Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

# Trust Board Meeting in Public – Agenda

**Date and Time:** Thursday 31 March 2022, 09:00 – 12:10
**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 27 January 2022 | Chairman | Approve | Report |
| | 1.4 | Action log and matters arising | All | Review | Report |
| 09:05 | 1.5 | Chief Executive Officer's Report | CEO | Inform | Verbal |
| **2.0 CARE** | | | | | |
| 09:15 | 2.1 | Quality and Safety Committee Report | Committee Chair | Assure | Report |
| 09:30 | 2.2 | Integrated Quality and Performance Report* | MD | Assure | Report |
| 10:00 | 2.3 | Health and Safety Report* | GCFO | Assure | Report |
| 10:05 | 2.4 | Learning from Deaths Q3 2021/22* | GCMO | Assure | Report |
| 10:10 | 2.5 | Ockenden – One Year On* | GCNO | Assure | Report |
| 10:20 | 2.6 | CQC Statement of Purpose | GCNO | Approve | Report |
| **3.0 CULTURE** | | | | | |
| 10:25 | 3.1 | Workforce and Education Committee Report | Committee Chair | Assure | Report |
| 10:40 | 3.2 | NHS Staff Survey* | GCPO | Assure | Report |
| 11:00 | 3.3 | Modern Slavery Statement* | GCPO | Assure | Report |
| **4.0 COLLABORATION** | | | | | |
| 11:05 | 4.1 | Audit Committee Report | Committee Chair | Assure | Report |
| 11:20 | 4.2 | Finance and Investment Committee Report | Committee Chair | Assure | Report |
| 11:35 | 4.3 | Finance Report (Month 11)* | GCFO | Note | Report |
| **5.0 CLOSING ADMINISTRATION** | | | | | |
| 11:45 | 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 | |
| 11:50 | 5.4 | Patient/Staff Story | | | |
| 12:10 | CLOSE | | | | |

**Date of Next Meeting: Thursday 5 May 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

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 |
| Stephen Collier | Non-Executive Director | SC |
| Paul da Gama | Group Chief People Officer | GCPO |
| Andrew Grimshaw | Group Finance Officer | GCFO |
| Jenny Higham | Non-Executive Director (St George's University Representative) | JH |
| Richard Jennings | Group Chief Medical Officer | GCMO |
| Stephen Jones | Group Chief Corporate Affairs Officer | GCCAO |
| Peter Kane | Non-Executive Director | PKa |
| Dame Parveen Kumar | Non-Executive Director | PKu |
| Pui-Ling Li | Associate Non-Executive Director | PLL |
| James Marsh | Group Deputy Chief Executive Officer | GDCEO |
| Kate Slemeck | Managing Director | MD |
| Arlene Wellman | Group Chief Nursing Officer | GCNO |
| 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.***

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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 27 January 2022**

**Held virtually via Microsoft Teams**

| | | |
|---|---|---|
| **PRESENT** | | |
| Gillian Norton | Chairman | Chairman |
| Jacqueline Totterdell | Group Chief Executive Officer | GCEO |
| Ann Beasley | Non-Executive Director | AB |
| Robert Bleasdale | Chief Nurse & Director of Infection Prevention & Control | CN |
| 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 (from item 2.3) | 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 |
| Tim Wright | Non-Executive Director | TW |
| | | |
| **IN ATTENDANCE** | | |
| Anna Macarthur | Director of Communications and Engagement | DCE |
| James Marsh | Group Deputy Chief Executive Officer designate | GDCEO |
| Geoff Stokes | Head of Corporate Governance/Board Secretary (minutes) | HCG |
| Arlene Wellman | Group Chief Nursing Officer designate | GCNO |
| | | |
| **APOLOGIES** | | |
| Suzanne Marsello* | Chief Strategy Officer | CSO |
| | | |

** Non-voting members of the Board*

*Items recorded in the order they were taken.*

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| **1.0 OPENING ADMINISTRATION** | | |
| 1.1 | **Welcome, introductions and apologies**<br>The Chairman welcomed everyone to the meeting and noted the apologies shown above.<br>She welcomed Arlene Wellman, Group Chief Nursing Officer designate, and James Marsh, Group Deputy Chief Executive Officer designate, who will commence their new roles from 1 February 2022. | |
| **1.2** | **Declarations of Interest**<br>The standing interests in relation to the shared roles with Epsom and St Helier University Hospitals NHS Trust (ESTH) of Gillian Norton as Chairman-in-Common, Anne Beasley and Peter Kane as non-executive directors, and Jacqueline Totterdell as Group Chief Executive Officer (GCEO) were noted, having previously been authorised by the Board. | |
| **1.2.1** | **Authorisation of Conflict of Interest Following Establishment of Group Executive** | |
| | Stephen Jones, Chief Corporate Affairs Officer (CCAO), introduced the paper which explained the potential inherent conflicts that could exist with the introduction of the new Group management structure in terms of directors having duties to both organisations. He advised that the Trust's Constitution and the NHS Foundation Trust Code of Governance permitted the Board to authorise any conflicts as long as it had considered the matter carefully and was clear as to the rationale for this. In this case, the joint appointment of the Group Executives at the Trust and ESTH was part of the implementation of the new group model which was expected to deliver benefits to the patients of both organisations. It was proposed that the Board authorise these conflicts of interest to exist on that basis. | |
| | The Board authorised the conflicts of interest that arise 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 the paper. | |
| **1.3** | **Minutes of the Previous Meeting**<br>The minutes of the meeting held on 25 November 2021 were approved as a true and accurate record. | |
| **1.4** | **Action Log and Matters Arising**<br>The Board noted the action log which had no outstanding items. | |
| **1.5** | **Group Chief Executive's Officer (CEO) Report**<br>Jacqueline Totterdell, Group Chief Executive Officer, presented her report to the Board and made the following points:<br>• The anticipated surge of Omicron cases occurred but has now passed its peak.<br>• Staff absences had been particularly high, especially over Christmas, but, again, the peak appears to have passed. | |

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| | • The implementation of the 'vaccination as a condition of deployment' (VCOD) regulations is particularly challenging, and the Board will hear more about this later in the meeting.<br>• The Nightingale surge hub had been erected on site in late December and January but thankfully has not needed to be used.<br>• The Covid Medicines Delivery Unit (CMDU) has been established to offer support to vulnerable people in the community. Particular thanks go to Carolyn Johnston, Deputy Chief Medical Officer, who led its establishment and which has provided treatments to the most patients of any such unit in the country.<br>• All Group executive appointments have been made and the structure will go live on 1 February 2022.<br>• Thanks were given to Robert Bleasdale, who has been acting Chief Nurse for two years and leaves the Trust to take up a post at Chelsea and Westminster Hospital NHS Foundation Trust at the end of March 2022. Thanks also were given to Suzanne Marsello, Chief Strategy Officer, who leaves the Trust at the end of January for a role at Surrey Heartlands ICS. Both will be greatly missed. | |
| | As a trustee of the St George's Hospital Charity, TW also added his personal thanks for the support that Suzanne Marsello had provided to the Charity. | |
| | The Chairman added her thanks to those of the GCEO for the contributions both the CN and CSO had made to the Board. | |
| | PKa asked about the ten planning priorities for 2022/23 highlighted in the report and noted the need to re-prioritise resources to address these. The GCEO explained that these are being reviewed to determine the implementation implications. | |
| | PKa also asked for more information to given about the work of the ICS and the Chairman noted that ICS is a regular item on the board agenda. | |
| | The Board noted the Group Chief Executive Officer's report. | |
| **2.0 CARE** | | |
| **2.1** | **Quality and Safety Committee Report**<br>Professor Dame Parveen Kumar, Chair of the Quality and Safety Committee, presented the report of the meetings held in December 2021 and January 2022. Some of the reports discussed by the Committee also feature later on the Board agenda.<br>The key matters of note from the Committee were as follows:<br>• The basic life support (BLS) training target has been met however advanced life support (ALS) and immediate life support (ILS) training targets have not yet been met. ILS performance has declined, and efforts continue to improve the position.<br>• Duty of Candour compliance has been maintained at 100%.<br>• There was one fall in December 2021 and two in November which are being investigated (this was a correction to the published report). | |

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| | • There have sadly been five stillbirths in the period, of which four were referred to the Healthcare Safety Investigation Branch (HSIB). It is being investigated whether the ethnic origin of mothers is a factor in these cases.<br>• Good assurance was received on improving the control of access to the mortuary, with improved access controls now implemented and DBS checks being addressed.<br>AB added her concern about the number of stillbirths and asked whether outcomes are routinely monitored in relation to ethnicity. The CN explained that the mothers involved came from a range of backgrounds and, as part of next report to QSC, outcomes by ethnicity will be reported using the national dataset. Early indications are that there were no common factors involved with the stillbirths. The GCEO asked whether deprivation was a factor and CN responded that deprivation scores are not routinely captured in the patient record, so it is difficult to know. JH added that research is being undertaken into stillbirths and the Trust is a leader in this field.<br>AB also asked whether the surgical site safety assurance took into account the recent never event relating to wrong site surgery. PKu confirmed that this particular issue was raised at the Committee and the case is being investigated.<br>The Board noted the updates from the December 2021 and January 2022 Committee meetings. | |
| **2.2** | **Covid-19 and Operational Update** | |
| | Anne Brierley, Chief Operating Officer (COO), shared a brief presentation and highlighted the following points. | |
| | • As of this morning there were 53 Covid cases in the hospital, which is a rapid decline since the 5 January 2022 when there were 183 cases.<br>• There are now only two wards open for Covid-19 patients.<br>• There are regular medical safer staffing reviews to ensure adequate staffing.<br>• There have been challenges in discharging patients as seven residential care homes are closed in Merton and Wandsworth which represents approximately 7% of the available bed base.<br>• Vaccination has led to much fewer admissions and much less use of ITU for Covid patients.<br>• The Neuro Day Surgery Unit was used to provide additional capacity during the first two weeks of January.<br>• There has been excellent co-operation between ESTH and SGUH. | |
| | The Board noted the Covid-19 and operational update. | |
| **2.3** | **Integrated Quality and Performance Report (IQPR)**<br>The Board received and noted the IQPR for month 9 (December 2021), which had been scrutinised at both the Finance and Investment Committee (FIC) and the Quality and Safety Committee (QSC) the previous week. | |

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| | Operational highlights were as follows:<br>• Elective performance:<br>○ Non-priority elective work was stood down for three weeks allowing staff to take some well-deserved leave and to enable some planned refurbishment to be carried out.<br>○ The Day Surgery Unit is now able to operate for 23 hours a day following an adjustment to the lift.<br>○ The theatres at Queen Mary Hospital (QMH) are fully booked which has helped with capacity. Thanks were expressed to colleagues for reviewing the procedures that enable more cases to be taken on a day surgery basis.<br>○ Diagnostics performance continues to improve, and the Community Diagnostics Centre (CDC) is significantly over-performing. The CDC investment has been successful, and Mike Richards is due to visit the Trust on 1 February 2022 to see what the Trust has done as part of his national leadership of diagnostic performance.<br>○ 52-week waiters remain steady and the 78-week waiting performance is on plan. Patient choice will impact on some delays but reducing the long waiters list is a constant focus for the teams.<br>○ Cancer referrals are still up at 140% of pre-Covid levels and as a result the national targets are not always being met.<br>○ Breast cancer continues to be an issue and investment has been made for both breast screening and to meet the two-week target. There have been 11% higher referrals than pre-Covid levels. Breast screening performance is on track to recover by the end of March 2022 but the average waiting time for pathways is 23 days (against a target of 14 days). Harm reviews are carried out, but it was acknowledged the anxiety and distress this additional delay will cause to patients.<br>○ It was noted that there are some administrative and pathway issues which are being addressed. However, discussions with the CCG have taken place to recognise and address the increased demand and there is concern about this service as it will take time to recover.<br>• Emergency performance:<br>○ Performance against the 4-hour emergency target remains challenged and steady at below 80%, however the reasons for this have changed. At the end of summer, it was mainly a case of staffing challenges causing discharge delays. Merton and Wandsworth Councils, however, have helped to provide appropriate capacity and the numbers of delays to discharge to home or care homes is the lowest for some time.<br>○ The acuity of patients attending the emergency department (ED) has increased significantly and there are a number of outlying patients in the hospital which leads to longer stays and provides | |

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| | added difficulties for clinical staff in having to manage patients dispersed across the hospital.<br>○ Unusually, there have been a number of 60-minute ambulance delays.<br>○ There is pressure on the tertiary pathways and the support of other acute trusts was acknowledged for repatriating patients allowing tertiary patients to be admitted.<br>AB commented that at FIC, the COO gave a thorough and clear explanation of performance at the hospital and was open and honest about the issues with breast services. FIC, however, was not yet assured that the targets for breast screening and two-week wait will be met so this will be kept under review.<br>AB also echoed the huge efforts the ED team have undertaken to maintain performance as much as possible. Following a Governors' visit, some concern had been raised about the perception that the rest of the hospital was not as supportive, and she was grateful to hear that this no longer appeared to be the case. The CMO commented on the strength of the team and in particular the leadership team in ED. He said that he had not heard about ED staff complaining about other parts of the Trust, but it may be to do with a more subtle point about the risk appetite elsewhere in the Trust and balancing this across the organisation. The COO added that terminology at bed meetings has been changed to focus on the number of patients that wards will take from ED, rather than just discharges. This has not led to more discharges but has meant that discharges occur earlier in the day which helps to decompress ED.<br>PLL noted that breast screening performance has deteriorated which means that the backlog will increase, so asked for assurance that the position will be recovered. The COO commented that the Trust is currently 70 slots short per week and that two-week wait performance will get worse in the short term as the number of screenings increase. Additional resource is required which is being worked on and in the short-term, the Royal Marsden Hospital NHS Foundation Trust has provided support. Breast screening is expected to be recovered by end of March 2022, but it is likely to be the first quarter of 2022/23 before improvement will be seen on cancer targets.<br>SC commended the COO on the enormous change that has taken place to develop surgical services at QMH and the change management that has been required. He added that there should be consistency on reporting to identify the reason for 'clock stops' for patients on elective waiting lists. The COO agreed and explained that new guidance will provide more coherence on the use of 'clock stops'.<br>SC also asked how a reduction in anaesthetic capability will impact on the ability to recover elective activity. The COO acknowledged the challenge and noted that this cohort of staff worked very hard during Covid surges and to enable elective recovery. There is not a surplus of anaesthetists, but recruitment is underway, and changes to enable greater flexible working are being introduced.<br>PKu noted the increase in referrals and asked whether this signalled a change in GP referral practice. The COO noted that patients did not seek NHS services during the pandemic and therefore (as reported by the Royal Marsden) there were a number of under-diagnosed cancer cases which are now coming onto the pathway. She added that current national guidance to issue blanket invites | |

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| | for screening is at odds with the need to prioritise cases. The COO acknowledged that there may be an element of risk aversion amongst some GPs to refer patients.<br><br>The following points were made about the patient care aspects of the IQPR:<br>• Two 'never events' have been reported.<br>• All clinical staff have been contacted following the insulin related 'never event' with reminders about following processes.<br><br>The GCEO asked about the Deprivation of Liberty Safeguards (DoLS) training issue raised at QSC and the CN explained to the Board that a number of staff need their DoLS training updated as part of their revalidation, however the training module was due to be updated to take account of forthcoming new guidance which has been delayed.<br><br>A summary of the key workforce performance was provided, and it was noted that:<br>• Absence rates increased significantly in December which was common across the country leading to approximately 8% staff absence either due to illness or self-isolation, this has now improved although is still higher than normal.<br>• There was a slight increase in turnover, and it is not yet known whether this is a normal cyclical pattern or more significant.<br><br>The Board noted the IQPR report. | |
| **3.0 CULTURE** | | |
| **3.1** | **Workforce and Education Committee Report**<br><br>Stephen Collier, Chair of the Workforce and Education Committee (WEC), presented the report of the meetings held in December 2021 and January 2022, which highlighted the following key issues:<br>• Tribute was made to the executive team in handling the issues caused by the 'vaccination as a condition of deployment' (VCOD) regulations.<br>• There was also recognition of staff resilience during the prolonged pandemic.<br>• The impact of Covid-19 hasn't been as detrimental on implementing the culture programme as had been expected.<br>• Spending will increase if more agency recruitment is needed to fill gaps caused by VCOD.<br>• VCOD has led to the risk score for SR9 (workforce) being recommended to rise from 16 to 20.<br><br>TW added that staff wellbeing was discussed at WEC, and it is good to see how much support is being provided to staff both in prevention and response. The Charity contributed significantly in providing food to staff over the Christmas period. | |
| | The Board noted the updates from the December 2021 and January 2022 Committee meetings. | |

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| **3.2** | **Vaccination as a condition of deployment** | |
| | Paul da Gama, Chief People Officer introduced the report and highlighted the following.<br>• There has been a focus on engaging with staff who are shown as not having had their Covid-19 vaccinations. This includes third parties, e.g., students and those on honorary contracts.<br>• The Trust is aiming to avoid dismissal, although redeployment opportunities will not be significant, and priority for these will be given to vulnerable staff. Some roles may be able to be redesigned to take staff out of scope.<br>• A panel has been established to determine those staff out of scope, based on the regulations.<br>• There is an additional, less tangible, risk relating to culture and engagement emerging given the divisive nature of this issue.<br>The Chairman asked for further assurance about third party staff and the CPO explained that clarity is still being sought on the assurance required. This is being done in conjunction with south-west London colleagues to ensure consistency. | |
| | TW asked about other vaccinations that are required as a condition of deployment and whether the scope was different for those staff. The CPO noted that existing vaccinations are mostly focussed on clinical staff and have been required for some time.<br>JH noted that the University is also having to address this for its staff on site and a consistent approach is important.<br>The Board:<br>• noted the work that has been achieved on the VCOD policy and the next steps being undertaken.<br>• recognised the risks that have been outlined and supported the VCOD steering group in its work to mitigate those risks. | |
| **4.0** | **COLLABORATION** | 1:35 |
| **4.1** | **Finance and Investment Committee Report**<br>Ann Beasley, Chair of the Finance and Investment Committee (FIC), provided an update on the meetings held in December 2021 and January 2022 and made the following points.<br>• The assurance level for SR3 (operational risk and timely access to care) was discussed and is recommended to improve from limited to partial assurance.<br>• The Emergency Preparedness, Resilience and Response (EPRR) assurance report was reviewed, and the Committee was pleased to see that it received substantial assurance.<br>• The financial position is on plan for 2021/22 but the challenges for 2022/23 are still being addressed. | |

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| | • The ICS has just received its allocation for 2022/23 enabling system and Trust planning.<br>• At its February meeting, the Committee will spend a great deal of time focussing on 2022/23 and the need to factor in cost improvement schemes in the context of the pressure on staff. Therefore, it is aimed to have a fewer number of schemes which are more transformational and deliver larger savings as well as improving patient care rather than delivering savings though a large number of small budget reductions. | |
| | The Board noted the updates from the December 2021 and January 2022 Committee meetings. | |
| **4.2** | **Finance Report (Month 9)** | |
| | Andrew Grimshaw, Chief Financial Officer and Deputy Chief Executive (CFO), presented the Trust's financial performance at month 9 and made the following points:<br>• The Trust is on plan due to additional funding provided to match unanticipated spending<br>• He reiterated the challenge relating to 2022/23 raised by the Chair of FIC. | |
| | The Board noted the month 9 financial position. | |
| **4.3** | **Emergency Preparedness, Resilience and Response (EPRR) Assurance Report** | |
| | Anne Brierley, Chief Operating Officer (COO), introduced the report which was reviewed at FIC. She explained;<br>• The EPRR assurance process is carried out annually and included a visit from NHS England and NHS Improvement (NHSE/I).<br>• There was no major incident training carried out during the year, due to the pandemic.<br>• The report was found to be substantially compliant.<br>• There is one action outstanding, to recruit to the vacant EPRR manager post. There have been several unsuccessful attempts at recruitment and there may be a need to seek support from the Divisions to fill this post.<br>• Development for the on-call rota is still underway. | |
| | The Board noted the EPRR assurance update and the 'substantial' rating with one outstanding action remining to be completed. | |
| **4.4** | **Board Assurance Framework** | |
| | Stephen Jones, Chief Corporate Affairs Officer (CCAO), introduced the Board Assurance Framework (BAF) and noted the following.<br>• There are plans to review the BAF in light of the move to the Group model to develop a consistent approach to the BAF and risk management across the two organisations. | |

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| | • SR3 (timely access to care) is being recommended to move from 'limited' to 'partial' assurance following review by FIC.<br>• The risk score for SR9 (workforce) is being recommended to increase from 16 to 20 in the light of the VCOD requirements and the high level of staff absence during the Omicron surge.<br>• As previously reported, there may be further changes to risk scores towards the end of the year as actions are completed. | |
| | The Board agreed the following:<br>• That there be no change in the score of 12 (4c x 3l) or the assurance rating of 'good' for the strategic risk reserved to itself (SR4 - system working).<br>• That the proposed risk scores, assurance ratings and statements from the relevant assuring committees be accepted for the other nine strategic risks.<br>• To note the progress achieved in year in mitigating identified gaps in control and assurance.<br>• 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. | |
| **4.5** | **Changes to Executive Membership of Committees** | |
| | Stephen Jones, Chief Corporate Affairs Officer (CCAO), introduced the report to address the short-term changes that need to be captured given the appointment of new Group chief officers, in advance of a wider review of committee terms of reference for 2022/23. He highlighted the following points.<br>• There is a need to ensure clarity of accountability in the context of the new management structure.<br>• Attendees at Committees have not been addressed in this report as it is not required for this purpose, but it is expected that Trust leads (such as the Trust Chief Medical Officer, Trust Chief Nurse, Trust Chief Operating Officer) will be regular attendees at relevant committees. | |
| | The Trust Board approved the 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 chief officers from 1 February 2022. | |
| **4.6** | **Trust lead roles** | |
| | Stephen Jones, Chief Corporate Affairs Officer (CCAO), explained that recent guidance has been issued from NHSE/I to simplify the number of non-executive lead roles and provided the following summary.<br>• Only five roles are recommended to be continued, three of which are mandatory.<br>• Doctors' disciplinary and security management leads are optional for NHS foundation trusts but are recommended to be covered for consistency. | |

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| | • Some outdated references will need to be reviewed, e.g., security management should also include violence against staff.<br>• Where named NEDs are no longer needed then committees will take over responsibility for receiving assurance. | |
| | The GCEO explained that she would welcome undertaking a similar exercise for executive leads. | |
| | The Chairman told the Board that TW has agreed to take on the role of security management lead. TW added that many aspects are already embedded in existing committees, e.g., violence against staff, fraud and corruption. The CFO offered to provide a briefing for TW on the current work undertaken. | |
| | The Board:<br>• Noted the new guidance on NED lead roles published by NHSE/I in December 2021;<br>• Approved the proposed allocation of NED lead roles as set out in Appendix A of the report; and<br>• Noted 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 governance and assurance processes. | |
| **5.0** | **CLOSING ADMINISTRATION** | |
| **5.1** | **Questions from Governors and the public**<br>No questions were received from the public.<br>Richard Mycroft (RM), Public Governor South West Lambeth, explained he had been part of the visit to ED and asked whether feedback has been provided to ED staff to reassure them about the support in the rest of the hospital. It was confirmed that the senior nurse on duty in ED is briefed following each bed meeting to enable them to assure staff.<br>RM also noted that governors' activity has been stood down and asked for assurance that the postponed Council of Governors (COG) meeting will be rearranged. The CCAO explained that the meeting was postponed following guidance issued from NHSE/I as party of the need to streamline non-clinical activity in response to the Omicron variant. Nominations and Remuneration Committee and Membership Engagement Committee are being arranged for the end of February with COG being arranged for March 2022.<br>John Hallmark, Public Governor, Wandsworth, asked about which staff will be in scope for the VCOD regulations, especially non-clinical staff. The CPO explained the complexity of providing a definitive answer given the guidance issued and that there a number of grey areas, hence the need for the panel being established to review these cases. | |
| | Adil Akram, Public Governor, Wandsworth, praised the sensitivity of the Trust's approach towards VCOD and asked about the legal position in changing staff contracts. The CPO explained that this will be based on an 'inability to meet a statutory requirement' and this is analogous to what would happen if a person's right to work status changed. | |
| **5.2** | **Any new risks or issues identified** | |

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| | There were no other risks or issues identified. | |
| **5.3** | **Any Other Business**<br>The Chairman noted that this meeting will be Anne Brierley's last as a Board member and thanked her for her efforts and the contribution she has made to the Board. | |
| **5.4** | **Draft Agenda for Next Meeting**<br>The CCAO highlighted that NHSE/I required trust boards to review progress against the actions set out in the first report of the Ockenden review of maternity services. As a result, an additional item to provide a review on Ockenden will be added to the March agenda. | CCAO |
| | PKa asked if more time should be allocated to budget setting on the agenda. The CCAO noted that the substantive discussion will take place in the private board. | |
| | SC asked for consideration to be given to returning to physical meetings and the Chairman explained that this is kept under constant review and the hope was that in person Board meetings could resume from April subject to advice from the Director of Prevention Infection and Control. | |
| **Date of next meeting: Thursday, 31 March 2022, MS Teams** | | |

The meeting closed at 11:05

**ACTION LOG - TRUST BOARD (PART 1)**

| ACTION REF | MEETING DATE | ITEM NO. | ITEM | ACTION | WHEN | WHO | UPDATE | STATUS |
|---|---|---|---|---|---|---|---|---|
| | | | | No actions outstanding | | | | |

Outstanding care every time

NHS
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| **Meeting Title:** | **Trust Board** | | |
| **Date:** | 31 March 2022 | **Agenda No.** | **1.5 1.5** |
| **Report Title:** | **Chief Executive Officer's Report** | | |
| **Lead Director/ Manager:** | Jacqueline Totterdell, Chief Executive | | |
| **Report Author:** | Jacqueline Totterdell, Chief Executive | | |
| **Presented for:** | Assurance | | |
| **Executive Summary:** | Overview of the Trust activity since the last Trust Board Meeting. | | |
| **Recommendation:** | The Board is requested to receive the report for information. | | |
| **Supports** | | | |
| **Trust Strategic Objective:** | All | | |
| **CQC Theme:** | All | | |
| **Single Oversight Framework Theme:** | All | | |
| **Implications** | | | |
| **Risk:** | N/A | | |
| **Legal/Regulatory:** | N/A | | |
| **Resources:** | N/A | | |
| **Previously Considered by:** | N/A | **Date:** | N/A |

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NHS
St George's University Hospitals
NHS Foundation Trust

**Chief Executive's report to the Trust Board**
**Trust Board, 31 March 2022**

Since my last report to the Board in January we have remained incredibly busy across our hospital and continue to see high demand for emergency care and challenges around flow through the hospital.

We also continue to see a significant number of high acuity patients which can require intensive staffing. Many people are also presenting at our emergency department with complex needs which makes it even more challenging to find suitable follow-on care when they are ready to be discharged. My thanks to everyone across St George's who innovate as they respond to the challenges while continuing to provide the best possible care to all our patients.

Our Same Day Emergency Care is helping to relieve some pressure in our emergency department and planning is underway to develop a community SDEC, as well as services such as Hospital @Home teams which supports patients to manage their condition while living independently. We are also working with London Ambulance Service to ensure pressures are better allocated between the four hospitals in South West London so we have fewer out of borough admissions.

The pressure of covid tailed off from its earlier peak over the new year but the prevalence has started to pick up again as we respond to the latest sub variant of Covid. At the time of writing, we had nine covid positive patients in our intensive care unit and were again looking to open another covid ward. Vaccines remain our first line of defence and in the last week the government has begun rolling out a spring booster vaccine for people aged 75 and over and those who are immunosuppressed.

We continue to work with partners across the whole system to care for our patients and I would like to put on record my thanks to our community, local authority and social care partners in Merton and Wandsworth for their continued support.

**Financial planning**

My executive team is continuing to plan for the year ahead which is expected to present significant challenges. The financial environment is looking to be particularly challenging as pressure remains high on our services, we continue to prioritise the elective backlog and costs are rising. At last week's NHS England Trust Board, the Chief Financial Officer said NHS funding is likely to be cut by £500m to cover the cost of covid testing which will no longer be free from 1 April. He also said that rising inflation could add an extra £1bn in financial pressure. Existing savings targets are already challenging and the Chancellor has doubled the annual efficiency target to 2.2 per cent. We submitted our business plans in time for the 17 March deadline but some further negotiation will be required.

**NHS delivery plan for tackling elective care backlog**

NHS England and NHS Improvement published a plan in February setting out four priority areas to tackle the Covid backlog:

1. Increasing health service capacity
2. Prioritising diagnosis and treatment
3. Transforming the way we provide elective care
4. Providing better information and support to patients

The way our teams adapted to provide care during the pandemic has shown how the NHS can deliver transformational change for our patients. Our priority in SWL is to ensure our patients can receive the treatment they need as safely and quickly as possible. We have collaborated with Epsom

and St Helier, Croydon and Kingston hospitals and partners in the region which has been key to our recovery efforts.

The SWL Elective Orthopaedic Centre (SWLEOC) has expanded capacity to include an additional theatre, allowing them to treat an additional 125 patients a month. And SWL has the lowest number of patients waiting over 52 weeks for High Volume, Low Complexity (HVLC) procedures in London. We are continuing to make the most of our capacity and – thanks to a read drive and focus by my team to create additional diagnostic capacity – routine diagnostic waits have come right down with over 98 per cent of patients seen within six weeks of a referral.

As we progress through the year we will continue to work toward the NHSE target of 110% of 2019/20 activity by working collaboratively with our system partners to develop new ways for patients to be treated sooner.

**My Planned Care Digital Platform**

Often patients turn first to their GP team for help; this can also place an additional strain on primary care services. So, in February, as part of its plan to tackle the Covid 19 elective care backlog, the NHS launched My Planned Care - an open access web-based platform to provide greater transparency to patients on waiting times**.**

The first phase of the platform details the waiting list size and average waiting times at hospitals including St Georges. It also includes general information for patients on how to manage their health while waiting. The second phase will include each acute trust's local support information across specialities.

As the platform is 'open access', everyone involved in the patients' care will be able to access this information and have a better-informed conversation about what an individual can expect whilst waiting for their elective procedure and what support is available to them locally.

**'Living with Covid-19' and infection control in our hospitals**

The government's 'Living with Covid-19' plan was announced in February, which sets out the plans to remove the legal restrictions that were put in place to manage the virus.

While this will be welcome news for businesses and communities across the country, infection, prevention and control measures remain in place in our hospitals. While infection rates are far lower than previous months, cases numbers have crept up since the start of March and preventing nosocomial transmission remains a priority at the Trust.

We continue to follow the UK Infection Prevention Control guidance shared by NHSE in February to ensure we are following the right process for the right treatments including the level of cleaning required, social distancing and preoperative testing.

However, we are expecting further guidance on 1 April around social distancing, mask wearing and testing from NHSE which we will review before implementing at our hospitals.

**Vaccination as a condition of Employment**

Since my last update to the Board, the government announced a public consultation on removing the requirements for NHS staff to have both doses of the Covid-19 vaccine as a condition of deployment. The results of the consultation were published earlier in the month which found widespread support for dropping the policy. This means that regulations requiring health and social care staff to be vaccinated have been revoked, and the rules ended on 15 March.

It has been a challenging process for all involved and my communications team ran a series of staff engagement events, led by my executive directors, to answer questions on the policy. More than 500 staff attended and we had some positive feedback on how helpful they were.

We will of course continue to encourage all staff to have their vaccinations to protect themselves and their patients and I'm pleased to note that more than nine in ten staff at George's are vaccinated against Covid.

I'd like to say thank you to the many members of our teams who worked incredibly hard on the VCOD project. From making sure our staff vaccinations records were up-to-date, to clinical staff that spent time having supportive conversations with staff that were unsure about having the vaccine –

**Our new Group executive team**

Tuesday 1 February marked the first day of the St George's, Epsom and St Helier University Hospitals and Health Group executive team - a really exciting and important step in our journey of working more closely together for the benefit of our patients and staff.

My new group executive team have been spending time getting to know new colleagues and visiting teams across our hospitals while working together on our plans to bring our trusts closer together. Over the coming weeks and months, we'll be engaging with our staff to determine how we manage our corporate teams to best effect and looking for synergies across our patient facing services to continue to improve patient care.

We recently held our first staff engagement event for the whole group, bringing together people who work in all our hospitals and community to empower and inspire them to bring about change themselves. As I meet staff across the Group I am pleased to be hearing stories from them on how they are taking the initiative to do just that.

We are already starting to realise some benefits of group working for patients. For example we are making joint clinical appointments and have around 50 consultants working across both hospitals. More will follow allowing more seamless care and access to the latest innovations.

In February we signed a contract with Cerner to share electronic patient records across the group. The shared system will allow clinical teams to access patient hospital information and records, irrespective of where care is provided across the group.

The news was covered in the digital health press and will mean that, when Epsom and St Helier implement its new EPR system, records for patients can be managed across the two trusts, freeing up clinical time and improving continuity of patient care.

**New go-live date for Integrated Care Systems**

NHS England and Improvement have announced that the new launch date for Integrated Care Systems (ICS) will be 1 July 2022. In between now and July, the ICS will continue to run in shadow and form and continue to plan for the future.

For example, work is underway to update the local Place Health and Care Plans, which will set out the health and care priorities for each south west London borough. At St George's we are excited to engage with the ICS and our partners on what the plans for our local boroughs should focus on. St George's is committed to working closely with both CCG and ICS leaders to break down the traditional barriers that have prevented health services from making more joined-up decisions that will benefit communities across the region.

Our Chairman, Gillian Norton, has spoken about this 'once in a lifetime opportunity' integrated care system creates to work collaboratively for the benefit of patients in a short film shared on YouTube. We look forward to the formal launch on 1 July.

**Principal Treatment Centre for Children's Cancer Services**

Lat week NHS London invited us to respond to an option appraisal setting out hurdle criteria to provide a PTC for children's cancer services in south London and the South East.

St George's offers one of the largest and most comprehensive paediatric services in England, from community services through to regional tertiary services such as neurosurgery, intensive care and specialist paediatric surgery. St George's children's services, which under our proposals would continue to provide the South Thames PTC in a consolidated single-site model, are rated outstanding by the CQC and have years of experience providing excellent care to children with cancer.

I was pleased to able to confirm that St George's is accessible, already provides a level 3 PICU, is committed to providing a single site PTC co located with a paediatric intensive care unit and that we have the ability to deliver this service within the expected timelines. We await to hear next steps.

**New Covid vaccine trial at St George's**

A new Covid vaccine trial is underway and we are proud to say it is being led by a team here at St George's. One of the world's first Omicron-specific Covid variant vaccines is to be trialled at multiple sites across the UK, with nearly 3,000 volunteers to be recruited on to the study.

Dr Catherine Cosgrove, Adult Lead at the Vaccine Institute at St George's, University of London and St George's Hospital, will lead the study which will be assessing the effectiveness of a fourth Covid vaccine dose.

Developing the treatments of tomorrow has never been more important so I'm pleased that St George's is helping to lead the way with ground-breaking research studies such as this.

**Russian invasion of Ukraine**

Like me, I am sure many of you are shocked and saddened at the Russian attack on Ukraine. The pictures which are being streamed to us are often distressing and harrowing to watch and seeing such human suffering will impact on our communities and staff alike. I have written to all staff across the group to encourage them to reach out for support should they need it. I've also asked my team to identify all Ukrainian and Russian staff so I can personally write to them and offer support. We are also conscious that we have a number of Polish staff who may also be impacted by the events in this region and will consider what further support we can offer them and our other staff.

NHS staff are very generous, and I have been contacted by many people across the group who are keen to offer aid where they can. Last week, we donated some supplies from our warehouse in Morden to groups in South London and Surrey who are co-ordinating relief efforts locally. We know these items are particularly needed, and they are already on the way to Ukraine via Natalia, an ICU Nurse at St George's, who has friends taking supplies to the Polish/Ukrainian border.

**Channel 4 documentary series on London's Trauma Network**

St George's has continued to shine in both the broadcast and print media positively appearing in national newspapers, in TV news packages and – at the end of February and early March, featuring in a Channel 4 documentary series called Emergency. The series was the first of its kind, a

collaboration between St George's, London's Air Ambulance, Kings, Imperial and the Royal London. It showcased the London Trauma Network and how it has revolutionised the way medical emergencies are tackled in the capital. In the past five years, the network which treats 12,000 people a year has improved the survival rates for major trauma patients by 50 per cent.

My communications teams continue to look for opportunities to show off the skills and expertise of our staff as it not only gives patients trust and confidence in our services but it helps us recruit and retain high calibre staff. We understand that the series was watched by more than 1.7m people.

**St George's Hospital Charity Thank You event**

St George's Hospital Charity organised a special event in February to say thank you to the many donors, fundraisers and volunteers that support the charity. It was a pleasure to attend this event and say a few words about the vital work they do here at St George's.

It was hard to put into words just how much we appreciate everything the charity does for St George's, especially during the pandemic.

I have seen first-hand how charity-funded improvements, such as the staff wellbeing room, can make a big difference for our staff that have had to work harder than ever as a result of Covid.

It was nice to have the time to properly say thank you to the many people that have supported St George's Hospital Charity over the years, and the event served as a welcome reminder of just how much appreciation there is for St George's in our local communities.

**St George's nurse, Edi Lorusso, wins national lifetime achievement award**

It was my honour to be invited to the annual Our Health Heroes Awards (sponsored by NHS Employers - part of NHS Confederation), held at the Science Museum in London and see Senior Thrombosis Nurse Specialist Practitioner Edi Lorusso win a lifetime achievement award. Despite tough national competition, Edi secured nearly 60% of the public vote.

Edi has been at St George's for 22 years. Since joining as a staff nurse in 2000, Edi has become a passionate advocate for thrombosis prevention. So much so that her hard work and dedication led to the Trust being awarded and acknowledged as one of the Exemplar Sites for Venous Thrombo Embolism prevention in the Houses of Parliament.

Edi was subsequently invited to participate in the All-Party Parliamentary Thrombosis Group (APPTG) and has attended meetings with MPs and NHS bosses in the House of Commons every year since 2010.

Aside from being a full-time nurse and a mum to two young children, Edi volunteers for various Black Asian and Minority Ethnic (BAME) networks related to healthcare, including Freedom To Speak Up and Philippine Nurses Association-UK, which provides pastoral welcome packages for newly arrived nurses from Philippines. Edi is also active in the wider community, visiting schools to inspire and educate young children to enter the nursing profession.

My huge congratulations to Edi and my heartfelt thanks for everything she does for staff and patients at St Georges.

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|---|---|---|---|
| **Meeting Title:** | **Trust Board** | | |
| **Date:** | **31 March 2022** | **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 February and March 2022.<br><br>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. | | |
| **Recommendation:** | The Board is asked to note the updates from the February and March 2022 meetings. | | |
| **Supports** | | | |
| **Trust Strategic Objective:** | All | | |
| **CQC Theme:** | All CQC domains | | |
| **Single Oversight Framework Theme:** | Quality of care, Operational Performance, Leadership and Improvement Capability | | |
| **Implications** | | | |
| **Risk:** | Relevant risks considered. | | |
| **Legal/Regulatory:** | CQC Regulatory Standards | | |
| **Resources:** | N/A | | |
| **Previously Considered by:** | N/A | Date: | N/A |
| **Appendices:** | N/A | | |

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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 24 February and 24 March 2022 and considered the following matters of business at these meetings:

| February 2022 | March 2022 |
|---|---|
| • Integrated Quality and Performance Report (M10)* | • Integrated Quality and Performance Report (M11)* |
| • Serious Incidents Report | • Serious Incidents Monthly Report |
| • Mortality Monitoring Committee and Learning from Patient Deaths | • Cardiac Surgery Update |
| • Infection Control Report (Including Antimicrobial Stewardship) | • Health and Safety Report |
| • General Surgery – Royal College of Surgeons' Review | • Nurse Staffing Report |
| • Pharmacy Governance & Oversight and Response to the MHRA | • Ockenden Report |
| • Seven Day Services Compliance (NHS Returns) Q3 | • National Patient Surveys – Children and Young People |
| • National Patient Surveys - Adult inpatient survey | • National Patient Surveys - Maternity |
| • Patient Safety & Quality Group Report | • Controlled Drug Accountable Officer Quarterly Report |
| • Quality Priorities - proposed new priorities | • Clinical Governance Q4 Update |
| • Board Assurance Framework Monthly Update | • Draft Quality Report (Account) 2021-22 |
| | • Research & Development Strategy Implementation (Q4) |
| | • Strategic Risk - 10 Deep Dive |
| | • Strategic Risk - 1 Deep Dive |
| | • Patient Safety & Quality Group Report |
| | • Board Assurance Framework Monthly Update |
| | • Trust-wide Policy Updates: Patient Care |
| | • Annual Review of Committee Effectiveness |

*These items are also presented to the Board for consideration at the March 2022 Board meeting.

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

## 1. Integrated Quality and Performance Report (IQPR) Months 10 and 11

The Committee considered the key areas of quality and safety performance in months 10 and 11 (2021/22) and would like to highlight the following issues, conscious that the Board will discuss the month 11 performance data later on the agenda:

- Areas of good or improving performance:
  - A training needs assessment has been carried out to rationalise those staff needing immediate life support (ILS) training which could result in a reduction of the staff needing to have undertaken ILS training which should improve compliance.
  - Duty of candour compliance has been maintained at 100%
  - There is now only one Covid ward open.
  - For the period 1 April 2021 to 31 January 2022 there were 38 cases of C. difficile infection against an NHSI/E threshold of no more than 52 cases for 2021-22.
  - The staffing position in maternity but sickness due to Covid remains a challenge
  - The challenges in achieving cancer and breast screening targets continue but waiting times have improved slightly and additional diagnostic slots are being made available
- Areas of challenge:
  - There has been an increase in 'did not attend' rates at outpatient clinics and as a result, patient communication is being reviewed
  - Compliance for BLS, ILS and ALS has reduced following the junior doctor rotation that took place at the beginning of February. There was a challenge from the committee about gaining traction on life support training
  - Meeting the cancer two-week standard is currently a challenge, especially in breast cancer and this is caused in part by an increase in referrals

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

### 2. Serious Incident Reporting

The Committee considered and noted the serious incident reports which covered January and February 2022. During these periods:

- 6 serious incidents were declared (2 in January, 4 in February);
- 6 serious incident investigations were concluded (5 in December, 1 in January).

The Committee sought assurance to ensure that there weren't any trends related to ethnicity for serious incidents and were assured that there were not.

The Committee heard the details of one sad case that had been investigated relating o a patient who attended the Trust with suicidal ideation, was discharged appropriately but sadly subsequently took his own life.

### 3. Never Events Gap Analysis

Work has been led by Karen Daly, Deputy Chief Medical Officer to analyse the never events that have occurred in recent times and it has been identified that most relate to human error. Whilst there are many areas of good practice in the Trust, more robust processes and fail-safe measures are being introduced within divisions to improve consistency.

### 4. Mortality Monitoring Committee and Learning from Patient Deaths

The quarter 3 report provided assurance that governance for mortality and morbidity (M&M) continues to improve, with co-ordinators being allocated to each care group.

Guidelines have been provided to set standards for how M&M meetings should be conducted.

There are good communications in relation to structure judgement reviews (SJRs) and with the Coroner.

### 5. Infection Control Report (Including Antimicrobial Stewardship)

The Committee heard that there have been a number of outbreaks of Covid that have had to be managed through the winter, although it was noted that the demand for intensive care for these patients reduced as have deaths.

There were two cases of MRSA since the last report and the cases of E.coli are within the threshold set for the Trust.

An audit showed that 94% of patients were prescribed antimicrobial agents appropriately.

### 6. General Surgery – Royal College of Surgeons Review

A report commissioned by the Chief Medical Officer was reported, following an invited review that took place during the summer.

The Committee were pleased to hear the level of engagement by consultants in addressing the issues in the report and that some key recommendations were acted upon immediately following the review. These include the implementation of new rotas to ensure the workload is evenly spread.

### 7. Pharmacy Governance & Oversight and Response to the MHRA

Following a request by the Board, the Committee received an update on progress made in addressing the points raised by the Medicines and Healthcare products Regulatory Agency (MRHA). External support has been commissioned and a further report is expected next month setting out key performance indicators.

### 8. Seven Day Service Compliance

Good progress is being made in providing additional MRI capacity and in recruiting to enable quicker access to consultant reviews at the weekends.

### 9. Cardiac Surgery Update

The Group Chief Medical Officer reminded the Committee that safety standards are being maintained with the cardiac surgery. Activity is still low, especially in relation to inter-hospital transfers. The reputation of the service is still affected when inquests are reported and referenced to previous issues.

### 10. Health and Safety Report

The Committee heard an update on health and safety which included news of the development of a three-year health and safety strategy and the work of the Violence Prevention and Reduction Group.

### 11. Nurse Staffing

The regular staffing report was reviewed which highlighted a number of ‘red flags’ in the five NICE categories but virtually all were mitigated and there were no serious incidents caused as a result.

### 12. Ockenden Report

An update on progress with compliance against the eight ‘immediate and essential action’ where the trust is one of only six London trusts demonstrating 100% compliance, which has been validated by external review. This is in spite of the staffing challenges faced by the Trust.

### 13. National Patient Surveys - Adult in patient survey

The Committee received the results from the National Adult Inpatient Survey 2020 and noted good progress, although direct comparison with previous years were not possible due to significant changes in the survey.

The Committee heard that the response rate improved and that confidence in our doctors and nurses was good. The lowest scoring responses included the quality of hospital food and noise levels at night from patients and staff.

### 14. National Patient Surveys – Children and Young People

The Committee heard the positive results of the national patient survey for children and young people which was last undertaken in 2018. Some of the results were directly affected by the pandemic. There was a perceived imbalance of ethnicity and gender and this will be explored to see if the sample can be targeted to achieve a more representative response in relation to the patient base.

### 15. National Patient Surveys – Maternity

As with the children and young people's survey, the Committee heard that the results for this survey were affected by the Covid pandemic and the staffing levels in maternity at the time. In spite of this results were generally positive, especially by comparison with other trusts across the country.

The Covid pandemic affected this cohort of patients, especially in the ability to have community appointments and having family present in the hospital.

### 16. Clinical Governance Q4 Update

The Committee heard of the positive progress made such that the action plan can be closed. This should enable the risk score for strategic risk 2 to be reduced, as recommended to the Board later in the agenda.

### 17. Quality Priorities - proposed new priorities

The proposed quality priorities for 2022/23 were presented to the Committee and it was explained that joint working with Epsom and St Helier University Hospitals NHS Trust (ESTH) will aim to align the priorities from both trusts.

### 18. Quality Report

The quality report format is specified for foundation trusts, and the Committee reviewed a draft copy which will be updated and provided for approval to the Trust Board as part of the year end processes for 2021/22.

### 19. Research & Development Strategy Implementation (Q4)

The Committee heard the latest update on research and development and the disappointing news that there is currently a funding shortfall. There was acknowledgement of the importance of research in improving the Trust's reputation and encouraging recruitment.

### 20. SR10 and SR1 Deep Dives

The Committee reviewed the deep dives that were undertaken, both of which involve reviews of contributory risks. For SR10 a temporary increase in risk scores was recommended pending further funding for research.

### 21. Controlled Drug Accountable Officer Quarterly Report

The formal report from the Controlled Drug Accountable Officer was reviewed and the Chief Pharmacist recommending reinstating regular meetings with heads of nursing to discuss controlled drug issues. These meetings and been suspended during the pandemic.

### 22. Trust-wide Policy Updates: Patient Care

The six-monthly report on policy compliance for patient safety policies was presented. There are a number of polices beyond their review dates and the Committee heard that PSQG take the lead on reviewing and approving patient safety policies.

An approach to aligning policies across the hospital Group is being developed.

### 23. Annual Review of Committee Effectiveness

The Committee received the effectiveness review and the key messages were highlighted, including the need to provide papers in a more timely way and there were also comments about the number of items that have been deferred..

### 24. Patient Safety & Quality Group Report

The report from the Patient Safety and Quality Group meetings in February and March highlighted a couple of areas for concern. These related to the level of non-attendance at immediate life support training due to operational pressures, and a need to improve the availability of doctors to support deteriorating adult patients.

The Committee were told of the encouraging news that the Trust's survival rate for cardiac arrest patients was 32% compared to a national average of about 20%. The Trist also compares favourably for the number of cardiac arrests per 1,000 admissions.

Compliance against the national patient safety strategy was noted as in draft currently as the national framework is yet to be published.

### 25. Board Assurance Framework (BAF) Monthly Update

The Committee reviewed a summary of the BAF which reflected the discussions of the strategic risk papers discussed earlier in the March agenda.

### 26. Recommendation

The Board is asked to note the updates from the February and March 2022 meetings.

Dame Parveen Kumar

Committee Chair

March 2022

| | | | |
|---|---|---|---|
| **Meeting Title:** | **Trust Board** | | |
| **Date:** | 31 March 2022 | **Agenda No** | **2.2** |
| **Report Title:** | Integrated Quality & Performance Report | | |
| **Lead Director/ Manager:** | James Marsh, Group Deputy Chief Executive Officer | | |
| **Report Author:** | Kaye Glover, Emma Hedges, Mable Wu | | |
| **Presented for:** | Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify)<br>(select using highlight) | | |
| **Executive Summary:** | This report consolidates the latest management information and improvement actions across our productivity, performance, and workforce for the month of February 2022.<br><br>**Our Finance & Productivity**<br><br>Outpatient performance is expected to be 107% after catch-up, which is higher than the 95% trajectory by 12%. As part of the Green Plan, the Trust will be working to encourage a change in culture to more virtual activity where appropriate.<br><br>Elective and Daycase performance is expected to be behind trajectory (after estimated catch up), with a percentage of 90%, lower than the 95% trajectory submitted for February. Across the month theatres have been heavily impacted by increased trauma demand. Theatre specialties are at 88%, with non-Theatre specialties at 91%. In February, on-the-day cancellations for non-clinical reasons has seen a 30% reduction compared to the previous month.<br><br>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 7.7 days. Increased LOS continues to be driven by higher patient acuity and patients waiting for large packages of care putting constraints on capacity. The Trust continues to focus on discharges before 10am to support flow from ED and is continuing to work closely with system partners, including the voluntary sector, to improve the capacity and process for discharging patients to the community who have on-going care needs.<br><br>**Our Patient Perspective**<br><br>Immediate Life Saving (ILS) training rates were at performance at 66.8% and Advanced Life Support (ALS) training rate has remained steady at 82.9%; the target is 85%.<br><br>There were No Never Events in February and no Serious Incidents where Medication was a Significant Factor.<br><br>There were 14 Hospital Onset Health Associated (HOHA) COVID-19 infections and 17 Hospital Onset Probably Associated (HOPA) COVID-19 infections.<br><br>Two further infections are now being reported to NHSI/E, they are Pseudomonas. Aeruginosa and Klebsiella ssp. Bacteraemia. NHSI/E has set a new threshold for *P. aeruginosa* bacteraemia of no more than 21 cases for 2021-22, or no more than 1.75 per month. Between 01 April 2021 and 28 February 2022 there were 23 cases, which is above the trajectory of no more than 19 cases.<br><br>*Klebsiella spp.* bacteraemia threshold is no more than 49 Trust apportioned cases for 2021-22, or no more than 4 per month. There were 3 cases during February 2022. Between 01 April 2021 and 28 February 2022 there were 46 | | |

cases, which is above the trajectory of no more than 45 cases for this point in the year. The 46 cases compare to 74 for the same period during 2020-21.

In Maternity services, the number of women giving birth has reduced month on month since October 2021, staffing challenges continued in February 2022 which has impacted on staffing ratios and training compliance.The Carmen suite which was closed 44.6% of the time this month.

There were no stillbirths and three neonatal deaths in February 2022. On initial review there were no concerns related to care and treatment. The neonatal deaths will be further reviewed using the perinatal mortality reporting tool

Inpatient, Maternity (Delivery), Community and Outpatient services achieved FFT targets where at least 90% of service users (98% for inpatients) rated the services as "Good" or "Very Good.

**Our Process Perspective**

In February, 73.1% of patients were admitted, discharged, or transferred within four hours of their arrival. The Trust continues to see significant challenges impacting waiting times with bed flow impacting front-end capacity driving an increase in 12-hour trolley waits. Further work is being undertaken to maximise space for doctors to see patients as well as a recruitment drive in both nursing and junior doctors as well as an Assistant General Manager for Flow.

Cancer performance remains challenged, both in terms of referrals and treatment volumes. Cancer activity is at 115% and diagnostics for cancer patients is at 140% of 2019-20 baseline, resulting in high pressures on clinical services.

The Trust did not meet six of the seven cancer standards in January with the 14-day standard at 69.8% against a target of 93% and the 62-day standard at 54.4% against a target of 85%. Additional clinics to address the large number of patients referred via the Two-Week Rule pathway are being undertaken. The main challenges to backlog recovery are within radiology affecting CTC and GI services, Breast front end challenges and Urology theatre capacity. Faster Diagnosis standard performance was 56.5%, the trust is working towards achieving 70% by Q2 and 75% compliance by Q3.

At the end of February, the Trust reported that 1.8% of patients were waiting to have a diagnostic test compared to 3.1% in January. Improvement was driven by a decrease in the number of patients waiting for more than six weeks for an Echocardiogram with the service now compliant against the 1% standard. Main challenges remain in Cardiac MRI where capacity is very limited.

January's 2021's RTT performance was 72.1% against a National target of 92% with 887 patients waiting longer than 52 weeks which is ahead of trajectory and a further improvement on December's performance. The Trust are committed to eliminate all 52 week waits in most specialties other than General Surgery, ENT, Plastics and Cardiology. Clock stop performance in January was better than December and ahead of the trajectory for admitted patients, however below for outpatients. This is linked to lower levels of outpatient activity at the start of January due to staffing challenge because of covid.

**Our Workforce Perspective**

In February the Trust's sickness absence rate fell to 4.4%, an improvement on last month performance of 5.1% however still above the threshold target of 3.2%.

| | |
|---|---|
| | Appraisal rates for non-medical staff and medical staff was 75.1% and 76.6% respectively remaining below the Trust target of 90%.<br><br>The Staff covid-19 vaccination rate for both jabs was 90% in February.<br><br>The Trust's total pay for February was £52.02m which is £0.31m adverse to a plan of £51.78m. Agency spend was £1.83m against a target of £1.25m which is an adverse variance of £0.58m. The largest areas of agency overspend were Interims (£0.52m), AHPs (£0.13m). |
| **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.<br><br>• **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.<br>• **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.<br>• **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.<br>• **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<br>Treat the Person<br>Right Care<br>Right Place<br>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 — **Date** 21 March 2022<br>Finance & Investment Committee — 24 March 2022<br>Quality & Safety Committee — 24 March 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 – 31 March 2022

James Marsh - Group Deputy Chief Executive Officer


18 March 2022




## Our Outcomes

# How Are We Doing?

February 2022

### Daycase and Elective Surgery operations

**Actual:** 4,351
**2019 Actual:** 5,221

### 6 Week Diagnostic Performance

**Actual:** 1.8% **Target:** 1%

### Four Hour Emergency Standard

**Actual:** 73.1%
**Plan:** 95%

### Whole Trust Inpatient Friends and Family Test

**Actual** 98.2%
**Target** 95%

### Outpatient First Attendance

**Actual** 17,743
**2019 Actual:** 16,816

### January 2022

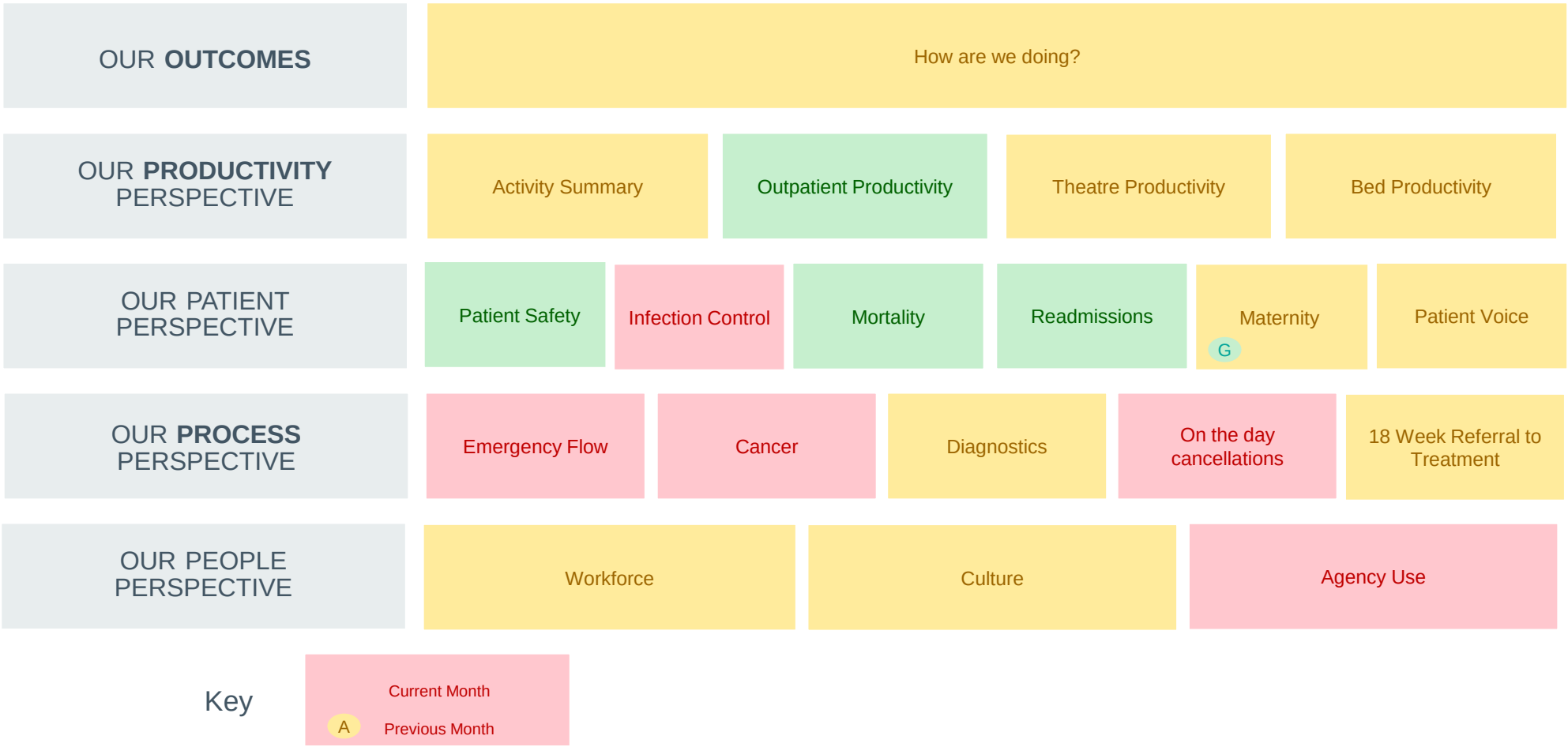
Referral to Treatment Standard - Number of 52 Week Breaches

887



Outstanding care every time

# Balanced Scorecard Approach



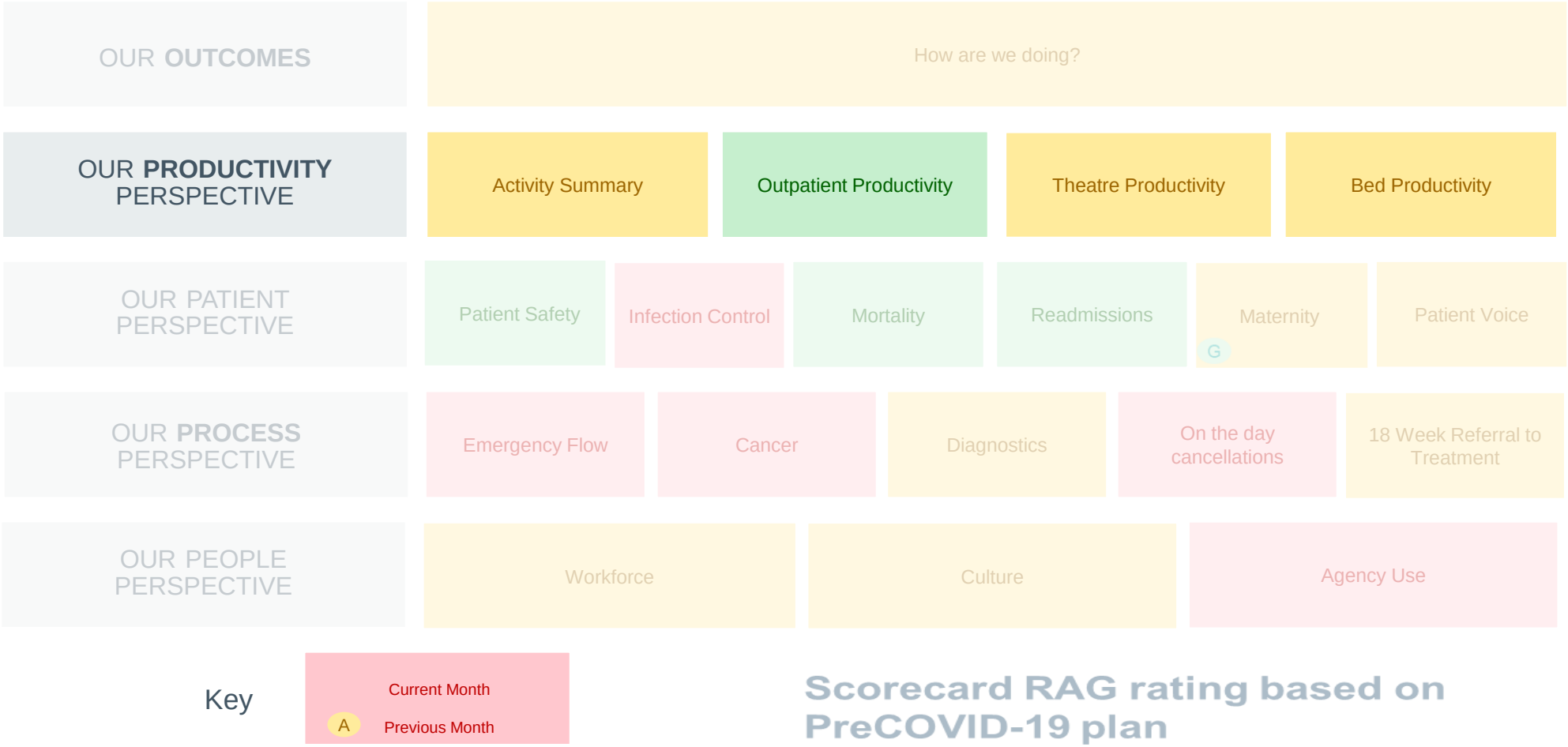
# Executive Summary – March 2022 (1 of 2)

| | What the Information tells us | Actions and Quality Improvement Projects |
|---|---|---|
| Finance & Productivity Perspective | • All outpatient activity in February 2022 was 102% of the activity reported in February 2020, this is expected to increase to 107% once data catch up is completed above trajectory of 95%.<br>• Overall elective activity was 83% of that reported in February 2019 and, although this will rise to 90% once data catch up is completed, levels are expected to be below trajectory of 95%.<br>• Non-Elective Lengths of Stay (LOS) continues to show special cause concern with average LOS at 7.7 days. High LOS impacted by acuity, external delays, covid, outlying patients and staffing challenges.<br>• Elective length of stay reduced and is showing only common cause variation. On average, patients stayed in a hospital bed for 3.7 days. | Outpatients<br>• Additional clinics to address the large number of patients referred via the Two Week Rule pathway are being undertaken<br>• As part of the Trust's Green Plan, services are working to encourage a change in culture to more virtual activity<br>Daycase & Elective activity<br>• DSU 23 hour overnight stay capacity continues to expand with Extended Recovery available on Thursdays and Fridays.<br>• ASA1 Streaming' project has been launched to enable safe streaming of these patients 'straight to swab', avoiding unnecessary POA<br>• Recruitment continues at pace across Anaesthetics; Launch of Cardiac Recruitment & Retention Group and Operating Department Practitioner workstream<br>Length of Stay<br>• External interface flow work focussed on Merton and Wandsworth: discharge, maximising community capacity and virtual frailty ward (Hospital at Home)<br>• local Age UK services engaged to provide support with discharge and delivery of practical services, for example key safe installation, furniture removal<br>• MedCard discharge SWAT team appointed to with start dates April-May (Clinical Flow Lead, Discharge Facilitators) |
| Patient Perspective | • Immediate Life Support (ILS) training rate was 66.8%; the target is 85%<br>• There were no Never Events in February<br>• Category 3, 4 and Unstageable Pressure Ulcers per 1,000 bed days shows special cause deterioration at 0.68 per 1,000 bed days compared to the mean of 0.30<br>• There were 14 Hospital Onset Health Associated (HOHA) COVID-19 infections and 17 Hospital Onset Probably Associated (HOPA) COVID-19 infections<br>• NHSI/E has set a new threshold for P. aeruginosa bacteraemia of no more than 21 cases for 2021-22; the Trust is currently above the annual threshold with 23 cases YTD.<br>• NHSI/E has set a new threshold for Klebsiella spp. bacteraemia of no more than 49 Trust apportioned cases for 2021-22. The Trust has reported 46 cases YTD.<br>• Maternity - staffing challenges continued in February 2022 which impacted on staffing ratios and training compliance and access to the Carmen suite which was closed 44.6% of the time this month.<br>• Inpatient, Maternity (Delivery), Community and Outpatient services achieved their respective Friends and Family Test targets. | • eILS recertification course available from April 2022 to ALL medical staff. Training needs reclassification informed by TNA review will see circa 50% decrease in training slots<br>• All category 3 and above pressure ulcers undergo root cause analysis to identify any learning<br>• National COVID-19 data submissions continue to be validated daily and signed off by the Chief Nurse and Director of Infection Prevention and Control. Thematic and individual reviews are taking place for nosocomial COVID-19 cases to ascertain learning and outcomes reported to the Infection Control Group.<br>• Maternity<br>  • Maternity Transformation Programmes have been paused nationally for at least another month in response to national staffing challenges<br>  • over 90% compliance for the OCKENDEN immediate and essential requirements; currently planning for a site visit from the Regional teams.<br>• FFT ED – ED falling response rates have been audited and confirmed; additional electronic handheld devices have been made available for patients after ward admissions via ED<br>• Maternity (post-natal) FFT - A number of new Healthcare Assistant colleagues have joined the team and they will be leading on improving the FFT results from a postnatal perspective. |

# Executive Summary – March 2022 (2 of 2)

| | What the Information tells us | Actions and Quality Improvement Projects |
|---|---|---|
| Process Perspective | Four Hour Operating Standards for February<br>• 73.1% of patients either admitted, discharged or transferred within four hours of their arrival; the target is 95%<br>• 387 patients breached the 12-hour ED target<br>January Cancer performance<br>• The Trust met the 31-Day Second or subsequent Treatment (Drug)<br>• 14 Day Performance decreased to 69.8% with referral numbers above the mean of 2019<br>• 62 Day Performance 54.4% against a target of 85% with lower treatment numbers.<br>• Faster Diagnosis Standard (FDS) was 56.4%; the Trust aims to reach 75% by Quarter 3<br>Six week diagnostic standard for February<br>• Further improvement in January with 1.8% of patients were waiting for more than six weeks for their diagnostic test or procedure against a national target of 1%;<br>Referral to Treatment for January:<br>• 887 patients have been waiting over 52 weeks since referral compared to the November's number of 923.<br>• Total 104 week wait focus has continued, with 2 patients forecast to breach at the end of February however expectation is that there will be no breaches by March 2022<br>• The Trust had 11,976 clock stops in January, achieving trajectory of 11,939; a clock stop generally means a patient has received their first definitive treatment. | Four Hour Operating Standards actions<br>• 15 nurses have been recruited in the month and will start employment during April<br>• 5 new specialty doctors recruited and starting employment in next month<br>• In-Hours GP service has expanded to offer paediatric sessions on a daily basis<br>Cancer<br>• The Trust has with the alliance, a trajectory to support covid recovery as part of recovery for 22/23, focused on achieving FDS and improving 62 day performance<br>• FDS - Clear communication and management of patients awaiting FDS communication has seen a reduction from over 1000 to 600 patients; Further work is planned with services to reduce this to support FDS clock stop completion<br>Diagnostics<br>• 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<br>Referral to Treatment<br>• Increased focus on solutions to support shorter waits for first outpatient appointments, particularly in ENT and General Surgery including network and community solutions which will improve equity of access.<br>• Focus on increasing productivity at the Surgical Treatment Centre, to deliver more activity and meet trajectory levels ; there is a recovery plan to double the throughput in 2022/23 |
| People Perspective | • Trust sickness absence rate fell this month by from 5.1% to 4.4%; target is 3.2%<br>• Trust vacancy rate is currently at 10% which is the threshold<br>• Medical and non-Medical appraisal rates remain below their target of 90% at 75.1% and 76.7% respectively<br>• Trust turnover rate was 16.8% against a target of 13%<br>• Agency cost was £1.83m which is £0.58m adverse to the monthly target of £1.25m, however total January Trust pay is £0.31m adverse to plan | • Nursing and HealthCare Assistant Recruitment campaigns continue with 140 new starter with booked dates confirmed<br>• Diversity & Inclusion workstreams continue with Recruitment Inclusion Specialist Annual Experience survey launched.<br>• Temporary staffing remained a challenge during February, particularly during the half term and with a number of Tube strikes. The team are proactively calling both Agencies and Bank |

# Balanced Scorecard Approach



# Activity Summary

| | | Activity compared to 2019/20 | | | Activity compared to previous year | | | Activity compared to 2020/21 | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Feb-20 | Feb-22 | Variance | YTD 19/20 | YTD 20/21 | Variance | Feb-21 | Feb-22 | Variance |
| ED | ED Attendances | 13,171 | 11,345 | -13.86% | 154,851 | 138,201 | -10.75% | 7,899 | 11,345 | 43.63% |
| Inpatient | Non Elective | 4,118 | 2,789 | -32.27% | 44,466 | 35,549 | -20.05% | 2,819 | 2,789 | -1.06% |
| | Elective & Daycase | 5,221 | 4,351 | -16.66% | 58,867 | 52,425 | -10.94% | 3,229 | 4,351 | 34.75% |
| Outpatient | OP Attendances | 47,317 | 48,098 | 1.65% | 548,141 | 543,308 | -0.88% | 43,598 | 48,098 | 10.32% |

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

Note: Figures quoted are as at 8/03/2022 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 February 2022 have been shown against activity levels reported in February 2020

For reference the grey boxes compare activity levels to February 2021

Outpatient data above **excludes COVID-19 activity** (Activity data presented above is based on Finance definition of POD1).

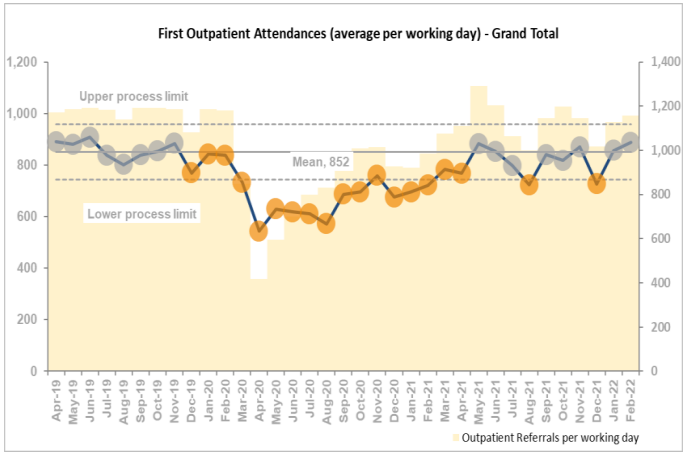
# February Activity Performance v Trajectories – Elective, Daycase & Outpatients

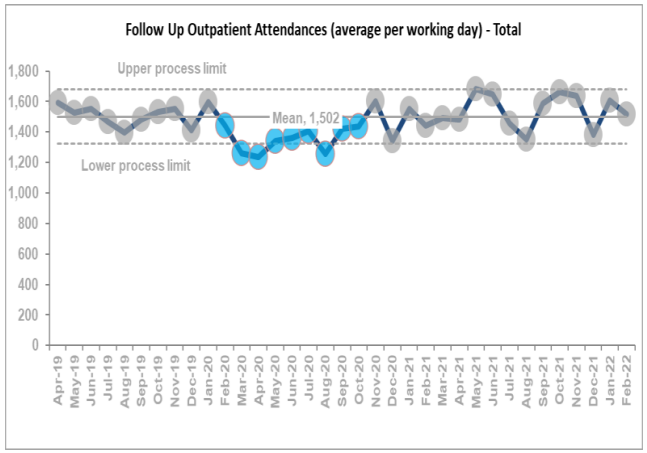
**The Trust has submitted final activity trajectories for H2, which forecast activity at 95% of 2019/20 levels adjusted for working days. In February, there are 20 working days compared to 20 in 2019/20, hence the target for February is 95%. The Trust no longer receives ERF payments based on activity 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.**

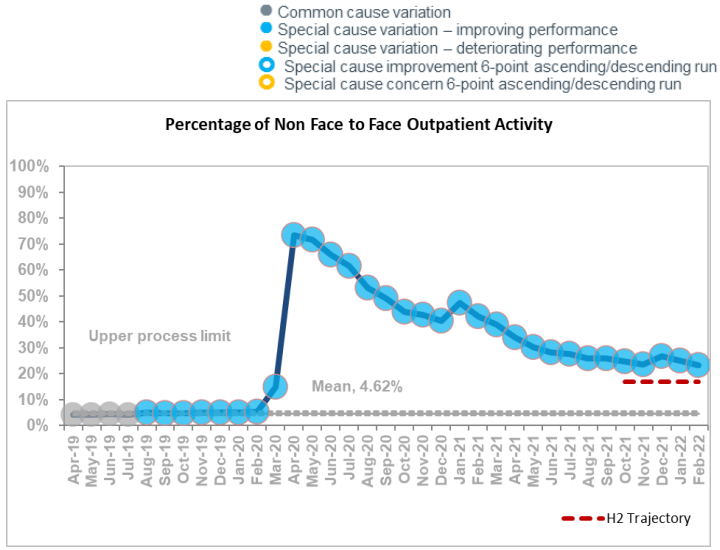
| | ACTIVITY QUANTUMS | | | | | ACTIVITY %s | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Specialty | Feb Trajectory | Feb Activity | Feb catch up estimate | Feb Activity after catch up | variance activity | Feb Trajectory | Feb Actual | Feb catch up estimate | Feb Activity after catch up | variance activity |
| Cardiac Surgery (172) | 47 | 30 | 1 | 31 | -16 | 115% | 73% | 1% | 74% | -40% |
| Colorectal Surgery (104) | 7 | 21 | 2 | 23 | 16 | 61% | 191% | 15% | 206% | 145% |
| Ear, Nose & Throat | 181 | 138 | 14 | 152 | -29 | 112% | 85% | 9% | 94% | -18% |
| General Surgery (100) | 74 | 49 | 4 | 53 | -22 | 76% | 50% | 4% | 54% | -22% |
| Gynaecology (502) | 179 | 150 | 13 | 163 | -16 | 92% | 77% | 7% | 84% | -8% |
| Neurosurgery (150) | 100 | 116 | 7 | 123 | 23 | 61% | 70% | 4% | 74% | 14% |
| Trauma & Orthopaedics (110) | 70 | 88 | 10 | 98 | 28 | 45% | 56% | 6% | 62% | 18% |
| Urology (101) | 387 | 321 | 33 | 354 | -33 | 130% | 108% | 11% | 119% | -11% |
| **Total Theatre Specialties** | **1,045** | **913** | **83** | **996** | **-49** | **91%** | **81%** | **7%** | **88%** | **-3%** |
| Gastroenterology (301) | 1,256 | 948 | 138 | 1,086 | -171 | 88% | 67% | 10% | 76% | -12% |
| Cardiology (320) | 233 | 211 | 6 | 217 | -16 | 84% | 76% | 2% | 78% | -6% |
| Dermatology (330) | 0 | 1 | 0 | 1 | 1 | 100% | | | | |
| Neurology (400) | 736 | 549 | 25 | 574 | -162 | 108% | 80% | 4% | 84% | -24% |
| Paediatrics (420) | 30 | 33 | 3 | 36 | 6 | 84% | 94% | 7% | 102% | 17% |
| Paed Surgery (171) | 82 | 89 | 4 | 93 | 11 | 92% | 100% | 5% | 105% | 12% |
| Clinical Haematology (303) | 170 | 121 | 41 | 162 | -9 | 201% | 142% | 48% | 190% | -10% |
| Medical Oncology (370) | 88 | 91 | 2 | 93 | 5 | 114% | 118% | 2% | 120% | 6% |
| All Other Specialties | 1,323 | 1,381 | 69 | 1,450 | 127 | 93% | 97% | 5% | 102% | 9% |
| **All Other** | **3,919** | **3,424** | **287** | **3,712** | **-207** | **96%** | **84%** | **7%** | **91%** | **-6%** |
| **Total Daycase / Elective** | **4,964** | **4,337** | **370** | **4,707** | **-257** | **95%** | **83%** | **7%** | **90%** | **-5%** |
| **Outpatients** | **44,938** | **48,067** | **2,403** | **50,470** | **5,533** | **95%** | **102%** | **5%** | **107%** | **12%** |

- 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 90%, lower than the 95% trajectory submitted for February. Theatre specialties are at 88%, with non-Theatre specialties at 91%.
- Outpatient performance is expected to be 107% after catch-up, which is higher than the 95% trajectory by 12%.

# Outpatient Productivity (1 of 2)




### What the information tells us

An increase in activity was seen throughout February with the daily average first attendance activity above the mean of the 2019 baseline. On average, there were 887 first outpatients attendances daily compared to 856 per day the previous month. Total outpatient activity across the month was 103% of 2019/20 activity levels, this is expected to increase to 107% following data catch up which is higher than the 95% trajectory by 12%. The Trust received, on average, 1,156 referrals per day, an increase of 2.5% compared to January.

At Trust level first outpatient activity reported in February 2022 was 105% of activity reported in February 2020. Surgery performance has seen an increase in activity levels moving towards the mean of 2019 and the highest levels seen since August 2019.

Follow-up activity continues to show common cause variation with activity levels 99.5% of 2019/20 levels.

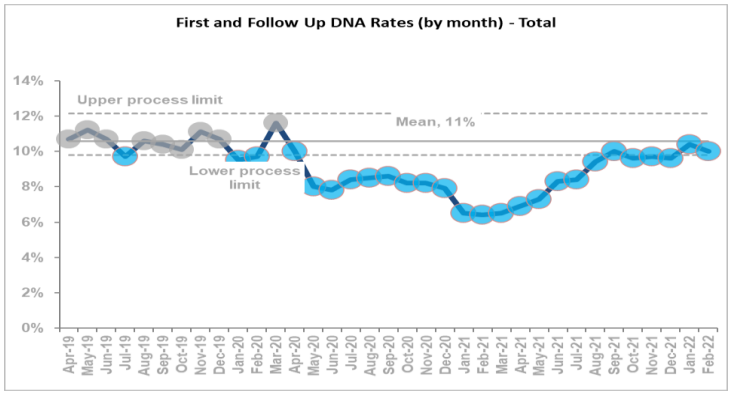
In January, 24% of our outpatient attendances were undertaken in a virtual setting, above the H2 trajectory of 17%.

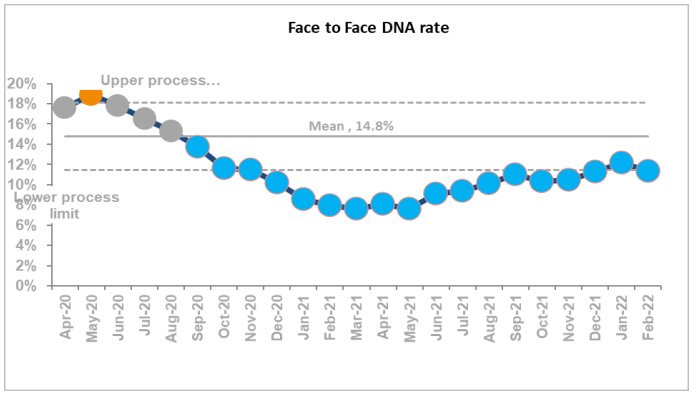
Please note that COVID-19 related OP activity has been excluded from the charts.

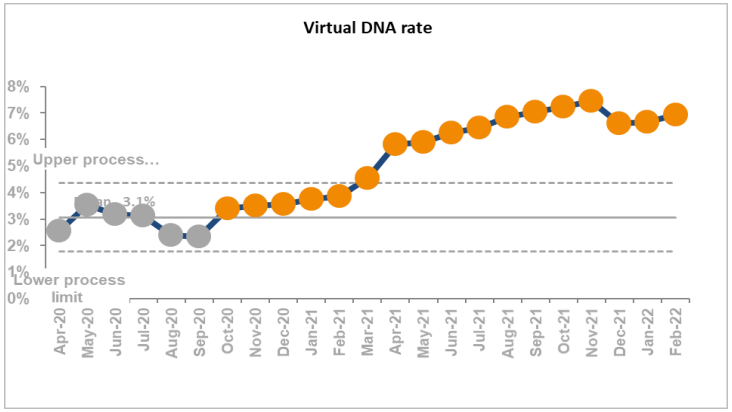
### Actions and Quality Improvement Projects

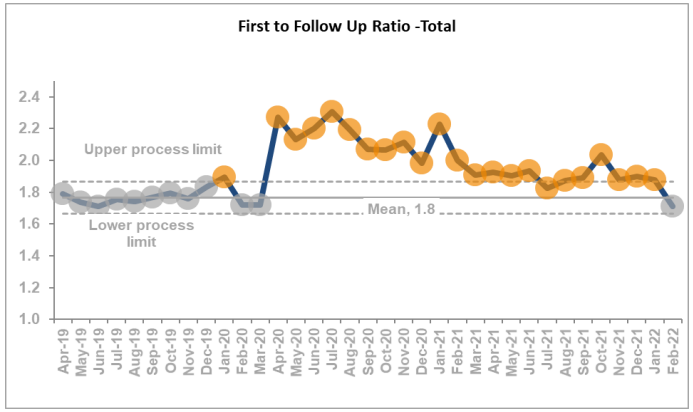
- As part of the Elective care recovery programme, the Trust is treating a large volume of patients who have waited a long time for their appointments and therefore there is a higher proportion requiring an appointment in a face-to-face setting. We will be looking to relaunch the use the Attend Anywhere in the new FY to encourage a move to more virtual activity which will support our Green Plan both for us and our patients.
- Additional clinics to address the large number of patients referred via the Two Week Rule pathway are being undertaken, including telephone clinics at weekends and this will likely contribute to an increase in the number of patients seen.
- As part of the Trust's Green Plan we will be working to encourage a change in culture to more virtual activity be that video or telephone, and all Care Groups will be encouraged to review their Outpatient clinical pathways with a view to re-designing with this in mind.
- The launch of the Patient Portal will support patients to be more invested in their care and we hope to use it to support the roll our of Patient Initiated Follow-up (PIFU) which should help to decrease the number of f/up appointments thus enabling an increase in New appointments which will support out ECRP.

# 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

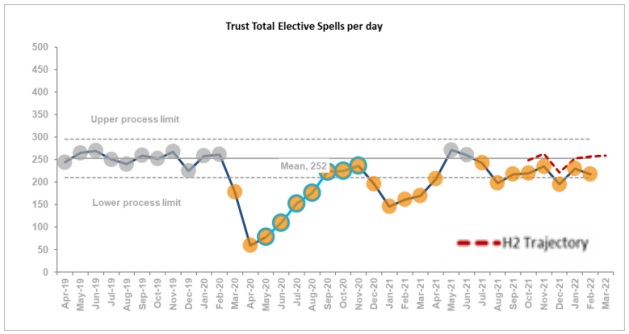
**What the information tells us**

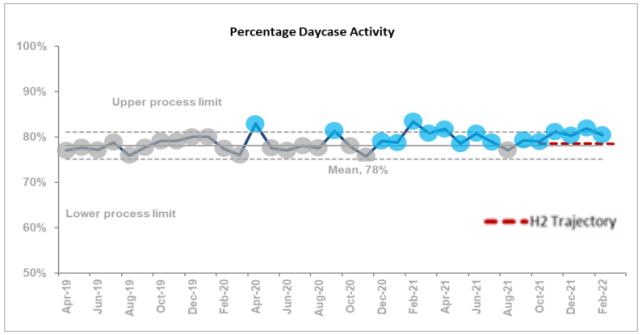
The proportion of patients not attending their outpatient appointment in February was 10%, seeing an improved position compared to the previous month and comparable to the London average. The 10% DNA rate equates to approximately 324 patients not attending their appointment per day. Where rates are above 10% and have high volumes of patients not attending are Neuro & T&O, Renal, Spec Med, Surgery and Therapies. 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. To minimise the number of DNAs in clinics, services are reviewing text messages and letter types that are sent out to ensure that patients are receiving the correct correspondence for their appointment type. Clinic and booking utilisation rates are above target.
The new to follow-up ratio has decreased in February, returning to within the upper and lower control limits.

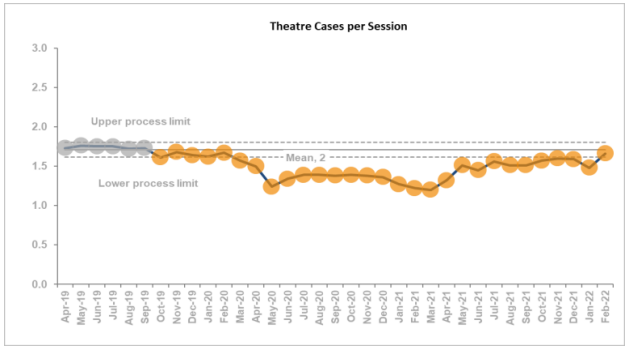
**Actions and Quality Improvement Projects**

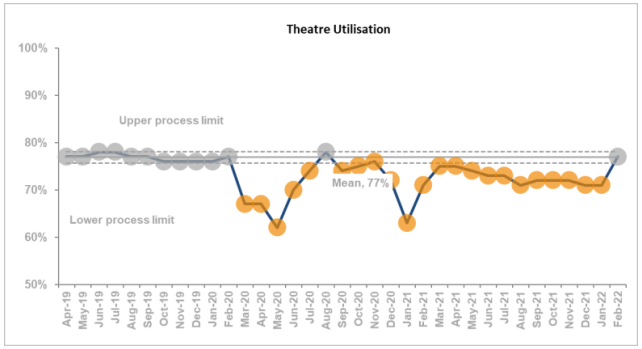
- Services are continuing to undertake clinic reviews to reflect the needs of their backlog. Some clinics may have additional new appointments depending on where the demand lies.
- Patient Initiated Follow ups (PIFU) are being looked at and may be able to assist with reducing DNA rates and free up capacity to see New patients.
- Work continues with services to review communications to patients which is believed to impact the DNA rates.
- The Patient Portal has gone live across the Trust which will be another way that patients can access details of their appointments, which will help reduce DNA rates

# Elective Activity & Theatre Productivity




**What the information tells us**

On average throughout February, 217 patients were treated per day compared to 229 in January. Overall elective activity was 83% of February 2020 and, although this is expected to rise once data catch up is completed, levels are expected to be below trajectory. T&O activity levels remains below the mean of 2019, theatres have been heavily impacted by increased trauma demand. Max Fax and Dental are almost on target, but complexity of cases has limited meeting target. General Surgery saw an increase in cases through February however remain below 19/20 levels, ongoing long term and short-term sickness absence has led to cancellations of some theatre lists. Endoscopy levels remain below plan with the service working on change in Infection Prevention & Control (IPC) guidance to support more effective booking and utilisation of capacity.

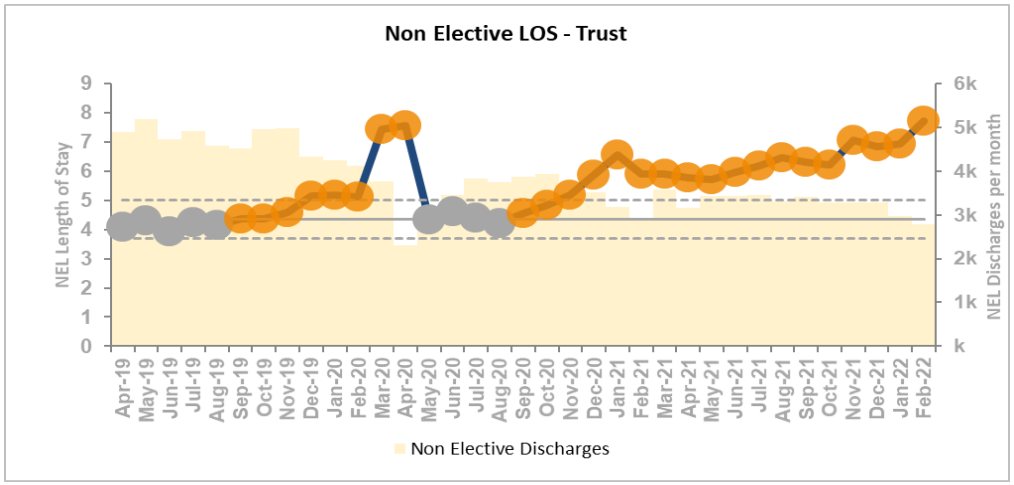
In February, Theatres ran 872 theatre lists, compared to 1,038 in the same period in 2020. Both the average number of cases per session and utilisation rates improved.

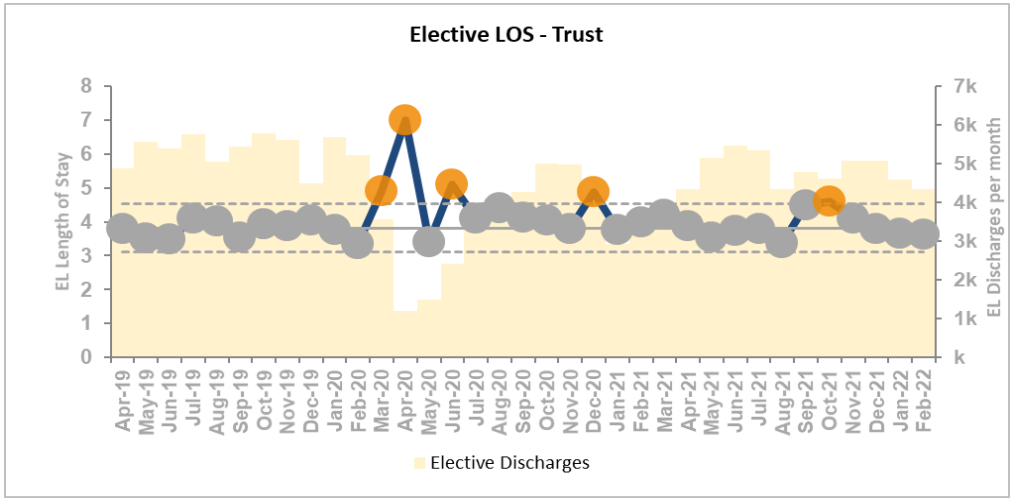
- Common cause variation
- Special cause variation – improving performance
- Special cause variation – deteriorating performance
- Special cause improvement 6-point ascending/descending run
- Special cause concern 6-point ascending/descending run

**Actions and Quality Improvement Projects**

- **DSU 23 hour/ Extended Recovery:** DSU 23 hour overnight stay capacity continues to expand with this service now available Monday-Wednesday, each week, with Extended Recovery available on Thursdays and Fridays. Plans in April to expand overnight stays to Thursday as well. T&O, Breast, Urology and Plastics patients have benefitted from this new service so far. This scheme will significantly increase DSU capacity and productivity as well as alleviating recovery flow issues in SJW and wider site bed pressures.
- **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 March/ April. A soft roll-out was launched in mid-January in POA to test the new proforma ahead of full pilot. This test has already reduced avoidable HCA appointments and helped to alleviate pressure on the POA team.
- **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 'Yellow' SDL Discharge pathway from SJW to DSU was also launched recently to relieve pressure on SJW Recovery, and avoid the need for Yellow patients to be transferred to a ward to be discharged. Since launching this discharge pathway, non-clinical OTD cancellations due to a lack of beds have fallen from 20 to just 3.
- **Recruitment:** The anaesthetic recruitment drive continues at pace. 14 posts are currently out to advert or awaiting interview. A new Cardiac Recruitment and Retention working group was launched in January to provide dedicated focus on this area. Similarly, a new ODP Recruitment and Retention workstream was launched in February to work to increase the number of permanent ODP and Anaesthetic Practitioners at SGH and reduce avoidable bank and agency spend by improving working conditions and career opportunities.

# 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 February, patients admitted via the non-elective pathways had a Length of Stay of 7.7 days increasing by 0.8 days compared to January. Acute Medicine and Senior Health saw particular increases across the month.

Higher length of stay continues to be driven by high acuity in the patients admitted and throughout the month, a high number of patients awaiting discharge due to external dependencies, with patients waiting for large packages of care, placement and community therapy putting constraints on capacity and increase in occupancy rates.

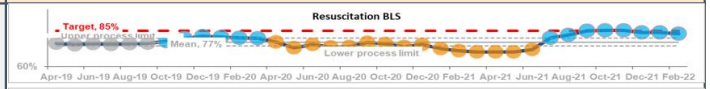
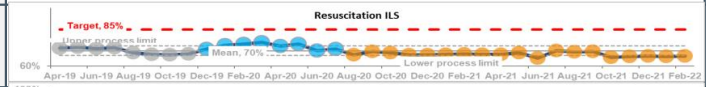
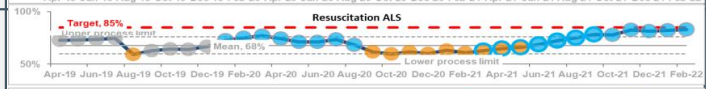
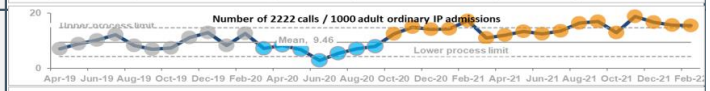
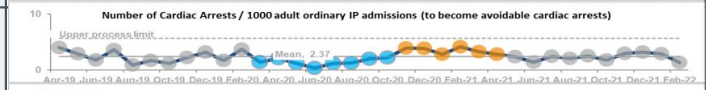
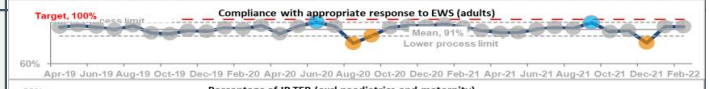
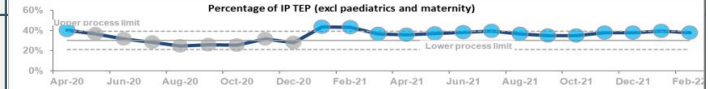
Elective length of stay reduced and is showing common cause variation. On average, patients stayed in a hospital bed for 3.7 days.

**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.
- Early Bird pilot programme, focusing on discharges before 10am to support flow from ED, is operational in all Surgical and Medical wards
- 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 (Hospital at Home)
- Focus on improving compliance with Red2Green, ward support and training along with improved coordination with Transfer of Care team.
- 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
- MedCard discharge SWAT team appointed to with start dates April-May (Clinical Flow Lead, Discharge Facilitators)

# Balanced Scorecard Approach

# Quality Priorities – Deteriorating Patients

| | Target | Feb-22 | Var to target | Trend |
|---|---|---|---|---|
| Basic Life Support Training (BLS) | 85.0% | 83.0% | –2.0% |  |
| Intermediate Life Support Training (ILS) | 85% | 66.8% | -18.2% |  |
| Advanced Life Support Training (ALS) | 85% | 82.9% | -2.1% |  |
| Number of 2222 Calls/1000 adult ordinary IP admissions | N/A | 15.48 | - |  |
| Number of Cardiac Arrests/ 1000 adult ordinary IP admissions (to become avoidable cardiac arrests | N/A | 1.3 | - |  |
| Compliance with appropriate response to Early Warning Scores (Adults) | 100% | 92.9% | -7.9% |  |
| Percentage of Inpatient Treatment Escalation Plans (excl paediatrics and maternity) | 40% | 37.7% | - 2.3% |  |



## What the information tells us

- BLS (Basic Life Support) training performance continues to shows special cause improvement with performance at 83.0% despite not achieving target
- ILS (Immediate Life Support) shows special cause deterioration, with performance at 66.8% for this month.
- ALS (Advanced Life Support) training performance was 82.9%.
- The rate of 2222 calls per 1,000 Inpatient (IP) admissions shows special cause variation with a deteriorating position however the rate of cardiac arrests per 1,000 adult ordinary inpatients shows common cause variation.
- Compliance with appropriate response to Early Warning Score (EWS), is 92.9% this month and shows common cause variation.
- Performance against our Treatment Escalation Plans has plateaued however continues to be above the long-term mean and show common cause variation with an improving position.

**Actions and Quality Improvement Projects**

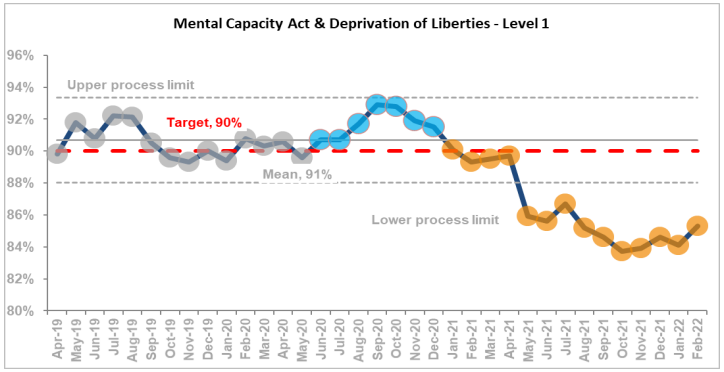
**BLS** - The Self-Assessment Pod continues to operate Monday to Friday 08:00 to 18:00 with additional 'drop-in' sessions at QMH and St Johns Health Centre. Targeted sessions and additional 'roaming' Self-assessment' sessions are provided supported by the Brayden on-line training system. Staff continue to be encouraged to attend the Pod and complete on-line learning. Resus Champions are being trained in assessment and will be available to run face to face sessions when the Training Needs Analysis is introduced. Senior ward based staff are encouraged to allocate Resus Champions in their areas. It is expected that the BLS compliance will reduce in March 2022 when staff are reclassified for BLS training rather than ALS and ILS informed by the TNA for all staff groups

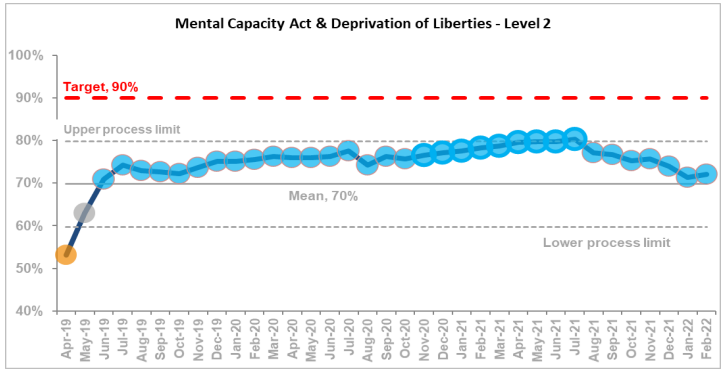
**ILS** – A minimum of 30 training places continue to be offered weekly although DNA rates remain high at 25 - 40% exacerbated by current operational pressures. eILS recertification course will be available from April 2022 to ALL medical staff and provide 15 places per month. The reclassification of the training needs of staff informed by the TNA review will see circa 50% decrease in demand for training slots. 15-30 ILS places will be provided per week. Further analysis of this change in demand together with an agreed trajectory is underway

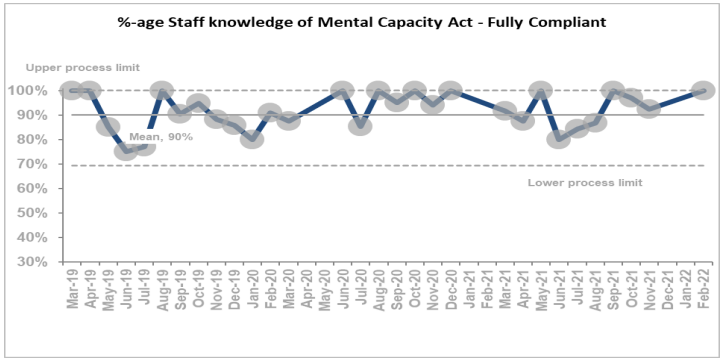
**ALS** - New rotation of Doctors started this month with usual dip in compliance. Of those showing as non-compliant approximately 50% have shown valid certificates – one is waiting validation from Advanced Life Support Group as undertaken in New Zealand. ALS places for non-compliant staff continue to be prioritised across all ALS courses.

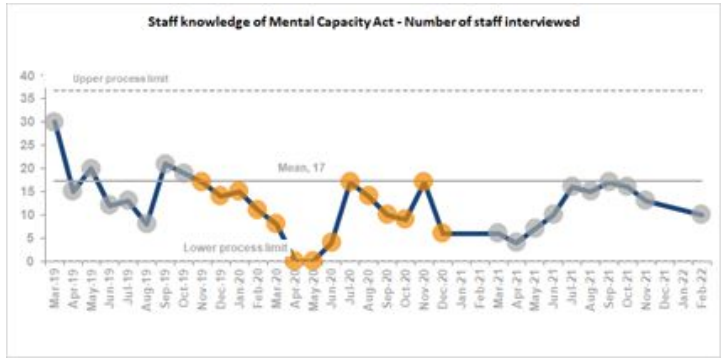
**TEP -** In order to continue to improve Treatment Escalation Plan (TEP) completion rates the following developments are now in place: Electronic dashboard to see how many patients in any clinical area have not had a TEP completed and Reporting at ward level in divisional performance reports; Easy electronic 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 year below the 2019/20 average. Performance in February was 85.3%.
- Overall Level 2 compliance was 72.1% this month and shows special cause variation with an improved position.
- Metrics showing the number of staff interviewed and their level of knowledge was suspended in December 21 and January 22. Performance against both metrics shows commons cause variation.

**Actions and Quality Improvement Projects**

Training compliance is showing slow improvement at Level 2, with staff engaging with the practical workshops supporting the Level 2 requirement. Positive feedback on application and documentation support. The content of the Level 2 training is currently being reviewed to create a refresher module

Due to ongoing sickness within the MCA team and vacancies within the Learning Disability team, project and improvement work is currently to focus on ensuring patients have the correct legal framework in place to prevent unlawful detention and that the patient voice is heard in capacity assessments.

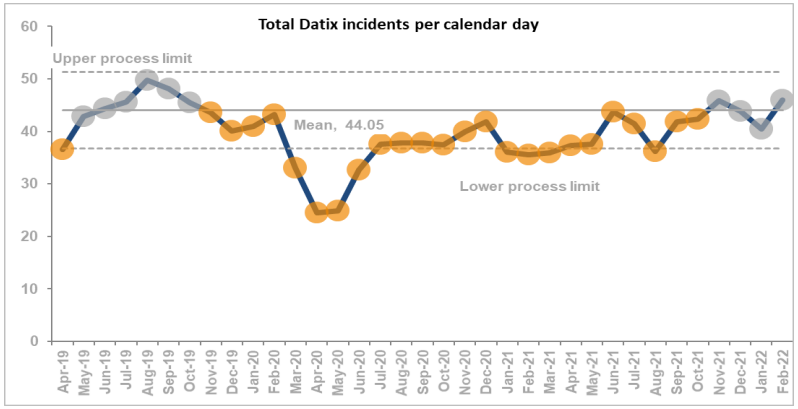
New Discharge to Assess paperwork is under development and includes improved questions with reference to Capacity Assessment for discharge arrangements to support patient flow between hospital and home.

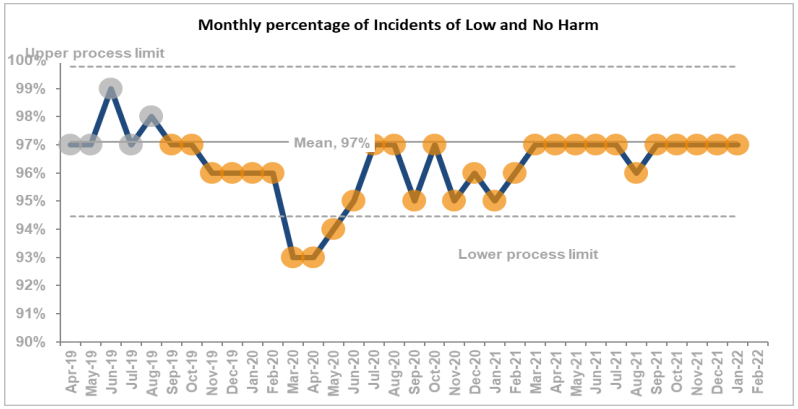
The Department of Health and Social Care have now released confirmation of a 16 week consultation on the draft Liberty Protection Safeguards with the Code of Practice and supporting documents to be released shortly. The wider Safeguarding Adults team (MCA, Safeguarding Adults and Learning Disability teams) are all completing their Best Interests Assessor training in preparation for the Trusts' new statutory duty.

# 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 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Monthly percentage of Incidents of Low and No Harm | | 96.0% | 97.0% | 97.0% | 97.0% | 97.0% | 97.0% | 96.0% | 97.0% | 97.0% | 97.0% | 97.0% | 97.0% | data one months in arrears |
| Open SI investigations >60 days | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Duty of Candour completed within 20 working days, for all incidents at moderate harm and above | 100% | 75.0% | 90.0% | 100.0% | 100.0% | 96.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | data two months in arrears | |
| Total Datix incidents per calendar day | | 36 | 36 | 37 | 38 | 44 | 42 | 36 | 42 | 42 | 46 | 44 | 40 | 46 |




### 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 5 consecutive months.

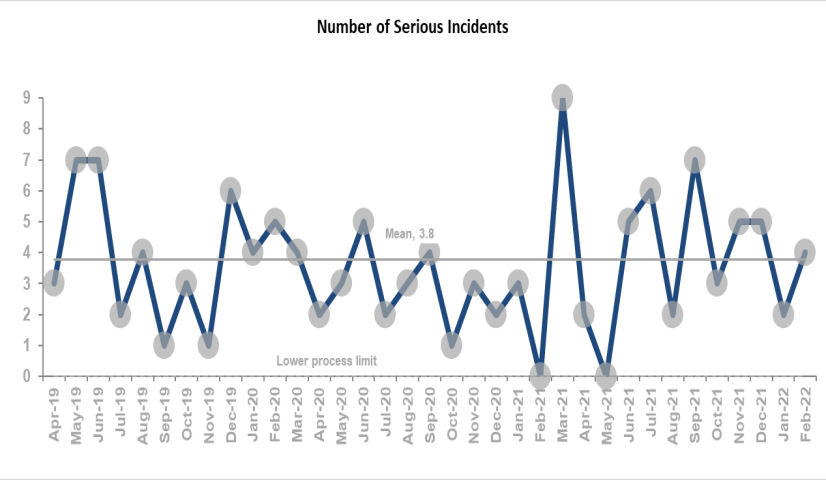
### Actions and Quality Improvement Projects

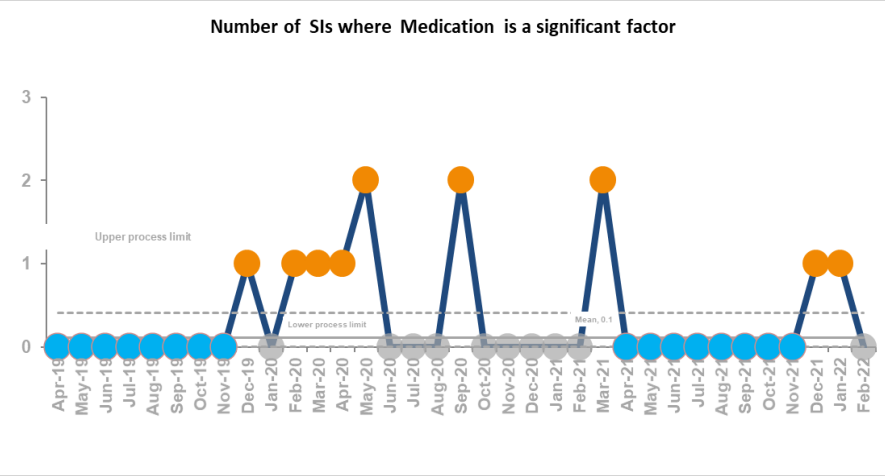
Duty of Candour (DoC) - There were 29 qualifying incidents reported in December 2021 and DoC was completed for all incidents within 20 working days.

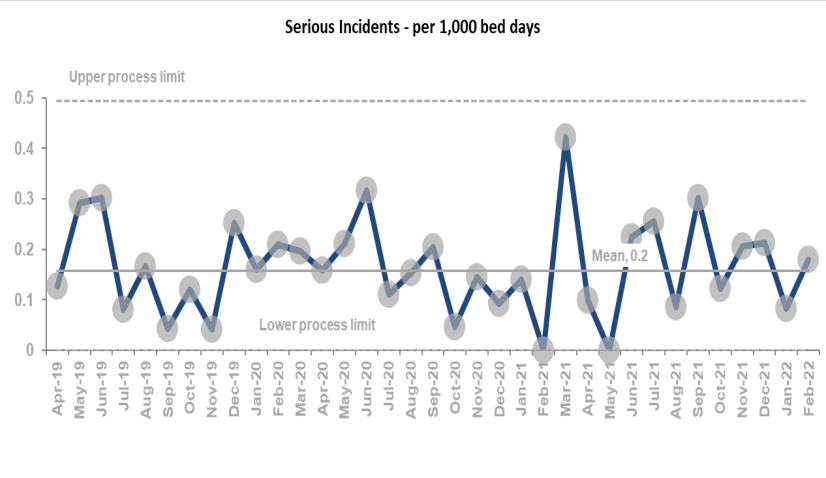
DoC compliance continues to be maintained. This continues to be monitored and support provided to the relevant departments in order to consistently sustain compliance.

# 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



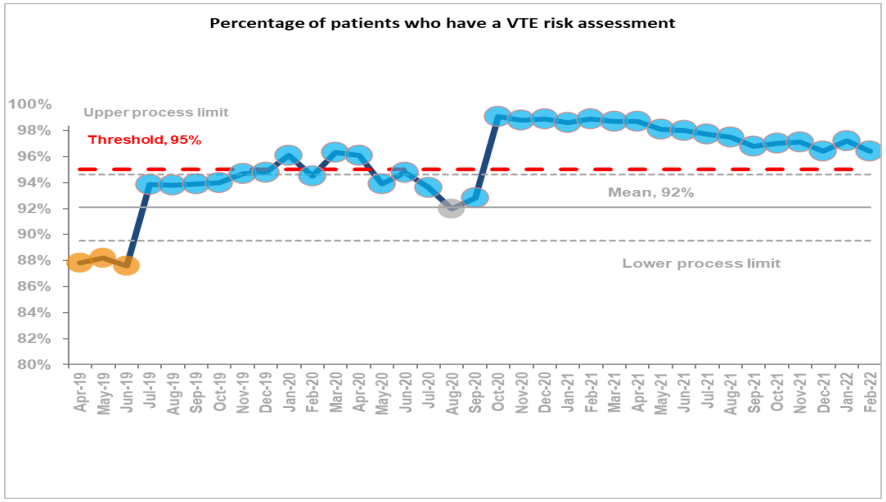



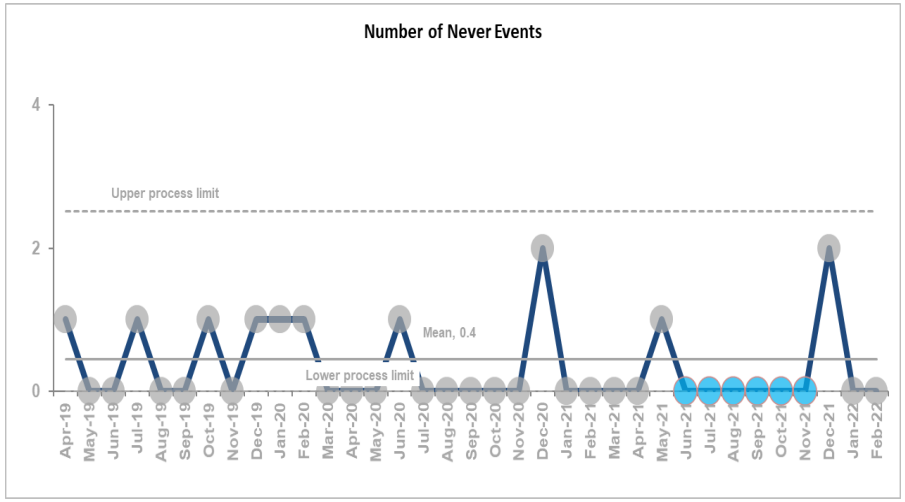




### What the information tells us

- Common cause variation is seen in the number of Serious Incidents and the number of Serious Incidents per 1,000 bed days.
- No Serious Incidents where Medication is a significant factor was recorded in February.

# Patient Safety- VTE and Never Events




**What the information tells us**

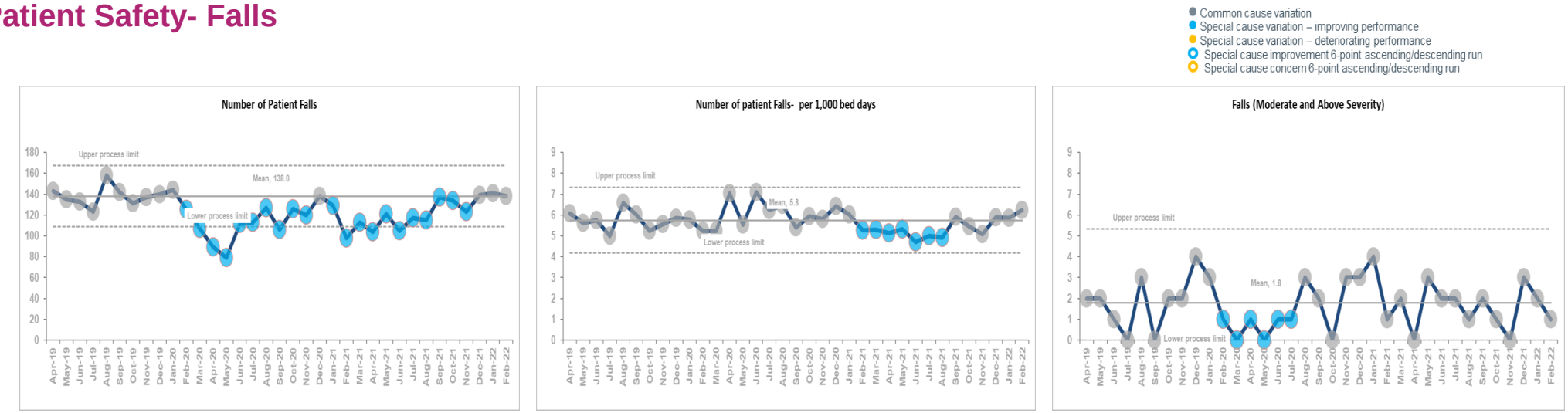
- The percentage of patients who have had a VTE risk assessment was 96.4% against a target of 95%.
- There were no Never Events declared in February 2022

**Actions and Quality Improvement Projects**

**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.

Our Patient Perspective

# Patient Safety- Falls



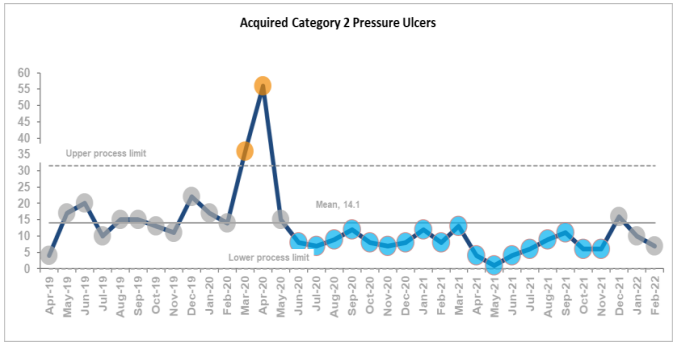

### What the information tells us

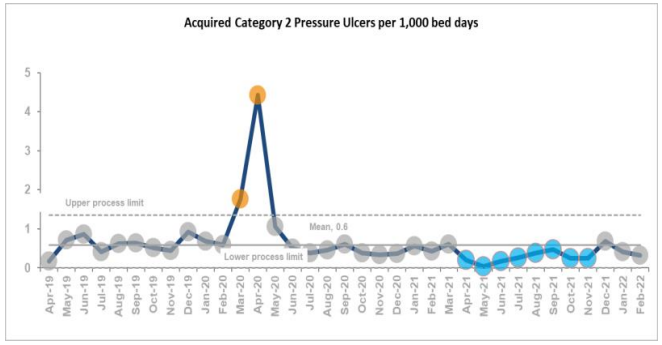
- The number of patients falls shows common cause variation; Patient Falls per 1,000 bed days also shows common cause variation.
- One patients had a fall in month with a severity of moderate harm or above.

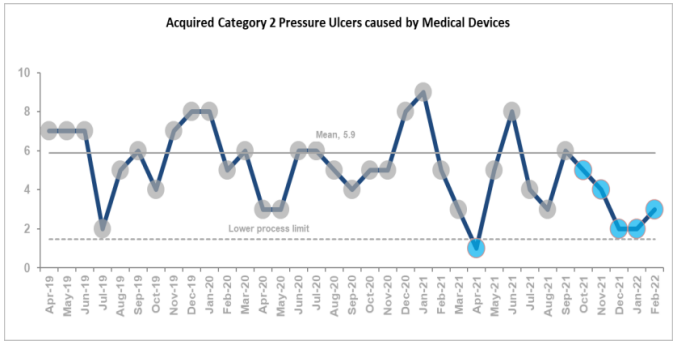
### Actions and Quality Improvement Projects

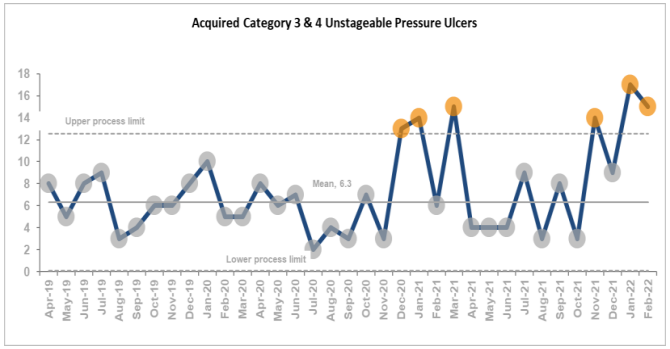
- Falls prevention measures continue to be implemented across inpatient wards
- Falls incidents continue to be monitored and reviewed locally by senior nursing teams with any learning identified and improvement actions implemented as appropriate.

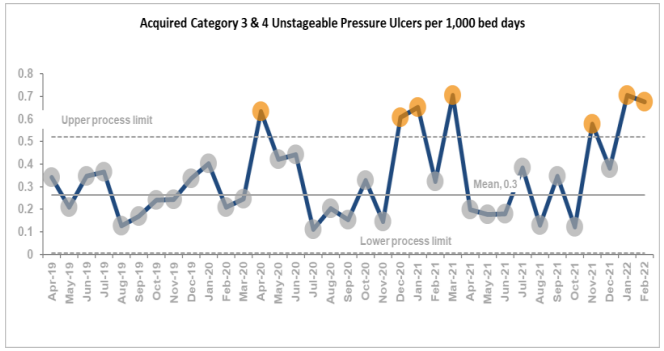
# Patient Safety- Pressure Ulcers

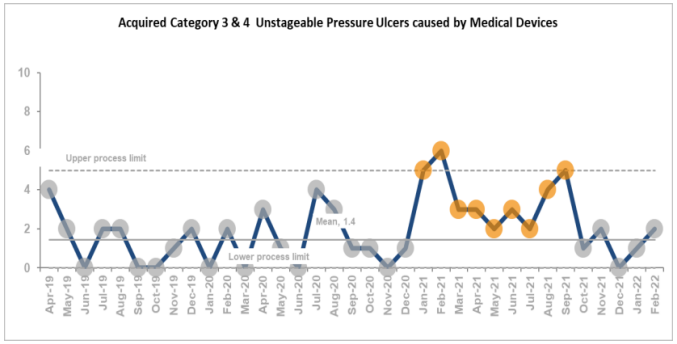



All PUs exclude Medical Devices except where stated

### What the information tells us

- There were 7 Acquired Category 2 Pressure ulcers this month. Acquired 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 special cause variation with a deteriorating position, and those caused by Medical Devices show common cause.

### Actions and Quality Improvement Projects

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

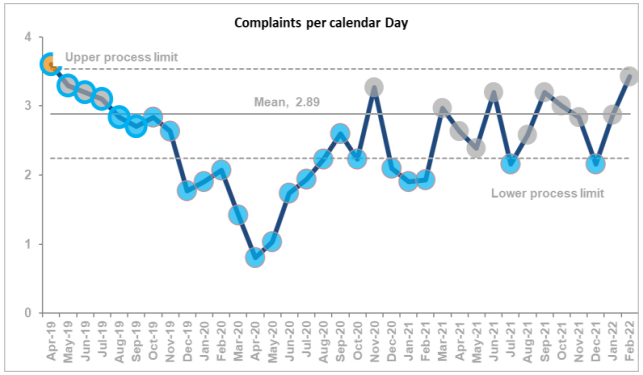
All category 3 and above pressure ulcers undergo root cause analysis to identify any learning

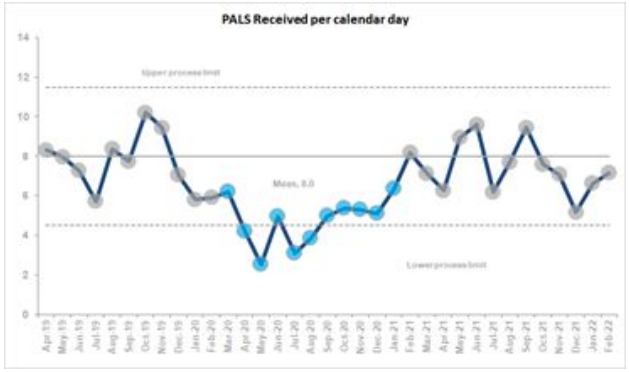
- Common cause variation
- Special cause variation – improving performance
- Special cause variation – deteriorating performance
- Special cause improvement 6-point ascending/descending run
- Special cause concern 6-point ascending/descending run

Our Patient Perspective

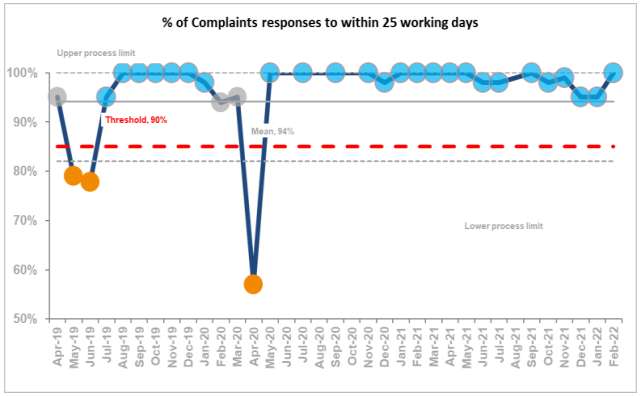
# Complaints

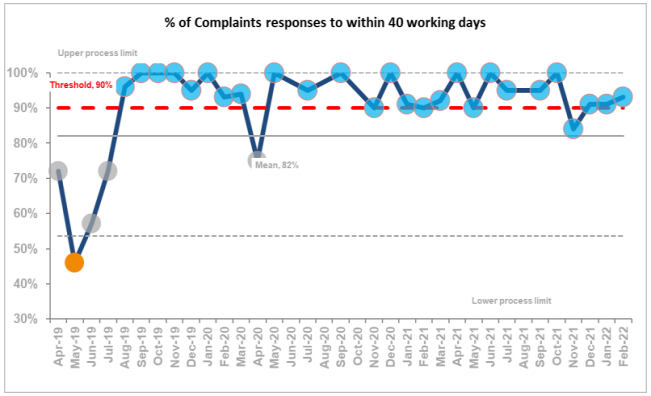
| Indicator Description | Target | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Complaints Received per calendar day | | 1.9 | 3.0 | 2.6 | 2.4 | 3.2 | 2.2 | 2.6 | 3.2 | 3.0 | 2.8 | 2.2 | 2.9 | 3.4 |
| % of Complaints responses to within 25 working days | 85% | 100% | 100% | 100% | 100% | 98% | 98% | 98% | 100% | 98% | 99% | 95% | 95% | 100% |
| % of Complaints responses to within 40 working days | 90% | 90% | 92% | 100% | 90% | 100% | 95% | 94% | 95% | 100% | 84% | 91% | 91% | 93% |
| % of Complaints responses to within 60 working days | 100% | 100% | 100% | N/A | 100% | 50.0% | N/A | N/A | 100% | N/A | N/A | 67.0% | N/A | 100% |
| Number of Complaints breaching 6 months Response Time | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |




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




### What the information tells us

- The number of complaints per calendar day shows common cause variation with the number of formal complaints received increasing from 89 to 96 in February 2022.
- Percentage of complaints responded to within 25 working days was achieved with performance at 100%.
- Percentage of complaints responded to within 40 working days was achieved with performance at 93%.
- There were no breaches of the number of Complaints required to be responded to within 60 working days.
- 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 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | YTD Actual |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| MRSA Incidences (in month) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 2 |
| Cdiff Hospital acquired infections | 52 | 3 | 2 | 2 | 2 | 2 | 0 | 3 | 4 | 4 | 5 | 5 | 3 | 2 | 41 |
| Cdiff Community Associated infections | | 0 | 1 | 1 | 0 | 0 | 0 | 2 | 1 | 1 | 1 | 0 | 2 | 1 | |
| MSSA | 25 | 5 | 5 | 5 | 3 | 3 | 3 | 3 | 0 | 3 | 10 | 2 | 4 | 3 | 39 |
| E-Coli | 111 | 6 | 6 | 7 | 6 | 5 | 6 | 5 | 4 | 5 | 7 | 5 | 5 | 2 | 57 |
| Covid-19 Nosocomial Infections Hospital Onset healthcare associated (>14 days) HOHA | N/A | 24 | 0 | 2 | 0 | 0 | 0 | 18 | 2 | 7 | 4 | 69 | 61 | 14 | 177 |
| Covid-19:Nosocomial Infections Hospital Onset Probable associated (8-14 days) HOPA | N/A | 35 | 4 | 0 | 1 | 1 | 0 | 10 | 1 | 4 | 1 | 31 | 31 | 17 | 97 |
| Pseudomonas aeruginosa | 21 | 2 | 1 | 1 | 0 | 3 | 3 | 1 | 3 | 3 | 1 | 3 | 4 | 1 | 23 |
| Klebsiella spp. bacteraemia | 49 | 8 | 4 | 2 | 5 | 2 | 4 | 5 | 7 | 4 | 7 | 4 | 3 | 3 | 46 |

## What the information tells us

- There were 3 *C. difficile* infections during February 2022; 2 were classified as Hospital Onset Healthcare Associated (HOHA), where the specimen was taken beyond admission day plus one day and 1 was classified as Community Onset Healthcare Associated (COHA), where the specimen was taken within admission day plus one day (and where the patient had also been an inpatient in the previous 4 weeks). For the period 01/04/21 to 28/02/22 there have been 41 cases of *C. difficile* infection against an NHSI/E threshold of no more than 52 cases for 2021-22; or no more than 4.3 cases per month or no more than 48 at this point in the year. The Trust is therefore under this trajectory. Of the 41 cases, 32 were classified as HOHA and 9 were classified as COHA. 5 lapses in care have so far been identified, relating to antimicrobial prescribing and timely isolation of patients. there were 3 patients with Trust apportioned MSSA during February 2022. There are no national or local trajectories for MSSA.
- There were 2 cases of Trust apportioned *E. coli* bacteraemia during February 2022. A new NHSI/E trajectory has been set for *E. coli* bacteraemia of no more than 111 cases for 2021-22, or no more than 9.25 cases per month. Between 01/04/21 and 28/02/22, there have been a total of 57 cases, against a trajectory of no more than 102 for this point in the year. The Trust is therefore under this trajectory.
- NHSI/E has set a new threshold for *P. aeruginosa* bacteraemia of no more than 21 cases for 2021-22 (where the sample has been taken >48 hours beyond admission), or no more than 1.75 per month. There was 1 case during February 2022. Between 01/04/21 and 28/02/22 there were 23 cases, which is above the trajectory of no more than 19 cases for this point in the year. The 23 cases compare to 27 during the same period 2020-21.
- NHSI/E has set a new threshold for *Klebsiella spp.* bacteraemia of no more than 49 Trust apportioned cases for 2021-22 (where the sample has been taken >48 hours beyond admission), or no more that 4 per month. There were 3 cases during February 2022. Between 01/04/21 and 28/02/22 there were 46 cases, which is above the trajectory of no more than 45 cases for this point in the year. The 46 cases compare to 74 for the same period during 2020-21.
- There were 14 Hospital Onset Healthcare Associated cases (HOHA) of Covid-19 during February 2022, where the sample was taken >14 days after admission and 17 Hospital Onset Probable Associated (HOPA) cases where the sample was taken 8-14 days after admission.

## Actions and Quality Improvement Projects

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

Our Patient Perspective

# Infection Control


Our Patient Perspective

# Mortality and Readmissions

| Indicator Description | 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-21 | Nov-21 | Dec 2020 to Nov 2021 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Hospital Standardised Mortality Ratio (HSMR) | 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 | 86.4 | 88.2 | 86.4 |
| Hospital Standardised Mortality Ratio Weekend Emergency | 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 | 79.9 | 102.3 | 101.4 |
| Hospital Standardised Mortality Ratio Weekday Emergency | 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 | 87.6 | 83.1 | 81.4 |

| Indicator Description | 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 | Sep 20-Aug 21 | Oct 20-Sep 21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary Hospital Mortality Indicator (SHMI) | 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 | 0.89 | 0.89 |

| Indicator Description | 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 | Dec-21 | Jan-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Emergency Readmissions within 30 days following non elective spell (reporting one month in arrears) | 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% | 6.8% | 7.9% |

Note: HSMR data reflective of period Dec 2020– Nov 2021 based on a rolling monthly published position.. SHMI data is based on a rolling 12 month period and reflective of period October 2020 to September 2021 published (Jan 2022). Readmission data excludes CDU, AAA and all ambulatory areas where there are design pathways

### What the information tells us

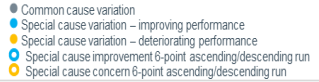
Mortality as measured by the summary hospital-level mortality indicator (SHMI) is lower than expected for the year October 2020 – September 2021. We are one of 14 trusts in this category, and one of 11 trusts that also had a lower-than-expected number of deaths for the same period in the previous year. Our latest HSMR, for the 12 months from December 2020 to November 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. 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.

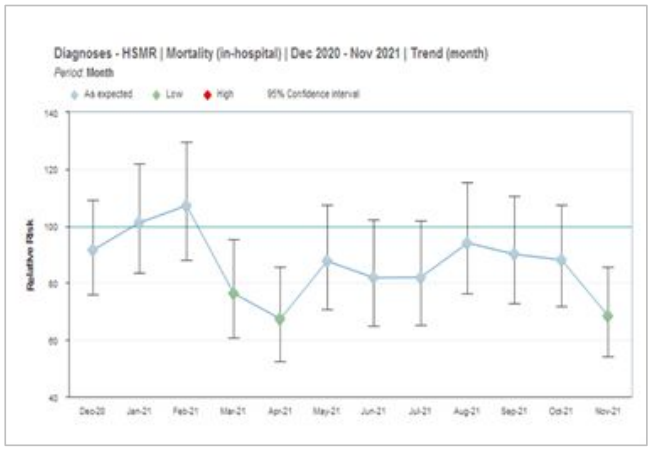
The percentage of patients readmitted within 30 days following an Emergency admission was 7.9% in January 22. Performance shows special cause variation with an improving position.

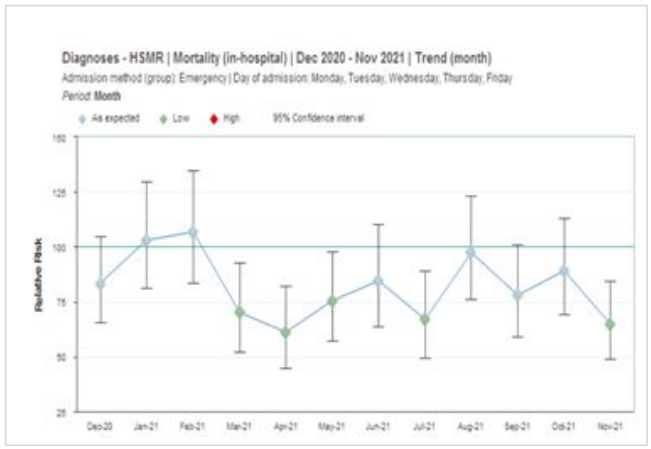
### Actions and Quality Improvement Projects

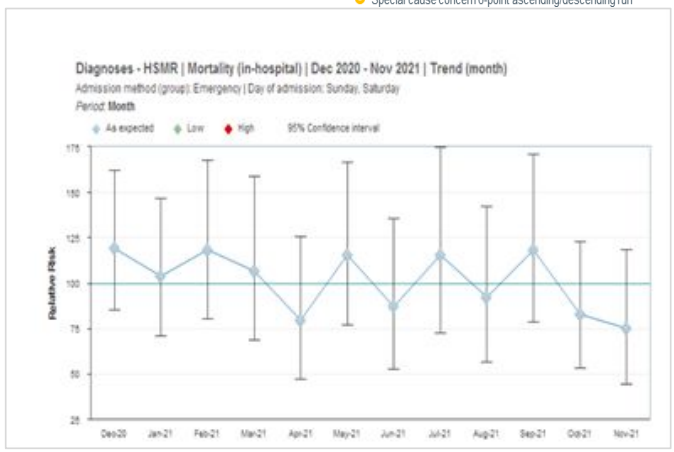
We continue to monitor and investigate mortality signals in discrete diagnostic and procedure codes from Dr Foster through the Mortality Monitoring Group (MMG). The group are currently overseeing an investigation of mortality in the diagnosis group Acute Myocardial Infarction, as higher than expected mortality is indicated by analysis of both the HSMR and SHMI. The Cardiology Clinical Governance Lead provided an update on the investigation to MMG in February. MMG acknowledged that there is an improvement action plan in place, which was agreed in response to a recent mortality investigation and is being monitored at divisional level. As time needs to be given to see the impact of these changes it was agreed that an update would be received in 6 months' time. In the meantime, the clinical team, the coding team and the strategic business intelligence team will work together to explore clinical coding for this group of patients.

# Mortality and Readmissions (Hospital Standardized Mortality Rate)

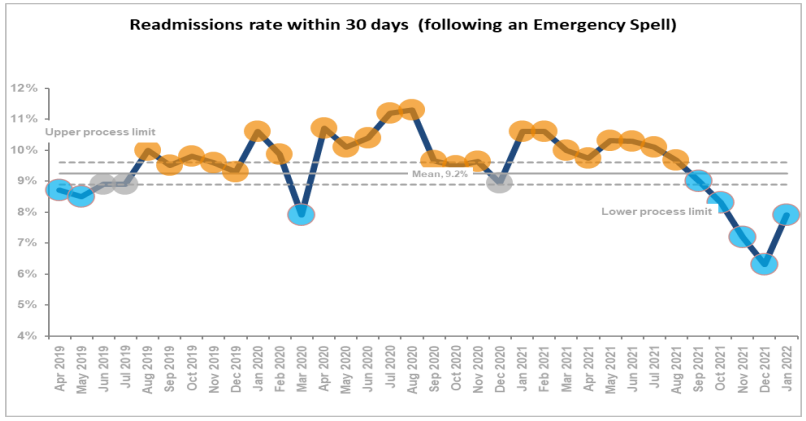


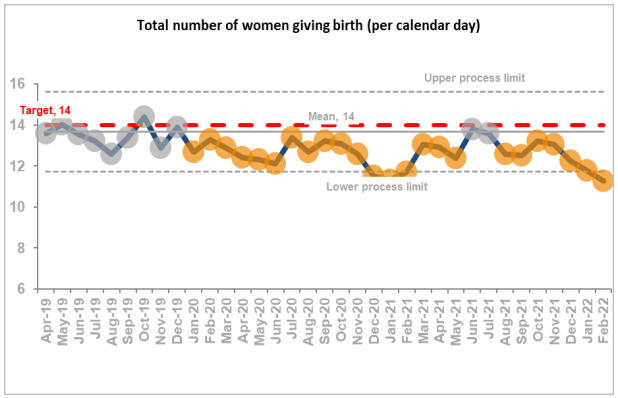



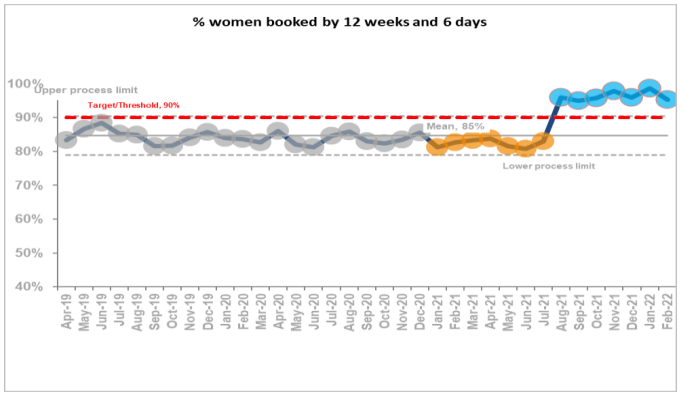



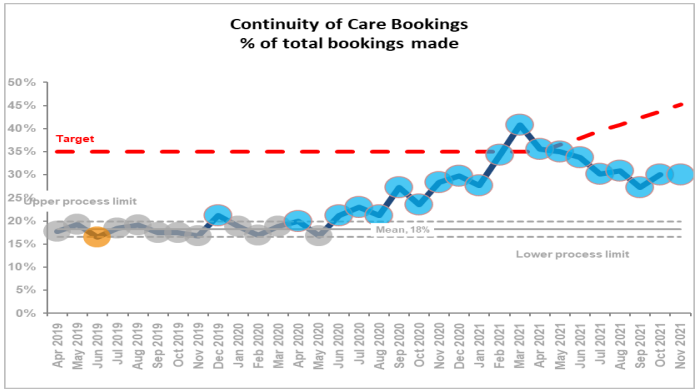




# Maternity




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

## What the information tells us

- Although the number of women giving birth has reduced month on month since October 2021, staffing challenges continued in February 2022 which impacted on staffing ratios and training compliance and access to the Carmen suite which was closed 44.6% of the time this month
- Part of the response to staffing challenges continued to include diverting birth centre and office based midwives to the Delivery Suite and other acute inpatient areas when required. The overall substantive staffing profile continued to improve throughout February 2022 although short term sickness and covid absences remain. There were some challenges in sickness within the outpatient setting and staff were diverted as described above to ensure women were booked on time
- There were no stillbirths and three neonatal deaths in February 2022. On initial review there were no concerns related to care and treatment. The neonatal deaths will be further reviewed using the perinatal mortality reporting tool
- There was a continued performance in antenatal bookings with 96.4% of women referred being booked by 12 weeks and 6 days.

## Actions and Quality Improvement Projects

We have recommenced working towards transforming our services in line with Continuity of Carer targets and have had input from the national Continuity of Care (CoC) midwifery team. We aim to implement CoC here at SGH in a number of waves with wave 1 due to be completed by September 2022.

Digital Transformation across Maternity supported by the £1.8M funding to provide a single health records solution by the addition of a maternity module to our enterprise wide EPR (electronic patient record) is currently being implemented and continues with some pace. 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 healthcare information pertinent to their circumstances. Although the digital platform has not yet been purchase, much of the bid money has now been allocated and the project team is working cohesively.

The Maternity Telephone Helpline will be launched in late March 2022 after a slight delay due to staffing pressures. 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. It has been co-produced with our MVP

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, with progress being made to achieve these elements.

Maternity Transformation Programmes have been paused nationally for at least another month in response to national staffing challenges.

# Maternity

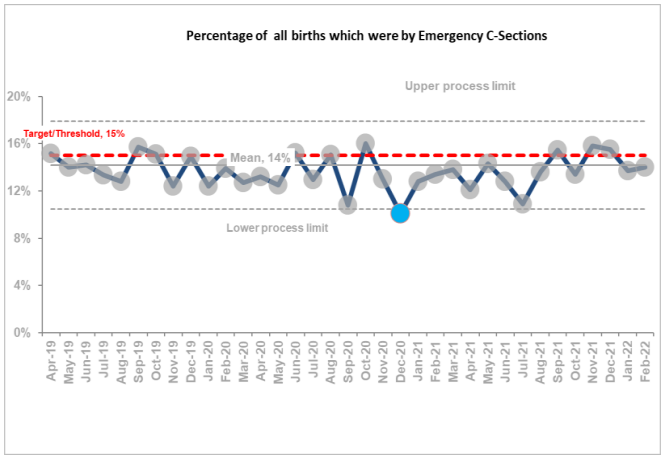
## Maternity Dashboard

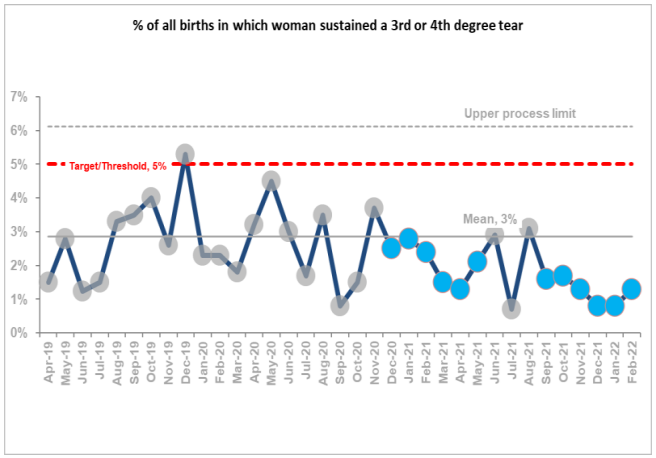
| Definitions | Target | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total number of women giving birth (per calendar day) | 14 per day | 11.7 | 13.1 | 12.9 | 12.4 | 13.8 | 13.6 | 12.6 | 12.5 | 13.2 | 13.1 | 12.3 | 11.8 | 11.3 |
| Caesarean sections (Total Emergency and Elective by Delivery date) | <28% | 28.0% | 29.1% | 25.5% | 27.6% | 24.6% | 24.7% | 27.2% | 28.3% | 27.3% | 31.4% | 31.3% | 27.1% | 27.5% |
| % deliveries with Emergency C Section (including no Labour) | <8% | 3.4% | 4.0% | 3.4% | 3.9% | 1.9% | 3.6% | 2.6% | 4.5% | 4.4% | 5.4% | 5.0% | 3.0% | 5.7% |
| % Time Carmen Suite closed | 0% | 9.0% | 26.0% | 8.3% | 8.0% | 18.3% | 30.6% | 74.2% | 56.0% | 21.0% | 15.0% | 27.4% | 12.9% | 44.6% |
| % of all births in which woman sustained a 3rd or 4th degree tear | <5% | 2.4% | 1.5% | 1.3% | 2.1% | 2.9% | 0.7% | 3.1% | 1.6% | 1.7% | 1.3% | 0.8% | 0.8% | 1.9% |
| % of all births where women had a Life Threatening Post Partum Haemorrhage >1.5 L | <4% | 1.2% | 3.2% | 2.8% | 4.2% | 2.4% | 3.6% | 2.3% | 1.3% | 2.9% | 3.6% | 2.4% | 1.9% | 2.5% |
| Number of term babies (37+ weeks), with unplanned admission to Neonatal Unit | | 9 | 11 | 8 | 13 | 14 | 13 | 16 | 13 | 12 | 12 | 10 | 11 | 13 |
| Number of term babies (37+ weeks), with unplanned admission to Neonatal Unit as a percentage of deliveries | 6% | 2.3% | 2.8% | 2.0% | 3.3% | 3.5% | 3.3% | 4.1% | 3.3% | 3.0% | 3.0% | 2.5% | 2.8% | 3.3% |
| Supernumerary Midwife in Labour Ward | >95% | 94.6% | 98.4% | 98.3% | 98.4% | 97.0% | 88.7% | 90.3% | 90.0% | 88.7% | 98.3% | 98.4% | 98.4% | 92.9% |
| Babies born with Hypoxic Ischaemic Encephalopathy / (1000 babies) | | 0.0 | 2.5 | 0.8 (Qtr1) | | | 2.4 (Qtr2) | | | 0.8 (Qtr3) | | | Qtr 4 | |
| Still Births per 1000 Births | <3 | 9.1 | 4.9 | 2.6 | 5.2 | 2.4 | 7.1 | 0.0 | 2.7 | 9.8 | 10.2 | 2.6 | 0.0 | 0.0 |
| Neonatal Deaths (KPI 72) per 1000 Births | <3 | 3.0 | 2.5 | 2.6 | 0.0 | 0.0 | 0.0 | 2.6 | 0.0 | 0.0 | 0.0 | 13.2 | 2.7 | 9.5 |
| Continuity of Care Bookings- % of total bookings made (Target increases monthly by 1.5% towards a 51% target in Mar 22) | 43.7% | 34.3% | 40.1% | 35.2% | 35.0% | 33.8% | 30.1% | 30.6% | 27.2% | 30.0% | 30.0% | 31.4% | 35.3% | 33.7% |
| Percentage of all births which were by Emergency C-Sections (KP25+26) | 15% | 13.4% | 13.8% | 12.1% | 14.3% | 12.8% | 10.9% | 13.6% | 15.5% | 13.4% | 15.8% | 15.5% | 13.7% | 14.9% |
| % women booked by 12 weeks and 6 days | 90% | 82.6% | 83.3% | 83.8% | 81.5% | 80.8% | 83.0% | 96.0% | 95.0% | 95.8% | 97.9% | 95.9% | 98.7% | 95.3% |

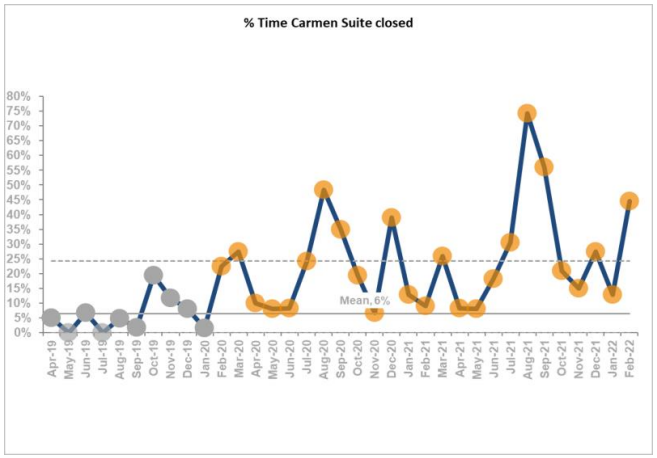
Our Patient Perspective

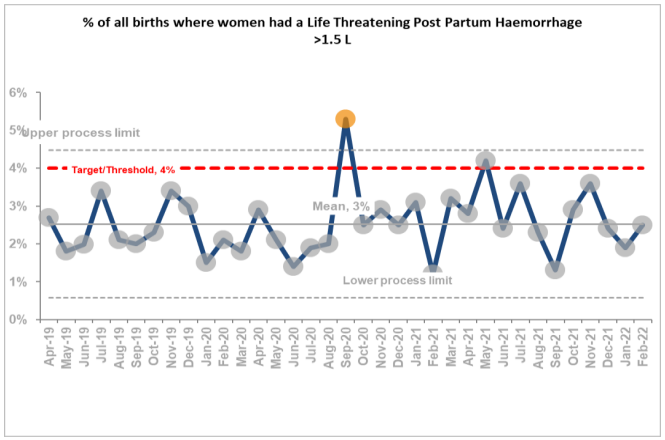
# Maternity

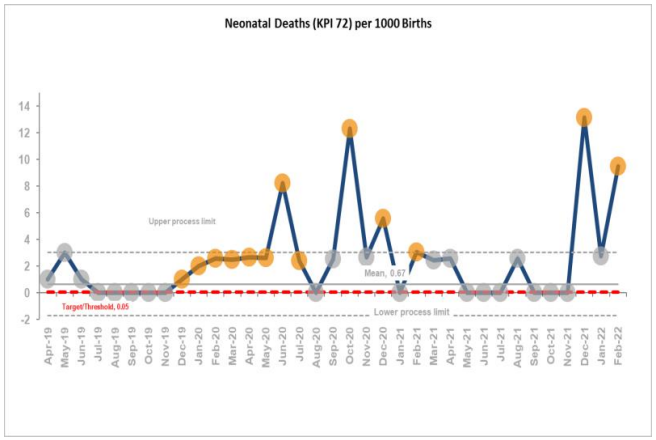
Common cause variation
Special cause variation – improving performance
Special cause variation – deteriorating performance
Special cause improvement 6-point ascending/descending run
Special cause concern 6-point ascending/descending run

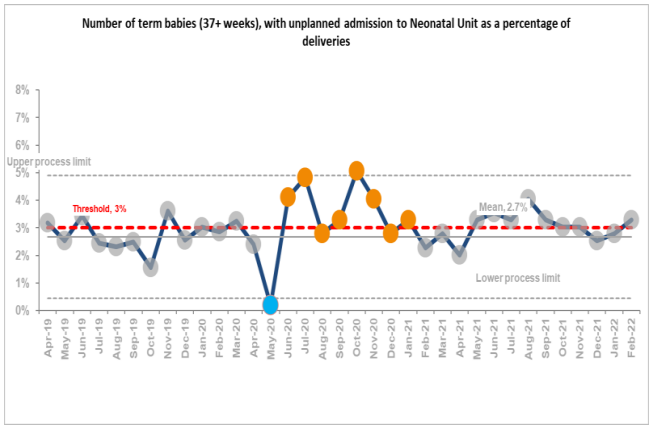


# Friends & Family Survey

| Indicator Description | Target | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Emergency Department FFT - % positive responses | 90% | 90.8% | 88.8% | 86.4% | 83.4% | 79.8% | 81.6% | 78.0% | 73.6% | 71.3% | 75.5% | 77.4% | 80.2% | 76.1% |
| Inpatient FFT - % positive responses | 95% | 98.3% | 99.3% | 98.2% | 97.1% | 97.5% | 97.2% | 98.4% | 97.9% | 98.9% | 98.3% | 96.0% | 95.8% | 98.2% |
| Maternity FFT - Antenatal - % positive responses | 90% | N/A | 50.0% | N/A | N/A | N/A | 100.0% | 50.0% | N/A | N/A | N/A | 100.0% | N/A | N/A |
| Maternity FFT - Delivery - % positive responses | 90% | 93.0% | 91.6% | 88.9% | 100.0% | 90.0% | 100.0% | N/A | 100.0% | 84.0% | 86.8% | 87.9% | 85.0% | 90.6% |
| Maternity FFT - Postnatal Ward - % positive responses | 90% | N/A | 81.8% | 100.0% | 95.8% | 91.9% | 100.0% | 0.0% | N/A | 94.4% | 100.0% | 90.5% | 100.0% | 88.9% |
| 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% | 91.7% | 87.5% | 91.7% | 100.0% | 100.0% | 92.9% | 89.5% | 94.1% | 94.4% | 100.0% | 90.9% |
| Outpatient FFT - % positive responses | 90% | 90.4% | 95.2% | 88.7% | 91.3% | 90.7% | 91.0% | 89.8% | 90.2% | 90.3% | 91.7% | 91.9% | 91.8% | 92.5% |

**What the information tells us**

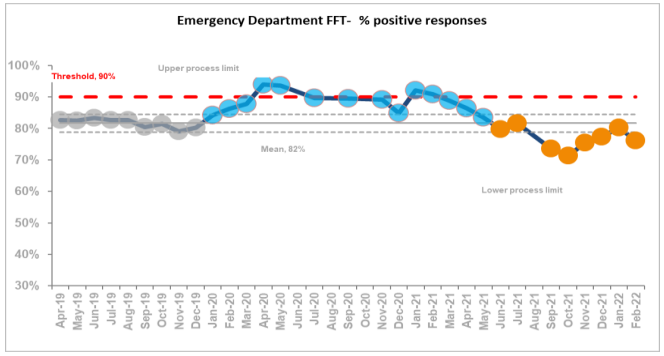
- Inpatient, Maternity (Postnatal Ward), Community and Outpatient services achieved FFT targets where patients rated the services as "Good" or "Very Good".
- Performance for Emergency Department and Postnatal Ward was 76.1% and 88.9% respectively and with ED showing common cause variation with a deteriorating position.

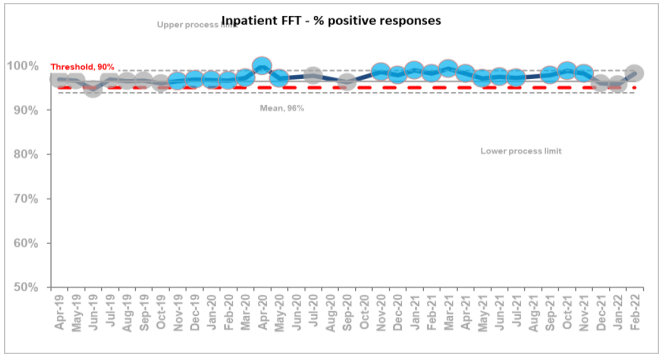
**Actions and Quality Improvement Projects**

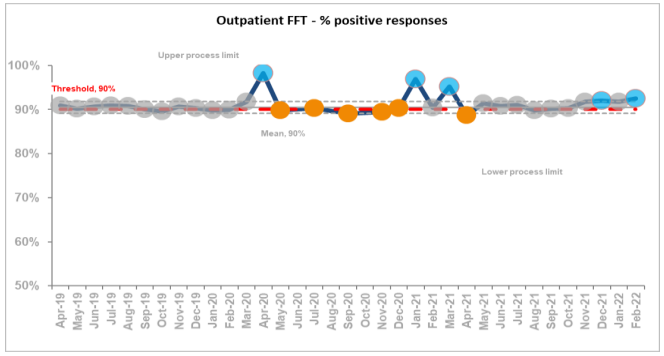
For the Emergency Department, the service moved from an external provider to the Trust's FFT collection system in January 2021, since then there has continued to be a reduction in reported response rate. The data accuracy has been confirmed and the process checked to ensure that reminder texts are being 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 introduce QR codes for posters in the department. In addition to handheld devices being available in the ED, additional electronic handheld devices have been made available for patients once they have been admitted to a ward in order for them to complete the questions related to their experience in the ED.

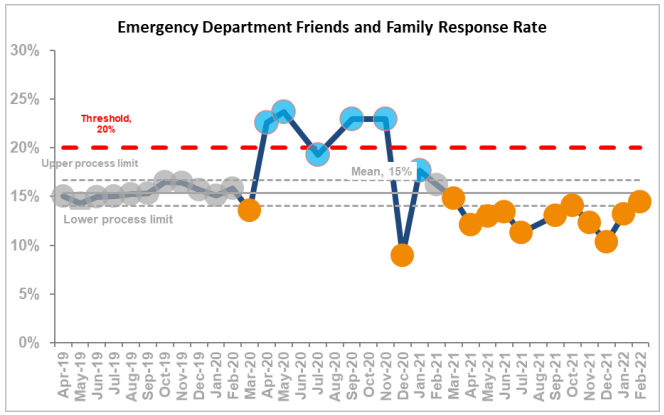
Midwifery Services in February 2022 were again busy with staffing challenges which may have influenced waiting times and bed allocation, although there were no reported delays in pain relief. The team have revised the current questions which are set for relaunch in April 2022. A number of new Healthcare Assistant colleagues have joined the team and they will be leading on improving the FFT results from a postnatal perspective. Our Continuity of Care team changes mean we will be better able to plan and increase our FFT responses – this is incorporated within the team planning. Additional electronic handheld devices have been made available for patients.

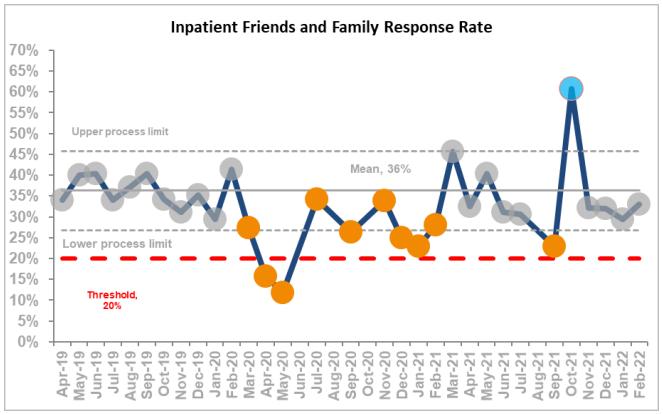
# Friends and Family Test

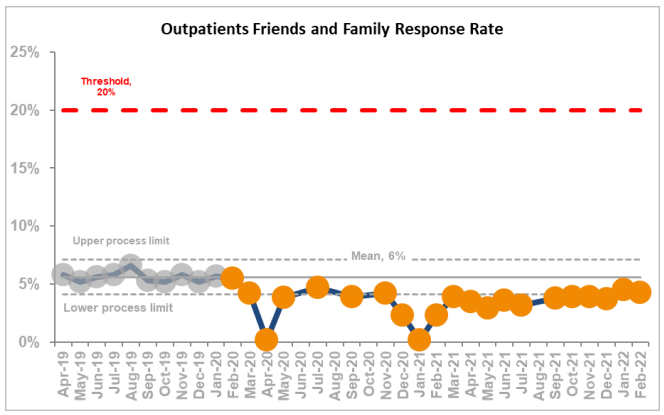


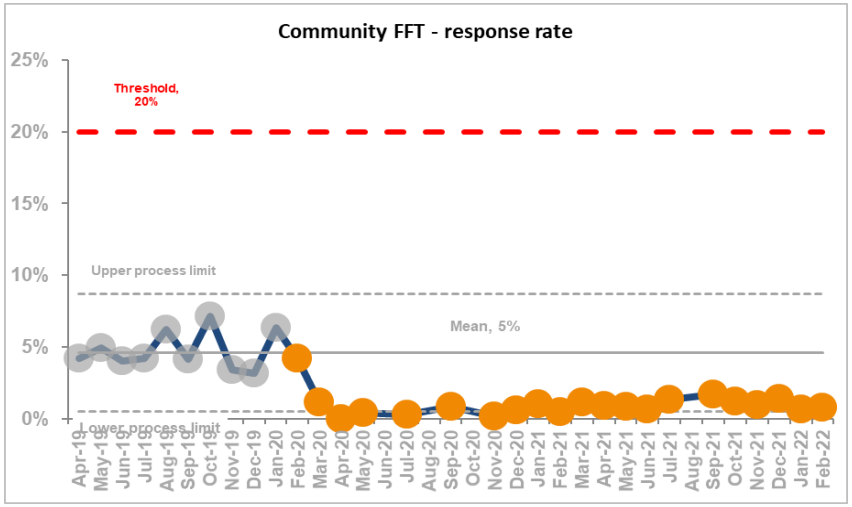



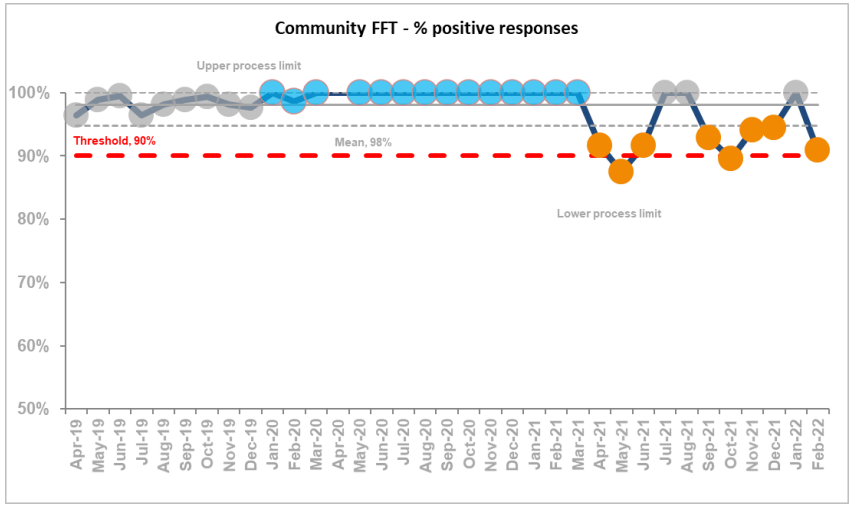



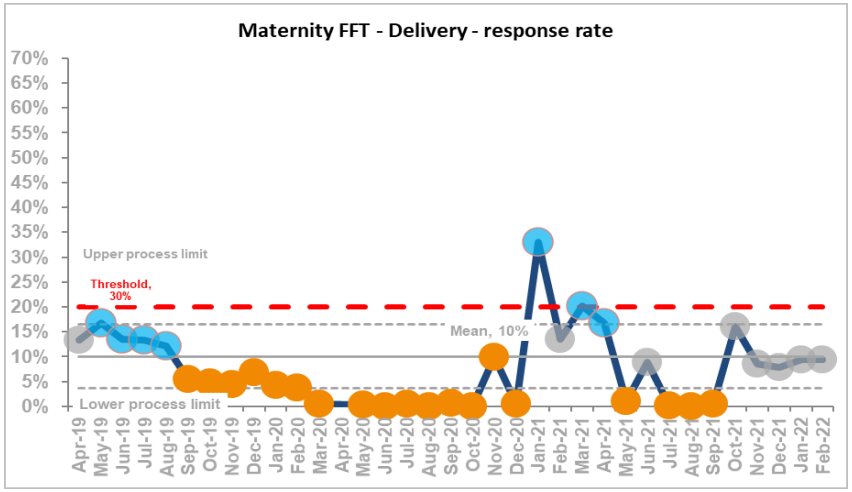

- Common cause variation
- Special cause variation – improving performance
- Special cause variation – deteriorating performance
- Special cause improvement 6-point ascending/descending run
- Special cause concern 6-point ascending/descending run

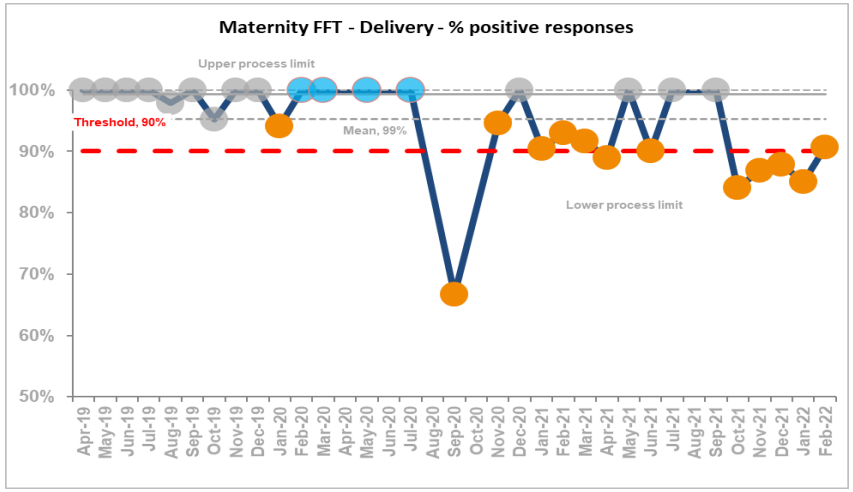
Our Patient Perspective

# Friends and Family Test



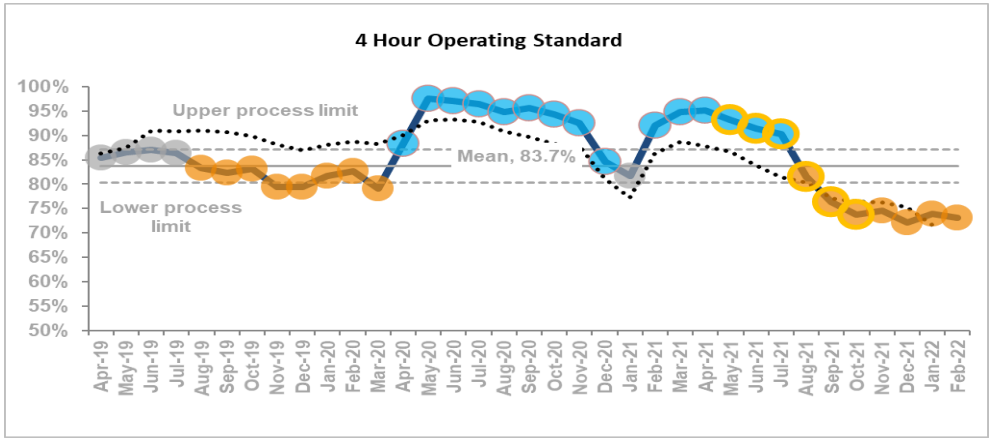



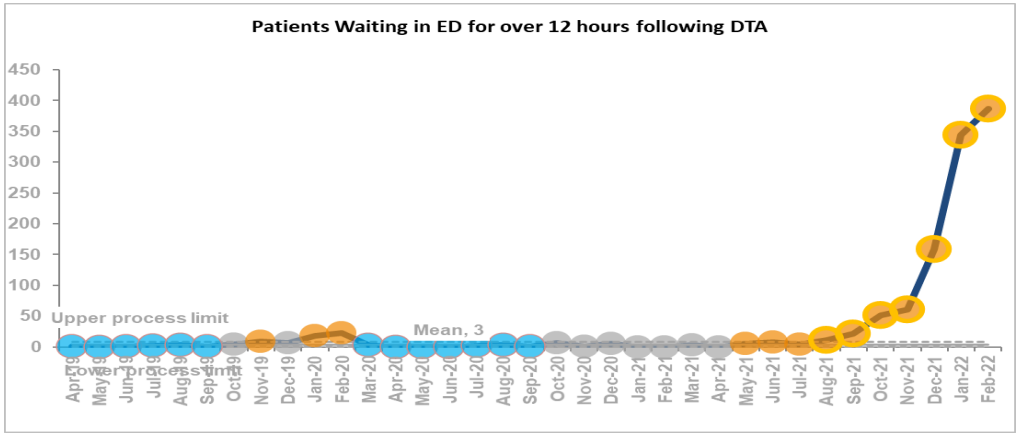



# Balanced Scorecard Approach

# Emergency Flow




**What the information tells us**

Performance throughout February saw 73.1% of patients attending the emergency department either discharged, admitted or transferred within four hours of their arrival. performance levels remain below the lower control limit however remaining in line with the London average. The Trust continues to see significant challenges impacting waiting times.

February saw the daily average attendance numbers increase although remaining below the levels seen pre-covid, however, the acuity of the patents presenting remain higher with 47% of patients triaged having a Manchester Triage Score between 1 and 3 and 26% of attendances converting to admissions.

Patient Flow and bed allocation has been extremely challenged with pressures remining high for children's, surgical and medical admissions. With high occupancy rates within our AMU unit, front end capacity has been adversely impacted, converting into a sharp rise in 12-hour trolley waits. The Trust reported 387 breaches in February, significantly above the upper control limit.

The number of patients staying over 7,14 days continues to increase, however the number of patients over 21 days has decreased across the month. Teams are working well with system partners to reduce external delays however patients are requiring large packages of care which is constraining capacity

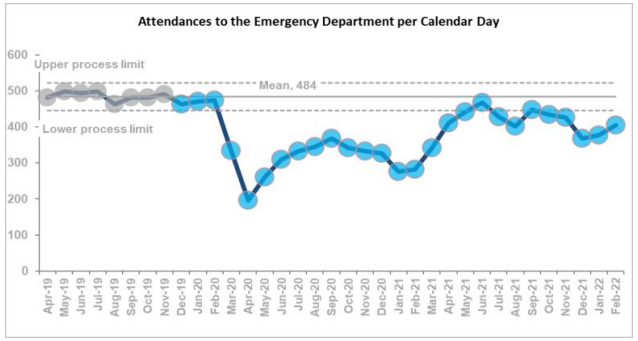
**Actions and Quality Improvement Projects**

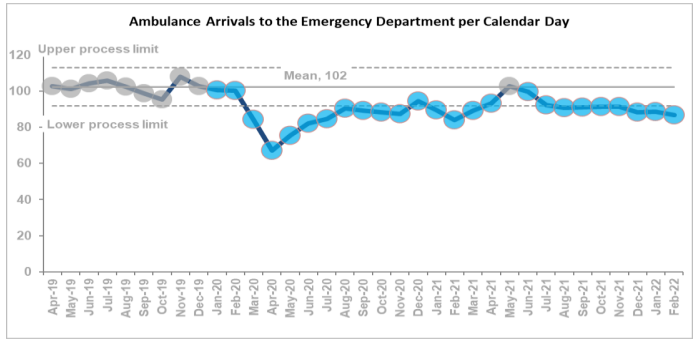
- In-Hours GP service has expanded to offer paediatric sessions on a daily basis.
- 15 nurses have been recruited in the month and will start employment during April
- On a wider level the Trust is continuing to work closely with system partners to improve the capacity and process for discharging patients to the community who have on-going care needs.
- New Assistant General Manager for flow - role advertised
- New step down nurse for Homelessness Inclusion Health team recruited to support earlier discharge of homeless patients.
- 5 new specialty doctors recruited and starting employment in next month
- Listening events and staff survey commenced with support from Organisational Development
- Further work being undertaken to maximise in out space for doctors to see patients whilst the number of Decision-to-Admits (DTAs) remains at high numbers

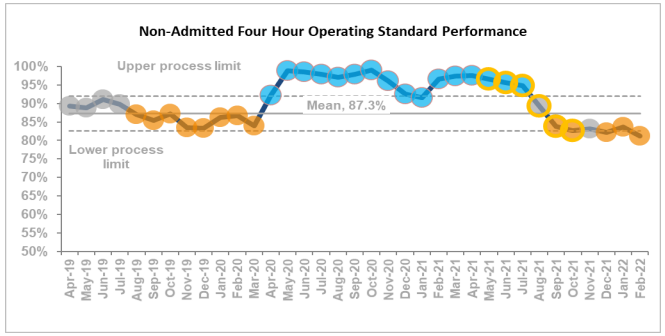
Common Cause
Special Cause Improvement
Special Cause Concern
Special cause concern 6-point ascending/descending run
Special cause improvement 6-point ascending/descending run

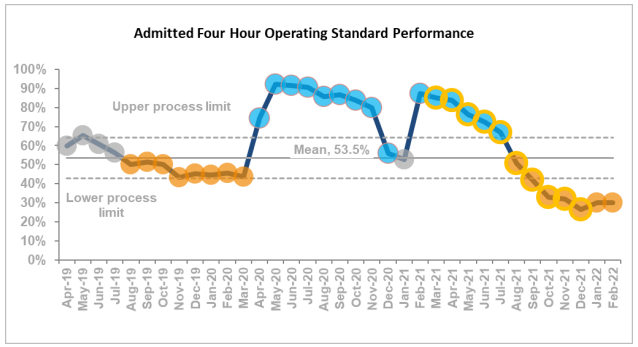
Our Process Perspective

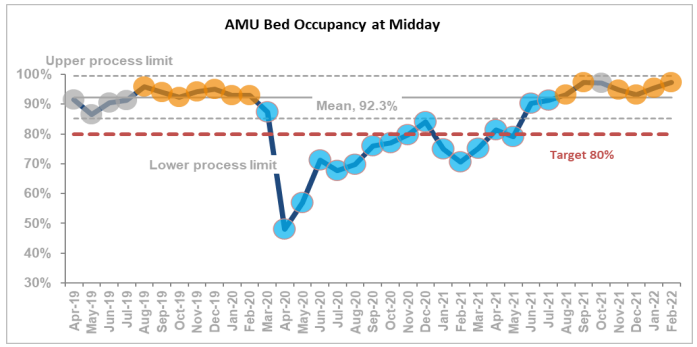
# Emergency Flow

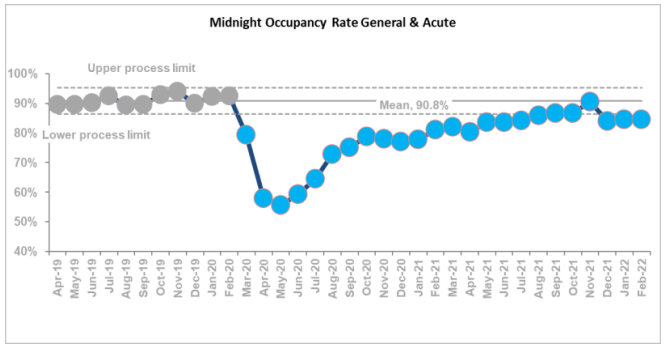


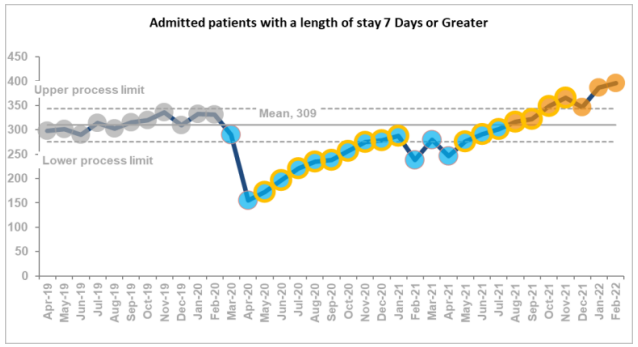



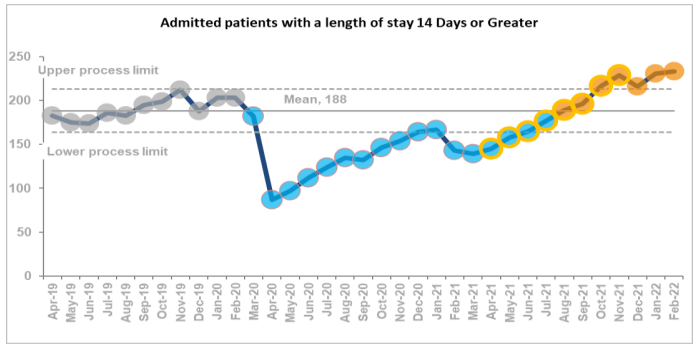



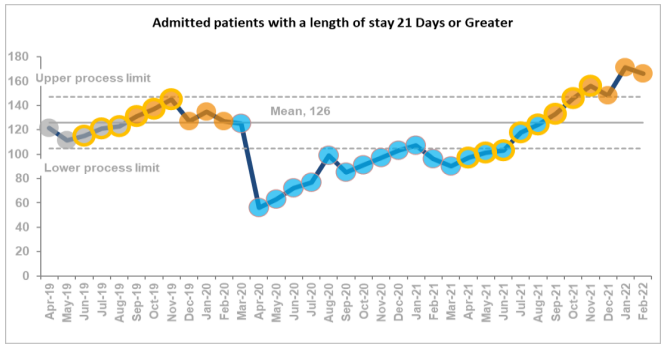



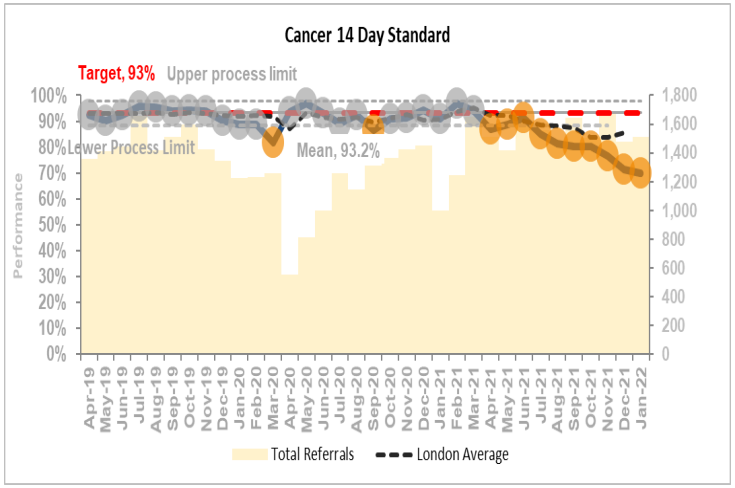



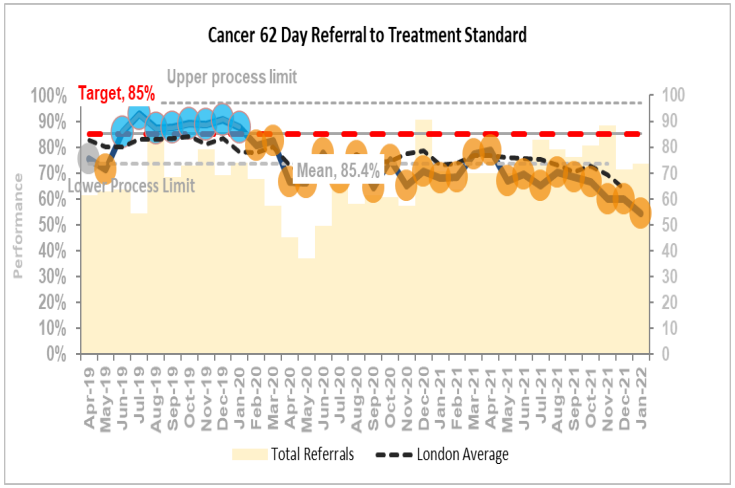




Our Process Perspective

# Cancer



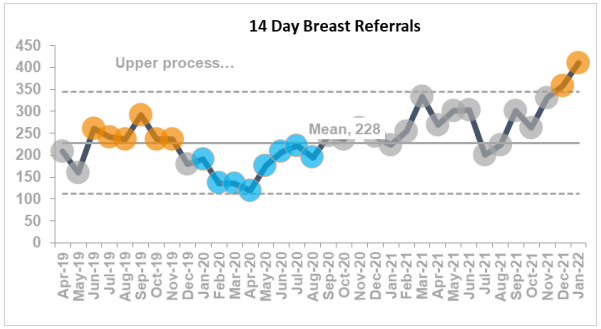

**What the information tells us**

January performance against the national cancer standards remains challenged with cancer activity, both in terms of referrals and treatment volumes. Cancer activity is at 115% and diagnostics for cancer patients is at 140% of 2019-20 baseline, resulting in high pressures on clinical services. The Trust did not meet six of the seven cancer standards in January; clinical and operational teams continue to remain focused on tracking patients through their pathways in order to reduce delays.

In January, the Trust received 1,513 Two-Week-Rule (TWR) referrals, an increase of 2.5% compared to the previous month. Performance fell with 69.8% of patients seen within 14 days of referral compared to 71.2% in December. Referral numbers continue to be above 2019-20 baseline with Skin, Head & Neck and Lower GI seeing recent spikes in demand coupled with capacity challenges. Breast services received 411 referrals compared to 358 in December, demand continues above the upper control limit and higher than the same period in 2019 by 116%; 25.3% of patients referred were able to be seen within target, an improved position. The Trust is not expecting to report compliance against the 14 Day Standard until the issues within the breast services are resolved. Breast Symptomatic 14-day performance remains significantly below the lower control limit however improvement in performance was seen throughout January with 21.5% of patients seen within 14 days of referral.

Performance against the 31-day treatment standard in January was 90.6% against a target of 96%. There were 203 treatments in month, compared to 181 in December. Four tumour groups were below target; Head & Neck (91.3%), Lower GI (91.7%), Upper GI (77.3%) and Urology (77.3%).

In January there was 73.5 accountable treatments on the 62-day GP pathway, of which 40 patients received treatment within 62 days, 54.4% against a target of 85%. All tumour groups were non-compliant. At the end of January, there were 166 patients on the 63 day plus patient tracking list, against a trajectory of 160 of which 49 were waiting for more than 104 days.




**Actions and Quality Improvement Projects**

**14 Day Standard**

- The Trust is not expecting to report compliance against the 14 Day Standard until the issues within the breast services are resolved. There is a recovery plan in place and a portion of referrals are on divert to SWL providers.

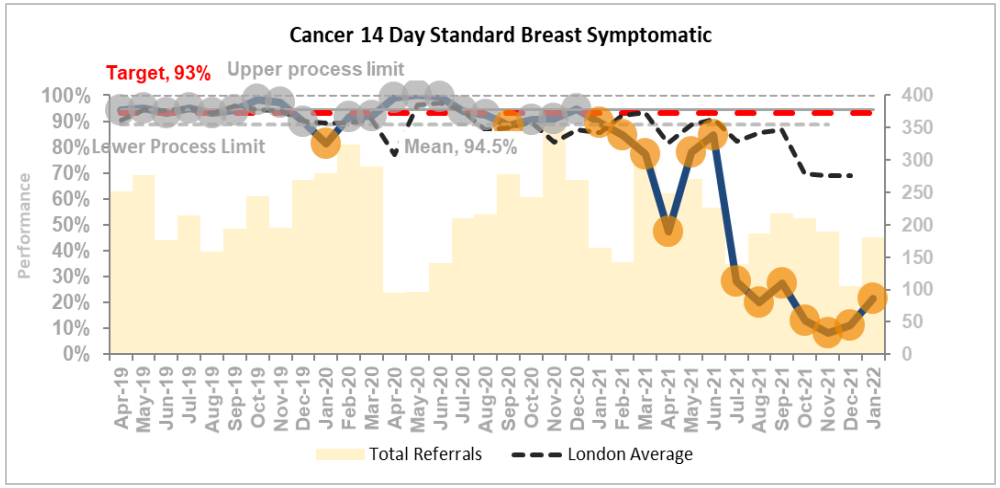
**Covid Recovery Trajectories**

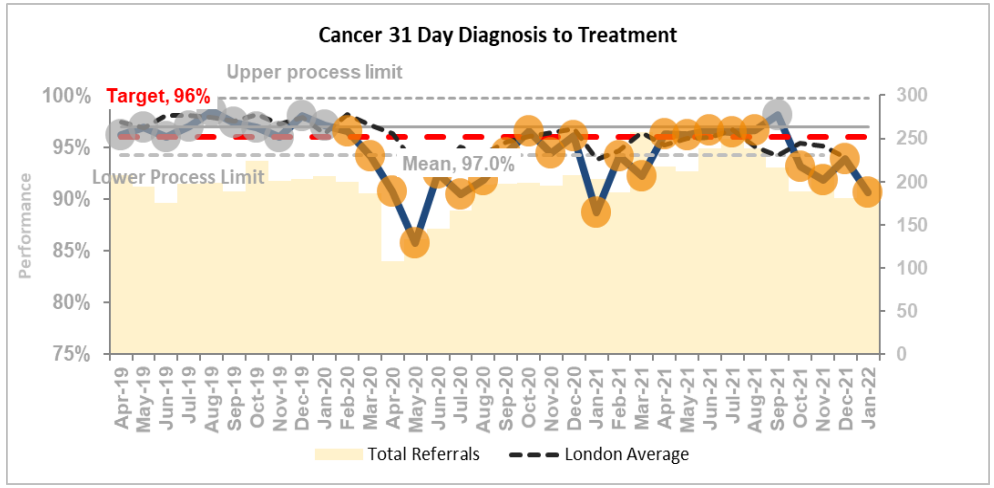
- The Trust has with the alliance a trajectory to support covid recovery as part of recovery for 22/23, focused on
  - Achieving less than 144 patients over day 62 on the PTL by Q3 Oct 22 and 140 by March 23. The trust is currently meeting this target
  - Achieving FDS performance by Q3 Oct 22.
  - Improving the 62-day performance metric by March 23 to 80%
- The main challenges to backlog recovery are, in radiology affecting CTC and GI services, Breast front end challenges, Urology theatre capacity. It is also impacted by some complex pathways and later inter trust transfers affecting H&N and Urology equating to 1/3 of the backlog.

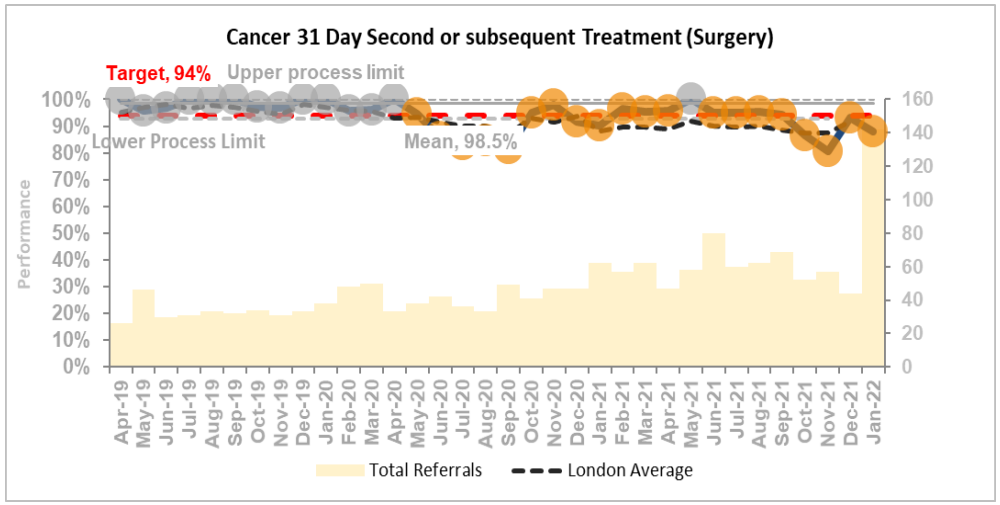
Common Cause | Special Cause Improvement | Special Cause Concern | Special cause concern 6-point ascending/descending run | Special cause improvement 6-point ascending/descending run

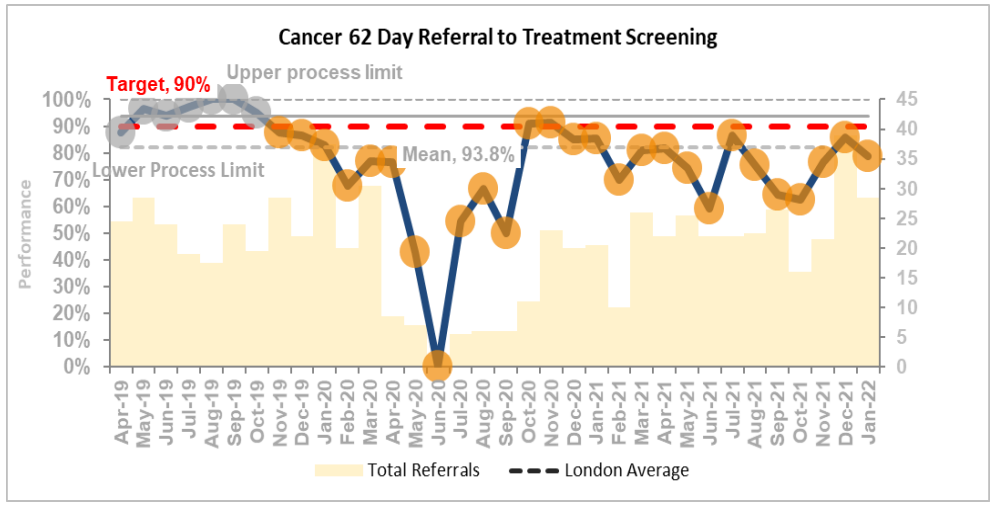
Our Process Perspective

# Cancer




Our Process Perspective

# Cancer

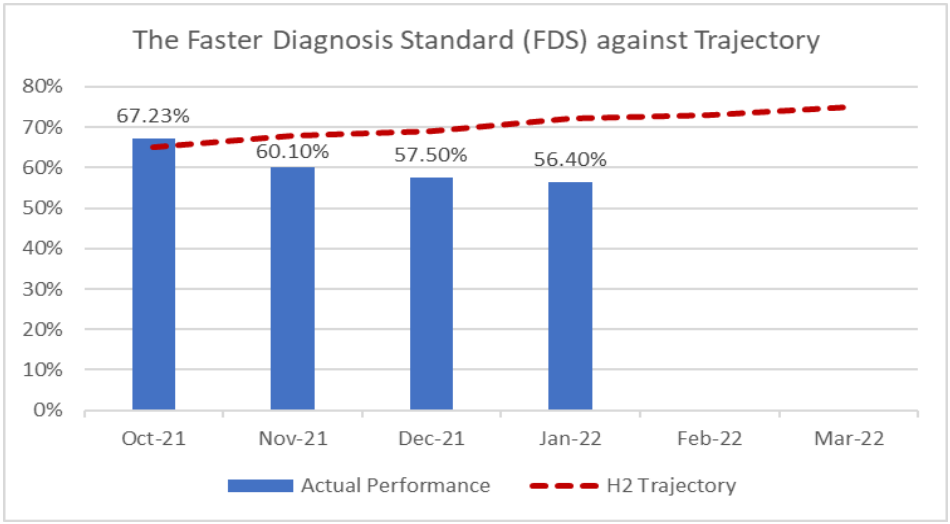
## 14 Day Standard Performance by Tumour Site - Target 93%

| Tumour Site | Target | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | No of Patients |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Brain | 93% | - | - | - | - | - | - | - | - | - | - | - | - | - | |
| Breast | 93% | 86.6% | 92.5% | 82.9% | 54.5% | 78.7% | 86.1% | 26.9% | 17.5% | 30.1% | 14.5% | 10.3% | 12.0% | 25.3% | 411 |
| Children's | 93% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 50.0% | 50.0% | 90.0% | 100.0% | 100.0% | 50.0% | 2 |
| Gynaecology | 93% | 79.3% | 94.9% | 94.9% | 87.2% | 92.6% | 91.7% | 95.0% | 94.5% | 85.4% | 88.7% | 88.1% | 91.3% | 83.3% | 96 |
| Haematology | 93% | 95.5% | 100.0% | 90.0% | 96.4% | 100.0% | 95.5% | 79.3% | 90.9% | 100.0% | 100.0% | 95.8% | 94.4% | 87.5% | 8 |
| Head & Neck | 93% | 91.6% | 96.4% | 94.6% | 95.7% | 96.9% | 93.4% | 95.5% | 88.1% | 92.4% | 93.8% | 91.9% | 95.3% | 88.5% | 104 |
| Lower Gastrointestinal | 93% | 99.3% | 98.6% | 98.2% | 95.9% | 67.6% | 82.2% | 96.7% | 95.7% | 98.3% | 98.3% | 99.6% | 100.0% | 96.6% | 223 |
| Lung | 93% | 90.0% | 100.0% | 94.4% | 91.9% | 97.5% | 93.9% | 74.3% | 68.2% | 82.6% | 85.7% | 74.3% | 31.3% | 60.0% | 50 |
| Skin | 93% | 90.7% | 98.7% | 98.0% | 93.6% | 97.5% | 94.5% | 91.4% | 94.8% | 91.0% | 93.7% | 90.4% | 88.8% | 79.2% | 389 |
| Upper Gastrointestinal | 93% | 95.3% | 100.0% | 95.4% | 98.1% | 96.9% | 97.4% | 96.6% | 97.2% | 95.2% | 96.8% | 96.6% | 93.4% | 93.5% | 108 |
| Urology (Suspected testicular cancer) | 93% | 95.3% | 98.9% | 97.1% | 89.6% | 97.0% | 98.3% | 98.1% | 88.6% | 86.6% | 94.4% | 94.7% | 92.1% | 95.9% | 122 |

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

| Tumour Site | Target | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | No of Treatments |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Brain | 85% | - | - | 100.0% | - | - | - | - | - | - | - | - | - | - | |
| Breast | 85% | 75.0% | 62.5% | 100.0% | 91.7% | 78.6% | 80.0% | 83.3% | 66.7% | 81.3% | 66.7% | 54.5% | 50.0% | 61.5% | 13 |
| Children's | 85% | - | - | - | - | - | - | - | - | - | - | - | - | - | 0 |
| Gynaecology | 85% | 50.0% | - | 50.0% | 75.0% | 40.0% | 60.0% | 50.0% | 100.0% | 66.7% | 40.0% | 55.6% | 16.7% | 40.0% | 2.5 |
| Haematology | 85% | 100.0% | 88.9% | 100.0% | 100.0% | 66.7% | 50.0% | 80.0% | 80.0% | 100.0% | 50.0% | 42.9% | 50.0% | 55.6% | 4.5 |
| Head & Neck | 85% | 52.9% | 57.9% | 83.3% | 90.9% | 46.7% | 70.6% | 50.0% | 86.7% | 58.3% | 36.4% | 56.5% | 47.4% | 25.0% | 12 |
| Lower Gastrointestinal | 85% | 60.0% | 33.3% | 33.3% | 75.0% | 46.2% | 66.7% | 18.2% | 61.5% | 70.6% | 75.0% | 75.0% | 46.2% | 50.0% | 4 |
| Lung | 85% | 50.0% | 73.3% | 100.0% | 90.9% | 100.0% | 62.5% | 25.0% | 100.0% | 66.7% | 70.6% | 70.0% | 100.0% | 55.6% | 4.5 |
| Skin | 85% | 87.1% | 88.9% | 92.6% | 78.8% | 87.9% | 78.8% | 76.5% | 74.1% | 89.5% | 72.7% | 77.5% | 75.9% | 70.0% | 15 |
| Upper Gastrointestinal | 85% | 50.0% | 71.4% | 33.3% | 60.0% | - | 100.0% | 100.0% | 25.0% | 0.0% | 50.0% | 0.0% | 100.0% | 50.0% | 2 |
| Urology | 85% | 57.6% | 73.3% | 70.8% | 56.5% | 45.8% | 47.8% | 69.2% | 55.6% | 58.1% | 81.3% | 54.1% | 62.9% | 58.1% | 15.5 |
| Other | 85% | - | 57.1% | 100.0% | 100.0% | - | 100.0% | 50.0% | 100.0% | 100.0% | 100.0% | 66.7% | 100.0% | 100.0% | 0.5 |

# 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.

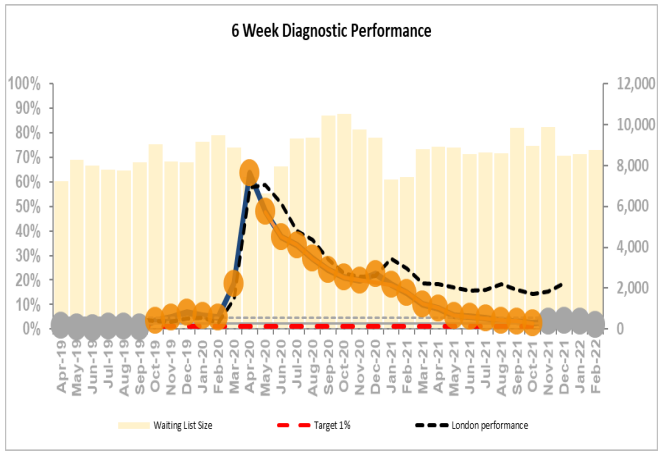
Rapid Diagnostic Centre (RDC) pathways and the Faster Diagnostic Standard (FDS) are designed to speed up cancer diagnosis and improve patient experience. They will also provide a mechanism to monitor and support the NHS Long Term Plan ambitions. Rapid Diagnostic Centre pathways ensures everyone with suspected cancer gets the right tests at the right time in as few visits as possible. The Trust has agreed an initial trajectory of 65% increasing to 75% by March 2022.

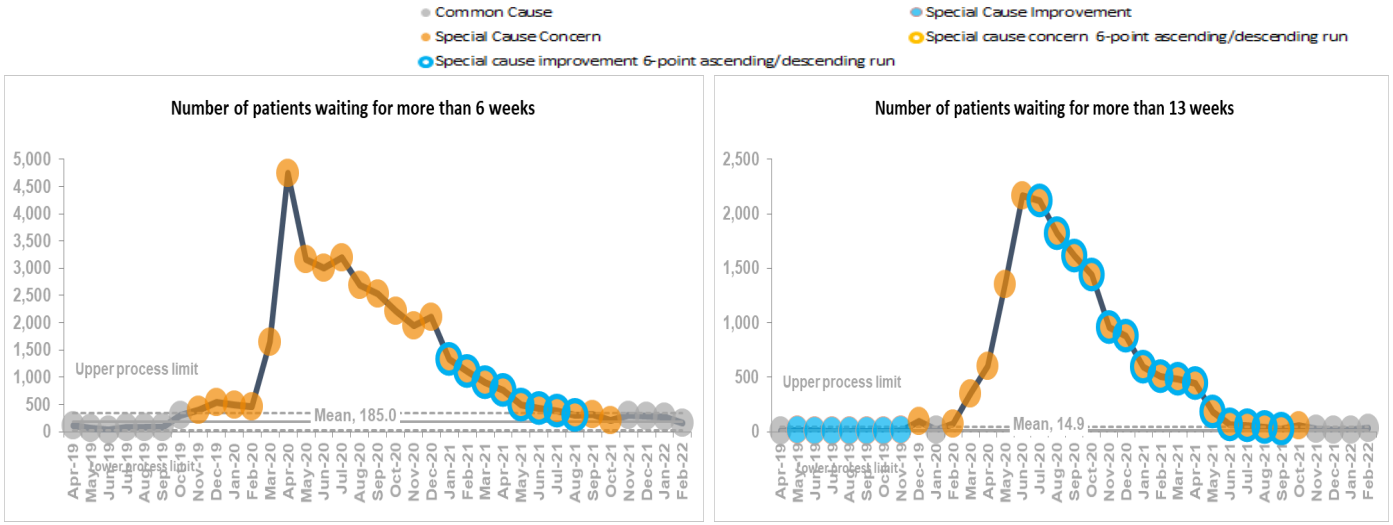
In January 56.5% of patient's received a communication of diagnosis for cancer or a ruling out of cancer, or a decision to treat if made before a communication of diagnosis within 28 days following referral. Performance was below the trajectory of 69%, however at the time of writing unvalidated performance for February was above 70%.

**Actions and Quality Improvement Projects**

- The trust is working towards achieving 70% by Q2 and 75% compliance by Q3 as agreed with the Alliance.
- **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.
- **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. Two additional validators have been appointed to support FDS validation and data quality.
- **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.
- **FDS champion** – Recruitment for a band 8a post is in progress 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 February, the Trust reported 1.8% of diagnostic patients waiting for more than six weeks. This is an improvement compared to the 3.1% reported at the end of January with 107 less patients waiting over six weeks. Performance remains much better than region; London's January performance was 18.1%.

The improved position has been heavily driven by a reduction in long waiters within Echocardiology, where the service is now compliant against the national target of 1%, this has been achieved with additional capacity throughout the month and tighter administrative processes including reminders to patients therefore maximising capacity.

Challenges within Cardiac MRI continue with capacity extremely limited with patients being booked into May sessions. In total, 96 patients were waiting for more than six weeks for a Cardiac MRI, this equates to 60% of the total breaches. Challenges are not unique to St George's.with patients being booked so far ahead the number of patients waiting above 13 weeks is seeing an increase.

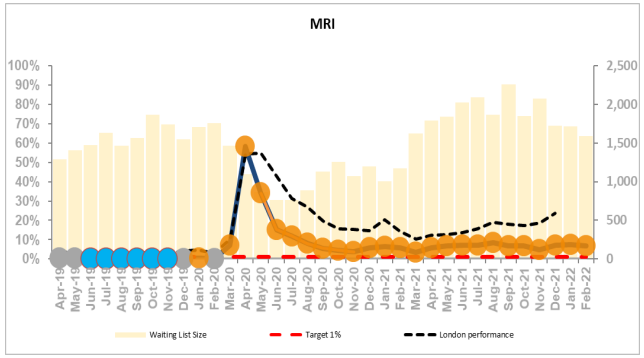
Endoscopy performance across all modalities is performing better than the London average however not achieving 1% target, current challenges are within Paediatrics where capacity remains an issue.

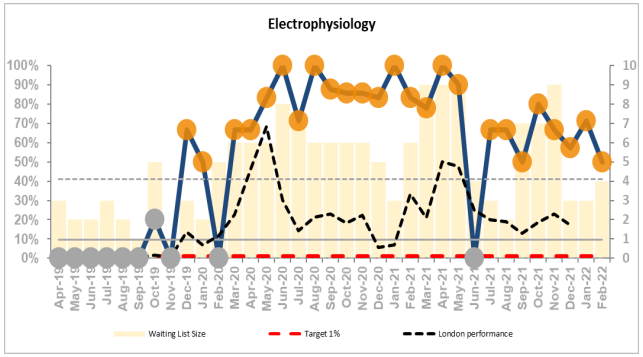
### Actions and Quality Improvement Projects

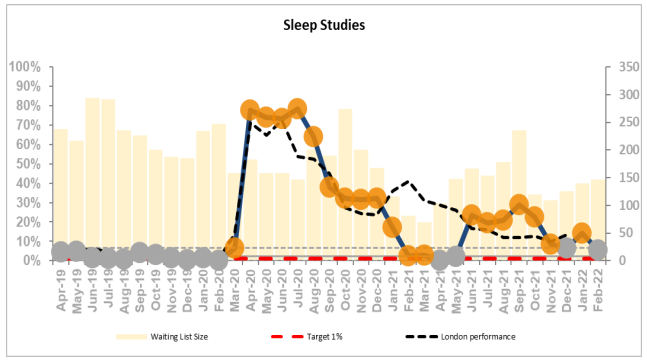
- Weekly performance meetings continue with particular focus on patients waiting for more than ten weeks. Divisional Director of Operations (DDO) support where areas are challenged.
- Cardiac MRI – Patients are now being booked into May capacity. All urgent patients are being clinically reviewed and moved around internal capacity to reduce their clinical risk . Admin teams are calling patients to limit the number of DNA's to maximise appointment slots. Challenges across London leaving options limited
- Paediatric Endoscopy - additional sessions have been requested throughout March pending anaesthetic staffing. Recovery business case to approve regular permanent schedules.

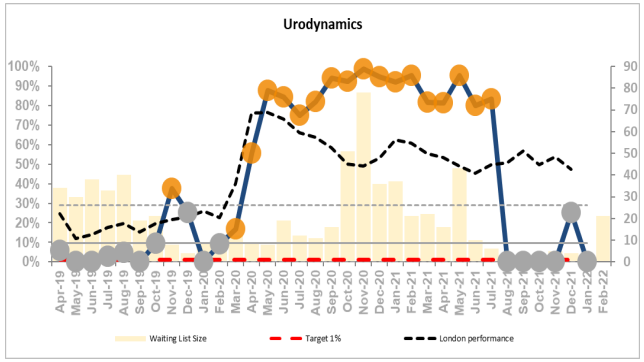
Our Process Perspective

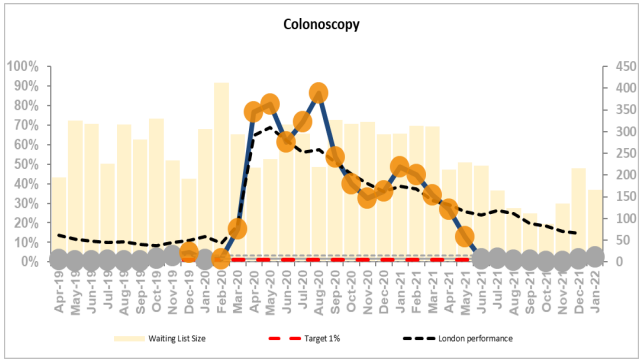
# Diagnostics – Modalities Not Meeting 1% Target

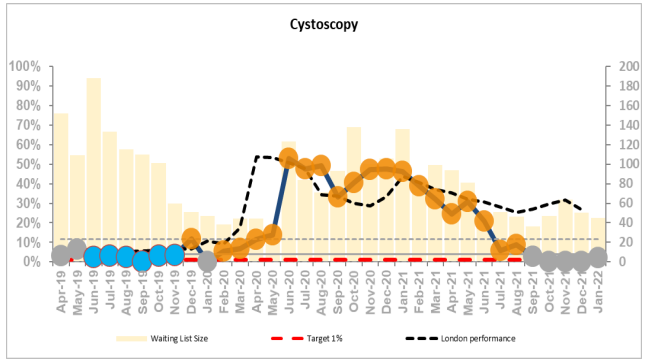


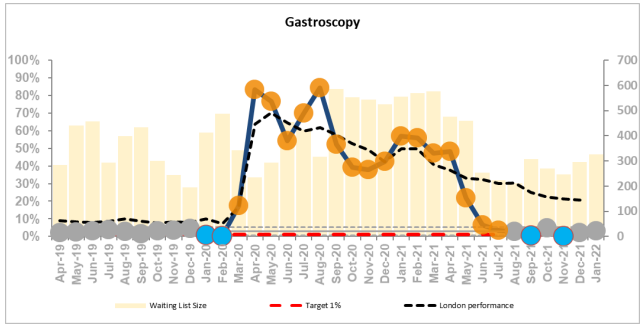



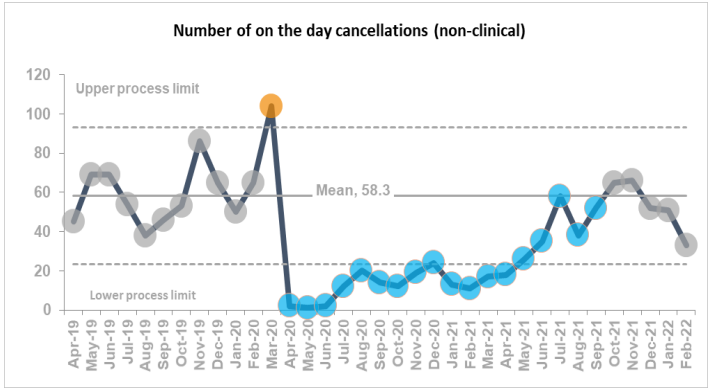



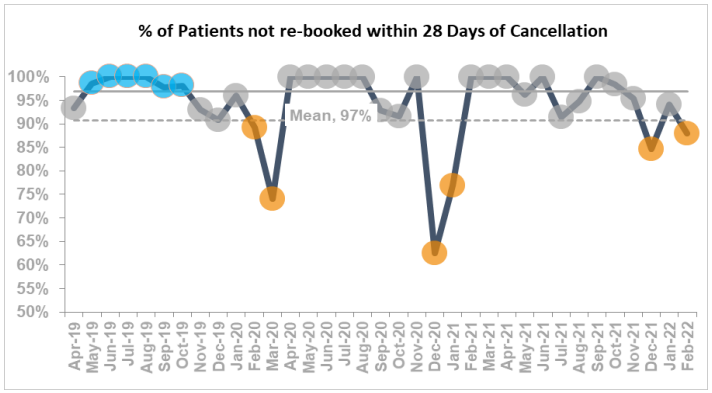



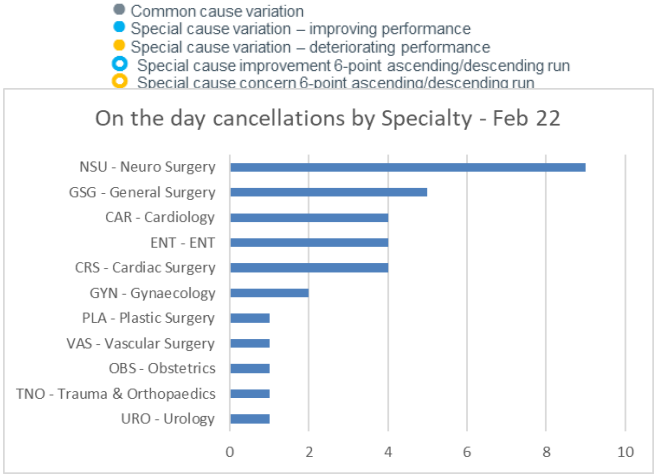




Our Process Perspective

# On the Day Cancellations for Non Clinical Reasons(OTD)




**What the information tells us**

In February, 33 patients had their procedure cancelled on the day for non-clinical reasons, this is an improved position compared to the 47 patients cancelled in January and below the mean of the 2019 baseline. Cancellations have been largely due to timing issues including emergency cases and complications with cases and staffing. Neurosurgery continues to be impacted by on-the-day cancellations with the largest proportion of on-the-day cancellations in the month; in total 9 patients were cancelled, a reduction from the 16 patients cancelled in January.

In total four patients were not re-booked within the required time frame of 28 days meaning that 87.9% of patients were re-booked against a target of 100%. Patients not re-booked were within Cardiology (2) due to GA capacity issues, Neurosurgery (1) capacity, ENT (1) Capacity.

Cancellation reasons for the month are broken down as follows:

- Staffing Availability – 7
- Timing - Emergency case took priority – 5
- Timing - Complication - previous case/-s – 4
- Timing - List cancelled / over booked - 4
- Equipment/Theatre - Equipment Issues – 3
- Bed Availability – 3
- Other - 8

**Actions and Quality Improvement Projects**

February saw the second **month-on-month reduction in OTD cancellations for non-clinical reasons** in a row and a **30% drop** compared with the previous month, January.

- This is partly attributable to the launch of a revamped OTD Cancellations for non-clinical reasons policy in January.
- The relaunch was focused on raising awareness of the escalation process, to ensure that unilateral decisions were not being taken without consultation with all colleagues capable of avoiding a cancellation.
- The new policy also widens the escalation protocol, to ensure that Divisional Silver, The Matron for Flow and Theatres and Anaesthetics Ops are simultaneously notified if there is a risk of OTDC for non-clinical reasons.
- The relaunch has coincided with a concerted comms push by operational and nursing leadership to emphasise the importance of escalating in a timely fashion to help maximise the chances of avoiding non-clinical OTDCs.

The main challenge remains flow and bed capacity. A number of interventions were launched last year to improve Recovery flow and reduce *avoidable* non-clinical OTDC. Following a review of the data, the initial signs of this work are encouraging:

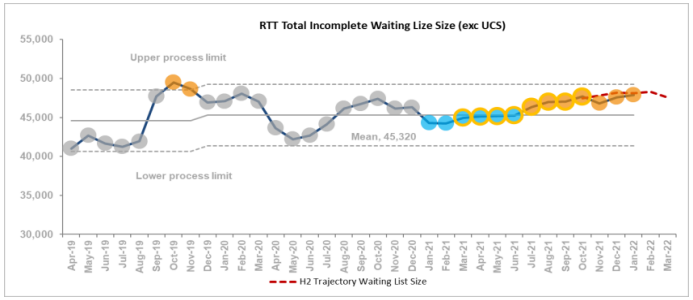
- **The time elapsed between patients in General SJW Recovery beds being 'ready to leave' recovery, and the patient actually leaving recovery, has more than halved**.
- Both PACU and SJW Recovery have seen substantial reductions in the LOS for patients 'Ready to Leave' (R2L) recovery.
- Cardiac has seen 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 are:
    1. Lack of Green Beds.
    2. Lack of ICU Beds.
    3. Flow delayed due to patients staying overnight in recovery.

A further intervention was launched in 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.

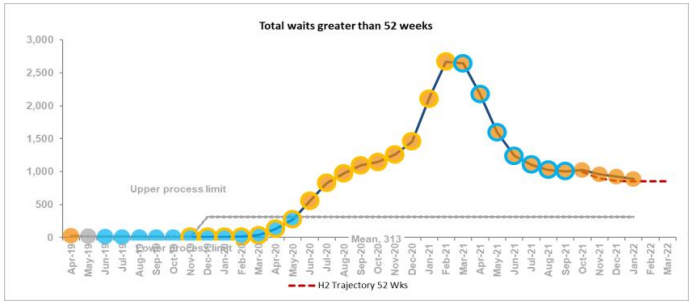
- Cancellations due to bed availability have fallen substantially in February (from 20 in January to just 3 in February).
- This is partly attributable to the new 'Yellow' SDL Discharge pathway.

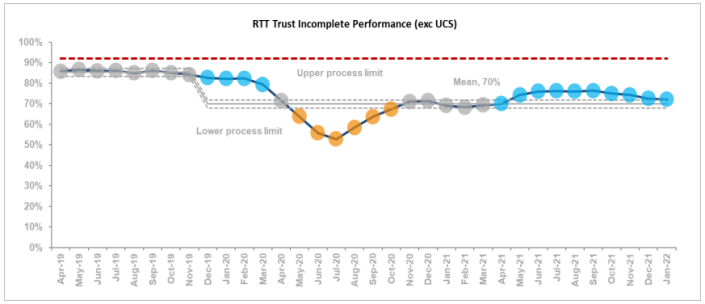
Our Process Perspective

# Referral to Treatment — January 2022








Note: Unknown Clock Starts (UCS) have been excluded from the above metrics. For context the number of UCS in January was 374, a decrease from 508 in December.

**Actions and Quality Improvement Projects**

- Total 104 week wait focus has continued, with 1 patient breaching this target at the end of January. There are two forecast breaches (both unavoidable) for the end of February, however we expect to meet the target of zero 104 week waits by the end of March
- The number of 78+ week waits and 52 week waits has decreased steadily throughout January 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 and eliminate 78 week breaches in all specialties other than Cardiology and General Surgery.
- Clock stop performance in January was better than December and ahead of the trajectory for admitted patients, however below for outpatients. This is linked to lower levels of outpatient activity at the start of January due to staffing challenge as a result of covid.
- Increased focus on solutions to support shorter waits for first outpatient appointments, particularly in ENT and General Surgery. This includes network and community solutions which will improve equity of access to timely care.
- Focus on increasing productivity at the Surgical Treatment Centre, so that we can deliver more activity and meet trajectory levels of activity. There is a recovery plan to double the throughput in 2022/23.

**What the information tells us**

The Trust continues to progress in reducing the number of long waiting patients on our Patient Tracking Lists (PTL).

At the end of January there were a total of 887 patients waiting for more than 52 weeks compared to 923 patients at the end of December - a favourable position against trajectory. The Trust is working towards having no patients breaching 52 weeks by the end of March 2022 with the exception of ENT, General Surgery, Cardiology and Plastics.

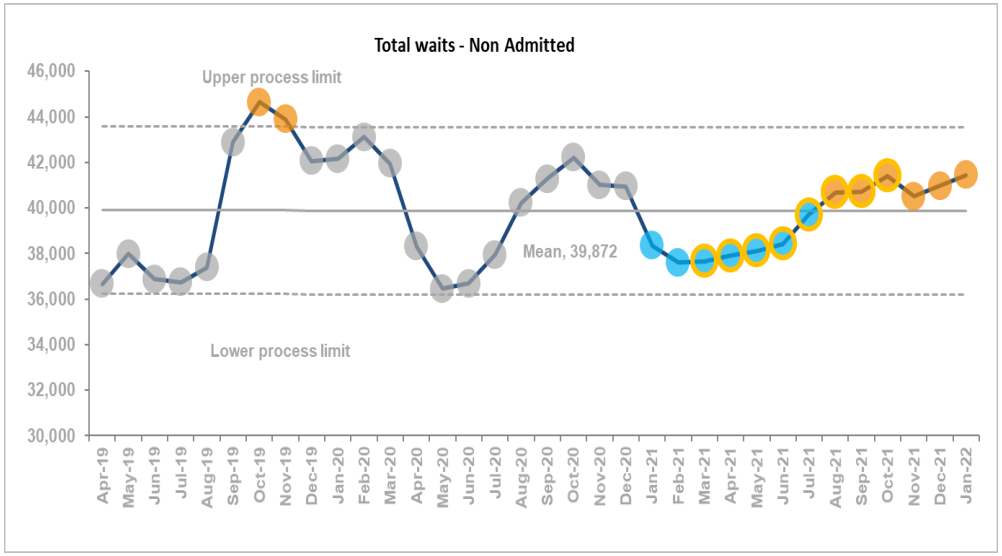
In total, 47,892 patients were waiting for treatment on the PTL keeping just above September levels as expected this month.

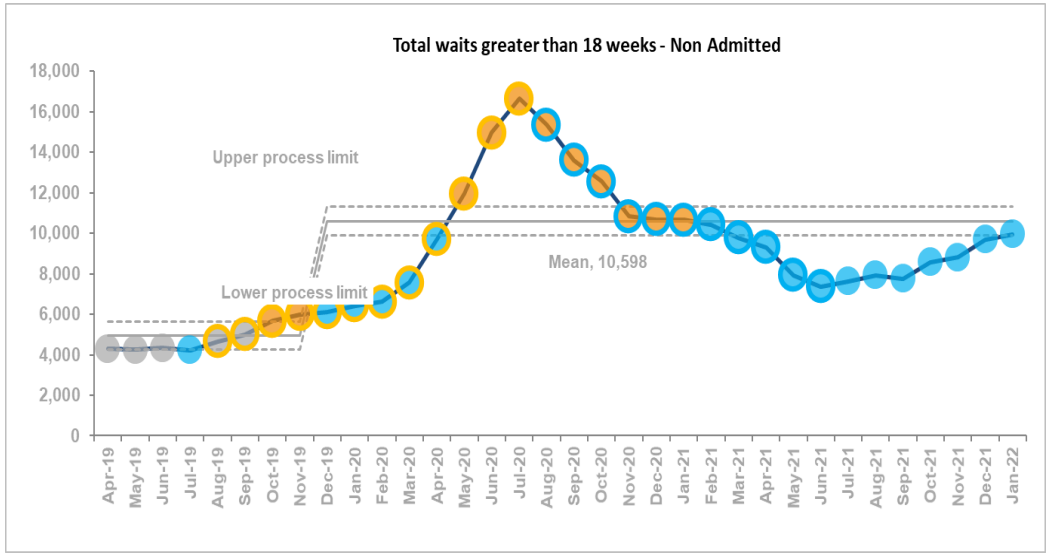
The total number of clock stops in the month was above H2 trajectory, ahead of trajectory for admitted pathway performance.

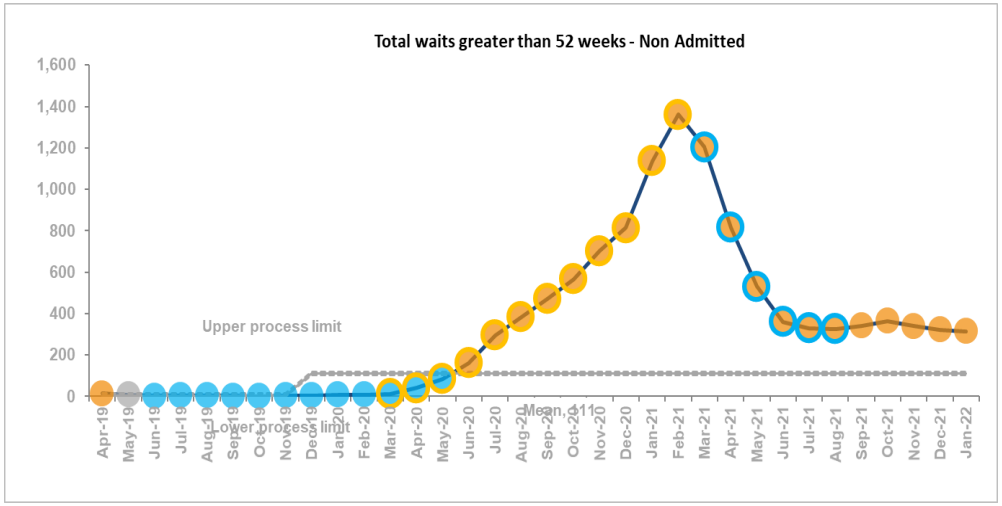
The number of patients on the non-admitted PTL waiting for more than 18 weeks continues below the mean although starting to see an upward trend. Compared to the previous month we have seen the number of patients waiting over 18 weeks increase by 2.5% (251 patients). At the end of January there were 315 patients waiting above 52 weeks, a reduction of 8 patients from December .

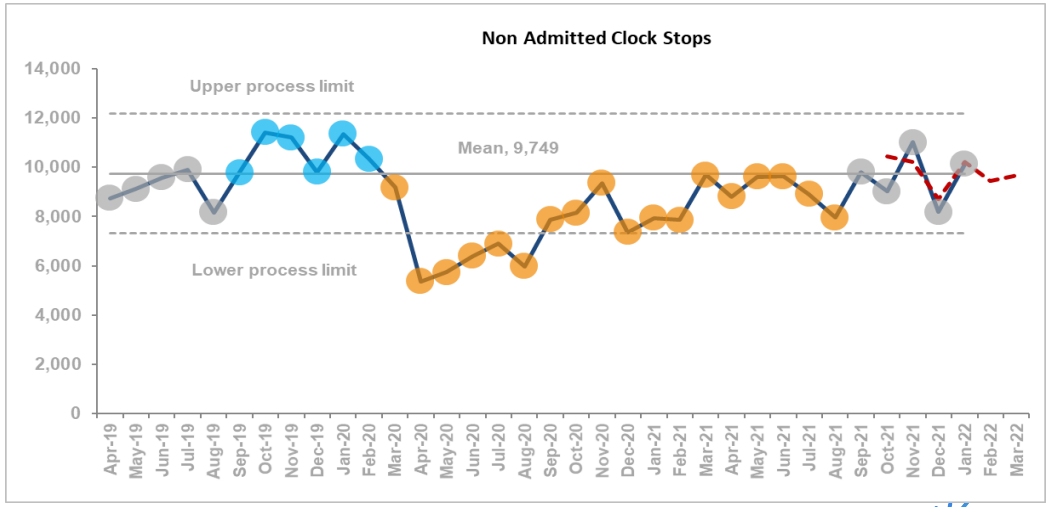
The total waiting list size for admitted patients remains above the upper control limit however January performance saw this reduce by 2.8% compared to the previous month with an increase in clock stops. Focus remains on long waiting patients and the number of patients waiting over 52 weeks continues to fall. In total, 572 patients were waiting with the highest proportion of waits within General Surgery and Cardiology.

# Referral to Treatment Non-Admitted Pathway — January 2022

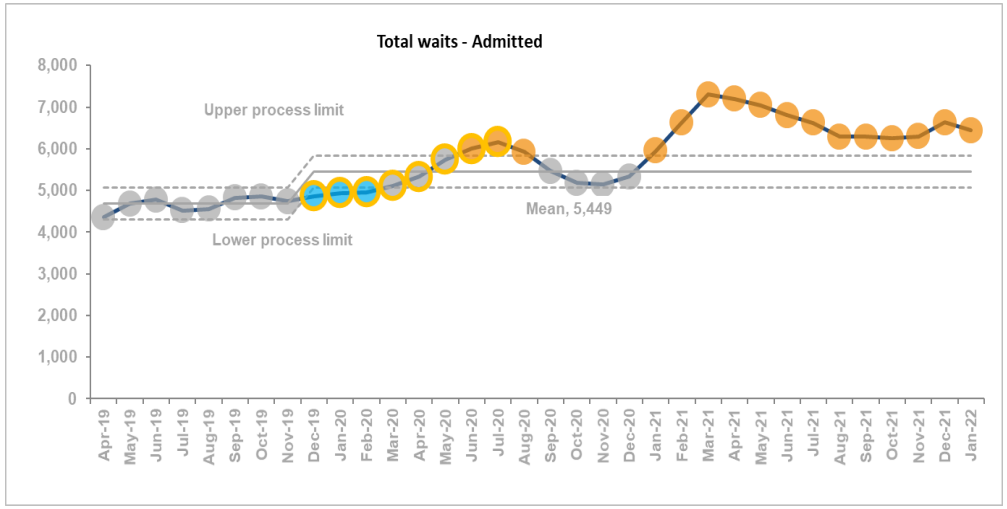


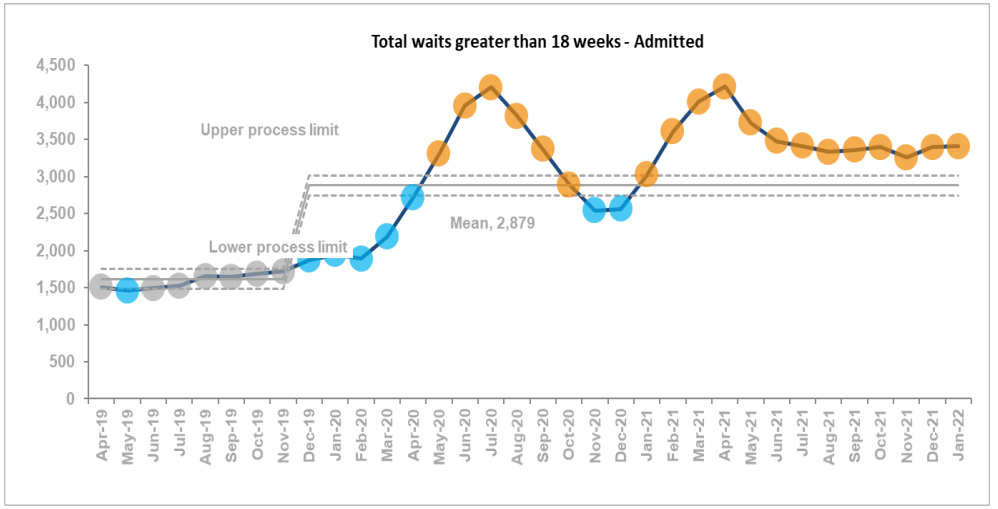



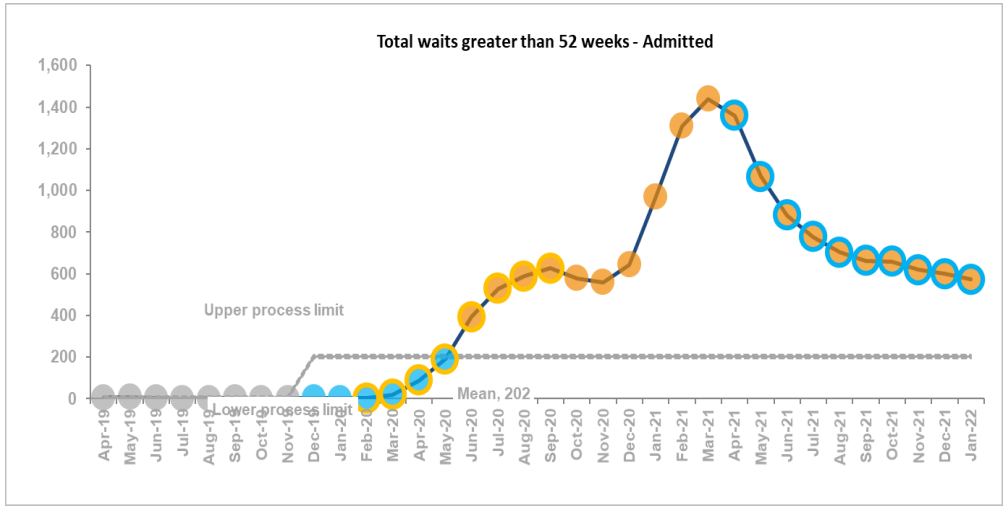



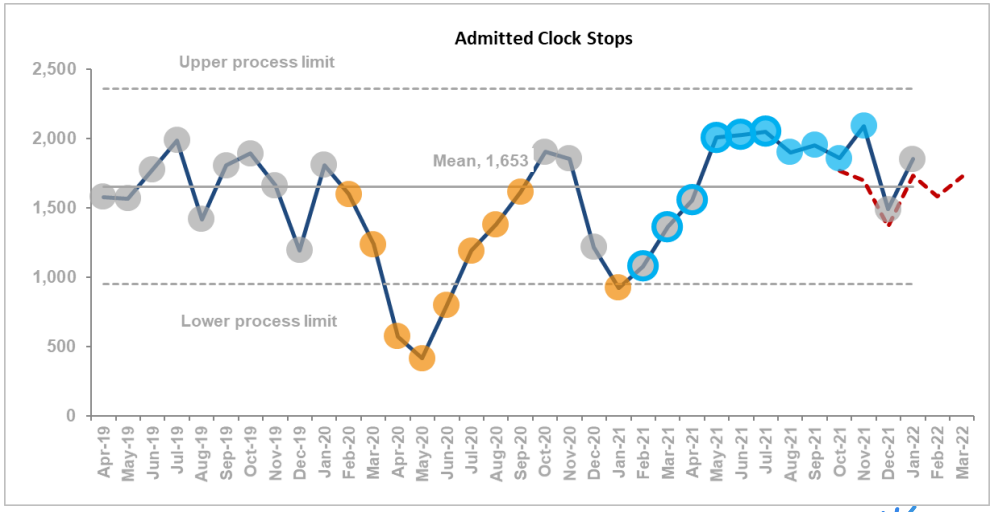



# Referral to Treatment Admitted Pathway — January 2022




Our Process Perspective

# Balanced Scorecard Approach

# Workforce

| Metric | Benchmark Average | Performance 12 months ago | Performance 3 months ago Nov-21 | Current Performance Feb 22 | Target | Distance to target | Current RAG Rating |
|---|---|---|---|---|---|---|---|
| Sickness | 4.0% | 3.6% | 4.7% | 4.4% | 3.2% | -1.2% | ✖ |
| Vacancy | 10.8% | 8.6% | 8.6% | 10.0% | 10.0% | 0.0% | ✓ |
| Turnover | | 14.7% | 15.4% | 16.8% | 13.0% | -3.8% | ! |
| Medical Appraisal | | 66.6% | 72.9% | 76.7% | 90.0% | -13.3% | ! |
| Non-Medical Appraisal | 72.0% | 65.6% | 73.9% | 75.1% | 90.0% | -14.9% | ! |
| MAST | 85.7% | 88.2% | 88.5% | 88.2% | 85.0% | +3.2% | ✓ |
| Stability | | 88.0% | 87.7% | 85.0% | 85.0% | 0.0% | ✓ |

**What the information tells us**

- The Trust's sickness absence rate is currently 4.4% and the target is to not exceed 3.2%, showing special cause deterioration.
- Vacancy Rate has increased this month to 10%, reaching the threshold of 10%.
- Trust turnover rate in February was 16.8% and is adverse to the target of 13%.
- Medical appraisal rates and non-medical appraisal rates continues to be non-compliant against the 90% target.
- Mandatory and Statutory Training (MAST) and Stability are both being achieved with performance at 88.2% and 85% respectively against a target of 85%.

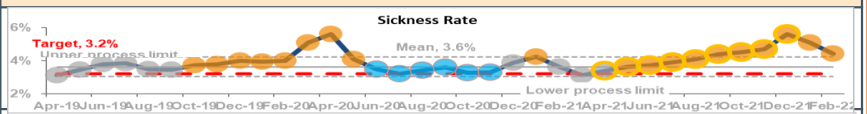
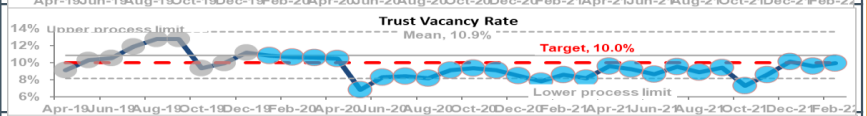
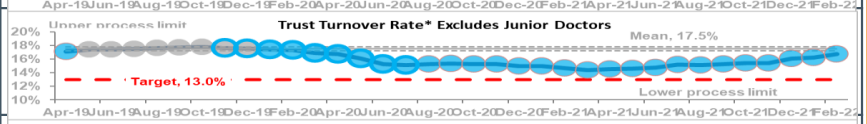
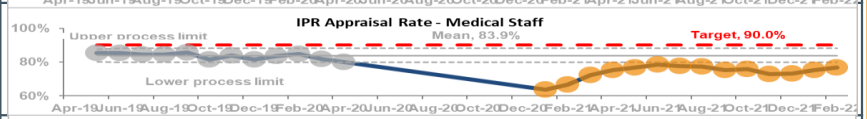
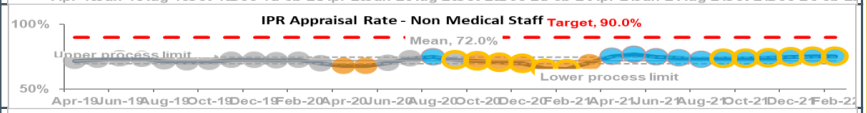
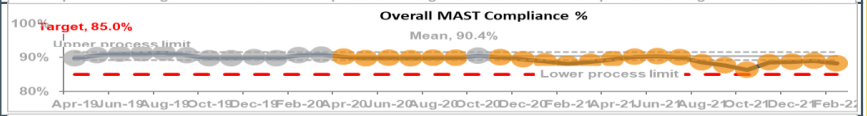
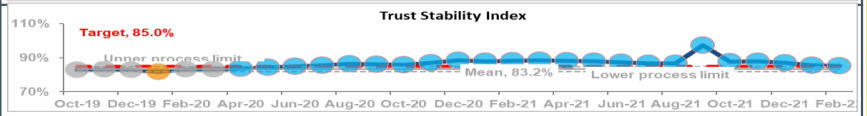
* Benchmark info is taken from Guy's & St Thomas', King's, Lewisham & Greenwich, Imperial, and UCLH.
* Turnover benchmarking isn't available as different Trusts calculate turnover in different ways

**Actions and Quality Improvement Project**

- MAST Compliance – Compliance as of 7th March is at 88%, a slight drop of 1% on last month. Junior Doctor training rotations have restarted which can impact on compliance levels due to "compliant" staff rotating out and lags to getting new starters through their training and into reporting processes.
- Temporary staffing remained a challenge during February, particularly during the half term and with a number of Tube strikes. The team are proactively calling both Agencies and Bank workers prior to shifts and also on the day.
- Stability – We are currently in the second phase of the Values into Action project, which is engaging the wider staff population through a values survey. We have had over 360 responses so far.
- The Trust has received the remainder of staff survey reporting and has distributed the Trust wide and Division reports. We have also consulted with Site Executive, Culture, Equity & Inclusion programme board and Divisions on our Big 5 and will be taking this back to the Site Executive for sign off.

# 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

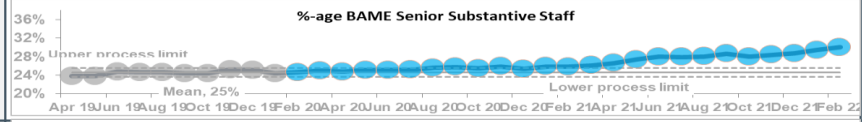
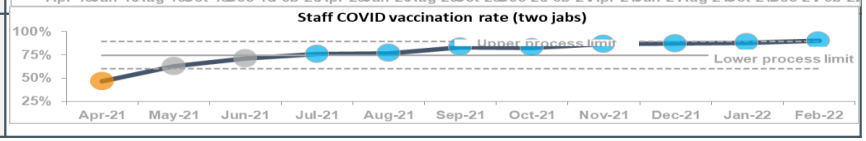
| | Metrics | Feb-22 | Target | Var to target | Trend |
|---|---|---|---|---|---|
| ✖ | Trust Level Sickness Rate | 4.4% | 3.2% | -1.2% |  |
| ✓ | Trust Vacancy Rate | 10.0% | 10% | 0.0% |  |
| ! | Trust Turnover Rate* Excludes Junior Doctors | 16.8% | 13% | -3.8% |  |
| ! | IPR Appraisal Rate - Medical Staff | 76.7% | 90% | -13.3% |  |
| ! | IPR Appraisal Rate - Non Medical Staff | 75.1% | 90% | -14.9% |  |
| ✓ | Overall MAST Compliance % | 88.2% | 85% | +3.2% |  |
| ✓ | Trust Stability Index | 85.0% | 85% | 0.0% |  |



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

| | Metrics | Feb-22 | Target | Var to target | Trend |
|---|---|---|---|---|---|
| ✓ | Internal Hire Rate (all bands) | 47% | 40% | +7.0% |  |
| NA | %-age BAME Senior Substantive Staff (Band 8 and up) | 30.0% | N/A | - |  |
| NA | Senior BAME Recruitment rate (Band 8 and up) | 34% | N/A | - |  |
| ✓ | COVID-19 Staff vaccination rate ( both Jabs) | 90% | 90% | 0% |  |



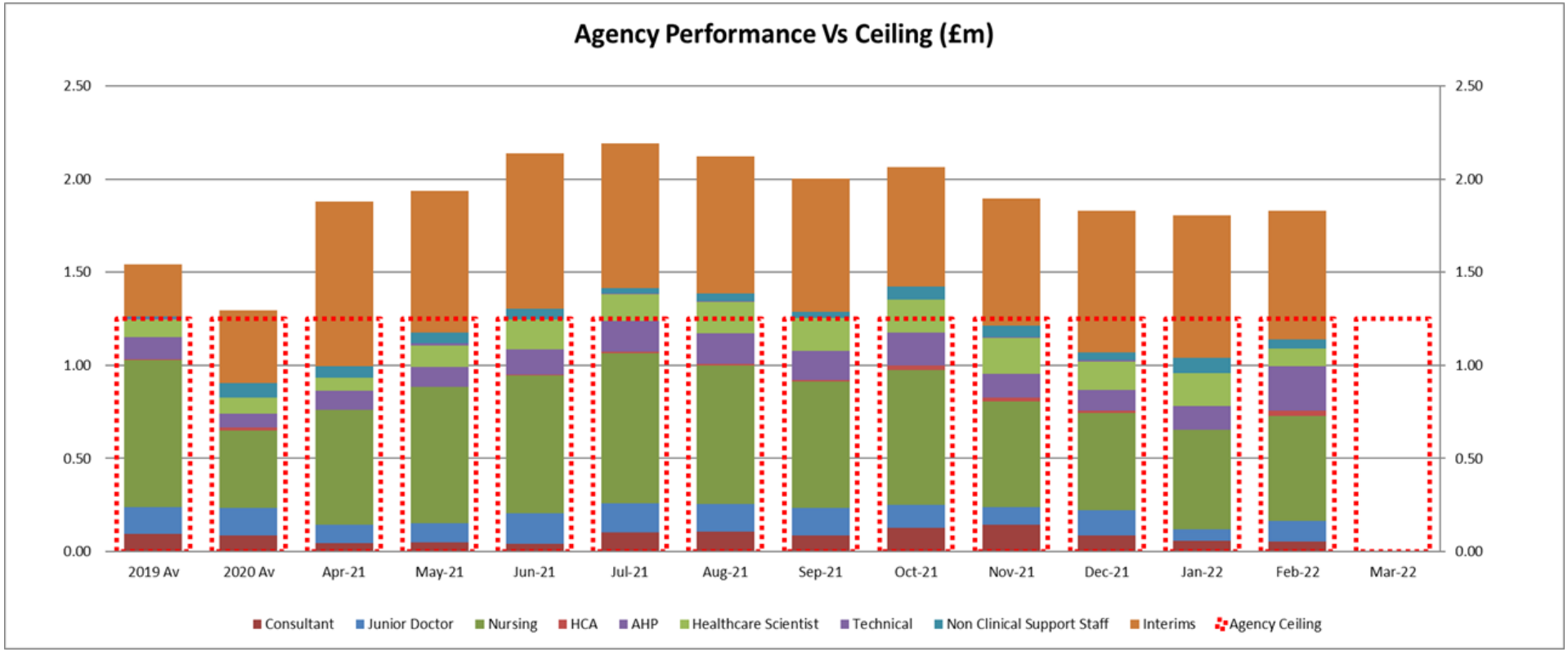
**What the information tells us**

- In February, the internal hire rate was 47% showing common cause variation.
- Of the Senior substantive staff (Band 8 and above) employed in the trust, Black and Minority Ethnic staff represent 30% of that group.
- The Senior BAME recruitment rate for staff 8 and above fell this month from 40.3% to 34%.
- At time of writing, the COVID-19 vaccination rate was 90%.

**Actions and Quality Improvement Project**

- 5 International nurses landing on 10th March.140 new starters with booked start date so far, this will increase. NQN and HCA campaigns on going.
- Analysis of Recruitment Inclusion Specialist Annual Experience Survey 2021/22 results and compliance for 21/22 findings and next steps reported via People Management Group and Workforce Executive Committee. Streamlined documentation, provided updated guidance and developed a monthly reporting template for SWL Hub
- Monthly compliance report now due by first Friday of each month with named lead at SWL Hub Agreed quarterly performance review/discussion with SWL Hub moving forwards
- There is an active communication plan promoting vaccinations for all staff.

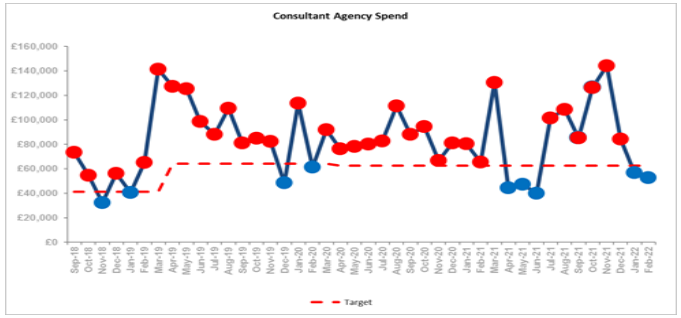
## Agency use

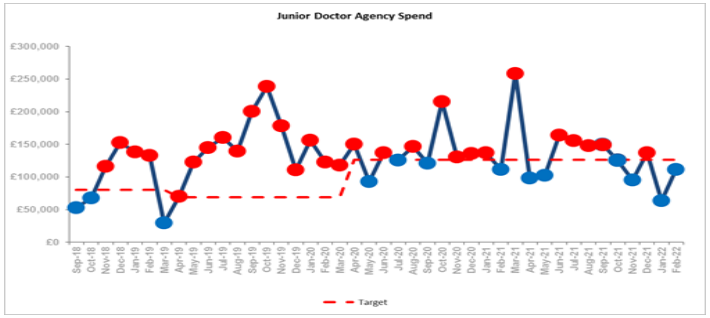


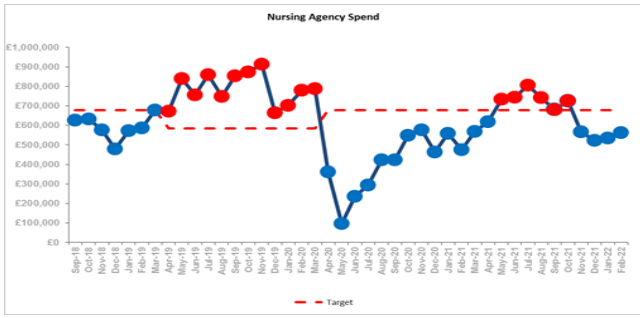

- The Trust's total pay for February was £52.09m. This is £0.31m adverse to plan of £51.78m
- There is an internal annual agency target of £15.00m
- Agency cost was £1.83m or 3.5% of the total pay costs. For 2020/21, the average agency cost was 2.5% of total pay costs
- For February, the monthly target set is £1.25m. The total agency cost is worse than the target by £0.58m
- The biggest areas of overspend were Interims (£0.52m) and AHP (£0.13m).The biggest areas of underspend were Nursing (£0.11m)

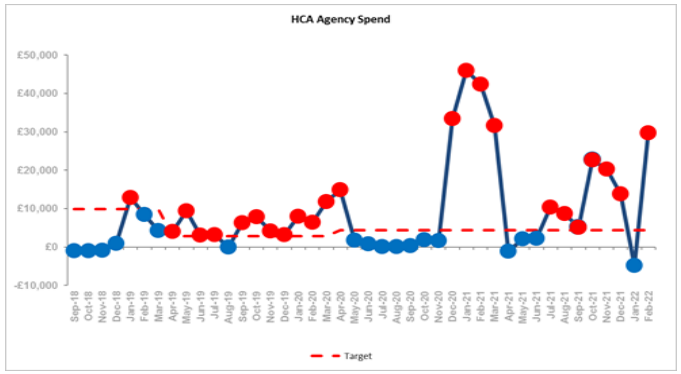
# Agency use

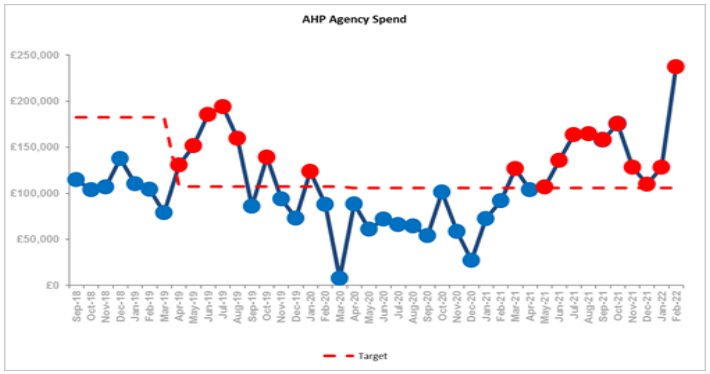
Below cap
Above cap

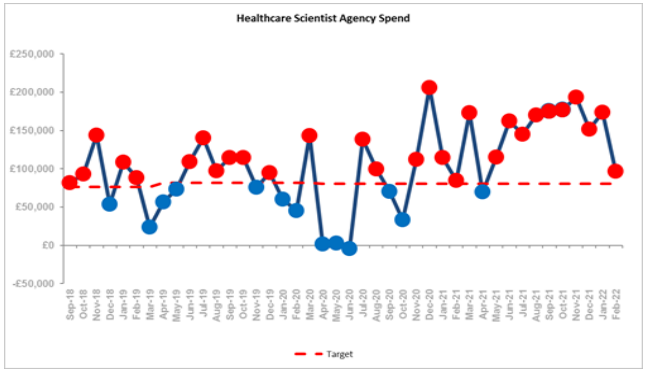


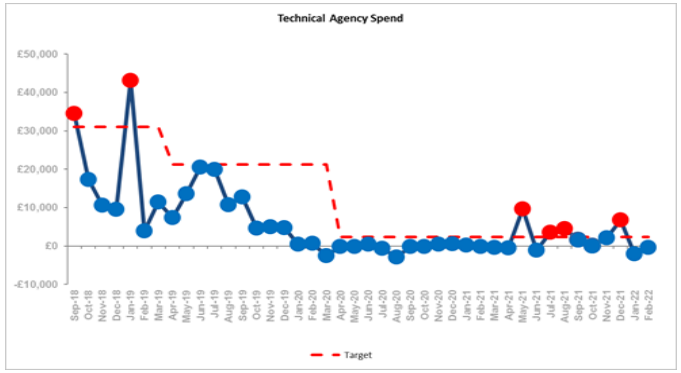



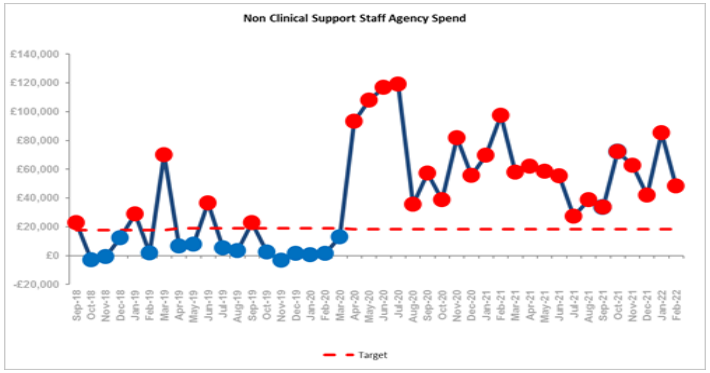



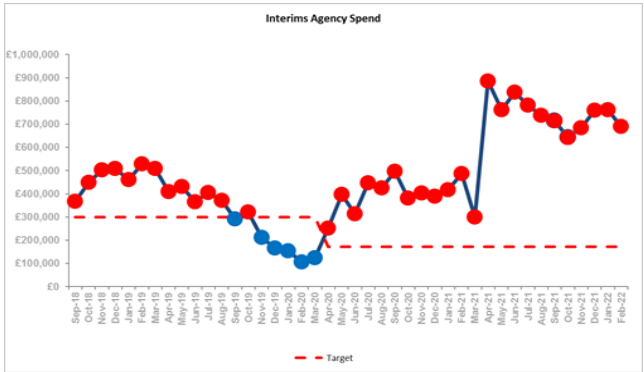



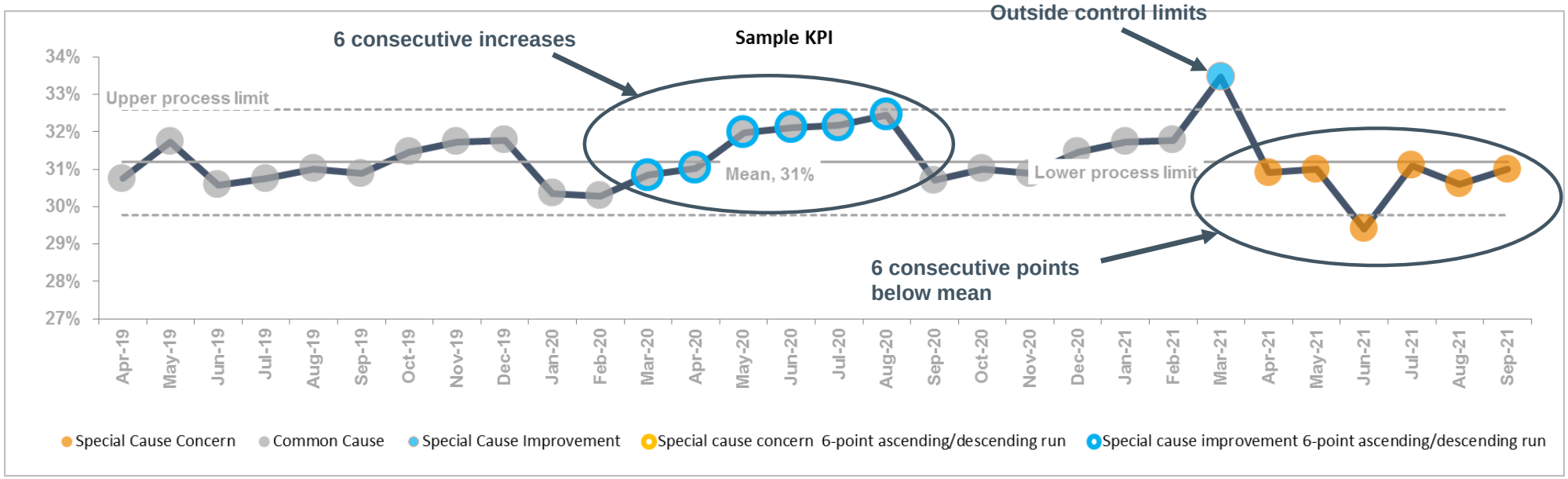




Our People Perspective

# Appendix
## Additional Information

# Interpreting SPC (Statistical Process Control) Charts




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

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

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

# RTT Performance – January 2022

| Indicator Description | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| RTT Trust Incomplete Performance (exc UCS) | 69.1% | 68.3% | 69.3% | 70.0% | 74.2% | 76.0% | 76.2% | 76.0% | 76.3% | 74.9% | 74.2% | 72.5% | 72.1% |
| RTT Total Incomplete Waiting Lize Size (exc UCS) | 44,291 | 44,236 | 44,960 | 45,109 | 45,156 | 45,242 | 46,319 | 46,977 | 47,014 | 47,667 | 46,802 | 47,601 | 47,892 |
| Total waits greater than 18 weeks (exc UCS) | 13,695 | 14,027 | 13,801 | 13,522 | 11,662 | 10,850 | 11,044 | 11,263 | 11,121 | 11,969 | 12,070 | 13,093 | 13,357 |
| Total waits greater than 52 weeks | 2,108 | 2,671 | 2,644 | 2,174 | 1,597 | 1,240 | 1,106 | 1,028 | 1,005 | 1,023 | 959 | 923 | 887 |
| RTT Incomplete Performance - Admitted | 49.2% | 45.6% | 45.1% | 41.4% | 47.1% | 48.9% | 48.4% | 47.0% | 46.6% | 45.7% | 48.3% | 48.8% | 47.1% |
| Total waits - Admitted | 5,950 | 6,634 | 7,301 | 7,193 | 7,045 | 6,809 | 6,619 | 6,291 | 6,293 | 6,250 | 6,299 | 6,630 | 6,442 |
| Total waits greater than 18 weeks - Admitted | 3,025 | 3,608 | 4,013 | 4,213 | 3,724 | 3,476 | 3,415 | 3,335 | 3,362 | 3,396 | 3,258 | 3,396 | 3,409 |
| Total waits greater than 52 weeks - Admitted | 971 | 1,310 | 1,439 | 1,359 | 1,067 | 880 | 777 | 702 | 663 | 658 | 619 | 600 | 572 |
| RTT Incomplete Performance -Non Admitted | 72.2% | 72.3% | 74.0% | 75.4% | 79.2% | 80.8% | 80.8% | 80.5% | 80.9% | 79.3% | 78.2% | 76.3% | 76.0% |
| Total waits - Non Admitted | 38,341 | 37,602 | 37,651 | 37,916 | 38,111 | 38,433 | 39,700 | 40,686 | 40,721 | 41,417 | 40,503 | 40,971 | 41,450 |
| Total waits greater than 18 weeks - Non Admitted | 10,670 | 10,419 | 9,788 | 9,309 | 7,938 | 7,374 | 7,629 | 7,928 | 7,759 | 8,573 | 8,812 | 9,697 | 9,948 |
| Total waits greater than 52 weeks - Non Admitted | 1,137 | 1,361 | 1,205 | 815 | 530 | 360 | 329 | 326 | 342 | 365 | 340 | 323 | 315 |

Note: Unknown Clock Starts (UCS) have been excluded from the above metrics. For context the number of UCS in January was 374, a decrease from 508 in December.

# RTT Performance – January 2022

| 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 | 419 | 9.1% | 1,365 | 68.1% | 968 | 816 | 1,784 | 54.3% | 104 | 176 |
| Urology Service | 490 | 67.6% | 1,443 | 89.2% | 1,618 | 315 | 1,933 | 83.7% | 20 | 36 |
| Trauma and Orthopaedics Service | 235 | 53.6% | 1,703 | 81.7% | 1,518 | 420 | 1,938 | 78.3% | 15 | 7 |
| Ear Nose and Throat Service | 530 | 52.5% | 4,338 | 65.1% | 3,100 | 1,768 | 4,868 | 63.7% | 210 | 158 |
| Ophthalmology Service | | | 125 | 78.4% | 98 | 27 | 125 | 78.4% | 2 | 2 |
| Oral Surgery Service | 244 | 39.8% | 609 | 82.9% | 602 | 251 | 853 | 70.6% | 27 | 18 |
| Neurosurgical Service | 240 | 63.8% | 2,261 | 66.4% | 1,654 | 847 | 2,501 | 66.1% | 59 | 28 |
| Plastic Surgery Service | 658 | 45.4% | 712 | 82.6% | 887 | 483 | 1,370 | 64.7% | 51 | 65 |
| Cardiothoracic Surgery Service | 69 | 1 | 142 | 1 | 183 | 28 | 211 | 86.7% | 1 | 0 |
| General Internal Medicine Service | | | 33 | 30.3% | 10 | 23 | 33 | 30.3% | 0 | 0 |
| Gastroenterology Service | 382 | 87.2% | 3,503 | 63.8% | 2,567 | 1,318 | 3,885 | 66.1% | 20 | 1 |
| Cardiology Service | 1,501 | 39.0% | 3,127 | 79.4% | 3,069 | 1,559 | 4,628 | 66.3% | 177 | 186 |
| Dermatology Service | 6 | 83.3% | 2,370 | 81.2% | 1,930 | 446 | 2,376 | 81.2% | 4 | 0 |
| Respiratory Medicine Service | 4 | 100.0% | 1,288 | 86.8% | 1,122 | 170 | 1,292 | 86.8% | 1 | 0 |
| Neurology Service | 27 | 81.5% | 2,652 | 76.1% | 2,041 | 638 | 2,679 | 76.2% | 23 | 17 |
| Rheumatology Service | | | 749 | 76.1% | 570 | 179 | 749 | 76.1% | 3 | 0 |
| Elderly Medicine Service | | | 92 | 64.1% | 59 | 33 | 92 | 64.1% | 1 | 0 |
| Gynaecology Service | 218 | 56.9% | 1,524 | 90.1% | 1,497 | 245 | 1,742 | 85.9% | 11 | 2 |
| Other – Medical Services | 144 | 72.9% | 7,435 | 78.5% | 5,941 | 1,638 | 7,579 | 78.4% | 36 | 14 |
| Other – Paediatric Services | 580 | 41.9% | 2,445 | 84.3% | 2,304 | 721 | 3,025 | 76.2% | 62 | 28 |
| Other – Surgical Services | 629 | 30.8% | 2,687 | 75.4% | 2,221 | 1,095 | 3,316 | 67.0% | 119 | 126 |
| Other – Other Services | 66 | 45.5% | 847 | 64.5% | 576 | 337 | 913 | 63.1% | 31 | 23 |
| **Grand Total** | **6,442** | **47.1%** | **41,450** | **76.0%** | **34,535** | **13,357** | **47,892** | **72.1%** | **977** | **887** |

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 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Compliance with appropriate response to EWS (Adults) | 100% | 92.8% | 89.9% | 88.0% | 88.0% | 91.0% | 92.3% | 91.6% | 96.9% | 88.5% | 89.7% | 78.5% | 93.1% | 92.9% |
| Number of EWS Patients (Adults) | | 360 | 553 | 483 | 581 | 443 | 531 | 429 | 479 | 532 | 507 | 480 | 362 | 434 |

Outstanding care every time

St George's University Hospitals NHS Foundation Trust

| | | | |
|---|---|---|---|
| **Meeting Title:** | Trust Board | | |
| **Date:** | 31 March 2022 | **Agenda No** | **2.3** |
| **Report Title:** | Health and Safety/Non Clinical Risk Group update. | | |
| **Lead Director/ Manager:** | Andrew Grimshaw | | |
| **Report Author:** | Alan Clark | | |
| **Presented for:** | Assurance | | |
| **Executive Summary:** | This report provides a detailed summary of the key health and safety/ non-clinical risk activity over the past 3 months:<br>1. Health and Safety/Non-Clinical Risk Group highlights and key themes<br>2. Introduces the development of a new three-year health and safety strategy<br>3. Update on the new NHS Violence Prevention and Reduction Standard and the work of the Violence Prevention and Reduction Group<br>4. Update on Fit Testing of staff for respiratory masks<br>5. Findings of the TIAA Health and Safety Management audit (reasonable assurance)<br>6. Findings of the external Fire Safety Management report (reasonable assurance) | | |
| **Recommendation:** | For review, assurance, and any comments | | |
| **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.<br>• **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.<br>• **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.<br>• **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.<br>• **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:** | Strategic Risk 7: 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 | | |
| **CQC Theme:** | Safe Well Led | | |
| **Single Oversight Framework Theme:** | N/A | | |
| **Implications** | | | |
| **Risk:** | Failure to provide a safe environment for our patients and staff. | | |
| **Legal/Regulatory:** | Health and Safety at Work etc. Act 1974 | | |
| **Resources:** | N/A | | |
| **Equality and Diversity:** | N/A | | |
| **Previously Considered by:** | Quality and Safety Committee | **Date** | 24 Mar 22 |
| **Appendices:** | Enclosure 1. Violence prevention and reduction standard report<br>Enclosure 2. Violence briefing paper<br>Enclosure 3. Fire Safety Audit Summary | | |

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

# Health and Safety/ Non Clinical Risk Report


**Alan Clark**
Assistant Director of Health & Safety, Fire and Security

March 2022

## Health & Safety / Non Clinical Risk Report

This report provides a detailed summary of the key health and safety/ non clinical risk activity over the past 3 months:

1. Health and Safety/Non Clinical Risk Group highlights and key themes
2. Introduces the development of a new three year health and safety strategy
3. Update on the new NHS Violence Prevention and Reduction Standard and the work of the Violence Prevention and Reduction Group
4. Update on Fit Testing of staff for respiratory masks
5. Findings of the TIAA Health and Safety Management audit
6. Findings of the external Fire Safety Management report

## Health & Safety Executive Interventions/Enquiries

There are currently no Health and Safety Interventions/Enquiries

## Health and Safety/Non-Clinical Risk Group



Highlights from the last 3 months meetings

- Respiratory masks for COVID-19: following a recent National Patient Safety Alert (NatPSA/2021/009/NHSPS) regarding the use of valved respirators and hoods and the IPC risks associated with non-filtered exhaled breath; it has been decided by Corporate Nursing, in consultation with IPC, H&S, to withdraw all valved respirators and limit the use of powered hoods to where a fit test cannot be achieved with the current disposable FFP3 masks.
- Lone worker devices – withdrawal of redundant/not used devices and trial of a lone worker app on Trust mobile phones.
- Violence prevention and reduction group – concerns raised with the increased levels of violence and aggression and current prevalence of weapons/knifes in emergency care.

## Health and Safety/Non-Clinical Risk Group

Highlights from the last 3 months meetings

- Wellbeing Report – overview of winter workforce wellbeing plan
- Concerns raised and discussed with regard to fire risks around smoking on site near sources of ignition and staff wellbeing issues around smoking.
- Fire Safety – Causes of false alarms discussed with the three main causes being aerosols, contractors and patients/visitors accidently activating fire alarm to exit wards/departments
- Sharps and Splashes Group has been reformed – importance of engagement from clinicians and the medical divisions clearly emphasised.

## Health and Safety/Non-Clinical Risk Group



Highlights from the last 3 months meetings

- Updated fire risk register entries tabled and discussed for Lanesborough Wing and St James Wing
- Policies currently under review and/or out to consultation: Sharps and Splashes, COSHH, Dermatitis Policy, Helipad Operational Policy, Security Policy and the Control of Contractors Policy (extended for 3 months)
- Home Working Policy – new additions in light of recommendations from a TIAA audit of the current policy

## Health and Safety/Non-Clinical Risk Group

Highlights from the last 3 months meetings

- Annual waste report highlighting: the planned introduction of ‘Sharpsmart’ re-usable sharps boxes which aims to reduce sharps disposal injuries, reduce waste, and save on costs and offset C02 omissions; and the recycling of food waste converted into renewable energy, last month this helped produce enough energy to provide approximately 4 UK households with electricity for one month and saving 601kg of CO2 per month.
- Health and Safety report highlighting increased demand for fit testing and the recent TIAA Health and Safety report. (see separate slide for further info)

## Health and Safety/Non-Clinical Risk Group



Highlights from the last 3 months meetings

- Fire report highlighting the provision of bariatric evacuation mats and improvements in fire training attendance especially face to face training.
- Wellbeing report highlighting the ‘take a break campaign’ and ensuring the basic needs of staff are met which is of vital importance to providing safe, effective patient care.
- Trade union report.
- Violence prevention and reduction standards review and violence risk review papers (see separate slides on VPR update).
- External Fire Safety Audit report  (see separate slide for further info).
- Procedural Justice/Rapport building presentation by Head of Health & Safety

## Health and Safety/Non-Clinical Risk Group

# New Health and Safety Strategy for 2022 to 2025

The proposed 2022 to 2025 draft Health and Safety Strategy is to be sent out for Trust wide consultation and approval in March 2022 following discussion and agreement at the March Health and Safety/Non-Clinical Risk Group

- This three-year Health and Safety strategic plan seeks to positively contribute and compliment the St George's University Hospitals NHS Foundation Trust's 2019 - 2024 corporate strategy and our ambition to provide outstanding care, every time for our patients.
- The Health and Safety of our staff, patients and other stakeholders, is central to the delivery of our services. Our intention is to deliver Health and Safety, through an effective management system of "Plan, Do Check Act," improving the quality of what we do and enabling our staff to deliver and share good practice and learn from situations and issues we encounter, that require improvement.
- We want our staff, patients, buildings and activities to be as safe as they can be and nurture and develop positive changes as the trust flexes, adapting to the future demands upon its services.

# Health and Safety/Non-Clinical Risk Group
## Key Themes/ Matters for Escalation

### Violence Prevention and Reduction Standard

The NHS violence prevention and reduction standard (VPRS) were published in December 2020 by NHS England and Improvement (NHSE&I). It is a requirement of the 2021/22 NHS standard contract that all NHS organisations should have regard to the VPRS and are required to review their status against it and **provide board assurance that the standards have been met twice a year.** Commissioners are also expected to undertake compliance assessments, twice a year as a minimum or quarterly if significant concerns are identified and raised.

On the 24 June 2021 the Assistant Director of Health & Safety, Fire and Security was contacted by NHSE&I asking for formal confirmation who the executive and operational lead for violence prevention and reduction is for St Georges University Hospitals NHS Foundation Trust. On the 7 July 2021 NHSE&I were informed that the designated executive lead in the Trust is Andrew Grimshaw, Deputy Chief Executive and Chief Finance Officer, and the operational lead is Alan Clark, Assistant Director of Health & Safety Fire and Security.

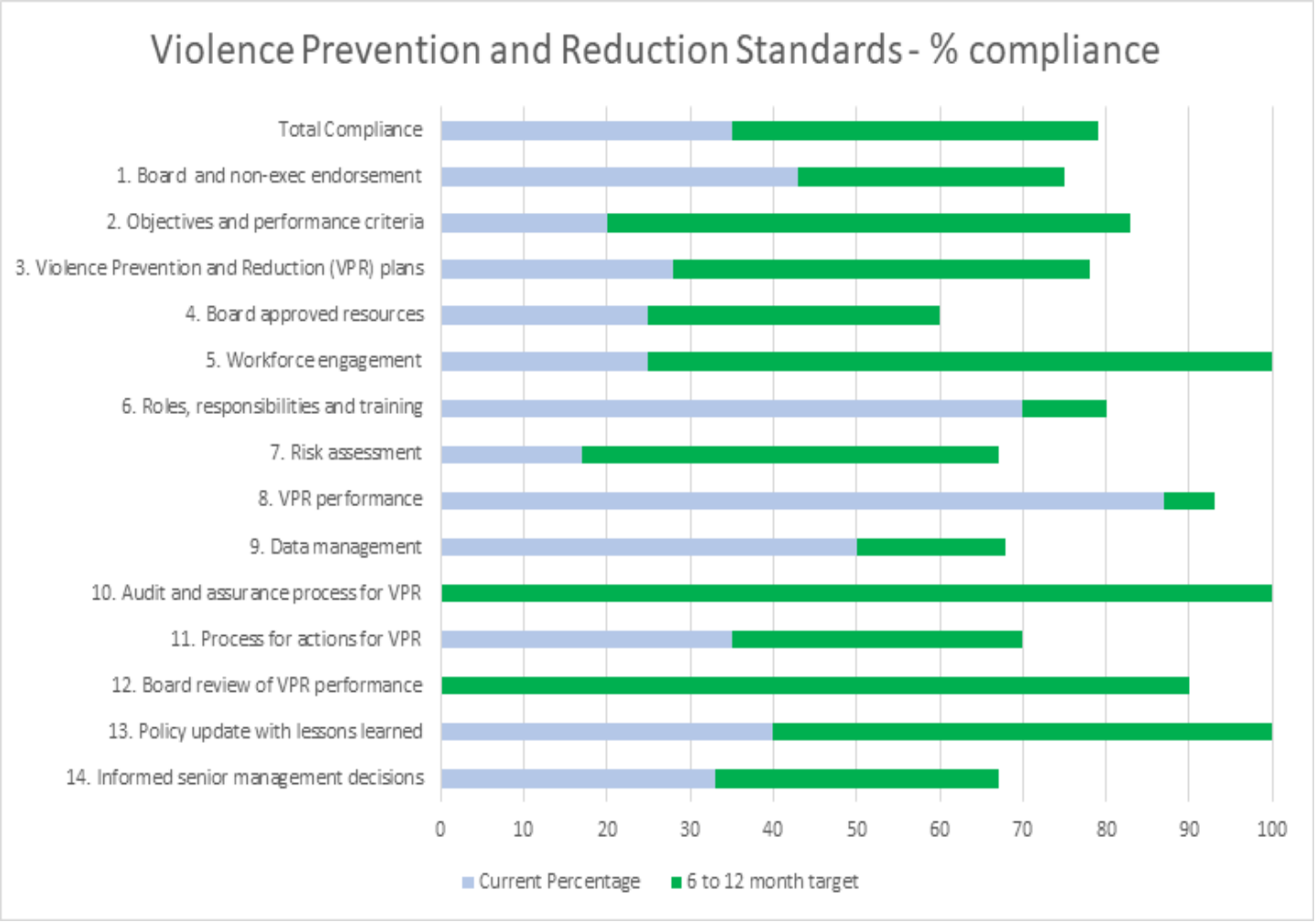
The VPRS are presented within the PLAN, DO, CHECK, ACT model for continual improvement. They include 14 aims which are accompanied by a total of 43 process indicators.

# Health and Safety/Non-Clinical Risk Group
## Key Themes/ Matters for Escalation

### Violence Prevention and Reduction Standard continued

- Violence Prevention and Reduction Standard briefing paper presented (**enclosure 1**) to Health and Safety/ Non Clinical Risk Group and the new Violence Prevention and Reduction Group in November 2021.
- Briefing paper includes a proposed compliance dashboard highlighting were the Trust is currently and the planned level of compliance to be achieved within a 6 to 12 month period.
- Draft VPR Strategy in progress to be completed for consultation end of April 2022 with Policy review and update in May 2022.
- Full stakeholder engagement in VPR Group including divisional nursing, patient safety, security, Health and Safety, Mast and eLearning manager, trade unions, Freedom to Speak up Guardian, Mental Health Lead, Diversity and Inclusion Leads, Women's Lead, local police representative, etc.
- See **enclosure 2** for report on the current and emerging violence risk profile St George's.

# Violence Prevention and Reduction - dashboard

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# Health and Safety/Non-Clinical Risk Group
## Key Themes/ Matters for Escalation

### Fit Testing

- There has been an increased demand on the provision of fit testing from Trust staff, intake of students and support staff from the Army.
- The Trust is looking to train up additional staff to become fit testers to assist with the fit testing programme.
- Communications have been sent out to Staff Bank and Human Resources requesting if staff are available to offer 1 – 2 day.
- In addition, the Health & Safety department have arranged training for non-clinical staff to be fit testers in the last year and the Education department have offered some staff who can provide some days of assistance.
- The current data management system is under review and meetings are arranged to meet with the ESR team to discuss transferring the data from one system to the other. This will enable members of staff to check their own records and will assist departments checking their compliance %.
- The Infection Control Committee continue to have fit testing as a standing item on their monthly agenda to monitor progress.

# Health and Safety/Non-Clinical Risk Group
## TIAA review

- Health & Safety  was audited by the Internal Audit department at the Trust and were found to have Reasonable Assurance.
- The report highlighted some areas of good practice and also highlighted some specific areas for further improved.
- Regular progress against action plan to be reported to H&SNCRG and RAG

### Executive Summary

**OVERALL ASSESSMENT**


**KEY STRATEGIC FINDINGS**

- Through audit testing and discussions with Management it was identified that Health and Safety controls were generally in place. However, some weaknesses were identified which once rectified would further strengthen the Health and Safety controls.
- Evidence of implementing an action plan and reporting progress against the action plan for the HSE (Health & Safety Executive) recommendations was not however provided.
- There were element of non-compliance identified with the Health and Safety Policy.
- Monitoring and reporting arrangements could be further strengthened.

**ASSURANCE OVER KEY STRATEGIC RISK / OBJECTIVE**

The 21/22 BAF was obtained, from which the following risk in relation to the scope of this audit were identified:

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

**GOOD PRACTICE IDENTIFIED**

- Evidence of reporting progress against the Matura action plan to a relevant Committee was seen.
- RIDDOR trends were monitored and reported.

**SCOPE**

The audit reviewed the data quality of indicators reported for Health and Safety and to evaluate the accuracy, completeness and timeliness of data reported, on a sample only basis.

**ACTION POINTS**

| Urgent | Important | Routine | Operational |
|---|---|---|---|
| 0 | 2 | 6 | 1 |

# Health and Safety/Non-Clinical Risk Group
## External Fire Safety Audit

The Trust instructed Alfor Fire Safety Service, Authorised Engineer Fire, to carry out an audit of its fire safety arrangements in accordance with the Department of Health's guidance Health Technical Memoranda (HTM) 05-01: *Managing healthcare fire safety* for the period up to September 2021. The final report issued on the 23 October 2021 provides a comparison of the recommendations of the Department of Health's published HTM fire safety management guidance, with a summary of recommendations for compliance and gives the Trust an overall level of assurance for fire safety. This report does not include the Atkinson Morley Wing (PFI) and the Community site specific fire safety infrastructure.

**Compliance Summary**

The Trust's mean average compliance is judged to be 72% (Reasonable Assurance). **See enclosure 3** Summary of report findings and recommendations.

SGH001-FSA-P20 Rev 00

**7.0.0. COMPLIANCE SUMMARY**

| Summary of compliance, per system section | | RAYG Ratings per System per Table | | | |
|---|---|---|---|---|---|
| Table | Fire System (as per HTM 05-01) | No of Factors[1] | Potential Score[2] | Total Score[2] | % Score[3] |
| 5.1 | Statutory Fire Safety Duties | 6 | 18 | 12 | 66 |
| 5.2 | Trust Fire Safety Policy | 4 | 12 | 10 | 83 |
| 5.3 | Effective Fire Safety Management | 7 | 21 | 12 | 57 |
| 5.4 | Appropriate Management Levels | 7 | 21 | 12 | 57 |
| 5.4.A | Maintenance and Testing | 20 | 60 | 36 | 60 |
| 5.5 | Fire Safety Management Roles and Responsibilities | 7 | 21 | 18 | 86 |
| 5.6 | Fire Safety Protocols | 1 | 3 | 2 | 67 |
| 5.7 | Fire Safety Information Manuals | 7 | 21 | 18 | 86 |
| 5.8 | Planning And Responding To A Fire Emergency | 4 | 12 | 10 | 83 |
| 5.9 | Training | 6 | 18 | 15 | 83 |
| 5.10 | Reporting and Audit | 2 | 6 | 4 | 67 |
| | | *Mean Average Compliance* | | | 72% |

NOTES:

1 – *The number of factors within the summary table for that section*

2 – *Scores allocated Green (3); Yellow (2): Amber (1); Red (0)*

3 – *Systems category average percentage, as per note 2 above*

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| | | | |
|---|---|---|---|
| **Meeting Title:** | **Trust Board** | | |
| **Date:** | 31 March 2022 | **Agenda No** | 2.4 |
| **Report Title:** | Learning from Deaths and Mortality Monitoring Group (MMG) Report – Quarter 3 2021/22 (October – December 2021) | | |
| **Lead Director:** | Dr Richard Jennings, Group Chief Medical Officer<br>Dr Luci Etheridge, Site Chief Medical Officer | | |
| **Report Author:** | Kate Hutt, Head of Mortality Services<br>Mr Ashar Wadoodi, Lead for Learning from Deaths<br>Maureen Emus Ijomoni, Team Leader Mortality and Morbidity Coordinators | | |
| **Presented for:** | Discussion Update | | |
| **Executive Summary:** | The paper provides an overview of the work of the Mortality Monitoring Group (MMG) and Learning from Deaths in Q3 2021/22. A number of objectives for the next 6 months are outlined, encompassing all workstreams included in the local Learning from Deaths framework. Priorities which will be monitored through MMG are defined.<br><br>An outline of progress against the Quality and Safety Strategy priority related to the implementation of Mortality & Morbidity Coordinators Team is included. All M&M meetings across the Trust are now supported by a member of the team. Clinical Governance leads have been consulted on a core data set and supporting templates, and on formulating guidance which defines minimum standards for M&Ms.<br><br>Established local mortality review processes and associated outcomes are reported, including a summary of the findings of structured judgement reviews over the last quarter.<br><br>To demonstrate processes in relation to monitoring and investigating mortality outlier alerts and understanding mortality at a granular level, a brief update on the current status of investigations is given. This includes timescales for reporting progress to MMG.<br><br>National mortality measures are also reported. Both our SHMI and HSMR remain lower than expected. | | |
| **Recommendation:** | • To note and support the objectives for MMG and Learning from Deaths over the next 6 months<br>• To note and support progress against Quality and Safety Strategy through implementation of the M&M team.<br>• To note and support plans to participate in the extension of the Learning Disability Mortality Review Programme (LeDeR) to include autistic people.<br>• To consider the assurance provided that current outlier alerts are being investigated robustly and that there is a granular understanding of our mortality data. | | |
| **Committee Assurance:** | The Committee is also asked that in considering contents of this report, its supporting documents and the discussion at the meeting which of the following assurance rating it would provide to the Trust Board. | | |

| | | | |
|---|---|---|---|
| | • **Substantial Assurance:** The report and discussions assured the Committee that there are robust systems of internal controls operating effectively to ensure that quality and safety risks are managed to deliver high quality services and care to patients.<br>• **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.<br>• **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.<br>• **No Assurance:** The report and discussions led the Committee to conclude that there was a fundamental breakdown or absence of core internal controls and systems to enable the Trust to deliver high quality services and care to its patients. | | |
| **Supports** | | | |
| **Trust Strategic Objective:** | Care.<br>Reducing avoidable harm. | | |
| **CQC Theme:** | Safe and Effective (Well Led in implementation of new framework) | | |
| **Single Oversight Framework Theme:** | Safe | | |
| **Implications** | | | |
| **Risk:** | Work to clearly define and implement Care group and Trust (Learning from Deaths and governance) processes, and their interconnectivity, is progressing but is not fully mature. Finalising this will ensure governance is effectively managed and opportunities for learning are not missed. | | |
| **Legal/Regulatory:** | 'Learning from Deaths' framework is regulated by CQC and NHS Improvement, and demands trust actions including publication and discussion of data at Board level. | | |
| **Resources:** | | | |
| **Previously Considered by:** | Patient Safety & Quality Group<br>Quality & Safety Committee | **Date** | 16 Feb 22<br>17 Feb 22 |
| **Equality Impact Assessment:** | N/A<br>This is in line with the principles of the Accessible Information Standard | | |

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1.0 **PURPOSE**

The purpose of this paper is to provide the Patient Safety and Quality Group with an update on the work of the Mortality Monitoring Group (MMG) and progress against the Learning from Deaths agenda. The paper also summarises the activity of the Medical Examiner office.

The report describes sources of assurance that the Trust is scrutinising mortality and identifying areas where further examination is required. In line with the Learning from Deaths framework we are working to ensure that opportunities for learning are identified and where appropriate, action is taken to achieve improvements.

2.0 **LEARNING FROM DEATHS**

2.1 **Learning from Deaths objectives Q4 2021/22 to Q1 2022/23**

The Trust is committed to continuing to improve processes around mortality monitoring, with the aim of maximising learning and consequently, improvements to patient care. To guide that development MMG has agreed a number of priorities for the next six months. These cover each of the workstreams incorporated in our local Learning from Deaths framework and are summarised below. Progress against these objectives will be monitored by MMG and reported to Patient Safety Group, Quality and Safety Committee and ultimately Trust Board, through subsequent versions of this report.

| | |
|---|---|
| **Mortality investigations to be concluded** | Cardiology diagnosis and procedure groups, principally Acute myocardial infarction |
| | Intracranial injury diagnosis group |
| | Major trauma (TARN) |
| **Mortality and Morbidity meetings development** | Continue pilot of M&M template, refine and implement more widely |
| | Define minimum standards for M&M meetings |
| | Engage with clinical governance leads to ensure that minimum standards are being met |
| | Explore ways to collate and share learning, possibly including development of a database and reporting to MMG |
| | Recruit to vacant posts |
| | Participate in TIAA evaluation of current status of service |
| **Learning from Deaths agenda** | Train and induct new reviewers so that we have a full mortality review team |
| | Define standard operating procedures for Learning from Deaths processes |
| | Review MMG terms of reference |
| | Review Learning from Deaths policy |

2.2 **Implementation of the Mortality & Morbidity Team**

The Mortality & Morbidity (M&M) team is now well established. Each clinical team has an allocated coordinator who is facilitating the meetings and supporting mortality governance. A summary of the current position for M&M meetings across the Trust is provided in Appendix 1. Cover arrangements within the team have also been defined and are working well, ensuring that effective support can be maintained in all circumstances. The coordinators are beginning to support the sharing of learning through enabling liaison between teams where M&M discussion identifies consideration of the case is required within another service. Through linking with the SJR process where additional information is required they are also able to provide additional assurance.

In November the Learning from Deaths Lead, Head of Mortality Services and M&M Team Leader attended the Clinical Governance Leads forum to propose a core data set and initial supporting templates. This was generally well received. Alongside this the Deputy Chief Medical Officer for Safety and Quality is also considering whether a task and finish group should be established to guide further development.

In January 2022, the M&M Team Leader began the process of piloting the proposed M&M reporting template within the Emergency Medicine care group. The proposed template has been amended to incorporate the proposed core data sets as well as mortality screening criteria tailored specifically to the Emergency Medicine care group. The Chest Medicine care group are also conducting a trial of the proposed template, supported by their designated M&M coordinator.

It is intended that the proposed template will be implemented in more pilot care groups in the first quarter of the new year (January 2022 – April 2022). Following the pilot programme, we will develop additional guidance and key performance indicators which will be presented to MMG for input, review, and approval prior to implementation across all care groups in the Trust.

There are currently two vacant M&M coordinators positions within the team due to resignations in December 2021. The M&M team leader and Head of Mortality services will begin the recruitment process for these positions in February 2022. Robust cover arrangements by the M&M coordinators has ensured that all care groups have an interim M&M coordinator pending the recruitment and joining of new members of the team.

The M&M team leader and Head of Mortality Services work closely with the mortality review team, in fostering a link between cases which are flagged for Structured Judgment Reviews (SJRS) and care group discussions of these cases at these meetings. This approach ensures that robust mortality reviews are carried out for cases and will highlight any areas of care where the mortality review team feel further scrutiny or clarity is required from the clinical team.

| | | | |
|---|---|---|---|
| Strategic priority | | 1: Improve patient safety by minimising avoidable harm | |
| Area of focus | | We will establish and implement standardised Mortality and Morbidity monitoring processes supported by relevant documentation, performance metrics and processes for shared learning | |
| Link to corporate objective & strategic risk | | Care: Strategic risk 1 [Our patients do not receive safe and effective care built around their needs because we fail to build and embed a culture of quality improvement and learning across the organisation]<br>Corporate objective: Embed a quality, safety and learning culture through monthly patient safety, mortality and morbidity meetings for every specialty | |
| Executive Lead | | Chief Medical Officer | |
| Operational Lead | | Medical Lead for Learning from Deaths | |
| Implementation stages | Q1 | Complete recruitment process for M&M coordinators | Complete |
| | Q2 | Embed M&M coordinators in practice<br>• Map M&M meetings and allocate coordinators<br>• Define core data set & essential elements of meetings<br>• Implement standardised agenda & supporting documentation (pilot)<br>• Highlight and share the learning | <br>Complete<br>Complete<br>In progress<br><br>Ongoing |
| | Q3 | Embed M&M coordinators in practice<br>• Revise standardised documentation and embed in practice | <br>In progress |

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

2.3 **Medical Examiner Service**

Each quarter all Medical Examiner (ME) offices are required to make a return directly to the office of the National ME, as summarised below. This quarterly return is used for financial reimbursement of costs, and to quantify the level of activity and outcomes of each service. These data are presented to the Regional ME team prior to submission to the National ME and feedback on performance continues to be positive. Below is a summary of the key data submitted by St George's ME office.

A key function of the ME service is to support the appropriate referral of deaths to the coroner. This quarter 105 deaths were referred. In 41 (39%) of these cases the coroner felt no further investigation was required and gave the doctor permission to issue the medical certificate of cause of death. This is associated with the coroner issuing a Form 100A, which indicates to the registrar that the coroner is aware of the death and that the death can be registered without any further investigation. In the remaining 64 (61%) cases, the coroner felt that further investigation, such as a post-mortem or inquest was required.

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

In addition to flagging areas where there are potential concerns the ME service highlights cases where best practice was observed. Wherever possible the ME will pass on messages of appreciation and thanks at the request of the bereaved. This quarter a cluster of compliments was received regarding the quality of end of life care on Richmond ward. This was fed back to the senior leadership team in order to celebrate good practice and to enable the service to learn from this success.

| DEATHS OCCURING AT THE ME OFFICE SITE THAT HAVE BEEN SCRUTINISED BY THE ME | |
|---|---|
| Number of in-hospital deaths scrutinised | **433** |
| Adult deaths | |
| Cases not notified to the Coroner and MCCD issued directly | 313 |
| Cases notified to the Coroner and MCCD issued following agreement by Coroner | 41 |
| Cases referred to the Coroner and taken for investigation | 64 |
| Child deaths | |
| Cases not notified to the Coroner and MCCD issued directly | 9 |
| Cases notified to the Coroner and MCCD issued following agreement by Coroner | 1 |
| Cases referred to the Coroner and taken for investigation | 5 |
| Timeliness and rejections by registration service | |
| Number of MCCDs not completed within 3 calendar days<br>(NB: no account of BH or weekend and requirement is 5 days) | 43 |

| | | |
|---|---|---|
| Number of MCCDs rejected by registrar after ME scrutiny | | 3 |
| Number of cases where urgent release of body is requested and achieved within requested time | | 53 |
| Number of cases where urgent release of body is requested and NOT achieved within requested time | | 3 |
| Achieving communication with the bereaved | | |
| Number of deaths in which communication did not take place | | 30 |
| Reasons for no communication: | Declined | 1 |
| | No response | 14 |
| | No NOK | 4 |
| | Not documented | 11 |
| Detection of issues and actions | | |
| ME referred for structured judgement review | | 27 |
| ME referred to other clinical governance processes | | 4 |
| ME referred to external organisation | | 2 |
| Families referred to PALS | | 5 |

The Lead ME and Head of Mortality Services have continued to collaborate with senior colleagues from primary care services in Wandsworth and Merton in preparation for the expansion of the ME service to include non-acute non-coronial deaths that occur in these boroughs. Several practices are keen to participate in the pilot period and we will continue to collaborate on the design of initial processes. The next working group meeting is scheduled in February.

Medical Examiner Officers (MEO) provide support to MEs in their role in scrutinising the circumstances and causes of death. They are a point of contact and source of expert advice for the bereaved, healthcare professionals and coroner and registration services. To date we have operated the service without dedicated MEOs, however, following receipt of national funding we have successfully recruited a team of three MEOs. The team will take up post during Q4 and will play a pivotal role in the expansion and continued development of the service.

## 3.0 MONTHLY INDEPENDENT REVIEW OF MORTALITY

3.1 This quarter two consultants were successfully recruited to the Mortality Review Team (MRT). This increased resource of 2 PAs and the expertise they bring to the team, will have a positive impact on our processes for completing SJRs and will support more robust follow-up, where required. One reviewer has completed their training and has started completing SJRs and the remaining reviewer will begin in the New Year.

During this quarter, independent reviews, using the structured judgement review (SJR), have been completed for 40 deaths. 27 of these were referred to the Learning from Deaths Lead by the Medical Examiner Office. The reasons for requesting a review are summarised below.

| **Triggers for review** | |
|---|---|
| Confirmed learning disability | 6 |
| Significant mental health diagnosis | 12 |
| ME detected potential issue with care or possible learning | 5 |
| Deaths following elective admission | 5 |
| Areas subject to enhanced oversight | 7 |
| Deaths where possibility of hospital acquired covid-19 infection | 5 |

The findings from these structured judgement reviews are shown below. It should be noted that the SJR is completed by a consultant who is independent of the care of the patient and is a first stage review process, conducted through a casenote review. Where the reviewer has questions or concerns these are raised with the clinical team and/or the Patient Safety Team and therefore the judgements reached at the initial review, and documented here, may not constitute final conclusions about treatment and care.

SJRs may be used as one element of a full portfolio of information considered in the evaluation of patient safety incidents at the weekly Serious Incident Declaration Meeting (SIDM). During this quarter there have been two serious incidents (SIs) where the patients involved had died at the point of SI declaration.

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

3.2 **Overview of October 2021 to December 2021**

Between October and December 2021 there were 433 deaths. Members of the Mortality Review Team (MRT) reviewed 40 deaths, representing 9.2% of deaths. The findings from these structured judgement reviews are summarised below, concluding with details of the cases where the review suggested opportunity for learning. It should be noted that all child deaths are reviewed locally by clinical teams and by the Child Death Overview Panel.

The structured judgement review methodology requires reviewers to identify problems in healthcare and to assess whether these have caused harm. Of the 40 deaths reviewed this quarter problems were identified in relation to 10 (25%) of the patients reviewed, although it should be noted that in one case the problem related to care at a different provider. One patient experienced two problems in healthcare, resulting in 11 problems in total. In the instance where a problem in healthcare was identified at a different provider this was escalated to that organisation via our Patient Safety Team.

| **Problem in healthcare** | No harm | Possible harm | Harm | TOTAL |
|---|---|---|---|---|
| Assessment | 0 | 2 | 0 | 2 |
| Medication | 0 | 1 | 0 | 1 |
| Treatment | 0 | 0 | 1 | 1 |
| Infection control | 1 | 3 | 1 | 5 |
| Procedure | 0 | 0 | 0 | 0 |
| Monitoring | 0 | 0 | 0 | 0 |
| Resuscitation | 0 | 0 | 0 | 0 |
| Communication | 0 | 0 | 0 | 0 |
| Other | 1 | 1 | 0 | 2 |
| TOTAL | 2 | 7 | 2 | 11 |

An assessment of overall care is also provided for each death reviewed. In 2 deaths (5%) the care provided was rated as excellent. For most patients (30, 75%) care was evaluated as good; for 8 patients (20%) care was felt to have been adequate. In no cases was care observed to be poor.

| **Overall care judgement** | Number | Percentage |
|---|---|---|
| Excellent care | 2 | 5 |
| Good care | 30 | 75% |

| | | |
|---|---|---|
| Adequate care | 8 | 20% |
| Poor care | 0 | 0% |
| Very poor care | 0 | 0 |
| Total | **40** | |

A judgement regarding avoidability of death is made for all reviews. A breakdown is shown below which demonstrates that in the majority of deaths there was not felt to be any avoidability. No deaths were found to be definitely avoidable, or to have strong evidence of avoidability.

| **Avoidability of death judgement** | Number | Percentage |
|---|---|---|
| Definitely not avoidable | 28 | 70 |
| Slight evidence of avoidability | 8 | 20 |
| Possibly avoidable but not very likely (less than 50:50) | 1 | 2.5 |
| Probably avoidable (more than 50:50) | 3 | 7.5 |
| Strong evidence of avoidability | 0 | |
| Definitely avoidable | 0 | |
| Total | **40** | |

There were three cases where the structured judgement review suggested that the death was probably avoidable. In two of these cases there were problems in healthcare that were thought to have led to harm.

One of the deaths that was felt by the reviewer to be probably avoidable was a death by suicide. The SJR was considered as part of the package of information considered at SIDM and an SI was subsequently declared (DW160555 2021/22479). This case was presented in the Serious Incidents report to QSC in December 2021 and a summary of the investigation findings and agreed actions was provided to the Patient Safety and Quality Group in March. The SI panel concluded that the care by the clinical teams was appropriate, timely and adequate and that there was no single root cause that led to the patient's death. Although the incident could not have been prevented several improvement actions were identified, the implementation of which is being monitored. Evidence of good practice was also observed and is acknowledged within the full SI report.

In the second case it was thought that a treatment-related problem led to harm, whereby anticoagulation was restarted in a patient with a history of bleeding. This case was declared as a serious incident (ref DW162305) and is currently being investigated by the Surgery, Theatres, Neuroscience and Cancer Division. The panel are due to present their draft report to SIDM in April. This incident was presented to QSC in February in the Serious Incidents report and summary of the investigation findings will be included in a future report to QSC.

The final death that was judged to be probably avoidable, and where harm was noted, related to hospital acquisition of covid-19. The SJR will contribute to the investigation process for hospital associated covid-19 infection. A review process is currently being drafted in conjunction with the divisions, the Infection Prevention and Control Team and patient safety leaders. This process will be discussed and agreed through the SIDM group.

3.3 **Learning disabilities**

All deaths that occur in patients with learning disabilities (aged 4 and over) are reported to the national Learning Disabilities Mortality Review Programme (LeDeR). The LeDeR reviews are co-ordinated by the CCG and we have established effective liaison with these colleagues. We work

closely together to share our local independent mortality reviews and in turn receive redacted copies of the completed LeDeR review.

The mortality review team carry out local review of every death of a patient with learning disability (LD) using our standard SJR methodology. The table below summarises these deaths from the beginning of 2018/19 to the end of Q3 2021/22. In total there have been 61 deaths, with reviews completed for each. This quarter there have been six deaths in patients with a learning disability. Overall care was judged to be good or adequate for all the patients and none of the deaths were felt to be avoidable. In one case where the reviewer found there to be slight evidence of avoidability the clinical team provided a detailed response, explaining the care and treatment of the patient, which resolved any concerns.

| **LD DEATHS Avoidability of death judgement score** | **2018/19** | **2019/20** | **2020/21** | **2021/22** | | |
|---|---|---|---|---|---|---|
| | | | | **Q1** | **Q2** | **Q3** |
| **TOTAL DEATHS** | **9** | **16** | **22** | **4** | **4** | **6** |
| **REVIEWS COMPLETED** | **9** | **16** | **22** | **4** | **4** | **6** |
| Definitely not avoidable | 9 | 16 | 22 | 2 | 4 | 5 |
| Slight evidence of avoidability | 0 | 0 | 0 | 2 | 0 | 1 |
| Possibly avoidable (< 50:50) | 0 | 0 | 0 | 0 | 0 | 0 |
| Probably avoidable (> 50:50) | 0 | 0 | 0 | 0 | 0 | 0 |
| Strong evidence of avoidability | 0 | 0 | 0 | 0 | 0 | 0 |
| Definitely avoidable | 0 | 0 | 0 | 0 | 0 | 0 |

In line with the new national LeDeR policy published in March 2021, *Learning from lives and deaths – People with a learning disability and autistic people (LeDeR) policy 2021,* NHS England and NHS Improvement are preparing to introduce the inclusion of reviews of adults who are autistic with no learning disability, as part of LeDeR. Notifications will be taken for any death of a person with a clinical diagnosis of autism who has died on or after 1st January 2022. A local standard operating procedure (SOP) was ratified by Mortality Monitoring Group in November which will support our full participation in this important work. This will be led by the Mortality Services team with MEOs identifying appropriate deaths and making a referral to the Learning from Deaths team to complete an SJR and make the notification.

At the time of reporting the national reporting system is operational; however, there have been no relevant deaths.

## 4.0 LEARNING FROM MORTALITY

The following summaries provide an overview of mortality investigations that are currently underway.

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

In 2020 the Trust was informed by the Trauma Audit & Research Network (TARN) that it appeared to be an outlier for case-mix adjusted mortality outcomes for the period July 2017 to June 2019, and previously for 2016 to June 2018. In January 2021 TARN informed us that as a result of improvements to our data quality we were no longer to be considered an outlying hospital and that our outcomes were within the normal range.

Earlier Learning from Death reports have explained in detail the nature of the alert and detailed the steps taken in a comprehensive investigation of our outcomes. The Lead for Major Trauma, Learning

from Deaths Lead and Head of Mortality Services are meeting in February to consider the action plan arising from the various strands of investigation and a report will be presented to MMG in April 2022. The final outcome of the mortality investigation will be summarised in a subsequent version of this paper.

4.2 **Acute Myocardial Infarction**

The last three publications of the Summary Hospital-level mortality indicator (SHMI), covering the periods July 2020 – June 2021, August 2020 – July 2021, and September 2020 – August 2021 have shown mortality to be higher than expected in the Acute Myocardial Infarction (AMI) diagnosis group. Dr Foster data for the periods October 2020 – September 2021 and November 2020 – October 2021 have also shown this grouping as having higher than expected mortality.

In response to earlier signals the cardiology care group recently completed a comprehensive clinical review and are implementing several improvement actions, as reported in this paper previously (Q4 2020/21). The Mortality Monitoring Group acknowledge that time is required to see the impact of those changes. Although the Medicine and Cardiovascular Division is responsible for monitoring the agreed action plan, the MMG has requested a full update in six months' time to assess whether these actions have led to improvement. Alongside this MMG has requested that the alert should be investigated through a review of clinical coding. This work is currently underway and is drawing on the expertise of the clinical team, the clinical coding team and the Strategic Business Intelligence Team. The outcome of this investigation will be reported in the Q2 2022/23 version of this paper.

5.0 **LATEST NATIONAL PUBLISHED RISK-ADJUSTED MORTALITY**

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

The latest SHMI data, covering discharges from September 2020 to August 2021, was published on 13th January 2022. The Trust's overall mortality is categorised as 'lower than expected' at 0.89. We were one of 13 Trusts in the category, and one of 11 trusts in the same category for the same period last year.

During the 12-month period there were 66,660 inpatient spells at the Trust, with 1,515 deaths observed, compared to 1,700 expected deaths. It should be noted that NHS Digital are excluding Covid-19 activity from the SHMI publication in order to make the indicator values as consistent as possible with those from previous reporting periods. The SHMI is not currently designed for pandemic activity and the statistical modelling used to calculate the SHMI may not be as robust if such activity was included. Excluding Covid-19 activity means that, as far as possible, consistency is maintained and each SHMI publication can be interpreted in the same way.

NHS Digital provides a SHMI value for ten diagnosis groups, detailed below. The latest information is summarised in the table below and shows that our mortality is either lower than, or in line with what would be expected for all the diagnosis groups analysed, other than acute myocardial infarction where mortality is higher than expected. This has been shared with the cardiology clinical governance lead and discussed by MMG. A report on progress against the action plan arising from the mortality investigation previously detailed in this paper (Q4 2020/21) will be presented to MMG in six months' time, alongside an analysis of clinical coding and data.

| Diagnosis Group | SHMI value | SHMI banding |
|---|---|---|
| Acute bronchitis | * | * |
| Acute myocardial infarction | 1.43 | Higher than expected |
| Cancer of bronchus; lung | 0.52 | Lower than expected |
| Fluid and electrolyte disorders | 0.65 | Lower than expected |

| | | |
|---|---|---|
| Fracture of neck of femur (hip) | 1.03 | As expected |
| Gastrointestinal haemorrhage | 1.08 | As expected |
| Pneumonia (excluding TB/STD) | 0.81 | Lower than expected |
| Secondary malignancies | 0.89 | As expected |
| Septicaemia (except in labour), shock | 1.04 | As expected |
| Urinary tract infections | 0.90 | As expected |

* Numbers are too low to disclose

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

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

| **HSMR analysis: November 2020 – October 2021** | **Value** | **Banding** |
|---|---|---|
| HSMR (all admission methods) | 88.2 | Lower than expected |
| HSMR: Weekday emergency admissions | 83.1 | Lower than expected |
| HSMR: Weekend emergency admissions | 102.3 | As expected |

In December the service provided by Telstra, the organisation that provides Dr Foster data, was restored following several months of disruption. The most recent data allows us to resume evaluation of risk-adjusted mortality at diagnosis and procedure group level. This shows a number of areas that the MMG concluded require further investigation, as summarised below.

| **Group** | **Action** |
|---|---|
| Acute myocardial infarction | A progress report against the action plan arising from the cardiology mortality investigation previously detailed in this paper (Q4 2020/21) will be presented to MMG in six months' time, alongside an analysis of clinical coding and data. |
| Coronary atherosclerosis & other heart disease | |
| Coronary angioplasty (PTCA) | |
| Intracranial injury | A coding review, two clinical reviews, and a benchmarking exercise have previously been carried out to investigate this grouping. As reported in this paper (Q1 2021/22) no areas of concern were identified at that time. A process for prospective clinical and coding review has recently been introduced and has not identified issues that require action; however, the MMG agreed that this signal needs to be revisited. The neurosurgery clinical governance lead will be invited to attend MMG in March 2022 to take this forward. |

It should be noted that no external mortality outlier alerts have been received in this period.

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**Appendix 1: Mortality & Morbidity meetings summary**

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

| Division: Medicine and Cardiovascular Services | | | |
|---|---|---|---|
| **Care Group** | **Status** | **Frequency of Meetings** | **Additional Information** |
| Emergency Medicine | Fully Established | Monthly | Piloting core dataset |
| Acute Medicine | Fully Established | Monthly | |
| Senior Health | Fully Established | Bi-Monthly (2 Months) | The senior health team have imminent plans to change to monthly meetings. |
| Cardiology | Fully Established | Monthly | Meetings alternate between Morbidity and Mortality cases each month to accommodate the volume of cases and facilitate adequate discussion time. |

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

| **Division: Surgery, Theatres, Neurosciences & Cancer** | | | |
|---|---|---|---|
| **Care Group** | **Status** | **Frequency of Meetings** | **Additional Information** |
| Neurology | Fully Established | Quarterly | |
| Interventional Neuroradiology | Fully Established | Monthly | |
| Neurosurgery | Fully Established | Bi-Monthly (2 Months) | |
| Stroke | Fully Established | Monthly | |
| Trauma & Orthopaedics | Fully Established | Bi-Monthly (2 Months) | |
| ENT & Audiology | Fully Established | Quarterly | |
| General Surgery | Fully Established | Monthly | |
| Maxillofacial | Fully Established | Monthly | |
| Plastic Surgery | Partially Established | Ad-Hoc | Low/ Minimal M&M activity |
| Urology | Fully Established | Monthly (2 times a month) | |
| Cancer | Integrated within other care groups | - | |

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

## Appendix 2: National Quality Board Dashboard – data to 31st December 2021

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

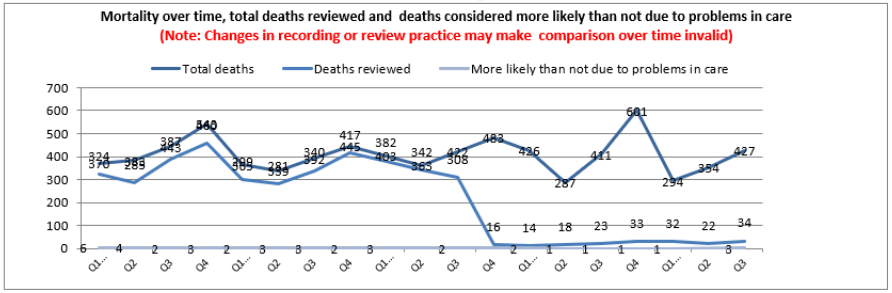
**Description:**
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

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

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

| Total Number of Deaths in Scope | | Total Deaths Reviewed | | Total Number of deaths considered more likely than not due to problems in care PRISM Score<=3 or equivalent measure | |
|---|---|---|---|---|---|
| This Month | Last Month | This Month | Last Month | This Month | Last Month |
| 172 | 130 | 16 | 8 | 2 | 0 |
| This Quarter (QTD) | Last Quarter | This Quarter (QTD) | Last Quarter | This Quarter (QTD) | Last Quarter |
| 427 | 354 | 34 | 22 | 3 | 0 |
| This Year (YTD) | Last Year | This Year (YTD) | Last Year | This Year (YTD) | Last Year |
| 1075 | 1725 | 88 | 88 | 4 | 5 |

**Time Series:** Start date 2017-18 Q1 — End date 2021-22 Q3




**Total Deaths Reviewed, categorised by SJR Avoidability Score**

| Score 1 Definitely avoidable | | | Score 2 Strong evidence of avoidability | | | Score 3 Probably avoidable (more than 50:50) | | | Score 4 Probably avoidable but not very likely | | | Score 5 Slight evidence of avoidability | | | Score 6 Definitely not avoidable | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| This Month | 0 | 0.0% | This Month | 0 | 0.0% | This Month | 2 | 12.5% | This Month | 0 | 0.0% | This Month | 4 | 25.0% | This Month | 10 | 62.5% |
| This Quarter (QTD) | 0 | 0.0% | This Quarter (QTD) | 0 | 0.0% | This Quarter (QTD) | 3 | 8.8% | This Quarter (QTD) | 1 | 2.9% | This Quarter (QTD) | 7 | 20.6% | This Quarter (QTD | 23 | 67.6% |
| This Year (YTD) | 0 | 0.0% | This Year (YTD) | 0 | 0.0% | This Year (YTD) | 4 | 4.5% | This Year (YTD) | 4 | 4.5% | This Year (YTD) | 12 | 13.6% | This Year (YTD) | 68 | 77.3% |

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

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

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

| Total Number of Deaths in scope | | Total Deaths Reviewed Through the LeDeR Methodology (or equivalent) | | Total Number of deaths considered more likely than not due to problems in care | |
|---|---|---|---|---|---|
| This Month | Last Month | This Month | Last Month | This Month | Last Month |
| 0 | 2 | | | | |
| This Quarter (QTD) | Last Quarter | This Quarter (QTD) | Last Quarter | This Quarter (QTD) | Last Quarter |
| 6 | 4 | | | | |
| This Year (YTD) | Last Year | This Year (YTD) | Last Year | This Year (YTD) | Last Year |
| 14 | 22 | | | | |

| Total Number of Deaths in scope | | Total Deaths Reviewed Through the Local Review Methodology | | Total Number of deaths considered more likely than not due to problems in care | |
|---|---|---|---|---|---|
| This Month | Last Month | This Month | Last Month | This Month | Last Month |
| 1 | 2 | 1 | 2 | 0 | 0 |
| This Quarter (QTD) | Last Quarter | This Quarter (QTD) | Last Quarter | This Quarter (QTD) | Last Quarter |
| 4 | 4 | 4 | 4 | 0 | 0 |
| This Year (YTD) | Last Year | This Year (YTD) | Last Year | This Year (YTD) | Last Year |
| 8 | 22 | 8 | 22 | 0 | 0 |

**Time Series:** Start date 2017-18 Q1 — End date 2021-22 Q3

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| | | | |
|---|---|---|---|
| **Meeting Title:** | Trust Board | | |
| **Date:** | 31 March 2022 | **Agenda No** | **2.5** |
| **Report Title:** | Ockenden Assurance Update Report for Maternity 2022 | | |
| **Lead Director/ Manager:** | Arlene Wellman, Group Chief Nursing Officer | | |
| **Report Author:** | Janet Bradley, Director of Midwifery and Gynaecology Outpatient Nursing | | |
| **Presented for:** | Review | | |
| **Executive Summary:** | Following the publication of the Ockenden Report in December 2020, NHS England sought assurance from all maternity services across England that they benchmarked themselves against the Immediate & Essential Actions (IEAs) by February 2021. These included themes of:<br><br>1. Enhanced safety<br>2. Listening to women and families<br>3. Staff training and working together<br>4. Managing complex pregnancy<br>5. Risk assessment throughout pregnancy<br>6. Monitoring fetal wellbeing<br>7. Informed consent<br>8. Workforce<br><br>The Ockenden assurance programme has required multiple levels and types of assessment and evidence. These have included an initial self-assessment against the 7 IEA and workforce criteria which was submitted in March 2021.<br><br>The Trusts self-assessment assurance template was then scrutinised by the South West London (SWL) sector Local Maternity and Neonatal System (LMNS) in February 2021 and additionally by a Regional Peer Review panel in March 2021.<br><br>NHSE then requested additional evidence was submitted to an online portal which demonstrated provision of care, pathways and framework that support the required IEA's. This element was completed on the 30th June 2021.<br><br>The outcome of this stage of the assurance process was delayed until December 2021. The delay was caused by multiple challenges which included both logistical aspects and concerns raised by the Regional Chief Midwives surrounding the validity and credibility of the responsible validators.<br><br>The reporting and governance framework across and upwards in the Trust has been via Divisional Board meetings, Patient Safety and Quality groups and Quality Safety Committee.<br><br>The Ockenden report and its requirements was presented at QSC in December 2020. The initial response and confirmation the Trusts was committed to reach compliance was taken to DMB, PSQG and QSC in January 2021.<br><br>At the April 2021 Board we reported to the Trust on the progress of the requested assessment and assurance template to NHS England which had been approved by the Trust Board Safety Champion (Chief Nurse) Non-Executive Director | | |

| | |
|---|---|
| | (specifically appointed for maternity and neonatal services) and the Chair and Chief Executive.<br><br>In May 2021 we received a further request from NHS England for evidence to support our compliance with all the 7 IEAs, together with workforce planning, midwifery leadership and compliance with NICE guidelines.<br><br>At the October and November 2021 Boards we confirmed the requested evidence has been submitted to NHS England in June 2021 and the information was also shared with the Local Maternity and Neonatal System Board. Since this time, the Quality Safety Committee has continued to provide oversight of the Trust's compliance with Ockenden and other maternity service quality standards.<br><br>In December 2021 the Regional teams, the Local Maternity and Neonatal System (LMNS) and St Georges received feedback from NHSE regarding the Ockenden evidence submission. The attached report confirms the latest compliance position. |
| **Recommendation:** | To note the current position of the Maternity Services in relation to the current and evolving climate of public and maternal health and the impact on our pregnant populations and overall safety. |
| **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.<br><br>• **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.<br>• **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.<br>• **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.<br>• **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:** | • The strategic objectives are to deliver full compliance with regulatory quality indicators and the national maternity patient safety, quality, and experience indicators |
| **CQC Theme:** | • Safe, Effective, Caring, Responsive, Well led |

| | | |
|---|---|---|
| | | |
| **Single Oversight Framework Theme:** | | |
| **Implications** | | |
| **Risk:** | Workforce and estates | |
| **Legal/Regulatory:** | NHSE - Ockenden report immediate and essential actions<br>CQC standards | |
| **Resources:** | Workforce | |
| **Equality and Diversity:** | Culture | |
| **Previously Considered by:** | Divisional Management Group<br>Patient Safety and Quality Group<br>Trust Management Group<br>Quality and Safety Committee | 15 Feb 2022<br>16 Feb 2022<br>23 Mar 2022<br>24 Mar 2022 |
| **Appendices:** | Addendum – March 2022 update | |

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**Ockenden Assurance Update Report for Maternity**
**Trust Management Group**

## 1.0 PURPOSE

This report provides an update on compliance with the 2020 Ockenden Report recommendations.

## 2.0 Ockenden National review of maternity services - background

In the summer of 2017, following a letter from bereaved families raising concerns where babies and mothers died or potentially suffered significant harm whilst receiving maternity care at The Shrewsbury and Telford Hospital NHS Trust, the former Secretary of State for Health and Social Care, Jeremy Hunt, instructed NHS Improvement to commission a review assessing the quality of investigations relating to new-born, infant and maternal harm at The Shrewsbury and Telford Hospital NHS Trust.

The first terms of reference in 2017 were written for a review comprising 23 families. These were then amended in November 2019 to encompass a much larger number of families who had come forward to raise concerns.

The review is looking at maternal and neonatal harm between the years 2000 and 2019 and includes cases of stillbirth, neonatal death, maternal death, hypoxic ischaemic encephalopathy (HIE) (grades 2 and 3) and other severe complications in mothers and new-born babies. The total number of families to be included in the final review and report will be 1,862.

This initial and first Ockenden report refers to 250 cases reviewed to date. The number of cases considered so far includes the original cohort of 23 cases. The review panel has identified important themes which must be shared across all maternity services as a matter of urgency and have formed Local Actions for Learning and make seven early recommendations for the wider NHS, labelled Immediate and Essential Actions (IEA).

The immediate requirement in December 2020 was to submit a letter of confirmation from the CEO also signed by Local Maternity System (LMS) Chair was submitted to NHSE describing the Trusts absolute commitment to fulfil and comply with the requirements of the IEA. An initial paper describing the requirement was presented and reviewed, commitment was supported at each board and the letter from St Georges CEO was submitted accordingly.

The maternity service has also completed the assurance assessment tool which reflects the position of the Trust in relation to elements including:

1) All seven IEAs of the Ockenden report
2) NICE guidance relating to maternity
3) Compliance against the CNST (Clinical Negligence Scheme for Trusts) safety actions
4) A current workforce gap analysis

These assurances have been reported locally via Divisional Management Board DMB, at Trust level via Patient Safety Quality Group (PSQG) and Quality Safety Committee (QSC) through the SWL

LMNS and submitted to the Regional teams in March 2021. This gap and thematic analysis were reported to the regional and national Maternity Transformation Boards.

To review staffing within the service and support the submission to Ockenden, the service completed the BirthRate Plus (BR+) midwifery staffing workforce review, including confirming timescales for implementation to achieve the recommendations. The completed BR+ maternity workforce review was undertaken within time and findings reported on 6th May 2021.

The BR+ report concluded that an additional 15.6 WTE clinical midwives and an additional 12 WTE Band 3 MSW support staff were required to reach minimal safe staffing levels at St Georges with a minimum recommended ratio of 1:24 midwives to births.

Additional national funding for maternity staffing was released by NHSE in May 2021. The BR+ workforce report including additional relevant WTE uplift required to enable the service to fulfil maternity mandatory training requirements, were used to support and inform the funding bid for St Georges. The results of the workforce funding bid were released in July 2021.

**Bid submitted**: 22 WTE midwives - 17 WTE midwives in main bid with an additional 5 WTE x MW (and 12 x Band 3 MSW and 1.9 WTE Obstetric Consultant) to support safe care and MDT training requirements as per Ockenden safety drivers.

**Award given**: 15.6 WTE Midwives, 0.5 WTE Obstetric Consultant. 2.56 WTE Midwifery Support Worker (MSW) support funded.

**Variance**: 6.4WTE midwives, 9.44 WTE band 3 MSW, 1.4WTE Obstetrician remain unfunded. The shortfall of funding will be reviewed through 2022/23 budget setting rounds.

The variance leaves a significant gap in recommended safe staffing levels and ratios specifically across MSW roles. The BirthRate plus report uses a ratio of 90:10 (midwife to MSW) to calculate the recommended safe staffing levels to appropriately support all pathways of care to meet the demands of both the community and inpatient settings. The service currently has a combined ratio of 1:25.5 so does not meet this overall recommended staffing ratio of 1:24 midwife to women.

## 2.1 Assurance of the evidence to demonstrate IEA for the initial Ockenden report

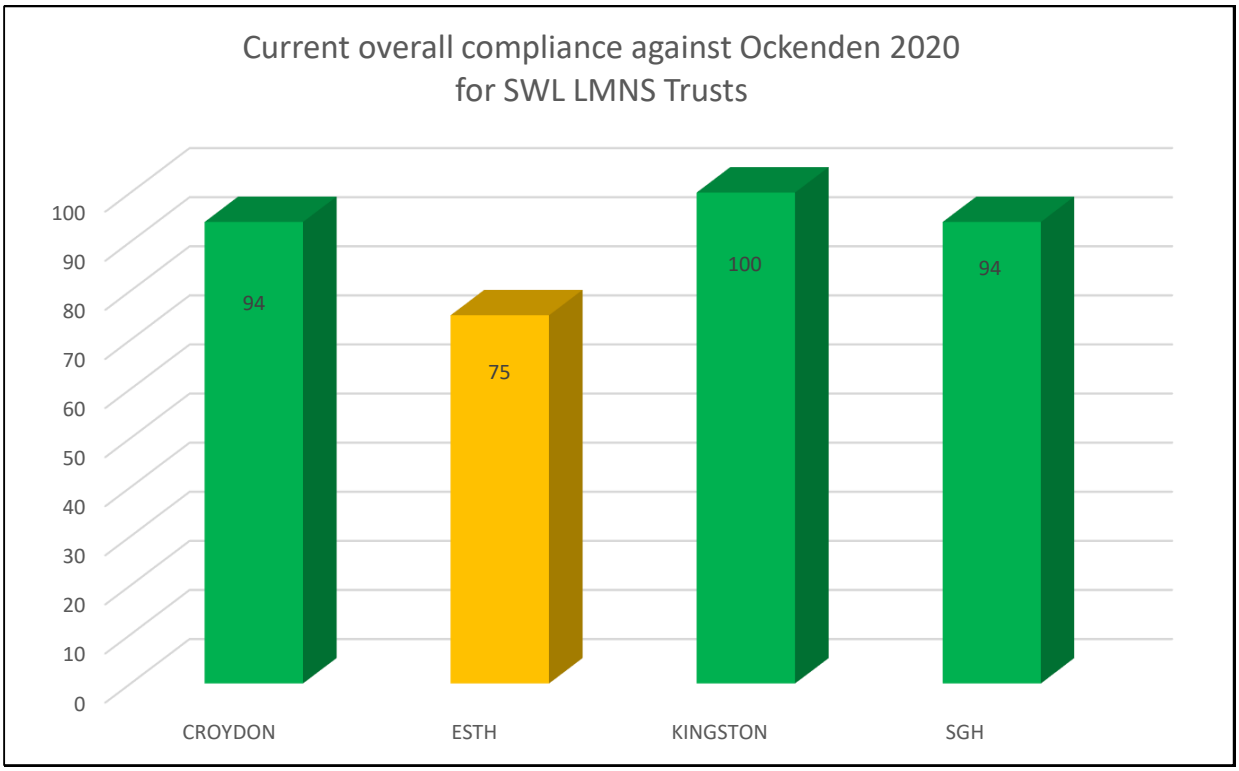
As part of the ongoing assurance processes for the Ockenden IEA St George's uploaded over 400 pieces of evidence to the NHSE digital portal demonstrating compliance with each of the 49 question streams, rooted within the seven immediate and essential actions and workforce standards. This process was completed with deadline of the 30th June 2021.

### Compliance Report

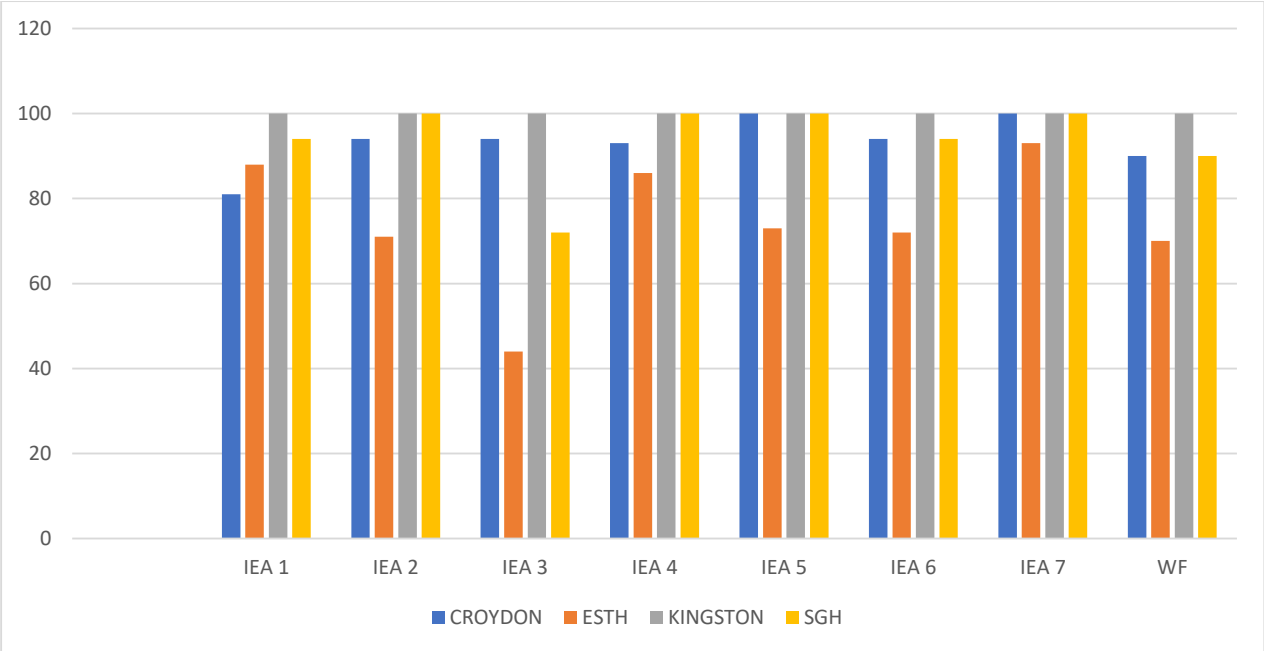
In October 2021 the Local Maternity and Neonatal System (LMNS) received feedback from NHS England on the Trust's compliance with the Ockenden Report's clinical priorities. In total the Trust submitted evidence in relation to all 128 questions. Further to a review of the evidence, the response from NHSE confirmed that St Georges had provided sufficient evidence for 121 of these questions achieving at the time of submission an overall compliance rate of **94%.** It was made clear that we were not able to submit new evidence at this time, however we will be able to point the assessors

to evidence they may have missed. We feel confident that we can provide robust evidence for all the questions where this was missed by the validators.

**SWL LMNS Compliance**




**SWL LMNS comparison on meeting all elements within each IEA**



## 3.0 Validators gaps in SGH assurance

| | | | | |
|---|---|---|---|---|
| **1 IEA Q7** | **Plan to implement the Perinatal Clinical Quality Surveillance Model Total** | Submit SOP and minutes and organogram of organisations involved that will support the above from the trust, signed of via the trust governance structure. | Validators 0% | SGH Evidence available to demonstrate compliance |
| | | **IEA1 Total** | **94%** | |

| | | | | |
|---|---|---|---|---|
| **3 IEA Q17 Q21 Q23 Q37** | **Multidisciplinary training and working occurs. Evidence must be externally validated through the LMS, 3 times a year.** | A clear trajectory in place to meet and maintain compliance as articulated in the TNA. (repeated across questions) | 0% | SGH Evidence available to demonstrate compliance |
| | | Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place. | 0% | |
| | | MTP spend reports to LMS | 0% | |
| | | **IEA3 Total** | **72%** | |

| | | | | |
|---|---|---|---|---|
| **Workforce Q45 Q20** | **Demonstrate an effective system of clinical workforce planning to the required standard** | Consider evidence of workforce planning at LMS/ICS level given this is the direction of travel of the people plan | Validators 0% | SGH Evidence available to demonstrate compliance |
| | | **WF Total** | **90%** | |

### Next Steps

The Regional London NHSE Maternity Team will be undertaking assurance meetings with each individual Maternity Service over the next few months. This will be to offer support and undertake a further review of the available evidence. The Regional Maternity Team are clinicians thus familiar with the various types of required evidence for each element. They will provide clarity and accurately determine where the submitted or available evidence is appropriate. We look forward to their visit and have the required and submitted information ready for their inspections.

The service is also currently undertaking a benchmarking exercise to review service provision and care against the 48 recommendations resulting from the Morecombe Bay report of 2015 (Kirkuk, 2015). We aim to compete this by April 2022 to offer additional assurance to the Board.

### Ockenden Two 2022

There will be a further iteration of IEA's from the second tranche of 250 cases investigated. This is expected to be published on the 22nd March 2022. We will respond to all the requirements accordingly.

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## Appendices

**South West London Local Maternity System - Evidence scores**

**IEA 1**

| IEA | | Action | Evidence Required | Croydon | EPSH | Kingston | STG | Total |
|---|---|---|---|---|---|---|---|---|
| IEA1 | Q1 | Maternity Dashboard to LMS every 3 months | Dashboard to be shared as evidence. | 100% | 100% | 100% | 100% | 100% |
| | | | Minutes and agendas to identify regular review and use of common data dashboards and the response / actions taken. | 100% | 100% | 100% | 100% | 100% |
| | | | SOP required which demonstrates how the trust reports this both internally and externally through the LMS. | 100% | 0% | 100% | 100% | 75% |
| | | | Submission of minutes and organogram, that shows how this takes place. | 100% | 100% | 100% | 100% | 100% |
| | | **Maternity Dashboard to LMS every 3 months Total** | | **100%** | **75%** | **100%** | **100%** | 94% |
| | Q2 | External clinical specialist opinion for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death | Audit to demonstrate this takes place. | 100% | 100% | 100% | 100% | 100% |
| | | | Policy or SOP which is in place for involving external clinical specialists in reviews. | 100% | 100% | 100% | 100% | 100% |
| | | **External clinical specialist opinion for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death Total** | | **100%** | **100%** | **100%** | **100%** | 100% |
| | Q3 & Q8 | Maternity SI's to Trust Board & LMS every 3 months | Individual SI's, overall summary of case, key learning, recommendations made, and actions taken to address with clear timescales for completion | 100% | 100% | 100% | 100% | 100% |
| | | | Submission of private trust board minutes as a minimum every three months with highlighted areas where SI's discussed | 100% | 100% | 100% | 100% | 100% |
| | | | Submit SOP | 100% | 100% | 100% | 100% | 100% |
| | | **Maternity SI's to Trust Board & LMS every 3 months Total** | | **100%** | **100%** | **100%** | **100%** | 100% |
| | Q4 & Q 12 | Using the National Perinatal Mortality Review Tool to review perinatal deaths | Audit of 100% of PMRT completed demonstrating meeting the required standard including parents notified as a minimum and external review. | 100% | 100% | 100% | 100% | 100% |
| | | | Local PMRT report. PMRT trust board report. Submission of a SOP that describes how parents and women are involved in the PMRT process as per the PMRT guidance. | 100% | 100% | 100% | 100% | 100% |
| | | **Using the National Perinatal Mortality Review Tool to review perinatal deaths Total** | | **100%** | **100%** | **100%** | **100%** | 100% |
| | Q5 | Submitting data to the Maternity Services Dataset to the required standard | Evidence of a plan for implementing the full MSDS requirements with clear timescales aligned to NHSR requirements within MIS. | 100% | 100% | 100% | 100% | 100% |
| | | **Submitting data to the Maternity Services Dataset to the required standard Total** | | **100%** | **100%** | **100%** | **100%** | 100% |

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| | Q6 | Reported 100% of qualifying cases to HSIB / NHS Resolution's Early Notification scheme | Audit showing compliance of 100% reporting to both HSIB and NHSR Early Notification Scheme. | 100% | 100% | 100% | 100% | 100% |
| | | **Reported 100% of qualifying cases to HSIB / NHS Resolution's Early Notification Scheme Total** | | **100%** | **100%** | **100%** | **100%** | 100% |
| | Q7 | Plan to implement the Perinatal Clinical Quality Surveillance Model | Full evidence of full implementation of the perinatal surveillance framework by June 2021. | 0% | 100% | 100% | 100% | 75% |
| | | | LMS SOP and minutes that describe how this is embedded in the ICS governance structure and signed off by the ICS. | 0% | 100% | 100% | 100% | 75% |
| | | | Submit SOP and minutes and organogram of organisations involved that will support the above from the trust, signed of via the trust governance structure. | 0% | 0% | 100% | 0% | 25% |
| | | **Plan to implement the Perinatal Clinical Quality Surveillance Model Total** | | **0%** | **67%** | **100%** | **67%** | 58% |
| | | **IEA1 Total** | | **81%** | **88%** | **100%** | **94%** | **91%** |
| | | | | **Croydon** | **EPSH** | **Kingston** | **STG** | **Total** |
| | | **IEA 2** | | | | | | |
| **IE A2** | **Q 11** | Non-executive director who has oversight of maternity services | Evidence of how all voices are represented: | 100% | 100% | 100% | 100% | 100% |
| | | | Evidence of link into MVP; any other mechanisms | 100% | 100% | 100% | 100% | 100% |
| | | | Evidence of NED sitting at trust board meetings, minutes of trust board where NED has contributed | 100% | 100% | 100% | 100% | 100% |
| | | | Evidence of ward to board and board to ward activities e.g., NED walk arounds and subsequent actions | 100% | 100% | 100% | 100% | 100% |
| | | | Name of NED and date of appointment | 100% | 100% | 100% | 100% | 100% |
| | | | NED JD | 100% | 0% | 100% | 100% | 75% |
| | | **Non-executive director who has oversight of maternity services Total** | | **100%** | **83%** | **100%** | **100%** | 96% |
| | **Q 13** | Demonstrate mechanism for gathering service user feedback, and work with service users through Maternity Voices Partnership to coproduce local maternity services | Clear co-produced plan, with MVP's that demonstrate that co-production and co-design of service improvements, changes and developments will be in place and will be embedded by December 2021. | 100% | 100% | 100% | 100% | 100% |
| | | | Evidence of service user feedback being used to support improvement in maternity services (E.G you said, we did, FFT, 15 Steps) | 100% | 100% | 100% | 100% | 100% |
| | | | Please upload your CNST evidence of co-production. If utilised, then upload completed templates for providers to successfully achieve maternity safety action 7. CNST templates to be signed off by the MVP. | 100% | 100% | 100% | 100% | 100% |
| | | **Demonstrate mechanism for gathering service user feedback, and work with service users through Maternity Voices Partnership to coproduce local maternity services Total** | | **100%** | **100%** | **100%** | **100%** | 100% |
| | **Q 14** | Trust safety champions meeting bimonthly with Board level champions | Action log and actions taken. | 100% | 0% | 100% | 100% | 75% |
| | | | Log of attendees and core membership. | 100% | 0% | 100% | 100% | 75% |
| | | | Minutes of the meeting and minutes of the LMS meeting where this is discussed. | 0% | 0% | 100% | 100% | 50% |
| | | | SOP that includes role descriptors for all key members who attend by-monthly safety meetings. | 100% | 100% | 100% | 100% | 100% |
| | | **Trust safety champions meeting bimonthly with Board level champions Total** | | **75%** | **25%** | **100%** | **100%** | 75% |

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| | Q 15 | Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services. | Clear co-produced plan, with MVP's that demonstrate that co-production and co-design of all service improvements, changes and developments will be in place and will be embedded by December 2021. | 100% | 100% | 100% | 100% | 100% |
| | | **Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services. Total** | | **100%** | **100%** | **100%** | **100%** | 100% |
| | Q 16 | Non-executive director supports the Board maternity safety champion | Evidence of participation and collaboration between ED, NED, and Maternity Safety Champion, e.g., evidence of raising issues at trust board, minutes of trust board and evidence of actions taken | 100% | 100% | 100% | 100% | 100% |
| | | | Name of ED and date of appointment | 100% | 100% | 100% | 100% | 100% |
| | | | Role descriptors | 100% | 0% | 100% | 100% | 75% |
| | | **Non-executive director supports the Board maternity safety champion Total** | | **100%** | **67%** | **100%** | **100%** | 92% |
| | | **IEA2 Total** | | **94%** | **71%** | **100%** | **100%** | **91%** |
| | | | | **Croydon** | **EPSH** | **Kingston** | **STG** | **Total** |
| **IEA 3** | | | | | | | | |
| IE A3 | Q 17 | Multidisciplinary training and working occurs. Evidence must be externally validated through the LMS, 3 times a year. | A clear trajectory in place to meet and maintain compliance as articulated in the TNA. | 100% | 0% | 100% | 0% | 50% |
| | | | LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data. | 100% | 100% | 100% | 100% | 100% |
| | | | Submit evidence of training sessions being attended, with clear evidence that all MDT members are represented for each session. | 100% | 0% | 100% | 100% | 75% |
| | | | Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements. | 100% | 100% | 100% | 100% | 100% |
| | | | Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place. | 100% | 0% | 100% | 0% | 50% |
| | | **Multidisciplinary training and working occurs. Evidence must be externally validated through the LMS, 3 times a year. Total** | | **100%** | **40%** | **100%** | **60%** | 75% |
| | Q 18 | Twice daily consultant-led and present multidisciplinary ward rounds on the labour ward. | Evidence of scheduled MDT ward rounds taking place since December, twice a day, day & night. 7 days a week (e.g., audit of compliance with SOP) | 100% | 0% | 100% | 100% | 75% |
| | | | SOP created for consultant led ward rounds. | 100% | 100% | 100% | 100% | 100% |
| | | **Twice daily consultant-led and present multidisciplinary ward rounds on the labour ward. Total** | | **100%** | **50%** | **100%** | **100%** | 88% |
| | Q 19 | External funding allocated for the training of maternity staff, is ring-fenced, and used for this purpose only | Confirmation from Directors of Finance | 100% | 100% | 100% | 100% | 100% |
| | | | Evidence from Budget statements. | 100% | 0% | 100% | 100% | 75% |
| | | | Evidence of funding received and spent. | 100% | 100% | 100% | 100% | 100% |
| | | | Evidence that additional external funding has been spent on funding including staff can attend training in work time. | 100% | 0% | 100% | 100% | 75% |
| | | | MTP spend reports to LMS | 0% | 0% | 100% | 0% | 25% |

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| | | **External funding allocated for the training of maternity staff, is ring-fenced, and used for this purpose only Total** | | **80%** | **40%** | **100%** | **80%** | 75% |
| | **Q 21** | 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session | A clear trajectory in place to meet and maintain compliance as articulated in the TNA. | 100% | 0% | 100% | 0% | 50% |
| | | | Attendance records - summarised | 100% | 100% | 100% | 100% | 100% |
| | | | LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data. Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place. | 100% | 100% | 100% | 100% | 100% |
| | | **90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session Total** | | **100%** | **67%** | **100%** | **67%** | 83% |
| | **Q 22** | Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week. | Evidence of scheduled MDT ward rounds taking place since December 2020 twice a day, day & night; 7 days a week (E.G audit of compliance with SOP) | 100% | 0% | 100% | 100% | 75% |
| | | **Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week. Total** | | **100%** | **0%** | **100%** | **100%** | 75% |
| | **Q 23** | The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime, we are seeking assurance that a MDT training schedule is in place | A clear trajectory in place to meet and maintain compliance as articulated in the TNA. | 100% | 0% | 100% | 0% | 50% |
| | | | LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation described as checking the accuracy of the data. | 100% | 100% | 100% | 100% | 100% |
| | | **The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place Total** | | **100%** | **50%** | **100%** | **50%** | 75% |
| | | | **IEA3 Total** | **94%** | **44%** | **100%** | **72%** | **78%** |
| | | | | **Croydon** | **EPSH** | **Kingston** | **STG** | **Total** |
| | | | **IEA 4** | | | | | |
| **IE A4** | **Q 24** | Links with the tertiary level Maternal Medicine Centre & agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre | Audit that demonstrates referral against criteria has been implemented that there is a named consultant lead, and early specialist involvement and that a Management plan that has been agreed between the women and clinicians | 100% | 100% | 100% | 100% | 100% |
| | | | SOP that clearly demonstrates the current maternal medicine pathways that includes: agreed criteria for referral to the maternal medicine centre pathway. | 100% | 100% | 100% | 100% | 100% |
| | | **Links with the tertiary level Maternal Medicine Centre & agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre Total** | | **100%** | **100%** | **100%** | **100%** | 100% |
| | **Q 25** | Women with complex pregnancies must have a named consultant lead | Audit of 1% of notes, where all women have complex pregnancies to demonstrate the woman has a named consultant lead. | 100% | 100% | 100% | 100% | 100% |
| | | | SOP that states that both women with complex pregnancies who require referral to maternal medicine networks and women with complex pregnancies but who do not require referral to maternal medicine network must have a named consultant lead. | 100% | 100% | 100% | 100% | 100% |

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| | | **Women with complex pregnancies must have a named consultant lead Total** | | **100%** | **100%** | **100%** | **100%** | 100% |
| | **Q 26** | Complex pregnancies have early specialist involvement and management plans agreed | Audit of 1% of notes, where women have complex pregnancies to ensure women have early specialist involvement and management plans are developed by the clinical team in consultation with the woman. | 100% | 100% | 100% | 100% | 100% |
| | | | SOP that identifies where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the teams. | 100% | 100% | 100% | 100% | 100% |
| | | **Complex pregnancies have early specialist involvement and management plans agreed Total** | | **100%** | **100%** | **100%** | **100%** | 100% |
| | **Q 27** | Compliance with all five elements of the Saving Babies' Lives care bundle Version 2 | Audits for each element. | 100% | 100% | 100% | 100% | 100% |
| | | | Guidelines with evidence for each pathway | 100% | 100% | 100% | 100% | 100% |
| | | | SOP's | 0% | 0% | 100% | 100% | 50% |
| | | **Compliance with all five elements of the Saving Babies' Lives care bundle Version 2 Total** | | **67%** | **67%** | **100%** | **100%** | 83% |
| | **Q 28** | All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place. | SOP that states women with complex pregnancies must have a named consultant lead. | 100% | 100% | 100% | 100% | 100% |
| | | | Submission of an audit plan to regularly audit compliance | 100% | 0% | 100% | 100% | 75% |
| | | **All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place. Total** | | **100%** | **50%** | **100%** | **100%** | 88% |
| | **Q 29** | Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres | Agreed pathways | 100% | 100% | 100% | 100% | 100% |
| | | | Criteria for referrals to MMC | 100% | 100% | 100% | 100% | 100% |
| | | | The maternity services involved in the establishment of maternal medicine networks evidenced by notes of meetings, agendas, action logs. | 100% | 100% | 100% | 100% | 100% |
| | | **Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres Total** | | **100%** | **100%** | **100%** | **100%** | 100% |
| **IEA4 Total** | | | | **93%** | **86%** | **100%** | **100%** | **95%** |
| | | | | **Croydon** | **EPSH** | **Kingston** | **STG** | **Total** |
| **IEA 5** | | | | | | | | |
| **IE A5** | **Q 30** | All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional | How this is achieved within the organisation. | 100% | 100% | 100% | 100% | 100% |
| | | | Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrates compliance of the above. | 100% | 100% | 100% | 100% | 100% |
| | | | Review and discussed and documented intended place of birth at every visit. | 100% | 0% | 100% | 100% | 75% |
| | | | SOP that includes definition of antenatal risk assessment as per NICE guidance. | 100% | 100% | 100% | 100% | 100% |
| | | | What is being risk assessed. | 100% | 100% | 100% | 100% | 100% |
| | | **All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional Total** | | **100%** | **80%** | **100%** | **100%** | 95% |
| | **Q 31** | Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture. | Evidence of referral to birth options clinics | 100% | 100% | 100% | 100% | 100% |
| | | | Out with guidance pathway. | 100% | 0% | 100% | 100% | 75% |
| | | | Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrates compliance of the above. | 100% | 100% | 100% | 100% | 100% |

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| | | | SOP that includes review of intended place of birth. | 100% | 0% | 100% | 100% | 75% |
| | | **Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture. Total** | | **100%** | **50%** | **100%** | **100%** | 88% |
| | **Q 33** | A risk assessment at every contact. Include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PCSP). Regular audit mechanisms are in place to assess PCSP compliance. | Example submission of a Personalised Care and Support Plan (It is important that we recognise that PCSP will be variable in how they are presented from each trust) | 100% | 100% | 100% | 100% | 100% |
| | | | How this is achieved in the organisation | 100% | 100% | 100% | 100% | 100% |
| | | | Personal Care and Support plans are in place and an ongoing audit of 5% of records that demonstrates compliance of the above. | 100% | 100% | 100% | 100% | 100% |
| | | | Review and discussed and documented intended place of birth at every visit. | 100% | 0% | 100% | 100% | 75% |
| | | | SOP to describe risk assessment being undertaken at every contact. | 100% | 100% | 100% | 100% | 100% |
| | | | What is being risk assessed. | 100% | 100% | 100% | 100% | 100% |
| | | **A risk assessment at every contact. Include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PCSP). Regular audit mechanisms are in place to assess PCSP compliance. Total** | | **100%** | **83%** | **100%** | **100%** | 96% |
| | | | **IEA5 Total** | **100%** | **73%** | **100%** | **100%** | **93%** |
| | | | | **Croydon** | **EPSH** | **Kingston** | **STG** | **Total** |
| | | | **IEA 6** | | | | | |
| **IE A6** | **Q 34 & Q 38** | Appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring | Copies of rotas / off duties to demonstrate they are given dedicated time. | 100% | 100% | 100% | 100% | 100% |
| | | | Examples of what the leads do with the dedicated time E.G attendance at external fetal wellbeing event, involvement with training, meeting minutes and action logs. | 100% | 100% | 100% | 100% | 100% |
| | | | Incident investigations and reviews | 100% | 100% | 100% | 100% | 100% |
| | | | Name of dedicated Lead Midwife and Lead Obstetrician | 100% | 100% | 100% | 100% | 100% |
| | | **Appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring Total** | | **100%** | **100%** | **100%** | **100%** | 100% |
| | **Q 35** | The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on elements of fetal health | Consolidating existing knowledge of monitoring fetal wellbeing | 100% | 0% | 100% | 100% | 75% |
| | | | Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported e.g., clinical supervision | 100% | 100% | 100% | 100% | 100% |
| | | | Improving the practice & raising the profile of fetal wellbeing monitoring | 100% | 100% | 100% | 100% | 100% |
| | | | Interface with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice. | 100% | 0% | 100% | 100% | 75% |
| | | | Job Description which has in the criteria as a minimum for both roles and confirmation that roles are in post | 100% | 100% | 100% | 100% | 100% |
| | | | Keeping abreast of developments in the field | 100% | 0% | 100% | 100% | 75% |
| | | | Lead on the review of cases of adverse outcome involving poor FHR interpretation and practice. | 100% | 100% | 100% | 100% | 100% |
| | | | Plan and run regular departmental fetal heart rate (FHR) monitoring meetings and training. | 100% | 100% | 100% | 100% | 100% |
| | | **The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on elements of fetal health Total** | | **100%** | **63%** | **100%** | **100%** | 91% |
| | **Q 36** | Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2? | Audits for each element | 100% | 100% | 100% | 100% | 100% |
| | | | Guidelines with evidence for each pathway | 100% | 100% | 100% | 100% | 100% |
| | | | SOP's | 0% | 0% | 100% | 100% | 50% |

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| | | **Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2? Total** | | **67%** | **67%** | **100%** | **100%** | 83% |
| | **Q 37** | Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019? | A clear trajectory in place to meet and maintain compliance as articulated in the TNA. | 100% | 0% | 100% | 0% | 50% |
| | | | Attendance records - summarised | 100% | 100% | 100% | 100% | 100% |
| | | | Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements. | 100% | 100% | 100% | 100% | 100% |
| | | **Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019? Total** | | **100%** | **67%** | **100%** | **67%** | 83% |
| | | | **IEA6 Total** | **94%** | **72%** | **100%** | **94%** | **90%** |
| | | | | **Croydon** | **EPSH** | **Kingt on** | **STG** | **Total** |
| | | | **IEA 7** | | | | | |
| **IE A7** | **Q 39 & Q 40** | Trusts ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery | Information on maternal choice including choice for caesarean delivery. | 100% | 100% | 100% | 100% | 100% |
| | | | Submission from MVP chair rating trust information in terms of accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites. | 100% | 100% | 100% | 100% | 100% |
| | | **Trusts ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery Total** | | **100%** | **100%** | **100%** | **100%** | 100% |
| | **Q 41** | Women must be enabled to participate equally in all decision-making processes | An audit of 1% of notes demonstrating compliance. | 100% | 100% | 100% | 100% | 100% |
| | | | CQC survey and associated action plans | 100% | 100% | 100% | 100% | 100% |
| | | | SOP which shows how women are enabled to participate equally in all decision-making processes and to make informed choices about their care. And where that is recorded. | 100% | 100% | 100% | 100% | 100% |
| | | **Women must be enabled to participate equally in all decision-making processes Total** | | **100%** | **100%** | **100%** | **100%** | 100% |
| | **Q 42** | Women's choices following a shared and informed decision-making process must be respected | An audit of 5% of notes demonstrating compliance, this should include women who have specifically requested a care pathway which may differ from that recommended by the clinician during the antenatal period, and a selection of women who request a caesarean section during labour or induction. | 100% | 100% | 100% | 100% | 100% |
| | | | SOP to demonstrate how women's choices are respected and how this is evidenced following a shared and informed decision-making process, and where that is recorded. | 100% | 100% | 100% | 100% | 100% |
| | | **Women's choices following a shared and informed decision-making process must be respected Total** | | **100%** | **100%** | **100%** | **100%** | 100% |
| | **Q 43** | Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services? | Clear co-produced plan, with MVP's that demonstrate that co-production and co-design of all service improvements, changes and developments will be in place and will be embedded by December 2021. | 100% | 100% | 100% | 100% | 100% |
| | | | Evidence of service user feedback being used to support improvement in maternity services (E.G you said, we did, FFT, 15 Steps) | 100% | 100% | 100% | 100% | 100% |
| | | | Please upload your CNST evidence of co-production. If utilised, then upload completed templates for providers to successfully achieve maternity safety action 7. CNST templates to be signed off by the MVP. | 100% | 100% | 100% | 100% | 100% |

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| | | **Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services? Total** | | **100%** | **100%** | **100%** | **100%** | 100% |
| | **Q 44** | Pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. | Co-produced action plan to address gaps identified | 100% | 100% | 100% | 100% | 100% |
| | | | Gap analysis of website against Chelsea & Westminster conducted by the MVP | 100% | 100% | 100% | 100% | 100% |
| | | | Information on maternal choice including choice for caesarean delivery. | 100% | 0% | 100% | 100% | 75% |
| | | | Submission from MVP chair rating trust information in terms of accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites. | 100% | 100% | 100% | 100% | 100% |
| | | **Pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. Total** | | **100%** | **75%** | **100%** | **100%** | 94% |
| | | **IEA7 Total** | | **100%** | **93%** | **100%** | **100%** | **98%** |
| | | | | **Croydon** | **EPSH** | **Kingston** | **STG** | **Total** |
| | | **WORKFORCE** | | | | | | |
| **WF** | **Q 45 & Q 20** | Demonstrate an effective system of clinical workforce planning to the required standard | Consider evidence of workforce planning at LMS/ICS level given this is the direction of travel of the people plan | 100% | 0% | 100% | 0% | 50% |
| | | | Evidence of reviews 6 monthly for all staff groups and evidence considered at board level. | 0% | 0% | 100% | 100% | 50% |
| | | | Most recent BR+ report and board minutes agreeing to fund. | 100% | 100% | 100% | 100% | 100% |
| | | **Demonstrate an effective system of clinical workforce planning to the required standard Total** | | **67%** | **33%** | **100%** | **67%** | 67% |
| | **Q 46** | Demonstrate an effective system of midwifery workforce planning to the required standard? | Most recent BR+ report and board minutes agreeing to fund. | 100% | 100% | 100% | 100% | 100% |
| | | **Demonstrate an effective system of midwifery workforce planning to the required standard? Total** | | **100%** | **100%** | **100%** | **100%** | 100% |
| | **Q 47** | Director/Head of Midwifery is responsible and accountable to an executive director | HoM/DoM Job Description with explicit signposting to responsibility and accountability to an executive director | 100% | 100% | 100% | 100% | 100% |
| | | **Director/Head of Midwifery is responsible and accountable to an executive director Total** | | **100%** | **100%** | **100%** | **100%** | 100% |
| | **Q 48** | Describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care: | Action plan where manifesto is not met | 100% | 0% | 100% | 100% | 75% |
| | | | Gap analysis completed against the RCM strengthening midwifery leadership: a manifesto for better maternity care | 100% | 100% | 100% | 100% | 100% |
| | | **Describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care: Total** | | **100%** | **50%** | **100%** | **100%** | 88% |
| | **Q 49** | Providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. | Audit to demonstrate all guidelines are in date. | 100% | 100% | 100% | 100% | 100% |
| | | | Evidence of risk assessment where guidance is not implemented. | 100% | 100% | 100% | 100% | 100% |
| | | | SOP in place for all guidelines with a demonstrable process for ongoing review. | 100% | 100% | 100% | 100% | 100% |

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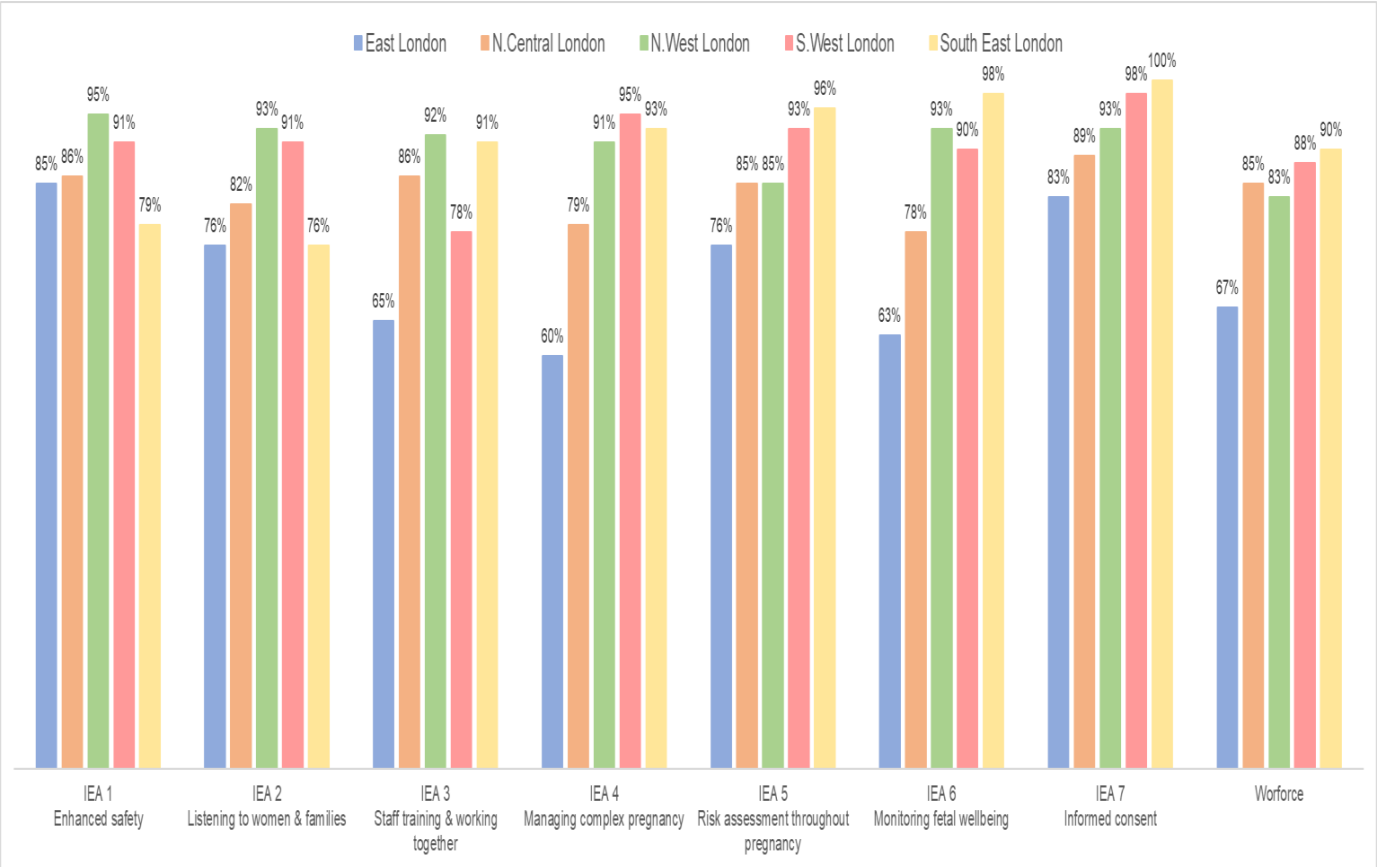
| | Providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Total | 100% | 100% | 100% | 100% | 100% |
| WF Total | | 90% | 70% | 100% | 90% | 88% |
| | | Croydon | EPSH | Kingston | STG | Total |

## London LMS comparison - meeting 100% of all elements within each IEA



Outstanding care every time

St George's University Hospitals NHS Foundation Trust

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| **Meeting Title:** | Trust Board | | |
| **Date:** | 31 March 2022 | **Agenda No** | 2.5 |
| **Report Title:** | **Addendum** - Ockenden Assurance Update Report for Maternity 2022 | | |
| **Lead Director/ Manager:** | Arlene Wellman, Group Chief Nursing Officer | | |
| **Report Author:** | Janet Bradley, Director of Midwifery and Gynaecology Outpatient Nursing | | |
| **Presented for:** | Update | | |
| **Executive Summary:** | Executive Summary<br><br>Following the publication of the Ockenden Report in December 2020, NHS England sought assurance from all maternity services across England that they benchmarked themselves against the Immediate & Essential Actions (IEAs) by February 2021. These included themes of:<br><br>1. Enhanced safety<br>2. Listening to women and families<br>3. Staff training and working together<br>4. Managing complex pregnancy<br>5. Risk assessment throughout pregnancy<br>6. Monitoring fetal wellbeing<br>7. Informed consent<br>8. Workforce<br><br>The Ockenden assurance programme has required multiple levels and types of assessment and evidence. These have included an initial self-assessment against the 7 IEA and workforce criteria which was submitted in March 2021.<br><br>The Trusts self-assessment assurance template was then scrutinised by the South West London (SWL) sector Local Maternity and Neonatal System (LMNS) in February 2021 and additionally by a Regional Peer Review panel in March 2021.<br><br>NHSE then requested additional evidence was submitted to an online portal which demonstrated provision of care, pathways and framework that support the required IEA's. This element was completed on the 30th June 2021.<br><br>The outcome of this stage of the assurance process was delayed until December 2021. The delay was caused by multiple challenges which included both logistical aspects and concerns raised by the Regional Chief Midwives surrounding the validity and credibility of the responsible validators.<br><br>The reporting and governance framework across and upwards in the Trust has been via Divisional Board meetings, Patient Safety and Quality groups and Quality Safety Committee.<br><br>The Ockenden report and its requirements was presented at QSC in December 2020. The initial response and confirmation the Trusts was committed to reach compliance was taken to DMB, PSQG and QSC in January 2021. | | |

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| | At the April 2021 Board we reported to the Trust on the progress of the requested assessment and assurance template to NHS England which had been approved by the Trust Board Safety Champion (Chief Nurse) Non-Executive Director (specifically appointed for maternity and neonatal services) and the Chair and Chief Executive.<br><br>In May 2021 we received a further request from NHS England for evidence to support our compliance with all the 7 IEAs, together with workforce planning, midwifery leadership and compliance with NICE guidelines.<br><br>At the October and November 2021 Boards we confirmed the requested evidence has been submitted to NHS England in June 2021 and the information was also shared with the Local Maternity and Neonatal System Board. Since this time, the Quality Safety Committee has continued to provide oversight of the Trust's compliance with Ockenden and other maternity service quality standards.<br><br>In December 2021 the Regional teams, the Local Maternity and Neonatal System (LMNS) and St Georges received feedback from NHSE regarding the Ockenden evidence submission. The attached report of Feb 2022 confirmed the compliance position status at that time.<br><br>This addendum to the report confirms that following further scrutiny by the NHSE regional teams of the evidence submitted we are confirmed to be **100%** compliant with all aspects of the IEA described in the Ockenden 2020 report. |
| **Recommendation:** | **To note confirmation of 100% compliance by the Maternity Services in relation to the Ockenden IEA of Dec 2020.** |
| **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.<br><br>• **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.<br>• **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.<br>• **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.<br>• **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.<br>• |

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| **Supports** | | |
| **Trust Strategic Objective:** | • The strategic objectives are to deliver full compliance with regulatory quality indicators and the national maternity patient safety, quality, and experience indicators | |
| **CQC Theme:** | • Safe, Effective, Caring, Responsive, Well led | |
| **Single Oversight Framework Theme:** | | |
| **Implications** | | |
| **Risk:** | Workforce and estates | |
| **Legal/Regulatory:** | NHSE - Ockenden report immediate and essential actions<br>CQC standards | |
| **Resources:** | Workforce | |
| **Equality and Diversity:** | Culture | |
| **Previously Considered by:** | Divisional Management Group<br>Patient Safety and Quality Group<br>Trust Management Board<br>Quality and Safety Committee | 15 Feb 2022<br>16 Feb 2022<br>23 Mar 2022<br>24 Mar 2022 |
| **Appendices:** | | |

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St George's University Hospitals NHS Foundation Trust

# Ockenden Assurance Update Report for Maternity Quality Safety Committee

## 1.0 PURPOSE

This report provides an update to the Trust Board on compliance with the 2020 Ockenden Report recommendations.

## 2.0 Ockenden National review of maternity services - background

In the summer of 2017, following a letter from bereaved families raising concerns where babies and mothers died or potentially suffered significant harm whilst receiving maternity care at The Shrewsbury and Telford Hospital NHS Trust, the former Secretary of State for Health and Social Care, Jeremy Hunt, instructed NHS Improvement to commission a review assessing the quality of investigations relating to new-born, infant and maternal harm at The Shrewsbury and Telford Hospital NHS Trust.

The first terms of reference in 2017 were written for a review comprising 23 families. These were then amended in November 2019 to encompass a much larger number of families who had come forward to raise concerns.

The review is looking at maternal and neonatal harm between the years 2000 and 2019 and includes cases of stillbirth, neonatal death, maternal death, hypoxic ischaemic encephalopathy (HIE) (grades 2 and 3) and other severe complications in mothers and new-born babies. The total number of families to be included in the final review and report will be 1,862.

This initial and first Ockenden report refers to 250 cases reviewed to date. The number of cases considered so far includes the original cohort of 23 cases. The review panel has identified important themes which must be shared across all maternity services as a matter of urgency and have formed Local Actions for Learning and make seven early recommendations for the wider NHS, labelled Immediate and Essential Actions (IEA).

The immediate requirement in December 2020 was to submit a letter of confirmation from the CEO also signed by Local Maternity System (LMS) Chair was submitted to NHSE describing the Trusts absolute commitment to fulfil and comply with the requirements of the IEA. An initial paper describing the requirement was presented and reviewed, commitment was supported at each board and the letter from St Georges CEO was submitted accordingly.

The maternity service has also completed the assurance assessment tool which reflects the position of the Trust in relation to elements including:

1) All seven IEAs of the Ockenden report
2) NICE guidance relating to maternity
3) Compliance against the CNST (Clinical Negligence Scheme for Trusts) safety actions
4) A current workforce gap analysis

These assurances have been reported locally via Divisional Management Board DMB, at Trust level via Patient Safety Quality Group (PSQG) and Quality Safety Committee (QSC) through the SWL

LMNS and submitted to the Regional teams in March 2021. This gap and thematic analysis were reported to the regional and national Maternity Transformation Boards.

To review staffing within the service and support the submission to Ockenden, the service completed the BirthRate Plus (BR+) midwifery staffing workforce review, including confirming timescales for implementation to achieve the recommendations. The completed BR+ maternity workforce review was undertaken within time and findings reported on 6th May 2021.

The BR+ report concluded that an additional 15.6 WTE clinical midwives and an additional 12 WTE Band 3 MSW support staff were required to reach minimal safe staffing levels at St Georges with a minimum recommended ratio of 1:24 midwives to births.

Additional national funding for maternity staffing was released by NHSE in May 2021. The BR+ workforce report including additional relevant WTE uplift required to enable the service to fulfil maternity mandatory training requirements, were used to support and inform the funding bid for St Georges. The results of the workforce funding bid were released in July 2021.

**Bid submitted**: 22 WTE midwives - 17 WTE midwives in main bid with an additional 5 WTE x MW (and 12 x Band 3 MSW and 1.9 WTE Obstetric Consultant) to support safe care and MDT training requirements as per Ockenden safety drivers.

**Award given**: 15.6 WTE Midwives, 0.5 WTE Obstetric Consultant. 2.56 WTE Midwifery Support Worker (MSW) support funded.

**Variance**: 6.4WTE midwives, 9.44 WTE band 3 MSW, 1.4WTE Obstetrician remain unfunded. The shortfall of funding will be reviewed through 2022/23 budget setting rounds.

The variance leaves a significant gap in recommended safe staffing levels and ratios specifically across MSW roles. The BirthRate plus report uses a ratio of 90:10 (midwife to MSW) to calculate the recommended safe staffing levels to appropriately support all pathways of care to meet the demands of both the community and inpatient settings. The service currently has a combined ratio of 1:25.5 so does not meet this overall recommended staffing ratio of 1:24 midwife to women.

## 2.1 Assurance of the evidence to demonstrate IEA for the initial Ockenden report

As part of the ongoing assurance processes for the Ockenden IEA St George's uploaded over 400 pieces of evidence to the NHSE digital portal demonstrating compliance with each of the 49 question streams, rooted within the seven immediate and essential actions and workforce standards. This process was completed with deadline of the 30th June 2021.

### Compliance Report

In October 2021 the Local Maternity and Neonatal System (LMNS) received feedback from NHS England on the Trust's compliance with the Ockenden Report's clinical priorities. In total the Trust submitted evidence in relation to all 128 questions. Further to a review of the evidence, the response from NHSE confirmed that St Georges had provided sufficient evidence for 121 of these questions achieving at the time of submission an overall compliance rate of **94%.** It was made clear that we were not able to submit new evidence at this time, however the DoM has met with the regional

Obstetric Lead for London, Ms Suzie Crowe and signposted her to evidence demonstrating compliance we requested. Confirmation by the NHSE regional teams was then given on 17.03.2022 to the Trust that we are now 100% with all IEA's.

| Summary of movement | | |
|---|---|---|
| | Dec-21 | Mar-22 |
| IEA 1 | 94% | 100% |
| IEA 2 | 100% | 100% |
| IEA 3 | 72% | 100% |
| IEA 4 | 100% | 100% |
| IEA 5 | 100% | 100% |
| IEA 6 | 94% | 100% |
| IEA 7 | 100% | 100% |
| Workforce | 90% | 100% |

## 3.0 Validators confirmation of SGH assurance

| | | | | |
|---|---|---|---|---|
| **1 IEA Q7** | **Plan to implement the Perinatal Clinical Quality Surveillance Model Total** | Submit SOP and minutes and organogram of organisations involved that will support the above from the trust, signed of via the trust governance structure. | Validators agree | SGH Evidence demonstrates compliance |
| | | | **IEA1 Total** | **100%** |

| | | | | |
|---|---|---|---|---|
| **3 IEA Q17 Q21 Q23 Q37** | **Multidisciplinary training and working occurs. Evidence must be externally validated through the LMS, 3 times a year.** | A clear trajectory in place to meet and maintain compliance as articulated in the TNA. (repeated across questions) | 100% | SGH Evidence demonstrates compliance |
| | | Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place. | 100% | |
| | | MTP spend reports to LMS | 100% | |
| | | | **IEA3 Total** | **100%** |

| | | | | |
|---|---|---|---|---|
| **Workforce Q45 Q20** | **Demonstrate an effective system of clinical workforce planning to the required standard** | Consider evidence of workforce planning at LMS/ICS level given this is the direction of travel of the people plan | Validators 100% | SGH Evidence demonstrates compliance |
| | | | **WF Total** | **100%** |

## Next Steps

The service is also currently undertaking a benchmarking exercise to review service provision and care against the 48 recommendations resulting from the Morecombe Bay report of 2015 (Kirkuk, 2015). We aim to compete this by April 2022 to offer additional assurance to the Board.

**Ockenden Two 2022**

There will be a further iteration of IEA's from the second tranche of 250 cases investigated. This is expected to be published on the 22nd March 2022. We will respond to all the requirements accordingly.

**Appendices**

| IEA | | Action | Evidence Required | STG |
|---|---|---|---|---|
| IEA1 | Q1 | Maternity Dashboard to LMS every 3 months | Dashboard to be shared as evidence. | 100% |
| | | | Minutes and agendas to identify regular review and use of common data dashboards and the response / actions taken. | 100% |
| | | | SOP required which demonstrates how the trust reports this both internally and externally through the LMS. | 100% |
| | | | Submission of minutes and organogram, that shows how this takes place. | 100% |
| | | **Maternity Dashboard to LMS every 3 months Total** | | **100%** |
| | Q2 | External clinical specialist opinion for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death | Audit to demonstrate this takes place. | 100% |
| | | | Policy or SOP which is in place for involving external clinical specialists in reviews. | 100% |
| | | **External clinical specialist opinion for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death Total** | | **100%** |
| | Q3 & Q8 | Maternity SI's to Trust Board & LMS every 3 months | Individual SI's, overall summary of case, key learning, recommendations made, and actions taken to address with clear timescales for completion | 100% |
| | | | Submission of private trust board minutes as a minimum every three months with highlighted areas where SI's discussed | 100% |
| | | | Submit SOP | 100% |
| | | **Maternity SI's to Trust Board & LMS every 3 months Total** | | **100%** |
| | Q4 & Q 12 | Using the National Perinatal Mortality Review Tool to review perinatal deaths | Audit of 100% of PMRT completed demonstrating meeting the required standard including parents notified as a minimum and external review. | 100% |
| | | | Local PMRT report. PMRT trust board report. Submission of a SOP that describes how parents and women are involved in the PMRT process as per the PMRT guidance. | 100% |
| | | **Using the National Perinatal Mortality Review Tool to review perinatal deaths Total** | | **100%** |

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|---|---|---|---|---|
| | Q5 | Submitting data to the Maternity Services Dataset to the required standard | Evidence of a plan for implementing the full MSDS requirements with clear timescales aligned to NHSR requirements within MIS. | 100% |
| | | **Submitting data to the Maternity Services Dataset to the required standard Total** | | **100%** |
| | Q6 | Reported 100% of qualifying cases to HSIB / NHS Resolution's Early Notification scheme | Audit showing compliance of 100% reporting to both HSIB and NHSR Early Notification Scheme. | 100% |
| | | **Reported 100% of qualifying cases to HSIB / NHS Resolution's Early Notification Scheme Total** | | **100%** |
| | Q7 | Plan to implement the Perinatal Clinical Quality Surveillance Model | Full evidence of full implementation of the perinatal surveillance framework by June 2021. | 100% |
| | | | LMS SOP and minutes that describe how this is embedded in the ICS governance structure and signed off by the ICS. | 100% |
| | | | Submit SOP and minutes and organogram of organisations involved that will support the above from the trust, signed of via the trust governance structure. | 100% |
| | | **Plan to implement the Perinatal Clinical Quality Surveillance Model Total** | | **100%** |
| | | | **IEA1 Total** | **100%** |
| | | | | **STG** |

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| IE A2 | Q 11 | Non-executive director who has oversight of maternity services | Evidence of how all voices are represented: | 100% |
| | | | Evidence of link into MVP; any other mechanisms | 100% |
| | | | Evidence of NED sitting at trust board meetings, minutes of trust board where NED has contributed | 100% |
| | | | Evidence of ward to board and board to ward activities e.g., NED walk arounds and subsequent actions | 100% |
| | | | Name of NED and date of appointment | 100% |
| | | | NED JD | 100% |
| | | **Non-executive director who has oversight of maternity services Total** | | **100%** |
| | Q 13 | Demonstrate mechanism for gathering service user feedback, and work with service users through Maternity Voices Partnership to coproduce local maternity services | Clear co-produced plan, with MVP's that demonstrate that co-production and co-design of service improvements, changes and developments will be in place and will be embedded by December 2021. | 100% |
| | | | Evidence of service user feedback being used to support improvement in maternity services (E.G you said, we did, FFT, 15 Steps) | 100% |
| | | | Please upload your CNST evidence of co-production. If utilised, then upload completed templates for providers to successfully achieve maternity safety action 7. CNST templates to be signed off by the MVP. | 100% |
| | | **Demonstrate mechanism for gathering service user feedback, and work with service users through Maternity Voices Partnership to coproduce local maternity services Total** | | **100%** |
| | Q 14 | Trust safety champions meeting bimonthly with Board level champions | Action log and actions taken. | 100% |
| | | | Log of attendees and core membership. | 100% |
| | | | Minutes of the meeting and minutes of the LMS meeting where this is discussed. | 100% |
| | | | SOP that includes role descriptors for all key members who attend by-monthly safety meetings. | 100% |
| | | **Trust safety champions meeting bimonthly with Board level champions Total** | | **100%** |

| | | | | |
|---|---|---|---|---|
| | Q 15 | Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services. | Clear co-produced plan, with MVP's that demonstrate that co-production and co-design of all service improvements, changes and developments will be in place and will be embedded by December 2021. | 100% |
| | | **Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services. Total** | | **100%** |
| | Q 16 | Non-executive director supports the Board maternity safety champion | Evidence of participation and collaboration between ED, NED, and Maternity Safety Champion, e.g., evidence of raising issues at trust board, minutes of trust board and evidence of actions taken | 100% |
| | | | Name of ED and date of appointment | 100% |
| | | | Role descriptors | 100% |
| | | **Non-executive director supports the Board maternity safety champion Total** | | **100%** |
| | | | **IEA2 Total** | **100%** |
| | | | | **STG** |

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|---|---|---|---|---|
| IE A3 | Q 17 | Multidisciplinary training and working occurs. Evidence must be externally validated through the LMS, 3 times a year. | A clear trajectory in place to meet and maintain compliance as articulated in the TNA. | 100% |
| | | | LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data. | 100% |
| | | | Submit evidence of training sessions being attended, with clear evidence that all MDT members are represented for each session. | 100% |
| | | | Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements. | 100% |
| | | | Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place. | 100% |
| | | **Multidisciplinary training and working occurs. Evidence must be externally validated through the LMS, 3 times a year. Total** | | **100%** |
| | Q 18 | Twice daily consultant-led and present multidisciplinary ward rounds on the labour ward. | Evidence of scheduled MDT ward rounds taking place since December, twice a day, day & night. 7 days a week (e.g., audit of compliance with SOP) | 100% |
| | | | SOP created for consultant led ward rounds. | 100% |
| | | **Twice daily consultant-led and present multidisciplinary ward rounds on the labour ward. Total** | | **100%** |
| | Q 19 | External funding allocated for the training of maternity staff, is ring-fenced, and used for this purpose only | Confirmation from Directors of Finance | 100% |
| | | | Evidence from Budget statements. | 100% |
| | | | Evidence of funding received and spent. | 100% |
| | | | Evidence that additional external funding has been spent on funding including staff can attend training in work time. | 100% |
| | | | MTP spend reports to LMS | 100% |

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| | | **External funding allocated for the training of maternity staff, is ring-fenced, and used for this purpose only Total** | | **100%** |
| | **Q 21** | 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session | A clear trajectory in place to meet and maintain compliance as articulated in the TNA. | 100% |
| | | | Attendance records - summarised | 100% |
| | | | LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data. Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place. | 100% |
| | | **90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session Total** | | **100%** |
| | **Q 22** | Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week. | Evidence of scheduled MDT ward rounds taking place since December 2020 twice a day, day & night; 7 days a week (E.G audit of compliance with SOP) | 100% |
| | | **Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week. Total** | | **100%** |
| | **Q 23** | The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime, we are seeking assurance that a MDT training schedule is in place | A clear trajectory in place to meet and maintain compliance as articulated in the TNA. | 100% |
| | | | LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation described as checking the accuracy of the data. | 100% |
| | | **The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place Total** | | **100%** |
| | | | **IEA3 Total** | **100%** |
| | | | | **STG** |

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| **IE A4** | **Q 24** | Links with the tertiary level Maternal Medicine Centre & agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre | Audit that demonstrates referral against criteria has been implemented that there is a named consultant lead, and early specialist involvement and that a Management plan that has been agreed between the women and clinicians | 100% |
| | | | SOP that clearly demonstrates the current maternal medicine pathways that includes: agreed criteria for referral to the maternal medicine centre pathway. | 100% |
| | | **Links with the tertiary level Maternal Medicine Centre & agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre Total** | | **100%** |
| | **Q 25** | Women with complex pregnancies must have a named consultant lead | Audit of 1% of notes, where all women have complex pregnancies to demonstrate the woman has a named consultant lead. | 100% |
| | | | SOP that states that both women with complex pregnancies who require referral to maternal medicine networks and women with complex pregnancies but who do not require referral to maternal medicine network must have a named consultant lead. | 100% |

| | | | | |
|---|---|---|---|---|
| | | **Women with complex pregnancies must have a named consultant lead Total** | | **100%** |
| | **Q 26** | Complex pregnancies have early specialist involvement and management plans agreed | Audit of 1% of notes, where women have complex pregnancies to ensure women have early specialist involvement and management plans are developed by the clinical team in consultation with the woman. | 100% |
| | | | SOP that identifies where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the teams. | 100% |
| | | **Complex pregnancies have early specialist involvement and management plans agreed Total** | | **100%** |
| | **Q 27** | Compliance with all five elements of the Saving Babies' Lives care bundle Version 2 | Audits for each element. | 100% |
| | | | Guidelines with evidence for each pathway | 100% |
| | | | SOP's | 100% |
| | | **Compliance with all five elements of the Saving Babies' Lives care bundle Version 2 Total** | | **100%** |
| | **Q 28** | All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place. | SOP that states women with complex pregnancies must have a named consultant lead. | 100% |
| | | | Submission of an audit plan to regularly audit compliance | 100% |
| | | **All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place. Total** | | **100%** |
| | **Q 29** | Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres | Agreed pathways | 100% |
| | | | Criteria for referrals to MMC | 100% |
| | | | The maternity services involved in the establishment of maternal medicine networks evidenced by notes of meetings, agendas, action logs. | 100% |
| | | **Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres Total** | | **100%** |
| **IEA4 Total** | | | | **100%** |
| | | | | **STG** |

| | | | | |
|---|---|---|---|---|
| **IE A5** | **Q 30** | All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional | How this is achieved within the organisation. | 100% |
| | | | Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrates compliance of the above. | 100% |
| | | | Review and discussed and documented intended place of birth at every visit. | 100% |
| | | | SOP that includes definition of antenatal risk assessment as per NICE guidance. | 100% |
| | | | What is being risk assessed. | 100% |
| | | **All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional Total** | | **100%** |
| | **Q 31** | Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture. | Evidence of referral to birth options clinics | 100% |
| | | | Out with guidance pathway. | 100% |
| | | | Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrates compliance of the above. | 100% |

| | | | | |
|---|---|---|---|---|
| | | | SOP that includes review of intended place of birth. | 100% |
| | | **Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture. Total** | | **100%** |
| | **Q 33** | A risk assessment at every contact. Include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PCSP). Regular audit mechanisms are in place to assess PCSP compliance. | Example submission of a Personalised Care and Support Plan (It is important that we recognise that PCSP will be variable in how they are presented from each trust) | 100% |
| | | | How this is achieved in the organisation | 100% |
| | | | Personal Care and Support plans are in place and an ongoing audit of 5% of records that demonstrates compliance of the above. | 100% |
| | | | Review and discussed and documented intended place of birth at every visit. | 100% |
| | | | SOP to describe risk assessment being undertaken at every contact. | 100% |
| | | | What is being risk assessed. | 100% |
| | | **A risk assessment at every contact. Include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PCSP). Regular audit mechanisms are in place to assess PCSP compliance. Total** | | **100%** |
| | | | **IEA5 Total** | **100%** |
| | | | | **STG** |

| | | | | |
|---|---|---|---|---|
| **IE A6** | **Q 34 & Q 38** | Appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring | Copies of rotas / off duties to demonstrate they are given dedicated time. | 100% |
| | | | Examples of what the leads do with the dedicated time E.G attendance at external fetal wellbeing event, involvement with training, meeting minutes and action logs. | 100% |
| | | | Incident investigations and reviews | 100% |
| | | | Name of dedicated Lead Midwife and Lead Obstetrician | 100% |
| | | **Appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring Total** | | **100%** |
| | **Q 35** | The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on elements of fetal health | Consolidating existing knowledge of monitoring fetal wellbeing | 100% |
| | | | Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported e.g., clinical supervision | 100% |
| | | | Improving the practice & raising the profile of fetal wellbeing monitoring | 100% |
| | | | Interface with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice. | 100% |
| | | | Job Description which has in the criteria as a minimum for both roles and confirmation that roles are in post | 100% |
| | | | Keeping abreast of developments in the field | 100% |
| | | | Lead on the review of cases of adverse outcome involving poor FHR interpretation and practice. | 100% |
| | | | Plan and run regular departmental fetal heart rate (FHR) monitoring meetings and training. | 100% |
| | | **The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on elements of fetal health Total** | | **100%** |
| | **Q 36** | Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2? | Audits for each element | 100% |
| | | | Guidelines with evidence for each pathway | 100% |
| | | | SOP's | 100% |

| | | | | |
|---|---|---|---|---|
| | | **Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2? Total** | | **100%** |
| | **Q 37** | Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019? | A clear trajectory in place to meet and maintain compliance as articulated in the TNA. | 100% |
| | | | Attendance records - summarised | 100% |
| | | | Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements. | 100% |
| | | **Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019? Total** | | **100%** |
| | | | **IEA6 Total** | **100%** |
| | | | | **STG** |

| | | | | |
|---|---|---|---|---|
| **IE A7** | **Q 39 & Q 40** | Trusts ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery | Information on maternal choice including choice for caesarean delivery. | 100% |
| | | | Submission from MVP chair rating trust information in terms of accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites. | 100% |
| | | **Trusts ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery Total** | | **100%** |
| | **Q 41** | Women must be enabled to participate equally in all decision-making processes | An audit of 1% of notes demonstrating compliance. | 100% |
| | | | CQC survey and associated action plans | 100% |
| | | | SOP which shows how women are enabled to participate equally in all decision-making processes and to make informed choices about their care. And where that is recorded. | 100% |
| | | **Women must be enabled to participate equally in all decision-making processes Total** | | **100%** |
| | **Q 42** | Women's choices following a shared and informed decision-making process must be respected | An audit of 5% of notes demonstrating compliance, this should include women who have specifically requested a care pathway which may differ from that recommended by the clinician during the antenatal period, and a selection of women who request a caesarean section during labour or induction. | 100% |
| | | | SOP to demonstrate how women's choices are respected and how this is evidenced following a shared and informed decision-making process, and where that is recorded. | 100% |
| | | **Women's choices following a shared and informed decision-making process must be respected Total** | | **100%** |
| | **Q 43** | Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services? | Clear co-produced plan, with MVP's that demonstrate that co-production and co-design of all service improvements, changes and developments will be in place and will be embedded by December 2021. | 100% |
| | | | Evidence of service user feedback being used to support improvement in maternity services (E.G you said, we did, FFT, 15 Steps) | 100% |
| | | | Please upload your CNST evidence of co-production. If utilised, then upload completed templates for providers to successfully achieve maternity safety action 7. CNST templates to be signed off by the MVP. | 100% |

| | | | | |
|---|---|---|---|---|
| | | **Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services? Total** | | **100%** |
| | **Q 44** | Pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. | Co-produced action plan to address gaps identified | 100% |
| | | | Gap analysis of website against Chelsea & Westminster conducted by the MVP | 100% |
| | | | Information on maternal choice including choice for caesarean delivery. | 100% |
| | | | Submission from MVP chair rating trust information in terms of accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites. | 100% |
| | | **Pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. Total** | | **100%** |
| | | | **IEA7 Total** | **100%** |
| | | | | **STG** |

| | | | | |
|---|---|---|---|---|
| **WF** | **Q 45 & Q 20** | Demonstrate an effective system of clinical workforce planning to the required standard | Consider evidence of workforce planning at LMS/ICS level given this is the direction of travel of the people plan | 100% |
| | | | Evidence of reviews 6 monthly for all staff groups and evidence considered at board level. | 100% |
| | | | Most recent BR+ report and board minutes agreeing to fund. | 100% |
| | | **Demonstrate an effective system of clinical workforce planning to the required standard Total** | | **100%** |
| | **Q 46** | Demonstrate an effective system of midwifery workforce planning to the required standard? | Most recent BR+ report and board minutes agreeing to fund. | 100% |
| | | **Demonstrate an effective system of midwifery workforce planning to the required standard? Total** | | **100%** |
| | **Q 47** | Director/Head of Midwifery is responsible and accountable to an executive director | HoM/DoM Job Description with explicit signposting to responsibility and accountability to an executive director | 100% |
| | | **Director/Head of Midwifery is responsible and accountable to an executive director Total** | | **100%** |
| | **Q 48** | Describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care: | Action plan where manifesto is not met | 100% |
| | | | Gap analysis completed against the RCM strengthening midwifery leadership: a manifesto for better maternity care | 100% |
| | | **Describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care: Total** | | **100%** |
| | **Q 49** | Providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. | Audit to demonstrate all guidelines are in date. | 100% |
| | | | Evidence of risk assessment where guidance is not implemented. | 100% |
| | | | SOP in place for all guidelines with a demonstrable process for ongoing review. | 100% |

| | | | |
|---|---|---|---|
| | | **Providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Total** | **100%** |
| | | **WF Total** | **100%** |
| | | | **STG** |

St George's University Hospitals NHS
NHS Foundation Trust

| | | | |
|---|---|---|---|
| **Meeting Title:** | Trust Board | | |
| **Date:** | 31 March 2022 | **Agenda No** | 2.6 |
| **Report Title:** | Statement of Purpose: Change of Registered Manager | | |
| **Lead Director/ Manager:** | Arlene Wellman, Group Chief Nursing Officer | | |
| **Report Author:** | Alison Benincasa, Director of Quality Governance and Compliance | | |
| **Presented for:** | Approval | | |
| **Executive Summary:** | **1.0 Context**<br><br>All organisations registered with the CQC are required by law to have a Statement of Purpose: the document includes a standard set of information about Trust services. The Statement of Purpose must be approved by the Board on an annual basis and any significant changes should be notified to the CQC.<br><br>For St George's University Hospitals NHS Foundation Trust (SGH) the Statement of Purpose at Appendix 1 provides the legal status of the Trust and the contact details for service of documents, describes the aims in providing healthcare services and the details of each of registered location. For each location the regulated activities and services provided are listed. The service user groups, as defined by the CQC, are also given.<br><br>**2.0 Purpose**<br><br>On 1 February 2022 the new St George's and Epsom and St Helier University Hospitals and Health Group (GESH) was formed.<br><br>It is recommended that the new Group Chief Nursing Officer is the registered manager for both Trusts within GESH.<br><br>**3.0 Change Proposal: Registered Manager SGH**<br><br>It is recommended to change the registered manager for SGH from the outgoing Chief Nurse and Director of Infection Prevention and Control to the new Group Chief Nursing Officer. The changes made with reference to the registered manager are reflected in the SGH Statement of Purpose at Appendix 1 on pages 10, 15, 21 and 29 and are shown in red text.<br><br>**Note:** From 7 February 2022 the South London and East Surrey Abdominal Aortic Aneurysm Screening Programme service was transferred to the new service provider, InHealth Group. This change to contracted services does not impact the SGH Statement of Purpose. | | |
| **Recommendation:** | Board is asked to:<br><br>1. Note and approve the change of registered manager | | |

St George's University Hospitals NHS
NHS Foundation Trust

| Supports | | | |
|---|---|---|---|
| **Trust Strategic Objective:** | All | | |
| **CQC Theme:** | Well led | | |
| **Single Oversight Framework Theme:** | Leadership and Improvement Capability (well led) | | |
| **Implications** | | | |
| **Risk:** | | | |
| **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 | | |
| **Equality and Diversity:** | No issues to consider | | |
| **Previously Considered by:** | | **Date** | |
| **Appendices:** | Appendix 1 - St George's University Hospitals NHS Foundation Trust Statement of Purpose March 2022 | | |

# Statement of purpose

Health and Social Care Act 2008

## Part 1

## The provider’s name, legal status, address and other contact details

Including address for service of notices and other documents

Please first read the guidance document *Statement of purpose: Guidance for providers*

## Statement of purpose, Part 1

Health and Social Care Act 2008, Regulation 12, schedule 3

The provider's business contact details, including address for service of notices and other documents, in accordance with Sections 93 and 94 of the Health and Social Care Act 2008

| **1. Provider's name and legal status** | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Full name**[1] | **St George's University Hospitals NHS Foundation Trust** | | | | | | |
| **CQC provider ID** | **RJ7** | | | | | | |
| **Legal status**[1] | Individual | ☐ | Partnership | ☐ | Organisation | ☒ | |

| **2. Provider's address, including for service of notices and other documents** | |
|---|---|
| **Business address**[2] | St George's Hospital<br>Blackshaw Road<br>Tooting |
| **Town/city** | **London** |
| **County** | |
| **Post code** | **SW17 0QT** |
| **Business telephone** | **020 8725 1635** |
| **Electronic mail (email)**[3] | **Jacqueline.totterdell@stgeorges.nhs.uk** |

By submitting this statement of purpose you are confirming your willingness for CQC to use the **email address** supplied at Section 2 above for service of documents and for sending all other correspondence to you. Email ensures fast and efficient delivery of important information. If you do not want to receive documents by email please check or tick the box below. We will not share this email address with anyone else.

| | | |
|---|---|---|
| I/we do **NOT** wish to receive notices and other documents from CQC by email | ☐ | |

[1] Where the provider is a partnership please fill in the partnership's name at 'Full name' in Section 1 above. Where the partnership does not have a name, please fill in the names of all the partners at Section 3 below

[2] Where you do not agree to service of notices and other documents by email they will be sent by post to the business address shown in Section 2. This includes draft and final inspection reports. This postal business address will be included on the CQC website.

[3] Where you agree to service of notices and other documents by email your copies will be sent to the email address shown in Section 2. This includes draft and final inspection reports.

*Please note:* CQC can deem notices sent to the email or postal address for service you supply in your statement of purpose as having been served as described in Sections 93 and 94 of the Health and Social Care Act 2008. The address supplied must therefore be accurate, up to date, and able to ensure prompt delivery of these important documents.

| **3. The full names of all the partners in a partnership** | |
|---|---|
| **Names:** | Not applicable |

# Statement of purpose

Health and Social Care Act 2008

## Part 2

## Aims and objectives

Please read the guidance document *Statement of purpose: Guidance for providers*.

**Aims and objectives**
*What are your aims and objectives in providing the regulated activities and locations shown in part 3 of this statement of purpose*

Our strategy for 2019 to 2024 supports our vision to provide outstanding care, every time, for patients, staff and the communities we serve. Our strategic priorities for the next five years describe what we aim to achieve by providing the regulated activities at the locations described in part 3 of this Statement of Purpose

Our strategy is founded on four key priorities that drive what we do and influence the decisions we will take over the next five years:

- **Strong foundations:** To provide outstanding care, every time
- **Excellent local services:** To provide excellent local hospital services for the people of Wandsworth and Merton
- **Closer collaboration:** To work with others to provide health services for people across south west London
- **Leading specialist healthcare:** To provide specialist healthcare for the people of south west London, Surrey, Sussex and beyond

In September 2020 in light of Covid-19 and the demands on our services and staff, the Trust Board agreed a refreshed set of corporate objectives for October 2020 to March 2021 against the four key priorities: Care; Culture; and Collaboration. Our new corporate objectives drive everything we do, help us focus our efforts on what matters most and will help us prioritise and guide decision-making at a Trust, managerial and staff level.

For each of our three new objectives, a series of priorities underpin them, and these are set out below.

| **Care** | **Culture** | **Collaboration** |
|---|---|---|
| We will keep staff safe, and invest in their health and wellbeing | We will share the findings of our culture discovery project, so we understand how staff feel about working at St George's | We will work more closely with local hospitals and partner organisations in south west London |
| We will make sure we are prepared to meet the demands of Covid-19, flu and winter | We will develop a plan with staff to improve our culture, and measure the impact it is having | We will overcome challenges together, rather than as individual organisations |
| We will provide routine and planned care, and keep patients safe during their stay | We will celebrate diversity, and support our leaders to be more inclusive | We will work with St George's, University of London to build our research, training and research expertise |

# Statement of purpose

Health and Social Care Act 2008

## Part 3 (1 of 4)

## Location(s), and

- the people who use the service there
- their service type(s)
- their regulated activity(ies)

Fill in a separate part 3 for each location

| The information below is for location no.: | 1 | of a total of: | 4 | locations |
|---|---|---|---|---|

| | |
|---|---|
| **Name of location** | St George's Hospital |
| **Address** | Blackshaw Road<br>Tooting<br>London |
| **Postcode** | SW17 0QT |
| **Telephone** | 020 8725 1635 |
| **Email** | Jacqueline.totterdell@stgeorges.nhs.uk |

**Description of the location**

(The premises and the area around them, access, adaptations, equipment, facilities, suitability for relevant special needs, staffing & qualifications etc)

The Trust has over 9,000 staff and is the largest healthcare provided in southwest London.

St George's University Hospitals NHS Foundation Trust serves a population of 1.3 million across south west London. A large number of services, such as cardiothoracic medicine and surgery, neurosciences and renal transplantation, also cover significant populations from Surrey and Sussex, totalling around 3.5 million people.

At this location we provide services used by the whole population.

We provide the following regulated activities at this location:

- Treatment of disease, disorder or injury
- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures
- Family planning
- Maternity and midwifery services
- Surgical procedures
- Termination of pregnancies

| | |
|---|---|
| **No of approved places / overnight beds (not NHS)** | |

| **CQC service user bands**<br>The people that will use this location ('The whole population' means everyone). | | | | | | |
|---|---|---|---|---|---|---|
| Adults aged 18-65 | ☒ | Adults aged 65+ | | | ☒ | |
| Mental health | ☐ | Sensory impairment | | | ☐ | |
| Physical disability | ☐ | People detained under the Mental Health Act | | | ☐ | |
| Dementia | ☐ | People who misuse drugs or alcohol | | | ☐ | |
| People with an eating disorder | ☐ | Learning difficulties or autistic disorder | | | ☐ | |
| Children aged 0 – 3 years | ☒ | Children aged 4-12 | ☒ | Children aged 13-18 | ☒ | |
| The whole population | ☒ | Other (please specify below) | | | ☐ | |
| | | | | | | |

| The CQC service type(s) provided at this location | |
|---|---|
| Acute services (ACS) | ☒ |
| Prison healthcare services (PHS) | ☐ |
| Hospital services for people with mental health needs, learning disabilities, and problems with substance misuse (MLS) | ☐ |
| Hospice services (HPS) | ☐ |
| Rehabilitation services (RHS) | ☒ |
| Long-term conditions services (LTC) | ☐ |
| Residential substance misuse treatment and/or rehabilitation service (RSM) | ☐ |
| Hyperbaric chamber (HBC) | ☐ |
| Community healthcare service (CHC) | ☐ |
| Community-based services for people with mental health needs (MHC) | ☐ |
| Community-based services for people with a learning disability (LDC) | ☐ |
| Community-based services for people who misuse substances (SMC) | ☐ |
| Urgent care services (UCS) | ☒ |
| Doctors consultation service (DCS) | ☒ |
| Doctors treatment service (DTS) | ☒ |
| Mobile doctor service (MBS) | ☐ |
| Dental service (DEN) | ☒ |
| Diagnostic and or screening service (DSS) | ☒ |
| Care home service without nursing (CHS) | ☐ |
| Care home service with nursing (CHN) | ☐ |
| Specialist college service (SPC) | ☐ |
| Domiciliary care service (DCC) | ☐ |
| Supported living service (SLS) | ☐ |
| Shared Lives (SHL) | ☐ |
| Extra Care housing services (EXC) | ☐ |
| Ambulance service (AMB) | ☐ |
| Remote clinical advice service (RCA) | ☐ |
| Blood and Transplant service (BTS) | ☒ |

| **Regulated activity(ies) carried on at this location** | | |
|---|---|---|
| Personal care | ☐ | |
| Registered Manager(s) for this regulated activity: | | |
| Accommodation for persons who require nursing or personal care | ☐ | |
| Registered Manager(s) for this regulated activity: | | |
| Accommodation for persons who require treatment for substance abuse | ☐ | |
| Registered Manager(s) for this regulated activity: | | |
| Accommodation and nursing or personal care in the further education sector | ☐ | |
| Registered Manager(s) for this regulated activity: | | |
| Treatment of disease, disorder or injury | ☒ | |
| Registered Manager(s) for this regulated activity: Arlene Wellman | | |
| Assessment or medical treatment for persons detained under the Mental Health Act | ☒ | |
| Registered Manager(s) for this regulated activity: Arlene Wellman | | |
| Surgical procedures | ☒ | |
| Registered Manager(s) for this regulated activity: Arlene Wellman | | |
| Diagnostic and screening procedures | ☒ | |
| Registered Manager(s) for this regulated activity: Arlene Wellman | | |
| Management of supply of blood and blood derived products etc | ☐ | |
| Registered Manager(s) for this regulated activity: | | |
| Transport services, triage and medical advice provided remotely | ☐ | |
| Registered Manager(s) for this regulated activity: | | |
| Maternity and midwifery services | ☒ | |
| Registered Manager(s) for this regulated activity: Robert Bleasdale | | |
| Termination of pregnancies | ☒ | |
| Registered Manager(s) for this regulated activity: Robert Bleasdale | | |
| Services in slimming clinics | ☐ | |
| Registered Manager(s) for this regulated activity: | | |
| Nursing care | ☐ | |
| Registered Manager(s) for this regulated activity: | | |
| Family planning service | ☐ | |
| Registered Manager(s) for this regulated activity: | | |

# Statement of purpose

Health and Social Care Act 2008

## Part 3 (2 of 4)

## Location(s), and

- the people who use the service there
- their service type(s)
- their regulated activity(ies)

| | | | | |
|---|---|---|---|---|
| The information below is for location no.: | 2 | of a total of: | 4 | locations |

| | |
|---|---|
| **Name of location** | Queen Mary's Hospital |
| **Address** | Roehampton Lane<br>Roehampton<br>London |
| **Postcode** | SW15 5PN |
| **Telephone** | 0208 487 6000 |
| **Email** | Jacqueline.totterdell@stgeorges.nhs.uk |

**Description of the location**

(The premises and the area around them, access, adaptations, equipment, facilities, suitability for relevant special needs, staffing & qualifications etc)

QMH offer services for the people of Roehampton and surrounding areas

As well as offering outpatients services, Queen Mary's Hospital has two inpatients rehabilitation wards providing rehabilitation services to the elderly, people with neurological conditions and amputees.

At this location we provide services used by children from 0 -18 and adults from 18 - 65+.

We provide the following regulated activities at this location:

- Diagnostic and screening procedures
- Surgical procedures
- Treatment of disease, disorder or injury

| | |
|---|---|
| **No of approved places / overnight beds (not NHS)** | |

| **CQC service user bands**<br>The people that will use this location ('The whole population' means everyone). | | | | | | |
|---|---|---|---|---|---|---|
| Adults aged 18-65 | ☒ | Adults aged 65+ | | | ☒ | |
| Mental health | ☐ | Sensory impairment | | | ☐ | |
| Physical disability | ☐ | People detained under the Mental Health Act | | | ☐ | |
| Dementia | ☐ | People who misuse drugs or alcohol | | | ☐ | |
| People with an eating disorder | ☐ | Learning difficulties or autistic disorder | | | ☐ | |
| Children aged 0 – 3 years | ☒ | Children aged 4-12 | ☒ | Children aged 13-18 | ☒ | |
| The whole population | ☒ | Other (please specify below) | | | ☐ | |
| | | | | | | |

| **The CQC service type(s) provided at this location** | |
|---|---|
| Acute services (ACS) | ☐ |
| Prison healthcare services (PHS) | ☐ |
| Hospital services for people with mental health needs, learning disabilities, and problems with substance misuse (MLS) | ☐ |
| Hospice services (HPS) | ☐ |
| Rehabilitation services (RHS) | ☒ |
| Long-term conditions services (LTC) | ☐ |
| Residential substance misuse treatment and/or rehabilitation service (RSM) | ☐ |
| Hyperbaric chamber (HBC) | ☐ |
| Community healthcare service (CHC) | ☐ |
| Community-based services for people with mental health needs (MHC) | ☐ |
| Community-based services for people with a learning disability (LDC) | ☐ |
| Community-based services for people who misuse substances (SMC) | ☐ |
| Urgent care services (UCS) | ☒ |
| Doctors consultation service (DCS) | ☒ |
| Doctors treatment service (DTS) | ☒ |
| Mobile doctor service (MBS) | ☐ |
| Dental service (DEN) | ☐ |
| Diagnostic and or screening service (DSS) | ☒ |
| Care home service without nursing (CHS) | ☐ |
| Care home service with nursing (CHN) | ☐ |
| Specialist college service (SPC) | ☐ |
| Domiciliary care service (DCC) | ☐ |
| Supported living service (SLS) | ☐ |
| Shared Lives (SHL) | ☐ |
| Extra Care housing services (EXC) | ☐ |
| Ambulance service (AMB) | ☐ |
| Remote clinical advice service (RCA) | ☐ |
| Blood and Transplant service (BTS) | ☐ |

| **Regulated activity(ies) carried on at this location** | | |
|---|---|---|
| Personal care | ☐ | |
| Registered Manager(s) for this regulated activity: | | |
| Accommodation for persons who require nursing or personal care | ☐ | |
| Registered Manager(s) for this regulated activity: | | |
| Accommodation for persons who require treatment for substance abuse | ☐ | |
| Registered Manager(s) for this regulated activity: | | |
| Accommodation and nursing or personal care in the further education sector | ☐ | |
| Registered Manager(s) for this regulated activity: | | |
| Treatment of disease, disorder or injury | ☒ | |
| Registered Manager(s) for this regulated activity: Arlene Wellman | | |
| Assessment or medical treatment for persons detained under the Mental Health Act | ☐ | |
| Registered Manager(s) for this regulated activity: | | |
| Surgical procedures | ☒ | |
| Registered Manager(s) for this regulated activity: Arlene Wellman | | |
| Diagnostic and screening procedures | ☒ | |
| Registered Manager(s) for this regulated activity: Arlene Wellman | | |
| Management of supply of blood and blood derived products etc | ☐ | |
| Registered Manager(s) for this regulated activity: | | |
| Transport services, triage and medical advice provided remotely | ☐ | |
| Registered Manager(s) for this regulated activity: | | |
| Maternity and midwifery services | ☐ | |
| Registered Manager(s) for this regulated activity: | | |
| Termination of pregnancies | ☐ | |
| Registered Manager(s) for this regulated activity: | | |
| Services in slimming clinics | ☐ | |
| Registered Manager(s) for this regulated activity: | | |
| Nursing care | ☐ | |
| Registered Manager(s) for this regulated activity: | | |
| Family planning service | ☐ | |
| Registered Manager(s) for this regulated activity: | | |

# Statement of purpose

Health and Social Care Act 2008

## Part 3 (3 of 4)

## Location(s), and

- the people who use the service there
- their service type(s)
- their regulated activity(ies)

Fill in a separate part 3 for each location

| | | | | |
|---|---|---|---|---|
| The information below is for location no.: | 3 | of a total of: | 4 | locations |

| | |
|---|---|
| **Name of location** | St John's Therapy Centre |
| **Address** | 162 St John's Hill<br>Battersea<br>London |
| **Postcode** | SW11 1SW |
| **Telephone** | 0208 725 0007 |
| **Email** | Jacqueline.totterdell@stgeorges.nhs.uk |

| **Description of the location**<br>(The premises and the area around them, access, adaptations, equipment, facilities, suitability for relevant special needs, staffing & qualifications etc) | |
|---|---|
| At this location we provide services used by adults from 18 – 65+ and children from 0 -18 as outpatients.<br>We also provide a day hospital service for residents of Wandsworth who are over 65 years of age. The Day Hospital provides an interim facility between acute and primary care settings for this group of patients who are resident in London Borough of Wandsworth and who need at least 2 disciplines' intervention. Patients are able to access multidisciplinary assessment and support together with treatment and rehabilitation by therapists on and individual and/ or group basis.<br><br>We provide the following regulated activities at this location:<br><br>**Diagnostic and screening procedures**<br>We provide this through the following services:<br>• X-ray<br>• Phlebotomy<br><br>**Treatment of disease, disorder or injury**<br>We provide this regulated activity through outpatient services for the following specialties:<br>• Integrated falls service and bone health<br>• Dietetics<br>• Ear, nose and throat<br>• Audiology<br>• Gynaecology<br>• General medicine<br>• Nephrology<br>• Plastic surgery<br>• Rheumatology<br>• Paediatrics<br>• Physiotherapy<br>• Speech and language therapy | |
| **No of approved places / overnight beds (not NHS)** | |

| **CQC service user bands**<br>The people that will use this location ('The whole population' means everyone). | | | | | | |
|---|---|---|---|---|---|---|
| Adults aged 18-65 | ☒ | Adults aged 65+ | | | ☒ | |
| Mental health | ☐ | Sensory impairment | | | ☐ | |
| Physical disability | ☐ | People detained under the Mental Health Act | | | ☐ | |
| Dementia | ☐ | People who misuse drugs or alcohol | | | ☐ | |
| People with an eating disorder | ☐ | Learning difficulties or autistic disorder | | | ☐ | |
| Children aged 0 – 3 years | ☒ | Children aged 4-12 | ☒ | Children aged 13-18 | ☒ | |
| The whole population | ☒ | Other (please specify below) | | | ☐ | |
| | | | | | | |

| The CQC service type(s) provided at this location | |
|---|---|
| Acute services (ACS) | ☐ |
| Prison healthcare services (PHS) | ☐ |
| Hospital services for people with mental health needs, learning disabilities, and problems with substance misuse (MLS) | ☐ |
| Hospice services (HPS) | ☐ |
| Rehabilitation services (RHS) | ☒ |
| Long-term conditions services (LTC) | ☐ |
| Residential substance misuse treatment and/or rehabilitation service (RSM) | ☐ |
| Hyperbaric chamber (HBC) | ☐ |
| Community healthcare service (CHC) | ☐ |
| Community-based services for people with mental health needs (MHC) | ☐ |
| Community-based services for people with a learning disability (LDC) | ☐ |
| Community-based services for people who misuse substances (SMC) | ☐ |
| Urgent care services (UCS) | ☐ |
| Doctors consultation service (DCS) | ☒ |
| Doctors treatment service (DTS) | ☒ |
| Mobile doctor service (MBS) | ☐ |
| Dental service (DEN) | ☐ |
| Diagnostic and or screening service (DSS) | ☒ |
| Care home service without nursing (CHS) | ☐ |
| Care home service with nursing (CHN) | ☐ |
| Specialist college service (SPC) | ☐ |
| Domiciliary care service (DCC) | ☐ |
| Supported living service (SLS) | ☐ |
| Shared Lives (SHL) | ☐ |
| Extra Care housing services (EXC) | ☐ |
| Ambulance service (AMB) | ☐ |
| Remote clinical advice service (RCA) | ☐ |
| Blood and Transplant service (BTS) | ☐ |

| **Regulated activity(ies) carried on at this location** | | |
|---|---|---|
| Personal care | ☐ | |
| Registered Manager(s) for this regulated activity: | | |
| Accommodation for persons who require nursing or personal care | ☐ | |
| Registered Manager(s) for this regulated activity: | | |
| Accommodation for persons who require treatment for substance abuse | ☐ | |
| Registered Manager(s) for this regulated activity: | | |
| Accommodation and nursing or personal care in the further education sector | ☐ | |
| Registered Manager(s) for this regulated activity: | | |
| Treatment of disease, disorder or injury | ☒ | |
| Registered Manager(s) for this regulated activity: Arlene Wellman | | |
| Assessment or medical treatment for persons detained under the Mental Health Act | ☐ | |
| Registered Manager(s) for this regulated activity: | | |
| Surgical procedures | ☐ | |
| Registered Manager(s) for this regulated activity: | | |
| Diagnostic and screening procedures | ☒ | |
| Registered Manager(s) for this regulated activity: Arlene Wellman | | |
| Management of supply of blood and blood derived products etc | ☐ | |
| Registered Manager(s) for this regulated activity: | | |
| Transport services, triage and medical advice provided remotely | ☐ | |
| Registered Manager(s) for this regulated activity: | | |
| Maternity and midwifery services | ☐ | |
| Registered Manager(s) for this regulated activity: | | |
| Termination of pregnancies | ☐ | |
| Registered Manager(s) for this regulated activity: | | |
| Services in slimming clinics | ☐ | |
| Registered Manager(s) for this regulated activity: | | |
| Nursing care | ☐ | |
| Registered Manager(s) for this regulated activity: | | |
| Family planning service | ☐ | |
| Registered Manager(s) for this regulated activity: | | |

# Statement of purpose

Health and Social Care Act 2008

## Part 3 (4 of 4)

## Location(s), and

- the people who use the service there
- their service type(s)
- their regulated activity(ies)

Fill in a separate part 3 for each location

| | | | | |
|---|---|---|---|---|
| The information below is for location no.: | 4 | of a total of: | 4 | locations |

| | |
|---|---|
| **Name of location** | Nelson Health Centre |
| **Address** | Kingston Road<br>Wimbledon Chase<br>London |
| **Postcode** | SW20 8DB |
| **Telephone** | 0203 688 3300 |
| **Email** | Jacqueline.totterdell@stgeorges.nhs.uk |

| **Description of the location**<br>(The premises and the area around them, access, adaptations, equipment, facilities, suitability for relevant special needs, staffing & qualifications etc) | |
|---|---|
| The Nelson Health Centre is funded through a NHS Local Improvement Finance Trust (LIFT), the overall responsibility for the Nelson Health Centre lies with Community Health Partnerships (CHP), a limited company wholly owned by the Department of Health. Merton CCG commissions the clinical services provided within The Nelson Health Centre. We share this location with a number of other healthcare providers, the Nelson GP Practice; Nelson Pharmacy; Central London Community Healthcare; and South West London and St George's Mental Health NHS Trust.<br><br>At this location we provide outpatient services to the whole population.<br>We provide the following regulated activities:<br><br>**Diagnostic and screening procedures**<br>We provide this regulated activity through the following services:<br>• X-ray<br>• Ultrasound<br>• Endoscopy<br>• Cardiac tests such as Echo and ECG<br>• Phlebotomy<br>**Treatment of disease, disorder or injury**<br>We provide this regulated activity through outpatient services for the following specialties:<br>• Gynaecology<br>• General medicine<br>• General surgery<br>• Respiratory medicine<br>• Rheumatology<br>• Dermatology<br>• Trauma and orthopaedics<br>• Diabetes<br>• Cardiology<br>• Urology<br>• Colorectal surgery<br>• Gastroenterology | |
| **No of approved places / overnight beds (not NHS)** | |

| **CQC service user bands**<br>The people that will use this location ('The whole population' means everyone). | | | | | |
|---|---|---|---|---|---|
| Adults aged 18-65 | ☒ | Adults aged 65+ | | ☒ | |
| Mental health | ☐ | Sensory impairment | | ☐ | |
| Physical disability | ☐ | People detained under the Mental Health Act | | ☐ | |
| Dementia | ☐ | People who misuse drugs or alcohol | | ☐ | |
| People with an eating disorder | ☐ | Learning difficulties or autistic disorder | | ☐ | |
| Children aged 0 – 3 years | ☐ | Children aged 4-12 | ☐ Children aged 13-18 | ☐ | |
| The whole population | ☒ | Other (please specify below) | | ☐ | |
| | | | | | |

| The CQC service type(s) provided at this location | |
|---|---|
| Acute services (ACS) | ☐ |
| Prison healthcare services (PHS) | ☐ |
| Hospital services for people with mental health needs, learning disabilities, and problems with substance misuse (MLS) | ☐ |
| Hospice services (HPS) | ☐ |
| Rehabilitation services (RHS) | ☐ |
| Long-term conditions services (LTC) | ☐ |
| Residential substance misuse treatment and/or rehabilitation service (RSM) | ☐ |
| Hyperbaric chamber (HBC) | ☐ |
| Community healthcare service (CHC) | ☐ |
| Community-based services for people with mental health needs (MHC) | ☐ |
| Community-based services for people with a learning disability (LDC) | ☐ |
| Community-based services for people who misuse substances (SMC) | ☐ |
| Urgent care services (UCS) | ☐ |
| Doctors consultation service (DCS) | ☒ |
| Doctors treatment service (DTS) | ☒ |
| Mobile doctor service (MBS) | ☐ |
| Dental service (DEN) | ☐ |
| Diagnostic and or screening service (DSS) | ☒ |
| Care home service without nursing (CHS) | ☐ |
| Care home service with nursing (CHN) | ☐ |
| Specialist college service (SPC) | ☐ |
| Domiciliary care service (DCC) | ☐ |
| Supported living service (SLS) | ☐ |
| Shared Lives (SHL) | ☐ |
| Extra Care housing services (EXC) | ☐ |
| Ambulance service (AMB) | ☐ |
| Remote clinical advice service (RCA) | ☐ |
| Blood and Transplant service (BTS) | ☐ |

| **Regulated activity(ies) carried on at this location** | | |
|---|---|---|
| Personal care | ☐ | |
| Registered Manager(s) for this regulated activity: | | |
| Accommodation for persons who require nursing or personal care | ☐ | |
| Registered Manager(s) for this regulated activity: | | |
| Accommodation for persons who require treatment for substance abuse | ☐ | |
| Registered Manager(s) for this regulated activity: | | |
| Accommodation and nursing or personal care in the further education sector | ☐ | |
| Registered Manager(s) for this regulated activity: | | |
| Treatment of disease, disorder or injury | ☒ | |
| Registered Manager(s) for this regulated activity: Arlene Wellman | | |
| Assessment or medical treatment for persons detained under the Mental Health Act | ☐ | |
| Registered Manager(s) for this regulated activity: | | |
| Surgical procedures | ☐ | |
| Registered Manager(s) for this regulated activity: | | |
| Diagnostic and screening procedures | ☒ | |
| Registered Manager(s) for this regulated activity: Arlene Wellman | | |
| Management of supply of blood and blood derived products etc | ☐ | |
| Registered Manager(s) for this regulated activity: | | |
| Transport services, triage and medical advice provided remotely | ☐ | |
| Registered Manager(s) for this regulated activity: | | |
| Maternity and midwifery services | ☐ | |
| Registered Manager(s) for this regulated activity: | | |
| Termination of pregnancies | ☐ | |
| Registered Manager(s) for this regulated activity: | | |
| Services in slimming clinics | ☐ | |
| Registered Manager(s) for this regulated activity: | | |
| Nursing care | ☐ | |
| Registered Manager(s) for this regulated activity: | | |
| Family planning service | ☐ | |
| Registered Manager(s) for this regulated activity: | | |

# Statement of purpose

Health and Social Care Act 2008

## Part 4

## Registered manager details

Including address for service of notices and other documents

Please first read the guidance document *Statement of purpose: Guidance for providers*

| | | | | |
|---|---|---|---|---|
| The information below is for manager number: | 1 | of a total of: | 1 | Managers working for the provider shown in part 1 |

| | |
|---|---|
| **1. Manager's full name** | Arlene Wellman |

| **2. Manager's contact details** | |
|---|---|
| **Business address** | St George's Hospital<br>Blackshaw Road<br>Tooting |
| **Town/city** | London |
| **County** | |
| **Post code** | SW17 0QT |
| **Business telephone** | 020 8725 1635 |
| **Manager's email address[1]** | |
| Arlene.Wellman@stgeorges.nhs.uk | |

[1] Where the manager has agreed to service of notices and other documents by email they will be sent to this email address. This includes draft and final inspection reports on all locations where they manage regulated activities.

Where the manager does not agree to service of notices and other documents by email they will be sent by post to the provider postal business address shown in Part 1 of the statement of purpose. This includes draft and final inspection reports on all locations.

*Please note:* CQC can deem notices sent to manager(s) at the relevant email or postal address for service in this statement of purpose as having been served, as described in Sections 93 and 94 of the Health and Social Care Act 2008. The address supplied must therefore be accurate, up to date, and able to ensure prompt delivery of these important documents to registered managers.

| **3. Locations managed by the registered manager at 1 above**<br>(Please see part 3 of this statement of purpose for full details of the location(s)) | |
|---|---|
| **Name(s) of location(s) (list)** | Percentage of time spent at this location |
| St George's Hospital | 50% |
| Queen Mary's Hospital | 0% |
| St John's Therapy Centre | 0% |
| Nelson Health Centre | 0% |
| Arlene Wellman as the Group Chief Nursing Officer for St George's, Epsom and St Helier University Hospitals and Health Group also has registered manager responsibilities for Epsom and St Helier, therefore | |
| St Helier Hospital | 50% |

| **4. Regulated activity(ies) managed by this manager** | | |
|---|---|---|
| Personal care | ☐ | |
| Accommodation for persons who require nursing or personal care | ☐ | |
| Accommodation for persons who require treatment for substance abuse | ☐ | |
| Accommodation and nursing or personal care in the further education sector | ☐ | |
| Treatment of disease, disorder or injury | ☒ | |
| Assessment or medical treatment for persons detained under the Mental Health Act | ☒ | |
| Surgical procedures | ☒ | |
| Diagnostic and screening procedures | ☒ | |
| Management of supply of blood and blood derived products etc | ☐ | |
| Transport services, triage and medical advice provided remotely | ☐ | |
| Maternity and midwifery services | ☒ | |
| Termination of pregnancies | ☒ | |
| Services in slimming clinics | ☐ | |
| Nursing care | ☒ | |
| Family planning service | ☐ | |

| **5. Locations, regulated activities and job shares**<br>Where this manager does not manage all of the regulated activities ticked / checked at 4 above at all of the locations listed at 3 above, please describe which regulated activities they manage at which locations below.<br>Please also describe below any job share arrangements that include or affect this manager. |
| --- |
| Not applicable |

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

| | | | |
|---|---|---|---|
| **Meeting Title:** | Trust Board Meeting | | |
| **Date:** | 31 March 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 11 February and 10th March.<br><br>One risk factor we draw to the attention of the Board is the continuing failure to bring down the resolution times for some (but not all) investigations initiated by the Freedom to Speak Up Guardian. Speed of resolution has been an issue for some time, and during the pandemic this was understandable. However, as the Trust returns to a more balanced footing there is a risk that the credibility of its FSU processes will be undermined in the eyes of staff by delay in completing investigations on behalf of the FSU Guardian.<br><br>This applies as much to the current backlog of investigations as it does to newly-initiated cases. The executive is aware of the challenge here, and the Committee's suggestion is that further HR resource is directed to bring case investigations right up to date. The danger otherwise is that the progress we have made on staff use of the Speaking Up system starts to reverse.<br><br>For completeness, we reference also the current non-compliance of the DBS status of some staff. The trajectory of improvement suggest that this is being addressed with vigour and continued progress made. This should therefore be viewed as a time-limited issue. We will continue to monitor progress.<br><br>The Board will discuss the Staff Survey results at its March meeting. The commentary in this report summarises certain issues identified. | | |
| **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 – mandatory vaccination.*** At the February meeting the Committee noted that the reversal by DHSC of the VCOD directive had removed the immediate risk to staffing levels, but had left a number of unanswered questions – particularly in the event that we experience another (more virulent) Covid surge. In addition, the experience has been a divisive one between staff, and for some staff their relationship with the Trust, as their employer, has also been damaged. There is a follow-on decision to be made as to whether the Trust imposes a requirement – for patient-facing roles – of vaccination as a condition of employment. The full implications of this are still being assessed, and there is the potential for national guidance to be issued although this now appears less likely. It would be sensible for the Board at its March meeting to look for an update from the Trust's Chief People Officer on this question and, at a wider level, likely changes to current guidance on infection prevention and control and the risk to patients and staff.

***Workforce Report*** – Covid-related absences had peaked in December and were a factor in a 5.6% sickness absence rate. The anticipation was that this would steadily fall as the pandemic receded. Ward staffing unfilled duty hours had reached 13.3% in December and we will monitor the position here carefully. The anticipation was that this was driven by high levels of absence, and would therefore trend down as the pandemic recedes. The Trust's establishment at the calendar year end stood at just under 10,000 FTEs – an increase of over 600 (+6.6%) over the last 12 months, but noting that the majority of the increase had been a consequence of TUPE transfers as functions transferred to the Trust. Nonetheless, the staffing increase will play through into a material cost pressure as the Trust sets its pay budgets for 22-23.

***Staff Survey*** – at the February meeting the Committee received a confidential summary of the Staff Survey results (embargoed until 31 March). Broadly, the results represented a backward step for the Trust, albeit the NHS as a whole had experienced a similar movement. The overall backward step is highly disappointing, even though in some areas the Trust had maintained previous progress – notably around values and behaviours and a material reduction in harassment, bullying and abuse of staff, from all directions. The biggest decline in the Trust's scores had related to staff views on morale and engagement – expressed through survey results on operational pressures, the Trust as a place to work, and individual enthusiasm for their job. We took some assurance for the way that the executive intended to respond to the results, and in particular the decision to engage widely with staff on setting corrective actions. But the starting point is a recognition that the results are not where we want to see them. At the March meeting the results were reviewed in more detail, and the Committee was updated on management's assessment of the ten central issues that the survey had identified as negative (see Appendix to this Report), and the process to be adopted to prioritise and address these. It is likely that this will be discussed in detail at the March Board meeting.

***Leadership Development - Update***. We received a helpful and timely update from Hasan Cagirtgan and Daniel Scott on a shift in the Trust's approach to leadership development. Greater focus was to be given to development initiatives which were centred on the workplace, rather than sending managers away for training. The logic was to ensure that training and development was in the full context of the operational challenges facing individual managers. This applied to Medical management and Other management staff, although additional resource was to be deployed to support the Trust's medical staff through a Consultant Leadership Development Programme, to be up and running from the early summer.

***Workforce Planning : Budget 22-23*** –.Paul DaGama our Chief People Officer outlined the scale of the challenge facing the Trust as it set budgets for the 22-23 financial year. In addition to an increased number of FTEs within the Trust, there was likely to be a reduction in the activity covered by the present block contracts and therefore an increased focus on delivered activity. There would therefore be continuing focus on service and staff efficiency, and the present initiatives on active management of sickness absence, and the effective deployment of resource would be maintained. The Committee reviewed the Workforce Improvement planning framework which was being used to inform the 22-23 budget-setting process.

***South-West London Workforce Partnership*** – we received a useful update at the March meeting on the progress being made on joint working across Trusts. The recruitment hub was up and running, and consideration was being given to extending its remit beyond AfC roles to VSM and medical workforce. The opportunity for a single, consolidated Occupational Health service was being explored. Funding had been received to establish a local NHS Reserve (akin to a staff bank), although it was noted that a proposal for a south-west London wide bank was not being taken forward. The Committee was disappointed to hear that the Positive Action Programme proposed by the Trust had not made the progress expected and was now being managed as an ICS led initiative..

***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. The complexity of e-rostering and the choices now facing the Trust were noted. Good progress was being made on reducing the numbers of staff without an up to date DBS, although at the time of the March meeting the Trust remained non-compliant.

## ***Staff Health and Wellbeing***

***Flu-Jab take-up***. The take up across staff had been a disappointing 55%. Potential reasons for this were discussed, and we were encouraged by the learning that the executive had taken from this on the need to offer the flu jab separately from the Covid booster, and the changes that will be made next year.

## ***Culture, Diversity and Inclusion***

***Culture Programme Update*** – progress on the Programme has broadly been maintained, despite the impact of the pandemic. The values refresh work continued, and a new brand had been adopted for the programme as a whole. There had been strong engagement with ESH and consideration was being given to whether some areas of work could be progressed jointly.

***Education Strategy – Implementation Plan***. The Committee received a very helpful update on Q3 delivery of his Strategy, noting the creative approach that had re-set the way education and training was being delivered within the Trust. The overall focus was being shifted to a greater level of internally delivered training. The expanded use of the i-learn platform was noted, as was the use of a mobile simulation techniques to help the capability development of clinical staff. Virtual work experience was being delivered by the Springpod system. Increased co-operation and joint working with ESH was noted.

***Diversity and Equality*** – Joseph Pavett-Downer, the Trust's D&I Lead, updated us at the February meeting on progress in appointing new leaders to three of the for staff networks, and a number of other initiatives which were bringing the networks up to full strength. In parallel, the executive sponsorship of each network was being re-set. A new trans-gender service was being developed at Queen Mary Hospital, and staff training was being undertaken in conjunction with the Trust's LGBTQ+ network.

***Recruitment Inclusion Specialist programme*** – Joseph updated the March meeting on the solid progress being achieved in the Trust's RIS programme. Involvement of a RIS was increasing across the Trust's recruitment interviews, but continued pressure was needed to make this universal. Consideration was being given to expanding the AfC bands covered by the RIS requirement, and for widening the ethnic groups from which RIS personnel were being drawn.

***Medical Training – Update***. Outside of the meeting schedule I received a very helpful update in early March from Luci Etheridge (our Responsible Officer and St George's Hospital Site CMO) on the progress of the various initiatives previously identified to the Committee in relation to medical training, and to the wider culture and behaviour in some medical areas. Of the four medical areas being focussed on, good progress was being made in Obs and Gynae, and the HEE undertook a further

review visit here last week. It is anticipated that this will acknowledge that progress there is on track with culture moving forward, and that the principal issues are being fully addressed.

The behavioural issues have been called out and a remediation programme is under way, with medical support. Within Vascular Surgery there has been solid progress , and the HEE will be undertaking a review visit to assess the position shortly, and specifically the recovery strategy we have proposed. Within Acute Internal Medicine, the core issue was the relatively small size of the non-consultant medical workforce there. This was leading to extensive pressure on the staff who are in post, increasing the potential for burn-out and attrition, and leading to high locum spend and discontinuity of care, and an adverse impact on the medical training experience. A recruitment and retention programme has been initiated and although it is too early to call the result, the initial indications are promising. Finally, within cardiac surgery the organisational development work continues in support of the Trust's wider culture programme and we understand that HEE will visit the department in April to review progress, and in particular the situation with regard to training posts.

It is important that the activity referenced above is viewed as a critical part of the Trust's wider commitment to culture and behaviour in all areas, and the recent extension of leadership development initiatives to more senior consultants (which is being well received and gaining traction) should be seen in this context. The plan to widen the access to that training to all consultants and medical staff is important and needs the Trust's full support. The recent initiative to ensure that all newly-appointed Consultants have a mentor (normally a senior consultant) to help them find their feet and orientate within the Trust is also an important step forward to developing a single Trust-wide culture, rather than a series of different experiences across different clinical areas.

## ***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), the VCOD risk set out in the previous report to the Board has receded. The risk score can therefore sensibly be reduced to 16. The observations earlier in this Report about the credibility of the Trust's Freedom to Speak Up process are repeated here. Without intervention and the deployment of additional resource, that credibility is at risk – which might well bring with it an adverse impact on the culture of the Trust and its attractiveness as a place to work.

***Recruitment to Band 8+ - Response to Internal Audit Report*** – we received an update on progress at the March meeting. There were still a number of actions to be completed and the Committee will continue to monitor progress on these.

## ***Trust Governance and Compliance***

***Q3 Report from Trust's Freedom to Speak-Up Guardian*** – We were joined by Karyn Richards-Wright, the Trust's FTSU Guardian who updated the Committee on concerns raised in Q3. 27 concerns had been raised in the quarter, with over a third related to nursing. Of the 27 concerns, over half were within the CWDT directorate. The vast majority of all concerns related to leadership and team functioning, bullying and harassment, and concerns about Trust processes. Of the 27 concerns raised in the quarter, just under half had already been resolved informally. The Trust's policy required updating, but this has been held back pending the issuing of new national guidance, which has been delayed. FTSU Guardians in the London Region are now working together to develop a common policy framework. The Committee accepted the recommendation of the executive that a six month extension of the existing policy this was the right way to address this.

***Committee Effectiveness*** – the Committee reviewed the results of its effectiveness review. There were no major adverse issues identified. Some helpful suggestions were made about Committee functioning and these will be actioned. The Committee agreed to undertake a 'sweep-up' of items

and reports that had been deferred over the last 18 months due to the pandemic and check that nothing had been overlooked.

***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, 15 March 2022

## APPENDIX - 10 KEY THEMES IDENTIFIED AT THE TRUST IN NHS STAFF SURVEY

Outstanding care every time

St George's University Hospitals NHS Foundation Trust

| | | | |
|---|---|---|---|
| **Meeting Title:** | Trust Board | | |
| **Date:** | 31 March 2022 | **Agenda No** | **3.2** |
| **Report Title:** | 2021 NHS Staff Survey Trust Report | | |
| **Lead Director/ Manager:** | Paul Da Gama, Chief People Officer<br>Humaira Ashraf, Director of Education, Culture & OD | | |
| **Report Author:** | Chloe Miller, Staff Engagement & OD Lead | | |
| **Presented for:** | Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify) | | |
| **Executive Summary:** | The NHS Staff Survey is our yearly opportunity to census our staff and gain their views on a range of topics and overall, their experience of working here. The staff survey results operate to assess the effectiveness of our culture change initiatives and help us to prioritise attention, effort, and investment. They are utilised at both a local and Trust wide level.<br><br>The results are usually shared from two sources, the Picker Management reporting, and the Staff Survey Coordination Centre reporting. This report is the Trust wide staff survey report and is based on the Staff Survey Coordination Centre reporting.<br><br>**These papers are meant to be for the internal audience only and due to the embargo, they should not be published or publicly shared. The embargo is set to lift at the end of March 2022.** | | |
| **Recommendation:** | It is recommended that the team discusses these results and provide thoughts on this paper, providing their view on the Big 5 long list as appropriate. | | |
| **Supports** | | | |
| **Trust Strategic Objective:** | Culture | | |
| **CQC Theme:** | Safe, Effective, Responsive, Well-Led | | |
| **Single Oversight Framework Theme:** | | | |
| **Implications** | | | |
| **Risk:** | As a Trust, it is important for us to appropriately act on feedback as it demonstrates the integrity of the process. There is also a risk that a decrease in staff engagement could lead to an increase sickness absence and reduce return to work and overall retention rates. This in time will affect the quality of care the Trust is able to deliver to patients. | | |
| **Legal/Regulatory:** | This considers the responsibility that the employer plays in ensuring the organisational and overall morale of staff are appropriately managed whilst in the workplace and that staff feedback is heard and acted upon. | | |
| **Resources:** | | | |
| **Equality and Diversity:** | The national staff survey and its findings include information regarding the experience of the different protected characteristics and informs WRES and WDES action plans. | | |
| **Previously Considered by:** | N/A | **Date** | N/A |
| **Appendices:** | NHS Staff Survey Report<br>NHS_staff_survey_2021_RJ7_full | | |

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NHS
St George's University Hospitals
NHS Foundation Trust

# 2021 NHS Staff Survey Trust Report


**Chloe Miller**
Staff Engagement & OD Lead

2 March 2022

# Introduction

## Report contents, response rate and survey changes

The National Staff Survey took place between 4 October – 26 November 2021 and we have received the results as a Trust. This report has been designed to share the latest National Staff Survey results for the Trust under embargo, which is set to lift at the end of March 2022.

This report covers:

- Summary of Results
- Staff Engagement & Morale scores and commentary
- People promise theme scores and commentary
- Other key findings
- Comparison to London Acute Trusts
- The Big 5
- Local Response
- Discussion questions and next steps

Both the Trust and Directorate Staff Survey Coordination Centre reports have been sent as an appendix to this paper for further information.

## Trust Response Rate

9146 eligible staff were invited to take part in the staff survey

5036 completed the survey

55.1% response rate for the Trust

52% was the average response rate for similar organisations

59% was our response rate for the 2020 staff survey

## Staff Survey Reporting Changes

This report is based on the Staff Survey Coordination Centre reports – the main reports that we use as a Trust to communicate the results. Any nuances in scoring that you would have previously seen from Picker reporting will be due to the weighting applied.

Furthermore, there are changes to this years Staff Survey Coordination Centre reporting in that it is now being reported as People Promise themes, rather than the key themes we've had previously. Whilst we will be able to see historical trend data for many of the questions, we will not have trend scores for the overall People Promise theme scores.

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# Summary of Results (part 1 of 2)

## Trust Overview

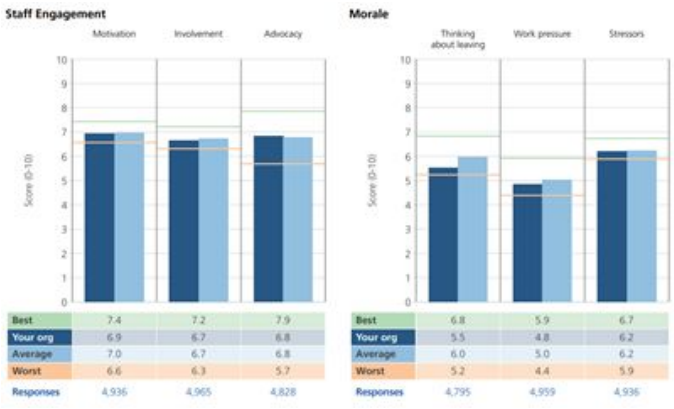
The National Staff Survey has been aligned to the People Promise. The below gives an indication as to how the Trust performed in each of these People Promise Themes as has RAG rated them based on whether they are above, below, or in line with the benchmark average. The benchmark average in this case is Acute and Acute & Community Trusts.

| People Promise Theme | Trust score | Avg. |
|---|---|---|
| *Promise 1: We are compassionate and inclusive* | 7.1 | 7.2 |
| *Promise 2: We are recognised and rewarded* | 5.7 | 5.8 |
| *Promise 3: We each have a voice that counts* | 6.5 | 6.7 |
| *Promise 4: We are safe and healthy* | 5.8 | 5.9 |
| *Promise 5: We are always learning* | 5.2 | 5.2 |
| *Promise 6: We work flexibly* | 5.7 | 5.9 |
| *Promise 7: We are a team* | 6.5 | 6.6 |

**6.8** Staff Engagement Score
**In line** with the benchmark average

**5.5** Morale Score
**Below** the benchmark average

### Staff Engagement and Morale sub-scores




## Areas of greatest improvement and decline

| Most improved scores | Trust 2021 | Trust 2020 |
|---|---|---|
| q14c. Not experienced harassment, bullying or abuse from other colleagues | 80% | 77% |
| q13d. Last experience of physical violence reported | 71% | 69% |
| q14b. Not experienced harassment, bullying or abuse from managers | 88% | 86% |
| q14a. Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public | 73% | 71% |
| q13a. Not experienced physical violence from patients/service users, their relatives or other members of the public | 86% | 84% |

| Most declined scores | Trust 2021 | Trust 2020 |
|---|---|---|
| q11d. In last 3 months, have not come to work when not feeling well enough to perform duties | 45% | 55% |
| q3i. Enough staff at organisation to do my job properly | 26% | 35% |
| q21c. Would recommend organisation as place to work | 58% | 67% |
| q28b. Disability: organisation made adequate adjustment(s) to enable me to carry out work | 63% | 71% |
| q2b. Often/always enthusiastic about my job | 65% | 73% |

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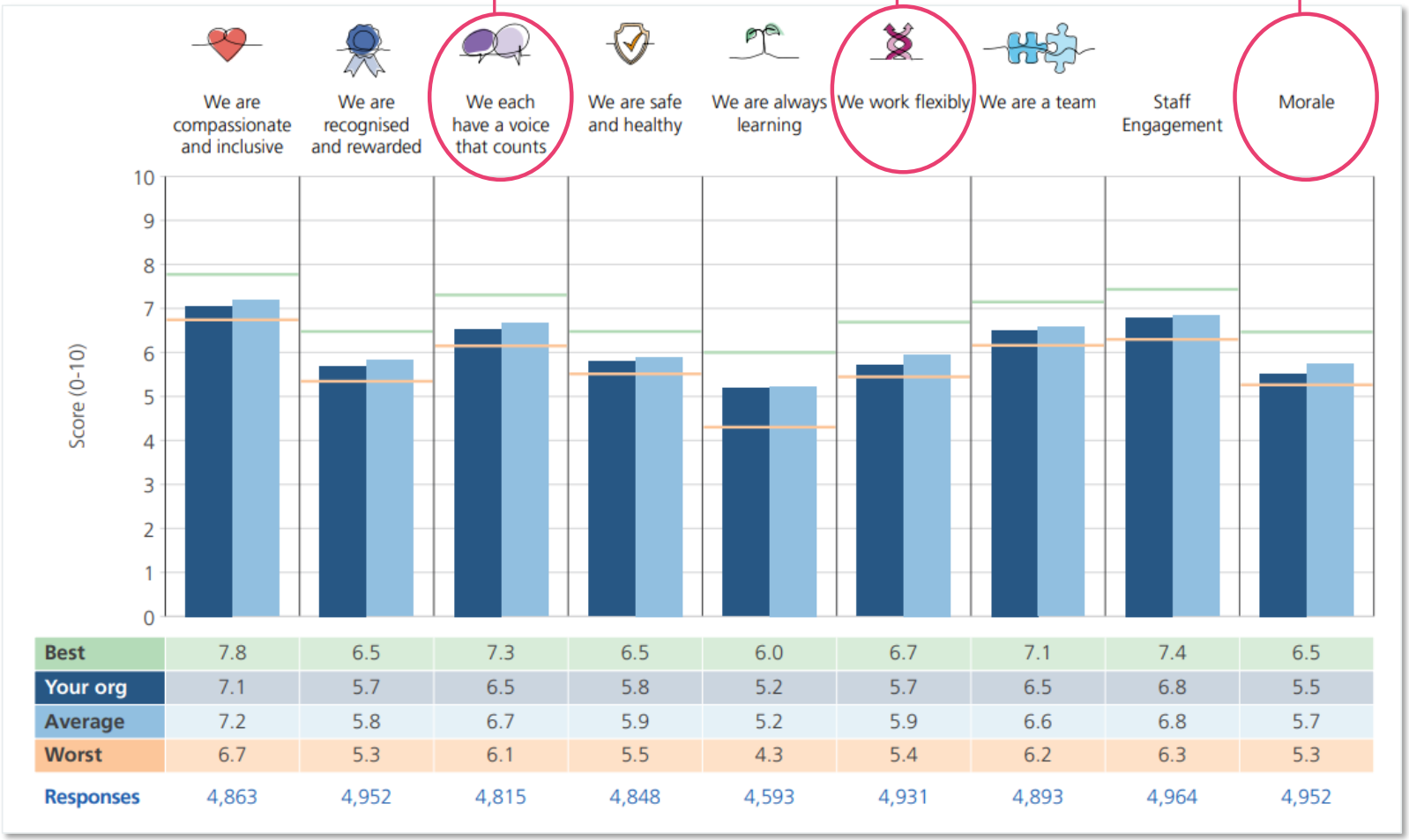
# Summary of Results (part 2 of 2)

## All themes at a glance




| | We are compassionate and inclusive | We are recognised and rewarded | We each have a voice that counts | We are safe and healthy | We are always learning | We work flexibly | We are a team | Staff Engagement | Morale |
|---|---|---|---|---|---|---|---|---|---|
| Best | 7.8 | 6.5 | 7.3 | 6.5 | 6.0 | 6.7 | 7.1 | 7.4 | 6.5 |
| Your org | 7.1 | 5.7 | 6.5 | 5.8 | 5.2 | 5.7 | 6.5 | 6.8 | 5.5 |
| Average | 7.2 | 5.8 | 6.7 | 5.9 | 5.2 | 5.9 | 6.6 | 6.8 | 5.7 |
| Worst | 6.7 | 5.3 | 6.1 | 5.5 | 4.3 | 5.4 | 6.2 | 6.3 | 5.3 |
| Responses | 4,863 | 4,952 | 4,815 | 4,848 | 4,593 | 4,931 | 4,893 | 4,964 | 4,952 |

Areas circled show greatest negative difference from the Acute benchmark average. Interestingly these are also the areas that saw the greatest negative difference from the benchmark ‘best’ scores.

Morale has shows the negative difference from the benchmark ‘best’ and is closest to the benchmark ‘worst’ score out of all the themes.

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# Staff Engagement

## This score has three sub-scores of motivation, involvement and advocacy

Our overall staff engagement score has seen a decline from 2020 and is now at its lowest point since 2018. The sub-scores for engagement are as follows: motivation (6.9), involvement (6.7) and advocacy (6.8).

### Motivation

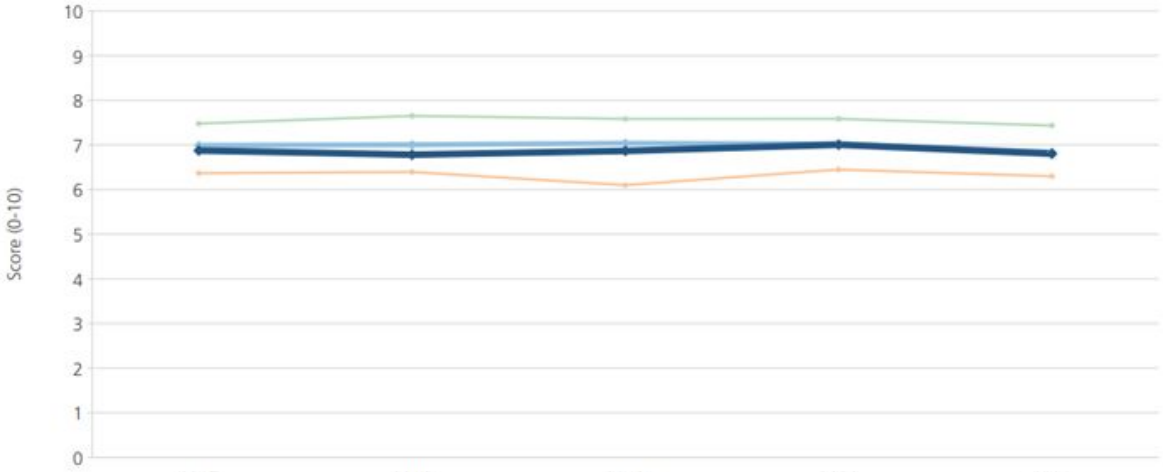
- Q2a I look forward to going to work – 52% (decline from 59.2% in 2020)
- Q2b I am enthusiastic about my job – 64.7% (decline from 72.5% from 2020)
- Q2c Time passes quickly when I'm working - 73.3% (decline from 75.3% in 2020)

### Involvement

- Q3c There are frequent opportunities for me to show initiative in my role – 72.4% (improvement from 71.3% in 2020)
- Q3d I am able to make suggestions to improve the work of my team / department – 68.6% (decline from 70.1.% in 2020)
- Q3f I am able to make improvements happen in my area of work – 51.3% (decline from 54.4% in 2020)

### Advocacy

- Q21a Care of patients / service users is my organisation's top priority – 74.4% (decline from 79.0% in 2020)
- Q21c I would recommend my organisation as a place to work – 58.3% (decline from 67% in 2020)
- Q21d If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation – 71.2% (decline from 76.1% in 2020)




| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| Best | 7.5 | 7.7 | 7.6 | 7.6 | 7.4 |
| Your org | 6.9 | 6.8 | 6.9 | 7.0 | 6.8 |
| Average | 7.0 | 7.0 | 7.0 | 7.0 | 6.8 |
| Worst | 6.4 | 6.4 | 6.1 | 6.4 | 6.3 |
| Responses | 4,269 | 4,445 | 4,896 | 5,015 | 4,964 |

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# Morale

## This score has three sub-scores of thinking about leaving, work pressure and stressors.

Our overall morale score has also seen a decline year on year and is at it's lowest point since 2018. The sub-scores for morale are as follows: thinking about leaving (5.5), work pressure (4.8) and stressors (6.2).

### Thinking about leaving

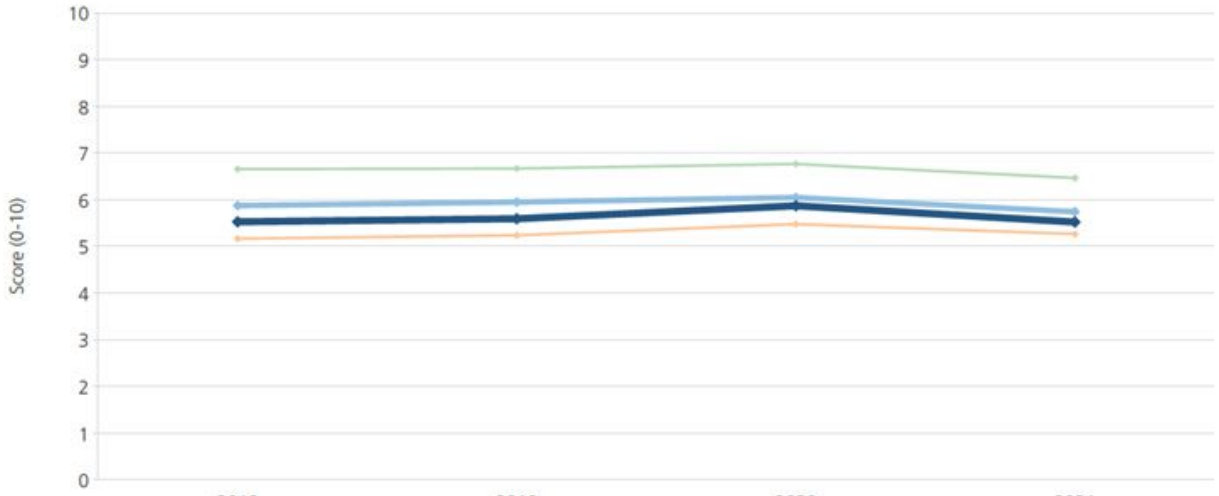
- There has been a sharp increase in the amount of respondents who *often think about leaving this organisation* with 33.5% agreeing with this statement (compared to 28.7% in 2020).
- Furthermore, 29.2% have said they *will probably look for a job in a new organisation in the next 12 months* (up from 25.8% in 2020).

### Work pressure

- Many of the questions in this sub-score overlap with those of the *we are safe and healthy* People Promise theme. Click here for more information.

### Stressors

- There has been an increase in the number of people who are saying that *relationships are strained* (42.9% in 2021)
- Similarly many questions in this sub-score overlap with other People Promise themes.




| | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|
| Best | 6.7 | 6.7 | 6.8 | 6.5 |
| Your org | 5.5 | 5.6 | 5.9 | 5.5 |
| Average | 5.9 | 5.9 | 6.0 | 5.7 |
| Worst | 5.2 | 5.2 | 5.5 | 5.3 |
| Responses | 4,416 | 4,858 | 4,993 | 4,952 |

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# People Promise Theme 1

## We are compassionate and inclusive

*We are compassionate and inclusive* theme measures compassionate culture and leadership as well as asks questions regarding the diversity, equality and inclusion agenda.


0.1

*Lower than the Acute benchmark average*

### Key Takeaways

Compassionate Culture

- 88.9% of respondents feel that *their role makes a difference to patients/service users* – this is slightly above the benchmark average of 87.7%.
- If a friend or relative needed treatment 71.2% of respondents would be *happy with the standard of care provided by the organisation* – this is above the benchmark average of 66.9%

Compassionate Leadership

- The Trust performed below the benchmark average in all of the questions within this sub-score, the largest difference being in Q9i *my immediate manager takes effective action to help me with any problems I face*. This is a 2% difference with our Trust score being 61.3% and the benchmark average being 63.3%.

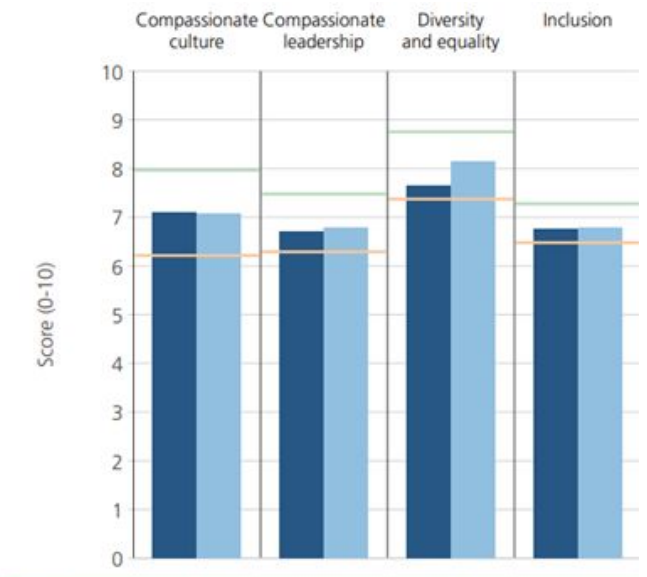
Diversity and equality

- The Trust performs worse than the benchmark average on all the sub-score questions, which contributes to the difference in the overall sub-score
- 46.6% of respondents believe that the organisation acts fairly with regards to career progression (compared to 55.7% benchmark average)
- 64.3% of respondents believes the organisation respects individual differences (compared to 68.8% benchmark average)

Inclusion

- The majority of respondents believe that the people they work with are polite and treat each other with respect – 70.2% (which is in line with the benchmark average)
- However 61.1% feel a strong personal attachment to the team – which is 2.5% below the benchmark average at 63.6%.

### People Promise 1 sub-scores




| | Compassionate culture | Compassionate leadership | Diversity and equality | Inclusion |
|---|---|---|---|---|
| Best | 8.0 | 7.5 | 8.8 | 7.3 |
| Your org | 7.1 | 6.7 | 7.6 | 6.8 |
| Average | 7.1 | 6.8 | 8.1 | 6.8 |
| Worst | 6.2 | 6.3 | 7.4 | 6.5 |
| Responses | 4,829 | 4,889 | 4,851 | 4,906 |

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# People Promise Theme 2

## We are recognised and rewarded

*We are recognised and rewarded* theme measures whether staff feel recognised, valued and appreciated by their organisation, by their managers and by other colleagues for the work they do. It also measures perceptions regarding pay.

### Key takeaways

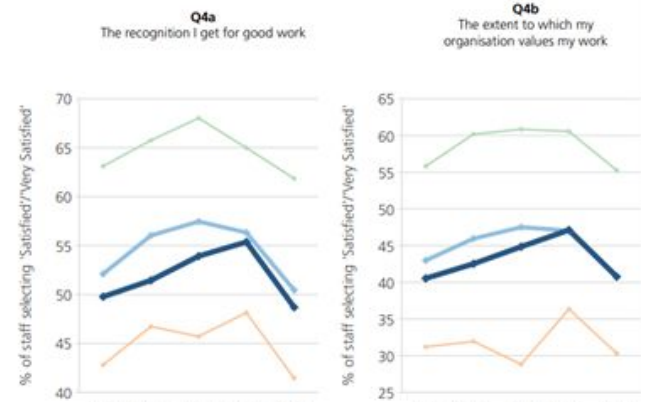
Whilst there are no sub-scores for this theme, overall, the questions have seen a decline year on year and are worse than the benchmark average.

- 48.7% of respondents are *satisfied with the recognition they get for good work* – this has suffered a significant decline from the 2020 score for this question at 55.4%
- Similarly 40.8% of respondents are *satisfied with the extent that the organisation values their work* – which has declined from 47.1% in 2020.
- 65.5% believe that *those they work with show appreciation to one another* (this is only slightly below the benchmark average at 65.8%)
- 69% believe that their *immediate manager values their work*, which has seen a slight decline in from 2020 score of 70%  and is also slightly below the benchmark average of 69.4%


⬇ 0.1

*Lower than the Acute benchmark average*

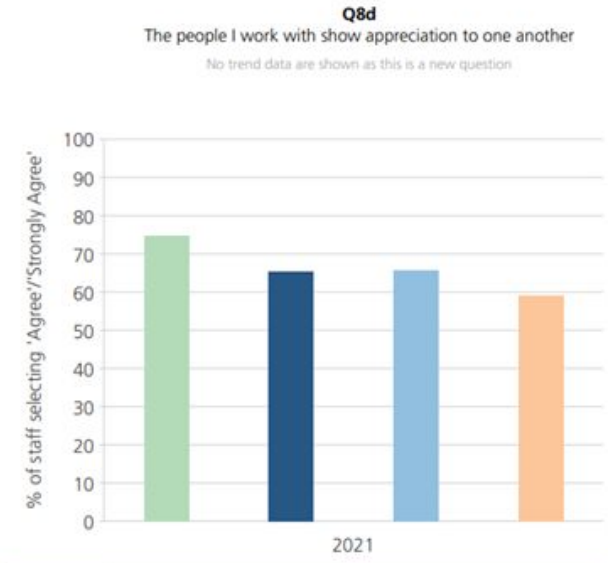
### Graphs for questions 4a and 4b




| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| Best | 63.1% | 65.8% | 68.0% | 65.0% | 61.9% |
| Your org | 49.8% | 51.4% | 53.9% | 55.4% | 48.7% |
| Average | 52.1% | 56.0% | 57.5% | 56.3% | 50.5% |
| Worst | 42.8% | 46.7% | 45.7% | 48.1% | 41.5% |
| Responses | 4,240 | 4,409 | 4,862 | 4,983 | 4,942 |

| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| Best | 55.8% | 60.2% | 60.8% | 60.6% | 55.2% |
| Your org | 40.5% | 42.5% | 44.8% | 47.1% | 40.8% |
| Average | 43.0% | 45.9% | 47.5% | 47.0% | 40.7% |
| Worst | 31.2% | 31.9% | 28.8% | 36.3% | 30.3% |
| Responses | 4,203 | 4,373 | 4,855 | 4,982 | 4,946 |

### Graph for question 8d




| | 2021 |
|---|---|
| Best | 74.7% |
| Your org | 65.5% |
| Average | 65.8% |
| Worst | 59.1% |
| Responses | 4,904 |

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# People Promise Theme 3

## We each have a voice that counts

*We each have a voice that counts* theme measures autonomy and control over ones work, being able to show initiative, as well as questions regarding raising concerns and confidence that these will be addressed.


⬇ 0.2

*Lower than the Acute benchmark average*

### Key takeaways

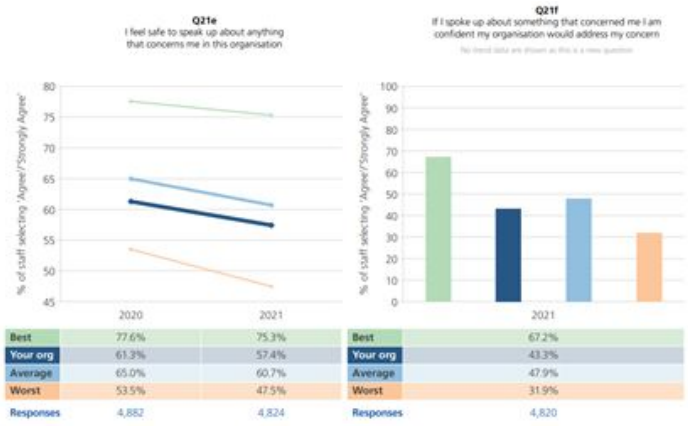
Autonomy and control

- Most staff *know what their work responsibilities are* (87.3%) and *feel trusted to do their jobs* (91%). Both of these scores are slightly above their benchmark averages.
- Furthermore, there has been a steady incline since 2019 of staff saying *there are frequent opportunities to show initiative in their roles*, with 72.4% saying there are.
- However there has been an overall decline, both nationally and as a trust, of staff feeling *they are make to suggestions for improvements* (68.6% score for the Trust in 2021); and *being able to make these improvements happen* (51.3% score for the Trust in 2021).

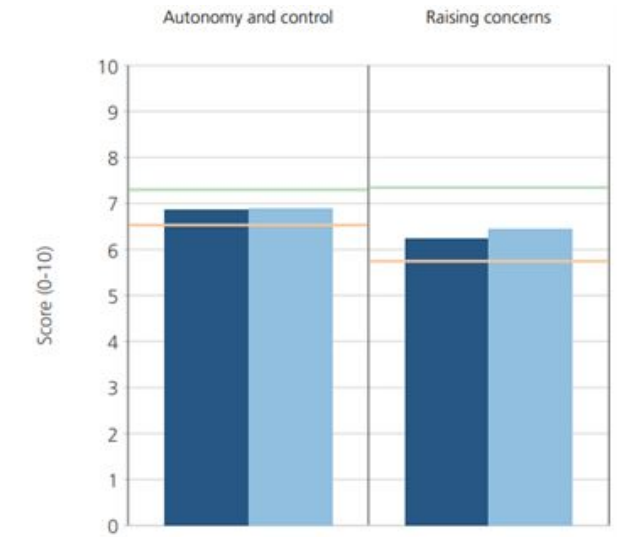
Raising concerns

- There has been a decline in staff saying they feel safe to speak up about their concerns (57.4% down from 61.3% in 2020).
- Furthermore, 43.3% are *confident that concerns would be addressed*.

### Graphs for questions 21e and 21f




### People Promise 3 sub-scores




| | Autonomy and control | Raising concerns |
|---|---|---|
| Best | 7.3 | 7.3 |
| Your org | 6.9 | 6.2 |
| Average | 6.9 | 6.4 |
| Worst | 6.5 | 5.7 |
| Responses | 4,965 | 4,819 |

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# People Promise Theme 4

## We are safe and healthy

*We are safe and healthy theme* measures the health and safety climate (e.g. meeting demands, time pressures and having enough resources and staff). It also measures burnout, exhaustion and stress. It also measures the negative experiences staff may face (e.g. the level of physical violence and abuse).

### Key takeaways

Health and safety climate

- Nationally and as a Trust, there has been a sharp decline in scores for Q3g and Q3i. That is, 43.7% of our respondents are *able to meet the conflicting demands at work* and 26.5% believe *there is enough staff within the organisation to do the job properly* (see graphs opposite).

Burnout

- In most of the questions for this sub-score, we perform slightly worse than the benchmark average.
- 37.3% feel *burnt out because of their work* (which is above the benchmark average of 35.2%)
- 34% have said that *they often don't have energy for friends and family during leisure time*.

Negative experiences

- Less staff year on year are experiencing bullying and harassment from managers, colleagues or members of the public. For example, Q14c (experiencing B&H from colleagues) has seen a sharp decline of 2.8%, whereas the average has stayed stable on this question.


↓ 0.1

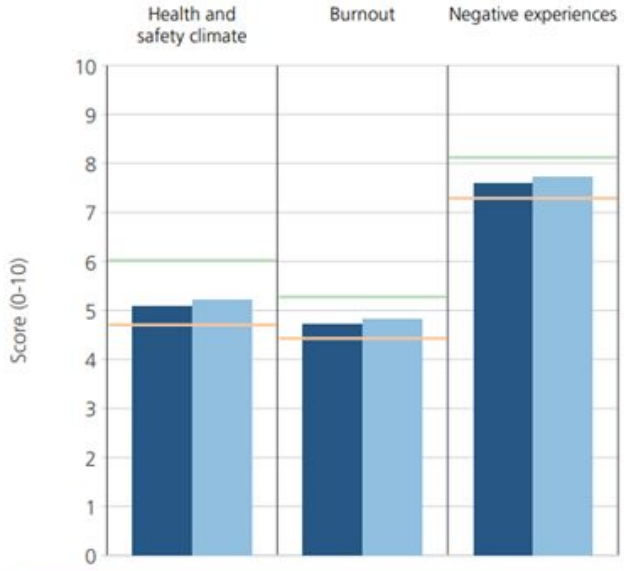
*Lower than the Acute benchmark average*

## Graphs for questions 3g and 3i


| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| Best | 61.8% | 59.4% | 59.2% | 62.1% | 54.7% |
| Your org | 44.6% | 45.2% | 45.6% | 49.3% | 43.7% |
| Average | 44.8% | 45.1% | 46.7% | 47.6% | 43.3% |
| Worst | 36.6% | 36.1% | 36.2% | 38.4% | 34.6% |
| Responses | 4,246 | 4,427 | 4,864 | 4,987 | 4,940 |

| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| Best | 44.4% | 44.5% | 48.1% | 52.4% | 37.8% |
| Your org | 30.7% | 31.1% | 29.6% | 35.7% | 26.5% |
| Average | 30.2% | 30.6% | 30.9% | 36.9% | 26.0% |
| Worst | 20.3% | 19.3% | 20.9% | 26.1% | 18.2% |
| Responses | 4,255 | 4,441 | 4,878 | 5,008 | 4,955 |

## People Promise 4 sub-scores




| | Health and safety climate | Burnout | Negative experiences |
|---|---|---|---|
| Best | 6.0 | 5.3 | 8.1 |
| Your org | 5.1 | 4.7 | 7.6 |
| Average | 5.2 | 4.8 | 7.7 |
| Worst | 4.7 | 4.4 | 7.3 |
| Responses | 4,963 | 4,873 | 4,859 |

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# People Promise Theme 5

## We are always learning

*We are always learning theme* measures views on development and career opportunities and how supported staff feel to develop their careers within the organisation. It also measures how many have had appraisals and the quality of these.


*In line with the Acute benchmark average*

### Key takeaways

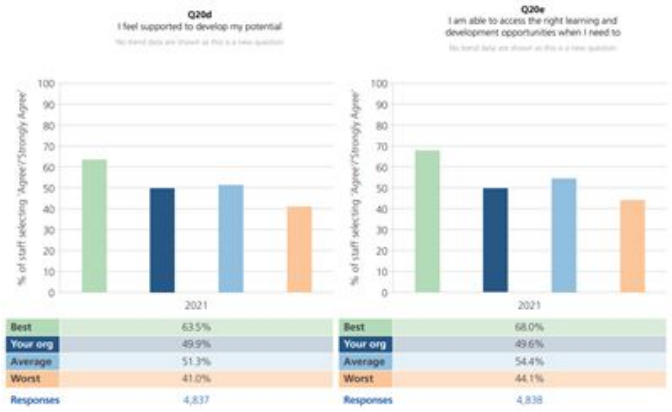
Development

- 68.9% of respondents believe that the organisation offers them challenging work and 53.5% believe there are opportunities to develop their career within the organisation (both of these scores are slightly above the benchmark average).
- However, only 49.9% feel *supported in developing their potential* and 49.6% feel they are *able to access the learning and development opportunities* they need.

Appraisals

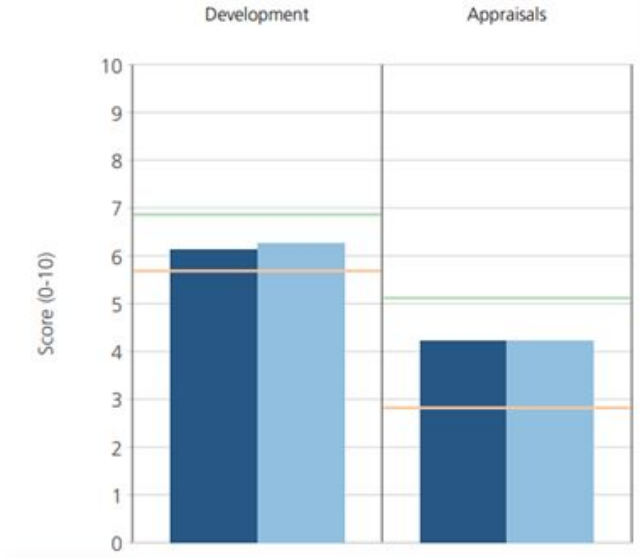
- Whilst the majority of respondents have said that they have had an appraisal (76.8%) only 24.3% believe that it has *helped them to improve how they do their job* and only 33.7% said that it *helped them to agree clear objectives for their work.*

### Graphs for questions 20d and 20e




| | Q20d | Q20e |
|---|---|---|
| Best | 63.5% | 68.0% |
| Your org | 49.9% | 49.6% |
| Average | 51.3% | 54.4% |
| Worst | 41.0% | 44.1% |
| Responses | 4,837 | 4,838 |

### People Promise 5 sub-scores




| | Development | Appraisals |
|---|---|---|
| Best | 6.9 | 5.1 |
| Your org | 6.1 | 4.2 |
| Average | 6.3 | 4.2 |
| Worst | 5.7 | 2.8 |
| Responses | 4,844 | 4,605 |

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# People Promise Theme 6

## We work flexibly

*We work flexibly* theme measures views on the organisational commitment to staff achieving work-life balance, and also openness from managers regarding flexible working.

5.7

Theme score

0.2

*Lower than the Acute benchmark average*

### Key takeaways

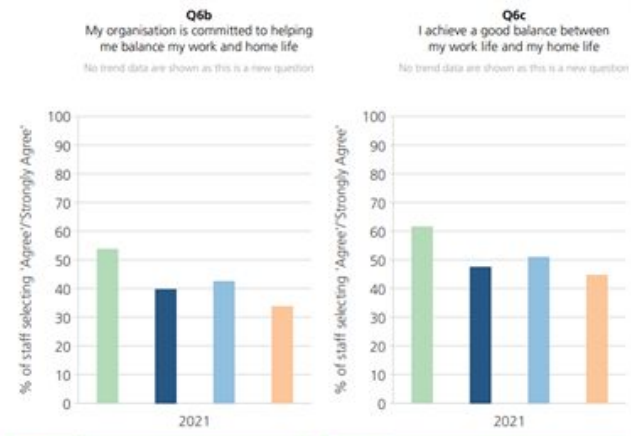
Support for work-life balance

- 39.9% believe the organisation is committed to helping them achieve work-life balance
- Despite this, 47.6% believe that they do achieve a good work-life balance
- Also, 61.8% feel they can approach their immediate managers about flexible working

Flexible working

- There has been an overall decline in staff saying they are satisfied with the opportunities for flexible working patterns – 48.6% in 2021, down from 53.8% in 2020.

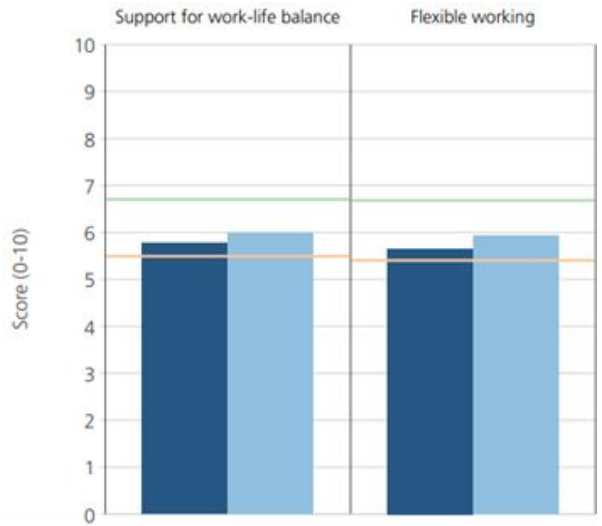
### Graphs for questions 6b and 6c




| | |
|---|---|
| Best | 53.8% |
| Your org | 39.9% |
| Average | 42.6% |
| Worst | 33.8% |
| Responses | 4,938 |

| | |
|---|---|
| Best | 61.6% |
| Your org | 47.6% |
| Average | 51.1% |
| Worst | 44.7% |
| Responses | 4,943 |

### People Promise 6 sub-scores




| | Support for work-life balance | Flexible working |
|---|---|---|
| Best | 6.7 | 6.7 |
| Your org | 5.8 | 5.7 |
| Average | 6.0 | 5.9 |
| Worst | 5.5 | 5.4 |
| Responses | 4,943 | 4,945 |

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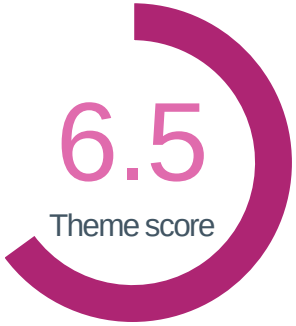
# People Promise Theme 7

## We are a team

*We are a team* theme measures team working and team effectiveness (e.g. having shared objectives, understanding each others roles, and working well together). It also measures staff experiences of their immediate line managers.




⬇ 0.1

*Lower than the Acute benchmark average*

### Key takeaways

#### Team working

- There has been an increase in those who have said the team they work in has a shared set of objectives – 71.1% in 2021 compared to 68.9% in 2020
- Furthermore 78.9% of respondents enjoy working with colleagues in their team
- However, only 55.4% believe that team disagreements are dealt with constructively
- Also, when answering the question regarding with teams within the organisation work well together to achieve it's objectives, only 49.8% of respondents positively agreed with this.

#### Line management

- Overall, questions on immediate line managers score beneath the benchmark average and it is apparent that staff and managers want us to support them more.

### Graphs for questions 7g and 8a


| | Q7g | Q8a |
|---|---|---|
| Best | 64.9% | 70.6% |
| Your org | 55.4% | 49.8% |
| Average | 54.7% | 52.2% |
| Worst | 48.0% | 39.1% |
| Responses | 4,913 | 4,909 |

### People Promise 7 sub-scores


| | Team working | Line management |
|---|---|---|
| Best | 7.0 | 7.3 |
| Your org | 6.5 | 6.5 |
| Average | 6.5 | 6.6 |
| Worst | 6.2 | 6.2 |
| Responses | 4,926 | 4,893 |

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# The Big 5 consultation

Having analysed all reports from both Picker, The Survey Coordination Centre and the comparison to other London Acute Trusts, we have determined a 'long list' of 10 themes for a potential Big 5 focus. This is currently out for consultation with the divisions. Consultation will close on 2nd March 2022. Our 10 themes are:

### Work life balance/ flexible working

Consistently 3+% below National and London averages for related 4 questions

### Inter-team / silo working

Significantly below National and London averages for perception of teams working well together

### Behaviours towards colleagues (inc. B&H)

Have actually improved 3+% from last year but still a little behind National and London averages on 8 relevant questions

### Line managers

Consistently a below averages for relevant questions and similar results to last year

### Violence

Whilst results in the survey have shown some improvements, anecdotal evidence suggests increase in abuse from relatives

### Burnout and stress

Consistently below averages for relevant questions, sometimes by 3+%. Results have dropped a little further from last year

### Anti-discrimination

Results similar to last year but still behind National and London averages on relevant questions

### Raising concerns

Results are similar to last year but still behind National and London averages on relevant questions. Evidence from F2SU also suggests there are concerns around speaking up

### Access to L&D opportunities

We are behind the average on questions with regards to access to L&D opportunities

### Disability

Behind the National average for making adequate adjustments (3% behind London average)

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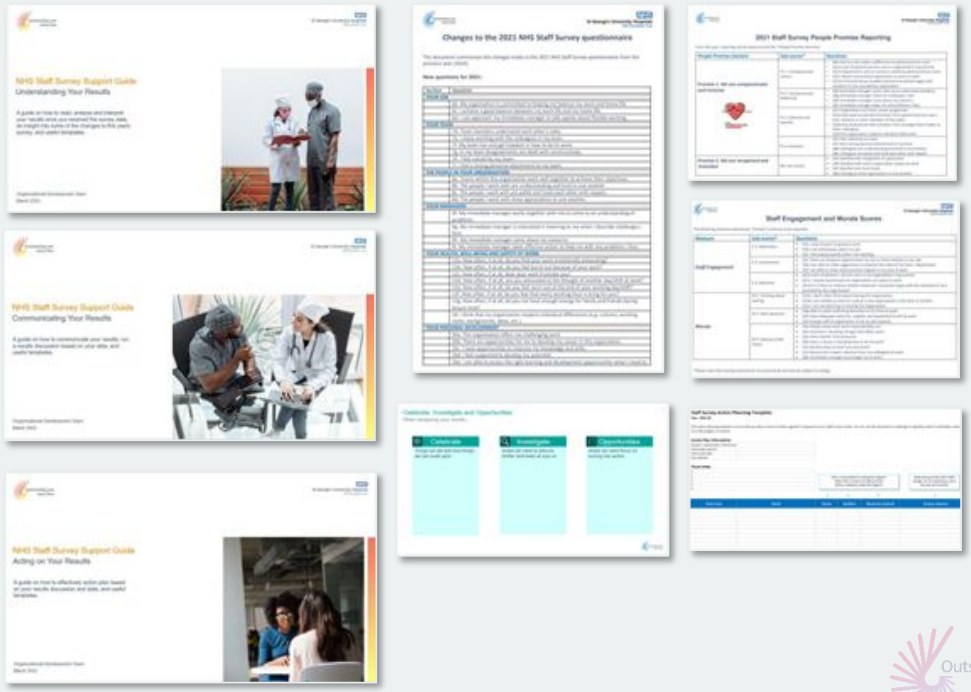
# Local reporting and support available

We are in the midst of creating and finalising local reporting for Divisions. This will be followed by the creation and distribution of Care Group reporting. Each Division will hold a workshop to discuss their results and create and action plan. A suite of supporting materials is also being made available at a local level in order to support Divisions and Care Groups with the survey.

## Reporting templates


## Supporting guides and templates

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# Conclusion

## What next and questions to consider

### Summary

Our results may tell the expected tale of the organisation, but we can and will turn this around.

Staff are telling us clearly that they are stressed, warned down and tired. Our managers need support and staff do not feel recognised. Morale and staff engagement has suffered as a result. Whilst the current national context would have undoubtedly played a significant role in how staff are feeling, we do perform worse than other organisations who are similar to us and have experienced that same context. Therefore there is some responsibility we have take as a Trust.

There are some silver linings. For example, the majority of respondents still believe that we deliver good patient care and that it is this organisations top priority. Furthermore, we have seen improvements in areas such as bullying and harassment, year on year.

There are many strong contenders for what our Big 5 should be, and we are currently engaging with our divisions and site Executive Team to ensure that we focus on the right things. Once we have decided and announced the Big 5, we will put a clear plan in place to ensure that staff see that we are acting as a result of their feedback.

### Priorities and next steps

The following has been identified as immediate priorities for action:

- Close of consultation period and agreement and sign off of the Big 5
- Establishing executive sponsorship for each Big 5 item and devising action plans which sit underneath each of the Big 5 items
- Finalising and distribution of Divisional survey reports and supporting materials
- Divisional staff survey workshops, ran in collaboration with HRBPs and the OD team

### Questions to consider

Some questions to pause and reflect on are:

- Do the results resonate with the current staff experience?
- Is there anything that surprises you?
- Is this something that we've heard before or elsewhere?
- What feels most important to focus on right now?
- How can we, as an organisation, have the most impact?
- Where are the opportunities?

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NHS

# St George's University Hospitals NHS Foundation Trust

2021 NHS Staff Survey

**Benchmark Report**

Survey Coordination Centre

# 2021 NHS Staff Survey Results – St George's University Hospitals NHS Foundation Trust

NHS

## Contents

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# Introduction

NHS

## About this report

This benchmark report for St George's University Hospitals NHS Foundation Trust contains results for the 2021 NHS Staff Survey, and historical results back to 2017 where possible. These results are presented in the context of the best, average and worst results for similar organisations where appropriate. Data in this report are weighted to allow for fair comparisons between organisations.

Please note: Results for q1, q10a, q22d, q23a-c, q24-q28a, and q29a-q31 are not weighted or benchmarked because these questions ask for demographic or factual information.

Full details of how the data are calculated and weighted are included in the Technical Document, available to download from our results website.

## How results are reported

For the 2021 survey onwards the questions in the NHS Staff Survey are aligned to the People Promise. This sets out, in the words of NHS staff, the things that would most improve their working experience, and is made up of seven elements:


In support of this, the results of the NHS Staff Survey are now measured against the seven People Promise elements and against two of the themes reported in previous years (Staff Engagement and Morale). The reporting also includes new sub-scores, which feed into the People Promise elements and themes. The next slide shows how the People Promise elements, themes and sub-scores are related and mapped to individual survey questions.

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# People Promise elements, themes and sub-scores

NHS

Please note that you can navigate to the results of a particular score or question result by clicking on it in the table below.

| People Promise element | Sub-scores | Question |
|---|---|---|
| We are compassionate and inclusive | Compassionate culture<br>Compassionate leadership<br>Diversity and equality<br>Inclusion | Q6a, Q21a, Q21b, Q21c, Q21d<br>Q9f, Q9g, Q9h, Q9i<br>Q15*, Q16a, Q16b, Q18<br>Q7h, Q7i, Q8b, Q8c |
| We are recognised and rewarded | [No sub-scores] | Q4a, Q4b, Q4c, Q8d, Q9e |
| We each have a voice that counts | Autonomy and control<br>Raising concerns | Q3a, Q3b, Q3c, Q3d, Q3e, Q3f, Q5b<br>Q17a, Q17b, Q21e, Q21f |
| We are safe and healthy | Health and safety climate<br>Burnout<br>Negative experiences | Q3g, Q3h, Q3i, Q5a, Q11a, Q13d, Q14d<br>Q12a, Q12b, Q12c, Q12d, Q12e, Q12f, Q12g<br>Q11b, Q11c, Q11d, Q13a, Q13b, Q13c, Q14a, Q14b, Q14c |
| We are always learning | Development<br>Appraisals | Q20a, Q20b, Q20c, Q20d, Q20e<br>Q19a, Q19b, Q19c, Q19d |
| We work flexibly | Support for work-life balance<br>Flexible working | Q6b, Q6c, Q6d<br>Q4d |
| We are a team | Team working<br>Line management | Q7a, Q7b, Q7c, Q7d, Q7e, Q7f, Q7g, Q8a<br>Q9a, Q9b, Q9c, Q9d |
| **Theme** | **Sub-scores** | **Question** |
| Staff Engagement | Motivation<br>Involvement<br>Advocacy | Q2a, Q2b, Q2c<br>Q3c, Q3d, Q3f<br>Q21a, Q21c, Q21d |
| Morale | Thinking about leaving<br>Work pressure<br>Stressors | Q22a, Q22b, Q22c<br>Q3g, Q3h, Q3i<br>Q3a, Q3e, Q5a, Q5b, Q5c, Q7c, Q9a |
| **Questions not linked to the People Promise elements or themes** | | |
| Q1, Q10a, Q10b, Q10c, Q11e, Q15 (historical calculation)* , Q16c, Q22d, Q28b | | |

*Please note: The approach to calculating the results for Q15 has changed for 2021, to include 'don't know' responses. These results feed into the Diversity and equality sub-score and the We are compassionate and inclusive promise element, as well as the WRES and WDES indicators. The Q15 results based on the historic calculation are reported in this section for transparency, but do not feed into any measure.

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# The structure of this report

NHS

## Introduction

This section provides a brief introduction to the report, including features of the graphs used throughout. The '**Organisation details**' page contains key information about the organisation's survey and its benchmarking group.

## People Promise element and theme results

This section provides a high-level **overview** of the results for the seven elements of the People Promise and the two themes, followed by results for each of the **sub-scores** that feed into these measures. **Trend data** are shown for the themes of Staff Engagement and Morale. Results for the People Promise elements and themes are also presented split by staff experience during the **Covid-19 pandemic**.

In the **Detailed information section**, question level results have been divided into sections based on the sub-score and People Promise element or theme they contribute to. These are presented as line charts, or as bar charts where no trend data is available.

## Questions not linked to a People Promise element or theme

**Results** for the small number of questions that do not contribute to the result for any People Promise element or theme are included in this section.

## About your respondents

This section provides details of the staff responding to the survey, including the results of questions relating to their experience during the **Covid-19 pandemic** and **demographic and other classification questions**.

## Workforce Equality Standards

**This section** shows the data required for the NHS Staff Survey indicators used in the **Workforce Race Equality Standard (WRES)** and the **Workforce Disability Equality Standard (WDES)**.

## Appendices

Here you will find:

- Response rate trends
- Significance testing of the theme results for 2020 vs 2021
- Tips on action planning and interpreting results
- Details of the other reporting outputs available

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# Using the report

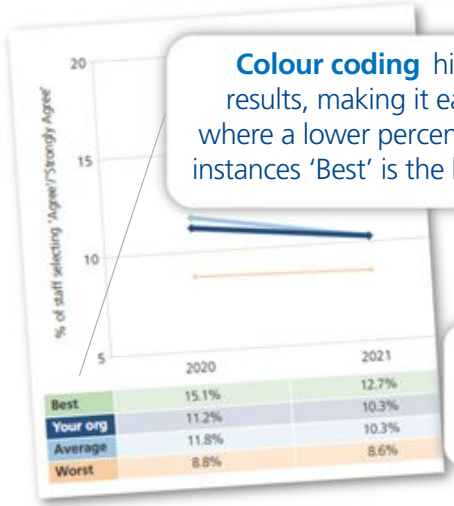
NHS

## Key features

Question number and text (or summary measure) specified at the top of each slide

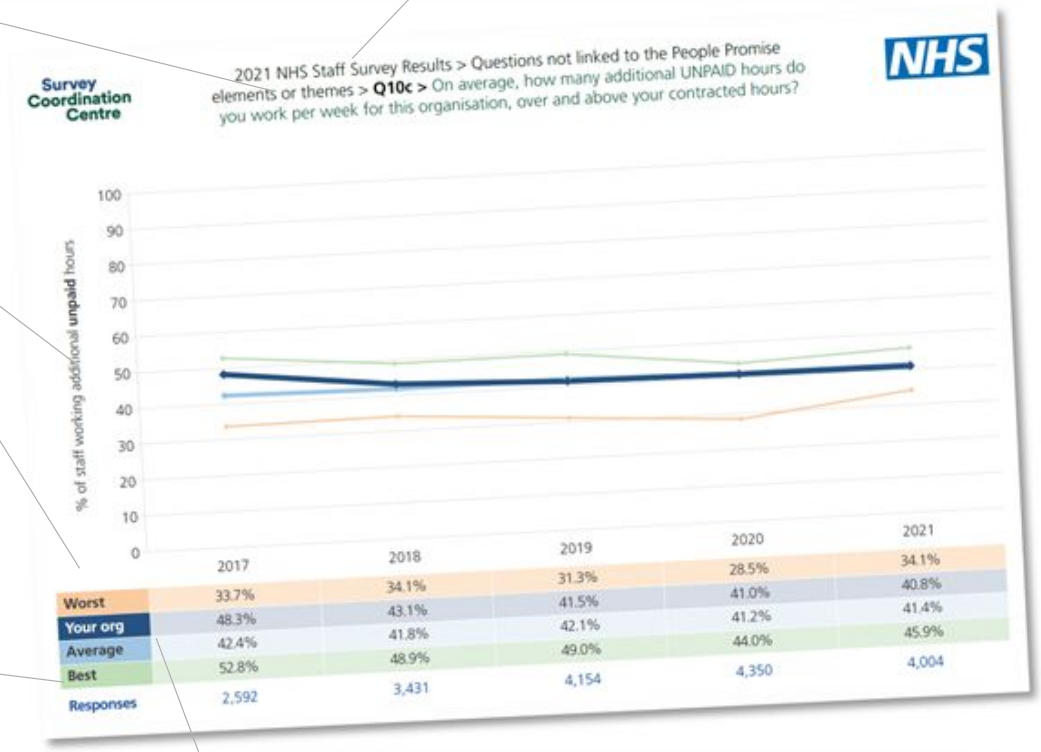
Slide headers are **hyperlinked** throughout the document. '2021 NHS Staff Survey Results' takes you back to the contents page (which is also hyperlinked to each section), while the rest of the text can be used to navigate to sections and sub-sections

Question-level results are always reported as percentages; the **meaning of the value** is outlined along the axis. Summary measures and sub-scores are always on a 0-10pt scale where 10 is the best score attainable




**Colour coding** highlights best / worst results, making it easy to spot questions where a lower percentage is better – in such instances 'Best' is the bottom line in the table

Keep an eye out!




**Number of responses** for the organisation for the given question

'Best', 'Average', and 'Worst' refer to the **benchmarking group's** best, average and worst **results**

Tips on how to read, interpret and use the data are included in the Appendices

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# Organisation details

NHS

## St George's University Hospitals NHS Foundation Trust

## 2021 NHS Staff Survey

### Organisation details

| | |
|---|---|
| Completed questionnaires | 5,009 |
| 2021 response rate | 55% |

See response rate trend for the last 5 years

### Survey details

| | |
|---|---|
| Survey mode | Online |
| Sample type | Census |

### This organisation is benchmarked against:

**Acute and Acute & Community Trusts**

#### 2021 benchmarking group details

Organisations in group: **126**

Median response rate: **46%**

No. of completed questionnaires: **444,326**

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NHS


# People Promise element and theme results

For more details please see the technical document.

St George's University Hospitals NHS Foundation Trust

2021 NHS Staff Survey Results

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# 2021 NHS Staff Survey Results > People Promise and theme results > Overview

NHS


| | We are compassionate and inclusive | We are recognised and rewarded | We each have a voice that counts | We are safe and healthy | We are always learning | We work flexibly | We are a team | Staff Engagement | Morale |
|---|---|---|---|---|---|---|---|---|---|
| **Best** | 7.8 | 6.5 | 7.3 | 6.5 | 6.0 | 6.7 | 7.1 | 7.4 | 6.5 |
| **Your org** | 7.1 | 5.7 | 6.5 | 5.8 | 5.2 | 5.7 | 6.5 | 6.8 | 5.5 |
| **Average** | 7.2 | 5.8 | 6.7 | 5.9 | 5.2 | 5.9 | 6.6 | 6.8 | 5.7 |
| **Worst** | 6.7 | 5.3 | 6.1 | 5.5 | 4.3 | 5.4 | 6.2 | 6.3 | 5.3 |
| **Responses** | 4,863 | 4,952 | 4,815 | 4,848 | 4,593 | 4,931 | 4,893 | 4,964 | 4,952 |

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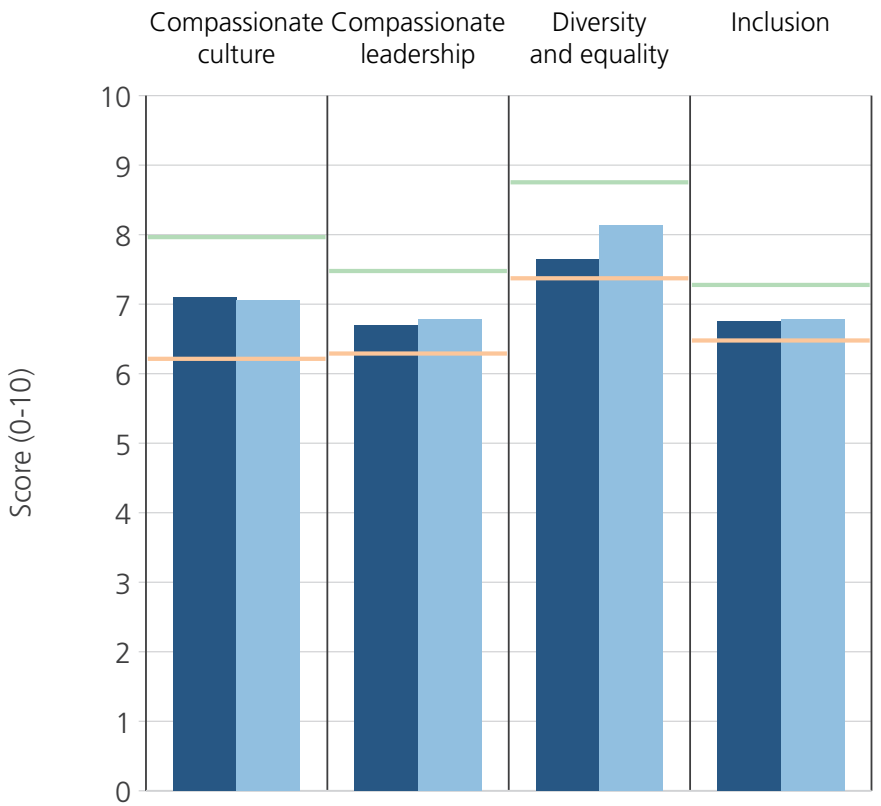
2021 NHS Staff Survey Results > People Promise and theme results > Detailed information > **Sub-score results page 1 of 4**

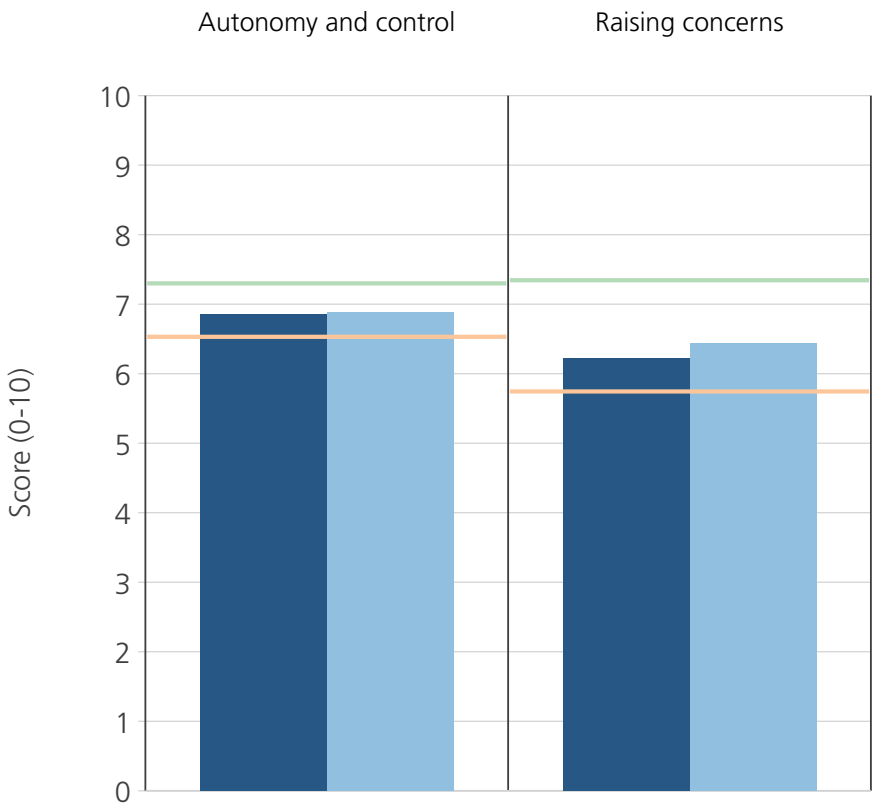
NHS

## Promise element 1: We are compassionate and inclusive




| | Compassionate culture | Compassionate leadership | Diversity and equality | Inclusion |
|---|---|---|---|---|
| **Best** | 8.0 | 7.5 | 8.8 | 7.3 |
| **Your org** | 7.1 | 6.7 | 7.6 | 6.8 |
| **Average** | 7.1 | 6.8 | 8.1 | 6.8 |
| **Worst** | 6.2 | 6.3 | 7.4 | 6.5 |
| **Responses** | 4,829 | 4,889 | 4,851 | 4,906 |

## Promise element 3: We each have a voice that counts




| | Autonomy and control | Raising concerns |
|---|---|---|
| **Best** | 7.3 | 7.3 |
| **Your org** | 6.9 | 6.2 |
| **Average** | 6.9 | 6.4 |
| **Worst** | 6.5 | 5.7 |
| **Responses** | 4,965 | 4,819 |

* Promise element 2 features no sub-scores and so is not included in this section of the benchmarking report

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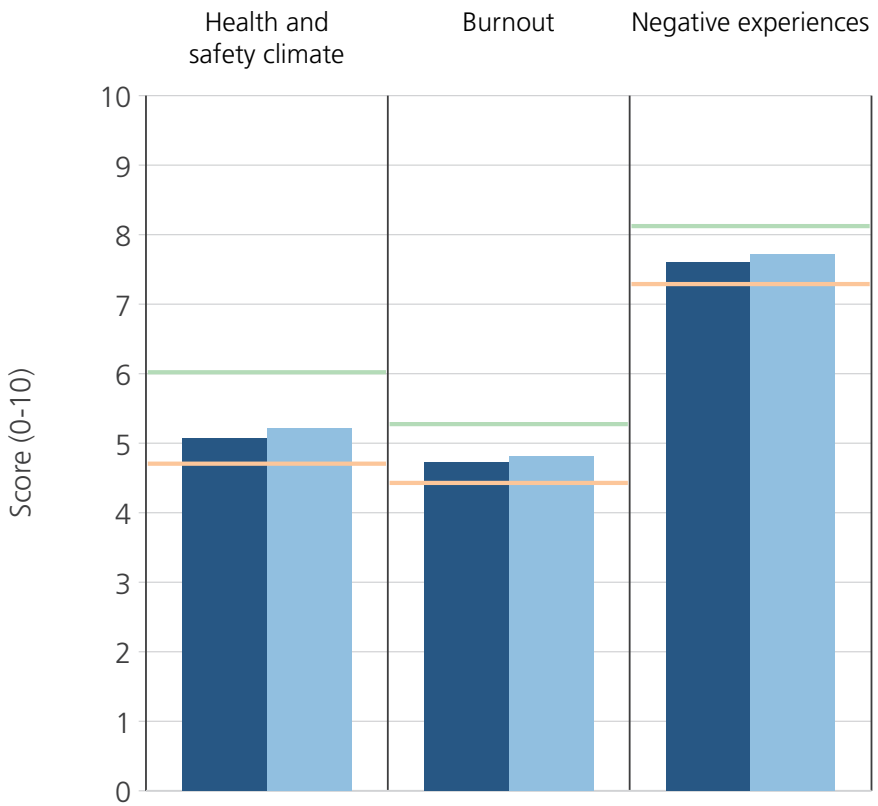
2021 NHS Staff Survey Results > People Promise and theme results > Detailed information > **Sub-score results page 2 of 4**

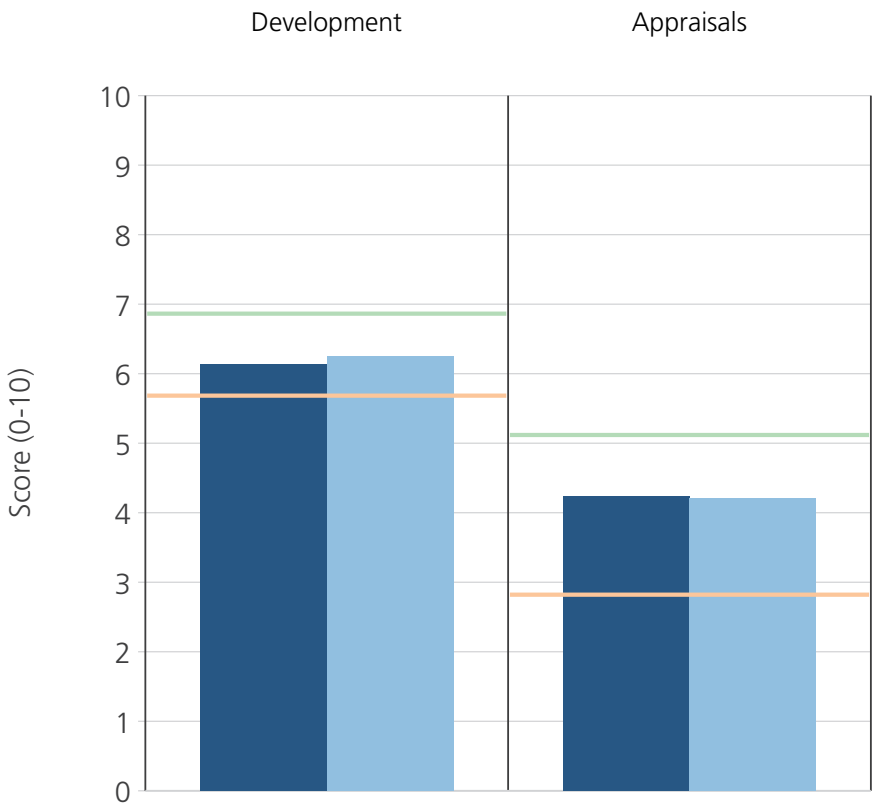
NHS

## Promise element 4: We are safe and healthy




| | Health and safety climate | Burnout | Negative experiences |
|---|---|---|---|
| **Best** | 6.0 | 5.3 | 8.1 |
| **Your org** | 5.1 | 4.7 | 7.6 |
| **Average** | 5.2 | 4.8 | 7.7 |
| **Worst** | 4.7 | 4.4 | 7.3 |
| **Responses** | 4,963 | 4,873 | 4,859 |

## Promise element 5: We are always learning




| | Development | Appraisals |
|---|---|---|
| **Best** | 6.9 | 5.1 |
| **Your org** | 6.1 | 4.2 |
| **Average** | 6.3 | 4.2 |
| **Worst** | 5.7 | 2.8 |
| **Responses** | 4,844 | 4,605 |

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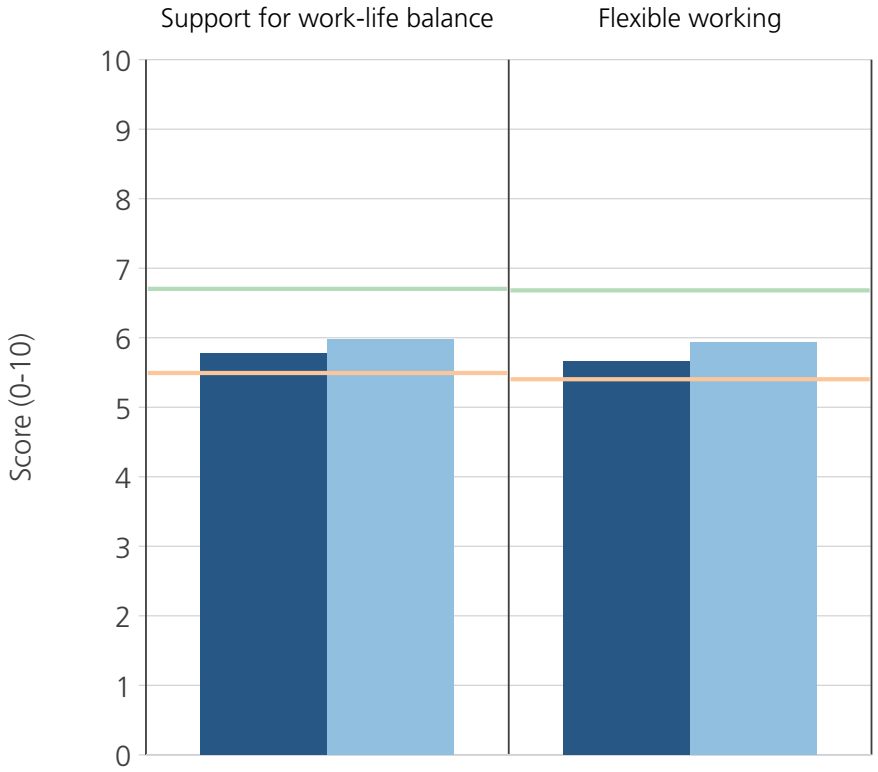
2021 NHS Staff Survey Results > People Promise and theme results > Detailed information > **Sub-score results page 3 of 4**

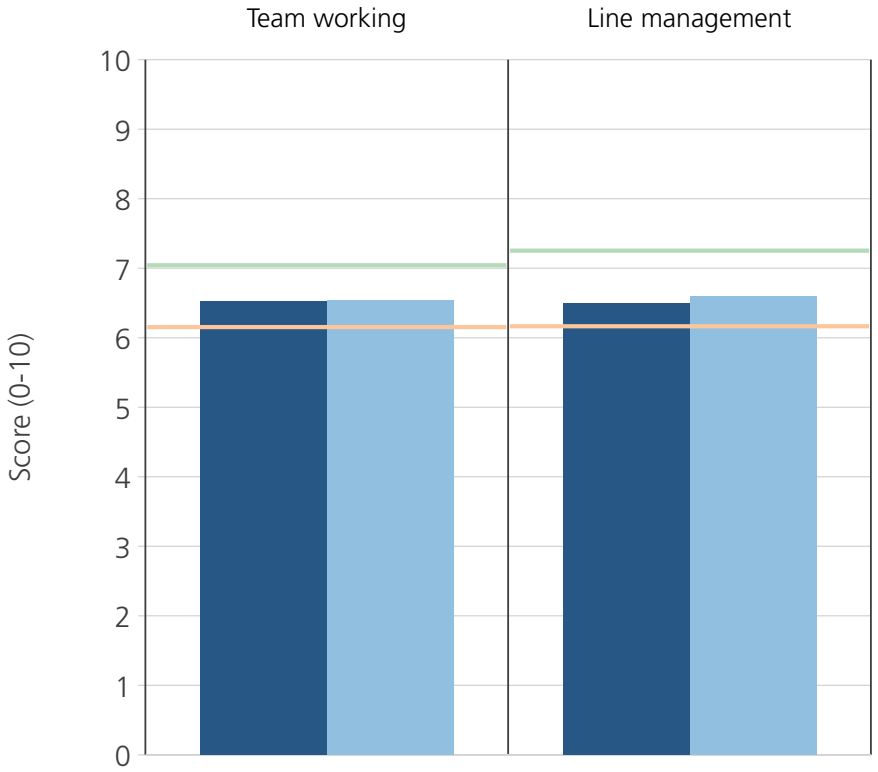
NHS

## Promise element 6: We work flexibly




| | Support for work-life balance | Flexible working |
|---|---|---|
| **Best** | 6.7 | 6.7 |
| **Your org** | 5.8 | 5.7 |
| **Average** | 6.0 | 5.9 |
| **Worst** | 5.5 | 5.4 |
| **Responses** | 4,943 | 4,945 |

## Promise element 7: We are a team




| | Team working | Line management |
|---|---|---|
| **Best** | 7.0 | 7.3 |
| **Your org** | 6.5 | 6.5 |
| **Average** | 6.5 | 6.6 |
| **Worst** | 6.2 | 6.2 |
| **Responses** | 4,926 | 4,893 |

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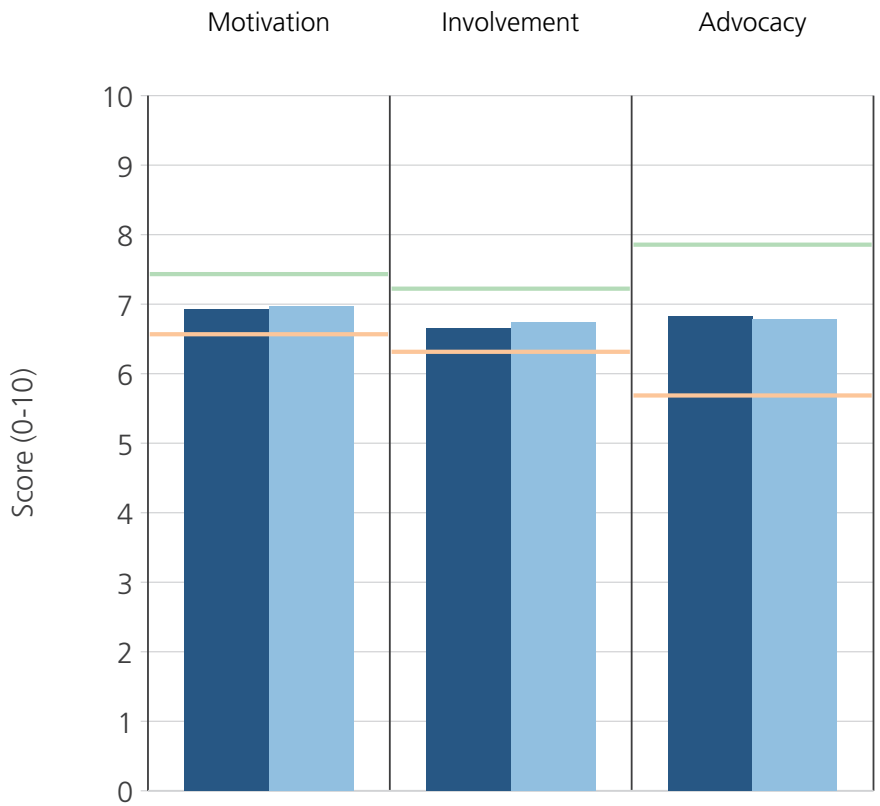
2021 NHS Staff Survey Results > People Promise and theme results > Detailed information > **Sub-score results page 4 of 4**

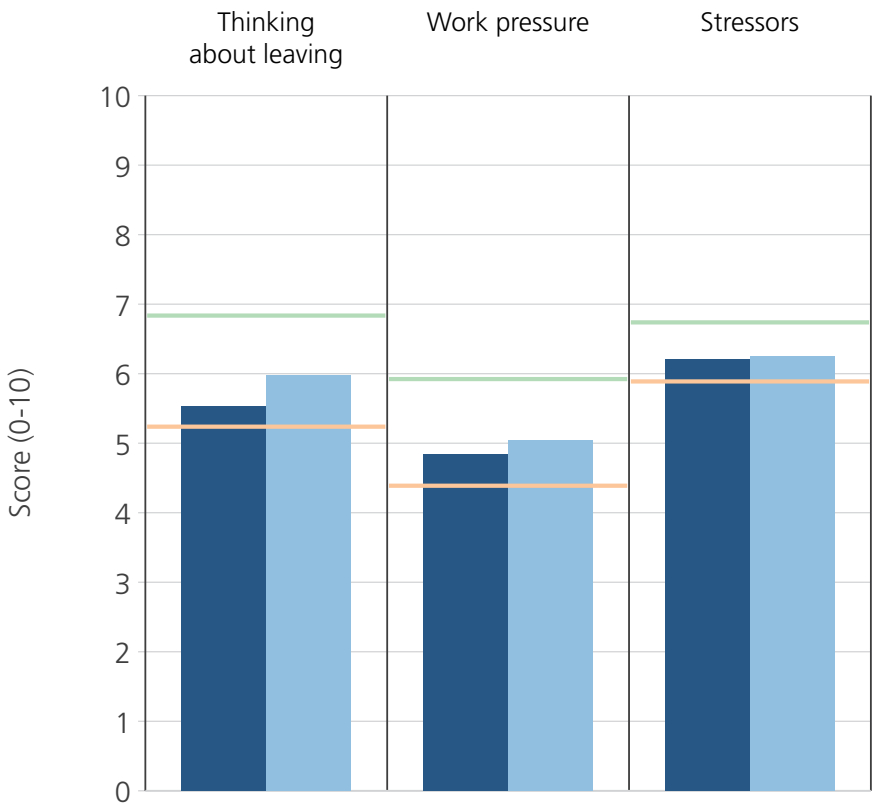
NHS

## Staff Engagement




| | Motivation | Involvement | Advocacy |
|---|---|---|---|
| **Best** | 7.4 | 7.2 | 7.9 |
| **Your org** | 6.9 | 6.7 | 6.8 |
| **Average** | 7.0 | 6.7 | 6.8 |
| **Worst** | 6.6 | 6.3 | 5.7 |
| **Responses** | 4,936 | 4,965 | 4,828 |

## Morale




| | Thinking about leaving | Work pressure | Stressors |
|---|---|---|---|
| **Best** | 6.8 | 5.9 | 6.7 |
| **Your org** | 5.5 | 4.8 | 6.2 |
| **Average** | 6.0 | 5.0 | 6.2 |
| **Worst** | 5.2 | 4.4 | 5.9 |
| **Responses** | 4,795 | 4,959 | 4,936 |

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NHS

# Staff Engagement and Morale – Trends

St George's University Hospitals NHS Foundation Trust

2021 NHS Staff Survey Results

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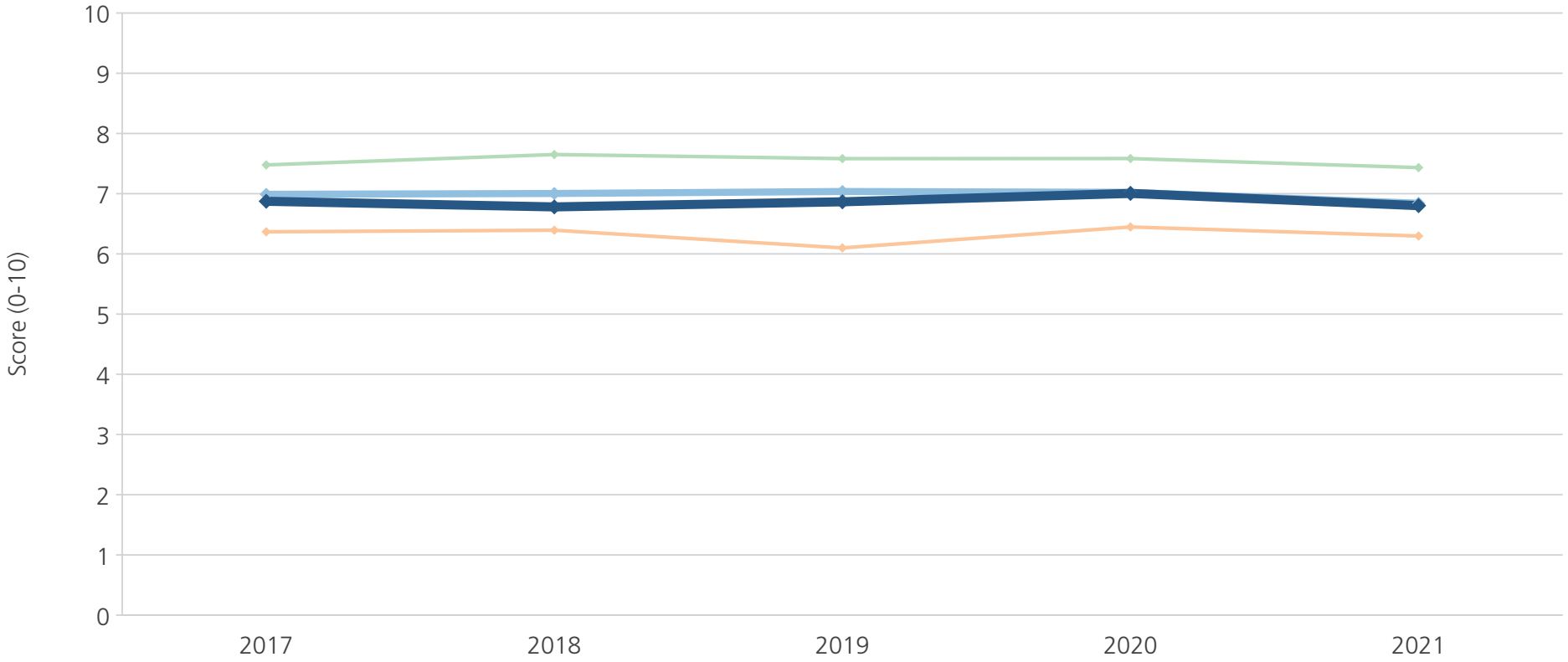
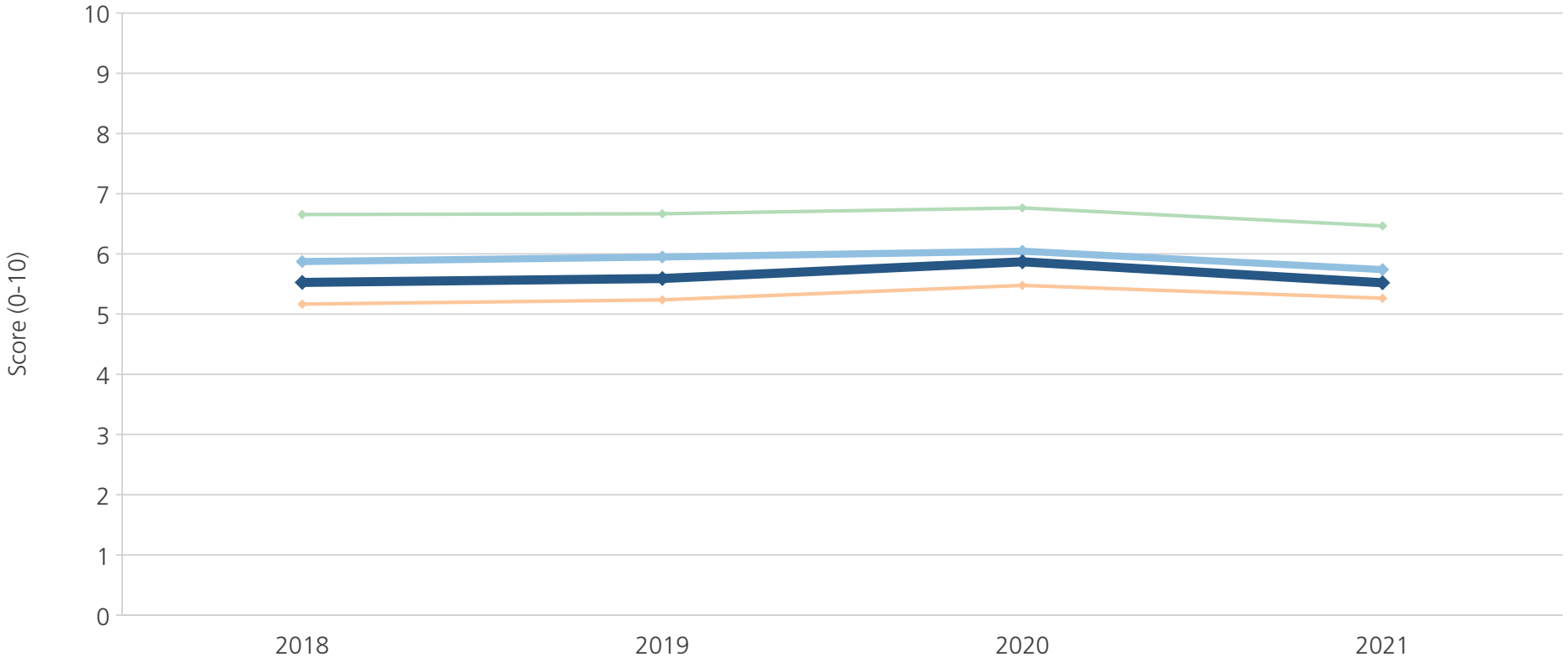
# 2021 NHS Staff Survey Results > People Promise and theme results > Staff Engagement




| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| **Best** | 7.5 | 7.7 | 7.6 | 7.6 | 7.4 |
| **Your org** | 6.9 | 6.8 | 6.9 | 7.0 | 6.8 |
| **Average** | 7.0 | 7.0 | 7.0 | 7.0 | 6.8 |
| **Worst** | 6.4 | 6.4 | 6.1 | 6.4 | 6.3 |
| **Responses** | 4,269 | 4,445 | 4,896 | 5,015 | 4,964 |

Survey Coordination Centre

# 2021 NHS Staff Survey Results > People Promise and theme results > Morale




| | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|
| **Best** | 6.7 | 6.7 | 6.8 | 6.5 |
| **Your org** | 5.5 | 5.6 | 5.9 | 5.5 |
| **Average** | 5.9 | 5.9 | 6.0 | 5.7 |
| **Worst** | 5.2 | 5.2 | 5.5 | 5.3 |
| **Responses** | 4,416 | 4,858 | 4,993 | 4,952 |

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NHS

# People Promise element and theme results – Covid-19 classification breakdowns

St George's University Hospitals NHS Foundation Trust

2021 NHS Staff Survey Results

Survey Coordination Centre

# Covid-19 classification breakdowns

NHS

## Covid-19 questions

In the 2021 survey, staff were asked three classification questions relating to their experience during the Covid-19 pandemic:

| | | |
|---|---|---|
| a. | Have you worked on a Covid-19 specific ward or area at any time? | ☐ Yes ☐ No |
| b. | Have you been redeployed due to the Covid-19 pandemic at any time? | ☐ Yes ☐ No |
| c. | Have you been required to work remotely/from home due to the Covid-19 pandemic? | ☐ Yes ☐ No |

The charts on the following pages show the breakdown of People Promise element scores for staff answering 'yes' to each of these questions, compared with the results for all staff at your organisation. Results are presented in the context of the highest, average and lowest scores for similar organisations.

## Comparing your data

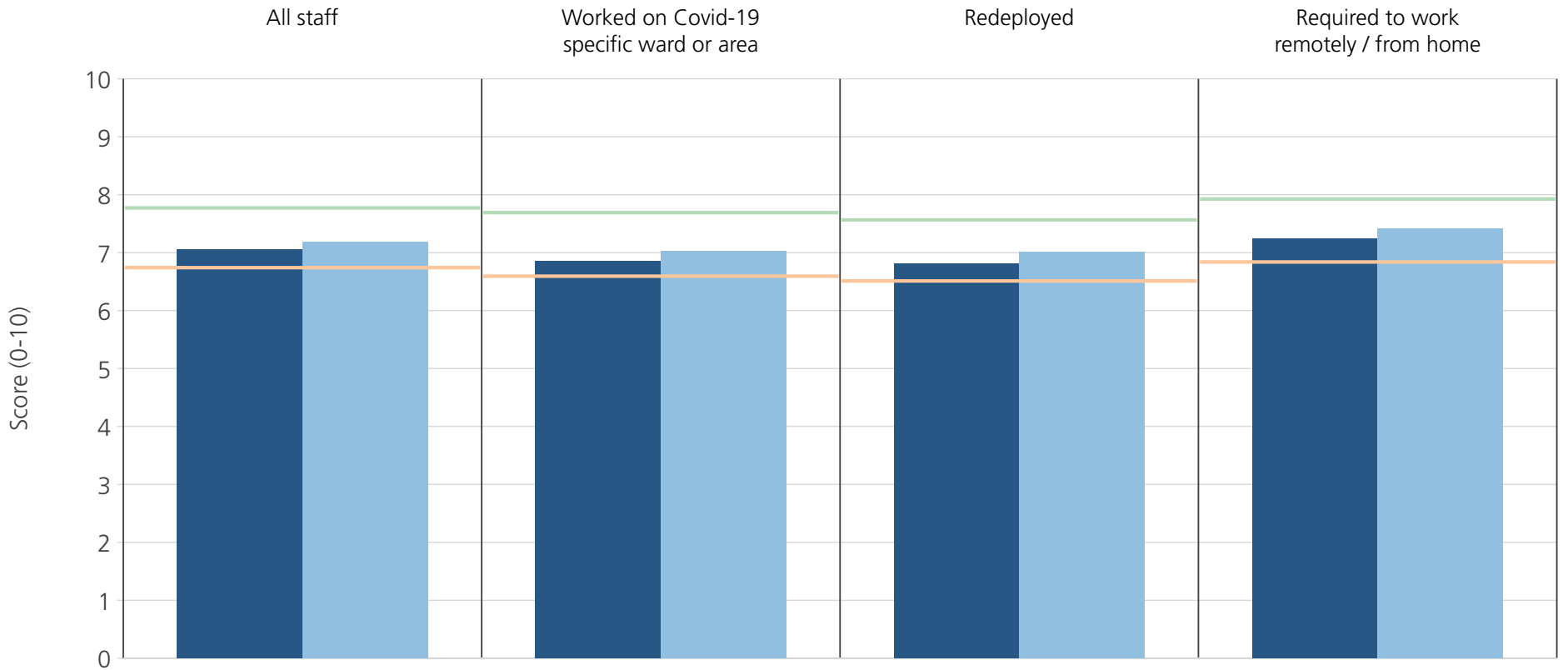
To improve overall comparability, the data have been weighted to match the occupation group profile of staff at your organisation to that of the benchmarking group, as in previous charts. However, there may be differences in the occupation group profiles of the individual COVID-19 subgroups. For example, the mix of occupational groups across redeployed staff at your organisation may differ from similar organisations. This difference would not be accounted for by the weighting and therefore may affect the comparability of results. As such, a degree of caution is advised when interpreting your results.

## Further information

Results for these groups of staff, including data for individual questions, are also available via the online dashboards. Please note that results presented in these dashboards have not been weighted where no benchmarking takes place and so may vary slightly from those shown in this report.

Survey Coordination Centre

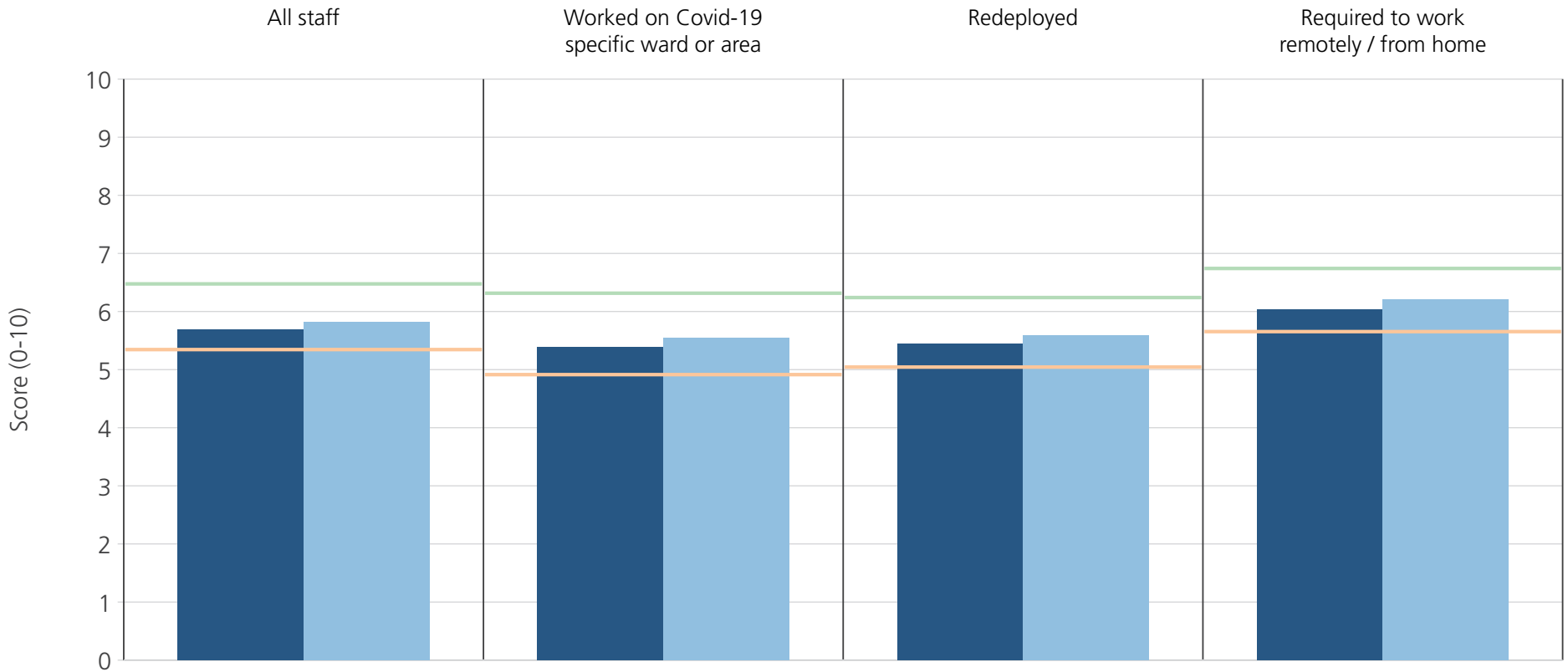
# 2021 NHS Staff Survey Results > People Promise element and theme results – Covid-19 classification breakdowns > **We are compassionate and inclusive**




| | All staff | Worked on Covid-19 specific ward or area | Redeployed | Required to work remotely / from home |
|---|---|---|---|---|
| **Highest** | 7.8 | 7.7 | 7.6 | 7.9 |
| **Your org** | 7.1 | 6.9 | 6.8 | 7.2 |
| **Average** | 7.2 | 7.0 | 7.0 | 7.4 |
| **Lowest** | 6.7 | 6.6 | 6.5 | 6.8 |
| **Responses** | 4,863 | 2,003 | 1,078 | 1,617 |

Survey Coordination Centre

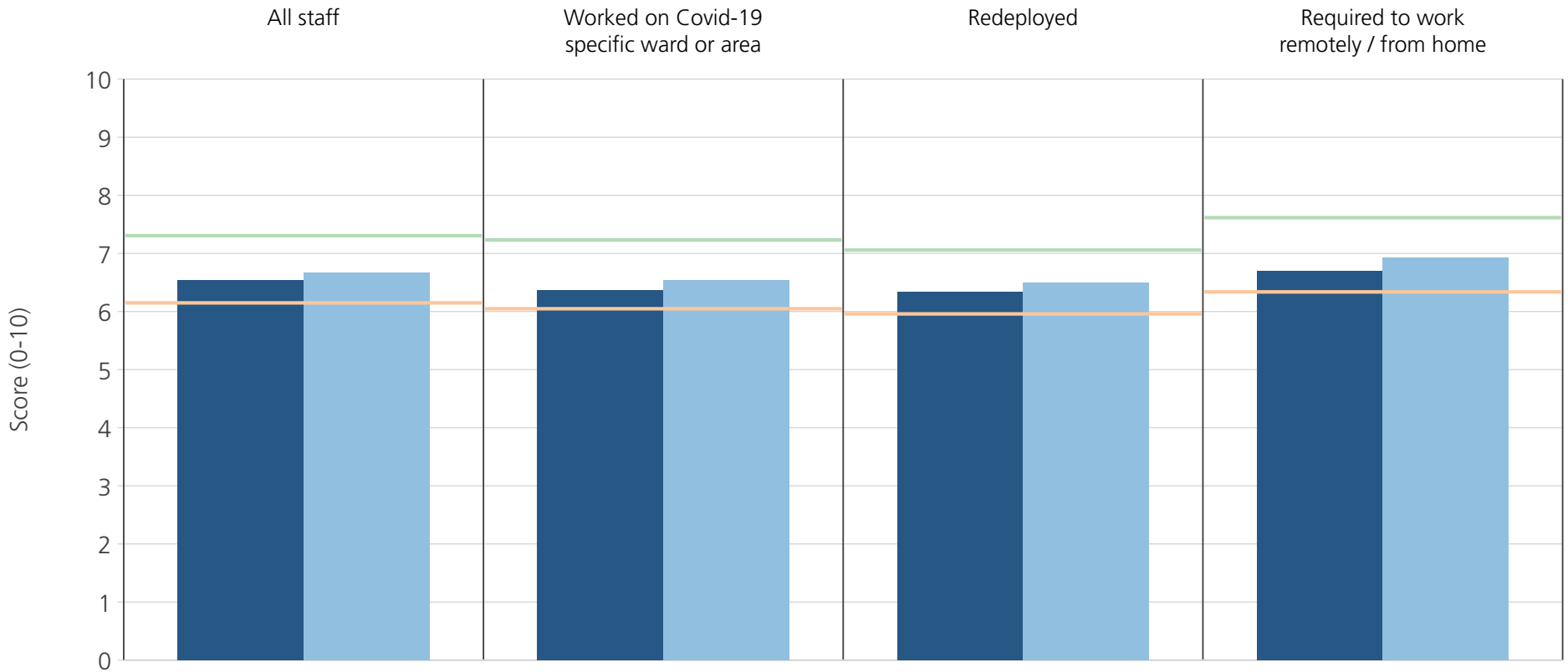
# 2021 NHS Staff Survey Results > People Promise element and theme results – Covid-19 classification breakdowns > We are recognised and rewarded




| | All staff | Worked on Covid-19 specific ward or area | Redeployed | Required to work remotely / from home |
|---|---|---|---|---|
| Highest | 6.5 | 6.3 | 6.2 | 6.7 |
| Your org | 5.7 | 5.4 | 5.4 | 6.0 |
| Average | 5.8 | 5.5 | 5.6 | 6.2 |
| Lowest | 5.3 | 4.9 | 5.0 | 5.7 |
| Responses | 4,952 | 2,001 | 1,078 | 1,618 |

Survey Coordination Centre

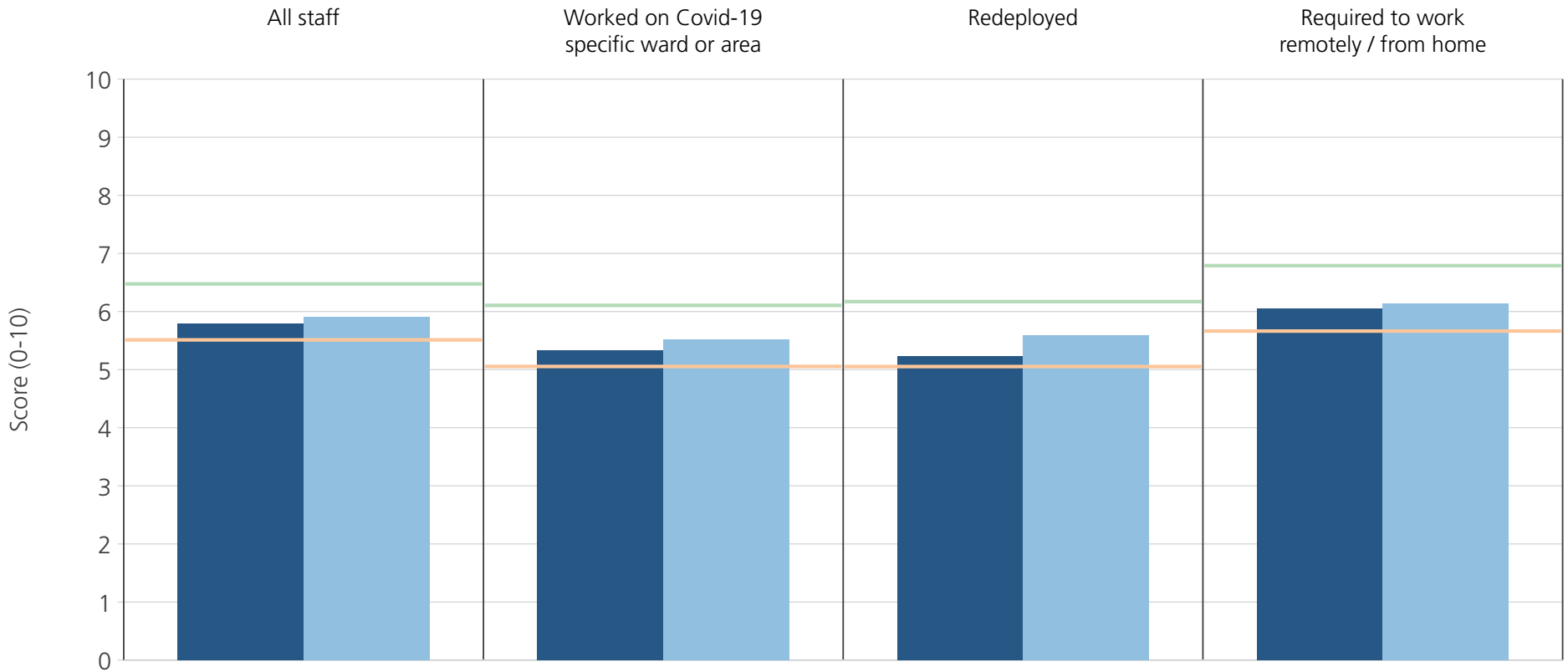
# 2021 NHS Staff Survey Results > People Promise element and theme results – Covid-19 classification breakdowns > We each have a voice that counts




| | All staff | Worked on Covid-19 specific ward or area | Redeployed | Required to work remotely / from home |
|---|---|---|---|---|
| Highest | 7.3 | 7.2 | 7.1 | 7.6 |
| Your org | 6.5 | 6.4 | 6.3 | 6.7 |
| Average | 6.7 | 6.5 | 6.5 | 6.9 |
| Lowest | 6.1 | 6.0 | 6.0 | 6.3 |
| Responses | 4,815 | 1,995 | 1,075 | 1,610 |

Survey Coordination Centre

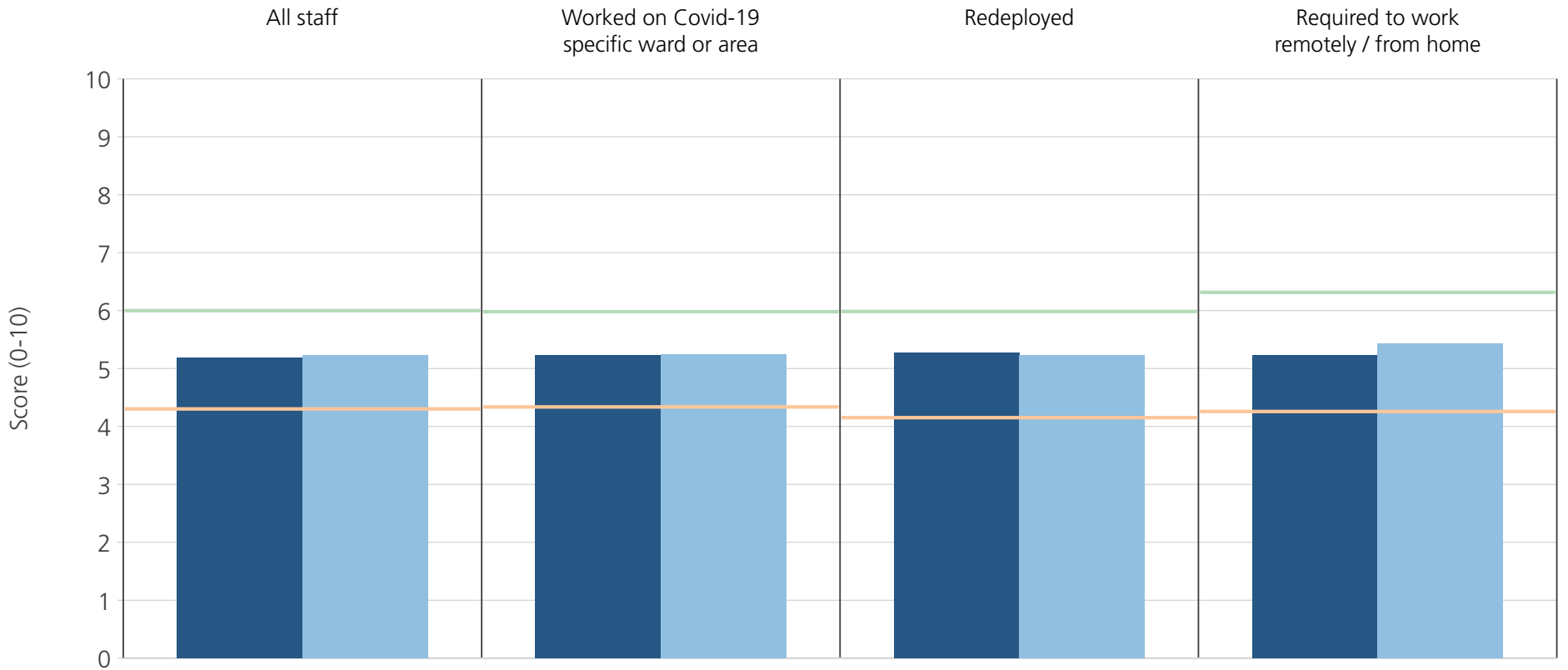
# 2021 NHS Staff Survey Results > People Promise element and theme results – Covid-19 classification breakdowns > We are safe and healthy




| | All staff | Worked on Covid-19 specific ward or area | Redeployed | Required to work remotely / from home |
|---|---|---|---|---|
| **Highest** | 6.5 | 6.1 | 6.2 | 6.8 |
| **Your org** | 5.8 | 5.3 | 5.2 | 6.1 |
| **Average** | 5.9 | 5.5 | 5.6 | 6.1 |
| **Lowest** | 5.5 | 5.1 | 5.1 | 5.7 |
| **Responses** | 4,848 | 1,994 | 1,076 | 1,613 |

Survey Coordination Centre

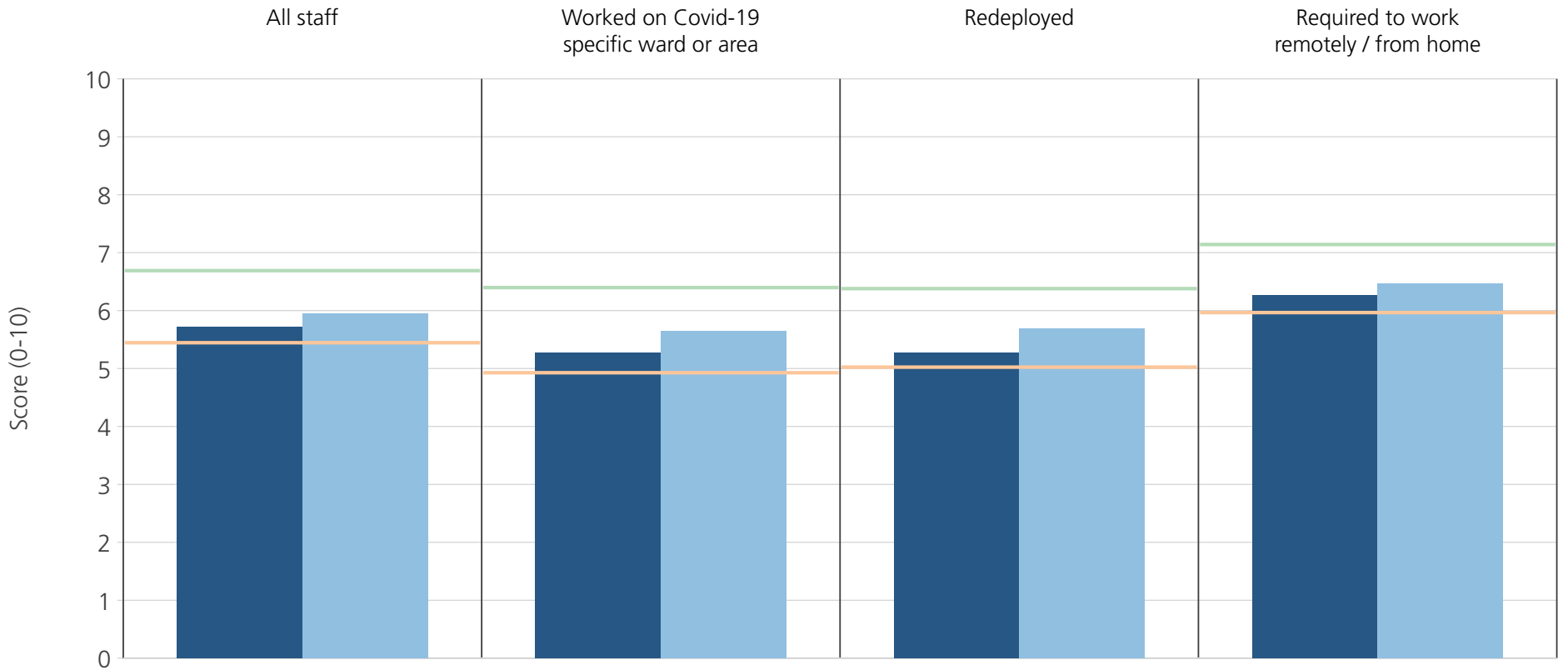
# 2021 NHS Staff Survey Results > People Promise element and theme results – Covid-19 classification breakdowns > We are always learning




| | All staff | Worked on Covid-19 specific ward or area | Redeployed | Required to work remotely / from home |
|---|---|---|---|---|
| **Highest** | 6.0 | 6.0 | 6.0 | 6.3 |
| **Your org** | 5.2 | 5.2 | 5.3 | 5.2 |
| **Average** | 5.2 | 5.2 | 5.2 | 5.4 |
| **Lowest** | 4.3 | 4.3 | 4.2 | 4.3 |
| **Responses** | 4,593 | 1,908 | 1,036 | 1,546 |

Survey Coordination Centre

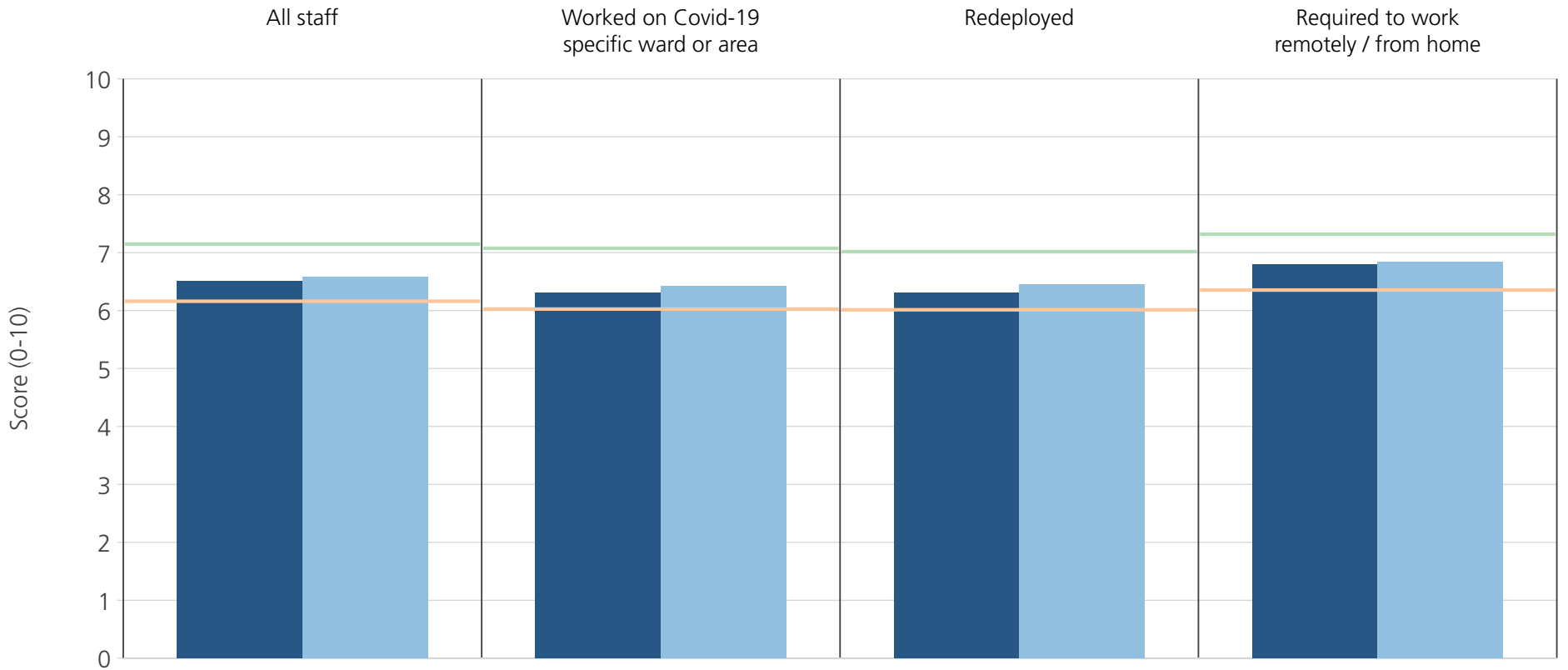
# 2021 NHS Staff Survey Results > People Promise element and theme results – Covid-19 classification breakdowns > We work flexibly




| | All staff | Worked on Covid-19 specific ward or area | Redeployed | Required to work remotely / from home |
|---|---|---|---|---|
| **Highest** | 6.7 | 6.4 | 6.4 | 7.1 |
| **Your org** | 5.7 | 5.3 | 5.3 | 6.3 |
| **Average** | 5.9 | 5.6 | 5.7 | 6.5 |
| **Lowest** | 5.4 | 4.9 | 5.0 | 6.0 |
| **Responses** | 4,931 | 1,999 | 1,078 | 1,616 |

Survey Coordination Centre

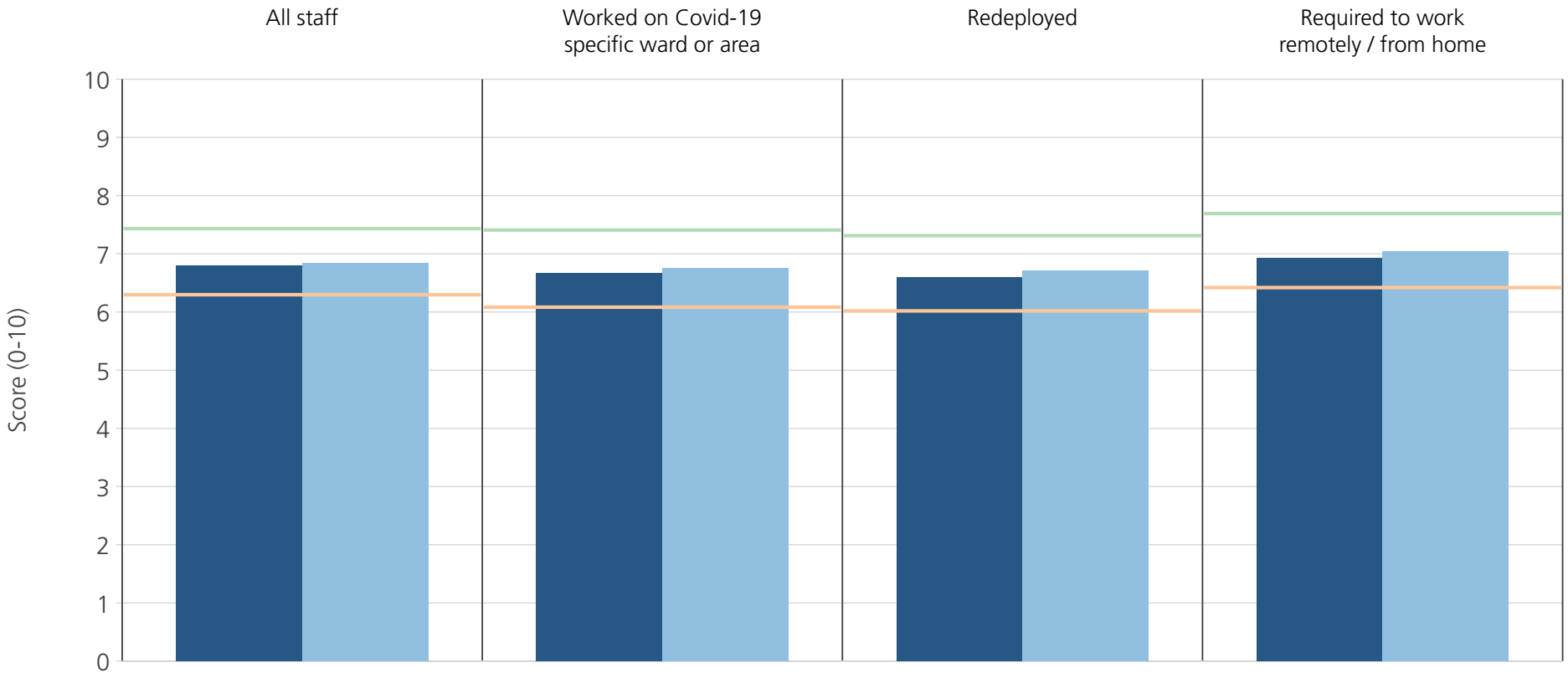
# 2021 NHS Staff Survey Results > People Promise element and theme results – Covid-19 classification breakdowns > We are a team




| | All staff | Worked on Covid-19 specific ward or area | Redeployed | Required to work remotely / from home |
|---|---|---|---|---|
| **Highest** | 7.1 | 7.1 | 7.0 | 7.3 |
| **Your org** | 6.5 | 6.3 | 6.3 | 6.8 |
| **Average** | 6.6 | 6.4 | 6.5 | 6.8 |
| **Lowest** | 6.2 | 6.0 | 6.0 | 6.4 |
| **Responses** | 4,893 | 2,002 | 1,079 | 1,618 |

Survey Coordination Centre

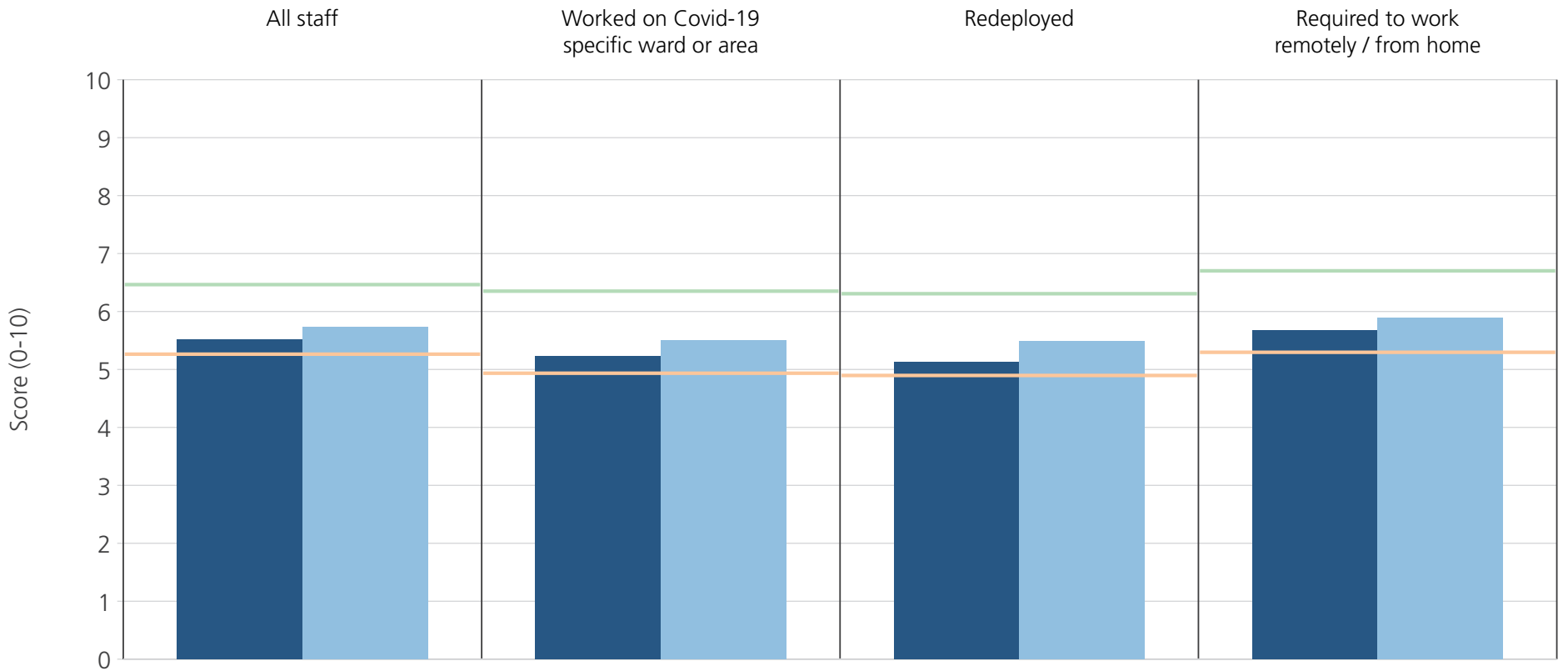
# 2021 NHS Staff Survey Results > People Promise element and theme results – Covid-19 classification breakdowns > Staff Engagement




| | All staff | Worked on Covid-19 specific ward or area | Redeployed | Required to work remotely / from home |
|---|---|---|---|---|
| **Highest** | 7.4 | 7.4 | 7.3 | 7.7 |
| **Your org** | 6.8 | 6.7 | 6.6 | 6.9 |
| **Average** | 6.8 | 6.8 | 6.7 | 7.0 |
| **Lowest** | 6.3 | 6.1 | 6.0 | 6.4 |
| **Responses** | 4,964 | 2,006 | 1,080 | 1,619 |

Survey Coordination Centre

# 2021 NHS Staff Survey Results > People Promise element and theme results – Covid-19 classification breakdowns > Morale




| | All staff | Worked on Covid-19 specific ward or area | Redeployed | Required to work remotely / from home |
|---|---|---|---|---|
| **Highest** | 6.5 | 6.4 | 6.3 | 6.7 |
| **Your org** | 5.5 | 5.2 | 5.1 | 5.7 |
| **Average** | 5.7 | 5.5 | 5.5 | 5.9 |
| **Lowest** | 5.3 | 4.9 | 4.9 | 5.3 |
| **Responses** | 4,952 | 2,005 | 1,080 | 1,619 |

Survey Coordination Centre

NHS

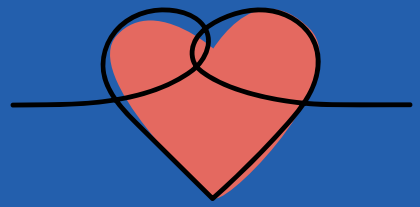
# People Promise element and theme results – Detailed information

St George's University Hospitals NHS Foundation Trust

2021 NHS Staff Survey Results

Survey Coordination Centre

NHS



# People Promise element detailed information – We are compassionate and inclusive

**Questions:**

Q6a, Q21a, Q21b, Q21c, Q21d
Q9f, Q9g, Q9h, Q9i
Q15, Q16a, Q16b, Q18
Q7h, Q7i, Q8b, Q8c

St George's University Hospitals NHS Foundation Trust

2021 NHS Staff Survey Results

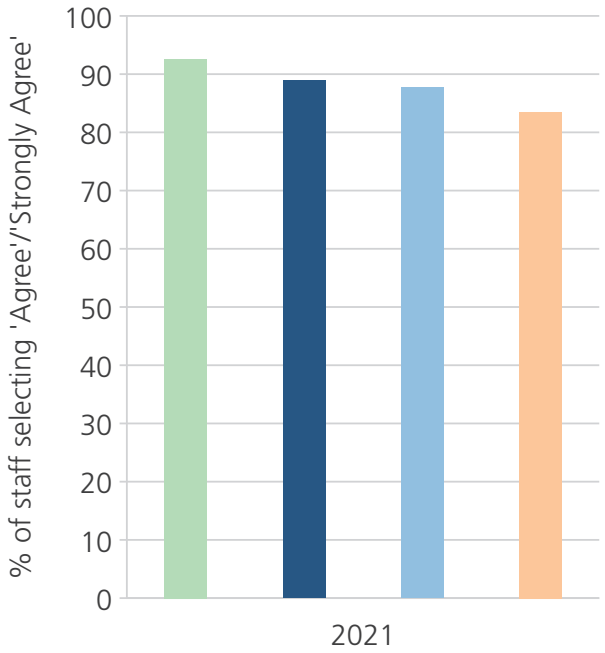
Survey Coordination Centre

# 2021 NHS Staff Survey Results > People Promise and theme results > Detailed information > **We are compassionate and inclusive** – Compassionate culture

NHS

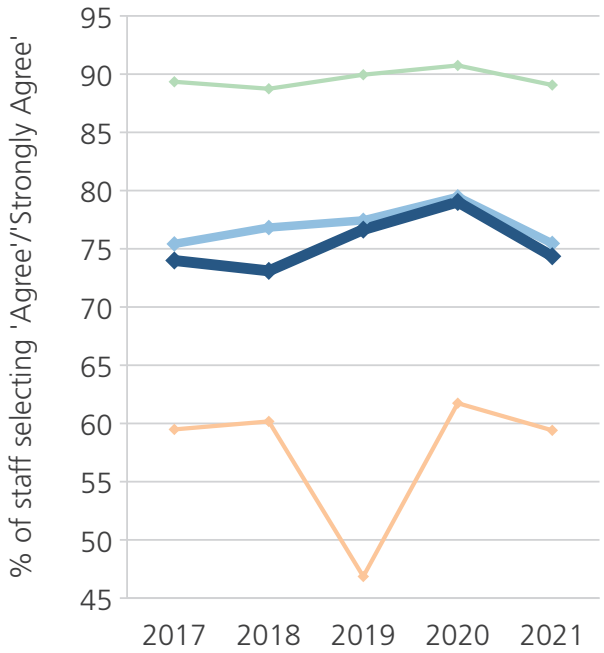
**Q6a**
I feel that my role makes a difference to patients / service users

Due to changes in this year's survey it is not possible to display trend data for this question



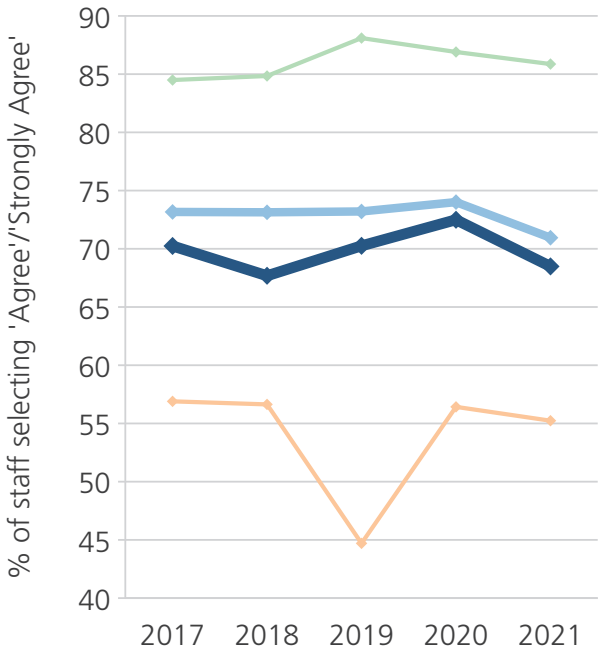

| | |
|---|---|
| Best | 92.6% |
| Your org | 88.9% |
| Average | 87.7% |
| Worst | 83.5% |
| Responses | 4,839 |

**Q21a**
Care of patients / service users is my organisation's top priority




| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| Best | 89.3% | 88.7% | 90.0% | 90.7% | 89.1% |
| Your org | 74.0% | 73.1% | 76.6% | 79.0% | 74.4% |
| Average | 75.4% | 76.8% | 77.4% | 79.5% | 75.5% |
| Worst | 59.5% | 60.2% | 46.9% | 61.7% | 59.4% |
| Responses | 4,023 | 4,270 | 4,759 | 4,889 | 4,825 |

**Q21b**
My organisation acts on concerns raised by patients / service users



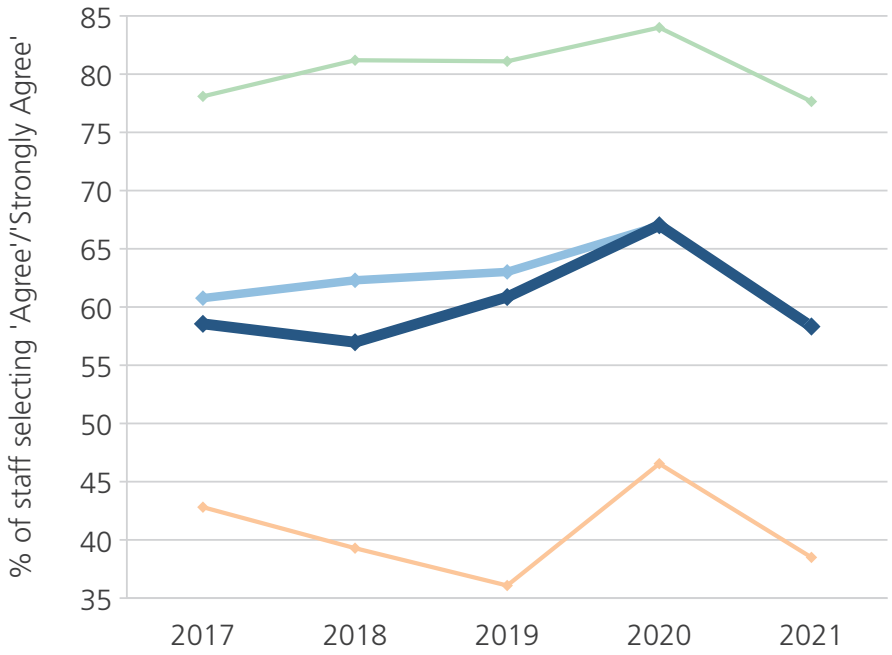

| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| Best | 84.5% | 84.8% | 88.1% | 86.9% | 85.9% |
| Your org | 70.2% | 67.7% | 70.3% | 72.5% | 68.5% |
| Average | 73.2% | 73.1% | 73.2% | 74.0% | 71.0% |
| Worst | 56.9% | 56.6% | 44.7% | 56.4% | 55.2% |
| Responses | 4,011 | 4,268 | 4,753 | 4,881 | 4,824 |

Survey Coordination Centre

# 2021 NHS Staff Survey Results > People Promise and theme results > Detailed information > **We are compassionate and inclusive** – Compassionate culture

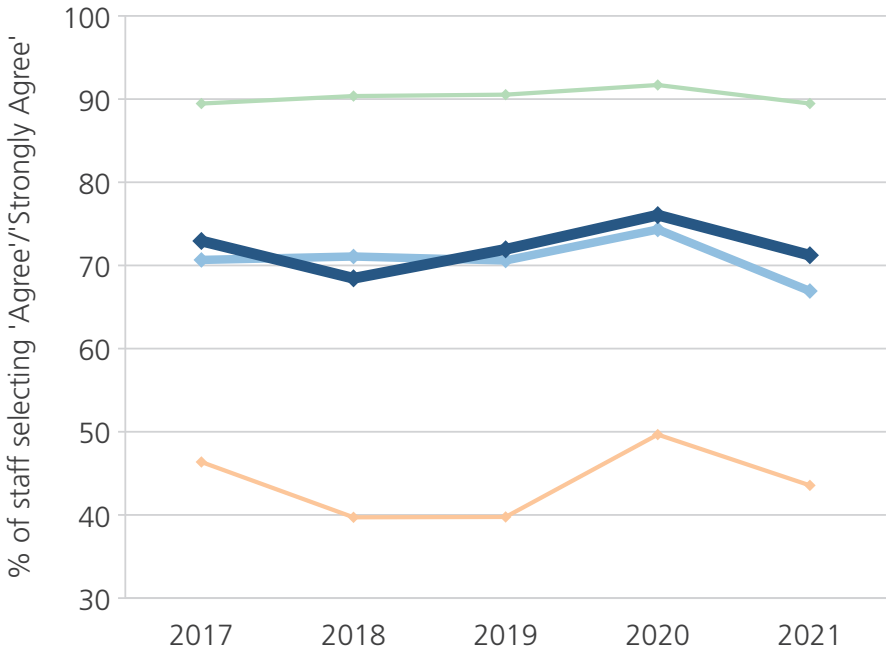
NHS

**Q21c**
I would recommend my organisation as a place to work




| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| **Best** | 78.1% | 81.2% | 81.1% | 84.0% | 77.6% |
| **Your org** | 58.6% | 57.0% | 60.9% | 67.0% | 58.3% |
| **Average** | 60.8% | 62.3% | 63.0% | 67.0% | 58.4% |
| **Worst** | 42.8% | 39.3% | 36.1% | 46.5% | 38.5% |
| **Responses** | 4,016 | 4,271 | 4,752 | 4,872 | 4,825 |

**Q21d**
If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation




| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| **Best** | 89.5% | 90.4% | 90.5% | 91.7% | 89.5% |
| **Your org** | 72.9% | 68.5% | 71.9% | 76.1% | 71.2% |
| **Average** | 70.7% | 71.1% | 70.6% | 74.3% | 66.9% |
| **Worst** | 46.4% | 39.7% | 39.8% | 49.7% | 43.6% |
| **Responses** | 4,003 | 4,252 | 4,753 | 4,884 | 4,828 |

Survey Coordination Centre

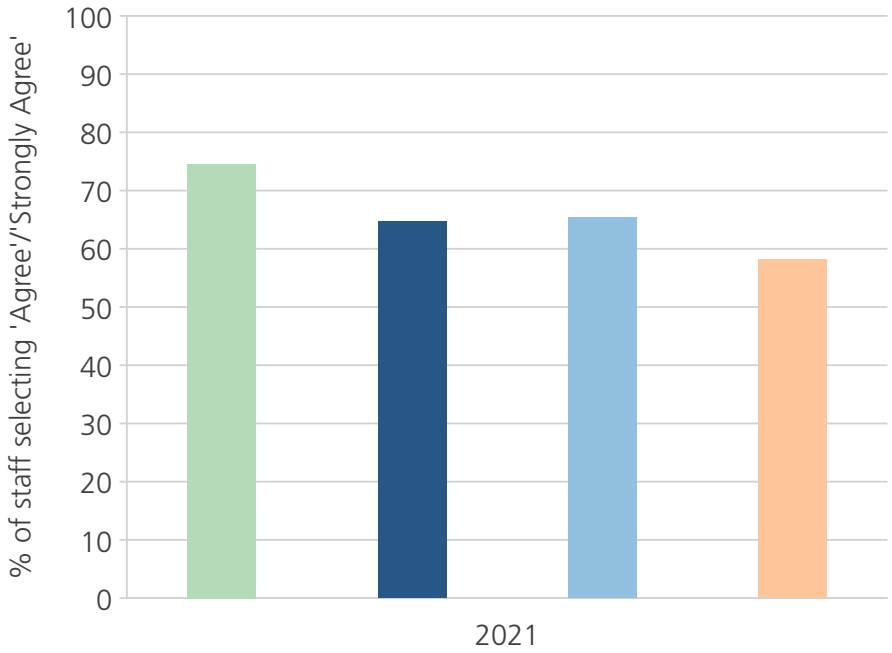
# 2021 NHS Staff Survey Results > People Promise and theme results > Detailed information > **We are compassionate and inclusive** – Compassionate leadership

NHS

**Q9f**

My immediate manager works together with me to come to an understanding of problems

No trend data are shown as this is a new question

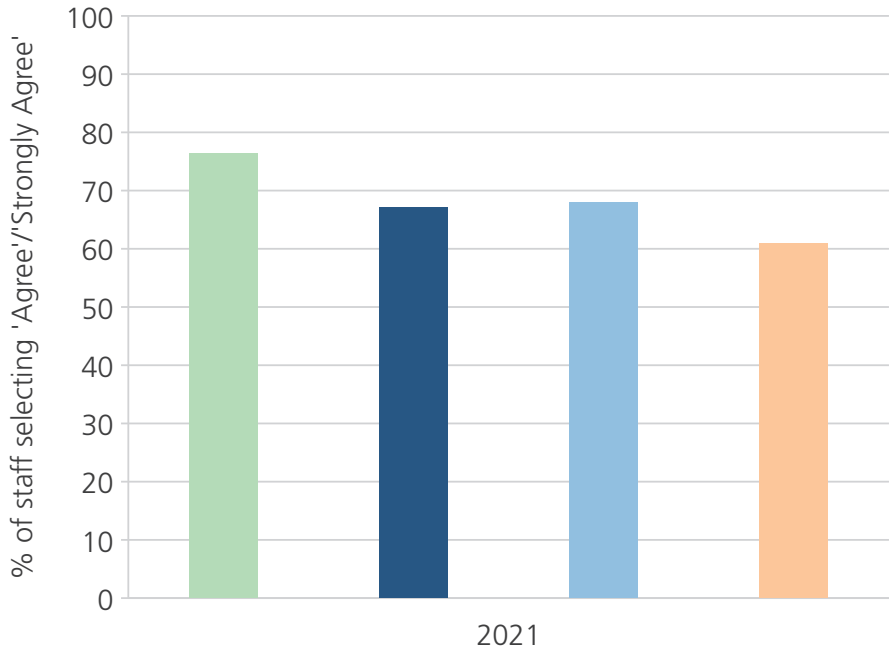



| | |
|---|---|
| **Best** | 74.6% |
| **Your org** | 64.6% |
| **Average** | 65.4% |
| **Worst** | 58.1% |
| **Responses** | 4,882 |

**Q9g**

My immediate manager is interested in listening to me when I describe challenges I face

No trend data are shown as this is a new question




| | |
|---|---|
| **Best** | 76.3% |
| **Your org** | 67.1% |
| **Average** | 67.9% |
| **Worst** | 60.9% |
| **Responses** | 4,888 |

Survey Coordination Centre

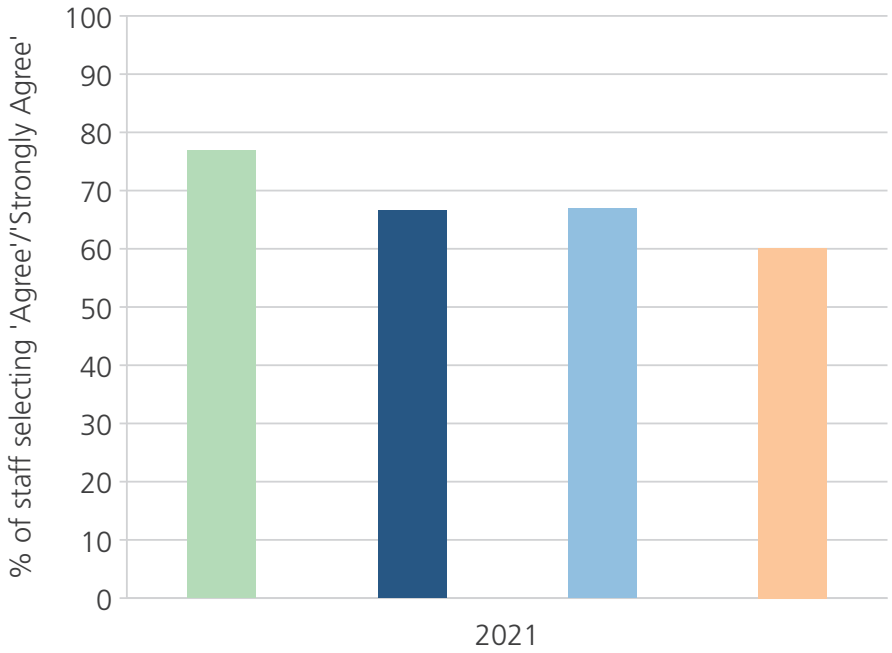
# 2021 NHS Staff Survey Results > People Promise and theme results > Detailed information > **We are compassionate and inclusive** – Compassionate leadership

NHS

**Q9h**

My immediate manager cares about my concerns

No trend data are shown as this is a new question

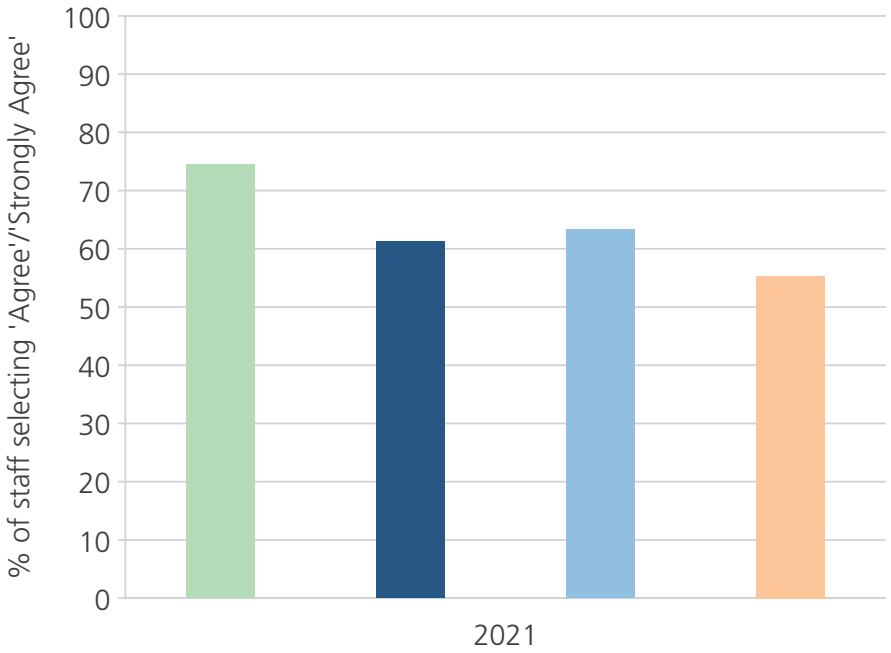



| | |
|---|---|
| **Best** | 76.9% |
| **Your org** | 66.5% |
| **Average** | 66.9% |
| **Worst** | 60.1% |
| **Responses** | 4,882 |

**Q9i**

My immediate line manager takes effective action to help me with any problems I face

No trend data are shown as this is a new question



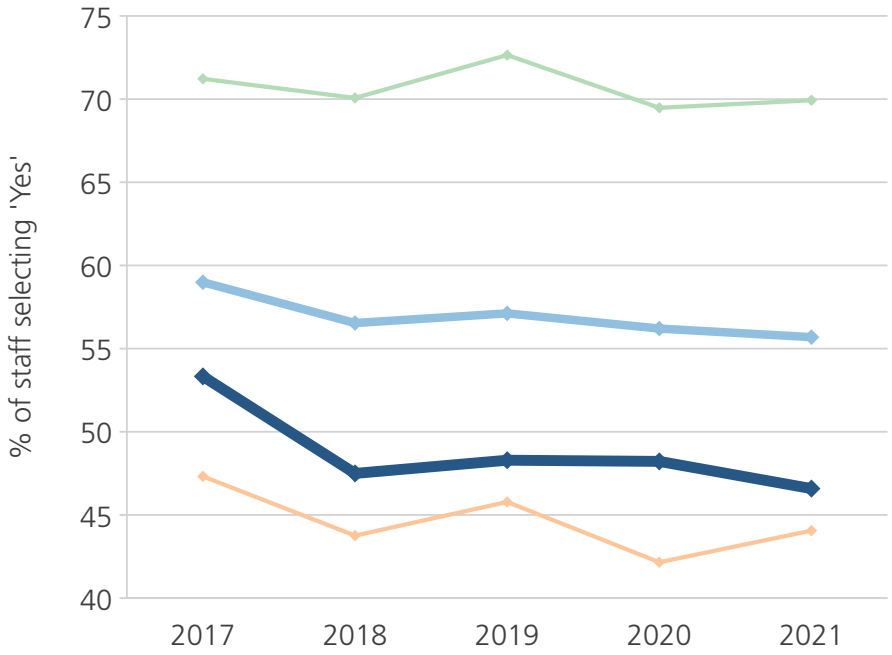

| | |
|---|---|
| **Best** | 74.4% |
| **Your org** | 61.3% |
| **Average** | 63.3% |
| **Worst** | 55.3% |
| **Responses** | 4,879 |

Survey Coordination Centre

# 2021 NHS Staff Survey Results > People Promise and theme results > Detailed information > **We are compassionate and inclusive** – Diversity and equality

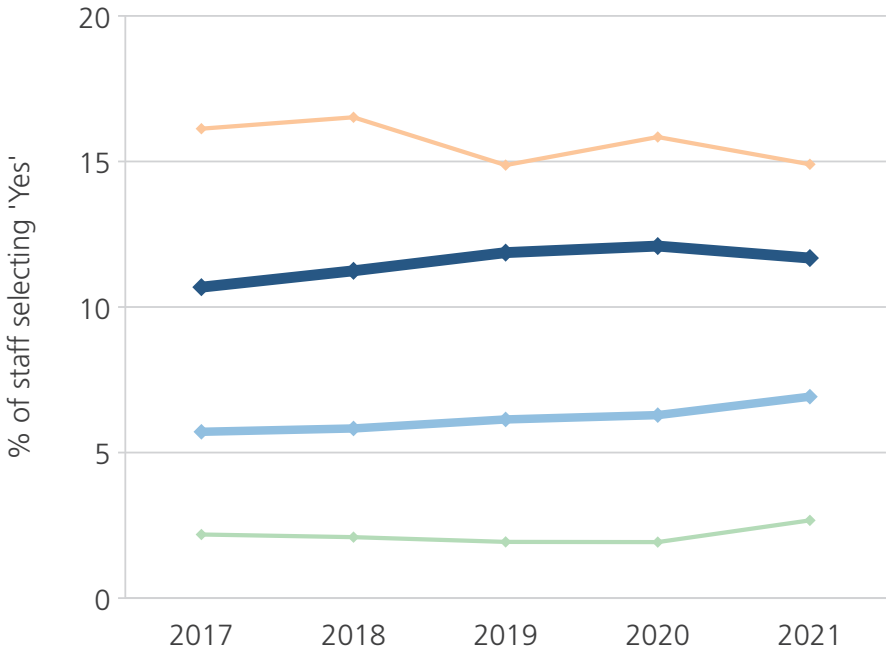
NHS

**Q15**
Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?




| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| Best | 71.2% | 70.1% | 72.6% | 69.5% | 69.9% |
| Your org | 53.3% | 47.5% | 48.3% | 48.2% | 46.6% |
| Average | 59.0% | 56.5% | 57.1% | 56.2% | 55.7% |
| Worst | 47.3% | 43.8% | 45.8% | 42.2% | 44.1% |
| Responses | 3,986 | 4,285 | 4,755 | 4,895 | 4,815 |

**Q16a**
In the last 12 months have you personally experienced discrimination at work from patients / service users, their relatives or other members of the public?




| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| Worst | 16.1% | 16.5% | 14.9% | 15.8% | 14.9% |
| Your org | 10.7% | 11.2% | 11.9% | 12.1% | 11.7% |
| Average | 5.7% | 5.8% | 6.1% | 6.3% | 6.9% |
| Best | 2.2% | 2.1% | 1.9% | 1.9% | 2.7% |
| Responses | 4,019 | 4,245 | 4,797 | 4,913 | 4,831 |

Please note: The approach to calculating the results for Q15 has changed for 2021, to include 'don't know' responses. These results feed into the Diversity and equality sub-score and the We are compassionate and inclusive promise element, as well as the WRES and WDES indicators. The Q15 results based on the historic calculation are reported in this section for transparency, but do not feed into any measure.

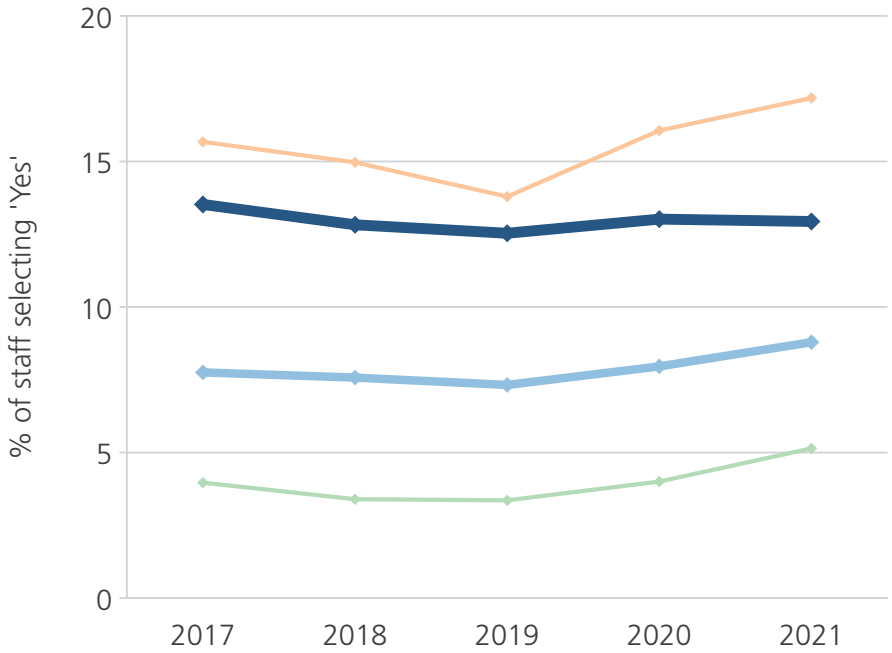
Survey Coordination Centre

# 2021 NHS Staff Survey Results > People Promise and theme results > Detailed information > **We are compassionate and inclusive** – Diversity and equality

NHS

## Q16b

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

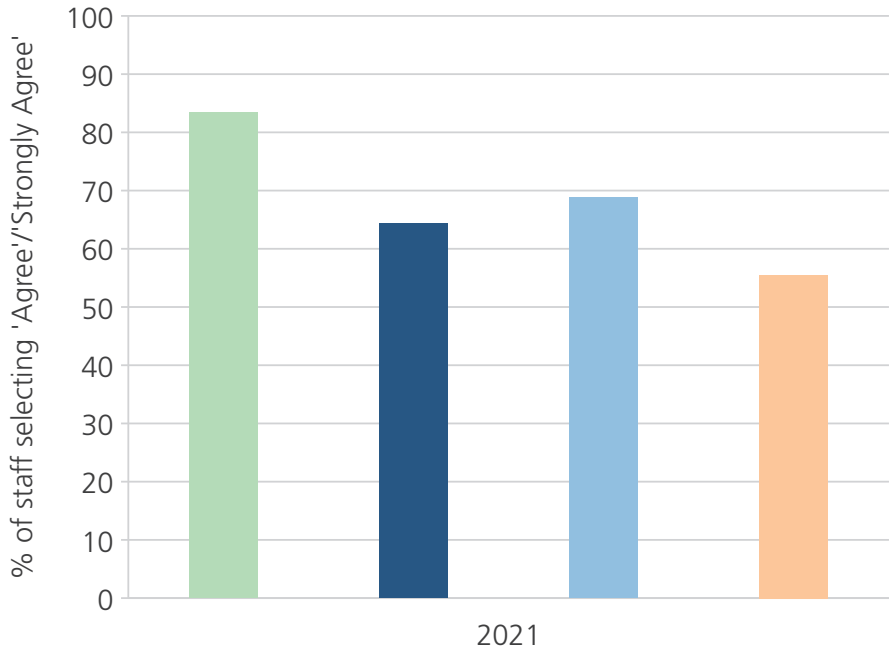



| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| **Worst** | 15.7% | 15.0% | 13.8% | 16.1% | 17.2% |
| **Your org** | 13.5% | 12.8% | 12.5% | 13.0% | 12.9% |
| **Average** | 7.8% | 7.6% | 7.3% | 8.0% | 8.8% |
| **Best** | 4.0% | 3.4% | 3.4% | 4.0% | 5.1% |
| **Responses** | 4,022 | 4,266 | 4,757 | 4,920 | 4,831 |

## Q18

I think that my organisation respects individual differences (e.g. cultures, working styles, backgrounds, ideas, etc).

No trend data are shown as this is a new question




| | 2021 |
|---|---|
| **Best** | 83.4% |
| **Your org** | 64.3% |
| **Average** | 68.8% |
| **Worst** | 55.5% |
| **Responses** | 4,839 |

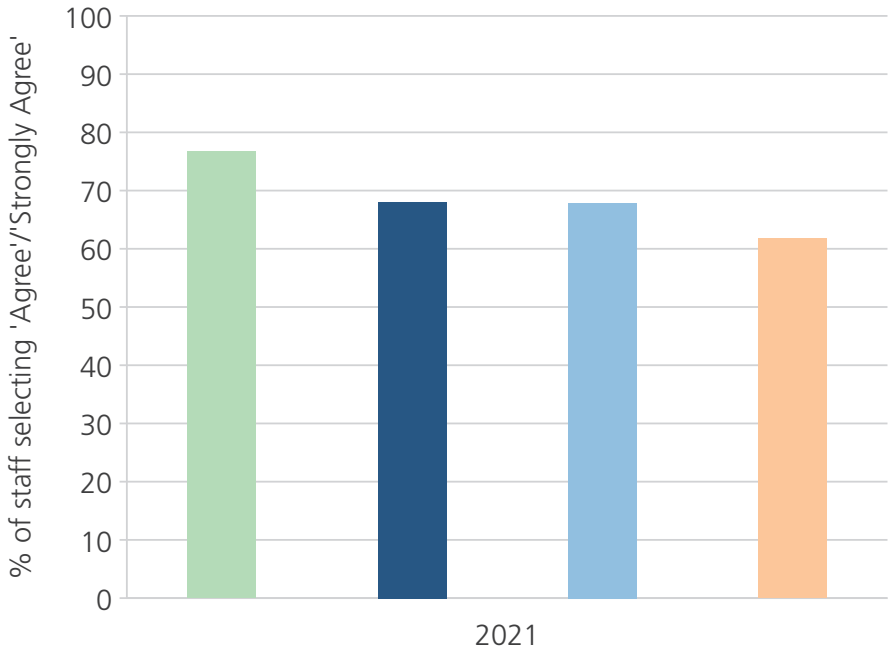
Survey Coordination Centre

2021 NHS Staff Survey Results > People Promise and theme results >
Detailed information > **We are compassionate and inclusive** – Inclusion

NHS

**Q7h**
I feel valued by my team

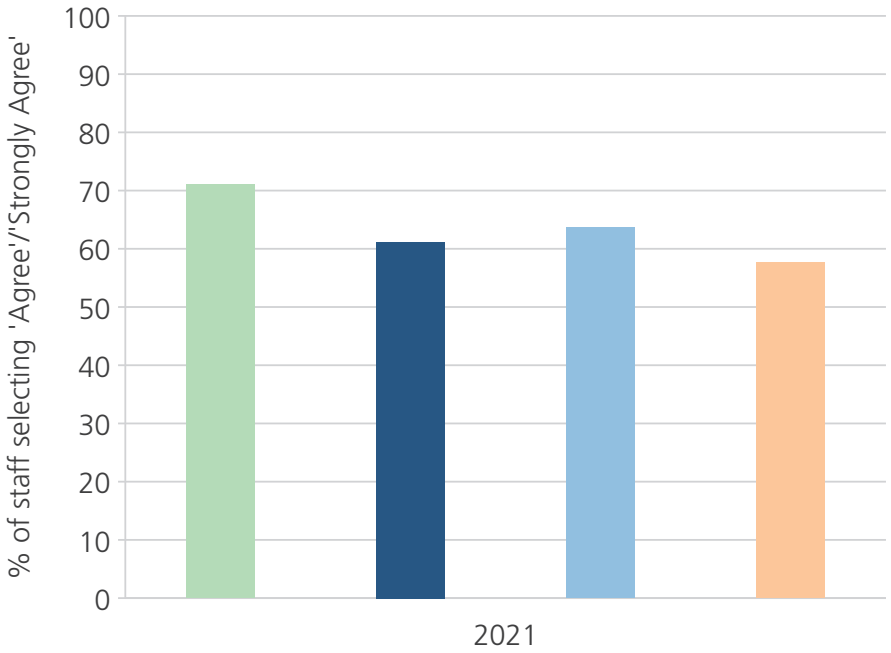
No trend data are shown as this is a new question




| | |
|---|---|
| **Best** | 76.8% |
| **Your org** | 68.1% |
| **Average** | 67.9% |
| **Worst** | 61.8% |
| **Responses** | 4,915 |

**Q7i**
I feel a strong personal attachment to my team

No trend data are shown as this is a new question




| | |
|---|---|
| **Best** | 71.1% |
| **Your org** | 61.1% |
| **Average** | 63.6% |
| **Worst** | 57.6% |
| **Responses** | 4,915 |

Survey Coordination Centre

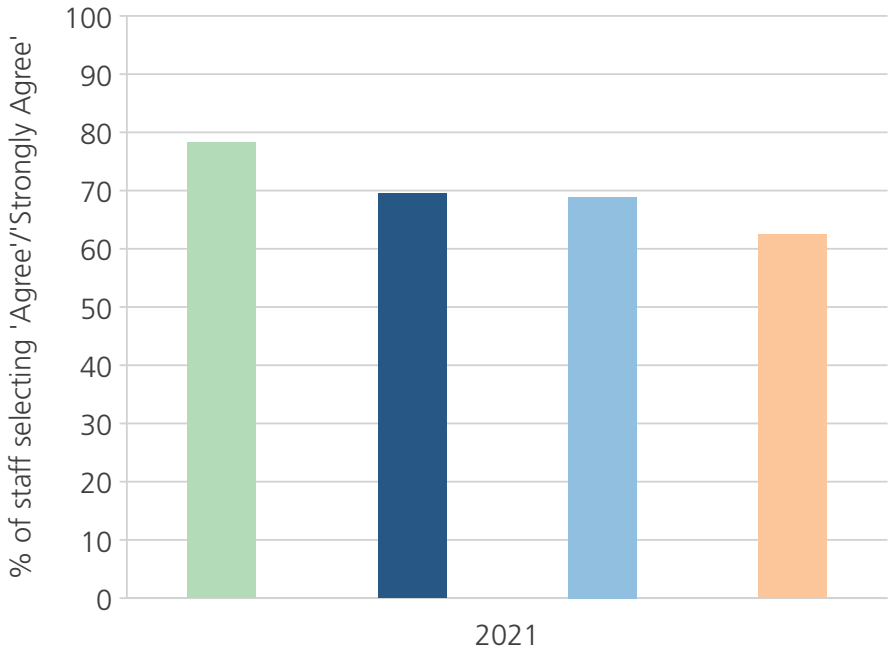
2021 NHS Staff Survey Results > People Promise and theme results >
Detailed information > **We are compassionate and inclusive** – Inclusion

NHS

**Q8b**

The people I work with are understanding and kind to one another

No trend data are shown as this is a new question

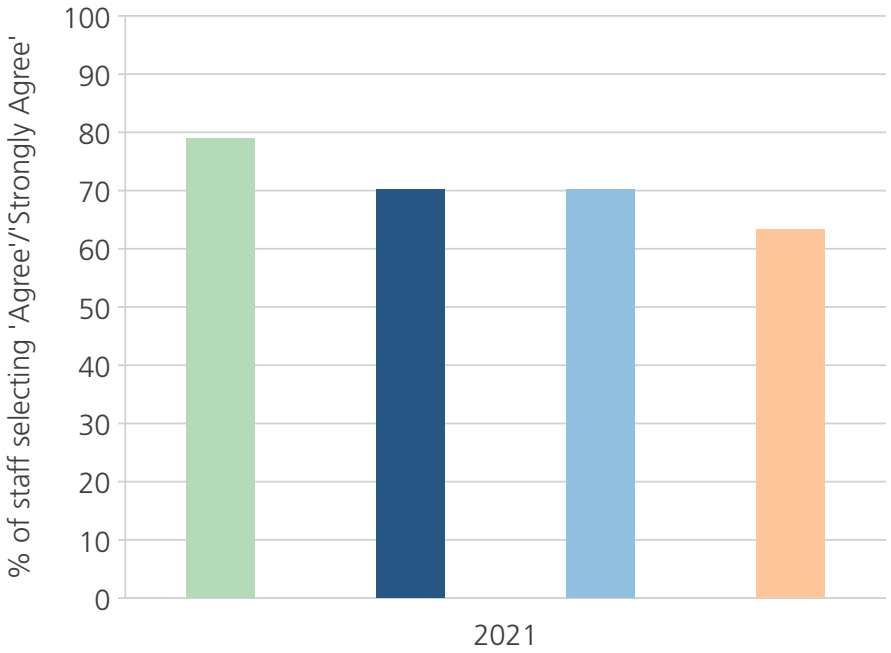



| | |
|---|---|
| **Best** | 78.3% |
| **Your org** | 69.5% |
| **Average** | 68.9% |
| **Worst** | 62.5% |
| **Responses** | 4,906 |

**Q8c**

The people I work with are polite and treat each other with respect

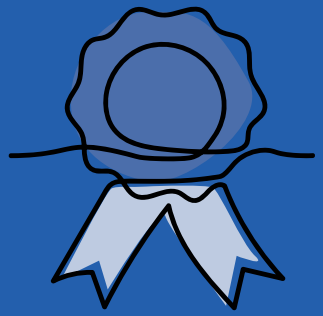
No trend data are shown as this is a new question




| | |
|---|---|
| **Best** | 79.0% |
| **Your org** | 70.2% |
| **Average** | 70.2% |
| **Worst** | 63.3% |
| **Responses** | 4,905 |

Survey Coordination Centre

NHS



# People Promise element detailed information – We are recognised and rewarded

**Questions:**

Q4a, Q4b, Q4c, Q8d, Q9e

St George's University Hospitals NHS Foundation Trust

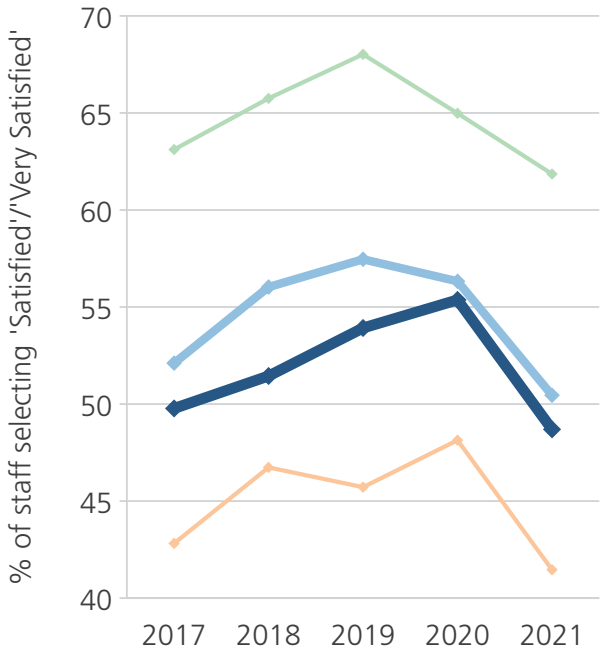
2021 NHS Staff Survey Results

Survey Coordination Centre

# 2021 NHS Staff Survey Results > People Promise and theme results > Detailed information > We are recognised and rewarded

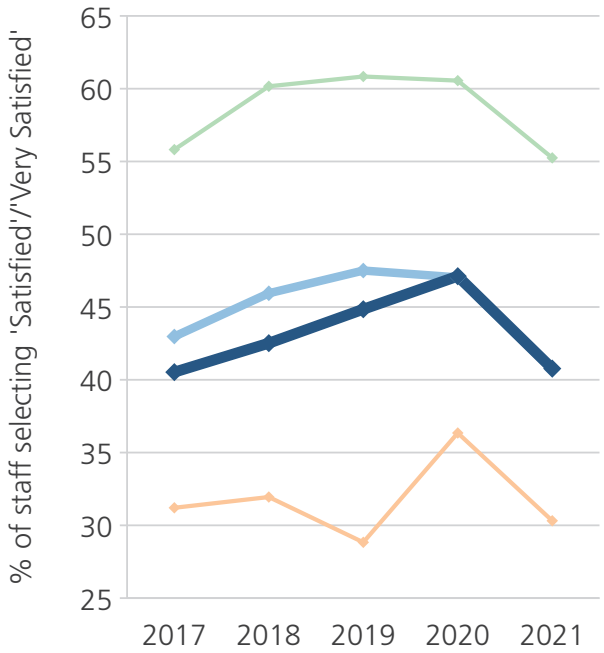
NHS

**Q4a**
The recognition I get for good work



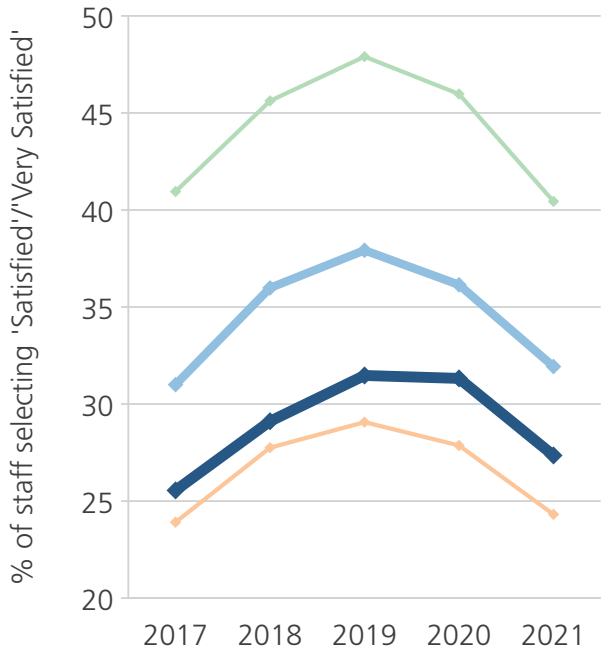

| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| Best | 63.1% | 65.8% | 68.0% | 65.0% | 61.9% |
| Your org | 49.8% | 51.4% | 53.9% | 55.4% | 48.7% |
| Average | 52.1% | 56.0% | 57.5% | 56.3% | 50.5% |
| Worst | 42.8% | 46.7% | 45.7% | 48.1% | 41.5% |
| Responses | 4,240 | 4,409 | 4,862 | 4,983 | 4,942 |

**Q4b**
The extent to which my organisation values my work




| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| Best | 55.8% | 60.2% | 60.8% | 60.6% | 55.2% |
| Your org | 40.5% | 42.5% | 44.8% | 47.1% | 40.8% |
| Average | 43.0% | 45.9% | 47.5% | 47.0% | 40.7% |
| Worst | 31.2% | 31.9% | 28.8% | 36.3% | 30.3% |
| Responses | 4,203 | 4,373 | 4,855 | 4,982 | 4,946 |

**Q4c**
My level of pay




| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| Best | 40.9% | 45.6% | 47.9% | 46.0% | 40.4% |
| Your org | 25.5% | 29.1% | 31.5% | 31.3% | 27.4% |
| Average | 31.0% | 36.0% | 37.9% | 36.1% | 31.9% |
| Worst | 23.9% | 27.8% | 29.1% | 27.9% | 24.3% |
| Responses | 4,223 | 4,389 | 4,853 | 4,983 | 4,948 |

Survey Coordination Centre

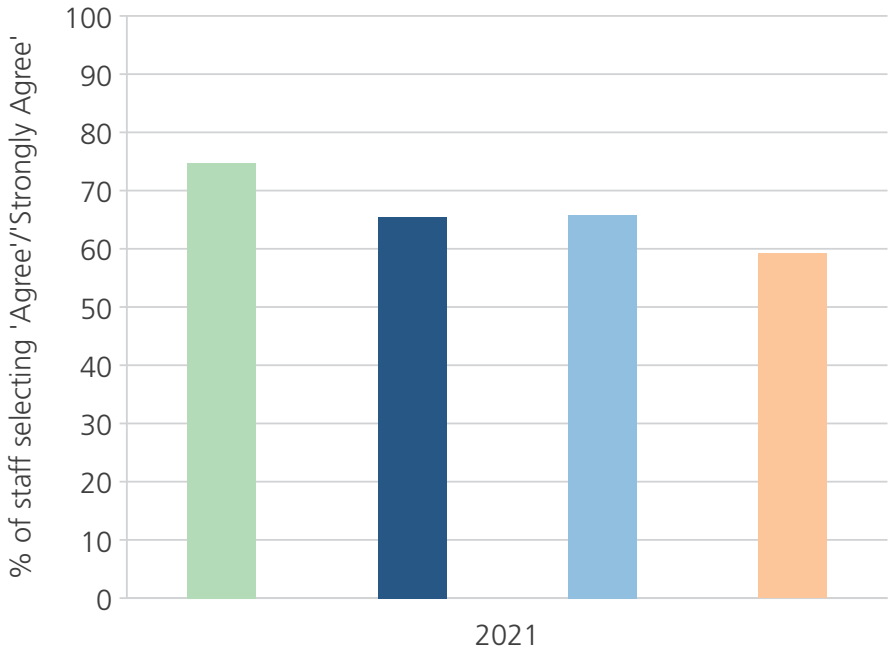
# 2021 NHS Staff Survey Results > People Promise and theme results > Detailed information > We are recognised and rewarded

NHS

**Q8d**

The people I work with show appreciation to one another

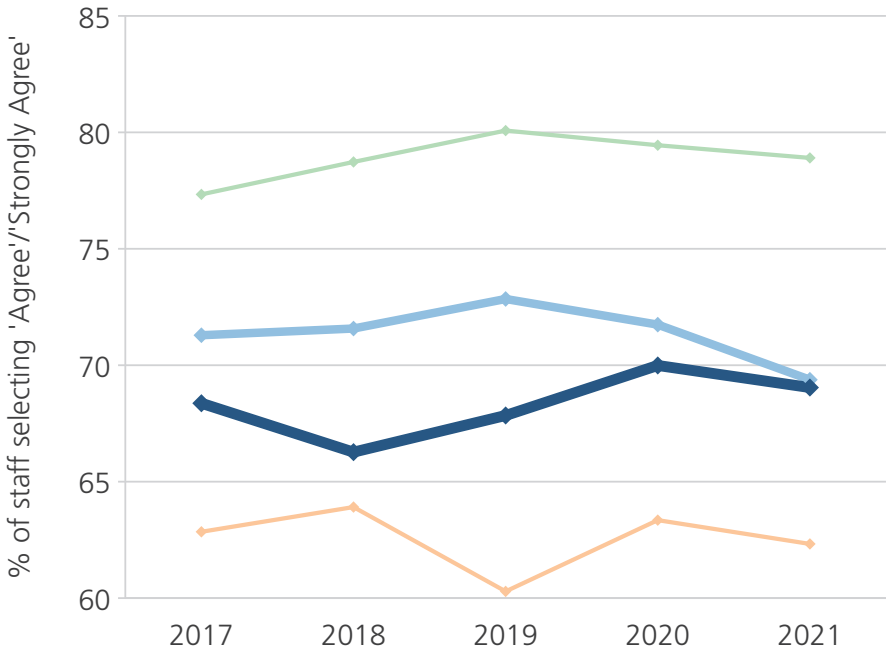
No trend data are shown as this is a new question




| | |
|---|---|
| Best | 74.7% |
| Your org | 65.5% |
| Average | 65.8% |
| Worst | 59.1% |
| Responses | 4,904 |

**Q9e**

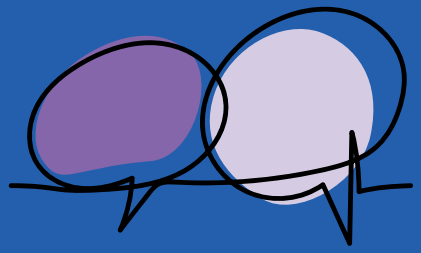
My immediate manager values my work




| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| Best | 77.3% | 78.7% | 80.1% | 79.4% | 78.9% |
| Your org | 68.4% | 66.3% | 67.8% | 70.0% | 69.0% |
| Average | 71.3% | 71.6% | 72.8% | 71.7% | 69.4% |
| Worst | 62.8% | 63.9% | 60.3% | 63.3% | 62.3% |
| Responses | 4,132 | 4,354 | 4,817 | 4,964 | 4,885 |

Survey Coordination Centre

NHS



# People Promise element detailed information – We each have a voice that counts

**Questions:**

Q3a, Q3b, Q3c, Q3d, Q3e, Q3f, Q5b
Q17a, Q17b, Q21e, Q21f

St George's University Hospitals NHS Foundation Trust

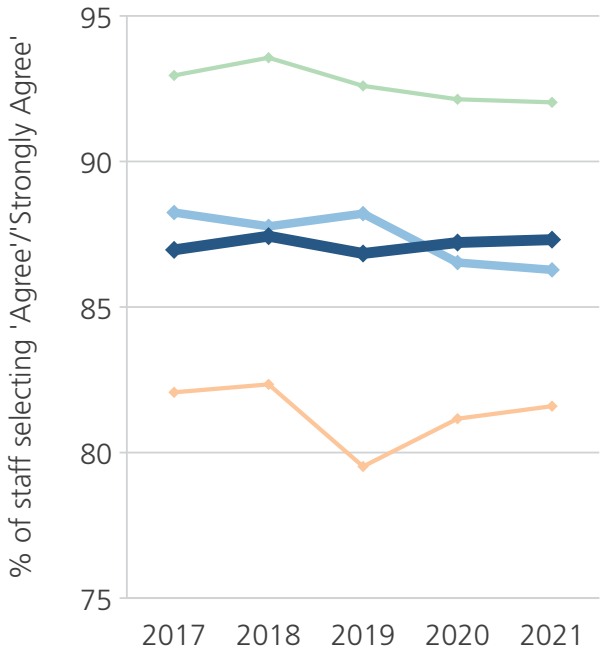
2021 NHS Staff Survey Results

Survey Coordination Centre

# 2021 NHS Staff Survey Results > People Promise and theme results > Detailed information > **We each have a voice that counts** – Autonomy and control

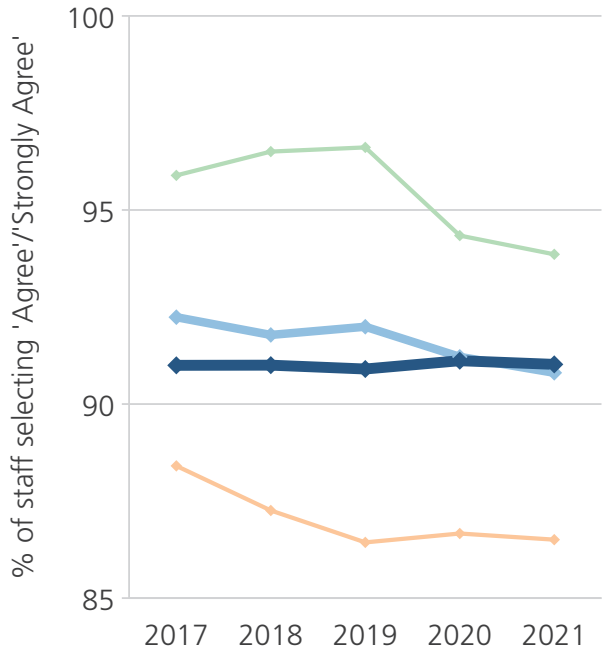
NHS

**Q3a**
I always know what my work responsibilities are



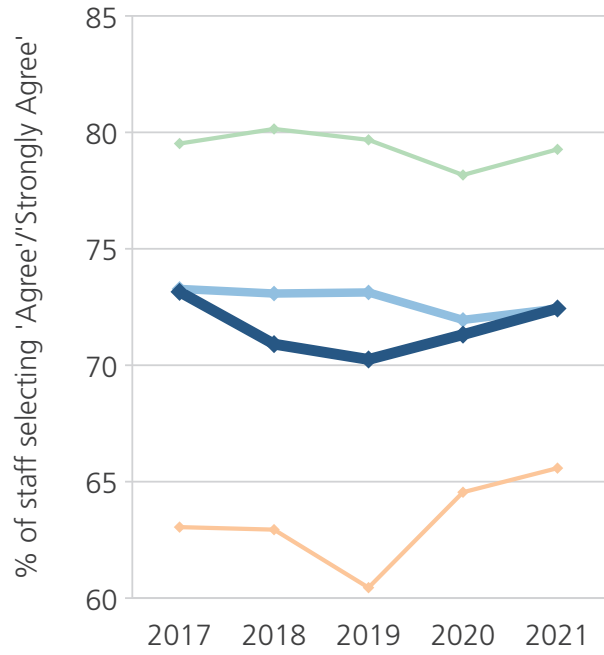

| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| Best | 93.0% | 93.6% | 92.6% | 92.1% | 92.0% |
| Your org | 87.0% | 87.4% | 86.8% | 87.2% | 87.3% |
| Average | 88.2% | 87.8% | 88.2% | 86.5% | 86.3% |
| Worst | 82.1% | 82.3% | 79.5% | 81.2% | 81.6% |
| Responses | 4,279 | 4,450 | 4,876 | 5,059 | 4,954 |

**Q3b**
I am trusted to do my job




| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| Best | 95.9% | 96.5% | 96.6% | 94.3% | 93.9% |
| Your org | 91.0% | 91.0% | 90.9% | 91.1% | 91.0% |
| Average | 92.2% | 91.8% | 92.0% | 91.2% | 90.8% |
| Worst | 88.4% | 87.3% | 86.4% | 86.7% | 86.5% |
| Responses | 4,248 | 4,422 | 4,860 | 5,044 | 4,954 |

**Q3c**
There are frequent opportunities for me to show initiative in my role



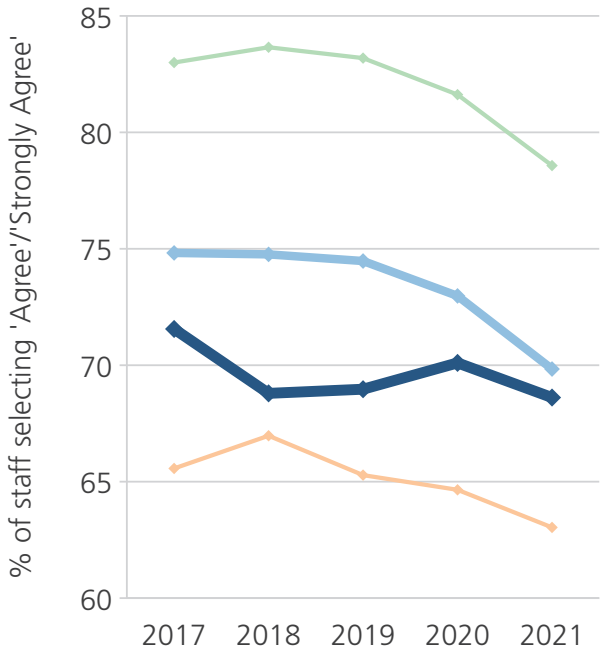

| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| Best | 79.5% | 80.1% | 79.7% | 78.2% | 79.3% |
| Your org | 73.2% | 70.9% | 70.2% | 71.3% | 72.4% |
| Average | 73.3% | 73.1% | 73.1% | 71.9% | 72.4% |
| Worst | 63.0% | 62.9% | 60.4% | 64.5% | 65.6% |
| Responses | 4,277 | 4,457 | 4,893 | 5,017 | 4,960 |

Survey Coordination Centre

# 2021 NHS Staff Survey Results > People Promise and theme results > Detailed information > **We each have a voice that counts** – Autonomy and control

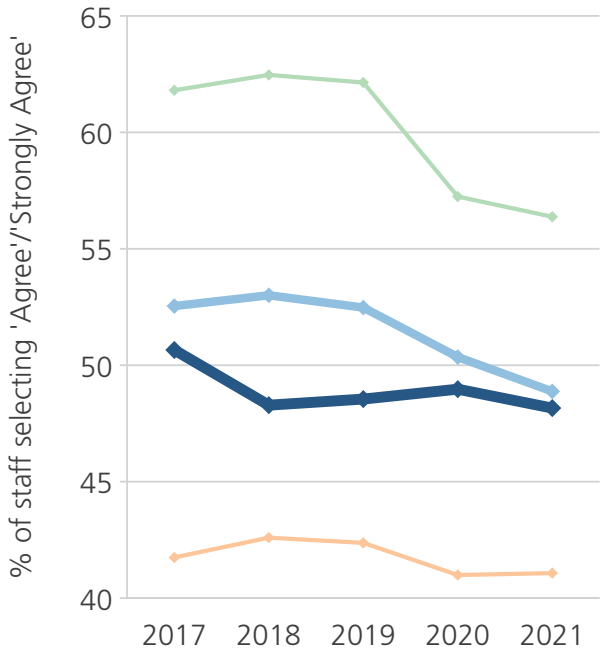
NHS

**Q3d**
I am able to make suggestions to improve the work of my team / department



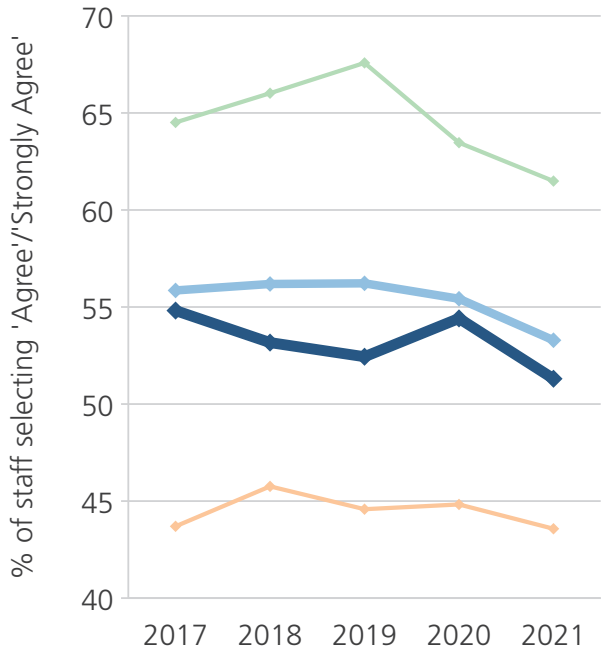

| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| Best | 83.0% | 83.7% | 83.2% | 81.6% | 78.6% |
| Your org | 71.6% | 68.8% | 69.0% | 70.1% | 68.6% |
| Average | 74.8% | 74.8% | 74.5% | 73.0% | 69.8% |
| Worst | 65.6% | 67.0% | 65.3% | 64.7% | 63.0% |
| Responses | 4,271 | 4,454 | 4,896 | 5,017 | 4,959 |

**Q3e**
I am involved in deciding on changes introduced that affect my work area / team / department




| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| Best | 61.8% | 62.5% | 62.1% | 57.2% | 56.4% |
| Your org | 50.7% | 48.3% | 48.5% | 49.0% | 48.2% |
| Average | 52.5% | 53.0% | 52.5% | 50.4% | 48.9% |
| Worst | 41.7% | 42.6% | 42.4% | 41.0% | 41.1% |
| Responses | 4,272 | 4,447 | 4,884 | 5,018 | 4,959 |

**Q3f**
I am able to make improvements happen in my area of work




| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| Best | 64.5% | 66.0% | 67.6% | 63.5% | 61.5% |
| Your org | 54.8% | 53.2% | 52.4% | 54.4% | 51.3% |
| Average | 55.9% | 56.2% | 56.2% | 55.4% | 53.3% |
| Worst | 43.7% | 45.8% | 44.6% | 44.8% | 43.6% |
| Responses | 4,258 | 4,438 | 4,878 | 5,006 | 4,949 |

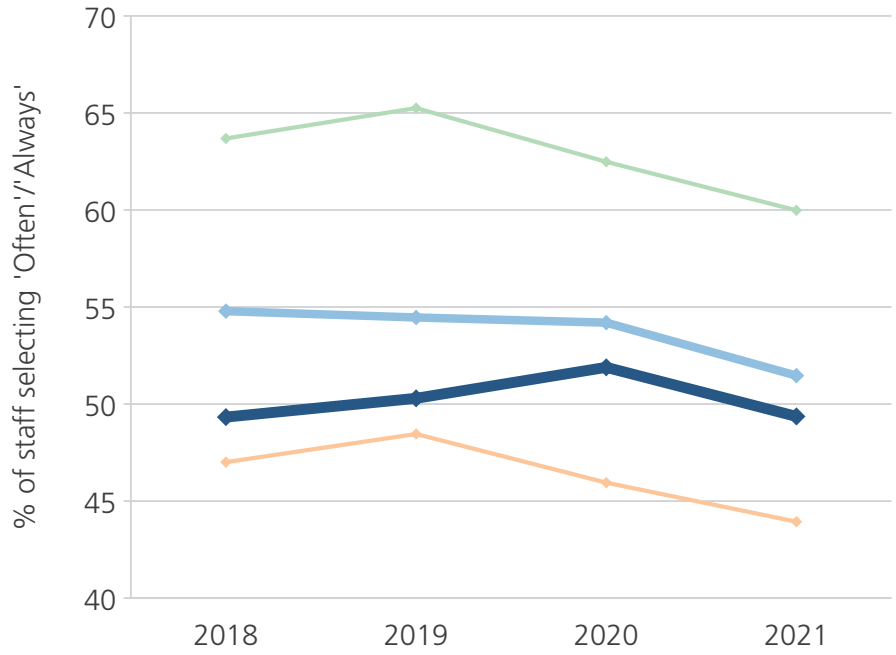
Survey Coordination Centre

# 2021 NHS Staff Survey Results > People Promise and theme results > Detailed information > **We each have a voice that counts** – Autonomy and control

NHS

**Q5b**

I have a choice in deciding how to do my work



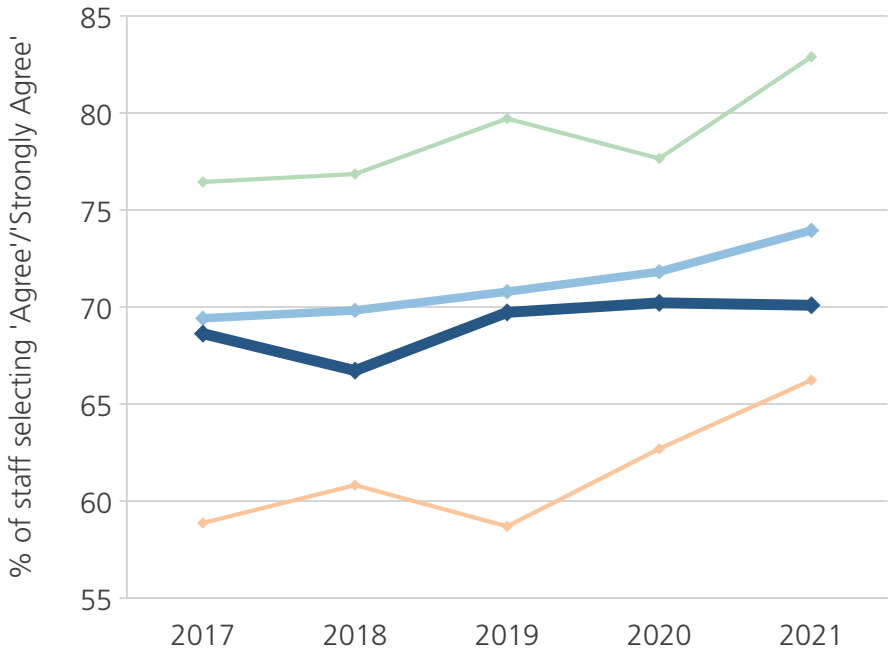

| | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|
| **Best** | 63.7% | 65.3% | 62.5% | 60.0% |
| **Your org** | 49.3% | 50.3% | 51.9% | 49.4% |
| **Average** | 54.8% | 54.5% | 54.2% | 51.5% |
| **Worst** | 47.0% | 48.5% | 45.9% | 43.9% |
| **Responses** | 4,393 | 4,816 | 4,988 | 4,932 |

Survey Coordination Centre

# 2021 NHS Staff Survey Results > People Promise and theme results > Detailed information > **We each have a voice that counts** – Raising concerns

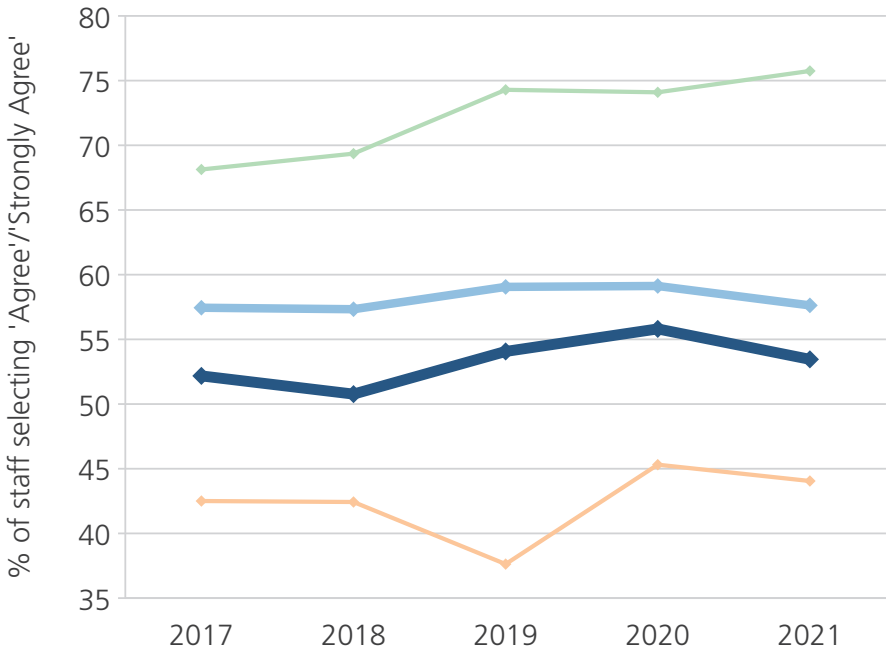
NHS

**Q17a**
I would feel secure raising concerns about unsafe clinical practice




| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| **Best** | 76.4% | 76.9% | 79.7% | 77.7% | 82.9% |
| **Your org** | 68.6% | 66.7% | 69.7% | 70.2% | 70.1% |
| **Average** | 69.4% | 69.8% | 70.8% | 71.8% | 73.9% |
| **Worst** | 58.9% | 60.8% | 58.7% | 62.7% | 66.2% |
| **Responses** | 4,075 | 4,298 | 4,796 | 4,898 | 4,848 |

**Q17b**
I am confident that my organisation would address my concern



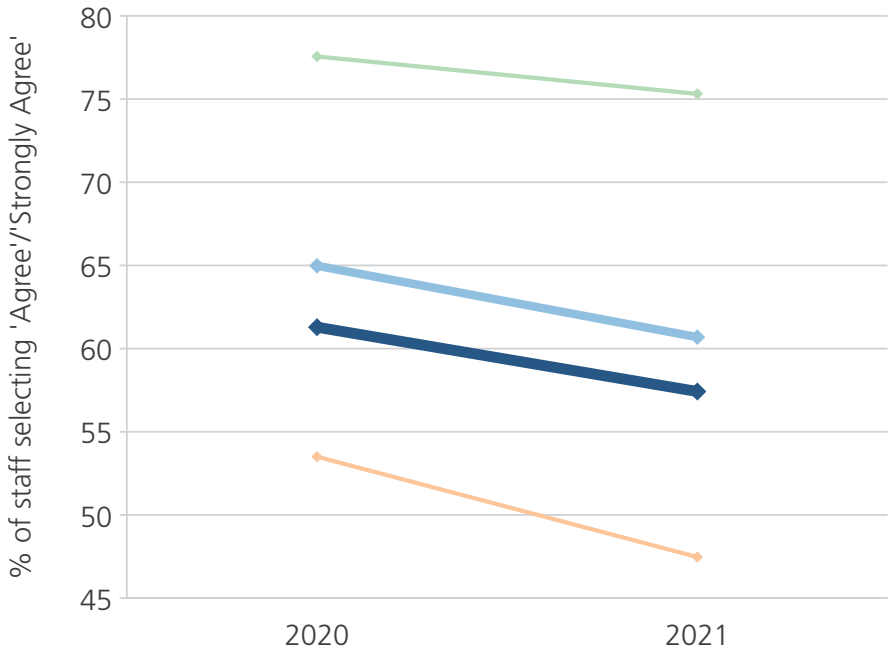

| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| **Best** | 68.1% | 69.4% | 74.3% | 74.1% | 75.7% |
| **Your org** | 52.2% | 50.8% | 54.1% | 55.8% | 53.5% |
| **Average** | 57.4% | 57.3% | 59.1% | 59.1% | 57.6% |
| **Worst** | 42.5% | 42.4% | 37.6% | 45.3% | 44.1% |
| **Responses** | 4,061 | 4,283 | 4,791 | 4,893 | 4,845 |

Survey Coordination Centre

# 2021 NHS Staff Survey Results > People Promise and theme results > Detailed information > **We each have a voice that counts** – Raising concerns

NHS

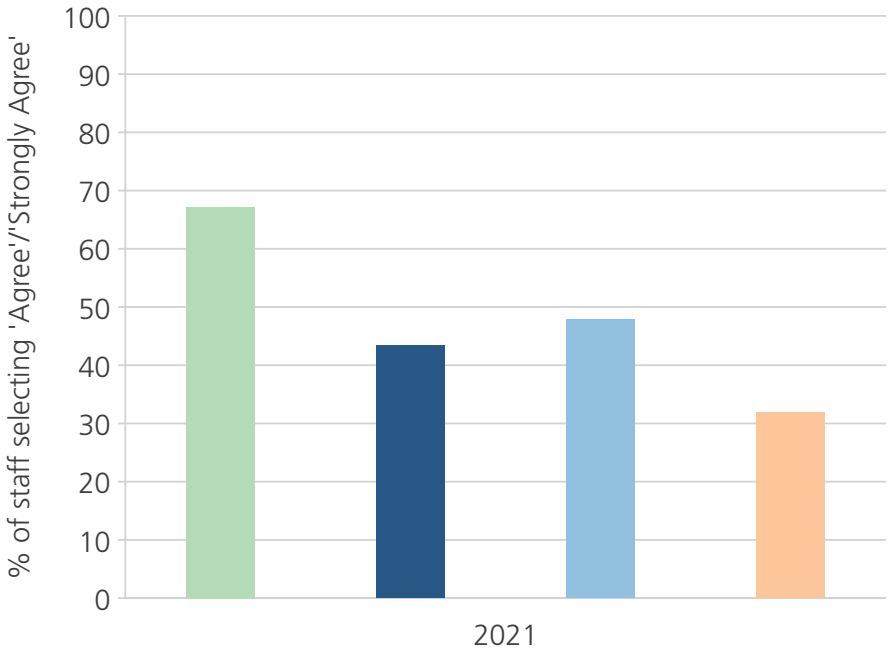
**Q21e**
I feel safe to speak up about anything that concerns me in this organisation




| | 2020 | 2021 |
|---|---|---|
| **Best** | 77.6% | 75.3% |
| **Your org** | 61.3% | 57.4% |
| **Average** | 65.0% | 60.7% |
| **Worst** | 53.5% | 47.5% |
| **Responses** | 4,882 | 4,824 |

**Q21f**
If I spoke up about something that concerned me I am confident my organisation would address my concern

No trend data are shown as this is a new question




| | 2021 |
|---|---|
| **Best** | 67.2% |
| **Your org** | 43.3% |
| **Average** | 47.9% |
| **Worst** | 31.9% |
| **Responses** | 4,820 |

Survey Coordination Centre

NHS

# People Promise element detailed information – We are safe and healthy

**Questions:**

Q3g, Q3h, Q3i, Q5a, Q11a, Q13d, Q14d
Q12a, Q12b, Q12c, Q12d, Q12e, Q12f, Q12g
Q11b, Q11c, Q11d, Q13a, Q13b, Q13c, Q14a, Q14b, Q14c

St George's University Hospitals NHS Foundation Trust

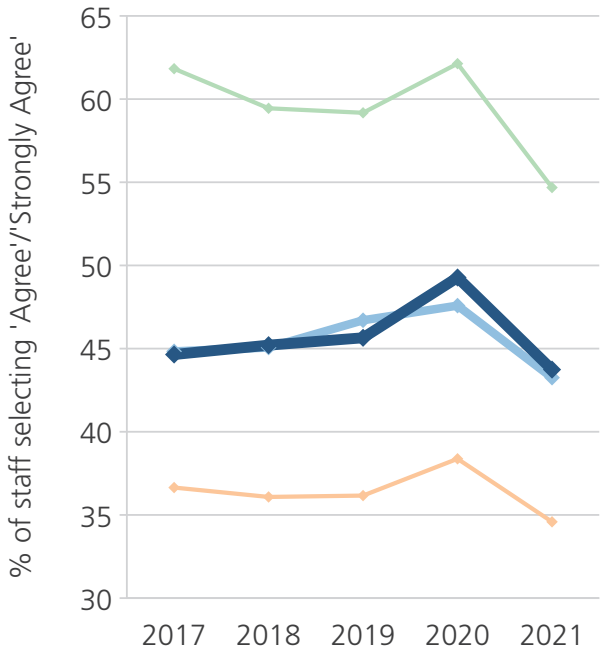
2021 NHS Staff Survey Results

Survey Coordination Centre

2021 NHS Staff Survey Results > People Promise and theme results >
Detailed information > **We are safe and healthy** – Health and safety climate

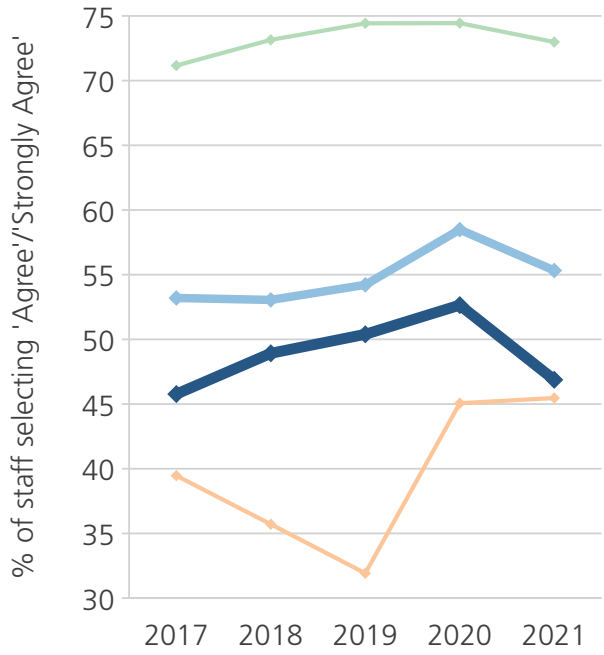
NHS

**Q3g**
I am able to meet all the conflicting demands on my time at work



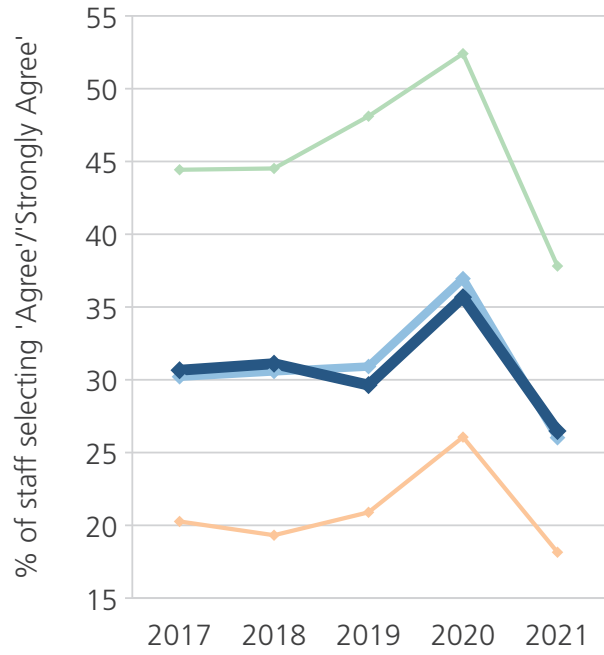

| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| **Best** | 61.8% | 59.4% | 59.2% | 62.1% | 54.7% |
| **Your org** | 44.6% | 45.2% | 45.6% | 49.3% | 43.7% |
| **Average** | 44.8% | 45.1% | 46.7% | 47.6% | 43.3% |
| **Worst** | 36.6% | 36.1% | 36.2% | 38.4% | 34.6% |
| **Responses** | 4,246 | 4,427 | 4,864 | 4,987 | 4,940 |

**Q3h**
I have adequate materials, supplies and equipment to do my work




| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| **Best** | 71.2% | 73.2% | 74.4% | 74.4% | 73.0% |
| **Your org** | 45.8% | 48.9% | 50.4% | 52.6% | 46.9% |
| **Average** | 53.2% | 53.0% | 54.2% | 58.5% | 55.3% |
| **Worst** | 39.5% | 35.7% | 31.9% | 45.1% | 45.5% |
| **Responses** | 4,249 | 4,420 | 4,862 | 5,006 | 4,951 |

**Q3i**
There are enough staff at this organisation for me to do my job properly



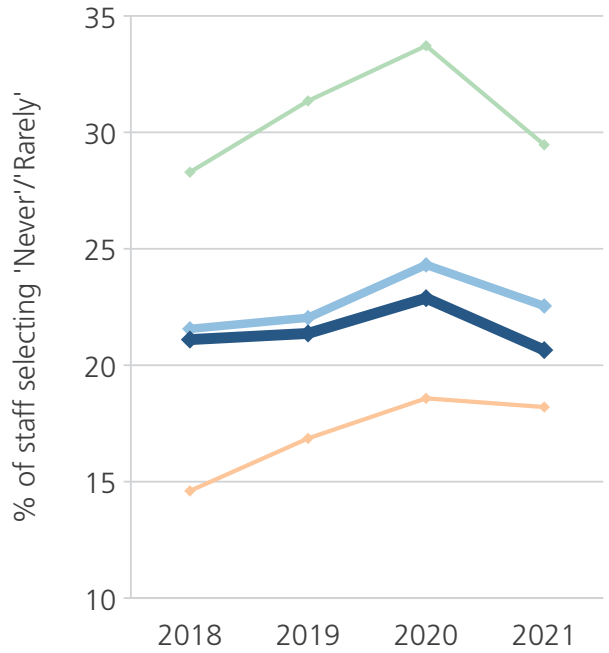

| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| **Best** | 44.4% | 44.5% | 48.1% | 52.4% | 37.8% |
| **Your org** | 30.7% | 31.1% | 29.6% | 35.7% | 26.5% |
| **Average** | 30.2% | 30.6% | 30.9% | 36.9% | 26.0% |
| **Worst** | 20.3% | 19.3% | 20.9% | 26.1% | 18.2% |
| **Responses** | 4,255 | 4,441 | 4,878 | 5,008 | 4,955 |

Survey Coordination Centre

# 2021 NHS Staff Survey Results > People Promise and theme results > Detailed information > **We are safe and healthy** – Health and safety climate

NHS

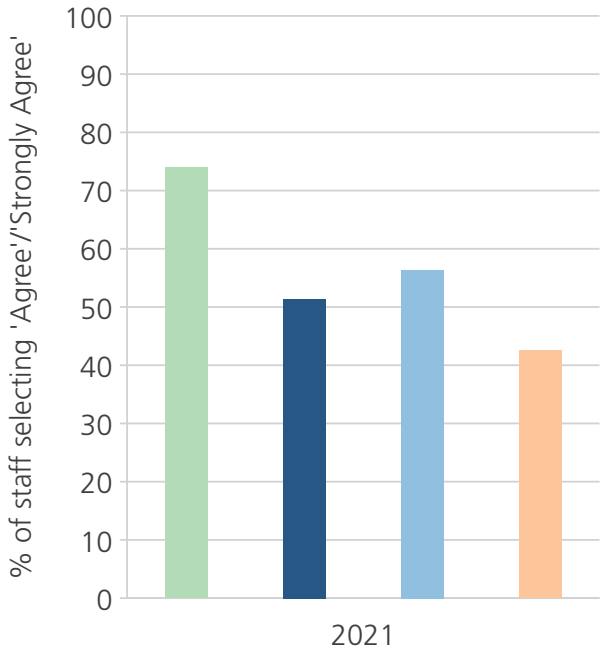
## Q5a
I have unrealistic time pressures




| | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|
| Best | 28.3% | 31.3% | 33.7% | 29.5% |
| Your org | 21.1% | 21.4% | 22.9% | 20.7% |
| Average | 21.6% | 22.0% | 24.3% | 22.5% |
| Worst | 14.6% | 16.9% | 18.6% | 18.2% |
| Responses | 4,401 | 4,814 | 4,981 | 4,925 |

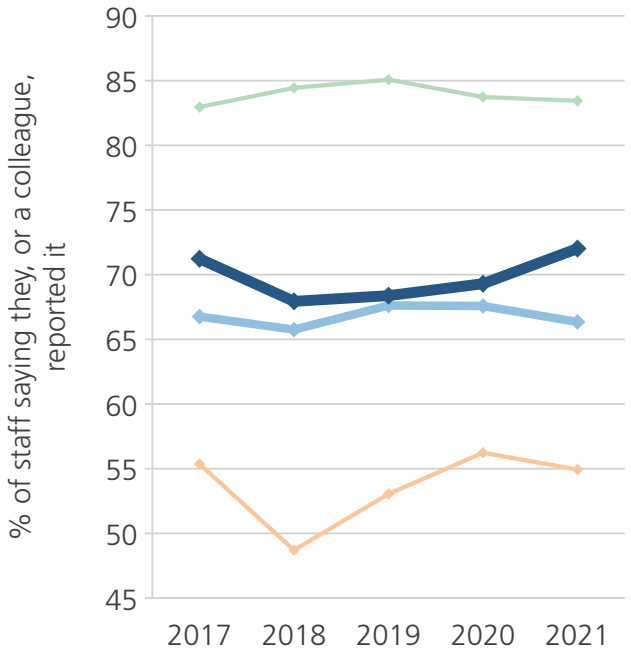
## Q11a
My organisation takes positive action on health and well-being

No trend data are shown as this is a new question




| | 2021 |
|---|---|
| Best | 74.0% |
| Your org | 51.4% |
| Average | 56.4% |
| Worst | 42.5% |
| Responses | 4,814 |

## Q13d
The last time you experienced physical violence at work, did you or a colleague report it?




| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| Best | 83.0% | 84.4% | 85.1% | 83.7% | 83.4% |
| Your org | 71.2% | 67.9% | 68.4% | 69.3% | 72.0% |
| Average | 66.8% | 65.7% | 67.6% | 67.6% | 66.3% |
| Worst | 55.4% | 48.7% | 53.0% | 56.2% | 54.9% |
| Responses | 524 | 509 | 591 | 670 | 609 |

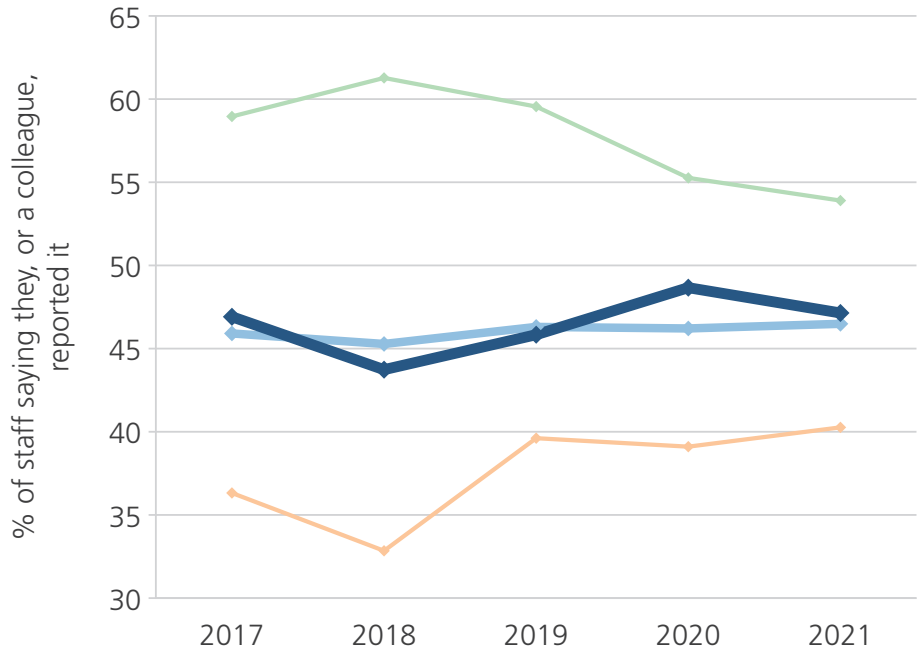
Survey Coordination Centre

# 2021 NHS Staff Survey Results > People Promise and theme results > Detailed information > **We are safe and healthy** – Health and safety climate

NHS

**Q14d**

The last time you experienced harassment, bullying or abuse at work, did you or a colleague report it?




| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| **Best** | 59.0% | 61.3% | 59.5% | 55.3% | 53.9% |
| **Your org** | 46.9% | 43.7% | 45.8% | 48.7% | 47.1% |
| **Average** | 45.9% | 45.3% | 46.3% | 46.2% | 46.5% |
| **Worst** | 36.3% | 32.8% | 39.6% | 39.1% | 40.3% |
| **Responses** | 1,643 | 1,716 | 1,945 | 1,856 | 1,663 |

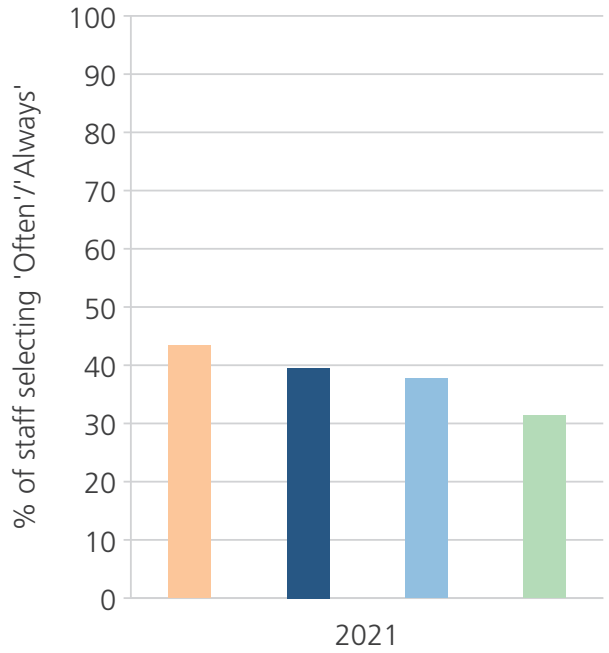
Survey Coordination Centre

# 2021 NHS Staff Survey Results > People Promise and theme results > Detailed information > **We are safe and healthy** – Burnout

NHS

**Q12a**
How often, if at all, do you find your work emotionally exhausting?

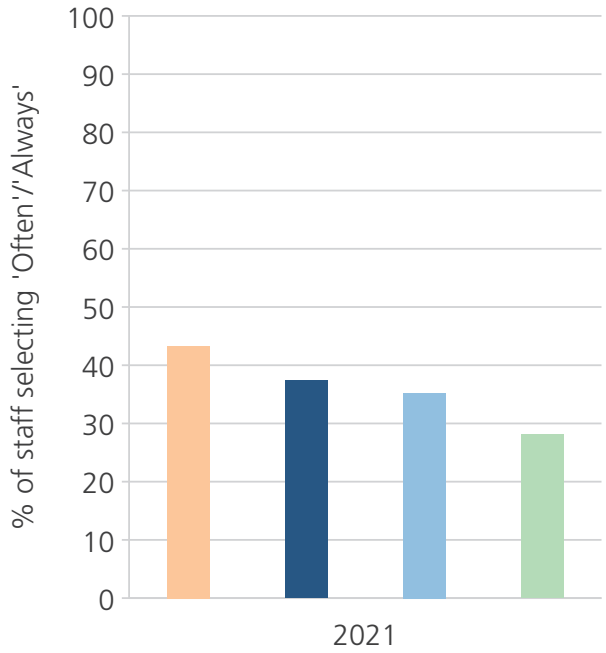
No trend data are shown as this is a new question




| | |
|---|---|
| **Worst** | 43.4% |
| **Your org** | 39.5% |
| **Average** | 37.7% |
| **Best** | 31.4% |
| **Responses** | 4,865 |

**Q12b**
How often, if at all, do you feel burnt out because of your work?

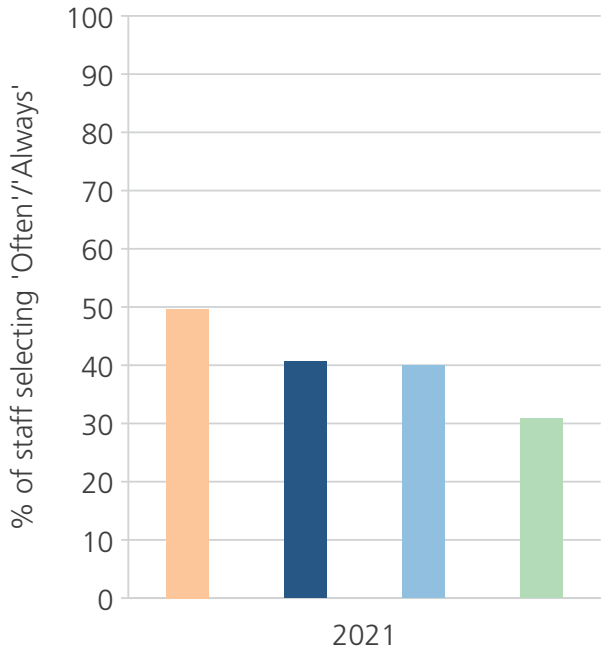
No trend data are shown as this is a new question




| | |
|---|---|
| **Worst** | 43.3% |
| **Your org** | 37.3% |
| **Average** | 35.2% |
| **Best** | 28.1% |
| **Responses** | 4,866 |

**Q12c**
How often, if at all, does your work frustrate you?

No trend data are shown as this is a new question




| | |
|---|---|
| **Worst** | 49.7% |
| **Your org** | 40.6% |
| **Average** | 39.9% |
| **Best** | 30.8% |
| **Responses** | 4,860 |

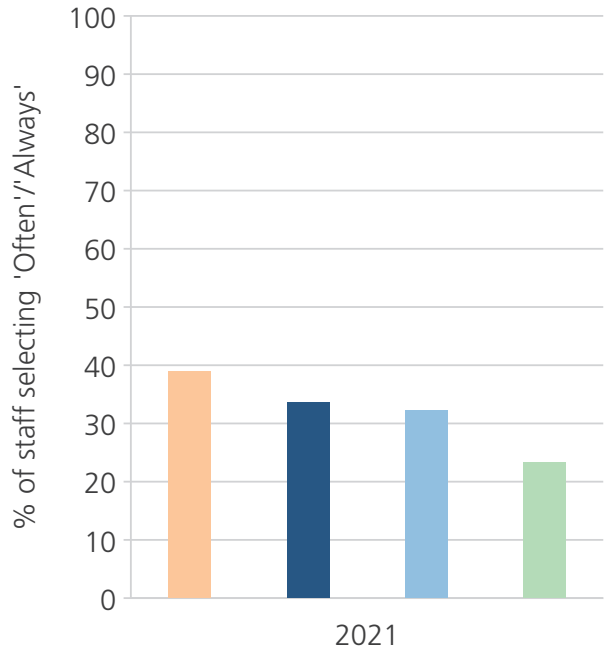
Survey Coordination Centre

# 2021 NHS Staff Survey Results > People Promise and theme results > Detailed information > **We are safe and healthy** – Burnout

NHS

**Q12d**
How often, if at all, are you exhausted at the thought of another day/shift at work?

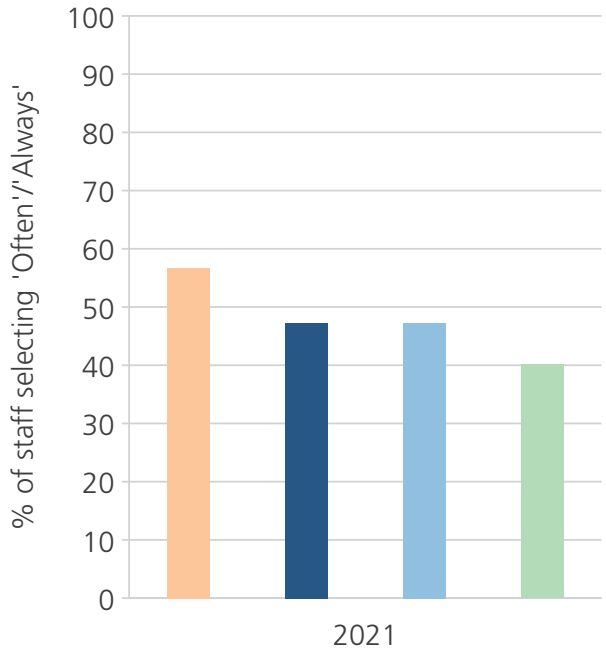
No trend data are shown as this is a new question




| | |
|---|---|
| **Worst** | 39.0% |
| **Your org** | 33.5% |
| **Average** | 32.2% |
| **Best** | 23.4% |
| **Responses** | 4,861 |

**Q12e**
How often, if at all, do you feel worn out at the end of your working day/shift?

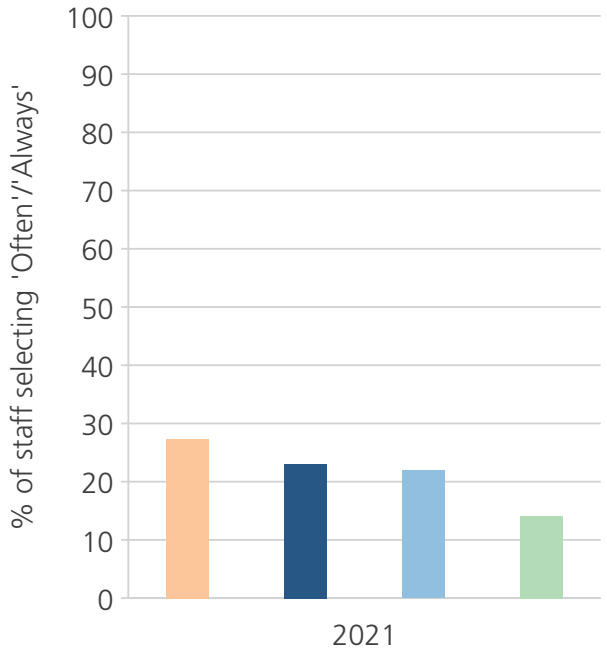
No trend data are shown as this is a new question




| | |
|---|---|
| **Worst** | 56.7% |
| **Your org** | 47.2% |
| **Average** | 47.2% |
| **Best** | 40.2% |
| **Responses** | 4,869 |

**Q12f**
How often, if at all, do you feel that every working hour is tiring for you?

No trend data are shown as this is a new question




| | |
|---|---|
| **Worst** | 27.3% |
| **Your org** | 23.0% |
| **Average** | 21.9% |
| **Best** | 14.1% |
| **Responses** | 4,859 |

Survey Coordination Centre

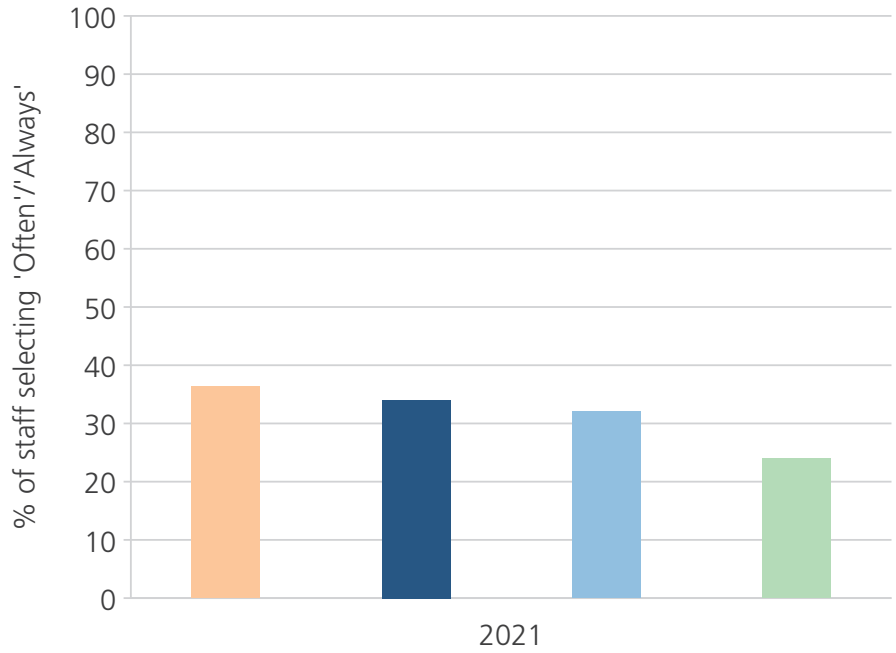
# 2021 NHS Staff Survey Results > People Promise and theme results > Detailed information > **We are safe and healthy** – Burnout

NHS

**Q12g**

How often, if at all, do you not have enough energy for family and friends during leisure time?

No trend data are shown as this is a new question



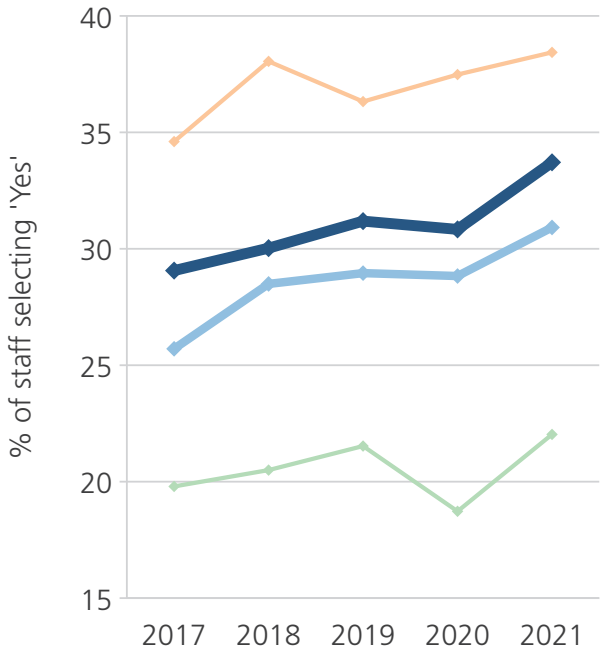

| | |
|---|---|
| **Worst** | 36.3% |
| **Your org** | 34.0% |
| **Average** | 32.1% |
| **Best** | 23.9% |
| **Responses** | 4,872 |

Survey Coordination Centre

# 2021 NHS Staff Survey Results > People Promise and theme results > Detailed information > **We are safe and healthy** – Negative experiences

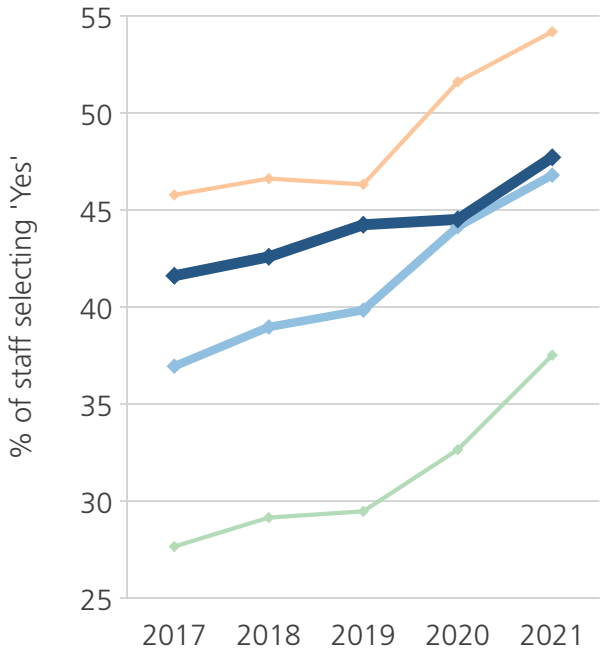
NHS

**Q11b**
In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities?



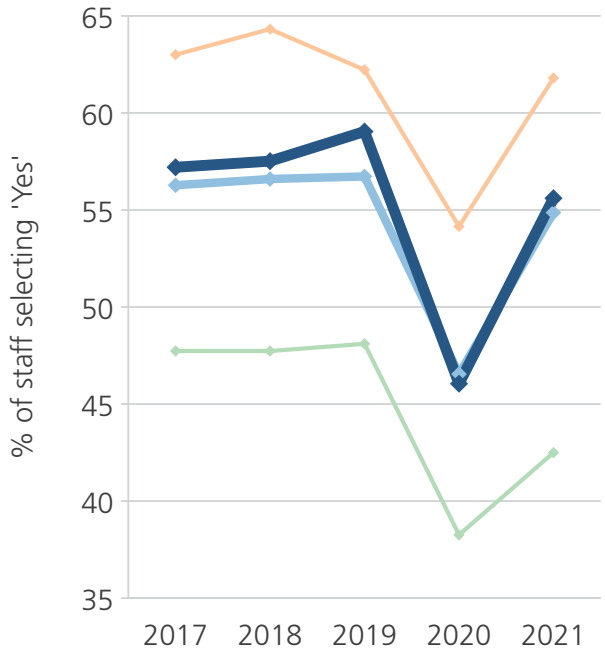

| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| Worst | 34.6% | 38.0% | 36.3% | 37.5% | 38.4% |
| Your org | 29.1% | 30.0% | 31.2% | 30.8% | 33.7% |
| Average | 25.7% | 28.5% | 29.0% | 28.8% | 30.9% |
| Best | 19.8% | 20.5% | 21.5% | 18.7% | 22.0% |
| Responses | 4,130 | 4,327 | 4,818 | 4,950 | 4,886 |

**Q11c**
During the last 12 months have you felt unwell as a result of work related stress?




| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| Worst | 45.8% | 46.6% | 46.3% | 51.6% | 54.2% |
| Your org | 41.6% | 42.6% | 44.2% | 44.5% | 47.7% |
| Average | 36.9% | 39.0% | 39.8% | 44.1% | 46.8% |
| Best | 27.7% | 29.1% | 29.5% | 32.6% | 37.5% |
| Responses | 4,135 | 4,334 | 4,825 | 4,952 | 4,883 |

**Q11d**
In the last three months have you ever come to work despite not feeling well enough to perform your duties?



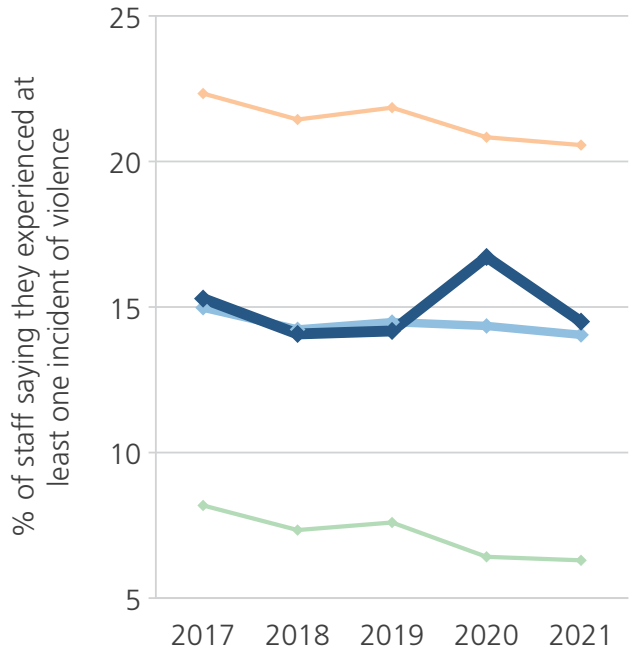

| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| Worst | 63.0% | 64.3% | 62.2% | 54.2% | 61.8% |
| Your org | 57.2% | 57.5% | 59.0% | 46.0% | 55.6% |
| Average | 56.3% | 56.6% | 56.7% | 46.5% | 54.9% |
| Best | 47.7% | 47.7% | 48.1% | 38.3% | 42.5% |
| Responses | 4,134 | 4,337 | 4,829 | 4,950 | 4,888 |

Survey Coordination Centre

# 2021 NHS Staff Survey Results > People Promise and theme results > Detailed information > **We are safe and healthy** – Negative experiences

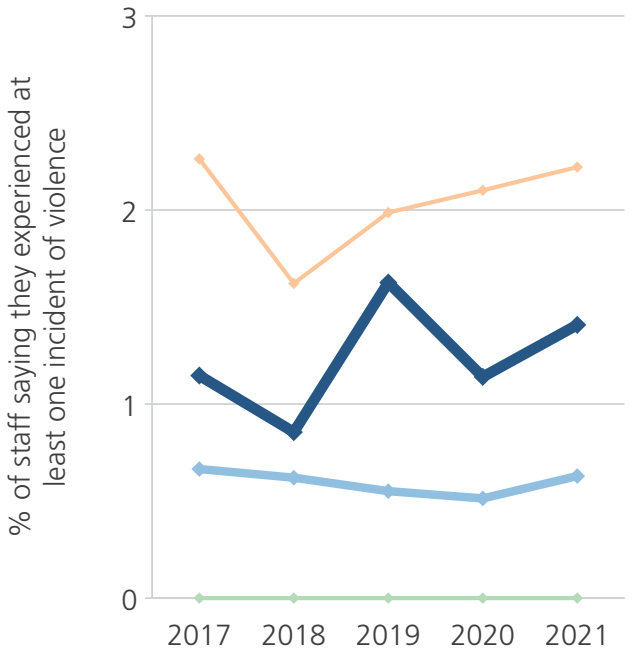
NHS

**Q13a**
In the last 12 months how many times have you personally experienced physical violence at work from patients / service users, their relatives or other members of the public?



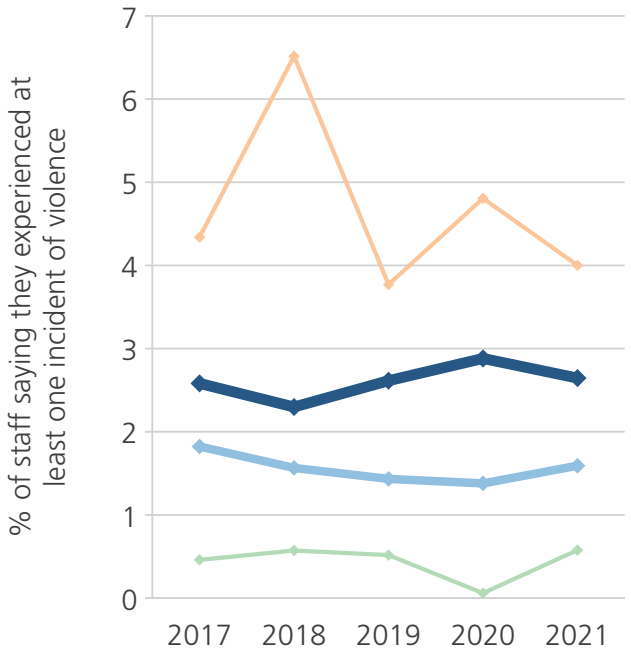

| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| Worst | 22.3% | 21.4% | 21.8% | 20.8% | 20.6% |
| Your org | 15.3% | 14.1% | 14.2% | 16.7% | 14.5% |
| Average | 15.0% | 14.2% | 14.5% | 14.3% | 14.0% |
| Best | 8.2% | 7.3% | 7.6% | 6.4% | 6.3% |
| Responses | 4,052 | 4,332 | 4,814 | 4,947 | 4,863 |

**Q13b**
In the last 12 months how many times have you personally experienced physical violence at work from managers?




| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| Worst | 2.3% | 1.6% | 2.0% | 2.1% | 2.2% |
| Your org | 1.1% | 0.9% | 1.6% | 1.1% | 1.4% |
| Average | 0.7% | 0.6% | 0.6% | 0.5% | 0.6% |
| Best | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% |
| Responses | 3,992 | 4,230 | 4,777 | 4,932 | 4,831 |

**Q13c**
In the last 12 months how many times have you personally experienced physical violence at work from other colleagues?




| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| Worst | 4.3% | 6.5% | 3.8% | 4.8% | 4.0% |
| Your org | 2.6% | 2.3% | 2.6% | 2.9% | 2.6% |
| Average | 1.8% | 1.6% | 1.4% | 1.4% | 1.6% |
| Best | 0.5% | 0.6% | 0.5% | 0.1% | 0.6% |
| Responses | 3,993 | 4,238 | 4,779 | 4,926 | 4,806 |

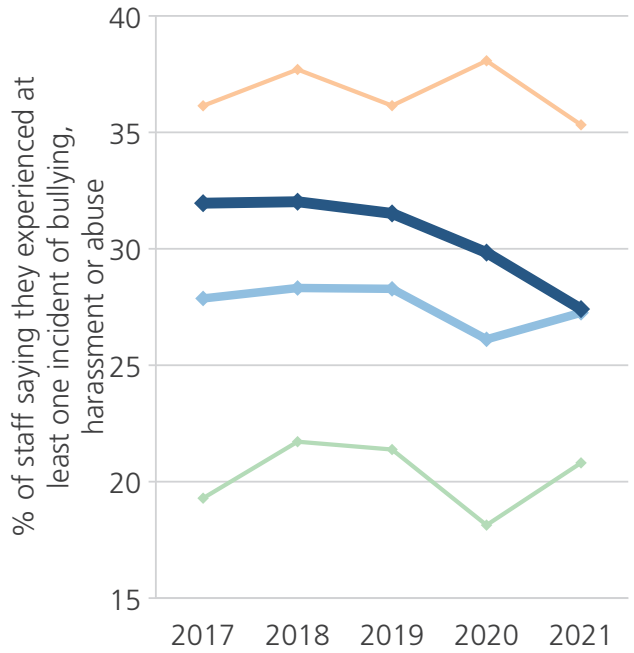
Survey Coordination Centre

# 2021 NHS Staff Survey Results > People Promise and theme results > Detailed information > **We are safe and healthy** – Negative experiences

NHS

## Q14a

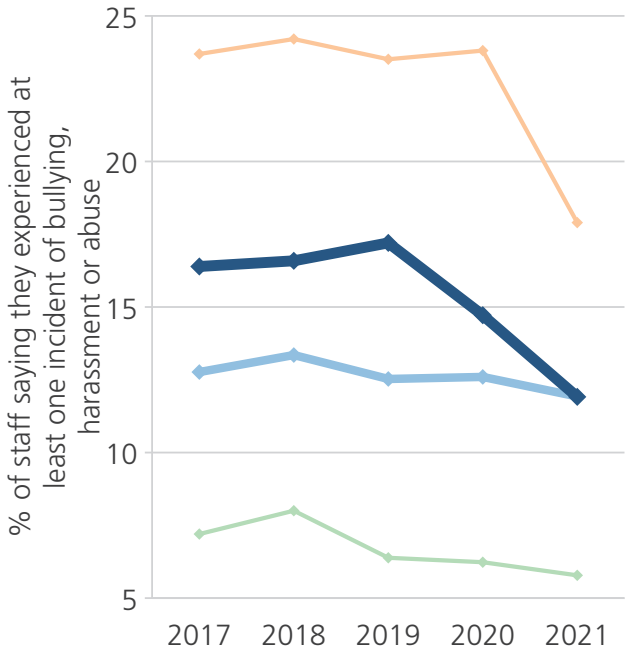
In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from patients / service users, their relatives or other members of the public?




| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| Worst | 36.1% | 37.7% | 36.1% | 38.1% | 35.3% |
| Your org | 32.0% | 32.0% | 31.5% | 29.8% | 27.4% |
| Average | 27.9% | 28.3% | 28.3% | 26.1% | 27.3% |
| Best | 19.3% | 21.7% | 21.4% | 18.1% | 20.8% |
| Responses | 4,046 | 4,327 | 4,786 | 4,802 | 4,689 |

## Q14b

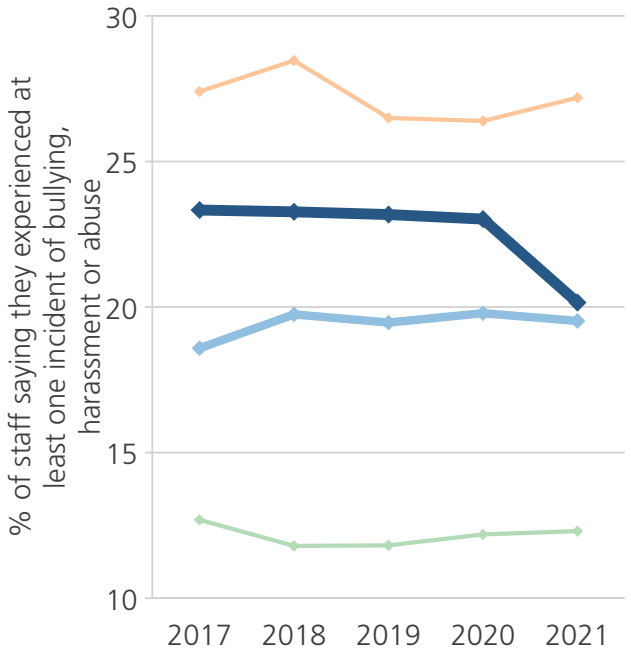
In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from managers?




| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| Worst | 23.7% | 24.2% | 23.5% | 23.8% | 17.9% |
| Your org | 16.4% | 16.6% | 17.2% | 14.7% | 11.9% |
| Average | 12.8% | 13.3% | 12.5% | 12.6% | 11.9% |
| Best | 7.2% | 8.0% | 6.4% | 6.2% | 5.8% |
| Responses | 3,986 | 4,265 | 4,757 | 4,794 | 4,672 |

## Q14c

In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from other colleagues?




| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| Worst | 27.4% | 28.5% | 26.5% | 26.4% | 27.2% |
| Your org | 23.3% | 23.3% | 23.2% | 23.0% | 20.2% |
| Average | 18.6% | 19.7% | 19.5% | 19.8% | 19.5% |
| Best | 12.7% | 11.8% | 11.8% | 12.2% | 12.3% |
| Responses | 3,976 | 4,246 | 4,762 | 4,790 | 4,671 |

Survey Coordination Centre

NHS

# People Promise element detailed information – We are always learning

**Questions:**

Q20a, Q20b, Q20c, Q20d, Q20e

Q19a, Q19b, Q19c, Q19d

St George's University Hospitals NHS Foundation Trust

2021 NHS Staff Survey Results

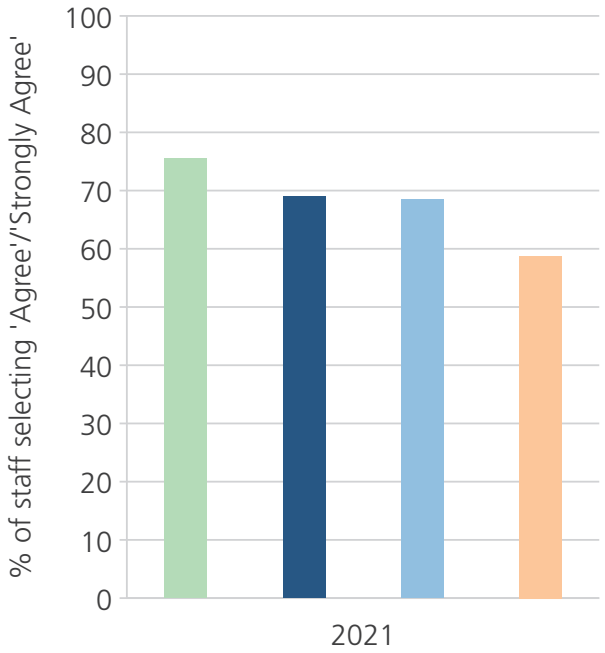
Survey Coordination Centre

# 2021 NHS Staff Survey Results > People Promise and theme results > Detailed information > **We are always learning** – Development

NHS

**Q20a**
This organisation offers me challenging work

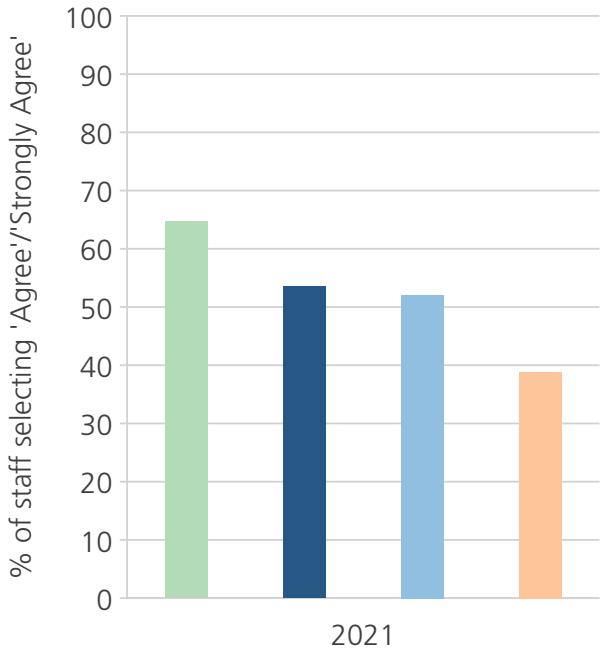
No trend data are shown as this is a new question




| | |
|---|---|
| **Best** | 75.6% |
| **Your org** | 68.9% |
| **Average** | 68.4% |
| **Worst** | 58.8% |
| **Responses** | 4,832 |

**Q20b**
There are opportunities for me to develop my career in this organisation

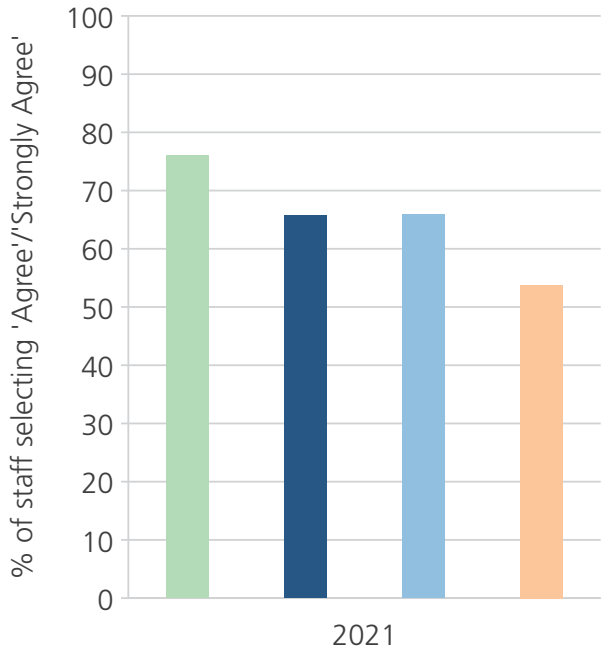
No trend data are shown as this is a new question




| | |
|---|---|
| **Best** | 64.6% |
| **Your org** | 53.5% |
| **Average** | 52.1% |
| **Worst** | 38.8% |
| **Responses** | 4,842 |

**Q20c**
I have opportunities to improve my knowledge and skills

No trend data are shown as this is a new question




| | |
|---|---|
| **Best** | 76.0% |
| **Your org** | 65.7% |
| **Average** | 65.9% |
| **Worst** | 53.8% |
| **Responses** | 4,840 |

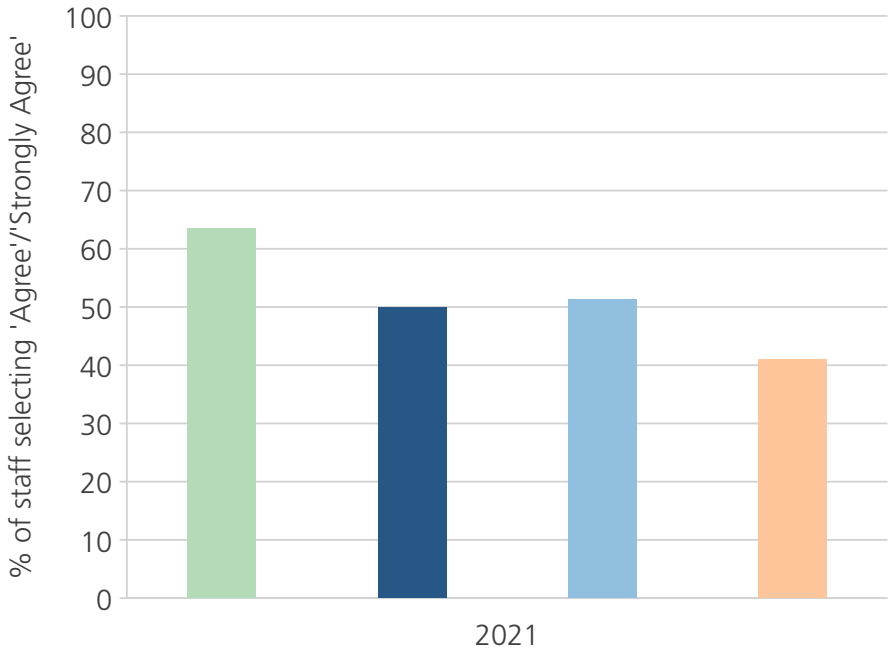
Survey Coordination Centre

# 2021 NHS Staff Survey Results > People Promise and theme results > Detailed information > **We are always learning** – Development

NHS

**Q20d**
I feel supported to develop my potential

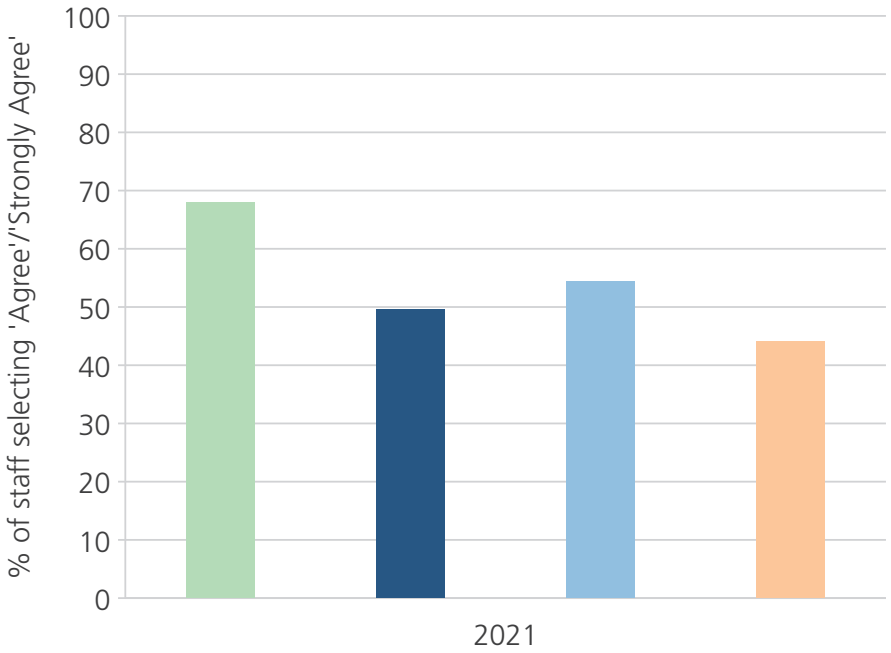
No trend data are shown as this is a new question




| | |
|---|---|
| **Best** | 63.5% |
| **Your org** | 49.9% |
| **Average** | 51.3% |
| **Worst** | 41.0% |
| **Responses** | 4,837 |

**Q20e**
I am able to access the right learning and development opportunities when I need to

No trend data are shown as this is a new question




| | |
|---|---|
| **Best** | 68.0% |
| **Your org** | 49.6% |
| **Average** | 54.4% |
| **Worst** | 44.1% |
| **Responses** | 4,838 |

Survey Coordination Centre

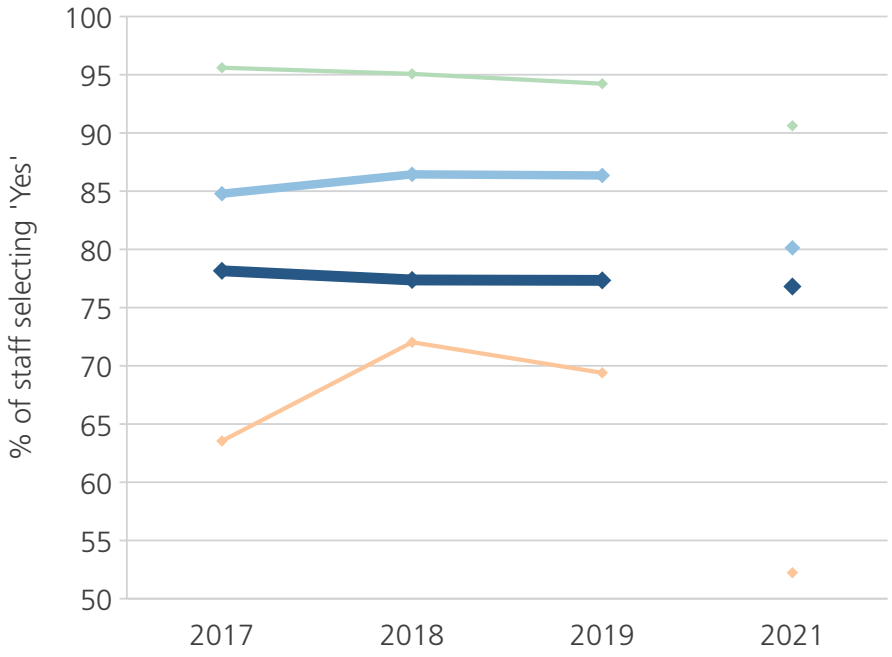
# 2021 NHS Staff Survey Results > People Promise and theme results > Detailed information > **We are always learning** – Appraisals

NHS

**Q19a**

In the last 12 months, have you had an appraisal, annual review, development review, or Knowledge and Skills Framework (KSF) development review?

Note that Q19a-d were not asked in 2020. In interpreting these results, consideration should be given to the gap in the data series and evidence of changes to the response profiles over time.

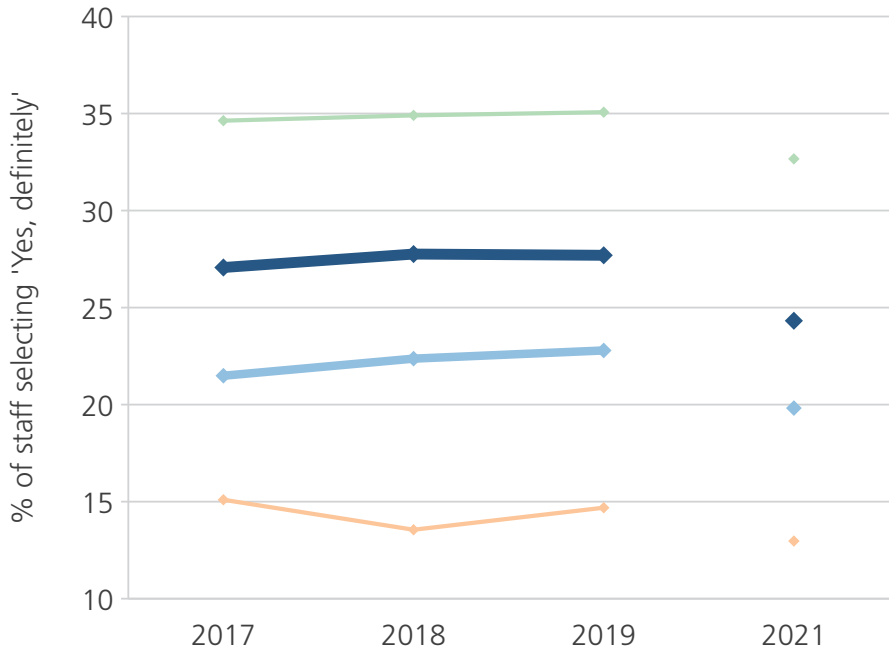



| | 2017 | 2018 | 2019 | 2021 |
|---|---|---|---|---|
| Highest | 95.6% | 95.1% | 94.2% | 90.6% |
| Your org | 78.2% | 77.4% | 77.3% | 76.8% |
| Average | 84.8% | 86.4% | 86.3% | 80.1% |
| Lowest | 63.5% | 72.0% | 69.4% | 52.2% |
| Responses | 4,024 | 4,293 | 4,781 | 4,838 |

**Q19b**

It helped me to improve how I do my job

Note that Q19a-d were not asked in 2020. In interpreting these results, consideration should be given to the gap in the data series and evidence of changes to the response profiles over time.




| | 2017 | 2018 | 2019 | 2021 |
|---|---|---|---|---|
| Best | 34.6% | 34.9% | 35.1% | 32.7% |
| Your org | 27.1% | 27.8% | 27.7% | 24.3% |
| Average | 21.5% | 22.4% | 22.8% | 19.8% |
| Worst | 15.1% | 13.6% | 14.7% | 13.0% |
| Responses | 3,139 | 3,286 | 3,705 | 3,728 |

Survey Coordination Centre

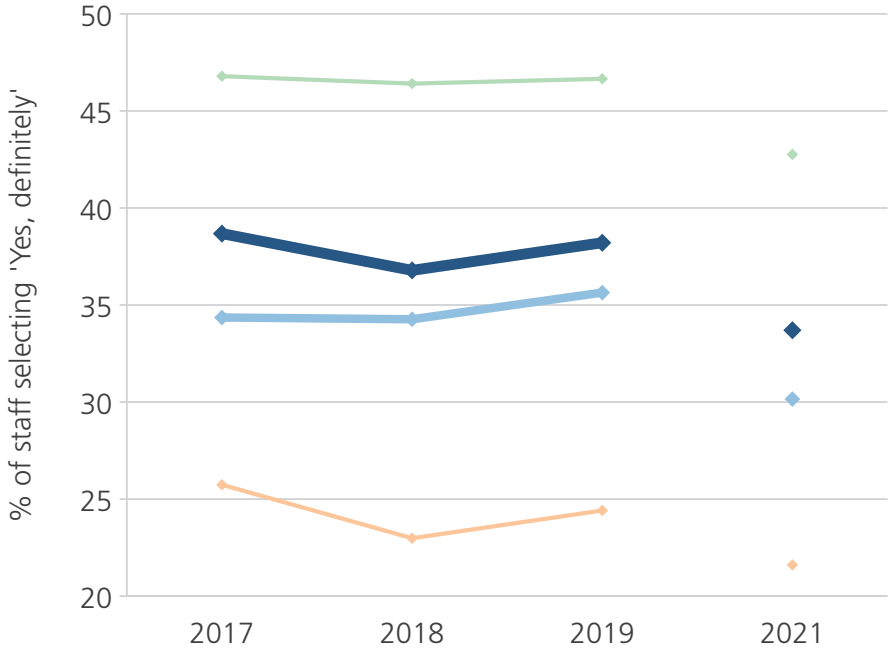
# 2021 NHS Staff Survey Results > People Promise and theme results > Detailed information > **We are always learning** – Appraisals

NHS

**Q19c**

It helped me agree clear objectives for my work

Note that Q19a-d were not asked in 2020. In interpreting these results, consideration should be given to the gap in the data series and evidence of changes to the response profiles over time.

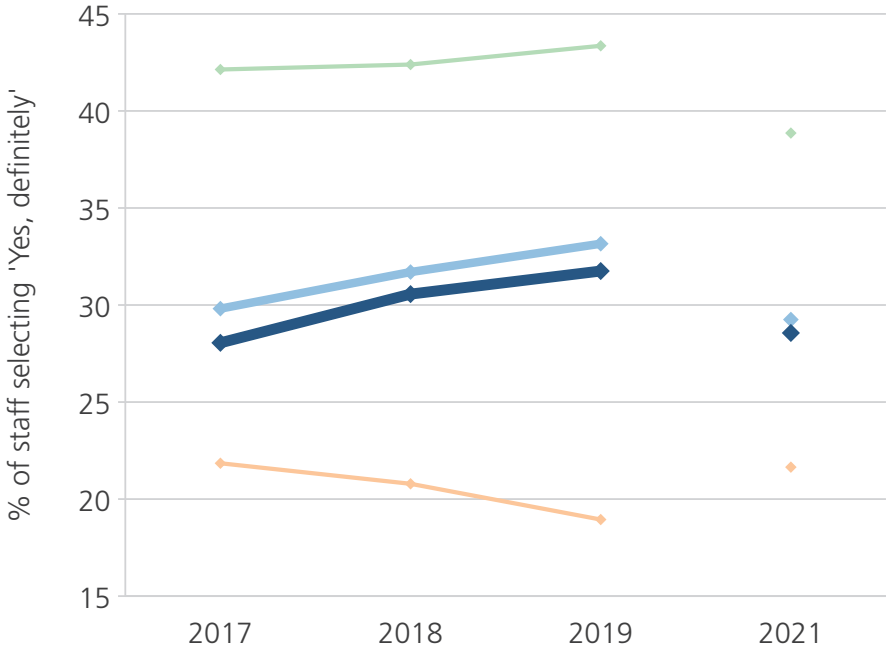



| | 2017 | 2018 | 2019 | 2021 |
|---|---|---|---|---|
| **Best** | 46.8% | 46.4% | 46.7% | 42.8% |
| **Your org** | 38.7% | 36.8% | 38.2% | 33.7% |
| **Average** | 34.4% | 34.3% | 35.6% | 30.2% |
| **Worst** | 25.7% | 23.0% | 24.4% | 21.6% |
| **Responses** | 3,137 | 3,288 | 3,699 | 3,721 |

**Q19d**

It left me feeling that my work is valued by my organisation

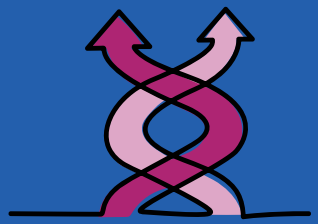
Note that Q19a-d were not asked in 2020. In interpreting these results, consideration should be given to the gap in the data series and evidence of changes to the response profiles over time.




| | 2017 | 2018 | 2019 | 2021 |
|---|---|---|---|---|
| **Best** | 42.1% | 42.4% | 43.4% | 38.9% |
| **Your org** | 28.1% | 30.6% | 31.8% | 28.6% |
| **Average** | 29.8% | 31.7% | 33.2% | 29.3% |
| **Worst** | 21.8% | 20.8% | 18.9% | 21.6% |
| **Responses** | 3,132 | 3,286 | 3,699 | 3,723 |

Survey Coordination Centre

NHS



# People Promise element detailed information – We work flexibly

**Questions:**
Q6b, Q6c, Q6d
Q4d

St George's University Hospitals NHS Foundation Trust

2021 NHS Staff Survey Results

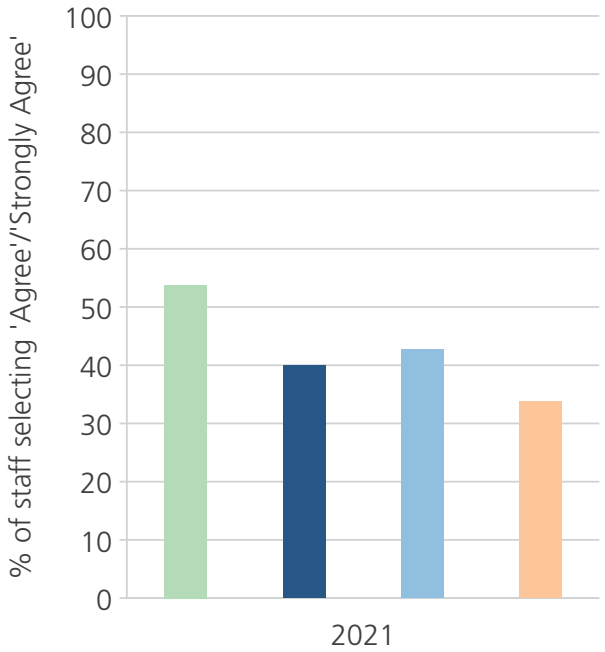
Survey Coordination Centre

# 2021 NHS Staff Survey Results > People Promise and theme results > Detailed information > **We work flexibly** – Support for work-life balance

NHS

## Q6b
My organisation is committed to helping me balance my work and home life

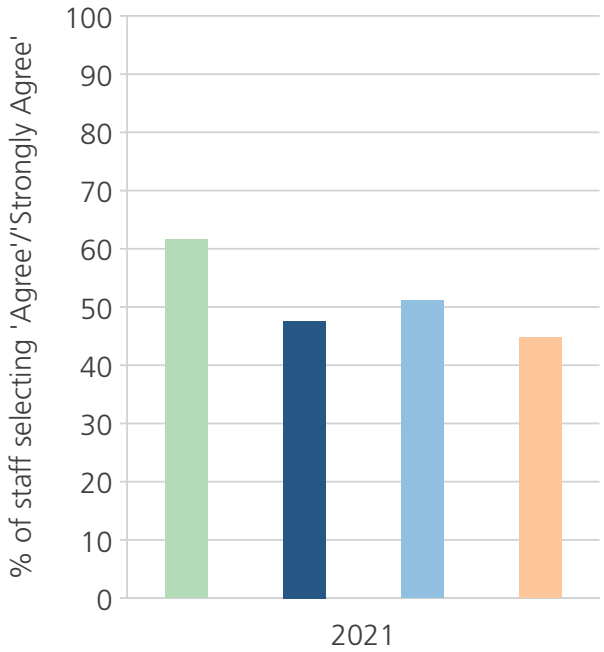
No trend data are shown as this is a new question




| | |
|---|---|
| **Best** | 53.8% |
| **Your org** | 39.9% |
| **Average** | 42.6% |
| **Worst** | 33.8% |
| **Responses** | 4,938 |

## Q6c
I achieve a good balance between my work life and my home life

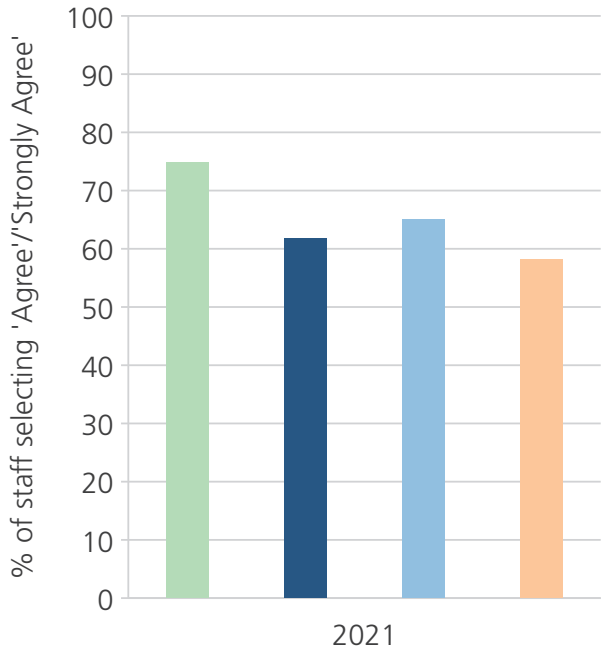
No trend data are shown as this is a new question




| | |
|---|---|
| **Best** | 61.6% |
| **Your org** | 47.6% |
| **Average** | 51.1% |
| **Worst** | 44.7% |
| **Responses** | 4,943 |

## Q6d
I can approach my immediate manager to talk openly about flexible working

No trend data are shown as this is a new question




| | |
|---|---|
| **Best** | 74.8% |
| **Your org** | 61.8% |
| **Average** | 65.0% |
| **Worst** | 58.2% |
| **Responses** | 4,940 |

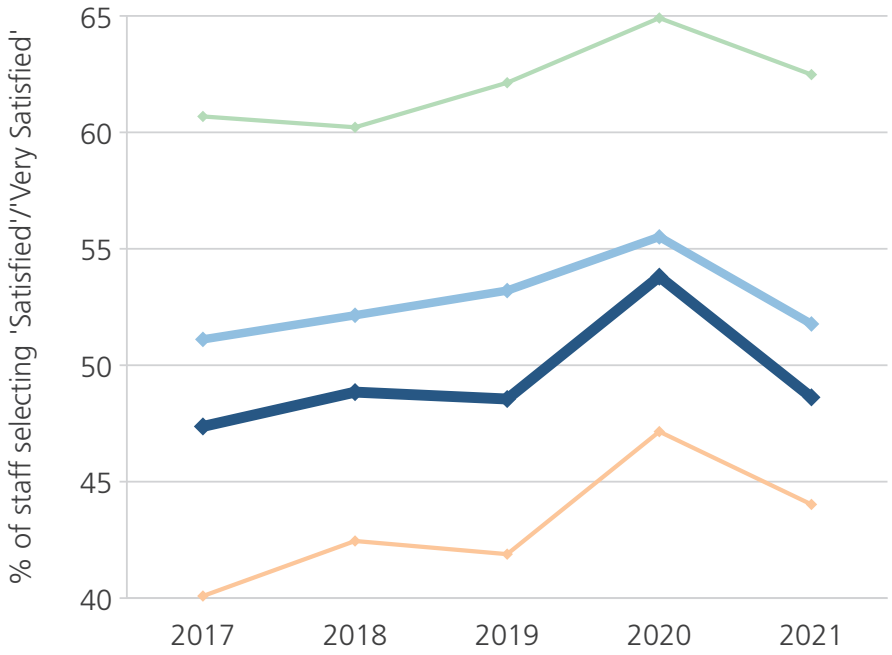
Survey Coordination Centre

# 2021 NHS Staff Survey Results > People Promise and theme results > Detailed information > **We work flexibly** – Flexible working

NHS

**Q4d**

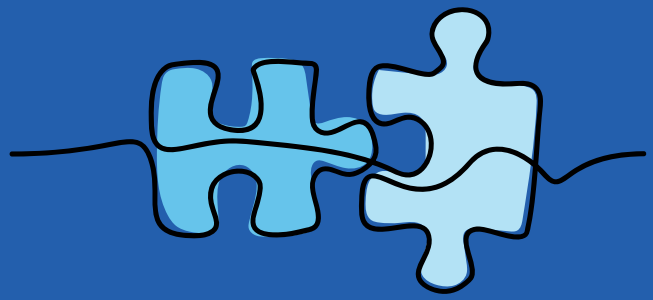
The opportunities for flexible working patterns




| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| **Best** | 60.7% | 60.2% | 62.1% | 64.9% | 62.5% |
| **Your org** | 47.4% | 48.8% | 48.5% | 53.8% | 48.6% |
| **Average** | 51.1% | 52.1% | 53.2% | 55.5% | 51.8% |
| **Worst** | 40.1% | 42.5% | 41.9% | 47.2% | 44.0% |
| **Responses** | 4,218 | 4,387 | 4,848 | 4,984 | 4,945 |

Survey Coordination Centre

NHS



# People Promise element detailed information – We are a team

**Questions:**

Q7a, Q7b, Q7c, Q7d, Q7e, Q7f, Q7g, Q8a
Q9a, Q9b, Q9c, Q9d

St George's University Hospitals NHS Foundation Trust

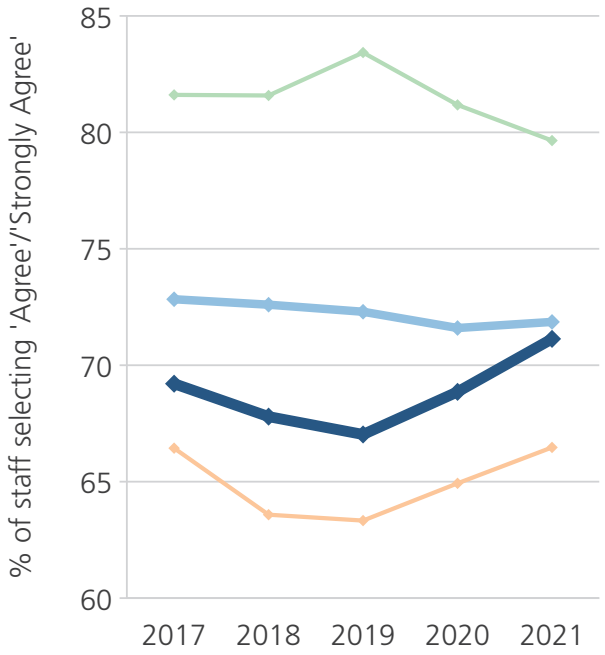
2021 NHS Staff Survey Results

Survey Coordination Centre

# 2021 NHS Staff Survey Results > People Promise and theme results > Detailed information > **We are a team** – Team working

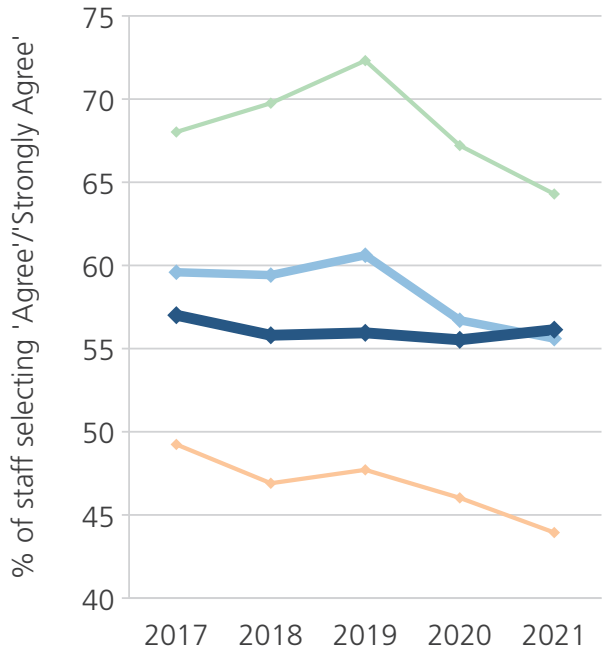
NHS

**Q7a**
The team I work in has a set of shared objectives



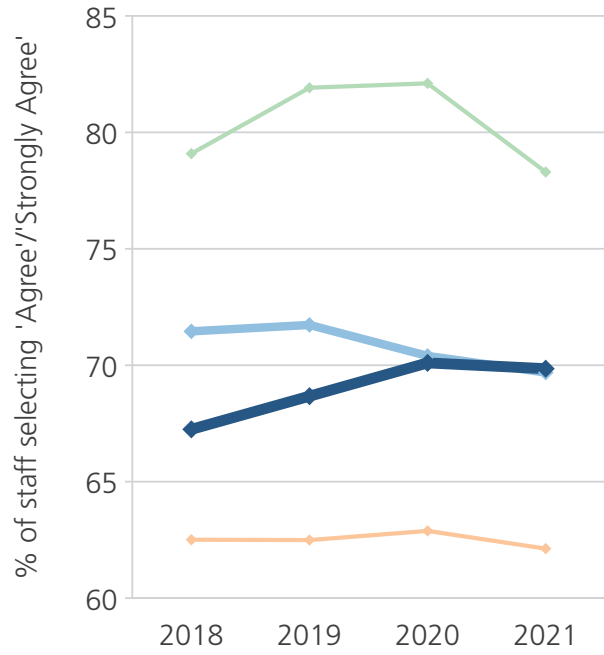

| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| Best | 81.6% | 81.6% | 83.4% | 81.2% | 79.6% |
| Your org | 69.2% | 67.8% | 67.0% | 68.9% | 71.1% |
| Average | 72.8% | 72.6% | 72.3% | 71.6% | 71.9% |
| Worst | 66.4% | 63.6% | 63.3% | 64.9% | 66.5% |
| Responses | 4,239 | 4,426 | 4,817 | 4,972 | 4,912 |

**Q7b**
The team I work in often meets to discuss the team's effectiveness




| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| Best | 68.0% | 69.8% | 72.3% | 67.2% | 64.3% |
| Your org | 57.0% | 55.8% | 55.9% | 55.5% | 56.1% |
| Average | 59.6% | 59.4% | 60.6% | 56.7% | 55.6% |
| Worst | 49.2% | 46.9% | 47.7% | 46.0% | 43.9% |
| Responses | 4,243 | 4,437 | 4,883 | 5,006 | 4,920 |

**Q7c**
I receive the respect I deserve from my colleagues at work




| | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|
| Best | 79.1% | 81.9% | 82.1% | 78.3% |
| Your org | 67.2% | 68.7% | 70.1% | 69.9% |
| Average | 71.5% | 71.7% | 70.4% | 69.7% |
| Worst | 62.5% | 62.5% | 62.9% | 62.1% |
| Responses | 4,446 | 4,888 | 5,010 | 4,921 |

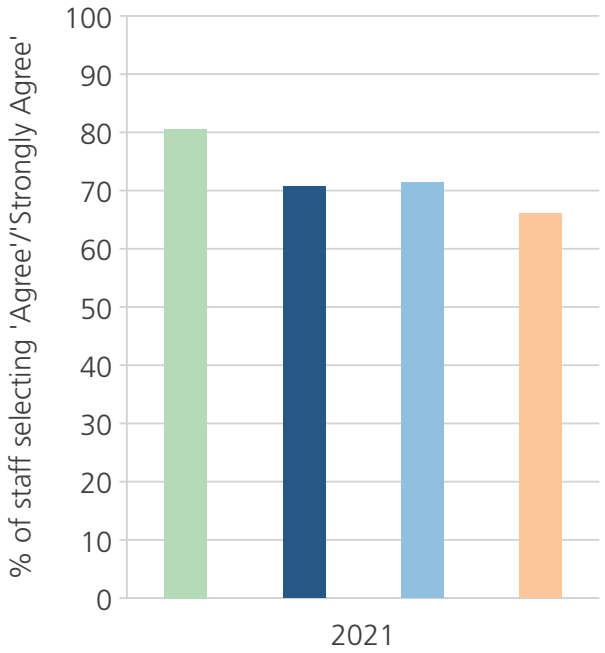
Survey Coordination Centre

# 2021 NHS Staff Survey Results > People Promise and theme results > Detailed information > **We are a team** – Team working

NHS

**Q7d**
Team members understand each other's roles

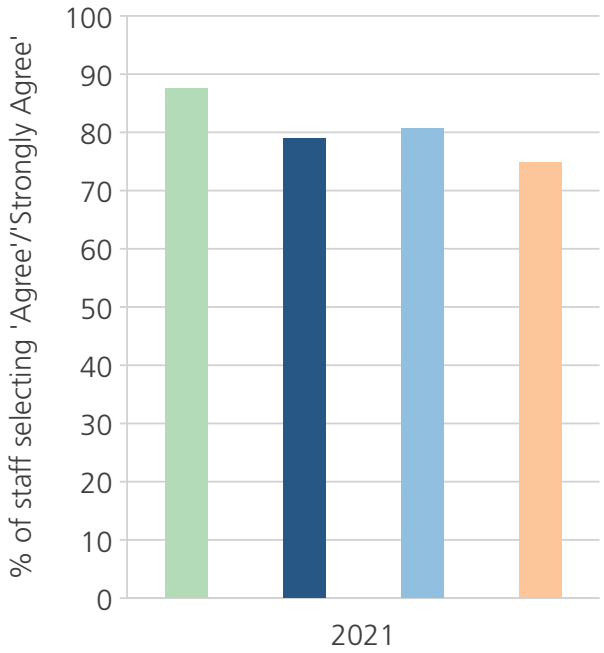
No trend data are shown as this is a new question




| | |
|---|---|
| **Best** | 80.6% |
| **Your org** | 70.7% |
| **Average** | 71.3% |
| **Worst** | 66.1% |
| **Responses** | 4,923 |

**Q7e**
I enjoy working with the colleagues in my team

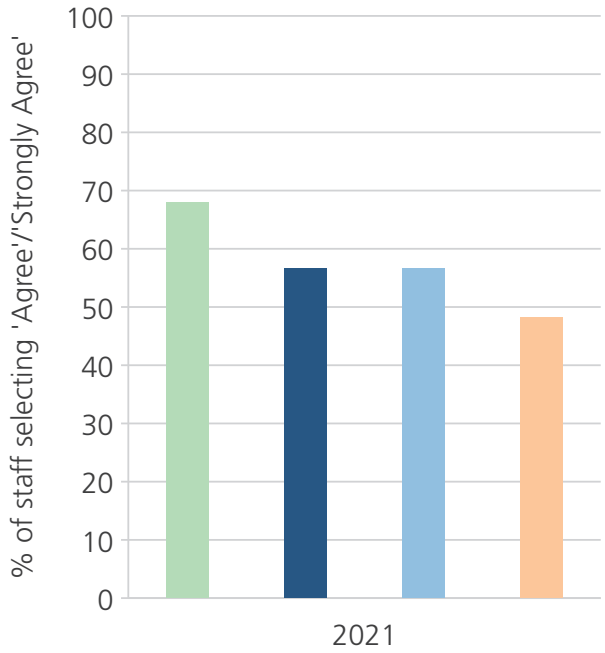
No trend data are shown as this is a new question




| | |
|---|---|
| **Best** | 87.6% |
| **Your org** | 78.9% |
| **Average** | 80.7% |
| **Worst** | 74.9% |
| **Responses** | 4,920 |

**Q7f**
My team has enough freedom in how to do its work

No trend data are shown as this is a new question




| | |
|---|---|
| **Best** | 68.0% |
| **Your org** | 56.6% |
| **Average** | 56.6% |
| **Worst** | 48.2% |
| **Responses** | 4,915 |

Survey Coordination Centre

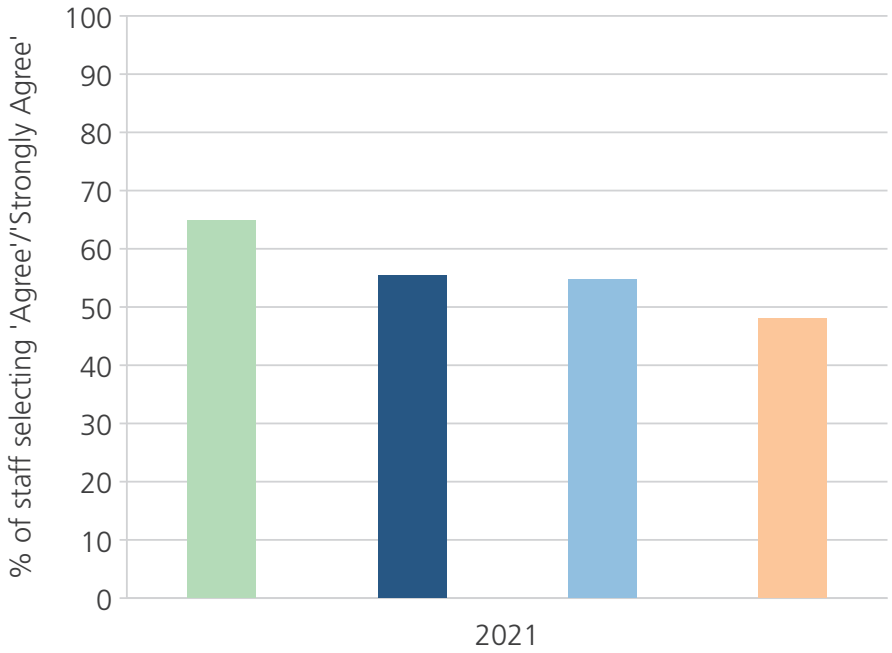
# 2021 NHS Staff Survey Results > People Promise and theme results > Detailed information > **We are a team** – Team working

NHS

**Q7g**

In my team disagreements are dealt with constructively

No trend data are shown as this is a new question

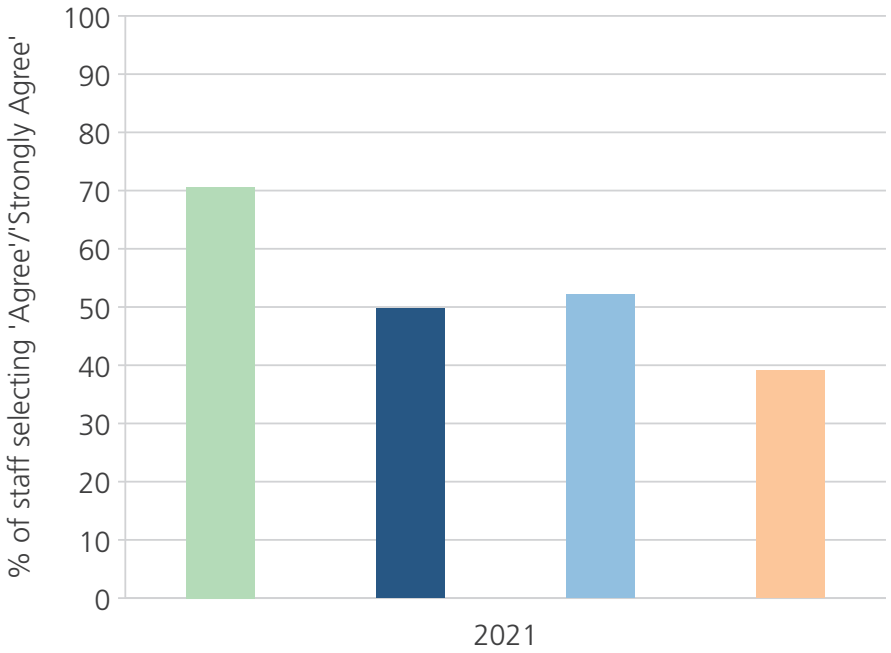



| | |
|---|---|
| **Best** | 64.9% |
| **Your org** | 55.4% |
| **Average** | 54.7% |
| **Worst** | 48.0% |
| **Responses** | 4,913 |

**Q8a**

Teams within this organisation work well together to achieve their objectives

No trend data are shown as this is a new question



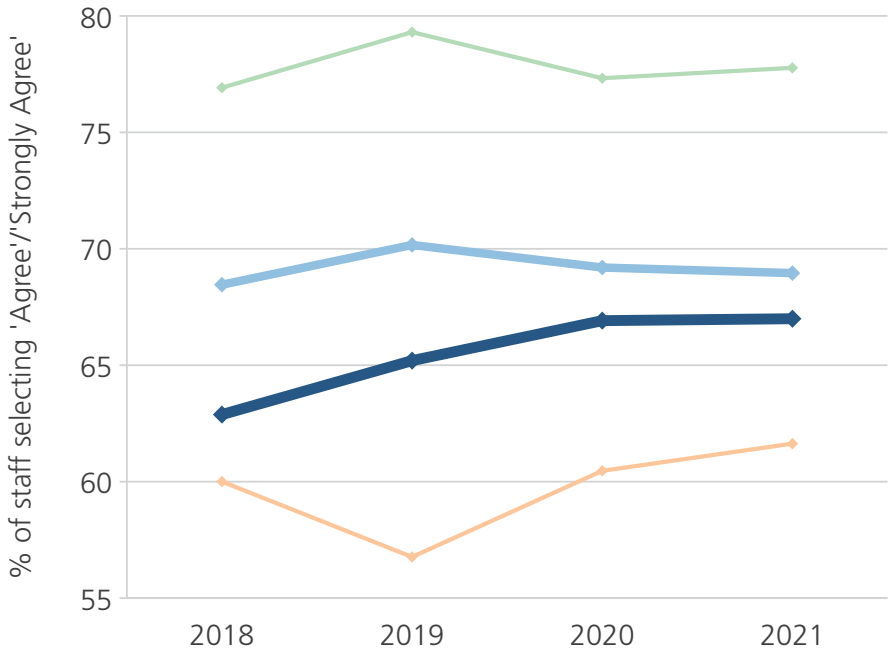

| | |
|---|---|
| **Best** | 70.6% |
| **Your org** | 49.8% |
| **Average** | 52.2% |
| **Worst** | 39.1% |
| **Responses** | 4,909 |

Survey Coordination Centre

# 2021 NHS Staff Survey Results > People Promise and theme results > Detailed information > **We are a team** – Line management

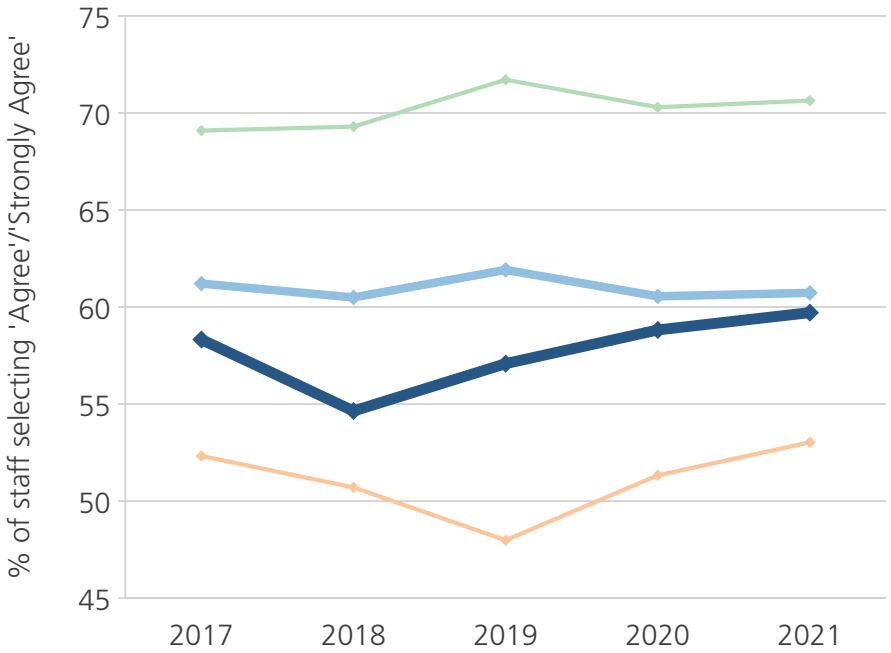
NHS

**Q9a**
My immediate manager encourages me at work




| | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|
| **Best** | 76.9% | 79.3% | 77.3% | 77.8% |
| **Your org** | 62.9% | 65.2% | 66.9% | 67.0% |
| **Average** | 68.5% | 70.2% | 69.2% | 69.0% |
| **Worst** | 60.0% | 56.8% | 60.5% | 61.6% |
| **Responses** | 4,355 | 4,831 | 4,962 | 4,889 |

**Q9b**
My immediate manager gives me clear feedback on my work



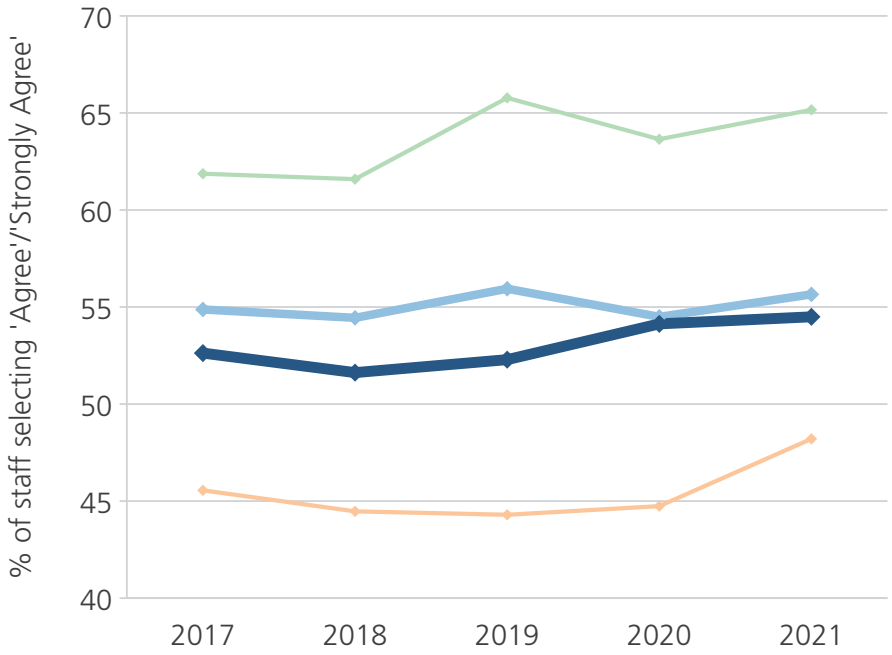

| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| **Best** | 69.1% | 69.3% | 71.7% | 70.3% | 70.6% |
| **Your org** | 58.3% | 54.6% | 57.1% | 58.8% | 59.7% |
| **Average** | 61.2% | 60.5% | 61.9% | 60.6% | 60.7% |
| **Worst** | 52.3% | 50.7% | 48.0% | 51.3% | 53.0% |
| **Responses** | 4,139 | 4,355 | 4,832 | 4,962 | 4,886 |

Survey Coordination Centre

# 2021 NHS Staff Survey Results > People Promise and theme results > Detailed information > **We are a team** – Line management

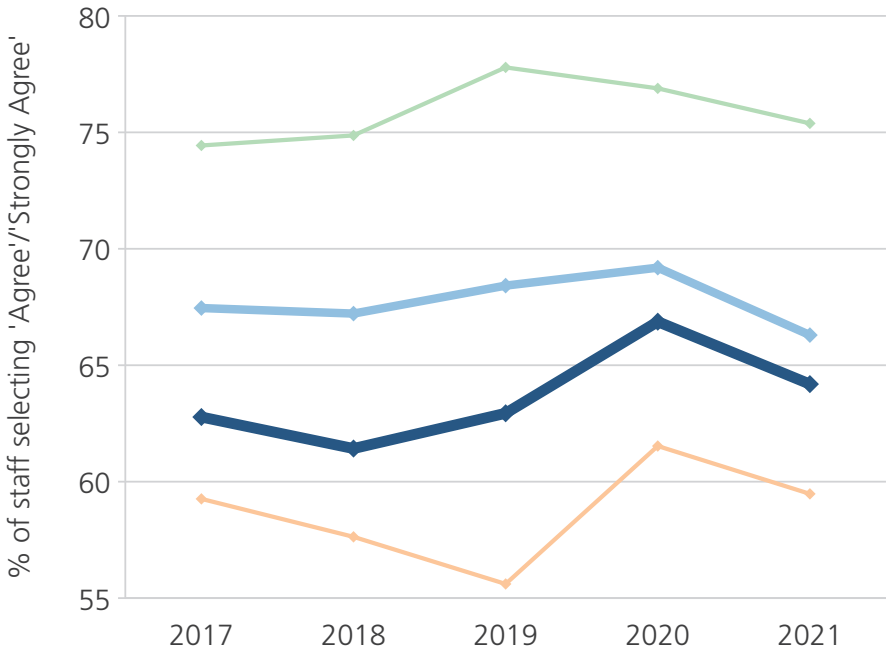
NHS

**Q9c**
My immediate manager asks for my opinion before making decisions that affect my work




| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| **Best** | 61.9% | 61.6% | 65.8% | 63.6% | 65.2% |
| **Your org** | 52.6% | 51.6% | 52.3% | 54.1% | 54.5% |
| **Average** | 54.9% | 54.4% | 55.9% | 54.5% | 55.7% |
| **Worst** | 45.6% | 44.5% | 44.3% | 44.7% | 48.2% |
| **Responses** | 4,136 | 4,348 | 4,831 | 4,959 | 4,890 |

**Q9d**
My immediate manager takes a positive interest in my health and well-being




| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| **Best** | 74.4% | 74.9% | 77.8% | 76.9% | 75.4% |
| **Your org** | 62.8% | 61.4% | 62.9% | 66.9% | 64.2% |
| **Average** | 67.5% | 67.2% | 68.4% | 69.2% | 66.3% |
| **Worst** | 59.3% | 57.6% | 55.6% | 61.5% | 59.5% |
| **Responses** | 4,143 | 4,356 | 4,831 | 4,965 | 4,893 |

Survey Coordination Centre

NHS

# Theme detailed information – Staff Engagement

**Questions:**

Q2a, Q2b, Q2c
Q3c, Q3d, Q3f
Q21a, Q21c, Q21d

St George's University Hospitals NHS Foundation Trust

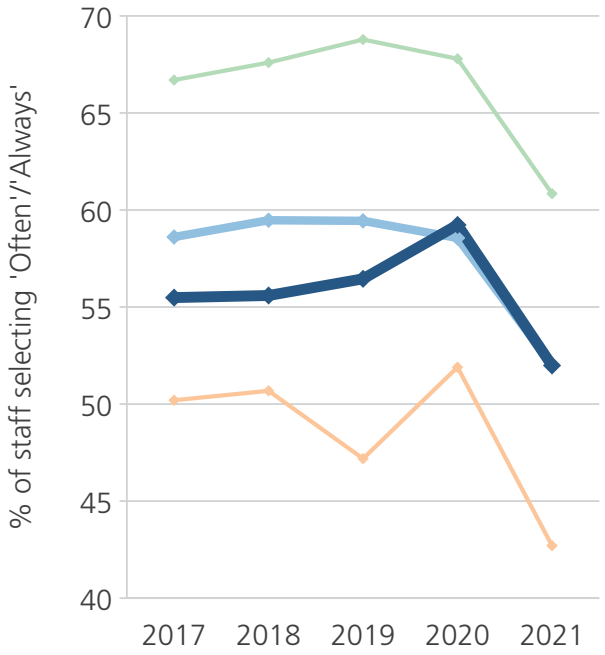
2021 NHS Staff Survey Results

Survey Coordination Centre

# 2021 NHS Staff Survey Results > People Promise and theme results > Detailed information > **Staff Engagement** – Motivation

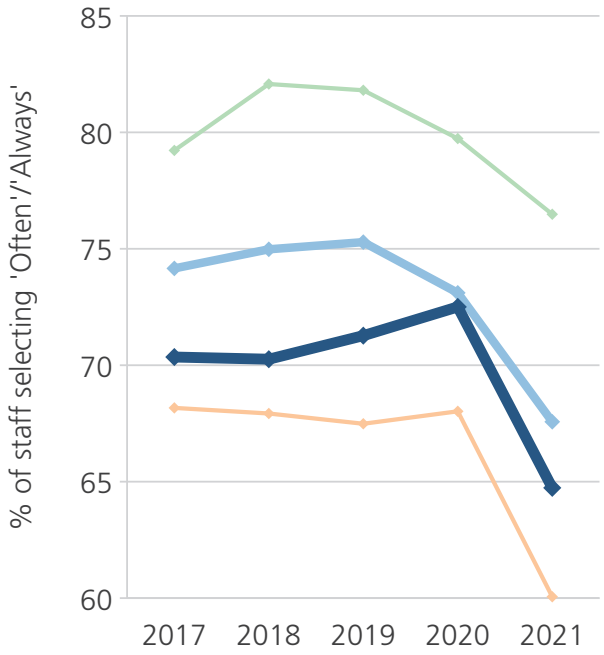
NHS

**Q2a**
I look forward to going to work



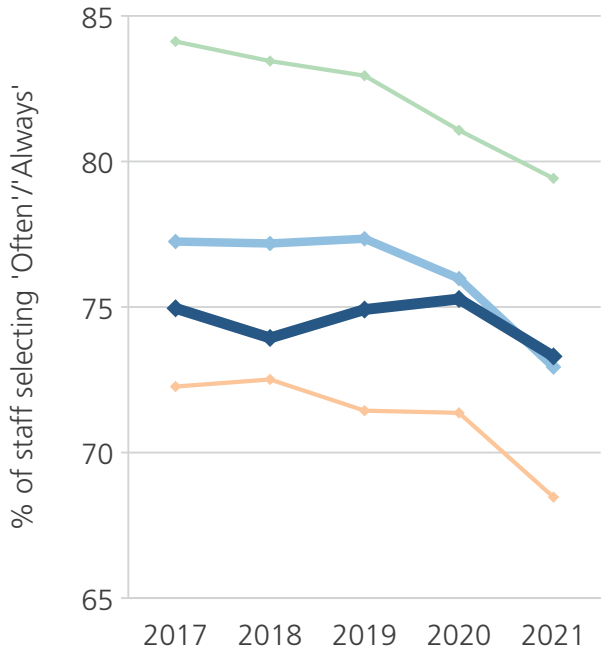

| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| **Best** | 66.7% | 67.6% | 68.8% | 67.8% | 60.8% |
| **Your org** | 55.5% | 55.6% | 56.5% | 59.2% | 52.0% |
| **Average** | 58.6% | 59.5% | 59.4% | 58.6% | 52.0% |
| **Worst** | 50.2% | 50.7% | 47.2% | 51.9% | 42.7% |
| **Responses** | 4,264 | 4,422 | 4,865 | 5,058 | 4,973 |

**Q2b**
I am enthusiastic about my job




| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| **Best** | 79.2% | 82.1% | 81.8% | 79.7% | 76.5% |
| **Your org** | 70.4% | 70.3% | 71.3% | 72.5% | 64.7% |
| **Average** | 74.2% | 75.0% | 75.3% | 73.1% | 67.6% |
| **Worst** | 68.2% | 67.9% | 67.5% | 68.0% | 60.1% |
| **Responses** | 4,189 | 4,365 | 4,838 | 5,020 | 4,943 |

**Q2c**
Time passes quickly when I am working



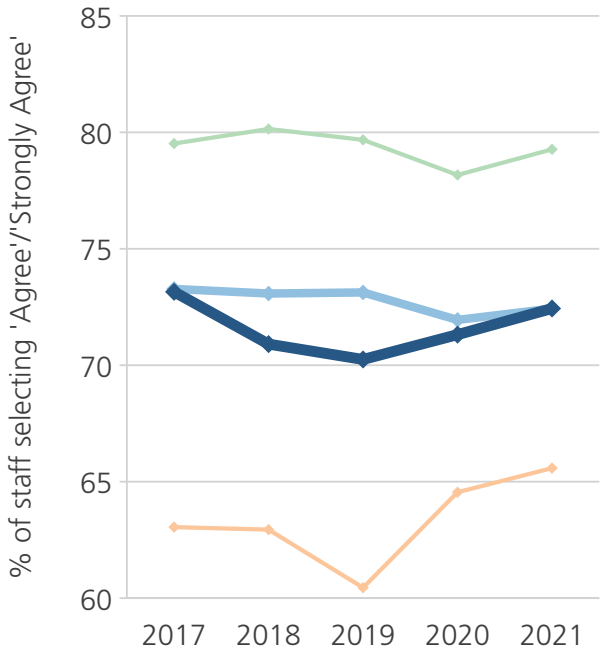

| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| **Best** | 84.1% | 83.4% | 82.9% | 81.1% | 79.4% |
| **Your org** | 75.0% | 73.9% | 74.9% | 75.3% | 73.3% |
| **Average** | 77.2% | 77.2% | 77.3% | 76.0% | 72.9% |
| **Worst** | 72.3% | 72.5% | 71.4% | 71.4% | 68.5% |
| **Responses** | 4,181 | 4,349 | 4,840 | 5,032 | 4,943 |

Survey Coordination Centre

# 2021 NHS Staff Survey Results > People Promise and theme results > Detailed information > **Staff Engagement** – Involvement

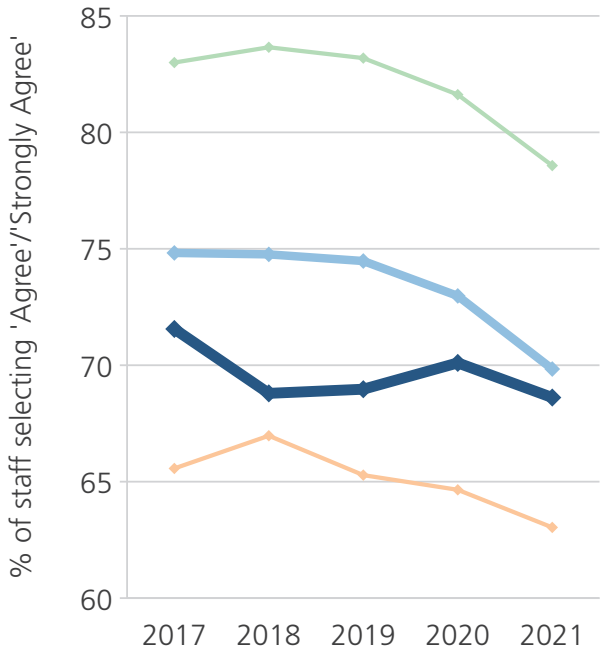
NHS

**Q3c**
There are frequent opportunities for me to show initiative in my role



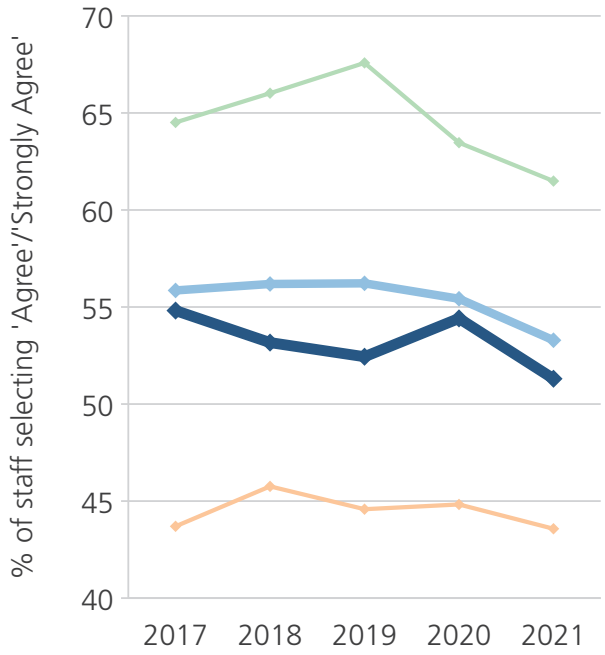

| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| Best | 79.5% | 80.1% | 79.7% | 78.2% | 79.3% |
| Your org | 73.2% | 70.9% | 70.2% | 71.3% | 72.4% |
| Average | 73.3% | 73.1% | 73.1% | 71.9% | 72.4% |
| Worst | 63.0% | 62.9% | 60.4% | 64.5% | 65.6% |
| Responses | 4,277 | 4,457 | 4,893 | 5,017 | 4,960 |

**Q3d**
I am able to make suggestions to improve the work of my team / department




| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| Best | 83.0% | 83.7% | 83.2% | 81.6% | 78.6% |
| Your org | 71.6% | 68.8% | 69.0% | 70.1% | 68.6% |
| Average | 74.8% | 74.8% | 74.5% | 73.0% | 69.8% |
| Worst | 65.6% | 67.0% | 65.3% | 64.7% | 63.0% |
| Responses | 4,271 | 4,454 | 4,896 | 5,017 | 4,959 |

**Q3f**
I am able to make improvements happen in my area of work



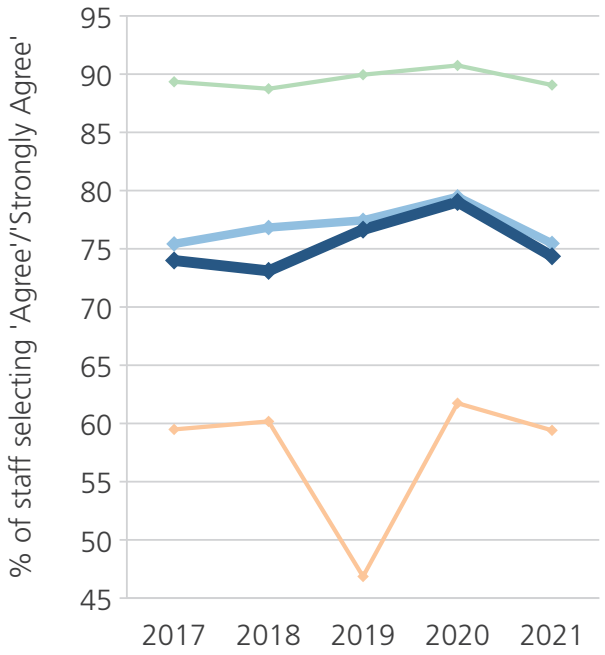

| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| Best | 64.5% | 66.0% | 67.6% | 63.5% | 61.5% |
| Your org | 54.8% | 53.2% | 52.4% | 54.4% | 51.3% |
| Average | 55.9% | 56.2% | 56.2% | 55.4% | 53.3% |
| Worst | 43.7% | 45.8% | 44.6% | 44.8% | 43.6% |
| Responses | 4,258 | 4,438 | 4,878 | 5,006 | 4,949 |

Survey Coordination Centre

# 2021 NHS Staff Survey Results > People Promise and theme results > Detailed information > **Staff Engagement** – Advocacy

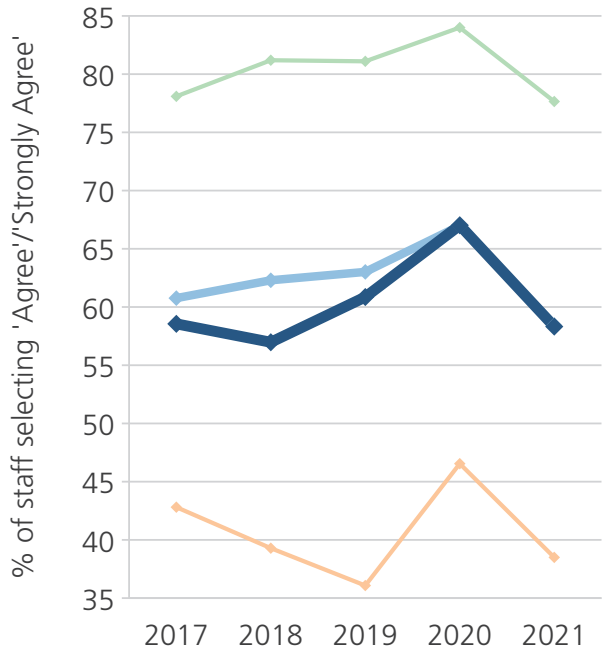
NHS

**Q21a**
Care of patients / service users is my organisation's top priority



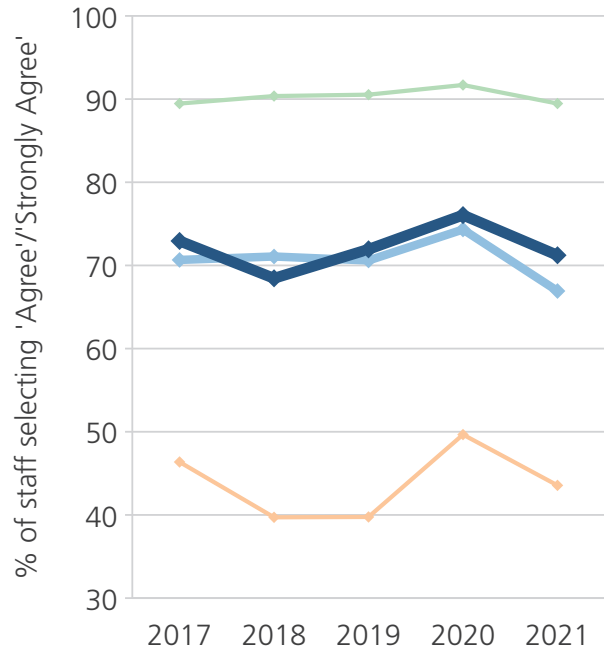

| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| Best | 89.3% | 88.7% | 90.0% | 90.7% | 89.1% |
| Your org | 74.0% | 73.1% | 76.6% | 79.0% | 74.4% |
| Average | 75.4% | 76.8% | 77.4% | 79.5% | 75.5% |
| Worst | 59.5% | 60.2% | 46.9% | 61.7% | 59.4% |
| Responses | 4,023 | 4,270 | 4,759 | 4,889 | 4,825 |

**Q21c**
I would recommend my organisation as a place to work




| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| Best | 78.1% | 81.2% | 81.1% | 84.0% | 77.6% |
| Your org | 58.6% | 57.0% | 60.9% | 67.0% | 58.3% |
| Average | 60.8% | 62.3% | 63.0% | 67.0% | 58.4% |
| Worst | 42.8% | 39.3% | 36.1% | 46.5% | 38.5% |
| Responses | 4,016 | 4,271 | 4,752 | 4,872 | 4,825 |

**Q21d**
If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation




| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| Best | 89.5% | 90.4% | 90.5% | 91.7% | 89.5% |
| Your org | 72.9% | 68.5% | 71.9% | 76.1% | 71.2% |
| Average | 70.7% | 71.1% | 70.6% | 74.3% | 66.9% |
| Worst | 46.4% | 39.7% | 39.8% | 49.7% | 43.6% |
| Responses | 4,003 | 4,252 | 4,753 | 4,884 | 4,828 |

Survey Coordination Centre

NHS

# Theme detailed information – Morale

**Questions:**

Q22a, Q22b, Q22c
Q3g, Q3h, Q3i
Q3a, Q3e, Q5a, Q5b, Q5c, Q7c, Q9a

St George's University Hospitals NHS Foundation Trust

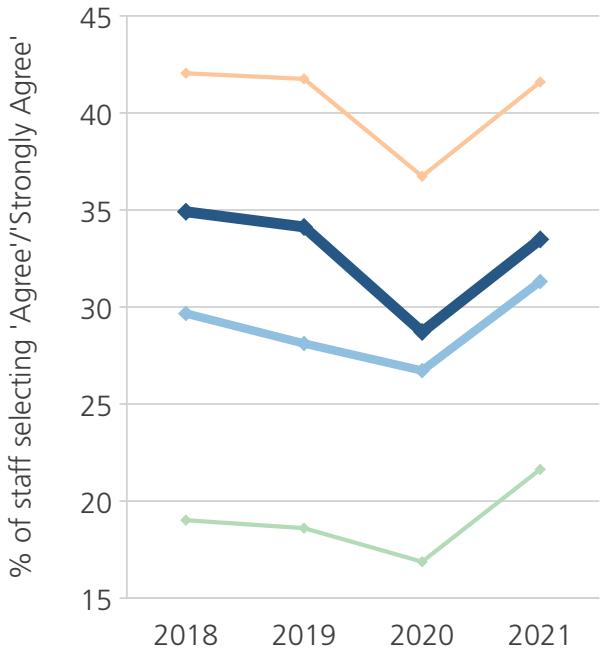
2021 NHS Staff Survey Results

Survey Coordination Centre

# 2021 NHS Staff Survey Results > People Promise and theme results > Detailed information > **Morale** – Thinking about leaving

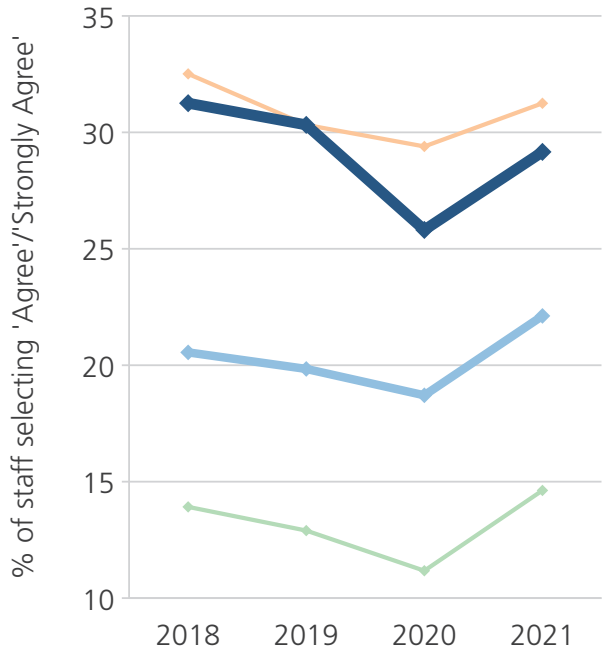
NHS

**Q22a**
I often think about leaving this organisation



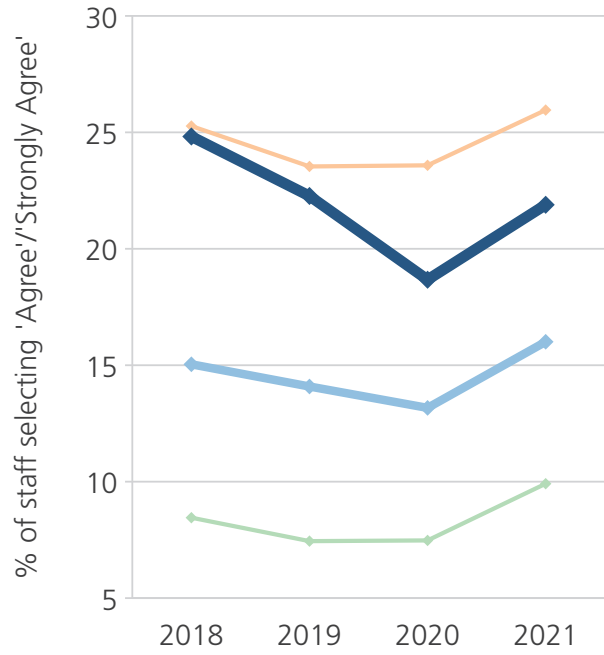

| | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|
| Worst | 42.0% | 41.8% | 36.7% | 41.6% |
| Your org | 34.9% | 34.1% | 28.7% | 33.5% |
| Average | 29.7% | 28.1% | 26.7% | 31.3% |
| Best | 19.0% | 18.6% | 16.9% | 21.6% |
| Responses | 4,282 | 4,753 | 4,882 | 4,794 |

**Q22b**
I will probably look for a job at a new organisation in the next 12 months




| | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|
| Worst | 32.5% | 30.3% | 29.4% | 31.2% |
| Your org | 31.3% | 30.3% | 25.8% | 29.2% |
| Average | 20.6% | 19.8% | 18.7% | 22.1% |
| Best | 13.9% | 12.9% | 11.2% | 14.6% |
| Responses | 4,274 | 4,747 | 4,881 | 4,791 |

**Q22c**
As soon as I can find another job, I will leave this organisation



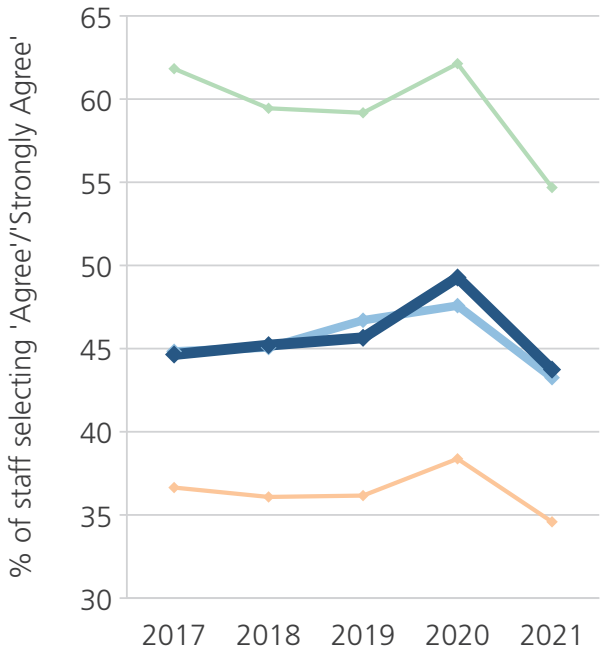

| | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|
| Worst | 25.3% | 23.5% | 23.6% | 26.0% |
| Your org | 24.8% | 22.3% | 18.7% | 21.9% |
| Average | 15.0% | 14.1% | 13.2% | 16.0% |
| Best | 8.5% | 7.4% | 7.5% | 9.9% |
| Responses | 4,099 | 4,736 | 4,882 | 4,785 |

Survey Coordination Centre

# 2021 NHS Staff Survey Results > People Promise and theme results > Detailed information > **Morale** – Work pressure

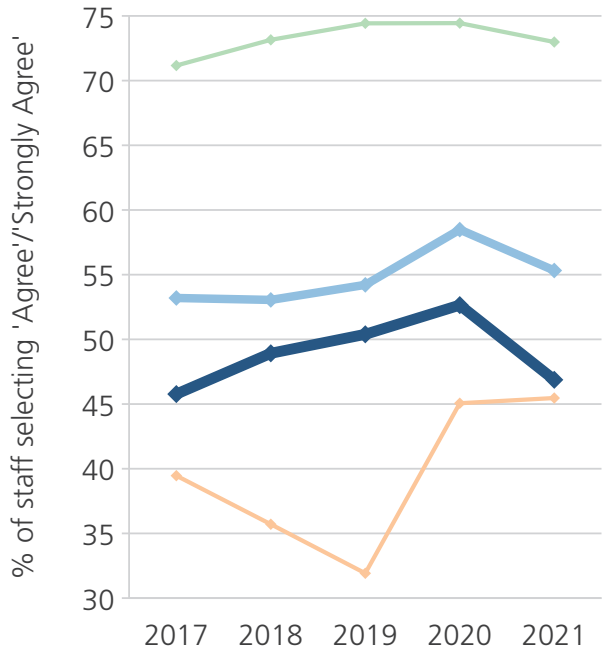
NHS

**Q3g**
I am able to meet all the conflicting demands on my time at work



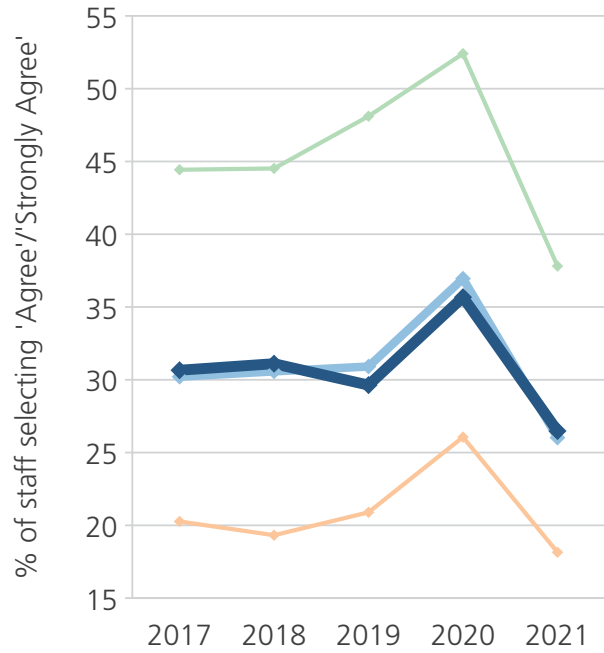

| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| **Best** | 61.8% | 59.4% | 59.2% | 62.1% | 54.7% |
| **Your org** | 44.6% | 45.2% | 45.6% | 49.3% | 43.7% |
| **Average** | 44.8% | 45.1% | 46.7% | 47.6% | 43.3% |
| **Worst** | 36.6% | 36.1% | 36.2% | 38.4% | 34.6% |
| **Responses** | 4,246 | 4,427 | 4,864 | 4,987 | 4,940 |

**Q3h**
I have adequate materials, supplies and equipment to do my work




| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| **Best** | 71.2% | 73.2% | 74.4% | 74.4% | 73.0% |
| **Your org** | 45.8% | 48.9% | 50.4% | 52.6% | 46.9% |
| **Average** | 53.2% | 53.0% | 54.2% | 58.5% | 55.3% |
| **Worst** | 39.5% | 35.7% | 31.9% | 45.1% | 45.5% |
| **Responses** | 4,249 | 4,420 | 4,862 | 5,006 | 4,951 |

**Q3i**
There are enough staff at this organisation for me to do my job properly



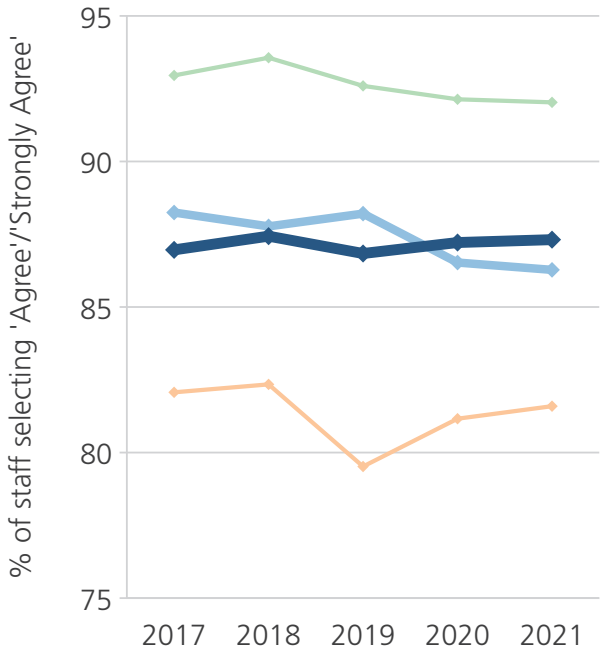

| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| **Best** | 44.4% | 44.5% | 48.1% | 52.4% | 37.8% |
| **Your org** | 30.7% | 31.1% | 29.6% | 35.7% | 26.5% |
| **Average** | 30.2% | 30.6% | 30.9% | 36.9% | 26.0% |
| **Worst** | 20.3% | 19.3% | 20.9% | 26.1% | 18.2% |
| **Responses** | 4,255 | 4,441 | 4,878 | 5,008 | 4,955 |

Survey Coordination Centre

# 2021 NHS Staff Survey Results > People Promise and theme results > Detailed information > **Morale** – Stressors

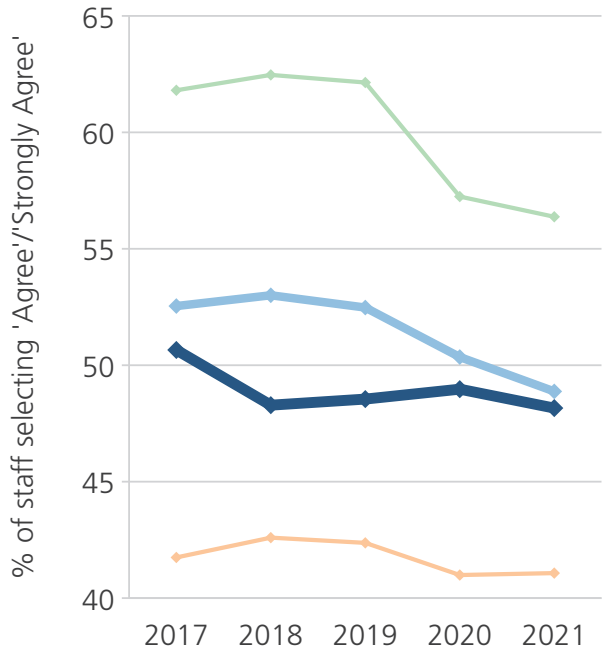
NHS

**Q3a**
I always know what my work responsibilities are



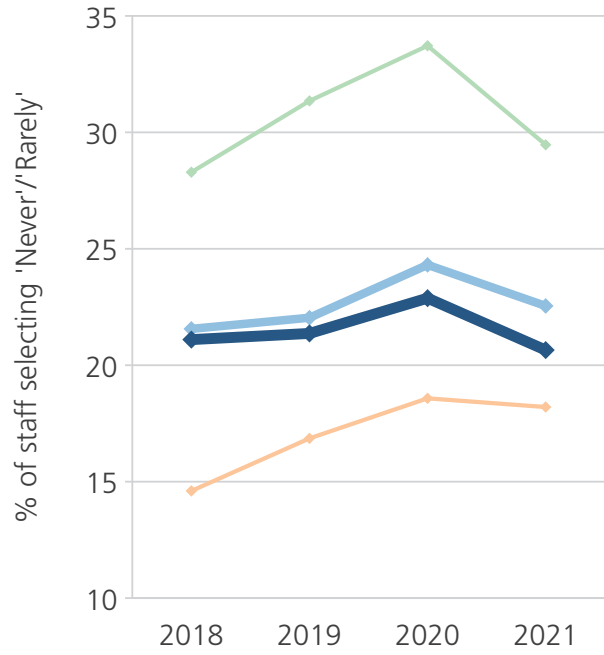

| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| Best | 93.0% | 93.6% | 92.6% | 92.1% | 92.0% |
| Your org | 87.0% | 87.4% | 86.8% | 87.2% | 87.3% |
| Average | 88.2% | 87.8% | 88.2% | 86.5% | 86.3% |
| Worst | 82.1% | 82.3% | 79.5% | 81.2% | 81.6% |
| Responses | 4,279 | 4,450 | 4,876 | 5,059 | 4,954 |

**Q3e**
I am involved in deciding on changes introduced that affect my work area / team / department




| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| Best | 61.8% | 62.5% | 62.1% | 57.2% | 56.4% |
| Your org | 50.7% | 48.3% | 48.5% | 49.0% | 48.2% |
| Average | 52.5% | 53.0% | 52.5% | 50.4% | 48.9% |
| Worst | 41.7% | 42.6% | 42.4% | 41.0% | 41.1% |
| Responses | 4,272 | 4,447 | 4,884 | 5,018 | 4,959 |

**Q5a**
I have unrealistic time pressures



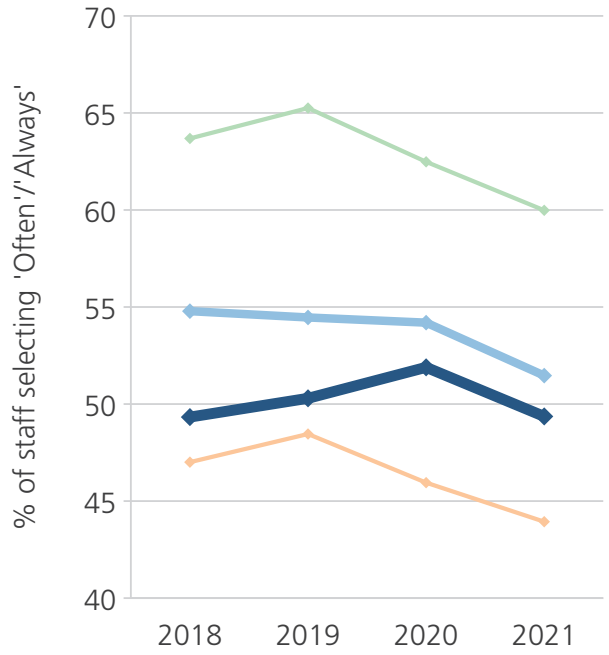

| | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|
| Best | 28.3% | 31.3% | 33.7% | 29.5% |
| Your org | 21.1% | 21.4% | 22.9% | 20.7% |
| Average | 21.6% | 22.0% | 24.3% | 22.5% |
| Worst | 14.6% | 16.9% | 18.6% | 18.2% |
| Responses | 4,401 | 4,814 | 4,981 | 4,925 |

Survey Coordination Centre

# 2021 NHS Staff Survey Results > People Promise and theme results > Detailed information > **Morale** – Stressors

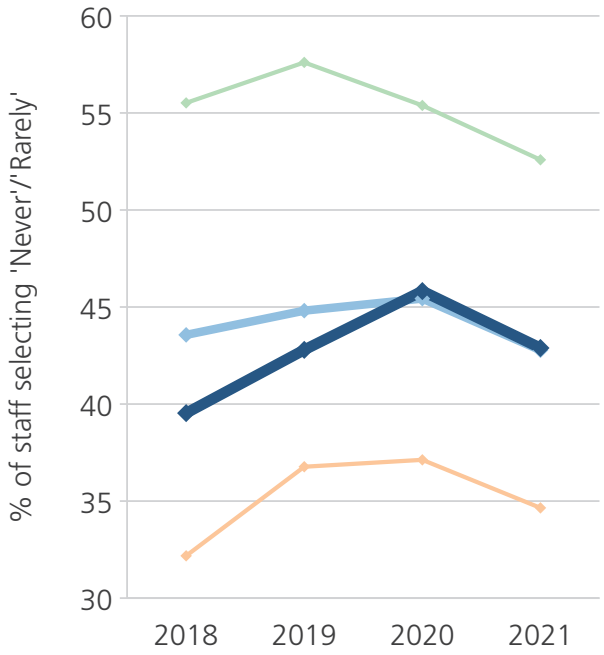
NHS

**Q5b**
I have a choice in deciding how to do my work



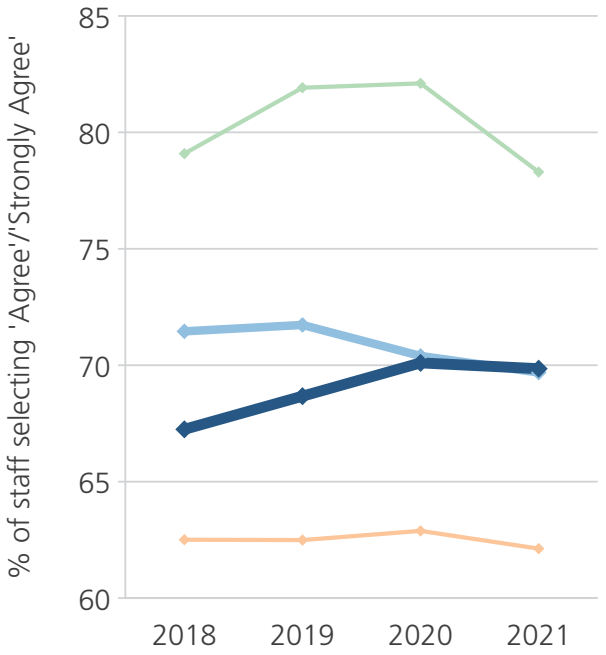

| | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|
| **Best** | 63.7% | 65.3% | 62.5% | 60.0% |
| **Your org** | 49.3% | 50.3% | 51.9% | 49.4% |
| **Average** | 54.8% | 54.5% | 54.2% | 51.5% |
| **Worst** | 47.0% | 48.5% | 45.9% | 43.9% |
| **Responses** | 4,393 | 4,816 | 4,988 | 4,932 |

**Q5c**
Relationships at work are strained




| | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|
| **Best** | 55.5% | 57.6% | 55.4% | 52.6% |
| **Your org** | 39.5% | 42.8% | 45.8% | 42.9% |
| **Average** | 43.6% | 44.8% | 45.4% | 42.8% |
| **Worst** | 32.2% | 36.8% | 37.1% | 34.6% |
| **Responses** | 4,389 | 4,808 | 4,978 | 4,933 |

**Q7c**
I receive the respect I deserve from my colleagues at work




| | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|
| **Best** | 79.1% | 81.9% | 82.1% | 78.3% |
| **Your org** | 67.2% | 68.7% | 70.1% | 69.9% |
| **Average** | 71.5% | 71.7% | 70.4% | 69.7% |
| **Worst** | 62.5% | 62.5% | 62.9% | 62.1% |
| **Responses** | 4,446 | 4,888 | 5,010 | 4,921 |

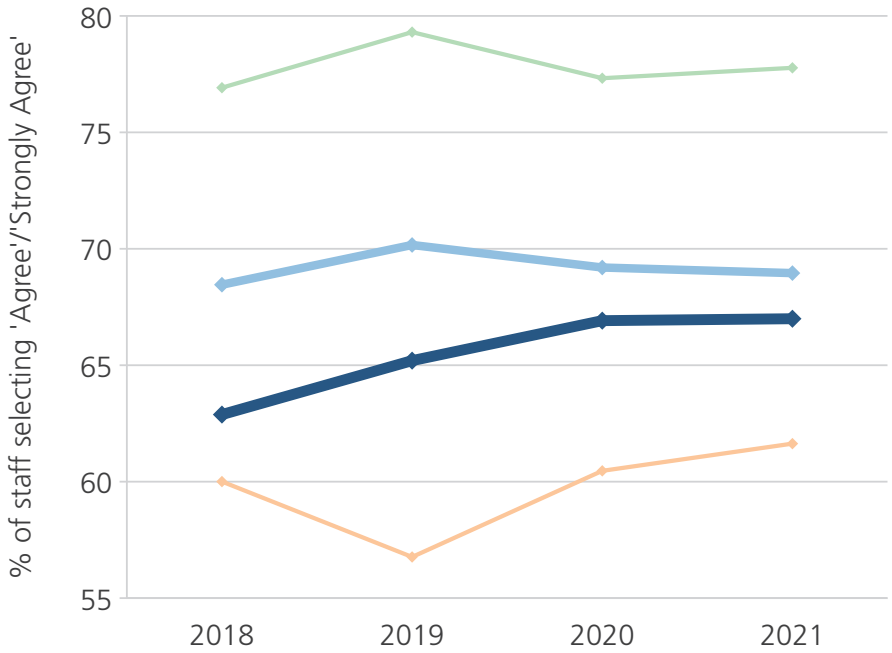
Survey Coordination Centre

# 2021 NHS Staff Survey Results > People Promise and theme results > Detailed information > **Morale** – Stressors

NHS

**Q9a**

My immediate manager encourages me at work




| | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|
| **Best** | 76.9% | 79.3% | 77.3% | 77.8% |
| **Your org** | 62.9% | 65.2% | 66.9% | 67.0% |
| **Average** | 68.5% | 70.2% | 69.2% | 69.0% |
| **Worst** | 60.0% | 56.8% | 60.5% | 61.6% |
| **Responses** | 4,355 | 4,831 | 4,962 | 4,889 |

Survey Coordination Centre

NHS

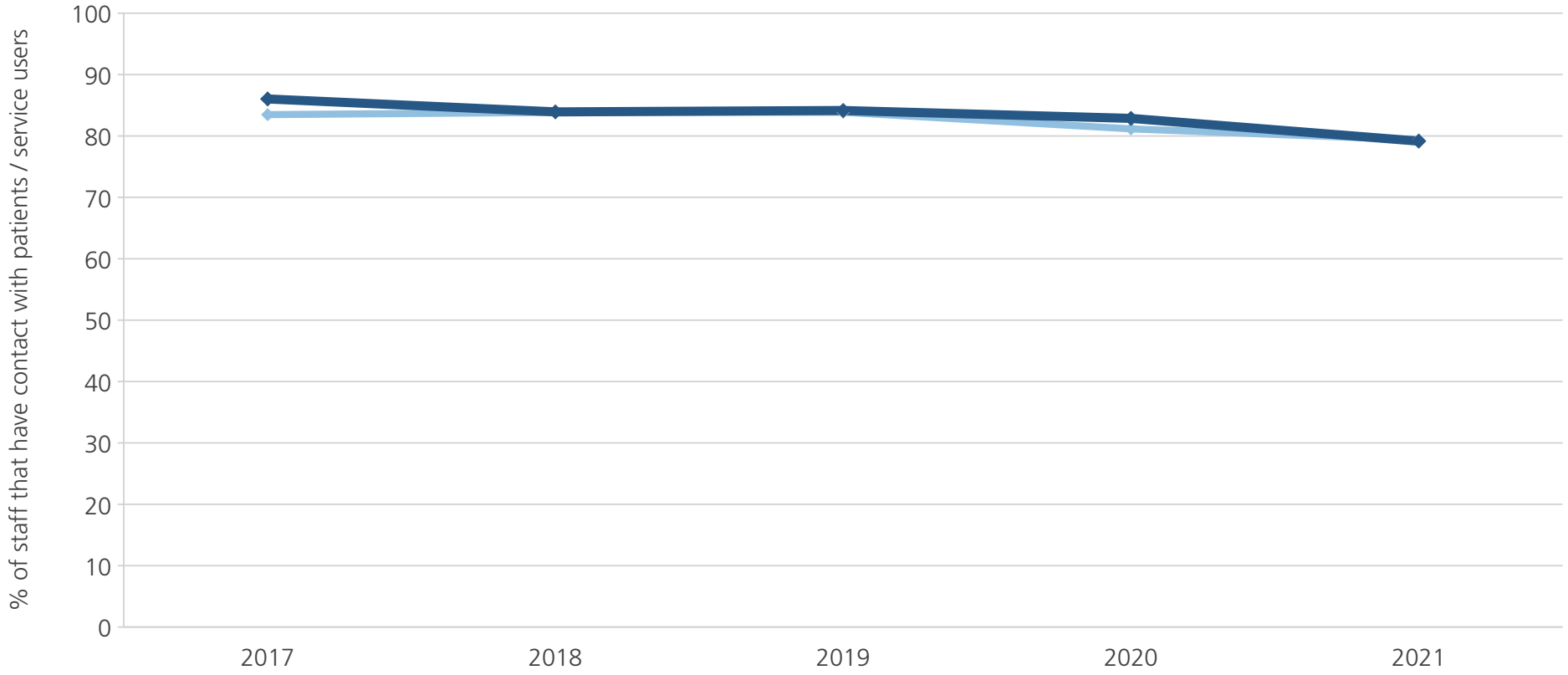
# Questions not linked to the People Promise elements or themes

St George's University Hospitals NHS Foundation Trust

2021 NHS Staff Survey Results

Survey Coordination Centre

# 2021 NHS Staff Survey Results > Questions not linked to the People Promise elements or themes > **Q1 >** Do you have face-to-face, video or telephone contact with patients / service users as part of your job?

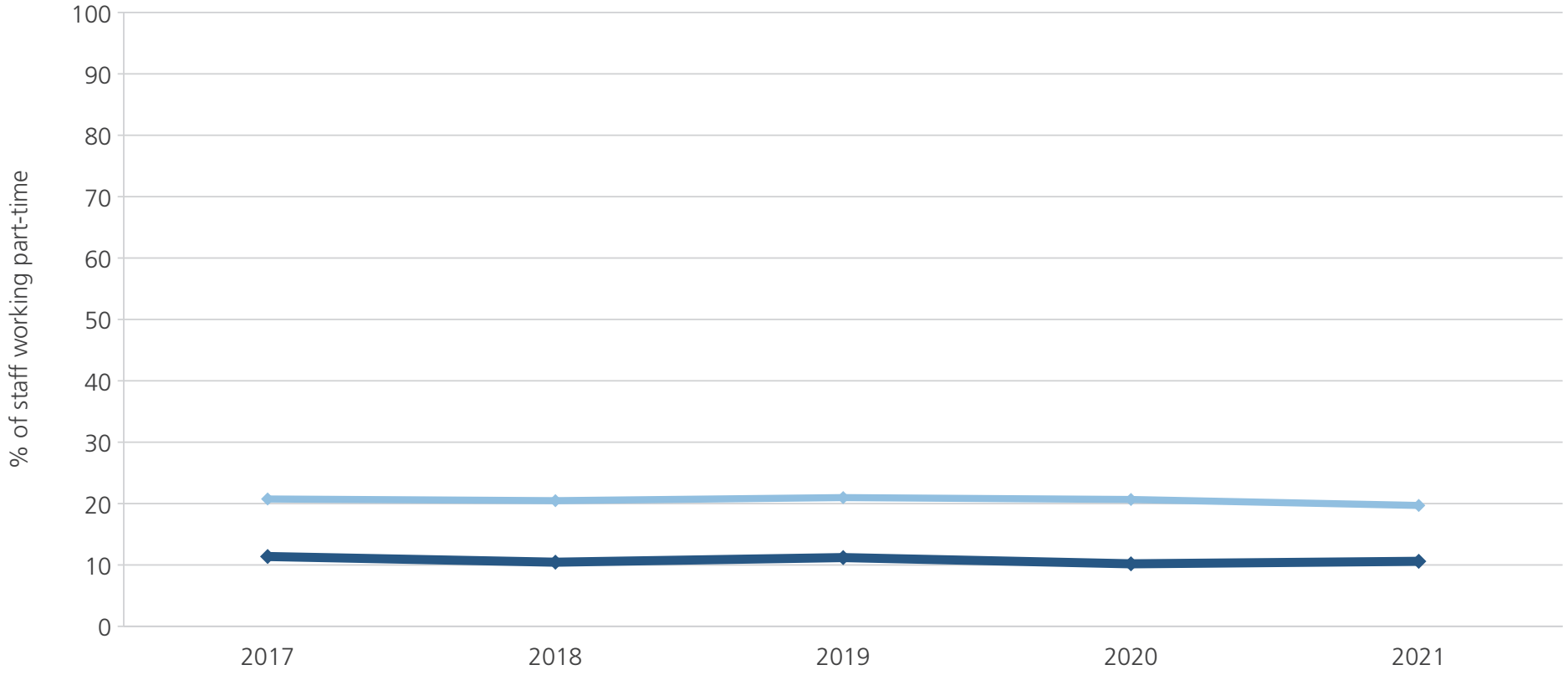



| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| **Your org** | 86.0% | 83.9% | 84.2% | 82.9% | 79.2% |
| **Average** | 83.5% | 83.8% | 83.9% | 81.2% | 79.4% |
| **Responses** | 3,980 | 4,317 | 4,909 | 5,089 | 4,985 |

Survey Coordination Centre

2021 NHS Staff Survey Results > Questions not linked to the People Promise elements or themes > **Q10a >** How many hours a week are you contracted to work?

NHS

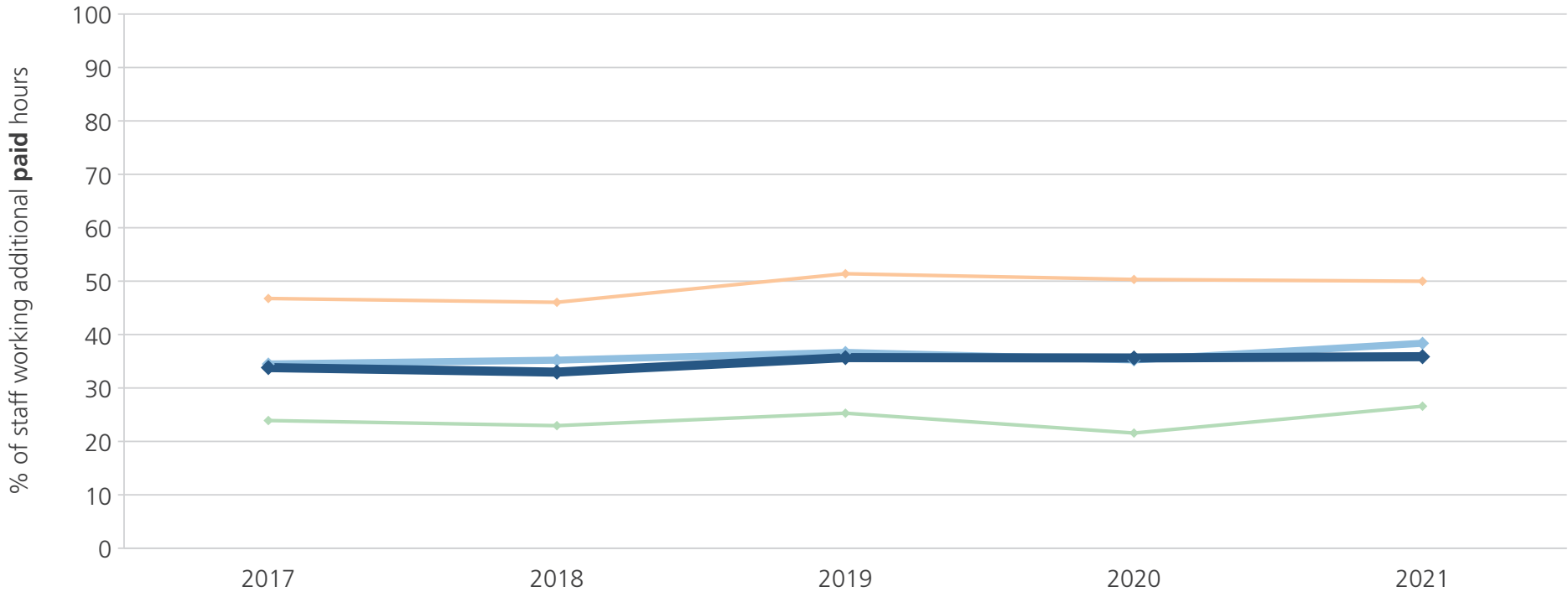



| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| **Your org** | 11.4% | 10.4% | 11.2% | 10.2% | 10.6% |
| **Average** | 20.7% | 20.5% | 21.0% | 20.7% | 19.7% |
| **Responses** | 4,079 | 4,307 | 4,785 | 4,889 | 4,786 |

Survey Coordination Centre

# 2021 NHS Staff Survey Results > Questions not linked to the People Promise elements or themes > **Q10b >** On average, how many additional PAID hours do you work per week for this organisation, over and above your contracted hours?

NHS

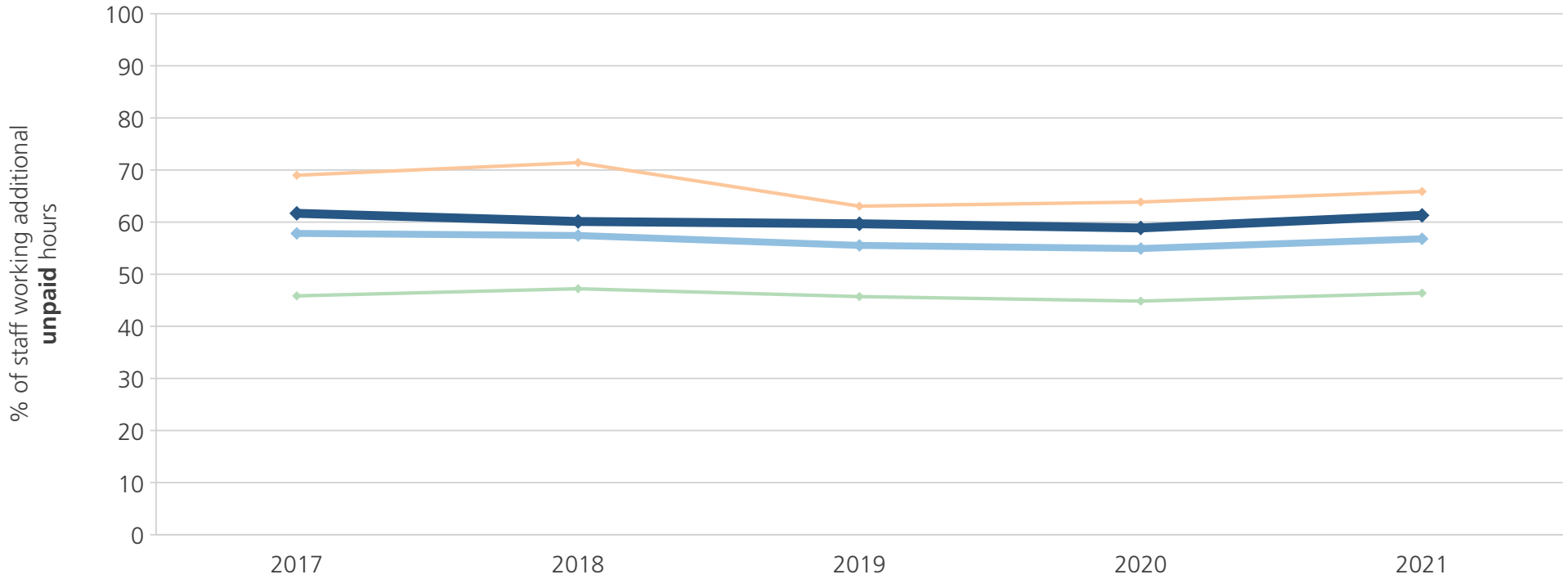



| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| **Highest** | 46.8% | 46.0% | 51.4% | 50.3% | 50.0% |
| **Your org** | 33.8% | 33.0% | 35.7% | 35.6% | 35.9% |
| **Average** | 34.5% | 35.2% | 36.7% | 35.2% | 38.4% |
| **Lowest** | 23.9% | 22.9% | 25.3% | 21.6% | 26.6% |
| **Responses** | 4,023 | 4,187 | 4,812 | 4,928 | 4,871 |

Survey Coordination Centre

## 2021 NHS Staff Survey Results > Questions not linked to the People Promise elements or themes > **Q10c >** On average, how many additional UNPAID hours do you work per week for this organisation, over and above your contracted hours?

NHS



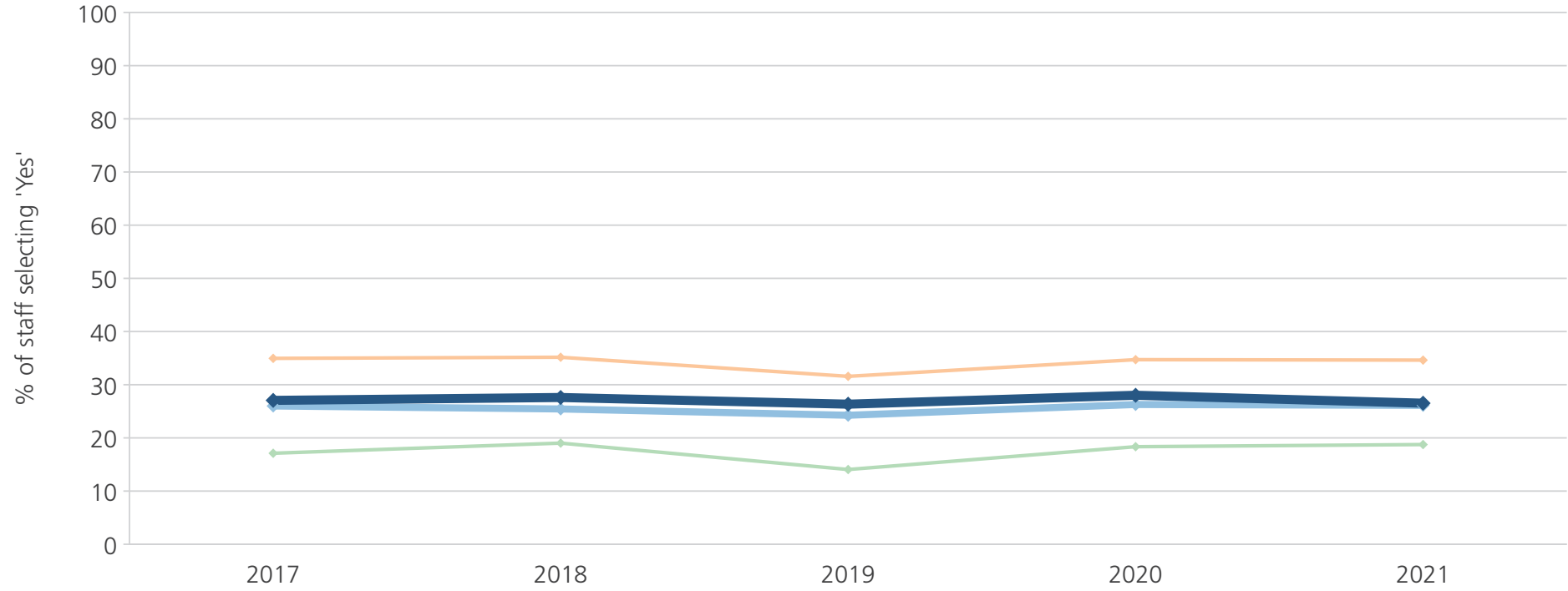

| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| **Highest** | 69.0% | 71.4% | 63.1% | 63.9% | 65.9% |
| **Your org** | 61.7% | 60.1% | 59.7% | 58.9% | 61.3% |
| **Average** | 57.8% | 57.4% | 55.5% | 54.9% | 56.8% |
| **Lowest** | 45.8% | 47.2% | 45.7% | 44.8% | 46.4% |
| **Responses** | 4,061 | 4,221 | 4,791 | 4,941 | 4,874 |

Survey Coordination Centre

# 2021 NHS Staff Survey Results > Questions not linked to the People Promise elements or themes > **Q11e >** Have you felt pressure from your manager to come to work?

NHS

This question was only answered by people who responded 'Yes' to Q11d.

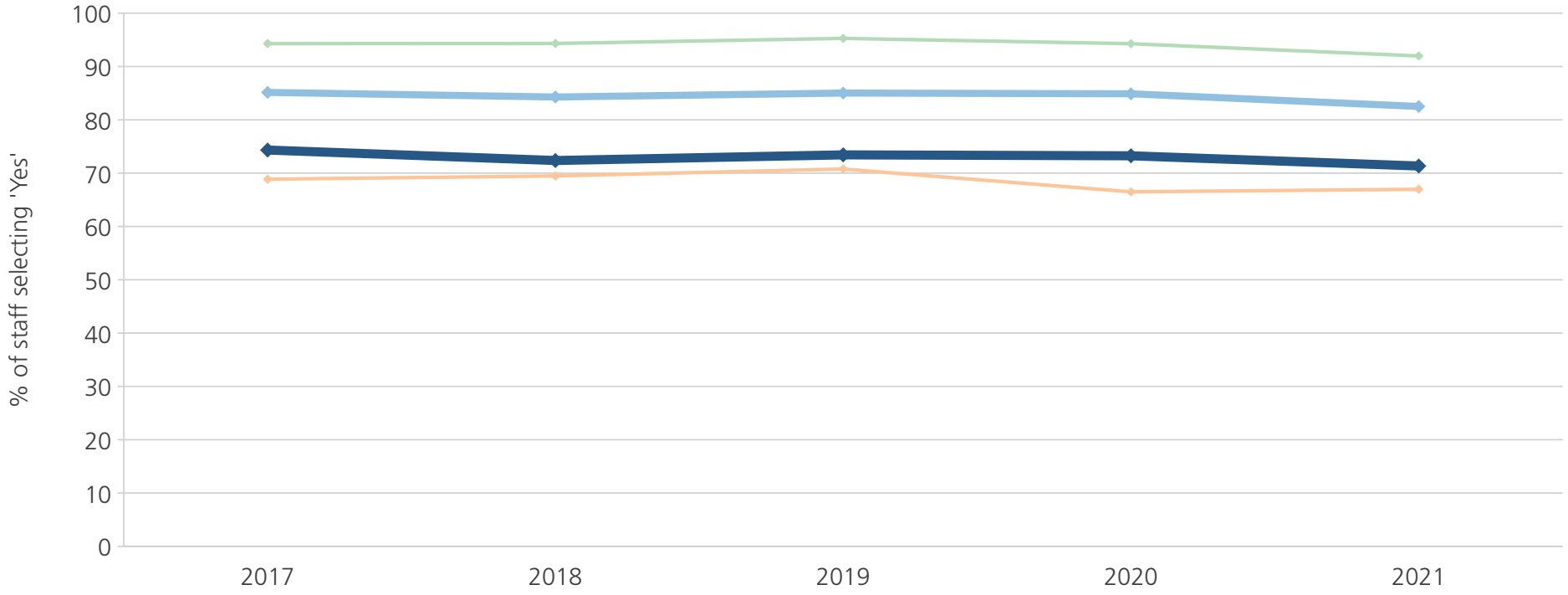



| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| **Worst** | 35.0% | 35.2% | 31.6% | 34.7% | 34.6% |
| **Your org** | 27.1% | 27.6% | 26.3% | 28.0% | 26.5% |
| **Average** | 26.0% | 25.4% | 24.3% | 26.3% | 26.1% |
| **Best** | 17.1% | 19.0% | 14.1% | 18.3% | 18.7% |
| **Responses** | 2,328 | 2,416 | 2,829 | 2,237 | 2,702 |

Survey Coordination Centre

2021 NHS Staff Survey Results > Questions not linked to the People Promise elements or themes > **Q15 (historical calculation) >** Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?

NHS

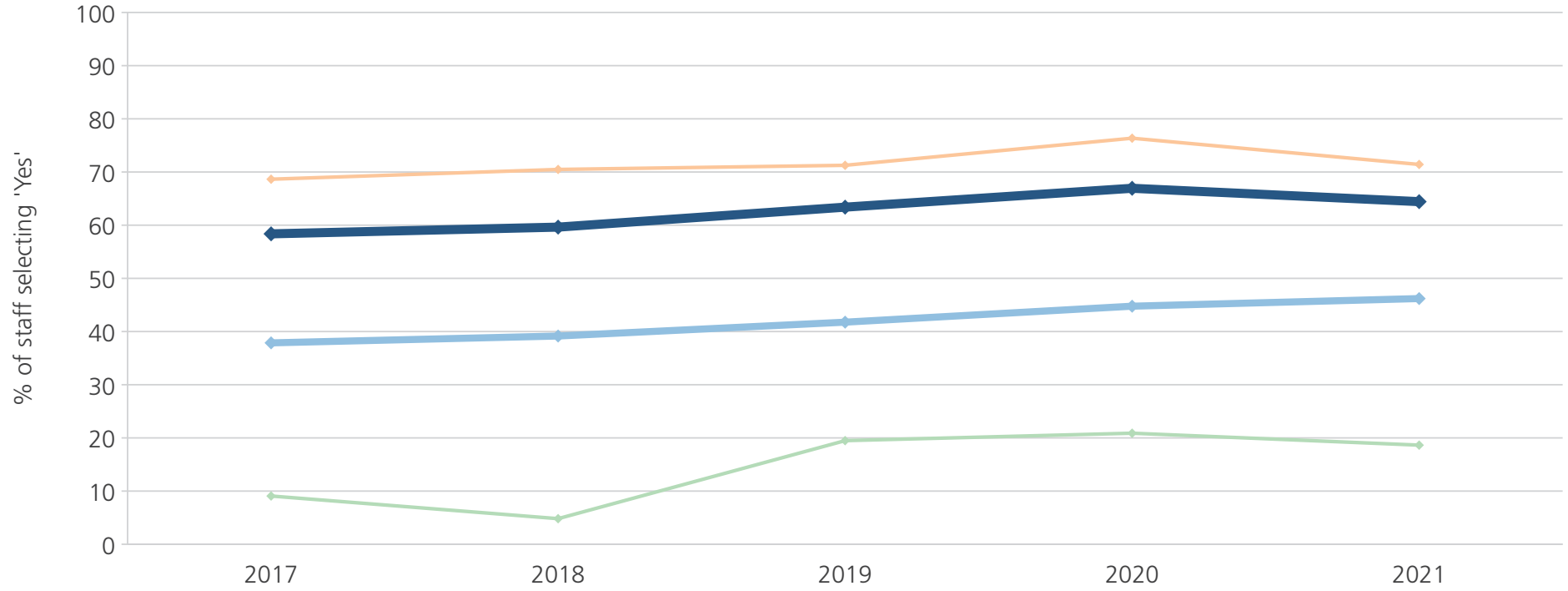



| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| **Best** | 94.3% | 94.3% | 95.3% | 94.3% | 92.0% |
| **Your org** | 74.3% | 72.4% | 73.4% | 73.3% | 71.3% |
| **Average** | 85.1% | 84.3% | 85.0% | 84.9% | 82.5% |
| **Worst** | 68.9% | 69.5% | 70.8% | 66.5% | 67.0% |
| **Responses** | 2,859 | 2,810 | 3,137 | 3,234 | 3,148 |

Please note: The approach to calculating the results for Q15 has changed for 2021, to include 'don't know' responses. These results feed into the Diversity and equality sub-score and the We are compassionate and inclusive promise element, as well as the WRES and WDES indicators. The Q15 results based on the historic calculation are reported in this section for transparency, but do not feed into any measure.

Survey Coordination Centre

# 2021 NHS Staff Survey Results > Questions not linked to the People Promise elements or themes > **Q16c.1 >** On what grounds have you experienced discrimination? - Ethnic background




| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| **Worst** | 68.6% | 70.5% | 71.3% | 76.4% | 71.4% |
| **Your org** | 58.4% | 59.6% | 63.4% | 66.9% | 64.4% |
| **Average** | 37.9% | 39.2% | 41.8% | 44.8% | 46.2% |
| **Best** | 9.1% | 4.8% | 19.5% | 20.9% | 18.6% |
| **Responses** | 773 | 806 | 918 | 955 | 923 |

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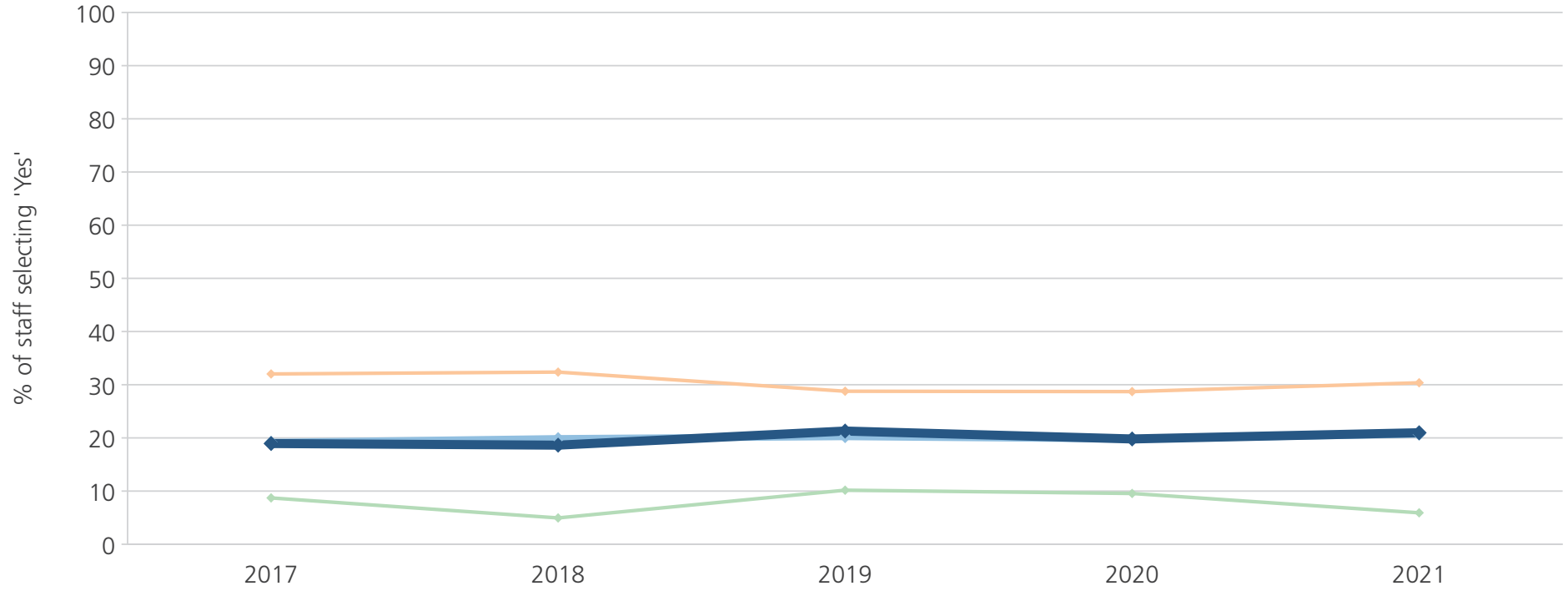
Survey Coordination Centre

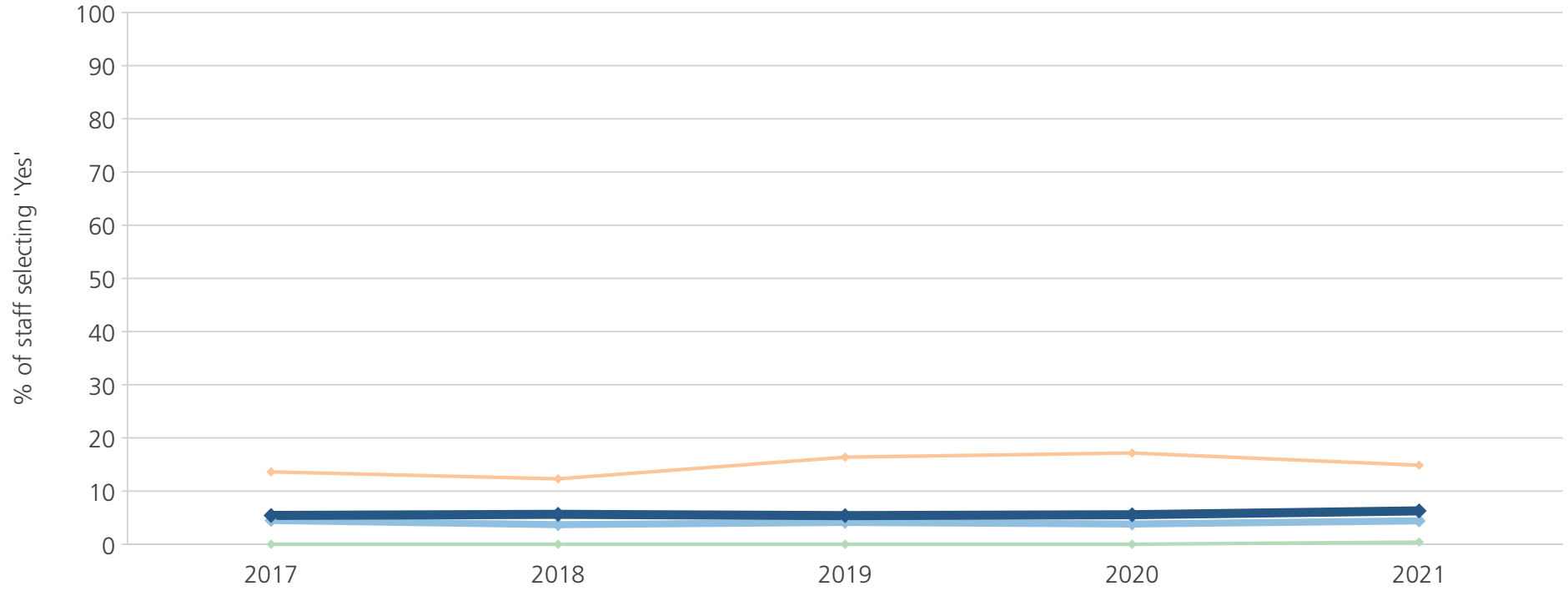
# 2021 NHS Staff Survey Results > Questions not linked to the People Promise elements or themes > **Q16c.2 >** On what grounds have you experienced discrimination? - Gender




| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| **Worst** | 32.0% | 32.4% | 28.8% | 28.7% | 30.4% |
| **Your org** | 18.9% | 18.6% | 21.3% | 19.8% | 21.0% |
| **Average** | 19.2% | 19.9% | 20.2% | 19.8% | 20.7% |
| **Best** | 8.7% | 4.9% | 10.2% | 9.6% | 5.9% |
| **Responses** | 773 | 806 | 918 | 955 | 923 |

Survey Coordination Centre

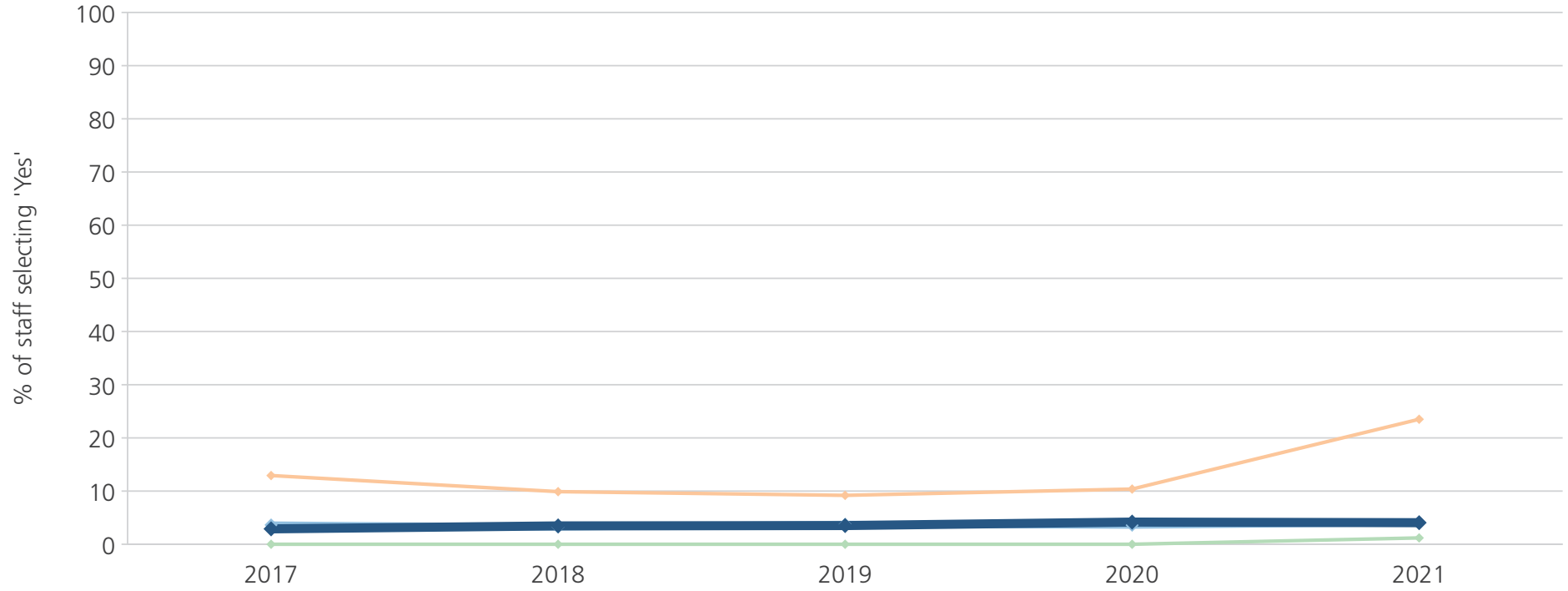
# 2021 NHS Staff Survey Results > Questions not linked to the People Promise elements or themes > **Q16c.3 >** On what grounds have you experienced discrimination? - Religion




| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| **Worst** | 13.6% | 12.3% | 16.4% | 17.2% | 14.9% |
| **Your org** | 5.4% | 5.6% | 5.4% | 5.6% | 6.3% |
| **Average** | 4.5% | 3.7% | 4.1% | 3.8% | 4.4% |
| **Best** | 0.0% | 0.0% | 0.0% | 0.0% | 0.4% |
| **Responses** | 773 | 806 | 918 | 955 | 923 |

Survey Coordination Centre

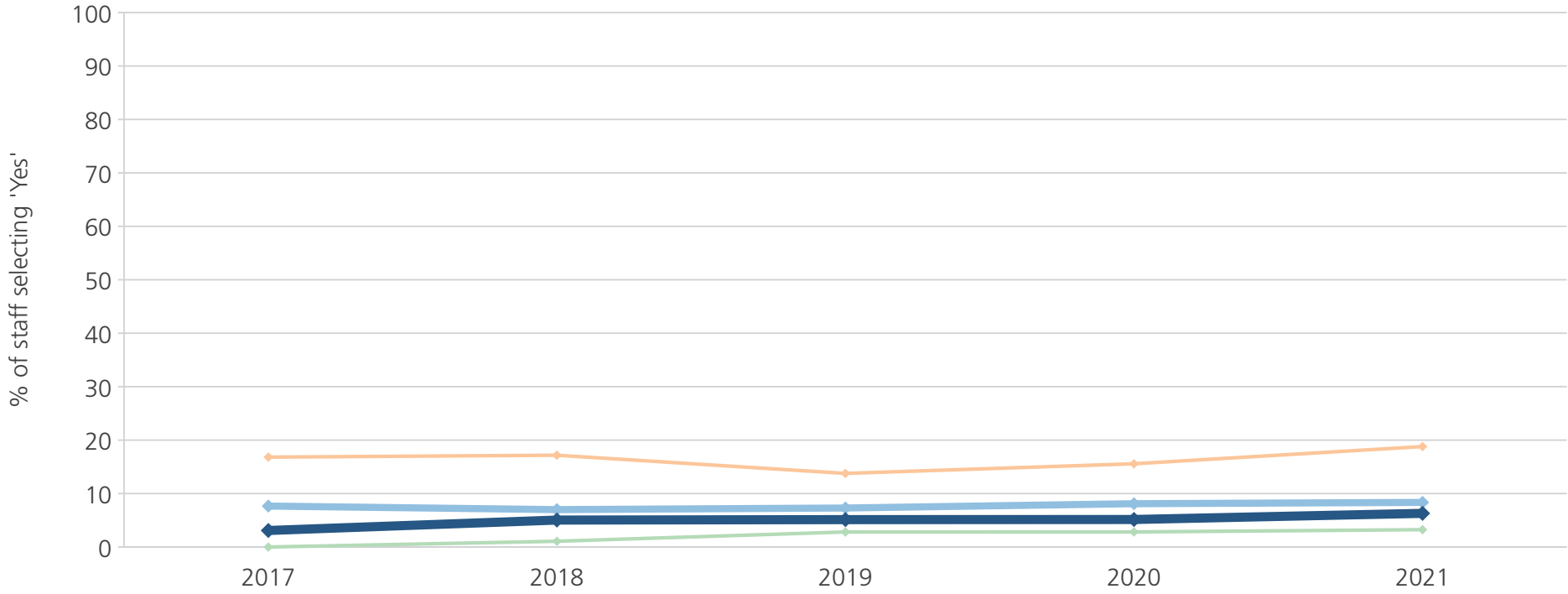
# 2021 NHS Staff Survey Results > Questions not linked to the People Promise elements or themes > **Q16c.4 >** On what grounds have you experienced discrimination? - Sexual orientation




| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| **Worst** | 12.9% | 9.9% | 9.2% | 10.4% | 23.5% |
| **Your org** | 2.9% | 3.5% | 3.5% | 4.2% | 4.1% |
| **Average** | 3.6% | 3.2% | 3.8% | 3.6% | 4.1% |
| **Best** | 0.0% | 0.0% | 0.0% | 0.0% | 1.2% |
| **Responses** | 773 | 806 | 918 | 955 | 923 |

Survey Coordination Centre

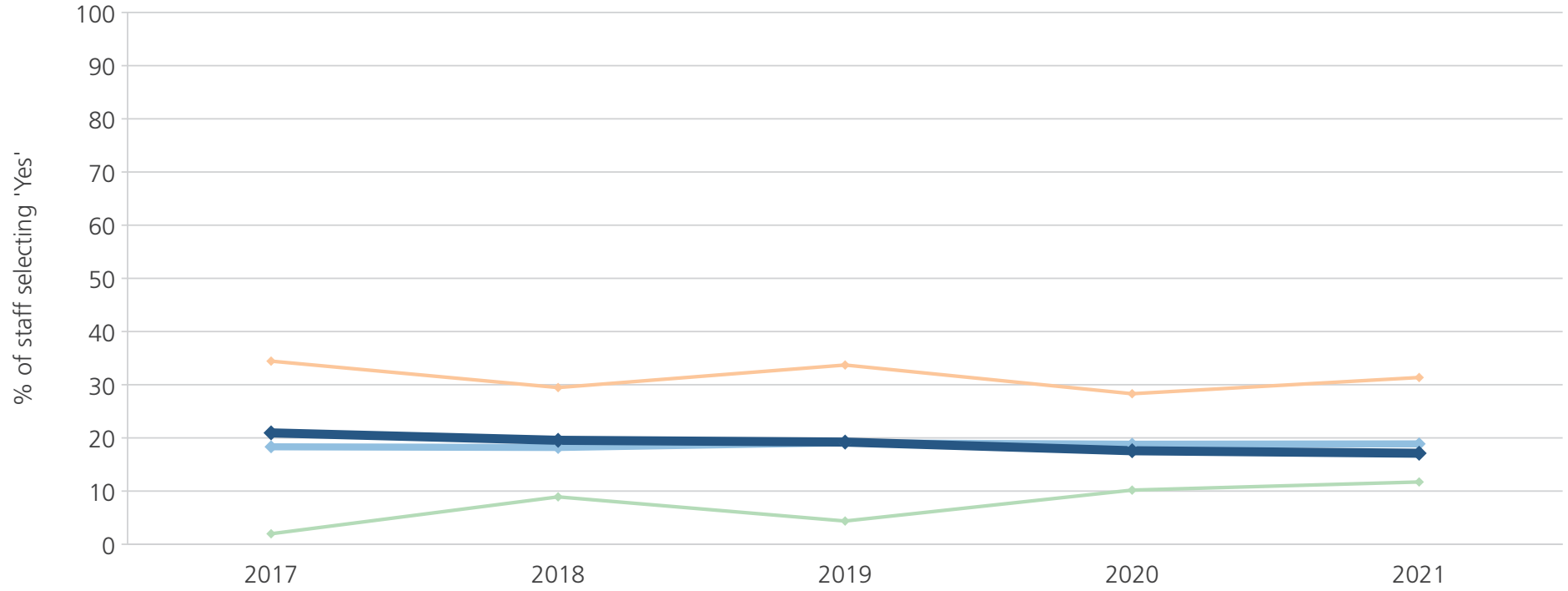
# 2021 NHS Staff Survey Results > Questions not linked to the People Promise elements or themes > **Q16c.5 >** On what grounds have you experienced discrimination? - Disability




| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| **Worst** | 16.8% | 17.2% | 13.8% | 15.6% | 18.8% |
| **Your org** | 3.1% | 5.0% | 5.1% | 5.1% | 6.3% |
| **Average** | 7.7% | 7.0% | 7.3% | 8.1% | 8.3% |
| **Best** | 0.0% | 1.1% | 2.8% | 2.8% | 3.2% |
| **Responses** | 773 | 806 | 918 | 955 | 923 |

Survey Coordination Centre

# 2021 NHS Staff Survey Results > Questions not linked to the People Promise elements or themes > **Q16c.6 >** On what grounds have you experienced discrimination? - Age




| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| **Worst** | 34.4% | 29.5% | 33.7% | 28.3% | 31.4% |
| **Your org** | 20.9% | 19.5% | 19.2% | 17.6% | 17.1% |
| **Average** | 18.3% | 18.2% | 19.1% | 18.8% | 18.9% |
| **Best** | 2.0% | 8.9% | 4.4% | 10.2% | 11.7% |
| **Responses** | 773 | 806 | 918 | 955 | 923 |

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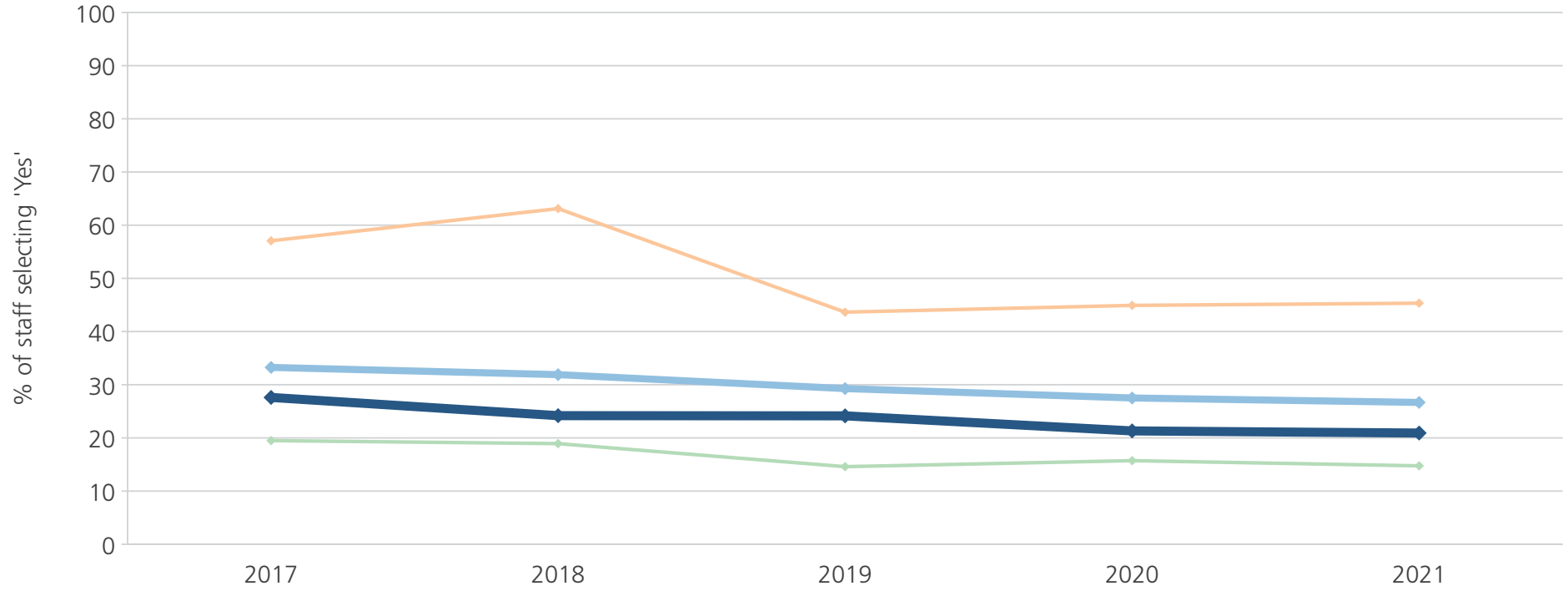
Survey Coordination Centre

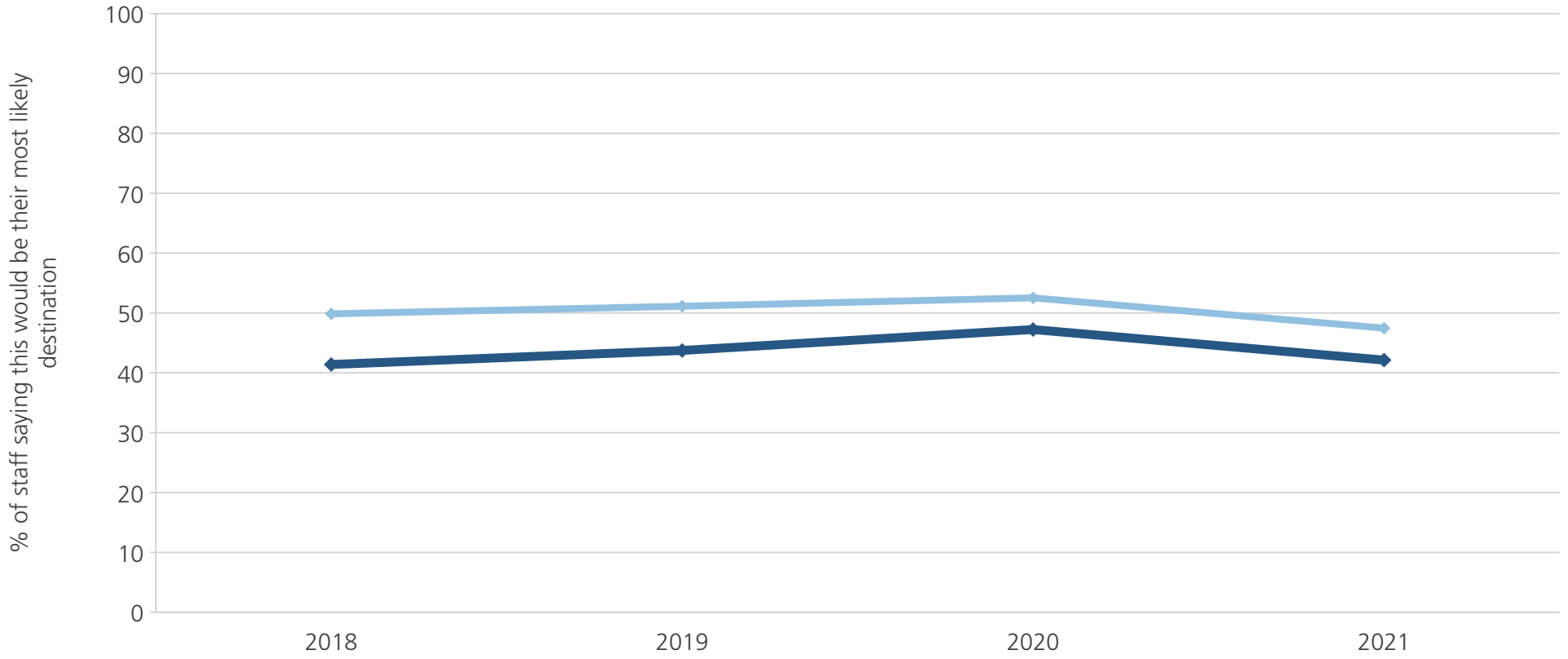
# 2021 NHS Staff Survey Results > Questions not linked to the People Promise elements or themes > **Q16c.7 >** On what grounds have you experienced discrimination? - Other




| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| **Worst** | 57.1% | 63.1% | 43.6% | 44.9% | 45.3% |
| **Your org** | 27.6% | 24.2% | 24.1% | 21.3% | 20.9% |
| **Average** | 33.3% | 31.9% | 29.3% | 27.5% | 26.7% |
| **Best** | 19.5% | 18.9% | 14.6% | 15.7% | 14.7% |
| **Responses** | 773 | 806 | 918 | 955 | 923 |

Survey Coordination Centre

# 2021 NHS Staff Survey Results > Questions not linked to the People Promise elements or themes > **Q22d.9 >** If you are considering leaving your current job, what would be your most likely destination? - I am not considering leaving my current job

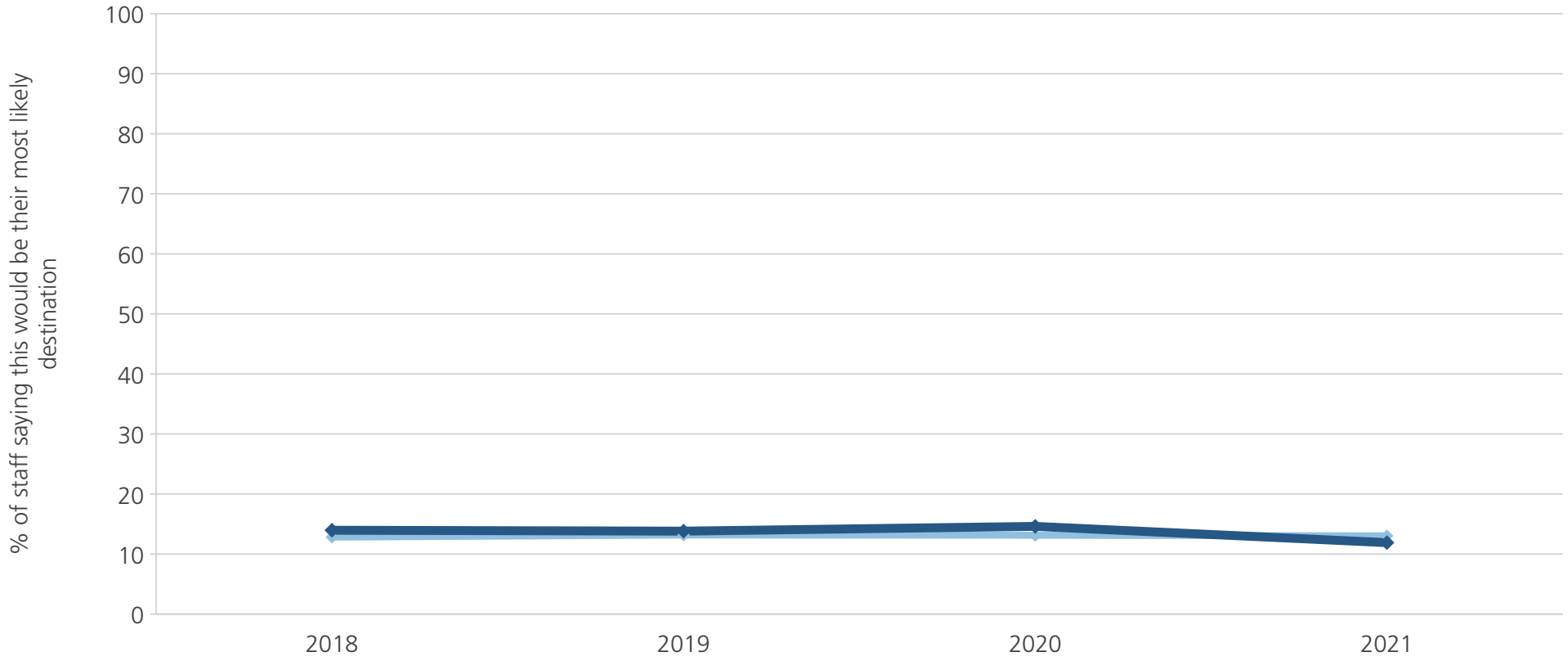



| | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|
| **Your org** | 41.4% | 43.7% | 47.2% | 42.1% |
| **Average** | 49.9% | 51.1% | 52.5% | 47.5% |
| **Responses** | 4,059 | 4,646 | 4,825 | 4,636 |

95

Survey Coordination Centre

# 2021 NHS Staff Survey Results > Questions not linked to the People Promise elements or themes > **Q22d.1 >** If you are considering leaving your current job, what would be your most likely destination? - I would want to move to another job within this organisation




| | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|
| **Your org** | 14.0% | 13.8% | 14.6% | 11.9% |
| **Average** | 12.8% | 13.2% | 13.1% | 13.0% |
| **Responses** | 4,059 | 4,646 | 4,825 | 4,636 |

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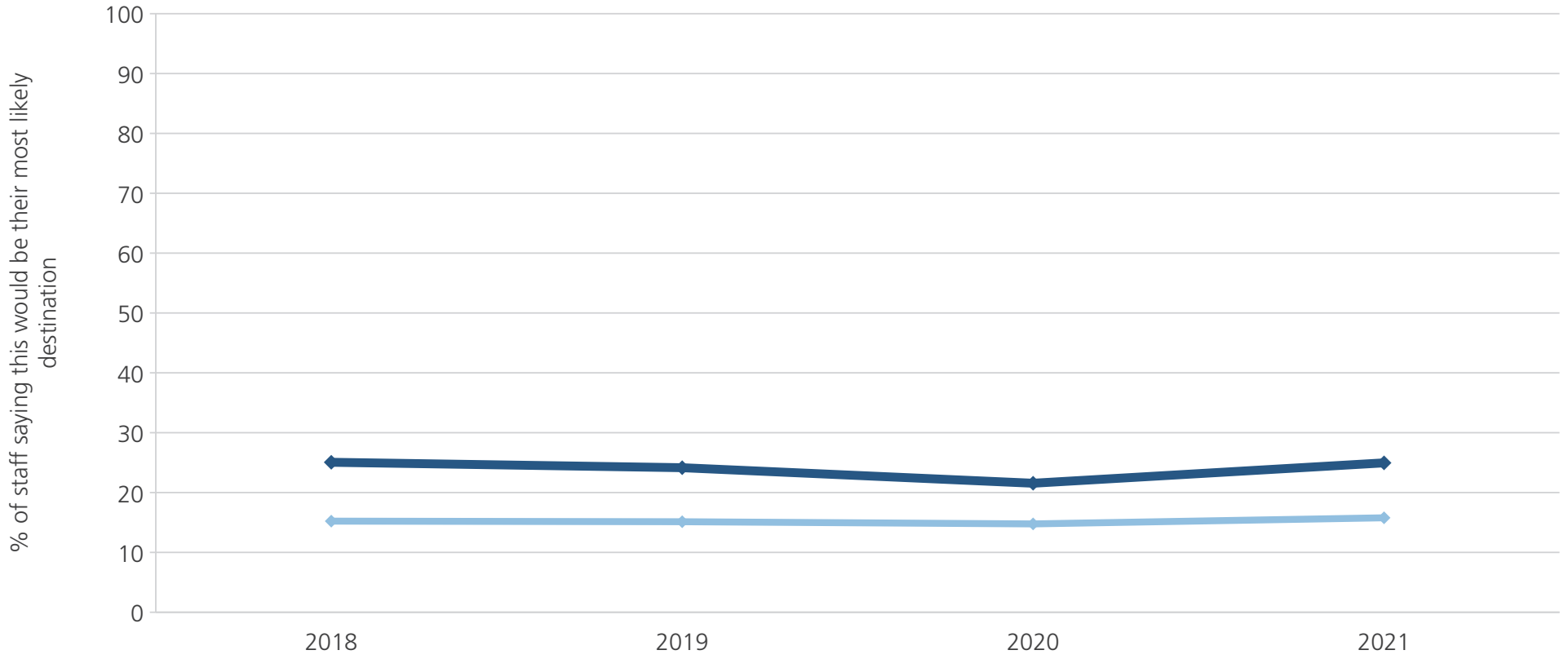
Survey Coordination Centre

2021 NHS Staff Survey Results > Questions not linked to the People Promise elements or themes > **Q22d.2 >** If you are considering leaving your current job, what would be your most likely destination? - I would want to move to a job in a different NHS trust/organisation

NHS



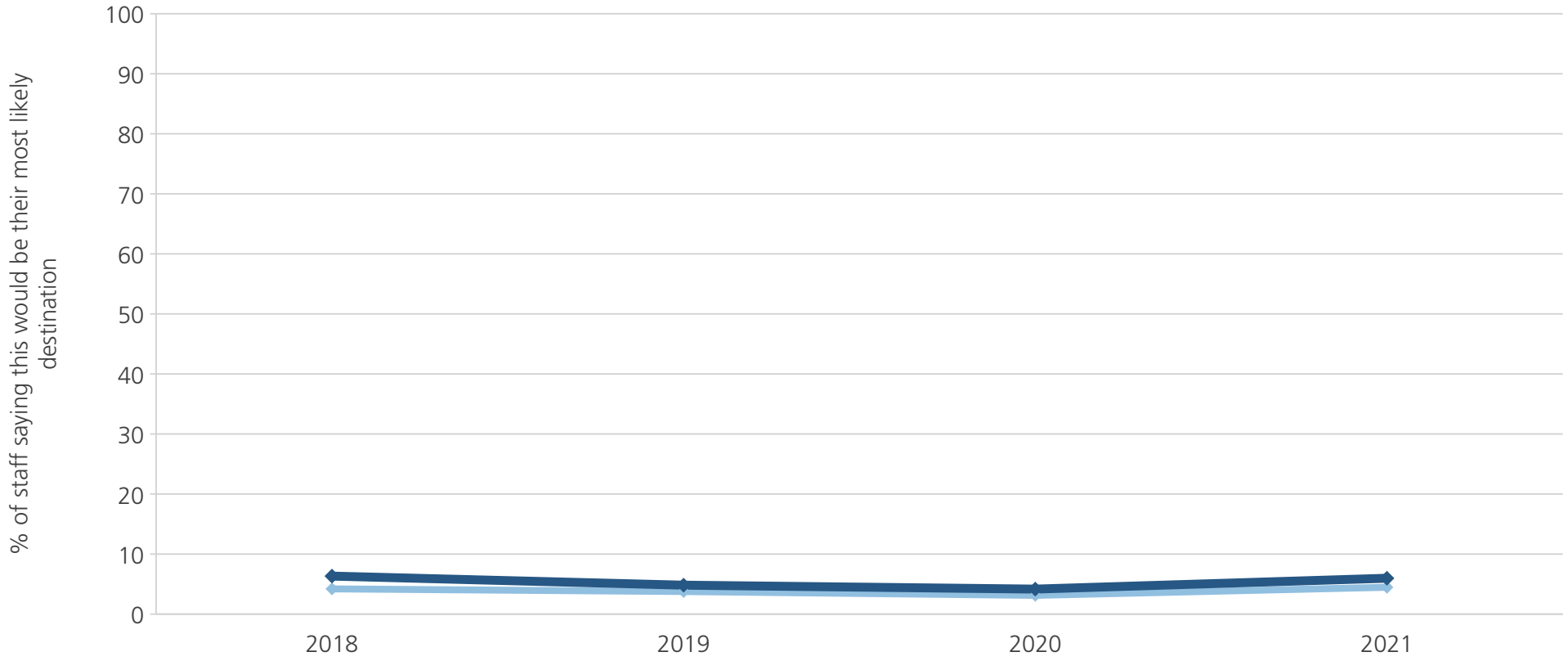

| | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|
| **Your org** | 25.1% | 24.1% | 21.6% | 25.0% |
| **Average** | 15.2% | 15.1% | 14.8% | 15.8% |
| **Responses** | 4,059 | 4,646 | 4,825 | 4,636 |

97

Survey Coordination Centre

2021 NHS Staff Survey Results > Questions not linked to the People Promise elements or themes > **Q22d.3 >** If you are considering leaving your current job, what would be your most likely destination? - I would want to move to a job in healthcare, but outside the NHS

NHS




| | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|
| **Your org** | 6.3% | 4.8% | 4.2% | 6.0% |
| **Average** | 4.2% | 3.8% | 3.1% | 4.5% |
| **Responses** | 4,059 | 4,646 | 4,825 | 4,636 |

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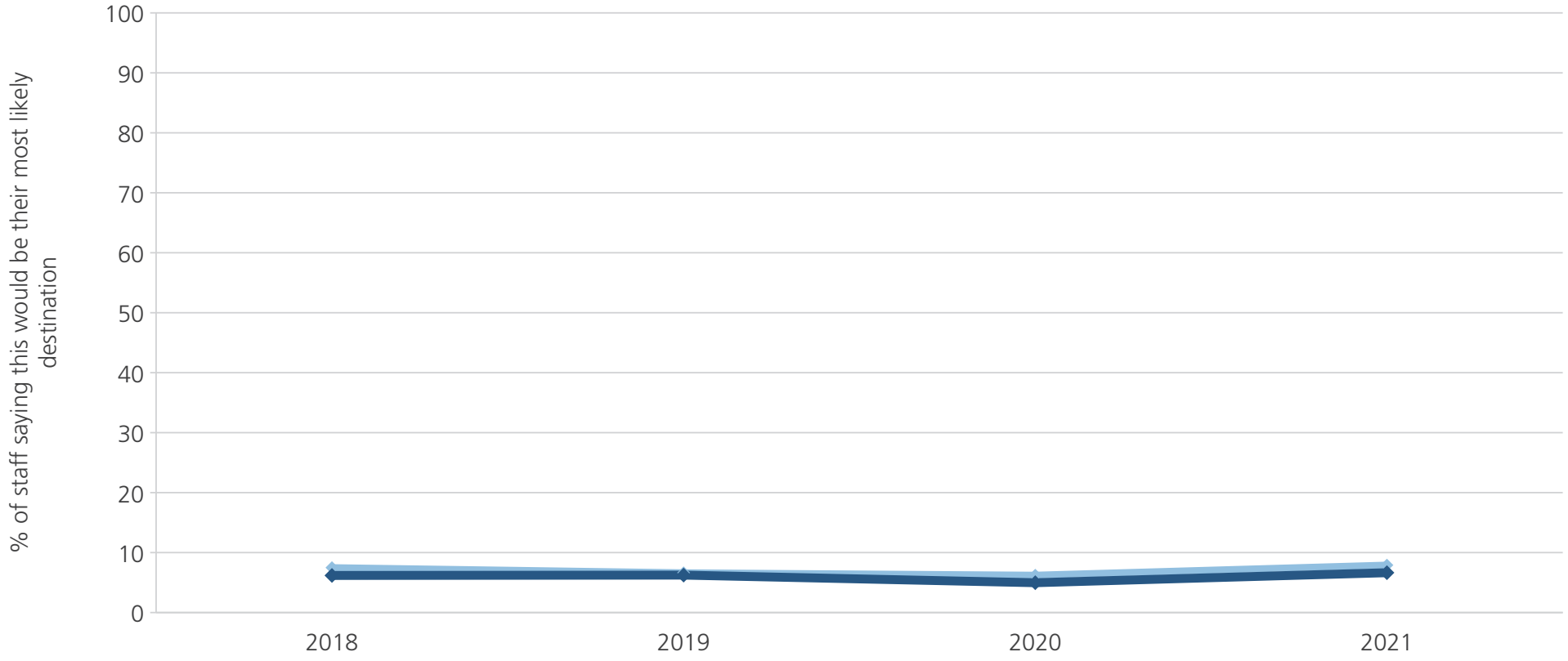
Survey Coordination Centre

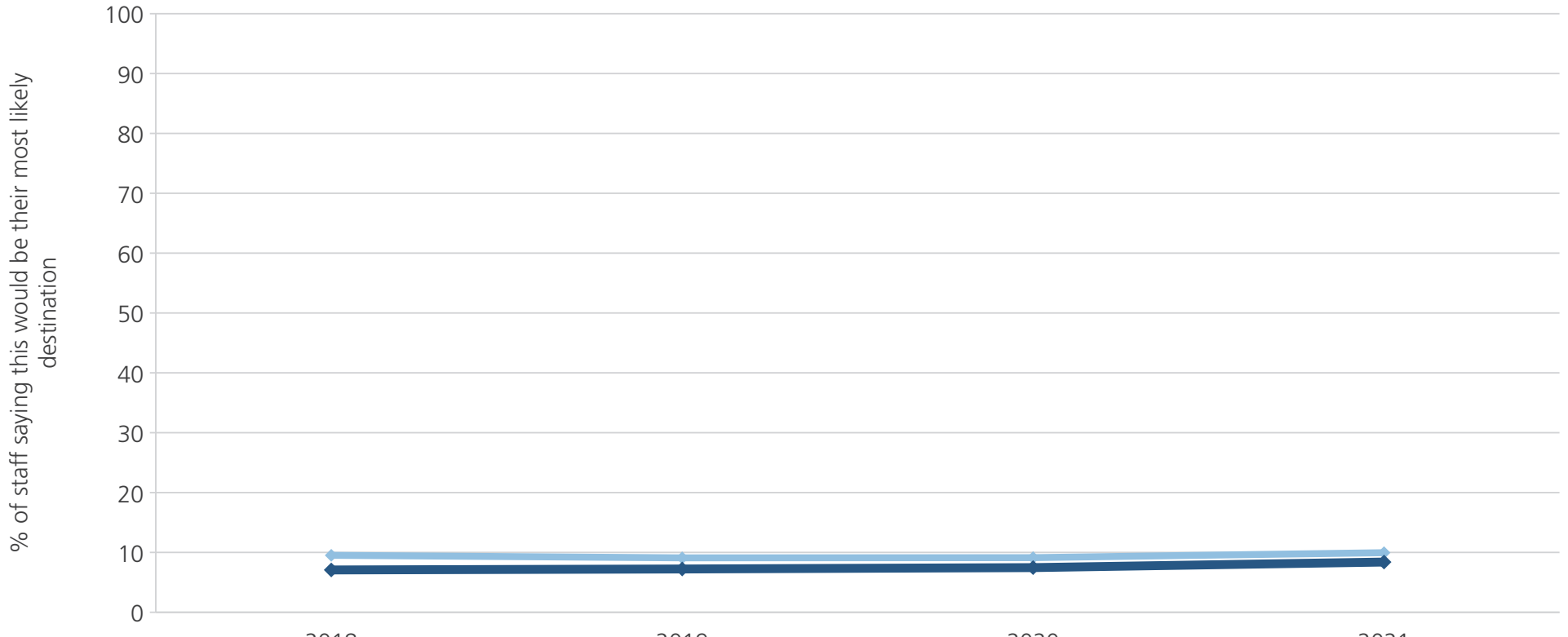
# 2021 NHS Staff Survey Results > Questions not linked to the People Promise elements or themes > **Q22d.4 >** If you are considering leaving your current job, what would be your most likely destination? - I would want to move to a job outside healthcare




| | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|
| **Your org** | 6.2% | 6.2% | 5.0% | 6.6% |
| **Average** | 7.5% | 6.6% | 6.2% | 7.9% |
| **Responses** | 4,059 | 4,646 | 4,825 | 4,636 |

Survey Coordination Centre

# 2021 NHS Staff Survey Results > Questions not linked to the People Promise elements or themes > **Q22d.5 >** If you are considering leaving your current job, what would be your most likely destination? - I would retire or take a career break




| | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|
| **Your org** | 7.1% | 7.2% | 7.5% | 8.4% |
| **Average** | 9.5% | 9.1% | 9.1% | 10.0% |
| **Responses** | 4,059 | 4,646 | 4,825 | 4,636 |

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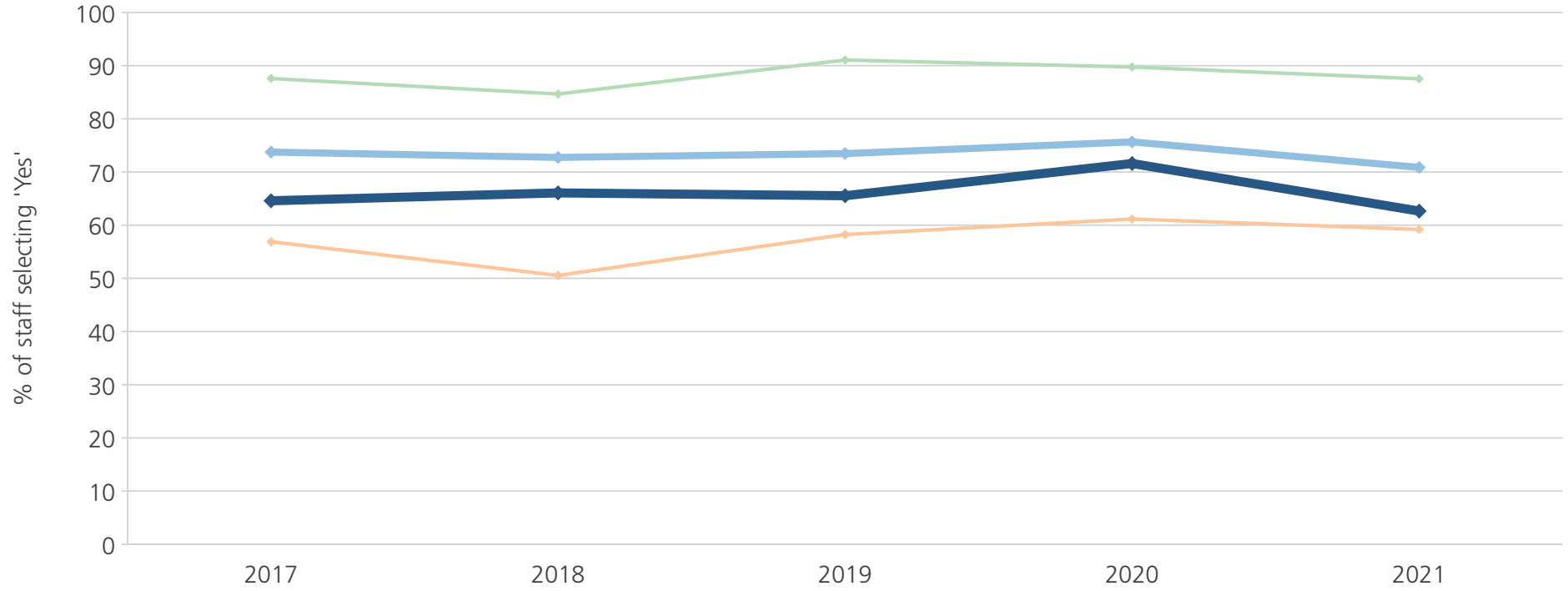
Survey Coordination Centre

# 2021 NHS Staff Survey Results > Questions not linked to the People Promise elements or themes > **Q28b >** Has your employer made adequate adjustment(s) to enable you to carry out your work?

NHS

This questions was only answered by people who responded 'yes' to Q28a




| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| **Best** | 87.6% | 84.7% | 91.1% | 89.7% | 87.5% |
| **Your org** | 64.6% | 66.1% | 65.5% | 71.6% | 62.6% |
| **Average** | 73.7% | 72.7% | 73.5% | 75.7% | 70.9% |
| **Worst** | 56.9% | 50.6% | 58.2% | 61.2% | 59.2% |
| **Responses** | 226 | 262 | 343 | 382 | 468 |

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Survey Coordination Centre

NHS

# About your respondents

St George's University Hospitals NHS Foundation Trust

2021 NHS Staff Survey Results

Survey Coordination Centre

NHS

# About your respondents – The Covid-19 pandemic

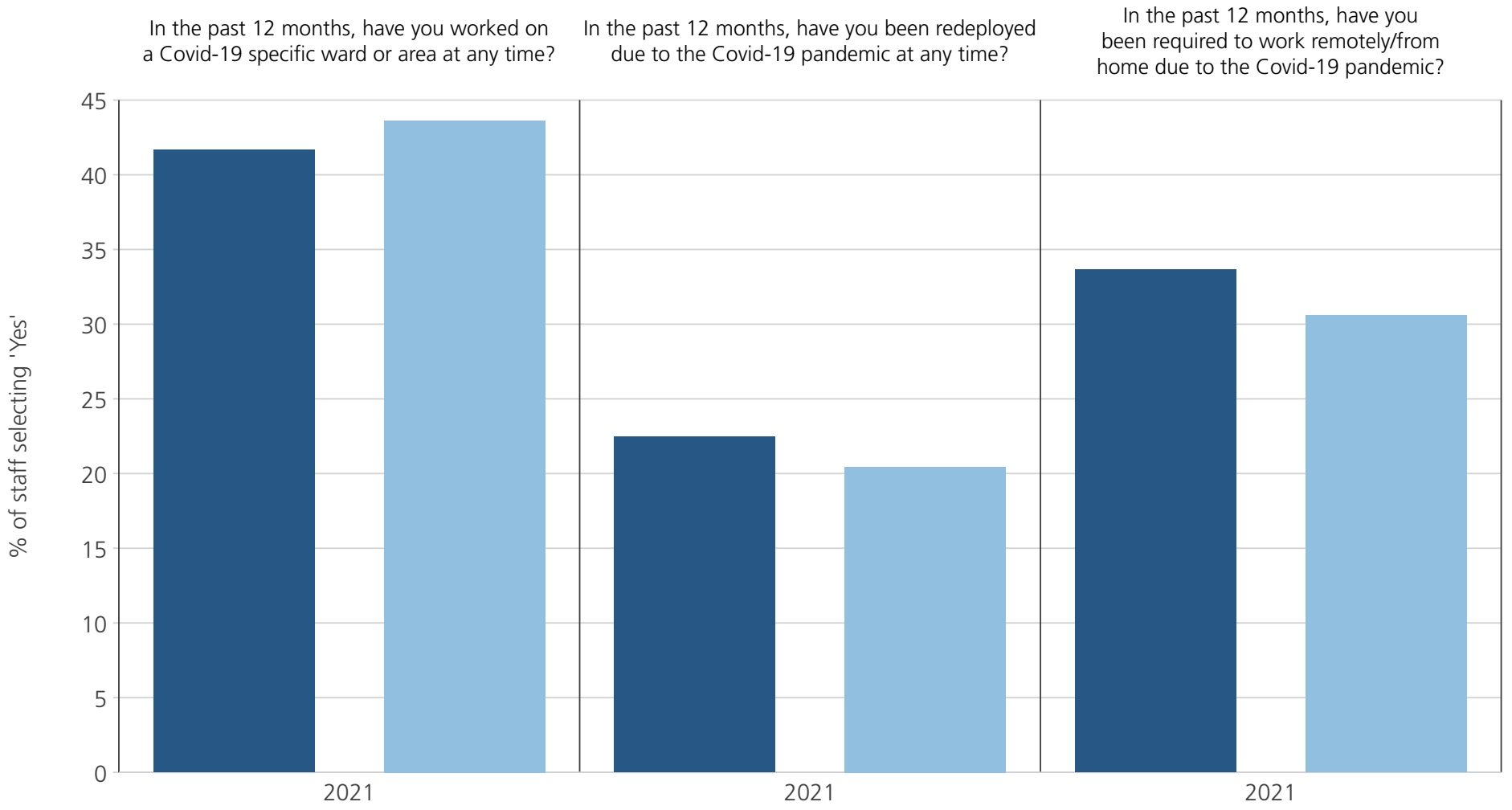
St George's University Hospitals NHS Foundation Trust

2021 NHS Staff Survey Results

Survey Coordination Centre

# 2021 NHS Staff Survey Results > Questions not linked to the People Promise elements or themes > The Covid-19 pandemic > **Your experience during the Covid-19 pandemic**

NHS




| | In the past 12 months, have you worked on a Covid-19 specific ward or area at any time? | In the past 12 months, have you been redeployed due to the Covid-19 pandemic at any time? | In the past 12 months, have you been required to work remotely/from home due to the Covid-19 pandemic? |
|---|---|---|---|
| **Your org** | 41.6% | 22.5% | 33.6% |
| **Average** | 43.6% | 20.4% | 30.6% |
| **Responses** | 4,819 | 4,808 | 4,812 |

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Survey Coordination Centre

NHS

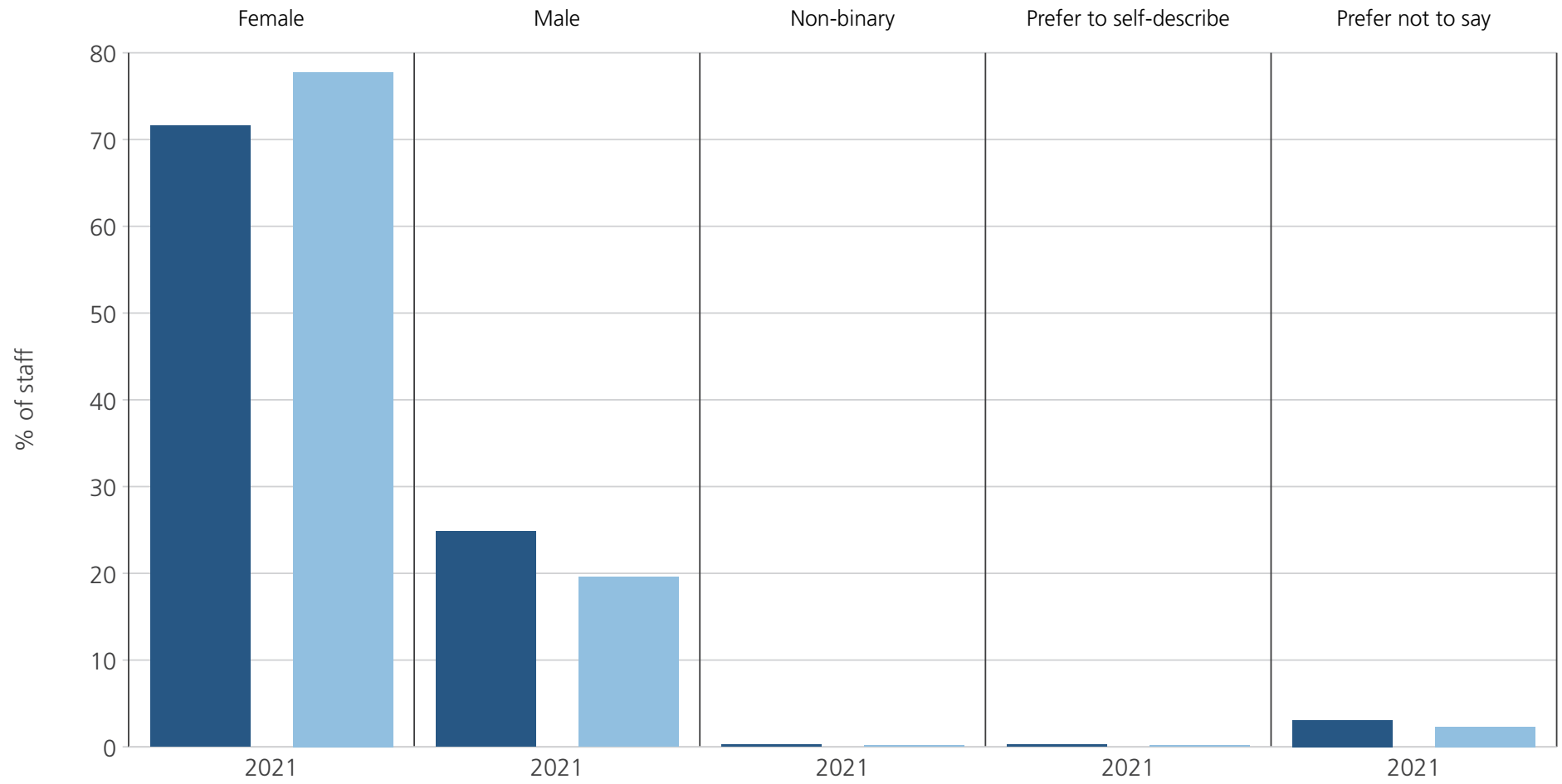
# About your respondents – Background details

St George's University Hospitals NHS Foundation Trust

2021 NHS Staff Survey Results

Survey Coordination Centre

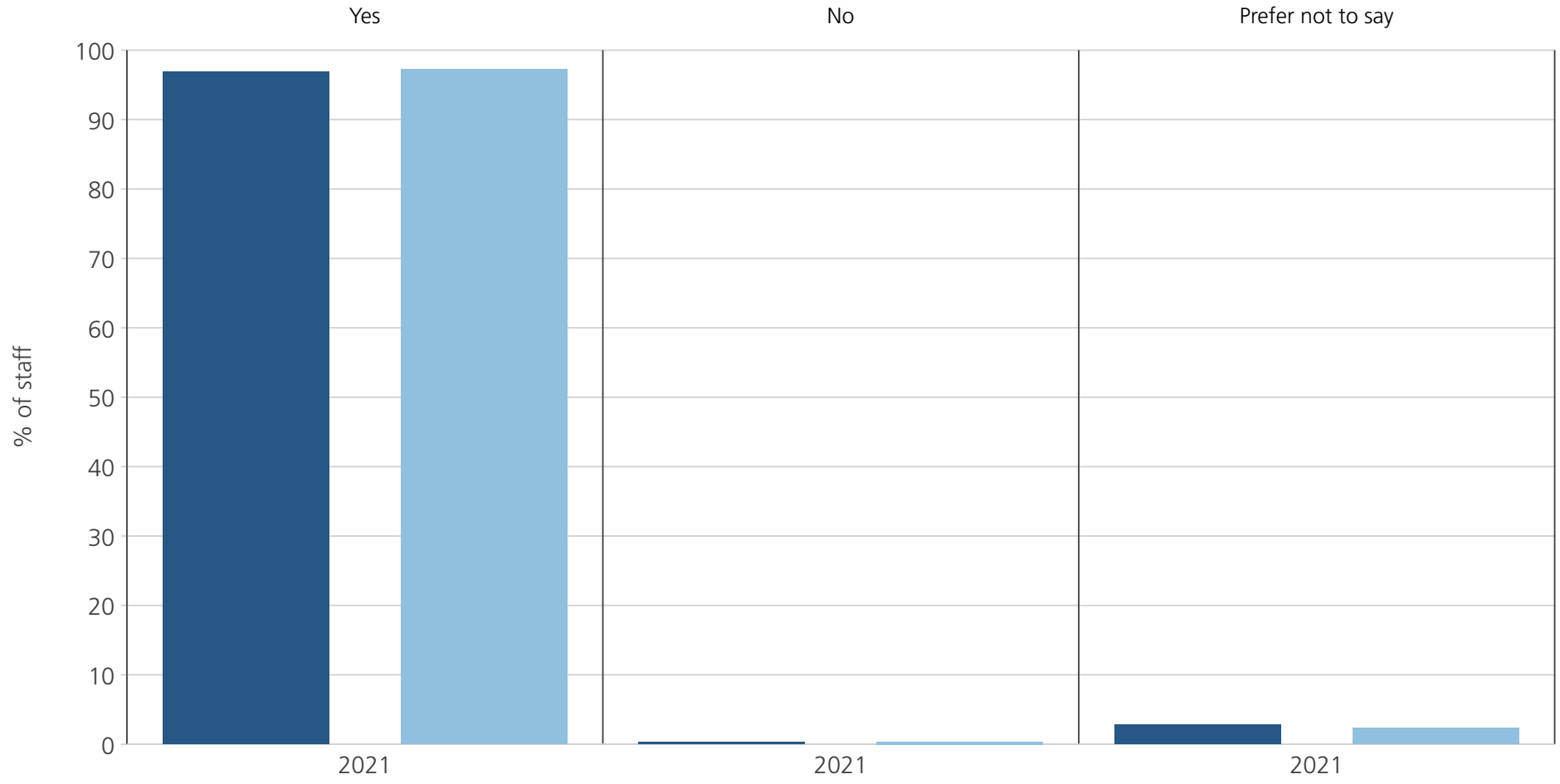
# 2021 NHS Staff Survey Results > Questions not linked to the People Promise elements or themes > Background details > **Gender**




| | Female | Male | Non-binary | Prefer to self-describe | Prefer not to say |
|---|---|---|---|---|---|
| **Your org** | 71.6% | 24.8% | 0.3% | 0.3% | 3.1% |
| **Average** | 77.8% | 19.6% | 0.1% | 0.2% | 2.3% |
| **Responses** | 4,798 | 4,798 | 4,798 | 4,798 | 4,798 |

Survey Coordination Centre

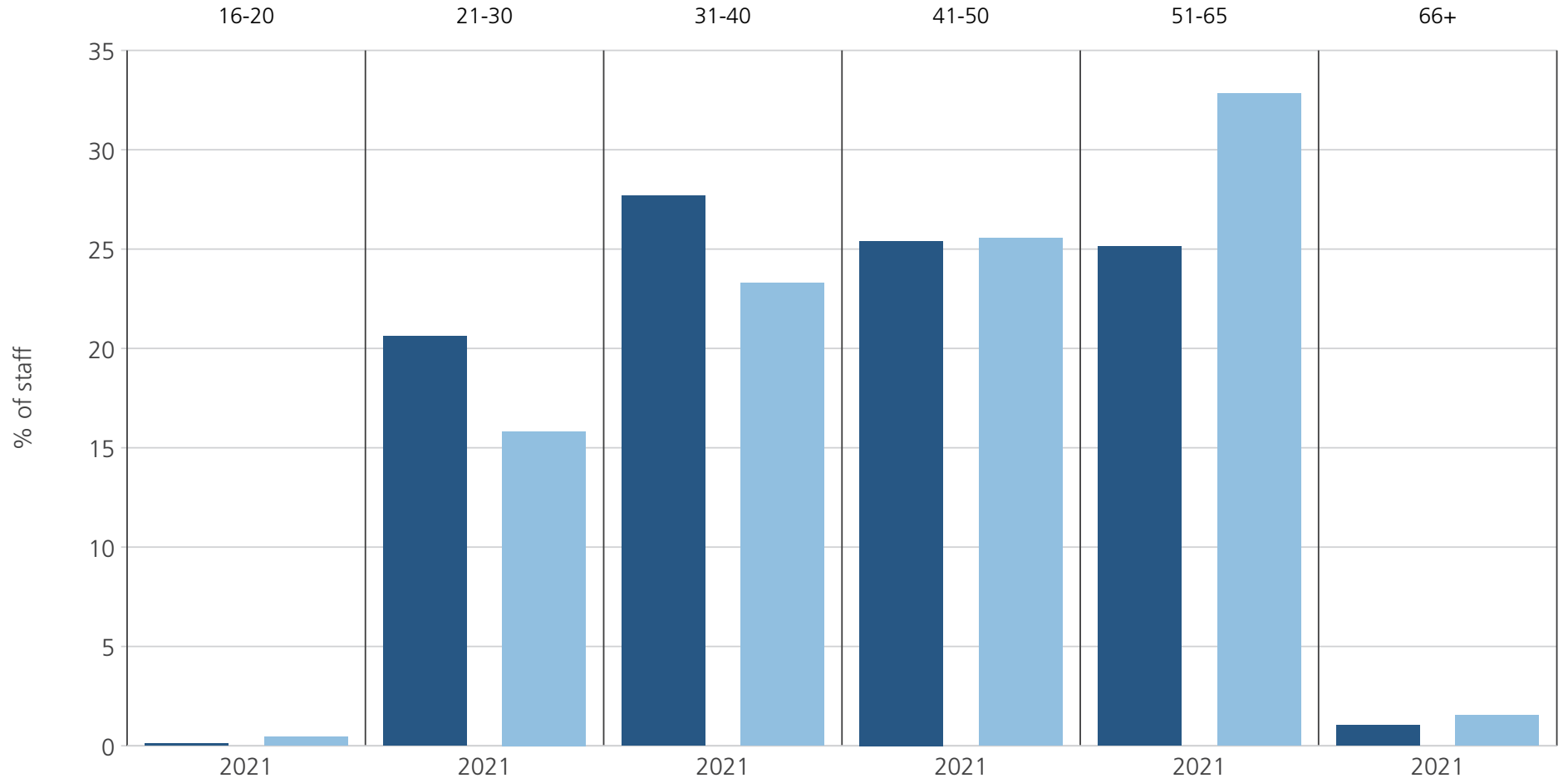
## 2021 NHS Staff Survey Results > Questions not linked to the People Promise elements or themes > Background details > **Is your gender identity the same as the sex you were registered at birth?**




| | Yes | No | Prefer not to say |
|---|---|---|---|
| **Your org** | 96.8% | 0.3% | 2.8% |
| **Average** | 97.2% | 0.4% | 2.3% |
| **Responses** | 4,752 | 4,752 | 4,752 |

Survey Coordination Centre

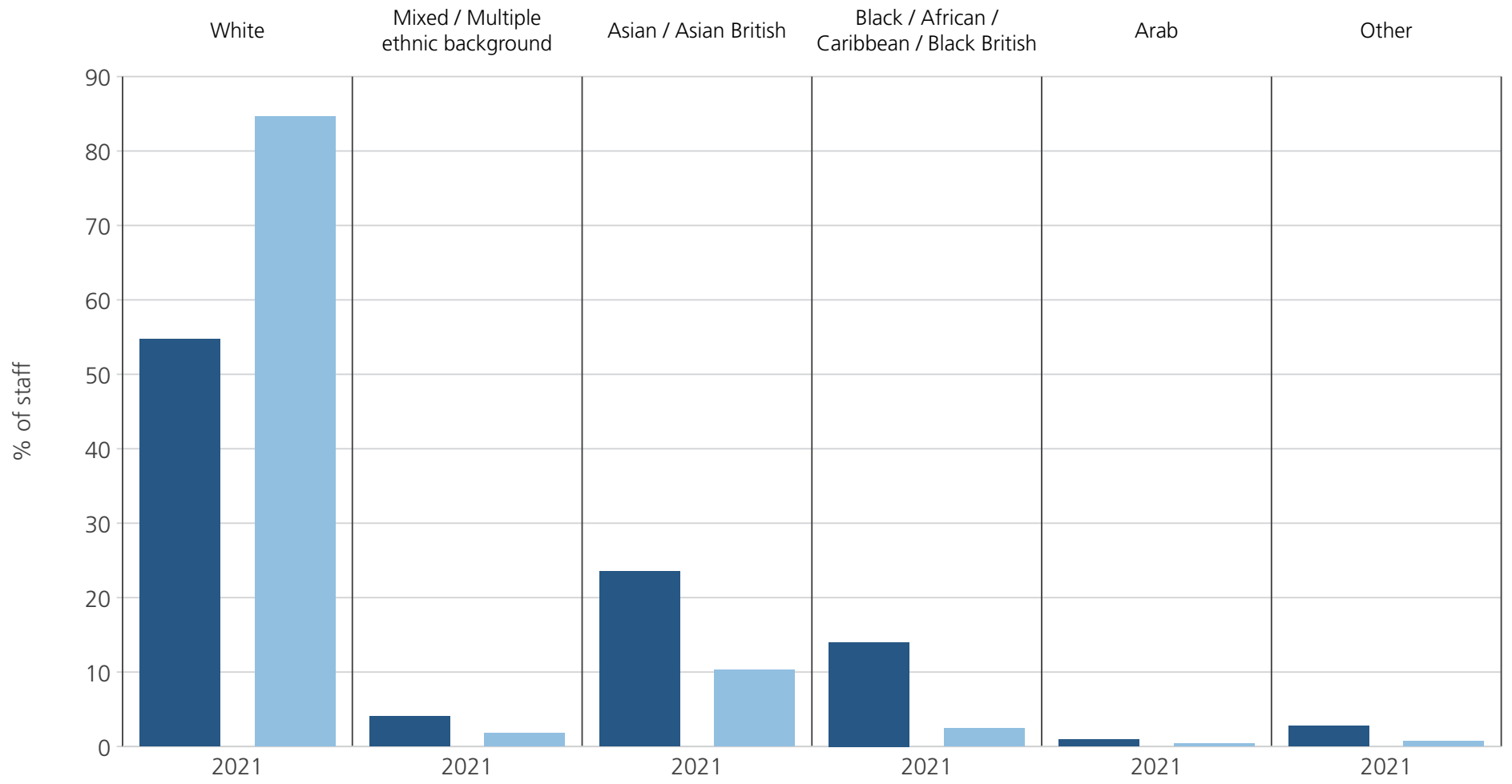
# 2021 NHS Staff Survey Results > Questions not linked to the People Promise elements or themes > Background details **> Age**




| | 16-20 | 21-30 | 31-40 | 41-50 | 51-65 | 66+ |
|---|---|---|---|---|---|---|
| **Your org** | 0.1% | 20.6% | 27.7% | 25.4% | 25.1% | 1.0% |
| **Average** | 0.4% | 15.8% | 23.3% | 25.6% | 32.8% | 1.5% |
| **Responses** | 4,799 | 4,799 | 4,799 | 4,799 | 4,799 | 4,799 |

Survey Coordination Centre

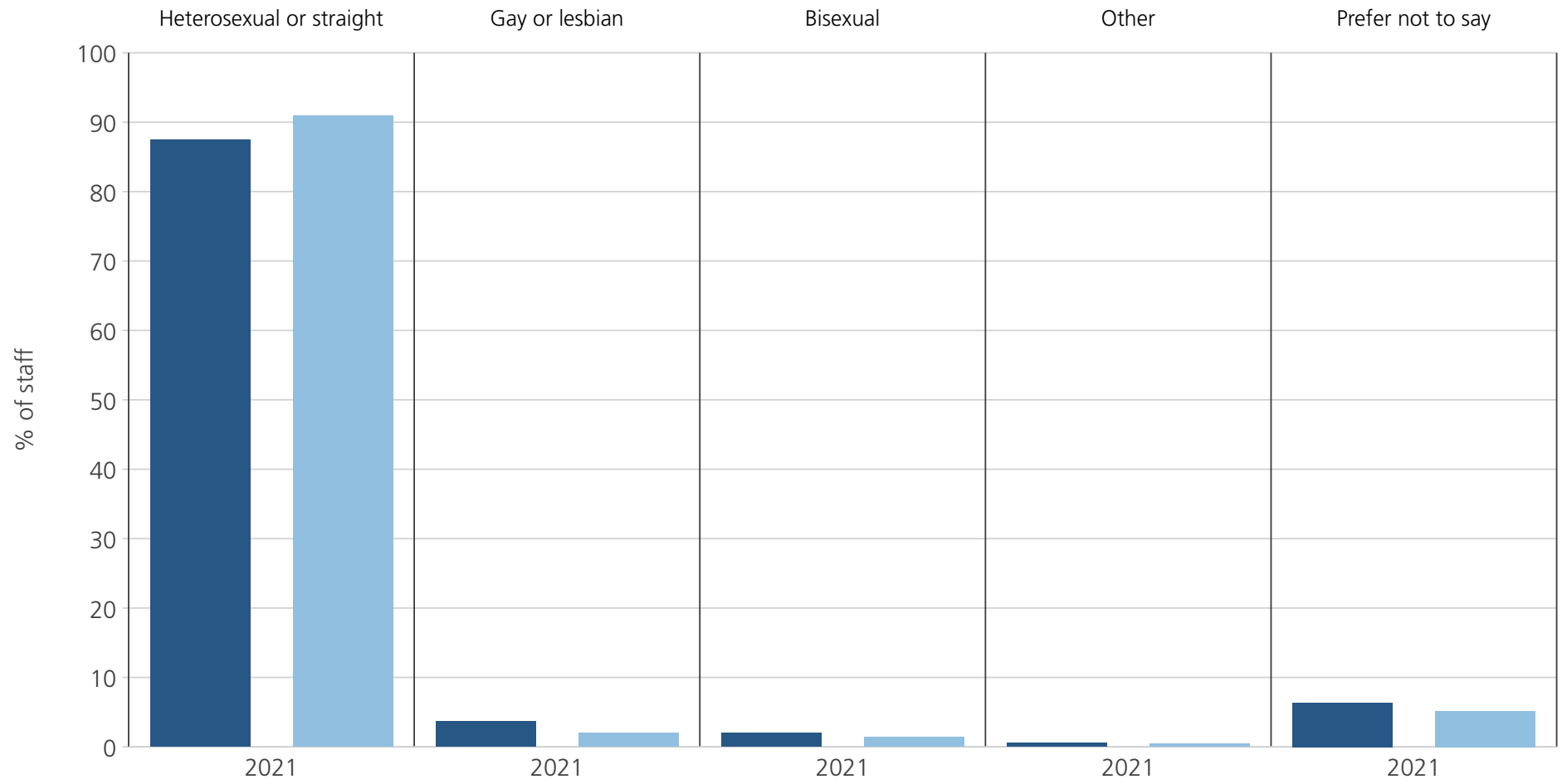
## 2021 NHS Staff Survey Results > Questions not linked to the People Promise elements or themes > Background details > **Ethnicity**




| | White | Mixed / Multiple ethnic background | Asian / Asian British | Black / African / Caribbean / Black British | Arab | Other |
|---|---|---|---|---|---|---|
| **Your org** | 54.7% | 4.0% | 23.6% | 14.0% | 0.9% | 2.8% |
| **Average** | 84.7% | 1.8% | 10.3% | 2.4% | 0.4% | 0.7% |
| **Responses** | 4,696 | 4,696 | 4,696 | 4,696 | 4,696 | 4,696 |

Survey Coordination Centre

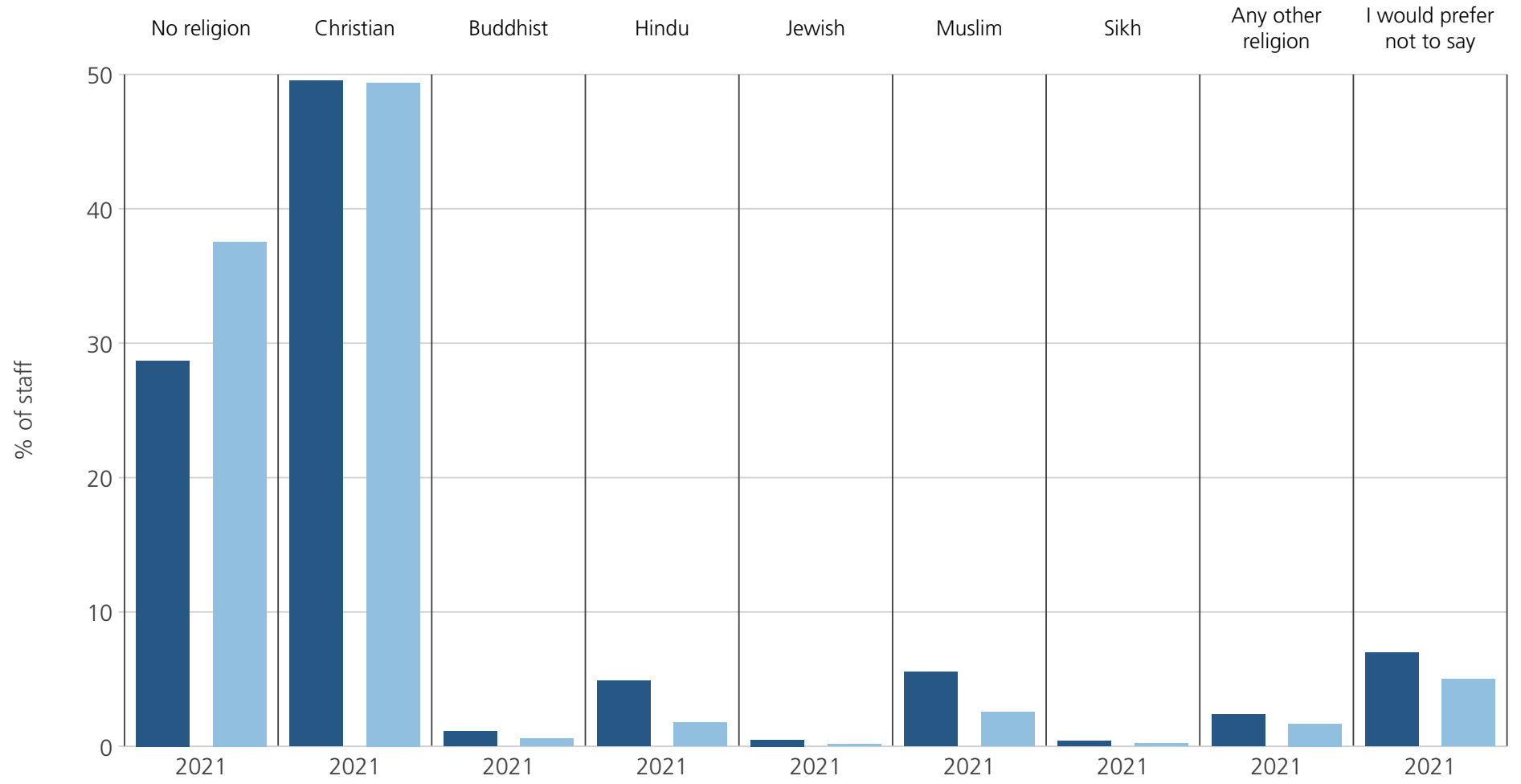
# 2021 NHS Staff Survey Results > Questions not linked to the People Promise elements or themes > Background details > **Sexual orientation**




| | Heterosexual or straight | Gay or lesbian | Bisexual | Other | Prefer not to say |
|---|---|---|---|---|---|
| **Your org** | 87.5% | 3.6% | 2.0% | 0.5% | 6.3% |
| **Average** | 90.9% | 2.0% | 1.4% | 0.5% | 5.1% |
| **Responses** | 4,780 | 4,780 | 4,780 | 4,780 | 4,780 |

Survey Coordination Centre

# 2021 NHS Staff Survey Results > Questions not linked to the People Promise elements or themes > Background details **> Religion**



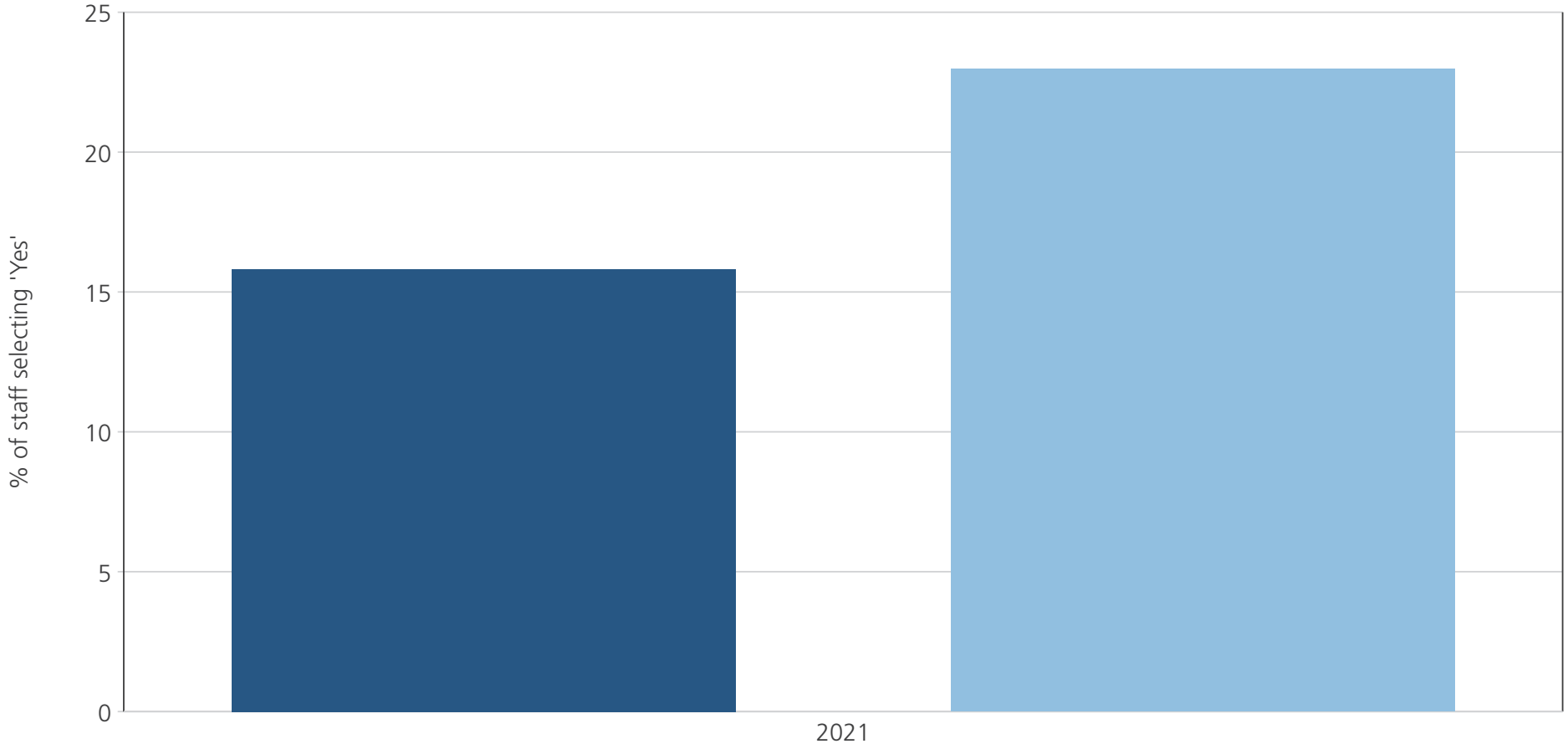

| | No religion | Christian | Buddhist | Hindu | Jewish | Muslim | Sikh | Any other religion | I would prefer not to say |
|---|---|---|---|---|---|---|---|---|---|
| **Your org** | 28.7% | 49.5% | 1.1% | 4.9% | 0.5% | 5.5% | 0.4% | 2.4% | 7.0% |
| **Average** | 37.6% | 49.4% | 0.6% | 1.8% | 0.2% | 2.6% | 0.2% | 1.7% | 5.0% |
| **Responses** | 4,796 | 4,796 | 4,796 | 4,796 | 4,796 | 4,796 | 4,796 | 4,796 | 4,796 |

Survey Coordination Centre

# 2021 NHS Staff Survey Results > Questions not linked to the People Promise elements or themes > Background details > **Long lasting health condition or illness**

NHS

Do you have any physical or mental health conditions or illnesses lasting or expected to last for 12 months or more?

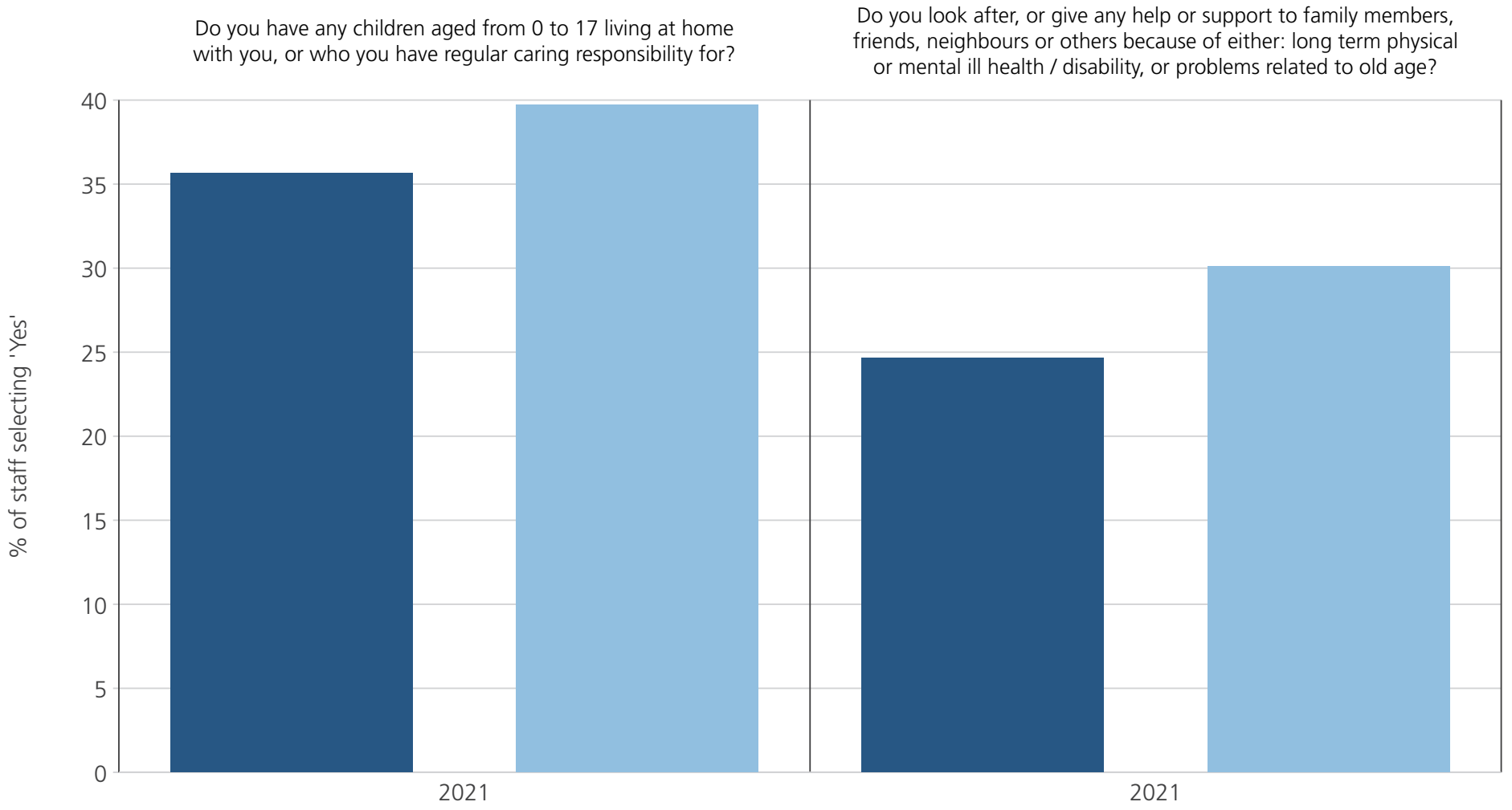



| | |
|---|---|
| **Your org** | 15.8% |
| **Average** | 23.0% |
| **Responses** | 4,792 |

Survey Coordination Centre

# 2021 NHS Staff Survey Results > Questions not linked to the People Promise elements or themes > Background details > **Parental / caring responsibilities**

NHS

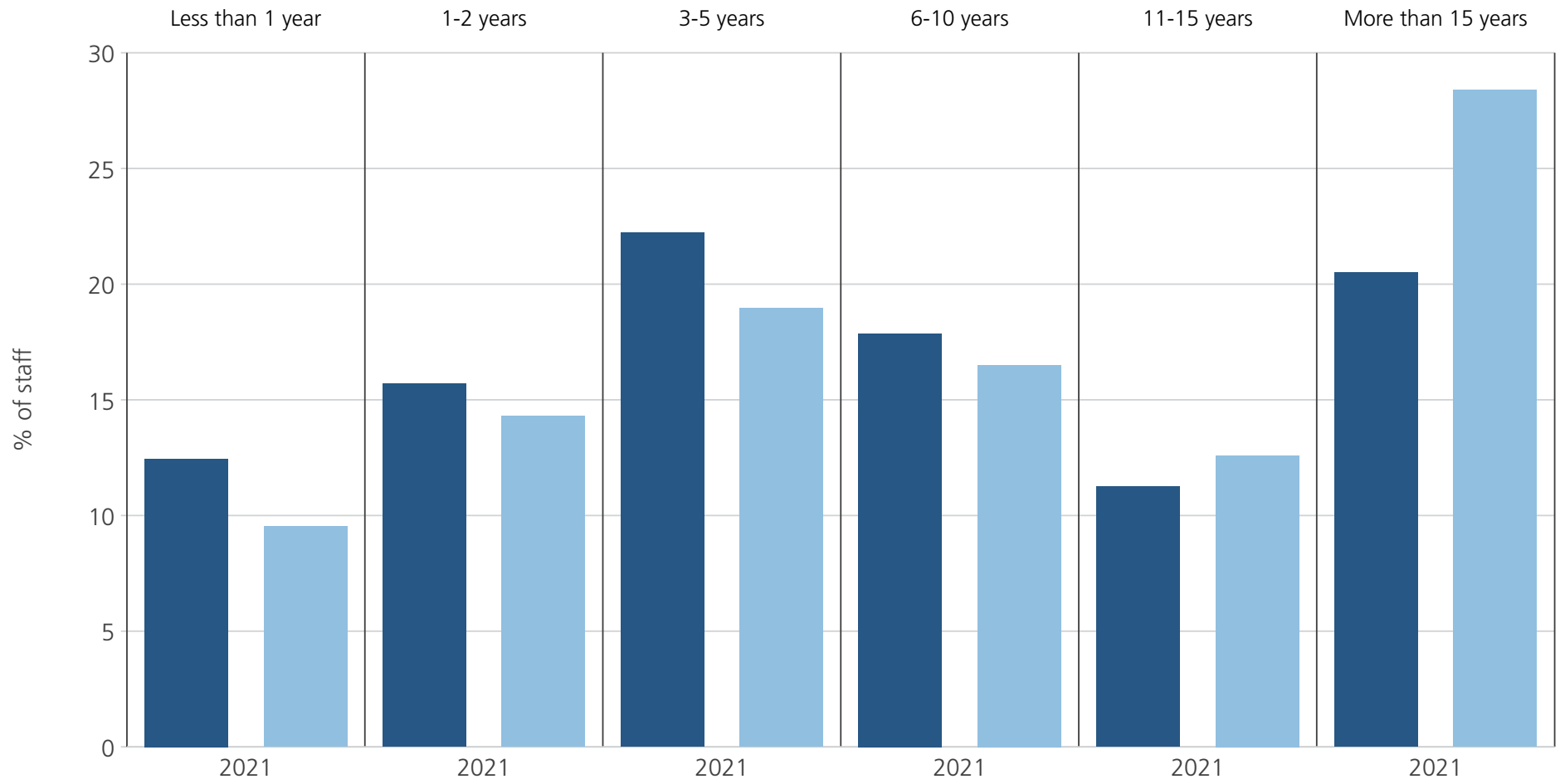



| | Do you have any children aged from 0 to 17 living at home with you, or who you have regular caring responsibility for? | Do you look after, or give any help or support to family members, friends, neighbours or others because of either: long term physical or mental ill health / disability, or problems related to old age? |
|---|---|---|
| **Your org** | 35.7% | 24.7% |
| **Average** | 39.7% | 30.1% |
| **Responses** | 4,796 | 4,791 |

113

Survey Coordination Centre

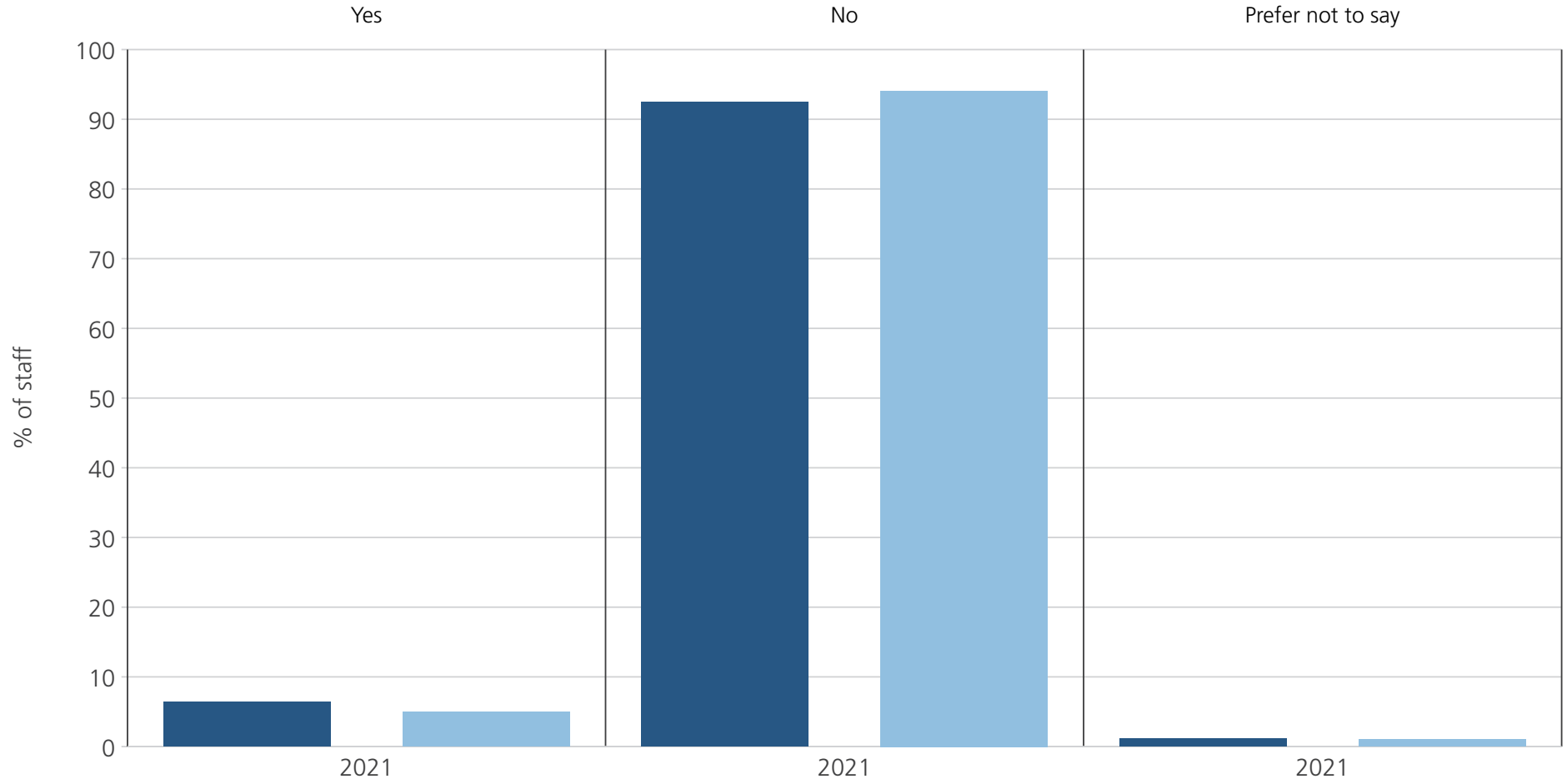
# 2021 NHS Staff Survey Results > Questions not linked to the People Promise elements or themes > Background details **> Length of service**




| | Less than 1 year | 1-2 years | 3-5 years | 6-10 years | 11-15 years | More than 15 years |
|---|---|---|---|---|---|---|
| **Your org** | 12.5% | 15.7% | 22.2% | 17.9% | 11.2% | 20.5% |
| **Average** | 9.5% | 14.3% | 19.0% | 16.5% | 12.6% | 28.4% |
| **Responses** | 4,801 | 4,801 | 4,801 | 4,801 | 4,801 | 4,801 |

Survey Coordination Centre

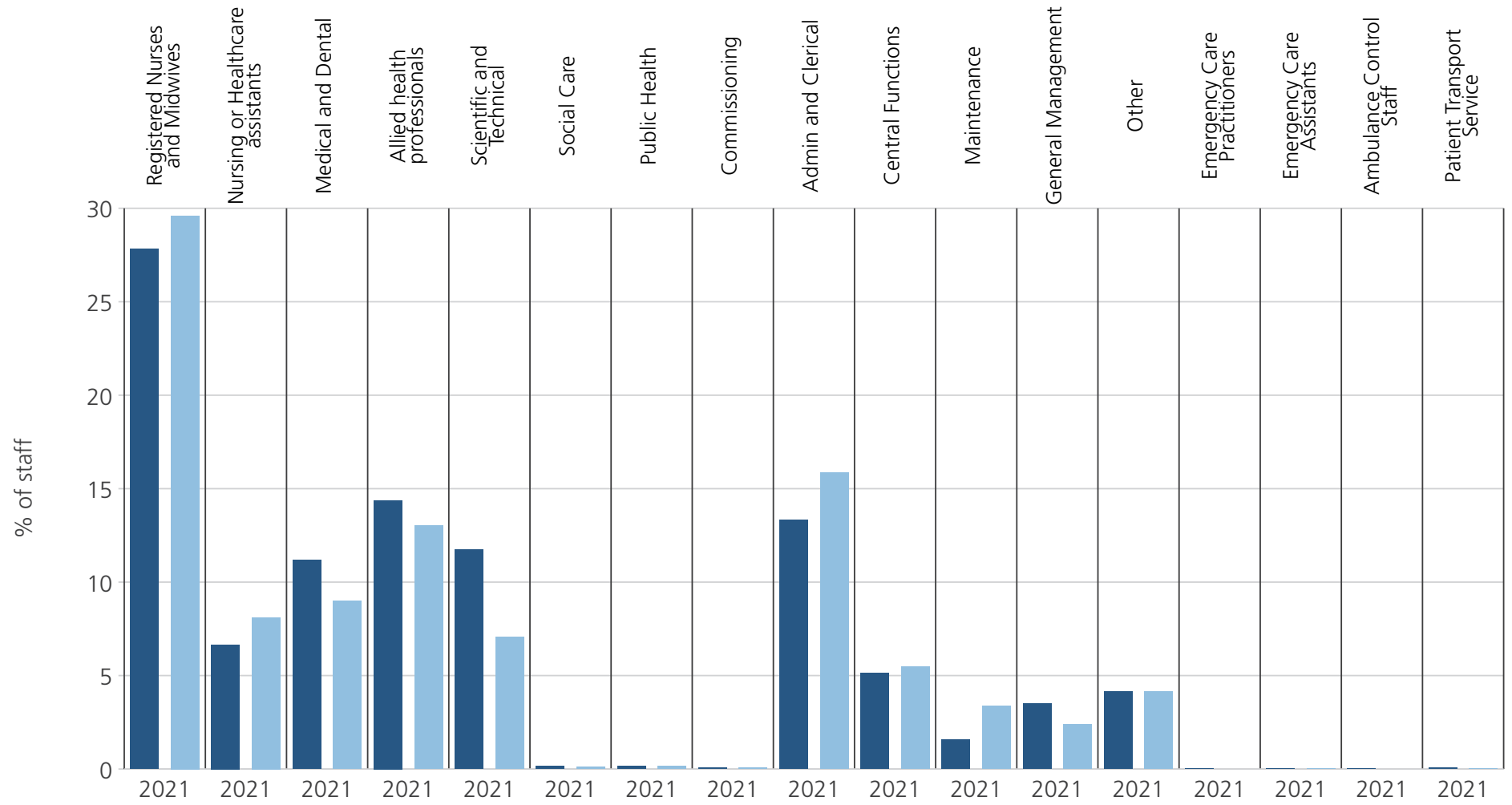
# 2021 NHS Staff Survey Results > Questions not linked to the People Promise elements or themes > Background details > **When you joined this organisation, were you recruited from outside of the UK?**




| | Yes | No | Prefer not to say |
|---|---|---|---|
| **Your org** | 6.4% | 92.5% | 1.1% |
| **Average** | 5.0% | 94.1% | 1.0% |
| **Responses** | 4,783 | 4,783 | 4,783 |

Survey Coordination Centre

2021 NHS Staff Survey Results > Questions not linked to the People Promise elements or themes > Background details **> Occupational group**




| | Registered Nurses and Midwives | Nursing or Healthcare assistants | Medical and Dental | Allied health professionals | Scientific and Technical | Social Care | Public Health | Commissioning | Admin and Clerical | Central Functions | Maintenance | General Management | Other | Emergency Care Practitioners | Emergency Care Assistants | Ambulance Control Staff | Patient Transport Service |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Your org** | 27.8% | 6.7% | 11.2% | 14.4% | 11.7% | 0.1% | 0.1% | 0.1% | 13.3% | 5.1% | 1.6% | 3.5% | 4.1% | 0.0% | 0.0% | 0.0% | 0.1% |
| **Average** | 29.6% | 8.1% | 9.0% | 13.0% | 7.1% | 0.1% | 0.2% | 0.1% | 15.9% | 5.5% | 3.4% | 2.4% | 4.1% | 0.0% | 0.0% | 0.0% | 0.0% |
| **Responses** | 4,763 | 4,763 | 4,763 | 4,763 | 4,763 | 4,763 | 4,763 | 4,763 | 4,763 | 4,763 | 4,763 | 4,763 | 4,763 | 4,763 | 4,763 | 4,763 | 4,763 |

Survey Coordination Centre

NHS

# Workforce Equality Standards

St George's University Hospitals NHS Foundation Trust

2021 NHS Staff Survey Results

Survey Coordination Centre

# Workforce Equality Standards

NHS

This section contains data required for the NHS Staff Survey indicators used in the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES). Data presented in this section are unweighted.

## Workforce Race Equality Standard (WRES)

- This contains data for each organisation required for the NHS Staff Survey indicators used in the Workforce Race Equality Standard (WRES). It includes the 2017-2021 organisation and benchmarking group median results for q14a, q14b&c combined, q15, and q16b split by ethnicity (by white / BME staff).

## Workforce Disability Equality Standard (WDES)

- This contains data for each organisation required for the NHS Staff Survey indicators used in the Workforce Disability Equality Standard (WDES). It includes the 2018-2021 organisation and benchmarking group median results for q4b, q11e, q14a-d, and q15 split by staff with a long lasting health condition or illness compared to staff without a long lasting health condition or illness. It also shows results for q28b (for staff with a long lasting health condition or illness only), and the staff engagement score for staff with a long lasting health condition or illness, compared to staff without a long lasting health condition or illness and the overall engagement score for the organisation.
- The WDES breakdowns are based on the responses to q28a ***Do you have any physical or mental health conditions or illnesses lasting or expected to last for 12 months or more?*** In 2020, the question text was shortened and the word 'disabilities' was removed but the question and WDES results still remain historically comparable.

## Changes to how the Workforce Equality Standards are calculated

- For 2021, the data way in which data for Q15 are reported has changed, with the inclusion of "don't know" responses in the base of the calculation.
- In 2020, the approach to calculating the benchmark median scores and the way in which data for Q14d are reported also changed.
- All these changes have been applied retrospectively so all historical results for Q14d and Q15 and data shown in the average calculations are comparable across years. However, the figures shown may not be directly comparable to the results reported in previous years.
- Full details of how the data are calculated are included in the Technical Document, available to download from our results website.

Survey Coordination Centre

NHS

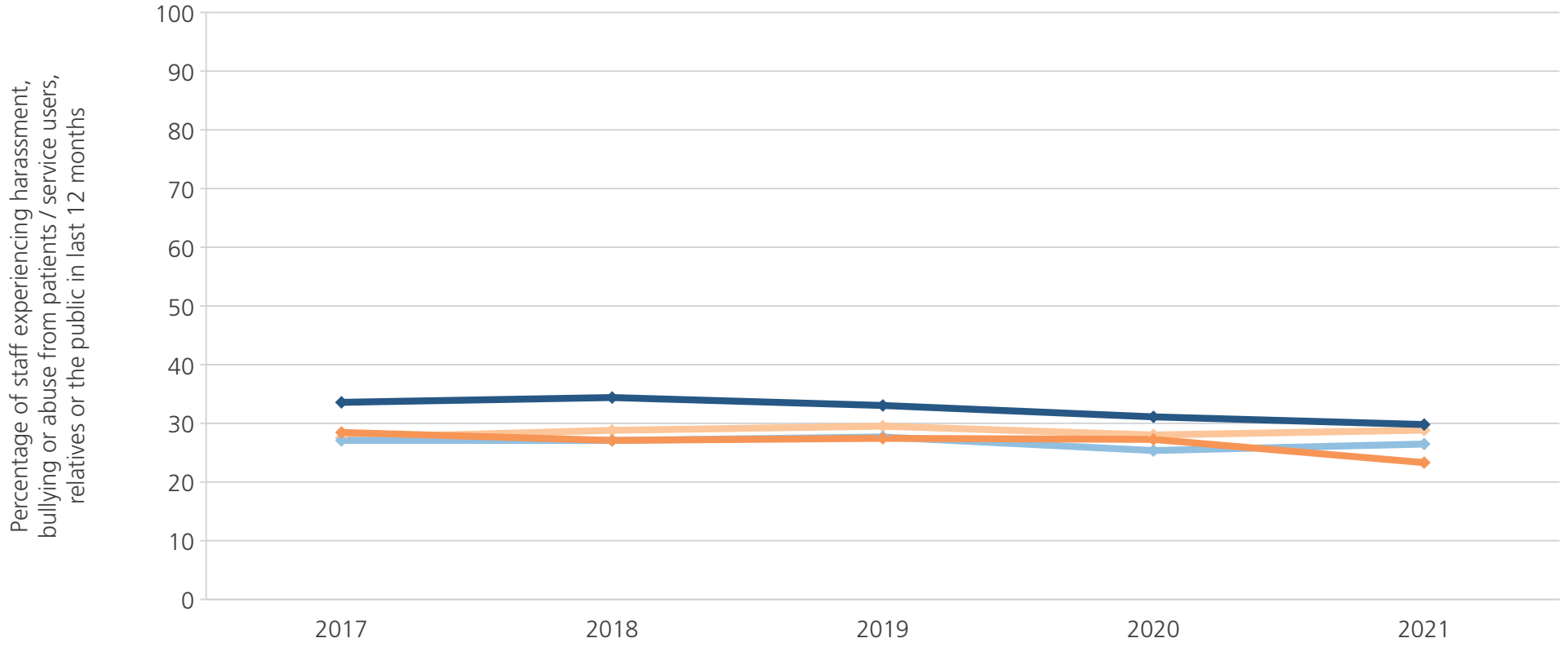
# Workforce Race Equality Standard (WRES)

St George's University Hospitals NHS Foundation Trust

2021 NHS Staff Survey Results

Survey Coordination Centre

## 2021 NHS Staff Survey Results > WRES > Percentage of staff experiencing harassment, bullying or abuse from patients / service users, relatives or the public in last 12 months

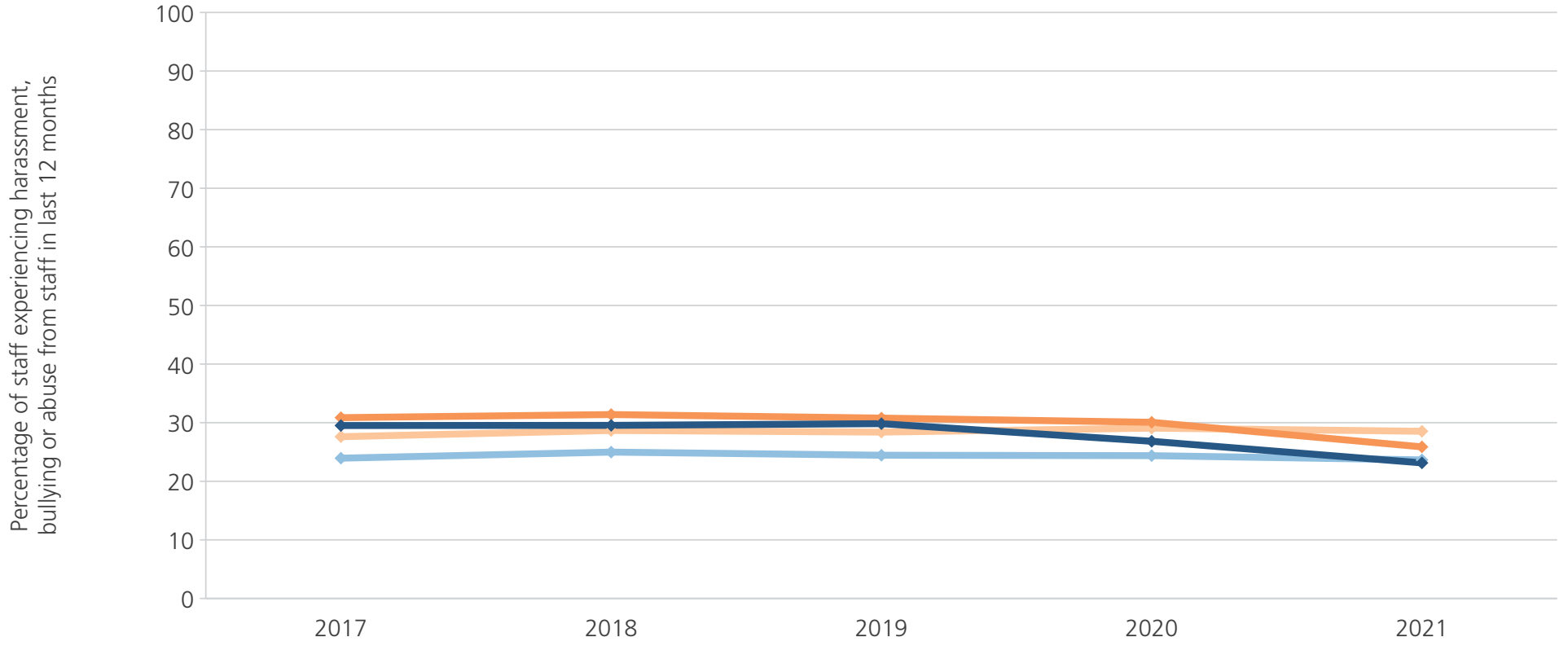



| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| White: Your org | 33.6% | 34.4% | 33.0% | 31.1% | 29.8% |
| BME: Your org | 28.4% | 27.1% | 27.4% | 27.3% | 23.3% |
| White: Average | 27.1% | 27.1% | 27.7% | 25.4% | 26.5% |
| BME: Average | 27.5% | 28.8% | 29.5% | 28.0% | 28.8% |
| White: Responses | 2,362 | 2,486 | 2,621 | 2,524 | 2,484 |
| BME: Responses | 1,554 | 1,702 | 1,902 | 1,904 | 2,034 |

Average calculated as the median for the benchmark group

Survey Coordination Centre

# 2021 NHS Staff Survey Results > WRES > **Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months**

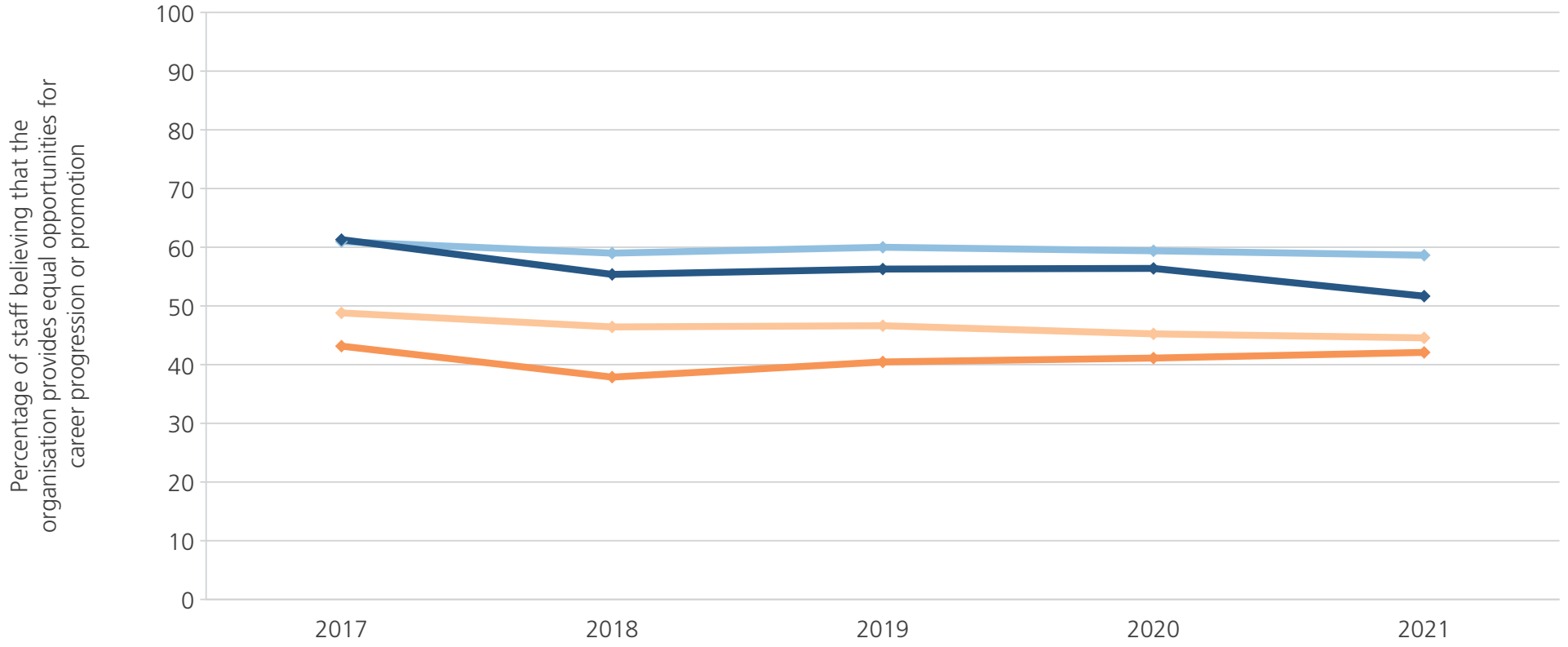



| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| **White: Your org** | 29.5% | 29.5% | 29.8% | 26.8% | 23.1% |
| **BME: Your org** | 30.9% | 31.4% | 30.8% | 30.1% | 25.9% |
| **White: Average** | 23.9% | 25.0% | 24.4% | 24.4% | 23.6% |
| **BME: Average** | 27.6% | 28.7% | 28.4% | 29.1% | 28.5% |
| **White: Responses** | 2,345 | 2,468 | 2,625 | 2,524 | 2,494 |
| **BME: Responses** | 1,533 | 1,676 | 1,894 | 1,906 | 2,041 |

Average calculated as the median for the benchmark group

Survey Coordination Centre

## 2021 NHS Staff Survey Results > WRES > **Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion**

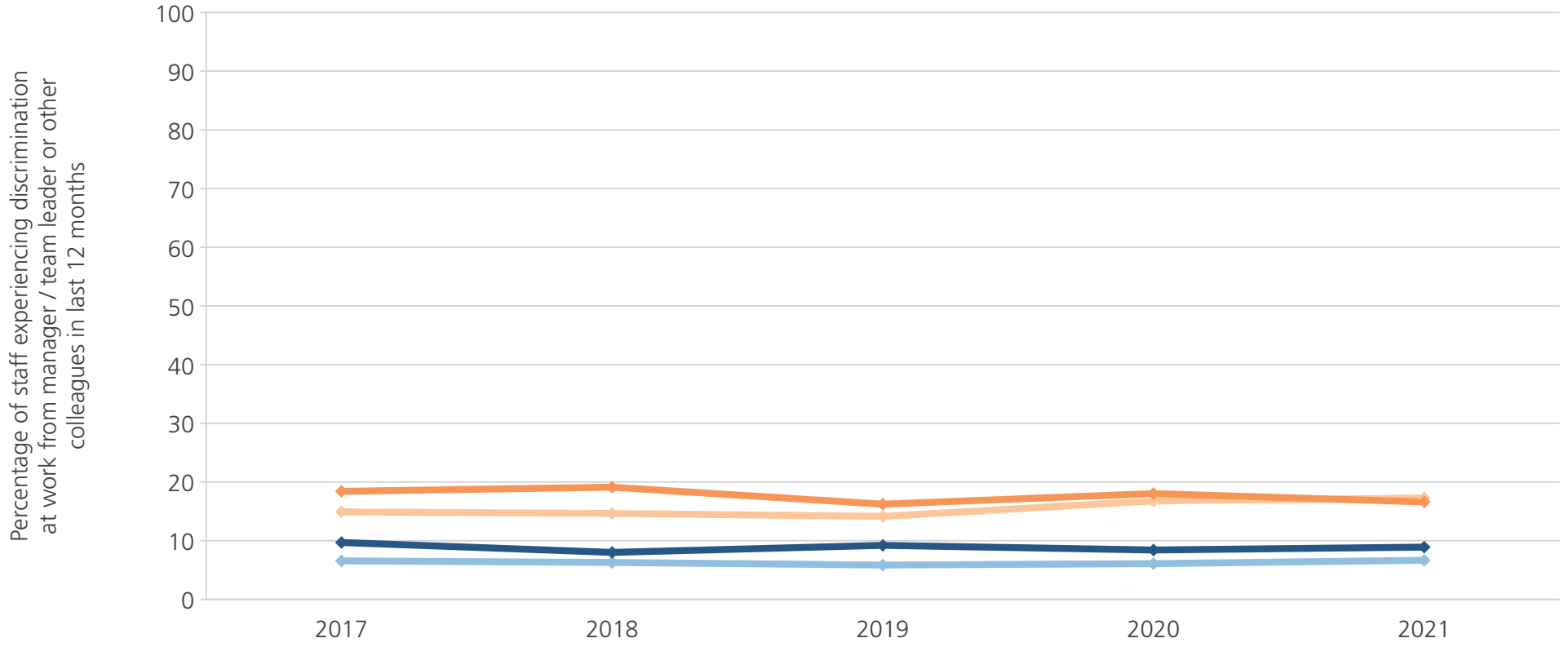



| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| **White: Your org** | 61.3% | 55.4% | 56.3% | 56.4% | 51.7% |
| **BME: Your org** | 43.1% | 37.9% | 40.5% | 41.1% | 42.1% |
| **White: Average** | 61.0% | 59.0% | 60.0% | 59.4% | 58.6% |
| **BME: Average** | 48.8% | 46.4% | 46.6% | 45.2% | 44.6% |
| **White: Responses** | 2,346 | 2,467 | 2,603 | 2,566 | 2,551 |
| **BME: Responses** | 1,525 | 1,682 | 1,886 | 1,953 | 2,096 |

Average calculated as the median for the benchmark group

Survey Coordination Centre

## 2021 NHS Staff Survey Results > WRES > Percentage of staff experiencing discrimination at work from manager / team leader or other colleagues in last 12 months




| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| White: Your org | 9.7% | 8.0% | 9.2% | 8.4% | 8.9% |
| BME: Your org | 18.4% | 19.1% | 16.2% | 18.0% | 16.6% |
| White: Average | 6.6% | 6.3% | 5.9% | 6.1% | 6.7% |
| BME: Average | 14.9% | 14.6% | 14.1% | 16.8% | 17.3% |
| White: Responses | 2,362 | 2,461 | 2,606 | 2,578 | 2,560 |
| BME: Responses | 1,548 | 1,674 | 1,886 | 1,964 | 2,102 |

Average calculated as the median for the benchmark group

Survey Coordination Centre

NHS

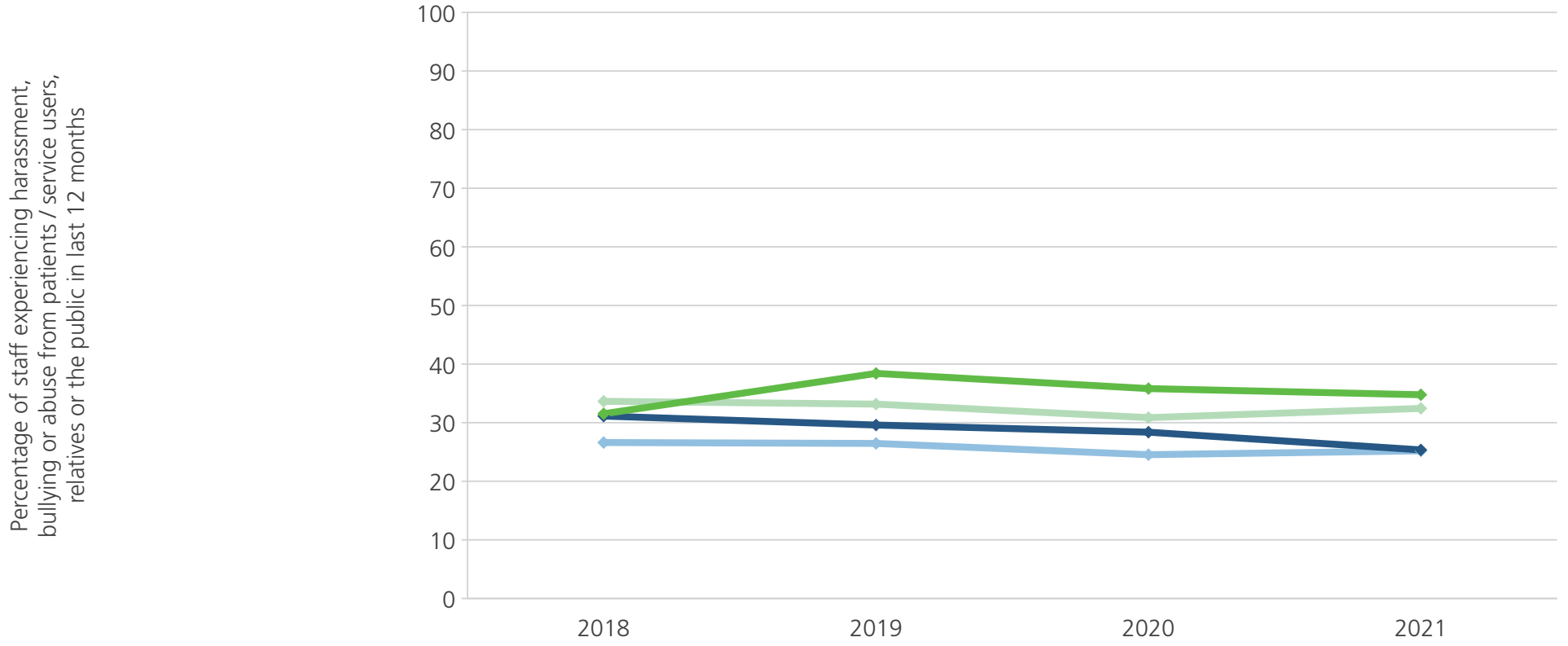
# Workforce Disability Equality Standard (WDES)

St George's University Hospitals NHS Foundation Trust

2021 NHS Staff Survey Results

Survey Coordination Centre

## 2021 NHS Staff Survey Results > WDES > Percentage of staff experiencing harassment, bullying or abuse from patients / service users, relatives or the public in last 12 months

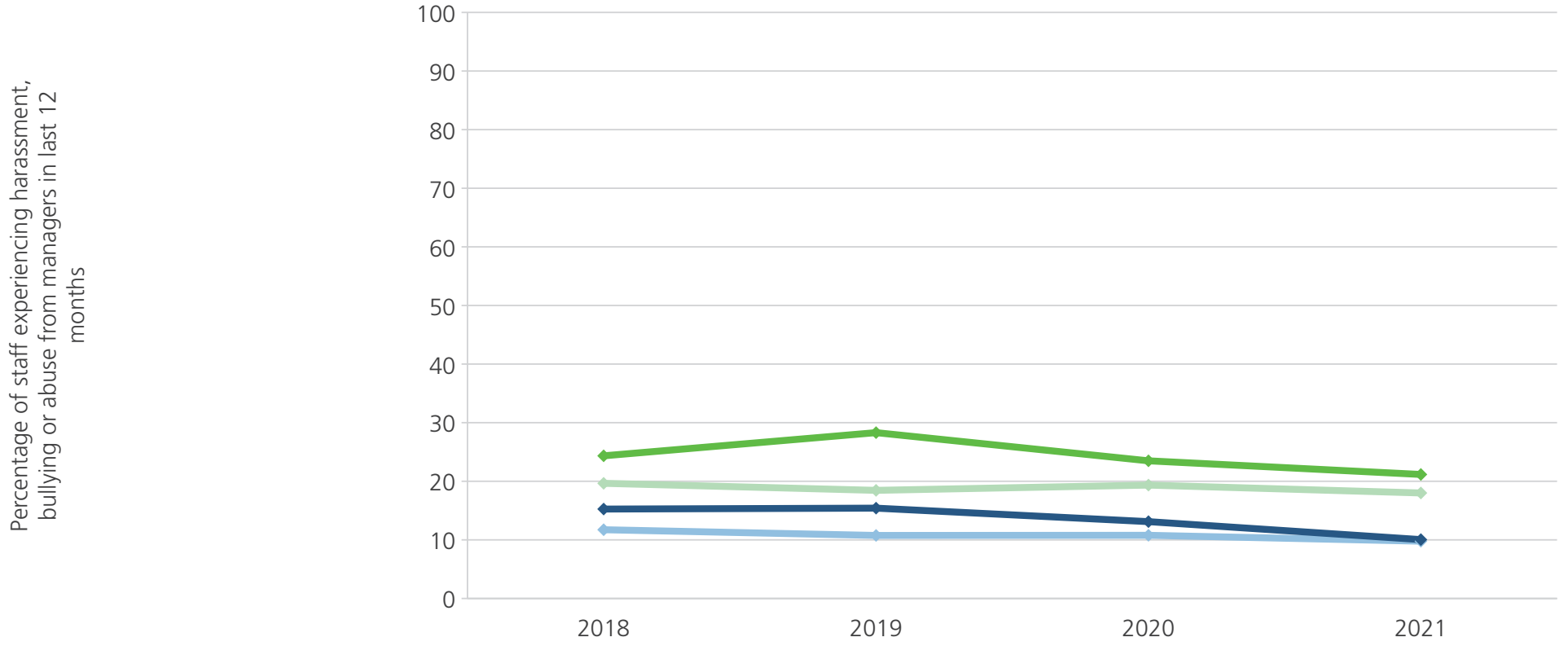



| | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|
| Staff with a LTC or illness: Your org | 31.5% | 38.4% | 35.8% | 34.8% |
| Staff without a LTC or illness: Your org | 31.1% | 29.6% | 28.4% | 25.4% |
| Staff with a LTC or illness: Average | 33.6% | 33.2% | 30.9% | 32.4% |
| Staff without a LTC or illness: Average | 26.6% | 26.5% | 24.5% | 25.2% |
| Staff with a LTC or illness: Responses | 460 | 526 | 578 | 722 |
| Staff without a LTC or illness: Responses | 3,653 | 4,190 | 4,074 | 3,889 |

Average calculated as the median for the benchmark group

Survey Coordination Centre

## 2021 NHS Staff Survey Results > WDES > Percentage of staff experiencing harassment, bullying or abuse from managers in last 12 months

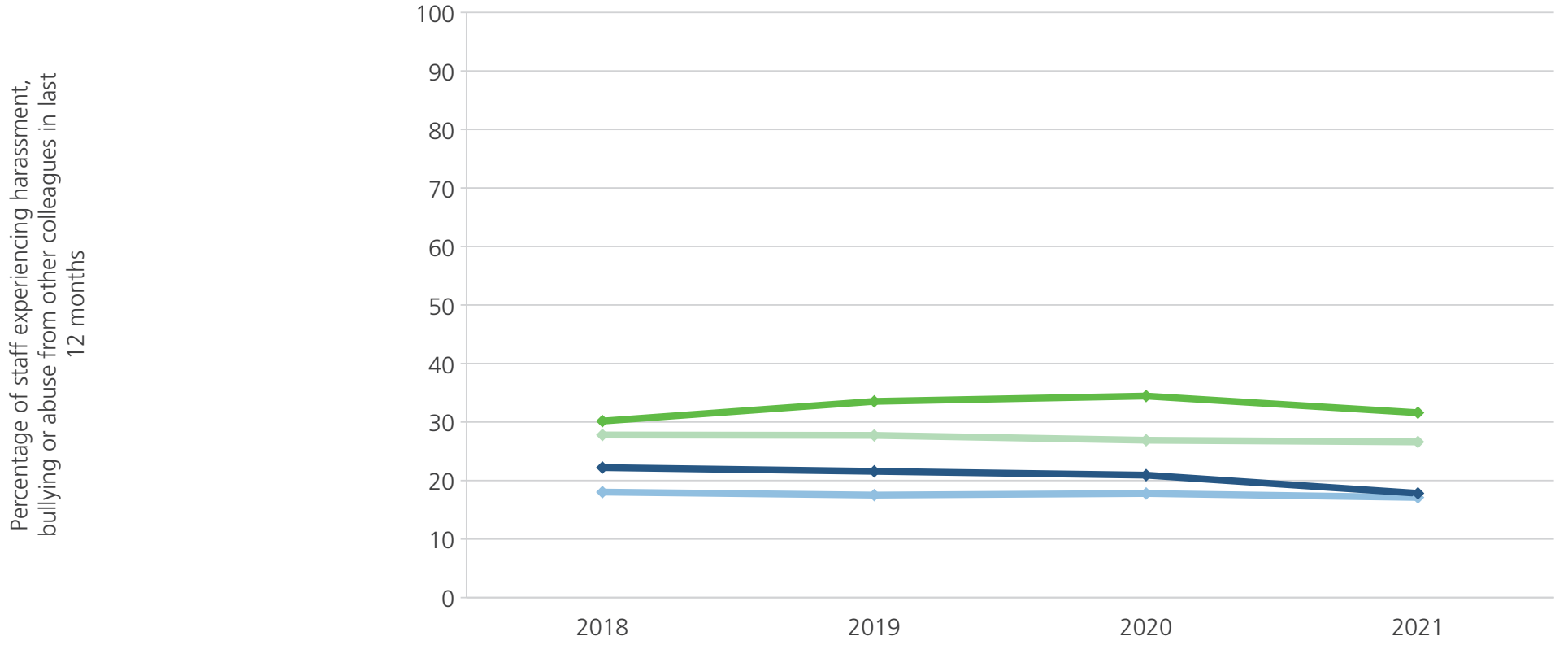



| | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|
| Staff with a LTC or illness: Your org | 24.3% | 28.3% | 23.5% | 21.2% |
| Staff without a LTC or illness: Your org | 15.3% | 15.4% | 13.1% | 10.0% |
| Staff with a LTC or illness: Average | 19.6% | 18.4% | 19.3% | 18.0% |
| Staff without a LTC or illness: Average | 11.7% | 10.8% | 10.8% | 9.8% |
| Staff with a LTC or illness: Responses | 456 | 523 | 579 | 723 |
| Staff without a LTC or illness: Responses | 3,598 | 4,165 | 4,065 | 3,872 |

Average calculated as the median for the benchmark group

Survey Coordination Centre

## 2021 NHS Staff Survey Results > WDES > Percentage of staff experiencing harassment, bullying or abuse from other colleagues in last 12 months

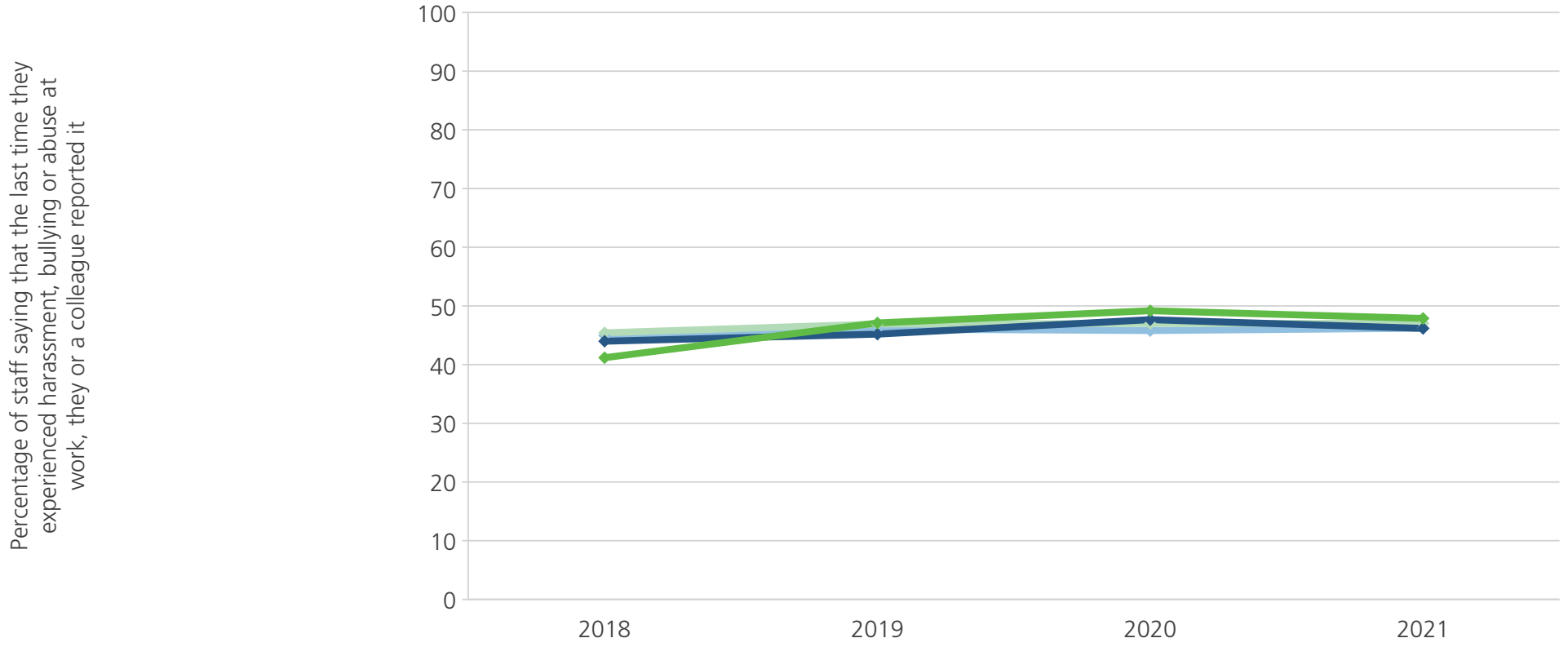



| | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|
| Staff with a LTC or illness: Your org | 30.2% | 33.5% | 34.4% | 31.6% |
| Staff without a LTC or illness: Your org | 22.2% | 21.6% | 20.9% | 17.8% |
| Staff with a LTC or illness: Average | 27.8% | 27.7% | 26.9% | 26.6% |
| Staff without a LTC or illness: Average | 18.0% | 17.5% | 17.8% | 17.1% |
| Staff with a LTC or illness: Responses | 451 | 525 | 575 | 722 |
| Staff without a LTC or illness: Responses | 3,584 | 4,168 | 4,064 | 3,873 |

Average calculated as the median for the benchmark group

Survey Coordination Centre

## 2021 NHS Staff Survey Results > WDES > Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it

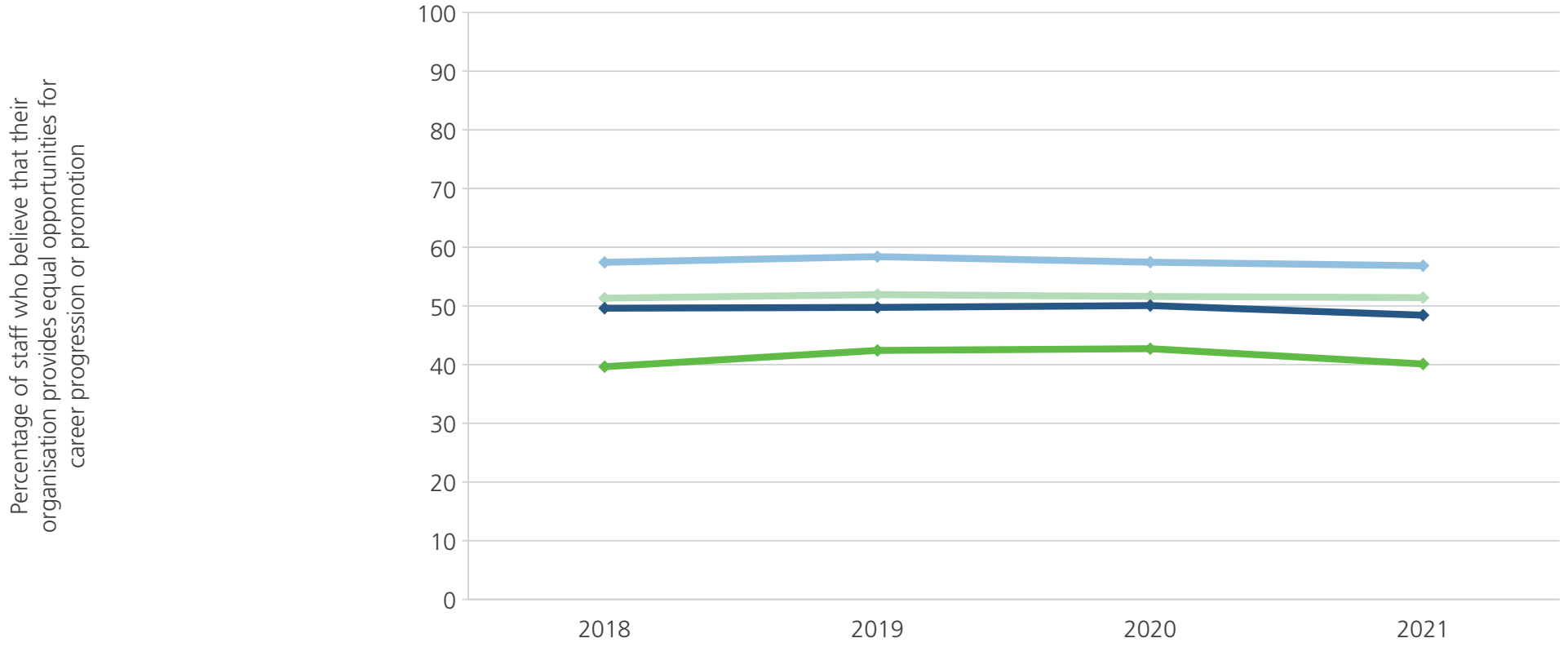



| | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|
| Staff with a LTC or illness: Your org | 41.2% | 47.1% | 49.2% | 47.9% |
| Staff without a LTC or illness: Your org | 44.0% | 45.2% | 47.7% | 46.2% |
| Staff with a LTC or illness: Average | 45.4% | 46.9% | 47.0% | 47.0% |
| Staff without a LTC or illness: Average | 45.0% | 46.1% | 45.8% | 46.2% |
| Staff with a LTC or illness: Responses | 221 | 293 | 305 | 353 |
| Staff without a LTC or illness: Responses | 1,405 | 1,622 | 1,496 | 1,280 |

Average calculated as the median for the benchmark group

Survey Coordination Centre

## 2021 NHS Staff Survey Results > WDES > Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion

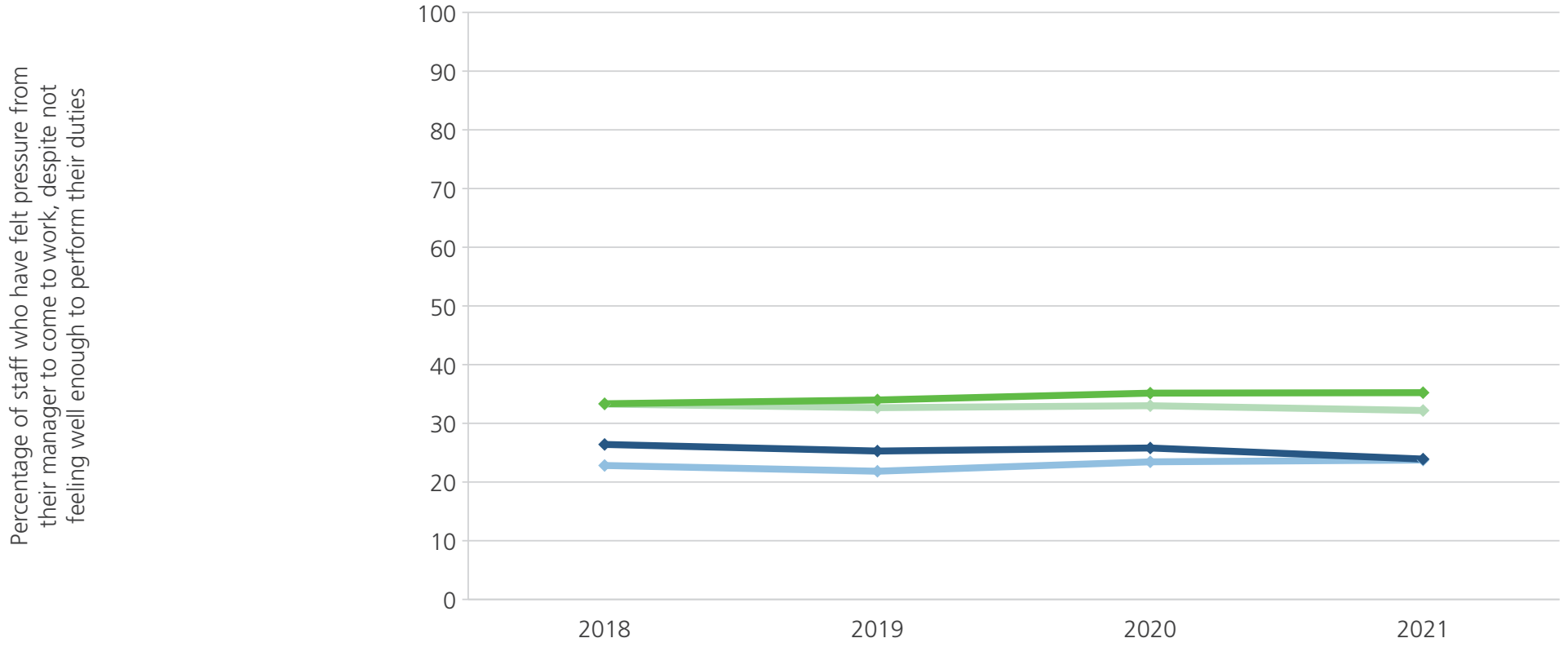



| | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|
| Staff with a LTC or illness: Your org | 39.6% | 42.4% | 42.7% | 40.1% |
| Staff without a LTC or illness: Your org | 49.6% | 49.7% | 50.1% | 48.4% |
| Staff with a LTC or illness: Average | 51.3% | 51.9% | 51.6% | 51.4% |
| Staff without a LTC or illness: Average | 57.4% | 58.4% | 57.4% | 56.8% |
| Staff with a LTC or illness: Responses | 454 | 521 | 597 | 748 |
| Staff without a LTC or illness: Responses | 3,628 | 4,163 | 4,155 | 3,992 |

Average calculated as the median for the benchmark group

Survey Coordination Centre

## 2021 NHS Staff Survey Results > WDES > Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties

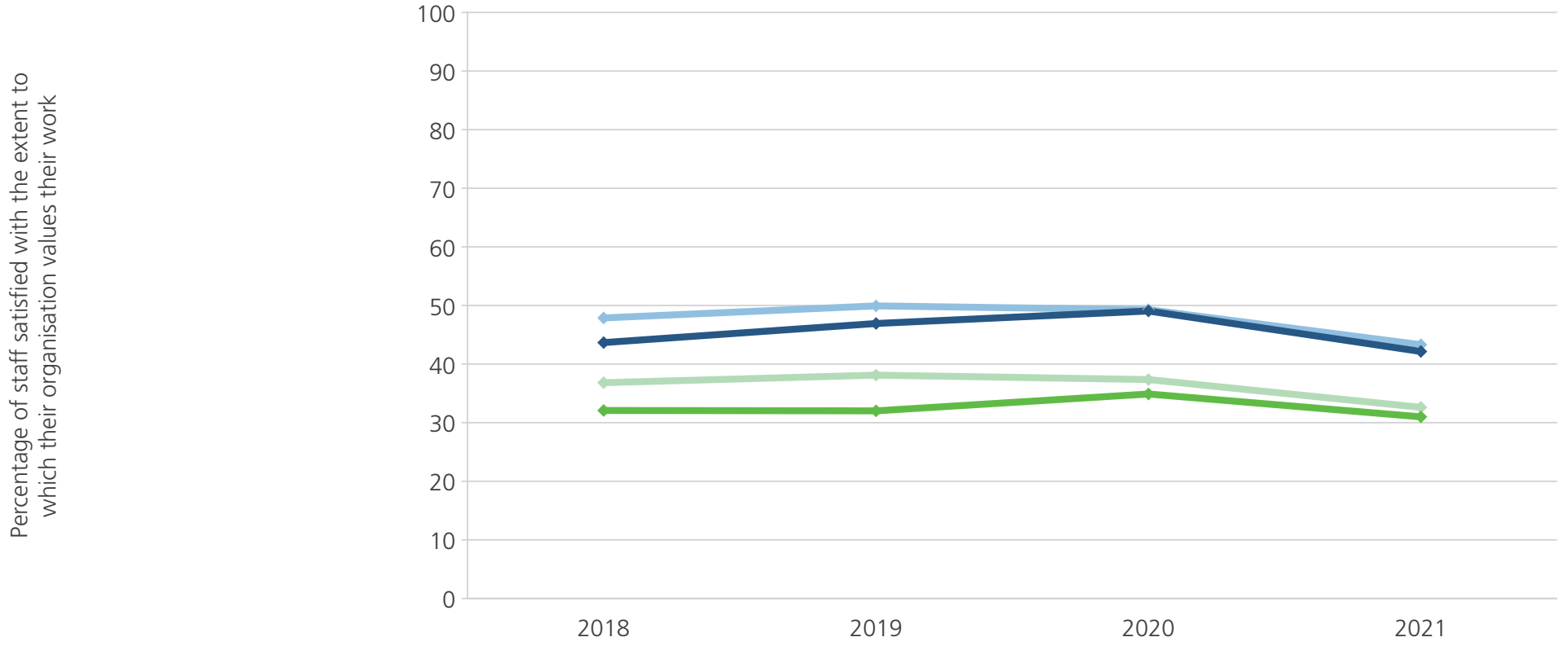



| | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|
| Staff with a LTC or illness: Your org | 33.3% | 34.0% | 35.1% | 35.2% |
| Staff without a LTC or illness: Your org | 26.4% | 25.3% | 25.8% | 23.9% |
| Staff with a LTC or illness: Average | 33.3% | 32.7% | 33.0% | 32.2% |
| Staff without a LTC or illness: Average | 22.8% | 21.8% | 23.4% | 23.7% |
| Staff with a LTC or illness: Responses | 336 | 418 | 387 | 565 |
| Staff without a LTC or illness: Responses | 1,966 | 2,354 | 1,760 | 2,083 |

Average calculated as the median for the benchmark group

Survey Coordination Centre

## 2021 NHS Staff Survey Results > WDES > Percentage of staff satisfied with the extent to which their organisation values their work




| | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|
| Staff with a LTC or illness: Your org | 32.1% | 32.0% | 34.9% | 31.0% |
| Staff without a LTC or illness: Your org | 43.7% | 46.9% | 49.1% | 42.1% |
| Staff with a LTC or illness: Average | 36.8% | 38.1% | 37.4% | 32.6% |
| Staff without a LTC or illness: Average | 47.9% | 49.9% | 49.3% | 43.3% |
| Staff with a LTC or illness: Responses | 452 | 531 | 599 | 755 |
| Staff without a LTC or illness: Responses | 3,630 | 4,205 | 4,179 | 4,022 |

Average calculated as the median for the benchmark group

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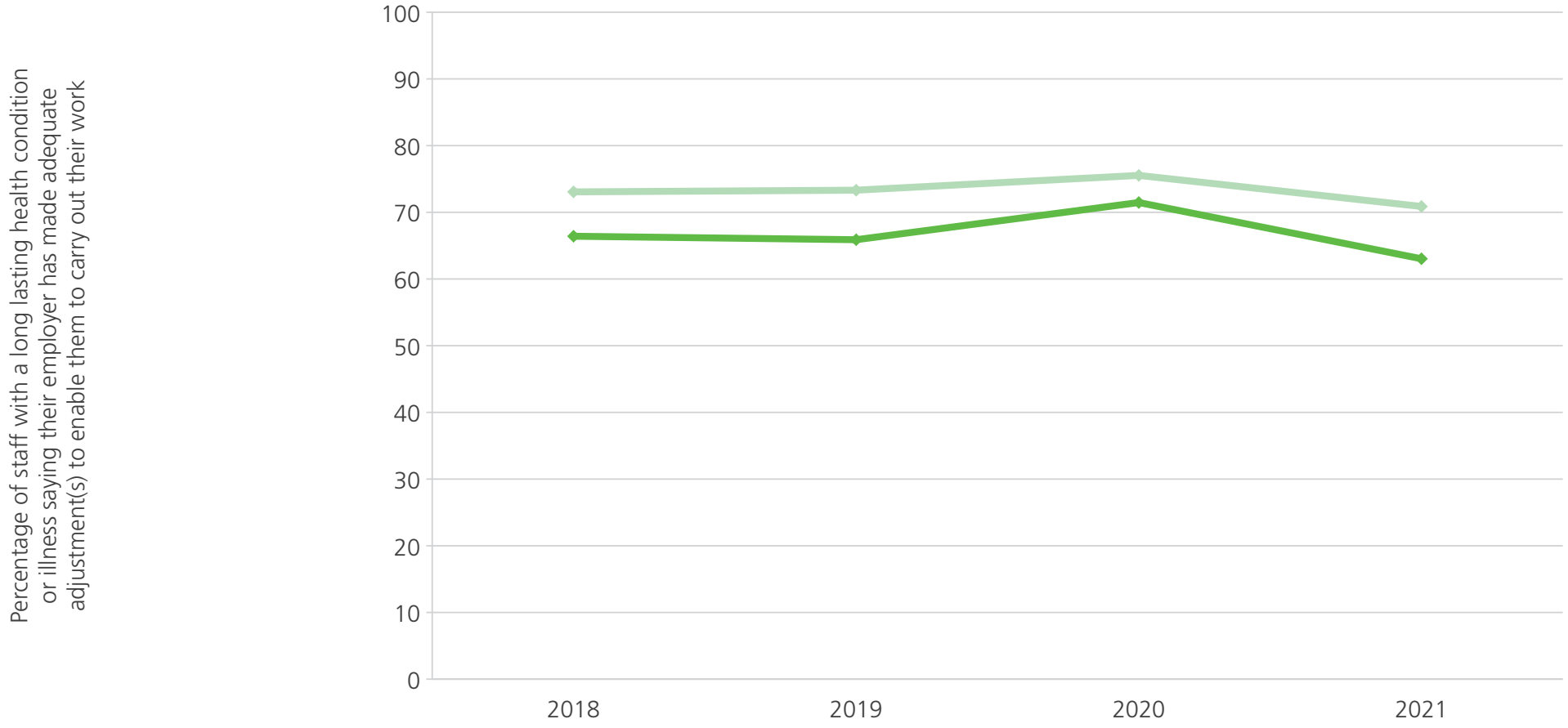
# 2021 NHS Staff Survey Results > WDES > Percentage of staff with a long lasting health condition or illness saying their employer has made adequate adjustment(s) to enable them to carry out their work




| | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|
| Staff with a LTC or illness: Your org | 66.4% | 65.9% | 71.5% | 63.0% |
| Staff with a LTC or illness: Average | 73.1% | 73.3% | 75.5% | 70.9% |
| Staff with a LTC or illness: Responses | 262 | 343 | 382 | 468 |

Average calculated as the median for the benchmark group

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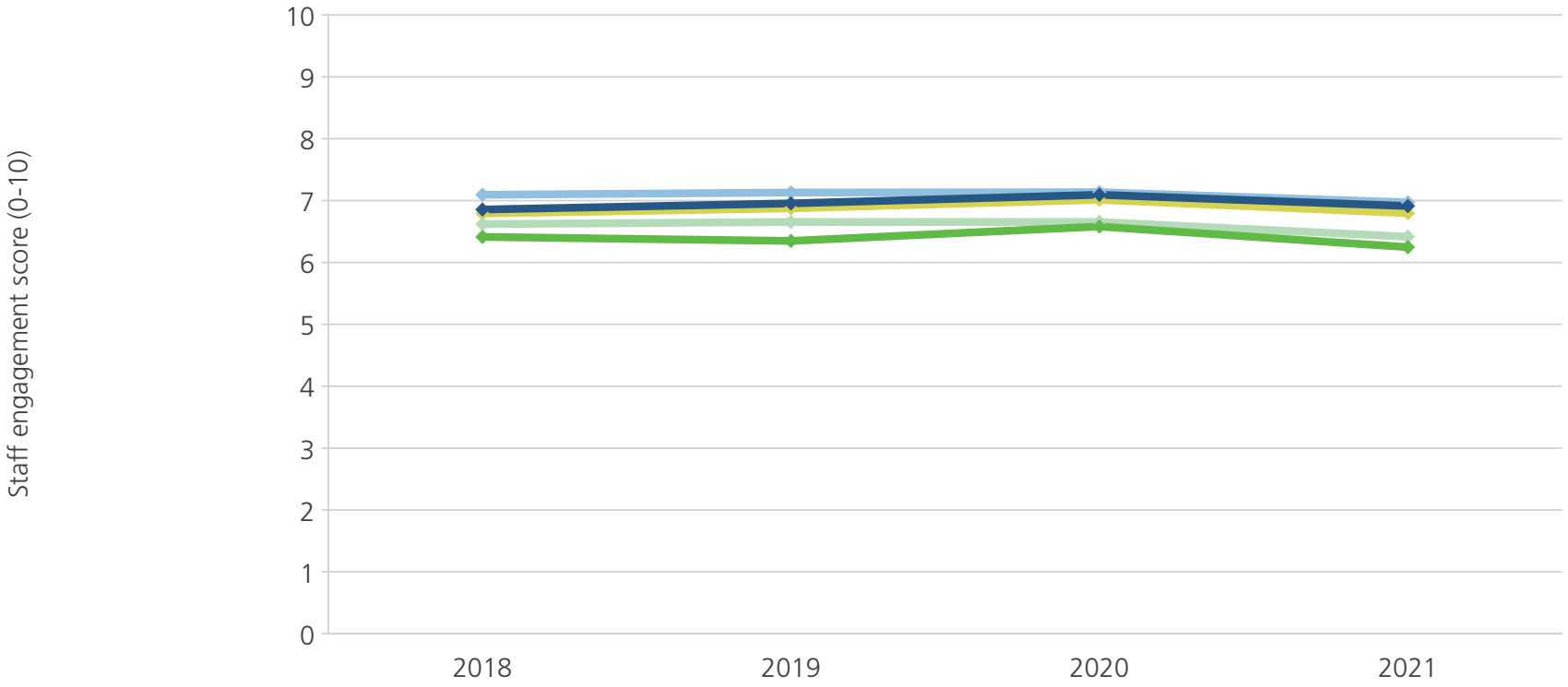
## 2021 NHS Staff Survey Results > WDES > Staff engagement score (0-10)




| | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|
| Organisation average | 6.8 | 6.9 | 7.0 | 6.8 |
| Staff with a LTC or illness: Your org | 6.4 | 6.3 | 6.6 | 6.2 |
| Staff without a LTC or illness: Your org | 6.9 | 7.0 | 7.1 | 6.9 |
| Staff with a LTC or illness: Average | 6.6 | 6.7 | 6.7 | 6.4 |
| Staff without a LTC or illness: Average | 7.1 | 7.1 | 7.1 | 7.0 |
| Organisation Responses | 4,445 | 4,896 | 5,015 | 4,964 |
| Staff with a LTC or illness: Responses | 459 | 530 | 601 | 757 |
| Staff without a LTC or illness: Responses | 3,663 | 4,211 | 4,191 | 4,032 |

Average calculated as the median for the benchmark group

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# Appendices

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# Appendix A: Response rate

St George's University Hospitals NHS Foundation Trust

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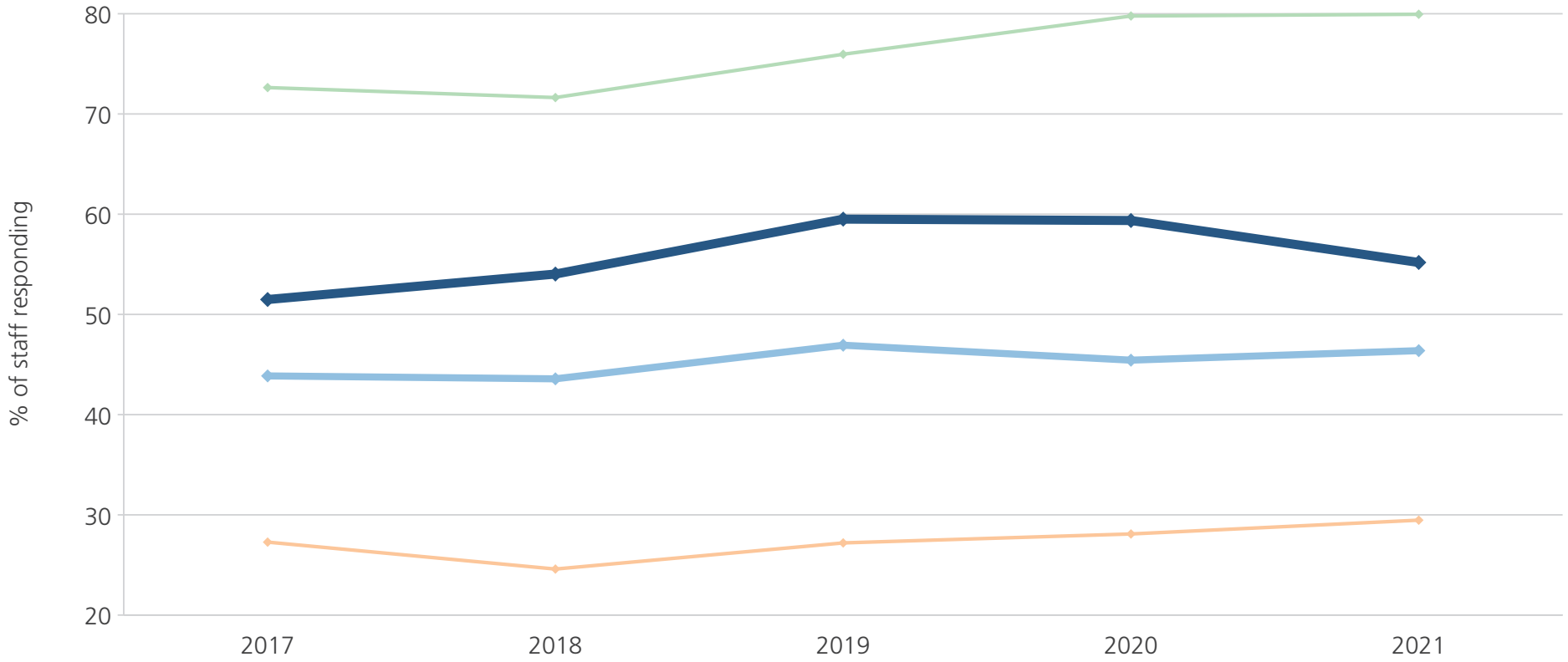
# 2021 NHS Staff Survey Results > Appendices > Response rate




| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| **Highest** | 72.6% | 71.6% | 76.0% | 79.8% | 79.9% |
| **Your org** | 51.5% | 54.0% | 59.5% | 59.4% | 55.2% |
| **Median** | 43.9% | 43.6% | 46.9% | 45.4% | 46.4% |
| **Lowest** | 27.3% | 24.6% | 27.2% | 28.1% | 29.5% |

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# Appendix B: Significance testing – 2020 vs 2021

St George's University Hospitals NHS Foundation Trust

2021 NHS Staff Survey Results

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# 2021 NHS Staff Survey Results > Appendices > Significance testing – 2020 vs 2021

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The table below presents the results of significance testing conducted on the theme scores calculated in both 2020 and 2021*. Note that results for the People Promise elements are not available for 2020. The table details the organisation's theme scores for both years and the number of responses each of these are based on.

The final column contains the outcome of the significance testing: ↑ indicates that the 2021 score is significantly higher than last year's, whereas ↓ indicates that the 2021 score is significantly lower. If there is no statistically significant difference, you will see 'Not significant'. When there is no comparable data from the past survey year, you will see 'N/A'.

| People Promise elements | 2020 score | 2020 respondents | 2021 score | 2021 respondents | Statistically significant change? |
|---|---|---|---|---|---|
| We are compassionate and inclusive | | | **7.1** | 4863 | N/A |
| We are recognised and rewarded | | | **5.7** | 4952 | N/A |
| We each have a voice that counts | | | **6.5** | 4815 | N/A |
| We are safe and healthy | | | **5.8** | 4848 | N/A |
| We are always learning | | | **5.2** | 4593 | N/A |
| We work flexibly | | | **5.7** | 4931 | N/A |
| We are a team | | | **6.5** | 4893 | N/A |
| **Themes** | **2020 score** | **2020 respondents** | **2021 score** | **2021 respondents** | **Statistically significant change?** |
| Staff Engagement | **7.0** | 5015 | **6.8** | 4964 | ↓ |
| Morale | **5.9** | 4993 | **5.5** | 4952 | ↓ |

* Statistical significance is tested using a two-tailed t-test with a 95% level of confidence.

For more details please see the technical document.

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# Appendix C: Tips on using your benchmark report

St George's University Hospitals NHS Foundation Trust

2021 NHS Staff Survey Results

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# Data in the benchmark reports

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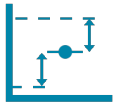
The following pages include tips on how to read, interpret and use the data in this report. The **suggestions are aimed at users who would like some guidance on how to understand the data** in this report. These suggestions are by no means the only way to analyse or use the data, but have been included to aid users who are new to the Staff Survey.

## Key points to note

- The seven People Promise elements, the two themes and the sub-scores that feed into them cover key areas of staff experience and present results in these areas in a clear and consistent way. All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, where a higher score is more positive than a lower score. These scores are created by scoring questions linked to these areas of experience and grouping these results together. Details of how the scores are calculated can be found in the technical document available on the Staff Survey website.

- A key feature of the reports is that they **provide organisations with up to five years of trend data**. For this year, trend data is provided for the two themes of Staff Engagement and Morale, the sub-scores that feed into these themes and for all questions except those added to the survey for the first time this year, and those impacted by survey change. Trend data provides a much more reliable indication of whether the most recent results represent a change from the norm for an organisation than comparing the most recent results only to those from the previous year. Taking a longer term view will help organisations to identify trends over several years that may have been missed when comparisons are drawn solely between the current and previous year.



- People Promise elements, themes and sub-scores are benchmarked so that organisations can make comparisons to their peers on specific areas of staff experience. Question results provide organisations with more granular data that will help them to identify particular areas of concern. The trend data are benchmarked so that organisations can identify how results on each question have changed for themselves and their peers over time by looking at a single graph.

# 1. Reviewing People Promise and theme results

When analysing People Promise element and theme results, it is easiest to start with the **overview** page to quickly identify areas which are doing better or worse in comparison to other organisations in the given benchmarking group.

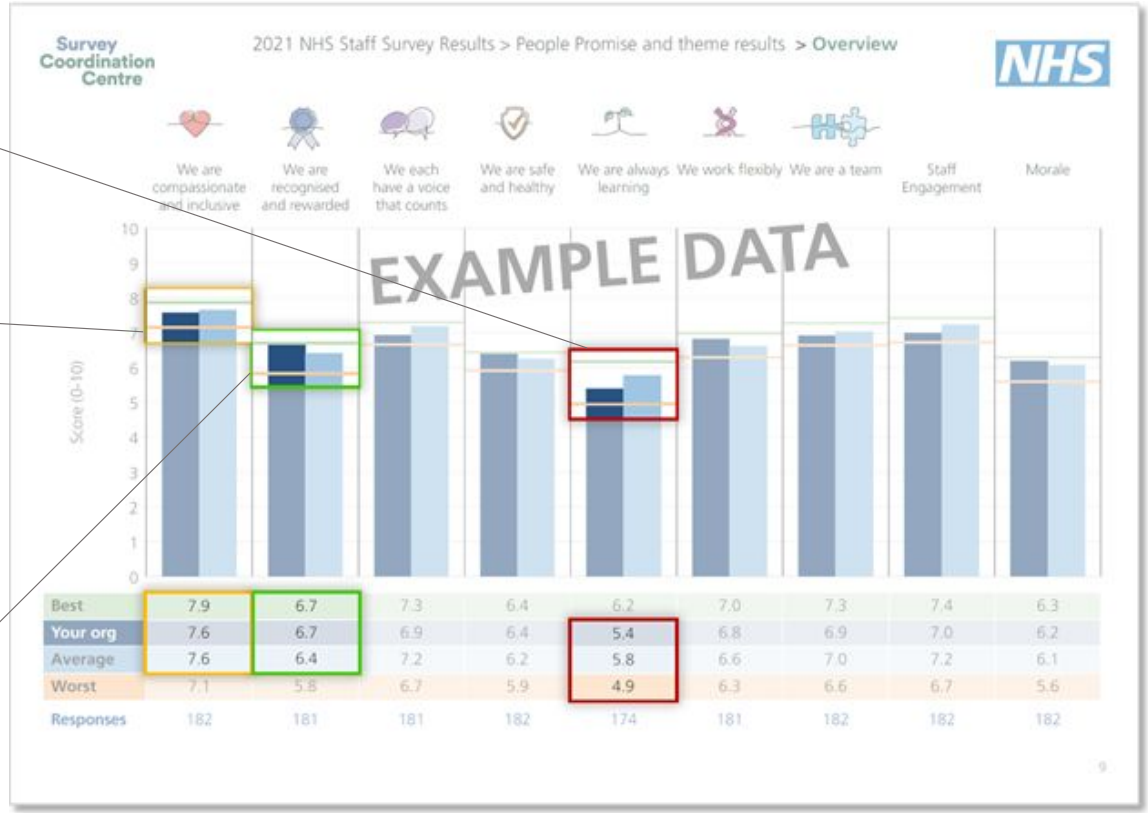
It is important to **consider each result within the range of its benchmarking group 'Best' and 'Worst' scores**, rather than comparing People Promise element and theme scores to one another. Comparing organisation scores to the benchmarking group average is another important point of reference.

## Areas to improve

- By checking where the 'Your org' column/value is lower than the benchmarking group 'Average' you can quickly identify areas for improvement.
- It is worth looking at the difference between the 'Your org' result and the benchmarking group 'Worst' score. The closer your organisation's result is to the worst score, the more concerning the result.
- Results where your organisation's score is only marginally better than the 'Average', but still lags behind the best result by a notable margin, could also be considered as areas for further improvement.

## Positive outcomes

- Similarly, using the overview page it is easy to identify People Promise elements and themes which show a positive outcome for your organisation, where 'Your org' scores are distinctly higher than the benchmarking group 'Average' score.
- Positive stories to report could be ones where your organisation approaches or matches the benchmarking group's 'Best' score.




*Only one example is highlighted for each point*

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# 2. Reviewing results in more detail

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## Review trend data

Trend data can be used to identify measures which have been consistently improving for your organisation (i.e. showing an upward trend) over the past years and ones which have been declining over time. These charts can **help establish if there is genuine change in the results** (if the results are consistently improving or declining over time), or whether a change between years is just a minor **year-on-year** fluctuation.

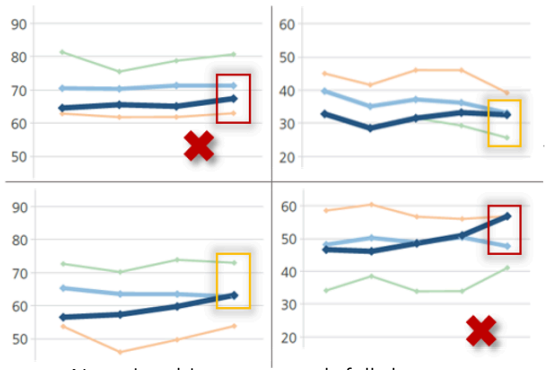

| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| Best | 6.3 | 6.5 | 6.3 | 6.3 | 6.2 |
| Your org | 5.7 | 5.8 | 5.8 | 6.0 | 6.2 |
| Average | 5.8 | 5.7 | 5.8 | 5.6 | 5.5 |
| Worst | 4.7 | 4.8 | 4.4 | 4.8 | 4.8 |
| No. responses | 344 | 803 | 668 | 738 | 764 |

Benchmarked trend data also allows you to review local changes and benchmark comparisons at the same time, allowing for various types of questions to be considered: e.g. how have the results for my organisation changed over time? Is my organisation improving faster than our peers?

## Review the sub-scores and questions feeding into the People Promise elements and themes

In order to understand exactly which factors are driving your organisation's People Promise element and theme scores, you should review the sub-scores and questions feeding into these scores. The **sub-score results** and the **'Detailed information'** section contain the sub-scores and questions contributing to each People Promise element and theme, grouped together. By comparing 'Your org' scores to the benchmarking group 'Average', 'Best' and 'Worst' scores for each question, the **questions which are driving your organisation's People Promise element and theme results can be identified**.

For areas of experience where results need improvement, action plans can be formulated to **focus on the questions where the organisation's results fall between the benchmarking group average and worst results**. Remember to keep an eye out for questions where a lower percentage is a better outcome – such as questions on violence or harassment, bullying and abuse.




✖ = Negative driver, org result falls between average & worst benchmarking group result for question

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# 3. Reviewing question results

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This benchmark report displays results for all questions in the questionnaire, including benchmarked trend data wherever available. While this a key feature of the report, at first glance the amount of information contained on more than 140 pages might appear daunting. The below suggestions aim to provide some guidance on how to get started with navigating through this set of data.

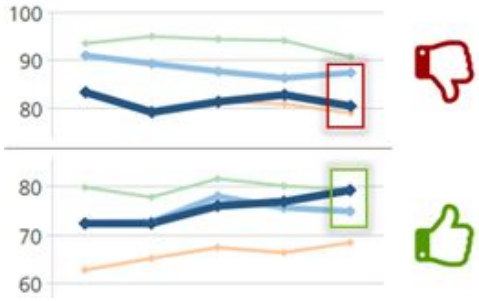
## Identifying questions of interest

### Pre-defined questions of interest – key questions for your organisation

Most organisations will have questions which have traditionally been a focus for them. Questions which have been targeted with internal policies or programmes, or whose results are of heightened importance due to organisation values or because they are considered a proxy for key issues. Outcomes for these questions can be assessed on the backdrop of benchmark and historical trend data. You can search for specific question results using the 'Find text' feature or by clicking on the question number in the table on page 4.

### Identifying questions of interest based on the results in this report

The methods recommended to review your People Promise and theme results can also be applied to pick out question level results of interest. However, **unlike People Promise elements, themes and sub-scores where a higher score always indicates a better result, it is important to keep an eye out for questions where a lower percentage relates to a better outcome** (see details on the 'Using the report' page in the 'Introduction' section).




- **To identify areas of concern**: look for questions where the organisation value falls between the benchmarking group average and the worst score, particularly questions where your organisation result is very close to the worst score. Review changes in the trend data to establish if there has been a decline or stagnation in results across multiple years, but consider the context of how the trust has performed in comparison to its benchmarking group over this period. A positive trend for a question that is still below the average result can be seen as good progress to build on further in the future.
- **When looking for positive outcomes**: search for results where your organisation is closest to the benchmarking group best result (but remember to consider results for previous years), or ones where there is a clear trend of continued improvement over multiple years.

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# Appendix D: Additional reporting outputs

St George's University Hospitals NHS Foundation Trust

2021 NHS Staff Survey Results

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# Additional reporting outputs

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Below are links to other key reporting outputs that complement this report. A full list and more detailed explanation of the reporting outputs is included in the Technical Document.

## Supporting documents

**Basic Guide**: Provides a brief overview of the NHS Staff Survey data and details on what is contained in each of the reporting outputs.

**Technical Document**: Contains technical details about the NHS Staff Survey data, including: data cleaning, weighting, benchmarking, People Promise, historical comparability of organisations and questions in the survey.

## Other local results

**Local Benchmarking**: Dashboards containing results for each participating organisation, similar those provided in this report, with trend data for up to five years where possible. These dashboards additionally show the full breakdown of response options for each question.

**Local Breakdowns**: Dashboards containing results for each organisation broken down by demographic characteristics. Data is available for up to five years where possible.

**Directorate Reports**: Reports containing People Promise and theme results split by directorate (locality) for St George's University Hospitals NHS Foundation Trust.

## National results

**National Trend Data** and **National Breakdowns**: Dashboards containing national results – data available for five years where possible.

**Regional/System overview** and **Regional/System breakdown**: Dashboards containing results for each region and each ICS/STP.

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| | | | |
|---|---|---|---|
| **Meeting Title:** | Trust Board | | |
| **Date:** | 31st March 2022 | **Agenda No** | **3.3** |
| **Report Title:** | Modern Slavery Act -Trust's Statement for Financial Year 2022/2023 | | |
| **Lead Director/ Manager:** | Paul Da Gama, Group Chief People Officer | | |
| **Report Author:** | Victoria Tyler, Head of HR Projects and Strategy | | |
| **Presented for:** | Approval and Assurance | | |
| **Executive Summary:** | Board approval and publication of a Modern Slavery Act Statement is a requirement under the Act for corporate organisations with a turnover above £36m. This statement must be reviewed on an annual basis and therefore the attached is a reviewed statement in preparation for publication on the Trust's intranet for the new financial year.<br><br>The statement has been reviewed within Workforce and discussed/agreed with the Director of Procurement. The statement was approved at People Management Group (PMG) on 2nd March 2022 and at Workforce and Education Committee (WEC) on 10th March 2022. | | |
| **Recommendation:** | Seeking approval of the attached annual statement for publication on the Trust's website. | | |
| **Committee Assurance:** | The Committee is also asked that in considering the 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.<br><br>• **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.<br><br>• **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.<br><br>• **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.<br><br>• **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:** | Culture | | |
| **CQC Theme:** | Well-lead | | |

| | | | |
|---|---|---|---|
| **Single Oversight Framework Theme:** | Not applicable | | |
| **Implications** | | | |
| **Risk:** | The absence of a published statement would result in the Trust not being compliant with the Modern Slavery Act 2015. | | |
| **Legal/Regulatory:** | Yes. The publication of a statement is a requirement of the Act. | | |
| **Resources:** | The previous annual statement has been reviewed with the Director of Procurement. | | |
| **Equality and Diversity:** | Modern slavery is a safeguarding issue, because it is concerned with the exploitation and abuse of people. It is therefore critical to have robust Trust protocols in place in respect of the supply chain, ensuring staff awareness/knowledge and processes in place for matters to be escalated. | | |
| **Previously Considered by:** | People Management Group<br>Workforce and Education Committee | **Date** | 02.02.2022<br>10.03.2022 |
| **Appendices:** | Modern Slavery Act Statement – 2022/2023 | | |

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# Modern Slavery Act Statement
# Performance Management Group: 2nd March 2022

## 1. PURPOSE

The purpose of this paper is to seek approval from Trust Board to publish the attached annual statement for the new financial year, as required by The Modern Slavery Act 2015. The statement was previously approved at People Management Group on 2nd March 2022 and Workforce and Education Committee on 10th March 2022.

The purpose of the statement is to set out the steps taken during the financial year to ensure that business and supply chains are modern slavery free. Board approval and publication of a statement is a requirement under the Act for corporate organisations with a turnover above £36 million.

## 2. BACKGROUND

The Modern Slavery Act 2015 is designed to consolidate various offences relating to human trafficking and slavery, with the Act creating a requirement for an annual statement to be prepared that demonstrates transparency in supply chains, in line with all businesses with a turnover of greater than £36 million per annum. We are therefore obliged to comply with the Act.

Section 54 of the Act specifically addresses the point about transparency in the supply chains, and states that a commercial organisation shall prepare a written slavery and human trafficking statement for the financial year to ensure slavery and human trafficking is not taking place in any part of the supply chain or its business. In addition to information pertaining to our supply chains and due diligence, the statement should also reference all other means to ensure our business is modern slavery free, which includes; reference to our relevant policies in place, training currently offered, indicators to measure the steps taken and any risks identified.

In line with the legislation, this statement must be approved by the Board of Directors and therefore it is necessary to seek Board approval in preparation for the publication of the 2022/2023 statement.

## 3. STATEMENT

A copy of the proposed statement is attached for review and agreement. In broad terms this sets out the following:

- The Trust's due diligence on modern slavery in respect of its supply chain;
- Details of the relevant policies/processes in place to ensure we are conducting our business in an ethical and transparent manner, as well as providing clarification on how concerns can be raised and what our escalation pathways are;
- Details of the relevant training that is currently offered which facilitates staff awareness of the signs of modern slavery and the process for raising a safeguarding concern;
- Assurance in respect of our pre-employment checks, including controls for both substantive and temporary staff.

## 4. IMPLICATIONS

The Trust is obliged to comply with the legislation. Failure to do so could result in proceedings against the Trust and significant reputational damage.

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Further to this, the requirement of a statement has been included as a mandatory Pass/Fail question in the template pre-qualification questionnaire used by CCGs, NHS England and Local Authorities to tender for health services. Consequently, the absence of a published Statement could result in the Trust not being shortlisted for future contracts.

## 5. RECOMMENDATION

Trust Board is asked to consider and approve the attached statement for publication on the Trust website and to continue to support the requirements of the legislation.

**Author:** Vicky Tyler, Head of HR Projects and Strategy
**Date:** 18th March 2022

Appendix 1

**Modern Slavery Act Trust's Statement for 2022/23 Financial year**

The Trust is aware of its responsibilities towards patients, service users, employees and the local community and expects all suppliers to adhere to the same ethical principles. The Trust is committed to ensuring that there is no modern slavery or human trafficking in our supply chains or in any part of our business. Our internal policies replicate our commitment to acting ethically and with integrity in all business relationships.

Currently, all awarded suppliers sign up to our terms and conditions of contract which contain a provision around Good Industry Practice to ensure each supplier's commitment to anti-slavery and anti-human trafficking in their supply chains. The provision around Good Industry Practice also ensures that the suppliers conduct their businesses in a manner that is consistent with the Trust's stance on anti-slavery. In addition, an increasing number of suppliers are implementing the Labour Standards Assurance System (LSAS) as a condition of contract for tenders within high risk sectors and product categories as referenced in the Government's Modern Slavery Strategy. Many aspects of the LSAS align to the seven reporting areas that the Government has outlined and should appear within any slavery and human trafficking statement.

The Trust has a number of internal policies to ensure that we are conducting business in an ethical and transparent manner. These include:

• Recruitment policy - We operate a robust Recruitment policy, including conducting eligibility to work in the UK checks for all directly employed staff, and agencies on approved frameworks are audited to provide assurance that pre-employment clearance has been obtained for agency staff. This is to safeguard against human trafficking or individuals being forced to work against their will.

• Equal Opportunities - We have a range of controls to protect staff from poor treatment and/or exploitation, that comply with all respective laws and regulations. These ensure we have fair terms and conditions of employment and that there is fair access to training and development opportunities.

• Safeguarding policies and training - We adhere to the principles inherent within both our safeguarding children and adults' policies. Our employees are clear on how to raise safeguarding concerns about how colleagues or people receiving our services are being treated, or about practices within our business or supply chain. Modern slavery is currently included in key safeguarding modules, with plans to expand across all modules in the forthcoming year.

• Raising Concerns Policy - We operate a Raising Concerns at Work policy so that all employees know that they can raise concerns about how colleagues or people receiving our services are being treated, or about practices within our business or supply chain, without fear of reprisals.

The Trusts' approach to procurement and our supply chain includes:

• Ensuring that our suppliers are carefully selected through our robust supplier selection criteria/processes;

• Requiring that the main contractor provides details of its sub-contractor(s) to enable the Trust to check their credentials;

• Random requests that the main contractor provides details of its supply chain;

• Ensuring invitation to tender documents contain a clause on human rights issues;

• Ensuring invitation to tender documents also contain clauses giving the Trust the right to terminate a contract for failure to comply with labour laws;

• Using the standard Supplier Selection Questionnaire (SQ) that has been introduced (which includes a section on Modern Day Slavery).

Staff within the Trust must contact and work with the Procurement department when looking to work with new suppliers to ensure appropriate checks can be undertaken.

Where it is verified that a subcontractor has breached the child labour laws or human trafficking, then this subcontractor will be excluded in accordance with Regulation 57 of the Public Contracts Regulations 2015. The Trust will require that the main contractor finds a new subcontractor. The Trust operates zero tolerance to slavery and human trafficking and expects all direct and indirect suppliers/contractors to follow suit

| | | | |
|---|---|---|---|
| **Meeting Title:** | **Trust Board** | | |
| **Date:** | 31 March 2022 | **Agenda No** | **4.1** |
| **Report Title:** | **Audit Committee Report** | | |
| **Lead Director/ Manager:** | Peter Kane, Chair of the Audit Committee | | |
| **Report Author:** | Peter Kane, Chair of the Audit Committee | | |
| **Presented for:** | Approval | | |
| **Executive Summary:** | The report sets out the key issues discussed and agreed by the Committee at its meeting on 14 February 2022. | | |
| **Recommendation:** | The Board is asked to note the report from the Audit Committee. | | |
| **Supports** | | | |
| **Trust Strategic Objective:** | All | | |
| **CQC Theme:** | Well Led | | |
| **Single Oversight Framework Theme:** | Finance and use of resources, Leadership and Improvement capability (Well Led) | | |
| **Implications** | | | |
| **Risk:** | N/A | | |
| **Legal/Regulatory:** | N/A | | |
| **Resources:** | N/A | | |
| **Previously Considered by:** | N/A | **Date**: | N/A |
| **Appendices:** | N/A | | |

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**Audit Committee Report**

**Report of Meeting Held on 14 March 2022**

**Matters for the Board's attention**

The Audit Committee met on 14 March 2022 and this report provides assurance to the Board of the areas covered at the meeting.

The items covered at the meeting were as follows:

- Annual Audit Plan & Fees
- Annual Report, Accounts and Quality Accounts Plan and Timetables and High Level Themes
- Accounting Policies
- Internal Audit Progress Report
- Internal Audit Recommendation Tracker
- Final Internal Audit Review Reports
    - Use of Staff Survey – reasonable assurance
    - Health and Safety – reasonable assurance
    - Data Quality (Key Performance Targets) - reasonable assurance
    - Homeworking – reasonable assurance
    - Review of Core Finance - substantial assurance
- Internal Audit Plan 2022/23
- Client Briefing Notes from TIAA
- Counter Fraud Update
- Breaches and Waivers
- Pharmacy Governance & Oversight and Response to the MHRA
- Review of Committee effectiveness

Issues of note arising from the report are shown below;

**1. Annual Audit Plan & Fees**

The plan for carrying out the year-end audit was presented by the external auditor, and it was confirmed that the value for money (VfM) audit will be aligned with the year end audit process. The Committee reminded the external auditor that suggestions about how the VfM review could be improved were made at the September meeting of the Committee.

**2. Annual Report, Accounts and Quality Accounts Plan and Timetables and High Level Themes**

The Committee were told of the requirement for final submission by 22 June 2022 and that other requirements had not yet been confirmed, although it is known that there is no statutory requirement to include the quality report within the annual report. The key themes for the annual report will include;

- Staff wellbeing
- Equalities and diversity
- Developing the group model

The Chair set a challenge to reduce the overall size of the annual report.

### 3. Internal Audit

The internal auditor told the Committee of the positive results received from recent internal audit reviews but that engagement was still needed to ensure the audit programme would be finished by year end.

There has been progress on closing actions arising from internal audit recommendations and the Committee reiterate the need to routinely close down actions quickly.

The internal audit plan for 2022/23 was discussed and agreed.

### 4. Breaches and Waivers

The Committee reinforced the  need to bear down on breaches and waivers.  It heard that the introduction of a new financial management system from April 2022 should help to reduce the number of breaches as it should provide greater clarity on workflows.

### 5. Pharmacy Governance & Oversight and Response to the MHRA

The action plan in response to the report by the Medicines and Healthcare Products Regulatory Agency (MRHA) was discussed at the Committee, as requested by the Board.

A task and finish group has been established and there will be regular reports to the Quality and Safety Committee (QSC) on progress.

There was a further discussion on whether the governance failures that led to the critical report could be replicated elsewhere in the Trust and have asked for a report to the next meeting on the broader lessons that need to be learned from this report.

**Recommendation**

The Board is asked to receive assurance from the report of the Audit Committee.

Peter Kane

Chair, Audit Committee

March 2022

St George's University Hospitals NHS
NHS Foundation Trust

| | | | |
|---|---|---|---|
| **Meeting Title:** | **Trust Board** | | |
| **Date:** | 31 March 2022 | **Agenda No** | **4.2** |
| **Report Title:** | **Finance and Investment Committee report** | | |
| **Lead Director/ Manager:** | Ann Beasley, Chairman of the Finance and Investment Committee | | |
| **Report Author:** | Ann Beasley, Chairman of the Finance and Investment Committee | | |
| **Presented for:** | Assurance | | |
| **Executive Summary:** | The report sets out the key issues discussed and agreed by the Committee at its meetings on the 17th February 2022 and 24th March 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 – February 2022 & March 2022**

The Committee met on 17th February 2022 and 24th March 2022. In addition to the regular items on strategic risks, operational performance and financial performance, it also considered papers on:

- Planning for 2022/23;
- Technical Releases;
- Committee Effectiveness Report;
- Financial Systems Update;
- Finance Policy Update; and
- An SWLP Report.

As is its usual practice, the Committee discussed the Board Assurance Framework (BAF) risks on a rotating basis by deep dives, with consideration by exception in intervening months. In March members undertook a deep dive into the finance and estates risks. Issues raised in discussion covered the unchanged financial risk owing to the significant revenue and capital challenge in the next financial year, and the improvement in Estates risk following improvements in water and fire safety. Members were assured that mitigations were receiving sufficient executive focus. While no deep dive on ICT or Operational risk was presented at either meeting, exception reports highlighted progress with cyber security and child mental health pressures in the Emergency Department. The Committee discussed current financial performance, cash management and capital expenditure as the Trust reported the M10 (in February) and M11 (in March) 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) and Director of Estates and Facilities (DE&F) all updated the committee on their respective strategic risks, with scores and assurance ratings agreed as follows:

- SR5- Financial Sustainability 20 – Partial Assurance
- SR6- Financial Investment 20 – Partial Assurance
- SR7- Estates Risk 16 – Good Assurance

**1.2 Estates Report –**the Director of Estates & Facilities (DE&F) introduced the normal monthly update, noting progress on the Estates Strategy.

**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 90% compared to 95% target) and Outpatient performance is expected to be ahead (at 107% compared to 95%).

**1.4 Emergency Department (ED) Update –** the performance of the Emergency Care Operating Standard was recorded at 73.1% in February. The Committee noted that the Trust continues to see significant challenges impacting waiting times, with bed flow impacting front-end capacity driving an increase in 12-hour trolley waits.

**1.5 Diagnostics Performance** – the COO noted that 1.8% of patients were waiting to have a diagnostic test compared to 3.1% in January. The Committee welcomed this improvement.

**1.6 Cancer Performance** – the COO noted Cancer performance in January where 1 of the 7 targets was met, noting the trajectories to deliver compliance in the coming months.

**1.7 Referral to Treatment (RTT) Update –** the performance against the RTT target was discussed, where performance in January of 72.1% had deteriorated against the previous month's value of 72.5%, with the number of 52 week waits of 887 being less than the previous month's 923. The size of the waiting list (including QMH patients) was 47,892 patients.

**1.8 Financial Performance–** the DCFO noted performance at M11 YTD for 2021/22, where a deficit of £4.6m was reported at the end of February, which is £4.2m favourable to plan. This includes additional funding of £4.2m 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 28th February 2022 was £65.7m (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.

**1.9 Planning 22-23 –** the DCFO noted the progress being made on planning for 2022/23 with a more challenging financial settlement. The Committee discussed the deliverability of CIP and how the Trust and ICS benchmarks against other NHS organisations.

**1.10 Technical Releases –** the DCFO highlighted the important aspects of the accounting policies paper already received by the Audit Committee.

**1.11 Committee Effectiveness –** the DCFO noted good progress in the committee effectiveness report for 2021/22, with areas for improvement discussed and actions agreed.

**1.12 Financial Systems Update –** the DCFO observed good progress in the financial systems upgrade due to go live on 1st April 2022. The Committee welcomed this progress .

**1.13 Financial Policy Update –** the DCFO noted no material changes to the Asset Valuation, Credit Management or Treasury Management Policies which were brought before the committee. **The committee approved the updated policies.**

**1.14 SWLP Report –** the DCFO noted the financial performance of SWLP at the end of Q3. The Committee discussed the latest position with the laboratory inventory management software implementation (LIMS).

**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,**
**February 2022 & 2022**

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St George's University Hospitals NHS Foundation Trust

| | | | |
|---|---|---|---|
| **Meeting Title:** | **TRUST BOARD** | | |
| **Date:** | **31st March 2022** | **Agenda No** | **4.3** |
| **Report Title:** | **M11 Financial Performance** | | |
| **Lead Director/ Manager:** | Andrew Grimshaw, Group Chief Financel Officer | | |
| **Report Author:** | Tom Shearer, Deputy Chief Finance Officer | | |
| **Presented for:** | Update | | |
| **Executive Summary:** | The Trust is reporting a deficit of £4.6m at the end of February, which is £4.2m 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.<br><br>This includes £25.2m of ERF income and £15.6m of ERF costs, both of which are £5m higher than plan (and so offset).<br><br>The Trust is forecast to breakeven at year end, which would be £5m favourable to the external plan submitted in November.<br><br>Excluding ERF, income is reported at £6.5m favourable to plan at Month 11. This is due to additional funding made available to SWL ICS. There is also additional funding to cover increased Vaccination and Surge Hub costs.<br><br>Excluding ERF, expenditure is reported at £2.3m adverse to plan at Month 11. This is due to higher staffing costs related to COVID, partially offset by lower Commercial Pharmacy costs.<br><br>Capital expenditure of £50.1m has been incurred year to date. This is to £0.1m favourable to a plan of £50.2m.<br><br>At the end of Month 11, the Trust's cash balance was £65.7m. Cash resources are tightly managed and will continue to be monitored. | | |
| **Recommendation:** | The Trust Board notes the M11 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:** | FIC | **Date** | 24/3/22 |
| **Appendices:** | N/A | | |

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# Financial Report Month 11 (February 2022)


**Andrew Grimshaw**
Chief Financial Officer

24th March 2022

# Executive Summary – Month 11 (February)



| Area | Key Issues | Current Month (YTD) | Previous Month (YTD) |
|---|---|---|---|
| Financial Position | The Trust is reporting a deficit of £4.6m at the end of February, which is £4.2m 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.<br><br>This includes £25.2m of ERF income and £15.6m of ERF costs, both of which are £5m higher than plan (and so offset). | £4.2m Fav to plan | £3.5m 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. | £5.0m favourable to plan (at year end) | £5.0m favourable to plan (at year end) |
| Income | Excluding ERF, income is reported at £6.5m favourable to plan at Month 11. This is due to additional funding made available to SWL ICS. There is also additional funding to cover increased Vaccination and Surge Hub costs. | £6.5m Adv to plan | £4.2m Fav to plan |
| Expenditure | Excluding ERF, expenditure is reported at £2.3m adverse to plan at Month 11. This is due to higher staffing costs related to COVID, partially offset by lower Commercial Pharmacy costs. | £2.3m Adv to plan | £0.9m Adv to plan |
| ERF | The Trust has received £25.2m of ERF income, which is £5m over plan. The Trust has incurred £15.6m of associated costs, which is £5m over plan. | On Plan | On Plan |
| Capital | Capital expenditure of £50.1m has been incurred year to date. This is to £0.1m favourable to a plan of £50.2m. | £0.1m Fav to plan | £0.5m Fav to plan |
| Cash | At the end of Month 11, the Trust's cash balance was £65.7m. Cash resources are tightly managed and will continue to be monitored. | £62.7m Fav to plan | £48.8m Fav to plan |

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# Contents





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# 1. Month 11 Financial Performance

| | | | Full Year Budget (£m) | M11 Budget (£m) | M11 Actual (£m) | M11 Variance (£m) | YTD Budget (£m) | YTD Actual (£m) | YTD Variance (£m) |
|---|---|---|---|---|---|---|---|---|---|
| Excluding ERF | **Income** | SLA Income | 852.9 | 70.8 | 73.3 | 2.5 | 782.2 | 789.2 | 7.0 |
| | | Other Income | 136.3 | 11.4 | 11.3 | (0.2) | 124.8 | 124.3 | (0.5) |
| | **Income Total** | | **989.2** | **82.3** | **84.5** | **2.3** | **906.9** | **913.4** | **6.5** |
| | **Expenditure** | Pay | (604.8) | (51.8) | (52.1) | (0.3) | (557.8) | (560.9) | (3.1) |
| | | Non Pay | (356.1) | (29.5) | (30.7) | (1.1) | (330.0) | (329.3) | 0.7 |
| | **Expenditure Total** | | **(960.9)** | **(81.3)** | **(82.8)** | **(1.5)** | **(887.8)** | **(890.2)** | **(2.3)** |
| | **Post Ebitda** | | (44.1) | (3.2) | (3.2) | 0.0 | (37.4) | (37.4) | (0.0) |
| | **Grand Total** | | **(15.8)** | **(2.3)** | **(1.5)** | **0.8** | **(18.3)** | **(14.2)** | **4.2** |
| ERF | **Income** | | 21.4 | 1.2 | 3.2 | 2.1 | 20.3 | 25.2 | 5.0 |
| | **Expenditure** | | (10.6) | 0.0 | (2.1) | (2.1) | (10.6) | (15.6) | (5.0) |
| | **Total** | | **10.8** | **1.2** | **1.2** | **0.0** | **9.6** | **9.6** | **0.0** |
| | **Reported Position** | | **(5.0)** | **(1.1)** | **(0.3)** | **0.8** | **(8.7)** | **(4.6)** | **4.2** |

## Trust Overview

The in month reported position at **M11 is a £0.3m deficit, which is on £0.8m favourable to plan. The YTD position is a £4.6m deficit, which is £4.2m favourable to plan**.

Excluding ERF income and costs:

- **Income** is £6.5m over plan, due to additional funding for SWL ICS and increased funding to cover Vaccination and Surge Hub costs.
- **Pay** is £3.1m overspent across Junior Doctor and Nursing staff groups due to additional costs related to COVID, such as sickness.
- **Non-pay** is £0.7m underspent due to lower costs in Commercial Pharmacy.

The Trust has received £25.2m of ERF income, which is £5m over plan. The Trust has incurred £15.6m of associated costs, which is £5m over plan.

# 2. Balance Sheet as at 28th February 2022



| Statement of Financial Position | M12 March-21 FY 20-21 Actual Audited (£m) | M11 Feb-22 FY21-22 YTD Actual (£m) | Movement YTD Feb-22 (£m) |
|---|---|---|---|
| | | | |
| **Fixed assets** | **470.7** | **495.7** | **25.0** |
| ***Current assets*** | | | |
| Stock | **13.2** | 15.0 | 1.8 |
| Debtors | **83.3** | 107.3 | 24.0 |
| Cash | **36.6** | 65.7 | 29.1 |
| | | | |
| ***Total Current Assets*** | **133.1** | **188.0** | **55.0** |
| ***Current liabilities*** | | | |
| Creditors | **(110.8)** | (190.7) | (79.9) |
| Capital creditors | **(36.0)** | (23.7) | 12.3 |
| PDC div creditor | **0.0** | (7.5) | (7.5) |
| Provision<1 Year | **(0.9)** | (0.9) | 0.0 |
| Borrowings< 1 year | **(5.1)** | (5.6) | (0.5) |
| Int payable creditor | **(0.1)** | (0.1) | 0.0 |
| ***Total current liabilities*** | **(152.9)** | **(228.4)** | **(75.5)** |
| **Net current assets/-liabilities** | **(19.9)** | **(40.4)** | **(20.5)** |
| | | | |
| Provisions> 1 year | **(3.3)** | (3.1) | 0.1 |
| Borrowings> 1 year | **(57.4)** | (55.7) | 1.7 |
| **Total Long-term liabilities** | **(60.7)** | (58.9) | 1.8 |
| **Net assets** | **390.2** | **396.5** | **6.3** |
| | | | |
| **Taxpayer's equity** | | | |
| Public Dividend Capital | **531.9** | 543.0 | 11.0 |
| Income & Expenditure Reserve | **(225.2)** | (230.0) | (4.8) |
| Revaluation Reserve | **82.4** | 82.4 | 0.0 |
| Other reserves | **1.2** | 1.2 | 0.0 |
| **Total taxpayer's equity** | **390.2** | **396.5** | **6.3** |

**M11 FY21-22 YTD Statement of Financial Position**

- Fixed assets have increased by £25.0m since March-21. This includes the impact of depreciation (£25.2m), capital expenditure (£50.1m) and Grove reversionary interest of £181k.
- Inventory value has increased by £1.8m compared to Mar-21 (slide 10i). This is due to increases in central store stock, pharmacy, cardiac catheter and cardiac pacing stocks (slide 10i).
- Debtors has increased by £24.0m since March 2021, which is offset by increased creditors and expected to reduce in M12.
- The cash position is £29.1m higher than reported at year-end in March-21. The increase in cash is due to timing differences from year end payments made in advance.
- Cash resources are tightly managed monthly to meet the £3.0m minimum cash target at the end of the year.
- Creditors are £79.9m 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, which is expected to significantly reduce at year end.
- Capital creditors are £12.3m lower than March-21. This decrease is due to FY 20-21 capital creditors paid in FY21-22.
- Provision has decreased by £0.1m which is due to the utilisation of early retirement provision.
- No new borrowing since March-21, except an increase in capital finance lease borrowing of £5.9m M11 YTD.
- PDC dividend charge creditor increased to £5.7m since March-21. This is due to the M11 YTD PDC dividend charge accrual of £10.1m. This accrual is based on the FY21-22 forecasted PDC dividend charge of £11.2m. In September-21, the Trust paid a PDC dividend charge payment of £2.3m and also received PDC dividend charge refund of £362k for FY20/21.
- Taxpayers equity has reduced by £6.3m at M11 YTD. This is mainly due the I&E YTD M11 deficit of £4.8m. M11 YTD I&E deficit, includes finance expense and PDC dividend charges.



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# 3. Month 11 Cash Flow Statement

| Statement of Cash Flow | M11 YTD FY 21-22 Actual £m |
|---|---|
| **Opening Cash balance** | **36.6** |
| Income and expenditure deficit | (4.8) |
| Depreciation | 25.2 |
| Impairment | 0.0 |
| Interest payable | 2.9 |
| PDC dividend | 10.1 |
| Other non-cash items | (0.2) |
| **Operating surplus/(deficit)** | **33.3** |
| Change in stock | (1.8) |
| Change in debtors | (24.0) |
| Change in creditors | 79.9 |
| Change in provisions | (0.1) |
| **Net change in working capital** | **54.0** |
| Capital spend | (50.1) |
| Capital Creditors | (12.3) |
| Capital additions Finance leases | 6.0 |
| Interest paid | (3.0) |
| PDC dividend charge paid | (2.7) |
| **Net change in investing activities** | **(62.1)** |
| PDC Capital Received | 11.0 |
| Accrued Interest YTD (DH & LEEF) | 0.0 |
| DH Capital £14.747m Loan repaid | (0.6) |
| LEEF Loan (Other Loan) | (1.5) |
| PFI | (1.2) |
| Finance lease payments | (3.9) |
| **Net change in financing activities** | **3.9** |
| **Cash balance as at 28.02.2022** | **65.7** |

**M11 FY21-22 YTD cash movement**

- The cumulative M11 21-22 I&E deficit is £4.8m. (*NB this includes the impact of donated grants and depreciation which is excluded from the NHSI performance total).
- Within the I&E deficit of £4.8m, depreciation (£25.2m) does not impact cash. The charges for interest payable (£2.9m) and PDC dividend (£10.1m) are added back and the amounts actually paid for these expenses shown lower down for presentational purposes. This generates a YTD cash "operating surplus" of £33.3m.
- The net change in working capital has increased to £54.0m in February-22 compared to March-21. This is due to a major movement in creditors of £79.9m, which is due to the increased NHS and Non-NHS accruals and NHS Pension liability in February-22 compared to March-21.
- The Stock value increased by £1.8m in February-22 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 Feb-22. LEEF loan repayment of £1.5m was paid in June-21 and Dec-21. In addition, until Febuary-22, Trust made a repayment of £1.2m and £3.9m for PFI and Finance leases, respectively.
- Capital creditors reduced by £12.3m compared to March-21 and new capital finance lease additions of £5.7m were made YTD at February-22.
- The Trust received £11.0m capital support PDC funding received in February-22.

**February-22 cash position**

- The Trust achieved a cash balance of £65.7m on 28th February-22, £62.7m higher than the £3m minimum cash balance required by NHSI. This is due to the February-22 contracts income including Covid-19 top-up received from CCG and NHS England.

# 4. M11 Capital

| Spend category | FY Budget £000 | YTD budget £000 | YTD exp £000 | *YTD var £000* |
|---|---|---|---|---|
| MRI | 9,900 | 9,900 | 8,224 | 1,676 |
| Cath Labs | 6,700 | 6,700 | 4,862 | 1,838 |
| Estates | 6,200 | 3,130 | 21,494 | -18,364 |
| IT | 6,600 | 3,302 | 6,470 | -3,168 |
| Lease Renewals | 3,500 | 3,500 | 3,500 | 0 |
| SWLP BAU Capital | 500 | 0 | 0 | 0 |
| SWLP 4TTP | 700 | 0 | 0 | 0 |
| **Total St George's Schemes** | **34,100** | **26,532** | **44,550** | **-18,018** |
| | | | | |
| **SWL Schemes** | | | | |
| Critical Care Expansion | 27,217 | 18,340 | 892 | 17,448 |
| SGH Emergency Floor | 3,070 | 2,560 | 68 | 2,492 |
| SWL LCHR (host TBC) | 2,000 | 1,665 | 0 | 1,665 |
| SWL PACs | 1,300 | 1,085 | 943 | 142 |
| Community Diagnostics Hub | 2,000 | 0 | 3,632 | -3,632 |
| **Total SWL Schemes** | **35,587** | **23,650** | **5,535** | **18,115** |
| | | | | |
| **Total Expenditure** | **69,687** | **50,182** | **50,085** | **97** |
| | | | | |
| Mitigations required in year | -4,040 | 0 | 0 | 0 |
| SWL contingency held at STG | 2,400 | 0 | 0 | 0 |
| | | | | |
| **Expenditure as per PFR** | **68,047** | **50,182** | **50,085** | **97** |

- The Trust is planning to spend £68.047m 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 £43.550m. 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 £50.085m YTD as at M11.
- Trust continues to exert tight control over capital expenditure, approving requisitions for all projects.