had the vaccination have been invited to an informal 1:1 meeting with their designated manager. This meeting is an opportunity for staff to ask any questions they

have regarding the vaccine and also to be informed of the legislative change so they understand the impact any decision they make could have on them.

3.6 Managers are also supported in this conversation with briefings, dedicated packs with information and access to skills workshops as it is recognised that this is a very sensitive area and therefore not a straightforward conversation to undertake.

3.7 In addition the Trust's Staff Support team having been offering staff the opportunity to have confidential conversations regarding this issue and also a group of senior managers have also been set up with the aim of offering supportive and confidential conversations.

External Service Providers

3.7 In addition to staff on site, the VCOD steering group has considered the new legislation in the context of our contractors coming on to site to deliver services and/or goods. All our external contractors are in the process of being written to, to ask them to comply with the spirit of the legislation and only send fully vaccinated staff on to SGH sites. The steering group felt that anyone going into our clinical areas to do a job was enabling us to undertake our CQC regulated activity and therefore was in scope. In response contractors, with very few exceptions, have been hugely supportive.

3.8 For new contractors, the terms and conditions for our contracts are being updated.

Bank/Agency/Students/Volunteers

3.9 All these staff groups need to be supported with access to information and vaccination if required. The VCOD steering group has contacted all those bank and agency staff who have taken up a post within the last year, along with the agencies themselves, to ensure they are aware of the legislative changes. Students on placement are being contacted via their education institution and volunteers via SGH. Clearly given that these individuals are not employees as such the Trust's ability to manage this process is more complex and limited.

Medical Exemption

3.10 Whilst the vast majority of people are able to have the vaccination, some people are medically exempt and the grounds for exemption are listed clearly in the regulations. The VCOD steering group has ensured that communications note that exemptions are possible, but that self-declaration is no longer acceptable. A formal exemption letter must be provided, and this must be within the time schedule or an employee's job would be at risk. Managers cannot approve an exemption but can advise on how a staff member can be assessed, which is to call 119.

Redeployment

3.11 Staff members who do not wish to be vaccinated and are in a role that falls within the scope of the legislation may have an opportunity to be redeployed, however the steering group is clear that there are very few roles to which a staff member could be moved. The VCOD group are reviewing roles that might be suitable, but staff are also being informed that should they move to a lower banded role, there is no pay protection available.

Termination of Employment

3.12 Whilst the vast majority of staff have chosen to have the vaccine, there are still many staff members who are hesitant to go ahead with vaccination. The VCOD steering group has put in place many opportunities for staff to discuss their position, but accepts that some will continue to choose to remain unvaccinated. In that case, a formal 1:1 meeting with the

individual will be held, along with a panel to determine whether the role is in or out of scope. If the role is considered in scope, then the Trust will have no option but to dismiss that member of staff. A right of appeal will be put in place. The notice of termination remains, or is removed, according to the outcome of that appeal.

3.13 It should be noted that St George's does not wish to terminate the employment of any of its staff and will support any staff member to receive their vaccination, however it will be breaking the law if a member of staff is employed in an 'in scope' role, beyond 31 March 2022.

In scope/out of scope

3.14 The regulations and guidance, whilst helpful, do not cover every scenario St George's represents. For those staff who do not wish to be vaccinated, their role will be assessed on an individual basis by a panel, to provide consistency across roles.

Recruitment

3.15 All adverts state the requirement for vaccination.

3.16 All the above actions have been put in place and actioned at some considerable speed. This is to give staff as much time as possible to be informed and to receive their vaccination if they choose to do so and to enable the HR procedures to be completed prior to the legislative deadline.

3.17 Throughout all these discussions staff side have been represented, contributing to the processes and ensuring staff are supported as best as possible.

4.0 IMPLICATIONS

Risks

4.1 VCOD presents several risks which are being actively assessed, with plans put in place to manage and mitigate those risks.

Workforce gaps

4.2 The most immediate and concerning risk is the impact of staff leaving the organisation due to their unvaccinated status, leaving gaps in the workforce. The VCOD steering group, along with the operational senior leaders are assessing where those gaps are and what impact they could have on patient care. Options being considered include amending roles of staff to remove patient facing elements, asking vaccinated staff to take on patient facing roles, working differently to support patients in their care.

4.3 The scale of the risk changes daily as more staff come forward to accept the vaccine and the final resource gap will not be known until the legislative deadlines pass.

4.3 VCOD continues to work with managers and staff to support as many staff as possible to choose to have the vaccination to reduce this risk to a minimum.

Trust liability

4.4 It is illegal for the Trust to employ an unvaccinated person after 31 March 2022 in a patient facing role, unless exempt. The Trust is therefore liable if an unvaccinated person remains in a role after that date. Significant effort is going into validating all the data held on staff members, to ensure it is accurate, all staff have been informed and any staff who remain

unvaccinated are taken through the appropriate HR process relating to termination of employment.

4.5 The liability for the Trust extends to external contractors where the vaccination status of individual contractors will need to be checked as they come on site. The VCOD steering group are working to introduce appropriate checking systems.

Data storage and management

4.6 The VCOD steering group recognise the importance of protecting the data being reviewed and held on staff members and contractors. Work is ongoing to ensure data is stored on a secure server, that the data is accessible by named people and what is held is appropriate.

Governance

4.7 Governance structures to support this legislative change are being drawn up, with the central policy management currently sitting with the VCOD steering group.

Legal Regulatory

4.8 On 6 January 2022 Parliament passed a law that required all NHS staff, if patient facing, or exempt, to be fully vaccinated by 31 March 2022. Guidance has been provided by Government outlining the intentions of the law and how it is to be implemented. Scenarios describe the type of jobs that are in scope of the legislation and those that are considered out of scope, with those out of scope being suitable for unvaccinated staff.

4.9 The VCOD steering group has scrutinised this guidance and applied it to the roles at SGH.

Resources

4.10 VCOD is likely to have two impacts:

There will be a requirement to recruit additional staff to help manage this process, particularly after 3rd February when the process will move into a more formal HR phase which will see more focus upon redeployment and dismissal. In order to ensure that these processes are undertaken in a fair and legally compliant manner there will be a need for additional HR support.

Longer term depending upon the impact that VCOD has in terms of staffing there may be a negative impact upon agency and bank as the Trust looks to use temporary staffing to fill gaps created by these regulations.

Equality & Diversity

4.11 An equality and diversity impact assessment is underway.

5.0 NEXT STEPS

5.1 The VCOD steering group continues to meet twice weekly to ensure progress continues to be made in delivering this legislation.

5.2 Communications will carry on, supporting staff with webinars, now scheduled weekly through to the end of February. Informal 1:1 meetings continue with allocated managers speaking

with their staff members to ensure they are fully cognisant of the implications of their decisions.

5.3 The schedule for the HR processes for staff who choose to remain unvaccinated is being put in place. Given the legislative deadlines, these are being put into diaries at speed, with appropriate staff on panels to provide consistency in support to staff and assessment of the in/out of scope roles.

5.4 To ensure future contracts reflect the legislative changes, the wording is to be reviewed and amended in line with the expectations from SGH.

5.5 The biggest risk from this legislation is the impact on service provision and quality of care due to increased gaps in workforce. Divisions and senior leaders are working through the data, mindful of the daily changes, to determine where the greatest impact is going to be felt and what mitigations could be put in place. Plans for these options are being drawn up at pace to minimise any interruptions in care.

6.0 RECOMMENDATION

6.1 The Board is asked to note the work that has been achieved on the VCOD policy and further to note the next steps being undertaken.

6.2 The Board is asked to recognise the risks that have been outlined, and to support the VCOD steering group in its work to mitigate those risks.

Author: Nicola Taylor
Date: 20 January 2022

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	27 January 2022	**Agenda No**	**4.1**
Report Title:	**Finance and Investment Committee report**		
Lead Director/ Manager:	Ann Beasley, Chairman of the Finance and Investment Committee		
Report Author:	Ann Beasley, Chairman of the Finance and Investment Committee		
Presented for:	Assurance		
Executive Summary:	The report sets out the key issues discussed and agreed by the Committee at its meetings on the 16 December 2021 and 20 January 2022		
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 – December 2021 & January 2022

The Committee met on 16th December 2021 and 20th January 2022. In addition to the regular items on strategic risks, operational performance and financial performance, it also considered papers on:

- Planning for 2022/23;
- Paediatric Cancer;
- SWLP Blood Transfusion and Courier Procurement;
- Emergency Preparedness Resilience and Response (EPRR) assurance,
- Nightingale Surge Hub;
- Renal Outline Business Case;
- Costing, SLR and PLICS;
- MITIE contract update;
- NEPT update;
- Finance Policy Update – Procurement Policy; and
- A Procurement 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 December members undertook a deep dive into the finance and estates risks. Issues raised in discussion covered the increased financial risk from the financial settlement expected in 2022/23, and the expected improvement in Estates risk following improvements in water and fire safety. Members were assured that mitigations were receiving sufficient executive focus. At the January meeting, ICT and Operational Risk focussed on the proposed financial system upgrade in the spring and proposed move from limited to partial assurance following improvements in areas such as elective performance. The Committee discussed current financial performance, cash management and capital expenditure as the Trust reported the M8 (in December) and M9 (in January) YTD financial performance of 2021/22. **The Committee wishes to bring the following items to the Board's attention:**

1.1 Board Assurance Framework Risks – the Deputy Chief Financial Officer (DCFO), Chief Operations Officer (COO), Deputy Chief Information Officer (DCIO) and Director of Estates and Facilities (DE&F) all updated the committee on their respective strategic risks. The Committee agreed with the assessments of each report for Q3:

- SR3- Operational and ICT Risk 20 – Partial Assurance
- SR5- Financial Sustainability 20 – Partial Assurance
- SR6- Financial Investment 20 – Partial Assurance
- SR7- Estates Risk 20 – Partial Assurance

1.2 Estates Report –the Director of Estates & Facilities (DE&F) introduced the normal monthly update, noting the latest on the Hospital Improvement Programme bid process.

1.3 Activity Performance – the Chief Operations Officer (COO) noted the expected performance against activity trajectories in December, where Daycase/Elective is expected to be slightly below (at 96% compared to 100% target) and Outpatient performance is expected to be ahead (at 111% compared to 100%).

1.4 Emergency Department (ED) Update – the performance of the Emergency Care Operating Standard was recorded at 72.1% in December. The Committee noted the challenges in recent months, related to the Omicron variant.

1.5 Diagnostics Performance – the COO noted that the six-week diagnostic standard performance was 3.3% in December, better than the London average.

St George's University Hospitals NHS
NHS Foundation Trust

1.6 Cancer Performance – the COO noted Cancer performance in November where 1 of the 7 targets was met, and discussion focussed on Breast Services capacity.

1.7 Referral to Treatment (RTT) Update – the performance against the RTT target was discussed, where performance in November of 74.2% had deteriorated against the previous month's value of 74.9%, with the number of 52 week waits of 959 being less than the previous month's 1,023. The size of the waiting list (including QMH patients) was 46,802 patients.

1.8 EPRR assurance – the COO noted the NHS England EPRR assurance update and the 'substantial' rating remains with one outstanding action to be completed.

1.9 Financial Performance– the DCFO noted performance at M9 YTD for 2021/22, where a £3.9m deficit is £2.5m favourable compared with the phased plan for H2 submitted on November 16th. This includes additional funding of £2.5m which is expected to total £5.0m by year end and assist the Trust in delivering a breakeven position.

He noted the cash balance as at 31st December 2021 was £49.5m (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 noted latest progress with the costing system upgrade and current work being undertaken with the assistance of Model Hospital.

1.11 Planning 21-22 – the DCEO noted the progress being made on planning for 2022/23 with a more challenging financial settlement. The Committee discussed the deliverability of CIP in view of the heightened operational difficulties being experienced.

1.12 SWLP Blood Transfusion and Courier Procurement – the DCFO introduced the paper asking the committee to approve the Blood Transfusion contract award to IBG Immucor at a value of £3.2m over 10 years, in line with the Trust Standing Financial Instructions (SFIs). **The Committee agreed for this to go to Trust Board.**

1.13 Procurement Policy Update – the AD-P noted the latest legal guidelines impacting the Trust's procurement activities. **The Committee approved the latest policy document that included these changes.**

1.14 Procurement Report – the AD-P noted latest performance against breaches and waivers targets and progress on delivering Procurement CIPs.

2.0 Recommendation

2.1 The Board is recommended to receive the report from the Finance and Investment Committee for information and assurance.

Ann Beasley
Finance & Investment Committee Chair,
December 2021 & January 2022

Outstanding care every time

St George's University Hospitals NHS Foundation Trust

Meeting Title:	**TRUST BOARD**		
Date:	**27th January 2022**	**Agenda No**	**4.2**
Report Title:	**M9 Financial Performance**		
Lead Director/ Manager:	Tom Shearer		
Report Author:	Tom Shearer		
Presented for:	Update		
Executive Summary:	The Trust is reporting a deficit of £3.9m at the end of December, which is £2.5m favourable to plan. This is due to additional funding made available to allow the Trust and SWL ICS to deliver a breakeven position, for which plans are still being confirmed. This includes £21.6m of ERF income and £14.4m of ERF costs, both of which are £3.7m higher and lower than plan (and so offset). The Trust is forecast to breakeven at year end, which would be £5m favourable to the external plan submitted in November. The Trust is expecting to resubmit a new plan of breakeven in the coming weeks. Excluding ERF, income is reported at £4.3m favourable to plan at Month 9. This is due to additional funding made available to SWL ICS. There is also additional funding to cover increased Vaccination costs. Excluding ERF, expenditure is reported at £1.8m adverse to plan at Month 9. This is due to lower Commmercial Pharmacy costs, partially offset by higher staffing costs related to COVID. Capital expenditure of £39.3m has been incurred year to date. This is to £0.4m favourable to a plan of £39.7m. At the end of Month 9, the Trust's cash balance was £49.5m, which is £46.5m 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 M9 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:	IFIC	**Date**	20/1/22
Appendices:	N/A		

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Financial Report Month 9 (December 2021)

Andrew Grimshaw
Chief Financial Officer

27th January 2022

Executive Summary – Month 9 (December)

Area	Key Issues	Current Month (YTD)	Previous Month (YTD)
Financial Position	The Trust is reporting a deficit of £3.9m at the end of December, which is £2.5m favourable to plan. This is due to additional funding made available to allow the Trust and SWL ICS to deliver a breakeven position, for which plans are still being confirmed. This includes £21.6m of ERF income and £14.4m of ERF costs, both of which are £3.7m higher and lower than plan (and so offset).	£2.5m Fav to plan	£1.7m Fav to plan
Forecast	The Trust is forecast to breakeven at year end, which would be £5m favourable to the external plan submitted in November. The Trust is expecting to resubmit a new plan of breakeven in the coming weeks.	£5.0m favourable to plan (at year end)	£5.0m favourable to plan (at year end)
Income	Excluding ERF, income is reported at £4.3m favourable to plan at Month 9. This is due to additional funding made available to SWL ICS. There is also additional funding to cover increased Vaccination costs.	£4.3m Fav to plan	£4.8m Fav to plan
Expenditure	Excluding ERF, expenditure is reported at £1.8m adverse to plan at Month 9. This is due to lower Commmercial Pharmacy costs, partially offset by higher staffing costs related to COVID.	£1.8m Adv to plan	£3.2m Adv to plan
ERF	The Trust has received £21.6m of ERF income, which is £3.7m over plan. The Trust has incurred £14.4m of associated costs, which is £3.7m under plan.	On Plan	On Plan
Capital	Capital expenditure of £39.3m has been incurred year to date. This is to £0.4m favourable to a plan of £39.7m.	£0.4m Fav to plan	£0.5m Fav to plan
Cash	At the end of Month 9, the Trust's cash balance was £49.5m, which is £46.5m higher than the £3m minimum cash balance required by NHSE&I. The Trust is actively ensuring suppliers are paid in good time.	£46.5m Fav to plan	£46.8m Fav to plan

Outstanding care every time

Contents

Outstanding care every time

1. Month 9 Financial Performance

			Full Year Budget (£m)	M9 Budget (£m)	M9 Actual (£m)	M9 Variance (£m)	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)
Excluding ERF	**Income**	SLA Income	852.9	70.7	72.4	1.7	640.6	644.5	4.0
		Other Income	136.3	11.5	10.6	(0.9)	101.9	102.2	0.4
	Income Total		**989.2**	**82.3**	**83.0**	**0.8**	**742.4**	**746.8**	**4.3**
	Expenditure	Pay	(604.8)	(51.8)	(52.1)	(0.3)	(454.2)	(456.7)	(2.5)
		Non Pay	(356.1)	(31.0)	(30.6)	0.4	(271.0)	(270.4)	0.6
	Expenditure Total		**(960.9)**	**(82.8)**	**(82.7)**	**0.1**	**(725.2)**	**(727.1)**	**(1.8)**
	Post Ebitda		(44.1)	(2.5)	(2.5)	(0.0)	(30.8)	(30.8)	(0.0)
	Grand Total		**(15.8)**	**(3.1)**	**(2.2)**	**0.8**	**(13.6)**	**(11.1)**	**2.5**
ERF	**Income**		21.4	1.2	2.0	0.8	18.0	21.6	3.7
	Expenditure		(10.6)	0.0	(0.8)	(0.8)	(10.7)	(14.4)	(3.7)
	Total		**10.8**	**1.2**	**1.2**	**0.0**	**7.3**	**7.3**	**0.0**
	Reported Position		**(5.0)**	**(1.9)**	**(1.1)**	**0.8**	**(6.4)**	**(3.9)**	**2.5**

Trust Overview

The in month reported position at **M9 is a £1.1m deficit, which is on £0.8m favourable to plan. The YTD position is a £3.9m deficit, which is £2.5m favourable to plan**.

Excluding ERF income and costs:

- **Income** is £4.3m over plan, due to additional funding for SWL ICS and increased funding to cover Vaccination costs.
- **Pay** is £2.5m overspent across Junior Doctor and Nursing staff groups due to additional costs related to COVID, such as sickness.
- **Non-pay** is £0.6m underspent due to lower costs in Commercial Pharmacy.

The Trust has received £21.6m of ERF income, which is £3.7m over plan. The Trust has incurred £14.4m of associated costs, which is £3.7m under plan.

2. Balance Sheet as at 31st December 2021

Statement of Financial Position	M12 March-21 FY 20-21 Actual Audited (£m)	M09 Dec-21 FY21-22 YTD Actual (£m)	Movement YTD Dec-21 (£m)
Fixed assets	**470.7**	**489.5**	**18.8**
Current assets			
Stock	**13.2**	16.9	3.7
Debtors	**83.3**	87.0	3.7
Cash	**36.6**	49.5	13.0
Total Current Assets	**133.1**	**153.4**	**20.3**
Current liabilities			
Creditors	**(110.8)**	(161.3)	(50.5)
Capital creditors	**(36.0)**	(23.6)	12.4
PDC div creditor	**0.0**	(5.8)	(5.8)
Provision<1 Year	**(0.9)**	(0.9)	0.0
Borrowings< 1 year	**(5.1)**	(9.4)	(4.3)
Int payable creditor	**(0.1)**	(0.0)	0.1
Total current liabilities	**(152.9)**	**(201.0)**	**(48.0)**
Net current assets/-liabilities	**(19.9)**	**(47.6)**	**(27.7)**
Provisions> 1 year	**(3.3)**	(3.2)	0.1
Borrowings> 1 year	**(57.4)**	(52.7)	4.7
Total Long-term liabilities	**(60.7)**	(55.8)	4.8
Net assets	**390.2**	**386.0**	**(4.1)**
Taxpayer's equity			
Public Dividend Capital	**531.9**	531.9	0.0
Income & Expenditure Reserve	**(225.2)**	(229.4)	(4.1)
Revaluation Reserve	**82.4**	82.4	0.0
Other reserves	**1.2**	1.2	0.0
Total taxpayer's equity	**390.2**	**386.0**	**(4.1)**

M09 FY21-22 YTD Statement of Financial Position

- Fixed assets increased by £18.8m since March-21. This includes the impact of depreciation £20.6m, capital expenditure £39.3m and Grove reversionary interest of £148k.
- The Inventory value increased by £3.7m compared to Mar-21 (slide 10h). This is due to an increase in central store stock, pharmacy, cardiac catheter and cardiac pacing stocks (slide 10h).
- Debtors has decreased by £3.7m since March 2021, and this is due to high accounts receivables turnover by the Trust from NHS debtors. There has been a significant reduction in NHS Debtor accrual, NHS CCG, NHS FT receivables and Other general debtors.
- The cash position is £13m higher than reported at year-end in March-21. The increase in cash is due to the YTD Dec-21 payment received from NHS England £251m, NHS SW London CCG £360m, HEE £31m, NHS SE London CCG £25m and NHS SU Heartland CCG £21m for the block payment, Covid-19 top-up and other invoices. The Trust also received £14.2m from Epsom & St Helier, £9.7m from Croydon NHS Trust and £9.1m from NHS Kingston Trust for SWL pathology and other invoices YTD to Dec-21. Major YTD payments are NHS LA £24.3m, NHS Pension £64m, HMRC £112m including advance payment and monthly payroll. Other payments include YTD LEEF and DHSC Capital Loan and PDC payment.
- Cash resources are tightly managed monthly to meet the £3.0m minimum cash target at the end of the year.
- Creditors are £50.5m higher than the figures reported at year-end in March-21. There is a significant increase in Non-NHS Non-Pay accruals since March-21. Other liabilities (deferred income) decreased by £0.6m since March-21. March-21 creditors were low due to HMRC, and NHS Pension liability was paid in advance compared to December-21.
- Capital creditors are £12.4m lower than March-21. This decrease is due to FY 20-21 capital creditors paid in FY21-22.
- Provisions has decreased by £0.1m which is due to the utilisation of the early retirement provision.
- There has been no new borrowing since March-21, except increase in capital finance lease borrowing of £5.5m M09 YTD.
- PDC dividend charge creditor increased to £5.8m since March-21. This is due to the M09 YTD PDC dividend charge accrual of £8.4m. This accrual is based on the FY21-22 forecasted PDC dividend charge of £11.3m. On September-21, Trust paid a PDC dividend charge payment of £2.3m and also received PDC dividend charge refund of £362k for FY20/21
- No PDC capital received between April-21 and December-21.
- Taxpayers equity reduced by £4.1m in M09 YTD. This is mainly due to the I&E YTD M09 deficit of £4.1m. The M09 YTD I&E deficit, includes finance expense and PDC dividend charges.

3. Month 9 Cash Flow Statement

Statement of Cash Flow	M09 YTD FY 21-22 Actual £m
Opening Cash balance	**36.6**
Income and expenditure deficit	(4.1)
Depreciation	20.6
Impairment	0.0
Interest payable	2.4
PDC dividend	8.4
Other non-cash items	(0.1)
Operating surplus/(deficit)	**27.2**
Change in stock	(3.7)
Change in debtors	(3.7)
Change in creditors	50.5
Change in provisions	(0.1)
Net change in working capital	**43.1**
Capital spend	(39.3)
Capital Creditors	(12.4)
Capital additions Finance leases	5.5
Interest paid	(2.5)
PDC dividend charge paid	(2.7)
Net change in investing activities	**(51.3)**
PDC Capital Received	0.0
Accrued Interest YTD (DH & LEEF)	0.0
DH Capital £14.747m Loan repaid	(0.6)
LEEF Loan (Other Loan)	(1.5)
PFI	(1.0)
Finance lease payments	(2.9)
Net change in financing activities	**(6.0)**
Cash balance as at 31.12.2021	**49.5**

M09 FY21-22 YTD cash movement

- The cumulative M09 21-22 I&E deficit is £4.1m. (*NB this includes the impact of donated grants and depreciation which is excluded from the NHSI performance total).
- Within the I&E deficit of £4.1m, depreciation (£20.6m) does not impact cash. The charges for interest payable (£2.4m) and PDC dividend (£8.4m) are added back and the amounts actually paid for these expenses shown lower down for presentational purposes. This generates a YTD cash "operating surplus" of £27.2m.
- The net change in working capital has increased by £43.1m in December-21 compared to March-21. This is due to major movement in creditors of £50.5m, which is due to the increased NHS and Non-NHS accruals and NHS Pension liability in December-21 compared to March-21.
- Stock value increased by £3.7m in December-21 compared to March-21. This is due to significant increase in Pharmacy, Cardiac Catheter and Cardiac Pacing clinic stocks.
- Trust paid DH Capital loan repayment of £0.6m YTD Dec-21. LEEF loan repayment of £1.5m was paid in June-21 and Dec-21. In addition, as at December-21, Trust made a repayment of £1m and £2.9m for PFI and Finance leases, respectively.
- Capital creditors reduced by £12.4m compared to £36m in March-21 and new capital finance lease additions of £5.5m were made YTD at December-21.
- No capital or revenue support PDC funding received between April-21 and December-21.

December-21 cash position

- The Trust achieved a cash balance of £49.5m on 31st December-21, £46.5m higher than the £3m minimum cash balance required by NHSI. This is due to the December-21 contracts income including Covid-19 top-up received from CCG and NHS England.

4. M9 Capital

Spend category	FY Budget £000	YTD budget £000	YTD exp £000	*YTD var £000*
MRI	9,900	9,900	7,450	2,450
Cath Labs	6,700	6,700	4,765	1,935
Estates	6,200	2,616	17,731	-15,115
IT	6,600	2,802	3,957	-1,155
Lease Renewals	3,500	3,500	3,450	50
SWLP BAU Capital	500	0	0	0
SWLP 4TTP	700	0	0	0
Total St George's Schemes	**34,100**	**25,518**	**37,353**	**-11,835**
SWL Schemes				
Critical Care Expansion	27,217	11,004	893	10,111
SGH Emergency Floor	3,070	1,536	56	1,480
SWL LCHR (host TBC)	2,000	999	0	999
SWL PACs	1,300	651	920	-269
Community Diagnostics Hub	2,000	0	53	-53
Total SWL Schemes	**35,587**	**14,190**	**1,922**	**12,268**
Total Expenditure	**69,687**	**39,708**	**39,275**	**433**
Mitigations required in year	-5,829	0	0	0
SWL contingency held at STG	2,400	0	0	0
Expenditure as per PFR	**66,258**	**39,708**	**39,275**	**433**

- The Trust is planning to spend £66.258m on capital expenditure this financial year, including £3.5m on finance leases.
- This spend is to be funded by Internal capital of £20.497m, leases of £3.5m and new PDC allocation of £41.761m. In addition to this there is a planned £500k on donated spend.
- The spend is planned to cover a number of spending initiatives this year covering IT Medical Equipment and estate infrastructure.
- The Trust has spent £39.275m YTD as at M09.
- Trust continues to exert tight control over capital expenditure, approving requisitions for all projects.

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Meeting Title:	**TRUST BOARD**		
Date:	9th January 2022	**Agenda No.**	**4.3**
Report Title:	Emergency Preparedness Resilience and Response - Annual EPRR Assurance Submission to NHS England (London)		
Lead Director/ Manager:	Anne Brierly, Chief Operating Officer and Authorised Executive Officer (AEO)		
Report Author:	Ben Rosling, Director of Site Operations (Interim)		
Presented for:	Assurance		
Executive Summary:	This report provides an update on the outcomes of the 2021/22 NHS England EPRR Assurance review and process. The main points: • The Trust maintains a **SUBSTANTIALLY COMPLIANT** against the EPRR Core Standards. • The Trust agreed an action plan in 2019 to achieve full compliance and this has been completed with the exclusion of appointing a substantive EPRR officer. • Mitigations in place to resolve but to be completed. • As part of this process the following policies have been updated and agreed; EPRR Policy, Major Incident Plan, Guidance for On Call Managers, Trust Business Continuity Plan.		
Recommendation:	The Board is asked to note the NHS England EPRR assurance update and the 'substantial' rating remains with one outstanding action to be completed.		
Supports			
Trust Strategic Objective:	Ensure the Trust has unwavering focus on all measures of quality and safety, and patient experience.		
CQC Theme:	Well Led		
Single Oversight Framework Theme:	Operational performance		
Implications			
Risk:	If the work is not maintained, there is a risk that the trust will not be prepared in the event of a Major Incident or a significant Business Continuity disruption.		
Legal/Regulatory:	Emergency Preparedness, Resilience and Response standards are a requirement under the NHS England EPRR Framework 2015 which are aligned to the statutory duties under the Civil Contingencies Act 2004, and the Health and Social Care Act 2012.		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A
Appendices:	Appendix 1 – Revised Action plan for areas of 'substantially compliant' Appendix 2 – Full 2021/22 EPRR Assurance Report		

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

EPRR Assurance Report 2021/22 - AEO response

As required by the EPRR 2021/22 assurance process, this response:

- confirms the EPRR RAG scores agreed at the 1st October review meeting
- outlines the updated action plan required to remedy identified weaknesses
- agrees our overall level of compliance with the EPRR core standards.

1 LEVEL OF COMPLIANCE

I am pleased to note that NHS England felt that 'overall, the trust continues to demonstrate its commitment to EPRR'. With an overall level of compliance agreed as "**SUBSTANTIALLY COMPLIANT"** with one action to complete.

A Summary of the action plan can be found in Appendix 1 and the full report can be found in the updated self-assessment tool in Appendix 2.

2 PRIORITIES FOR 2021/22

The key priorities as identified at the assurance review meeting for the next twelve months include:

- Recruitment to the vacant EPRR post and consideration for an enlargement of the EPRR establishment commensurate with Acute Major Trauma Centre provision.
- Review and consolidation of the Major Incident Plan
- Director on call procedures to be reviewed.

3 NEXT STEPS

St Georges University Hospitals NHS Foundation Trust is required to submit the following documentation to England.london-assurance@nhs.net :

- The organisation's final EPRR RAG scores, as agreed at the review meeting using the self-assessment tool
- A resulting action/work plan providing clear actions, timescales and leads on areas where the organisation scored Red or Amber using the self-assessment tool
- A declaration from the AEO of the overall level of compliance achieved.

Anne Brierley

Chief Operating Officer,

AEO for St George's University Hospitals NHS Foundation Trust

Ref	Domain	Standard	Detail	Acute Providers	Evidence - examples listed below	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.
Domain 1 - Governance							
1	Governance	Senior Leadership	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director, and have the appropriate authority, resources and budget to direct the EPRR portfolio. A non-executive board member, or suitable alternative, should be identified to support them in this role.	Y	• Name and role of appointed individual	Anne Brierley - COO (AEO) Anna Clough - Deputy COO (Support officer)	Fully compliant
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy statement. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes. The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested • Include references to other sources of information and supporting documentation.	Y	Evidence of an up to date EPRR policy statement that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	See EPRR Policy July 2021, recently ammended as per version control.	Fully compliant
3	Governance	EPRR board reports	The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually. These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process.	Y	• Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board	Annual assurance review not undertaken last year, historically presented to board and published in Trust Board Annual Report. See 2019 Annual report.	Fully compliant

5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	Y	• EPRR Policy identifies resources required to fulfill EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff • Organisation structure chart • Internal Governance process chart including EPRR group	See EPRR Policy July 2021, recently ammended as per version control. Awaiting final sign off approval. No substansive EPRR Manager / EPLO in post, mitigated currently through interim arrangements. No structure chart as one individual.	Partially compliant
6	Governance	Continuous improvement process	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the development of future EPRR arrangements.	Y	• Process explicitly described within the EPRR policy statement	See EPRR Policy July 2021, recently ammended as per version control.	Fully compliant
Domain 2 - Duty to risk assess							
7	Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider community and national risk registers.	Y	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register	See EPRR risk register (export from Datix)	Fully compliant
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks.	Y	• EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	See Trust Risk Management Policy April 2021 See EPRR Policy July 2021 recently ammended as per version control.	Fully compliant
Domain 3 - Duty to maintain plans							
11	Duty to maintain plans	Critical incident	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as defined within the EPRR Framework).	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	See Trust Business Continuity plan July 2021. Recently ammended as per version control.	Fully compliant
12	Duty to maintain plans	Major incident	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as defined within the EPRR Framework).	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	See Trust Major Incident plan July 2021. Recently ammended as per version control.	Fully compliant
13	Duty to maintain plans	Heatwave	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of heatwave on the population the organisation serves and its staff.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	See Trust Heat Wave Plan June 2021	Fully compliant
14	Duty to maintain plans	Cold weather	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of snow and cold weather (not internal business continuity) on the population the organisation serves.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	See Trust Cold Weather Plan 2021-2022	Fully compliant

18	Duty to maintain plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to free up 10% of their bed base in 6 hours and 20% in 12 hours, along with the requirement to double Level 3 ITU capacity for 96 hours (for those with level 3 ITU bed).	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	See Trust Major Incident plan July 2021. Recently ammended as per version control.	Fully compliant
19	Duty to maintain plans	Mass Casualty - patient identification	The organisation has arrangements to ensure a safe identification system for unidentified patients in an emergency/mass casualty incident. This system should be suitable and appropriate for blood transfusion, using a non-sequential unique patient identification number and capture patient sex.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	See Trust Major Incident plan July 2021. Recently ammended as per version control.	Fully compliant
20	Duty to maintain plans	Shelter and evacuation	In line with current guidance and legislation, the organisation has effective arrangements in place to shelter and/or evacuate patients, staff and visitors. This should include arrangements to shelter and/or evacuate, whole buildings or sites, working in conjunction with other site users where necessary.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	See Trust Evacuation Plan July 2021	Fully compliant
21	Duty to maintain plans	Lockdown	In line with current guidance and legislation, the organisation has effective arrangements in place to safely manage site access and egress for patients, staff and visitors to and from the organisation's facilities. This should include the restriction of access / egress in an emergency which may focus on the progressive protection of critical areas.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	See Trust Lockdown Plan June 2021	Fully compliant
22	Duty to maintain plans	Protected individuals	In line with current guidance and legislation, the organisation has effective arrangements in place to respond and manage 'protected individuals'; Very Important Persons (VIPs), high profile patients and visitors to the site.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	See Trust Media and Social Media Policy Incldung High Profile Patients and VIP Visits January 2019	Fully compliant
Domain 4 - Command and control							
24	Command and control	On-call mechanism	A resilient and dedicated EPRR on-call mechanism is in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents. This should provide the facility to respond to or escalate notifications to an executive level.	Y	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Include 24 hour arrangements for alerting managers and other key staff.	See Trust On Call Policy April 2021	Fully compliant
Domain 5 - Training and exercising							
Domain 6 - Response							
30	Response	Incident Co-ordination Centre (ICC)	The organisation has Incident Co-ordination Centre (ICC) arrangements	Y		See Trust HICC SOP July 2021	Fully compliant
32	Response	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Y	• Business Continuity Response plans	See Trust Business Continuity plan July 2021. Recently ammended as per version control.	Fully compliant
34	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to business continuity incidents, critical incidents and major incidents.	Y	• Documented processes for completing, signing off and submitting SitReps	See Trust HICC SOP July 2021	Fully compliant
35	Response	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Y	• Guidance is available to appropriate staff either electronically or hard copies	Printed copy in ED MI Cupboard and also HICC MI Cupboard. Digital copies available on Trust Intranet	Fully compliant
36	Response	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the PHE 'CBRN incident: Clinical Management and health protection' guidance.	Y	• Guidance is available to appropriate staff either electronically or hard copies	Printed copy in ED MI Cupboard and also HICC MI Cupboard. Digital copies available on Trust Intranet	Fully compliant
Domain 7 - Warning and informing							

37	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident.	Y	• Have emergency communications response arrangements in place • Social Media Policy specifying advice to staff on appropriate use of personal social media accounts whilst the organisation is in incident response • Using lessons identified from previous major incidents to inform the development of future incident response communications • Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes • Being able to demonstrate that publication of plans and assessments is part of a joined-up communications strategy and part of your organisation's warning and informing work	See Trust Media and Social Media Policy Incldung High Profile Patients and VIP Visits January 2019 See Coomunications on-call and major incident planing pack Sept 2021	Fully compliant
38	Warning and informing	Warning and informing	The organisation has processes for warning and informing the public (patients, visitors and wider population) and staff during major incidents, critical incidents or business continuity incidents.	Y	• Have emergency communications response arrangements in place • Be able to demonstrate consideration of target audience when publishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing	See Trust Media and Social Media Policy Incldung High Profile Patients and VIP Visits January 2019 See Coomunications on-call and major incident planing pack Sept 2021	Fully compliant
39	Warning and informing	Media strategy	The organisation has a media strategy to enable rapid and structured communication with the public (patients, visitors and wider population) and staff. This includes identification of and access to a media spokespeople able to represent the organisation to the media at all times.	Y	• Have emergency communications response arrangements in place • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing • Having an agreed media strategy	See Trust Media and Social Media Policy Incldung High Profile Patients and VIP Visits January 2019 See Coomunications on-call and major incident planing pack Sept 2021	Fully compliant
Domain 8 - Cooperation							
42	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Y	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Signed mutual aid agreements where appropriate	See Trust Major Incident plan July 2021. Recently ammended as per version control. Supported SWL Critical Care Newtowk with mutual aid in height of Covid-19 waves with ITU Surge capacity for both adult & paediatric (Covid & non Covid)	Fully compliant
46	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders, during major incidents, critical incidents or business continuity incidents.	Y	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation and the Civil Contingencies Act 2004 'duty to communicate with the public'.	See EPRR Policy July 2021, recently ammended as per version control. See Data Protection and Confidentiality Policy Febuary 2021 Information Governance Policy January 2021	Fully compliant
Domain 9 - Business Continuity							
47	Business Continuity	BC policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continutiy Management System (BCMS) in alignment to the ISO standard 22301.	Y	Demonstrable a statement of intent outlining that they will undertake BC - Policy Statement	See EPRR Policy July 2021, recently ammended as per version control.	Fully compliant

48	Business Continuity	BCMS scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented.	Y	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • Stakeholders	See EPRR Policy July 2021, recently ammended as per version control.	Fully compliant
50	Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	Statement of compliance	https://www.dsptoolkit.nhs.uk/OrganisationSearch/RJ7	Fully compliant
51	Business Continuity	Business Continuity Plans	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Y	• Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation	See Trust Business Continuity plan July 2021. Recently ammended as per version control. Local BC plans due update New BC template for trust revised July 2021 Local BC plans to be updated.	Fully compliant
53	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Audit reports	See EPRR Policy July 2021, recently ammended as per version control.	Fully compliant
54	Business Continuity	BCMS continuous improvement process	There is a process in place to assess the effectivness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Action plans	See EPRR Policy July 2021, recently ammended as per version control.	Fully compliant
55	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements work with their own.	Y	• EPRR policy document or stand alone Business continuity policy • Provider/supplier assurance framework • Provider/supplier business continuity arrangements	See EPRR Policy July 2021, recently ammended as per version control.	Fully compliant
Domain 10: CBRN							
56	CBRN	Telephony advice for CBRN exposure	Key clinical staff have access to telephone advice for managing patients involved in CBRN incidents.	Y	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements	See CBRNe plan July 2021, recently ammended as per version control.	Fully compliant
57	CBRN	HAZMAT / CBRN planning arrangement	There are documented organisation specific HAZMAT/ CBRN response arrangements.	Y	Evidence of: • command and control structures • procedures for activating staff and equipment • pre-determined decontamination locations and access to facilities • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • interoperability with other relevant agencies • plan to maintain a cordon / access control • arrangements for staff contamination • plans for the management of hazardous waste • stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • contact details of key personnel and relevant partner agencies	See CBRNe plan July 2021, recently ammended as per version control.	Fully compliant
58	CBRN	HAZMAT / CBRN risk assessments	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste.	Y	• Impact assessment of CBRN decontamination on other key facilities	Previous impact assessment - see risk assessmnet form Paeds Majors and tent July 2021	Fully compliant
59	CBRN	Decontamination capability availability 24 /7	The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four patients per hour), 24 hours a day, 7 days a week.	Y	• Rotas of appropriately trained staff availability 24 /7	See ED staff shift allocation template	Fully compliant

60	CBRN	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Y	• Completed equipment inventories; including completion date	See equipment checklist	Fully compliant
62	CBRN	Equipment checks	There are routine checks carried out on the decontamination equipment including: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other decontamination equipment. There is a named individual responsible for completing these checks	Y	• Record of equipment checks, including date completed and by whom. • Report of any missing equipment	Equipment checked monthly as part of refresher training. ED Matron - Major Incident Lead Responsible.	Fully compliant
63	CBRN	Equipment Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date decontamination equipment for: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other equipment	Y	• Completed PPM, including date completed, and by whom	PRPS Suits booked for service 3rd & 4th November 2021	Fully compliant
64	CBRN	PPE disposal arrangements	There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance.	Y	• Organisational policy	Waste Management Policy June 2021	Fully compliant
65	CBRN	HAZMAT / CBRN training lead	The current HAZMAT/ CBRN Decontamination training lead is appropriately trained to deliver HAZMAT/ CBRN training	Y	• Maintenance of CPD records	Lachlan Attwooll - see certificate 2018	Fully compliant
67	CBRN	HAZMAT / CBRN trained trainers	The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.	Y	• Maintenance of CPD records	Lachlan Attwooll & Cameron Barnes - see certificate 2018	Fully compliant
68	CBRN	Staff training - decontamination	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	Y	• Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • All service providers - see Guidance for the initial management of self presenters from incidents involving hazardous materials - https://www.england.nhs.uk/publication/eprr-guidance-for-the-initial-management-of-self-presenters-from-incidents-involving-hazardous-materials/ • All service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • A range of staff roles are trained in decontamination technique	See CBRNe plan July 2021, recently ammended as per version control.	Fully compliant
69	CBRN	FFP3 access	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to, and are trained to use, FFP3 mask protection (or equivalent) 24/7.	Y		FFP3 Masks readily available in every clincial area across the Trust. Also included on Cardiac Arrest Trolley PPE 'grab packs'. Corporate Nursing Team responsible for fit testing.	Fully compliant

2021 EPRR Assurance Report

St George's University Hospitals NHS Foundation Trust

Version number: 1.0 FINAL

First published: 24 November 2021

Prepared by: David Robinson, Graham Leedham, Anneke Biginton

Classification: OFFICIAL

OFFICIAL

Contents

1 2021-22 Assurance review summary

Annually, all NHS funded organisations are asked to provide an assurance return against the Emergency Preparedness, Resilience and Response (EPRR) core standards. The London regional office then holds individual review meetings with each organisation to discuss and agree a level of compliance.

For 2020-21, in recognition of the ongoing COVID response, a decision was made that the majority of organisations would not be required to participate in a review meeting to discuss their self-assessment return.

In 2021-22 the regional team returned to holding individual review meetings with all organisations. Nationally the core standards have been amended to reflect the ongoing challenges of the COVID response and the simultaneous recovery and restoration work. Regionally the meetings and reviews have focused on operational effectiveness and the safety of patients and staff.

A number of standards were removed for this year's process and others modified to reflect the potential interruptions from the pandemic on the usual planning cycles but, does not detract from their importance within EPRR. It is essential for all organisations to maintain their resilience and preparedness but inevitable that the COVID response will have impacted on areas of EPRR in the same way it has across all parts of the NHS. The regional team recognise this may result in some organisations assurance ratings not matching their previous achievements.

The regional team will use the results of the assurance process to highlight targeted support for the system through the regional business plan, work programme and ongoing EPRR engagement activities.

The assurance meeting for St Georges University Hospitals NHS Foundation Trust took place via MSTeams on Friday 1st October 2021. As a result of this meeting, St. Georges University Hospitals NHS Foundation Trust has an assessed level of compliance as **Substantially Compliant**. The details of the review can be found in the following report.

2 Assurance review process

The assurance process for St Georges University Hospitals NHS Foundation Trust was conducted as follows,

Assurance Meeting	Date of Visit	Assurance Review attendance
Main Assurance Meeting	01 October 2021	**David Robinson** (Chair)– NHS England and NHS Improvement – London **Graham Leedham** – NHS England and NHS Improvement - London **Anneke Biginton** – NHS England and NHS Improvement – London **Steve Jupp** – The Hillingdon Hospitals NHS Foundation Trust **Carla Ryan** – The Hillingdon Hospitals NHS Foundation Trust **Daniel Ryan** – St Georges Hospitals NHS Foundation Trust **Vinodh Kumar** – St Georges Hospitals NHS Foundation Trust **Brian Dunne** – St Georges Hospitals NHS Foundation Trust

3 Overall level of compliance

In accordance with the requirements laid out in the EPRR 2021-22 Assurance Process Letter (27 July 2021), the overall level of compliance is based on the total percentage of amber and red ratings.

In respect of St Georges University Hospitals NHS Foundation Trust for Core Standards 1 – 69, the following RAG ratings were agreed at the review meeting:

Red ratings	Amber ratings	Green ratings
0	1	45

Total number of red / amber ratings	1

This means St Georges University Hospitals NHS Foundation Trust has an assessed level of compliance of **Substantially Compliant.**

OFFICIAL

4 Assurance review outcomes

4.1 Main Assurance Visit Outcomes

Amber ratings were received for the following core standards:

- CS 5 EPRR Resource

Full details of the assurance review meeting agreed RAG ratings and discussion points can be found in appendix A.

4.1.2 Deep dive outcomes – Oxygen Supply

The deep dive was reviewed by EPRR practitioners and not technical experts or authorised individuals. As such, the outcomes below are based on the expert opinion of the organisation.

The trust received all fully compliant ratings for the deep dive.

Full details of the deep dive review, agreed RAG ratings and discussion points can be found in appendix A. The deep dive does not contribute to the overall compliance level.

4.2 Assurance review meeting agreed actions

NHS England and NHS Improvement (London) EPRR / Panel-agreed actions as follows:

- NHS England to forward comments from peer reviewer to the trust.
- St Georges University Hospitals NHS Foundation Trust to change CBRN Action Card reference from '999 Fire Brigade to CRCE/NPIS as referenced in the CBRN appendix.

4.3 Identified areas of good practice

The review panel noted the comprehensive suite of incident management and business continuity plans evidenced by the trust. Specific areas of good practice were noted as below:

- Critical Incident Planning – Good to show the structure at the front of the plan
- Loggist and Senior ICT Action Cards.
- Hazmat and CBRN Plan – An overall good plan

5 Next Steps: Action Plans and Governance

St Georges University Hospitals NHS Foundation Trust is required to submit the following documentation to england.london-assurance@nhs.net by 23 December 2021.

- The organisation's final EPRR RAG scores, as agreed at the review meeting using the self-assessment tool
- A resulting action/work plan providing clear actions, timescales and leads on areas where the organisation scored Red or Amber using the self-assessment tool
- A declaration from the AEO of the overall level of compliance achieved.

5.1 Identified key priorities

The key priorities as identified at the assurance review meeting for the next twelve months include:

- Recruitment to the vacant EPRR post and consideration for an enlargement of the EPRR establishment commensurate with Acute Major Trauma Centre provision.
- Review and consolidation of the Major Incident Plan.
- Director on call procedures to be reviewed.

6 Conclusion

Despite the impacts of COVID, the organisation has continued to maintain an appropriate level of preparedness. The regional team would like to note the excellent work in this area by the previous Emergency Planning Manager, Kristel McDevitt that provides a foundation for the trust going forward.

The review noted the continued provision of EPRR training throughout the challenging COVID response however these standards were not assessed this year. It is anticipated that the organisation will be able to maintain and build on this provision when these standards return for the next EPRR assurance process in 2022-23 with the appropriate resources in post.

It is understood that the trust is actively seeking to recruit a substantive post holder. This combined with an overall review of the EPRR establishment will enable the trust to continue to embed and to champion contingency planning throughout the organisation. The regional EPRR team do have concerns that if the dedicated resource is not provided the organisation will struggle to maintain its current level of preparedness.

The regional EPRR team look forward to working with St Georges University Hospitals NHS Foundation Trust over the next financial year and onwards for the good of our patients, staff and the communities in South London.

David Robinson
EPRR Senior Manager – South London
David.robinson38@nhs.net

Graham Leedham
EPRR Manager – South London
Graham.Leedham@nhs.net

Anneke Biginton
EPRR Officer – South London
Anneke.Biginton@nhs.net

Appendix A - assurance review meeting agreed RAG ratings and discussion points.

EPRR Core Standards					
CS Ref	**Standard**	**Detail**	**Self-assessment RAG rating**	**Agreed 2021 RAG rating**	**RAG rating rationale and review meeting comments**
Governance					
1	**Appointed AEO**	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director, and have the appropriate authority, resources and budget to direct the EPRR portfolio. A non-executive board member, or suitable alternative, should be identified to support them in this role.	**Fully compliant**	**Fully compliant**	**Agreed as per trust evidence**
2	**EPRR Policy Statement**	The organisation has an overarching EPRR policy statement. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes. The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for making sure the policies and arrangements are updated, distributed and regularly tested • Include references to other sources of information and supporting documentation.	**Fully compliant**	**Fully compliant**	**Agreed as per trust evidence** **Comprehensive document** • **Need to check currency of some references to groups** • **Risk section would benefit from being expanded** • **Suggestion of Sub section numbers for ease of reading**
3	**EPRR board reports**	The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually. These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • business continuity, critical incidents and major incidents • the organisation's position in relation to the NHS England EPRR assurance process.	**Partially compliant**	**Fully compliant**	**The review panel discussed this standard and agreed that whilst the board may not have received a direct report on the EPRR core standards they would definitely be sighted on EPRR activity.** **This standard was agreed to be fully compliant.**

4	**EPRR work programme**	The organisation has an annual EPRR work programme, informed by lessons identified from: • incidents and exercises • identified risks • outcomes from assurance processes.			**This Core Standard is not assessed this year**
5	**EPRR Resource**	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	**Partially compliant**	**Partially compliant**	**Current issues with EPRR role recruitment.** **The review team expressed concern about future maintenance of procedures and plans without any EPRR dedicated resource.**
6	**Continuous improvement process**	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the development of future EPRR arrangements.	**Fully compliant**	**Fully compliant**	**Agreed as per trust evidence**
Duty to risk assess					
7	**Risk assessment**	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider community and national risk registers.	**Fully compliant**	**Fully compliant**	**Agreed as per trust evidence** **Referenced on p6 but suggestion of expanding this reference.** **Robust method of reporting – suggestion to expand upon in documentation potentially using a flow chart or diagram.**
8	**Risk Management**	The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks.	**Fully compliant**	**Fully compliant**	**Agreed as per trust evidence**
Duty to maintain plans					
9	**Collaborative planning**	Plans have been developed in collaboration with partners and service providers to ensure the whole patient pathway is considered.			**This Core Standard is not assessed this year**
11	**Critical incident**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as per the EPRR Framework).	**Fully compliant**	**Fully compliant**	**Agreed as per trust evidence** **Overall a good document** • **Loggist action card good and best practice** • **ICT senior manager card good practice** • **Organisational names need a review** • **Page numbers need review** • **Structure- good to have at the front – good practice** • **Flow of document – suggestion to review ordering**
12	**Major incident**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as per the EPRR Framework).	**Fully compliant**	**Fully compliant**	**Agreed as per trust evidence** **Overall a good document** • **Change history and governance would benefit form a review** • **Organisational names need a review** • **Suggestion to make role title generic rather than named individuals** • **Large document which makes keeping up to date challenging**

13	**Heatwave**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of heat wave on the population the organisation serves and its staff.	**Fully compliant**	**Fully compliant**	**Agreed as per trust evidence**
14	**Cold weather**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of snow and cold weather (not internal business continuity) on the population the organisation serves.	**Fully compliant**	**Fully compliant**	**Agreed as per trust evidence**
15	**Pandemic influenza**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to pandemic influenza as described in the National Risk Register.			**This Core Standard is not assessed this year**
16	**Infectious disease**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including Viral Haemorrhagic Fever. These arrangements should be made in conjunction with Infection Control teams; including supply of adequate FFP3.			**This Core Standard is not assessed this year**
17	**Mass Countermeasures**	In line with current guidance and legislation, the organisation has effective arrangements in place to distribute Mass Countermeasures - including the arrangement for administration, reception and distribution, eg mass prophylaxis or mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop Mass Countermeasure distribution arrangements. These will be dependent on the incident, and as such requested at the time. CCGs may be required to commission new services dependant on the incident.			**This Core Standard is not assessed this year**
18	**Mass Casualty - surge**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to increase capacity by 10% in 6 hours and 20% in 12 hours.	**Fully compliant**	**Fully compliant**	**Agreed as per trust evidence**
19	**Mass Casualty - patient identification**	The organisation has arrangements to ensure a safe identification system for unidentified patients in emergency/mass casualty incident. Ideally this system should be suitable and appropriate for blood transfusion, using a non-sequential unique patient identification number and capture patient sex.	**Fully compliant**	**Fully compliant**	**Agreed as per trust evidence**

20	**Shelter and evacuation**	In line with current guidance and legislation, the organisation has effective arrangements in place to place to shelter and / or evacuate patients, staff and visitors. This should include arrangements to perform a whole site shelter and / or evacuation.	**Fully compliant**	**Fully compliant**	**Agreed as per trust evidence** **Learning and best practice from recent flooding incidents may support plan revision.**
21	**Lockdown**	In line with current guidance and legislation, the organisation has effective arrangements in place safely manage site access and egress of patients, staff and visitors to and from the organisation's facilities. This may be a progressive restriction of access / egress that focuses on the 'protection' of critical areas.	**Fully compliant**	**Fully compliant**	**Agreed as per trust evidence**
22	**Protected individuals**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to manage 'protected individuals'; including VIPs, high profile patients and visitors to the site.	**Fully compliant**	**Fully compliant**	**Agreed as per trust evidence** **Making sure all staff aware of comms plan**
23	**Excess death planning**	Organisation has contributed to and understands its role in the multiagency planning arrangements for excess deaths, including mortuary arrangements.			**This Core Standard is not assessed this year**
Command & Control					
24	**On call mechanism**	A resilient and dedicated EPRR on call mechanism in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents. This should provide the facility to respond or escalate notifications to an executive level.	**Fully compliant**	**Fully compliant**	**Agreed as per trust evidence** • **Feedback from recent regional communications exercise (commex) – the trust failed to respond in requested time frame and the response should have been from Director on call rather than EPLO.** • **Acknowledged by trust that further work required regarding on call responsibilities** • **Support offered by regional team with the above.**
25	**Trained on call staff**	On-call staff are trained and competent to perform their role and are in a position of delegated authority on behalf of the Chief Executive Officer / Clinical Commissioning Group Accountable Officer. The identified individual: • Should be trained according to the NHS England EPRR competencies (National Occupational Standards) • Can determine whether a critical, major or business continuity incident has occurred • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout.			**This Core Standard is not assessed this year**

Training & exercising					
26	**EPRR Training**	The organisation carries out training in line with a training needs analysis to ensure staff are competent in their role; training records are kept demonstrating this.			**This Core Standard is not assessed this year**
27	**EPRR exercising and testing programme**	The organisation has an exercising and testing programme to safely test major incident, critical incident and business continuity response arrangements. Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement.			**This Core Standard is not assessed this year**
28	**Strategic and tactical responder training**	Strategic and tactical responders must maintain a continuous personal development portfolio demonstrating training in accordance with the National Occupational Standards, and / or incident / exercise participation			**This Core Standard is not assessed this year**
Response					
30	**Incident Co-ordination Centre (ICC)**	The organisation has a pre-identified an Incident Co-ordination Centre (ICC) and alternative fall-back location. Both locations should be tested and exercised to ensure they are fit for purpose and supported with documentation for its activation and operation.	**Fully compliant**	**Fully compliant**	**Agreed as per trust evidence**
31	**Access to planning arrangements**	Version controlled, hard copies of all response arrangements are available to staff at all times. Staff should be aware of where they are stored; they should be easily accessible.			**This Core Standard is not assessed this year**
32	**Management of business continuity incidents**	The organisations incident response arrangements encompass the management of business continuity incidents.	**Fully compliant**	**Fully compliant**	**Agreed as per trust evidence**
33	**Loggist**	The organisation has 24-hour access to a trained loggist(s) to ensure decisions are recorded during business continuity incidents, critical incidents and major incidents.			**This Core Standard is not assessed this year**

34	**Situation Reports**	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to business continuity incidents, critical incidents and major incidents.	**Fully compliant**	**Fully compliant**	**Agreed as per trust evidence**
35	**Access to 'Clinical Guidance for Major Incidents'**	Emergency Department staff have access to the NHSE 'Clinical Guidance for Major Incidents' handbook.	**Fully compliant**	**Fully compliant**	**Agreed as per trust evidence**
36	**Access to 'CBRN incident: Clinical Management and health protection'**	Clinical staff have access to the PHE 'CBRN incident: Clinical Management and health protection' guidance.	**Fully compliant**	**Fully compliant**	**Agreed as per trust evidence**
Warning & Informing					
37	**Communication with partners and stakeholders**	The organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident.	**Fully compliant**	**Fully compliant**	**Agreed as per trust evidence**
38	**Warning and informing**	The organisation has processes for warning and informing the public and staff during major incidents, critical incidents or business continuity incidents.	**Fully compliant**	**Fully compliant**	**Agreed as per trust evidence**
39	**Media strategy**	The organisation has a media strategy to enable communication with the public. This includes identification of and access to trained media spokespeople able to represent the organisation to the media at all times.	**Fully compliant**	**Fully compliant**	**Agreed as per trust evidence**
Cooperation					
40	**LRHP attendance**	The Accountable Emergency Officer, or an appropriate director, attends (no less than 75%) of Local Health Resilience Partnership (LHRP) meetings per annum.			**This Core Standard is not assessed this year**
41	**LRF / BRF attendance**	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with other responders.			**This Core Standard is not assessed this year**
42	**Mutual aid arrangements**	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, co-ordinating and maintaining resource e.g. staff, equipment, services and supplies. These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA).	**Fully compliant**	**Fully Compliant**	**Agreed as per trust evidence**

46	**Information sharing**	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders.	**Fully compliant**	**Fully compliant**	**Agreed as per trust evidence**
Business Continuity					
47	**BC policy statement**	The organisation has in place a policy statement of intent to undertake Business Continuity Management System (BCMS).	**Fully compliant**	**Fully compliant**	**Agreed as per trust evidence**
48	**BCMS scope and objectives**	The organisation has established the scope and objectives of the BCMS, specifying the risk management process and how this will be documented.	**Fully compliant**	**Fully compliant**	**Agreed as per trust evidence**
49	**Business Impact Assessment**	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(s).			**This Core Standard is not assessed this year**
50	**Data Protection and Security Toolkit**	Organisation's IT department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	**Fully compliant**	**Fully compliant**	**Agreed as per trust evidence**
51	**Business Continuity Plans**	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure These plans will be updated regularly (at a minimum annually), or following organisational change.	**Fully compliant**	**Fully compliant**	**Agreed as per trust evidence** • **Review of BC leads – NHS Wandsworth CCG to be updated to SWL STP/ ICS** • **Suggestion of use of hyperlinks and consistency of presentation could be improved** • **Suggestion of critical services in the plan could be expanded** • **Suggestion to review the flow of the document** • **NHS E/I acknowledges workforce challenges for EPRR**
52	**BCMS monitoring and evaluation**	The organisation's BCMS is monitored, measured and evaluated against the Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.			**This Core Standard is not assessed this year**
53	**BC audit**	The organisation has a process for internal audit, and outcomes are included in the report to the board.	**Fully compliant**	**Fully compliant**	**Agreed as per trust evidence**
54	**BCMS continuous improvement process**	There is a process in place to assess and take corrective action to ensure continual improvement to the BCMS.	**Fully compliant**	**Fully compliant**	**Agreed as per trust evidence**
55	**Assurance of commissioned providers / suppliers BCPs**	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers arrangements work with their own.	**Fully compliant**	**Fully compliant**	**Agreed as per trust evidence** • **Identification of critical services** • **Acknowledged the recent challenges around suppliers** • **The trust are aware this is an area that needs further exploring and time on**

CBRN						
56	**Telephony advice for CBRN exposure**	Staff have access to telephone advice for managing patients involved in CBRN exposure incidents.	**Fully compliant**	**Fully compliant**	**Agreed as per trust evidence**	
57	**HAZMAT / CBRN planning arrangement**	There are organisation specific HAZMAT/ CBRN planning arrangements (or dedicated annex).	**Fully compliant**	**Fully compliant**	**Agreed as per trust evidence** **Overall a good plan** **Need to review the action card referencing 999 call for Fire and Rescue support.**	
58	**HAZMAT / CBRN risk assessments**	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste.	**Fully compliant**	**Fully compliant**	**Agreed as per trust evidence**	
59	**Decontamination capability availability 24/7**	The organisation has adequate and appropriate decontamination capability to manage self-presenting patients (minimum four per hour), 24 hours a day, 7 days a week.	**Fully compliant**	**Fully compliant**	**Agreed as per trust evidence**	
60	**Equipment and supplies**	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients.	**Fully compliant**	**Fully compliant**	**As evidenced by trust and CBRN visits by LAS**	
61	**PRPS availability**	The organisation has the expected number of PRPS (sealed and in date) available for immediate deployment. There is a plan and finance in place to revalidate (extend) or replace suits that are reaching their expiration date.			**This Core Standard is not assessed this year**	
62	**Equipment checks**	There are routine checks carried out on the decontamination equipment including: • Suits • Tents • Pump • RAM GENE (radiation monitor) • Other decontamination equipment. There is a named individual responsible for completing these checks	**Fully compliant**	**Fully compliant**	**As evidenced by trust and CBRN visits by LAS**	
63	**Equipment PPM**	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date decontamination equipment for: • Suits • Tents • Pump • RAMGENE (radiation monitor) • Other equipment	**Fully compliant**	**Fully compliant**	**As evidenced by trust and CBRN visits by LAS**	

64	**PPE disposal arrangements**	There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance.	**Fully compliant**	**Fully compliant**	**Agreed as per trust evidence**
65	**HAZMAT / CBRN training lead**	The current HAZMAT / CBRN Decontamination training lead is appropriately trained to deliver HAZMAT / CBRN training	**Fully compliant**	**Fully compliant**	**Agreed as per trust evidence** **Trust acknowledges it would be beneficial to have further trainers as currently have two members that can train**
66	**Training programme**	Internal training is based upon current good practice and uses material that has been supplied as appropriate. Training programme should include training for PPE and decontamination.			**This Core Standard is not assessed this year**
67	**HAZMAT / CBRN trained trainers**	The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.	**Fully compliant**	**Fully compliant**	**Agreed as per trust evidence**
68	**Staff training - decontamination**	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	**Fully compliant**	**Fully compliant**	**Agreed as per trust evidence**
69	**FFP3 access**	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to FFP3 mask protection (or equivalent) 24 / 7.	**Fully compliant**	**Fully compliant**	**Agreed as per trust evidence**

Deep Dive – Oxygen supply

CS Ref	Standard	Suggested areas for review & evidence suggested by national	Self-assessed RAG	Agreed 2021 RAG rating	RAG rating rationale & meeting comments
DD1	**Medical gasses - governance**	The organisation has in place an effective Medical Gas Committee as described in Health Technical Memorandum HTM02-01 Part B.	**Fully compliant**	**Fully compliant**	**Agreed as per trust evidence** **Committee – Estates and chief Pharmacist co lead including nursing, medical and executive representation with supporting policy.**
DD2	**Medical gasses - planning**	The organisation has robust and tested Business Continuity and/or Disaster Recovery plans for medical gases	**Fully compliant**	**Fully compliant**	**Agreed as per trust evidence** **As above**
DD3	**Medical gasses - planning**	The organisation has used Appendix H to the HTM 0201 part A to support the planning, installing, upgrading of its cryogenic liquid supply system.	**Fully compliant**	**Fully compliant**	**Agreed as per trust evidence** **SGH estates – no further comments however representation on the meeting**
DD4	**Medical gasses - workforce**	The organisation has reviewed the skills and competencies of identified roles within the HTM and has assurance of resilience for these functions.	**Fully compliant**	**Fully compliant**	**Agreed as per trust evidence**
DD5	**Oxygen systems - escalation**	The organisation has a clear escalation plan and processes for management of surge in oxygen demand	**Fully compliant**	**Fully compliant**	**Agreed as per trust evidence**
DD6	**Oxygen systems**	Organisation has an accurate and up to date technical file on its oxygen supply system with the relevant instruction for use (IFU)	**Fully compliant**	**Fully compliant**	**Agreed as per trust evidence**
DD7	**Oxygen systems**	The organisation has undertaken as risk assessment in the development of the medical oxygen installation to produce a safe and practical design and ensure that a safe supply of oxygen is available for patient use at all times as described in Health Technical Memorandum HTM02-01 6.6	**Fully compliant**	**Fully compliant**	**Agreed as per trust evidence**

This page is intentionally left blank

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	27 January 2022	**Agenda No**	**4.4**
Report Title:	**Board Assurance Framework (BAF) Quarter 3 2021/22 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 Maria Prete, Risk Manager		
Presented for:	**Assurance**		
Executive Summary:	This paper presents the Trust Board with the Board Assurance Framework as at January 2022 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 key changes at January 2022 are that the risk score for SR9 (workforce) is proposed to increase from 16 to 20 in the context of the risks related to vaccination as a condition of deployment, and an increase in the assurance rating for SR3 (timely access to care).		
	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 Executive Management Team	**Date**	20.01.2022 20.01.2022 13.01.2022 19.01.2022
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 January 2022		

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Board Assurance Framework 2021/22

Trust Board
BAF Report – January update

Stephen Jones
Chief Corporate Affairs Officer

27 January 2022

Executive Summary

1. Purpose

This paper presents the Trust Board with the Board Assurance Framework as at January 2022 and sets out the proposed risk scores and assurance ratings, as well as the actions being taken to address identified gaps in control and assurance.

With the exception of Strategic Risk 4, which is reserved to the Board, the information set out for each strategic risk has been reviewed by the relevant Board Committee, following review by the responsible sub-Group of the Trust Management Group and by the Executive Management Team.

2. Background

The Board Assurance Framework (BAF) brings together in one place all of the relevant information on the risks to the delivery of the Board's strategic objectives 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 2020, the Board agreed a set of "stretching but realistic" year-end target risk scores, which were proposed by the Executive Director responsible for each individual strategic risk and endorsed by the relevant Board Committee. The Board Committees are assigned the Strategic Risks as follows, with Strategic Risk 4 (system working) reserved to the Board:

- Quality and Safety Committee: Strategic Risks 1 (patient safety and learning), 2 (clinical governance), and 10 (research)
- Finance and Investment Committee: Strategic Risks 3 (operational performance and access), 5 (financial sustainability), 6 (capital), and 7 (estates)
- Workforce and Education Committee: Strategic Risks 8 (culture) and 9 (workforce)

At Executive level, the sub-groups of the Trust Management Group oversee the following risks:

- Patient Safety and Quality Group: SR1, SR2, SR10
- Operations Management Group: SR3, SR5, SR6
- People Management Group: SR8, SR9
- Risk and Assurance Group: SR4, SR7

In line with the decision of the Board in May 2020, the impact of Covid-19 has been measured against each strategic risk on the BAF. The Board considered including a stand alone Covid-19 strategic risk, but considered that given that the pandemic had implications across the BAF it would be more appropriate to track the impact of the pandemic against the existing strategic risks. Defined Covid-19 risks are set out on the Corporate Risk Register.

Executive Summary

3. Update at January 2022:

- **Risk scores:** There are seven extreme risks, two high risks and 1 moderate risk. There is one proposed change to the strategic risk scores – an uplift in the risk score for Strategic Risk 9 (workforce): "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 is proposed to move from 16 (4x4) to 20 (5x4) as the potential consequence of the introduction of vaccination as a condition of deployment and a period of higher staff absences during the Omicron wave means that the consequence of the risk is increased. This increase in risk score was endorsed by the Workforce and Education Committee at its January 2022 meeting.

- **Assurance Ratings**: Seven of the ten strategic risks currently have a 'partial' assurance rating; and three have a 'good' assurance rating. The assurance rating for SR3 (timely access to care) has been increased from limited to partial this month, as endorsed by the Finance and Investment Committee at its meeting in January 2022.

- **Target risks:** Target risks were initially defined by the Board in September 2020. Performance against the target risks was reviewed by the Board Committees prior to submission of the Q4 BAF to the Board. The target risks are proposed for Q3 2021/22 (slide 15) as recommended by the relevant Committees. The Committees will review in March the year-end position.

- **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 on the risk register in Datix (see as highlighted for SR5 and 6 slide 68 and 69). This compromises the integrity of the BAF as the information from the risk register in Datix should populate the BAF. Risk owners are in the process of updating these risks.

- **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 2 in November 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, but a change in the assurance rating for SR3 is recommended.

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 May, the Board set 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 Q2, 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 Q3, a risk score of 12 and assurance rating of "good" is proposed to be maintained. An in-year target risk score of 12(4x3) was set in May 2021 to reflect a realistic year end position for this risk to reflect the risk that other members of the Acute Provider Collaborative in SWL will pursue clinical/ commercial relationships with other tertiary NHS providers that pose a strategic threat to SGUH.

4. Recommendation

The Board is asked:

1. For the strategic risk reserved to itself (SR4) to: agree the proposed score of 12 (4c x 3l) (no change), and agree the proposed assurance rating of 'good'.
2. For the nine risks assigned to its assuring committees to:
   - Agree the proposed risk scores, assurance ratings and statements from the relevant assuring committee, including approving the increase in risk rating for SR9 (workforce) and an increase in the assurance rating from limited to partial for SR3 (timely access to care).
   - Note the progress achieved in year in mitigating identified gaps in control and assurance

Outstanding care every time

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 Q3 2021/22: Summary		
Proposed risk score at Q3 2021/22:	**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 20 January 2022
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 Q3 2021/22:	**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 Q3 2021/22 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
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**	The Trust has successfully appointed to all new posts as recommended by the Clinical Governance Improvement Program. Progress has also been made to address the non-compliance with 7 day clinical standards. Directorates have defined plans in place to address all non- compliance. Capital works to install 2 static MRIs has commenced, expected to go-live in the Spring time of 2022. Progress has also been made with the development of electronic reporting for treatment escalation plans at divisional level. However, there has been slippage on the development of the ability to see this information at ward level which is now expected in February 2022. This will support the implementation of the Quality and Safety strategy

Overview

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

SR2 position at Q3 2021/22: Summary		
Proposed risk score at Q3 2021/22:	**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 20 January 2022
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.
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 Q3 2021/22:	**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 Q4 2021/22.
Change from last quarter:	⟷ **No change**	No changes are proposed to the overall risk score or to the assurance rating 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**	There has been significant progress against the Clinical Governance Improvement programme presented to the Board which had been informed by the three independent governance reviews. 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 seven remaining actions to address gaps in control and assurance. 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. For risk mitigations not associated with the Clinical Governance Improvement Program apart from one gap in control associated with delivery of improved eDischarge summaries, all actions are on track for delivery by the respective due dates. There has also been slippage in a due date for one risk mitigation until June 2022 due to the need to divert resources from this improvement project to Covid-19 priorities: OrderComms catalogue not kept up to date therefore not all results are reported via Cerner

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 Q3 2021/22: Summary		
Proposed risk score at Q3 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.
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 Q3 2021/22:	**Partial**	Proposal for the assurance rating to be improved from Limited to Partial was agreed at the Finance and Investment Committee in January 2022
Change from last month:	⇧ **Improvement**	It is proposed that the assurance rating on this risk is improved from Limited to Partial. This reflects a number of changes: greater confidence during this winter / COVID period to sustain elective activity at a much higher levels than in previous COVID surges; delivery of actions to address specific risks, and increased place-based assurance and oversight of key issues such as capacity and flow. 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. Completion of some actions have been delayed pending capital allocation and COVID restrictions. There is a chance that the network outage risk could be reduced at the end of the financial year 21/22 if the core/DMZ work completes.
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 Q3 as outlined in the Winter Plan. 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. Following planned reduction in elective provision for 3 weeks in December / January (holiday period coinciding with major theatres refurbishment), elective activity has resumed at planned levels from 10th January. There is a chance that the network outage risk could be reduced at the end of the financial year 21/22 if the core/DMZ work completes.

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 Q3 2021/22: Summary		
Proposed risk score at Q3 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.
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 Q3 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**	Risk score: A review of all risks has been undertaken 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 Q3 2021/22: Summary		
Proposed risk score at Q3 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. 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 20 January 2022.
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 Q3 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 Q3 2021/22 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: Whilst the Trust is forecasting financial balance for 21/22, the Trust is still not in receipt of financial envelopes, or confirmed financial planning guidance 22/23. What is known is that funding levels are expected to be materially reduced, with the Trust currently not able to identify secure actions to mitigate this in full. 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 Q3 2021/22: Summary		
Proposed risk score at Q3 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. SWL has mitigated the capital over commitment it had through additional funding confirmed through the Targeted Investment Fund. However, the Trust has not yet been able to confirm funding to address the 22/23 capital requirement, and doesn't currently have funding confirmed for the 5 year capital from 22/23 and beyond. It is expected that 3 year CDEL allocations will be received at ICS level in the coming weeks. Reviewed and endorsed by Finance and Investment Committee on 20 January 2022
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 Q3 202122:	**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 December 2021 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 Q3 2021/22: Summary		
Proposed risk score at Q3 2021/22:	**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 Q4 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 22 July 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 has been mitigated by the production of a new estate strategy and will be further mitigated by the development of 5 year capital strategies. There has been a slight slippage in the originally identified timetable due to COVID pressures but we are still on track for this risk reduction by the end of 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 Q3 2021/22:	**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 December 2021. Risk score: Unchanged pending agreement of reductions to fire / water safety risks 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. Detailed strategy work is ongoing to produce capital strategies for two scenarios, based on us receiving / not receiving HIP funding. We have agreed and are implementing a clearer approach to statutory compliance management, with a strategic assurance group overseeing all areas, backed up by specialist area working groups. Independent assurance from external experts confirms good improvements on two key areas, fire engineering and water safety. This will be reviewed by the strategic assurance group to recommend the reduction in our risk score. The first cardiac catheter labs are now in use with work continuing on the next set of labs. Additional capital has been made available for remedial fire engineering work. Some capital project works are being delayed by supply chain issues with long lead items.

Overview

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 Q3 2021/22: Summary		
Proposed risk score at Q3 202122:	**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 15 July 2021.
Proposed year-end target risk score	**12** (4 consequence x 3 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 Q3 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 month:	⟷ **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**	The 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 • Full review of risks and actions to be undertaken in Q4

Overview

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 Q3 2021/22: Summary		
Proposed risk score at Q3 2021/22:	**20** (4 consequence x 5 likelihood)	This risk has sat at a score of 16 for some time, but it is proposed that the risk score be increased to a score of 20 (4C and 5L). This reflects in part the significantly increased staff absence position during the current wave of the pandemic. More directly, however, it reflects the risks related to the introduction by the Government of Vaccination as a Condition of Deployment (VCOD). It is anticipated that potentially between 400 – 1000 staff may not be vaccinated in time for the introduction of this requirement and that the Trust may need to start taking steps to give notice to unvaccinated staff in early February. The risk assessment could be altered by anticipated guidance from government, but the risk related to this is considered extreme as of the present time.
Proposed year-end target risk score	**12** (4 consequence x 3 likelihood)	A target risk score of 12 at year-end was agreed by the Board and 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, however the VCOD introduction could impact on the degree to which the target risk score is achievable.
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 Q3 2021/22:	**Partial**	An assurance rating of 'partial' was agreed by WEC for Q2 2021/22.
Change from last quarter:	⇧ **Increase in risk score**	Risk score: Proposed for increase to 20(5cX4L) reflecting in particular the scale of the potential impact of VCOD 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.
SR9 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 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.

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 Q3 2021/22: Summary		
Proposed risk score at Q3 2021/22:	**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 20 January 2022
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 now scheduled to be delivered in Q4 2021/22
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 Q3 2021/22:	**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 quarter:	⟷ **No change**	No changes are proposed to the overall risk score or to the assurance rating at Q3 2021/22. Risk score: Unchanged due to ongoing actions to mitigate risk and address gaps due for completion later in the year. Assurance rating: Some slippage in the actions that address gaps
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**	Three actions to address identified gaps in control and assurance were due for completion in Q3 2021/22. The Translational & Clinical Research Institute (TACRI) is fully functioning and this action has been removed. The other two actions have been deferred for completion in December 2022. Appointing clinical academics is dependent on the Trust research strategy being fully funded – this is not yet confirmed and is being considered in the business planning process. The set up of a research data warehouse has been stalled pending the appointment of a contractor for the data warehouse – now that Bedrock have been appointed, work will progress on the research component.

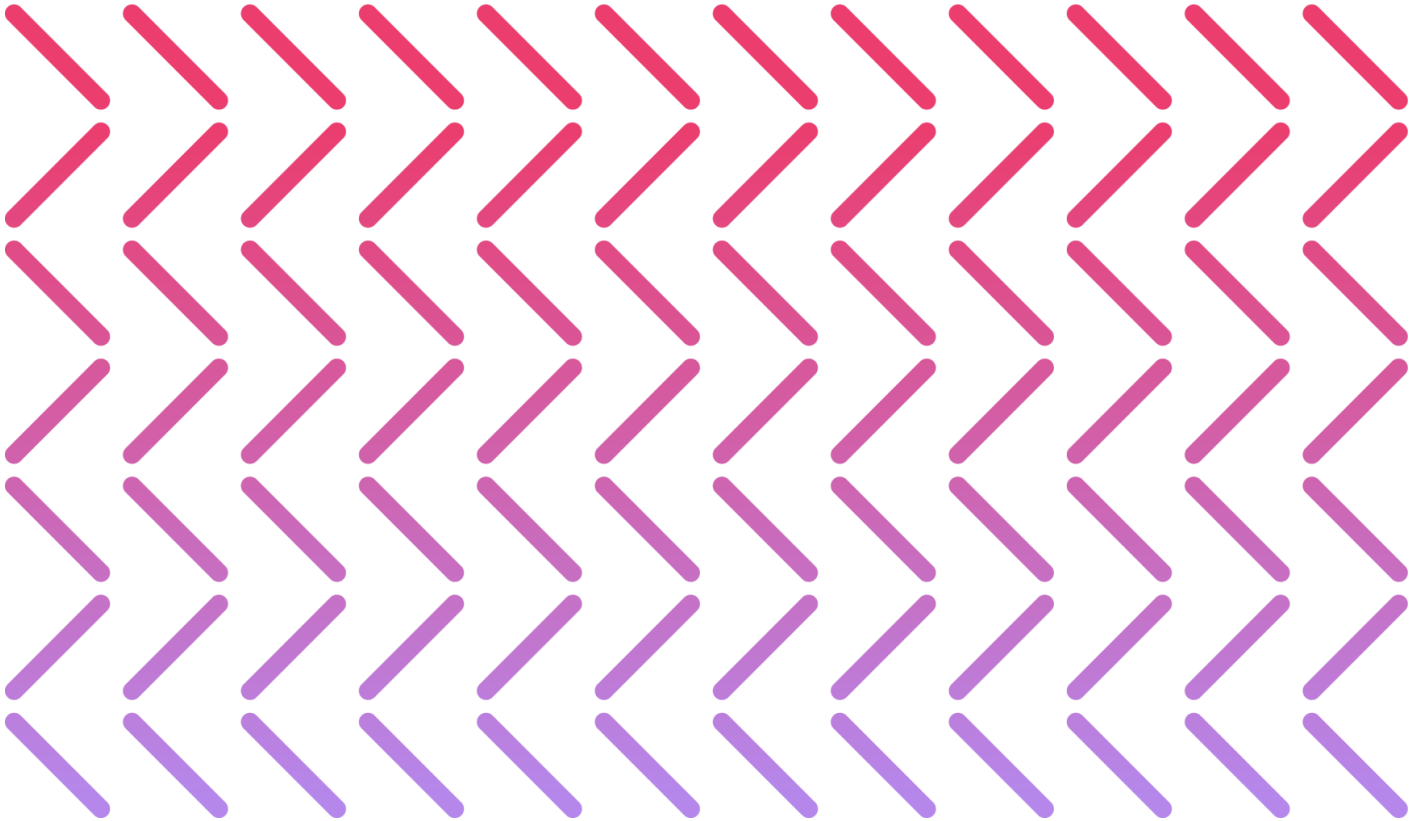
Strategic Risks: High Level Summary – Assurance Rating and Risk Score

Strategic Objective	Corporate Objective	Risk Reference	2021/22 Strategic Risks	Assurance Rating	Risk Score Q3 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	Partial ⇧	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 - 20 ⇧	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

Strategic Objective 1: Treat the Patient, Treat the Person
Strategic Risks SR1 and SR2

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

SR2:
We are unable to provide outstanding care as a result of weaknesses in our clinical governance



Strategic Objective	Treat the patient, treat the person	*Corporate Objective 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 January 2022

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 Q3 2021/22, the risk has been mitigated by the successful recruitment to the new posts as recommended by the Clinical Governance Improvement Program. Progress has also been made to address the non-compliance with 7 day clinical standards. Directorates have defined plans in place to address all non- compliance. Capital works to install 2 static MRIs has commenced, expected to go-live in February 2022. Progress has also been made with the development of electronic reporting for treatment escalation plans at divisional level. However, there has been slippage on the development of the ability to see this information at ward level which is now expected in February 2022. 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), particularly with reference to the new variant, Omicron. 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	N/A	20 = 4(C) x 5(L)	12 = 4(C) x 3(L)
Q2	Extreme 16 = 4(C) x 4(L)	Partial	N/A		
Q3	Extreme 16 = 4(C) x 4(L)	Partial	N/A		
Q4					

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 known 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 has developed 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	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	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	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	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	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	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	G		• Sepsis tool on iClip in place	X		
COVID-19 measures: patient testing, masks, and facilities	G	R	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	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	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.	Feb 2022	
Critical Care Outreach team not recruited to full establishment	**Deliver recruitment plan to Critical Care** *CCOT recruited*	Complete	
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~~ Dec 2022	
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	

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					December 2021 - TEP Performance against our Treatment Escalation Plans was 39.5% and continues to show common cause variation with an improving position
Compliance with appropriate response to Early Warning Score (adult)					December 2021 - Compliance with appropriate response to EWS (adults) was 78.5%
Severity of reported incidents					December 2021 - Severity of adverse incidents – 97% No harm/ Low harm
Number of declared serious incidents					5 serious incidents were declared in November 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)					Two Never Event declared in December 2021
Infection Control (MRSA, C. Diff, MSSA, E-Coli)					MRSA 0, Hospital Acquired CDiff 5; MSSA 2; and E-Coli 6 reported in December 2021
Number of hospital acquired pressure ulcer category 3 and above					9 category 3 and 4 unstageable pressures ulcers in December 2021
Safety Thermometer percentage of patients with Harm Free Care (new harm)	N/A	N/A	**N/A**		National reporting paused since April 2020
Friends and Family Test					In December 2021, 2 services did not meet their target for positive FFT response: Emergency Department; Maternity Delivery.
ALS training attainment					81.4% performance in December 2021 against the 85% trajectory
ILS training attainment					66.5% performance in December 2021 against the 85% trajectory
BLS training attainment					83.8% performance target maintained in December 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 January 2022						
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 showed that there was a need for significant strengthening of clinical governance. The Trust has made significant progress implementing the recommendations from the reviews, albeit over an extended timeframe due to the impact of Covid-19, and the remaining 7 recommendations are on track for completion by end-March 2022. 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. There is one remaining action to be completed regarding medical staffing within CTICU out of hours which has been delayed due to the impact of Covid-19 but is on track for completion by end-March 2022. 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. Apart from one gap in control associated with delivery of improved eDischarge summaries all risk mitigation actions are on track for delivery by the respective due dates. 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 complete the improvements in 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. Given the progress made as outlined above it is anticipated that the target risk score of 8 (moderate) will be achieved by the end of Q4 2021/22.		**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	N/A	20 = 4(C) x 5(L)	8 = 4(C) x 2(L)
				Q2	High 12= 4(C) x 3(L)	Partial	N/A		
				Q3	High 12= 4(C) x 3(L)	Partial	N/A		
				Q4					
			Summary COVID-19 Impact	Covid-19 initially 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 i.e. the project associated with the improvement of eDischarge summaries was delayed due to resources being diverted to the establishment of the Covid-19 vaccination clinic and 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	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	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	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	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	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	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	G		• Electronic templates for the recording of Capacity Assessment launched on 2 November 2020	X		
Medical Examiner System in place	S	S	S		• Medical Examiner office reviewed all non-coronial inpatient deaths in May 2020		X	X
Mortality Monitoring Committee and Learning from Deaths lead in place	G	G	G		• Learning from Deaths report including SHMI and sources of individual mortality alerts e.g. NICOR		X	
Updated IT technical system to support eDischarge summary	R	R	R		• Trust does not comply with NHSE Standard Contract for Discharge Summary			X
Governance structure – new appointed recruited to	R	R	R			X		
Agreed methodology for Consent and Trust lead in place	R	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** One remaining action left to be completed regarding medical staffing within CTICU out of hours, due to covid-19 pandemic this has not yet been addressed.	~~Oct 2021~~ Mar 2022	
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. Due to the complexities and multiple stakeholders of SWLP the completion date has been moved to Jun 2022	~~Dec 2021~~ Jun 2022	
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

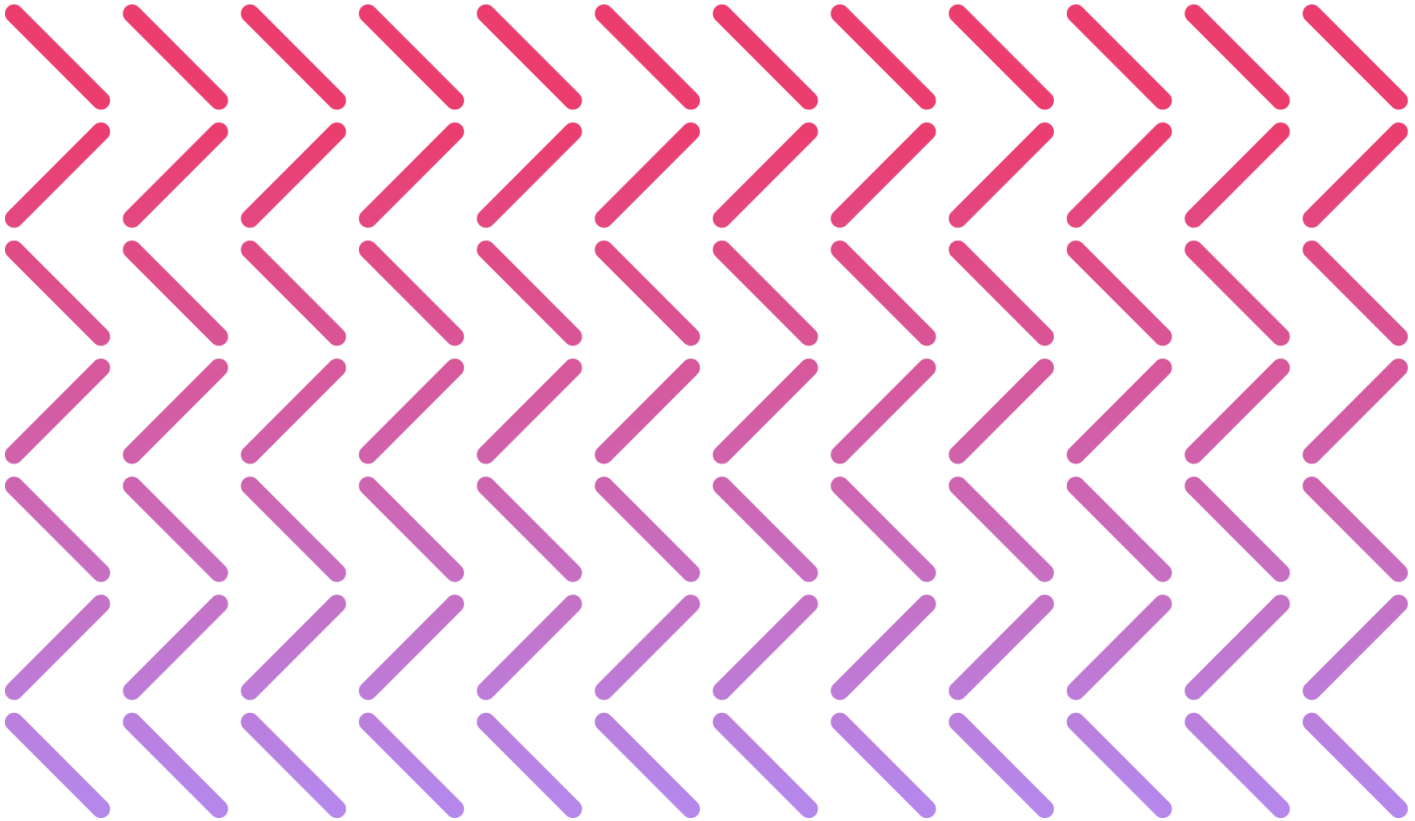
Lead indicators	RAG Rating Q1	Q2	Q3	Q4	Lead indicators: Progress update
Progress against phase 1 and phase 2 governance reviews					Learning from Deaths lead in place. Successful recruitment to all 14 posts in the original business case Progress report on actions in the Clinical Governance Improvement 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 0.88 for the year August 2020 – July 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)					7.2% readmission rate in November 2021, compared with 8.3% in October 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					December 2021 - Level 1 MCA training compliance is 84.6%, level 2 compliance is 73.9% against the performance target of 85%
Diagnostic indicators – DM01					In December 2021 performance against the six-week diagnostic standard was 3.3% with a reduction in the number of patients waiting for more than six weeks against a decrease in the overall waiting list size.

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	20 January 2022

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).

The enactment of the Winter Plan means that priority elective diagnostics, outpatients and surgery have been protected and sustained during Q3

The assurance strength is rated as partial to reflect the growing confidence regarding the extent of the impact of Covid-19 / winter pressures.

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	Extreme 20= 5(C) x 4(L)	Partial	↑ Improved Assurance		
Q4					

Summary COVID-19 Impact

During Q3 proactive partnership with place-based and SWL partners has reduced the number of patients awaiting supported discharges packages by 25%, although COVID continues to limit capacity in care homes and nursing homes. Non-elective admissions for adults (medical and surgical) are consistent with pre-COVID levels, although the acuity of admitted patients is significantly higher. Since December, the increasing provision of COVID wards has disrupted speciality ward arrangements, with length of stay higher as a result of increased outliers (COVID and non-COVID) and higher acuity of medical admissions.

However, the material change is in very compromised flow through ED due to limited bed capacity – with 12 hour breaches a daily occurrence, and even instances where ambulance handovers breach 60 minutes. This reflects in reduced ED performance and poorer patient experience. Current available actions to rapidly de-compress ED have limited impact at peak pressure times, and actions are ongoing to improve flow overall and ensure quick and effective de-compression of ED when required.

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	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	R		Performance included in Integrated Quality and Performance Report (IQPR)	X	X	
Digital strategy - ICT Work plan aligned to Digital strategy	G	G	G		Digital strategy aligned to clinical strategy and outpatient strategy			XX
VDI	G	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	R		Informatics Governance Group		X	
New workflow in iClip for Referral Assessment Service (RAS) clinics as part of Covid19 changes and rolled out to Trust as BAU	S	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	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	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	G		Clinical pathway and Standard Operating Procedure (SOP)	X		
Direct access pathways	G	G	G		Clinical Pathway and SOP	X		
Partnership working between ED and local Mental Health organisations to improve care and waiting time for patients attending the ED with mental health needs	R	R	R		Clinical Pathway, Memorandum of Understanding/ COMPACT, and local service performance metrics	X		
UCC direct pathways	G	G	G		Clinical Pathway and SOP	X		
Clinical Decision Outcome Form (CDOF) incorporated within iClip	R	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 Using the Insourcing switchover budget, We have now recruited another 2xBand 7 staff and the 3rd vacancy is in the offer stage. Insourcing is now only being used to cover 4 x maternity leaves and CDC activity.	Closed	
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 Spring 2022, and can provide 24/7 cover for emergency imaging dependant on funding for 1 extra member of staff.	~~Sep 2020~~ ~~Feb 2022~~ Apr 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	Completed the ICT outpatient projects that were in flight for these gaps	Completed	
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. Delay completing as 2 further rooms need to be identified by organisation.	~~Sep 2020~~ ~~Sep 2021~~ ~~Dec 2021~~ Apr 2022	
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. Detailed project plan but not scheduled to complete until Nov 2022	~~Mar 2021~~ ~~Apr 2022~~ Nov 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 for theatres has commenced.	~~Dec 2020~~ ~~Dec 2021~~ Sept 2022	
Sufficient availability of VDI upgrade to support remote working	VDI Horizon upgrade to Wini10 rolled out autumn 2021: some additional VDI infrastructure to be installed to complete this action. Additional NHSX funding approved to complete this financial year.	~~Oct 2020~~ ~~Dec 2021~~ Apr 2022	
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~~ Dec 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 Q1	Q2	Q3	Q4	Lead indicators: Progress update
ED attendances					December 2021 – 11,391 ED Attendances. Attendance numbers through the month averaged 367 patients per day with on average 88 daily ambulance arrivals showing a decrease compared to the previous month. The acuity of the patients requiring treatment remains high with 49% of patients with a Manchester Triage Score of between 1 and 3
Inpatient – non elective					December 2021 – 3,160 Non Elective Spells. patients admitted through the non-elective pathways stayed in a hospital bed for 6.9 days on average remaining above the upper control limit.
Inpatient – elective and day case					December 2021– 3,980 Elective and Daycase performance is expected to be behind trajectory (after estimated catch up), with a percentage of 96%, lower than the 100% trajectory submitted for December. Theatre specialties are at 89%, with non-Theatre specialties at 98%.
Outpatient attendances					December 2021 – 54,961 Attendances. Outpatient performance is expected to be 111% after catch-up, which is higher than the 100% trajectory by 11
RTT					November 2021 the Trust reported 959 patients waiting for more than 52 weeks to receive treatment. The number of patients waiting for more than 52 weeks continues to show a favourable position against our trajectory
6 week Diagnostic Performance					December 2021 performance against the six-week diagnostic standard was 3.3% with a reduction in the number of patients waiting for more than six weeks against a decrease in the overall waiting list size.
ED 4hr operating standard					December 2021 performance was 72.1%. impact of COVID 19 still widely evident, high acuity of patients , capacity and flow throughout the Trust has remained challenged challenged.
Cancer 14 Day Standard					November 2021 Performance against the 14 day standard was below the target of 93% reporting 76.4% compared to 80.4% in October 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					November 2021 Performance was at 60.1% against the 85% target. There were 34.5 breaches of the 62 Day standard, attributed to radiology, pathology, clinical complexity, patient choice and late inter-trust transfers affecting H&N and urology

Emergent / future risks	Future opportunities
The combination of increased patient acuity, ineffective speciality pathways caused by COVID wards (COVID and non-COVID patients) making patient flow slower; together with challenges in onward capacity in care homes / nursing homes means that there has been a fundamental mismatch between admission rates / length of stay and discharge rates on medical non-elective inpatient pathways. This has had a significant deleterious impact on flow through the Emergency Department, evidenced by the deterioration in performance against the 4 hour access standard. This under-performance has also caused 12 hour breaches for patients awaiting an inpatient bed and, on occasion, 60+ minute ambulance handover breaches, although George's continues to perform at or above average for the latter when compared against other London Trusts. Although performance for breast screening has returned to normal levels, a combination of staff sickness / pathway under-performance and ongoing increased referrals means that the TWR performance for breast has deteriorated further. Additional resourcing has been secured from January to address this, together with a number of operational actions to improve pathway management.	The Trust continues to implement QI projects to optimise flow, and is supporting our community health partner in the implementation of a sub-acute Hospital@Home model, which takes patients home for treatment and care once the patient has been assessed, diagnosed and a treatment plan implemented by AMU. In the first 10 days of this service's operation, over 30 referrals have been made, and there is system commitment to expand and develop this service to minimise avoidable admissions for people with frailty / long term conditions if they can be cared for at home through this collaborative pathway, in line with the 2022/23 Operating Plan. There are also actions ongoing to expand the capacity and resilience of medical and surgical Same Day Emergency Care pathways (SDEC) which divert patients away from ED to speciality 'hot' clinics that can best meet their need and minimise numbers in ED

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	25 November 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 ICS, contributed to developing the five year plan, and is an active member of the various forums across ICS, offering opportunities to influence system priorities and contribute to delivery.

COVID-19 has had an impact on this risk (see summary, right).

National policy and upcoming legislation to put ICSs on a statutory footing are also impacting on this risk. The Government's intent (in making ICSs statutory organisations with acute providers represented on their Boards, strengthening the role of provider collaboratives, strengthening place/borough-based collaborative arrangements, and devolving the specialised budget) is to make it easier for providers like St George's to transform and integrate services. The changes will for instance mean that the Trust has a place on the Integrated Care Board, that its CEO is the lead CEO for the SWL Acute Provider Collaborative, and that it has a greater role in shaping specialised services. However there is a risk that the changes create new tensions (e.g. between place, ICS and supra-ICS arrangements for tertiary services) that make transformation more difficult to pursue. The Trust is actively involved in shaping the way these national intentions are translated into practice at a SWL level.

The development of a Group model between the Trust and Epsom St Helier is in part designed to better enable both trusts to pursue service transformation and integration, both across the two trusts and with partners at place level. There is however a risk that other system partners see the new Group as a threat and become less open to ambitious collaboration.

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	High 12= 4(C)x3(L)	Good	N/A		
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.

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	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	S		• The APC is chaired by the Trust CEO		X	X
SWL Covid-19 Recovery Structure has been established	R	R	R		• Trust representation on key workstreams • CEO is a member of the Recovery Board and chair of the Elective Recovery Programme		X	X
SWL Clinical Senate - set the clinical priorities for SWL	R	R	R		• The Trust is represented on the Clinical Senate by the CMO		X	X
SWL ICS Five Year Plan - the Trust contributed to developing the five year plan which set the priorities for SWL	R	R	R		• 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
SWL Covid-19 Recovery Plan - driving greater collaboration	R	R	R		• The Trust CEO is a member of the SWL ICS Covid-19 Recovery Board , Steering Group and is chair of the Acute Cell		X	X
The Trust Workforce Strategy approved by Trust Board in November 2019 – a key driver being delivery of the SWL five year plan as well as the Trust's clinical strategy	R	R			• Implementation plans are in place and being delivered against		X	
Annual review of Trust Strategy	S	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	R		• The Trust is represented on this Board and an active contributor to both of the Borough Health and Care Partnership Boards		X	X
Development of Group model to pursue closer collaboration between St George's and Epsom and St Heliers Hospitals			S		• Group model agreed and being implemented		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
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	
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 are reviewing the priorities in the LCHPs in light of Covid-19 and changes to the ICS structure, 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. This action was originally envisaged as part of planning for 2021/22, but due to COVID-related disruption to the NHS planning cycle in that year will be addressed as part of planning for 2022/23.	~~March 2021~~ Mar 2023	
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**		

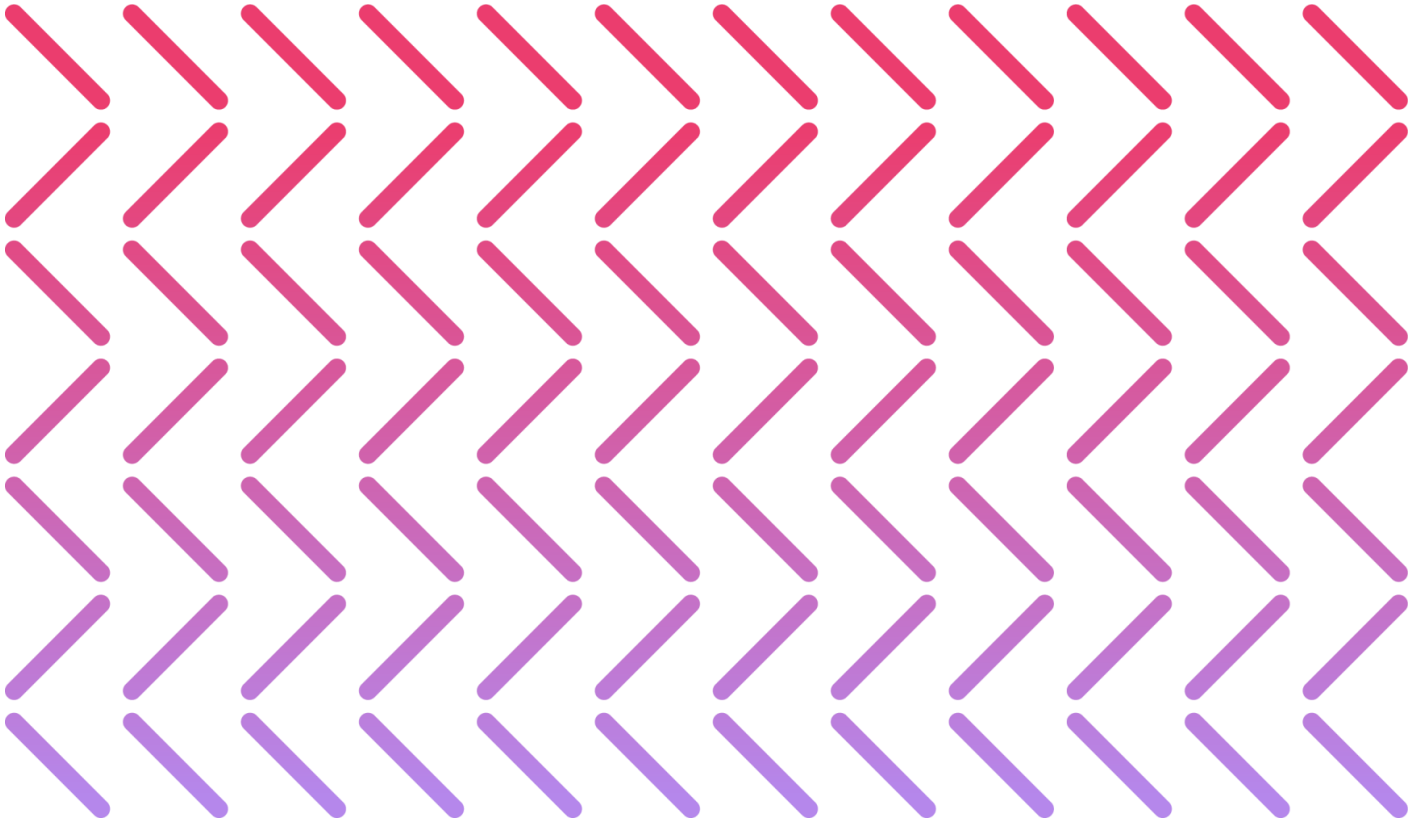
Lead indicators	RAG Rating Q1	Q2	Q3	Q4	Lead indicators: Progress update
A SWL Covid19 recovery plan in place					The Trust is represented on the SWL Recovery Board and associated workstreams leading the development of the Covid-19 recovery plan, which has now been agreed.
Clinical Safety Strategy in 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 attended by members of the executive team.

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 collaborating with system partners to transform services.	The development of the ICS into a statutory organisation may support closed system working and provide a statutory framework on which to build closer collaboration and integration. The Group model between the Trust and Epsom St Helier will offer opportunities to transform and integrate services between the two trusts. Epsom St Helier's Building Your Future Hospitals programme may provide an opportunity for greater collaboration between St George's, Epsom and St Helier and the Royal Marsden

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	20 January 2022

Current risk and assurance assessment

- Financial planning for within the NHS is currently operating to revised timetables and frameworks due to the pandemic.
- A balance financial position for 21/22 is currently forecast, with significant levels of non-recurrent benefits required to achieve this position.
- A significant level of income, above LTP assumptions is currently required to support the increased expenditure position resulting from operational pressure since the start of the pandemic.
- 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, and are expected to continue into 22/23.
- There is no provision in the plan for a further COVID surge, as per guidance.
- The 22/23 financial position is expected to show a material challenge, as some of the additional funding the Trust is in receipt of starts to be removed.
- 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= 4(c)x3(L)
Q2	Extreme 20 = 5(c) x 4(L)	Partial	N/A		
Q3	Extreme 20 = 5(c) x 4(L)	Partial	N/A		
Q4					

Summary COVID-19 Impact

- **New financial framework in place for 21/22aimed 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 21/22, and is expected to continue in to 22/23.**

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	S		Monthly divisional finance reports	xx	xx	
Monthly reporting of financial issues through to OMG, TMG, FIC and Trust Board	S	S	S		Monthly Trust finance reports	xx	xx	
Monthly external review of Trust position by NHSE/I as part of monthly top-up payment review	S	S	S		Top up payment made to Trust		x	x
Financial plan in place, with monthly performance being scrutinised vs budget	S	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	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	S		Plan agreed as part of SWL for financial balance in 21/22. New financial frameworks expected to provide increased risk in H2			x
Plan is place for financial balance in 22/23			p		Plan to be developed through Q4 21/22			

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**		

Gaps in controls and assurances	Actions to address gaps in controls and assurances	Complete by (date)	Progress
Baseline budgets that are out of date with current situation	- Financial forecast to be developed to drive improvement and efficiency within divisional positions	Complete	
Lack of consistent performance management within divisions, down to directorate and Care Group level	- DCFO to seek assurance of divisional financial governance arrangement, and intervene where necessary. - Issues picked up by CFO following monthly review. Escalation in place via HoFs.	Complete	
No formal CIP plan of efficiency plan in place	- CIP/efficiency targets to be established alongside financial forecast - Limited is scope due to constraints of COVID - Trust reporting balanced financial position including some efficiencies. Delivery to be monitored through monthly reporting.	Complete	
Current forecast predicts material risk against current levels of funding	- Challenge to be made through divisional financial reviews - Issues to be raised through SWL ICS to NHSEI regarding funding shortfalls - Awaiting confirmation of M7-12 funding to confirm scale of challenge.	Complete	
South West London financial performance management structure in place to drive and ensure financial performance and best practise within sector	- Trust to lead development of financial governance with SWL ICB ahead of 22/23alongside change in governance structure at SWL level. - Framework agreed by CFOs and CEOs - Further work required to ensure full benefit realised from SWL working.	Sep 2020	
Capacity plan not fully developed inline with new working environment post COVID	- Ongoing operational changes within the hospital are meaning this work is ever evolving and fluid. - 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.	Nov 2021	
Lack of accountability within services for financial performance and delivery	- Ongoing operational challenges have delayed the implementation of this mitigation. - Finance to be included within objectives of all leadership posts with financial responsibility within the organisation	Nov 2021	
Plan for H2 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 2022	
Plan for 22/23 beginning to be worked up, but currently showing material financial risk	- Plan to be developed internally within the Trust ahead of 22/23 - Plan to be developed alongside SWL ICS plans and financial envelopes - Planning guidance to be received, digested, and built into assumptions.	Mar 2022	

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				Lead indicators: Progress update
	Q1	Q2	Q3	Q4	
Financial balance achieved YTD					Financial balance reported at M8
Financial balance forecast through to year end					Financial balance forecast to year end
CIP/improvement plan to be agreed and delivered					Further work required on stepping back up recurrent efficiency programme for 21/22 and in to 22/23 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.
SWL plan to be developed for financial balance in 22/23					Plan in its infancy, with further development required to provide assurance.

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	20 January 2022

Current risk and assurance assessment

- Current capital funding available (CDEL) to SWL has now been confirmed, with all element of the 21/22 plan now funded.
- Weekly reviews taking place with DCFO to ensure limited funds are prioritised and risks articulated from funding shortfalls.
- Mitigations to risks 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 22/23 and beyond.
- Significant shortfall currently in existence across South West London when comparing essentially plans to CDEL allocation for 22/23 and beyond. 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	Extreme – 20 4(c) x 5(L)	Partial	N/A		
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	Mitigation developed via successful Targeted Investment Fund bids.	Mar 22	
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 21	

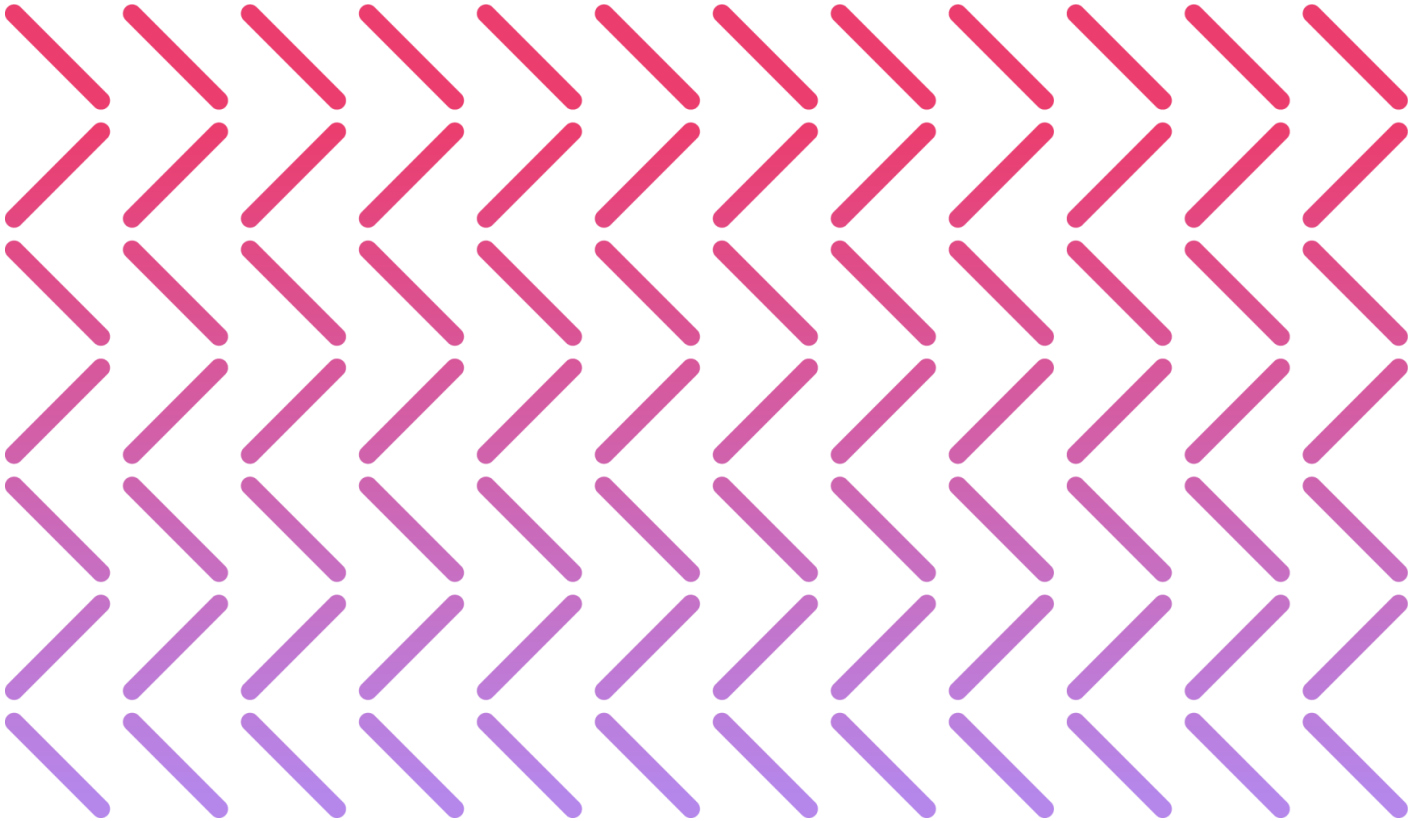
Strategic Objective	Balance the books, invest in our future	*Corporate Objectives 2021/22:*	Collaboration
SR6	**We are unable to invest in the transformation of our services and infrastructure, and address areas of material risk to our staff and patients, due to our inability to source sufficient capital 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 for 22/23 and beyond	- 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.

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	16 December 2021	

Current risk and assurance assessment

Our current risk assessments indicate that this continues to be an extreme risk for the Trust.

We have introduced improvements to our internal compliance assurance groups and are hoping to reduce our risk ratings on three of our highest risks, fire, water and cath labs, enabling our target risk score to be achieved.

In Q2 2021/22, the final Estate Strategy and Green Plan was presented and approved by the Trust Board in August 21. We are developing this strategy into 5 year capital planning scenarios based on receiving / not receiving HIP funding.

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 was 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. It seems likely that additional funding may become available in year.

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	**Extreme 20 = 4(c) x 5(L)**	Partial	N/A		
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	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	X X X
Investment profile provides plans to manage backlog maintenance investment	W	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	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	P		The Group will review PAM data together with assurance reports prepared for working groups.		XX	
Green Plan		S	S		Approved at Board at the end of August 2021 – road map in place for delivery		X	X
Estates Strategy		S	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
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 is underway now.	~~Jan 2021~~ Jan 2022	
Governance groups are not aligned with new wider assurance arrangements	Work to align is complete and new structure will commence from Jan 2022.	~~Feb 2021~~ Dec 2022	
Capital plan for the next 3-5 years	Agree 3-5 years capital plan Draft plans are in place now and further detailed planning underway	Mar 2022	
Estates restructure	Complete the ongoing Estates restructure, to ensure the right size and shape of team is in place to complete the work.	Mar 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**		

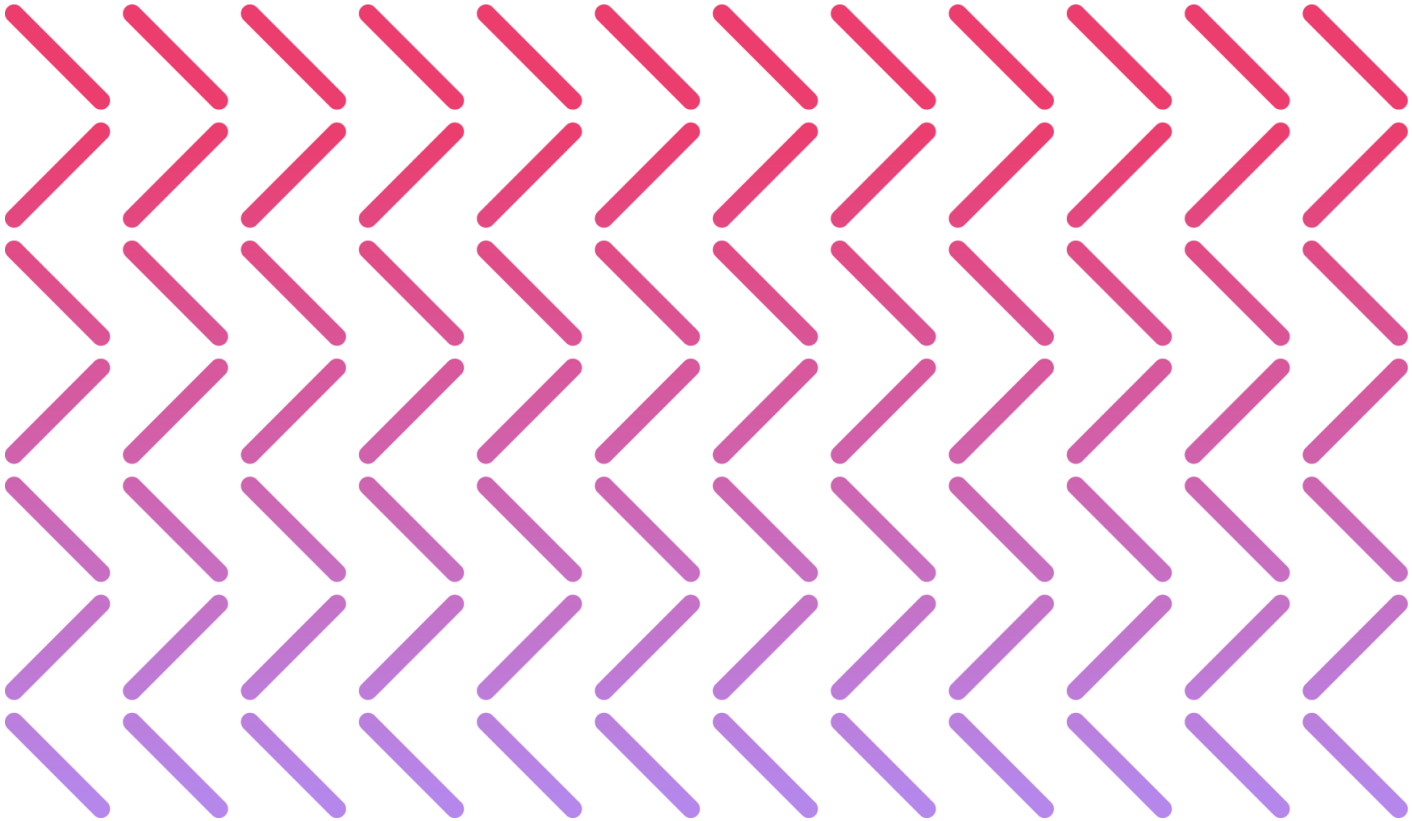
Lead indicators	RAG Rating				Lead indicators: Progress update
	Q1	Q2	Q3	Q4	
% of reports on items of statutory compliance completed to required timescales					Current progress good in completing statutory compliance works
% of backlog maintenance tasks (reactive / planned) undertaken in line with plan					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 5: Champion Team St George's
Strategic Risks SR8 and SR9

SR8:
We fail to build an open and inclusive culture across the organisation which celebrates and embraces our diversity because our staff do not feel safe to raise concerns and are not empowered to deliver to their best

SR 9:
We are unable to meet the changing needs of our patients and the wider system because we do not recruit, educate, develop and retain a modern and flexible workforce and build the leadership we need at all levels



Strategic Objective	Champion Team St George's	*Corporate Objective:*	Culture

SR8	Our staff are not empowered to deliver to their best and do not feel safe to raise concerns because we fail to build an open and inclusive culture across the organisation which celebrates and embraces our diversity

Risk Appetite / Tolerance	**LOW**	Due to concerns around bullying and harassment and the ability of staff to speak up without fear, we have a low appetite for risks that could impact on the culture of the Trust	**Assurance Committee**	**Workforce and Education Committee**
			Exec Review Group	People Management Group
			Executive Lead(s)	Chief People Officer
			Date last Reviewed	13 January 2022

Current risk and assurance assessment

The Board has identified the need to strengthen organisational culture as a key strategic priority. There are a number of significant risks that impact on this. The Trust continues to face significant challenges in relation to diversity and inclusion, staff do not always feel able to raise concerns without fear of detriment, and the culture diagnostics work, while highlighting a number of positive elements, set of the scale and significance of the work to strengthen our culture.

During Q2 2020/21 to date, this risk has been mitigated by the completion of a number of identified gaps in control and assurance:

- 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

A number of key risks and gaps in assurance remain, particularly in relation to the development of the culture change action plan, seeing further progress in improving D&I, improving staff confidence in speaking up. While the Trust has approved a range of new plans and strategies to strengthen areas associated with this risk, the Trust remains in the early phases of delivery.

Overall SR Rating – Quarterly Scores

Period 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)	Good	↑ Improved assurance	20 = 4(C) x 5(L)	TBC
Q2	Extreme 16= 4(C) x 4(L)	Good	N/A		
Q3	Extreme 16= 4(C) x 4(L)	Good	N/A		
Q4					

Summary COVID-19 Impact

Covid-19 has had a significant impact on staff health and wellbeing, which is an increasingly significant area of focus for the Trust, and on the original timescales for developing our programme of work to strengthen our organisational culture. Covid-19 has also highlighted underlying issues in relation to diversity and inclusion, particularly in relation to the experience of our BAME staff, which the Trust is now working to address through its new D&I action plan. At the same time, the pandemic has highlighted and helped foster elements of a Team St George's spirit and staff network groups have continued to meet (and faith calendar days have been celebrated), it has also revealed issues relating to diversity and inclusion and the willingness of staff to speak up which has enabled the organisation to develop plans for addressing these long-standing issues.

The most pressing impact of Covid-19 at present is its impact on staff health and wellbeing. Winter is historically a challenging period for staff, but the added pressures puts extraordinary pressure on staff.

Strategic Objective	Champion Team St George's	*Corporate Objective:*	Culture
SR8	**We fail to build an open and inclusive culture across the organisation which celebrates and embraces our diversity because our staff are not empowered to deliver to their best and do not feel safe to raise concerns**		

Key risk controls in place	Control effectiveness				Key sources of assurance	Lines of Assurance (positive / negative)		
	Q1	Q2	Q3	Q4		1	2	3
Workforce strategy in place and approved by the Trust Board	S	S			Workforce Strategy refreshed and approved by Trust Board.		X	
Culture change programme established with clear timelines for delivery	S	S			Culture diagnostics findings reported to Board in Nov 2020; action plan being developed; Culture, Diversity and Inclusion Programme Board established. Initial plan in place and business case for resource has been approved		X	
Culture, Diversity and Inclusion Programme Board established	S	S			First meeting held of CDI programme board, and governance established	X	X	
The Diversity and Inclusion action plan agreed by the Trust Board in July 2020	S	S			Progress of D&I action plan delivery reviewed at PMG fortnightly and at the monthly WEC	X	X	
Trust D&I lead recruited and in place	S	S			D&I Lead in post.	X	X	
Staff networks in place to support particular groups	R	R			Networks in place and meeting regularly. Positive early engagement from staff in staff network groups. Some gaps in network leadership positions	X	X	
Big 5 launched in order to address issues raised by staff in NHS Staff Survey 2020	S	S			Staff survey. Engagement with Big 5 plans, and feedback from this. Pulse surveys		X	
Freedom to Speak Up Strategy and Vision in place	S	S			FTSU vision and strategy approved by Trust Board. Trust is rated 195 out of 230 Trusts in England on FTSU Index 2021 – Improvement on 2020 position.		X	
Freedom to Speak Up function established with dedicated Guardian in place	R	R			Additional resource in place, but further support through Deputy and Champions required		XX	
IT software package to record FTSU concerns	R	R			Case management solution in place to support FTSU case tracking and reporting	X		
Policy framework in place (EDI, Dignity at Work, Raising Concerns)	S	S			Approved by PMG and available on intranet.		X	
Leadership and Management Development Programmes in place (paused during COVID-19 and challenges in organising new meetings	P	P			Kings Fund and Matron Development programme now in place.		X	
Board visibility through Board visits and Chairman and CEO monthly TeamTalks	S	S			Executive and Board visibility assessed through staff survey and Culture diagnostic review.		X	
Inclusion of BAME Recruitment Inclusion Specialists (RIS) on panels at Bands 8a+	P	P			Percentage of 8a+ panels that include a RIS monitored DI Dashboard	X		
Software system (Selenity) in place to manage employee relations data	S	S			Selenity implemented on 22 February 2021	X	X	
Covid surge plan and Health and Well-being plan available on the Intranet	S	S			Plan reviewed by PMG, OMG. Surge plan includes initiatives in place to support staff about the physical and emotional well-being of staff		X	

Strategic Objective	Champion Team St George's	*Corporate Objective:*	Culture
SR8	**We fail to build an open and inclusive culture across the organisation which celebrates and embraces our diversity because our staff are not empowered to deliver to their best and do not feel safe to raise concerns**		

Gaps in controls and assurances	Actions to address gaps in controls and assurances	Complete by (date)	Progress
Positive shift in culture whereby staff feel engaged, safe to raise concerns and are empowered to deliver outstanding care	Complete culture diagnostics phase and define action plan to address key findings Diagnostic phase completed 11/2020, Design phase in progress (output = action plan to address key findings) completed 05/2021. Action plan now agreed by Board and high level implementation begun.	March 2022	
Need for skilled Organisational Development capability and capacity to deliver agreed culture programme and D&I interventional activities and training programme	Build Organisational Development capacity for the delivery of the D&I and Culture programmes Operational pressures due to Covid have redirected focus on health and well-being, development of OD capacity plan has been delayed. Business case for support for Culture programme approved by Trust Management Group on 14 July 2021. Recruitment of new role complete for D&I programme. 2 OD roles to recruit for the Culture Programme.	~~Mar 2021~~ ~~Sept 2021~~ Mar 2022	
Trustwide culture change programme not having the desired impact at local level at this stage for local clinical areas that are currently experiencing behavioural / culture change issues	Direct OD resources to support local culture change Interventions at local level. The local culture change action plan will be connected to the Trustwide culture change programme via the CEI programme board – this will address issues raised by learners and doctors in training	~~Nov 2021~~ March 2022	
Time allocation of Network Chairs and member engagement in network activity not clearly established	Develop proposal to address challenges faced by D&I staff networks (including time allocation of Network Chairs and member engagement in network activity, and undertaken work to finalise proposals with Network Chairs Proposal approved (reviewed ToRs)	~~Mar 2021~~ ~~August 2021~~ Mar 2022	
Staff do not feel safe to raise concerns and lack confidence that actions will be taken where concerns are raised	Implementation of 2020/21 FTSU action plan, including development of FTSU Charter, revision of raising concerns policy, development of JD for FTSU champions, review of FTSU champions network, development of reporting pack on concerns for sharing / engagement with divisions. Successful Lets Talk month held in June 2021. FTSU Charter and Raising Concerns group to be launched in Q2 2021/22.	March 2022	
Not all D&I network chairs are in place	Recruitment of new D&I network chairs Currently in the process of advertising and recruiting new D&I network chairs	Jan 2022	
Current leadership programme does not cover all leaders within the Trust	Develop Leadership skills programme for all team leaders, leadership programme for consultants and medical staff	Mar 2022	

Strategic Objective	Champion Team St George's	*Corporate Objective:*	Culture
SR8	**We fail to build an open and inclusive culture across the organisation which celebrates and embraces our diversity because our staff are not empowered to deliver to their best and do not feel safe to raise concerns**		

Lead indicators	RAG Rating Q1	Q2	Q3	Q4	Lead indicators: Progress update
Number of Freedom to Speak Up concerns raised with Guardian					The number of cases raised with the FTSUG has continued to be higher than historically, though at a slower rate compared with Q1 2020/21. This suggests staff are more willing to raise concerns.
Quarterly Friends and Family Staff Survey (via Go Engage)					This has now begun using NHS Pulse Survey tool.
Number of BAME staff entering formal disciplinary processes					This continues to be higher for BAME staff compared with white counterparts. 2021 WRES report highlighted that BAME staff are 1.82 times more likely to enter into a formal disciplinary process compared to white staff. Improvement can be seen when compared with WRES report in Nov 2020 which indicated BAME staff were 2.38 times more likely to enter into a formal disciplinary process
Trust turnover rate					Trust turnover rate (excluding junior doctors) in Q2 2021/22 was 15.3% against a target of 13%
Number of BAME staff in band 6, 7 and 8a roles					BAME recruitment Sept 2021 band 6 = 51.5% (50.2% in Jan); band 7 = 38.7% (37.6% in Jan) band 8a = 32%, band 8b = 28.5%, band 8c = 21.8%, band 8d = 18.3%, band 9 = 13.5%, VSM 15.3%

Emergent / future risks	Future opportunities
• Impact of Covid-19 on staff health and well-being continues to be significant issue and any summer 2021 surge could impact further on this. • Covid-19 has led to the cancellation and / postponement of a range of training and development opportunities for staff, including management training • Risk that culture programme does not deliver anticipated changes / improvements	• Delivery of the culture change programme • Embedding support for staff health and wellbeing into plans for recovery of services • Learning from Trusts with positive FTSU cultures and from NHSE&I's ongoing support on FTSU. • Intelligence from latest NHS staff survey can be used to further inform and develop our plans for supporting staff and developing our culture change programme.

Strategic Objective	Champion Team St George's	*Corporate Objective:*	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**		

Risk Appetite / Tolerance	**LOW**	Due to concerns regarding quality and diversity in our workforce, we have a low appetite for risks relating to workforce. However, in relation to developing future roles and recruitment and retention strategies our risk appetite is higher	**Assurance Committee**	**Workforce and Education Committee**
			Exec Review Group	People Management Group
			Executive Lead(s)	Chief People Officer
			Date last Reviewed	13 January 2022

Current risk and assurance assessment

The Board has identified recruitment, education, development and retention of staff as a key risk to the delivery of its strategy.

During 2021/22 to date, this risk has been mitigated by the completion of a number of identified gaps in control and assurance:

- 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

Some key challenges and gaps in assurance remain. Although COVID-19 has eased immediate challenges of recruitment and retention due to our ability to redeploy staff across the organisation, our vacancy rate remains above target as does our turnover rate. Training and developing our leaders remains a particular gap and this links to the cultural development work set out in Strategic Risk 8. Junior doctor supply continues to be an issue

The risks related to Vaccination as a Condition of Deployment, and the potential impact of this on the Trust's staffing, are considered to be very significant. As a result an increase in the risk score for SR9 is proposed.

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	N/A	**20 = 4(C) x 5(L)**	**TBC**
Q2	**Extreme 16 = 4(C) x 4(L)**	Partial	N/A		
Q3	**Extreme 20 = 4(C) x 5(L)**	Partial	⇧ Increase in Risk Score		
Q4					

Summary COVID-19 Impact

Covid-19 has placed staff under intense pressure, however the Trust has been able to successfully redeploy staff meaning that it has been able to reduce its agency spend during this period. Appraisal rates, however, have fallen and a number of education and training programmes have been delayed / deferred due to the pandemic.

Social distancing requirements have impacted the delivery of education programmes (due to lack of suitable space large enough for face-to-face training and infrastructure for remote provision). Additionally, there is an increasingly significant risk in relation to staff health and well-being due to both the intense pressures of responding to the pandemic, particularly within certain teams, and as a consequence of reduced face-to-face staff and network meetings which contribute to feelings of isolation and exclusion among some of our staff.

Outstanding care every time

Strategic Objective	Champion Team St George's	*Corporate Objective:*	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**		

Key risk controls in place	Control effectiveness				Key sources of assurance	Lines of Assurance (positive / negative)		
	Q1	Q2	Q3	Q4		1	2	3
Workforce Strategy in place and approved by the Trust Board (Nov 2019)	S	S			Refresh workforce strategy submitted to September WEC		X	
Workforce strategy implementation plan -	S	S			Quarterly report to Trust Board Update workforce strategy implementation plan progress report submitted to PMG and WEC on a quarterly basis		X X	
Education Strategy in place and approved by the Trust Board (Dec. 2019)	S	S			Education strategy implementation progress report to WEC		X	
Education implementation plan	S	S			Monthly Strategy group meeting to monitor progress with all key stakeholders		X	
Development of new roles (i.e. ACPs) to help fill the gaps in vacancies	S	S			Workforce report to PMG and WEC		X	
Monthly review of the funded establishment	S	S			Monthly reports to Trust Board		X	
Advanced Clinical Practitioner Working Group established to work with HEE	G	G			Working group reports quarterly to PMG		X	
Recruitment open days for healthcare assistants and nursing now run by the Recruitment Hub.	S	S			Quarterly report received from Recruitment Hub.		X	X
Appraisal training sessions / ad hoc training in place	R	R			Training completion log in Education Centre booking system		X	
New compliant (section 1 update) contracts of employment templates on TRAC	S	S			New contract uploaded that is being issued to new starters (from 01/10/2020)	X		
Performance and Development Review (Appraisal) guidance reviewed and in place. Totara system upgraded	W	R			Appraisal completion monitoring via ESR, appraisal training available for all appraisers. PDR system transformation programme	X		
CPD funding system process	G	G			Funding established for NMAP staff. Progress review submitted to PMG and WEC in October 2021		X	
Apprenticeship Strategy	R	R			Current apprenticeship strategy is not as comprehensive as it should be.		X	
Disciplinary policy in place which includes 'Dido Harding' approach. Staff trained on the new approach to disciplinary cases	S	S			Policy in place and staff trained to support (completed Nov 2020)		X	
Flexible Working Policy/procedure implemented	S	S			On intranet, available to staff.		X	
Process to keep records for honorary contracts	S	S			New process established and list of honorary contract holders now reconciled with ESR	X		

Strategic Objective	Champion Team St George's	*Corporate Objective:*	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**		

Gaps in controls and assurances	Actions to address gaps in controls and assurances	Complete by (date)	Progress
Trust-wide workforce plan that sets out recruitment requirements for 2021/22	Divisional workforce plans to be produced by HR Business Partners and these will lay out clear workforce planning. Workforce plans being devised - currently being reviewed	~~Mar 2021~~ ~~Apr 2021~~ ~~Aug 2021~~ Mar 2022	
Governance process for existing extended roles – ACPs and PA	Deploy new roles on relevant patient pathway – for ACPs and PAs Delayed due to 2nd Covid surge. Likely to complete in September 2021. Governance process in place for ACPs	~~Mar 2021~~ ~~Jul 2021~~ ~~Sept 2021~~ Mar 2022	
Structured identification and development of new roles required to deliver patient care	Develop governance process for the identification of new roles and required funding. On-going identification of new roles and development governance process for the new roles identified Identified training needs required and funding where relevant Delayed due to 2nd Covid surge	~~Mar 2021~~ ~~Jul 2021~~ ~~Sept 2021~~ Mar 2022	
International Recruitment Strategy for hard to recruit to posts	HRBPs to identify hard to recruit to posts . ACPW - Develop an International Recruitment Strategy working with SWL APC Recruitment Hub Delay due to competing interests post-Covid surge	~~Mar 2021~~ ~~Apr 2021~~ ~~Sept 2021~~ Mar 2022	
Comprehensive Apprenticeship Strategy	Rework apprenticeship strategy. Apprenticeship manager has been recruited to facilitate the implementation of the Apprenticeship strategy. Apprenticeship Roles to be identified. Strategy being reformulated	~~Apr 2021~~ ~~Sept 2021~~ Mar 2022	
Trust-wide workforce plan that sets out education & development needs to upskill existing and future workforce	Develop Trust-wide workforce plan that sets our Education & Development needs: HRBPs to Conduct Training Needs Analysis for each division by staff group; Deliver advanced leadership programme; Develop programme of blended on-line/face-to-face training Delayed due to capacity issues.	~~May 2021~~ ~~Sept 2021~~ Mar 2022	
No minimum CPD funding allocated for non-NMAP staff	Include the CPD funding for non-NMAP into the 2021/22 business planning process Partial funding secured – currently reviewing for 2022/23 requirements	~~Jul 2021~~ Mar 2022	
Senior leadership that reflects the diversity of the workforce	Develop inclusive talent management, succession planning and career planning pathways. Further embed fair and equitable recruitment & selection process at senior level (further intervention over and above a RIS on every recruitment panel is needed. Leadership and talent management lead post approved (band 8a) - to be advertised	~~Oct 2021~~ Mar 2022	
Inadequate ICT infrastructure, hardware and software to access on-line learning	Established Education Delivery IT (EDIT) Group to review current position on training delivery technology, future design and gap analysis. The group includes representatives from IT.	~~Oct 2021~~ Mar 2022	

Outstanding care every time

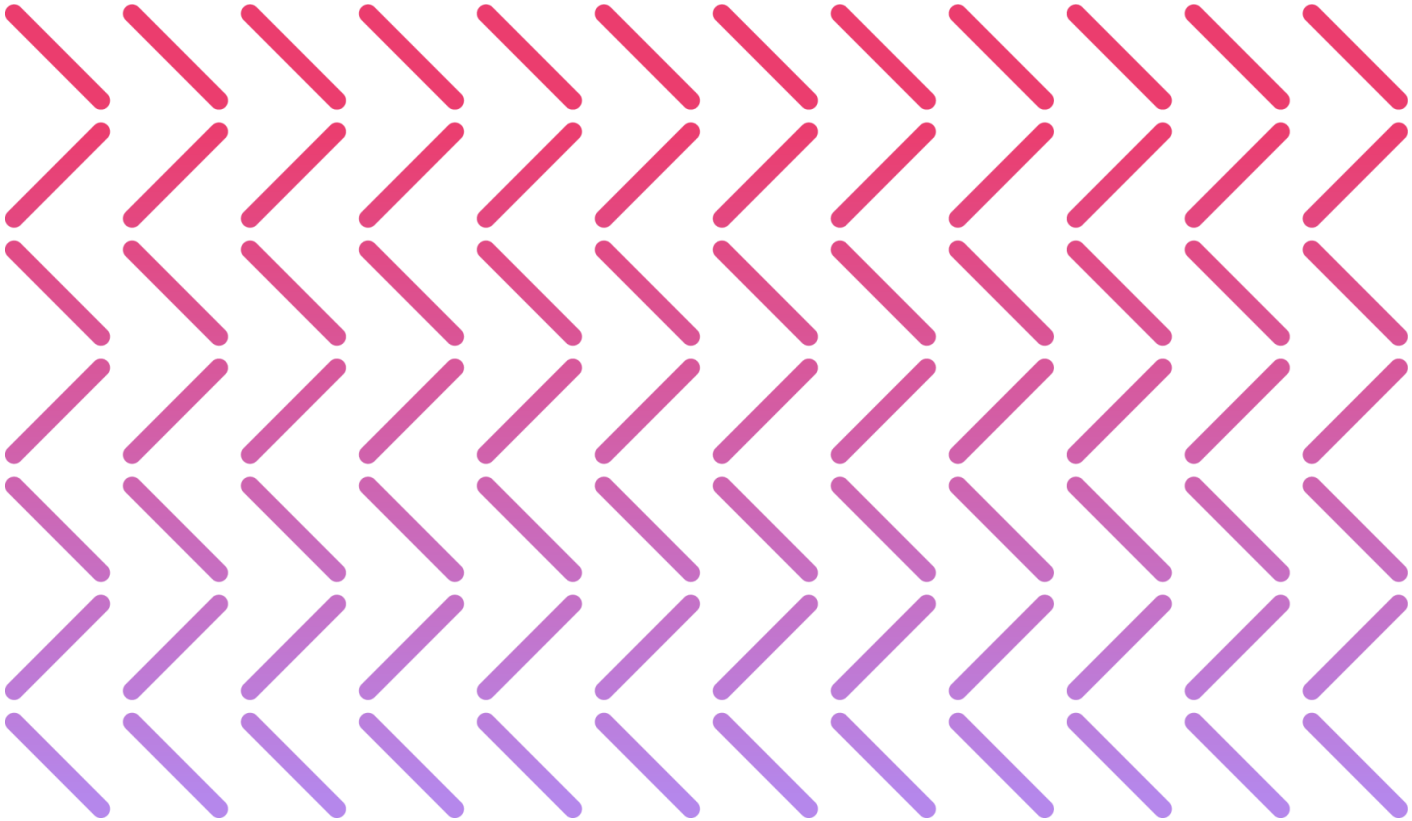
Strategic Objective	Champion Team St George's	*Corporate Objective:*	Culture
SR9	**We are unable to meet the changing needs of our patients and the wider system because we do not recruit, educate, develop and retain a modern and flexible workforce and build the leadership we need at all levels**		

Lead indicators	RAG Rating				Lead indicators: Progress update
	Q1	Q2	Q3	Q4	
Trust vacancy rate					Trust vacancy rate in September 2021 was 9.21% against a target of 10%
Turnover Rate					Trust turnover rate (excluding junior doctors) in September 2021 was 15.3% against a target of 13%
Sickness absence rates					Trust sickness absence rate of 4.4% in September 2021 compared with Trust target of 3.2%
Bank and agency rate					The Trust remains well below its NHSI agency ceiling due to staff redeployment due to COVID-19
IPR appraisal rate medical staff					Appraisal rates for medical staff in September 2021 were at 72.2%
IPR appraisal rate non-medical staff					Appraisal rates for non-medical staff in September 2021 were at 73.54% compared with Trust target of 90%. Target not met throughout 2019/20
MAST compliance percentage					September 2021 performance of 85.6% compared with Trust target of 85%
Stability Index					September 2021 87.3% (target 85%)

Emergent / future risks	Future opportunities
• Staff remote working requirements • Scaling back of HEE funding • Establishment of clear governance arrangements for SWL Recruitment Hub (SLAs, KPIs) • Risk against recruitment targets linked to continuing pressures experienced by staff leading to sickness and subsequent leavers • Risks associated with the introduction of the mandatory Covid-19 vaccine.	• Further collaboration with SWL ICS and the Acute Provider Collaborative • Development of different roles • Links to University – opportunity to develop more 'in-house' training / courses with the university, cost effective, accredited • Apprenticeships

Strategic Objective 6: Develop tomorrow's treatments today
Strategic Risk SR10

SR10:
Research is not embedded as a core activity which impacts on our ability to attract high calibre staff, secure research funding and detracts from our reputation for clinical innovation



Strategic Objective	Develop tomorrow's treatments today		Corporate Objectives 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 January 2022

Current risk and assurance assessment

There was a significant boost to the research profile in the Trust due to a 100% increase in patient recruitment to clinical trials over the three years before Covid. The Trust has been 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), and the submission of an application for NIHR Clinical Research Facility funding (outcome pending). However, strategy implementation has been slower than anticipated in some areas mainly 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 most of our strategy implementation, however we have requested £500K Trust investment for strategy implementation for 2022/23 and cannot proceed with all research staff initiatives unless this is approved (it is currently under discussion as part of business planning).

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	N/A		
Q3	Moderate 9=3(c) x 3(L)	Good	N/A		
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. The vast majority of studies have since resumed. The Trust has successfully participated in a large number Covid-19 clinical research studies and has currently recruited over 7,000 patients to 48 Covid-19 studies. We are leading a major Vaccine Task Force funded clinical trial on Covid vaccines in pregnancy. The implementation of the Research Strategy was impacted by Covid-19 but is now progressing well in most areas.

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	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	S		• Partnership in place. TACRI and all four Clinical Academic Groups, which are joint Trust/University structures, have been set up. Reports from CAGs due to Joint Strategy Board in March 2022.	X	X	
Key role in south London Clinical Research Network (chaired by CEO)	S	S	S		• Leadership positions in the Clinical Research Network - St George's CEO now chairs the CRN Partnership Board.		X	X
Implementation of process of horizon scanning clinical studies, including 'easy win' studies to balance portfolio against lower recruiting more intensive studies	S	S	S		• We have increased the numbers of patients recruited to clinical trials, which doubled over 3 years.	X	X	
Regular research resource and portfolio review meetings with research teams	S	S	S		• JRES holds regular meetings with research teams to review patient recruitment and troubleshoot any problems.	X		
Joint Research and Enterprise Services review and ratify (with researchers) all study targets and resources required	S	S	S		• There is annual target setting process for patient recruitment which is monitored and supported by JRES	X	X	X
Translational and Clinical Research Institute (TACRI) Steering Committee set up	S	S	S		• Steering Committee in place and reports to Patient Safety Quality Group and QSC	X	X	
Funding to implement 2019-24 research strategy approved for 2021/22	S	S	S		• £200K funding to implement the research strategy agreed. Statistical support for TACRI commenced, along with 7 fellowships for research nurses. We await the outcome of the 2022/23 funding request.		X	
Four Clinical Academic Groups formerly established	S	S	S		• Four CAGs have been established, and a CAG Director has been appointed for each.		X	

Strategic Objective	Develop tomorrow's treatments today	*Corporate Objectives 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**		

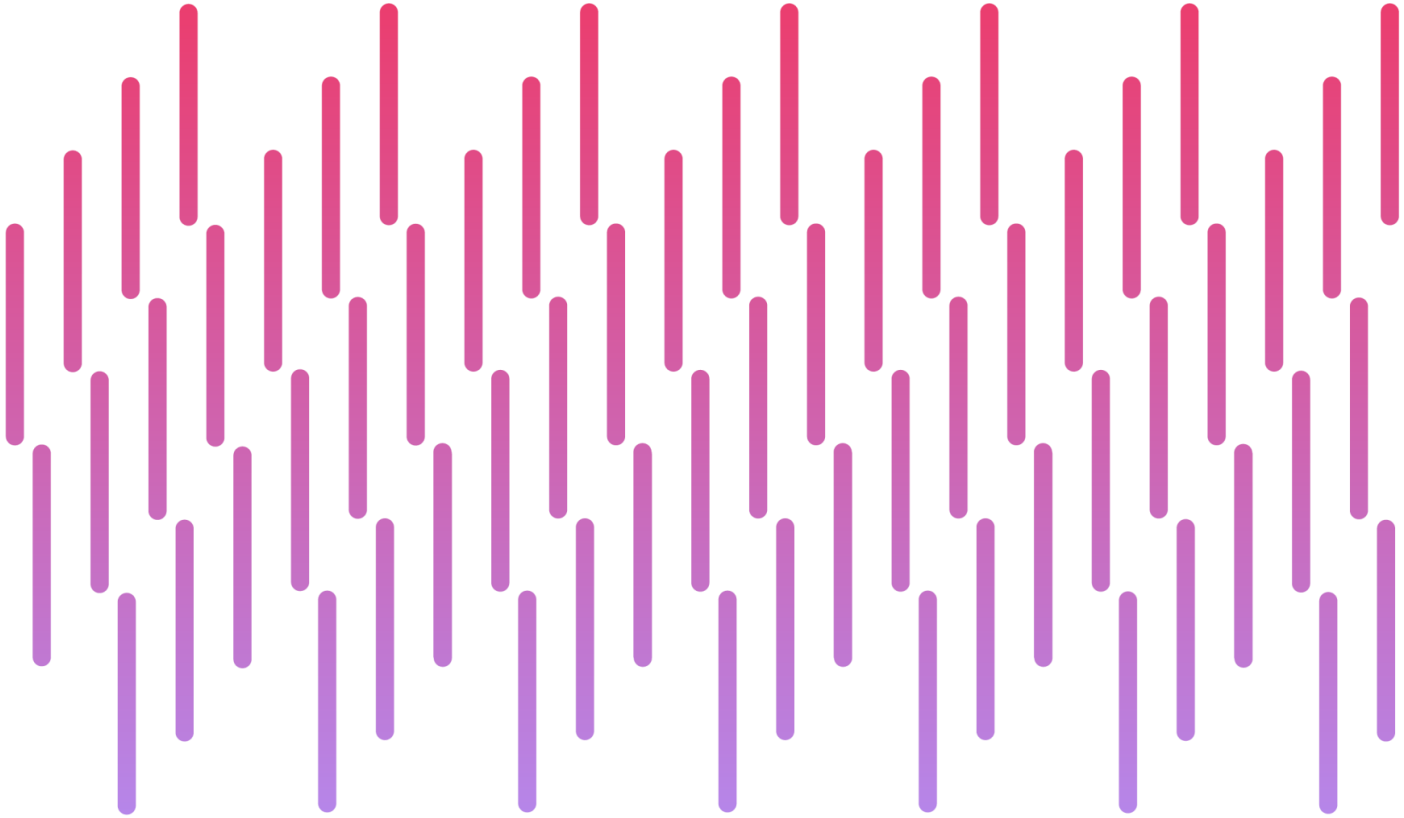
Gaps in controls and assurances	Actions to address gaps in controls and assurances	Complete by (date)	Progress
Few clinical academics - Many areas of Trust activity are not reflected in St George's University London research	**Seek investment to allow more clinical academic appointments** Investment will be needed from the Trust if new clinical academic posts are to be appointed (or new Trust consultants with protected time for research). Investment in the research strategy of £500K has been requested for 2022/23 and is currently been considered as part of business planning processes.	~~Dec 2021~~ Dec 2022	
Poor research IT infrastructure	**Seek investment /work with IT to set up research data warehouse** There is interest in a data warehousing project from both Trust and SGUL researchers and we have held initial discussions with Trust IT. A group comprising interested researchers and Trust IT will meet in January 2022 to progress this.	~~Dec 2021~~ Dec 2022	
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.	Complete	

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% (2019/20); 10% (2020/21) Given the NIHR have advised prioritisation of Covid research, the 2020/21 and 2021/22 percentages will not impact CRN funding (which has been fixed for 2021 to 2023). The RAG rating remains green as the % in the pre-Covid year (2019/20) was high and had increased, and 2020/21 was affected by prisonisation of Covid trials.
Patient recruitment numbers					10,538 (2019/20); 7,881 (2020/21). NIHR have advised prioritisation of Covid research, with most non-Covid research suspended during the first and second waves of Covid. For the same reason as % recruitment above, the RAG rating remains green.
Number of clinical research studies led from St George's					130 (current St George's Trust/ University sponsored clinical research studies). Awarded grant to lead major Covid pregnancy vaccine trial, which commenced August 2021. However, most of our clinical research is led outside 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 – awaiting outcome of application • 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 Dec 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)	20 (4x5)
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)**
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	12 (4x3)	**8 (4x2)**
Covid-19-PPE	COVID-2107	Lack of PPE to effectively manage exposure to Covid-19 virus	Apr 2020	20 (4x5)	4 (4x1)

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 Dec 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)
Discharge	MD2052	Non-compliance with the eDischarge Summary Standard	Mar 2020	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)
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	8 (2x4)	6 (2x3)
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)	4 (4x1)

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 Dec 2021
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)
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)
Emergency care 4hr operating standard	NEW	Failure to deliver and sustain the 95% Emergency Care Operating Standard	Jan 2022	20 (4x5)	20 (4x5)
Patient flow	COO-2393	Risk of inadequate patient flow in the Trust (and across the health care system) for emergency admission	Nov 2021	20	20

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 Dec 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**
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)	**12 (4x3)**
Paediatric ECHO delivery	CCAG-1980	Inability of safely provide a paediatric ECHO service at St Georges Hospital	Nov 2019	20 (4x5)	**12 (4x3)**
Management of RTT	COO-2371	Failed to meet the constitutional standard of 92% of patients being treated within 18 weeks from referral due to COVID-19 and insufficient capacity	July 2020	20 (4x5)	**12 (4x3)**
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)**
Clinical Decision Outcome Form	S2060	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	COO-2372	Failure to comply with 6 week diagnostic standard which may result in poor quality of care for patients	Dec 2021	**8**	Close
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)	Close
Emergency care 4hr operating standard	ED-1514 ED-852	Failure to deliver and sustain the 95% Emergency Care Operating Standard	May 2014	20 (4x5)	Close
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)	Close

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 Dec 2021
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
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)
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	Aug 2019	15 (5x3)	10 (5x2)
Disagreement on future of QMH	STR-2311	There is a risk that the Trust and system partners (CCG, Kingston) are unable to agree on future use of QMH	Aug 2021	9 (3x3)	6 (3x2)
Lack of collaboration across SWL Acute Providers	STR1496	There is a risk that other acute provider organisations in SWL will pursue clinical/ commercial relationships with other tertiary NHS providers that pose a strategic threat to SGUH	Oct 2018	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 Dec 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 (5x5)	**9 (3x3)**
Managing within new contract forms (block contracts)	Fin- 1858	There is a risk that the Trust could be financially impacted by a failure to manage performance inline with new contract models, specifically a block contract.	May 2019	**9 (3x3)**	**9 (3x3)**
Risk that the Trust could be financially penalised due to non-delivery of control totals within South West London	Fin-1857	Risk that the Trust could be financially penalised due to non-delivery of control totals within South West London. It is unclear within planning guidance what the impact of other organisations within the South West London patch not hitting control totals will be on the organisations.	May 2019	**9 (3x3)**	**9 (3x3)**
Unsupported finance and procurement system		A risk that the Trust has an unsupported finance and procurement system.		**8**	**8**

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 Dec 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)	8 (2x4)
Risk short form title	**CRR Ref**	**Description**	**Open Date**	**Inherent Score**	**Current Score Dec 2021**
Strategic Risk 7	**We are unable provide a safe environment for our patients and staff and to support the transformation of services due to the poor condition of our estates infrastructure**			**20**	**20**
Bacterial contamination of water supply	CRR-0016	Risk from exposure to potential pathogenic bacteria in water	May 2014	**20 (5x4)**	**20 (5x4)**
Inability to address infrastructure backlog maintenance to maintain safe site	CRR-0008	Inability to address infrastructure backlog maintenance to maintain safe site due to lack of capital	Jul 2016	**20 (4x5)**	**20 (4x5)**
Risk of fire starting in Lanesborough Wing developing into a major fire	EF2036	Risk that an undetected and immediately extinguished fire could develop into a major fire resulting in area evacuation	Feb 2020	**20 (5x4)**	**20 (5x4)**
Cardiac Catheter Labs breakdowns	CCAG-1025	Cardiac Catheter Labs breakdown /failure due to old equipment/ infrastructure	Sep 2016	**20 (4x5)**	**20 (4x5)**
Electrical Infrastructure - Risk of non-compliance	CRR-1311	Risk of electrical non-compliance with Electricity at Work Regulations and BS7671 due to lack of regular testing	Aug 2017	**16 (4x4)**	**16 (4x4)**
Lack of UPS/IPS power supplies	EF2061	Lack of UPS/IPS power supplies	Mar 2020	**20 (5x4)**	**15 5x3)**
Data Centre	CRR-810	Risk that a fire, flood, power failure in the Data Centre could cause loss of data due to having a single data centre hosting all on-site critical systems	Mar 2014	**20 (5x4)**	**15 (5x3)**

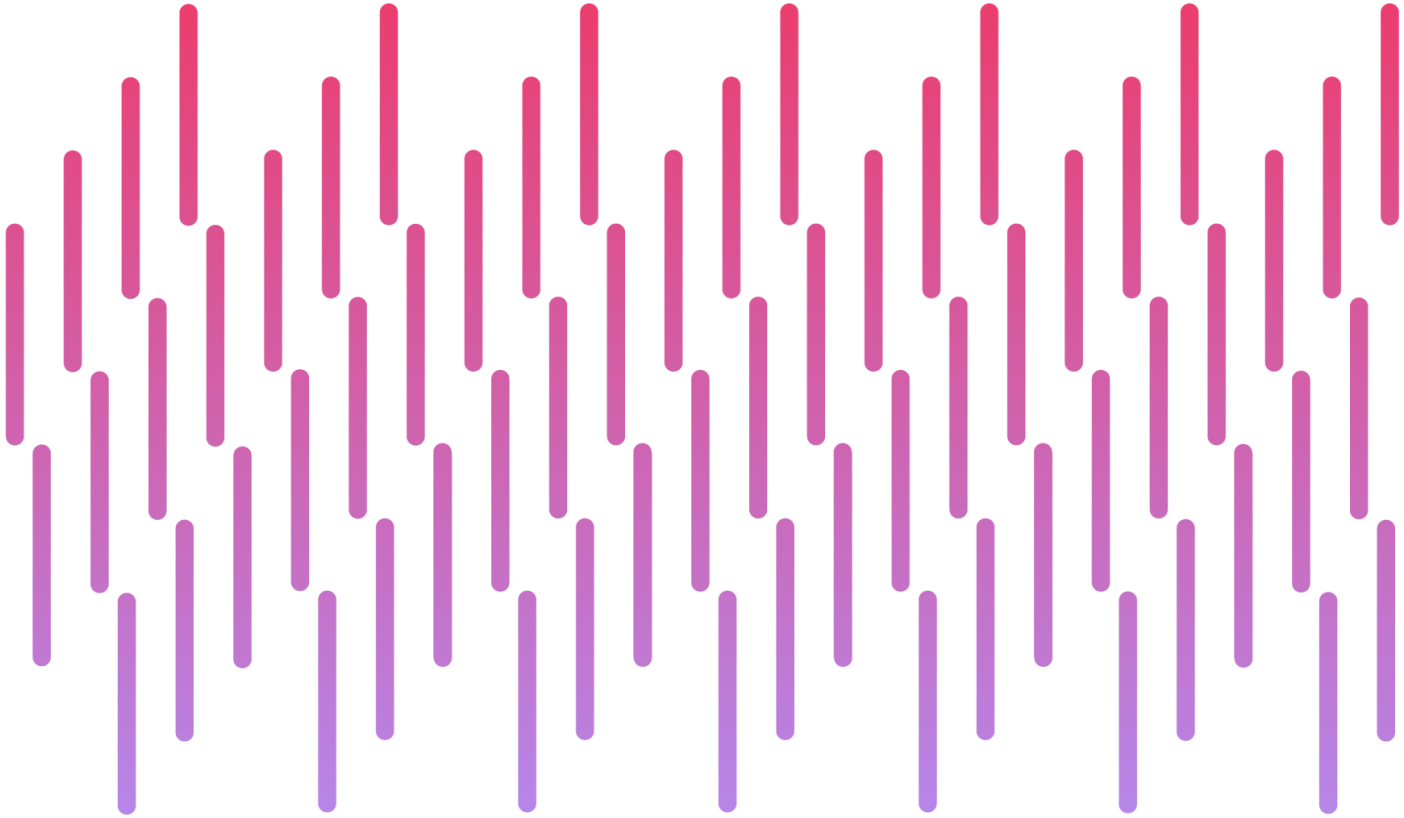
Individual Risks contributing to Strategic Risks
Linked risks on the Corporate Risk Register

Risk short form title	CRR Ref	Description	Open Date	Inherent Score	Current Score Dec 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 Dec 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**	**20** ↑
VCOD compliance	HR-2381	Compliance with Covid vaccinations for all Health and Social Care workers		**25 (5x5)**	**25 (5x5)**
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)**
Risk short form title	**CRR Ref**	**Description**	**Open Date**	**Inherent Score**	**Current Score Dec 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)**
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)**
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)**

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

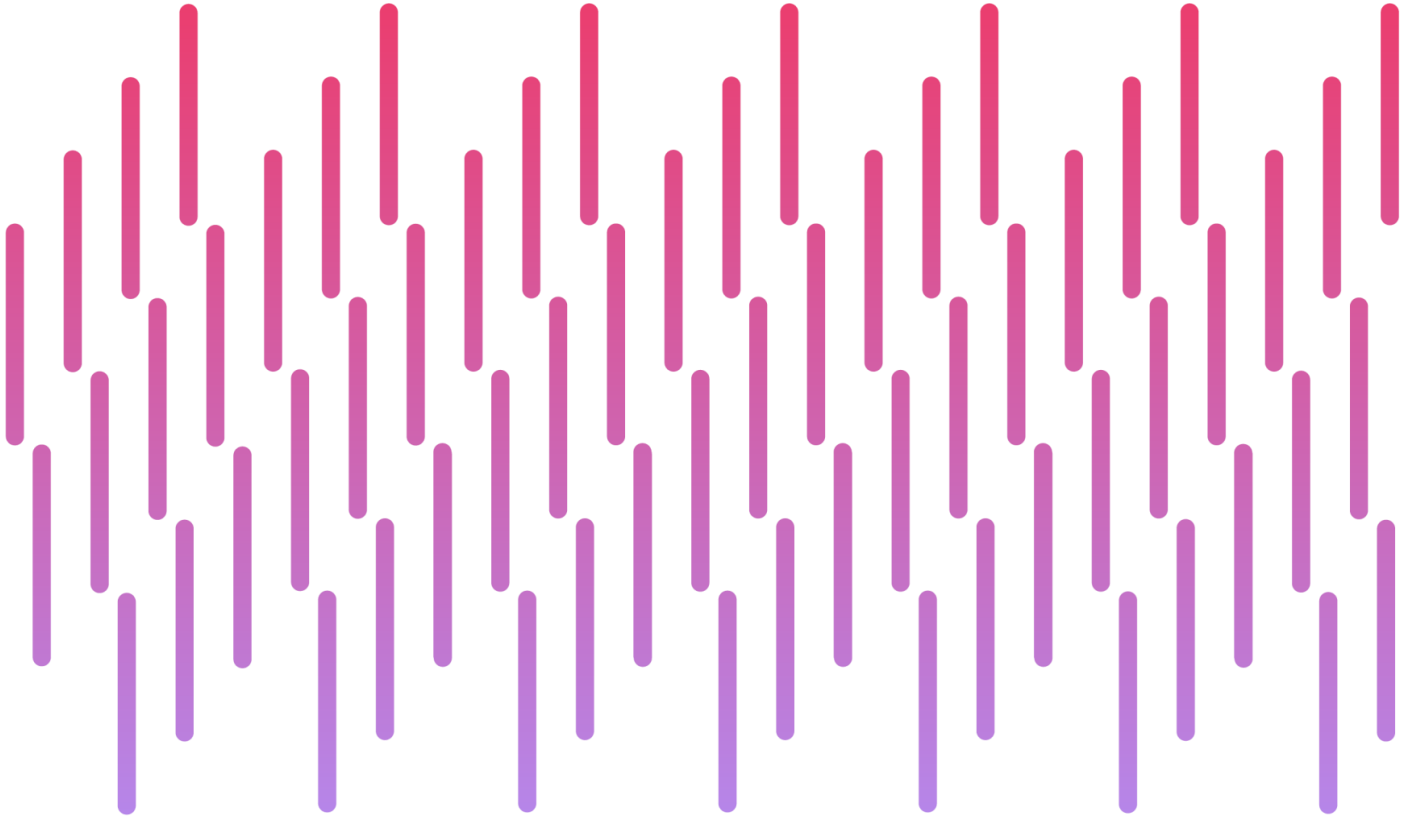
Delivered	
On track to deliver to agreed timescale	
Slippage against agreed timescales (non-material)	
Progress materially off track	
Action not delivered to agreed timescale	

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

Outstanding care every time



Meeting Title:	**Trust Board**		
Date:	27 January 2022	**Agenda No**	**4.5**
Report Title:	**Changes to Executive Membership of Committees**		
Lead Director/ Manager:	Stephen Jones, Chief Corporate Affairs Officer (CCAO)		
Report Author:	Geoff Stokes, Head of Corporate Governance		
Presented for:	Approval		
Executive Summary:	Following the decision to create a group model with Epsom and St Helier University Hospitals NHS Trust, a new group executive management structure was agreed in December 2021 which comes into effect from 1 February 2022. This paper sets out existing executive membership of Board committees and makes proposals to take account of the new group executive management structure approved as part of the move to a new group model. It shows the implications of the new group executive management structure for the membership and attendance at Board committees in the short-term. These changes will amend the current terms of reference pending the approval of new terms of reference for the committee structure being introduced April 2022.		
Recommendation:	Trust Board is asked to approve changes to the Committee terms of reference for the Quality and Safety Committee, Finance and Investment Committee, and Workforce and Education Committee to take account of the appointment of new Group Executive Directors from 1 February 2022.		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	Well Led		
NHS Oversight Framework Theme:	Leadership and Improvement Capability (Well Led)		
Implications			
Risk:	As set out in paper.		
Legal/Regulatory:	As set out in paper.		
Resources:	There are no resource implications associated with this proposal.		
Equality and Diversity:	There are no equality and diversity implications of this proposal.		
Previously Considered by:	N/A	**Date**	N/A
Appendices:	N/A		

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Committee Membership and Dates – February 2022 to March 2022
Trust Board

1.0 PURPOSE

1.1 This paper sets out existing executive membership of Board committees and makes proposals to take account of the new group executive management structure approved as part of the move to a new Group model with Epsom and St Helier University Hospitals NHS Trust.

2.0 BACKGROUND

2.1 Terms of reference for existing Board committees were last approved by the Board in May and July 2021 and listed the non-executive and executive members, along with identifying regular attendees.

2.2 The Board agreed to establish a group model with Epsom and St Helier University Hospitals NHS Trust at its meeting in June 2021 which has involved the appointment of a new group executive management structure which is common across both trusts. This means that some individuals and job titles shown in the existing terms of reference for the Board Committees of St George's need to be updated both to reflect the group executive structure and, importantly, ensure appropriate accountability at committees.

2.3 This is a short-term measure to ensure effective and robust governance at the point at which the new group executive structure takes effect. A wider piece of work is underway to develop new committee terms of reference from April 2022 when both trusts seek to align some of their governance arrangements.

3.0 ANALYSIS AND PROPOSALS

3.1 Below are tables showing existing and proposed executive membership for Board committees (non-executive membership remains unchanged at this stage):

Quality and Safety Committee

CURRENT	
Chief Nurse and Director of infection Prevention and Control	Robert Bleasdale
Chief Medical Officer	Richard Jennings
Chief Operating Officer	Anne Brierley

PROPOSED – from 1 February 2022	
Group Chief Nursing Officer	Arlene Wellman
Group Chief Medical Officer	Richard Jennings
Managing Director for St George's Hospital	Kate Slemeck

Finance and Investment Committee

CURRENT	
Chief Financial Officer and Deputy Chief Executive	Andrew Grimshaw
Chief Nurse and Director of infection Prevention and Control	Robert Bleasdale
Chief Medical Officer	Richard Jennings
Chief Operating Officer	Anne Brierley

PROPOSED – from 1 February 2022	
Group Chief Finance Officer	Andrew Grimshaw
Group Chief Nursing Officer	Arlene Wellman
Group Chief Medical Officer	Richard Jennings
Managing Director for St George's Hospitals	Kate Slemeck

Workforce and Education Committee

CURRENT	
Chief People Officer	Paul da Gama
Chief Nurse and Director of infection Prevention and Control	Robert Bleasdale
Chief Medical Officer	Richard Jennings

PROPOSED	
Group Chief People Officer	Paul da Gama
Group Chief Nursing Officer	Arlene Wellman
Group Chief Medical Officer	Richard Jennings

3.1 This paper does not address attendance of non-members at Committees – each executive member should agree with the relevant committee chair the appropriateness of other attendees based on the agenda, bearing in mind the need to limit the size of meetings to make them manageable and the importance of having appropriate knowledge and experience present to assist the committees. However, it is expected that the Trust-level directors (Trust Chief Medical Officer, Trust Chief Nurse, Trust Chief Operating Officer) would continue to attend the relevant Committees of the Board during February and March 2022. Attendees at Board Committees from April 2022 will be set out as part of the new terms of reference for Committees, which will be brought to the Board for consideration in March 2022.

3.2 Audit Committee and the Board Nominations and Remuneration Committee are not included in this paper as they have no executive members.

4.0 RISKS AND IMPLICATIONS

4.1 There are no significant risks to this proposal although new members of committees will need to become familiar with their brief and this can be mitigated by having well written papers and attendance by authors, where necessary.

4.2 If changes to committee terms of reference are not agreed then there is a possibility that the validity of decisions could be challenged as the accountable officers are not members of the committee.

5.0 NEXT STEPS OR TIMELINE

5.1 If approved, these terms of reference will take effect immediately.

5.2 Separately, work is underway to review terms of reference to enable committees-in-common to be established. It is expected these will be approved by both Boards in March 2022 after appropriate consultation.

6.0 RECOMMENDATION

6.1 Trust Board is asked to approve the executive membership for Quality and Safety Committee, Finance and Investment Committee, and Workforce and Education Committee as proposed in section 3.0.

Author: Geoff Stokes, Head of Corporate Governance
Date: January 2022

Meeting Title:	**Trust Board**		
Date:	27 January 2022	**Agenda No**	**4.6**
Report Title:	**Non-Executive Director Lead Roles**		
Lead Director/ Manager:	Stephen Jones, Group Chief Corporate Affairs Officer		
Report Author:	Geoff Stokes, Head of Corporate Governance		
Presented for:	Approval		
Executive Summary:	This paper sets out the Trust's proposed approach to Non-Executive Director (NED) lead roles, following the publication of new guidance by NHS England and NHS Improvement (NHSE/I) in December 2021. The guidance sets out a new approach for Board-level oversight of important issues by streamlining the number of named NED lead roles and discharging roles previously exercised by NED leads through Board Committee structures. The guidance responds to the proliferation of NED lead roles in recent years. There remain a small number of statutory and regulatory requirements that continue to require a named NED and the guidance sets out five continuing NED lead roles. Nonetheless, the principle of the unitary Trust Board – with joint decision-making – remains. NHSE/I consider that the new approach will enhance Board oversight of these issues by ensuring they are embedded in the governance arrangements and assurance processes of trusts, and through this providing an audit trail of discussions and actions identified by committees. The Trust has reviewed its NED lead roles in the context of the guidance and this paper sets out proposals for designating NED leads to the five roles retained under the guidance, and ensuring previous named NED responsibilities are appropriately embedded in the assurance work of Board committees.		
Recommendation:	The Board is asked to: • Note the new guidance on NED lead roles published by NHSE/I in December 2021; • Approve the proposed allocation of NED lead roles as set out in Appendix A; • Note that the review of committee terms of reference, which is already underway, will address the requirements to ensure issues previously designated to NED leads are appropriately captured in our governance and assurance processes.		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	Well Led		
NHS Oversight Framework Theme:	Leadership and Improvement Capability (Well Led)		
Implications			

Risk:	This report aims to reduce the risk of false assurance amongst other board directors, not designated as 'champions'.		
Legal/Regulatory:	Various inquiry reports and NHSE/I directions		
Resources:	There are no resource implications relevant to this report.		
Equality and Diversity:	There are no equality and diversity implications relevant to this report.		
Previously Considered by:	N/A	**Date**	N/A
Appendices:	Appendix A: Rationale for retention of five NED Lead roles – NHS Guidance Appendix B: Proposed SGUH NED Lead roles		

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Non-Executive Director Lead Roles
Trust Board 27 January 2022

1.0 PURPOSE

1.1 This paper sets out the Trust's proposed approach to Non-Executive Director (NED) lead roles, following the publication of new guidance by NHS England and NHS Improvement (NHSE/I) in December 2021.

2.0 BACKGROUND OR CONTEXT

2.1 In recent years there have been a number of non-executive 'champion' roles created following reports from national inquiries and other policy initiatives. The designation of new NED lead roles have often followed the perceived need for additional board level focus to respond to examples of high profile failings in care or leadership. These roles have varied in terms of the expectations placed on NEDs and have raised concerns amongst trusts about diluting collective accountability through the unitary board and risks of overlapping with executive responsibilities.

2.2 Through its engagement with the sector, NHSEI recognised that the number of NED champion roles had started to make it difficult for trusts to discharge them all effectively, particularly with a limited number of NEDs, and many do not have a role description, making it difficult to measure their impact on delivering change.

2.3 Non-mandatory guidance[1] has been issued by NHS England and NHS Improvement (NHSE/I) which has proposed keeping only five NED 'champion' roles with the remaining responsibilities being overseen at committee level, as shown below. These are to be retained because they are either a statutory requirement, the function requires a named individual to discharge or because we consider having an individual NED to be the most effective way of delivering the changes that are needed.

Roles to be retained				
Maternity board safety champion	Wellbeing guardian	Freedom to speak up	Doctors disciplinary	Security management
Roles to transition to new approach				
Hip fracture, falls and dementia	Learning from deaths	Safety and risk	Palliative and end of life care	Health and safety
Children and young people	Resuscitation	Cybersecurity	Emergency preparedness	Safeguarding
Counter fraud	Procurement	Security management- violence and aggression		

[1] NHS England and NHS Improvement, 'Enhancing board oversight: A new approach to non-executive director champion roles', December 2021

2.4 The guidance recommends that Trusts:

- Review their current NED role arrangements in the context of the guidance, retaining those roles that should be retained and transitioning the remaining roles to discharge through the assurance roles of board committees.
- For each of the roles that should transition to committee oversight, review which committee would be the appropriate committee for providing assurance to the board on these issues.
- Determine the way in which the committees will provide assurance to the board, either through existing reporting mechanisms or through periodic board updates.
- Review the terms of reference for board committees to ensure that the NED roles transitioning to the new approach are appropriately integrated into committee governance and assurance processes.

2.5 The guidance also includes useful references where more detail about all the requirements can be found.

2.6 Annex A sets out the rationale for retaining each of the five continuing NED lead roles as set out in the NHSEI guidance.

3.0 PROPOSAL

3.1 This paper recommends that the Trust adopts the approach outlined in the new guidance, although it is not statutory guidance.

3.2 In the majority of roles proposed for transitioning to committee oversight, the Trust already has in place committee assurance mechanisms to provide oversight and assurance to the Board. For example, the terms of reference for the Quality and Safety Committee provide for the Committee's oversight of learning from deaths, end of life care, safeguarding and health and safety. Likewise, the Finance and Investment Committee terms of reference already requires the Committee to provide assurance in relation to emergency preparedness and the Audit Committee provides assurance around cyber security, as does FIC through its oversight of ICT risks.

3.3 In some areas, terms of reference of Committees will need to be explicitly changed to reflect the area of responsibility. The Trust proposed to make these amendments to its committee terms of reference. However, given the imminent change to terms of reference that is planned to take account of the new Group governance structure, it is proposed that these changes are included as part of that review.

3.4 For those NED roles that are retained under the new guidance, the Trust already has NED leads identified for four out of five of these roles. The Trust proposes to retain the incumbent NEDs in the these roles and appoint a new NED lead for security management.

3.5 Appendix B shows the above roles with the current nominated NED (where known) and the recommended approach, moving forward. All remaining Trust NED lead roles, other than those specified in the guidance, are proposed for transitioning to committee oversight.

4.0 IMPLICATIONS

Risks

4.1 Allocating specific roles to NEDs could dilute collective responsibility of the Board and provide an unhelpful overlap with executive responsibilities and accountability. This risk is mitigated through the assigning of formal assurance responsibilities to committees, even where there is a named NED lead.

Legal Regulatory

4.2 The guidance issues is non-mandatory, but references regulations and mandatory guidance as part of the appendices.

Resources

4.3 Holding specific lead responsibilities will impact on the workload of individual NEDs.

Equality & Diversity

4.4 There are no direct equality and diversity issues arising from this paper.

5.0 NEXT STEPS OR TIMELINE

5.1 Terms of reference for relevant committees will be updated by 1 April 2022 as part of the review of committees taking place for the new Group governance arrangements.

5.2 Specific guidance and further resources will be sent to named NED leads and Committee Chairs.

6.0 RECOMMENDATION

6.1 The Board is asked to:

- Note the new guidance on NED lead roles published by NHSE/I in December 2021;
- Approve the proposed allocation of NED lead roles as set out in Appendix A;
- Note that the review of committee terms of reference, which is already underway, will address the requirements to ensure issues previously designated to NED leads are appropriately captured in our governance and assurance processes.

Author: **Geoff Stokes, Interim Head of Corporate Governance**
Date: **January 2022**

Outstanding care every time

St George's University Hospitals NHS Foundation Trust

APPENDIX A

Rationale for retention of five NED Lead Roles – NHSEI Guidance

Role	Rationale for retention
Maternity board safety champion	In response to the Morecambe Bay Investigation (2015), this role was established through Safer Maternity Care 2016, which stated that "Senior trust managers will want to ensure unfettered communication from 'floor-to-board' by appointing a board level maternity champion". The role is in line with recommendations from the Ockenden Review (2020) and while not a statutory requirement, for trusts providing maternity services having a named NED maternity board safety champion is recommended.
Wellbeing guardian	This role originated as an overarching recommendation from the Health Education England 'Pearson Report' (NHS Staff and Learners' Mental Wellbeing Commission 2019) and was adopted in policy through the 'We are the NHS People Plan for 2020-21 – action for us all'. The NED should challenge their trust to adopt a compassionate approach that prioritises the health and wellbeing of its staff and considers this in every decision.
Freedom to Speak Up	The Robert Francis Freedom to Speak Up Report (2015) sought to develop a more supportive and transparent environment where staff are encouraged to speak up about patient care and safety issues. In line with the review, it is recommended that all NHS trusts should have this functional FTSU guardian role so that staff have a clear pathway and an independent and impartial point of contact to raise their concerns in the organisation.
Doctors disciplinary	Under the 2003 Maintaining High Professional Standards in the modern NHS: A Framework for the Initial Handling of Concerns about Doctors and Dentists in the NHS and the associated Directions on Disciplinary Procedures 2005 there is a requirement for chairs to designate a NED member as "the designated member" to oversee each case to ensure momentum is maintained. There is no specific requirement that this is the same NED for each case. The framework was issued to NHS foundation trusts as advice only.
Security management	Under the Directions to NHS Bodies on Security Management Measures 2004 there is a statutory requirement for NHS bodies to designate a NED or non-officer member to promote security management work at board level. Security management covers a wide remit including counter fraud, violence and aggression and also security management of assets and estates. Strategic oversight of counter fraud now rests with the Counter Fraud Authority and violence/aggression is overseen by NHS England and NHS Improvement.

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

APPENDIX B

Proposed SGUH NED Lead Roles and Board Committee Allocations

Role	Proposals
Maternity board safety champion	Dame Parveen Kumar
Wellbeing guardian	Tim Wright
Freedom to Speak Up	Stephen Collier
Doctors disciplinary	Stephen Collier
Security management	Tim Wright
Hip fracture, falls and dementia	Quality and Safety Committee
Learning from deaths	Quality and Safety Committee
Safety and risk	Quality and Safety Committee
Palliative and end of life care	Quality and Safety Committee
Health and safety	Quality and Safety Committee
Children and young people	Quality and Safety Committee
Resuscitation	Quality and Safety Committee
Cybersecurity	Audit Committee
Emergency preparedness	Finance and Investment Committee
Safeguarding	Quality and Safety Committee
Counter fraud	Audit Committee
Procurement	Finance and Investment Committee
Security management - violence and aggression	Workforce and Education Committee

DRAFT AGENDA FOR NEXT MEETING
PUBLIC TRUST BOARD 31 MARCH 2022

HEADING	ITEM NO.	ITEM	LEAD	ACTION	FORMAT	TIME	DUR.
OPENING ADMINISTRATION	1.1	Welcome and Apologies	Chairman	Note	Verbal	9:00	00:00
OPENING ADMINISTRATION	1.2	Declarations of Interest	All	Note	Verbal	9:00	00:00
OPENING ADMINISTRATION	1.3	Minutes of previous meeting	Chairman	Approve	Report	9:00	00:05
OPENING ADMINISTRATION	1.4	Action Log and Matters Arising	All	Review	Report	9:05	00:00
OPENING ADMINISTRATION	1.5	Chief Executive Officer's Report	GCEO	Inform	Report	9:05	00:10
CARE	2.1	Quality and Safety Committee Report	Committee Chair	Assure	Report	9:15	00:15
CARE	2.2	Integrated Quality and Performance Report	MD	Assure	Report	9:30	00:15
CARE	2.3	Learning from Deaths Q3 2021/22*	GCMO	Assure	Report	9:45	00:10
CULTURE	3.1	Workforce and Education Committee Report	Committee Chair	Assure	Report	9:55	00:10
CULTURE	3.2	NHS Staff Survey 2021: Results and Action Plan*	GCPO	Assure	Report	10:05	00:10
CULTURE	3.3	Vaccination as a condition of deployment	GCPO	Assure	Report	10:15	00:10
CULTURE	3.4	Freedom to Speak Up Guardian Report*	GCCAO	Assure	Report	10:25	00:10
CULTURE	3.5	Modern Slavery Statement*	GCPO	Assure	Report	10:35	00:05
COLLABORATION	4.1	Audit Committee Report	Committee Chair	Assure	Report	10:40	00:15
COLLABORATION	4.2	Finance and Investment Committee Report	Committee Chair	Assure	Report	10:55	00:15
COLLABORATION	4.3	Finance Report	GCFO	Update	Report	11:10	00:10
COLLABORATION	4.4	Horizon Scanning Report	GCCAO	Note	Report	11:20	00:05
COLLABORATION	4.5	Corporate Records Policy	GCCAO	Approve	Report	11:25	00:05
CLOSING ADMINISTRATION	5.1	Questions from Governors and the Public	Chairman	Note	Verbal	11:30	00:05
CLOSING ADMINISTRATION	5.2	Any New Risks or Issues Identified	All	Note	Verbal	11:35	00:00
CLOSING ADMINISTRATION	5.3	Any Other Business	All	Note	Verbal	11:35	00:00
CLOSING ADMINISTRATION	5.4	Draft Agenda for Next Meeting	Chairman	Note	Report	11:35	00:00
CLOSING ADMINISTRATION	5.5	Patient/Staff Story	GCNO	Note	Verbal	11:35	00:20
CLOSING ADMINISTRATION		CLOSE				11:55	