St George's University Hospitals NHS Foundation Trust

Trust Board

Date and Time: Thursday, 5 May 2022, 10.00
Venue: etc. Venues - Avonmouth House, 6 Avonmouth Street, London, SE1 6NX

TIME	ITEM NO.	ITEM	LEAD	ACTION	FORMAT
1. OPENING ADMINISTRATION					
10:00	1.1	Welcome and Apologies	Chairman	Note	Verbal
	1.2	Declarations of Interest	All	Note	Verbal
	1.3	Minutes of previous meeting	Chairman	Approve	Report
10:05	1.4	Action Log and Matters Arising	All	Review	Report
10:05	1.5	Chief Executive Officer's Report	GCEO	Inform	Report
2. CARE					
10:15	2.1	Quality Committee Report	Committee Chair	Assure	Report
10:30	2.2	Integrated Quality and Performance Report*	MD	Assure	Report
11:00	2.3	Maternity Service Updates Following Publication of the Ockenden Report	GCNO	Assure	Report
4. COLLABORATION					
11:10	3.1	Finance Committee Report	Committee Chair	Assure	Report
11:25	3.2	Finance Performance Report Month 12*	GCFO	Assure	Report
11:35	3.3	Board Assurance Framework Q4 Report	GCCAO	Assure	Report
5. GOVERNANCE					
11:45	4.1	Group Governance Arrangements	GCCAO	Approve	Report
12:00	4.2	Use of Trust Seal	GCCAO	Assure	Report
	4.3	Annual Self-Certification with Foundation Trust Licence*	GCCAO	Assure	Report
6. CLOSING ADMINISTRATION					
12:05	6.1	Questions from Governors and the Public	Chairman	Note	Verbal
	6.2	Any Other Business	Chairman	Note	Verbal
	6.3	Any New Risks or Issues Identified	Chairman	Note	Verbal

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St George's University Hospitals
NHS Foundation Trust

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

Thursday 31 March 2022

Held virtually via Microsoft Teams

PRESENT		
Gillian Norton	Chairman	Chairman
Jacqueline Totterdell	Group Chief Executive Officer	GCEO
Ann Beasley	Non-Executive Director	AB
Stephen Collier	Non-Executive Director	SC
Paul Da Gama*	Group Chief People Officer	CPO
Andrew Grimshaw	Group Chief Finance Officer	CFO
Dr Richard Jennings	Group Chief Medical Officer	CMO
Stephen Jones*	Group 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
James Marsh*	Group Deputy Chief Executive Officer	GDCEO
Kate Slemeck*	Managing Director – St George's	MD-SGUH
Arlene Wellman	Group Chief Nursing Officer	GCNO
Tim Wright	Non-Executive Director	TW
IN ATTENDANCE		
Anna Macarthur	Director of Communications and Engagement	DCE
Janice Minter	Head of Nursing, Cancer (item 5.4)	JM
Estelle Le Galliot	Health and Wellbeing Co-Ordinator, Cancer Services (item 5.4)	ELG
APOLOGIES		
Prof Jenny Higham	Non-Executive Director	JH
Thirza Sawtell*	Managing Director – Integrated Care	MD-IC

** Non-voting members of the Board*

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Items recorded in the order they were taken.

		Action
1.0 OPENING ADMINISTRATION		
1.1	**Welcome, introductions and apologies** The Chairman welcomed everyone to the meeting and noted the apologies shown above.	
1.2	**Declarations of Interest** The standing interests in relation to the shared roles with Epsom and St Helier University Hospitals NHS Trust (ESTH) of the following directors was noted, which have previously been authorised by the Board: • Gillian Norton as Chairman-in-Common; • Ann Beasley and Peter Kane as non-executive directors; • Jacqueline Totterdell, Paul Da Gama, Andrew Grimshaw, Richard Jennings, Stephen Jones, James Marsh, Thirza Sawtell and Arlene Wellman as executive directors.	
1.3	**Minutes of the Previous Meeting** The minutes of the meeting held on 27 January 2022 were approved as a true and accurate record.	
1.4	**Action Log and Matters Arising** The Board noted the action log which had no outstanding items.	
1.5	**Group Chief Executive's Officer (CEO) Report** Jacqueline Totterdell, Group Chief Executive Officer, presented her report to the Board and made the following points: • The Trust remains very busy, compounded by increasing staff absences due to Covid. • The new Group executive team formally started on 1 February 2022. • Support has been offered to both staff affected by the Ukrainian crisis and directly to Ukraine. • Edi Lorusso, Senior Thrombosis Nurse Specialist Practitioner, won a national lifetime achievement award at the recent Our Health Heroes awards ceremony, sponsored by NHS Employers. • Robert Bleasdale, Chief Nurse, is leaving the Trust today to be the Chief Nurse at Chelsea and Westminster Hospital NHS Foundation Trust and his contribution to the Trust over many years is to be applauded.	
	AB commented that she was pleased to see progress with the Principal Treatment Centre for Children's Cancer Services as it is important for the welfare of children and the Trust's future strategy. The GCEO added that the Trust treats the most poorly children across south London and surrounding areas.	
	The Chairman added her thanks and best wishes to Robert Bleasdale on behalf of the whole Board.	

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	The Board noted the Group Chief Executive Officer's report.	
2.0 CARE		
2.1	**Quality and Safety Committee Report** Professor Dame Parveen Kumar, Chair of the Quality and Safety Committee, presented the report of the meetings held in February and March 2022. Some of the reports discussed by the Committee also featured later on the Board agenda. The key matters of note from the Committee were as follows: • Life support training performance is still not where it needs to be and has been affected by the intake of junior doctors that occurred at the beginning of February. Work was ongoing to increase training uptake. • Learning from serious incident reporting was scrutinised. • A report on anti-microbial stewardship showed good progress on the appropriate use of antibiotics. • An update from pharmacy on the points raised by the Medicines and Healthcare products Regulatory Agency (MRHA) has been received with a further update to follow. • Results from three national patient surveys were reviewed for inpatients, maternity and children and young people. AB commented on the number of out-of-date clinical policies and whether there was any link between this and serious incidents. PKu commented that the relevant chief officers are taking responsibility for ensuring policies are brought up-to-date. The GCMO explained that there have been no serious incidents caused by out-of-date policies, but some had exposed the need for a new policy or standard operating procedure or had involved staff not following established policies and protocols. The Board noted the updates from the February and March 2022 Committee meetings.	
2.2	**Integrated Quality and Performance Report (IQPR)** The Board received and noted the IQPR for month 11 (February 2022), which had been scrutinised at both the Finance and Investment Committee (FIC) and the Quality and Safety Committee (QSC) the previous week. Operational highlights were as follows: • Emergency performance: ○ The emergency department has been particularly challenged during February and March, and numbers of attendees appear back to pre-pandemic levels. ○ An analysis of data is being undertaken to understand why performance against the 4-hour standard is not as required, reasons for which may include higher acuity of patients leading to longer lengths of stay. Covid cases have risen over the last few weeks which has also led to increased staff sickness.	

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	○ A new urgent treatment centre is opening in May which should see an improvement in turnaround times. • Elective performance: ○ Cancer referrals are now higher than pre-pandemic levels, impacting on cancer performance, especially breast. ○ Diagnostics performance against the 6 week target has improved to 1.8% non-compliance from 3.5% last month. ○ The patient tracking list (PTL) is relatively stable, and outpatient activity is above pre-pandemic levels. ○ There are now no patients waiting longer than 104 weeks and by the end of March it is anticipated that there will be fewer than 50 patients waiting more than 78 weeks. ○ 52-week waits are lower than forecast and are currently at approximately 800, mainly in general surgery, cardiac surgery, ENT and plastics. Mutual aid is being sought from neighbouring trusts. ○ Utilisation of QMH and day surgery is improving to increase capacity. PLL asked about the utilisation of digital and other technological approaches to increase outpatient capacity. The MD-SGUH noted that 25% of outpatients should be virtual, but this lends itself to some specialities more than others and transformation is needed to ensure the appropriate technology is available and utilised effectively. GDCEO added that there is also opportunity to ensure that all outpatient appointments add value, especially follow-up appointments. The GCEO asked about the trajectory for breast cancer performance to achieve the 2-week wait targets. The MD-SGUH commented that currently this will not be until the autumn of 2022 and depends upon the further implementation of 'triple-assessment clinics' (to minimise the number of separate visits that patients need to make). Other efficiencies are also being sought to minimise wastage and delays in the pathway. The GDCEO noted that although breast is a high volume cancer site and therefore will impact on overall performance, other sites need focus too. The Chairman asked for a further update on this at the meeting in July (given that the next meeting is just over a month away) The patient care aspects of the IQPR were noted and the GCNO commented that there have been two MRSA cases this year. The GCEO noted that updated infection prevention and control guidance was issued on 30 March 2022 which may be helpful in increasing staff availability and capacity for additional patients. A summary of the key workforce performance was provided, and it was noted that: • Sickness absence has increased but this is due to Covid as non-covid absence has remained stable. • There has been an improvement in the recruitment of band 8a and above staff from a black or ethnic minority background. The Board noted the IQPR report.	MD-SGUH

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2.3	**Health and Safety Report** The health and safety report was noted and the following points were made: • The report relates to non-clinical risks. • It is important for the Board to see this report on at least an annual basis to provide assurance. • Special thanks go to Alan Clark, Assistant Director of Health & Safety, Fire and Security, who has brought a great deal of experience to the Trust in this area. • There is good engagement from colleagues across the Trust.	
	TW commented positively on the breadth of the report and the compliance dashboard that is being developed.	
	The GCEO commented on the increase in the levels of violence and aggression against staff. The GCPO noted that there is a lot of work being done across London looking at different initiatives to address this issue, including communication, training and the provision of body-worn cameras. It will also be a key focus following the staff survey.	
	The Committee received assurance from the health and safety report.	
2.4	**Learning from Deaths Q3 2021/23** The GCMO presented the learning from deaths report and made the following points: • A positive meeting was held with the governance leads across the Trust. • The medical examiner service is due to be extended later this year to include Wandsworth and Merton community deaths and preparation to this end continues. • There is a greater level of assurance about the engagement in mortality meetings across the Trust.	
	The Chairman noted that there were fewer than usual structured judgement reviews (SJRs) and the GCMO explained that the establishment of the medical examiner services has led to a short term reduction in capacity. The focus is on ensuring that SJRs are carried out for key groups, such as patients with learning difficulties. The GDCEO noted that there is a different approach to learning from deaths between the Trust and ESTH and there is an opportunity for shared learning.	

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	The Board: • noted and supported the objectives for the Mortality Monitoring Group and Learning from Deaths over the next 6 months; • noted and supported progress against Quality and Safety Strategy through implementation of the mortality and morbidity team; • noted and supported plans to participate in the extension of the Learning Disability Mortality Review Programme (LeDeR) to include people with autism; • considered the assurance provided that current outlier alerts are being investigated robustly and that there is a granular understanding of our mortality data.	
2.5	**Ockenden – One Year On** The GCNO presented a report showing progress made in relation to the initial findings of the Ockenden report and made the following points: • The interim Ockenden report was published in December 2020 identifying eight 'immediate and essential actions' (IEAs) that trusts were required to benchmark themselves against. • The benchmarking information was provided for scrutiny to the local maternity system (LMS), amongst others. • A workforce gap analysis was also carried out against Birth-rate Plus which identified that just over 15 additional midwives and 12 midwife support workers were required. • Funding was made available from NHS England and NHS Improvement (NHSE/I) to increase staffing in maternity. • The Trust has been informed that it is 100% compliant against the IEAs.	
	PKu added that, as the non-executive maternity champion for the Trust, she was assured and noted that the morale of the team is high. This was affirmed by the MD-SGUH who noted the high standard of leadership provided by Janet Bradley, the Director of Midwifery and Gynaecology Outpatient Nursing.	
	TW noted that although the report is positive, there are still some staffing challenges that need to be addressed. The GCNO explained that funding has been secured and recruitment continues.	
	The Chairman asked about continuity of care and the GCNO acknowledged Donna Ockenden has challenged the established approach and urged that further implementation of continuity of care be subject to satisfactory staffing levels.	
	The GCEO noted that the rate of caesarean sections at the Trust is lower than across London and asked for assurance that this was not too low. The GCNO explained that caesarean rates are being reviewed to provide assurance on this.	
	The question of ensuring that mothers' voices are heard was raised and the GCNO commented that the Maternity Voices Partnership enables the views of	

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	mothers to be heard in a proactive way. This was a key piece of evidence to demonstrate compliance against the IEAs.	
	The Board noted the current position of maternity services in relation to the current and evolving climate of public and maternal health, the impact on our pregnant populations and overall safety.	
2.6	**CQC Statement of Purpose** The GCNO presented the report which reflected changes in the Trust's management structure following the introduction of the Group model.	
	The Board noted and approved the change of registered manager.	
3.0 CULTURE		
3.1	**Workforce and Education Committee Report** Stephen Collier, Chair of the Workforce and Education Committee (WEC), presented the report of the meetings held in February and March 2022, which highlighted the following key issues: • The effectiveness and utilisation of Recruitment Inclusion Specialists (RISs) has been reviewed, with some areas identified for improvement. • The staff survey showed that the recommendation of the Trust as a place to work had deteriorated following increases in prior years and although this may be related to Covid, further assurance on this is needed. The recommendation of the Trust as a place to be treated has been maintained. The Committee has been assured by the management response to the staff survey results. • There has been a focus on issues raised about the junior doctor experience and although this is not yet resolved, positive steps have been taken. • Responsiveness of the organisation to issues raised to the Freedom to Speak Up Guardian had been raised at the Committee and despite progress in strengthening the FTSU function it remained a concern at the length of time taken to address cases. • Addressing DBS compliance continues and progress is being made. AB asked about the reference in the report to disappointment with progress with the South West London Workforce Partnership. The GCPO noted that this may be an example where working as a single trust might have enabled quicker progress to be made and he was happy to provide more details outside the meeting.	
	PKa noted that it would have been surprising if staff survey results had not fallen, given the impact of the pandemic and asked if there were any other surveys that were planned to test progress before the next national survey. SC acknowledged that although there had been a deterioration across the NHS, the Trust had fallen back in some areas compared to other trusts. The GCPO added that the 'Pulse' survey was a more regular, albeit less robust, method of gaining insights from staff.	
	The Board noted the updates from the February and March 2022 Committee meetings.	

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3.2	**NHS Staff Survey**	
	Paul da Gama, Group Chief People Officer introduced the report and highlighted the following: • Overall results have reduced across the NHS and the Trust remained marginally below average. • Some of the behavioural scores (e.g., bullying and harassment) have improved. • Advocacy scores in recommending the Trust have deteriorated. • The top 10 themes arising from the survey have been analysed from which the 'Big 5' will be identified, with a monthly focus on each of those areas. • More localised information is being provided to managers to enable them to understand and address the issues raised in their care groups. • Positive outliers are being identified to understand the approach taken so that it can be disseminated and shared across the Trust. PKu asked about best practice and the GCPO added that there is a need to focus on some key areas to ensure there is traction in making progress, especially on the basics, such as the management of vacancies including recruitment.	
	TW commented on the 'Big 5' and recognised the difference in the London staffing market from elsewhere. He also noted that there were overlaps between some of the areas and there should be focus on staff wellbeing, collaboration and team working, and the Trust's approach to its staff with disabilities.	
	The GCEO added that there will be a challenge in the forthcoming year to look after staff and their wellbeing at the same time as the Trust is expected to deliver elective and financial recovery. During the pandemic, the Trust did more that it has ever done in supporting its staff but this did not penetrate as much as it should have done, so understanding how teams that rate highly on engagement operate is crucial.	
	The Chairman noted that she hoped to see more traction from the implementation of the cultural change programme as there had been a lot of work done in this area with disappointing impact.	
	The GCNO commented that a range of campaigns can be established but without the basic processes in place, such as fair recruitment and progression, there will be a minimal impact.	
	The GCNO concluded by acknowledging that there may be differences between perception and reality, but that perception is as important and should not be under-estimated. The Board noted the report and gave views on the 'Big 5' priorities for 2022/23.	
3.3	**Modern Slavery Statement**	
	Paul da Gama, Group Chief People Officer, introduced the report and highlighted that the statement will be published on the Trust's website to	

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	demonstrate the Trust's commitment to the elimination of modern slavery in both the organisation and its supply chain. The Chairman asked about the robustness of the checks that take place and whether the statement was prepared in conjunction with procurement. It was confirmed that procurement had been consulted on the statement and the GCFO added that the focus is on compliance at the beginning of contracts but that it was a fair challenge that there may need to be further compliance checks made as contracts continue.	
	The Board approved the modern slavery statement for publication on the Trust's website.	
4.0	**COLLABORATION**	
4.1	**Audit Committee Report**	
	Peter Kane, Chair of the Audit Committee, presented an update following the meeting of the Committee on 14 February 2022 and highlighted the following: • The plans for year-end for both external and internal auditors are progressing well. • Five internal audit reports were received with effective assurance given. • The internal audit plans for 2022/23 were discussed, although it was acknowledged that further iterations may be needed. • In line with a request from the Board, the Committee reviewed the report on pharmacy governance which is also being substantively reviewed by the Quality and Safety Committee (QSC).	
	The Board noted the updates from the February 2022 Committee meeting.	
4.2	**Finance and Investment Committee Report** Ann Beasley, Chair of the Finance and Investment Committee (FIC), provided an update on the meetings held in February and March 2022 and made the following points: • The improvement in diagnostics performance was acknowledged by the Committee. • The performance in the emergency department against the 4-hour target was also discussed and the Committee was assured that all necessary actions were being taken by the Trust to address what is a wider system issue. • An update on the plan for the recovery of cancer standards has been requested. • The shortage of anaesthetists was acknowledged as a significant risk. • The Committee assured itself that the Trust's cyber-security arrangements were up to date, especially in the context of the current conflict in Ukraine.	

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	• The score for the Board Assurance Framework risk SR7 (estates) was recommended to be reduced to 16 (from 20) given the recent improvements that have been made in the estate. • The financial position for 2021/22 is relatively stable, but the position for 2022/23 is very challenged both on revenue and capital.	
	PKu asked about the cyber-security threat and whether external support was used to deal with this. The GCFO explained that there is a dedicated team in the Trust that ensures that software updates are enacted as soon as possible. External assurance is provided by the wider NHS through the data security toolkit. TW added that the Trust has moved and is moving to more cloud-based solutions (e.g., Office 365, Cerner, Oracle) which offer a higher level of security protection.	
	PKa noted that the financial risk for 2022/23 is still uncertain and additional cost pressures could lead to further difficulties for the Trust.	
	The Board noted the updates from the February and March 2022 Committee meetings.	
4.2	**Finance Report (Month 11)**	
	Andrew Grimshaw, Group Chief Financial Officer (GCFO), presented the Trust's financial performance at month 11 and made the following points: • The Trust is on track to deliver planned performance for both revenue and capital in 2021/22 and there have been some positive developments in recent weeks. • As referenced above, the position for 2022/23 is extremely challenged with revenue forecast to be some distance from the required position and capital allocations have still not been confirmed.	
	The Board noted the financial position for month 11 of 2021/22.	
5.0	**CLOSING ADMINISTRATION**	
5.1	**Questions from Governors and the public** No questions were received from the public. Hilary Harland, Public Governor for Merton, asked about the level of agency spend reported in February 2022 and that it appeared high in that it related to interim managers and not clinical staff. The GCPO explained that the majority of the spend in this area tends to be in IT and finance where the market is very difficult and so premiums are sometimes paid to attract quality candidates. The GCFO added that the targets for agency spend were set in 2019/20 and have not been updated to reflect the changing environment but this will be one of the areas that will be addressed as part of dealing with the financial challenge for 2022/23. Richard Mycroft, Public Governor for South West Lambeth, asked what the pharmacy update report requested by QSC will include. The GCMO explained that the QSC report referenced an internal report from the Chief Pharmacist in his role as the Controlled Drugs Accountable Officer. An appreciative inquiry has been carried out with pharmacy, which has identified lots of good practice and a few areas for improvement.	

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5.2	**Any new risks or issues identified** There were no other risks or issues identified.	
5.3	**Any Other Business** There were no items of any other business	
5.4	**Patient story**	
	Janice Minter (JM), Head of Cancer Nursing and Estelle Le Galliot (ELG), Health and Wellbeing Co-Ordinator were welcomed and made the following points. • A video was produced to coincide with world cancer day on 4 February 2022. • The aim of the video was to support staff who interact with patients receiving a cancer diagnosis or attending for treatment. • There are over 4,000 cancer patients treated every year at the Trust and many staff will interact with patients who have been diagnosed with cancer, not just those who work in the service. • Feedback from the national cancer patients' survey highlighted some key issues raised, including asking about patients' preferred name and gender identity. • The video was co-produced with cancer patients to provide insights into their experiences. • The education team have been engaged to ensure the video can be provided on an appropriate platform to be accessible to all staff. • Other partners are also interested in sharing it more widely.	
	The video was presented.	
	JM was thanked for her leadership on this issue and all the Board found the video to be very powerful and moving in highlighting the work of the Trust and some of the frustrations felt by cancer patients.	
	PKa asked about treating patients whose preferred language is not English and it was explained that the Trust's information is in a variety of languages and that literature and videos produced by Macmillan in other languages is also utilised. Interpreters are also available where necessary.	
	It was suggested that the video could be shared more widely, amongst primary care networks, the ICS and other stakeholders, and potentially on YouTube and other social media platforms.	
	The Chairman commented that time needs to be found for staff to watch the video as it gives some useful tips that are relevant across the whole trust and highlights some of the fantastic work the Trust does.	
Date of next meeting: Thursday, 5 May 2022		

The meeting closed at 11:40

ACTION LOG - TRUST BOARD (PART 1)

ACTION REF	MEETING DATE	ITEM NO.	ITEM	ACTION	WHEN	WHO	UPDATE	STATUS
PUBLIC220331.1	31 Mar 2022	2.2	Integrated Quality and Performance Report	A further update on breast cancer performance to be rovided to ensure that the trajectory to achieve the 2 week wait targets is met by the Autumn of 2022.	7 Jul 2022	MD-SGUH	**12 Apr** Added to agenda for 7 July 22	PROPOSED FOR CLOSURE

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Meeting Title:	**Trust Board**		
Date:	5 May 2022	**Agenda No.**	**1.5**
Report Title:	**Chief Executive Officer's Report**		
Lead Director/ Manager:	Jacqueline Totterdell, Chief Executive		
Report Author:	Jacqueline Totterdell, Chief Executive		
Presented for:	Assurance		
Executive Summary:	Overview of the Trust activity since the last Trust Board Meeting.		
Recommendation:	The Board is requested to receive the report for information.		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	All		
Single Oversight Framework Theme:	All		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A

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CEO Board Report May 2022

It has been just over a month since my last report to the Board and the NHS remains pressured - with St George's no exception. Our urgent and emergency care pathway has been very busy and flow is increasingly difficult through the hospital, to the wards and home.

My team did lots of preparation for the Easter holiday, when larger numbers of staff were taking well-earned breaks but, as expected, we had high volumes of patients in ED. I am pleased to report that the emergency floor managed to reduce ambulance handover times and delays to the four-hour standard with internal delays to discharge also much reduced.

My communications team rallied the system and partners across south west London and were able to run a campaign promoting alternatives to ED. We know that tens of thousands of people saw our messages and we hoped it helped to ensure some people were redirected to the right care for their needs.

My thanks to everyone who worked the holiday weekend and continue to work in often challenging circumstances.

We are now starting to plan for the forthcoming Jubilee four-day bank holiday weekend at the beginning of June and take our learning from Easter to help us further develop plans.

St Georges, Epsom and St Helier Group (GESH)

We continue to make strides towards collaboration with St Georges for the benefit of staff and patients. We are starting to have good conversations on cancer collaboration and how we work with our partners in the system. We continue to look at where we have variations in care, where we can learn from each other, integrate services across the group, and are asking our staff to talk to their partners at St Georges.

My Deputy CEO James Marsh has brought together four interims who will help us make progress over the next year and I am pleased to welcome:

- Liz Howarth, who has been appointed as our director of integration to explore how we can collaborate, learn, and potentially integrate services across the group.
- Anna Clough who has been appointed director of performance who will interrogate our performance data and support stretch conversations.
- Martin Haynes who has been appointed director of quality improvement and our programme management office. He will take forward a structured approach to QI and service transformation as well as develop a PMO structure.
- And finally, Ralph Michell who has been appointed director of strategy and will develop a clear strategy and strength of purpose for the group over this first year.

Congratulations to them all on their new roles.

We held our second all staff engagement event for everyone who works at both hospitals and in the community and almost 400 people joined live with dozens more watching on catch

up. It is at these sessions that we are sharing our plans and actively encouraging our staff to get involved.

Infection prevention and control in our hospitals

In the last month, there have been a number of changes to the national guidance around infection prevention and control in hospitals. We are all learning to live with Covid-19, but we are of course still conscious of the risk the virus poses to vulnerable people here in our hospitals – which is why a number of measures remain in place to keep us all safe.

Testing is still vitally important for controlling the spread of the virus, and I'm pleased that our staff will still be able to order free lateral flow tests so they can test themselves regularly before coming into work.

Our staff will also continue to wear face masks at all times when at work, and we are politely reminding all patients and visitors to keep wearing their masks when inside our hospitals.

We have been able to relax some of our rules around social distancing in waiting rooms, cleaning routines and self-isolation for staff that are contacts of a positive Covid case. These are small but positive changes that will make things easier for staff as we focus on challenges such as emergency care and caring for our patients that are waiting for their operations.

Ockenden Review

I have reflected on the findings of the Ockenden Review – published on 30 March – which examined maternity practices at Shrewsbury and Telford over 20 years and found repeated failings in care. Staff did not feel confident in speaking up when they knew things were wrong.

The Board will know that I personally champion an open culture at St George's where everyone feels psychologically safe to raise concerns. We have been working on this for 18 months and we will continue with our culture programme, supported and championed by the Board.

Our maternity unit is working hard to check it meets the standard that Ockenden has set out and we have an Ockenden maternity visit to the hospital in mid-May.

Planned CQC inspection of Ionising Radiation Medical Exposure (IRMER)

Medical ionising radiation, such as x-rays and treatments like radiotherapy, is used in our hospital to help diagnose and treat conditions and the Trust is required to maintain safety standards. Last week the CQC carried out a planned inspection of IMER in Cardiology and Neuro Radiology. The two inspectors also visited the hybrid theatre. While formal feedback was not given, the visit went well and we will take forward any recommendations we receive.

NHS Staff Survey results

Every year we ask all 9,500 staff to fill in the NHS Staff Survey to give us an insight into what life is like for everyone working at St George's. We have now had the results of the 2021 survey, which have identified a number of areas for improvement for us to focus on, as well as the positive changes staff have seen.

It was encouraging to read that incidents of bullying and harassment have declined, and that Black, Asian and Minority Ethnic colleagues are reporting fewer instances of discrimination in the workplace. However, there has been a decrease in the number of staff that feel engaged at work, while many staff are reporting feeling worn out.

We are committed to acting on what our staff have told us and trying to make St George's a better place to work. Our priority now is to support divisional teams to deliver action plans to address the issues that matter to staff in each of their areas.

Visits to our outstanding children's services

We were pleased to welcome a number of visitors to our paediatric services since my last update to the Board. Chairman Gillian Norton and I hosted a visit from Millie Banerjee, Designate Chair and Sarah Blow, Designate CEO of the NHS South West London Integrated Care Board. And Managing Director Kate Slemeck and I also welcomed representatives from specialised commissioning at NHS England in London who also visited in March.

Both groups had a tour of our paediatrics and met our highly experienced clinicians who spoke passionately about the outstanding care they provide – not just for patients in south west London – but children and new born babies with complex and life threatening illnesses who travel from all across the south east of England to receive the best possible specialist care.

They also met expert staff who work in our world-class children's cancer centre, one of the largest in the UK as well as the only one in London to care for children with cancer from as young as 12 months right through to 18 years old.

New Health and Care Act

The Health and Care Bill received Royal Assent on 28 April to become the Health and Care Act 2022. It is the biggest legislative reform to the NHS in a decade reducing competition and supporting collaboration by creating a legal framework for integrated care systems.

The Act abolishes CCGs and introduces two-part statutory ICSs, made up of an integrated care board (ICB), responsible for NHS strategic planning and allocation decisions, and an integrated care partnership (ICP), responsible for bringing together a wider set of system partners to develop a plan to address the broader health, public health and social care needs of the local population.

The Act also introduces other measures to help tackle long waiting lists and address challenges such as inequalities in health outcomes. It will also regulate unhealthy food and drink advertising and establish the Health Services Safety Investigations Body, an

independent public body which will investigate incidents that have implications for patient safety.

This Act will allow us to build on the work we have already begun in south west London to improve the health of our local population.

ICS update

Since my last update to the Board, the South West London Integrated Care Board has announced ICB executive director appointments with each executive remaining designate until 1 July 2022. The remaining appointments will be made over the coming weeks, including non-executive and partner members.

Appointments continue to be made across the six south west London Places for the leadership roles, including Place convenor and primary care lead roles. Our SWL Places are agreeing their 2022/23 ambitions reflecting their Local Health and Care Plans.

18,000 patients register for MyCare St George's

MyCare St George's is our new, secure online portal that allows patients to access their hospital record, view upcoming appointments, and receive test results and messages from clinicians.

Allowing patients to be better informed about their care is really important to us, especially as evidence shows that people being more actively involved in their own care can improve outcomes and experience for patients.

Since its launch in March, I'm pleased to say that more than 18,000 patients have signed up to the portal. One patient got in touch with some lovely feedback, writing: "Not a technical problem - a technical compliment! Portal is fab, thank you so much. Getting to see all my results going back years is fascinating, but also being able to go paperless for appointments is wonderful."

Over the coming months, we'll continue to add new features to make the service even more useful, including being able to rearrange appointments.

New finance system

Being part of a hospital group with Epsom and St Helier has presented us with lots of opportunities to make ways of working easier and more efficient for staff. One such opportunity has been our move to a new finance system, which is the same system used at Epsom and St Helier, and by Trusts across south west London.

The new system will make ordering a much smoother and simpler process for our teams, and by using the same system as ESTH, it makes collaboration and benchmarking of finances a much easier thing to do.

New training suite for parents at St George's

A brand new training suite for parents and carers of ill children has recently opened at St George's, offering training in life-saving interventions.

Parents will be supported by a new specialist nurse, in the WellChild Better at Home training suite, which was funded by WellChild, the national charity for seriously ill children.

Previously, training for parents and carers would often take place at a child's hospital bedside prior to discharge. This training can be limited and does not always prepare families for emergency situations which might arise.

We are extremely proud of our 'Outstanding' rated children's services at the Trust, and this training suite is a wonderful addition that is already helping parents and carers learn the skills they need to care for children after they leave hospital.

St George's Hospital charity

The charity continues to work hard for our staff and patients and last month raised £50,000 in a three day abseil event. I nervously joined the 120 staff, former patients and friends of St George's who went over the edge of the Pelican Hotel and abseiled down to the ground. The Charity is now busy planning its first Gala Dinner in May to help raise funds to improve the environment of our paediatrics department which is rated outstanding by CQC.

Awards and recognition

It has been quite a month for recognition at St George's. Our Group CNO, Arlene Wellman, was awarded her MBE at Windsor Castle by HRH Prince Charles at the end of April. I'm incredibly proud of Arlene and she massively deserves this recognition and honour. She is a fantastic role model and visible leader who listens to staff and flies the flag for the thousands of nurses, midwives and health care support workers across our hospital group.

St George's documentary 'Baby Surgeons: Delivering Miracles' has been nominated for a BAFTA. The documentary was filmed inside our fetal medicine, neonatal and maternity units at St George's, and follows the extraordinary work of our staff as they treat women experiencing rare and complex pregnancies.

But I am especially pleased to report that Jenni Doman, our Deputy Director of Estates and Facilities, has been shortlisted for the Health Estates and Facilities Management Association Leader of the year. Jenni was nominated by her line manager Andrew Asbury who collected supporting comments from a range of staff who spoke of her commitment to patient care and described her as the 'ultimate problem solver' who goes out of her way to look after all our staff. Jenni is already a winner in my eyes.

And finally, I too was recognised last month. I am proud to be named as one HSJ's top 50 hospital CEO's - which coincides with my five-year anniversary at St George's.

The 15 strong panel look at a range of criteria including performance during the pandemic, overall performance and the Trust's contribution to the wider health and social care system.

In my view, HSJ's recognition is for what we have all achieved together – despite the pressure and challenges – and my thanks goes to everyone at George's for helping make this hospital a truly great place to work.

Meeting Title:	**Trust Board**		
Date:	**5 May 2022**	**Agenda No**	**2.1**
Report Title:	**Quality Committee Report**		
Lead Director/ Manager:	Prof. Dame Parveen Kumar, Chair of the Quality Committee		
Report Author:	Prof. Dame Parveen Kumar, Chair of the Quality Committee		
Presented for:	Assurance		
Executive Summary:	The report sets out the key issues covered by the Committee at its meeting in April. This was the first meeting of the joint committee held in common with Epsom and St Helier University Hospitals NHS Trust (ESTH). This report highlights only those issues related to St George's although some issues were relevant to both trusts. The Committee reviewed the draft terms of reference and work programme which are included for approval by the Board later in the agenda.		
Recommendation:	The Board is asked to note the update from the April 2022 meeting of the Committee.		
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 Committee met on 21 April 2022 in its first meeting as a committee-in-common with Epsom and St Helier University Hospitals NHS Trust (ESTH). The Committee will be chaired in rotation by the respective chairs of ESTH and SGUH and this meeting was chaired by the ESTH Chair.

The Committee considered the following matters of business at these meetings:

April 2022

- Quality Performance Report (M12)*
- Serious Incidents Report
- Infection Control Update
- Maternity Services Report (Following Publication of the final Ockenden Report)
- General Surgery – Royal College of Surgeons' Review
- Pharmacy Report
- Corporate Risk Register
- Committee terms of reference and work programme

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

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

1. Quality Performance Report Month 12

The Committee considered the key areas of quality and safety performance in month 12 and would like to highlight the following issues, conscious that the Board will discuss the month 12 performance data later on the agenda:

- Areas of challenge:
  - Basic life support (BLS), immediate life support (ILS) and advanced life support (ALS) are all below target. The change in the number of staff needing ILS has been reviewed and there has been a large number of non-attendances due to staff absences and other pressures.
  - There have been two never events, one related to wrong site surgery and another to a misplaced naso-gastric tube
- Areas of good or improving performance:
  - Addressing Complaints - performance remains high, with virtually all cases addressed within target timescales

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 2022. During this period:

- 8 serious incidents were declared (including two never events)
- 5 serious incident investigations were concluded

The wrong site surgery never event was similar to two others cases and did not cause a high level of harm, but still highlight the need for proper checks to be carried out.

The second never event related to the incorrect placement of a naso-gastric tube which was not identified. Proper processes were not followed and the patient was admitted to the integrated care unit.

The report on the Covid outbreak on Amyand ward was completed and praised as being one of the most comprehensive and effective reports seen. The most important learning was to ensure that appropriate ventilation is provided. The inadequacy of some of the Trust's estate is a factor in the context of ventilation for an air-borne virus.

3. Infection Control Update

The infection prevention and control team are working to understand and interpret recent changes to national guidance which will be implemented from 22 April 2022. This will improve patient flow as fewer patients will need to be isolated.

4. Maternity Services Report (Following Publication of the final Ockenden Report)

The Committee received assurance from the Group Chief Nursing Officer that issues raised in the Ockenden report are being addressed. The Trust has been confirmed has having 100% compliance to the 'immediate and essential' actions announced in December 2020.

An assurance visit by the regional Chief Midwife is due to take place on 12 May 2022 to ensure processes have been embedded. This will involve meetings with the Chairman, Chief Executive and lead non-executive director.

The Trust is working closely with ESTH to ensure shared learning across both trusts.

5. Pharmacy Report

The Committee received the first of a regular report on pharmacy to provide continuing assurance, following issues raised last year.

6. Corporate Risk Register

The GCCAO explained that there will be alignment across both trusts so the approach will change in the coming months.

7. Committee terms of reference and work programme

The Committee reviewed the draft terms of reference and work programme and recommend them for approval to the Board.

8. Recommendation

The Board is asked to note the updates from the April 2022 meeting.

Dame Parveen Kumar

Committee Chair

April 2022

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St George's University Hospitals NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	5 May 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		
Presented for:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify)		
Executive Summary:	This report consolidates the latest management information and improvement actions across our productivity, performance, and workforce for the month of March 2022. Our Finance & Productivity Outpatient performance is expected to be 111% after catch-up, which is higher than the 100% trajectory by 11%. The Trust are looking at a number of options around virtual clinic delivery and increasing capacity to address the large number of patients referred via the Two Week Rule pathway. Elective and Daycase performance is expected to be behind trajectory (after estimated catch up), with a percentage of 97%, lower than the 100% trajectory submitted for March. Theatre specialties are at 90%, with non-Theatre specialties at 98%. In March, the Trust continued to see a reduction in the number of patients cancelled on the day for non-clinical reasons. In March, the Trust saw a daily increase in the number of emergency patients requiring admission to hospital compared to the previous month with length of stay remaining higher than average. Actions and Quality Improvement Projects ongoing to optimise discharge processes within system partners, increase discharges before 10am to support flow from ED and external interface flow work. **Our Patient Perspective** There were two Never Events reported in March, occurring as a result of a wrong site surgery and a misplaced nasogastric tube. The patients subsequently underwent the corrective treatment. There were eight Serious Incidents in March, one being where Medication was a Significant Factor. The Trusts Life Support Training for Immediate Life Support (ILS) and Advance Life Support Training (ALS) remains challenged. This month the ILS performance rate was 67.7% and ALS performance rate fell from 82.9%; to 76.2% against a of 85%. There were 50 Hospital Onset Health Associated (HOHA) covid-19 infections and 40 Hospital Onset Probably Associated (HOPA) covid-19 infections. Two further infections being reported to NHSI/E, are Pseudomonas. Aeruginosa and Klebsiella ssp. Bacteraemia. NHSI/E has set a threshold for P. aeruginosa bacteraemia of no more than 21 cases for 2021-22. For 2021-22 the Trust had 27 cases, which is above the yearly trajectory of no more than 21 cases.		

Klebsiella spp. bacteraemia threshold is no more than 49 Trust apportioned cases for 2021-22, Between 01 April 2021 and 31st March 2022 there were 48 cases, which is above the trajectory of no more than 49 cases for the year.

In Maternity services, the number of women giving birth has reduced month on month since October 2021, in March this trajectory turned, with daily birthing number the highest seen since October. Staffing remained challenging across the month with sickness and covid isolation, along with recruitment delays to fill our vacant band 5 and band 6 midwifery posts. which has impacted on staffing ratios resulting in diverting birth centre and office-based midwives to the Delivery Suite and other acute inpatient areas when required, with our Birth Centre closed 35.54%. There were no stillbirths and three neonatal deaths in March.

Inpatient, Maternity, Maternity (Postnatal Ward), Community and Outpatient services achieved FFT targets where patients rated the services as "Good" or "Very Good ".

Our Process Perspective

In March, 72% of patients were admitted, discharged, or transferred within four hours of their arrival. Patient Flow and bed allocation remains challenged driven by high acuity, external delays, closed beds, and rising occupancy rates resulting in increased waiting times and front-end capacity.

February cancer performance against the 14-day standard was 75.4% against a target of 93%, an improvement of 5.6% compared to January. Breast continues to be the main contributor to TWR performance reporting 26.8% with ongoing recovery plans agreed with the alliance. The 62 day performance was at 48.3% against a target of 85%, the trust has agreed to Improve the 62-day performance metric by March 23 to 80% with the alliance. The main challenges to backlog recovery are within radiology affecting CTC and GI services, Breast front end challenges and late inter trust transfers within Head & Neck. Faster Diagnosis standard performance was 79.5% seeing a significant improvement.

At the end of March, the Trust reported that 1.8% of patients were waiting to have a diagnostic test, maintaining a steady trend, and performing better than London average. In total 159 patients were waiting for more than six weeks for a diagnostic test, of which 60% are attributed to Cardiac MRI where capacity challenges continue, leading to cancellations of outpatients appointments and longer waits having an associated patient safety risk.

February's 2021's RTT performance was 72.1% against a National target of 92% with 802 patients waiting longer than 52 weeks which is ahead of trajectory and a further improvement compared to January. The total waiting list size has grown in February, largely as a result of an increase in the number of average daily referrals and lower volumes of outpatient clock stops. The focus on increasing productivity at the Surgical Treatment Centre is starting to see results, with the highest number of completed procedures in February and an increase in utilisation.

	Our Workforce Perspective This report consolidates the latest management information and improvement actions across our productivity, performance, and workforce for the month of March 2022. In March the Trust's sickness absence rate increased to 4.7% and has fluctuated in recent months. and above the threshold target of 3.2%. Human Resources continues to support managers to make timely Occupation Health referrals to establish support for staff on long term sick leave to better utilise the return-to-work meetings to identify support for staff to enable them to improve their level of absence. Appraisal rates for non-medical staff and medical staff was 75.1% and 76.6% respectively remaining below the Trust target of 90%. The Staff covid-19 vaccination rate for both jabs was 89.3% in March and an active communication plan promoting vaccination for all staff is in place
Recommendation:	The Committee is requested to note the report
Committee Assurance:	The Committee is also asked that in considering contents of this report, its supporting documents and the discussion at the meeting which of the following assurance rating it would provide to the Trust Board. • **Substantial Assurance:** The report and discussions assured the Committee that there are robust systems of internal controls operating effectively to ensure that quality and safety risks are managed to deliver high quality services and care to patients. • **Reasonable Assurance:** The report and discussions assured the Committee that the system of internal controls is generally adequate and operating effectively but some improvements are required to ensure that quality and safety risks are managed to deliver high quality services and care to patients. • **Limited Assurance:** The report and discussions supported the Committee's conclusion that that the system of internal controls is generally inadequate or not operating effectively and significant improvements were required to ensure that the quality and safety risks are managed effectively to improve the position and ensure that high quality services and care is provided to patients. • **No Assurance:** The report and discussions led the Committee to conclude that there was a fundamental breakdown or absence of core internal controls and systems to enable the Trust to deliver high quality services and care to its patients.
Supports	
Trust Strategic Objective:	Treat the Patient Treat the Person Right Care Right Place Right Time
CQC Theme:	Safe, Caring, Responsive, Effective, Well Led
Single Oversight Framework Theme:	
Implications	
Risk:	NHS Constitutional Access Standards are not being consistently delivered and risk remains that planned improvement actions fail to have sustained impact
Legal/Regulatory:	

Resources:	Clinical and operational resources are actively prioritised to maximise quality and performance		
Equality and Diversity:			
Previously Considered by:	Quality Committee Finance & Investment Committee	**Date**	21/04/2022 22/04/2022
Appendices:			

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NHS
St George's University Hospitals
NHS Foundation Trust

Integrated Quality and Performance Report

For Trust Board
Meeting Date – 5 May 2022

James Marsh - Group Deputy Chief Executive Officer

14 April 2022

Our Outcomes

How Are We Doing?

March 2022

Daycase and Elective Surgery operations

Actual: **5,129**

2019/20 Actual **3,834**

6 Week Diagnostic Performance

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

Four Hour Emergency Standard

Actual: **72%**

Plan: **95%**

Whole Trust Inpatient Friends and Family Test

Actual **97.4%**

Target **95%**

Outpatient First Attendance

Actual **19,850**

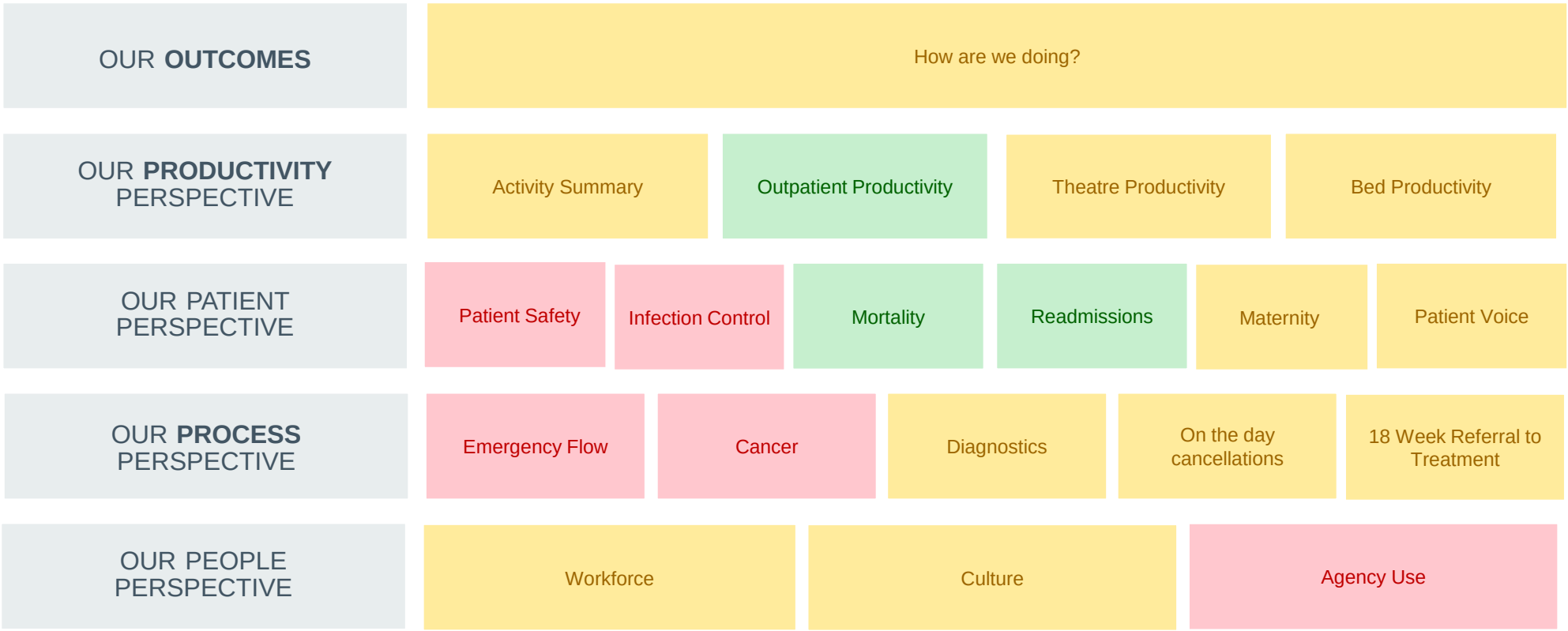
2019/20 Actual: **16,110**

February 2022

Referral to Treatment Standard - Number of 52 Week Breaches

802

Balanced Scorecard Approach



Executive Summary – March 2022 (1 of 2)

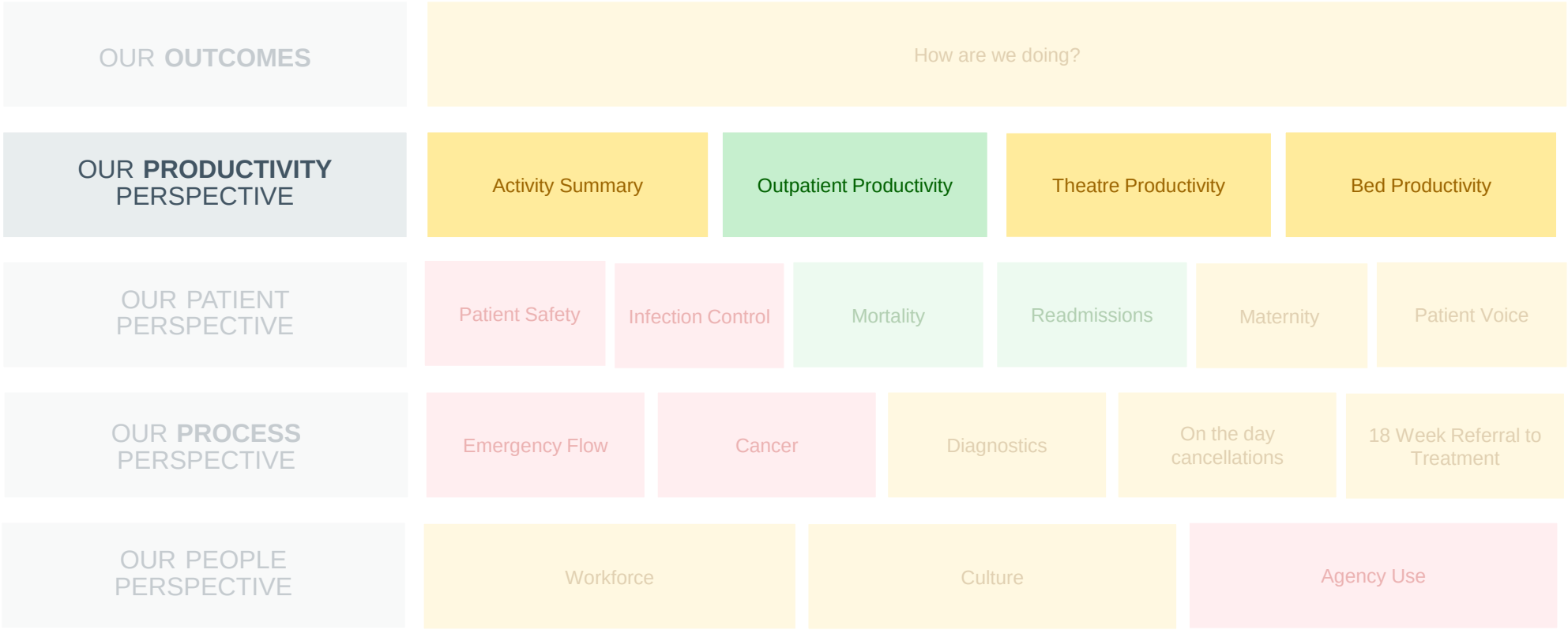
	What the Information tells us	Actions and Quality Improvement Projects
Finance & Productivity Perspective	• All outpatient activity in March 2022 is expected to be at 111% once data catch up is complete, which is higher than the 100% trajectory by 11% • Elective and Daycase performance is expected to be behind trajectory (after estimated catch up), with a percentage of 97%, lower than the 100% trajectory submitted for March • Non-Elective Lengths of Stay (LOS) continues to show special cause concern with average LOS at 7.1 days. High LOS impacted by acuity, external delays, rising occupancy rates.	Outpatients • Additional clinics to address the large number of patients referred via the Two Week Rule pathway are being undertaken • Reviewing options around virtual clinic delivery, including but not limited to relaunching Attend Anywhere which will support the Trust's Green Plan Daycase & Elective activity • DSU 23 hour overnight stay capacity continues to expand • ASA1 Streaming' project full pilot in T&O and Urology to commence 6th May to enable safe streaming of patients 'straight to swab', avoiding unnecessary POA • The anaesthetic recruitment drive continues at pace. 10 posts are currently out to advert or awaiting interview. Length of Stay • External interface flow work focussed on Merton and Wandsworth: discharge, maximising community capacity and virtual frailty ward (Hospital at Home) • MedCard discharge SWAT team appointed to with start dates April-May (Clinical Flow Lead, Discharge Facilitators) • Increasing the use of the departure lounge where appropriate

Patient Perspective	• Immediate Life Support (ILS) training rate was 67.7%; the target is 85%
	• There were 2 Never Events in March, and a total of 5 for the year 2021-22.
	• 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
	• There were no MRSA incidents in March. A total of 2 for the year period 2021-22.
	• There were 50 Hospital Onset Health Associated (HOHA) COVID-19 infections and 40 Hospital Onset Probably Associated (HOPA) COVID-19 infections
	• The NHSI/E new threshold for P. aeruginosa bacteraemia for 2021-22 was for no more than 21 cases. For 2021-22 the trust had 27 cases, which is above trajectory.
	• NHSI/E new threshold for Klebsiella spp. bacteraemia was for no more than 49 Trust apportioned cases for 2021-22. Between 01/04/21 and 31/03//22 there were 48 cases, which is 1 below trajectory.
	• Maternity - staffing challenges continued in March 2022 which impacted on staffing ratios and training compliance and access to the Carmen suite which was closed 35.5% of the time this month.
	• Inpatient, Maternity, Maternity (Delivery and Postnatal Ward), Community and Outpatient services achieved FFT targets where patients rated the services as "Good" or "Very Good". The Emergency department.
		• eILS recertification course to be made available to ALL medical staff.
		• All category 3 and above pressure ulcers undergo root cause analysis to identify any learning
		• 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.
		• Maternity -
		  • Digital Transformation across Maternity is being implemented which will provide a single health records solution with the addition of a maternity module to our enterprise wide EPR (electronic patient record).
		  • The Maternity Telephone Helpline was successfully launched in late March 2022 and enables direct access to the service for advice. The feedback to date from both women and colleagues has been fantastic.
		• 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. The Department is currently undertaking a detailed review of the raw data, Initial findings are that the increase in negative responses is almost entirely due to issues around waiting .

Executive Summary – March 2022 (2 of 2)

	What the Information tells us	Actions and Quality Improvement Projects
Process Perspective	Four Hour Operating Standards for March • 72% of patients either admitted, discharged or transferred within four hours of their arrival; the target is 95% • 412 patients breached the 12-hour ED target February Cancer performance • 14 Day Performance improved to 75.4% with referral numbers above the mean of 2019/20 • 62 Day Performance 48.3% against a target of 85%, backlog recovery ahead of trajectory. • Faster Diagnosis Standard (FDS) improved significantly to 79.5%. Compliant within Breast, Gynae, Head & Neck, Lung, Skin Six week diagnostic standard for March • Strong performance is being maintained with 1.8% of patients waiting for more than six weeks for their diagnostic test at the end of March against a national target of 1%. • Capacity challenges continue within Cardiac MRI accounting for 60% of six week breaches. Referral to Treatment for February: • 802 patients have been waiting over 52 weeks since referral for treatment, this is a decrease of 9.6% compared to January and achieving trajectory. • The total waiting list size has grown in February, largely as a result of an increase in the number of average daily referrals and lower volumes of outpatient clock stops • The Trust had 11,220 clock stops in February, achieving trajectory of 11,024; a clock stop generally means a patient has received their first definitive treatment.	Four Hour Operating Standards actions • 4 hour, 12 hour and 60 minute breaches are in the process of being added to Risk Register • Rounds of ED waiting room, to ensure safety of our patients waiting to be seen • Further work is being undertaken to maximise in out space for doctors to see patients Cancer • Ongoing challenges and recovery work is taking place to support urology theatre capacity • Continual ongoing pathway improvements are being led by dedicated project managers. • Clear communication and management of patients awaiting an FDS communication with benign results awaiting a FU or clinic letter is in place via a weekly PTL assurance meetings and Access Committee Diagnostics • Cardiac MRI - Outpatient clinic appointments are being cancelled as patients are unable to have their diagnostic MRI prior to their appointment. All urgent patients are being clinically reviewed and patients are being called as well as receiving a text prior to appointments to reduce the DNA rate. • Additional capacity provided within Sleep Studies and Paediatric Endoscopy to reduce long waiting patients Referral to Treatment • 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. • 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 increased slightly this month by from 4.4% to 4.7%; target is 3.2% • Trust vacancy rate is currently at 8.9% which is below the threshold of 10%. • Medical and non-Medical appraisal rates remain below their target of 90% at 77.7% and 72.2% respectively • Trust turnover rate was 17.6% against a target of 13% • At time of writing, the COVID-19 vaccination rate was 89.3%.	• HR continues to support managers to make timely Occupation Health referrals, better utilise the return to work meetings to establish support for staff on long or short term sickness. • Human Resources Business Partners are working closely with divisions to develop recruitment plans for the top 10 vacancy hotspots per division. Local discussions and plans are also being developed to tackle hard to recruit areas. • A refreshed appraisal drive is underway to work with divisions to increase the uptake of appraisals • The Values Survey has now concluded and our contractors are utilising staff feedback to further develop the values framework policy, • There is an active communication plan promoting vaccinations for all staff

Balanced Scorecard Approach



Scorecard RAG rating based on PreCOVID-19 plan

Activity Summary

		Activity compared to 2019/20			Activity compared to previous year			Activity compared to 2020/21		
		Mar-20	Mar-22	Variance	YTD 19/20	YTD 20/21	Variance	Mar-21	Mar-22	Variance
ED	ED Attendances	9,934	13,265	33.53%	164,785	151,466	-8.08%	10,589	13,265	25.27%
Inpatient	Non Elective	3,090	3,069	-0.68%	47,556	38,553	-18.93%	3,286	3,069	-6.60%
	Elective & Daycase	3,834	5,111	33.31%	62,701	57,802	-7.81%	4,265	5,111	19.84%
Outpatient	OP Attendances	46,450	55,068	18.55%	594,591	597,467	0.48%	53,640	55,068	2.66%

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

Note: Figures quoted are as at 8/04/2022 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 March 2022 have been shown against activity levels reported in March 2020 (start of covid pandemic)

For reference the grey boxes compare activity levels to March 2021

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

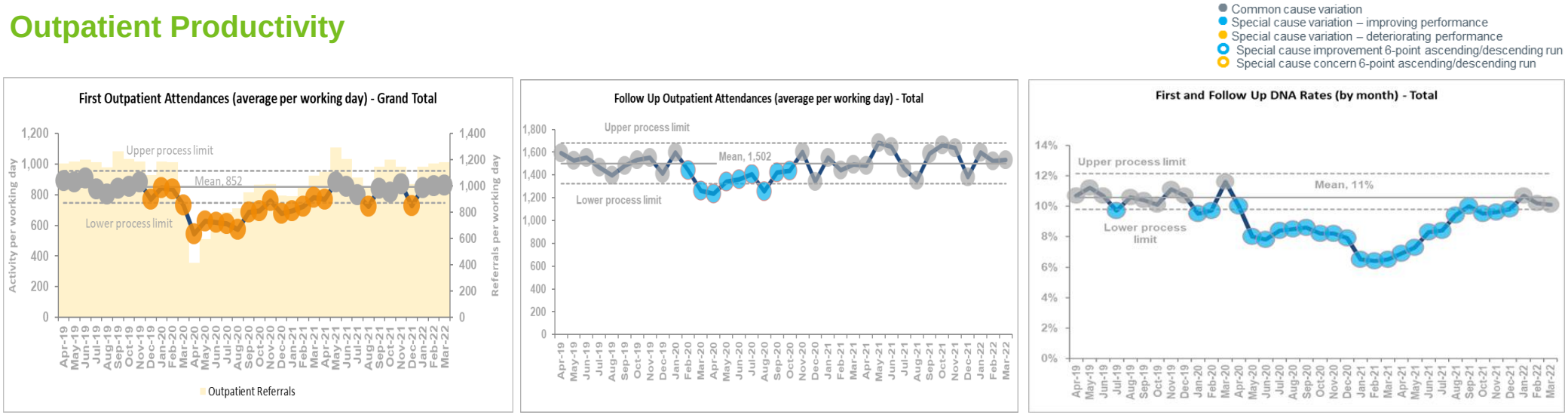
March Activity Performance v Trajectories – Elective, Daycase & Outpatients

The Trust has submitted final activity trajectories for H2, which forecast activity at 95% of 2019/20 levels adjusted for working days. In March, there are 23 working days compared to 22 in 2019/20, hence the target for March is 100%. The Trust no longer receives ERF payments based on activity trajectory performance, as it now factors in activity clock stop data. Note: The below activity information is shown in 'SLAM' currency, as this is the currency the Trust is used to seeing and reporting.

	ACTIVITY QUANTUMS					ACTIVITY %s				
Specialty	Mar Trajectory	Mar Activity	Mar catch up estimate	Mar Activity after catch up	variance activity	Mar Trajectory	Mar Actual	Mar catch up estimate	Mar Activity after catch up	variance activity
Cardiac Surgery (172)	54	30	1	31	-24	120%	67%	1%	68%	-52%
Colorectal Surgery (104)	8	20	2	22	14	63%	165%	13%	178%	115%
Ear, Nose & Throat	208	158	16	174	-34	117%	89%	9%	98%	-19%
General Surgery (100)	86	91	7	98	12	80%	84%	7%	91%	11%
Gynaecology (502)	206	166	14	180	-26	97%	78%	7%	84%	-12%
Neurosurgery (150)	115	118	7	125	10	63%	65%	4%	69%	5%
Trauma & Orthopaedics (110)	81	97	11	108	27	47%	56%	6%	62%	16%
Urology (101)	446	345	36	381	-66	137%	106%	11%	117%	-20%
Total Theatre Specialties	**1,205**	**1,025**	**93**	**1,118**	**-87**	**96%**	**83%**	**7%**	**90%**	**-6%**
Gastroenterology (301)	1,449	1,148	167	1,315	-134	92%	73%	11%	84%	-9%
Cardiology (320)	269	234	7	241	-28	88%	77%	2%	79%	-9%
Dermatology (330)	0	0	0	0	0	105%				
Neurology (400)	849	620	29	649	-201	113%	82%	4%	86%	-27%
Paediatrics (420)	34	52	4	56	22	89%	135%	10%	145%	57%
Paed Surgery (171)	95	87	4	91	-4	97%	89%	4%	93%	-4%
Clinical Haematology (303)	197	140	47	187	-9	210%	150%	50%	200%	-10%
Medical Oncology (370)	101	88	2	90	-12	120%	104%	2%	106%	-14%
All Other Specialties	1,525	1,717	86	1,803	278	97%	110%	5%	115%	18%
All Other	**4,519**	**4,086**	**345**	**4,431**	**-88**	**101%**	**91%**	**8%**	**98%**	**-2%**
Total Daycase / Elective	**5,723**	**5,111**	**438**	**5,549**	**-175**	**100%**	**89%**	**8%**	**97%**	**-3%**
Outpatients	**51,813**	**55,068**	**2,753**	**57,822**	**6,008**	**100%**	**106%**	**5%**	**111%**	**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 97%, lower than the 100% trajectory submitted for March. Theatre specialties are at 90%, with non-Theatre specialties at 98%.
- Outpatient performance is expected to be 111% after catch-up, which is higher than the 100% trajectory by 11%.

Outpatient Productivity



What the information tells us

In March, first and follow-up outpatient activity remains within the upper and lower control limits and above 2019/20 baseline, On average across the month there were 863 first attendances per day compared to 858 in February. Follow-up activity averaged 1,532 attendances per day compared to 1,524 per day in February. Referral rates remain comparable to previous months seeing a slight daily increase in March.

At Trust level total outpatient activity reported in March 2022 is expected to be at 111% once data catch up is complete, this is above trajectory by 11%.

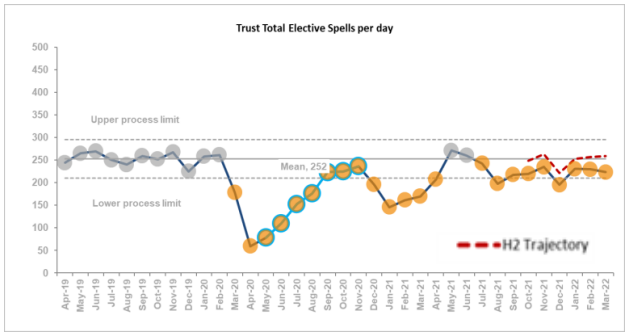
DNA rates continues to show a steady trend with 10.% of patients not attending their outpatient appointment in March.

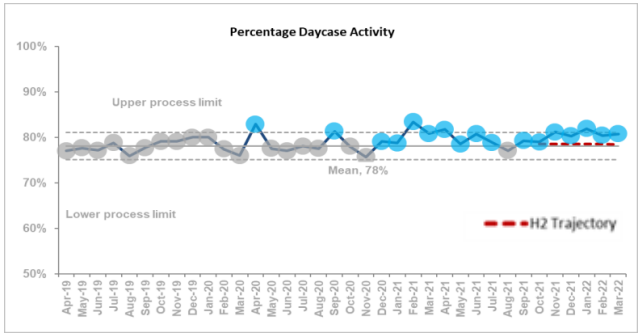
Please note that COVID-19 related OP activity has been excluded from the charts.

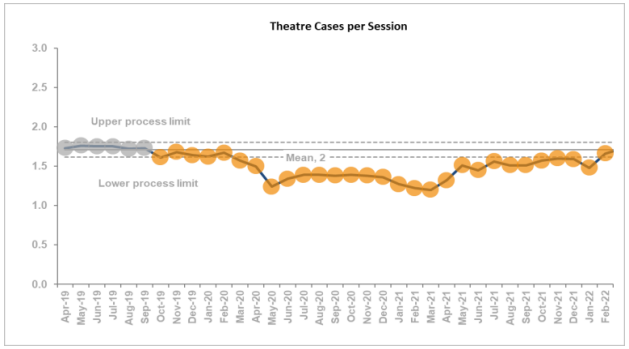
Actions and Quality Improvement Projects

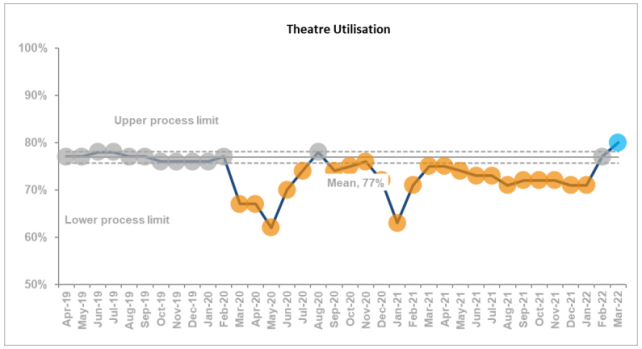
- As space issues continue to a challenge we are looking at a number of options around virtual clinic delivery, including but not limited to relaunching Attend Anywhere which will support the Trust's Green Plan both for us and our patients and working with Estates to create a Virtual Clinic Hub enabling clinicians to deliver virtual activity in an appropriate environment.
- 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 and Breast Service are delivering face to face weekend clinics as part of their recovery plan.
- 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. Once we have a Virtual Clinic Hub services will be encouraged to review their templates again to separate out their face to face and virtual activity so we can maximise the use of our physical space for patients that need to be seen in the F2F environment.
- 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. We will also start to look at implementing the paper letter opt out option which will provide a cost saving to the Trust and support the Trust's Green Plan.

Elective Activity & Theatre Productivity









What the information tells us

On average throughout March, 223 patients were treated per day compared to 230 in February, this is expected to increase once data catch up is complete. Activity levels remain below the 2019/20 baseline and performance is expected to be behind trajectory (after estimated catch up), with a percentage of 97%, lower than the 100% trajectory submitted for March.

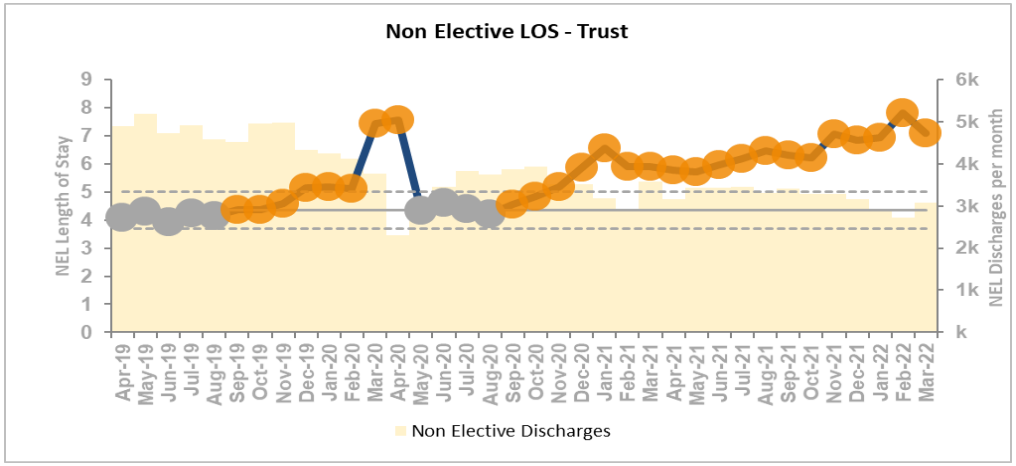
In March, Theatres ran 924 theatre lists, compared to 1,042 in the same period in 2020. Theatres cases per session increased across the month although remaining within the upper and lower control limits. Theatre utilisation rates saw a significant increase reporting an average 81% utilisation of sessions.

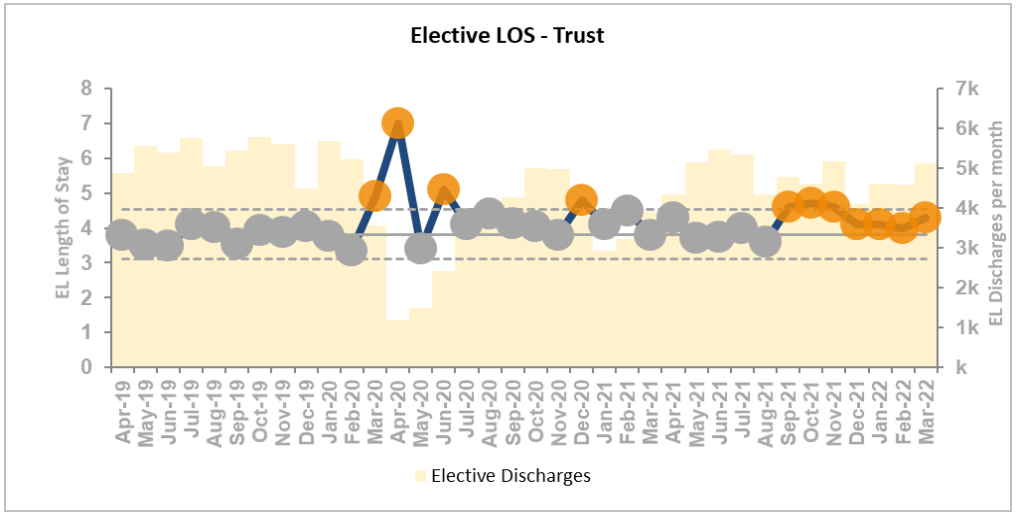
- Common cause variation
- Special cause variation – improving performance
- Special cause variation – deteriorating performance
- Special cause improvement 6-point ascending/descending run
- Special cause concern 6-point ascending/descending run

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 are now in place to expand overnight stays to Thursday from late April. 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 6th May. 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 in January, to 3 in February and 2 in March (excluding ICU beds which are out of scope for the project). In spite of these improvements, this issue continues to negatively impact upon staff working conditions, and so the project continues, with a new Tableau dashboard now created to help track the situation.
- **Recruitment:** The anaesthetic recruitment drive continues at pace. 10 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 continues at pace to work to increase the number of permanent ODP and Anaesthetic Practitioners at SGH, improve working conditions, clear up issues around bank pay and create a new Workforce Development plan to enhance 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

In March, the Trust saw a daily increase in the number of emergency patients requiring admission to hospital compared to the previous month. Non elective length of stay remains above the upper control limit however, throughout March, this reduced to 7.1 days compared to 7.8 days in February. Reductions are primarily seen in patients with a typical length of stay of less than seven days whilst patients staying longer than 7, 14 and 21 days has seen a slight increase.

Elective length of stay, although above the mean is showing a steady trend. On average, patients stayed in a hospital bed for 4.3 days in March.

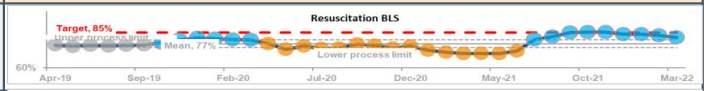
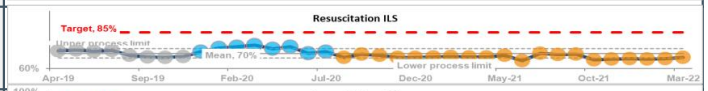
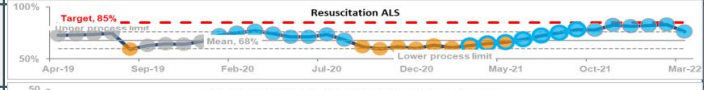
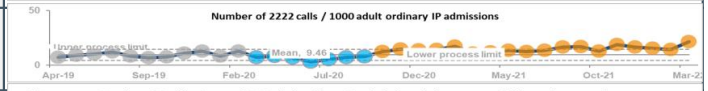
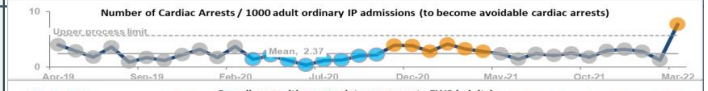
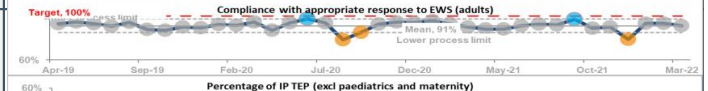
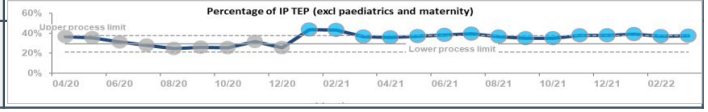
Actions and Quality Improvement Projects

- 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
- 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
- MedCard discharge SWAT team appointed to with start dates April-May (Clinical Flow Lead, Discharge Facilitators)

Balanced Scorecard Approach

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

Quality Priorities – Deteriorating Patients

	Target	Mar-22	Var to target	Trend
Basic Life Support Training (BLS)	85.0%	81.5%	–3.5%	
Immediate Life Support Training (ILS)	85%	67.7%	-17.3%	
Advanced Life Support Training (ALS)	85%	76.2%	-8.8%	
Number of 2222 Calls/1000 adult ordinary IP admissions	N/A	21.65	-	
Number of Cardiac Arrests/ 1000 adult ordinary IP admissions (to become avoidable cardiac arrests	N/A	7.7	-	
Compliance with appropriate response to Early Warning Scores (Adults)	100%	90.8%	-9.2%	
Percentage of Inpatient Treatment Escalation Plans (excl paediatrics and maternity)	40%	37.4%	- 2.6%	

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

- BLS (Basic Life Support) training performance saw a further reduction and continues to shows special cause improvement despite not achieving target, with performance at 81.5%
- ILS (Immediate Life Support) shows special cause deterioration, with performance slightly improved on last month at 67.7% this month.
- ALS (Advanced Life Support) training performance was 76.2%.
- The rate of 2222 calls per 1,000 Inpatient (IP) admissions and the rate of cardiac arrests per 1,000 adult ordinary inpatients shows special cause variation with a deteriorating position.
- Compliance with appropriate response to Early Warning Score (EWS), is 90.8% 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

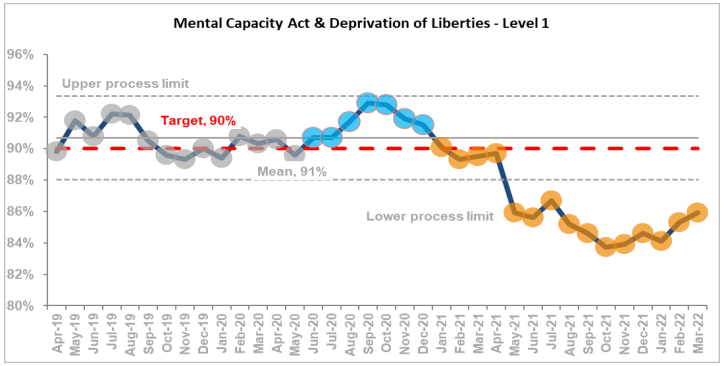
BLS - The Self-Assessment Pod continues to operate Monday to Friday 08:00 to 18:00 with additional 'drop-in' sessions at QMH and St Johns Health Centre. Targeted sessions and additional 'roaming' Self-assessment' sessions are provided supported by the Brayden on-line training system. Staff continue to 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 - No Change in BLS – New TNA agreed at DMB level – needs to go through PSQG

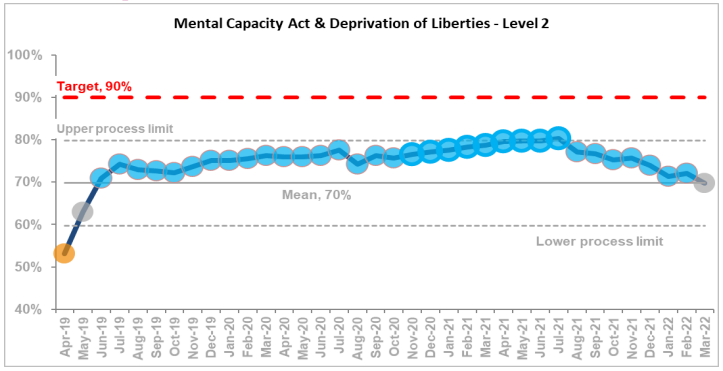
ILS – A minimum of 30 training places continue to be offered weekly although DNA rates remain high at 25 - 40% exacerbated by current operational pressures. eILS recertification course will be available from April 2022 to ALL medical staff and provide 15 places per month. The reclassification of the 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 - Slight reduction in DNAs, poor uptake of ILS recert (only available for medical staff at present) Communicating with Lead RO at ESTH to work out a joint way of working and improving TNA across all sites

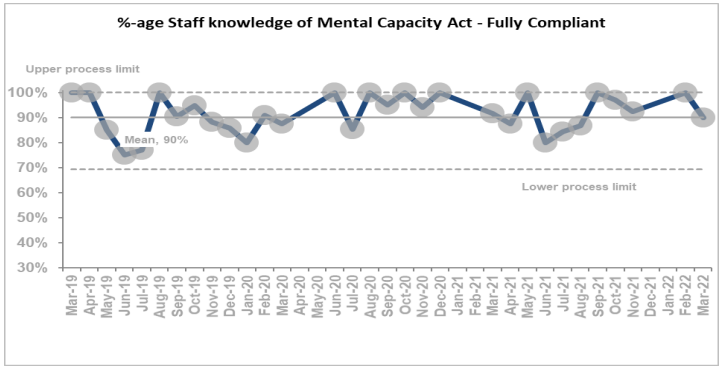
ALS - New rotation of Doctors started this month with usual dip in compliance. Of those showing as non-compliant approximately 50% have shown valid certificates – one is waiting validation from Advanced Life Support Group as undertaken in New Zealand. ALS places for non-compliant staff continue to be prioritised across all ALS courses. .- Will complete a 'deep dive' into ALS non-compliance – expected to improve once TNA is reviewed.

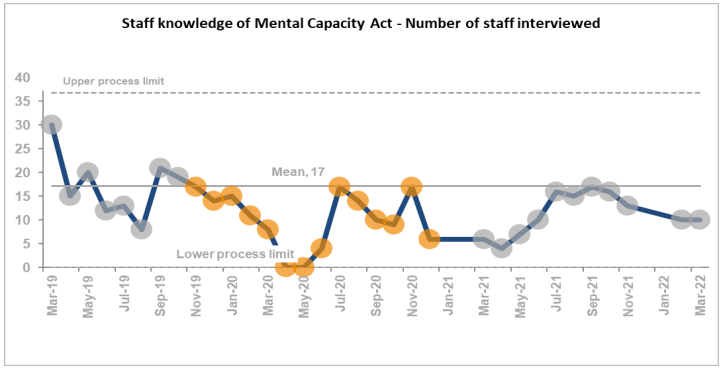
TEP - In order to continue to improve Treatment Escalation Plan (TEP) completion rates the following developments are now in place: Electronic dashboard to see how many patients in any clinical area have not had a TEP completed and Reporting at ward level in divisional performance reports; Easy electronic 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 – Performance in March for Level 1 was 85.9% and shows special cause variation with a deteriorating performance with the past year below the 2019/20 average.
- Overall Level 2 compliance was fell to 69.7% this month, the lowest performance seen since May 2019 and now shows common cause variation.
- 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 alongside the development of Level 3 training in conjunction with Safeguarding Adult training.

Project and improvement work is continues 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.

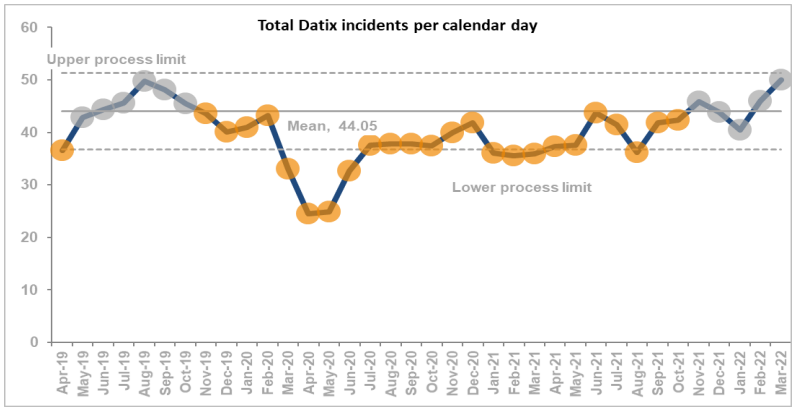
The Department of Health and Social Care have now released confirmation of a 16 week consultation on the draft Liberty Protection Safeguards with the Code of Practice and supporting documents to be released shortly. The wider Safeguarding Adults team (MCA, Safeguarding Adults and Learning Disability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

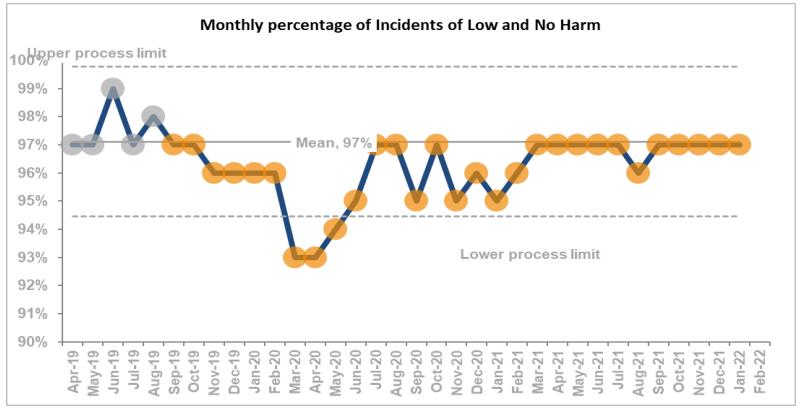
Project work has begun across the system to respond to the consultation and to develop the roles and responsibilities that will be required in order for the Trust to fulfil it's legal responsibilities under the MCA

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	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Monthly percentage of Incidents of Low and No Harm		97.0%	97.0%	97.0%	97.0%	97.0%	96.0%	97.0%	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%	90.0%	100.0%	100.0%	96.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	data two months in arrears	
Total Datix incidents per calendar day		36	37	38	44	42	36	42	42	46	44	40	46	50





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.
- Total were a total of 50 Datix incidents per calendar day.

Actions and Quality Improvement Projects

Duty of Candour (DoC) for January, February and March was 100% across the 3 Divisions
DoC compliance continues to be maintained. This continues to be monitored and support provided to the relevant departments in order to consistently sustain compliance.

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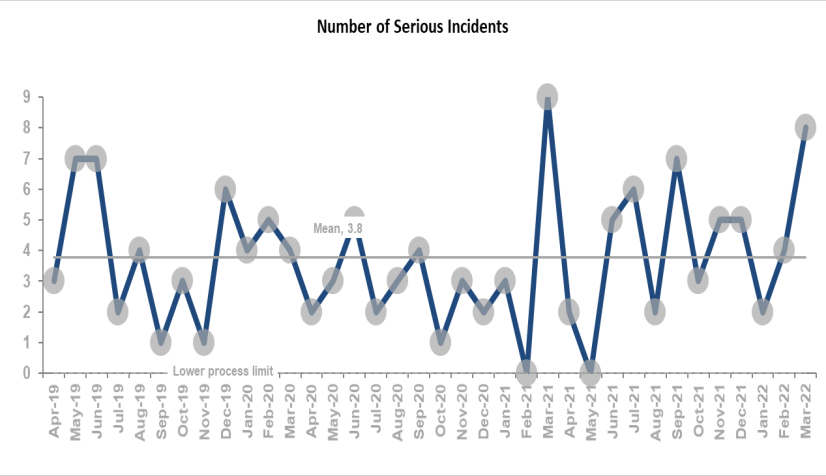
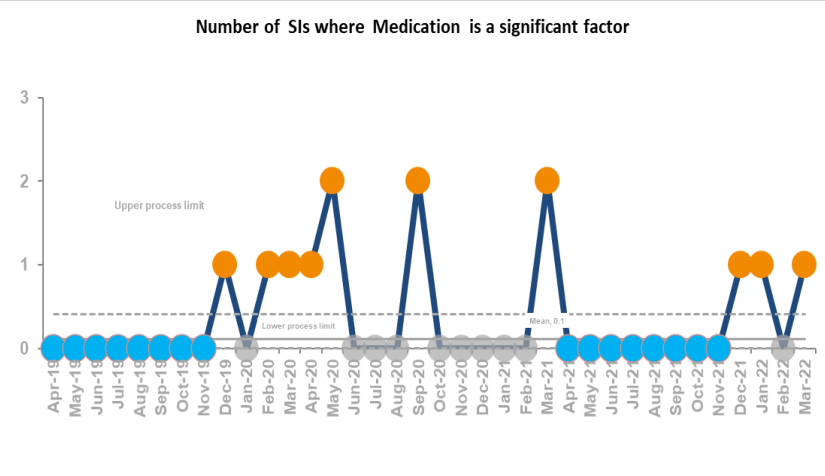
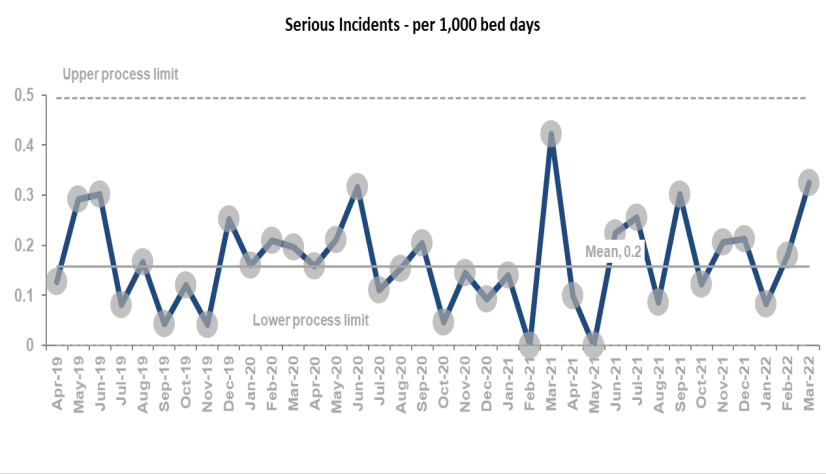
Our Patient Perspective

Patient Safety- Serious Incidents

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



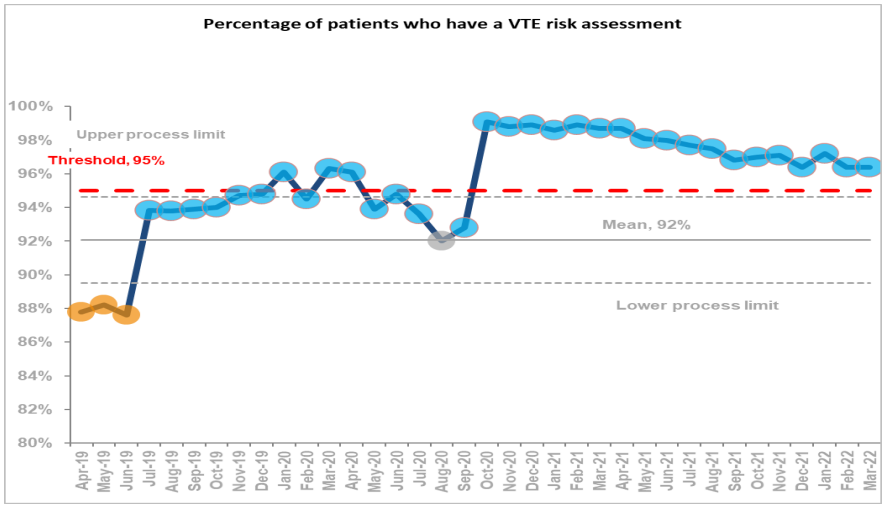


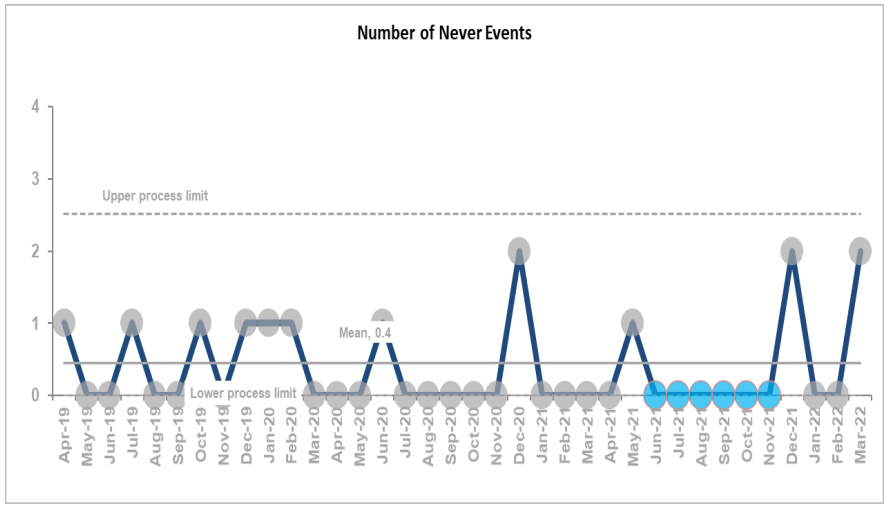


What the information tells us

- Common cause variation is seen in the number of Serious Incidents and the number of Serious Incidents per 1,000 bed days.
- One Serious Incidents where Medication is a significant factor was recorded in March, now showing common cause variation with a deteriorating performance.

Patient Safety- VTE and Never Events





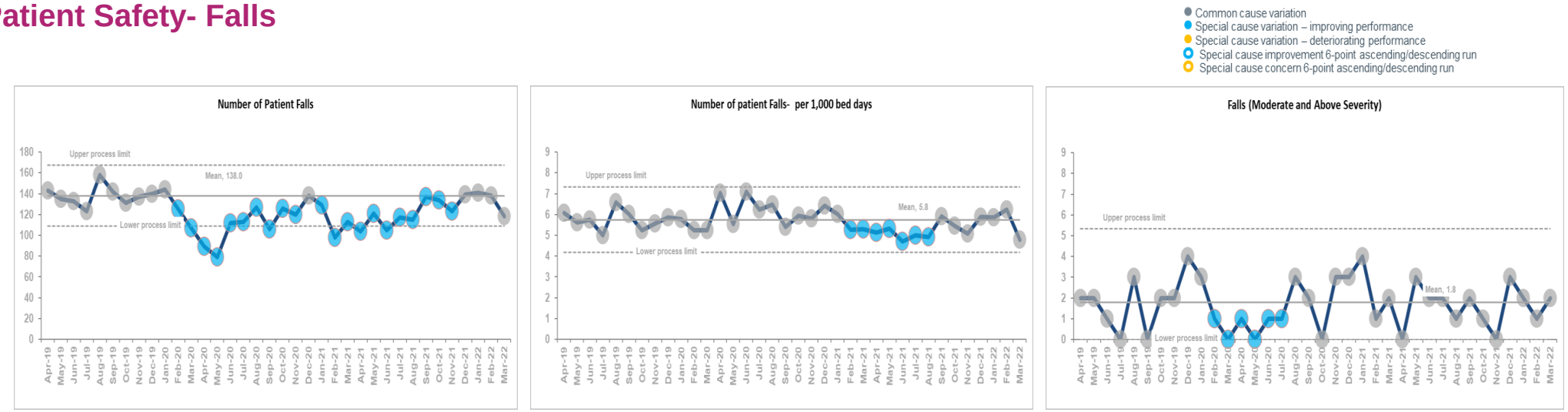
What the information tells us

- The percentage of patients who have had a VTE risk assessment was 96.4% against a target of 95%.
- There were two Never Events declared in March 2022, one Wrong site relates to a patient who underwent a wide local excision of the wrong lesion on their right cheek. The patient subsequently underwent excision of the correct site without complication
- The other was a misplaced nasogastric tube. This incident relates to a patient who had a naso-gastric tube inserted which was located in the right bronchus. There was a delay in escalating the patient's deteriorating condition. Following a chest x-ray, the tube was removed, and the patient intubated, ventilated and transferred to the General Intensive Care Unit for further care.

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.

Patient Safety- Falls



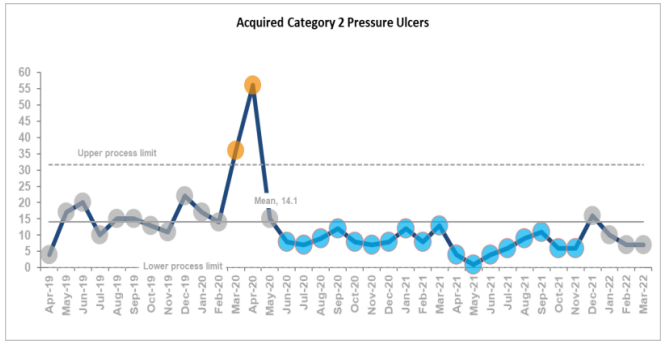
What the information tells us

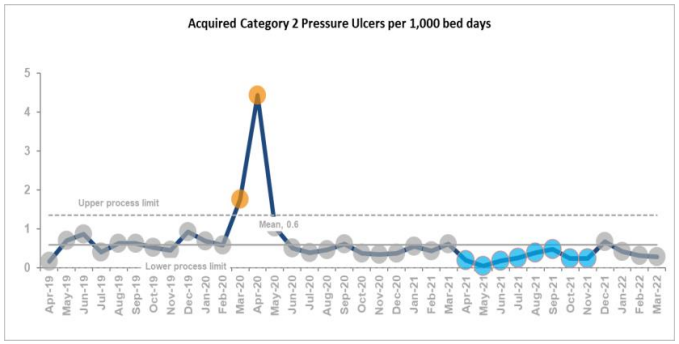
- The number of patients falls shows common cause variation; Patient Falls per 1,000 bed days also shows common cause variation.
- Two patients had a fall in month with a severity of moderate harm or above.

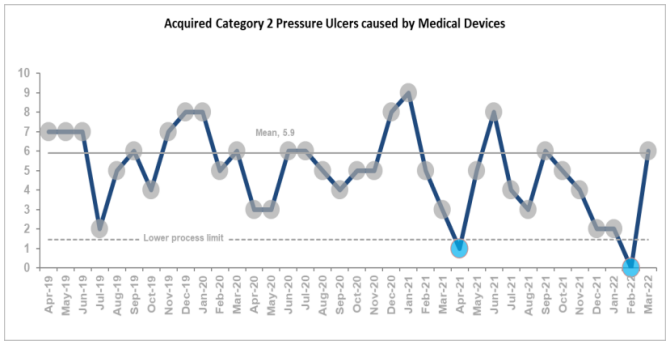
Actions and Quality Improvement Projects

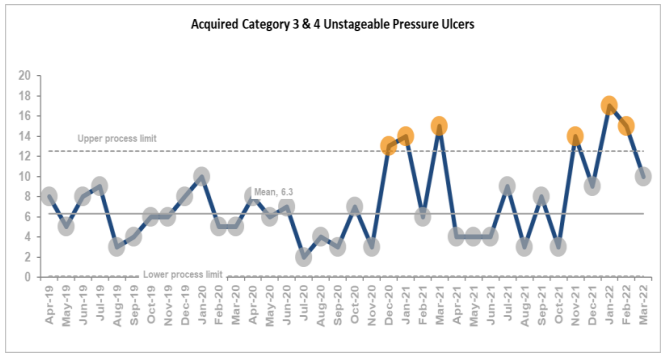
- Falls prevention measures continue to be implemented across inpatient wards
- Falls incidents continue to be monitored and reviewed locally by senior nursing teams with any learning identified and improvement actions implemented as appropriate.

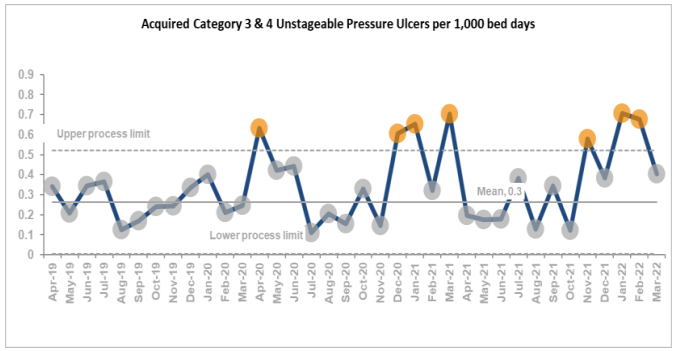
Patient Safety- Pressure Ulcers

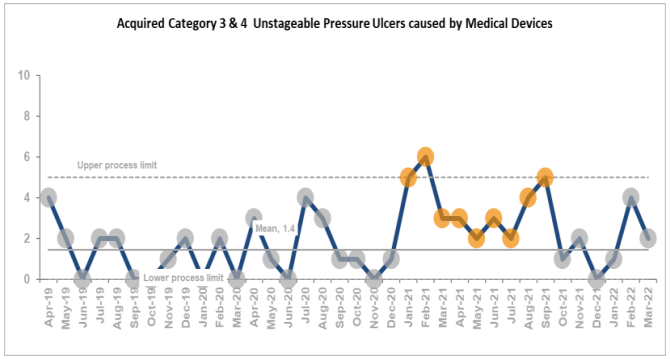


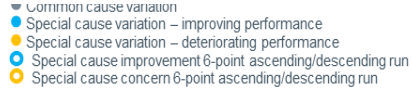












All PUs exclude Medical Devices except where stated

What the information tells us

- There were 8 Acquired Category 2 Pressure ulcers this month. Acquired Category 2 PUs and rate per 1,000 bed days shows common cause variation.
- There were a total of 10 Category 3 & 4 Unstageable Pressure ulcers this month The number, the rate per 1,000 bed and those caused by Medical Devices all show common cause variation.

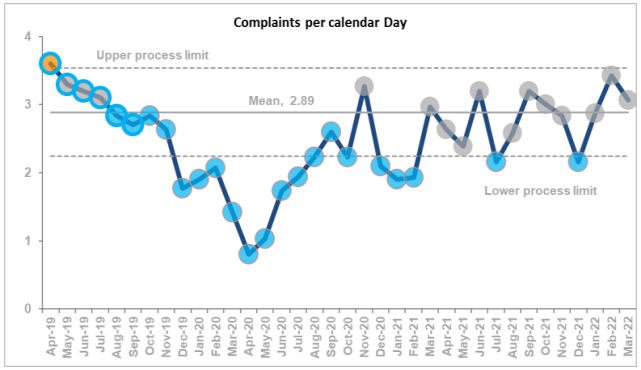
Actions and Quality Improvement Projects

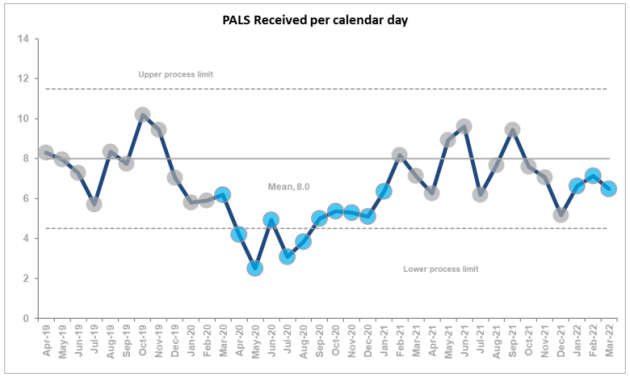
- All category 3 and above pressure ulcers undergo root cause analysis to identify any learning
- On-going mandatory and induction teaching sessions occur, with regular visits to QMH.
- Continue the review of rapid response reports with wards and support their individualised action plans.
- Continue Senior nurse Pressure Ulcer Prevention workshops and develop a poster for categories of pressure ulcers in dark skin tones and teach pressure ulcer prevention to newly qualified nurses on preceptorship day.

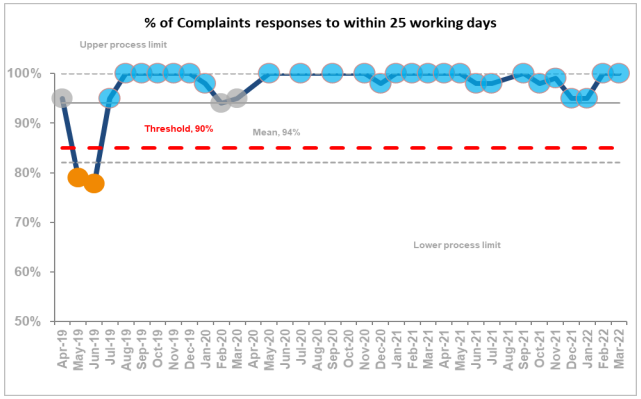
Our Patient Perspective

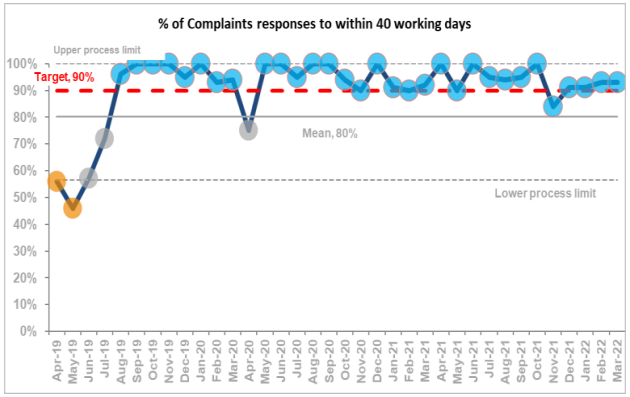
Complaints

Indicator Description	Target	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Complaints Received per calendar day		3.0	2.6	2.4	3.2	2.2	2.6	3.2	3.0	2.8	2.2	2.9	3.4	3.1
% of Complaints responses to within 25 working days	85%	100%	100%	100%	98%	98%	98%	100%	98%	99%	95%	95%	100%	100%
% of Complaints responses to within 40 working days	90%	92%	100%	90%	100%	95%	94%	95%	100%	84%	91%	91%	93%	93%
% of Complaints responses to within 60 working days	100%	100%	N/A	100%	50.0%	N/A	N/A	100%	N/A	N/A	67.0%	N/A	100%	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 decreasing from 96 to 95 in March 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 special cause variation with an improving position.

Actions and Quality Improvement Projects

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

Outstanding care every time

Infection Control

Indicator Description	Threshold 2021-2022	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	YTD Actual
MRSA Incidences (in month)	0	0	0	0	0	0	0	1	1	0	0	0	0	0	2
Cdiff Hospital acquired infections	52	2	2	2	2	0	3	4	4	5	5	3	2	1	43
Cdiff Community Associated infections		1	1	0	0	0	2	1	1	1	0	2	1	1	
MSSA	25	5	5	3	3	3	3	0	3	10	2	4	3	6	45
E-Coli	111	6	7	6	5	6	5	4	5	7	5	5	2	8	65
Covid-19 Nosocomial Infections Hospital Onset healthcare associated (>14 days) HOHA	N/A	0	2	0	0	0	18	2	7	4	69	61	14	50	227
Covid-19:Nosocomial Infections Hospital Onset Probable associated (8-14 days) HOPA	N/A	4	0	1	1	0	10	1	4	1	31	31	17	40	137
Pseudomonas Aeruginosa	21	1	1	0	3	3	1	3	3	1	3	4	1	4	27
Klebsiella spp. Bacteraemia	49	4	2	5	2	4	5	7	4	7	4	3	3	2	48

What the information tells us

- There were 2 *C. difficile* infections during March 2022; 1 was 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 31/03/22 there have been 43 cases of *C. difficile* infection against an NHSI/E threshold of no more than 52 cases for 2021-22. The Trust has therefore finished the year under this trajectory. Of the 43 cases, 33 were classified as HOHA and 10 were classified as COHA. 5 lapses in care have so far been identified, relating to antimicrobial prescribing and timely isolation of patients, however, further reviews remain outstanding and will be completed during April 2022
- There were 6 patients with Trust apportioned MSSA blood stream infection during March 2022. There are no national or local trajectories for MSSA, Between 01/04/21 and 31/03/22 there were 45 cases, comparing to 46 during 2020-21.
- There were 8 cases of Trust apportioned *E. coli* bacteraemia during March 2022. A new NHSI/E trajectory has been set for *E. coli* bacteraemia of no more than 111 cases for 2021-22. Between 01/04/21 and 31/03/22, there have been a total of 65 cases, and 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 were 4 cases during March 2022. Between 01/04/21 and 31/03/2022 there were 27 cases, which is above trajectory. The 27 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 2 cases during March 2022. Between 01/04/21 and 31/03//22 there were 48 cases, which is 1 below trajectory. The 48 cases compare to 77 for the same period during 2020-21
- There were 50 Hospital Onset Healthcare Associated cases (HOHA) of Covid-19 during March 2022, where the sample was taken >14 days after admission and 40 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 leading on discussion to implement changes in patient isolation and screening guidance, whereby isolation / cohorting of contacts of a positive case is now reduced to 7 days, and screening is now only undertaken when contacts become symptomatic, or are clinically extremely vulnerable. This position has been agreed across the Group.

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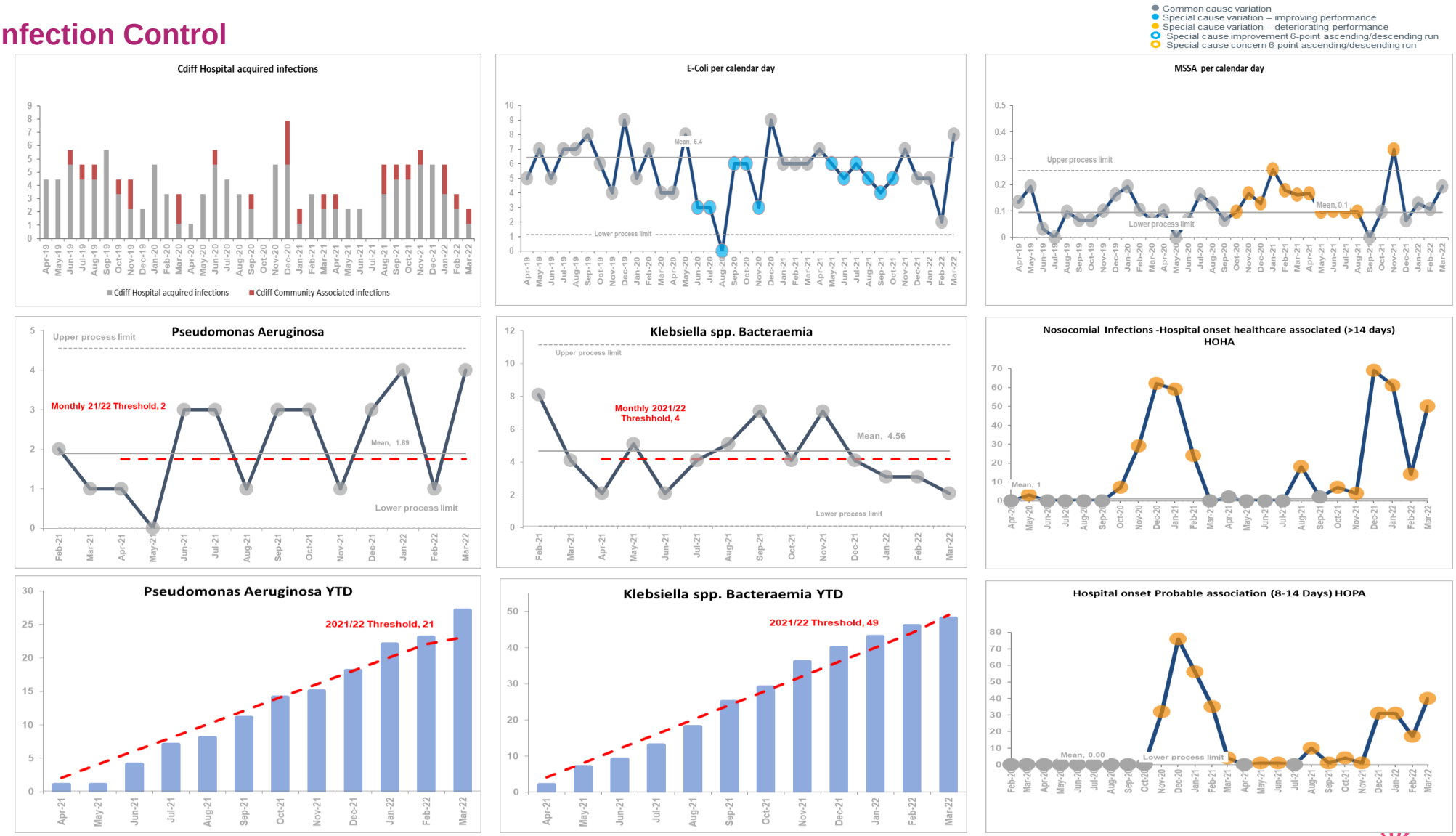
Infection Control



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-21	Jan 2021 to Dec 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	81.2	85.1
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	75.3	96.4
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	77.4	80.7

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	Nov 20-Oct 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	0.90

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	Feb-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%	8.9%	9.3%

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

What the information tells us

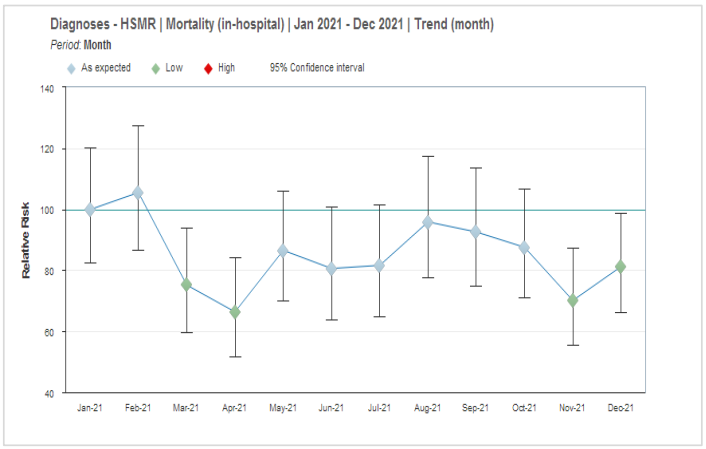
Mortality as measured by the summary hospital-level mortality indicator (SHMI) is lower than expected for the year November 2020 – October 2021. We are one of 16 trusts in this category, and one of 12 trusts that also had a lower than expected number of deaths for the same period in the previous year. Our latest HSMR, for the 12 months from January 2021 to December 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.

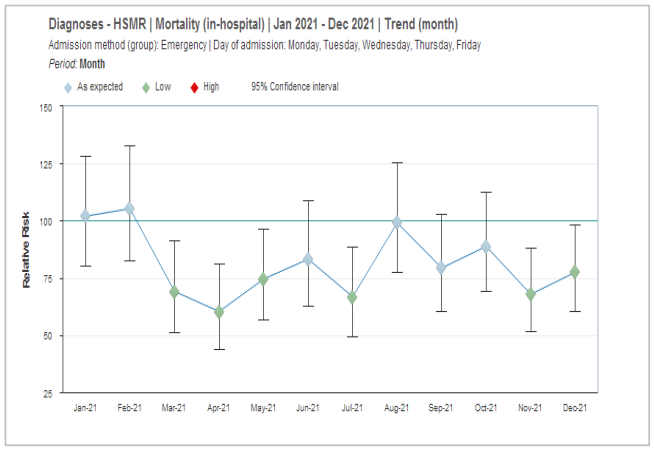
The percentage of patients readmitted within 30 days following an Emergency admission was 9.3% February 22. Performance shows common cause variation.

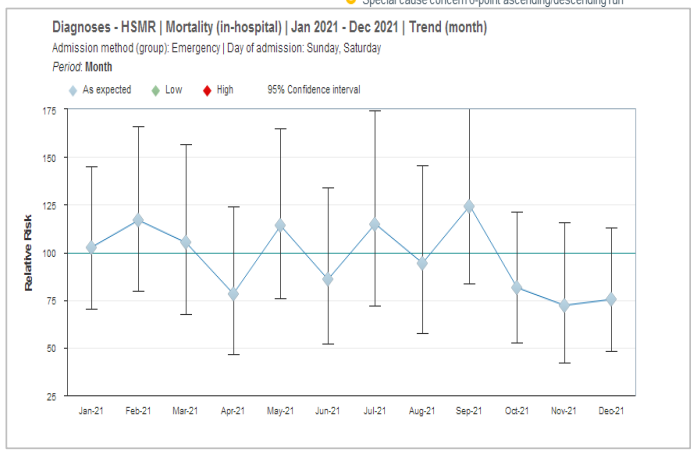
Actions and Quality Improvement Projects

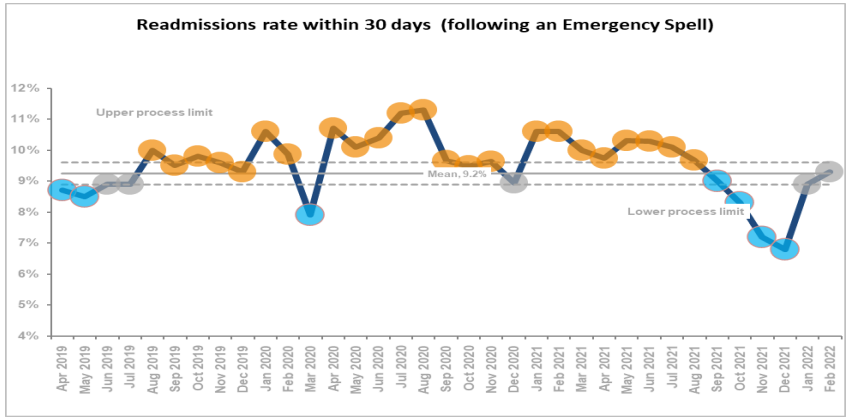
We continue to monitor and investigate mortality signals in discrete diagnostic and procedure codes from Telstra/Dr Foster through the Mortality Monitoring Group (MMG). The group are currently overseeing an investigation of mortality in the diagnosis group Acute Myocardial Infarction, as higher than expected mortality is indicated by analysis of both the HSMR and SHMI. Following a mortality investigation in the previous year an improvement action plan is in place, which is being monitored at divisional level. The Cardiology Clinical Governance Lead has been invited to provide an update against the agreed action plan in May 2022, prior to a full report in August 2022. An alert in the diagnosis group ‘Intracranial injury’ continues to be observed. At MMG in March it was agreed that the Neurosurgery service would develop a clear investigation plan, including ongoing actions that are likely to improve outcomes. This is to be monitored through the divisional structure, but with oversight from MMG. A progress report to MMG is scheduled for May 2022.

Mortality and Readmissions (Hospital Standardized Mortality Rate)





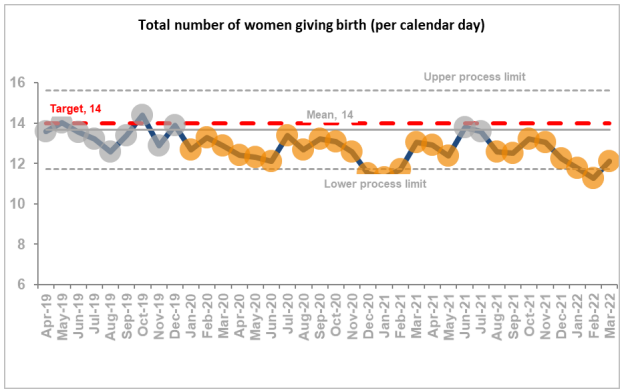


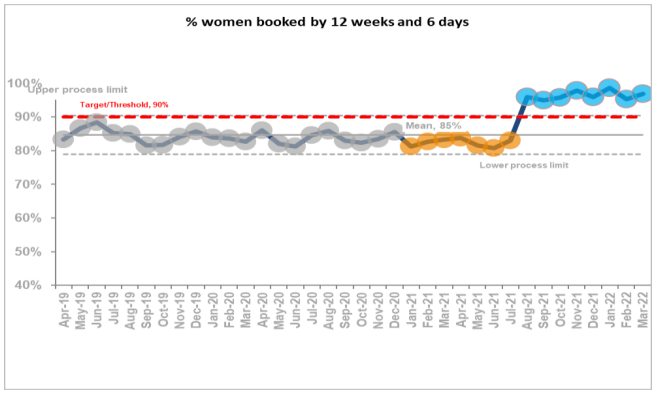


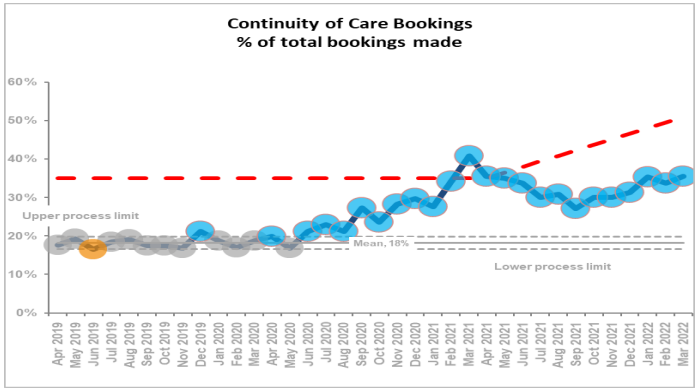
Common cause variation
Special cause variation – improving performance
Special cause variation – deteriorating performance
Special cause improvement 6-point ascending/descending run
Special cause concern 6-point ascending/descending run

Our Patient Perspective

Maternity







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

- After we saw month on month reductions in women giving birth since October 2021, March 2022 shows this trajectory now turned. Staffing remained challenging across the month with sickness and covid isolation, along with recruitment delays to fill our vacant band 5 and band 6 midwifery posts.
- 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, with our Birth Centre closed 35.54% in March, a slight improvement on February's position. There was a significant challenge in receiving our referrals into the service with an IT error leading to 268 referrals being 'lost' in the system. The OP team have validated these and we have planned for evening midwifery clinics to book in the 68 women who still require entry into our system to prevent any breaching the 12+6 KPI. Discussions are on-going to ensure this does not happen again,.
- There were no stillbirths and no neonatal deaths in March 2022.
- Caesarean section rates increased in March to 33.3% primarily due to elective procedures as our emergency rate reduced to 3.7%. We are not able to deduce if this rise is an anomaly or has a specific cause,
- There was a continued excellent performance in antenatal bookings with 98.25% of women referred being booked by 12 weeks and 6 days.

Actions and Quality Improvement Projects

- We 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 in February with the aim to further implement CoC here at SGH in a number of waves, with wave 1 due to be completed by September 2022. We are currently waiting for confirmation from the National team on whether we can continue this planned trajectory in line with Ockenden recommendations although we continue to make outline plans towards the safe implementation of wave1 which will support women within an area of deprivation. All further plans are on hold until directive is received and reviewed in line with staffing and vacancy/recruitment rates and plans.
- 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. The digital platform will be purchased and much of the bid money has now been allocated with the project team working cohesively.
- The Maternity Telephone Helpline was successfully launched in late March 2022 after a slight delay due to staffing pressures. The Helpline enables 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 Maternity Voice Partnership and the feedback to date has been fantastic, from both women and colleagues. The Helpline has already been taking in excess of 1 call per 10 minutes with communication and advertising planned to ensure all women have the Helpline number.
- Following confirmation of 100% compliance for the OCKENDEN immediate and essential requirements we are currently planning for a site visit from the Regional teams, confirmed as May 12th, 2022. There remains a number of assurance documents to be submitted in advance of this site visit which we are working to achieve in line with the deadlines and our governance processes.
- Maternity Transformation Programmes have been temporarily paused nationally in response to national staffing challenges.

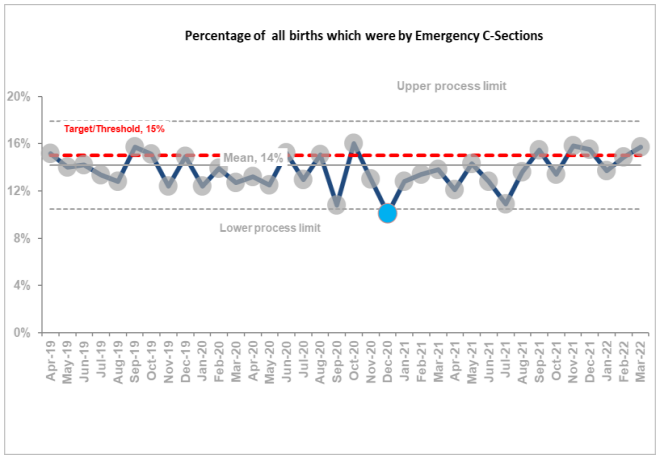
Maternity

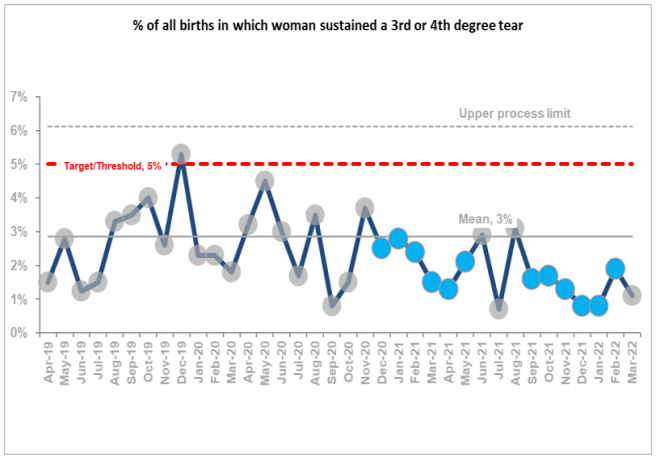
Maternity Dashboard

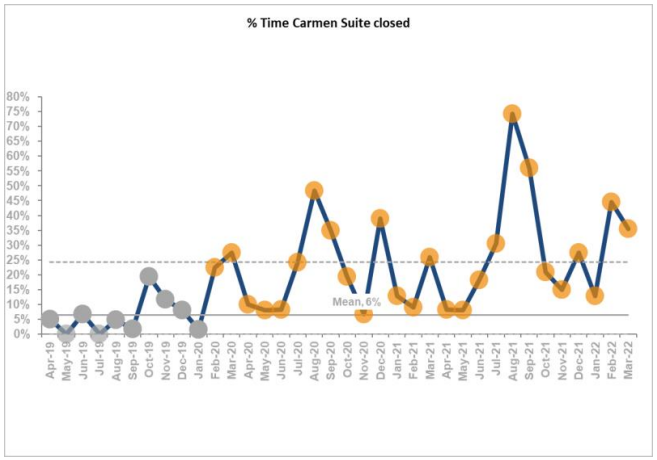
Definitions	Target	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Total number of women giving birth (per calendar day)	14 per day	13.1	12.9	12.4	13.8	13.6	12.6	12.5	13.2	13.1	12.3	11.8	11.3	12.1
Caesarean sections (Total Emergency and Elective by Delivery date)	<28%	29.1%	25.5%	27.6%	24.6%	24.7%	27.2%	28.3%	27.3%	31.4%	31.3%	27.1%	27.5%	33.3%
% deliveries with Emergency C Section (including no Labour)	<8%	4.0%	3.4%	3.9%	1.9%	3.6%	2.6%	4.5%	4.4%	5.4%	5.0%	3.0%	5.7%	3.7%
% Time Carmen Suite closed	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%	35.5%
% of all births in which woman sustained a 3rd or 4th degree tear	<5%	1.5%	1.3%	2.1%	2.9%	0.7%	3.1%	1.6%	1.7%	1.3%	0.8%	0.8%	1.9%	1.1%
% of all births where women had a Life Threatening Post Partum Haemorrhage >1.5 L	<4%	3.2%	2.8%	4.2%	2.4%	3.6%	2.3%	1.3%	2.9%	3.6%	2.4%	1.9%	2.5%	3.5%
Number of term babies (37+ weeks), with unplanned admission to Neonatal Unit		11	8	13	14	13	16	13	12	12	10	11	13	13
Number of term babies (37+ weeks), with unplanned admission to Neonatal Unit as a percentage of deliveries	6%	2.7%	2.1%	3.4%	3.4%	3.1%	4.1%	3.5%	2.9%	3.1%	2.6%	3.0%	4.1%	3.5%
Supernumerary Midwife in Labour Ward	>95%	98.4%	98.3%	98.4%	97.0%	88.7%	90.3%	90.0%	88.7%	98.3%	98.4%	98.4%	92.9%	95.2%
Babies born with Hypoxic Ischaemic Encephalopathy / (1000 babies)		2.5	0.8 (Qtr1)			2.4 (Qtr2)			0.8 (Qtr3)			3.8 (Qtr4)		
Still Births per 1000 Births	<3	4.9	2.6	5.2	2.4	7.1	0.0	2.7	9.8	10.2	2.6	0.0	0.0	0.0
Neonatal Deaths (KPI 72) per 1000 Births	<3	2.5	2.6	0.0	0.0	0.0	2.6	0.0	0.0	0.0	13.2	2.7	9.5	0.0
Continuity of Care Bookings- % of total bookings made (Target increases monthly by 1.5% towards a 51% target in Mar 22)	43.7%	40.1%	35.2%	35.0%	33.8%	30.1%	30.6%	27.2%	30.0%	30.0%	31.4%	35.3%	33.7%	35.5%
Percentage of all births which were by Emergency C-Sections (KP25+26)	15%	13.8%	12.1%	14.3%	12.8%	10.9%	13.6%	15.5%	13.4%	15.8%	15.5%	13.7%	14.9%	14.9%
% women booked by 12 weeks and 6 days	90%	83.3%	83.8%	81.5%	80.8%	83.0%	96.0%	95.0%	95.8%	97.9%	95.9%	98.7%	95.3%	96.9%

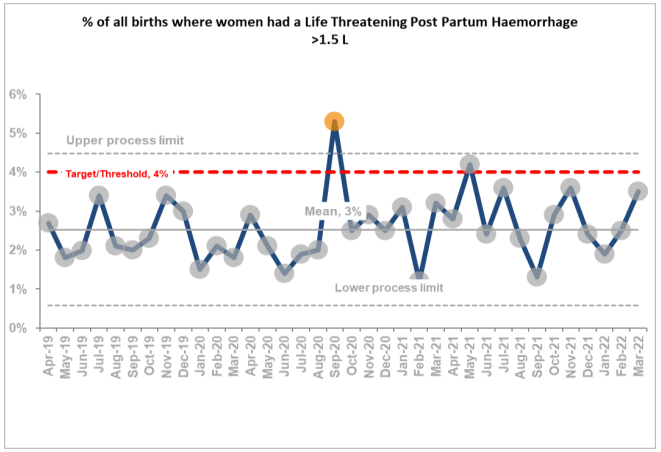
Maternity

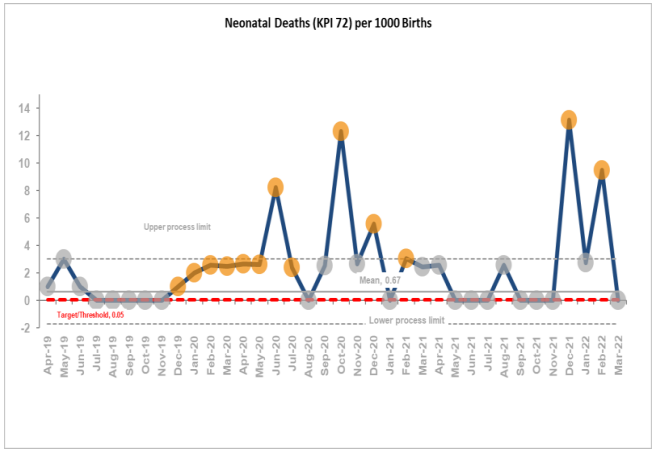
Common cause variation
Special cause variation – improving performance
Special cause variation – deteriorating performance
Special cause improvement 6-point ascending/descending run
Special cause concern 6-point ascending/descending run

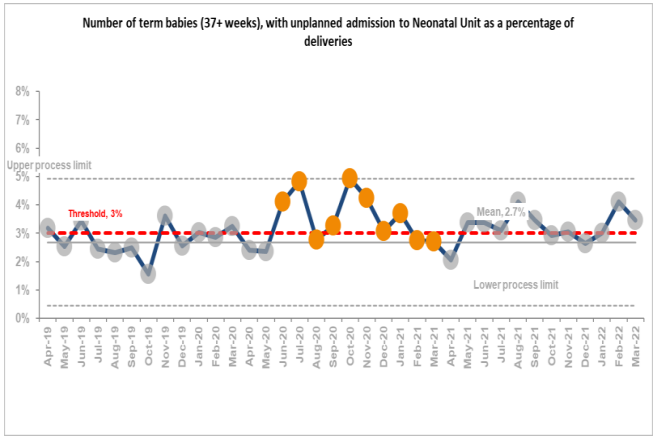












Friends & Family Survey

Indicator Description	Target	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Emergency Department FFT - % positive responses	90%	88.8%	86.4%	83.4%	79.8%	81.6%	78.0%	73.6%	71.3%	75.5%	77.4%	80.2%	76.1%	72.0%
Inpatient FFT - % positive responses	95%	99.3%	98.2%	97.1%	97.5%	97.2%	98.4%	97.9%	98.9%	98.3%	96.0%	95.8%	98.2%	97.4%
Maternity FFT - Antenatal - % positive responses	90%	50.0%	N/A	N/A	N/A	100.0%	50.0%	N/A	N/A	N/A	100.0%	N/A	N/A	N/A
Maternity FFT - Delivery - % positive responses	90%	91.6%	88.9%	100.0%	90.0%	100.0%	N/A	100.0%	84.0%	86.8%	87.9%	85.0%	90.6%	92.5%
Maternity FFT - Postnatal Ward - % positive responses	90%	81.8%	100.0%	95.8%	91.9%	100.0%	0.0%	N/A	94.4%	100.0%	90.5%	100.0%	88.9%	100.0%
Maternity FFT - Postnatal Community Care - % positive responses	90%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Community FFT - % positive responses	90%	100.0%	91.7%	87.5%	91.7%	100.0%	100.0%	92.9%	89.5%	94.1%	94.4%	100.0%	90.9%	96.0%
Outpatient FFT - % positive responses	90%	95.2%	88.7%	91.3%	90.7%	91.0%	89.8%	90.2%	90.3%	91.7%	91.9%	91.8%	92.5%	90.5%

What the information tells us

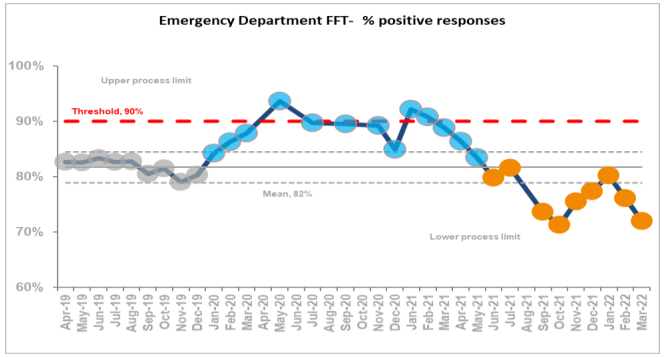
- Inpatient, Maternity, Maternity (Delivery and Postnatal Ward), Community and Outpatient services achieved FFT targets where patients rated the services as "Good" or "Very Good".
- Performance for Emergency Department was 72% with ED showing common cause variation with a deteriorating position.

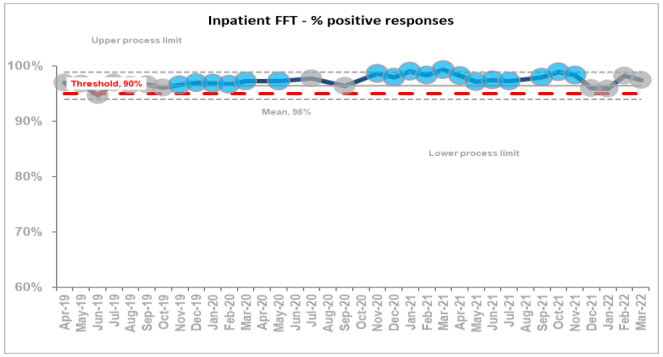
Actions and Quality Improvement Projects

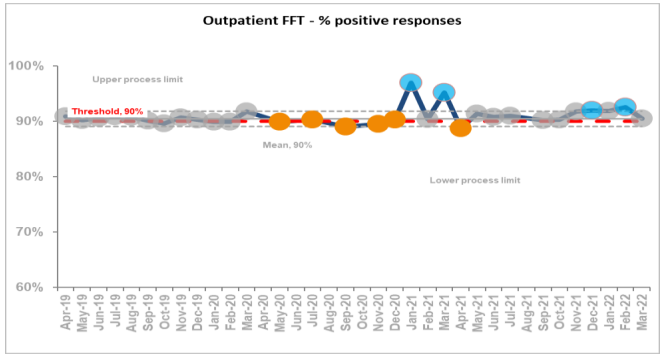
For the Emergency Department, the service moved from an external provider to the Trust's FFT collection system in January 2021, since then there has continued to be a reduction in reported response rate. The data accuracy has been confirmed and the process checked to ensure that reminder texts are being 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. The Department is currently undertaking a detailed review of the raw data, Initial findings are that the increase in negative responses is almost entirely due to issues around waiting times.

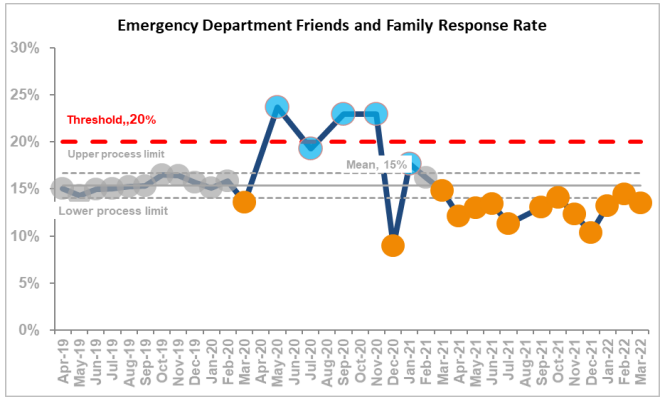
Midwifery Services were busy again with staffing challenges which may have influenced waiting times and bed allocation, although there were no reported delays in pain relief. The team have revised the current questions to be launch in April 2022. New Healthcare Assistant colleagues have joined the team 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

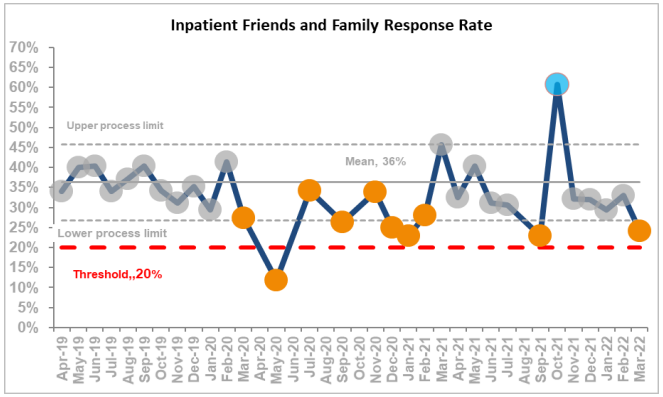
Friends and Family Test

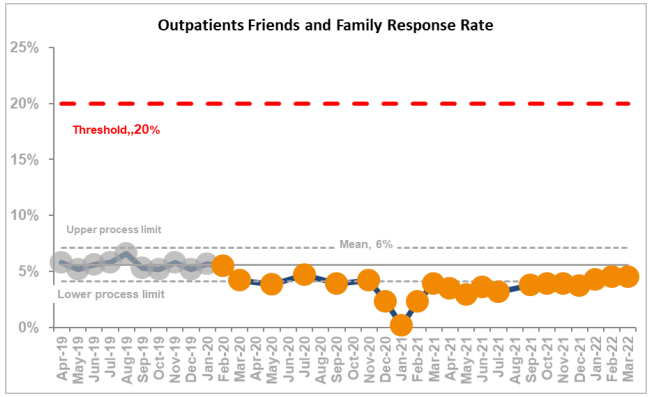








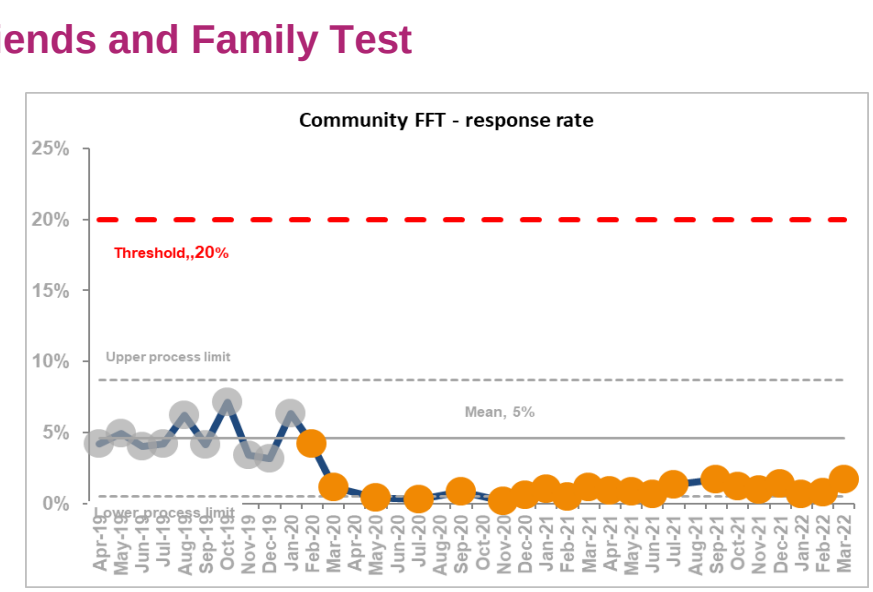


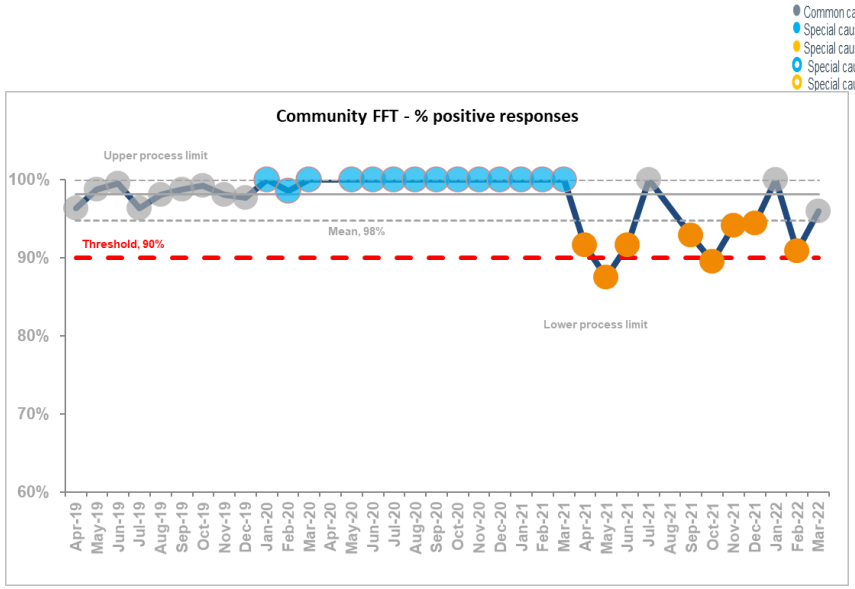


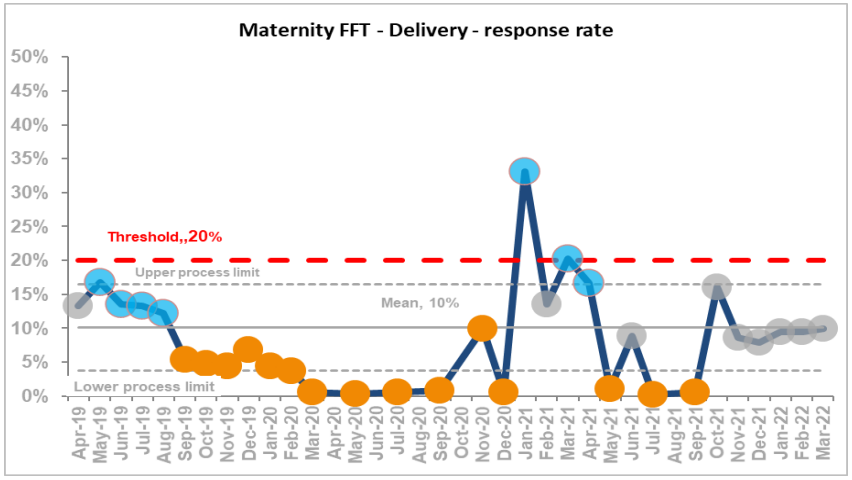
- Common cause variation
- Special cause variation – improving performance
- Special cause variation – deteriorating performance
- Special cause improvement 6-point ascending/descending run
- Special cause concern 6-point ascending/descending run

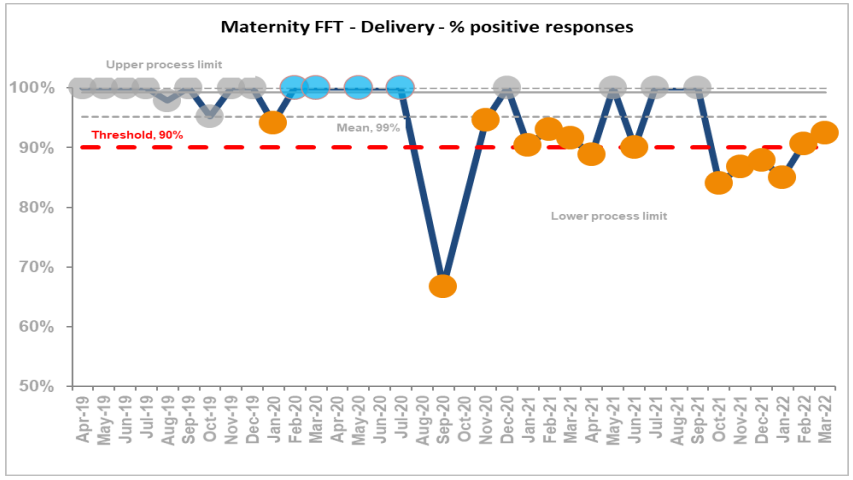
Our Patient Perspective

Friends and Family Test

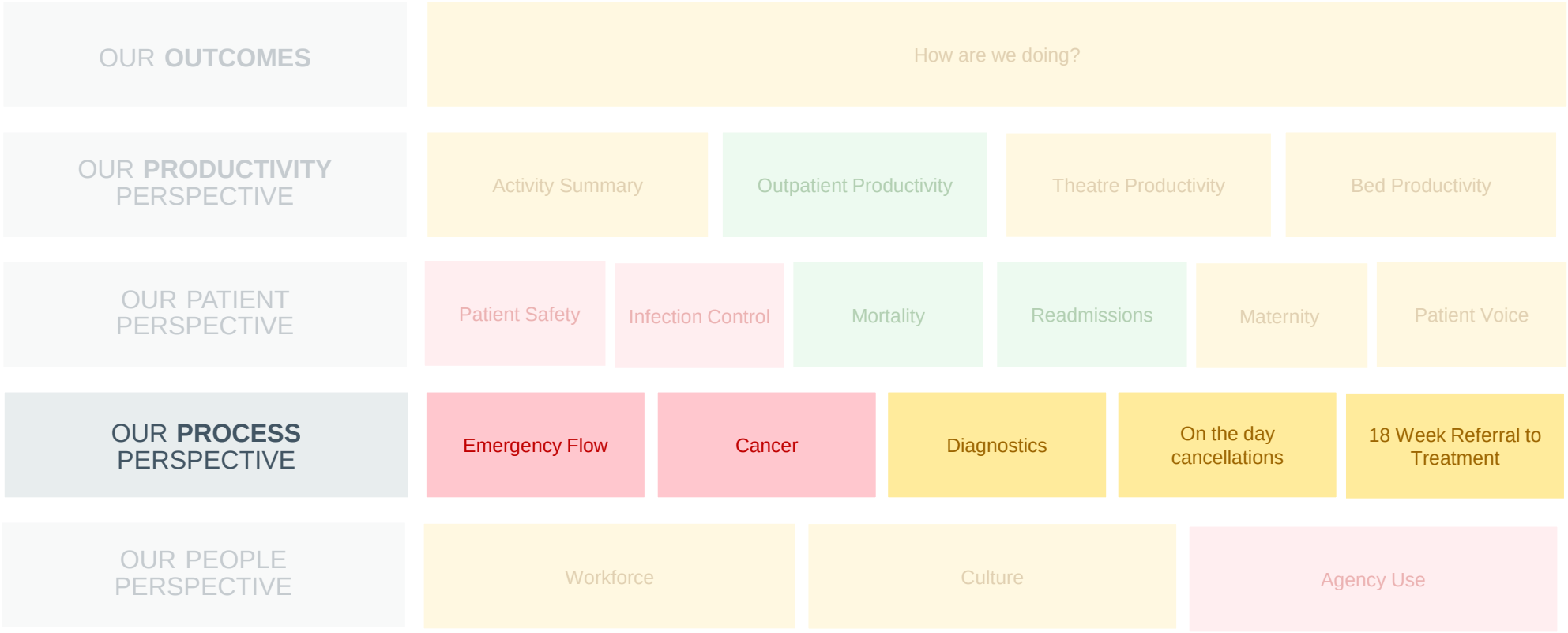




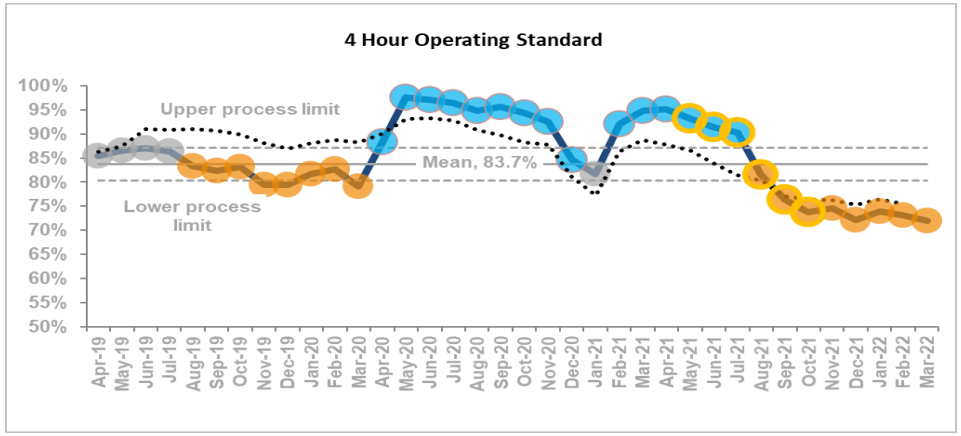


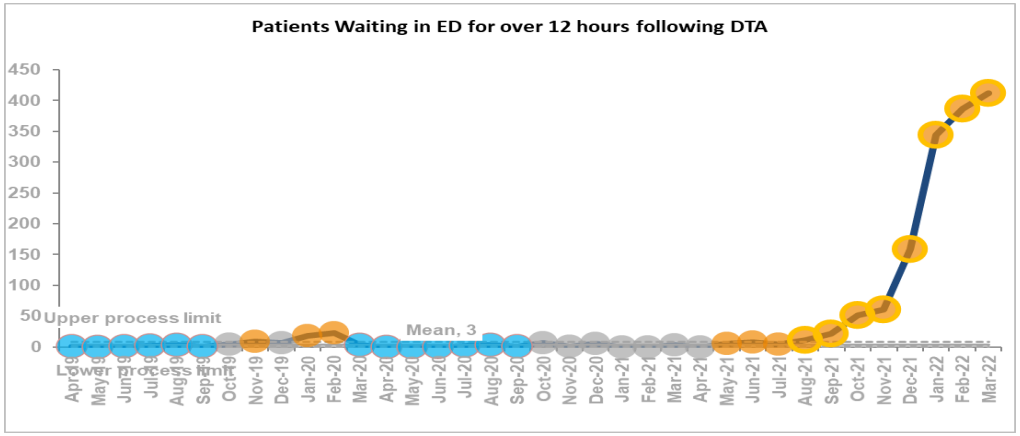


Balanced Scorecard Approach



Emergency Flow





What the information tells us

In March, 13,299 patients attended the Emergency Department, on average 429 patients attending per day, an increase of 24 patients compared to February. Of the patients attending, 72% were either discharged, admitted or transferred within four hours of their arrival, with 25% of patients requiring hospital admission. Across the month, the acuity of patients has varied significantly; on average, 47% of patients presenting were triaged having a Manchester Triage Score of between 1 and 3. However, 13 days of the month were above this average, reaching 60% on the 30th of March.

Patient Flow and bed allocation remain challenged impacted by; high acuity leading to longer length of stay, patients awaiting discharge to nursing home / POC placement that are medically fit, patients requiring repatriation, closed beds across the Trust due to infection control and rising occupancy rates. This continues to impact waiting times and front end capacity resulting in a rise in the number of 12-hour trolley waits reported in March (412 breaches) and delays in ambulance handover times, both hold risk of significant safety issues along with floor space within the department. This risk is managed on a daily basis by the Consultant and Nurse on the shop floor and escalated appropriately.

The average number of patients staying in a hospital bed for over 7,14 and 21 days has seen an increase in the month; the Trust is working with system partners to reduce external delays where the majority of patients waiting are within Geriatric Medicine and awaiting larger packages of care.

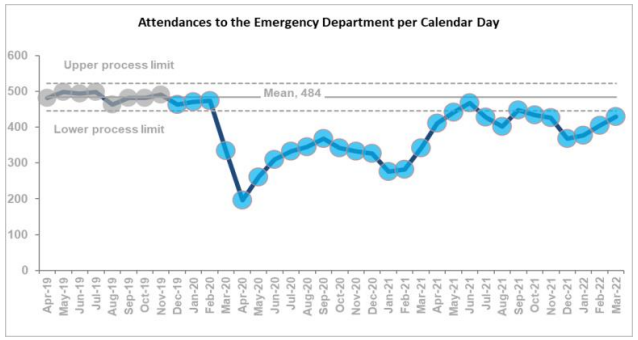
Actions and Quality Improvement Projects

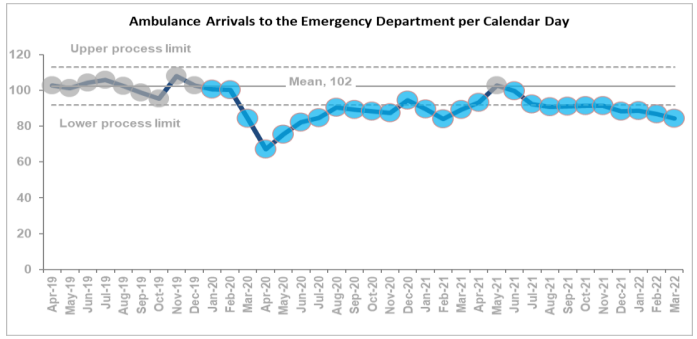
- The Trust is continuing to work seamlessly with system partners to reduce the number of patients waiting for social services
- Length of Stay Reviews as well as Daily matron reviews
- 4 hour, 12 hour and 60 minute breaches are in the process of being added to Risk Register. Risks and safety issues are being reported on datix and discussed with COO / Exec daily
- Senior ED Team spending more time in the department to support staff on the ground
- Rounds of ED waiting room, to ensure safety of our patients waiting to be seen
- Further work is being undertaken to maximise in out space for doctors to see patients whilst the number of Decision-to-Admits (DTAs) remains at high numbers
- HALO (LAS team member) on site twice weekly to assist with safety of LAS awaiting cubicle space.

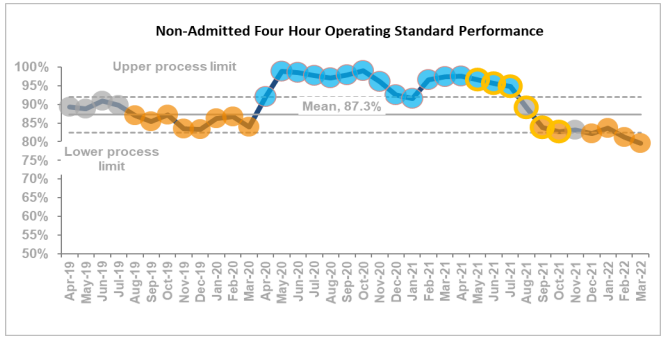
Common Cause
Special Cause Improvement
Special Cause Concern
Special cause concern 6-point ascending/descending run
Special cause improvement 6-point ascending/descending run

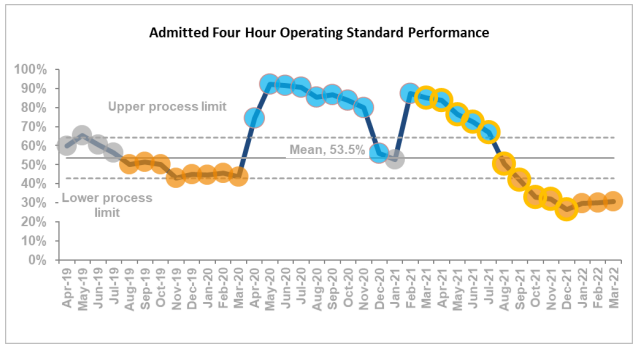
Our Process Perspective

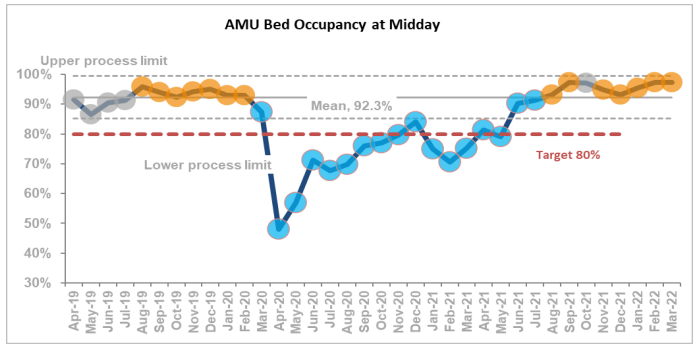
Emergency Flow

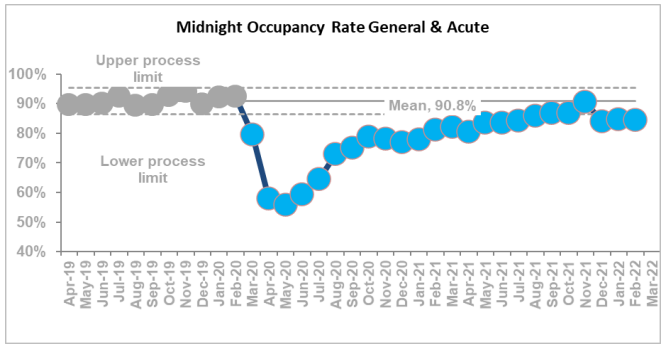


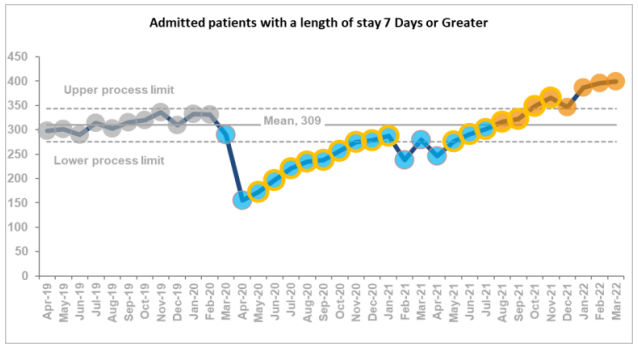


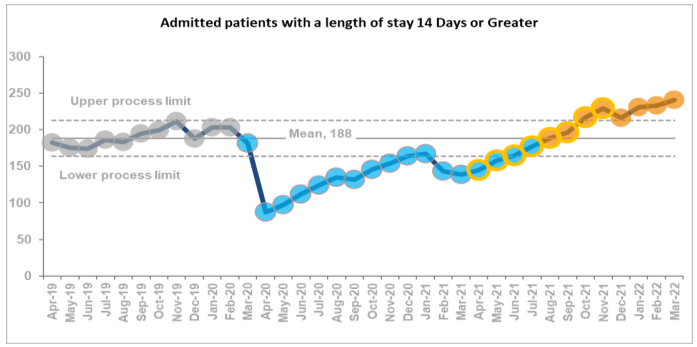


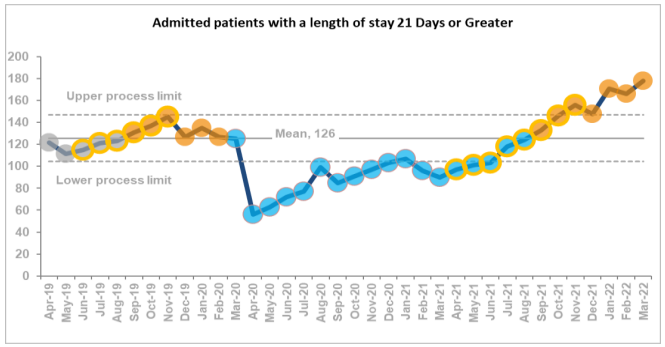






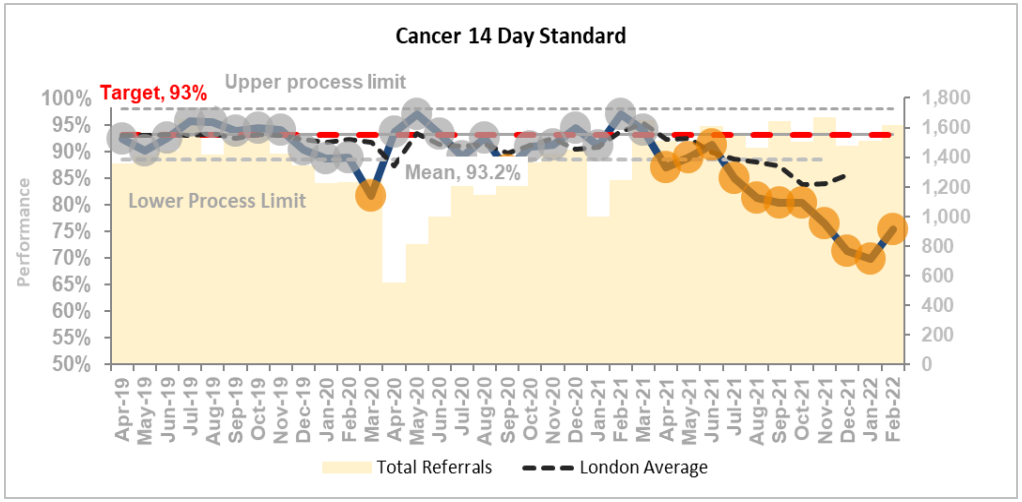


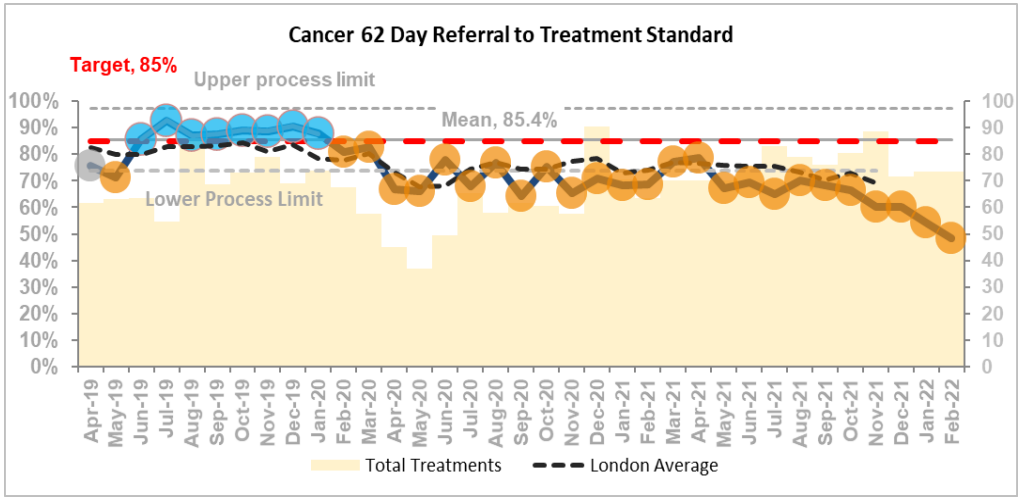




Our Process Perspective

Cancer





What the information tells us

Cancer performance against the national cancer standards, although remaining challenged with continued high demand, reported positive improvements throughout February.

The number of referrals received remains above the 2019/20 baseline with 1,615 14-day referrals received in February, of which 75.4% of patients were seen within 14 days. This is an improvement of 5.6% compared to January. Four tumour groups are below the national standard of 93%; Breast (26.8%), Gynae (79.2%, Head & Neck (89.7%) and Lung (76.1%).

Performance against the 31-day treatment standard in February was 93.5% against a target of 96%, improving by 2.9% compared to January. Four tumour groups were below target; Head & Neck (85.7%), Lower GI (85.7%), Skin (77.8%) and Urology (93.5%).

In February there was 73.5 accountable treatments on the 62-day GP pathway, of which 38 patients received treatment within 62 days, 48.3% against a target of 85%. All tumour groups, with the exception of Haematology were non-compliant. At the end of February, there were 138 patients waiting for treatment above 63 days, an improved position against a trajectory of 160.

Actions and Quality Improvement Projects

14 Day Standard

- **Breast** continues to be the main contributor to TWR performance reporting 26.8% in February with ongoing recovery plans agreed with the alliance.
- **Gynecology and Lung** saw a dip in performance due to increase in referrals. Skins continues to have over 500 referrals per month but remained compliant in the month of Feb 21.

Backlog Recovery Trajectory

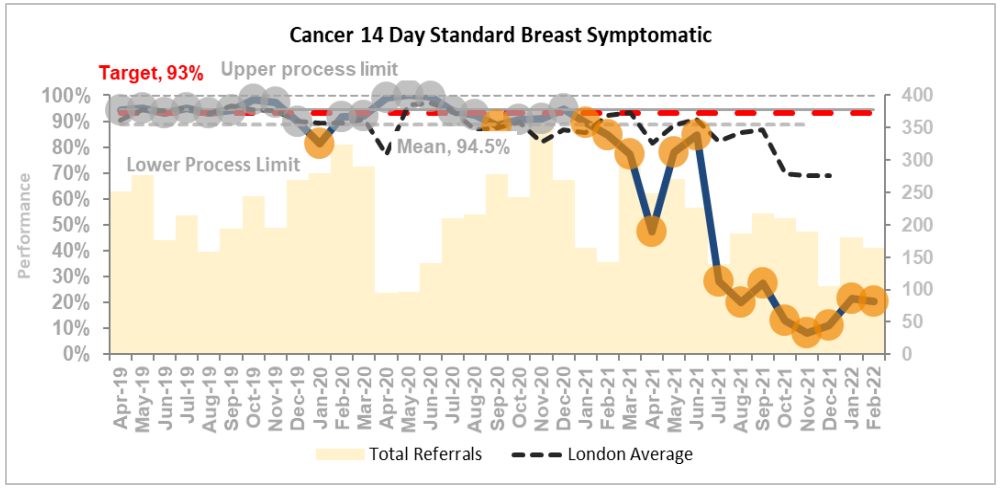
- The trajectory agreed with alliance is to achieve less than 160 over 62 days on the PTL by Q3 (Oct 22) and 140 by March 23. The trust has now met this trajectory with 113 on the backlog as of March 22.
- Ongoing challenges and recovery work is taking place to support urology theatre capacity for surgery and template biopsies, skin mops capacity due to high volume of referrals, Pathology turn around and Gynaecology Hysto capacity.

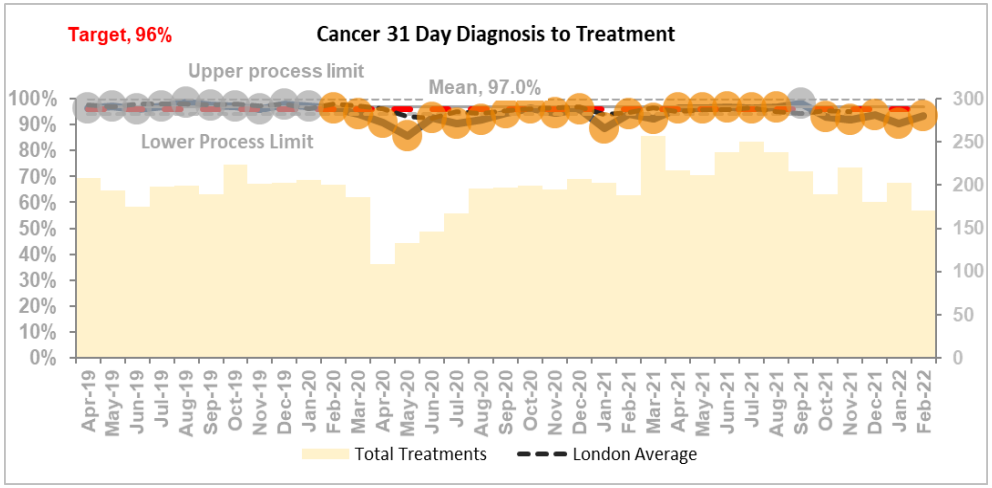
62-day Performance

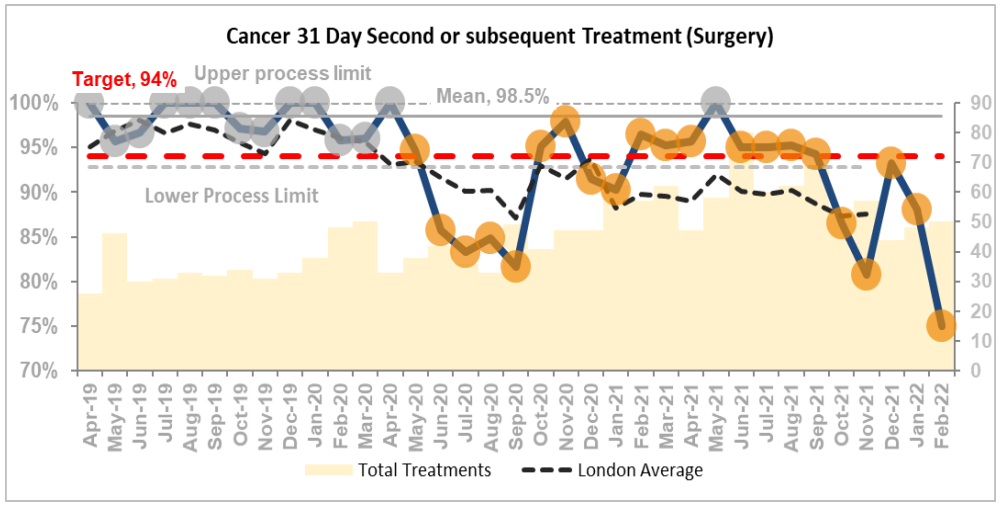
- The trust has agreed to Improve the 62-day performance metric by March 23 to 80% with the alliance.
- The main risk to achieving this are:
  - Patient choice and complex pathways
  - Late inter trust transfers in the H&N pathway with an ongoing workstream across the sector to improve and streamline the pathway across the patch.
  - Radiology and pathology delays with ongoing work to increase capacity
  - Breast front end challenges

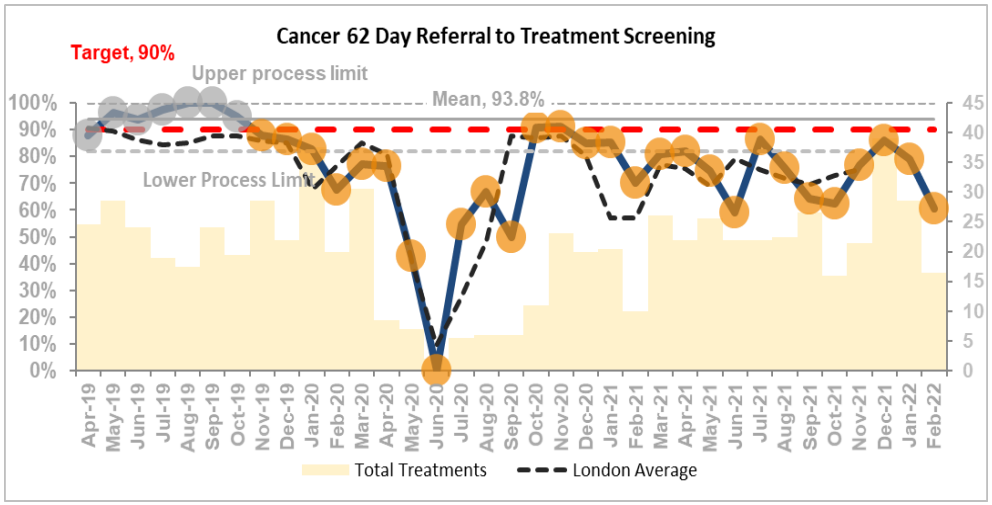
Our Process Perspective

Cancer



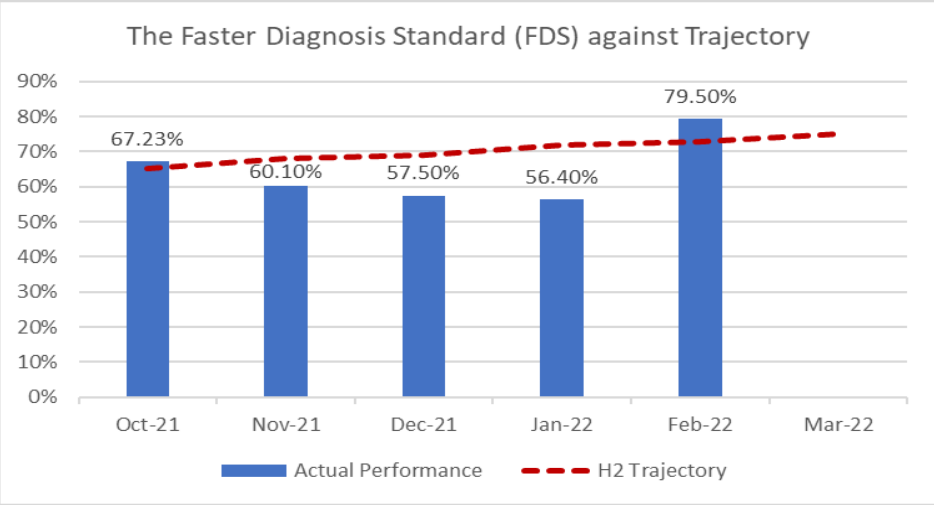


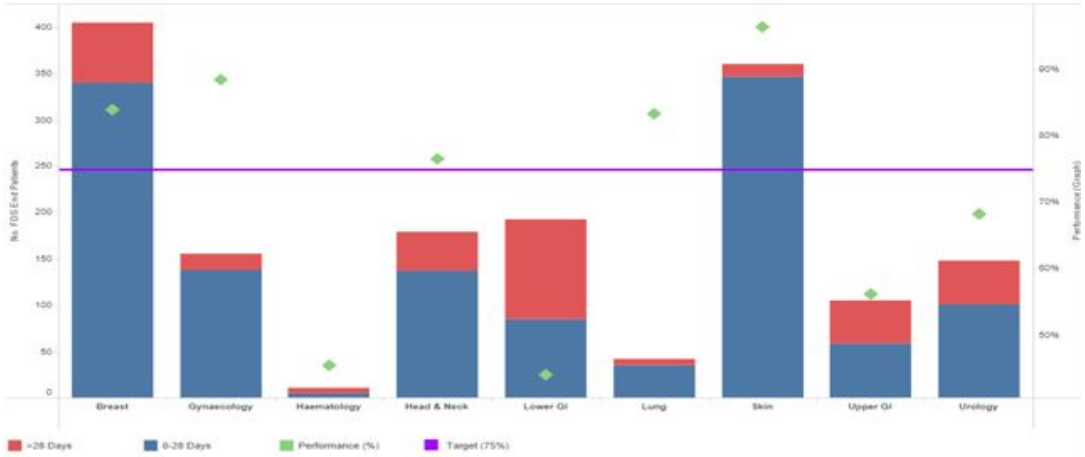




Our Process Perspective

Cancer – Faster Diagnosis Standard (FDS)





What the information tells us

The Faster Diagnosis Standard (FDS) is a new performance standard that has been 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.

In February, the Trust delivered a significant improvement with 79.5% of patient's receiving 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. The tumour groups of Breast, Gynae, Head & Neck, Lung, Skin were all compliant.

Actions and Quality Improvement Projects

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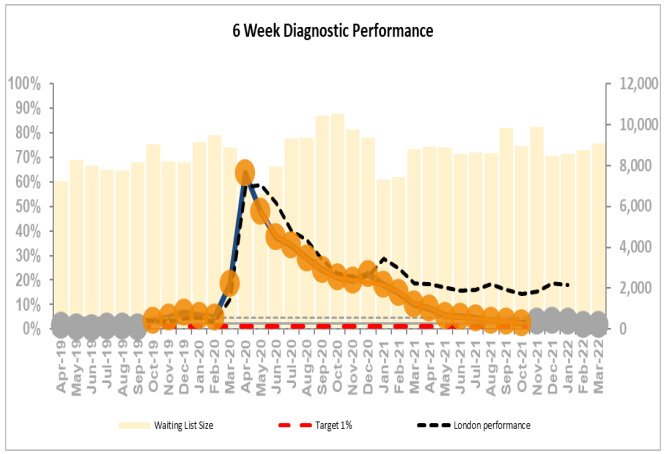
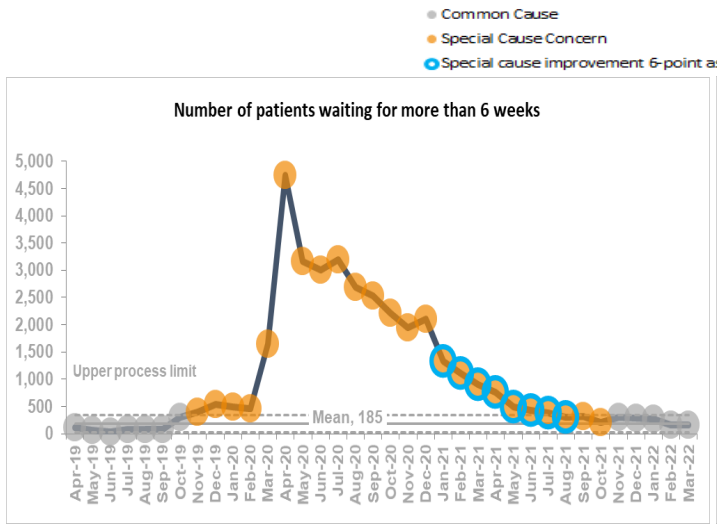
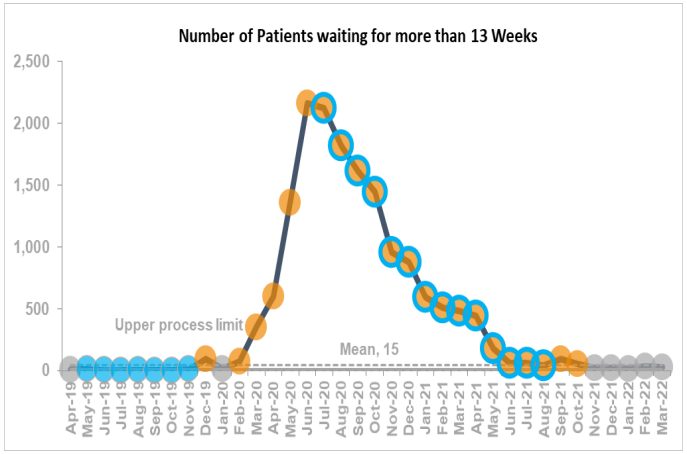
- GI services – continues to be the lowest performers, due to ongoing capacity for radiology, CTC, and result FU. The UGI service continues to improve month on month since Sept 21 from 10% to 56.2% due to efficient management of PTL and capacity planning by the service. Continual ongoing pathway improvements are being led by dedicated project managers.
- 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. Escalation of FDS breaches at the weekly PTL assurance effectively enables visibility and action planning
- Clear communication and management of patients awaiting an FDS communication with benign results awaiting a FU or clinic letter is in place via a weekly PTL assurance meetings and Access Committee.
- 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 has been recruited 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







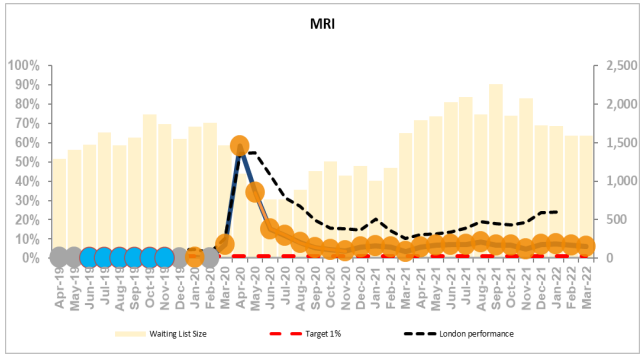
What the information tells us

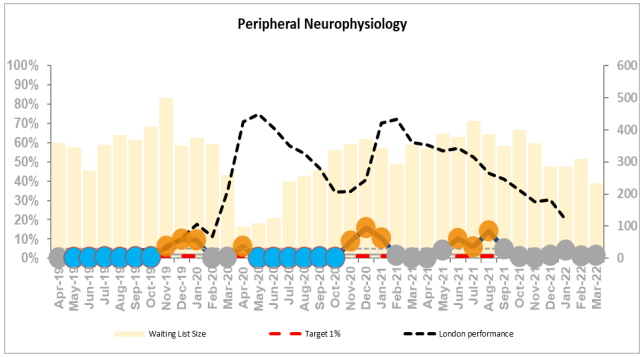
At the end of March, the Trust reported 1.8% of diagnostic patients waiting for more than six weeks, maintaining a steady trend and performing better than the London average. The total waiting list size although seeing a 3.5% increase compared to February remains comparable to previous months. In total 159 patients were waiting for more than six weeks for a diagnostic test, of which 60% are attributed to Cardiac MRI whilst also seeing breaches within Paediatric Endoscopy, Urodynamics and Sleep Studies . The overall number of patients waiting for more than 13 weeks continues on a downward trend.

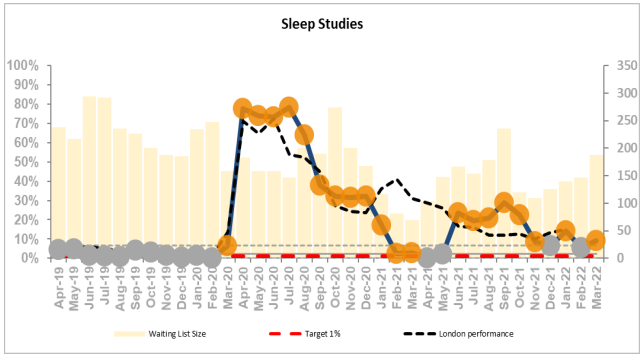
Actions and Quality Improvement Projects

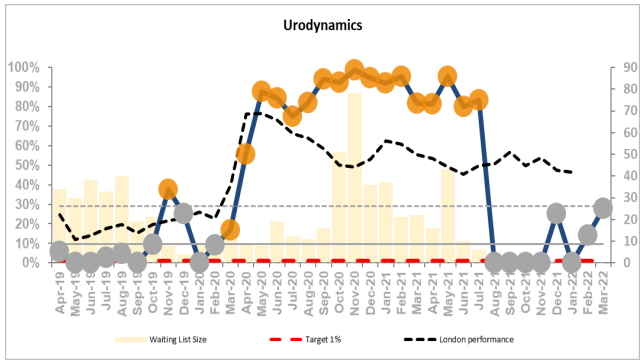
- Weekly performance meetings continue with particular focus on patients waiting for more than ten weeks. Divisional Director of Operations (DDO) support where areas are challenged.
- Cardiac MRI – Cardiac MRI – Capacity challenges continue with patients referred in February not yet booked. Patient safety risk associated with long waiting times leading to poor patient experience. Outpatient clinic appointments are being cancelled as patients are unable to have their diagnostic MRI prior to their appointment. All urgent patients are being clinically reviewed and patients are being called as well as receiving a text prior to appointments to reduce the DNA rate, saving 2 slots per week.
- Paediatric Endoscopy – capacity has been stretched due to anaesthetic staffing issues. Additional sessions have been approved for April. Recovery business case to approve regular permanent schedules.
- Urodynamics – currently running a reduced service due to a number of Clinical Nurse Specialists leaving the Trust, recruitment is underway . Pressures will be alleviated once positions are filled, one new starter in April, leaving two positions yet to be recruited to.
- Sleep Studies – additional ad hoc capacity will be provided through April continuing to bring forward long waiting patients. Capacity has been challenged due to delay in recruitment and covid related sickness.

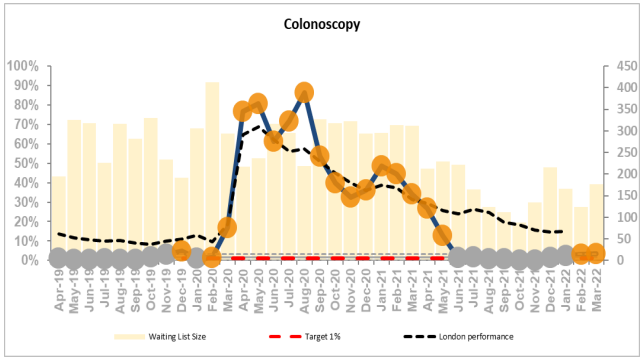
Diagnostics – Modalities Not Meeting 1% Target

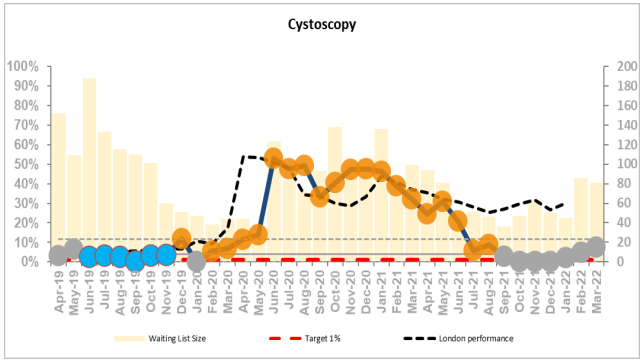


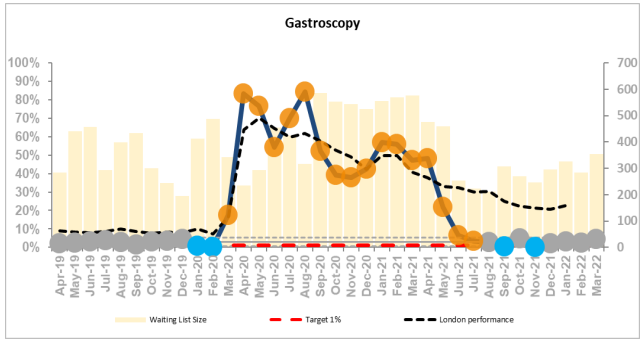






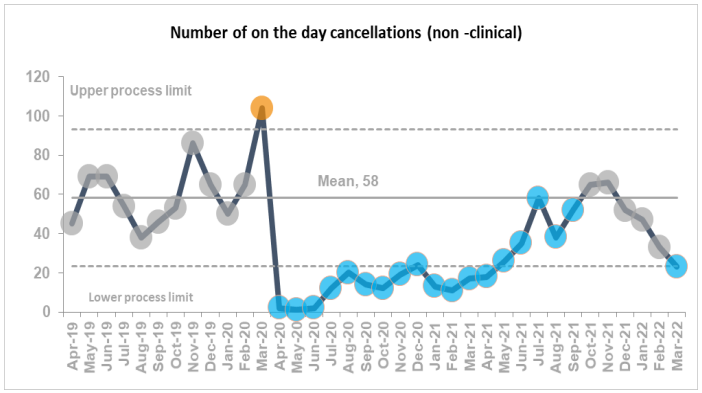


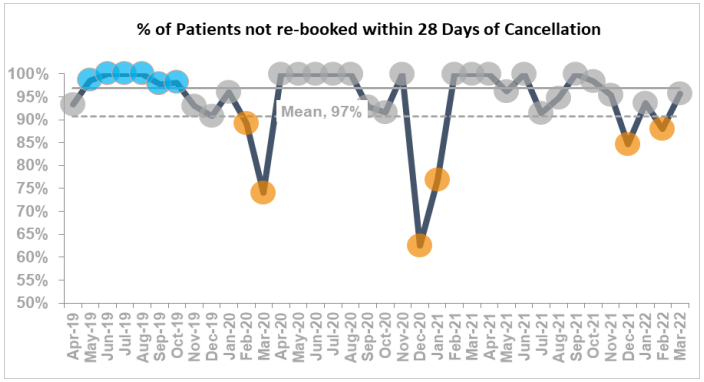


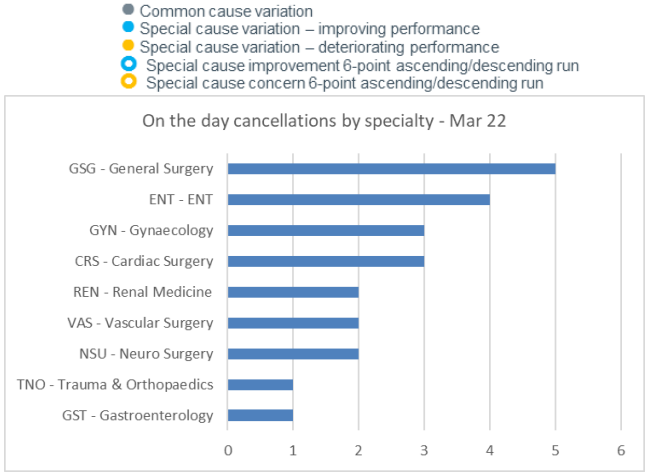


Our Process Perspective

On the Day Cancellations for Non Clinical Reasons(OTD)







What the information tells us

The Trust continues to see a month on month reduction in the number of elective on the day cancellations. In March, 23 patients had their procedure cancelled for non-clinical reasons, this is an improved position compared to the 33 patients cancelled in February. Of the patients cancelled, one patients was not able to be re-booked within 28 days due to capacity (multiple specialty procedure). Cancellations have been largely due to timing issues including emergency cases taking priority and staffing availability. General Surgery reported the largest proportion of cancellations in the month (5) whereas Neurosurgery saw the largest improvement reporting 2 cancellations compared to 9 in February.

Cancellation reasons for the month are broken down as follows:

- Timing - Emergency case took priority– 7
- Timing - Complication - previous case/-s– 5
- Bed - No Critical Care bed available– 2
- Bed - No Ward bed available - 2
- Staffing - Anaesthetist unavailable– 2
- Staffing - Other– 2
- Timing - List over booked – 1
- Staffing - Surgeon unavailable -1
- Other - 1

Actions and Quality Improvement Projects

Continued reductions in the number of on the day cancellations have been driven by;

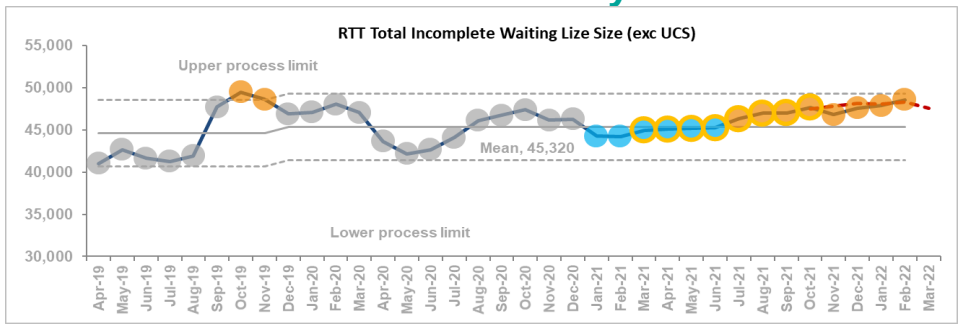
- Launch of a revamped OTD Cancellations for non-clinical reasons policy which focuses on raising awareness of the escalation process, to ensure that unilateral decisions were not being taken without consultation with all colleagues capable of avoiding a cancellation
- The relaunch has coincided with 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.

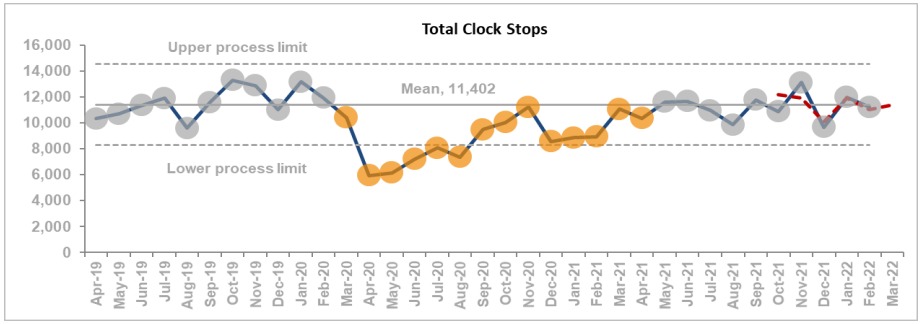
A further intervention was launched in January to open up a 'Yellow' SDL Discharge pathway from SJW to DSU to improve flow in SJW Recovery, maximise SDLs and minimise failed SDLs.

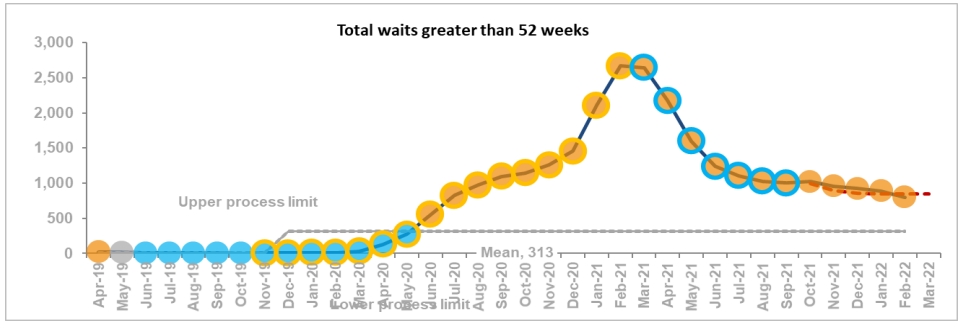
- Cancellations due to bed availability have fallen substantially
- This is partly attributable to the new 'Yellow' SDL Discharge pathway.

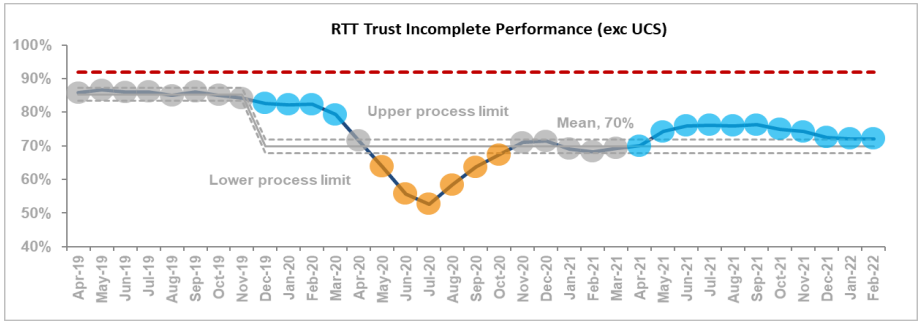
Our Process Perspective

Referral to Treatment — February 2022









Note: Unknown Clock Starts (UCS) have been excluded from the above metrics. For context the number of UCS in February was 374, compared to 374 in January.

What the information tells us

The Trust continues to prioritise the sickest patients whilst also focusing on reducing the RTT backlog.

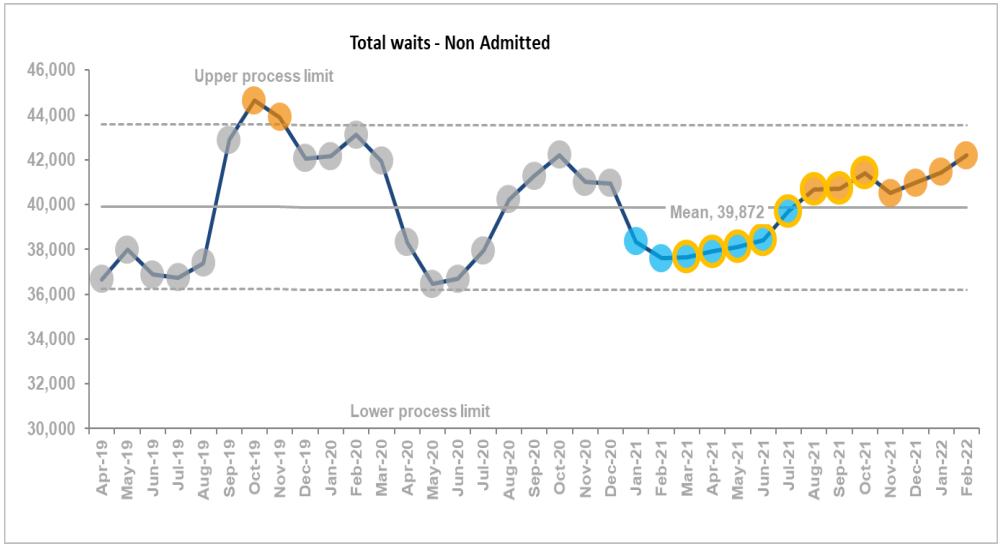
Significant progress continues to be made in reducing long waiters (52, 78 and 104-week waiters). At the end of February, the Trust reported 802 patients waiting for more than 52 weeks, this is a 9.6% reduction compared to January and a favourable position against a trajectory of 850. Significant challenges remain in ENT, General Surgery, Cardiology and Plastics.

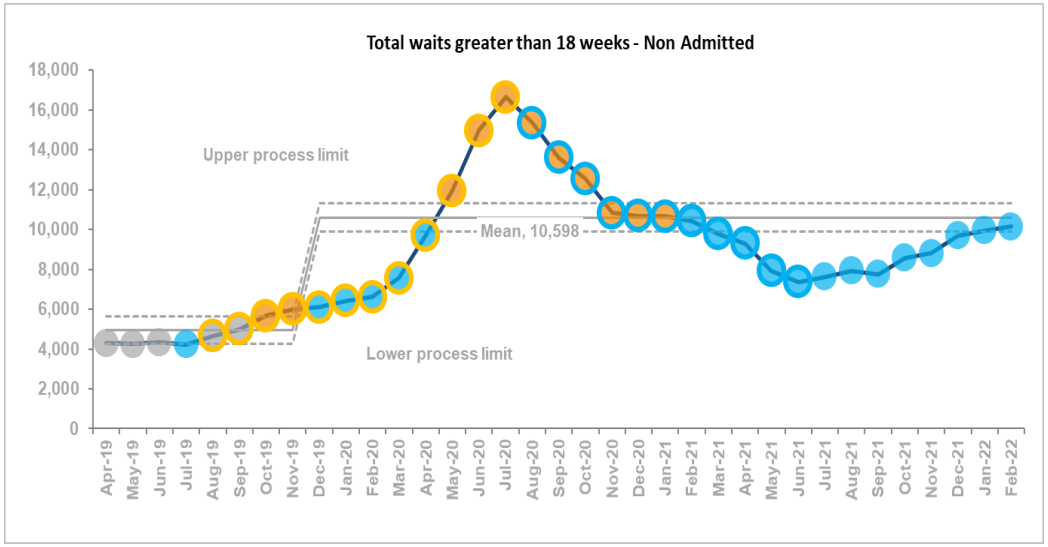
The clock stops in the month were above trajectory exceeding in both admitted and non-admitted pathways. The total waiting list size continues to grow driven by additions to the non-admitted PTL, the size of the Admitted waiting list has reduced slightly.

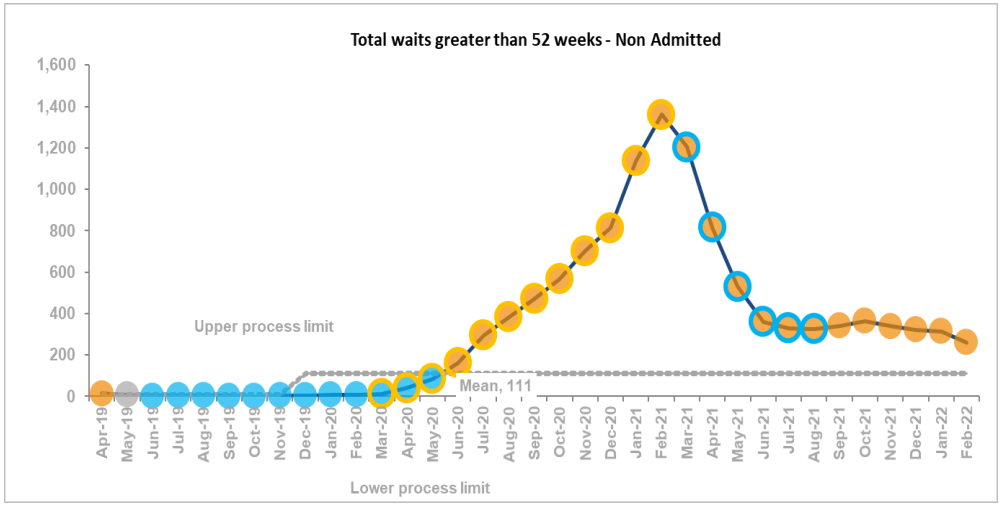
Actions and Quality Improvement Projects

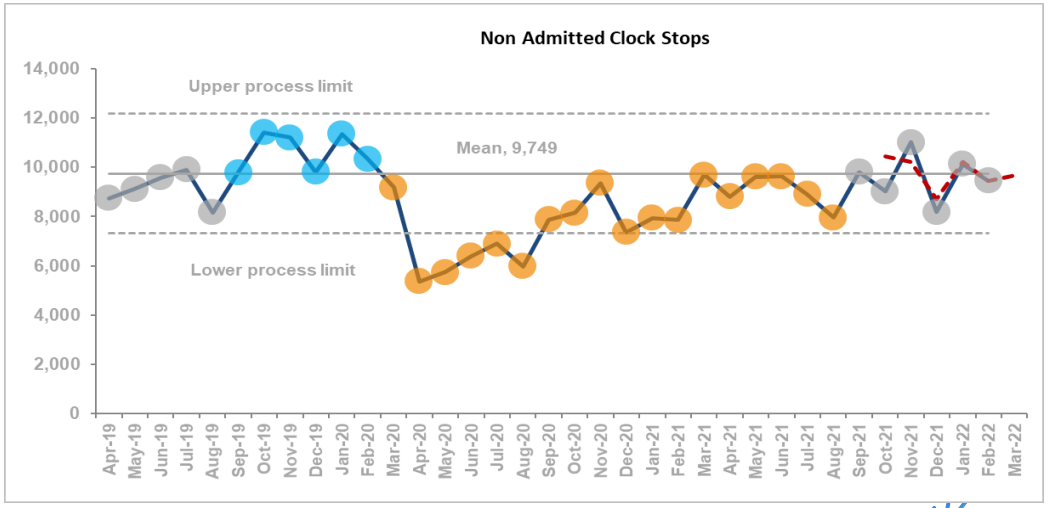
- The total waiting list size has grown in February, largely as a result of an increase in the number of average daily referrals and lower volumes of outpatient clock stops. There are a number of actions aimed at reducing this, for example focusing on DQ issues at the front end of the pathway (which result in duplicate pathways) and a focus on the cashing up of outpatient appointments in a timely manner.
- A successful pilot of 'Quick Question' using an external technology provider is ongoing. The next cohort of patients awaiting an outpatient appointment are being contacted to determine if they still need an appointment. This will ensure only patients actively waiting to be seen are on the PTL.
- 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 across SWL.
- The focus on increasing productivity at the Surgical Treatment Centre is starting to see results, with the highest number of completed procedures in February and an increase in utilisation. The Theatre Transformation Board has also recommenced to support the productivity of all theatres and we are seeing positive movement in March.

Referral to Treatment Non-Admitted Pathway — February 2022



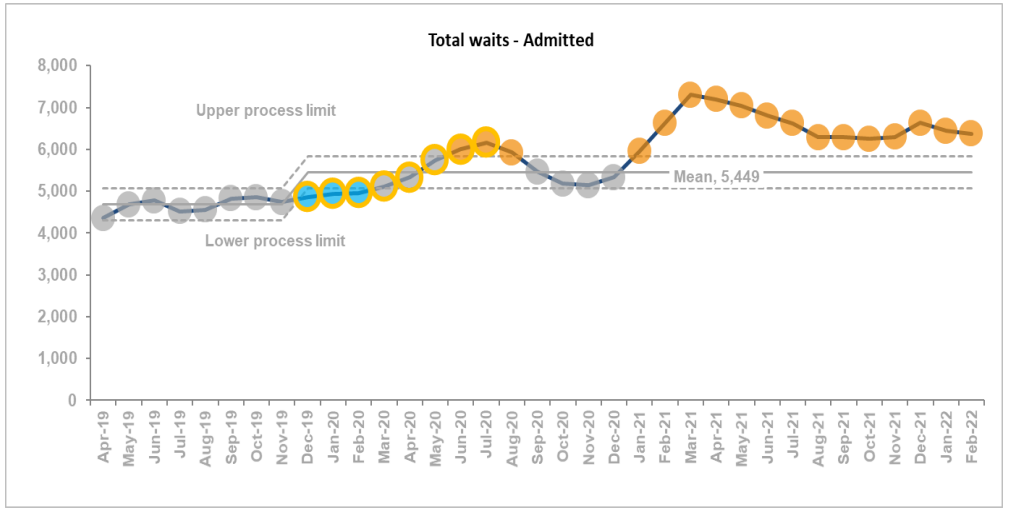


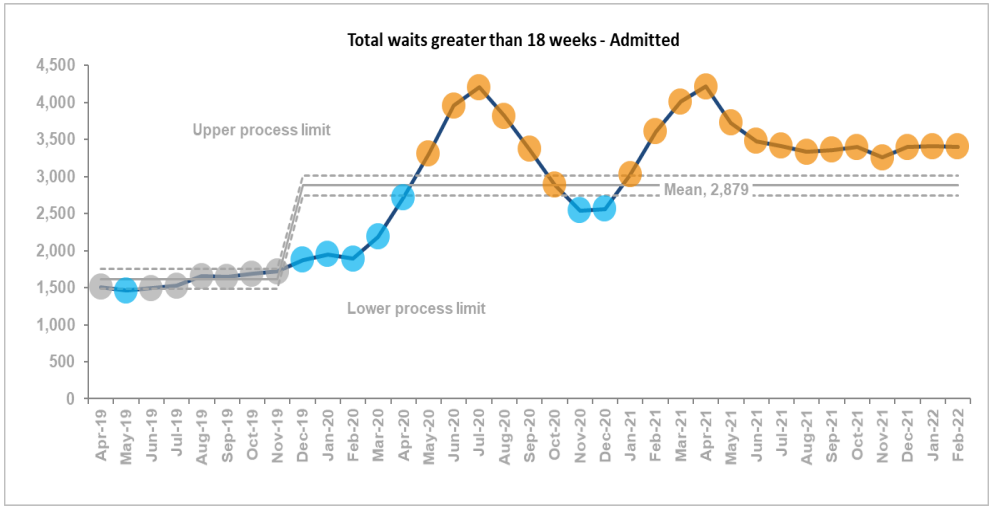


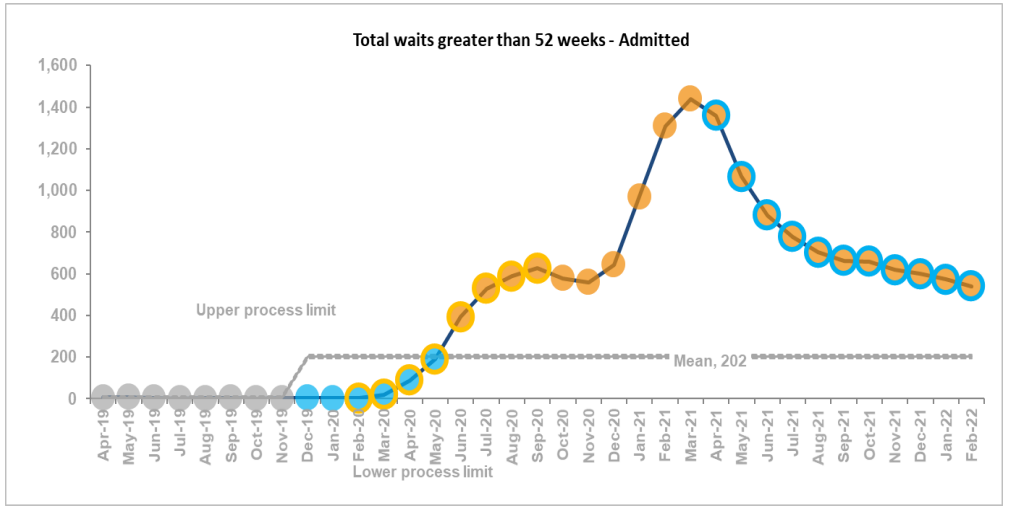


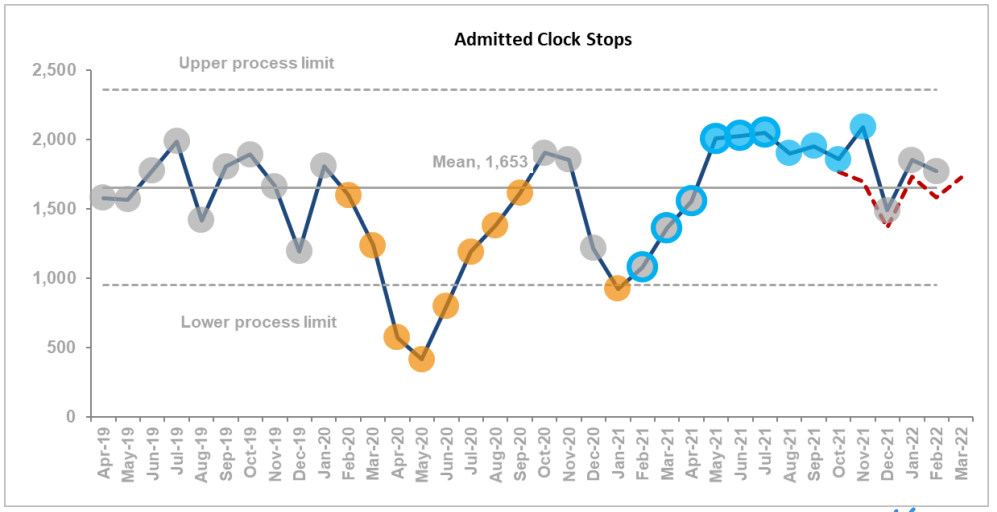
Our Process Perspective

Referral to Treatment Admitted Pathway — February 2022



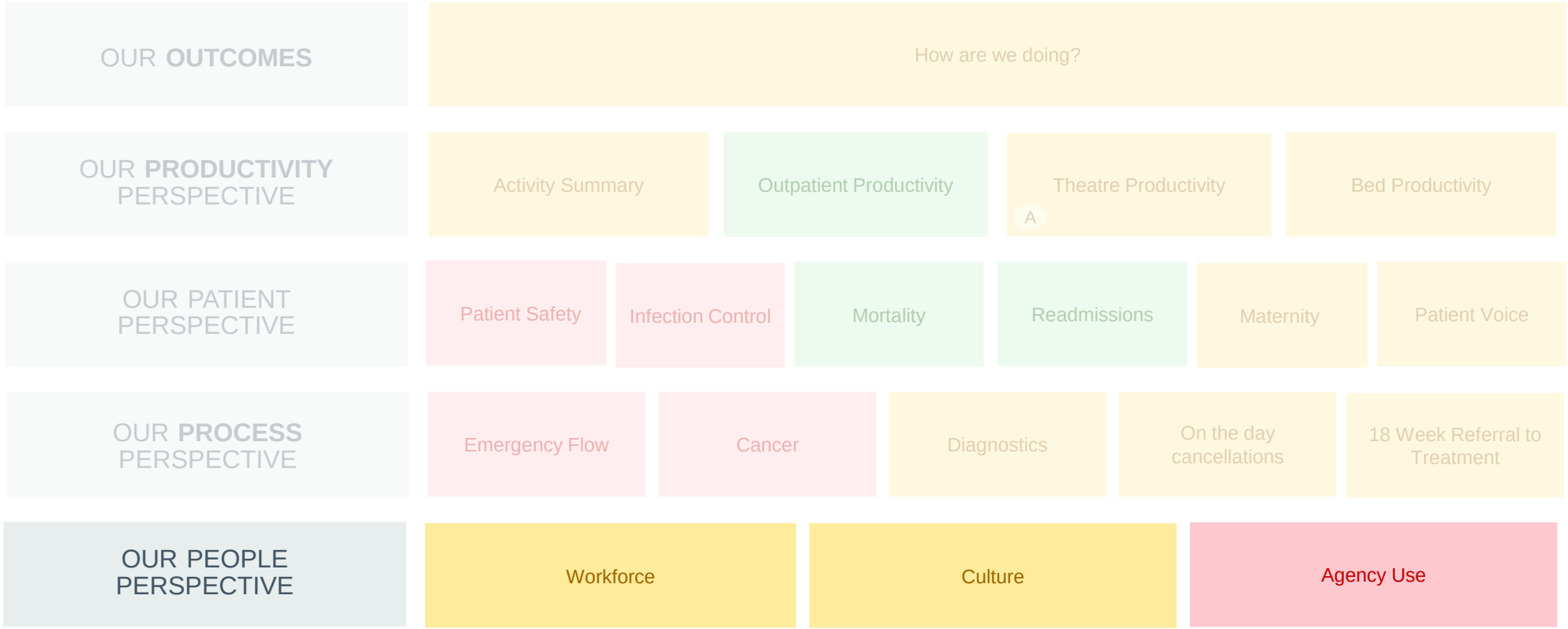






Our Process Perspective

Balanced Scorecard Approach



Workforce

Metric	Benchmark Average	Performance 12 months ago	Performance 3 months ago Dec-21	Current Performance Mar-22	Target	Distance to target	Current RAG Rating
Sickness	4.0%	3.1%	5.6%	4.7%	3.2%	-1.5%	
Vacancy	10.8%	8.2%	10.1%	8.9%	10.0%	+1.1%	
Turnover		14.4%	16.0%	17.6%	13.0%	-4.6%	
Medical Appraisal		72.3%	73.1%	77.7%	90.0%	-12.3%	
Non-Medical Appraisal	72.0%	70.5%	74.9%	72.2%	90.0%	-17.8%	
MAST	85.7%	88.7%	88.7%	88.4%	85.0%	+3.4%	
Stability		88.5%	86.9%	85.7%	85.0%	+0.7%	

What the information tells us

- The Trust's sickness absence rate is currently 4.7% and the target is to not exceed 3.2%, showing special cause deterioration.
- Vacancy Rate has fell this month to 8.9%, which is below the threshold of 10%.
- Trust turnover rate in March was 17.6% 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 88.4% and 85.7% respectively against a target of 85%.

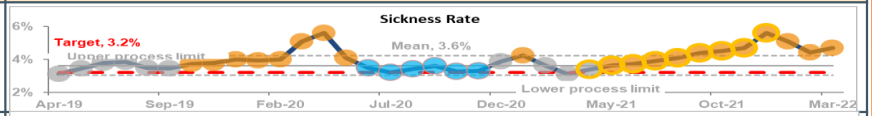
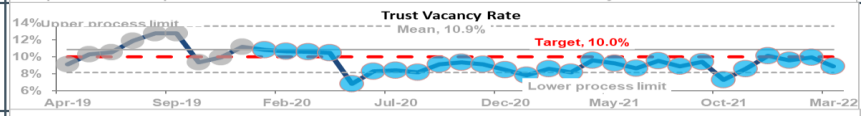
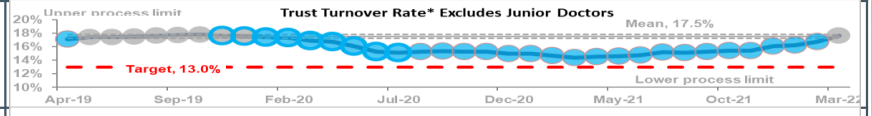
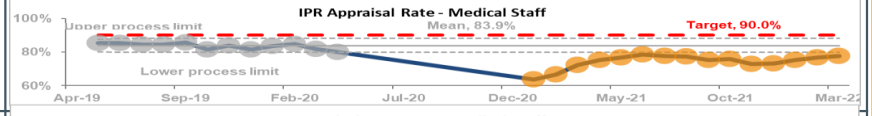
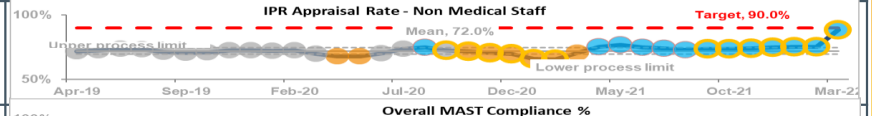
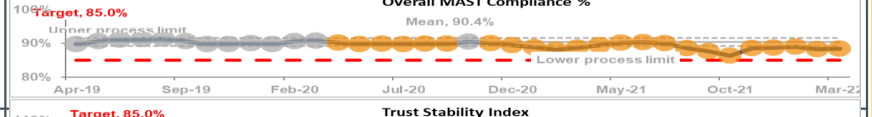
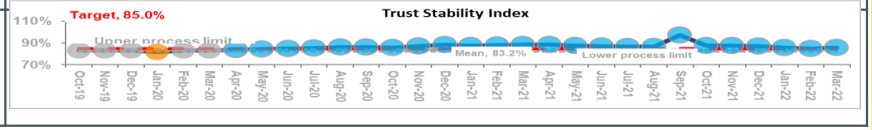
* Benchmark info is taken from Guy's & St Thomas', King's, Lewisham & Greenwich, Imperial, and UCLH.
* Turnover benchmarking isn't available as different Trusts calculate turnover in different ways

Actions and Quality Improvement Project

- Sickness- For both long and short term sickness, Human Resources continues to support managers to make timely Occupation Health referrals to establish support for staff on long term sick leave to facilitate their return to work including due consideration for reasonable adjustment. For those on short term sickness, HR will be working with management to better utilise the return to work meetings and an engagement too to identify support for staff to enable them to improve the level of attendance.
- Vacancy-Human Resources Business Partners are working closely with divisions, attending monthly recruitment meeting and the development of recruitment plans for the top 10 vacancy hotspots per division. Local discussions and plans are also being developed to tackle hard to recruit areas.
- Appraisals- A refreshed appraisal drive is underway to work with divisions to increase the uptake of appraisals reinforcing the value add and best practice approach. Trajectories have been developed and visibility at performance and board meeting where teams are held accountable.
- Temporary staffing remained a challenge during March, 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.
- MAST Compliance – Core Mast compliance remains stable and above target. Work with colleagues at Epsom and St Heliers to align compliance approaches is underway.
- Stability – The Values Survey has now concluded and our contractors are utilising staff feedback to further develop the values framework policy, as well as supporting materials and workshops. The Staff Survey Big 5 has been agreed and signed off by the Site Executive Team, with task groups being set up for each of the 5 themes. Divisional workshops have been taking place with the support of the HR & OD team.

Workforce Metrics

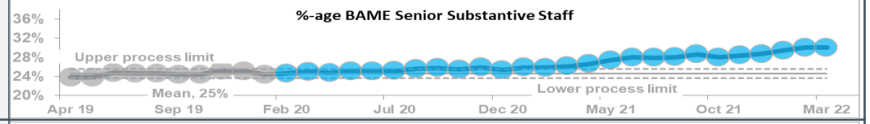
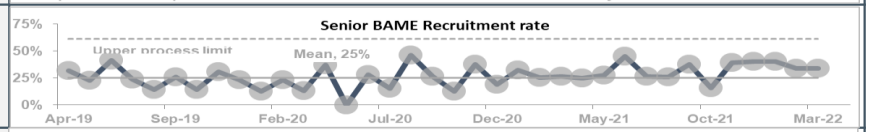
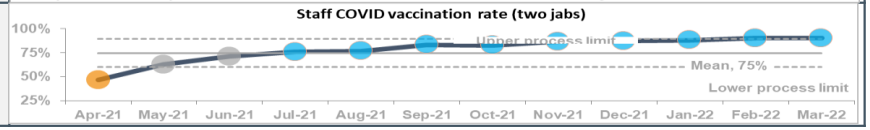
Common cause variation
Special cause variation – improving performance
Special cause variation – deteriorating performance
Special cause improvement 6-point ascending/descending run
Special cause concern 6-point ascending/descending run

	Metrics	Mar-22	Target	Var to target	Trend
✖	Trust Level Sickness Rate	4.7%	3.2%	-1.5%	
✓	Trust Vacancy Rate	8.9%	10.0%	+1.1%	
!	Trust Turnover Rate* Excludes Junior Doctors	17.6%	13.0%	-4.6%	
!	IPR Appraisal Rate - Medical Staff	77.7%	90.0%	-12.3%	
!	IPR Appraisal Rate - Non Medical Staff	72.2%	90.0%	-17.8%	
✓	Overall MAST Compliance %	88.4%	85.0%	+3.4%	
✓	Trust Stability Index	85.7%	85.0%	+0.7%	

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.	Mar-22	Target	Var to target	Trend
✓	Internal Hire Rate (all bands)	48.1%	40%	+8.1%	
NA	%-age BAME Senior Substantive Staff (Band 8 and up)	30.0%	N/A	-	
NA	Senior BAME Recruitment rate (Band 8 and up)	33.9%	N/A	-	
!	COVID-19 Staff vaccination rate (both Jabs)	89.3%	90%	-0.7%	

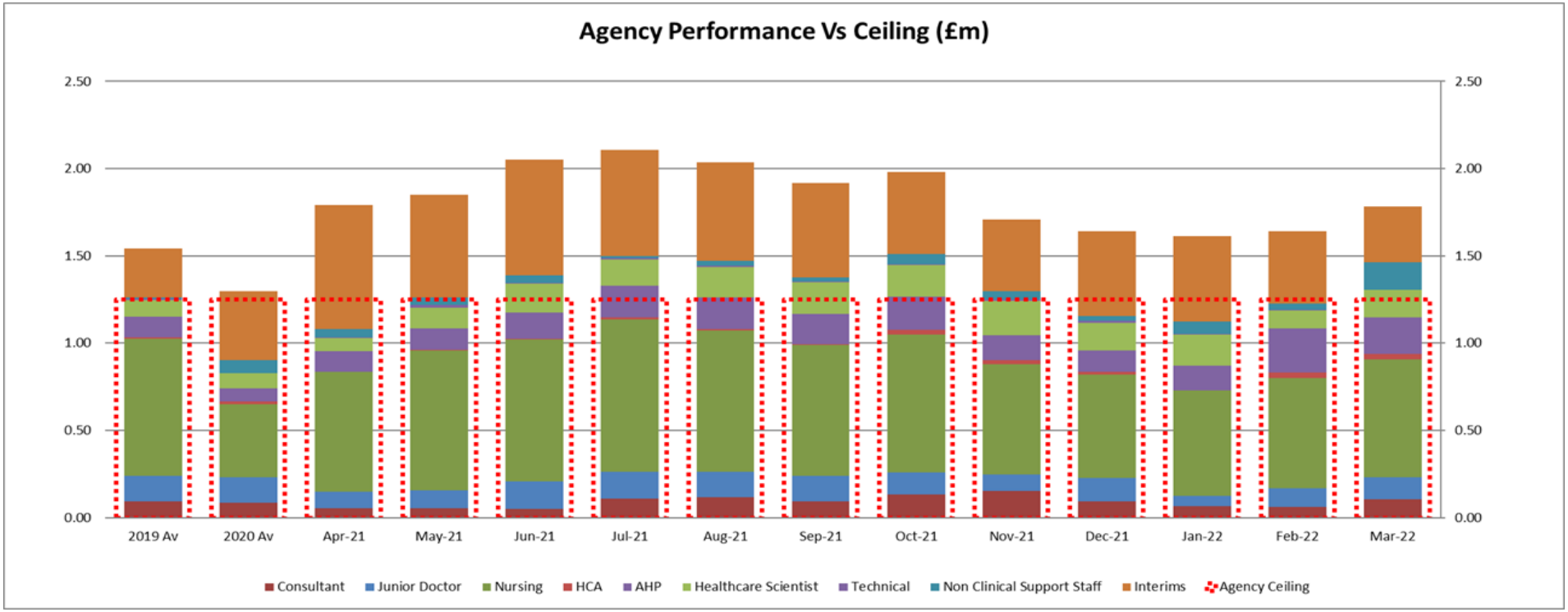
What the information tells us

- In March, the internal hire rate was 48.1% 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 34% to 33.9%.
- At time of writing, the COVID-19 vaccination rate was 89.3%.

Actions and Quality Improvement Project

- 7 International nurses landing Mid March. 103 new starters with booked start dates. Newly Quality Nurse (NQN) and Health care Assistant (HCA) campaigns on-going.
- Following the changes introduced across the last three a small quality assurance review will be conducted of the streamlined documentation and monthly reporting template that is being populated by the SWL Hub. This will help us to understand the specific reasons why some interviews (held since we introduced the changes) have not had a Recruitment Inclusion Specialist representative and further reinforce a clear line of accountability
- There is an active communication plan promoting vaccinations for all staff.

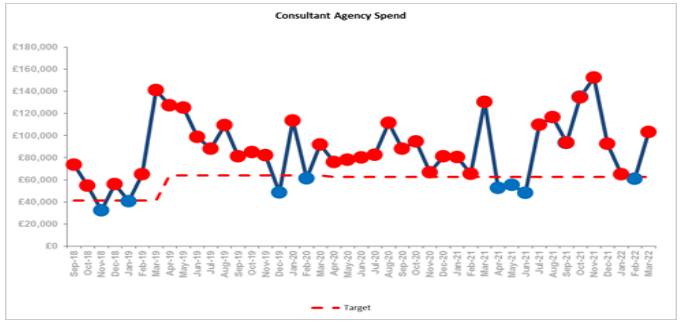
Agency use

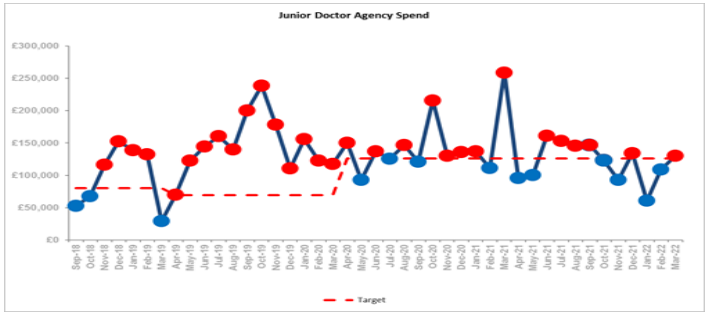


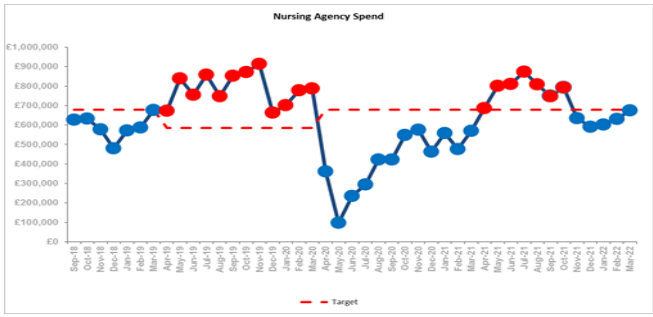
- Agency cost was £1.78m**.** For 2020/21, the average agency cost was 2.5% of total pay costs
- For March, the monthly target set is £1.25m. The total agency cost is worse than the target by £0.53m
- There is an internal annual agency target of £15.00m
- The biggest areas of overspend were Interims (£0.15m) and Non Clinical Support Staff(£0.14m)

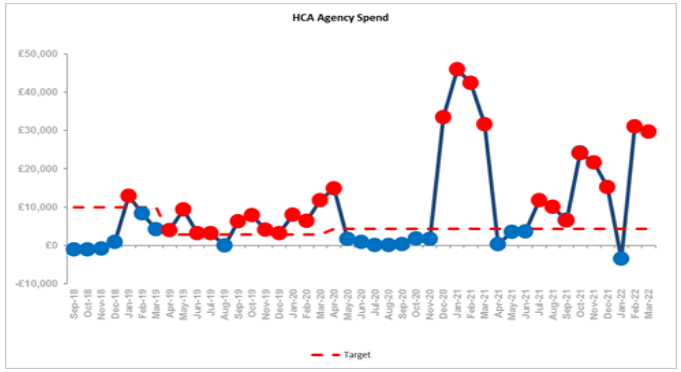
Agency use

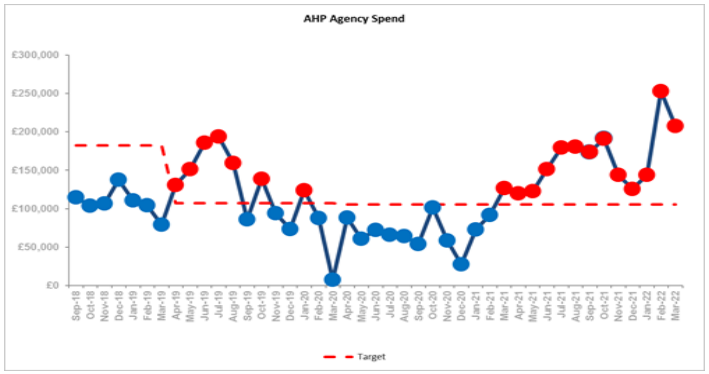
Below cap
Above cap

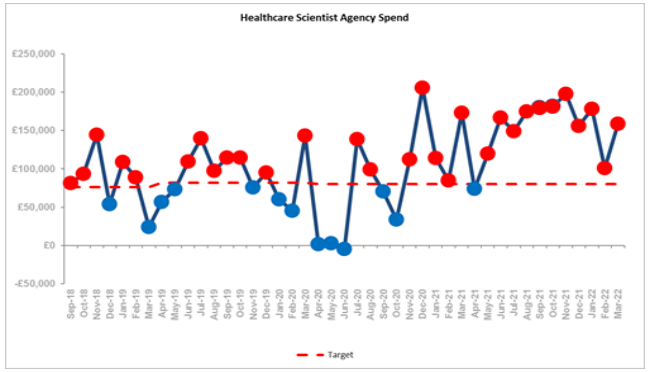


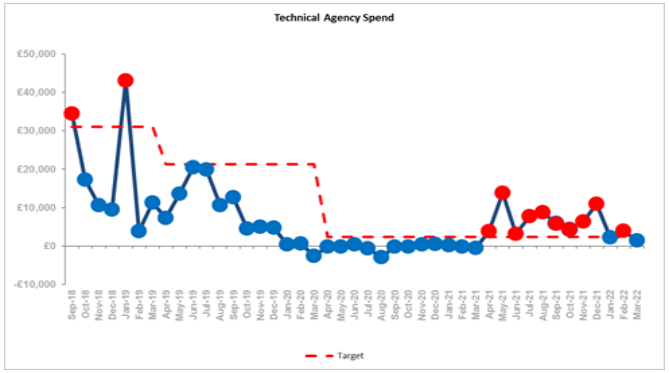


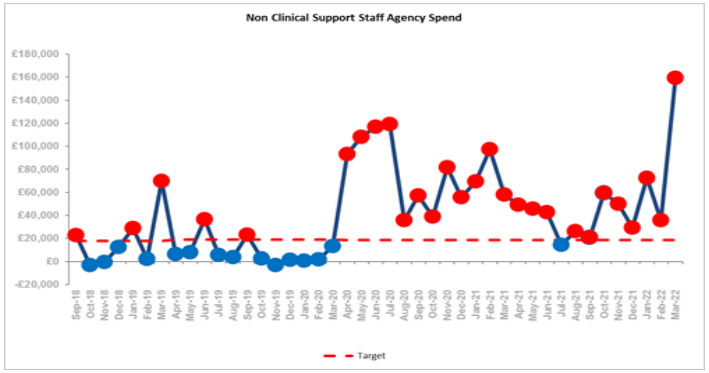


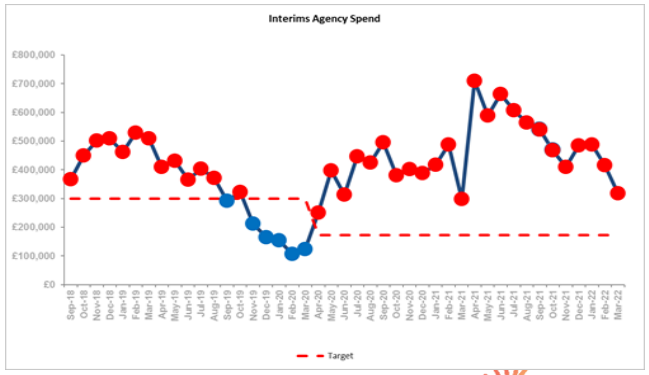








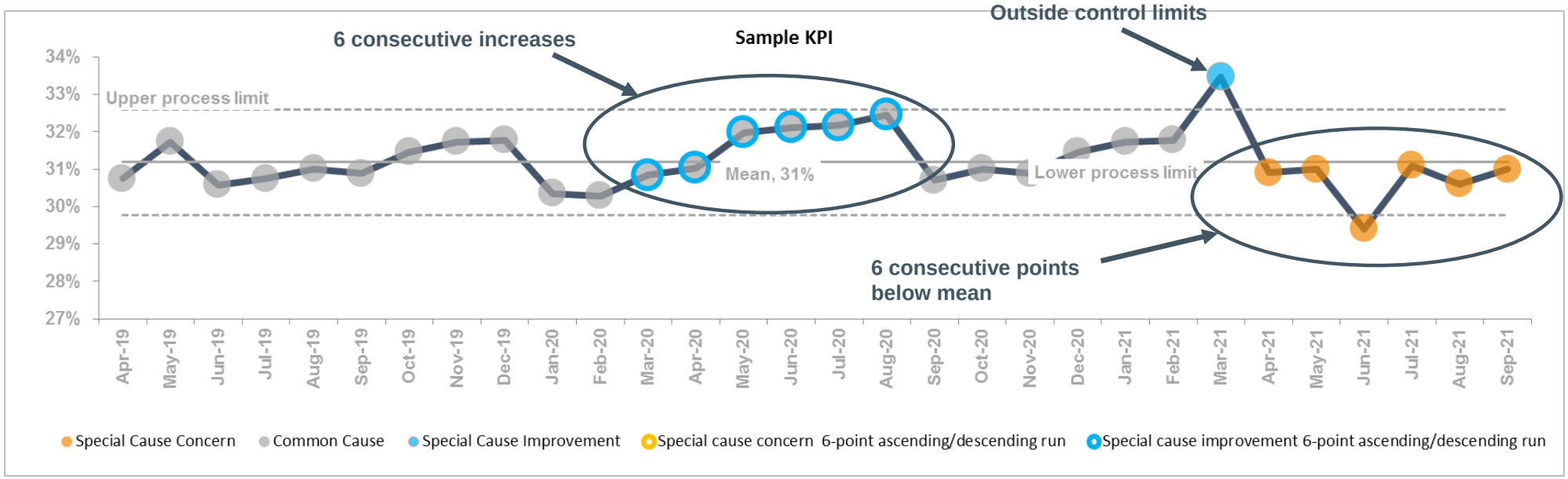




Our People Perspective

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

Appendix Cancer Performance – February 2022

14 Day Standard Performance by Tumour Site - Target 93%

Tumour Site	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	No of Patients
Brain	93%	-	-	-	-	-	-	-	-	-	-	-	-	-	
Breast	93%	92.5%	82.9%	54.5%	78.7%	86.1%	26.9%	17.5%	30.1%	14.5%	10.3%	12.0%	25.3%	26.8%	403
Children's	93%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	50.0%	50.0%	90.0%	100.0%	100.0%	50.0%	100.0%	2
Gynaecology	93%	94.9%	94.9%	87.2%	92.6%	91.7%	95.0%	94.5%	85.4%	88.7%	88.1%	91.3%	83.3%	79.2%	154
Haematology	93%	100.0%	90.0%	96.4%	100.0%	95.5%	79.3%	90.9%	100.0%	100.0%	95.8%	94.4%	87.5%	100.0%	10
Head & Neck	93%	96.4%	94.6%	95.7%	96.9%	93.4%	95.5%	88.1%	92.4%	93.8%	91.9%	95.3%	88.5%	89.7%	174
Lower Gastrointestinal	93%	98.6%	98.2%	95.9%	67.6%	82.2%	96.7%	95.7%	98.3%	98.3%	99.6%	100.0%	96.6%	95.4%	196
Lung	93%	100.0%	94.4%	91.9%	97.5%	93.9%	74.3%	68.2%	82.6%	85.7%	74.3%	31.3%	60.0%	76.1%	46
Skin	93%	98.7%	98.0%	93.6%	97.5%	94.5%	91.4%	94.8%	91.0%	93.7%	90.4%	88.8%	79.2%	94.4%	377
Upper Gastrointestinal	93%	100.0%	95.4%	98.1%	96.9%	97.4%	96.6%	97.2%	95.2%	96.8%	96.6%	93.4%	93.5%	94.6%	111
Urology (Suspected testicular cancer)	93%	98.9%	97.1%	89.6%	97.0%	98.3%	98.1%	88.6%	86.6%	94.4%	94.7%	92.1%	95.9%	95.7%	141

62 Day Standard Performance by Tumour Site - Target 85%

Tumour Site	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	No of Treatments
Brain	85%	-	100.0%	-	-	-	-	-	-	-	-	-	-	-	
Breast	85%	62.5%	100.0%	91.7%	78.6%	80.0%	83.3%	66.7%	81.3%	66.7%	54.5%	50.0%	61.5%	60.0%	15
Children's	85%	-	-	-	-	-	-	-	-	-	-	-	-	-	0
Gynaecology	85%	-	50.0%	75.0%	40.0%	60.0%	50.0%	100.0%	66.7%	40.0%	55.6%	16.7%	40.0%	40.0%	2.5
Haematology	85%	88.9%	100.0%	100.0%	66.7%	50.0%	80.0%	80.0%	100.0%	50.0%	42.9%	50.0%	55.6%	100.0%	1.5
Head & Neck	85%	57.9%	83.3%	90.9%	46.7%	70.6%	50.0%	86.7%	58.3%	36.4%	56.5%	47.4%	25.0%	29.2%	12
Lower Gastrointestinal	85%	33.3%	33.3%	75.0%	46.2%	66.7%	18.2%	61.5%	70.6%	75.0%	75.0%	46.2%	50.0%	40.0%	5
Lung	85%	73.3%	100.0%	90.9%	100.0%	62.5%	25.0%	100.0%	66.7%	70.6%	70.0%	100.0%	55.6%	25.0%	4
Skin	85%	88.9%	92.6%	78.8%	87.9%	78.8%	76.5%	74.1%	89.5%	72.7%	77.5%	75.9%	70.0%	46.7%	7.5
Upper Gastrointestinal	85%	71.4%	33.3%	60.0%	-	100.0%	100.0%	25.0%	0.0%	50.0%	0.0%	100.0%	50.0%	50.0%	4
Urology	85%	73.3%	70.8%	56.5%	45.8%	47.8%	69.2%	55.6%	58.1%	81.3%	54.1%	62.9%	58.1%	54.5%	22
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

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Appendix RTT Performance – February 2022

Indicator Description	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
RTT Trust Incomplete Performance (exc UCS)	68.3%	69.3%	70.0%	74.2%	76.0%	76.2%	76.0%	76.3%	74.9%	74.2%	72.5%	72.1%	72.1%
RTT Total Incomplete Waiting Lize Size (exc UCS)	44,236	44,960	45,109	45,156	45,242	46,319	46,977	47,014	47,667	46,802	47,601	47,892	48,570
Total waits greater than 18 weeks (exc UCS)	14,027	13,801	13,522	11,662	10,850	11,044	11,263	11,121	11,969	12,070	13,093	13,357	13,544
Total waits greater than 52 weeks	2,671	2,644	2,174	1,597	1,240	1,106	1,028	1,005	1,023	959	923	887	802
RTT Incomplete Performance - Admitted	45.6%	45.1%	41.4%	47.1%	48.9%	48.4%	47.0%	46.6%	45.7%	48.3%	48.8%	47.1%	46.6%
Total waits - Admitted	6,634	7,301	7,193	7,045	6,809	6,619	6,291	6,293	6,250	6,299	6,630	6,442	6,373
Total waits greater than 18 weeks - Admitted	3,608	4,013	4,213	3,724	3,476	3,415	3,335	3,362	3,396	3,258	3,396	3,409	3,405
Total waits greater than 52 weeks - Admitted	1,310	1,439	1,359	1,067	880	777	702	663	658	619	600	572	541
RTT Incomplete Performance -Non Admitted	72.3%	74.0%	75.4%	79.2%	80.8%	80.8%	80.5%	80.9%	79.3%	78.2%	76.3%	76.0%	76.0%
Total waits - Non Admitted	37,602	37,651	37,916	38,111	38,433	39,700	40,686	40,721	41,417	40,503	40,971	41,450	42,197
Total waits greater than 18 weeks - Non Admitted	10,419	9,788	9,309	7,938	7,374	7,629	7,928	7,759	8,573	8,812	9,697	9,948	10,139
Total waits greater than 52 weeks - Non Admitted	1,361	1,205	815	530	360	329	326	342	365	340	323	315	261

Note: Unknown Clock Starts (UCS) have been excluded from the above metrics. For context the number of UCS in February was 374, compared to 374 in January

Appendix RTT Performance – February 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	432	13.2%	1,331	68.2%	965	798	1,763	54.7%	85	173
Urology Service	511	71.0%	1,583	91.4%	1,810	284	2,094	86.4%	27	29
Trauma and Orthopaedics Service	228	57.9%	1,830	82.4%	1,640	418	2,058	79.7%	21	2
Ear Nose and Throat Service	512	50.8%	4,493	65.7%	3,211	1,794	5,005	64.2%	233	145
Ophthalmology Service			99	78.8%	78	21	99	78.8%	2	0
Oral Surgery Service	242	43.8%	622	85.4%	637	227	864	73.7%	27	14
Neurosurgical Service	215	53.5%	2,357	63.9%	1,621	951	2,572	63.0%	74	27
Plastic Surgery Service	673	43.4%	656	80.6%	821	508	1,329	61.8%	62	68
Cardiothoracic Surgery Service	63	1	175	1	218	20	238	91.6%	0	0
General Internal Medicine Service			31	32.3%	10	21	31	32.3%	0	0
Gastroenterology Service	304	83.2%	3,557	66.2%	2,606	1,255	3,861	67.5%	30	2
Cardiology Service	1,478	38.8%	3,286	76.3%	3,079	1,685	4,764	64.6%	187	178
Dermatology Service	4	75.0%	2,498	82.3%	2,058	444	2,502	82.3%	7	1
Respiratory Medicine Service	2	100.0%	1,227	86.6%	1,065	164	1,229	86.7%	7	0
Neurology Service	35	91.4%	2,721	76.0%	2,101	655	2,756	76.2%	29	4
Rheumatology Service			792	76.8%	608	184	792	76.8%	4	0
Elderly Medicine Service			100	59.0%	59	41	100	59.0%	1	0
Gynaecology Service	236	63.1%	1,585	88.6%	1,553	268	1,821	85.3%	5	1
Other – Medical Services	157	73.9%	7,491	77.9%	5,951	1,697	7,648	77.8%	51	11
Other – Paediatric Services	594	38.0%	2,459	83.0%	2,268	785	3,053	74.3%	45	24
Other – Surgical Services	615	32.0%	2,510	75.7%	2,096	1,029	3,125	67.1%	126	110
Other – Other Services	72	44.4%	794	67.9%	571	295	866	65.9%	26	13
Grand Total	**6,373**	**46.6%**	**42,197**	**76.0%**	**35,026**	**13,544**	**48,570**	**72.1%**	**1,049**	**802**

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.

Appendix Early Warning Score

Indicator Description	Threshold	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Compliance with appropriate response to EWS (Adults)	100%	89.9%	88.0%	88.0%	91.0%	92.3%	91.6%	96.9%	88.5%	89.7%	78.5%	93.1%	92.9%	90.8%
Number of EWS Patients (Adults)		553	483	581	443	531	429	479	532	507	480	362	434	403

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St George's University Hospitals NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	**5 May 2022**	**Agenda No**	**2.3**
Report Title:	**Maternity Services Update: Following the publication of the final Ockenden Report**		
Lead Director/ Manager:	Arlene Wellman, Group Chief Nursing Officer		
Report Author:	Nicola Shepherd, Director of Midwifery and Gynaecology Nursing, Epsom and St Helier University Hospitals NHS Trust (ESTH) Annabelle Keegan, Deputy Director of Midwifery, St George's University Hospitals NHS Foundation Trust (SGUH)		
Presented for:	**Assurance**		

Executive Summary:

Purpose
The purpose of this report is to provide assurance on the compliance at ESTH and SGH with the Immediate and Essential Actions (IEAs) for maternity services as recommended in the Ockenden Report, see Appendix 1.

Background
Following the publication of the Ockenden Report in December 2020, NHS England sought assurance from all maternity services across England that they had benchmarked themselves against the IEAs by February 2021.

ESTH and SGH responded to this and further requests from NHS England throughout 2021 and 2022 to provide assurance on on-going self-assessment, external compliance reviews and assurance reports to the respective Trust Boards, see Appendix 2.

In February 2022 the maternity services from both Trusts reported the following compliance to the respective Trust Boards:

- ESTH 70%
- SGH 100%

NOTE: In April 2022 further local review of the ESTH position has confirmed completion of a number of outstanding improvement actions. **Subject to external ratification ESTH current compliance is 84%.**

ESTH: IEAs (Outstanding)
The following actions are due for completion and the4 current progress is detailed within the body of the report. All actions are on track for completion by the reported due date.

Immediate and Essential Action	By when
IEA 1 Quarterly submission of Maternity Dashboard to Local Maternity System	30.04.2022
IEA 2 Q11 - Non-executive director who has oversight of maternity services	30.04.2022
IEA 2	30.04.2022

	Q14 - Trust safety champions to meet bimonthly with Board level champions |
	IEA 3 Q17 - Multidisciplinary training and working occurs | 30.05.2022
	IEA 3 Q28 - All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place | 30.04.2022
	IEA 5 Q37 - At least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of Maternity Incentive Scheme year three in December 2019? | 03.05.2022
	IEA 5 Q44 - Pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the Trust website. Information on maternal choice including choice for caesarean delivery | 30.06.2022
	Workforce | 03.05.2022

Next Steps

On 11 and 12 May 2022 the regional Chief Midwife will be conducting **assurance visits at ESTH and SGH** respectively to establish if the improvement actions are embedded in practice. Assurance visits will continue on an annual basis thereafter. For 2022, the Regional Maternity Team will lead each visit, with involvement from Local Maternity and Neonatal System leads.

A national report format is in development and elements will consist of the Ockenden RAG template with a written overview using the WESEE reporting method which looks at workforce, efficiency, safety, experience and effectiveness. The Trusts will receive written feedback (in draft) within two weeks for factual accuracy checking with the requirement to respond within one week. The regional maternity team will then issue the final reports within two weeks of the receipt.

At this point ESTH and SGH will report internally to the Trust Board.

By 15 June 2022 and in line with the maternity transformation programme ESTH and SGH are required to submit their **Maternity Continuity of Carer (MCoC)** plan. ESTH and SGH have assessed their staffing position and at this time further roll out of MCoC will cease. MCoC support will continue at the current level of provision with service provided to existing women on MCoC pathways. New women will currently not be booked into MCoC provision.

Recommendation:	The Committee is asked to: 1. Note the progress made to date and the IEA compliance at both Trusts 2. Note the outstanding actions identified for ESTH maternity services 3. Note the external annual assurance process and internal and external governance

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 Boards. • **Substantial Assurance:** The report and discussions assured the Committee that there are robust systems of internal controls operating effectively to ensure that quality and safety risks are managed to deliver high quality services and care to patients. • **Reasonable Assurance:** The report and discussions assured the Committee that the system of internal controls is generally adequate and operating effectively but some improvements are required to ensure that quality and safety risks are managed to deliver high quality services and care to patients. • **Limited Assurance:** The report and discussions supported the Committee's conclusion that that the system of internal controls is generally inadequate or not operating effectively and significant improvements were required to ensure that the quality and safety risks are managed effectively to improve the position and ensure that high quality services and care is provided to patients. • **No Assurance:** The report and discussions led the Committee to conclude that there was a fundamental breakdown or absence of core internal controls and systems to enable the Trust to deliver high quality services and care to its patients.		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	All		
Single Oversight Framework Theme:	Leadership and Improvement Capability (Well-led)		
Implications			
Risk:	None		
Legal/Regulatory:	Enforcement undertakings applicable to ESTH and SGH Compliance with the Health and Social Care Act 2008 (Regulations 2014) and CQC Registration Regulations		
Resources:	N/A		
Equality and Diversity:	No issues to consider		
Previously Considered by:	Quality Committee	**Date**	21 Apr 22
Appendices:	Appendix 1: Immediate and Essential Actions Appendix 2: Outline of ESTH and SGH Internal and External Compliance Reports		

Outstanding care every time

St George's University Hospitals NHS Foundation Trust

Maternity Services Update: Following the publication of the final Ockenden Report
Quality Committee, 21 April 2022

1.0 Purpose

1.1 The purpose of this report is to provide assurance on the compliance for maternity services at ESTH and SGH with the Immediate and Essential Actions (IEAs) as recommended in the Ockenden Report.

2.0 Background

2.1 On 30 March 2022 the final report was published following the review of maternity services at Shrewsbury and Telford Hospital NHS Trust (SaTH). The review lead by Donna Ockenden followed the interim report published in December 2020. Both reports identified IEAs to improve the safety and quality of maternity care nationally.

2.2 The maternity services review at SaTH looked at 1,592 clinical incidents between 2000 to 2019 which found 'significant or major concerns' relating to 201 deaths, 131 stillbirths, 70 neonatal deaths and nearly 100 permanent injuries including brain damage and cerebral palsy. Widespread avoidable harm and death were identified which were due to the quality of care provided and failings around governance. Over 60 local actions were identified for SaTH as well as a national 'call for action' in 15 IEAs, that all organisations providing maternity services were recommended to consider, see Appendix 1.

2.3 The Ockenden Report made recommendations for the following specific areas:

- funding for a safe maternity workforce
- improved postnatal care
- ensuring proper training for staff who work together
- improving Trust board oversight of maternity services
- conducting robust investigations that lead to wider learning
- the development of robust procedures to assess and manage risk with established pathways for complex pregnancies
- listening to families

3.0 Assessment and Compliance with the Immediate and Essential Actions

3.1 ESTH and SGH have responded to all requests from NHSE/I throughout 2021 and 2022 to provide assurance with reference to on-going self-assessments, external compliance reviews and assurance reports to the respective Trust Boards, see appendix 2.

3.2 In February 2022 the maternity services from both Trusts reported their compliance to NHS England as assessed by the SW London Sector Local Maternity and Neonatal System and additionally by a regional peer review panel, with the recommendations of the Ockenden report to the respective Trust Boards as follows:

- ESTH 70%
- SGH 100% (Following further scrutiny by the NHS England regional teams of submitted evidence)

3.3 In April 2022 further local review of the ESTH position has confirmed the completion of a number of outstanding improvement actions and subject to external ratification, ESTH self-

assessment of current compliance is 84%. Table 1 below identifies the outstanding actions, the progress to date and the date for completion.

4.0 ESTH: IEAs (Outstanding)

4.1 The following actions have been completed and are subject to ratification at the Maternity Guidelines Group.

Table 1: ESTH Immediate and Essential Actions (Outstanding)

Immediate and Essential Action	Action required	Current position	By when
IEA 1 Quarterly submission of Maternity Dashboard to LMS	Standard Operating Procedure to be developed to confirm internal and external reporting to LMS	Maternity Clinical Governance and Risk Management Strategy and Guideline (Section 6.2) has been re-written and awaiting ratification	30.04.2022
IEA 2 Q11 - Non-executive director who has oversight of maternity services.	Role description to be drafted and approved	Final role description awaiting approval	30.04.2022
IEA 2 Q14 - Trust safety champions to meet bimonthly with Board level champions	Schedule of future meetings	Previous meetings have taken place and minutes available Schedule of future meetings to be finalised	30.04.2022
IEA 3 Q17 - Multidisciplinary training and working occurs	Evidence must be externally validated through the LMS, 3 times a year. A clear trajectory should be in place to meet and maintain compliance as articulated in the Training Needs Analysis	Training Needs Analysis awaiting approval	30.05.2022
IEA 3 Q28 - All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place	Submission of an audit plan to regularly audit compliance	A standard operating procedure for antenatal risk assessment has been written and the audit compliance framework to be added	30.04.2022
IEA 5 Q37 - At least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of Maternity Incentive	Performance compliance reports together with any required action plan for improvement with agreed trajectory	Action plan with agreed trajectories for improvement in development to address areas of underperformance	03.05.2022

Scheme year three in December 2019?			
IEA 5 Q44 - Pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the Trust website. Information on maternal choice including choice for caesarean delivery	Develop a dedicated platform for maternity services on the Trust website	Information on maternal choice for caesarean delivery is embedded in the woman's hand-held digital notes Dedicated platform for maternity services in development	30.06.2022
Workforce	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	A gap analysis against the Royal College of Midwives manifesto in progress	03.05.2022

5.0 Next Steps

5.1 **On 11 and 12 May 2022** the regional Chief Midwife will be conducting assurance visits at ESTH and SGH respectively to establish if the improvement actions are embedded in practice.

5.2 A national report format is in development and elements will consist of the Ockenden RAG template with a written overview using the WESEE reporting method which looks at workforce, efficiency, safety, experience and effectiveness.

5.3 The Trusts will receive written feedback (in draft) within two weeks for fact checking and with the requirement to respond within one week. The regional maternity team will issue the final reports within two weeks of receipt.

5.4 At this point ESTH and SGH will report internally to the Trust Board. Local Maternity and Neonatal System Boards will report to its Quality Committee within the Integrated Care System. The Regional Maternity Team will report to the London Perinatal Board and Regional Joint Strategic Oversight Group. At National level, information will be reported to the National Maternity Programme Insights group.

5.5 Assurance visits will continue on an annual basis thereafter. For 2022, the Regional Maternity Team will lead each visit, with involvement from Local Maternity and Neonatal System leads. Each year, the process will be reviewed and amended accordingly. It is expected from 2023, Integrated Care System Boards, through its Local Maternity and Neonatal Systems (LMNS) will lead the process, with support from Regional Maternity Teams.

5.6 **By 15 June 2022** and in line with the maternity transformation programme ESTH and SGH are required to submit their **Maternity Continuity of Carer (MCoC)** plan. In doing so, they must take into account this IEA in ensuring that safe midwifery staffing plans are in place.

ESTH and SGH have assessed their staffing position and are required make one of the following decisions for their maternity service:

1. Trusts that can demonstrate staffing meets safe minimum requirements can continue existing MCoC provision and continue to roll out, subject to ongoing minimum staffing requirements being met for any expansion of MCoC provision
2. Trusts that cannot meet safe minimum staffing requirements for further roll out of MCoC, but can meet the safe minimum staffing requirements for existing MCoC provision, should cease further roll out and continue to support at the current level of provision or only provide services to existing women on MCoC pathways and suspend new women being booked into MCoC provision
3. Trusts that cannot meet safe minimum staffing requirements for further roll out of MCoC and for existing MCoC provision, should immediately suspend existing MCoC provision and ensure women are safely transferred to alternative maternity pathways of care, taking into consideration their individual needs; and any midwives in MCoC teams should be safely supported into other areas of maternity provision

5.7 The reported decision for **MCoC for both ESTH and SGH** is decision 2 as outlined above: further roll out of MCoC will cease. MCoC support will continue at the current level of provision with service provided to existing women on MCoC pathways. New women will currently not be booked into MCoC provision.

6.0 Recommendations

The Quality Committee is asked to:

1. Note the progress made to date and the compliance at both Trusts
2. Note the outstanding actions identified for ESTH maternity services
3. Note the external annual assurance process and internal and external governance

Appendix 1

Ockenden Report: Immediate and Essential Actions

IEA 1: Workforce Planning and sustainability
Essential Action – financing a safe maternity workforce

- *The recommendations from the Health and Social Care Committee Report: The safety of maternity services in England must be implemented.*

Much more investment will be needed through recurrent annual spending to ensure safe level of workforce. To facilitate this, there should be an agreement on the minimum staffing levels required nationally or, when not possible, within Local Maternity and Neonatal Systems (LMNS), which must incorporate and consider the increased level of complexity and acuity of pregnancies and births, vulnerable families, as well as further mandatory training, to help trusts meet the organisational requirements from the Care Quality Commission (CQC) and Clinical Negligence Scheme for Trusts (CNST).

Additionally, minimum staffing levels must also incorporate a 'locally calculated uplift', which considers the data from the previous three years on staffing around sickness absences, annual and maternity leave, as well as mandatory training.

All relevant health bodies should review the feasibility and accuracy of the BirthRate Plus tool.

Essential action – training

- *We state that the Health and Social Care Select Committee view that a proportion of maternity budgets must be ring-fenced for training in every maternity unit should be implemented.*

All trusts should establish a 'robust preceptorship programme' for newly qualified midwives (NQM), to aid in their supernumerary status over the course of their orientation, as well as time set aside for professional development, in line with the RCM's position statement from 2017. Additionally, all NQMs should remain within the hospital setting for at least one year after they qualify to facilitate the development of their knowledge and skills. Beyond NQMs, all trusts should ensure that midwives responsible for coordinating care in a labour ward attend a fully funded and national recognised education model for labour ward coordination.

All trusts should develop and train a core team of senior midwives in 'high dependency maternity care', with the team large enough to ensure that there is always one high dependency unity (HDU) trained midwife on each shift. A plan should be developed for succession-planning to support and develop the knowledge and skills of future potential clinical leaders and senior managers.

IEA 2: Safe staffing

- *All trusts must maintain a clear escalation and mitigation policy where maternity staffing falls below the minimum staffing levels for all health professionals*

When agreed staffing levels are not achieved routinely, the report says this should be escalated to the senior management team, the chief nurse, medical director, as well as patient safety champion and Local Maternity System (LMS).

Where there are no separate consultant rotas for obstetrics and gynaecology within trusts, there should be protocols established around risk assessment and escalation for periods of competing workload, as agreed by the board.

All trusts must review and suspend the practice of the Midwifery Continuity of Carer (MCoC) model unless they can demonstrate that they meet the minimum safe staffing requirements to protect the safety of patients in consideration of the current operational pressures faced by trusts.

The report also states that there should be time provided around maternity training for consultants and local doctors within their job plans, which will set aside additional protected time beyond that of generic trust mandatory training.
Trusts should also ensure that there are 'visible, supernumerary clinical skills facilitators' to support all midwives, with newly appointed Band 7/8 midwives also being allocated an experienced mentor. Finally, trusts should develop strategies to maintain robust pathways across midwifery staff in the community and hospital settings and follow the latest RCOG guidance on the management of locums.

IEA 3: Escalation and accountability

- *Staff must be able to escalate concerns if necessary.*
- *There must be clear processes for ensuring that obstetric units are staffed by appropriately trained staff at all times.*
- *If not, resident there must be clear guidelines for when a consultant obstetrician should attend.*

The review found that the staff were fearful of speaking up about concerns. All trusts must develop a policy to support all staff to be able to escalate any clinical concerns when there is a disagreement between clinicians. Assurance processes should also be developed to ensure that any trainee or middle grade obstetrician has an adequate level of competence when managing the service without a direct presence of a consultant. Additionally, all trusts should aim to increase the presence of resident consultant obstetricians where possible, develop local guidelines for when their attendance is mandatory in the unit, as well as create local guidelines informing when the midwifery manager and consultant obstetrician on-call should be informed of any activity within the ward.

IEA 4: Clinical governance-leadership

- *Trust boards must have oversight of the quality and performance of their maternity services.*
- *In all maternity services the Director of Midwifery and Clinical Director for obstetrics must be jointly operationally responsible and accountable for the maternity governance systems.*

Several recommendations are made around clinical governance and leadership. Trust boards must work closely together with maternity departments to jointly develop routine progress and exception reports, assurance reviews, as well as regularly review the progress of any plans based on improvement and transformation. All maternity service senior leadership teams must complete the National Maternity Self-Assessment Tool using appreciative inquiry and share it with the Trust board. Additionally, they suggest that all trusts have a patient safety specialist dedicated to maternity care.

Concerning all clinicians with maternity governance responsibilities, trusts should provide enough time for them to engage with these responsibilities, as well as ensuring maternity governance teams are trained in 'human factors, causal analysis and family engagement'.

Trusts should establish midwifery and obstetric co-leads for developing any guidelines in maternity care and have these co-leads for audits of maternity care.

IEA 5: Clinical governance – incident investigation and complaints

- *Incident investigations must be meaningful for families and staff and lessons must be learned and implemented in practice in a timely manner.*

The language used by maternity governance teams in reports should be understandable by families and written in simple and lay language. Any lessons from clinical incidents should be reflected within the delivery of the local multidisciplinary training plan, and any actions from a serious incident investigations (SI's) should be audited when there is a change in practice within six months of the incident.

Complaints which meet the threshold for SI's should be investigated, and Trusts should involve service users in developing processes for responding to complaints. Any trends and themes emerging from complaints should be monitored by the team dedicated to maternity governance within each trust to help identify underlying concerns earlier.

IEA 6: Learning from maternal deaths

- *Nationally all maternal post-mortem examinations must be conducted by a pathologist who is an expert in maternal physiology and pregnancy related pathologies.*
- *In the case of a maternal death a joint review panel/investigation of all services involved in the care must include representation from all applicable hospitals/clinical settings.*

NHSE/I should work with the relevant Royal Colleges to ensure that post-mortem examinations by a specialist maternal physiology and pregnancy related pathologist are provided in the case of any death. Any joint review panel must have an independent chair, be aligned with local and regional staff and must seek external clinical expert opinions where needed. The panel should include representation of all services involved in the provision of maternity care. Any learnings from such reviews should be introduced into clinical practice within six months of the panel and the learning should be shared across the local maternity system (LMS).

IEA 7: Multidisciplinary training

- *Staff who work together must train together.*
- *Staff should attend regular mandatory training and rotas. Job planning needs to ensure all staff can attend.*
- *Clinicians must not work on labour ward without appropriate regular CTG training and emergency skills training.*

All members of the maternity multidisciplinary team should attend regular joint training events and regular training time should be included as a part of staff job plans. This training should also integrate the use of local handover tools into teaching programmes at trusts, and training recommended by the report includes annual human factor training for all staff working in a maternity setting.

There should be regular multidisciplinary skills drills and on-site training for the management of common obstetric emergencies and all trusts should have a system in place to ensure that staff have the most up to date training in cardiotocography (CTG) and emergency skills. Clinicians should not work on labour wards or provide intrapartum care in any location without the appropriate regular CTG training and emergency skills training.

IEA 8: Complex antenatal care

- *Local Maternity Systems, Maternal Medicine Networks and trusts must ensure that women have access to pre-conception care.*
- *Trusts must provide services for women with multiple pregnancy in line with national guidance.*
- *Trusts must follow national guidance for managing women with diabetes and hypertension in pregnancy.*

Any woman with pre-existing medical disorders, including cardiac disease, epilepsy and chronic hypertension, must have access to a specialist who is familiar with managing that disorder and who can understand the impact that pregnancy may have. Trusts should have specialist antenatal clinics dedicated to women with multifetal pregnancies, and these should have dedicated consultant and specialist midwifery training.

Trusts should follow the NICE Diabetes and Pregnancy Guidance 2020 when managing women with pre-existing or gestational diabetes. For women with chronic hypertension, trusts should develop antenatal services that care for them. Trusts should ensure that women with chronic hypertension are seen in a specialist consultant clinic to discuss and evaluate the risks and benefits to treatment, and they should be cared for in accordance with the NICE Hypertension and Pregnancy Guideline (2019).

IEA 9: Preterm birth

- *The LMNS, commissioners and trusts must work collaboratively to ensure systems are in place for the management of women at high risk of preterm birth.*
- *Trusts must implement NHS Saving Babies Lives Version 2 (2019).*

Senior clinicians, the LMNS, commissioners and trusts must work in collaboration to make sure there are systems in place to manage women who are at high risk of ‘very pre term birth’. Expert advice for women and their partners on what the most appropriate fetal monitoring should be, and what mode of delivery should be considered. Any conversations should involve local and tertiary neonatal teams, so that parents have the chance to understand the risks of possible associated disability and the chances of neonatal survival. Additionally, audits should be a continuous process where all in utero transfers, cases where a decision has been made to not transfer, and when a delivery occurs in the local unit, are all reviewed. Trusts across England should implement NHS Saving Babies Lives Version Two.

IEA 10: Labour and birth

- *Women who choose birth outside a hospital setting must receive accurate advice with regards to transfer times to an obstetric unit should this be necessary.*
- *Centralised CTG monitoring systems should be mandatory in obstetric units.*

All midwifery-led units must undertake both yearly operational risk assessments and regular multidisciplinary team 'skills drills'. Additionally, any woman who is presenting in early or established labour must undergo a full clinical assessment, which includes a review of risk factors that may change the recommendations around place of birth. Any woman who decides to give birth outside a hospital setting must receive accurate and up to date written information about transfer times to the consultant obstetric unit, and this information should be co-produced by both maternity services and the local ambulance trust. For induction of labour, Trusts must have a mechanism in place to describe a clear, safe pathway in case delays occur due to high activity or short staffing. In addition, CTG monitoring systems must be made mandatory in obstetric units across England.

IEA 11: Obstetric anaesthesia

- *In addition to routine inpatient obstetric anaesthesia follow-up, a pathway for outpatient postnatal anaesthetic follow-up must be available in every trust to address incidences of physical and psychological harm.*
- *Documentation of patient assessments and interactions by obstetric anaesthetists must improve. The determination of core datasets that must be recorded during every obstetric anaesthetic intervention would result in record-keeping that more accurately reflects events.*
- *Staffing shortages in obstetric anaesthesia must be highlighted and updated guidance for the planning and provision of safe obstetric anaesthesia services throughout England must be developed.*

Conditions that require further follow up include, but are not limited to, postdural puncture headache, accidental awareness during general anaesthesia or neurological injury relating to anaesthetic interventions. This will help to create a pathway for outpatient postnatal anaesthetic follow-up, which must be available in every trust to address incidences of physical and psychological harm, in addition to the routine inpatient obstetric anaesthesia follow-up.

All anaesthetic departments must review the adequacy of maternity patient records documentation, and where necessary, take steps to improve this as recommended in Good Medical Practice by the General Medical Council (GMC). Resources must be made available for the anaesthetic professional bodies to determine a consensus regarding what constitutes a satisfactory anaesthetic record and the contents of core datasets.

Staffing shortages in obstetric anaesthesia must be highlighted, and updated guidance for the planning and provision of safe obstetric anaesthesia services throughout England must be developed. Anaesthesia staffing guidance should include:

- What the role of consultants, staff, SAS doctors, and doctors in training is in service provision, as well as understanding where the need is for prospective cover to ensure safe services continue whilst allowing for staff leave.
- The full range of obstetric anaesthesia workload including elective caesarean lists, clinic work, labour ward cover, as well as teaching, attendance at multidisciplinary training, and governance activity.
- What competency is required for consultant staff who cover obstetric services out of hours, but who have no regular obstetric commitments.
- How anaesthetists participate in the multidisciplinary ward rounds, as recommended in the interim report.

IEA 12: Postnatal care

- *Trusts must ensure that women readmitted to a postnatal ward and all unwell postnatal women have timely consultant review.*
- *Postnatal wards must be adequately staffed at all times.*

Trusts must develop systems that ensure consultants review all postnatal readmissions and unwell postnatal women, including any women who require care on a non-maternity ward. Unwell women should have timely consultant involvement in their care and should be seen daily as a minimum.

Additionally, postnatal readmissions must be seen within 14 hours of readmissions or urgently if necessary. Postnatal wards must be appropriately staffed to cover the activity and acuity of care required for both mothers and babies, day and night.

IEA 13: Bereavement care

- *Trusts must ensure that women who have suffered pregnancy loss have appropriate bereavement care services.*

Trusts must provide bereavement care services for women and families who suffer pregnancy loss, and these services must be provided seven days a week. All trusts must ensure appropriate numbers of staff are trained to take post-mortem consent, so that families can be counselled about post-mortem within 48 hours of birth. Staff should also be trained to deal with bereavement and the purpose and procedures of post-mortem examinations. Trusts must develop a system to ensure that families can be offered follow up appointments after perinatal loss or serious neonatal outcome. For all families who experience a perinatal loss, trusts must deliver compassionate, high quality and individualised care to them, with reference to guidance such as the National Bereavement Care Pathway.

IEA 14: Neonatal care

- There must be clear pathways of care for provision of neonatal care.
- *This review endorses the recommendations from the Neonatal Critical Care Review (December 2019) to expand neonatal critical care, increase neonatal cot numbers, develop the workforce and enhance the experience of families. This work must now progress at pace.*

Neonatal and maternity care providers, commissioners, and networks must agree on pathways of care, including both the designation of each unit and on the level of neonatal care that is provided. Any care that is delivered outside of this agreed pathway must be monitored by at least quarterly exception reporting, which should be reviewed by providers and the network. The results of this should then be reported to both commissioners and Local Maternity Neonatal Systems quarterly. Neonatal Operational Delivery Networks must ensure that staff in provider units have the opportunity to share best practice and education to ensure provider units do not operate in isolation from their local clinical support network. Each network should report annually to commissioners summarising the steps they are taking in this work.

Maternity services should work towards a position of at least 85% of births at less than 27 weeks gestation taking place at a maternity unit with an onsite neonatal unit (NICU).

The report highlights the importance of sufficient staffing numbers who are appropriately trained in neonatal providers, and they must be available in every type of unit to deliver safe care. During neonatal resuscitations, if the consultant is not immediately available, there must be a mechanism

in place that allows for real time dialogue. Additionally, the report endorses the recommendations from the Neonatal Critical Care Review and says this work must progress at pace. This includes increasing neonatal cot numbers, developing the workforce and enhancing the experience of families.

IEA 15: Supporting families

- *Care and consideration of the mental health and wellbeing of mothers, their partners and the family as a whole must be integral to all aspects of maternity service provision.*
- *Maternity care providers must actively engage with the local community and those with lived experience, to deliver services that are informed by what women and their families say they need from their care.*

There must be robust mechanisms for identifying psychological distress and clear pathways for women and their families to access support. This must be an integral aspect of all parts of maternity care. Timely psychological support should be available without a formal mental health diagnosis, but for those who have complex needs, support should be delivered by specialist psychological practitioners who have experience in maternity care. This should be underpinned by ensuring maternity care providers actively engage with the local community and those with lived experience, to deliver services that are informed by what women and their families say they need from their care.

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Appendix 2

Outline of ESTH and SGH Internal and External Compliance Reports

December 2020: On 11 December 2020, NHS England wrote to all Trusts providing maternity services to ask them to confirm and commit to the implementation of 12 clinical priorities which were identified from the immediate and essential actions (IEA's) detailed in the interim report. On 18 December 2020 in accordance with this requirement, **ESTH and SGH responded** to confirm commitment to ensuring that all the urgent actions identified were prioritised by the respective Trust and Local Maternity Systems (LMS).

January to March 2021: NHS England also asked every Trust providing maternity services to review the interim Ockenden Report at the next public Trust Board and asked the Trust Board to reflect on whether the assurance mechanisms within the Trust were effective. To support these discussions, NHS England asked Trusts to complete an Assurance and Assessment Tool and to share this with the Board, the Local Midwifery Systems and the regional teams by 15 February 2021. The completed template was approved by the **ESTH Board on 8 January 2021** and was sent to both LMSs (Surrey Heartlands and South West London) on 15 February 2021. **SGH self-assessment assurance template was 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.**

April 2021: SGH reported to the Trust Board 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.

March to June 2021: ESTH and SGH both participated in an external peer review process. Following this each Trust was asked to upload evidence of compliance/completion of actions through a nationally developed portal by the deadline of 30 June 2021.

December 2021: ESTH and SGH received the outcome for each Trust following submission of the evidence and committed to working towards full compliance.

January to April 2022: NHS England asked every Trust to again assure themselves one year on that they are confident that mothers and babies are safe in their maternity units. The previously used NHSE Assurance and Assessment Tool was updated to demonstrate both Trusts position against the IEAs and actions as previously set out. **ESTH and SGH** have completed this assessment; ESTH demonstrated 70% compliance and SGH demonstrated 100% compliance.

By June 2022: In line with the maternity transformation programme, Trusts have been asked to submit plans for Midwifery Continuity of Carer by 15 June 2022. **ESTH and SGH** are waiting to receive clarity and timetabling by the national team on further requirements to comply with the Ockenden IEA's which remain undefined, this includes any further expansion of Midwifery Continuity of Carer plans.

St George's University Hospitals NHS
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Meeting Title:	**Trust Board**		
Date:	5 May 2022	**Agenda No**	**3.1**
Report Title:	**Finance Committee report**		
Lead Director/ Manager:	Ann Beasley, Chair of the Finance Committee		
Report Author:	Ann Beasley, Chair of the Finance Committee		
Presented for:	Assurance		
Executive Summary:	The report sets out the key issues discussed and agreed by the Finance Committee at its meeting on 22nd April 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
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Finance Committee – April 2022

The Committee met on 22nd April 2022 for the first time as a committee in common with Epsom & St Helier University Hospitals NHS Trust. This paper focuses on agenda items that relate to St George's. In addition to the regular items on strategic risks, operational performance and financial performance, the committee also considered papers on:

- Financial Planning for 2022/23;
- Terms of Reference for the new committees in common;
- A Cyber Essentials Application;
- Finance Policy Updates; and
- A Procurement Report.

As is its usual practice, the Committee discussed the Board Assurance Framework (BAF) risks on a rotating basis by deep dives, with consideration by exception in intervening months. In April members undertook a deep dive into the ICT and operational risks. Issues raised in discussion covered the sub-acute Hospital at Home model and the proposed switch of assurance score between likelihood and consequence, with the latter proposed to reduce from '5' to a '4', but with the likelihood increasing from '4' to '5'. Members were assured that mitigations were receiving sufficient executive focus.

While no deep dive on Finance or Estate risks were presented at the meeting, exception reports highlighted the latest status of the financial plan for 2022/23 in capital and revenue terms, with no proposed change to any of the 3 strategic risks.

The Committee discussed current financial performance, cash management and capital expenditure as the Trust reported the draft year-end 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 Chief Operating Officer (COO) and Chief Information Officer (CIO) both updated the committee on their joint strategic risk, with score and assurance rating agreed as follows:

- SR3- ICT and Operational Risk 20 – Partial Assurance

1.2 Estates Report –the Director of Estates & Facilities (DE&F) introduced the normal monthly update, noting progress on the Estates Strategy. In particular, he highlighted that the Trust was one of the first to achieve carbon neutral patient menus. The Committee asked for a report on progress with the overall green plan at a future meeting, noting concerns raised by Governors at their meeting.

1.3 Activity Performance – the COO noted the expected performance against activity trajectories in March, where Daycase/ Elective performance is expected to be slightly below target (at 97% compared to 100% target) and Outpatient performance is expected to be ahead of target (at 111% compared to 100%).

1.4 Emergency Department (ED) Update – the performance of the Emergency Care Operating Standard was recorded at 72.0% in March. The Committee noted that the Trust continues to see significant challenges impacting waiting times, with discussion on the lack of optimum care being provided following attendances in the department by patients with significant mental health issues.

1.5 Diagnostics Performance – the COO noted that 1.8% of patients were waiting longer than six weeks to have a diagnostic test in March. The Committee welcomed the improvement in the performance against this standard.

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1.6 Cancer Performance – the COO noted Cancer performance in February, where improvements were noted against the 14-day target, although challenges remain against all cancer metrics. The Committee had previously against for a report indicating when the cancer standards would be achieved, and was pleased to note that the report should be available for its May meeting.

1.7 Referral to Treatment (RTT) Update – the performance against the RTT target was discussed, where performance in February of 72.1% had remained consistent with the previous month's value of 72.1%. The number of patients waiting over 52 weeks was 802, less than the previous month's figure of 887. The size of the waiting list (including QMH patients) was 48,570 patients.

1.8 Financial Performance– the Group Chief Financial Officer (GCFO) noted performance in the draft accounts for the year 2021/22, where a breakeven was reported which is £5.0m favourable to plan. This includes additional funding of £5.0m.

He noted the cash balance as at 31st March 2022 was £68.5m (which is higher than at the previous 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.

He also noted the capital position at year end was an underspend of £1.2m, with total expenditure at £65.7m.

1.9 Planning 22-23 – the GCFO noted the progress being made on planning for 2022/23 with the financial gap expected to be submitted in the coming week. The Committee discussed financial mitigations and the work being done with operational teams to deliver CIPs. The Committee was concerned on a number of fronts: the lateness at which the planning was taking place, albeit in line with national guidance; the size of the remaining deficit and the level of cost improvement initiatives that would be required even with the proposed deficit. The Committee further noted that some of the assumptions on which the Trust was being asked to base its plan, such as around the treatment of inflation, would appear to have been overtaken by events.

1.10 Joint Committee Terms of Reference – the GCFO introduced the proposed Terms of Reference together with previous Terms of Reference from the individual Trust's committees. The Committee agreed for a few items to be clarified ahead of sending a final version to members for agreement in the coming fortnight, before final ratification by the individual Trust Boards.

1.11 Cyber Essentials Application – the GCFO noted the government backed minimum standard scheme that provides assurance that an organisation is protected against a range of the most common cyber attacks. The Committee were satisfied with the assurance given that answers would be submitted that would be verified by the assessor.

1.12 Financial Policy Update – the GCFO noted no material changes to the Transactions Management Policy. **The committee approved the updated policy.**

1.13 Procurement Report – the GCFO noted the latest update from the Procurement department, including breaches and waivers and progress against the Procurement CIP target.

2.0 Recommendation

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

Ann Beasley
Finance Committee Chair,
May 2022

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Meeting Title:	TRUST BOARD		
Date:	5th May 2022	**Agenda No**	**3.2**
Report Title:	2021/2022 St George's Financial Performance		
Lead Director/ Manager:	Andrew Grimshaw		
Report Author:	Tom Shearer		
Presented for:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify) (select using highlight)		
Executive Summary:	The Trust is reporting a £0.1m surplus at year end. This is consistent with the forecast held throughout H2. Between the Key Data Return on 19th April and the final accounts submitted on the 26th April, the Trust's position improved by £113k to reflect a late notification of additional testing income as required by NHS Improvement.		
Recommendation:	The Board is asked to note the financial performance as per the final accounts submission on 26th April		
Committee Assurance:	The Committee is also asked that in considering contents of this report, its supporting documents and the discussion at the meeting which of the following assurance rating it would provide to the Trust Board. • **Substantial Assurance:** The report and discussions assured the Committee that there are robust systems of internal controls operating effectively to ensure that quality and safety risks are managed to deliver high quality services and care to patients. • **Reasonable Assurance:** The report and discussions assured the Committee that the system of internal controls is generally adequate and operating effectively but some improvements are required to ensure that quality and safety risks are managed to deliver high quality services and care to patients. • **Limited Assurance:** The report and discussions supported the Committee's conclusion that that the system of internal controls is generally inadequate or not operating effectively and significant improvements were required to ensure that the quality and safety risks are managed effectively to improve the position and ensure that high quality services and care is provided to patients. • **No Assurance:** The report and discussions led the Committee to conclude that there was a fundamental breakdown or absence of core internal controls and systems to enable the Trust to deliver high quality services and care to its patients.		
Supports			
Trust Strategic Objective:	Balance the books, invest in our future.		
CQC Theme:	Well-Led		
Single Oversight Framework Theme:	N/A		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		

Equality and Diversity:	There are no equality and diversity impact related to the matters outlined in the report.		
Previously Considered by:	Finance Committee	**Date**	22/4/22
Appendices:			

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[Insert the Title of the Report/Paper]
[Insert Name of Meeting and Date of Meeting]

1.0 PURPOSE

1.1

1.2

1.3

2.0 BACKGROUND OR CONTEXT [select]

2.1

2.2

2.3

3.0 PROPOSAL OR ISSUE OR ANALYSIS OR OPTIONS APPRAISAL [select one or provide an alternative]

3.1

3.2

3.3

4.0 IMPLICATIONS

Risks
4.1

Legal Regulatory
4.2

Resources
4.3

Equality & Diversity
4.4

5.0 NEXT STEPS OR TIMELINE [select one or do not use if not required]

5.1

5.2

6.0 RECOMMENDATION

6.1

6.2

Author:
Date:

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APPENDIX [insert letter]

[Insert Heading of Appendix]

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2021/2022 St George's Financial Performance

This paper provides the Trust Board with a high level summary of the draft 2021/2022 financial performance of the Trust.

Andrew Grimshaw

Group CFO

5th May 2022

SGH
21/22 Draft Year End Position

The numbers included within this slide are consistent with the numbers to be included within the final accounts submission to NHSI on Tuesday 26th April. This shows performance against control totals, excluding items such as donated capital and impairments.

I/E	Budget £m	Actual £m	Variance £m
Income	1,010.6	1,076.6	66.0
Expenditure	(1,015.6)	(1,076.5)	(60.9)
Surplus / (Deficit)	**(5.0)**	**0.1**	**5.1**

Income and Expenditure

- The Trust is reporting a £0.1m surplus at year end. This is consistent with the forecast held throughout H2. Between the Key Data Return on 19th April and the final accounts submitted on the 26th April, the Trust's position improved by £113k to reflect a late notification of additional testing income as required by NHS Improvement.

Capital	Forecast £m	Actual £m	Variance £m
Capital Spend	(67.0)	(65.8)	1.2

Capital Spend

- The Trust is reporting capital spend of £65.8m, vs a plan of £67.0m. This £1.2m underspend is due to a national funded diagnostics scheme in Croydon, as part of SWLP, not being delivered.

Cash	2021 Closing Cash £m	2122 Closing Cash £m	Movement £m
Cash Balance	36.6	68.5	31.9

Cash

- The Trust ended the year with a cash balance of £68.5m which is £31.9m higher than the opening balance for the year.

Meeting Title:	**Trust Board**		
Date:	5 May 2022	**Agenda No**	**3.3**
Report Title:	**Board Assurance Framework (BAF) Quarter 4 2021/22 Review**		
Lead Director/ Manager:	Stephen Jones, Chief Corporate Affairs Officer		
Report Author:	James Brind, Head of Risk Maria Prete, Risk Manager		
Presented for:	**Assurance**		
Executive Summary:	This paper presents the Trust Board with the Board Assurance Framework as at year end 2021/22 and sets out the proposed risk scores and assurance ratings, as well as the actions being taken to address identified gaps in control and assurance. With the exception of Strategic Risk 4, which is reserved to the Board, the information set out for each strategic risk has been reviewed by the relevant Board Committee, following review by the responsible sub-group of the Trust Management Group and by the Trust Management Group and Executive Management Team. The key changes at year end 2021/22 are: **SR2 – *'We are unable to provide outstanding care as a result of weaknesses in our clinical governance'*** • Assurance rating increased from partial to 'Good'; • Reduction in the risk score from 12(4C x3L) to 8(4C x 2L). The reduction in the score would change the grade of the risk from 'high' to **'moderate'** • Yearend target score has been assessed as met **SR3 – *'Our patients do not receive timely access to the care they need due to delays in treatment and the inability of our technology and transformation programmes to provide accessible care built around our patients' lives'*** • Assurance rating increased from 'Limited' to 'Partial'. **SR7 – *'We are unable provide a safe environment for our patients and staff and to support the transformation of services due to the poor condition of our estates infrastructure'*** • Assurance rating increased from 'Partial' to 'Good'; • Risk score downgraded from 20 (4C x 5L) to 16 (4C x 4L). The reduction in the score would result in no change to the grading of this strategic risk, so remains '**extreme'.** • Yearend target score has been assessed as met **SR8 – *'We fail to build an open and inclusive culture across the organisation which celebrates and embraces our diversity because our staff do not feel safe to raise concerns and are not empowered to deliver to their best'*** • Assurance rating increased from Partial to Good **SR9 – *'We are unable to meet the changing needs of our patients and the wider system because we do not recruit, educate, develop and retain a modern and flexible workforce and build the leadership we need at all levels'***		

	• The risk score briefly increased to 20 (4C x 5L) in view of the potential consequence of the introduction of vaccination as a condition of deployment (VCOD legislation). Following the VCOD legislation being revoked, the April 2022, Workforce and Education Committee endorsed the proposal that the risk score should be reduced to 16 (4C x 4L). The reduction in the score would result in no change to the grading of this strategic risk, so remains 'extreme'.
	The Board is asked: a) For the Strategic Risk (system working) reserved to itself (SR4): ○ Agree the proposed score of 12 (4C x 3L) (no change) ○ Agree the proposed assurance rating of 'good' (no change) b) For the remaining 9 strategic risks assigned to its sub committees to: ○ Agree the proposed risk scores, assurance ratings and statements from the relevant assuring committee ○ Note the progress achieved in year in mitigating identified gaps in control and assurance
Supports	
Trust Strategic Objective:	All
CQC Theme:	Well led
Single Oversight Framework Theme:	Quality of Care Leadership and Improvement Capability
Implications	
Risk:	The strategic risk profile
Legal/Regulatory:	Compliance with Heath and Social Care Act (2008), Care Quality Commission (Registration Regulations) 2014, the NHS Act 2006, NHSI Single Oversight Framework, Foundation Trust Licence
Resources:	N/A
Previously Considered by:	Quality and Safety Committee Finance and Investment Committee Workforce and Education Committee Group Executive
Date	21.03.2022 22.04.2022 10.03.2022 27.04.2022
Equality and diversity:	The BAF reflects agreed risks in relation to quality and diversity and the actions being taken to address these.
Appendices:	Board Assurance Framework Q4 2021/22

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Board Assurance Framework 2021/22

Trust Board
BAF Report – Q4 update

Stephen Jones
Group Chief Corporate Affairs Officer

5 May 2022

Executive Summary

1. Purpose

This paper presents the Trust Board with the Board Assurance Framework as at Q4 2021/22 and sets out the proposed risk scores and assurance ratings, as well as the actions being taken to address identified gaps in control and assurance. With the exception of Strategic Risk 4, which is reserved to the Board, the information set out for each strategic risk has been reviewed by the relevant Board sub committee, following review by the responsible sub-Group of the Trust Management Group and by the Executive Management Team.

2. Background

The Board Assurance Framework (BAF) brings together in one place all of the relevant information on the risks to the delivery of the Board's strategic objectives as set out in its five-year clinical strategy, Delivering Outstanding Care, Every Time. The BAF provides a structured approach for identifying and mapping the main sources of assurance and coordinating them to best effect. It also highlights where there are gaps in assurance and / or ineffective controls that need to be addressed. The BAF provides a framework through which the Board can understand the sources and levels of assurance relevant to the management of its strategic risks, and it provides an evidence-base of effective oversight of risks to the organisation and its strategic objectives.

The Board approved the new strategic risks on the Board Assurance Framework (BAF) at its meeting in May 2020. In July 2020, the Board agreed a set of "stretching but realistic" year-end target risk scores, which were proposed by the Executive Director responsible for each individual strategic risk and endorsed by the relevant Board Committee. The Board Committees are assigned the Strategic Risks as follows, with Strategic Risk 4 (system working) reserved to the Board:

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

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

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

3. Update at Q4 2021/22:

- **Risk scores:** There are seven extreme risks, one high risks and two moderate risk.

  - **SR2 –** As endorsed by the March 2022 Quality and Safety Committee, the strategic risk score is proposed to be reduced from 12 (4C x3L) to 8 (4C x 2L). The reduction in the score would change the grade of the risk from 'high' to **'moderate'.**
  - **SR7** – As endorsed by the March 2022 Finance and Investment Committee, the strategic risk score is proposed to be reduced from 20 (4C x 5L) to 16 (4C x 4L). The reduction in the score would result in no change to the grading of this strategic risk, so remains '**extreme'.**
  - **SR9** - The risk score briefly increased to 20 (4C x 5L) in view of the potential consequence of the introduction of vaccination as a condition of deployment (VCOD legislation). Following the VCOD legislation being revoked, the April 2022, Workforce and Education Committee endorsed the proposal that the risk score should be reduced to 16 (4C x 4L). The reduction in the score would result in no change to the grading of this strategic risk, so remains **'extreme**'.

Executive Summary

- **Assurance ratings**: Five of the ten strategic risks currently have a 'partial' assurance rating; and five have a 'good' assurance rating.
  - **SR2** - The assurance rating increased in Q4 2021/22 from Partial to Good, as endorsed by the Quality and Safety Committee at its meeting in March 2022;
  - **SR3** - The assurance rating increased in Q3 2021/22 from Limited to Partial, as endorsed by the Finance and Investment Committee at its meeting in January 2022;
  - **SR7** - The assurance rating increased in Q4 2021/22 from Partial to Good, as endorsed by the Finance and Investment Committee at its meeting in March 2022 ;
  - **SR8** - The assurance rating increased in Q1 2021/22 from Partial to Good, as endorsed by the Workforce and Education Committee in May 2021.

- **Target risk scores achieved:** Target risks were initially defined by the Board in September 2020. Performance against the target risks was reviewed by the Board Committees prior to submission of the Q4 BAF to the Board. The target risks proposed for 2021/22 are on slide 14 as recommended by the relevant Committees. The Trust has met the target risk score for 2 strategic risks:

  - **SR2** - We are unable to provide outstanding care as a result of weaknesses in our clinical governance
  - **SR7** - We are unable provide a safe environment for our patients and staff and to support the transformation of services due to the poor condition of our estates infrastructure

- **Linked operational risks:** A review of the linked operational risks held at the corporate and divisional risk registers is regularly undertaken which are considered by the relevant Sub-Groups of the Trust Management Group. The central risk team regularly request and support risk owners with their review and updating of entries.

- **Progress in mitigating risks:** Included in the summaries of each strategic risk are overviews of the actions completed in-year to address identified gaps in control and assurance. This is intended to demonstrate the progress achieved in mitigating the strategic risk even where this has not progressed to the point where a change in the risk score can be recommended. A number of gaps in control have been addressed across the BAF which have been considered sufficient to justify a change in the risk score for SR2 and SR7; and a change in the assurance for SR2, SR7 and SR9.

Strategic Risk 4 (system working) is reserved to the Board: The Board is asked to review and confirm the risk score and assurance level for this risk. In May, the Board set the risk score at 12 (4 consequence x 3 likelihood), with an increased assurance rating of 'good' from 'partial' on the basis of the progress achieved in-year. When the Board reviewed the risk score at Q2, it considered that while the Trust had made significant progress in working as part of the SWL ICS, the inherent risks around system working that went beyond the Trust's control warranted the risk score being maintained at 12. At Q4, a risk score of 12 and assurance rating of "good" is proposed to be maintained. An in-year target risk score of 12 (4x3) was set in May 2021 to reflect a realistic year end position for this risk to reflect the risk that other members of the Acute Provider Collaborative in SWL will pursue clinical/ commercial relationships with other tertiary NHS providers that pose a strategic threat to SGUH.

4. Recommendation

The Board is asked:

1. For the strategic risk reserved to itself (SR4) to: agree with the score of 12 (4C x 3L) (no change), and the assurance rating of 'good' (no change).
2. For the remaining nine strategic risks assigned to its sub-committees to:
   - Agree the proposed risk scores, assurance ratings and statements from the relevant assuring committee;
   - Note the progress achieved over the financial year in mitigating identified gaps in control and assurance.

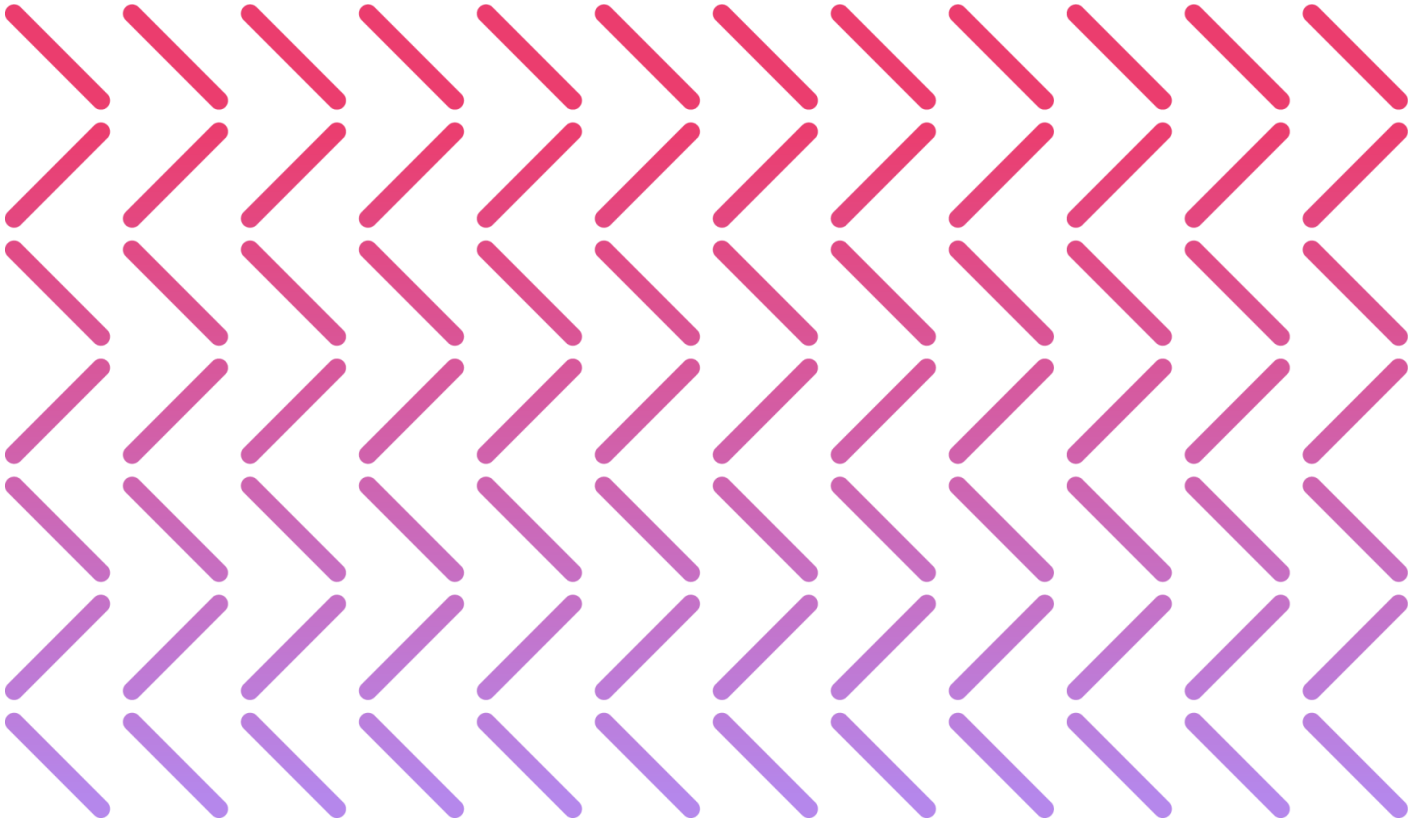
Strategic Risks: High Level Summary – Assurance Rating and Risk Score at Year End

Strategic Objective	Corporate Objective	Risk Reference	2021/22 Strategic Risks	ASSURANCE RATING		RISK RATING		TARGET RISK SCORES	
				Year start (April 2021)	Year end (March 2022)	Year start (April 2021)	Year end (March 2022)	Target t year end (Mar 22)	Target Met
1. Treat the patient, treat the person	Care	SR1	Our patients do not receive safe and effective care built around their needs because we fail to build and embed a culture of quality improvement and learning across the organisation	Partial	Partial	Extreme 16	Extreme 16	High 12	NO
	Care	SR2	We are unable to provide outstanding care as a result of weaknesses in our clinical governance	Partial	Good	High 12	Moderate 8	Moderate 8	YES
2. Right care, right place, right time	Care	SR3	Our patients do not receive timely access to the care they need due to delays in treatment and the inability of our technology and transformation programmes to provide accessible care built around our patients' lives	Limited	Partial	Extreme 20	Extreme 20	Extreme 16	NO
	Collaboration	SR4	As part of our local Integrated Care System, we fail to deliver the fundamental changes necessary to transform and integrate services for patients in South West London	Partial	Good	High 12	High 12	High 12	YES
3. Balance the books, invest in our future	Collaboration	SR5	We do not achieve financial sustainability due to under delivery of cost improvement plans and failure to realise wider efficiency opportunities	Partial	Partial	Extreme 20	Extreme 20	High 12	NO
	Collaboration	SR6	We are unable to invest in the transformation of our services and infrastructure, and address areas of material risk to our staff and patients, due to our inability to source sufficient capital funds	Partial	Partial	Extreme 20	Extreme 20	High 12	NO
4. Build a better St George's	Care	SR7	We are unable provide a safe environment for our patients and staff and to support the transformation of services due to the poor condition of our estates infrastructure	Partial	Good	Extreme 20	Extreme 16	Extreme 16	YES
5. Champion team St George's	Culture	SR8	We fail to build an open and inclusive culture across the organisation which celebrates and embraces our diversity because our staff do not feel safe to raise concerns and are not empowered to deliver to their best	Partial	Good	Extreme 16	Extreme 16	High 12	NO
	Culture	SR9	We are unable to meet the changing needs of our patients and the wider system because we do not recruit, educate, develop and retain a modern and flexible workforce and build the leadership we need at all levels	Partial	Partial	Extreme 16	Extreme 16	High 12	NO
6. Develop tomorrow's treatments today	Collaboration	SR10	Research is not embedded as a core activity which impacts on our ability to attract high calibre staff, secure research funding and detracts from our reputation for clinical innovation.	Good	Good	Moderate 9	Moderate 9	Low 6	NO

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

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

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



Outstanding care every time

Strategic Objective	Treat the patient, treat the person	*Corporate Objective 2021/22:*	*Care*

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

Risk Appetite / Tolerance		
	LOW	Patient safety is our highest priority and we have a **low appetite** for risks that impact on patient safety. Our appetite for risks affecting patient experience is also low, but is higher than for risks impacting on patient safety. If patient experience conflicts with patient safety, the safety of services will always be our highest priority.

Assurance Committee	**Quality and Safety Committee**
Executive Group	Patient Safety and Quality Group
Executive Lead(s)	Chief Nurse & DIPC Chief Medical Officer
Date last Reviewed	24 March 2022

Current risk and assurance assessment

Risk score:
The current risk score for SR1 of 16 continues to reflect the level of risk around patient and staff exposure to the SARS-CoV-2 virus and delays in patient treatment and the elective backlog due to Covid-19. Reviewed and endorsed by Quality and Safety Committee on 24 March 2022.

Assurance rating:
An assurance rating of partial is proposed. The assurance rating reflects the fact that there are five actions identified to increase assurance which are not yet completed. There also continue to be significant unknowns related to the future development of the pandemic, and controls the Trust can put in place either individually or together with partners can only go some way to addressing the level of risk associated with Covid-19.

Changes since last quarter:
No changes are proposed to the overall risk score or to the assurance rating.

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

Overall SR Rating – Quarterly Scores

Period 2021/ 2022	Risk Score	Assurance Strength	Change (last reporting period)	Inherent Risk Score	Target Risk Score 2021/22
Q1	Extreme 16 = 4(C) x 4(L)	Partial	N/A	20 = 4(C) x 5(L)	12 = 4(C) x 3(L)
Q2	Extreme 16 = 4(C) x 4(L)	Partial	N/A		
Q3	Extreme 16 = 4(C) x 4(L)	Partial	N/A		
Q4	Extreme 16 = 4(C) x 4(L)	Partial	N/A		

Emerging risks

- Culture shift to embed quality improvement does not happen, or does not happen quickly enough
- System working related to hospital specific clinical pathways may mean we cannot manage our own activity
- Quality Improvement Academy does not have traction to effectively promote a culture of learning across the Trust
- Impact of any future surge of Covid-19 on the Trust's ability to provide care to all patients in a timely way

Future opportunities

- We can utilise the data we hold related to our patients and the activity across our services to improve our learning in the organisation and how we plan and/ or deliver our services.
- We can also develop, adopt and promote key safety measurement principles and use culture metrics to better understand how safe our care is
- The new National Patient Safety Incident Reporting Framework with its enhanced focus on learning will enable us to work together with our patients and their families to improve our investigation of incidents
- Covid-19 provides opportunities to think differently about how we engage with patients, service users and their families

Strategic Objective	Treat the patient, treat the person	*Corporate Objectives 2021/22:*	*Care*
SR1	**Our patients do not receive safe and effective care built around their needs because we fail to build and embed a culture of quality improvement and learning across the organisation**		

Key risk controls in place	Control effectiveness				Key sources of assurance	Lines of assurance (positive/ negative)		
	Q1	Q2	Q3	Q4		1	2	3
Quality and Safety Strategy in place and approved by the Trust Board (January 2020) supported by an implementation plan	S	S	S	S	• Trust removed from Quality Special Measures in March 2020 following improvements documented in CQC inspection report published in Dec 2019 • Quarterly update reports to QSC re delivery against Quality and Safety Strategy year 2 implementation plan		X X	X
Serious Incident reporting and Investigation Policy including electronic incident reporting system (Datix) in place	S	S	S	S	• Weekly review of serious incidents at serious incident declaration meeting and monthly report to PSQG and QSC (Note the Trust is currently awaiting the new -Patient Safety Incident Reporting Framework) • Internal Audit report/internal management action plan: rated substantial assurance		X X	X X
Complaints Policy in place	G	G	G	G	• Quarterly complaints report to Patient Safety Quality Group identifying emerging themes and learning • Internal Audit report including internal management action plan: rated reasonable assurance • Learning from complaints included in divisional governance reports		X X X	X
Friends and Family Test – *SMS feedback method in place for virtual and face to face outpatient appointments* - Text messaging – SMS surveys for inpatient surveys setup. Ward display of FFT report 'You siad, we did'.	G	G	G	G	• Friends and Family Test: Monthly performance reports to QSC via IQPR		X	X
Infection Control Policy including Root Cause Analysis (RCA) for all C. Diff cases to ensure learning in place	S	S	S	S	• Infection control audit reports identifying emerging themes and improvement actions • Ward round monitoring to ascertain that infection control requirements are in place and followed and periods of increased Surveillance and Assessment (PISA)	X X	X X	
Early Warning Score training in place	G	R	R	R	• nEWS assurance audit	X	X	
Treatment Escalation Plans in place for all non-elective adult patients within 24 hours of admission	N/A	N/A	N/A	R	• Report to PSQG,		X	
Sepsis tool live on iClip	G	G	G	G	• Sepsis tool on iClip in place	X		
COVID-19 measures: patient testing, masks, and facilities	G	R	R	R	• Covid testing carried out on day 0, 3 and 7 of admission; Masks wearing for in-patients; Emergency floor development increased number of single isolation facilities • Daily compliance performance report for PCR testing	XX		
Governance structure – new positions all recruited to	R	R	R	G		X		
Life support training - Programme to increase the numbers of staff who have undertaken required life support training is in place	N/A	R	R	R	• March 2022 BLS 81.5%, ALS 76.2% and ILS 67.7%,	XX		

Strategic Objective	Treat the patient, treat the person	*Corporate Objectives 2021/22:*	*Care*
SR1	**Our patients do not receive safe and effective care built around their needs because we fail to build and embed a culture of quality improvement and learning across the organisation**		

Gaps in controls and assurances	Actions to address gaps in controls and assurances	Complete by (date)	Progress
Seven day clinical services standards (also see SR3)	**Implementation of Divisional action plans to achieve seven day clinical service standards compliance.** All Care Groups have updated their risk assessment. Directorates have defined plans to address all non- compliance. Capital works to install 2 static MRIs has commenced, with the equipment was expected to go-live in January 2022, however it has now been deferred to Spring 2022. Budget setting and job planning for 2021/22 will address a number of gaps in 7 day services.	~~Feb 2022~~ May 2022	
Early Warning Score electronic devices not reliable due to IT issues as patient observations are not visible by the bedside. Lack of handheld devices to facilitate nurses' awareness of vital signs	**Improve Early Warning Score electronic device availability in the wards through Wi-Fi and address cold spot** *Wi-Fi will be addressed through the ICT Network improvement Project which is expected to run until the end of 2022*	~~Dec 2021~~ Dec 2022	
Divisional reporting by ward to PSQG on the number of Treatment Escalation Plans in place for all non-elective adult patients within 24 hours of admission	**Commencement of divisional reporting on TEPs** The divisional reporting has commenced and TEP is part of the reporting template. Information available on Tableau and can be accessed at ward level. Data updated daily.	Close	
Appropriate level of training for Resus	Implementation of training needs analysis to support RNs undertaking BLS training instead of ILS TNA has just been approved at DMB level – to be presented at PSQG. Following approval, MAST team to implement the changes on the ARIS system	Sep 2022	

Strategic Objective	**Treat the patient, treat the person**		***Corporate Objectives 2021/22:***	***Care***
SR2	**We are unable to provide outstanding care as a result of weaknesses in our clinical governance**			

Risk Appetite / Tolerance	**LOW**	We have a **low appetite** for risks that affect the robustness of our clinical governance structures, systems and processes as these can impact directly on the quality of care patients receive.	**Assurance Committee**	**Quality and Safety Committee**
			Executive Group	Patient Safety and Quality Group
			Executive Lead(s)	Chief Nurse & DIPC Chief Medical Officer
			Date last Reviewed	24 March 2022

Current risk and assurance assessment

Risk score:
A change to the risk score for SR2 from 12 to 8 was agreed at the March Quality and Safety Committee meeting. The new risk score reflects the progress made in implementing the clinical governance improvement plan. The risk score for SR2 would reflect the target risk score set by the Board.

Assurance rating:
The assurance rating of good was agreed at the March Quality and Safety Committee meeting. This is on the basis of progress achieved in implementing the clinical governance improvement plan.

Changes since last quarter:
Risk score: A reduction in the risk score from 12 to 8
Assurance rating: Improvement from partial to good

Gaps in control and assurance addressed year-to-date:
There has been significant progress against the Clinical Governance Improvement programme. There are two outstanding actions from the phase 1 and 2 clinical governance reviews which will be taken forward under the remit of the Mortality Monitoring Group and three outstanding actions from the phase 3 review which require further work following the establishment of the St George's, Epsom and St Helier University Hospitals and Health Group which will be completed in Q1 2022/23. There are 5 further gaps in control where action is being taken

Overall SR Rating – Quarterly Scores

Period 2021/ 2022	Risk Score	Assurance Strength	Change (last reporting period)	Inherent Risk Score	Target Risk Score 2021/22
Q1	High 12= 4(C) x 3(L)	Partial	N/A	20 = 4(C) x 5(L)	8 = 4(C) x 2(L)
Q2	High 12= 4(C) x 3(L)	Partial	N/A		
Q3	High 12=4(C) x 3(L)	Partial	N/A		
Q4	Moderate 8 = 4(C) x2(L)	Good	Improved assurance, lower risk		

Emerging risks	**Future opportunities**
• Impact of any further Covid-19 waves • Impact of operational pressures on clinical governance meetings	• IT developments to support new ways of working e.g. care group meetings and communication

Strategic Objective	Treat the patient, treat the person	*Corporate Objectives 2021/22:*	*Care*
SR2	**We are unable to provide outstanding care as a result of weaknesses in our clinical governance**		

Key risk controls in place	Control effectiveness				Key sources of assurance	Lines of assurance (positive/ negative)		
	Q1	Q2	Q3	Q4		1	2	3
Action plan to deliver improvements identified by the CQC	S	S	S	S	• CQC action plan close report to QSC in May 2021 • One should do action remained open and monitored on an exception basis in PSQG (measures to avoid mixed sex breaches in children's services). Close report approved at PSQG in September 2021 and all actions completed	X	X	X X X
Board agreement to invest in identified improvements to clinical governance	S	S	S	S	• Phase 1 and phase 2 external governance reviews • Phase 3 report and Board approved analysis of outstanding recommendations • Actions from the external governance reviews integrated into the year 2 implementation plan for the Quality and Safety Strategy with quarterly updates reports to QSC		X	X X
Improvement plan for Cardiac Surgery services	S	S	S	S	• Independent external mortality review • CQC inspection report December 2019: recognised improvements in Cardiac Surgery governance processes • NICOR: The Trust is out of alert and is within the expected mortality range	X	X	X X X
Risk management framework in place	R	R	R	R	• CQC inspection report December 2019: negative references to documentation of risks on risk registers • Internal audit report 2021 gives reasonable assurance		X X	X X
Mental Capacity Act (MCA) and Depravation of Liberty Standards strategy in place	S	G	G	G	• MCA Steering Group reports to PSQG demonstrating progress against MCA strategy. MCA Steering Group to be re-launched in October 2021 due to changes in leadership		XX	
MCA level 1 and level 2 training programme in place	R	R	R	R	• MCA level 1 and 2 training levels across all staff groups reported	X X	X X	
Electronic templates for the recording of Capacity Assessment and best interest decisions	G	G	G	G	• Electronic templates for the recording of Capacity Assessment launched on 2 November 2020	X		
Medical Examiner System in place	S	S	S	S	• Medical Examiner office reviewed all non-coronial inpatient deaths in May 2020		X	X
Mortality Monitoring Committee and Learning from Deaths lead in place	G	G	G	G	• Learning from Deaths report including SHMI and sources of individual mortality alerts e.g. NICOR		X	
eDischarge summary live on iClip	R	R	R	R	• Trust does not comply with NHSE Standard Contract for Discharge Summary.	X		X
Governance structure – new appointed recruited to	R	R	R	R		X		
Agreed methodology for Consent and Trust lead in place	R	R	R	R	• Bi-annual Consent audit included in Audit Committee agreed Clinical Audit Programme 2021/22	X	X	

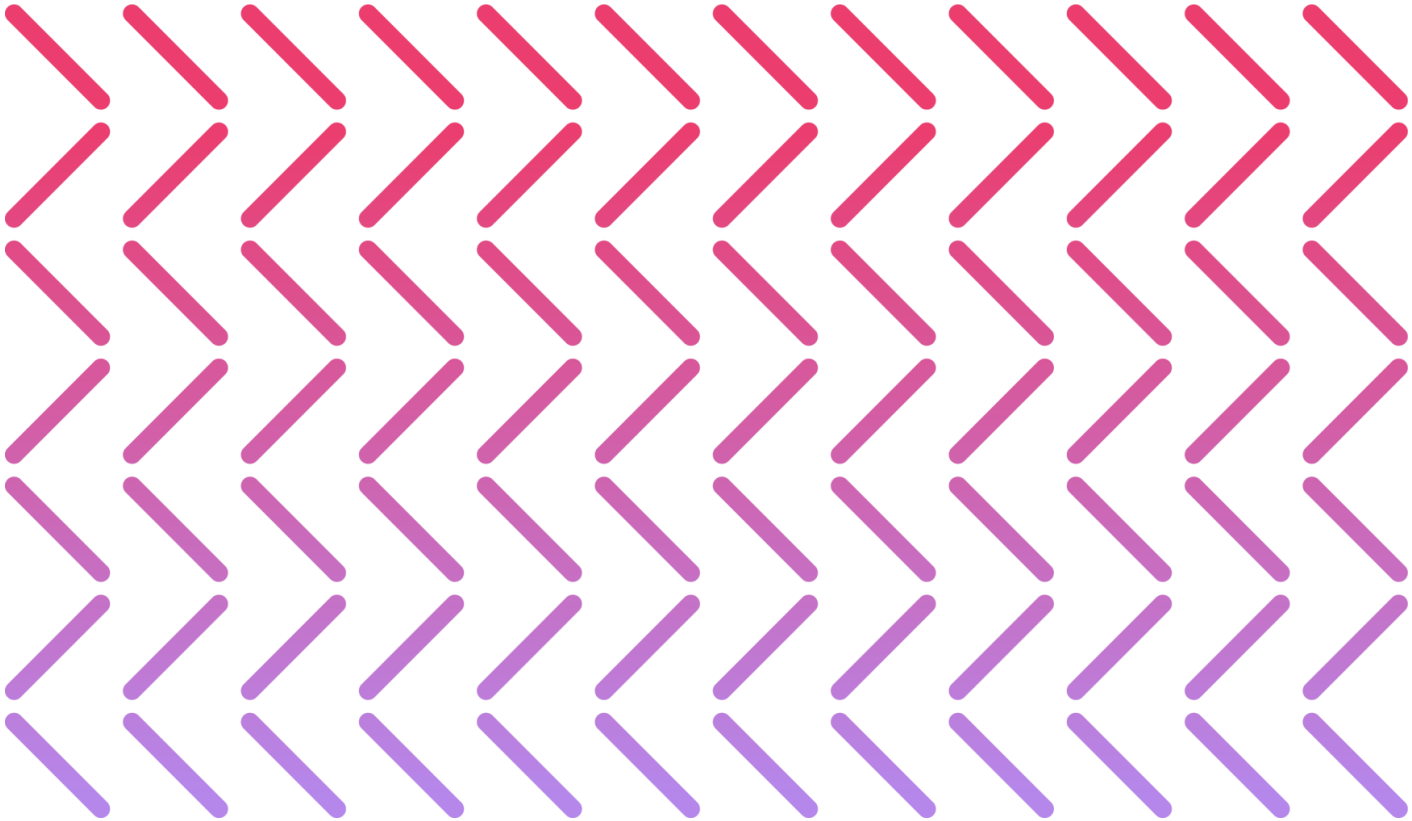
Strategic Objective	Treat the patient, treat the person	*Corporate Objectives 2021/22:*	*Care*
SR2	**We are unable to provide outstanding care as a result of weaknesses in our clinical governance**		

Gaps in controls and assurances	Actions to address gaps in controls and assurances	Complete by (date)	Progress
Areas for improvement identified by the three phases of the external clinical governance review	Delivery of the Clinical Governance Improvement Programme 2021/22, which incorporates all agreed recommendations from the three phases of the external clinical governance review. Latest update to QSC provided to the Mach 2022 QSC with the recommendation of the formal closure of the clinical governance improvement plan – not withstanding the remaining outstanding actions and their progress to completion.	Closed	
Full implementation of the Cardiac Surgery action plan to address all recommendations from the reviews	**Implement the Cardiac Surgery action plan** One remaining action left to be completed regarding medical staffing within CTICU out of hours, due to covid-19 pandemic this has not yet been addressed.	~~Oct 2021~~ Jun 2022	
MCA level 3 training module	**Develop and implement MCA level 3 training module. Level 3 / Champions programme** *The development of a level 3 MCA training programme has been paused. The programme will be developed as part of the preparation for the implementation of the Liberty Protection Safeguards.*	~~April 2022~~ Sep 2022	
OrderComms catalogue not kept up to date therefore not all results are reported via Cerner	**Update Cerner OrderComms catalogue:** *Delayed as resources diverted to set up COVID vaccine hub* The SWLP LIMS project is working through each discipline in terms of order comms and completing end to end testing of the orders between Clinisys WinPath Enterprise and all of the order comms systems in the sector including SGH's iCLIP. Due to the complexities and multiple stakeholders of SWLP the completion date has been moved to Jun 2022	~~Dec 2021~~ Jun 2022	
eDischarge Summary Form not available on iClip	**Finalise the eDischarge form to be included onto iClip:** The discharge MPage workflow went live within iClip during February 2022. This includes sections to be completed for different elements of the patients' clinical care, which contribute to the end production of the discharge summary. This has been adopted as standard, and ongoing support is available to embed the process.	Closed	
Liberty Protection Safeguards (LPS) process not yet issued by DoH	*Trust to implement LPS from April 2022 following DoH guidance. Consultation started in April 2022*	Sep 2022	

Strategic Objective 2: Right Care, Right Place, Right Time
Strategic Risks SR3 and SR4

SR3:
Our patients do not receive timely access to the care they need due to delays in treatment and the inability of our technology and transformation programmes to provide accessible care built around our patients' lives

SR4:
As part of our local Integrated Care System, we fail to deliver the fundamental changes necessary to transform and integrate services for patients in South West London



Strategic Objective	Right care, right place, right time	*Corporate Objectives 2021/22:*	Care

SR3	Our patients do not receive timely access to the care they need due to delays in treatment and the inability of our technology and transformation programmes to provide accessible care built around our patients' lives

Risk Appetite / Tolerance	LOW	We have a low appetite for risks that impact on operational performance as this can impact on patient safety, but our appetite here is higher than for risks that directly affect the safety of our services

Assurance Committee	Finance and Investment Committee
Executive Lead(s)	Chief Operating Officer
Date last Reviewed	22 April 2022

Current risk and assurance assessment

Risk score:
It is proposed that a risk score of 20 continues to reflect the level of risk in relation to both access to treatment and ICT.

Assurance rating:
Proposal for the assurance rating to be improved from Limited to Partial was agreed at the Finance and Investment Committee in January 2022

Changes since last quarter:
Risk score: Change only to configuration of the risk score to consequence = 4, likelihood = 5
Assurance rating: It is proposed that the assurance rating remains unchanged at 'Partial'. Whilst the grip, monitoring and assurance on mitigations is now 'good' for both operational delivery and IT, overall the Trust does not meet the standard outlined on slide 18 defining 'good' because performance does not meet one element of the assurance criteria, namely "Outcomes are generally achieved but with inconsistencies in some areas". In essence the control of the risks are good, but their impact is not completely mitigated hence remaining at 'Partial' assurance

Gaps in control and assurance addressed year-to-date:
The Trust has continued to demonstrate consistent delivery for Priority 1 patients (cancer and non-cancer, treat within 72 hours) and Priority 2 patients (cancer and non-cancer, treat within 28 days) and in Q2 has moved to treat lower priority patients. This means that we are treating patients with urgent clinical needs in a timely way.

The Flow Improvement Programme has commenced, with specific QI actions regarding RedtoGreen, morning discharges, timely completion of D2A referrals.

Overall SR Rating – Quarterly Scores

Period 2021/ 2022	Risk Score	Assurance Strength	Change (last reporting period)	Inherent Risk Score	Target Risk Score For 2021/22
Q1	Extreme 20= 5(C) x 4(L)	Limited	N/A	25 = 5(C) x 5(L)	15= 5(C) x 3(L)
Q2	Extreme 20= 5(C) x 4(L)	Limited	N/A		
Q3	Extreme 20=5(C) x 4(L)	Partial	↑ Improved Assurance		
Q4	Extreme 20=5(C) x 4(L)	Partial	N/A		

Emerging threats

The combination of increased patient acuity, ineffective speciality pathways caused by COVID wards (COVID and non-COVID patients) making patient flow slower; together with challenges in onward capacity in care homes / nursing homes means that there has been a fundamental mismatch between admission rates / length of stay and discharge rates on medical non-elective inpatient pathways, with significant deleterious impact on flow through the ED. This has caused 12 hour breaches for patients awaiting an inpatient bed and, on occasion, 60+ minute ambulance handover breaches, although George's continues to perform at or above average for the latter when compared against other London Trusts. Although performance for breast screening has returned to normal levels, a combination of staff sickness / pathway under-performance and ongoing increased referrals means that the TWR performance for breast has deteriorated further. Additional resourcing has been secured from January to address this, together with a number of operational actions to improve pathway management.

Future opportunities

The Trust continues to implement QI projects to optimise flow, and is supporting our community health partner in the implementation of a sub-acute Hospital@Home model, which takes patients home for treatment and care once the patient has been assessed, diagnosed and a treatment plan implemented by AMU. There is system commitment to expand and develop this service to minimise avoidable admissions for people with frailty / long term conditions if they can be cared for at home through this collaborative pathway, in line with the 2022/23 Operating Plan. There are also actions ongoing to expand the capacity and resilience of medical and surgical Same Day Emergency Care pathways (SDEC) which divert patients away from ED to speciality 'hot' clinics that can best meet their need and minimise numbers in ED.

Strategic Objective	Right care, right place, right time	*Corporate Objectives 2021/22:*	Care
SR3	**Our patients do not receive timely access to the care they need due to delays in treatment and the inability of our technology and transformation programmes to provide accessible care built around our patients' lives**		

Key risk controls in place	Control effectiveness				Key sources of assurance	Lines of assurance (positive/ negative)		
	Q1	Q2	Q3	Q4		1	2	3
Clinical Safety Strategy	S	S	S	S	Clinically driven plan agreed at Operational Management Group and approved at Quality and Safety Committee		X	
Insourced company to manage adult and paediatric ECHO.	R	R	R	A	Performance included in Integrated Quality and Performance Report (IQPR)	X	X	
Digital strategy - ICT Work plan aligned to Digital strategy	G	G	G	G	Digital strategy aligned to clinical strategy and outpatient strategy			XX
VDI	G	G	G	S	VDI project updates to IGG – project has completed	X	X	
Virtual clinics – video conferencing system with patients (Attend Anywhere) in use with supporting laptops, webcams and headsets installed; operational management by Corp OPD	R	R	R	G	Informatics Governance Group		X	
New workflow in iClip for Referral Assessment Service (RAS) clinics as part of Covid19 changes and rolled out to Trust as BAU	S	S	S	S	ICT Outpatient Project Steering Group and the Trust Communications news story published in Staff Bulletin 26 June 2020	X		
Provision of iCLIP clinic documentation for physical or virtual OPA available.	S	S	S	S	Trust Communications news story published in Staff Bulletin 26 June 2020	X		
Provision of Office365 and Microsoft Teams to support MDT cancer and orthopaedic meetings and further roll out in progress	S	S	S	S	ICT Covid-19 Service Management Report presented to IGG in April 2020 10,000 staff migrated to Office 365 with access to teams presented to IGG Oct 2020		X X	
ED rapid assessment and triage process in place	G	G	G	G	Clinical pathway and Standard Operating Procedure (SOP)	X		
Direct access pathways	G	G	G	G	Clinical Pathway and SOP	X		
Partnership working between ED and local Mental Health organisations to improve care and waiting time for patients attending the ED with mental health needs	R	R	R	A	Clinical Pathway, Memorandum of Understanding/ COMPACT, and local service performance metrics	X		
UCC direct pathways	G	G	G	G	Clinical Pathway and SOP	X		
Clinical Decision Outcome Form (CDOF) incorporated within iClip	R	R	R	R	eCDOF Tableau report showing operational non-compliance	XX		

Strategic Objective	Right care, right place, right time	*Corporate Objectives 2020/21:*	Care
SR3	**Our patients do not receive timely access to the care they need due to delays in treatment and the inability of our technology and transformation programmes to provide accessible care built around our patients' lives**		

Gaps in controls and assurances	Actions to address gaps in controls and assurances	Complete by (date)	Progress
Seven day clinical services standards	**Implementation of Divisional action plans to achieve seven day clinical service standards compliance.** All Care Groups have updated their risk assessment. Directorates have defined plans to address all non-compliance. Capital works to install 2 static MRIs has commenced, with the equipment was expected to go-live in January 2022, however it has now been deferred to Spring 2022. Budget setting and job planning for 2021/22 will address a number of gaps in 7 day services.	~~Sep 2020~~ ~~Feb 2022~~ ~~Apr 2022~~ May 2022	
Cyber security	Implement recommendation to improve cyber security - 2020/21 Project Plan – completed after penetration test. The network is segmented via VLAN, migration from N3 to HSCN done, password policy implemented. Forcepoint and IPS in place. Cyber Essentials Plus task and finish group underway to provide assurance for end December 2021. It is envisaged that this will not meet the standards as Agresso not updated until April 2022. Q4 update= CE+ assessment is being updated so during 22/23 the trust will evaluate the changes prior to seeking accreditation so due date modified	~~Mar 2021~~ ~~Dec 2021~~ ~~April 2022~~ Oct 2022	
ICT disaster recovery (DR) plan – require solution for 2nd data centre	Design ICT disaster recovery (DR) plan to include provision for second data centre Draft plan for hybrid model approved by IGG in Dec 2020; Site for a 2nd physical onsite data centre will be longer term depending on internal build such a renal unit, or availability in community or sites in SW London. Cloud solution for partial DR now purchased and being configured. Current phase is implementation, moving suitable systems across to cloud solution with view to reducing score when complete so due date modified but awaiting high speed VPN - delays due to resourcing constraints but new ICT Head and Deputy Head of Infrastructure now in post to complete the work. Funding to secured during 22/23 for the second data centre	~~Mar 2021~~ Oct 2022	
MDT teleconferencing for SWLP, equipment not yet provisioned; workflows changed due to Covid-19	ICT Project Plan 2020/21 to improve hardware and workflow for MDT teleconferencing. 4 rooms out of the original requirement for 6 rooms have been delivered. Delay completing as 2 further rooms need to be identified by organisation.	~~Sep 2020~~ ~~Sep 2021~~ ~~Dec 2021~~ Apr 2022	

Strategic Objective	Right care, right place, right time	*Corporate Objectives 2020/21:*	Care
SR3	**Our patients do not receive timely access to the care they need due to delays in treatment and the inability of our technology and transformation programmes to provide accessible care built around our patients' lives**		

Gaps in controls and assurances	Actions to address gaps in controls and assurances	Complete by (date)	Progress
Data warehouse capacity - not built to deal with current volume of data / continue use of paper based records. Cerner nightly extracts being terminated.	Project to improve data warehouse in capital plan 20/21 delayed due to Covid and now in 21/22 plan. Improvement project identifying alternative models of data management, with requirements developed to consider other organisations in SW London. Detailed project plan but not scheduled to complete until Nov 2022	~~Mar 2021~~ ~~Apr 2022~~ Nov 2022	
Multiple clinical systems which do not interoperate leading to fragmented clinical records (use of standalone systems not using patient MRN as single identifier)	Anaesthesia project to roll out Anaesthesia Module and retire paper charts during 2022 Funding secured for upgrade of Viewpoint and integration to iCLIP during 2022/23 and to replace the current maternity solution with iCLIP maternity solution which will be a 1year project Funding to be secured for integration projects of smaller standalone systems e.g. Auditbase and Optimum	~~Dec 2020~~ ~~Dec 2021~~ ~~Sept 2022~~ Sept 2023	
Sufficient availability of VDI upgrade to support remote working	VDI Horizon upgrade to Wini10 rolled out ~~.~~ VDI upgrade project has closed	Close	
ICT network infrastructure is old and not sufficiently resilient or able to meet today's demands for Wi-Fi and video-conferencing	Replacement of network core completed in Q2; additional requirements to implement DMZ being resourced; followed by campus network and Wi-Fi completing Q4 2022/23. Phased improvement over this time period.	~~Mar 2022~~ Dec 2022	

Strategic Objective	Right care, right place, right time		*Corporate Objectives 2021/22:*	Collaboration

SR4	As part of our local Integrated Care System, we fail to deliver the fundamental changes necessary to transform and integrate services for patients in South West London

Risk Appetite / Tolerance	MODERATE	Because we recognise that significant changes are necessary across the South West London system, we have a moderate appetite for risks that impact on system transformation and cross-system working in order to facilitate changes that will improve care for patients across South West London.

Assurance Committee	**Trust Board**
Executive Lead(s)	Chief Strategy Officer
Date last Reviewed	27 January 2022

Current risk and assurance assessment

Risk score:
The current risk score for SR4 of 12 continues to reflect the significance and importance of system working, and attendant risks.

Assurance rating:
The Board increased its assurance rating for SR4 from "partial" to "good" at Q4 2020/21, and a continuation of this position is proposed.

Changes since last quarter:
No changes to risk scores or assurance ratings since Q3.

Gaps in control and assurance addressed year-to-date:
During 2021/22, this risk has been mitigated by the establishment of new controls :

- The opening of the new modular surgery unit at Queen Mary Hospital as a centre for elective surgery which will assist the Trust and the wider SWL system reduce the elective backlog.
- The appointment of the Trust Chief Executive as Lead CEO for the SWL Acute Provider Collaborative
- Establishment of the St George's, Epsom and St Helier Hospital Group, including:
  - A single Executive team in place from 1 February
  - MoU and Information Sharing arrangements developed
  - Group governance arrangements developed
  - Appointments to key roles at Group and Site level made
  - Strengthened arrangements across Group for engagement at Place and with ICS
- Passage of Health and Care Act 2022 provides greater clarity about future system working arrangements.
- Executive Director appointments made to SWL ICB.

Overall SR Rating – Quarterly Scores

Period 2021/ 2022	Risk Score	Assurance Strength	Change (last reporting period)	Inherent Risk Score	Target Risk Score For 21/22
Q1	High 12= 4(C)x3(L)	Good	N/A	16 = 4(C) x 4(L)	12= 4(C)x3(L)
Q2	High 12= 4(C)x3(L)	Good	N/A		
Q3	High 12= 4(C)x3(L)	Good	N/A		
Q4	High 12= 4(C)x3(L)	Good	N/A		

Emerging risks

- The continued focus on the response to Covid-19 may put additional pressure on the clinical and management capacity within the Trust to focus on collaborating with system partners to transform services.
- System-wide financial pressures impacting on transformation opportunities

Future opportunities

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

Strategic Objective	Right care, right place, right time	*Corporate Objectives 2021/22:*	Collaboration
SR4	**As part of our local Integrated Care System, we fail to deliver the fundamental changes necessary to transform and integrate services for patients in South West London**		

Key risk controls in place	Control effectiveness				Key sources of assurance	Lines of Assurance (positive / negative)		
	Q1	Q2	Q3	Q4		1	2	3
The SWL ICS Programme Board on which the Trust CEO is a member	R	R	R	R	• CEO representation on the Board • Quarterly SWL ICS Updates to Trust Board		X	X
The Trust is a member of the SWL Acute Provider Collaborative	S	S	S	S	• The APC is chaired by the Trust CEO		X	X
SWL Covid-19 Recovery Structure has been established	R	R	R	R	• Trust representation on key workstreams • CEO is a member of the Recovery Board and chair of the Elective Recovery Programme		X	X
SWL Clinical Senate - set the clinical priorities for SWL	R	R	R	R	• The Trust is represented on the Clinical Senate by the CMO		X	X
SWL ICS Five Year Plan - the Trust contributed to developing the five year plan which set the priorities for SWL	R	R	R	R	• The Trust is represented at all SWL Integrated Care System meetings • The SWL ICS and Acute Provider Collaborative Forums allow general oversight of commissioner and provider plans to develop relationships outside the sector • The Trust is an active contributor to the key 'enabling' workstreams across the SWL ICS e.g. Workforce, Digital, Finance		X	X
SWL Covid-19 Recovery Plan - driving greater collaboration	R	R	R	R	• The Trust CEO is a member of the SWL ICS Covid-19 Recovery Board , Steering Group and is chair of the Acute Cell		X	X
The Trust Workforce Strategy approved by Trust Board in November 2019 – a key driver being delivery of the SWL five year plan as well as the Trust's clinical strategy	R	R	R	R	• Implementation plans are in place and being delivered against		X	
Annual review of Trust Strategy	S	S	S	S	• The review of Trust strategy undertook in June confirmed that the priorities are still relevant taking account the changes in the external environment.		X	
Trust contribution to the Wandsworth and Merton Local Health and Care Plans	R	R	R	R	• The Trust is represented on this Board and an active contributor to both of the Borough Health and Care Partnership Boards		X	X
Development of Group model to pursue closer collaboration between St George's and Epsom and St Heliers Hospitals	N/A	N/A	S	S	• Group model agreed and being implemented		X	

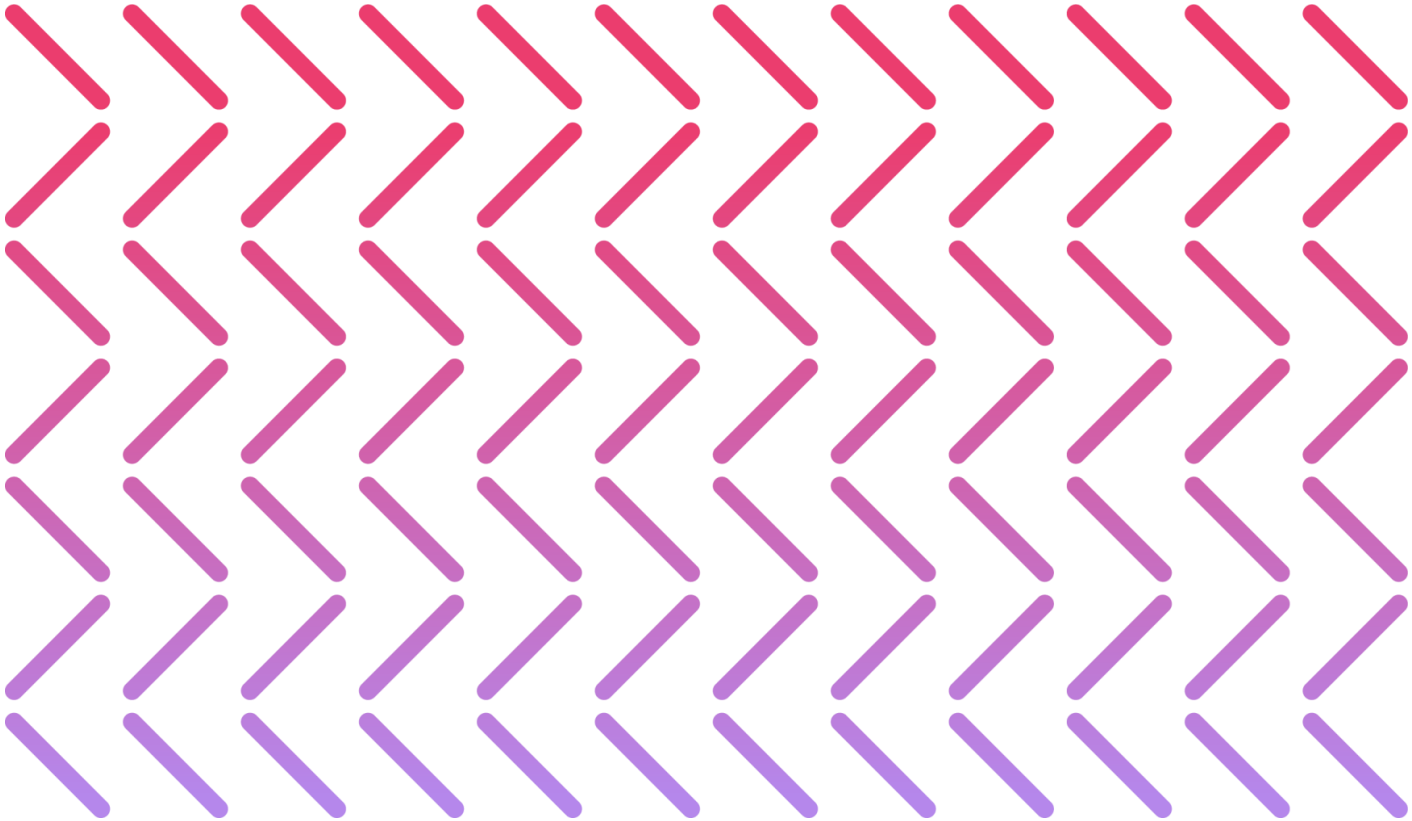
Strategic Objective	Right care, right place, right time	*Corporate Objectives 2021/22*	Collaboration
SR4	**As part of our local Integrated Care System, we fail to deliver the fundamental changes necessary to transform and integrate services for patients in South West London**		

Gaps in controls and assurances	Actions to address gaps in controls and assurances	Complete by (date)	Progress
Limited clinical and management capacity within the Trust to engage with and deliver the clinical priorities for Wandsworth and Merton as set out in their respective Local Health and Care Plans	Both Wandsworth and Merton Health and Care Partnership Boards are reviewing the priorities in the LCHPs in light of Covid-19 and changes to the ICS structure, and this will provide an opportunity to re-assess the Trust's role in delivering these (The Trust is represented on both Boards) Future business planning activities to take account of the Trust's contribution to delivering the key priorities in the LHCP. This action was originally envisaged as part of planning for 2021/22, but due to COVID-related disruption to the NHS planning cycle in that year will be addressed as part of planning for 2022/23.	~~March 2021~~ Mar 2023	
Impact of specialised commissioning devolution on the Trust's clinical service income	Engagement with the SWL system to shape arrangements for spec com devolution in SWL.	Jun 2022	

Strategic Objective 3: Balance the books, invest in our future
Strategic Risks SR5 and SR6

SR5:
We do not achieve financial sustainability due to under-delivery of cost improvement plans and failure to realise wider efficiency opportunities

SR6:
We are unable to invest in the transformation of our services and infrastructure, and address areas of material risk to our staff and patients, due to our inability to source sufficient capital funds



Strategic Objective	Balance the books, invest in our future
SR5	**We do not achieve financial sustainability due to under delivery of cost improvement plans and failure to realise wider efficiency opportunities**

Risk Appetite / Tolerance	**LOW**	We have a low appetite for risks that will threaten the Trust's ability to deliver services within our financial resources	**Assurance Committee**	**Finance and Investment Committee**
			Executive Lead(s)	Chief Finance Officer
			Date last Reviewed	24 March 2022

Current risk and assurance assessment

Risk score:
The current risk score for SR5 of 20 continues to reflect the level of financial uncertainty and risk the Trust faces in year, particularly in relation to the H2 position. What is known is that there will be more challenging targets around ERF income, and more challenging efficiency ask, and operational pressures requiring investment that are to create a material financial challenge. Reviewed and endorsed by Finance and Investment Committee on 24 March 2022

Assurance rating:
The Finance and Investment Committee endorsed an assurance rating of "partial" at its meeting on 23 September 2021.

Changes since last quarter:
No changes are proposed to the overall risk score or to the assurance rating at Q4 2021/22

Gaps in control and assurance addressed year-to-date:
Whilst the Trust is forecasting financial balance for 21/22, a material financial gap is currently forecast for 22/23 (£81m). On that basis, and whilst financial positions remain a work in progress until final submissions on 28th April, it is proposed that this strategic risks remains as a 20.

- A balance financial position for 21/22 is currently forecast, with significant levels of non-recurrent benefits required to achieve this position.
- A significant financial gap has been submitted as part of the first draft 22/23 financial plan (£81m), as additional cost pressures, and reduction in income envelopes are planned for 22/23.
- Actions to close this gap are being reviewed by both site, group, and ICS teams.

Overall SR Rating – Quarterly Scores

Period 2021/ 2022	Risk Score	Assurance Strength	Change (last reporting period)	Inherent Risk Score	Target Risk Score
Q1	Extreme 20 =5(c) x 4(L)	Partial	N/A	20= 5(c) x 4(L)	12 4(c) x 3(L)
Q2	Extreme 20 =5(c) x 4(L)	Partial	N/A		
Q3	Extreme 20 =5(c) x 4(L)	Partial	N/A		
Q4	Extreme 20 =5(c) x 4(L)	Partial	N/A		

Emerging risks

- Financial envelopes for 22/23 materially lower than current expenditure levels.
- Non-NHS income recovery will continue to be challenged.
- Competing priorities within divisions meaning finance isn't prioritised

Future opportunities

- Financial improvement/mitigation through further collaboration within the SWL ICS

Strategic Objective	Balance the books, invest in our future
SR5	We do not achieve financial sustainability due to under delivery of cost improvement plans and failure to realise wider efficiency opportunities

Key risk controls in place	Control effectiveness				Key sources of assurance	Lines of Assurance (positive / negative)		
	Q1	Q2	Q3	Q4		1	2	3
Monthly divisional finance meetings with in place with DCFO to discuss areas for escalation (underspends/overspends)	S	S	S	S	Monthly divisional finance reports	xx	xx	
Monthly reporting of financial issues through to OMG, TMG, FIC and Trust Board	S	S	S	S	Monthly Trust finance reports	xx	xx	
Monthly external review of Trust position by NHSE/I as part of monthly top-up payment review	S	S	S	S	Top up payment made to Trust		x	x
Financial plan in place, with monthly performance being scrutinised vs budget	S	S	S	S	Monthly report to Finance and Investment Committee			
South West London FAC continued to develop system financial management processes in support of delivery of control totals.	G	G	G	G	SWL Monthly Finance Report			x
Plan in place for financial balance in 21/22 , or in line with NHSI/E control total	P	P	s	s	Plan agreed as part of SWL for financial balance in 21/22. New financial frameworks expected to provide increased risk in H2			x
Plan in place for financial balance in 22/23			p		Plan continually being reviewed by FAC			

Strategic Objective	Balance the books, invest in our future
SR5	We do not achieve financial sustainability due to under delivery of cost improvement plans and failure to realise wider efficiency opportunities

Gaps in controls and assurances	Actions to address gaps in controls and assurances	Complete by (date)	Progress
South West London financial performance management structure in place to drive and ensure financial performance and best practise within sector	- Trust to lead development of financial governance with SWL ICB ahead of 22/23alongside change in governance structure at SWL level. - Framework agreed by CFOs and CEOs - Further work required to ensure full benefit realised from SWL working.	Sept 20	
Baseline budgets that are out of date with current situation	- Financial forecast to be developed to drive improvement and efficiency within divisional positions	Complete	
Lack of consistent performance management within divisions, down to directorate and Care Group level	- DCFO to seek assurance of divisional financial governance arrangement, and intervene where necessary. - Issues picked up by CFO following monthly review. Escalation in place via HoFs.	Complete	
No formal CIP plan of efficiency plan in place	- CIP/efficiency targets to be established alongside financial forecast - Limited is scope due to constraints of COVID - Trust reporting balanced financial position including some efficiencies. Delivery to be monitored through monthly reporting.	Complete	
Capacity plan not fully developed inline with new working environment post COVID	- Ongoing operational changes within the hospital are meaning this work is ever evolving and fluid. - Capacity plan to be agreed in line with financial forecasts and performance trajectories through OMG - Capacity plan agreed as part of activity trajectory's. Still a work in progress - Whilst complete for theatres and inpatient beds, further work required on outpatients.	Nov 21	
Lack of accountability within services for financial performance and delivery	- Ongoing operational challenges have delayed the implementation of this mitigation. - Finance to be included within objectives of all leadership posts with financial responsibility within the organisation	Nov 21	
Current forecast predicts material risk against current levels of funding	- Challenge to be made through divisional financial reviews - Issues to be raised through SWL ICS to NHSEI regarding funding shortfalls - Awaiting confirmation of M7-12 funding to confirm scale of challenge.	Complete	
Plan for H2 21/22 currently year still in infancy, with no clarity in level of income the Trust will be in receipt of for H2.	- Work up plans for H2, as much as practically possible with no planning guidance. - Await planning guidance for H2, and funding enveloped so scale of challenge, and action required can be confirmed.	Mar 22	
Plan for 22/23 beginning to be worked up, but currently showing material financial risk	- Plan to be developed internally within the Trust ahead of 22/23 - Plan to be developed alongside SWL ICS plans and financial envelopes - Planning guidance to be received, digested, and built into assumptions.	Apr 22	

Strategic Objective	Balance the books, invest in our future
SR6	We are unable to invest in the transformation of our services and infrastructure, and address areas of material risk to our staff and patients, due to our inability to source sufficient capital funds

Risk Appetite / Tolerance	LOW	Due to the importance of securing investment in the Trust's ageing estates infrastructure, we have a low appetite for risks that could impact on the availability of capital	Assurance Committee	Finance and Investment Committee
			Executive Lead(s)	Chief Finance Officer
			Date last Reviewed	24 March 2022

Current risk and assurance assessment

Risk score:
The current risk score of 20 reflects the challenges the Trust faces in relation to capital funding. SWL has mitigated the capital over commitment it had through additional funding confirmed through the Targeted Investment Fund. However, the Trust has not yet been able to confirm funding to address the 22/23 capital requirement, and doesn't currently have funding confirmed for the 5 year capital from 22/23 and beyond. It is expected that 3 year CDEL allocations will be received at ICS level in the coming weeks.

Assurance rating:
The Finance and Investment Committee endorsed an assurance rating of "partial" at its meeting on 23 September 2021.

Changes since last quarter:
No changes in risk score or assurance rating.

Gaps in control and assurance addressed year-to-date:
During 2021/22 the Trust pursued emergency funding through the ICS to NHSEI and alternative methods of financing the programme have been developed by the DCFO. Whilst the Trust currently has its capital programme fully funded for 21/22, next years capital plan, and 23/24 onwards remains a significant challenge with many high risks schemes falling outside of expected allocations. For this reason, it is recommended that this risks remains at a 20

There is one proposed change to individual risk score – "Funding for current year capital plan" - as this now looks at both the in year capital plan, but also the 22/23 capital plan. Whilst the 2021/22 capital plan remains funded, next years plan remains materially underfunded, so a move from an 8, to a 20 (5x4) has been approved at the March Finance and Investment Committee to reflect the increased risk in the year ahead.

Overall SR Rating – Quarterly Scores

Period 2021/ 2022	Risk Score	Assurance Strength	Change (last reporting period)	Inherent Risk Score	Target Risk Score
Q1	Extreme – 20=4(c) x 5(L)	Partial	N/A	20 = 4(c) x 5(L)	12 4(c) x 3(L)
Q2	Extreme – 20=4(c) x 5(L)	Partial	N/A		
Q3	Extreme – 20=4(c) x 5(L)	Partial	N/A		
Q4	Extreme – 20=4(c) x 5(L)	Partial	N/A		

Emerging risks	Future opportunities
- Funding for 21/22 BAU and projects identified - Funding relating to the Trusts key strategic priorities, and the estates strategy is still to be confirmed for 22/23 and beyond.	- Emergency capital funding made available from NHSE/I - Further prioritisation within SWL to move money to address material and urgent risk at St George's.

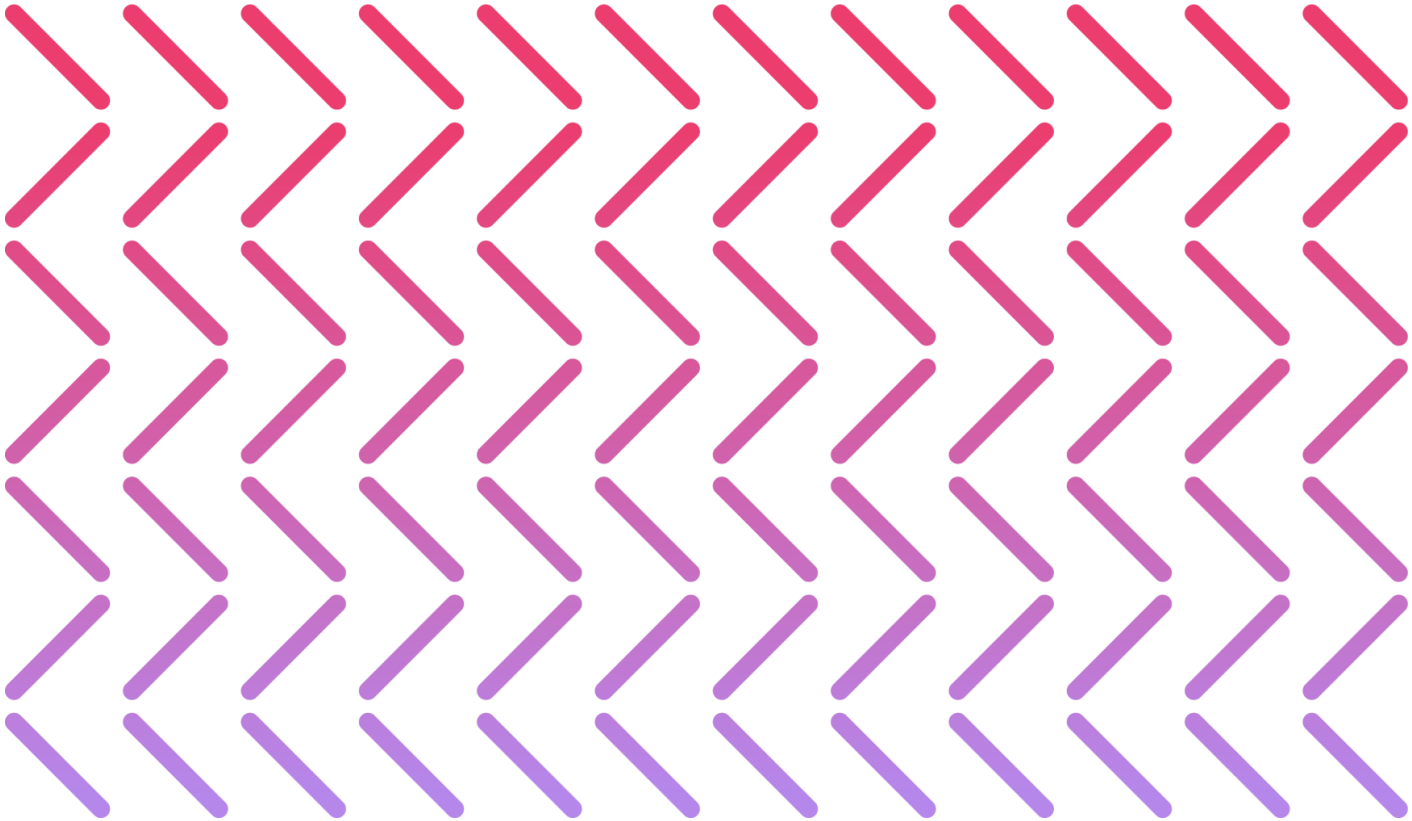
Strategic Objective	Balance the books, invest in our future
SR6	We are unable to invest in the transformation of our services and infrastructure, and address areas of material risk to our staff and patients, due to our inability to source sufficient capital funds

Key risk controls in place	Control effectiveness				Key sources of assurance	Lines of Assurance (positive / negative)		
	Q1	Q2	Q3	Q4		1	2	3
Monthly reporting to FIC and Trust Board on key areas of risk, both financially, and due to non-investment.	S	S	S	S	Monthly finance reports		X	
Weekly Capital funding update and discussion, to review clinical urgency of requests.	S	S	S	S	Weekly update to OMG on status of COVID capital bids		X	
Evolution and development of capital prioritisation at SWL level through CFO meeting (FAC)	S	S	S	S	SWL Capital Plan report		X	

Gaps in controls and assurances	Actions to address gaps in controls and assurances	Complete by (date)	Progress
Confirmation of emergency financing to fund essential programme of capital works within CDEL allocation	Pursue emergency funding through the ICS through to NHSI/E London through CFO Emergency funding application submitted and with national team Additional CDEL allocation pursued to mitigate critical infrastructure risk with NHS London	Aug 21	
No alternative means of financing identified to fund programme	Alternative methods of financing current programme to be developed by DCFO Further work is ongoing to ensure all options are explored between now and the end of the year.	Mar 22	
Confirmation of funding for 21/22 programme in place	Mitigation developed via successful Targeted Investment Fund bids.	Mar 22	
Confirmation of funding for 22/23 programme and beyond in place	Further work required through ICS to ensure funding for 21/22 in place.	Mar 21	

Strategic Objective 4: Build a better St George's
Strategic Risk SR7

SR7:
We are unable to provide a safe environment for our patients and staff and to support the transformation of services due to the poor condition of our estates infrastructure



Strategic Objective	Build a better St George's	*Corporate Objective 2021/22*	*Care*

SR7	We are unable provide a safe environment for our patients and staff and to support the transformation of services due to the poor condition of our estates infrastructure

Risk Appetite / Tolerance	LOW	We have a low appetite for risks that affect the safety of our patients and staff

Assurance Committee	**Finance and Investment Committee**
Executive Group	Risk and Assurance Group
Executive Lead(s)	Chief Finance Officer
Date last Reviewed	24 March 2022

Current risk and assurance assessment

Risk score:
Based on the improving physical and control environment, it is proposed to reduce our risk score from 20 to 16 by reducing the likelihood score from 5 to 4.

Assurance rating:
Based on the independently verified assurance reports, it is proposed to improve our assurance rating to Good

Changes since last quarter:
Improvements are proposed to both the risk score and assurance rating

Gaps in control and assurance addressed year-to-date:

- In terms of the physical environment, we have continued to invest capital to reduce our maintenance backlog, improve electrical, fire and water infrastructure whilst also improving the clinical service environment in key areas such as ED and cardiac catheter labs. New investments in the MRI and ITU buildings will come on line in the coming months.
- We have improved our internal processes on assurance together with revitalising our assurance reviews. This has been reflected by seeing good reports from our authorised engineers on fire and water assurance, both of which noted the continued process of improvement to both the physical environment and management systems.
- Moving forward, reducing the risk further will still require investment in infrastructure, particularly fire. This requirement is being collated into an overall capital programme, with a number of approaches to be detailed, in the work to develop our estate strategy into a strategic outline case.

Overall SR Rating – Quarterly Scores

Period 2021/ 2022	Risk Score	Assurance Strength	Change (last reporting period)	Inherent Risk Score	Target Risk Score For 2021/22
Q1	**Extreme 20 = 4(c) x 5(L)**	Partial	N/A	**25 = 5(C) x 5(L)**	**16 = 4(C) x 4(L)**
Q2	**Extreme 20 = 4(c) x 5(L)**	Partial	N/A		
Q3	**Extreme 20 = 4(c) x 5(L)**	Partial	N/A		
Q4	**Extreme 16=4(C) x 4(L)**	Good	⇧ Increase Assurance - ⇩ Decrease Risk Score		

Emerging risks

- Lack of long term capital availability affects ability to plan and deliver improvements
- Failure to secure HIP funding as first building block of estate strategy
- Relationship with University blocks future development of the site

Future opportunities

- Alternatives to HIP scheme being developed by estate strategy team
- Improving relationship with University may unlock future development opportunities
- Working with commercial partners to source alternative means of development / funding

Strategic Objective	Build a better St George's	*Corporate Objective 2021/22*	*Care*
SR7	**We are unable provide a safe environment for our patients and staff and to support the transformation of services due to the poor condition of our estates infrastructure**		

Key risk controls in place	Control effectiveness				Key sources of assurance	Lines of Assurance (positive / negative)			
	Q1	Q2	Q3	Q4		1	2	3	4
Risk adjusted backlog maintenance programme informed by Authorised Engineer reports and independent condition surveys	S	S	S	S	The most recent independent reports have shown good levels of assurance Safety working groups are now all meeting again PAM now provides enhanced assurance, this has now been assessed externally and improvements being implemented.. CQC report 2019 - technical assurance has been provided on the key areas of concern where reactive maintenance could potentially impact patient care		X	X X X X	X X X X
Investment profile provides plans to manage backlog maintenance investment	W	W	W	W	Longer term capital planning is still a concern but is due to be addressed in the next financial year		X		
Governance systems in place to provide oversight on critical estates issues	P	P	P	P	The PAM has been submitted for 20-21 and actions are being monitored. Costed action plans need further development due to the changes with the Estates strategy.			X	
Estate Assurance Group to review all key assurance and activities	P	P	P	S	The Group is now meeting regularly to review key assurance activities		X X		X
Green Plan	N/A	S	S	S	A first Green Committee has been held and more detailed action planning is underway		X	X	
Estates Strategy	N/A	S	S	S	Estates strategy is now being developed into a Strategic Business Case which will provide further details on options and implementation		X		X

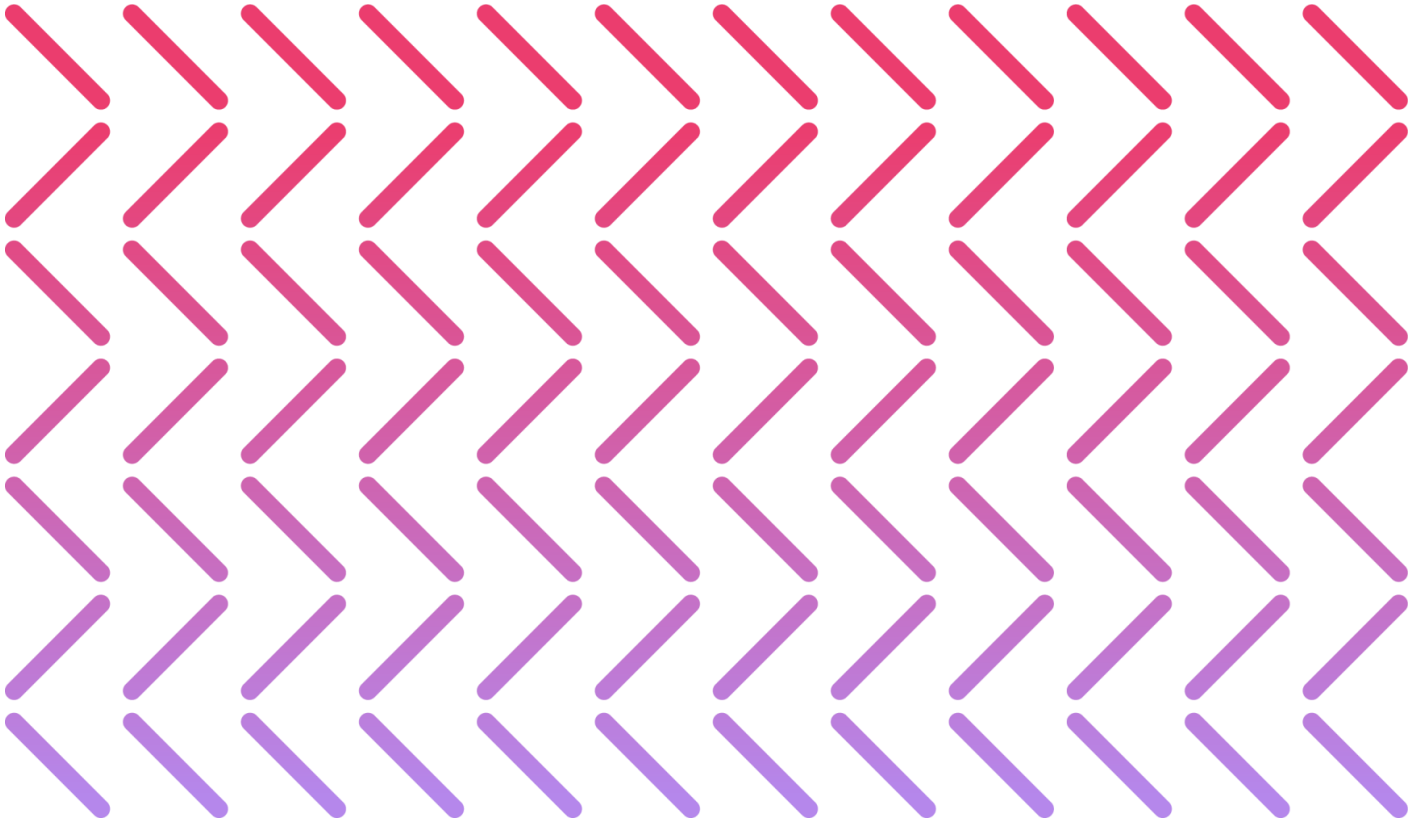
Strategic Objective	Build a better St George's	*Corporate Objectives 2021/22:*	Care
SR7	**We are unable provide a safe environment for our patients and staff and to support the transformation of services due to the poor condition of our estates infrastructure**		

Gaps in controls and assurances	Actions to address gaps in controls and assurances	Complete by (date)	Progress
No centralised data management system in place to ensure all required information is available and coordinated	We have a dedicated resource working on our data management system. We believe we have now found a suitable system, that was been developed jointly by Trusts in NW London and are looking to join their consortium to bring together our ERIC / PAM / Asset data into a single cloud database. We are developing a business case to deliver this and anticipate a first draft of this being available in Q1 22/23	~~Jan 2022~~ Jun 2022	
Governance groups are not aligned with new wider assurance arrangements	This work has now been agreed and implemented	~~Feb 2021~~ Dec 2022	
Capital plan for the next 3-5 years	A 5 year capital plan has been agreed with Finance. This will be further detailed by the Estate Strategy SOC work, looking to extend the plan to 10 years if possible.	Mar 2022	
Estates restructure	This work has been delayed due to the need to respond to COVID pressures but is being prioritised over the coming months	~~Mar 2022~~ July 2022	

Strategic Objective 5: Champion Team St George's
Strategic Risks SR8 and SR9

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

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



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

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

Risk Appetite / Tolerance	LOW	Due to concerns around bullying and harassment and the ability of staff to speak up without fear, we have a low appetite for risks that could impact on the culture of the Trust

Assurance Committee	**Workforce and Education Committee**
Exec Review Group	People Management Group
Executive Lead(s)	Chief People Officer
Date last Reviewed	8 April 2022

Current risk and assurance assessment

Risk score:
The current risk score for SR8 of 16 reflects the level of risk in relation to culture across the organisation. The strengthening culture action plan has been developed and is now being implemented, which is monitored via the Culture, Equality and Inclusion Programme Board on a monthly basis.

Assurance rating:
It is proposed that we maintain the assurance rating at Good for Q4 to reflect the progress the Trust has made in mitigating the SR8 during 2021/22 but also the challenges the Trust still faces as shown in various staff surveys conducted.

Changes since last quarter:
No changes compared with Q3.

Gaps in control and assurance addressed year-to-date:
During 2021/22 the risk has been mitigated by the completion of a number of identified gaps in controls:

- There is clear governance and reporting through the Culture Diversity and Inclusion Programme Board, which meets on a monthly basis to review action plans and monitor progress.
- Successful recruitment to the OD team
- Staff Survey 2020 priorities developed into implemented Big 5
- Quarterly Pulse Survey implemented.
- New IT system implemented for recording PDRs.
- Management Fundamentals training outlined and due for design and implementation in May 2022.
- Progress has been made in delivering the D&I action plan to date, which is now being implemented
- Progress has been made in implementing the FTSU strategy to date
- Staff Networks have been established with Terms and References and appointed Chairs

Overall SR Rating – Quarterly Scores

Period 2021/ 2022	Risk Score	Assurance Strength	Change (last reporting period)	Inherent Risk Score	Target Risk Score For 2021/22
Q1	Extreme 16= 4(C) x 4(L)	Good	Improved assurance	20 = 4(C) x 5(L)	12 = 4Cx3L
Q2	Extreme 16= 4(C) x 4(L)	Good	N/A		
Q3	Extreme 16= 4(C) x 4(L)	Good	N/A		
Q4	Extreme 16= 4(C) x 4(L)	Good	NA		

Emerging risks

- Impact of Covid-19 on staff health and well-being continues to be significant issue.
- Covid-19 has led to the cancellation and / postponement of a range of training and development opportunities for staff, including management training
- Risk that culture programme does not deliver anticipated changes / improvements

Future opportunities

- Delivery of the culture change programme
- Embedding support for staff health and wellbeing into plans for recovery of services
- Learning from Trusts with positive FTSU cultures and from NHSE&I's ongoing support on FTSU.
- Intelligence from latest NHS staff survey can be used to further inform and develop our plans for supporting staff and developing our culture change programme.

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

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

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

Gaps in controls and assurances	Actions to address gaps in controls and assurances	Complete by (date)	Progress
Positive shift in culture whereby staff feel engaged, safe to raise concerns and are empowered to deliver outstanding care	Complete culture diagnostics phase and define action plan to address key findings Diagnostic phase completed 11/2020, Design phase in progress (output = action plan to address key findings) completed 05/2021. Action plan now agreed by Board and high level implementation begun. This is completed, action plan in place and monitored via the CEI programme board and PMG on a monthly basis.	Complete	
Time allocation of Network Chairs and member engagement in network activity not clearly established	Develop proposal to address challenges faced by D&I staff networks (including time allocation of Network Chairs and member engagement in network activity, and undertaken work to finalise proposals with Network Chairs Proposal approved (reviewed ToRs) Network Chairs established and proposal agreed, ToRs have been developed.	Complete	
Not all D&I network chairs are in place	Recruitment of new D&I network chairs Currently in the process of advertising and recruiting new D&I network chairs All D&I network chairs in place, recruitment is complete.	Complete	
Need for skilled Organisational Development capability and capacity to deliver agreed culture programme and D&I interventional activities and training programme	Build Organisational Development capacity for the delivery of the D&I and Culture programmes Operational pressures due to Covid have redirected focus on health and well-being, development of OD capacity plan has been delayed. Business case for support for Culture programme approved by Trust Management Group on 14 July 2021. Recruitment for 2 OD for the D&I programme complete. Leadership and Talent role has not yet been appointed into, partial completion.	~~Mar 2021~~ ~~Sept 2021~~ ~~Mar 2022~~ Jun 2022	
Trust wide culture change programme not having the desired impact at local level at this stage for local clinical areas that are currently experiencing behavioural / culture change issues	Direct OD resources to support local culture change Interventions at local level. The local culture change action plan will be connected to the Trust wide culture change programme via the CEI programme board – this will address issues raised by learners and doctors in training. The additional ~OD resources in place – nominate OD to establish a governance process for focusing OD interventions at a local level.	Complete	
Staff do not feel safe to raise concerns and lack confidence that actions will be taken where concerns are raised	Implementation of 2020/21 FTSU action plan, including development of FTSU Charter, revision of raising concerns policy, development of JD for FTSU champions, review of FTSU champions network, development of reporting pack on concerns for sharing / engagement with divisions. FTSU Charter and Raising Concerns group to be launched in Q1 2022/23. FTSU Policy and processes is being reviewed in the context of the establishment of the new Group model with ESTH, with a view to having a common approach across the two trusts.	July 2022	
Current leadership programme does not cover all leaders within the Trust	Develop Leadership skills programme for all team leaders, leadership programme for consultants and medical staff Management fundamentals programme for all staff has been outlined and is currently in design phase, implementation planned for May 2022. Leadership programme for Consultants and Medical staff is in design phase.	~~Mar 2022~~ May 2022	
Produce Equality Delivery System (EDS2) report	The Trust is required to produce and publish a summary of our EDS2 implementation.	Mar 2023	

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

Risk Appetite / Tolerance	**LOW**	Due to concerns regarding quality and diversity in our workforce, we have a low appetite for risks relating to workforce. However, in relation to developing future roles and recruitment and retention strategies our risk appetite is higher

Assurance Committee	**Workforce and Education Committee**
Exec Review Group	People Management Group
Executive Lead(s)	Chief People Officer
Date last Reviewed	8 April 2022

Current risk and assurance assessment

Risk score:
It is proposed that the risk score be decreased to a score of 16 (4C x 4L). This reflects the Government's decision to revoke the Vaccination on Condition of Deployment (VCOD) regulations, which was previously approved as an extreme risk on the corporate register. There has been partial completion on a number of gaps in controls and assurances, however several remain open for completion in the new financial year.

Assurance rating:
An assurance rating of 'partial' was agreed by WEC for Q4 2021/22, It is proposed that we maintain the assurance rating at 'partial' for Q4

Changes since last quarter:
Risk score: Proposed for downgrading to 16(4x4) reflecting in particular the revocation of VCOD
Assurance rating: Given that a significant number of gaps in control and assurance remain, and the complexity in completion of actions, it is not considered the appropriate time to increase the assurance rating.

Gaps in control and assurance addressed year-to-date:
During 2021/22 the risk has been mitigated by the completion of a number of identified gaps in controls:

- The Workforce Strategy was reviewed and refreshed, with an implementation plan reviewed and communicated to PMG and WEC;
- The King's Fund leadership programme for Deputy General Managers and Service Managers has been delivered
- The matron and senior clinical leaders programme has been delivered;
- Divisional workforce plans have been developed and are due to be circulated in April 2022;
- The governance process has been established for extended roles – an ACP Steering Group has been established and approval given for a Chief Physician Associate;
- Revised Apprenticeship Plan has been agreed and approved at PMG.

Overall SR Rating – Quarterly Scores

Period 2021/ 2022	Risk Score	Assurance Strength	Change (last reporting period)	Inherent Risk Score	Target Risk Score For 2021/22
Q1	**Extreme 16 = 4(C) x 4(L)**	Partial	N/A	**20 = 4(C) x 5(L)**	**12 = 4C x 3L**
Q2	**Extreme 16 = 4(C) x 4(L)**	Partial	N/A		
Q3	**Extreme 20 = 4(C) x 5(L)**	Partial	⇧ Increase in Risk Score		
Q4	**Extreme 16 = 4(C) x 4(L)**	**Partial**	⇩ Decrease in Risk Score		

Emerging risks

- Staff remote working requirements
- Scaling back of HEE funding
- Establishment of clear governance arrangements for SWL Recruitment Hub (SLAs, KPIs)
- Risk against recruitment targets linked to continuing pressures experienced by staff leading to sickness and subsequent leavers

Future opportunities

- Further collaboration with SWL ICS and the Acute Provider Collaborative
- Development of different roles
- Links to University – opportunity to develop more 'in-house' training / courses with the university, cost effective, accredited
- Apprenticeships

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

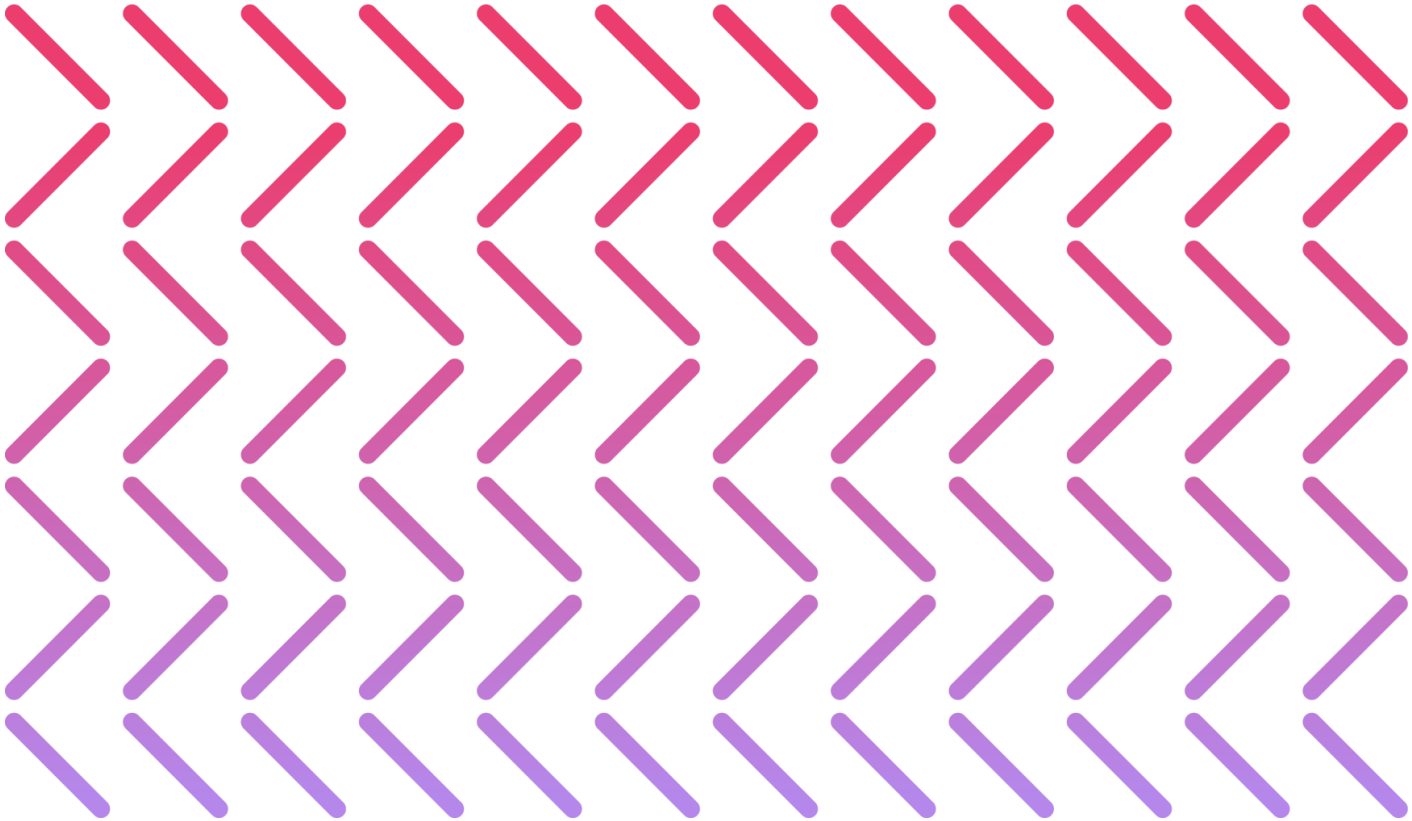
Key risk controls in place	Control effectiveness				Key sources of assurance	Lines of Assurance (positive / negative)		
	Q1	Q2	Q3	Q4		1	2	3
Workforce Strategy in place and approved by the Trust Board (Nov 2019)	S	S	S	S	Refresh workforce strategy submitted to September WEC		X	
Workforce strategy implementation plan -	S	S	S	S	Quarterly report to Trust Board Update workforce strategy implementation plan progress report submitted to PMG and WEC on a quarterly basis		X X	
Education Strategy in place and approved by the Trust Board (Dec. 2019)	S	S	S	S	Education strategy implementation progress report to WEC		X	
Education implementation plan	S	S	S	S	Monthly Strategy group meeting to monitor progress with all key stakeholders		X	
Development of new roles (i.e. ACPs) to help fill the gaps in vacancies	S	S	S	S	Workforce report to PMG and WEC		X	
Monthly review of the funded establishment	S	S	S	S	Monthly reports to Trust Board		X	
Advanced Clinical Practitioner Working Group established to work with HEE	G	G	G	G	Working group reports quarterly to PMG		X	
Recruitment open days for healthcare assistants and nursing now run by the Recruitment Hub.	S	S	S	S	Quarterly report received from Recruitment Hub.		X	X
Appraisal training sessions / ad hoc training in place	R	R	R	R	Training completion log in Education Centre booking system		X	
New compliant (section 1 update) contracts of employment templates on TRAC	S	S	S	S	New contract uploaded that is being issued to new starters (from 01/10/2020)	X		
Performance and Development Review (Appraisal) guidance reviewed and in place. Totara system upgraded	W	R	R	R	Appraisal completion monitoring via ESR, appraisal training available for all appraisers. PDR system transformation programme	X		
CPD funding system process	G	G	G	G	Funding established for NMAP staff. Progress review submitted to PMG and WEC in October 2021		X	
Apprenticeship Strategy	R	R	R	G	Apprenticeship plan reviewed and approved at PMG		X	
Disciplinary policy in place which includes 'Dido Harding' approach. Staff trained on the new approach to disciplinary cases	S	S	S	S	Policy in place and staff trained to support (completed Nov 2020)		X	
Flexible Working Policy/procedure implemented	S	S	S	S	On intranet, available to staff.		X	
Process to keep records for honorary contracts	S	S	S	S	New process established and list of honorary contract holders now reconciled with ESR	X		

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

Gaps in controls and assurances	Actions to address gaps in controls and assurances	Complete by (date)	Progress
Trust-wide workforce plan that sets out recruitment requirements for 2021/22	Divisional workforce plans to be produced by HR Business Partners and these will lay out clear workforce planning. Workforce plans being devised - currently being reviewed Active discussions are underway in divisions, supported by HR Business Partners to land divisional workforce plans in April 2022.	~~Mar 2021~~ ~~Apr 2021~~ ~~Aug 2021~~ May 2022	
Governance process for existing extended roles – ACPs and PA	Deploy new roles on relevant patient pathway – for ACPs and PAs Delayed due to 2nd Covid surge. Roles have been deployed. Appropriate governance has now been put in place. The ACP Steering Group approves training posts and JDs. Mapping ACP roles with the national framework, to ensure they meet HEE standards and to support in accessing accredited modules if necessary. Developing the Physician Associate Workforce for the Future was presented at PMG in January 2022 and agreement was given to recruit a Chief PA at 8b. Consultant Job plans are being reviewed to ensure appropriate clinical supervision for PAs and an education programme/CPD budget - applied for WFD funding from ICS to support partial CPD requirements	~~Mar 2021~~ ~~Jul 2021~~ ~~Sept 2021~~ May 2022	
Structured identification and development of new roles required to deliver patient care	Develop governance process for the identification of new roles and required funding. On-going identification of new roles and development governance process for the new roles identified - Identified training needs required and funding where relevant Delayed due to 2nd Covid surge. Identification of new roles included in divisional workforce plans to be circulated in April 2022. Central governance of newly established roles will form part of the wider workforce plans for the new Deputy CPO to coordinate.	~~Mar 2021~~ ~~Jul 2021~~ ~~Sept 2021~~ July 2022	
International Recruitment Strategy for hard to recruit to posts	HRBPs to identify hard to recruit to posts . ACPW - Develop an International Recruitment Strategy working with SWL APC Recruitment Hub Delay due to competing interests post-Covid surge. International recruitment strategy to be included as part of the corporate workforce plans to be circulated in April 2022.	~~Mar 2021~~ ~~Apr 2021~~ ~~Sept 2021~~ May 2022	
Comprehensive Apprenticeship Strategy	Rework apprenticeship strategy. Apprenticeship manager has been recruited to facilitate the implementation of the Apprenticeship strategy. Apprenticeship Roles to be identified. Strategy being reformulated. Revised action plan approved at PMG, which will be overseen by a working group which is due to be established.	Complete	
Trust-wide workforce plan that sets out education & development needs to upskill existing and future workforce	Develop Trust-wide workforce plan that sets our Education & Development needs: HRBPs to Conduct Training Needs Analysis for each division by staff group; *Deliver advanced leadership programme*; Develop programme of blended on-line/face-to-face training Delayed due to capacity issues. HRBPs not completed TNA due to operational pressures, the education team will conduct a TNA for 2022/23, working with the HRBPs to develop plans for divisions.	~~May 2021~~ ~~Sept 2021~~ May 2022	
No minimum CPD funding allocated for non-NMAP staff	Include the CPD funding for non-NMAP into the 2021/22 business planning process Partial funding secured – currently reviewing for 2022/23 requirements. Bid has been submitted to PMG (02.03.22) and to be reviewed by finance as part of 2022/23 business planning process.	~~Jul 2021~~ Mar 2022	
Senior leadership that reflects the diversity of the workforce	Develop inclusive talent management, succession planning and career planning pathways. Further embed fair and equitable recruitment & selection process at senior level (further intervention over and above a RIS on every recruitment panel is needed. Leadership and talent management lead post approved (band 8b) - to be advertised. Unsuccessful in appointing, therefore will be advertised again.	~~Oct 2021~~ ~~Mar 2022~~ Aug 2022	
Inadequate ICT infrastructure, hardware and software to access on-line learning	Established Education Delivery IT (EDIT) Group to review current position on training delivery technology, future design and gap analysis. The group includes representatives from IT. 2022/23 review is being planned. Group has been established. Premises are a challenge, and therefore capital plans are being reviewed.	~~Oct 2021~~ Dec 2022	

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

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



Strategic Objective	Develop tomorrow's treatments today	*Corporate Objectives 2021/22:*	Collaboration

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

Risk Appetite / Tolerance	HIGH	We have a high appetite for risks in this area in order to pursue research and innovation

Assurance Committee	**Quality and Safety Committee**
Executive Group	Patient Safety and Quality Group
Executive Lead(s)	Chief Medical Officer
Date last Reviewed	24 March 2022

Current risk and assurance assessment

Risk score:
The current risk score for SR10 of 9 continues to reflect the level of risk in relation to research, which balances the strong progress on Covid research against the impact of the pandemic on non-Covid research and the continuing absence of clarity on funding.

Assurance rating:
We have considered whether the assurance rating can be upgraded. While the assurance rating is "good", it is not considered to yet meet the requirements of "substantial" given the impact of Covid and the limitations on the Trust's control environment to mitigate to the risk to non-Covid research.

Changes since last quarter:
No changes are proposed to the overall risk score or to the assurance rating
Risk score: Unchanged due to ongoing actions to mitigate risk and address gaps due for completion later in the year.
Assurance rating: Some slippage in the actions that address gaps

Gaps in control and assurance addressed year-to-date:
Three actions to address identified gaps in control and assurance were due for completion in Q3 2021/22. The Translational & Clinical Research Institute (TACRI) is fully functioning and this action has been removed. The other two actions have been deferred for completion in December 2022. Appointing clinical academics is dependent on the Trust research strategy being fully funded – this is not yet confirmed and is being considered in the business planning process. The set up of a research data warehouse has been stalled pending the appointment of a contractor for the data warehouse – now that Bedrock have been appointed, work will progress on the research component.

Overall SR Rating – Quarterly Scores

Period 2021/ 2022	Risk Score	Assurance Strength	Change (last reporting period)	Inherent Risk Score	Target Risk Score For 2021/22
Q1	Moderate 9= 3(c) x 3(L)	Good	N/A	16 = 4(c) x 4(L)	6 = 3(c) x 2(L)
Q2	Moderate 9=3(c) x 3(L)	Good	N/A		
Q3	Moderate 9=3(c) x 3(L)	Good	N/A		
Q4	Moderate 9=3(c) x 3(L)	Good	N/A		

Emerging risks

- Restrictions on funding/ investment to extend research activities, with consequent inability to exploit research opportunities in full
- Alignment of St George's and St George's University research priorities recognised as a risk in the Research Strategy
- Reduced availability of National Institute for Health research funding

Future opportunities

- National Institute for Health Research call for core Clinical Research Facility funding – awaiting outcome of application
- Opportunity for a greater research leadership role in SW London / partnership with other Acute Provider Collaborative Trusts
- Build on current profile related to Covid-19 research activity/ studies
- Develop closer collaboration between St George's and St George's University

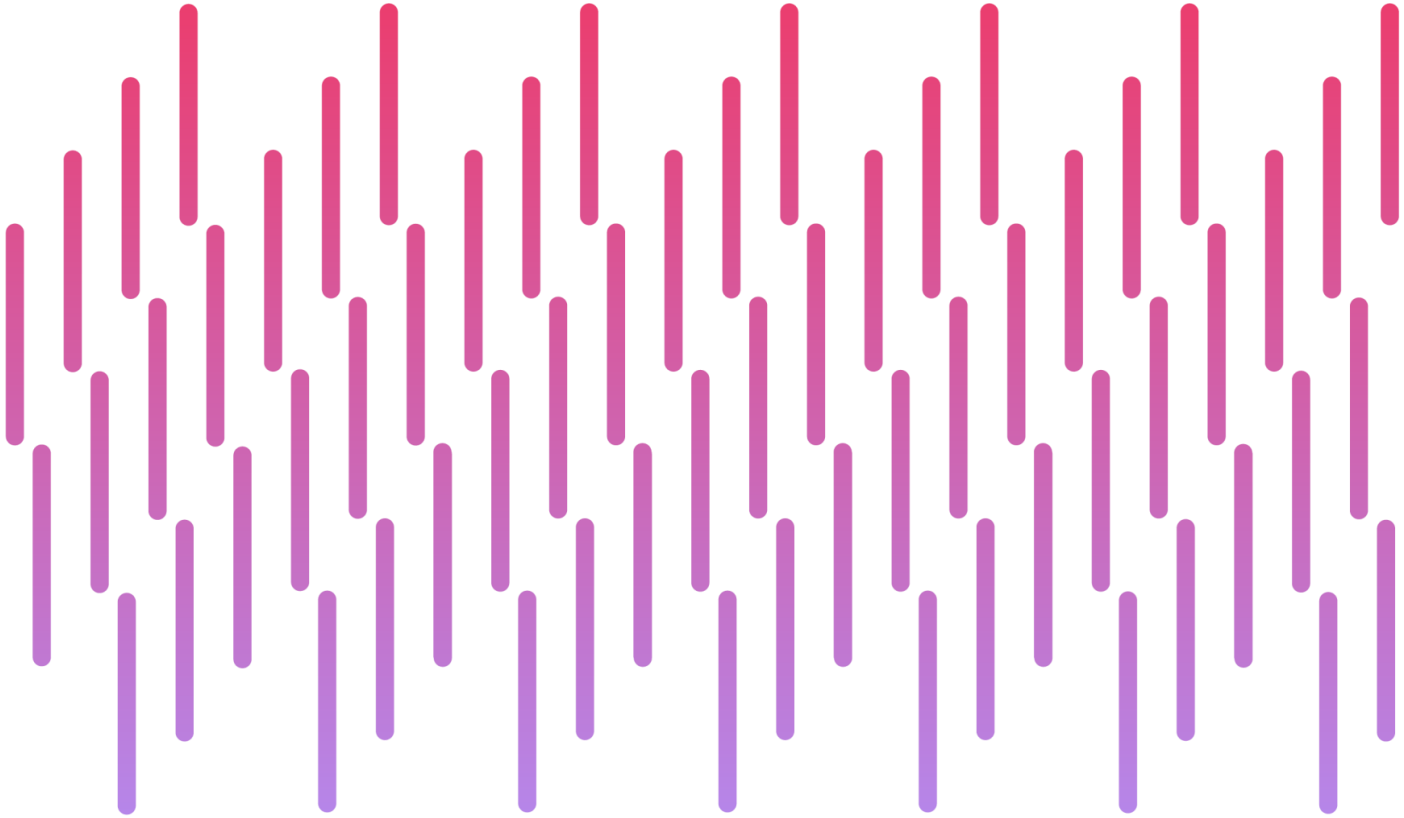
Strategic Objective	Develop tomorrow's treatments today	*Corporate Objectives 2021/22:*	Collaboration
SR10	**Research is not embedded as a core activity which impacts on our ability to attract high calibre staff, secure research funding and detracts from our reputation for clinical innovation**		

Key risk controls in place	Control effectiveness				Key sources of assurance	Lines of Assurance (positive / negative)		
	Q1	Q2	Q3	Q4		1	2	3
Research Strategy 2019-24 : approved by the Trust Board in December 2019 and supported by an implementation plan for the research strategy	S	S	S	S	• Increased numbers of clinical research studies led from St George's	X		
Partnership between St George's and St George's University London	G	G	S	S	• Partnership in place. TACRI and all four Clinical Academic Groups, which are joint Trust/University structures, have been set up. Reports from CAGs due to Joint Strategy Board in March 2022.	X	X	
Key role in south London Clinical Research Network (chaired by CEO)	S	S	S	S	• Leadership positions in the Clinical Research Network - St George's CEO now chairs the CRN Partnership Board.		X	X
Implementation of process of horizon scanning clinical studies, including 'easy win' studies to balance portfolio against lower recruiting more intensive studies	S	S	S	S	• We have increased the numbers of patients recruited to clinical trials, which doubled over 3 years.	X	X	
Regular research resource and portfolio review meetings with research teams	S	S	S	S	• JRES holds regular meetings with research teams to review patient recruitment and troubleshoot any problems.	X		
Joint Research and Enterprise Services review and ratify (with researchers) all study targets and resources required	S	S	S	S	• There is annual target setting process for patient recruitment which is monitored and supported by JRES	X	X	X
Translational and Clinical Research Institute (TACRI) Steering Committee set up	S	S	S	S	• Steering Committee in place and reports to Patient Safety Quality Group and QSC	X	X	
Funding to implement 2019-24 research strategy approved for 2021/22, but not yet for 2022/23	S	S	S	G	• £200K funding to implement the research strategy agreed. Statistical support for TACRI commenced, along with 7 fellowships for research nurses. We await the outcome of the 2022/23 funding request.		X	
Four Clinical Academic Groups formerly established	S	S	S	S	• Four CAGs have been established, and a CAG Director has been appointed for each.		X	

Strategic Objective	Develop tomorrow's treatments today	*Corporate Objectives 2021/22:*	Collaboration
SR10	**Research is not embedded as a core activity which impacts on our ability to attract high calibre staff, secure research funding and detracts from our reputation for clinical innovation**		

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

Appendix 1: Operational risks linked to strategic risks



Operational risks linked to strategic risk 1

Risk short form title	CRR Ref	Description	Open Date	Inherent Score	Current Score Mar 2022
Strategic Risk 1	**Our patients do not receive safe and effective care built around their needs because we fail to build and embed a culture of quality improvement and learning across the organisation**			**20**	**16**
Covid-19 - exposure	COVID-2051	Risk of exposure to Covid-19 virus	Feb 2020	20 (5x4)	15 (5x3)
Covid-19-wait too long (2)	COVID-2105	Non Covid-19 patients not known to the Trust wait too long for treatment (patients group B) (also see SR3)	Apr 2020	20 (4x5)	**12 (4x3)**
Covid-19-wait too long (1)	COVID-2104	Non Covid-19 patients, known to the Trust, wait too long for treatment (patient group A) (also see SR3)	Apr 2020	20 (4x5)	**12 (4x3)**
7 Day Service Standards	MD1118	Failure to comply with 4 standards of the Seven day Service due to resource limitation and/or lack of defined operating model	Nov 2016	**12 (3x4)**	**12 (3x4)**
Infection control	CN2050	C Diff; MRSA; MSSA; E.Coli	Mar 2020	**12 (3x4)**	**9 (3x3)**
Covid-19-Fit test	COVID-2106	Lack of fit test for FFP3 masks	Apr 2020	**12 (4x3)**	**8 (4x2)**
Learning from incidents	CN1166	Failure to learn from incidents	Nov 2016	16 (4x4)	**8 (4x2)**
Deteriorating patients	MD1527	Staff fail to recognise, escalate and respond appropriately to the signs of a deteriorating patient. This may happen because the Early Warning Score is inaccurately recorded or the escalation process is not applied correctly	Dec 2016	16 (4x4)	**8 (4x2)**
Learning from complaints	CN2009	Failure to learn from complaints	Dec 2019	16 (4x2)	**8 (4x2)**
Covid-19-PPE	COVID-2107	Lack of PPE to effectively manage exposure to Covid-19 virus	Apr 2020	20 (4x5)	4 (4x1)

Operational risks linked to strategic risk 2

Risk short form title	CRR Ref	Description	Open Date	Inherent Score	Current Score Mar 2022
Strategic Risk 2	**We are unable to provide outstanding care as a result of weaknesses in our clinical governance**			20	**12**
Compliance with the CQC regulatory framework	CN-1179	Failure to comply with the CQC regulatory framework and deliver actions in response to CQC inspections may prevent the Trust achieving an improved rating at our next inspection	Jan 2017	20 (5x4)	**12 (4x3)**
Diagnostic findings	MD1526	Acting on diagnostic findings	Jul 2016	16 (4x4)	**12 (4x3)**
Mental capacity Act	CN751	Failure to comply with Mental Capacity Act (MCA)	Jun 2016	16 (4x4)	**12 (4x3)**
Discharge	MD2052	Non-compliance with the eDischarge Summary Standard	Mar 2020	16 (4x4)	**12 (4x3)**
Improving the quality of clinical governance	CN-2056	There is a risk that we may not improve the quality of clinical governance following the external reviews of mortality monitoring & MDT and clinical governance in a timely manner which may have an adverse impact on patient care	Sep 2019	12 (4x3)	**12 (4x3)**
Cardiac surgery service – patient safety impact	CVT-1660	There is a risk that we may not make effective improvements to patient safety following the second NICOR mortality alert for cardiac surgery	Sep 2018	16 (4x4)	4 (4x1)
Learning from deaths	MD1119	Variation in practice in M&M / MDT meetings may mean we fail to learning from deaths and fail to make improvement actions to prevent harm to patients	Nov 2016	**8 (2x4)**	6 (2x3)

Operational risks linked to strategic risk 3

Risk short form title	CRR Ref	Description	Open Date	Inherent Score	Current Score Mar 2022
Strategic Risk 3	**Our patients do not receive timely access to the care they need due to delays in treatment and the inability of our technology and transformation programmes to provide accessible care built around our patients' lives**			**20**	**20**
Network outage	CRR-1395	Infrastructure - Risk of further major network outages due to out-dated, unreliable, and prone to failure network, as a result of a lack of investment and maintenance in the Trust's ICT Network Infrastructure	Sec 2017	25 (5x5)	20 (5x4)
ICT Disaster Recovery Plan	CRR-803	In the event of an ICT disaster, there is a RISK this would result in delays or a complete failure in the Trust's ability to recover its ICT systems.	Feb 2011	20 (5x4)	20 (5x4)
Emergency care 4hr operating standard	ED-2449	Failure to deliver and sustain the 95% Emergency Care Operating Standard	Jan 2022	20 (4x5)	20 (5x4)
Patient flow	COO-2393	Risk of inadequate patient flow in the Trust (and across the health care system) for emergency admission	Nov 2021	20 (4x5)	20 (5x4)
Virtual by Design	IT-2157	There is a risk that IT Audiovisual/infrastructure are not met by IT resources, impacting on patient care	Sep 2020	20 (4x5)	16 (4x4)
Telephony	CRR-1292	Infrastructure - Potential failure of the Trust's central telecoms system (ISDX) (1), radio tower system (DDI) (2), and/or VoIP platform (500 handsets) (3) due to aged telecoms infrastructure	Jul 2017	20 (5x4)	16 (4x4)
Data Warehouse/ Information Management Fragmentation	CRR-1312	Information - Risk of poor daily operational performance reporting due to difficulties to retrieve data stored on multiple storage	Aug 2017	20 (4x5)	16 (4x4)
Wrong blood in tube	RHO-1626	Misidentification of patient or of the blood sample at venepuncture for transfusion samples, leading to wrong blood in tube (WBIT).leading to ABO incompatible blood transfusion	Aug 2018	20 (5x4)	15 (5x3)

Operational risks linked to strategic risk 3

Risk short form title	CRR Ref	Description	Open Date	Inherent Score	Current Score Mar 2022
Strategic Risk 3 (continue)	**Our patients do not receive timely access to the care they need due to delays in treatment and the inability of our technology and transformation programmes to provide accessible care built around our patients' lives**			**25**	**20**
Covid-19-wait too long (2)	COVID-2105	Non Covid-19 patients not known to the Trust wait too long for treatment (patients group B) (also see SR1)	Apr 2020	20 (4x5)	**12 (4x3)**
Covid-19-wait too long (1)	COVID-2104	Non Covid-19 patients, known to the Trust, wait too long for treatment (patient group A) (also see SR1)	Apr 2020	20 (4x5)	**12 (4x3)**
Paediatric ECHO delivery	CCAG-1980	Inability of safely provide a paediatric ECHO service at St Georges Hospital	Nov 2019	20 (4x5)	**12 (4x3)**
Management of RTT	COO-2371	Failed to meet the constitutional standard of 92% of patients being treated within 18 weeks from referral due to COVID-19 and insufficient capacity	July 2020	20 (4x5)	**12 (4x3)**
Exposure to Cyber or Malware attack	CRR-0013	Infrastructure - Risk of potential successful malware / cyber attack due to weakness in the ICT infrastructure. This could lead to loss of data and operational disruption	Apr 2016	20 (4x5)	**12 (4x3)**
Fragmented Clinical Records	CRR-1398	Unavailability of all the correct and up to date clinical information at point of care due to fragmented patient records as a consequence of: Cerner implementation, multiple clinical system running in parallel but separate from Cerner,	Dec 2017	20 (4x5)	**12 (4x3)**
Diagnostic findings	MD1526	Acting on diagnostic findings	Jul 2016	16 (4x4)	**12 (4x3)**
7 day services	MD1118	Failure to be compliant with 4 of the Seven Day Services clinical standards	Nov 2016	**12 (3x4)**	**12 (3x4)**
Clinical Decision Outcome Form	S2060	There is an on-going risk that patients on any elective pathway could be lost to follow up. This can be caused by the incorrect outcome being recorded on the Clinical Decision Outcome	Mar 2020	**12 (4x3)**	**12 (4x3)**
VDI Sub-optimal	IT- 1717	Sub-optimal Virtual Desktop Infrastructure (VDI) due to insufficient licenses, insufficient compute power, and upgrade to Win10.	Nov 2018	**12 (3x4)**	**12 (3x4)**

Operational risks linked to strategic risk 4

Risk short form title	CRR Ref	Description	Open Date	Inherent Score	Current Score Mar 2022
Strategic Risk 4	As part of our local Integrated Care System, we fail to deliver the fundamental changes necessary to transform and integrate services for patients in South West London			16	12
Children's cancer services		Children's cancer services - risk of losing service as part of service reconfiguration across London		20 (5x4)	15 (5x3)
Devolution of specialised commissioning	STR-2220	There is a risk that the devolution of NHSE specialised commissioning is effected in a way that conflicts with the Trust's strategy to be the tertiary centre for SWL and Surrey	Feb 2021	12 (4x3)	12 (4x3)
Other providers' strategies conflicting with Trust Strategy	CRR-1899	There is a risk that other acute providers in SWL will pursue clinical/commercial relationships with other tertiary providers that pose a strategic threat to SGUH	Aug 2019	15 (5x3)	10 (5x2)
Disagreement on future of QMH	STR-2311	There is a risk that the Trust and system partners (CCG, Kingston) are unable to agree on future use of QMH	Aug 2021	9 (3x3)	6 (3x2)

Operational risks linked to strategic risk 5

Risk short form title	CRR Ref	Description	Open Date	Inherent Score	Current Score Mar 2022
Strategic Risk 5	We do not achieve financial sustainability due to under delivery of cost improvement plans and failure to realise wider efficiency opportunities			25	20
Managing Income & Expenditure in line with budget	CRR-1411	Risk the Trust is not able to manage income and expenditure against agreed budgets to delivery the financial plan.	Dec 2017	25 (5x5)	20 (5x4)
Managing an effective financial control environment	CRR-0028	Risk of not meeting statutory obligations, prevent fraud, mismanagement of funds or inappropriate decision making by Trust officers due to ineffective financial systems and processes	Oct 2016	20 (4x5)	20 (4x5)
Identifying and delivering CIPs	CRR-1865	Risk that the Trust doesn't have sufficient capacity and capability to deliver CIPs at the level required to hit the financial plan.	Apr 2019	20 (5x4)	20 (5x4)
Future cash requirements are understood	CRR-1416	Risk that future cash requirements are not understood	Dec 2017	20 (5x4)	15 (5x3)
Manage commercial relation with non-NHS organisations	Fin-1856	Risk that the Trust does not have sufficient capacity, or skills to manage commercial relationships with non-NHS organisations procuring services from the Trust.	May 2019	12 (4x3)	12 (4x3)
Processes to manage cash and working capital	CRR-1417	Risk that the Trust does not have up to date processes to manage cash and working capital	Dec 2017	20 (5x4)	12 (4x3)
Understanding cost structures	Fin-1372	A risk that we do not understand our current cost and performance baseline and structures, or benchmark ourselves against others in this area to identify efficiencies and improvements.	Nov 2017	15 (5x3)	9 (3x3)

Operational risks contributing to strategic risks 5 & 6

Risk short form title	CRR Ref	Description	Open Date	Inherent Score	Current Score Mar 2022
Strategic Risk 5 continue	We do not achieve financial sustainability due to under delivery of cost improvement plans and failure to realise wider efficiency opportunities			25	20
Maintaining a five year forward view	CRR-1413	The Trust has insufficient capacity to develop a five year long term financial plan that is aligned to an agreed clinical strategy.	Dec 2017	16 (4x4)	9 (3x3)
Maintaining an effective procurèrent environnent	Fin-1083	Risk the Trust has insufficient capacity and capability to ensure best value is achieved on all procurement.	Oct 2016	15 (3x5)	9 (3x3)
Managing within new contract forms (block contracts)	Fin- 1858	There is a risk that the Trust could be financially impacted by a failure to manage performance inline with new contract models, specifically a block contract.	May 2019	9 (3x3)	9 (3x3)
Risk that the Trust could be financially penalised due to non-delivery of control totals within South West London	Fin-1857	Risk that the Trust could be financially penalised due to non-delivery of control totals within South West London. It is unclear within planning guidance what the impact of other organisations within the South West London patch not hitting control totals will be on the organisations.	May 2019	9 (3x3)	9 (3x3)
Unsupported finance and procurement system	Fin-1083	A risk that the Trust has an unsupported finance and procurement system.		8 (4x2)	8 (4x2)
Strategic Risk 6	We are unable to invest in the transformation of our services and infrastructure, and address areas of material risk to our staff and patients, due to our inability to source sufficient capital funds			20	20
Funding for 5 year capital plan	1414	The Trusts does not have funding sources confirmed to deliver years 2 through to 5 of the 5 year capital plan.		20 (5x4)	20 (5x4)
Funding for current year capital plan	2451	The Trusts does not have funding sources confirmed to deliver the next 1 year of the capital plan		12 (3x4)	20 (5x4)

Operational risks linked to strategic risk 7

Risk short form title	CRR Ref	Description	Open Date	Inherent Score	Current Score Mar 2022
Strategic Risk 7	**We are unable provide a safe environment for our patients and staff and to support the transformation of services due to the poor condition of our estates infrastructure**			**20**	**16**
Inability to address infrastructure backlog maintenance to maintain safe site	CRR-0008	Inability to address infrastructure backlog maintenance to maintain safe site due to lack of capital	Jul 2016	**20 (4x5)**	**20 (4x5)**
Risk of fire starting in Lanesborough Wing developing into a major fire	EF2036	Risk that an undetected and immediately extinguished fire could develop into a major fire resulting in area evacuation	Feb 2020	**20 (5x4)**	**20 (5x4)**
Lack of UPS/IPS power supplies	EF2061	Lack of UPS/IPS power supplies	Mar 2020	**20 (5x4)**	**15 5x3)**
Data Centre	CRR-810	Risk that a fire, flood, power failure in the Data Centre could cause loss of data due to having a single data centre hosting all on-site critical systems	Mar 2014	**20 (5x4)**	**15 (5x3)**
Electrical Infrastructure - Risk of non-compliance	CRR-1311	Risk of electrical non-compliance with Electricity at Work Regulations and BS7671 due to lack of regular testing	Aug 2017	**16 (4x4)**	**12 (4x3)**
Bacterial contamination of water supply	CRR-0016	Risk from exposure to potential pathogenic bacteria in water	May 2014	**20 (5x4)**	**12 (4x3)**
Cardiac Catheter Labs breakdowns	CCAG-1025	Cardiac Catheter Labs breakdown /failure due to old equipment/ infrastructure	Sep 2016	**20 (4x5)**	**8 (4x2)**

Operational risks linked to strategic risk 8

Risk short form title	CRR Ref	Description	Open Date	Inherent Score	Current Score Mar 2022
Strategic Risk 8	Our staff are not empowered to deliver to their best and do not feel safe to raise concerns because we fail to build an open and inclusive culture across the organisation which celebrates and embraces our diversity			20 (4x5)	16 (4x5)
Organisational culture	HR-2178	There is a risk that we fail to achieve a significant shift in culture to support the delivery of the Trust strategic objectives	Sep 2020	20 (4x5)	16 (4x5)
Diversity and Inclusion	HR-1967	There is a risk that we are unable to deliver our Diversity and Inclusion Strategy or that it does not have the required impact	Jul 2019	20 (4x5)	16 (4x4)
Raising Concerns	HR-1978	There is a risk that our staff a) don't know how to raise concerns at work b) don't know who to raise concerns with c) are not confident the concerns will be properly address and d) don't feel safe in raising concerns	Nov 2019	20 (4x5)	16 (4x4)
Bullying and Harassment	HR-881	There is a risk that our staff continue to report high levels of bullying and harassment compared with peers and that we have not taken adequate measures to address this	May 2010	20 (4x5)	16 (4x4)
Effective Engagement	HR-1364	There is a risk that we fail to engage effectively with our staff	Apr 2016	15 (3x5)	12 (3x4)
Organisational Development	HR-1360	There is a risk that we do not ensure that our senior managers are developed to have the right leadership skills to be able to deliver our vision of outstanding care every time	Nov 2017	12 (3x4)	12 (3x4)
Recognise good practice	HR-1361	A risk that we do not recognise success or good practice amongst our workforce.	Nov 2017	12 (3x4)	12 (3x4)

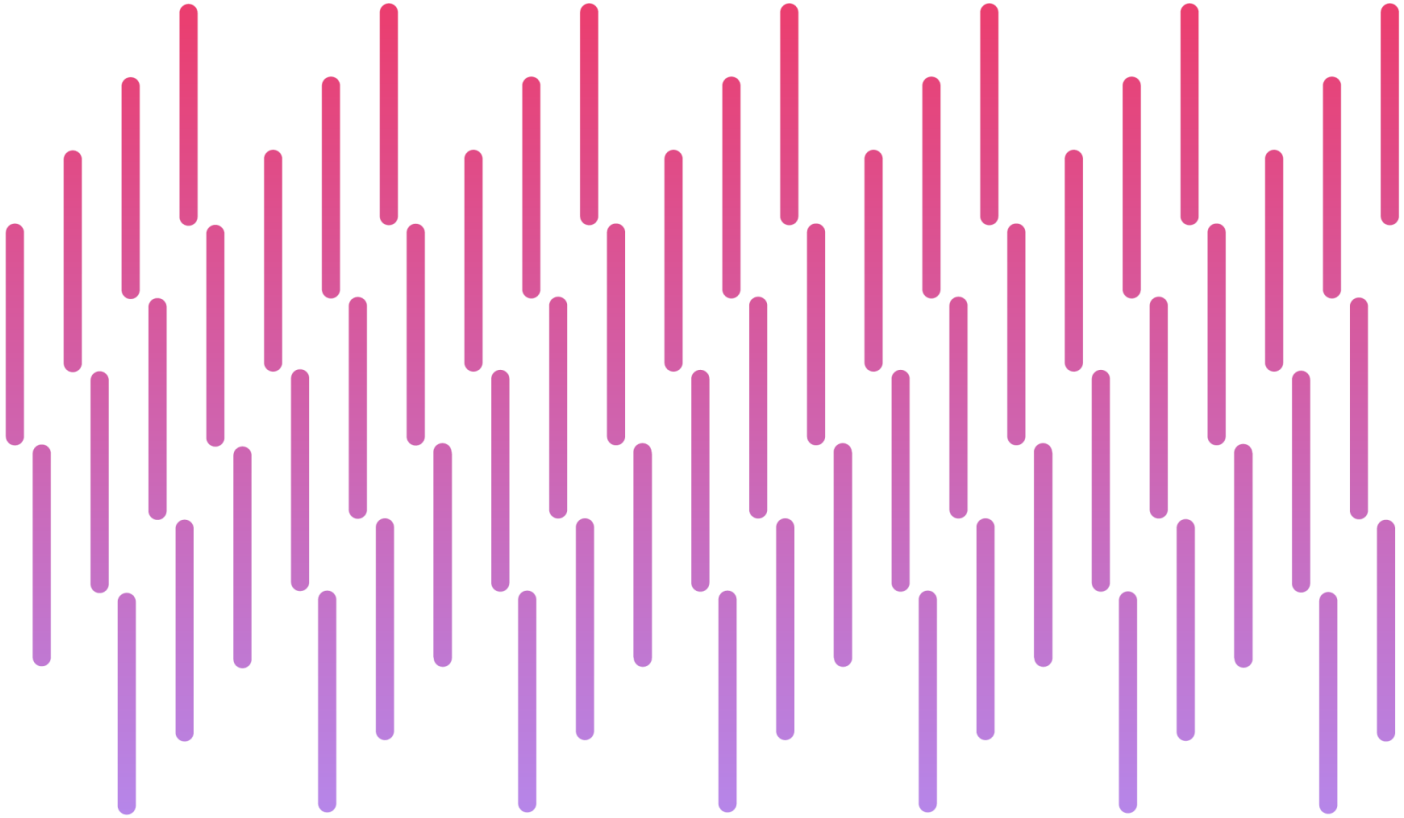
Operational risks linked to strategic risk 9

Risk short form title	CRR Ref	Description	Open Date	Inherent Score	Current Score Mar 2022
Strategic Risk 9	We are unable to meet the changing needs of our patients and the wider system because we do not recruit, educate, develop and retain a modern and flexible workforce and build the leadership we need at all levels			20	16
Junior Doctors vacancies	CRR-1684	There is a risk that we are unable to fill Junior Doctor rota vacancies, leading to rota gaps which may impact on patient safety	Oct 2018	20 (4x5)	16 (4x4)
Recruitment and Retention	CRR-0025	There is a risk that we fail to recruit and retain sufficient and suitable workforce with the right skills to provide quality of care and service at appropriate cost	Jan 2015	16 (4x4)	16 (4x4)
High quality appraisals	HR-1363	Risk that we do not ensure all of our staff have a high quality appraisal.	Nov 2017	12 (3x4)	12 (3x4)
Health and Wellbeing	HR-2242	There is a risk that health and wellbeing is not embedded in the organisation.	Apr 2021	12 (3x4)	9 (3x3)
Education Strategy	HR-2179	Failure to deliver the Education Strategy due to potential lack of organisational engagement and financial constraints	Oct 2020	9 (3x3)	9 (3x3)
Workforce Strategy	HR-2038	There is a risk that the identified priorities in the Workforce Strategy do not produce the improvements or changes desired.	Feb 2020	9 (3x3)	9 (3x3)

Operational risks linked to strategic risk 10

Risk short form title	CRR Ref	Description	Open Date	Inherent Score	Current Score Mar 2022
Strategic Risk 10	**Research is not embedded as a core activity which impacts on our ability to attract high calibre staff, secure research funding and detracts from our reputation for clinical innovation**			16	9
The profile of research in SGHT being low	MD-1133	There is a risk that insufficient focus is given to research in SGHT. This could lead to a lack of investment in research, impacting on research delivery, income, reputation and ability to recruit and retain high calibre staff	Nov 2016	**12 (3x4)**	**12 (3x4)**
Clinical Research recruitment reduction	MD-1132	Risk of Clinical Research recruitment reduction. could result in a significant shortfall in overall (CRN and Commercial) recruitment and therefore reduction in research funding and income	Nov 2016	**12 (3x4)**	**9 (3x3)**
MHRA accreditation of the research department	MD-1405	There is a risk that the research department does not retain its MHRA accreditation due to poor infrastructure/ compliance	Dec 2017	**16 (4x4)**	**8 (4x2)**
Research partnership with St George's University	MD-1495	There is a risk that if research priorities are not aligned across SGUH and SGUL we will miss opportunities to translate academic research in to improved patient outcomes	Mar 2018	**12 (3x4)**	**6 (3x2)**

Appendix 2: Scoring the Board Assurance Framework
Risk Assessment & Assurance sources and descriptors



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Scoring the Board Assurance Framework

Risk Assessment and tracking of actions to address gaps in controls

Calculating Risk Scores

Risk Grading (Scoring)

CONSEQUENCE INDEX			LIKELIHOOD INDEX*		
5	Catastrophic	Multiple deaths caused by an event; ≥£5m loss; May result in Special Administration or Suspension of CQC Registration; Hospital closure due to enforcement action; Total loss of public confidence	5	Almost Certain	No effective control; or ≥ 1 in 5 chance within 12 months
4	Major	Severe permanent harm or death caused by an event; £1m - £5m loss; Prolonged adverse publicity; Prolonged disruption to one or more Divisions; Extended service closure	4	Likely	Weak control; or ≥1 in 10 chance within 12 months
3	Moderate	Moderate harm – medical treatment required up to 1 year; £100K - £1m loss; Temporary disruption to one or more Divisions; Service closure	3	Possible	Limited effective control; or ≥ 1 in 100 chance within 12 months
2	Minor	Minor harm – first aid treatment required up to 1 month; £50K - £100K loss; or Temporary service restriction	2	Unlikely	Good control; or ≥ 1 in 1000 chance within 12 months
1	Insignificant	No harm; 0 - £50K loss; or No disruption – service continues without impact	1	Rare	Very good control; or <1 in 1000 chance (or less) within 12 months

*Use of relative frequency can be helpful in quantifying risk, but a judgment may be needed in circumstances where relative frequency measurement is not appropriate or limited by data.

Risk scoring matrix

L/C	1	2	3	4	5
5					
4					
3					
2					
1					

Calculating Strength of Controls

Strength of controls

Control Strength	Description
Substantial	The identified control provides a strong mechanism for helping to control the risk
Good	The identified control provides a reasonable mechanism for helping to control the risk
Reasonable	The identified control provides a partial mechanism for controlling the risk but there are weaknesses in this
Weak	The identified control does not provide an effective mechanism for controlling the risk

Scoring the Board Assurance Framework
Assurance sources and descriptors

Sources of Assurance

Sources of Assurance

Line of Assurance	First Line Assurance	Second Line Assurance	Third Line Assurance
Description	Care Group / Operational level	Corporate Level	Independent and external
Examples	Service delivery / day-to-day management Care Group level oversight Divisional level oversight	Board and Board Committee oversight Executive oversight Specialist support (e.g. finance, corporate governance)	Internal audit External audit Care Quality Commission NHSE&I Independent review Other independent challenge

Progress on actions to address gaps in control / assurance

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

Calculating Ratings of Assurance

Assurance Levels

Level of Assurance	Description
Substantial	Governance and risk management arrangements provide substantial assurance that the risks identified are managed effectively. Evidence provided to demonstrate that systems and processes are being consistently applied and implemented across relevant services. Outcomes are consistently achieved across all relevant areas
Good	Governance and risk management arrangements provide a good level of assurance that the risks identified are managed effectively. Evidence is available to demonstrate that systems and processes are generally being applied and implemented but not across all relevant services. Outcomes are generally achieved but with inconsistencies in some areas
Partial	Governance and risk management arrangements provide reasonable assurance that the risks identified are managed effectively. Evidence is available to demonstrate that systems and processes are being applied but insufficient to demonstrate implementation widely across services. Some evidence that outcomes are being achieved but this is inconsistent across areas and / or there are identified risks to current performance
Limited	Governance and risk management arrangements provide limited assurance that the risks identified are managed effectively. Little or no evidence is available that systems and processes are being consistently applied or implemented within relevant services. Little or no evidence that outcomes are being achieved and / or there are significant risks identified to current performance

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NHS
St George's University Hospitals
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	5 May 2022	**Agenda No**	**4.1**
Report Title:	**Group Governance Arrangements**		
Lead:	Stephen Jones, Chief Corporate Affairs Officer		
Report Author:	Stephen Jones, Chief Corporate Affairs Officer		
Presented for:	Approval		
Executive Summary:	After years of collaboration and creating closer working ties, Epsom and St Helier University Hospitals NHS Trust (ESTH) and St George's University Hospitals NHS Foundation Trust (SGUH) have formed a hospital group, the St George's, Epsom and St Helier University Hospitals and Health Group (GESH). Working as a hospital group enables greater joined-up decision-making for the benefit of local people, a larger and more resilient workforce, reduced variation in levels of care, and greater access to a wider range of clinical services for the patients of both organisations. The Trusts remain separate legal entities but with a single executive team and harmonised corporate governance arrangements which enable and support closer collaborative working. This paper sets out the proposed governance arrangements for the new Group, which have been developed through extensive engagement with the Boards of both Trusts between November 2021 and April 2022. The paper includes: • An overview of the proposed governance framework • Proposals for the establishment of Board Committees-in-Common across quality, finance and people • A draft Memorandum of Understanding (MoU) to provide a clear framework for the closer collaboration between the two organisations which will be achieved through the formation of the Group • Information Sharing Agreement is intended to provide a framework through which the two sovereign Trusts can share information for the purposes of the Group as set out in the MoU.		
Recommendation:	The Board is asked to: a) Approve the proposed group governance arrangements, including plans to establish committees-in-common for quality, finance and people across the two Trusts, and approve the terms of reference and 2022/23 annual business plan for the quality committee, and the terms of reference for the finance committee; b) Note that the terms of reference and 2022/23 annual business plan for the people committee will be presented to the Board for consideration following review by the respective Trust committees later this month. c) Approve the Memorandum of Understanding to provide a framework for closer collaboration between the two organisations which will be achieved through the formation of the Group;		

	d) Approve the Information Sharing Agreement to provide a framework through which the two sovereign Trusts can share information for the purposes of the Group as set out in the MoU; e) Note that subject to the approval of these proposals the Standing Orders, Scheme of Delegation and Standing Financial Instructions for both Trusts will be reviewed with reference to the new Group arrangements.		
Supports			
Trust Strategic Objective:	All objectives		
CQC Theme:	Addresses all five themes: Safe, Effective, Caring, Responsive and Well-led		
NHS System Oversight Framework:	Well-led		
Implications			
Risk:	Failure to put in place effective group governance arrangements that reflect the statutory and regulatory position of the two Trusts could impact on regulatory or statutory compliance or otherwise undermine the integrity of the governance of either Trust. The proposals set out in this paper ensure that each Trust continues to operate with effective Board and Committee structures and processes which are robust both at group and trust level.		
Legal/Regulatory:	As sovereign statutory organisations, each trust is required to have in place effective systems of governance and internal control. The group governance arrangements set out in this paper take account of this.		
Resources:	There are no specific material resource implications in relation to the governance arrangements set out in this paper. However, the strategic case for the establishment of the group identifies potential efficiencies and enhanced sustainability of both organisations as a result of the formation of the group.		
Previously Considered by:	Group Executive Meeting Finance Committee Quality Committee	**Date**	27 April 2022 21 April 2022 20 April 2022
Equality Impact Assessment:	The proposals set out in this paper ensure that there continues to be in place effective and robust arrangements for the scrutiny of and assurance in relation to equality, diversity and inclusion issues impacting on patients and staff.		
Appendix:	• Appendix 1: Draft Terms of Reference, Quality Committee • Appendix 2: Draft Quality Committee Annual Plan 2022/23 • Appendix 3: Draft Terms of Reference, Finance Committee • Appendix 4: Draft Memorandum of Understanding • Appendix 5: Draft Information Sharing Agreement		

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NHS
St George's University Hospitals
NHS Foundation Trust

Developing the St George's, Epsom and St Helier University Hospitals and Health Group:

Proposed Group Governance Arrangements

5 May 2022

Executive Summary

NHS
St George's, Epsom and St Helier
University Hospitals and Health Group

Purpose

This paper sets out the proposed governance arrangements for the new Group, which have been developed through extensive engagement with the Boards of both Trusts between November 2021 and April 2022. The paper includes:

- An overview of the proposed governance framework
- Proposals for the establishment of Board Committees-in-Common across quality, finance and people
- A draft Memorandum of Understanding (MoU) to provide a clear framework for the closer collaboration between the two organisations which will be achieved through the formation of the Group
- Information Sharing Agreement is intended to provide a framework through which the two sovereign Trusts can share information for the purposes of the Group as set out in the MoU.

Background

After years of collaboration and creating closer working ties, Epsom and St Helier University Hospitals NHS Trust (ESTH) and St George's University Hospitals NHS Foundation Trust (SGUH) have formed a hospital group, the St George's, Epsom and St Helier University Hospitals and Health Group (GESH). Working as a hospital group enables greater joined-up decision-making for the benefit of local people, a larger and more resilient workforce, reduced variation in levels of care, and greater access to a wider range of clinical services for the patients of both organisations. The Trusts remain separate legal entities but with a single executive team and harmonised corporate governance arrangements which enable and support closer collaborative working.

Group governance arrangements

- While both Boards will continue to meet separately in 2022/23, there are opportunities to bring together a number of the committees of the Boards into 'in common' arrangements, which will help promote greater synergy and learning between the two Trusts, while strengthening assurance across the Group: quality, finance and people committees will meet as committees-in-common, supported by a common agenda which permits for ongoing scrutiny of Trust-specific items. Chairing of the committees-in-common will alternate between the established chairs of the respective ESTH and SGUH committees.

- The Audit Committees of the two Trusts will meet separately in order to provide assurance to their respective boards on the robustness of governance and internal control for each separate corporate entity. The Boards will review this later in the year to consider the scope for establishing the Audit Committee on an 'in common' in the future.

Executive Summary

NHS
St George's, Epsom and St Helier
University Hospitals and Health Group

- All other Trust-specific Board Committees will continue to operate as they have done prior to the establishment of the Group. In practice, this means that the following ESTH Board Committees will continue to meet on a Trust-only basis: Building Your Future Hospitals Programme Board; Estates Assurance Committee; and Charitable Funds Committee. The SGUH Council of Governors would continue as it currently does.

- A single Group Executive has been established and has been in place since 1 February 2022. The Group Executives are the accountable Executive Directors and Board members of both organisations. Each of the Managing Directors, for ESTH, SGUH and Integrated Care will lead a site-based leadership team which is tailored to the specific needs of each site.

Memorandum of Understanding and Information Sharing Agreement

To support the establishment of the new St George's, Epsom and St Helier University Hospitals and Health Group, a draft Memorandum of Understanding (MoU) and a draft Information Sharing Agreement (ISA) have been prepared for consideration by the Boards of the two Trusts. The drafts have been developed with external legal advice and support. Together, the MoU and ISA are intended to provide a robust framework to support the collaborative arrangements provided for through the group model. These will, of course, need to be reviewed and updated as the collaboration through the Group develops.

Recommendations

- The Boards are asked to:

  - Approve the proposals to establish committees-in-common for quality, finance and people across the two Trusts, including approving the terms of reference and 2022/23 annual business plan for the quality committee, and the terms of reference for the finance committee
  - Note that the terms of reference and 2022/23 annual business plan for the people committee will be presented to the Board for consideration following review by the respective Trust committees later this month.
  - Approve the Memorandum of Understanding to provide a framework for closer collaboration between the two organisations which will be achieved through the formation of the Group;
  - Approve the Information Sharing Agreement to provide a framework through which the two sovereign Trusts can share information for the purposes of the Group as set out in the MoU;
  - Note that subject to the approval of these proposals the Standing Orders, Scheme of Delegation and Standing Financial Instructions for both Trusts will be reviewed with reference to the new Group arrangements.

2. Group Governance Structure (1 of 2)

Overview

NHS
St George's, Epsom and St Helier
University Hospitals and Health Group

Under the new Group arrangements, Epsom and St Helier University Hospitals NHS Trust and St George's University Hospitals NHS Foundation Trust remain separate legal entities.

As such, each Trust within the Group will continue to be led by their Board of Directors, under the leadership of a Group Chairman. The Board of Directors for each Trust will continue to be responsible for setting strategy, ensuring accountability, and shaping a healthy culture. Each Board will hold separate meetings in public every other month. Board development will be undertaken on a group-wide basis.

A new cycle of meeting dates is being introduced, where the Boards meet on consecutive days on the first Thursday and Friday of the month. From May 2022, the Boards of both organisations plan to resume in-person Board meetings, and members of the public will continue to be able to attend meetings of the Boards held in public, and will be able to submit questions in advance of Board meetings.

Each Board will be supported by a Committee structure which will provide the Board with assurance in relation to the issues within its terms of reference. The quality, finance and people committees will meet 'in common', which will support greater collaboration, closer working, and enhanced learning between the two organisations. Committees established on a Trust-specific basis will continue to meet separately.

The Group Executive Directors will be the accountable Executive Directors of each Trust and the members of the respective Boards. Each of the Managing Directors - for ESTH, SGUH and Integrated Care - will lead a site-based leadership team which is tailored to the specific needs of each site.

A Group Operating Model will be prepared which will set out the role of the Group Executive and the role of the site-based leadership teams. The following principles underpin the Group Operating Model:

- Focus on the delivery of benefits to our patients and staff working together as a Group;
- Deliver on our aspiration to be clinically-led organisations: empowering clinical teams to develop solutions to their problems, supporting clinical leaders to see and lead all aspects of their service, and ensuring clinicians shape every aspect of how the organisations run;
- Take decisions that affect the Group with a single mind, and foster a collective / shared purpose across the wider leadership teams;
- Empower site teams to deliver, and delegate decision-making authority to the lowest appropriate level, supported by a common accountability framework;
- Ensure clarity of roles and responsibilities at all levels across the Group to avoid duplication, supported by a standardised governance framework across the sites;
- Support clinical collaboration and reduce unwarranted clinical variation whilst supporting sites to respond to the different needs of their local communities and to actively embrace the local cultures of the different sites;
- Recognise the continuing legal and regulatory requirements of the Trusts as sovereign statutory organisations – and internal accountabilities of Group Executives and Board members of each Trust.

2. Group Governance Structure (2 of 3)

Overview

NHS
St George's, Epsom and St Helier
University Hospitals and Health Group

In high level terms, the approach to the Group Operating Model will provide for the following:

Accountability for day-to-day operations, safety and performance will be devolved to sites. This would include responsibility for: implementation of Group strategy at site level; local service transformation; oversight of clinical safety; delivery of operational performance standards; delivery of control total and cost improvement plans; site-based workforce planning; site-level risk management; management of local estates and site infrastructure; oversight of place interface; and oversight of research and educational delivery.

The Group Executive will be responsible for strategic direction and support to sites. This will include: development of Group-wide strategy; oversight of Group benefits; enabling site performance; developing Group-wide policies, standards and frameworks; developing a Group-wide approach to risk; leadership of corporate governance; promoting cultural alignment across the Group; leading equality, diversity and inclusion across the Group; leading engagement with the ICSs; and development Group-wide communications.

The Group Executive and Sites will develop collaborative ways of working, which will include matrix working, joint Group and Site teams meeting jointly to solve key challenges, with a range of mechanisms to ensure that collectively grip is maintained on quality, operational performance, and finance and effective assurance is provided upwards to the two Boards.

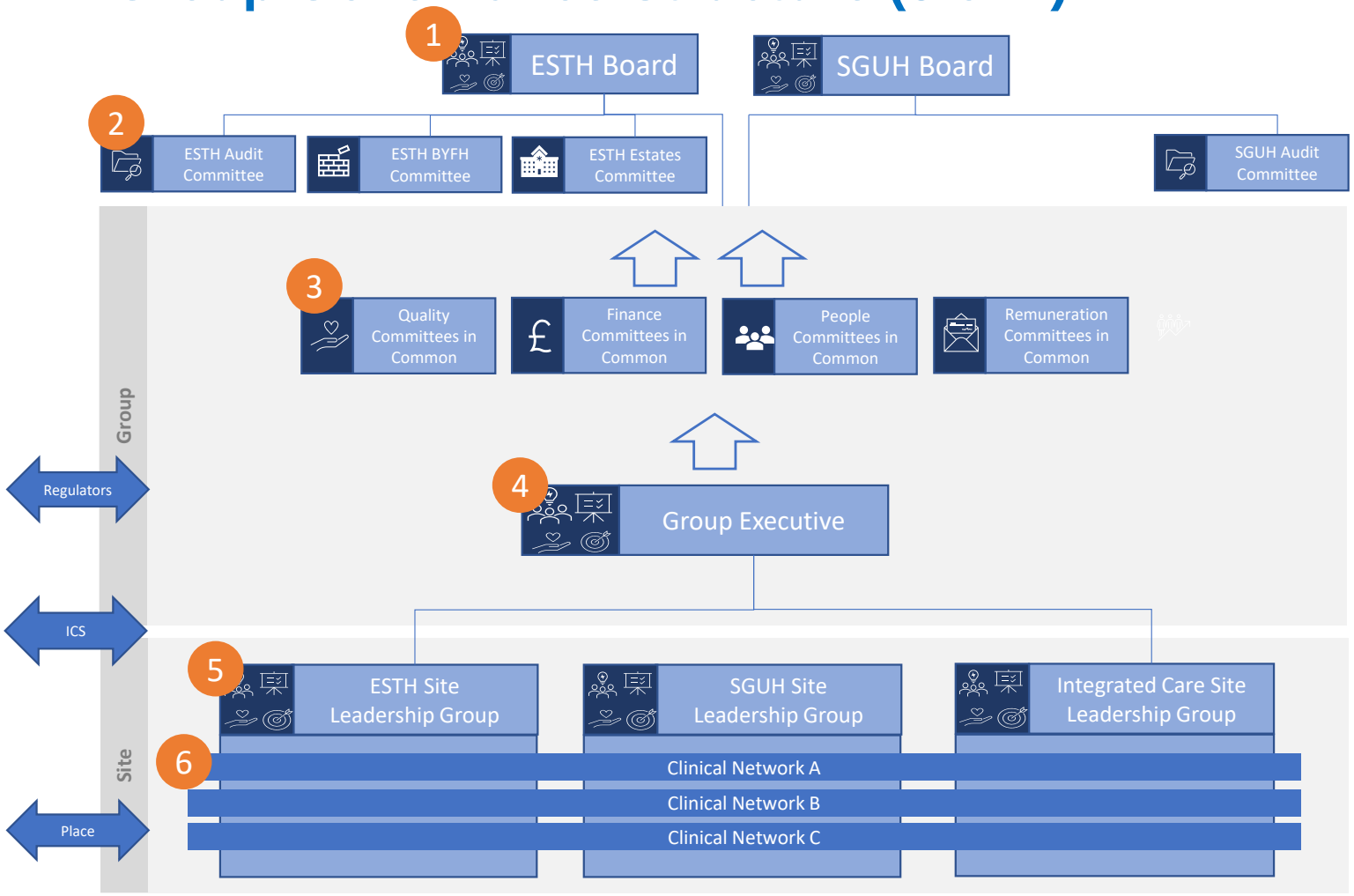
The Group Executive will develop plans for the establishment of Group-wide corporate services where these plans assist in the delivery of the anticipated Group benefits.

The new structure will support enhanced oversight and assurance across the two Trusts, as well as enhance the Trusts' effectiveness working at Place, with the South West London and Surrey Downs Integrated Care Systems, and with regional and national bodies.

Collaboration will be furthered by the development of clinical networks between clinical teams across the organisations.

2. Group Governance Structure (3 of 2)

St George's, Epsom and St Helier
University Hospitals and Health Group



1. **Boards** set strategy, hold Executive accountable and shape culture for each sovereign Trust
2. **Audit Committees** provide Trust-specific scrutiny of internal control, governance and compliance
3. **Committees-in-Common** meet concurrently and provide assurance to each Board on issues within their remit.
4. **Group Executive** responsible for developing strategy, ensuring robust governance, developing culture and leading system engagement
5. **Site leadership** with devolved accountability for day-to-day operations, safety and performance managed through local Trust Management Groups
6. **Clinical networks** across Trusts develop collaboration between teams, led by local clinicians, aligned with divisions

3. Board Committees

Developing ‘in-common’ arrangements

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

To promote greater scope for greater collaboration, enhanced assurance and shared learning, the quality, finance and people committees would meet ‘in common’.

- Under these arrangements, Board Committees for each trust will be constituted with their own separate chairs, their own memberships, and would need to be quorate in their own right.
- Meetings of ‘in common’ committees will be chaired by one of the two committee chairs on an alternating basis.
- Meetings of ‘in common’ committees will operate with a single agenda, developed to cover the respective assurance needs of both committees.
- These single agendas will provide for both common agenda items as well as items that are specific to an individual trust.
- A single set of minutes and a common action log would be prepared for the committees-in-common.
- Audit Committees would continue to meet separately in order to provide assurance to their respective boards on the robustness of governance and internal control for each separate corporate entity.

A summary of the role, key duties, standard monthly reports, membership and attendance for each of the proposed committees-in-common are set out in slides 8-10. The detailed Terms of Reference for the Quality and Finance Committees are attached. The Terms of Reference for the People Committee will be presented to the Board following review by the People Committees which meet later this month.

The key points to highlight in terms of changes to the committees’ proposed responsibilities are:

- That patient-related equality, diversity and inclusion issues be brought within the scope of the Committee and move, on the ESTH side, from the People Committee;
- That health and safety be transferred from the Quality Committee to the Finance Committee given the synergy between this and the estates roles of the Finance Committee

The Board is asked to review and approve the following:

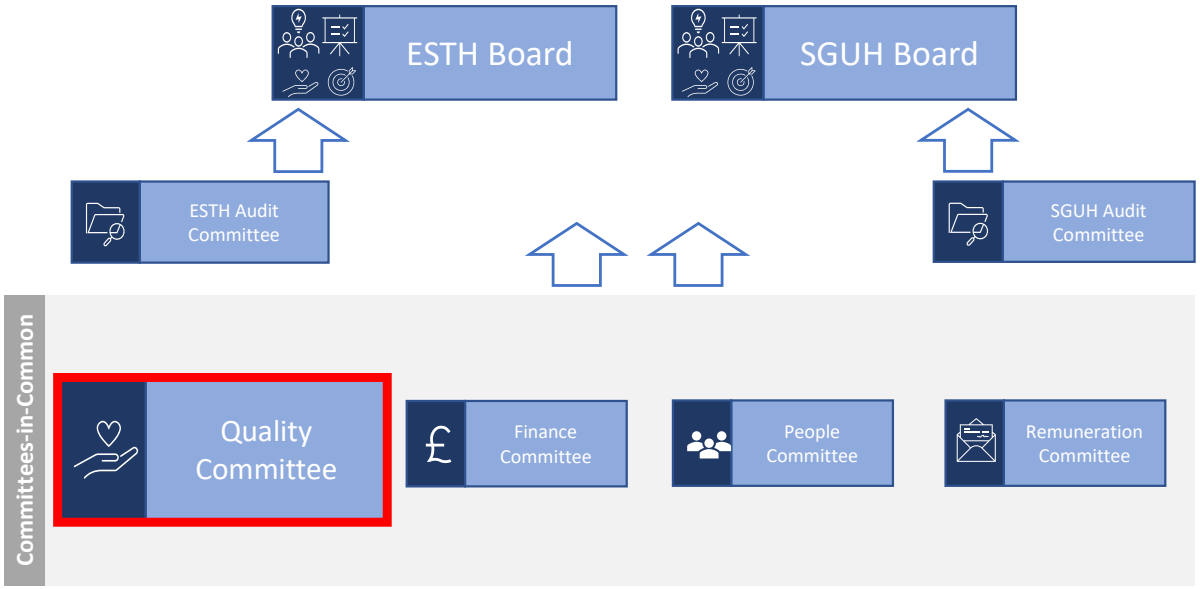
- Terms of Reference and 2022/23 annual business plan for the Quality Committee (Appendix 1 and Appendix 2)
- Terms of Reference for the Finance Committee (Appendix 3)

3. Board Committees
Quality Committee

St George's, Epsom and St Helier
University Hospitals and Health Group

Role

The role of the Quality Committee is to provide assurance to the Board on the quality of care provided by the Trust, specifically in relation to patient safety, clinical governance and effectiveness, and patient experience. The Committee is responsible for ensuring the Trust has in place appropriate quality and clinical governance systems, processes and controls to achieve high quality care; to identify and review key themes and trends in quality indicators, assess risks to the delivery of high quality care, and oversee the implementation of the quality and safety strategy and associated plans.



Key duties

- Patient safety
- Clinical Effectiveness
- Patient Experience
- Research
- Health and Safety

Standard reports

- Quality Performance Report
- Serious Incidents
- Safe Staffing
- Risk Report
- Deep Dive

Membership

- x4 NEDs (inc. Committee Chair)
- Group Chief Medical Officer
- Group Chief Nursing Officer & DIPC
- Managing Director(s)

Regular attendees – at all meetings

- Trust Chief Medical Officers
- Trust Chief Nursing Officers
- Trust Chief Operating Officers
- Director of Quality
- Governance & Compliance
- Group Chief Corporate Affairs Officer

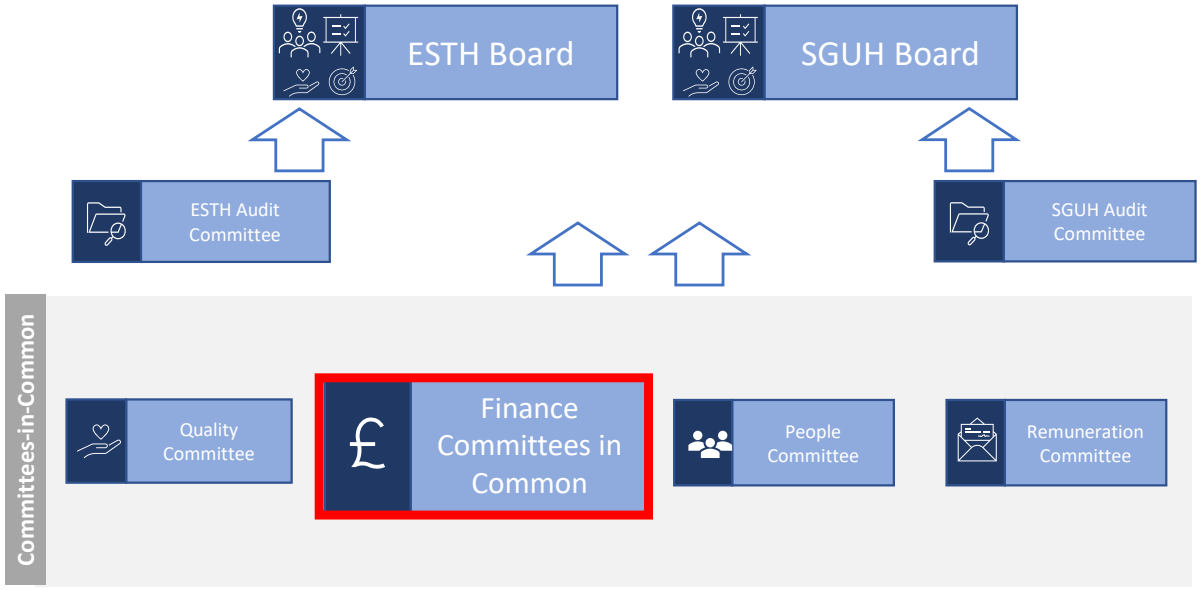
3. Board Committees
Finance Committee

NHS
St George's, Epsom and St Helier
University Hospitals and Health Group

Role

The role of the Finance Committee is to assist the Board in maximising its healthcare provision within the available constraints by:

- Approving the annual financial plan and reviewing financial performance to ensure the Trust achieves its financial goals and uses public funds wisely
- Approving the annual operational plan and reviewing performance to ensure the trust achieves its annual performance targets
- Reviewing and approving investment in service development opportunities and approving tenders
- Overseeing management of the Trust's estates, facilities and IT services



Key duties

- Financial and Business Planning
- Financial strategy and management
- Procurement
- Business cases, benefits realisation
- Operational performance
- ICT
- Estates

Standard reports

- Monthly Finance Report
- Financial Planning Report
- Integrated Performance Report
- Risk Reports
- Business Cases

Membership

- x4 NEDs (inc. Committee Chair)
- Group Chief Finance Officer
- Group Deputy CEO
- Group Chief Medical Officer **or** Group Chief Nursing Officer & DIPC
- Managing Director(s)

Regular attendees – at all meetings

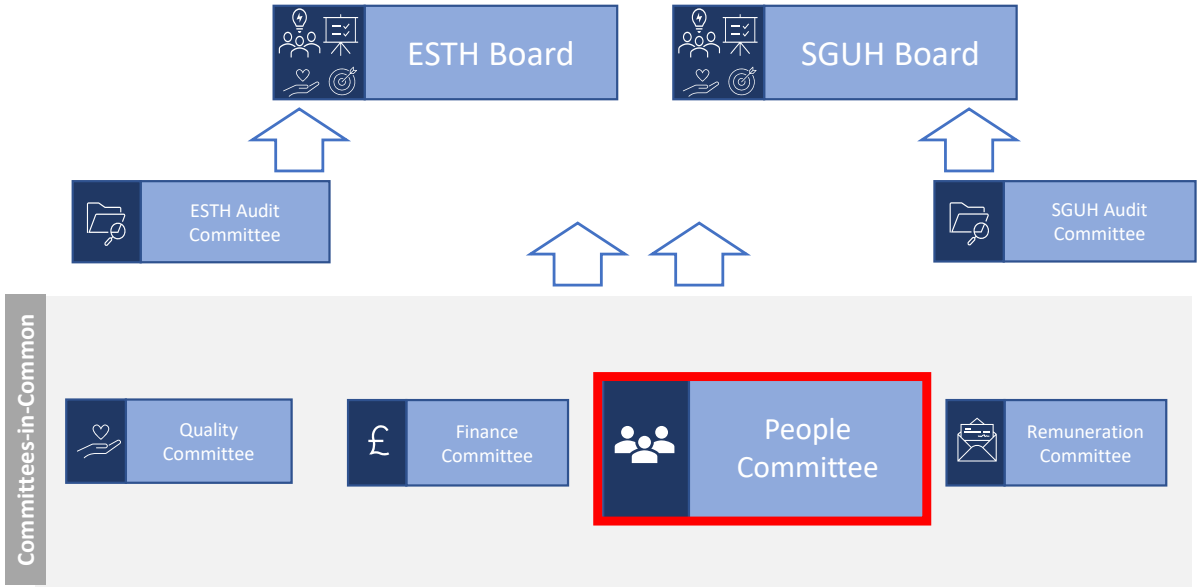
- Deputy CFO (both sites)
- Trust Chief Operating Officers
- Chief Digital Officer
- Group Chief Corporate Affairs Officer

3. Board Committees
People Committee

St George's, Epsom and St Helier
University Hospitals and Health Group

Role

The role of the People Committee is to provide assurance to the Board on the delivery of the Trust's strategies and action plans in relation to workforce. The Committee is responsible for overseeing and monitoring workforce planning, employee relations, education, staff health and wellbeing, and the impact of workforce on the overall performance of the Trust. It oversees the work of the Trust in developing organisational culture and values. It is responsible for seeking assurance in relation to equality, diversity and inclusion within the Trust's workforce.



Key duties

- Workforce Planning
- Employee Relations
- Staff Engagement
- Culture
- Equality and Diversity
- Education and Development

Standard reports

- Workforce KPIs
- Diversity and inclusion report
- Risk Report
- Deep dive

Membership

- x4 NEDs (inc. Committee Chair)
- Group Chief People Officer
- Group Chief Medical Officer
- **or** Group Chief Nursing Officer & DIPC
- Group Chief Finance Officer
- Managing Director(s)

Regular attendees – at all meetings

- Deputy CPO – OD & Culture
- Deputy CPO – HR Ops
- HR Director of Strategy, Planning and Change
- People Director
- Group Chief Corporate Affairs Officer

4. Memorandum of Understanding

A framework for closer collaboration

NHS
St George's, Epsom and St Helier
University Hospitals and Health Group

Under the new Group arrangements, Epsom and St Helier University Hospitals NHS Trust and St George's University Hospitals NHS Foundation Trust remain separate legal entities. As such it is important that there is a clear framework for the closer collaboration between the two organisations which will be achieved through the formation of the Group.

A draft Memorandum of Understanding (MoU) has been developed between ESTH and SGUH. An MoU is not legally binding, but sets out the agreement reached between the Trusts and their expectations of each other.

The draft MoU sets out:

a) The parties to the Memorandum, and summary background to the Trusts;

b) The purpose of the Memorandum in setting out the intentions and responsibilities of the parties

c) The purpose and scope of the Group, drawing on the strategic case

d) The governance of the Group, including leadership and management arrangements at Group and site level, corporate governance arrangements including the ongoing sovereignty of the two Trusts and their respective Boards and the establishment of committees-in-common, the principles informing the Group operating model;

e) Provisions for the duration, variation and termination of the MoU;

f) Processes for resolving disagreements and disputes arising from the establishment of the Group as provided for under the MoU;

g) Provisions relating to charges and liabilities of the parties;

h) Provisions, at a high level, relating to the sharing of information, with the expectation that an Information Sharing Agreement is incorporated as a Schedule to the MoU.

The MoU, by necessity, will need to be reviewed and updated as the Group develops and the wider collaboration between the Trusts evolves. The MoU is therefore drafted in such a way as to capture the core elements of the collaboration agreed by the Trusts as set out in the Strategic Case and core information related to the purpose, scope and governance of the Group, rather than seeking to set out every potential future area of collaboration between the Trusts. It therefore seeks to provide a high level framework for realising the purpose of establishing the Group rather than a detailed operating framework.

The draft MoU is set out at Appendix 4 for consideration by the Board.

5. Information Sharing Agreement

A framework for the lawful sharing of information

NHS
St George's, Epsom and St Helier
University Hospitals and Health Group

The Information Sharing Agreement is intended to provide a framework through which the two sovereign Trusts can share information for the purposes of the Group as set out in the MoU. Given that the Group has been established in order to enhance clinical quality and sustainability including delivering services jointly, to maximise capacity of management resources to deliver change, to deliver corporate functions more effectively, and to speak with one voice to key stakeholders, amongst other objectives, it is clear that the Trusts will need to share a range of information in order to realise the purposes and anticipated benefits of the Group. This information is likely to include the sharing of personal data, including some special categories of personal data, as well as other confidential information. An ISA is necessary to set out how the Trusts will ensure that this data sharing will comply with the requirements of relevant data protection legislation and confidentiality obligations, and how the Trusts will assist each other to ensure compliance.

Specifically, it is important to ensure that we have a robust information sharing arrangements that:

- Supports and facilitates the identification and implementation of opportunities for closer collaboration and joint working across the Trusts, particularly clinical collaboration between clinical teams
- Ensures Group Executives and Non-Executives with joint appointments (who are accountable directors at both Trusts) are able to access information they need to discharge their responsibilities.
- Enables the sharing of confidential corporate information (such as Board and Committee papers) with individuals from the "other" Trust.
- Supports the establishment of group-wide corporate functions
- Ensures both Trusts meet their statutory and regulatory obligations in relation to data protection legislation at all times, including in relation to shared personal data, special categories of data, and other confidential information.

The draft ISA sets out:

- The intention and scope of the ISA;
- The agreed purposes for the sharing of personal data and other confidential information;
- The types of shared personal data that would be relevant to the ISA;
- The commitment of both Trusts to comply with data protection legislation;
- Provisions for role-based access to ensure only staff who have a need to know have access to share personal data;
- Arrangements for data retention and storage;
- Provisions relating to personal data breaches;
- Provisions for the resolution of disputes with data subjects or the Information Commissioner;
- Provisions for the review and termination of the ISA

As with the MoU, the ISA will, by necessity, will need to be reviewed and updated as the Group develops and the wider collaboration between the Trusts evolves.

The draft ISA is set out at Appendix 5 for consideration by the Board.

Quality Committee

Terms of Reference

1. NAME

The Committee shall be known as the Quality Committee.

2. AUTHORITY

The Committee is constituted as a committee of the Trust's Board of Directors and is authorised by the Board to:

- Act within its terms of reference.
- Seek any information it requires, and all staff are required to cooperate with any request made by the Committee.
- Instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions.
- Obtain such internal information as is necessary and expedient to the fulfilment of its functions.

3. PURPOSE

The purpose of the Committee is to provide assurance to the Board on the quality of care provided to the Trust's patients, specifically in relation to patient safety, clinical governance and clinical effectiveness and patient experience, as summarised below:

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

4. DUTIES

The Committee's duties as delegated by the Trust Board, include:

Patient Safety

- Seeking assurances that services are safe, and that best practice guidance is being followed, especially in the following areas:
    - Mortality

  - Infection control
  - Pressure ulcers
  - Falls
  - Nursing and medical staffing
  - National Core Standards for Seven Day Working,
  - Maternity standards
  - Safeguarding.
- Identifying the quality impact from any workforce gaps and refer any concerns to the People Committee.
- Review and seek assurance in relation to key risks related to the patient safety.
- The role of reviewing the Integrated Performance Report on a monthly basis will be primarily undertaken by the Finance Committee. The Quality Committee will review key quality indicators as set out above.

Patient Experience

- Monitoring patient experience through the 'Friends and Family Test', national and local surveys, complaints and compliments.
- Monitoring and overseeing issues relating to equality, diversity and inclusion in relation to all matters of patient safety and quality, including access to care and health inequalities.
- Review and seek assurance in relation to key risks related to patient experience.

Clinical Governance and Clinical Effectiveness

- Reviewing and providing assurance to the Board in relation to the structures, systems, processes and controls in place to ensure effective and robust clinical governance within the Trust.
- Monitoring clinical effectiveness through a review of the outcomes from the annual clinical audit programme. This activity will be aligned with the Audit Committee who also have a responsibility in the clinical audit programme.
- Review and seek assurance in relation to key risks related to clinical governance and effectiveness.

Research and Development

- Providing strategic oversight to the Trust's research and development programme, ensuring it is effective and meets the needs of the Trust and the wider NHS.
- Review and seek assurance in relation to key risks related to research and development.

General

- Referring any matter to any other Board Committee and respond to items referred to the Committee from other Board Committees.
- Obtaining assurance on the risks to delivery of the Trust's strategic and corporate objectives in relation to quality and safety with a particular focus on issues that are cross-cutting or trust-wide, or specific issues which should be reviewed at the committee. This includes reviewing regularly relevant risks on

the Corporate Risk Register and reviewing the entries on the Board Assurance Framework which relate to the scope of the Committee.

- Reviewing material findings arising from internal and external audit reports covering matters within the Committee's remit and seek assurance that appropriate actions are taken in response, as requested by the Audit Committee.
- Ensuring there is a system in place to review and approve relevant policies and procedures that fall under the Committee's areas of interest (as shown at Appendix B).
- Receiving and review reports on significant concerns or adverse findings highlighted by regulators, peer review exercises, surveys and other external bodies in relation to areas under the remit of the Committee, seeking assurance that appropriate action is being taken to address these.
- Reviewing any Trust strategies (as shown at Appendix B) prior to approval by the Board (if required) and monitor their implementation and progress.
- Seeking assurance that the Trust is compliant with the requirements of its registration with the Care Quality Commission (CQC) and oversee any remedial action that may be required and monitor progress against any must and should do actions identified by the CQC.

5. CHAIR AND MEMBERSHIP

A non-executive director will be Chair of the Committee and in his/her absence, an individual will be nominated by the remaining members of the Committee to chair the meeting.

The Group Chief Medical Officer and Group Chief Nursing Office are the executive leads for the Committee.

Membership of the Committee comprises:

- Four Non-Executive Directors (including the Chair)
- Group Chief Medical Officer
- Group Chief Nursing Officer
- Managing Director(s)

The following are expected to attend but will not be counted towards quoracy.

- Trust Chief Medical Officer
- Trust Chief Nurse
- Trust Chief Operating Officer
- Director of Quality Governance and Compliance

Other directors and staff may attend meetings with the prior permission of the Chair.

6. REQUIREMENTS OF MEMBERSHIP

Members of the Committee should aim to attend all scheduled meetings, but must attend at least 75% of meetings each financial year. An attendance register shall be taken at each meeting of the Committee and an annual register of attendance shall be included in the Committee's annual report to the Board.

7. QUORACY

In order to achieve quoracy:-

- At least two non-executive directors must be in attendance
- At least two executive directors must be in attendance.

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

8. DECLARATIONS OF INTEREST

All members and those in attendance must declare any actual or potential conflicts of interest which will be recorded in the minutes. Anyone with a relevant or material interest in a matter under consideration must be excluded from the meeting for the duration of the discussion.

The Board has approved the potential conflict relating to those members who are also directors for Epsom and St Helier University Hospitals NHS Trust, so this will not need to be declared at each meeting under normal circumstances.

9. MEETING FREQUENCY

The Committee will meet monthly and ahead of Trust Board meetings so that a report to the Board can be provided and any advice on material matters given. Additional meetings may be called by the Chair as necessary, who may also cancel or rearrange meetings in exceptional circumstances

10. RELATIONSHIP WITH OTHER COMMITTEES

Quality Committee is a committee of the Trust Board and sits alongside other committees of the Board as shown at Appendix A.

11. MEETING ARRANGEMENTS AND SECRETARIAL

The Group Chief Corporate Affairs Officer will ensure secretarial support is provided for the Quality Committee. This will include the following;

- Preparing a forward plan for the Committee.
- Calling for, collating and distributing meeting papers.
- Taking accurate minutes.
- Producing an action log and chasing completion of actions.

The agenda for the meeting will be agreed with the Committee Chair, based on the forward plan and in conjunction with the executive lead.

All papers and reports to be presented at the Committee must be approved by the relevant executive director.

The agenda and the supporting papers for the meeting will be circulated not less than five working days before the meeting.

12. REPORTING

The Committee Chair will provide a report to the Board on the meetings that have taken place since the last Board meeting. This will include a list of items covered and brief narrative descriptions of the topics the Committee Chair considers should be brought to the Trust Board's attention.

An annual report of effectiveness will be prepared by the Committee for review by the Audit Committee and the Board.

13. REVIEW OF TERMS OF REFERENCE

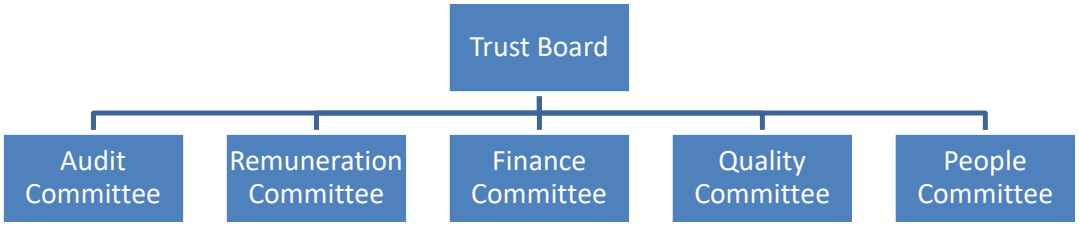
These Terms of Reference shall be subject to an annual review. This review should consider the performance of the Committee including the delivery of its purpose, compliance with the terms of reference and adherence to the Committee's forward plan.

14. DOCUMENT CONTROL

Profile	
Document name	Quality Committee, Terms of Reference
Version	0.2
Executive Sponsor	Group Chief People Officer
Author	Group Chief Corporate Affairs Officer
Approval	
Date of Quality Committee approval	
Date of Trust Board approval	
Date for next review	

Appendix A

Relationship with Other Committees



Appendix B

To be confirmed.

NB: Will be different for each trust.

DRAFT Work Programme
2022/23

MEETING	HEADING	ITEM NO.	ITEM	LEAD	AUTHOR	ACTION	FORMAT	FREQUENCY	TIMES PER YEAR	Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023
QUALITY	OPENING ADMINISTRATION	1.1	Welcome and Apologies	Committee Chair		Note	Verbal	Every meeting	12	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
QUALITY	OPENING ADMINISTRATION	1.2	Declarations of Interest	All		Note	Verbal	Every meeting	12	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
QUALITY	OPENING ADMINISTRATION	1.3	Minutes of Previous Meeting	Committee Chair		Approve	Report	Every meeting	12	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
QUALITY	OPENING ADMINISTRATION	1.4	Matters Arising and Action Log	Committee Chair		Note	Report	Every meeting	12	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
QUALITY	DEEP DIVE	2.1	<Various>	GCNO/GCMO		Assure	Report	Every meeting	12	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
QUALITY	DEEP DIVE	2.1	Never Events Gap Analysis - follow-up	CMO/DCM	DCMO(Quality and	Assure	Report	Annual	1							Y					
QUALITY	SAFETY & QUALITY IMPROVEMENT	3.1	Integrated Quality & Performance Report*	GCNO	Ed Donald	Assure	Report	Every meeting	12	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
QUALITY	SAFETY & QUALITY IMPROVEMENT	3.2	Serious Incidents Report (including Never Events)	GCMO	Jenny Miles	Assure	Report	Every meeting	12	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
QUALITY	SAFETY & QUALITY IMPROVEMENT	3.2	Serious Incidents Thematic Analysis	GCMO	Jenny Miles	Assure	Report	Annual	1											Y	Y
QUALITY	SAFETY & QUALITY IMPROVEMENT	3.3	Mortality Monitoring Committee and Learning from	GCMO	Ashar Wadoodi /Ka	Assure	Report	Quarterly	4		Y			Y			Y			Y	
QUALITY	SAFETY & QUALITY IMPROVEMENT	3.3	Pharmacy Update	GCMO	Vin Kumar	Assure	Report	Quarterly	4		Y			Y			Y			Y	
QUALITY	SAFETY & QUALITY IMPROVEMENT	3.4	Cardiac Surgery Report	GCMO	Steve Livesey	Assure	Report	Quarterly	4			Y			Y			Y			
QUALITY	SAFETY & QUALITY IMPROVEMENT	3.7	Infection Control Report (verbal update)	GCNO	David Shakespeare	Assure	Verbal	Monthly	8	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
QUALITY	SAFETY & QUALITY IMPROVEMENT	3.7	Infection Control Report (including Anti-Microbial S	GCNO	David Shakespeare	Assure	Report	Quarterly	4		Y			Y			Y			Y	
QUALITY	SAFETY & QUALITY IMPROVEMENT	3.7	Maternity Service Updates	GCNO	Janet Bradley	Assure	Report	Quarterly	4	Y			Y			Y			Y		Y
QUALITY	SAFETY & QUALITY IMPROVEMENT	3.8	Health and Safety Report	GCFO	Associate Director	Assure	Report	Bi-annually	2						Y						Y
QUALITY	EFFECTIVENESS	4.2	Seven Day Services Annual Report	GCMO	Carolyn Johnston	Assure	Report	Bi-annually	2		Y					Y					Y
QUALITY	EFFECTIVENESS	4.4	Clinical Audit Annual Plan	GCNO		Assure	Report	Bi-annually	2	Y						Y					Y
QUALITY	EFFECTIVENESS	4.4	Trust-Wide Policy Updates	GCCAO	Head of Corporate	Assure	Report	Bi-annually	2					Y						Y	Y
QUALITY	EFFECTIVENESS	4.4	Medicine's Management and Controlled Drugs Rep	GCMO	Chief Pharmacist	Assure	Report	Bi-annually	2			Y						Y			Y
QUALITY	EFFECTIVENESS	4.5	Winter Plan*	MD	Chief Operating Of	Assure	Report	Annually	1						Y						Y
QUALITY	EFFECTIVENESS	4.5	Clinical Ethics Committee Report	GCMO		Assure	Report	Annually	1		Y										Y
QUALITY	EFFECTIVENESS	4.6	Controlled Drug Accountable Officer Annual Report	GCMO	Chief Pharmacist	Assure	Report	Annually	1												
QUALITY	EXPERIENCE	5.1	Patient Experience and Engagement Report	GCNO	Head of Patient Ex	Assure	Report	Bi-annually	2					Y						Y	
QUALITY	EXPERIENCE	5.2	National Patient Surveys - Adult Inpatients	GCNO		Review	Report	Ad hoc	1								Y				
QUALITY	EXPERIENCE	5.2	National Patient Surveys - Maternity	GCNO		Review	Report	Ad hoc	1											Y	
QUALITY	EXPERIENCE	5.2	National Patient Surveys - Urgent an Emergency Ca	GCNO		Review	Report	Ad hoc	1												
QUALITY	EXPERIENCE	5.2	National Patient Surveys - Child and Young People	GCNO		Review	Report	Ad hoc	1												
QUALITY	STRATEGY, GOVERNANCE AND RISI	6.1	Patient Safety and Quality Group Report	GCNO	Director of Quality	Assure	Report	Every meeting	12	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
QUALITY	STRATEGY, GOVERNANCE AND RISI	6.2	Board Assurance Framework and Corporate Risk Re	GCCAO	Head of Risk and C	Assure	Report	Every meeting	12	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
QUALITY	STRATEGY, GOVERNANCE AND RISI	6.3	Board Assurance Framework Deep Dive	GCCAO	Head of Risk and C	Assure	Report	Bi-monthly	6	Y		Y		Y		Y		Y		Y	
QUALITY	STRATEGY, GOVERNANCE AND RISI	6.4	Quality Strategy Implementation Update	GCNO		Assure	Report	Bi-annually	2				Y						Y		
QUALITY	STRATEGY, GOVERNANCE AND RISI	6.4	Research & Development Strategy Implementation	GCMO	Associate Medical I	Assure	Report	Bi-annually	2			Y						Y			
QUALITY	STRATEGY, GOVERNANCE AND RISI	6.5	Quality Priorities	GCNO	Director of Quality	Assure	Report	Ad hoc	2										Y	Y	
QUALITY	STRATEGY, GOVERNANCE AND RISI	6.6	CQC Statement of Purpose	GCNO	Director of Quality	Assure	Report	Annually	1								Y				
QUALITY	ANNUAL TRUST REPORTING	7.1	Quality Accounts*	GCNO	Director of Quality	Approve	Report	Annually	2		Y	Y									
QUALITY	ANNUAL TRUST REPORTING	7.1	Complaints Annual Report*	GCNO	Head of Patient Ex	Assure	Report	Annually	1				Y								
QUALITY	ANNUAL TRUST REPORTING	7.1	Duty of Candour Annual Report*	GCNO	Deputy Chief Nurse	Assure	Report	Annually	1							Y					
QUALITY	ANNUAL TRUST REPORTING	7.1	Learning Disability Services Annual Report*	GCNO	Learning Disabilitie	Assure	Report	Annually	1						Y						
QUALITY	ANNUAL TRUST REPORTING	7.1	Mental Capacity Act and Deprivation of Liberty Safe	GCNO		Assure	Report	Annually	1						Y						
QUALITY	ANNUAL TRUST REPORTING	7.1	Infection Prevention and Control Annual Report*	GCNO	Head of Infection P	Assure	Report	Annually	1					Y							
QUALITY	ANNUAL TRUST REPORTING	7.1	Clinical Negligence Scheme for Trusts (CNST) Renev	GCNO		Assure	Report	Annually	1			Y									
QUALITY	ANNUAL TRUST REPORTING	7.1	Human Tissue Authority Report	GCMO		Assure	Report	Annually	1							Y					
QUALITY	ANNUAL TRUST REPORTING	7.2	Caldicott Guardian Annual Report	GCMO	Caldicott Guardian	Assure	Report	Annually	1								Y				
QUALITY	ANNUAL TRUST REPORTING	7.2	Nurse Establishment Annual review	GCNO	Deputy Chief Nurse	Assure	Report	Annually	1			Y									
QUALITY	ANNUAL TRUST REPORTING	7.2	Safeguarding Children Annual Report*	GCNO	Head of Safeguardi	Assure	Report	Annually	1				Y								
QUALITY	ANNUAL TRUST REPORTING	7.3	Safeguarding Adults Annual Report*	GCNO	Head of Safeguardi	Assure	Report	Annually	1				Y								
QUALITY	ANNUAL TRUST REPORTING	7.3	Research & Development Annual Report	GCMO	Associate Medical I	Assure	Report	Annually	1						Y						
QUALITY	ANNUAL TRUST REPORTING	7.3	Claims and Inquests Annual Report	GCCAO	Head of Legal	Assure	Report	Annually	1											Y	
QUALITY	COMMITTEE GOVERNANCE	8.1	Review of Committee Effectiveness	GCCAO	Head of Corporate	Assure	Report	Annually	2										Y		
QUALITY	COMMITTEE GOVERNANCE	8.2	Review of Committee Terms of Reference	GCCAO	Head of Corporate	Assure	Report	Annually	1												
QUALITY	COMMITTEE GOVERNANCE	8.3	Annual Work Programme	GCCAO	Head of Corporate	Assure	Report	Annually	1												
QUALITY	COMMITTEE GOVERNANCE	8.4	Committee Annual Report to Trust Board	GCCAO	Head of Corporate	Assure	Report	Annually	1	Y											
QUALITY	CLOSING ADMINISTRATION	99.1	Any Other Business	All		Note	Verbal	Every meeting	12	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
QUALITY	CLOSING ADMINISTRATION	99.2	New Risks or Issues Identified	All		Note	Verbal	Every meeting	12	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
QUALITY	CLOSING ADMINISTRATION	99.3	Draft Agenda for Next Meeting	Committee Chair		Note	Report	Every meeting	12	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
QUALITY	CLOSING ADMINISTRATION	99.4	Reflections on the Meeting	All		Note	Verbal	Every meeting	12	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	

Finance Committee

Terms of Reference

1. NAME

The Committee shall be known as the Finance Committee.

2. AUTHORITY

The Committee is constituted as a committee of the Trust's Board of Directors and is authorised by the Board to:

- Act within its terms of reference.
- Seek any information it requires, and all staff are required to cooperate with any request made by the Committee.
- Instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions.
- Obtain such internal information as is necessary and expedient to the fulfilment of its functions.

3. PURPOSE

The purpose of the Committee is to assist the Board in maximising the Trust's healthcare provision within available financial constraints by:

- Approving the annual financial plan and reviewing financial performance to ensure the Trust achieves its annual financial targets and uses public funds wisely.
- Approving the annual operational plan and reviewing performance to ensure the Trust achieves its annual performance targets.
- Ensuring financial, workforce and operational plans triangulate.
- Reviewing and approving the investment in service development opportunities and approving tender proposals.
- Seeking assurance in relation to the management of the Trust's estates, facilities and IT services.
- Seeking assurance that key risks relating to finance, performance, IT and estates, as included on the Board Assurance Framework and the Corporate Risk Register, are being effectively managed and mitigated.
- Overseeing the implementation of strategies and other frameworks as listed at **Error! Reference source not found.** and risks to their delivery.

4. DUTIES

The Committee's duties as delegated by the Trust Board, include:

Finance and Business Planning

- Assessing the timeliness and robustness of the annual business planning process.
- Reviewing and recommending the annual financial plan, including capital plan, for approval by the Board.
- Approving cost improvement and income plans and seeking assurances that any resulting service changes are safe and do not have an adverse effect on the quality of patient care.
- Approving returns and submissions on behalf of the Board.
- Reviewing productivity, profitability and efficiency metrics.

Financial Strategy and Management

- Reviewing all aspects of financial performance against plan in order to provide assurances to the Board.
- Approving policies in relation to cash management and ensuring they are effective.
- Reviewing arrangements for effective compliance and reporting in respect of loan covenants in place or other requirements relating to borrowed funds.
- Reviewing and seek assurance in relation to key risks related to the operation of the Trust's financial systems and processes and the delivery of the financial plan.

Procurement

- Overseeing the implementation of the Trust's Procurement Strategy.
- Approving the annual procurement plan and receiving progress reports on their implementation.
- Seeking assurance in respect of the effective operation and financial management of any collaborative activity hosted by the Trust.
- Seeking assurance in respect of the effective operation and financial management of any collaborative activity hosted by the Trust.

Business Cases, Benefits Realisation and Return on Investment

- Reviewing and approving business cases, tenders and bids for new business opportunities and investment required in service developments in line with approved limits in the Trust's financial Scheme of Delegation.
- Considering any significant infrastructure investment prior to proposals being put to the Board for consideration/approval.
- Reviewing benefits realisation and return on investment of major projects.

Operational Performance

- Reviewing the performance of the Trust on a monthly basis across the range of performance indicators within the Integrated Performance Report prior to consideration by the Trust Board, including NHS Constitutional Standards.

- Scrutinising key indicators where performance is deteriorating and/or is off-trajectory and seeking assurance that appropriate actions are being taken to bring performance back to trajectory.
- Reviewing the Trust's performance against any other key metrics and performance indicators included in the NHS System Oversight Framework and seeking assurance that appropriate actions are being taken to bring performance back to trajectory where applicable.
- Reviewing the development of the Trust's operational plan and other relevant regulatory submissions, including the winter plan, prior to submission to the Trust Board for approval.
- Overseeing the Trust's arrangements for, and compliance with, national standards in relation to Emergency Preparedness Resilience and Response (EPRR), and reviewing the annual EPRR submission to NHS England and NHS Improvement.

Estates, information technology, and health and safety

- Seeking assurance in relation to he safe operation and performance of the Trust's estates and facilities, including security management of the Trust's assets and estates.
- Providing oversight and seek assurance in relation to the Premises Assurance Model.
- Making recommendations to the Board about any estate disposal, acquisition or estate change of use in accordance with the Trust's Strategy.
- Seeking assurance in relation to the operation and performance of the Trust's information technology infrastructure, systems and processes.
- Ensuring the Trust has robust processes for complying with health and safety legislation and that all relevant risks are identified, mitigated and reported.

General

- Referring any matter to any other Board Committee and responding to items referred to the Committee from other Board Committees and / or the Board.
- Obtaining assurance on the risks to delivery of the Trust's strategic and corporate objectives in relation to finance, performance, estates and IT with a particular focus on issues that are cross-cutting or trust-wide, or specific issues which should be reviewed at the committee. This includes reviewing regularly relevant risks on the Corporate Risk Register and reviewing the entries on the Board Assurance Framework which relate to the scope of the Committee.
- Reviewing material findings arising from internal and external audit reports covering matters within the Committee's remit and seeking assurance that appropriate actions are taken in response, as requested by the Audit Committee.
- Ensuring there is a system in place to review and approving relevant policies and procedures that fall under the Committee's areas of interest.
- Receiving and reviewing reports on significant concerns or adverse findings highlighted by regulators, peer review exercises, surveys and other external bodies in relation to areas under the remit of the Committee, and seeking assurance that appropriate action is being taken to address these.

- As required, reviewing any Trust strategies within the remit of the Committee prior to approval by the Board (if required) and monitor their implementation and progress.

5. CHAIR AND MEMBERSHIP

A non-executive director will be Chair of the Committee and in his/her absence, an individual will be nominated by the remaining members of the Committee to chair the meeting.

The Group Chief Finance Officer is the executive lead for the Committee

The membership of the Committee comprises;

- Four Non-Executive Directors (including the Chair)
- Group Chief Finance Officer
- Group Chief Nursing Officer / Group Chief Medical Officer
- Managing Director(s)
- Group Deputy Chief Executive Officer

The following are expected to attend but will not be counted towards quoracy.

- Deputy Chief Finance Officer
- Chief Operating Officer
- Chief Digital Officer
- Director of Estates and Facilities

Other directors and staff may attend meetings with the prior permission of the Chair.

6. REQUIREMENTS OF MEMBERSHIP

Members of the Committee should aim to attend all scheduled meetings, but must attend at least 75% of meetings each financial year. An attendance register shall be taken at each meeting of the Committee and an annual register of attendance shall be included in the Committee's annual report to the Board.

7. QUORACY

In order to achieve quoracy;

- At least two non-executive directors must be in attendance
- At least two executive directors must be in attendance.

Non-quorate meetings: Non-quorate meetings may go ahead unless the Chair decides not to proceed. Any decision made by a non-quorate meeting must however be formally reviewed and ratified at the subsequent quorate meeting or the Board.

8. DECLARATIONS OF INTEREST

All members and those in attendance must declare any actual or potential conflicts of interest which will be recorded in the minutes. Anyone with a relevant or material interest in a matter under consideration must be excluded from the meeting for the duration of the discussion.

The Board has approved the potential conflict relating to those members who hold in-common appointments across the St George's, Epsom and St Helier University Hospitals and Health Group, so this will not need to be declared at each meeting under normal circumstances.

9. MEETING FREQUENCY

The Committee will meet monthly and ahead of Trust Board meetings so that a report to the Board can be provided and any advice on material matters given. Additional meetings may be called by the Chair as necessary, who may also cancel or rearrange meetings in exceptional circumstances.

10. RELATIONSHIP WITH OTHER COMMITTEES

Finance Committee is a committee of the Trust Board and sits alongside other committees of the Board as shown at Appendix A.

11. MEETING ARRANGEMENTS AND SECRETARIAL

The Group Chief Corporate Affairs Officer will ensure secretarial support is provided for the Finance Committee. This will include the following:

- Preparing a forward plan for the Committee.
- Calling for, collating and distributing meeting papers.
- Taking accurate minutes.
- Producing an action log and chasing completion of actions.

The agenda for the meeting will be agreed with the Committee Chair, based on the forward plan and in conjunction with the executive lead.

All papers and reports to be presented at the Committee must be approved by the relevant executive director.

The agenda and the supporting papers for the meeting will be circulated not less than five working days before the meeting.

12. REPORTING

The Committee Chair will provide a report to the Board on the meetings that have taken place since the last Board meeting in order to provide assurance to the Board. This will include a list of items covered and brief narrative descriptions of the topics the Committee Chair considers should be brought to the Trust Board's attention.

An annual report of effectiveness will be prepared by the Committee for review by the Audit Committee and the Board.

13. REVIEW OF TERMS OF REFERENCE

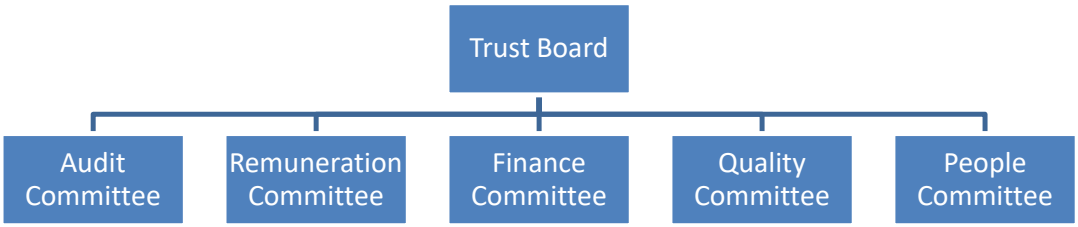
These Terms of Reference shall be subject to an annual review. This review should consider the performance of the Committee including the delivery of its purpose, compliance with the terms of reference and adherence to the Committee's forward plan.

14. DOCUMENT CONTROL

Profile	
Document name	Finance Committee, Terms of Reference
Version	0.2
Executive Sponsor	Group Chief Finance Officer
Author	Group Chief Corporate Affairs Officer
Approval	
Date of Finance Committee approval	
Date of Trust Board approval	
Date for next review	

Appendix A

Relationship with Other Committees



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NHS
Epsom and St Helier University Hospitals
NHS Trust

NHS
St George's University Hospitals
NHS Foundation Trust

Memorandum of Understanding

DRAFT

May 2022

Epsom and St Helier University Hospitals NHS Trust

St George's University Hospitals NHS Foundation Trust

Contents

Epsom and St Helier University Hospitals NHS Trust

St George's University Hospitals NHS Foundation Trust

1. Introduction

1.1 After years of collaboration and creating closer working ties, Epsom and St Helier University Hospitals NHS Trust and St George's University Hospitals NHS Foundation Trust ("**the Trusts**") have formed a hospital group, the St George's, Epsom and St Helier University Hospitals and Health Group ("**the Group**").

1.2 Working as a hospital group enables greater joined-up decision-making for the benefit of local people, a larger and more resilient clinical workforce, reduced variation in levels of care, and greater access to a wider range of services for our patients. The Trusts remain separate legal entities but with a single executive team and harmonised corporate governance arrangements which enable and support closer collaborative working.

1.3 This Memorandum of Understanding is an agreement between the Trusts which sets out the framework through which we are formalising our shared commitment to working more closely together.

2. Parties to the Memorandum

2.1 The parties to this Memorandum are:

- Epsom and St Helier University Hospitals NHS Trust; and
- St George's University Hospitals NHS Foundation Trust

2.2 As parties to the MoU, the Trusts agree to the governance and accountability arrangements set out herein, commit to the vision and principles of the Group, and to maximising the benefits to patients and local communities of strengthening the collaboration between the Trusts.

Background to the Trusts

2.3 Epsom and St Helier University Hospitals NHS Trust (ESTH) is an acute, community and specialist renal services provider based in South West London and Surrey. ESTH provides local hospital services in the London boroughs of Sutton and Merton and the Surry boroughs/districts of Epsom and Ewell, Mole Valley, Elmbridge and Reigate, and Banstead. ESTH operates from two principal sites: St Helier Hospital (SHH) in the London borough of Sutton; and Epsom General Hospital (EGH) in Surrey. In 2020, via the Improving Healthcare Together programme, the Trust secured approval to develop a new Specialist Emergency Care Hospital (SECH) at the Sutton Hospital site in Belmont, Sutton. Under this plan, now termed Building Your Future Hospitals (BYFH) programme, the Trust will retain district hospital services at both SHH and EGH, centralising six major acute services at the SECH. The Trust employs around 6,500 staff.

2.4 St George's University Hospitals NHS Foundation Trust (SGUH) is an acute and specialist services provider based in South West London. SGUH provides local hospital services to the London boroughs of Wandsworth, Merton and south west Lambeth, and a range of specialist services to South West London, Surrey, Sussex and beyond, including major trauma, cancer services, paediatrics, and neurosciences.

SGUH operates from two principal sites: St George's Hospital (SGH) in Tooting, and Queen Mary's Hospital in Roehampton, with additional services provided from St John's Centre in Battersea and the Nelson Hospital in Raynes Park, Merton, as well as a number of community premises. The Trust employs around 9,300 staff.

2.5 Taken together, provision by ESTH and SGUH stretches across a population of around 3 million in South West London and Surrey. Both Trusts operate within the South West London Integrated Care System, with SGUH principally involved in Merton and Wandsworth and ESTH via Sutton Health and Care. ESTH also operates within the Surrey Heartlands Integrated Care System. SGUH's specialist provision and ESTH's specialist renal provision extends into other localities in Surrey Heartlands Integrated Care System and Frimley Health and Care Integrated Care System.

3. Purpose of the Memorandum

3.1 The purpose of this Memorandum is to set out the intentions and responsibilities of the participating Trusts working as the St George's, Epsom and St Helier University Hospitals and Health Group (GESH). In doing so, it codifies the shared ambitions and commitment of the Trusts to work together for the benefit of the patients and communities served by both organisations.

3.2 This Memorandum sets out:

- the purpose of the St George's, Epsom and St Helier University Hospitals and Health Group;
- the principles and operational approach of the Group;
- the governance and accountability arrangements for the Group;
- the arrangements for resolving disagreements and disputes;
- the duration of the agreement;
- provisions for the approval, variation and termination of the agreement;
- the liabilities of the Trusts;
- the arrangements for the sharing of information between the Trusts under the agreement.

3.3 The MoU does not create a new organisation, but rather establishes new ways of working for the benefit of our patients and for meeting the changing needs of our local communities. It does not, and is not intended to, replace or supersede the Standing Orders, Scheme of Delegation, Standing Financial Instructions or the Constitution of either Trust.

3.4 The MoU is not a legal contract between the Trusts. It is not intended to be legally binding and no legal obligations or legal rights shall arise between the parties from this Memorandum. It is a formal understanding between the Trusts which have entered into this Memorandum intending to honour all obligations under it. It is based on the ethos that the Group is established to improve the health and care of people in South West London, Surrey and beyond.

3.5 The MoU does not replace or override the legal and regulatory frameworks that apply to the Trusts as statutory bodies established under the Health and Social Care Act

2006 (as amended). Instead, this Memorandum sits alongside and complements the existing statutory and regulatory frameworks relating to each of the Trusts.

3.6 Nothing in this agreement is intended to, or shall be deemed to, establish any partnership or joint venture between the parties to the Memorandum, constitute a party as the agent of another, nor authorise either of the parties to make or enter into any commitments for or on behalf of the other party.

4. Purpose and scope of the Group

4.1 The overriding purpose of the St George's, Epsom and St Helier University Hospitals and Health Group is to maximise the benefits of collaboration across the two Trusts, in particular:

- Enhanced clinical quality and sustainability through greater scale in the provision of acute, community and specialist care;
- More effective and efficient corporate functions delivered once on behalf of two statutory bodies;
- Maximising the capacity of management resources to deliver change;
- Enhancing the ability of the participating Trusts to speak with one voice to key stakeholders including Integrated Care Systems and regional and national system leaders and to engage effectively at Place;
- Learning from good practice in working with local health and care systems;
- Enhancing co-operation with other Trusts, including through the South West London Acute Provider Collaborative;
- Enabling the Trusts to manage the performance of existing shared services.

4.2 There are significant synergies between the two Trusts' existing strategies and opportunities to enhance and combine the delivery of both strategies through the formation of the Group. The Trusts will work to develop a single Group-wide strategy within which there is a clear articulation of the role and identity of each Trust. This will provide a common sense of direction and clear set of priorities for the years ahead.

4.2 It is expected that the majority of strategic service developments undertaken by the Trusts will benefit from a co-ordinated approach across the Group. Each Trust will remain independently responsible for the planning and delivery of service developments but will ensure a co-ordinated, Group-wide approach is adopted.

4.3 If the Group proposes to establish any partnership or joint venture:

- specific business cases will be prepared for approval by the respective Trusts setting out the costs and benefits on both a Group-wide and Trust basis;
- each business case will set out the terms of any proposed single budget and risk sharing agreement for the initiative.

4.4 The Trusts will continue to be required to submit separate annual plans to NHS England and NHS Improvement annual plans. With the development of a Group-wide

strategy, each Trust's annual plan will be developed in a co-ordinated way across the Group.

Principles informing the Group

4.5 This MoU recognises the sovereignty of the Trusts as independent statutory bodies.

4.6 It recognises that the operation of the Group relies on the agreement of the two boards of directors to delegate powers to groups and individuals to give effect to the Group arrangements.

4.7 To ensure the effective operation of the Group, the Trusts commit to maintain a positive and trusting relationship and promote co-operation and efficient use of resources.

4.8 The Trusts recognise that there will be a need to review the scope and nature of the Group on a regular basis, and that the Group's approach will need to be flexible and responsive and this may necessitate adjustments to the Group model.

4.9 The governance arrangements to take forward the Group will require changes to existing Trust governance so that executive directors are able to operate effectively across the two Trusts.

4.10 The resources that the Trusts commit to the leadership of the Group, as described in this MoU, should used equitably across the Trusts.

5. Governance of the Group

Leadership and management of the Group

5.1 At Executive level, the Group will be led by a Group Executive Team consisting of the posts set out below, all of which are joint appointments across the Trusts:

- Group Chief Executive Officer, who will act as the accountable officer for each of the Trusts;
- Group Deputy Chief Executive Officer;
- Group Chief Medical Officer;
- Group Chief Nursing Officer;
- Group Chief Financial Officer;
- Group Chief People Officer;
- Group Chief Corporate Affairs Officer;
- Group Chief Communications Officer;
- Managing Director – Epsom and St Helier
- Managing Director – St George's
- Managing Director – Integrated Care

5.2 The Group Executives will act as the Executive Directors of each Trust.[1]

5.3 Each of the Managing Directors (for ESTH, SGUH and Integrated Care) will lead a site-based leadership team which is structured for the specific needs of each site.

Group governance arrangements

5.1 Each Trust within the Group will continue to be led by their Board of Directors, under the leadership of a Group Chairman. The Board of Directors for each Trust will continue to be responsible for setting strategy, ensuring accountability, and shaping a healthy culture. Each Board will hold separate meetings in public every other month. Board development will be undertaken on a group-wide basis.

5.2 Each Board will be supported by a Committee structure which will provide the Board with assurance in relation to the issues within its terms of reference.

5.3 Under the Group arrangements, each Board's Committee structure will provide for meetings to be held 'in common' with the corresponding Committee of the other Trust for the following Committees:

- Quality Committee
- Finance Committee
- People Committee

5.4 The following arrangements will apply to meetings of Committees-in-Common:

- A common terms of reference will apply for each in common Committee;
- Each Committee (from each Trust) will need to be constituted and quorate in its own right;
- The chairing of meetings will alternate between the chair's of each Trust's Committee;
- Meetings will operate with a single agenda, which will provide for reports from each Trust on the same subject to be taken under the same agenda item, and items specific to each Trust to be taken separately on the agenda;
- A single set of minutes for each meeting will be prepared.
- A common format of agendas, minutes, action logs, and papers will be used;
- Governors from SGUH will be permitted to attend as observers.

5.5 In order to provide assurance to their respective Boards on governance, risk and internal control, each Trust's Audit Committee will meet separately for the first year of the operation of the Group, after which this will be reviewed.

5.6 All other Board Committees will be held on a Trust-specific basis.

[1] Managing Directors are Executive Directors of the Trust for which they hold functional responsibilities.

5.7 The core governance documents for the Group will be the individual Establishment Orders / Constitutions, Standing Orders, Schemes of Delegation, and Standing Financial Instructions of the constituent Trusts. These documents will be developed to reflect the new Group arrangements and will be developed to ensure consistency in process and delegations within the Trusts across the Group.

5.8 The Boards of each Trust will provide effective oversight of the management of the interests of directors that relate to the Group.

5.9 The Group will develop a 'governance manual' which will describe the system of governance, assurance and internal control at Trust and Group level, with reference to the two organisations.

Group operating model

5.10 A Group Operating Model will be prepared which will set out the role of the Group Executive and the role of the site-based leadership teams. The following principles underpin the Group Operating Model:

- Focus on the delivery of benefits to our patients and staff working together as a Group;
- Deliver on our aspiration to be clinically-led organisations: empowering clinical teams to develop solutions to their problems, supporting clinical leaders to see and lead all aspects of their service, and ensuring clinicians shape every aspect of how the organisations run;
- Take decisions that affect the Group with a single mind, and foster a collective / shared purpose across the wider leadership teams;
- Empower site teams to deliver, and delegate decision-making authority to the lowest appropriate level, supported by a common accountability framework;
- Ensure clarity of roles and responsibilities at all levels across the Group to avoid duplication, supported by a standardised governance framework across the sites;
- Support clinical collaboration and reduce unwarranted clinical variation whilst supporting sites to respond to the different needs of their local communities and to actively embrace the local cultures of the different sites;
- Recognise the continuing legal and regulatory requirements of the Trusts as sovereign statutory organisations – and internal accountabilities of Group Executives and Board members of each Trust.

5.11 In high level terms, the approach to the Group Operating Model will provide for the following:

- Accountability for day-to-day operations, safety and performance will be devolved to sites. This would include responsibility for: implementation of Group strategy at site level; local service transformation; oversight of clinical safety; delivery of operational performance standards; delivery of control total and cost improvement plans; site-based workforce planning; site-level risk management; management of local estates and site infrastructure; oversight of place interface; and oversight of research and educational delivery.

- The Group Executive will be responsible for strategic direction and support to sites. This will include: development of Group-wide strategy; oversight of Group benefits; enabling site performance; developing Group-wide policies, standards and frameworks; developing a Group-wide approach to risk; leadership of corporate governance; promoting cultural alignment across the Group; leading equality, diversity and inclusion across the Group; leading engagement with the ICSs; and development Group-wide communications.
- The Group Executive and Sites will develop collaborative ways of working, which will include matrix working, joint Group and Site teams meeting jointly to solve key challenges, with a range of mechanisms to ensure that collectively grip is maintained on quality, operational performance, and finance and effective assurance is provided upwards to the two Boards.

Group shared services

5.12 The Group Executive will develop plans for the establishment of Group-wide corporate services where these plans assist in the delivery of the anticipated Group benefits.

5.13 Any Group-wide corporate services will be developed within a framework which will set out clearly arrangements for the hosting and / or employment of staff, arrangements for establishing service level agreements and cross charging mechanisms and rates, exit arrangements, and communications plans. Once developed, these arrangements will be incorporated as a schedule to this Memorandum.

6. Duration

6.1 This MoU shall commence on the date of the signature of the parties, following review and approval by the two boards of directors.

6.2 The agreement shall be reviewed within its first year of operation to ensure it remains consistent with the evolving requirements of the Group. It shall thereafter be subject to an annual review of the arrangements by the boards of directors of the parties.

7. Variation

7.1 This Memorandum, and any schedules to it, may only be varied by written agreement of both parties, following review and approval by the Trusts' boards of directors.

8. Termination

8.1 The agreement shall remain in force until it is terminated. Either of the Trusts may terminate this agreement with the approval of its board of directors by giving a minimum of six months' notice in writing. Where a notice for termination of the agreement (served by either of the Trusts in accordance with the provisions of paragraph 5.2) expires on the last day of the financial year, the agreement shall terminate on that date. Where the notice expires on any other date, the agreement shall terminate at the end of the financial year in which the notice expires.

9. Resolving disagreements and disputes

9.1 The Trusts will be led by their individual boards of directors, under the leadership of a Group Chairman and Group Chief Executive, supported by a Group Executive team. These arrangements are expected to minimise the scope for disagreements and disputes between the Trusts.

9.2 In the event of disagreements and disputes, the Trusts will take all reasonable steps to reach a mutually acceptable resolution and will attempt to resolve disputes in good faith at the lowest possible level. Decisions on matters related to the overall governance of the Group are reserved to the boards of directors of each Trust.

10. Charges and liabilities

10.1 Except as otherwise provided, the Trusts shall each bear their own costs and expenses incurred in complying with their obligations under this agreement.

10.2 By separate agreement, the Trusts may agree to share specific costs and expenses (or equivalent) arising in respect of the agreement between them.

10.3 The Trusts shall each remain liable for any losses or liabilities incurred due to their own or their employees' actions.

11. Sharing of information

11.1 The Trusts will provide to each other all information that is reasonably required in order to achieve the objectives of the establishment of the Group as provided for in this Memorandum.

11.2 The Trusts have developed a separate information sharing agreement to facilitate joint working and the effective discharge of roles and functions which work across the group. This information Sharing Agreement is attached as Schedule 1 to this Memorandum.

11.3 The Trusts recognise they have obligations to comply with data protection legislation. The Trusts will therefore ensure that they share information, and in particular personal data, including special categories of personal data and other confidential information, in such a way that is compliant with data protection legislation.

11.4 Each Trust shall keep in strictest confidence all confidential information it receives from another party to this agreement except to the extent that such confidential information is required by law to be disclosed or is already in the public domain or comes into the public domain otherwise than through an unauthorised disclosure by one of the parties. Each party shall use confidential information received from another party solely for the purpose of complying with its obligations under this Memorandum and for no other purpose. No party shall use any confidential information received under this Memorandum for any other purpose including its own commercial gain outside of the Group or to inform any competitive bid without the express written permission of the disclosing party.

11.5 To the extent that any confidential information is covered or protected by legal privilege, then disclosing such confidential information to the other party to this Memorandum does not constitute a waiver of privilege or of any rights which a party may have in respect of such confidential information.

11.6 Nothing in this paragraph will affect the parties' regulatory or statutory obligations, including but not limited to competition law and data protection law.

XXXX 2022

Epsom and St Helier University Hospitals NHS Trust

St George's University Hospitals NHS Foundation Trust

Schedule 1

Information Sharing Agreement

1 Intention and Scope of this Information Sharing Agreement

1.1 Unless otherwise defined in the MoU or this Information Sharing Agreement (ISA), all capitalised terms in this ISA have the meaning set out in the UK General Data Protection Regulation (UK GDPR) and the Data Protection Act 2018 (DPA 2018) (together the Data Protection Legislation).

1.2 As part of the arrangements set out in the MoU, and in order to fulfill the overriding purposes of the Group as set out in the MoU, the Trusts acknowledge that they will be sharing Personal Data, including some Special Categories of Personal Data as well as other confidential information. The Trusts have therefore agreed to set out in this ISA how they will ensure that this data sharing initiative will comply with the requirements of the Data Protection Legislation and confidentiality obligations, and how they will assist each other to ensure such compliance.

1.3 The Trusts acknowledge and agree that they will share the "Shared Personal Data" (as set out in Appendix 2 to this ISA) and any other confidential information for the "Agreed Purposes" (as set out in Appendix 1 to this ISA), on the basis that they are Joint Data Controllers in relation to the Shared Personal Data.

1.4 The Trusts will periodically review and update this ISA as the collaborative arrangement between them develops and evolves.

2 Single Point of Contact

2.1 The Trusts shall each appoint a single point of contact (SPoC) who will work together to reach an agreement with regards to any issues arising from the data sharing and to actively improve the effectiveness of the data sharing initiative. The points of contact for each of the Trusts are:

SGUH *Data Protection Officer*

ESTH *Data Protection Officer*

3 Compliance with the Data Protection Legislation

3.1 The Trusts shall each comply with all the obligations imposed on a Data Controller under the Data Protection Legislation.

3.2 Each Trust agrees to:

3.2.1 ensure that it Processes the Shared Personal Data fairly and lawfully, and will provide fair processing information to Data Subjects where lawfully required, in accordance with Article 5(1)(a) of the UK GDPR;

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3.2.2 only Process the Shared Personal Data to achieve the Agreed Purposes and not further Process for any other purpose any Shared Personal Data supplied to it by the other Trust (in compliance with Article 5(1)(b) UK GDPR);

3.2.3 only Process Shared Personal Data which is necessary and proportionate about Data Subjects, so as to comply with Article 5(1)(c) of the UK GDPR;

3.2.4 take reasonable steps to ensure that, before any Shared Personal Data is shared, such data is accurate and will promptly notify the recipient Trust of any inaccuracy or deficiency in the quality of the Shared Personal Data (in compliance with Article 5(1)(d) UK GDPR);

3.2.5 keep Shared Personal Data for the minimum retention period specified in the NHS Records Management Code of Practice and maintain a retention policy, together with such other procedures and measures are considered appropriate to secure compliance with Article 5(1)(e) of the UK GDPR;

3.2.6 maintain appropriate technical and organisational measures, in order to comply with Article 5(1)(f) of the UK GDPR, to:

(a) protect against unauthorised or unlawful Processing of the Shared Personal Data and against accidental loss or destruction of, or damage to, the Shared Personal Data;

(b) demonstrate how the UK GDPR is complied with generally, and in connection with this specific arrangement, including through compliance with the requirements of the NHS Data Security and Protection Toolkit; and

(c) ensure compliance with the information security arrangements set out in paragraph 7 below;

3.2.7 ensure that only those employees and agents who need access to the Shared Personal Data will have such access and will be subject to written contractual obligations concerning the Shared Personal Data (including obligations of confidentiality) and have undergone adequate training in the use, care, protection and handling of Personal Data and how it applies to their particular duties;

3.2.8 ensure that its record of processing activities maintained for the purposes of Article 30 of the UK GDPR covers the Processing of the Shared Personal Data for the Agreed Purposes;

3.2.9 ensure there is a written data processing agreement in place with any Data Processor engaged to Process the Shared Personal Data, in accordance with Article 28 of the UK GDPR;

3.2.10 ensure that their registration with the Commissioner reflects the receipt and Processing of the Shared Personal Data; and

3.2.11 not transfer any Shard Personal Data outside the United Kingdom or European Economic Area without conducting appropriate due diligence, notifying Data Subjects and ensuring appropriate safeguards are in place in accordance with Chapter V of the UK GDPR.

3.3 The Trusts agree to take all reasonable steps to comply with the requirements of all relevant laws, good practice, and Codes of Practice issued by the Commissioner.

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4 Lawful, Fair and Transparent Processing

4.1 The Trusts will only share the Shared Personal Data with each other on the "Lawful Bases for Sharing" (as set out in Appendix 3 to this ISA) and only further Process the Shared Personal Data on one or more of the legal bases set out in the Data Protection Legislation.

4.2 The Trusts agree to cooperate so as to ensure fairness to Data Subjects through such means as necessary and on an ongoing basis during the lifetime of this arrangement.

4.3 Each Trust is separately responsible for ensuring that it provides clear and sufficient information to Data Subjects, in respect of the Shared Personal Data, in accordance with the Data Protection Legislation, of the purposes for which it will Process their Personal Data, the legal basis for Processing their Personal Data and such other information as is required by Articles 13 and 14 of the UK GDPR.

4.4 Where appropriate, each Trust shall ensure that it has all necessary consents in place to enable lawful transfer of the Shared Personal Data for the Agreed Purposes.

5 Accuracy of Shared Personal Data and other confidential information

5.1 The Trusts will work together to ensure that any Shared Personal Data and other confidential information is accurate and up to date. In the event that either Trust becomes aware of any changes to the Shared Personal Data or other confidential information, or aware or suspects that any of the Shared Personal Data or other confidential information contains inaccuracies, it shall notify the other Trust without undue delay and work cooperatively to rectify the issue in a timely manner.

5.2 Integration work between the Trusts will further ensure that the Shared Personal Data and other confidential information is compatible between systems, in order to achieve the Agreed Purposes.

5.3 Before sharing, the Trusts will take steps to ensure that the Shared Personal Data and other confidential information are accurate, and it will update the same if required prior to transferring the Shared Personal Data.

6 Data Subjects' Rights

6.1 The Trusts agree that they will each be separately responsible for responding to requests from Data Subjects in respect of the Shared Personal Data.

6.2 The Trusts each agree to provide such assistance as is reasonably required to enable the other Trust to comply with requests from Data Subjects to exercise their rights under the Data Protection Legislation within the time limits imposed by the Data Protection Legislation.

6.3 The SPoC for each Trust is responsible for maintaining a record of individual requests for information, the decisions made and any information that was exchanged. Records must include copies of the request for information, details of the data accessed and shared and where relevant, notes of any meeting, correspondence or phone calls relating to the request. The SPoC for each Trust are detailed in paragraph 2 of this ISA.

7 Data Security

7.1 Any Shared Personal Data and other confidential information will be transferred securely between the Trusts through secure electronic means/NHSmail.

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7.2 The Trusts will have regard to each other's information security and governance needs and take appropriate measures (including any which are requested by the Trust disclosing the Shared Personal Data or other confidential information) to keep the Shared Personal Data or other confidential information secure and prevent unauthorised access to or other Processing of the Shared Personal Data. In particular, this means that each Trust will ensure that:

7.2.1 it adheres to any specified security arrangements notified by the other Trust from time to time;

7.2.2 its personnel will be appropriately trained in matters relating to data protection and confidentiality;

7.2.3 its personnel will have read and accepted the relevant policies and acceptable usage agreements when given access to systems;

7.2.4 its offices and equipment (including in particular portable IT equipment) on which the Shared Personal Data or other confidential information is used or stored will be kept secure and encryption technology will be deployed where possible in relation to the Shared Personal Data;

7.2.5 any Shared Personal Data or other confidential information which is not needed temporarily is stored securely;

7.2.6 any Shared Personal Data or confidential information which is no longer needed permanently is securely destroyed.

8 Role Based Access and Restrictions on use of Shared Personal Data and Other Information

8.1 Each Trust will ensure that only staff who have a 'need to know' or see the Shared Personal Data and other confidential information shared further to this ISA, have access to it.

8.2 Each Trust undertakes to keep the Shared Personal Data or other shared confidential information confidential and to only share it: (a) where necessary for the Agreed Purposes; (b) to comply with a legal obligation; or (c) with the agreement of the originating Trust.

9 Data Retention and Deletion

9.1 All Shared Personal Data or other confidential information should be stored appropriately by each Trust in accordance with that Trust's data storage and retention policies and procedures. No Shared Personal Data or other confidential information should be stored by personnel on their own personal computer systems.

9.2 Each Trust shall ensure that once Shared Personal Data or other confidential information is no longer required and relevant retention periods have expired, Shared Personal Data or other confidential information is securely and permanently deleted in accordance with that Trust's retention and disposal policies or returned to the originating party as appropriate.

10 Personal Data Breaches

10.1 Each Trust shall comply with its obligation to report a Personal Data Breach to the Information Commissioner under Article 33 of the UK GDPR and (where applicable) Data Subjects under Article 34 of the UK GDPR.

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10.2 On one Trust becoming aware of an actual or suspected Personal Data Breach, that Trust agrees to promptly (and in any event within twenty-four (24) hours) inform the SPoC of the other Trust, where the other Trust is likely to be affected by the Personal Data Breach, irrespective of whether there is a requirement to notify the Information Commissioner or Data Subjects.

10.3 The Trusts agree to provide reasonable assistance as is necessary to each other to facilitate the investigation and handling of any actual or suspected Personal Data Breach in an expeditious and compliant manner.

11 Resolution of Disputes with Data Subjects or the Information Commissioner

11.1 In the event of a dispute or claim brought by a Data Subject or the Information Commissioner concerning the Processing of Shared Personal Data against one or both of the Trusts, the Trusts agree to inform each other about any such disputes or claims and will cooperate with a view to settling them amicably in a timely fashion.

12 Review and Termination of this Data Sharing Arrangement

12.1 The Trusts will keep this data sharing arrangement under regular review and will periodically update this ISA to reflect the outcome of this review. This will involve:

12.1.1 considering the purposes for which the Shared Personal Data or other confidential information is being shared between them and ensuring those are accurately reflected in Appendix 1 to this ISA;

12.1.2 assessing whether the Shared Personal Data is still as listed in Appendix 2 to this ISA, and updating Appendix 2 where necessary;

12.1.3 considering the lawful bases on which Shared Personal Data is being shared and ensuring this is accurately reflected in Appendix 3 to this ISA;

12.1.4 considering whether the sharing of the Shared Personal Data remains necessary and proportionate to achieve the Agreed Purposes;

12.1.5 reviewing and updating any Data Protection Impact Assessment covering this data sharing arrangement and considering whether a further Data Protection Impact Assessment needs to be undertaken;

12.1.6 assessing the relevance and accessibility of fair processing information provided to Data Subjects in accordance with paragraph 4.3 of this ISA;

12.1.7 considering whether any issues have arisen in relation to the quality and accuracy of the Shared Personal Data, or the handling of Data Subjects' right, and deciding whether further measures need to be put in place to avoid similar issues in the future;

12.1.8 assessing whether actual and suspected Personal Data Breaches involving the Shared Personal Data have been handled in accordance with this ISA and the Data Protection Legislation, and whether further measures need to be put in place to avoid similar incidents arising, or improve the handling of such incidents, in the future; and

12.1.9 assessing whether this ISA needs to be updated to comply with any amendments to the Data Protection Legislation or guidance from the Information Commissioner.

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12.2 On termination of this ISA, the recipient Trust shall either delete (including all existing copies) or return all Shared Personal Data and other confidential information to the disclosing Trust (at the disclosing Trust's discretion), unless an applicable law requires storage of the Shared Personal Data but only to the extent and for such period as required by such law.

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Appendix 1 to the ISA – Agreed Purposes

12.3 The Trusts consider this data sharing initiative necessary to facilitate collaborative working between the Trusts for the benefit of patients and communities served by both organisations. The Trusts are committed to improving the services they provide to patients through a more harmonised approach, such as through the sharing and enhancing of functions and services.

12.4 The purposes for which the Trusts will share the Shared Personal Data and other confidential information include:

12.4.1 To enable Group Executives and NEDs with joint appointments to freely access information from both Trusts needed to discharge their responsibilities.

12.4.2 To enable the Trusts to share private Board papers and Board Committee papers with each other.

12.4.3 To support the establishment of group-wide corporate functions and support the operation of existing group-wide corporate functions, such as in the establishing and supporting of a single group-wide HR function.

12.4.4 To facilitate the identification and implementation of opportunities for closer collaboration and joint working across the Trusts, particularly clinical collaboration between clinical teams, where those teams remain on a Trust-specific basis.

12.4.5 To manage any potential conflicts of information that may impact on information sharing.

12.4.6 To otherwise achieve the purpose of the St George's, Epsom and St Helier University Hospitals and Health Group as set out in the MoU.

12.4.7 To enable compliance with any data protection obligations as set out in this ISA.

12.4.8 To enable the handling of any complaints, issues or requests in relation to the Shared Personal Data.

12.5 The Trusts acknowledge that sharing information with regulators where appropriate forms part of and is compatible with the Agreed Purposes.

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Appendix 2 – Shared Personal Data

12.6 Shared Personal Data shall include the following types of Personal Data relevant to the following categories of Data Subject:

12.6.1 *Patients: name, contact details, date of birth, gender, NHS number*

12.6.2 *Employees: name, contact details, job role, employment information including but not limited to salary and performance, next of kin*

12.7 Shared Personal Data shall include the following types of Special Categories of Personal Data relevant to the following categories of Data Subject:

12.7.1 *Patients: health data, race/ethnicity, religious beliefs*

12.7.2 *Employees: health data, race/ethnicity, sexual orientation, trade union membership, criminal convictions and offences*

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Appendix 3 – Lawful Bases for Sharing

12.8 The sharing of the Shared Personal Data between the parties will be carried out on the following lawful bases (Lawful Bases for Sharing):

12.8.1 Personal Data:

(a) For the performance of a contract to which the Data Subject is party or in order to take steps prior to entering into a contract, for example in relation to employment contracts (Article 6(1)(b) UK GDPR);

(b) For compliance with a legal obligation, for example, employment law obligations (Article 6(1)(c) UK GDPR);

(c) For the performance of a task carried out in the public interest or in the exercise of official authority, including powers to employ or engage staff, and powers to jointly exercise functions, as set out in Schedule 4 of the NHS Act 2006 (Article 6(1)(e) UK GDPR);

(d) Where the sharing of Shared Personal Data is not further to the exercise of the Trusts' public functions, the sharing is in the legitimate interests of the Trusts (having taken account of the rights and interests of Data Subjects) (Article 6(1)(f) UK GDPR).

12.8.2 Special Categories of Personal Data:

(a) For the purposes of carrying out the obligations and exercising specific rights of the Trusts or of the Data Subjects in the field of employment and social protection law (Article 9(2)(b) UK GDPR and Schedule 1, paragraph 1 of the DPA 2018);

(b) For the purpose of providing health care and as part of the management of healthcare services and systems (Article 9(2)(h) UK GDPR and Schedule 1 paragraph 2 of the DPA 2018;

(c) For the establishment, exercise or defence of legal claims, for example, where a Data Subject initiates a legal claim against one or both of the Trusts, and in order to properly defend that legal claim, the Trusts need to cooperate and share information (Article 9(2)(f) UK GDPR);

(d) Where the Shared Personal Data includes information relating to criminal convictions and offences, where such sharing is carried out under official authority or is authorised by law, such as in relation to the sharing of DBS information relating to staff members, where those staff members will be a shared resource between the Trusts (Article 10 UK GDPR).

12.9 This ISA, together with any other relevant documentation forms an Appropriate Policy Document for the purposes of Schedule 1, Part 4 of the DPA 2018.

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Meeting Title:	Trust Board		
Date:	5 May 2022	**Agenda No**	4.2
Report Title:	Use of the Trust Seal		
Lead Director/ Manager:	Stephen Jones, Group Chief Corporate Affairs Officer		
Report Author:	Geoff Stokes, interim Head of Corporate Governance/Board Secretary		
Presented for:	Assurance		
Executive Summary:	Under s8.2 of the Trust's Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions, there is a requirement for the use of the Trust seal to be reported to the Board. Appendix 1 shows the sealing register for 2021/22.		
Recommendation:	Trust Board is asked to note the report for assurance.		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	Well Led		
Single Oversight Framework Theme:	All		
Implications			
Risk:	Improper use of the Trust seal may make contracts invalid or expose the trust to unauthorised liabilities.		
Legal/Regulatory:	Application of the Trust seal is set out in the Standing orders, Reservation and Delegation of Powers and Standing Financial Instructions.		
Resources:	Not relevant to this report		
Equality and Diversity:	Not relevant to this report		
Previously Considered by:	N/A	**Date**	N/A
Appendices:	Sealing Register 2021/22		

Ref	Date	Title	Reason	Signatories	Witness
720	29/04/2021	**Deed of Termination**	The deed of termination to terminate in full the current consortium agreement between St George's, Kingston and Croydon (in triplicate)	Jacqueline Totterdell (CEO) Andrew Grimshaw (CFO)	Tamara Croud (HoCG)
721	29/04/2021	**Consortium Agreement**	The Consortium Agreement	Jacqueline Totterdell (CEO) Andrew Grimshaw (CFO)	Tamara Croud (HoCG)
722	29/04/2021	**Customer Contract**	The Customer Contract between St Georges (As host of SWLP) and St George's (As customer)	Jacqueline Totterdell (CEO) Andrew Grimshaw (CFO)	Tamara Croud (HoCG)
723	29/04/2021	**Customer Contract**	The Customer Contract between St Georges (As host of SWLP) and Kingston (As customer)	Jacqueline Totterdell (CEO) Andrew Grimshaw (CFO)	Tamara Croud (HoCG)
724	29/04/2021	**Customer Contract**	The Customer Contract between St Georges (As host of SWLP) and Epsom and St Helier (As customer)	Jacqueline Totterdell (CEO) Andrew Grimshaw (CFO)	Tamara Croud (HoCG)
725	29/04/2021	**Trust Services Agreement**	The Trust Services Agreement between St George's (As Host of SWLP) and St George's (As service provider)	Jacqueline Totterdell (CEO) Andrew Grimshaw (CFO)	Tamara Croud (HoCG)
726	29/04/2021	**Trust Services Agreement**	The Trust Services Agreement between St George's (As Host of SWLP) and Kingston (As service provider)	Jacqueline Totterdell (CEO) Andrew Grimshaw (CFO)	Tamara Croud (HoCG)
727	29/04/2021	**Joint Protocol for the Management of Retained Staff**	The Joint Protocol for the Management of Retained Staff between St George's (As Host of SWLP) and Croydon for retained staff	Jacqueline Totterdell (CEO) Andrew Grimshaw (CFO)	Tamara Croud (HoCG)
728	29/04/2021	**Joint Protocol for the Management of Retained Staff**	The Joint Protocol for the Management of Retained Staff between St George's (As Host of SWLP) and Epsom and St Helier for retained staff	Jacqueline Totterdell (CEO) Andrew Grimshaw (CFO)	Tamara Croud (HoCG)
729	29/04/2021	**Lease between Kingston and St George's**	Lease between Kingston and St George's in relation to ESL hub at Kingston where the Pathology Services will be located	Jacqueline Totterdell (CEO) Andrew Grimshaw (CFO)	Tamara Croud (HoCG)
730	29/04/2021	**Lease between Croydon and St George's**	Lease between Croydon and St George's in relation to ESL hub at Croydon where the Pathology Services will be located	Jacqueline Totterdell (CEO) Andrew Grimshaw (CFO)	Tamara Croud (HoCG)

Ref	Date	Title	Reason	Signatories	Witness
731	29/04/2021	**Lease between Epsom and St Helier and St George's**	Lease between Epsom and St Helier and St George's in relation to ESL hub at St Helier and St George's where the Pathology Services will be located	Jacqueline Totterdell (CEO) Andrew Grimshaw (CFO)	Tamara Croud (HoCG)
732	29/04/2021	**Trust Services Agreement**	The Trust Services Agreement between St George's (As Host of SWLP) and Croydon (As service provider)	Jacqueline Totterdell (CEO) Andrew Grimshaw (CFO)	Tamara Croud (HoCG)
733	29/04/2021	**Trust Services Agreement**	The Trust Services Agreement between St George's (As Host of SWLP) and Epsom and St Helier (As service provider)	Jacqueline Totterdell (CEO) Andrew Grimshaw (CFO)	Tamara Croud (HoCG)
734	29/04/2021	**Joint Protocol for the Management of Retained Staff**	The Joint Protocol for the Management of Retained Staff between St George's (As Host of SWLP) and St George's for retained staff	Jacqueline Totterdell (CEO) Andrew Grimshaw (CFO)	Tamara Croud (HoCG)
735	29/04/2021	**Joint Protocol for the Management of Retained Staff**	The Joint Protocol for the Management of Retained Staff between St George's (As Host of SWLP) and Kingston for retained staff	Jacqueline Totterdell (CEO) Andrew Grimshaw (CFO)	Tamara Croud (HoCG)
736	29/04/2021	**Lease between Epsom and St Helier and St George's**	Lease between Epsom and St Helier and St George's (As Host of SWLP) in relation to GP hub site at St Helier Hospital	Jacqueline Totterdell (CEO) Andrew Grimshaw (CFO)	Tamara Croud (HoCG)
737	29/04/2021	**Deed of surrender**	The deed of surrender in relation to the surrender of the current lease between St George's (As Host) and Kingston	Jacqueline Totterdell (CEO) Andrew Grimshaw (CFO)	Tamara Croud (HoCG)
738	29/04/2021	**Deed of surrender**	The deed of surrender in relation to the surrender of the current lease between St George's (As Host) and Croydon	Jacqueline Totterdell (CEO) Andrew Grimshaw (CFO)	Tamara Croud (HoCG)
739	29/04/2021	**Purpose specific Information Sharing Agreement**	The Purpose Specific Information Sharing Agreement between St George's, Kingston, Croydon and Epsom and St Helier	Jacqueline Totterdell (CEO) Andrew Grimshaw (CFO)	Tamara Croud (HoCG)
740	13/06/2021	**Lease between NHS Protect Services and the Trust**	Lease for part of the Upper Ground Floor, Queen Mary's Hospital, Roehampton Lane, Putney, London	Robert Bleasdale (CAN), Andrew Grimshaw (CFO)	Tamara Croud (HoCG)

Ref	Date	Title	Reason	Signatories	Witness
741	26/05/2021	**Standard Building Contract with Quantities 2016 (SBC/Q 2016)**	Agreement between the Trust (Employer) and Logan Construction (South East) Limited (the Contractor)	Jacqueline Totterdell (CEO), Andrew Grimshaw (CFO)	Tamara Croud (HoCG)
742	08/11/2021	**Intermediate Building Contract with Contractor's design (Cath Labs) - Enabling Works**	THE EMPLOYER- St Georges University Hospitals NHS Foundation Trust and THE CONTRACTOR- Cuffe Plc	Jacqueline Totterdell (CEO), Andrew Grimshaw (CFO)	Geoff Stokes (HocG)
743	27/01/2022	**Cardiac Catheter Laboratories Refurbishment**	Form of Contract and Schedule of further modifications	Jacqueline Totterdell (CEO), Stephen Jones (CCAO))	Geoff Stokes (HocG)
744	27/01/2022	**Cardiac Catheter Laboratories Refurbishment**	Appendix E - Collateral Warranty for CDP - Wardray Premise Ltd (radiation protection)	Jacqueline Totterdell (CEO), Stephen Jones (CCAO))	Geoff Stokes (HocG)
745	27/01/2022	**Cardiac Catheter Laboratories Refurbishment**	Appendix E - Collateral Warranty for CDP - Fire Delay Contractors Ltd	Jacqueline Totterdell (CEO), Stephen Jones (CCAO))	Geoff Stokes (HocG)
746	27/01/2022	**Cardiac Catheter Laboratories Refurbishment**	Appendix E - Collateral Warranty for CDP - J&R Steel Fabrication	Jacqueline Totterdell (CEO), Stephen Jones (CCAO))	Geoff Stokes (HocG)
747	27/01/2022	**Cardiac Catheter Laboratories Refurbishment**	Appendix E - Collateral Warranty for CDP - Elmstead Mechanical	Jacqueline Totterdell (CEO), Stephen Jones (CCAO))	Geoff Stokes (HocG)
748	27/01/2022	**Cardiac Catheter Laboratories Refurbishment**	Appendix E - Collateral Warranty for CDP - MDN UK Ltd (electrical)	Jacqueline Totterdell (CEO), Stephen Jones (CCAO))	Geoff Stokes (HocG)

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	5 May 2022	**Agenda No**	**4.3**
Report Title:	**Annual Self-Certification of Compliance with Foundation Trust Licence**		
Lead:	Stephen Jones, Chief Corporate Affairs Officer		
Report Author:	Stephen Jones, Chief Corporate Affairs Officer		
Presented for:	Approval		
Executive Summary:	Each year each NHS Foundation Trust must undertake a self-certification of compliance with its licence. The self-certification covers three licence conditions: • Systems for compliance with licence conditions and related obligations (Condition G6) • Availability of resources (Condition CoS7(3)) • NHS foundation trust governance arrangements (condition FT4(8)) • Training of Governors NHS Foundation Trusts are no longer required to submit their self-certifications to NHS England and NHS Improvement (NHSE&I). However, NHSE&I selects a number of Trusts to audit the self-certifications. St George's was selected for audit in 2018 and NHSI (as it was at the time) was content with its self-certification. As there have been no material changes in the process, the self-certification set out in this paper adopts the same approach as used by the Trust in the past few years. The self-certification must be published on the Trust's website by 30 June 2022. The Audit Committee will review the annual self-certification at its meeting on 10 May 2022. As Board meeting dates have changed, this is the last public Board meeting available before the submission deadline, therefore it is proposed that Board make a provisional declaration subject to comment by the Audit Committee.		
Recommendation:	The Board is asked to review the self-certification against each of the licence conditions, including the proposed response in each area. This certification will be uploaded to the Trust's website by 30 June 2022, subject to any comments from Audit Committee.		
Supports			
Trust Strategic Objective:	All objectives		
CQC Theme:	Addresses all five themes: Safe, Effective, Caring, Responsive and Well-led		
NHS Oversight Framework Theme:	Well-led		
Implications			
Risk:	Failure to demonstrate compliance with the Trust's licence conditions could result in regulatory action being taken to enforce the conditions by NHSI.		

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Legal/Regulatory:	An assessment of compliance with licence conditions is required to be undertaken annually and to be approved by the Board.		
Resources:	There are no resource implications.		
Previously Considered by:	Group Executive Meeting	**Date**	4 May 2022
Equality Impact Assessment:	N/A		
Appendix:	N/A		

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Annual Self-Certification of Compliance with Foundation Trust Licence

Trust Board, 5 May 2022

1.0 PURPOSE

1.1 This paper sets out the Trust's proposed annual self-certification against its provider licence. The proposed self-certification is due to be reviewed by the Audit Committee on 10 May 2022.

2.0 BACKGROUND

2.1 NHS England and NHS Improvement (NHSE&I) requires all NHS Foundation Trusts to undertake a self-certification on an annual basis against three licence conditions and one further activity, the training of governors. The purpose of the self-certification is to provide assurance that the Trust is compliant with the conditions of its licence. Compliance with the licence is routinely monitored through the NHS Oversight Framework but the annual self-certification is intended to provide additional assurance.

2.2 Providers were previously required to submit their self-assessments to NHSI via a dedicated portal. However, since 2018 this is no longer the case and NHSE&I instead selects a number of Trusts to ask for evidence that they have self-certified by providing the completed self-certification or relevant Board minutes and papers recording sign-off. In 2018, St George's was selected as one of the Trusts whose self-certification was audited. The Trust provided its self-certification and related documentation, as approved by the Board, and NHSI was satisfied that the process had been completed appropriately. The 2022 self-certification follows the same format and approach undertaken in recent years.

3.0 SELF-CERTIFICATION REQUIREMENTS

3.1 The Trust is required to self-certify the following conditions after the financial year end:

- That the Trust has taken all precautions to comply with the licence, NHS Acts and NHS Constitution. This involves the Trust self-certifying that it has systems and processes that identify risks to compliance with the licence, NHS acts and NHS Constitution and that guard against those risks occurring (Condition G6).

- That the Trust has a reasonable expectation that required resources will be available to deliver designated services over the coming 12 months (Condition CoS7(3)). The Trust is required to self-certify against one of the following statements:

    - The required resource will be available for 12 months from the date of the statement;
    - The required resources will be available over the next 12 months, but specific factors may cast doubt on this; or
    - The required resources will not be available over the next 12 months.

  The required resources include: management resources, financial resources and facilities, personnel, physical and relevant asset guidance.

- That the Trust has appropriate governance structures and systems in place. There is no set approach for demonstrating this, but NHSE&I expects a compliant approach to

involve a review of the effectiveness of the Board and Committee structures, reporting lines and performance and risk management systems (Condition FT4(8)).

- That the Trust has provided adequate and appropriate training to its governors to enable them to carry out their roles.

3.2 For each condition or activity the Trust must either:

- Confirm it has complied with the specific requirement; or
- Confirm it has not complied with the specific requirements, and explain why.

3.3 It is considered good practice to set out a brief statement explaining how the Trust considers it has complied, including any risks and mitigating actions. These will not be submitted to NHSE&I, though NHSE&I may review these should it select the Trust for audit purposes.

3.4 The deadline for completion of self-certifications, except for FT4(8) and G6(3), is the end of May. For FT4(8), the deadline is the end of June, but there is no reason not to provide all responses at the same time. The self-certifications must be published on the Trust's website by 30 June 2022.

4.0 SELF-ASSESSMENT

4.1 The self-assessment set out at Appendix 1 proposes that the Trust is compliant with all three conditions, as well as the additional declaration in relation to the training of governors.

4.2 In relation to licence condition CoS7(3) (sufficient resources to deliver services over the coming 12 months), in previous years the Board has agreed that the Trust confirm that it is compliant notwithstanding the fact that its annual plan forecast a deficit position at year end. It is proposed the Trust again state that it is compliant.

4.3 The views of the Council of Governors are being sought ahead of the Board meeting as to whether Governors are content the Trust makes a positive self-certification in relation to Governor training.

5.0 RECOMMENDATION

5.1 The Board is asked to review and approve the self-certification against each of the licence conditions, and note the proposed response in each area.

Stephen Jones
Group Chief Corporate Affairs Officer
5 May 2022

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APPENDIX 1: SELF CERTIFICATION AGAINST LICENCE CONDITIONS 2021/22: CERTIFICATION DECLARATIONS AND STATEMENTS

Licence condition	Description of licence condition	Suggested declaration (Confirmed / Not confirmed)	Suggested statement
G6	Has the Trust taken appropriate steps to establish, review and maintain systems to identify and effectively manage risks?	*Confirmed*	*The Trust has taken appropriate steps to establish sound arrangements for risk management in the Trust. The Board has developed a Board Assurance Framework and process for assessing the strategic risks set out in the BAF. The BAF contains the controls in place to manage the risk, the sources of assurance that exist, identified gaps in control and assurance and the actions identified to close those gaps. The BAF was formally reviewed by the Board on a quarterly basis during 2021/22. A further review of the BAF is currently being undertaken in the context of the establishment of the Group model with Epsom and St Helier University Hospitals NHS Trust (ESTH) and the arrangements for regular review of the BAF by the Board will continue in 2022/23. In addition, the full BAF will continue to be presented to the Board in public in 2022/23, which addresses feedback provided by the CQC in its December 2019 inspection of the Trust.* *Strategic risks on the BAF are allocated to the Committees of the Board, with the exception of one strategic risk (SR4 - System Working) that is reserved to the Board. The Board Committees review the risks allocated to them on a regular basis and consider the risk scores, including any changes, and assurance statements to the Board. The Audit Committee received a paper setting out the internal control position for the BAF at its meeting in May.* *Risks on the Corporate Risk Register are scrutinised monthly by each of the sub-groups of the Trust Management Group (Patient Safety and Quality Group; People Management Group; Operations Management Group; and Risk and Assurance Group). The Risk and Assurance Group (RAG) provides oversight of corporate risk management level and reports on this to the Trust Management Group (TMG). RAG is supported by the Risk Management and Coordination Group which ensures consistency in the application of the risk management policy. The risks on the Corporate Risk Register inform the risk scoring of the BAF. The BAF is also reviewed by the Group Executive.* *The Trust updated its risk management policy in March 2021. The Audit Committee receives an annual report on the application of the risk management policy. An internal audit of the Trust's risk management processes was undertaken in 2020/21 and was considered by the Trust's Audit Committee in July 2021. The review had an assurance rating of 'reasonable assurance'. An independent clinical governance review has looked at the Trust's risk management process as part of its work. This was reported to the Board in May 2021 and contained findings and recommendations in relation to further strengthening risk management, which the Trust has implemented.*

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Licence condition	Description of licence condition	Suggested declaration (Confirmed / Not confirmed)	Suggested statement
FT4(8)	Does the Trust have in place the governance systems necessary achieve the objectives set out in the licence condition?	*Confirmed*	*Following an external review of governance undertaken in 2017/18, the Trust made a number of changes to strengthen its Committee structures, reporting lines and risk management systems. The changes agreed have been implemented fully and the implementation of these was overseen by the Board.* *The Trust has in place established Board and Committee structures. Committees review their effectiveness on an annual basis and these are used to identify areas for improvement. In 2021/22, committee effectiveness reviews were conducted for the Quality and Safety Committee, Finance and Investment Committee, Audit Committee and the Workforce and Education Committee. These effectiveness reviews seek non-attributed feedback from members and regular attendees. All Committees in 2021/22 were judged to be effective, albeit specific actions to further improve each Committee's effectiveness were identified and have been built into each Committee's plans for 2022/23. Terms of reference for the Committees of the Board are agreed by the Board, and in 2021/22 the Board agreed minor changes to the Terms of Reference of the Quality and Safety Committee, Finance and Investment Committee, Workforce and Education Committee, and Audit Committee. With the creation of the Group model with ESTH, committees-in-common have been formed by the two trusts with Finance, Quality and People Committees replacing Finance and Investment, Quality and Safety and Workforce and Education Committees respectively. These committees started operating from April 2022 and will provide further opportunities for shared learning and collaboration. The Audit Committee will remain a separate entity and will meet independently of its counter-part at ESTH.* *There is an established risk management system (see statement above relating to condition G6). The Trust's performance is reviewed by the Board at each meeting, supported by the work of its committees. The Trust monitors its compliance with the NHS Foundation Trust Code of Governance and with its Constitution.* *The progress the Trust has made in improving its governance systems and processes was evidenced in the latest inspection report by the CQC and the decision of NHS England and NHS Improvement, on the recommendation of the CQC, to take the Trust out of special measures for both quality and finance in March 2020 and December 2020 respectively. These were a significant steps for the Trust, which had previously been placed in special measures for quality in November 2016 and for finance in April 2017.*

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Licence condition	Description of licence condition	Suggested declaration (Confirmed / Not confirmed)	Suggested statement
CoS7(3)	Does the Trust have a reasonable expectation that it will have the required resources available to deliver designated services for the next 12 months?	*Confirmed*	*The Trust was taken out of financial special measures by NHS England and NHS Improvement in December 2020.* *In line with the planning processes in place for 2022/23, the Trust has prepared and submitted a high level financial plan to NHS England and NHS Improvement. The draft financial plan demonstrates a significant deficit at the end of the year but work continues to identify savings and mitigations to reduce the gap and help meet the requirement for the system to achieve an overall breakeven position. The key risks to the financial plan relate to the ability of the Trust to identify and delivery significant levels of savings through transformation and in working to improve capacity to achieve elective recovery. The high levels of cost inflation and reduction in the compensation available for Covid-19 measures add to the risks of delivery.* *The Trust recognises that aspects of its IT infrastructure and estate, in particular, need further investment. Within the financial plan submitted in May the availability of capital funding for the full year is very constrained. Work continues to investigate the impact of this on the management of risks in estates and IT; the available capital is being focused on known priorities. On IT, significant work has been undertaken in 2021/22 to reduce a significant number of IT risks facing the Trust. However, further work is needed and the timeline for completing the work is dependent on the availability of capital funds. On estates, the Board has significantly increased its assurance regarding the management of the estate, and action has been taken to develop a new estates strategy which was approved by the Board in July 2021.* *A new shared senior management structure has been put in place across the Trust and ESTH with the following Group posts being created, all of which took effect from 1 February 2022 with the exception of the Group Chief Executive Officer which commenced on 16 August 2021:* • *Group Chief Executive Officer* • *Group Deputy Chief Executive Officer* • *Group Chief Financial Officer* • *Group Chief Medical Officer* • *Group Chief Nursing Officer* • *Group Chief People Officer* • *Group Chief Corporate Affairs Officer* • *Managing Director for St George's* • *Managing Director for Integrated Care*

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Licence condition	Description of licence condition	Suggested declaration (Confirmed / Not confirmed)	Suggested statement
			• *Managing Director for Epsom and St Helier (note this post is a member of the Group Executive and attends the St George's Trust Board, but is not a member of the Board.* *The capability and continuity of the Board was also maintained with the Council of Governors extending the terms of office of the Chairman and three other non-executive directors at its meeting in March 2022. This will provide continuity and also enable a more graduated succession over the coming years. The Council of Governors also appointed a new non-executive director as Audit Committee chair from October 2021.*

-	Has the Trust taken steps to ensure Governors are equipped with the skills and knowledge they require to fulfil their roles?	*Confirmed*	*The Trust has continued to provide a range of training and development opportunities for Governors to support them in their roles throughout 2021/22. The Covid-19 pandemic has meant that Governors have not had their usual opportunities to attend the Trust for meetings or to participate in PLACE inspections, Ward accreditation visits, and Meet Your Governor events. However, online meetings of the Council of Governors and its Committees, online development sessions and online Members talks have all been held during 2021/22, and in March 2022 the Council of Governors held its first in-person meeting since the start of the pandemic.*
			
			During 2021/22, the following training and development activities were provided to Governors:
			
			• *<u>May 2021:</u> The Trust held a development session for Governors focused on:*
			  ○ *South West London Procurement Collaborative, delivered by the Director of Procurement*
			  ○ *Quality Improvement Academy and transformation, delivered by the Improvement Methodology Director and the Deputy Chief Medical Officer*
			  ○ *Specialist learning disability service, delivered by the Clinical Nurse Specialist for Learning Disabilities*
			
			• *<u>June 2021:</u> The Trust held two separate development sessions:*
			  ○ *A focused session on the Trust's approach to learning from deaths, delivered by the Clinical Effectiveness Manager; and*
			  ○ *Collaboration with Epsom and St Helier University Hospitals, delivered by the Collaboration Programme Director*

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Licence condition	Description of licence condition	Suggested declaration (Confirmed / Not confirmed)	Suggested statement

			• *<u>September 2021</u>: The Trust held an in-depth seminar session for Governors focussed on Covid-19 infection prevention and control and the Trust's Covid-19 vaccination programme. This responded to the interest expressed by Governors at their formal Council meeting in July 2021 for a detailed seminar session on these topics. The session covered the Trust's approach to IPC in the first and second waves of the pandemic, the lessons learnt, the Trust's approach to Covid-19 testing of staff, the Trust's approach to the management of Covid-19 outbreaks, and vaccinations.*
			
			• *<u>January 2022</u>: The Trust funded a development session for Governors provided externally by NHS Providers. The session, delivered as part of NHSP's GovernWell Programme, focused on:*
			  ○ *A detailed briefing on key political, legislative, financial, regulatory and other national developments that were relevant to the NHS;*
			  ○ *A workshop session on membership engagement, the role of Governors in membership engagement, examples of good practice, and reflections on potential engagement activity.*
			
			In addition, governor visits were reinstated during 2021/22 which enabled access to staff and patients in various services across the Trust.
			
			There were no elections to the Council of Governors during 2021/22
			
			Governors receive Parts 1 and 2 Board papers and are welcome to attend Part 2 of the Board as well as the Board Committees as observers. This ensures Governors have a wide range of information available to help them perform their roles effectively.