Outstanding care every time

St George's University Hospitals NHS Foundation Trust

Trust Board Meeting in Public
Agenda

Date and Time: **Thursday 1 September 2022, 10:00 – 12:50**
Venue: **Tooting and Balham Rooms, Wandsworth Professional Development Centre, Building 1, Burntwood School, Burntwood Lane, SW17 0AQ**

Time	Item	Subject	Lead	Action	Format
FEEDBACK FROM BOARD VISITS					
10:00	**A**	**Feedback from visits to various parts of the site**	**Board Members**	-	Oral
1.0 OPENING ADMINISTRATION					
10:30	**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
	1.4	**Action log and matters arising**	**All**	Review	Report
10:35	**1.5**	**Group Chief Executive Officer's Report**	**GCEO**	Inform	Report
2.0 CARE					
10:45	**2.1**	**Quality Committee-in-Common Report**	**Committee Chair**	Assure	Report
		*2.1.1 Safeguarding Children and Adults Annual Report**	**GCNO**	Assure	Report
		*2.1.2 Infection Prevention and Control Annual Report**	**GCNO**	Assure	Report
11:05	**2.2**	**Maternity Services: Perinatal Quality Surveillance Measures July 2022***	**GCNO**	Assure	Report
11:15	**2.3**	**Integrated Quality and Performance Report***	**MD-SGUH**	Assure	Report
3.0 CULTURE					
11:30	**3.1**	**People Committee-in-Common Report**	**Committee Chair**	Assure	Report
		*3.1.1 Medical Revalidation and Responsible Officer Report**	**GCMO**	Assure	Report
4.0 COLLABORATION					
11:45	**4.1**	**Audit Committee Report**	**Committee Chair**	Assure	Report
11:55	**4.2**	**Finance Committee-in-Common Report**	**Committee Chair**	Assure	Report
12:05	**4.3**	**Finance Report (Month 4)***	**GCFO**	Review	Report
5.0 CLOSING ADMINISTRATION					
12:15	**5.1**	**Questions from Governors and Public**	**All**	Note	Verbal
	5.2	**Any new risks or issues identified**	**All**	Note	
	5.3	**Any Other Business**	**All**	Note	
	5.4	**Draft Agenda for Next Meeting**	**Chairman**	Note	Report

These reports were reviewed, discussed and endorsed by the relevant Board Committees and the Committee provided an assurance overview in the reports to the Board.

Time	Item	Subject	Lead	Action	Format
	5.5	**Reflections on meeting**	**All**	Note	Verbal
12:30	**5.6**	**Patient Story**	**GCNO**	Inform	Verbal
12:50	**CLOSE**				

Date of Next Meeting: Thursday 3 November 2022

These reports were reviewed, discussed and endorsed by the relevant Board Committees and the Committee provided an assurance overview in the reports to the Board.

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St George's University Hospitals NHS Foundation Trust

Trust Board
Purpose, Meetings and Membership

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

Membership and Attendees		
Members	**Designation**	**Abbreviation**
Gillian Norton	Chairman	Chairman
Jacqueline Totterdell	Group Chief Executive Officer	GCEO
Ann Beasley	Non-Executive Director/Vice Chairman	AB
Stephen Collier	Non-Executive Director	SC
Paul da Gama	Group Chief People Officer	GCPO
Andrew Grimshaw	Group Chief Finance Officer	GCFO
Jenny Higham	Non-Executive Director (St George's University Representative)	JH
Richard Jennings	Chief Medical Officer	GCMO
Stephen Jones	Chief Corporate Affairs Officer	GCCAO
Peter Kane	Non-Executive Director	PKa
Dame Parveen Kumar	Non-Executive Director	NED
Pui-Ling Li	Associate Non-Executive Director	ANED
James Marsh	Group Deputy Chief Executive Officer	GDCEO
Kate Slemeck	Managing Director – St George's	MD-SGUH
Tim Wright	Non-Executive Director	NED
Arlene Wellman	Group Chief Nursing Officer	GCNO
In Attendance		
James Blythe	Managing Director – Epsom and St Helier	MD-ESTH
Emily Sands	Deputy Head of Communications	DHC
Patricia Morrissey	Head of Corporate Governance	HoCG
Wendy Doyle	Head of Patient Experience and Partnership	HPEP
Apologies		
Thirza Sawtell	Managing Director – Integrated Care	MD-IC
Quorum:	*The quorum of this meeting is a third of the voting members of the Board which must include one non-executive director and one executive director.*	

These reports were reviewed, discussed and endorsed by the relevant Board Committees and the Committee provided an assurance overview in the reports to the Board.

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NHS
St George's University Hospitals
NHS Foundation Trust

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

Thursday 7 July 2022

Tooting and Balham Rooms, Wandsworth PDC

Building 1, Burntwood School, Burntwood Lane, SW17 0AQ

PRESENT		
Gillian Norton	Chairman	Chairman
Jacqueline Totterdell	Group Chief Executive Officer	GCEO
Ann Beasley	Non-Executive Director/Vice Chairman	AB
Stephen Collier	Non-Executive Director	SC
Paul Da Gama*	Group Chief People Officer	GCPO
Andrew Grimshaw	Group Chief Finance Officer	GCFO
Jenny Higham	Non-Executive Director (St George's University Representative)	JH
Parveen Kumar	Non-Executive Director	PKu
Richard Jennings	Group Chief Medical Officer	GCMO
Stephen Jones*	Group Chief Corporate Affairs Officer	GCCAO
James Marsh	Group Deputy Chief Executive Officer	GDCEO
Pui-Ling Li*	Associate Non-Executive Director	PL
Kate Slemeck*	Managing Director – St George's	MD-SGUH
Tim Wright	Non-Executive Director	TW
Arlene Wellman	Group Chief Nursing Officer	GCNO
IN ATTENDANCE		
Matteo Carnio	Senior Corporate Governance Manager (minutes)	SCGM
Wendy Doyle	Head of Patient Experience and Partnership	HPEP
Anna Macarthur	Director of Communications and Engagement	DCE
OBSERVERS		
Tunde Odutoye	Staff Governor, Medical & Dental	TO
John Hallmark	Public Governor, Wandsworth	JH
APOLOGIES		
Thirza Sawtell*	Managing Director – Integrated Care	MD - IC
Peter Kane	Non-Executive Director	PKa

** Non-voting members of the Board*

		Action
1.0	**OPENING ADMINISTRATION**	
1.1	**Welcome, introductions and apologies**	
	The Chairman welcomed everyone to the meeting. The apologies set out above were received and noted.	
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 and Arlene Wellman, as Executive Directors. Ann Beasley also declared her interest as Chair of South-West London and St George's Mental Health NHS Trust.	
1.3	**Minutes of the Previous Meeting**	
	The minutes of the meeting held on 5 May 2022 were approved as a true and accurate record.	
1.4	**Action Log and Matters Arising**	
	The Board noted that there were no open actions on the action log.	
1.5	**Group Chief Executive's Officer (GCEO) Report**	
	The Board received the report from the GCEO, who made the following points: • Significant pressures remained in emergency care and the hospital also had to contend with managing two business continuity events whilst under that pressure. • Covid admissions had increased with 91 Covid positive patients in the hospital on 22 June 2022. However, it was noted that some of these patients were incidental (i.e. attending the hospital for other reasons and being diagnosed as Covid positive). Only two patients had to be admitted to ITU. • The Trust had changed its guidance on mask wearing in its hospitals in line with national infection prevention and control guidance. Masks were no longer required to be worn in hospital except for areas with vulnerable patients. • Mitie staff, who are part the GMB union, had held industrial action on three occasions in May and June. • The Trust was working to develop a Group Strategy by March 2023, which the GDCEO was leading on.	

		Action
	• The GCEO attended the first meeting of the Integrated Care Board for South West London on 1 July 2022. The Board aims to improve outcomes and tackle inequalities in the local population. Members of the public are welcome to join meetings online, via the ICS website. The Chairman is also a member of the Integrated Care Partnership. • The GCEO had recently welcomed the Secretary of State for Health and Social Care and the CEO of Moderna during a visit to St George's. The visit coincided with the Government's announcement of the £1 billion vaccine deal with Moderna to build the country's first manufacturing centre for vaccines. • The Trust had celebrated International Nurses Day, International day of the Midwife; and the first National Healthcare, Estates and Facilities day. • In June the Trust held a range of LGBTQ+ events, celebrating diversity, whilst raising awareness of issues. • Congratulations were due to Professor Chakravorty, Consultant in Acute Respiratory Medicine at St George's and the Director of Medical Education, who was awarded an MBE for his support to Indian doctors during the Covid surge in India last year. • The Trust had received Improving Quality in Liver Services accreditation. TW commended the GCEO for helping the St George's Hospital Charity reach the £5m in 5 years target, which was also well supported by the Trust's clinicians. The Board noted the Group Chief Executive's report.	
2.0	**CARE**	
2.1	**Quality Committee Report** The Chair of the Committee, Professor Dame Parveen Kumar, presented the report of the meetings held on 19 May and 23 June 2022. The following key matters of note from the Committee were highlighted: • A total of four serious incidents (SI) had been declared across April and May 2022, one of which had been declared as a Never Event. Four SI investigations were concluded. It was noted that, in order to facilitate the alignment of processes and thresholds of SIs reporting across the two Trusts within the new St George's, Epsom and St Helier University Hospitals and Health Group, the GCMO was considering a rotation of the composition of SI panels. • Training levels for Basic Life Support (BLS), Immediate Life Support (ILS) and Advanced Life Support (ALS) continued to be below target, despite showing some improvements. A review of the training needs would be completed by the end of June. • Infection Prevention and Control (IPC) – As part of its work programme, the Committee had a monthly focus on IPC in addition to its standing quarterly IPC update.	

		Action
	• A total of 441 Covid-19 positive cases had been detected in the year-to-date, with a total of 19 deaths. There had been three outbreaks on wards in May 2022 which had now been resolved. • In relation to maternity services, the Trust was 100% compliant with regards to immediate and essential actions arising from the interim Ockenden review. This was confirmed through an assurance visit from the Regional Chief Midwife, which took place on 12 May 2022. Congratulations were conveyed to the Director of Maternity and her team. • The Trust had been awarded NIHR Clinical Research Facility designation for the first time and had received funding of £1m from a bid of £3.5 to commence in September 2022. • No changes were reported on the Board Assurance Framework. The Committee also reviewed the Corporate Risks related to quality and safety that sit below the BAF and noted that a review of risk management arrangements and processes across the Group was being undertaken. • The Committee endorsed a framework for the selection of deep dive topics, which it had used in previous years and a fully developed deep dive programme would be presented to the Committee in July. The GCEO enquired about the apparent 40% drop in early warning scores that had been highlighted by the Committee. PKu stated that the Committee was looking into this and that this would be clarified at the next meeting. The Board noted the updates from the May and June 2022 Committee meetings.	**PKu**
2.2	**Learning from Deaths Q4 2021/22 Report*** The GCMO presented the report, and highlighted the following: • Assurance was provided that current outlier alerts were being investigated robustly and that there was a granular understanding of the Trust's mortality data. • The Trust had previously received a mortality alert in relation to trauma and one of the actions to improve the Trust's position was the establishment of a dedicated trauma ward. This work had recently been approved and was due to commence later in the month. This activity provided assurance of work ongoing to improve outcomes in the trauma service. TW commented about learning across the Group and wondered whether the Trust was exploiting all opportunities. The GCMO stated that work was in progress to identify areas for learning, e.g. rotating senior medical staff at SI meetings, which would provide an understanding of each Trust's thresholds for declaring SIs. Another area for learning related to health inequalities, an area in which ESTH had made significant progress, and how to include this data in Learning from Deaths. The Chairman congratulated the GCMO on the quality of the report and for the work undertaken to analyse the Trust's mortality data. The Board noted the report.	

		Action
2.3	**Integrated Quality and Performance Report***	
	The Board received and noted the IQPR for June 2022, which had been scrutinised at both the Finance Committee and Quality Committee the previous week. The MD-SGUH introduced the report, and highlighted the following: • The emergency department (ED) continued to be very busy and the flow of patients out of ED continued to be slower than desired. • A nurse-led programme had been introduced to look at the flow in ED. It was noted that the number of people attending ED was not dissimilar to the number recorded in the pre-Covid period. However, there was an increase in the number of patients with mental health needs coming through ED and who were staying longer. It was noted that there were also issues with staff resilience during this period of sustained pressure. • The Trust recorded an increase in the length of stay, which was impacting on capacity. The reasons for the increase were under investigation. • HR continued to work with managers to support staff with resilience. This work includes making timely OH referrals, supporting staff in the case of long- and short-term sickness, and mitigating actions to improve attendance levels. The Trust is also developing a toolkit to support staff who are off sick and returning after sickness absence. • High occupancy rates along with late discharges, staff absences and infection control measures continued to impact capacity and flow across the hospital. The Trust is working on plans to see how the organisation can respond more quickly to capacity issues, including with system partners to reduce the number of patients waiting for social services. • There is a new focus on triaging activities to identify patients who don't need hospitalisation. • The first Theatre Transformation Board (TTB) took place on 14 June. The TTB looks at improving productivity and access to consumables and equipment. • Improvement was recorded in Diagnostics. At the end of May only 1.5% of patients were waiting for more than six weeks for their diagnostic test compared to 2.4% in April – it was noted that this was one of best rates in London. • On cancer, performance against the 14-day standard continued to improve and had reached 79.8% compared with 75.2% in March 2022. The 62-day performance was at 71.7%, ahead of the agreed trajectory of 70%. • Urology moved into a compliant position, reporting 85.7% compliance on treatments on the 62-day GP pathway. The GDCEO enquired about the upgrade of the Trauma Ward and asked whether the mitigations put in place were enough to maintain patient flow. It was noted that the Trust was opening up other capacity to ensure that this was the case. However, the MD-SGUH noted that repatriation was still an issue and	

		Action
	numbers were going down. Works were planned to start the following week and were expected to last two to three weeks. A question was asked about how the Trust could ensure a more sustainable approach for cancer services. It was noted that the Trust was working to facilitate earlier triage. In addition, it was improving Multidisciplinary Team (MDT) working, which coupled with pathology and radiology expansion will deliver and sustain a faster diagnosis standard. The recorded improvements with compliance were due to the cancer leadership team and the Board thanked the team for its efforts. SC enquired about the effect of the step-up plans which were introduced for May and June and queried whether there was indication that elective activities were going to plan. It was noted that the Trust was monitoring progress and, although there was evidence of very good performance, assurance could not be provided that the Trust would fully meet its targets. Some insight was sought around the reasons for the delays in complaints responses. The MD-SGUH stated that she would arrange for this to be looked into. The GCNO commented that, sometimes the complainants were not engaging in the process, which resulted in the complaints missing deadlines. A question was raised about how the Trust could bring agency rates down. The MD-SGUH explained that work was in progress including the need to emphasise what makes it attractive to come and work at the Trust. The GCEO commented that financial support to staff and help to cope with the increased costs of living were two areas the Trust was looking into. The GCNO highlighted that there were some delays in onboarding which resulted in agency spend. The GCPO highlighted the need to support staff through sickness. In addition, understanding the reason why staff were leaving was important and having earlier discussions at the time of resignation rather than after exit would provide more meaningful insight. The opportunities for development and career progression also required improvement. In terms of equality, diversity and inclusion, it was noted that more white staff were leaving than those in other groups. The Trust Board noted the IPQR report.	**MD-SGUH**
2.3.1	**Breast Recovery Update** The MD-SGUH introduced the report which the Board had asked for at a previous meeting meeting. She highlighted that the one-stop clinic was very successful, but also very intensive for resources, and required a great amount of coordination to deliver triple assessments. Staff were working long hours and this was not sustainable in the long term. The Trust had applied for some funding to increase the capacity of the service, but this had not been granted, and the Trust was therefore reviewing the pathway. Medical job plans were also being reviewed and it was expected that there would be a reduction in the TWR position in the summer and an increase as of October with full recovery by March 2023. PL asked for a clarification on the approach, specifically whether the Trust was asking clinicians to do more with the resources they have and how realistic was it to shift the job plan. The MD-SGUH noted that additional sessions were planned but some of the clinicians had commitments with other services. Job planning had started but had not progressed as rapidly the Trust would have liked.	

		Action
	The GDCEO enquired about the opportunity to change ways of working and queried whether this was enough to fill the gap between demand and capacity. The MD-SGUH explained that the Trust still did not have an answer on that. It had agreed on identifying new ways of working, rather than requesting more funding (which the Trust had done in the past), but more triage work was necessary. The Chairman asked the MD-SGUH to pass the Board's thanks to staff on the good work to date. The Board noted the report.	
3.0	**CULTURE**	
3.1	**People Committee Report**	
	Stephen Collier, Chair of the Committee, provided an update on the People Committee meetings held in May and June 2022 and highlighted the following: • There are advantages to working as a committee-in-common with ESTH, particularly being able to cross-compare experience and develop shared learning. However, Group working was placing additional workload on the Executive team and this would continue to be monitored. • Disclosure and Barring Service (DBS): This was a risk affecting a number of staff who had not provided their DBS checks or whose check had time-expired. SC noted that this was not just an issue of compliance; it posed a potential patient safety risk, and therefore would be escalated to the Trust's corporate risk register. • Workforce Improvement Plan: A programme was underway with a number of strands to receive regular updates and deep-dive reporting. A deep dive on staff turnover had taken place and highlighted three main reasons for staff leaving: health and wellbeing, personal development and career progression. Vertical relationships were also identified as a key reason for turnover and the Trust would explore the data behind this. The GCPO noted that, currently, there were 172 individuals with no DBS checks. Of those, 132 had not yet engaged with the process, despite numerous attempts at contact. The Trust was going to ask them one more time inviting them to a formal interview with their line manager. If, after that, there was still no engagement, the option to proceed with suspensions would be utilised, as required. The Board: • Noted the report; and • Approved the Committee's Terms of Reference and Annual Work Plan.	
4.0	**COLLABORATION**	
4.1	**Audit Committee Report**	

		Action
	In the absence of Chair of the Committee, Ann Beasley presented the report and highlighted the key items considered at the meetings held in May and June 2022. She highlighted the following: • The Audit Committee was assured that there were good working relationships with the Trust's external Auditors and that the Trust had good Governance and processes in place as confirmed by the Head of Internal Audit opinion. • The Audit Committee was reassured by the Quality Accounts 2021/22 which had been scrutinised by the Quality Committee. • In light of the above, the Annual Report and Accounts 2021/22 were recommended to the Board. • The Committee had also received regular reports on Breaches and Waivers, and Counter Fraud activity. The Board • Noted the report, and • Approved the updated Terms of Reference and the Committee's Annual Work Plan for 2022/23.	
4.2	**Finance Committee Report**	
	Ann Beasley, Chair of the Committee, provided an update on the meetings held on 20 May 2022 and 24 June 2022, and highlighted the following: • Estates – The Committee acknowledged that the Trust was in a much better place now compared to a few years ago. An update on the progress in implementing the Green Plan was appended to the report. • IT – The Committee had a comprehensive discussion on cyber security, which was particularly relevant given the current international situation. • Performance – the Committee welcomed improvements in cancer performance in April where 3 of the 7 standards were met, but requested clear trajectories to understand what it would take to achieve all the standards. The Committee understood that some of the targets would not be achieved in this financial year and that more work was needed. • The Finance Committee had discussed the scale of the financial challenges facing the Trust and had recognised the level of risk in relation to delivering a balanced year-end position. It commended the efforts to date, but requested detailed plans on activities and further consideration of the challenges on the cash balance. The Board noted the update and the appended Green Plan implementation progress report.	
4.3	**Finance Report (Month 2)**	
	Andrew Grimshaw, Group Chief Financial Officer, presented the report and noted that it was brief given that it was still early in the new financial year. At present, the Trust was largely on-plan, but the big challenge related to delivery of the required Cost Improvement Programme (CIPs) to achieve a break-even position by year end. At the moment there was not the required	

		Action
	visibility of all the CIPs that were needed in order to achieve that position, and the measure was therefore, rated as 'red'. The Finance team would continue to work to close this gap, but the scale of work is considerable. Capital was on plan and cash resources would continue to be on monitored, with the team running various cash scenarios. The Board noted the report.	
4.4	**Board Assurance Framework Q1 2022/23*** The GCCAO presented the Board Assurance Framework (BAF) Q1 report for 2022/23 and highlighted the following: • The main update to the BAF at Q1 related to financial sustainability, where the risk score had been increased to 25 and the assurance rating downgraded to limited in the context of the significant financial challenges facing the Trust and the wider system. This change had been reviewed and endorsed by the Finance Committee. • In relation to Strategic Risk 4, which was reserved to the Board, the proposal was to keep this at a risk score of 12 and an assurance rating of good. While the Trust was engaging well across the system, and was making clear progress in developing the new Group with ESTH, there remained inherent risk related to the changes being introduced in relation to system working, and the establishment of Integrated Care Boards on a statutory basis. • The paper set out proposed year-end target risk scores for each of the Strategic Risks. As in previous years, these were intended to be stretching but realistic as in-year targets. • A review of the risks on the BAF and the format of the report would be undertaken as part of the planned risk management review. The Board agreed to the score of 12 and the proposed assurance rating of good for the Strategic Risk 4 (system working), which was reserved to the Board. With regards to Strategic Risk 5, financial sustainability., the Board agreed with the recommendation of the Finance Committee to increase the risk score to 25 and to lower the assurance rating to 'limited'. The Board agreed the risk scores and assurance ratings for the remaining 8 strategic risks which had been reviewed by the relevant Board Committees. The Board agreed on the end-of-year target risk scores for all risks. The Chair enquired about the plans for reviewing risk management, and confirmed that she would be supportive of committing additional resources to support this. The GCCAO explained that undertaking a comprehensive and independent review of risk management at the Trust and across the Group was a key priority, having taken on Executive lead responsibility for risk management earlier in the year. It was clear that there were opportunities to strengthen the Trust's approach and to develop robust and aligned risk management processes across the Group. The GCCAO had drafted an approach to undertaking the review and was holding discussions with potential independent external providers to take forward this work. There was a balance to be stuck between completing the review rapidly and ensuring it was comprehensive and	

		Action
	assisted the Trust in developing its approach. Early indications were that the review envisaged could be completed in around two months from the point at which a supplier was appointed. Realistically, the review would likely commence in September and the ambition was to complete the review by late October or early November. The outcomes and proposed changes in approach would ideally be brought to the Board development seminar in early December for discussion. As well as developing a new risk management strategy and policy, risk processes and reporting and ensure these were fully aligned across the Group, the aim was to help foster a growing maturity in the Trusts' approach to risk management. The Board noted the report.	
5.0	**CLOSING ADMINISTRATION**	
5.1	**Questions from Governors and the public** The Chairman noted that no questions had been submitted by members of the public in advance of the meeting and invited questions from Governors. Tunde Odutoye, Staff Governor – Medical and Dental – explained that he had been engaged with the work that HR was doing on DBS checks and suggested that it could have been handled more effectively. He noted that, in some cases, emails, because of their layout and format, were received as junk mail and were deleted by staff. In some cases, a communication went out notifying that some records had been lost and this raised concerns amongst staff. TO also raised concerns about the breast review and noted that this was the third review held in 10 years and seemed to show that while there are plans to change things and make improvements, change was not taking place. The MD-SUGH thanked TO for his comments and noted that the Trust had resources to carry out the changes planned in terms of breast services and was working to design the service around the patients, not around the clinicians. The GCPO responded to the point raised on DBS checks and noted that, when work had started, it was initially believed that this was an administrative exercise and the project was not sufficiently resourced with senior staff. When the complexity of the project became apparent, a team of more senior staff was appointed to take this forward which had improved the process and engagement with staff. The GCPO acknowledged the communications issues regarding emails being recognised as junk mail and confirmed that this was the reason why the Trust decided to make several attempts to communicate with the affected staff. John Hallmark, Public Governor – Wandsworth, asked what could be done to improve the 52 week waits. The MD-SGUH noted that it was affecting a small number of specialties (principally general surgery, ENT, cardiology and plastics). The Trust was working collaboratively with Kingston Hospital to look at how these could be improved.	
5.2	**Any new risks or issues identified** There were no other risks or issues identified.	

		Action
5.3	**Any Other Business** No other business was raised.	
5.4	**Draft Agenda for Next Meeting** The draft Agenda for the next meeting was noted.	
5.5	**Patient Story** The Head of Patient Experience and Partnership presented the patient's story on behalf of the patient concerned, as they wished to remain anonymous given the sensitivities of the subject matter which related to safeguarding. The Chairman thanked the HPEP and asked her to pass on the thanks from the Board to the patient for agreeing to share her story. The Chairman invited Board members to ask questions. AB stated that she was pleased to hear of the good outcome for this patient, she however wondered whether this was a case of good luck or the result of good synergies within the Trust and with other organisations involved. The HPEP reassured that the latter was the case. The GCMO enquired whether there was more the Trust could do to raise awareness of domestic abuse. The HPEP reported that there was a lot of work underway which overlapped with the work of the homeless team. She noted that there was always more that could be done to help. If people felt uncomfortable or did not know what to do, there was always the opportunity to refer them to someone who can help. PKu enquired what had happened to the perpetrator. The HPEP would ask the Safeguarding Team for an update and provide feedback in confidence.	
	CLOSE	
Date of next meeting: Thursday, 1 September 2022, venue tbc		

The meeting closed at 11:50

Trust Board (Public) - 1 September 2022

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St George's University Hospitals
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Action Log

ACTION REFERENCE	MEETING DATE	ITEM NO.	ITEM	ACTION	WHEN	WHO	UPDATE	STATUS
PUBLIC220707.1	7 Jul 2022	2.1	Quality and Safety Committee Report	Clarify 40% drop in early warning scores	1 Sep 2022	GCMO / GCNO	Oral update to be provided at meeting	DUE
PUBLIC220707.2	7 Jul 2022	2.3	Integrated Quality and Performance Report	Provide insight on the reasons for the delays in complaints responses	1 Sep 2022	MD-SGUH / GCNO	Oral update to be provided at meeting	DUE

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St George's University Hospitals NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	1 September 2022	**Agenda No**	**1.5**
Report Title:	**Chief Executive Officer's Report**		
Lead Director/ Manager:	Chief Executive Officer		
Report Author:	Jacqueline Totterdell, CEO		
Presented for:	Update		
Executive Summary:	A summary of key events over the past two months to update the Board on strategic and operational activity at SGUH.		
Recommendation:	To note the update.		
Supports			
Trust Strategic Objective:	Well-led		
CQC Theme:	Leadership and improvement capability (well-led)		
Single Oversight Framework Theme:			
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Equality and Diversity:	N/A		
Previously Considered by:	N/A	**Date**	N/A
Appendices:			

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NHS
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Chief Executive Officer's Report

Introduction

We are approaching the end of a hot and challenging summer. Heatwaves, the continued impact of COVID-19, and strained emergency departments have coincided to create a difficult operating environment at St George's over the past two months. I'm pleased to report to you that our teams rose to the challenge fantastically and we are applying all the lessons learnt from these extraordinary circumstances across our organisation. Now, as we emerge from the summer and start looking ahead to winter, we are working on robust plans to ensure we have appropriate capacity to meet winter demands. This includes work on a vaccine programme for flu and COVID-19 boosters, surge capacity preparation and an additional focus on supporting staff that are facing the strains of a cost-of-living crisis and addressing associated health inequalities. These operational challenges are being tackled as we simultaneously drive forward progress on our longer-term strategic goals too, including our Group strategy work and the budget deficit.

Before I turn to our future plans, it is important to record my thanks and admiration for our teams over the past two months. The pressures as described above created extraordinary circumstances for St George's, its patients and our staff. The last time I updated you, we were experiencing a rise in COVID-19 numbers. Now the admission numbers are very low, but the impact on staffing remains severe and our teams are working hard to maintain the pace of delivery. It is worth noting a number of specific actions we took to tackle the challenges of the heat wave. We deployed a special communications plan to keep staff constantly informed, and help keep patients safe. A multi-channel campaign included daily heatwave bulletins, a Group press release on how to stay safe and access health services and social media video messages from staff encouraging people to 'talk before they walk' by contacting NHS 111 or visiting their local pharmacy for advice. Separately, St George's hosted broadcast news crews to share our key messages further, creating footage which was shared by local MPs for their constituents. Our communications team is currently using the lessons learnt from the integrated communications plan to form a winter pressures plan, and they welcome any feedback or views.

NHS England's Business Plan: Strategic Priorities

In addition to the immediate demands on our service delivery, we are driving forward our longer-term strategic goals. Since my last update to the Board, NHS England has published its business plan, which aims to support the NHS on its pathway to post-Covid recovery and to transform our services to meet new challenges. This plan flows from the government's mandate for the NHS to recover from the impacts of the pandemic, to continue to manage COVID-19, and to use this moment in time to transform our organisation to meet the challenges of the future. At a Group level, St George's – along with Epsom and St Helier – will use these clear objectives to guide our overall direction. The ten business objectives are as follows:

1. Support the NHS to attract and retain more people, working differently in a compassionate and inclusive culture.
2. Continue to lead the NHS in responding to COVID-19 ever more effectively.
3. Deliver more elective care to tackle the elective backlog, reduce long waits and improve performance against cancer waiting times standards.
4. Improve the responsiveness of urgent and emergency care and increase its capacity.
5. Improve access to primary care.

6. Improve mental health services and services for people with a learning disability and/or autistic people.
7. Deliver improvements in maternity care.
8. Prevent ill health and tackle health inequalities.
9. Drive the integration of care and enable change.
10. Improve productivity and reduce variation across the health system

These objectives articulate the ways in which the NHS will focus on tackling the post-Covid backlog, and use the opportunity to transform services by accelerating service delivery integration and collaboration across our regions. We will use the NHS business plan priorities to guide the development of our Group-wide strategy for St George's, Epsom and St Helier. Collaboration and integration will support us in meeting our strategic goals, making progress on the road to recovery, and continue to deliver excellent care to all.

Values, Staff Well-Being and Anti-Racism Agenda

One of the key objectives set out by NHS England is to ensure staff attraction and retention. On 27th July, we launched our Values-Based Behaviours. Our Values-Based Behaviours is a guide for staff which explicitly describes how we can all live the St George's values of Excellent, Kind, Responsible and Respectful. This was launched with a staff video which was well-received. The diagnostic work underpinning this launch has taken place over a two-year period. 30 culture champions - working on behalf of the Board - consulted our staff on what it is like working at St George's and used those findings to inform guidance for how we can act to ensure it is a brilliant, compassionate and respectful place to work. This is an important piece of work in itself, and critical in underpinning our work to enhance staff well-being and retention. Our Values-Based Behaviours guide has been launched throughout the organisation and I am committed to supporting staff well-being and to making St George's a brilliant place to work.

We are also undertaking an important step towards combatting racism. On 4th October, as part of the Black Awareness Month, we will launch "See Me First" badges at St George's. This initiative is a demonstration of our commitment to the anti-racism agenda. Wearing the badge demonstrates that you have signed up to a statement that says you belong to an open, non-judgmental, and inclusive NHS organisation that treats all Black, Asian and Minority Ethnic (B.A.M.E.) staff with dignity and respect, and that people should "not be judged by the colour of their skin but by the content of their character". I hope you will join me in signing up to this statement, so we – as a Board – can demonstrate our continued commitment to combatting racism:

- **"The Trust is an open, non-judgemental and inclusive organisation that will not tolerate racism or discrimination. We celebrate the diversity of our staff and community. We will treat all our staff equitably, with dignity and respect, whatever their race, gender, religion, age, disability or sexual orientation."**

The cost-of-living crisis is also having an impact on our staff and patients. For our staff, the crisis will impact on well-being. For our patients, the crisis will unfortunately exacerbate existing health inequalities across the UK. Internally, we are working on ways to improve the ease of access for our staff to the support that is on offer to them individually. In terms of service provision for patients, we continue to work hard through our integrated care collaborations to work towards equitable access to excellent health services across the UK.

Autumn Plans: Vaccination Programmes and Surge Capacity

In June 2022, we received correspondence from NHS England outlining the completion of the current Spring Booster programme by the end of August 2022, and the delivery of the autumn vaccination campaign commencing September 2022. It has been mandated that in Autumn 2022, a COVID-19 vaccine should be offered to:

- Residents in a care home for older adults and staff working in care homes for older adults
- Frontline health and social care workers
- All those 65 years of age and over
- Adults aged 16 to 64 years in a clinical risk group

As part of our planning for autumn, we are also preparing in case of a surge of COVID-19, whilst also taking steps to limit the impact on primary care, routine and elective NHS activities where possible.

There will also be an NHS-wide campaign to help manage the strains on emergency departments by supporting people to stay at home if it is safe to do so. Important work around Virtual Wards is also underway to ensure care in the community is applied effectively, to ease pressure on in-patient care.

Group Strategy Development: Phases

As we respond to the priorities set out at a national level, we at St George's, Epsom and St Helier have conducted a consultation on Group-wide strategies. These strategies will seek to improve patient services and to tackle challenges such as the financial deficit, together. As you know, we have committed to publishing our Group strategy by March 2023, to provide clear direction for all staff.

Over the summer, we consulted a wide range of stakeholders on our Group strategy. This included key groups such as clinical services, corporate teams, broader staff workshops, public workshops and workshops on particular themes (including health inequalities and collaboration across SWL), engagement with each of the four local 'place' health and care boards. Now, we are moving into the next phase of strategy development in which we will leverage the findings of the consultation to inform next steps. We will continue to keep the Board updated on the progress of Group strategy development, and we will use the next Board development seminar on 7th October to delve into our plans in more depth and detail.

Financial Update: Budget Deficit

Tackling the budget deficit continues to be a top priority. Through work led by Andrew Grimshaw, our Group Chief Financial Officer, we are systematically working through cost improvement programmes across St George's, Epsom and St Helier. By working together, we will be able to make progress against our challenging financial targets. I would also like to assure you that we have Group-wide quality governance processes in place, to ensure that the high quality of our care is always protected.

Operational and Elective Care Recovery Update

I am proud to report to you that a new Urgent Treatment Centre (UTC) has opened at St George's. The new UTC is in a purpose-designed area, close to our Emergency Department, and will significantly support our capacity for treating urgent cases. Additionally, I am pleased to report that our cath labs three and four are now operational, and cath lab five is on track to open in September. Again, this will boost our capacity for diagnostics and support efficient and speedy patient care. We also continue to make progress on our Elective Care Recovery Programme. I'm pleased to report that, based on activity over the past six weeks, we are overall on track with our Recovery Programme for theatre and non-

theatre activity combined. We continue to focus on optimising our theatre utilisation to support this progress, and I will keep you informed.

Integrated Care Services: Update

South-West London Integrated Care Services (ICS) are now in action, and I continue to play my role as the lead for the Acute Provider Collaborative on the Integrated Care Board (ICB). The Health and Care Act 2022 implemented a number of important statutory requirements for these collaborative organisations, in particular around requirements for integrated care strategies. We now have clear guidance now on how to embed these requirements. I look forward to playing my role in this important collaboration, ensuring that we, as NHS providers, continue to provide excellent health services for all and tackle health inequalities across our regions – particularly in the face of the cost-of-living crisis.

Appointments and Awards

I am delighted to announce that Luci Etheridge has been formally appointed to the position of Chief Medical Officer at St George's. Luci has started in her new role straight away and she is now a permanent member of our site leadership team. Luci joined St George's in 2013 and is a consultant paediatrician, working in both acute paediatrics and young people's health and eating disorders. She has extensive experience and qualifications in education and social science research. Before January, Luci was one of our deputy medical directors and Responsible Officer. Additionally, I am very pleased to announce that Natilla Henry has been appointed to the position of Chief Nursing Officer at St George's. Natilla joins us from University College London Hospital where she has been Deputy Chief Nurse for the past two years. Prior to this, she was Head of Midwifery at King's College London Hospital, during the time that they merged with the Princess Royal. I am thrilled to inform you of this news, and I hope you will join me in congratulating our new appointees.

Finally, I would like to share news of two recent awards with the Board. Firstly, my congratulations to Dr Sree Kondapally, a Locum Consultant Cardiologist at St George's Hospital, who has been awarded the top prize for his service improvement project in cardiology. Dr Kondapally received their award at this year's centenary conference of the British Cardiovascular Society (BCS), under the society's flagship Emerging Leadership Programme (ELP). Dr Kondapally's project was on the implementation of iClip triage for cardiology outpatient referrals, and was judged the top service improvement project for this year. I'm also pleased to report that St George's Hospital Charity won a Tooting Heroes Award at a special ceremony in the Houses of Parliament, hosted by the Awards' founder and Labour MP for Tooting, Dr Rosena Allin-Khan. The award was given for working to fund improvements to St George's, and their vital support provided during the pandemic. Congratulations to Dr Kondapally and the charity for all their hard work and dedication to improving the lives of the patients we serve.

Meeting Title:	**Trust Board**		
Date:	1 September July 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 Quality Committee at its meetings in July and August 2022. The Committee has been operating as a Committee-in-Common with the Epsom and St Helier University Hospitals NHS Trust Quality Committee since April 2022. This report highlights only those issues related to St George's although some issues were relevant to both Trusts.		
Recommendation:	The Board is asked to note the update from the July and August 2022 meetings of the Committee.		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	All CQC domains		
NHS System 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		

Outstanding care every time

St George's University Hospitals NHS Foundation Trust

Quality Committee Report
Trust Board, 1 September 2022

Matters for the Board's attention

The Quality Committee met on 21 July and 18 August 2022. As the Board is aware, chairing of meetings of the Quality Committees-in-Common rotates between the respective chairs of the Committees at ESTH and SGUH. I chaired the July 2022 meeting and the ESTH Chair chaired the August 2022 meeting.

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

July 2022	August 2022
• Quality Performance Report (M3) • Serious Incidents Report • Maternity Services Report • Maternity Services External Assurance visits – Ockenden May 2022 • Group Infection Prevention and Control Update • Deep Dive Annual Programme • Deep Dive on Falls • Quality Strategy Implementation Update • Patient Safety and Quality Group Report	• Quality Performance Report (M4)* • Serious Incidents Report • Maternity Services Report* • Infection Prevention and Control Update and Annual Report* • New Patient Safety Framework • Cardiac Surgery Report • Safeguarding Children and Adults Annual Report* • The use of Personal Protective Equipment (PPE) during Cardio Pulmonary Resuscitation (CPR) • Corporate Risk Register and Board Assurance Framework • Updated Deep Dive Annual Programme • Deep Dive on the National Screening Programme • Patient Safety and Quality Group Report

**These items are also presented to the Board for consideration at the July 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: Months 3 and 4 2022/23

The Committee considered the key areas of quality and safety performance in months 3 and 4 and would like to highlight the following issues, recognising that the Board will discuss the performance data at month 4 later on the agenda:

- Areas of challenge:
  - Basic life support (BLS), immediate life support (ILS) and advanced life support (ALS) training levels continued to be below target, despite improvements. Targeted training is in place to help improve uptake.

  - There were four *C.difficile* cases in July in addition to the six cases in June, which brought the year to date total to 28 and the Trust remained significantly above the trajectory set by NHS England.
  - The percentage of inpatient Treatment Escalation Plans (excluding paediatrics and maternity) had not sustained and had fallen to 39.7% despite having previously reached 49.8%.
  - Positive Friends and Family Survey responses for the emergency department had increased slightly to 70.9% in July against a target of 90%. However, responses continued to be impacted by the significant operational pressures on ED and increased waiting times, and the Committee queried whether this was having an impact on patient safety.

- Areas of good or improving performance:
  - Compliance with appropriate response to Early Warning Scores (Adults) had increased from 77.2% in May to 90.0% in July but remained off the 100% target.
  - There were no Never Event incidents reported in July. The investigation into the one Never Event declared in May was closed in June and learning has been disseminated.
  - The improvement in Cancer performance in May against the trajectory was commended. The 62-day performance had improved to 72.2% ahead of the trajectory of 70%.
  - Mental Capacity Act and Deprivation of Liberty Standards (MCA/DoLs) level 1 training performance had increased to 89.6% in July but remained below the average in 2019/20, and level 2 MCA/DoLs training levels had improved slightly from 71.3% in May to 71.9% in July.
  - The Trust maintained its 100% compliance on complaint responses being issued within 40 working days.

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

2. Serious Incident Reporting

The Committee considered and noted the new style serious incident (SI) report which provided an overview of the SIs reported by SGUH in June 2022 and provided assurance on the Trust's commitment to learning from SI investigations and embedding that learning in everyday practice to improve patient safety.

- Three serious incidents were declared in June 2022.
- Four serious incident investigations were concluded in June 2022, including the one never event related to a misplaced NG feeding tube.

The Committee noted that the format of the report would continue to evolve over the next 18 months as the Trust implements the new NHS Patient Safety Strategy.

3. Infection Prevention Control

The Committee continued its monthly focus on infection prevention and control (IPC), as well as receiving a quarterly IPC update, which supplements the IPC data set out in the Quality Performance Report.

Covid-19 continued to be the major focus of the IPC team. A total of 401 Covid-19 infections were detected in July 2022. Of these, 277 cases were detected within two days of admission; 32 cases between three and seven days of admission; 26 cases between eight and 14 days post admission; and 66 cases detected 15 or more days post admission. A total of 842 Covid-19 positive cases had been detected year-to-date, and there had been a total of 73 deaths of patients between April and July 2022 who

were Covid-positive during their admission. In line with national guidance, the Trust had updated and relaxed certain aspects of its Covid-19 related IPC arrangements relating to mask wearing in non-clinical areas. The Committee had sought further assurance from the Executive regarding the use of Personal Protective Equipment (PPE) during Cardio Pulmonary Resuscitation (CPR) and a position statement for staff treating patients with or with suspected Covid was provided.

In relation to *C.difficile*, a threshold of 43 cases had been set for the Trust by NHS England for 2022/23 as a whole, which equated to around 3.5 cases a month. In June there had been 6 cases, 5 of which were classified as Hospital Onset Healthcare Associated (HOHA). In July, there had been 4 cases, of which 3 were classified as HOHA. This meant that the year had started significantly above trajectory. However, subsequent months had reflected a more expected and near monthly trajectory position and a focus on antimicrobial stewardship was underway. The Committee was assured that the IPC team were working well with clinical teams to address this.

The Committee heard that, in relation to Monkeypox, the regional Infectious Diseases unit based at St Georges, together with SWLP, continued to coordinate the clinical diagnosis and management of cases in the SWL Sector. The Trust also participates in the daily national teleconferences of the national HCID (High Consequences Infectious Diseases) Network, which is coordinating the response at a national and regional level.

There had been a small number of monkeypox exposure incidents. The most recent incident involved a patient presenting to the Emergency Department with swelling and abscess. 9 patient contacts were identified. 1 had 12 hours exposure and 5 patients had been discharged. All discharged patients were contacted by the Infection Prevention & Control Team. No patient contacts have been reported to date as showing any symptoms.

The Committee also received the IPC Annual report for 2021-21 and approved the IPC priorities for 2022-23.

4. Maternity Services Report

The Committee received assurance from the Group Chief Nursing Officer setting out the Trust's position in relation to the actions in the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) as well as an update on completed SI reports.

The Committee noted that SGUH was non-compliant with safety action 6 regarding evidence provided to the Trust Board that the quarterly care bundle surveys from May 2022 have been completed and submitted.

The Committee also received the final reports of the Regional and System Assurance Visits on maternity services at SGUH. The Committee noted that existing arrangements supported agile and open relationships from ward to Board and continue to work well within the new Group model and that no further action was required on this point.

The Committee noted the external assurance of 100% compliance with the recommendations set out in the Ockenden Report.

5. Cardiac Surgery Report

The Committee received its regular quarterly report on cardiac surgery for the period March to May 2022. Based on the quality and safety data presented, the Committee was assured regarding the continued safe operation of the service. The Committee also noted the assurance provided in the St Georges response to the Coroners Regulation 28 Report to prevent future deaths.

6. Deep Dive Programme

The Committee reviewed the Deep Dive Programme for 2022/23 and the criteria for triggering a deep dive. The purpose of the deep dives would be for the Committee to explore an issue in-depth particularly where the Committee considered assurance was lacking or required further exploration. The Committee noted that as a general principle, deep dives would be aligned and conducted on a Group-wide basis. However, site specific deep dives would take place if there was good reason to do so. A number of site-specific deep dives were already part of the proposed programme. To ensure flexibility within the programme two slots would be held open to respond to areas of concern in-year.

The Committee requested a further review of the topic areas in light of the discussion and the addition of clear timings for each review. Suggested topics for inclusion included: winter preparedness, cardiology, bed management and fundamentals of care were other areas suggested for inclusion.

With regards to bed management, the reality on the ground was that with increasing pressure in the system there was an on-going challenge with finding the ‘right’ bed for a patient and that the main priority was to admit the patient to hospital. Any deep dive looking at this subject would have to be undertaken with a degree of pragmatism as to the outcomes that could be delivered given the scale of operational pressures. While it was not currently realistic to address the challenges with bed management, the planned deep dive on Hospital Standardised Mortality Ratio (HSMR) could consider the location of the patient during their stay in hospital and whether a prolonged stay in ED impacted on the outcome of care.

The Committee considered and agreed the updated programme at its August meeting.

7. Deep Dives

The Committee considered two deep dives:

Falls

In 2021/22 the total number of moderate and above harm fall rates had increased to 17 compared with 16 in 2020/21 and 13 in 2019/20. No harm and low harm falls had increased in 2021/22. No harm falls had risen to 1279 in 2021/22 from 1178 in 2020/21, with low harm rising to 200 in 2021/22 from 169 in 2020/21. The number of patient falls per 1000 bed days had reduced in 2021/22 to 5.4% from 6% in 2020/21 and 5.7% in 2019/20.

In 2021 there were 5 hip fractures recorded as a result of a fall. None of patients had completed multifactorial falls risk assessments, including lying and standing BP. Further work was taking place to understand why risk assessments were not being completed and improving compliance with risk assessments was a priority for 2022/23.

The Committee was reasonably assured on falls within the Trust but recognised that there was further work still to be done.

Screening

In managing Covid-19 some diagnostics such as the national screening programme had paused and steps had now been put in place to recover the position and support patients. The Committee noted the recovery plan update in place for Breast screening, including assurance on delivery and required workforce resourcing, operational process improvements to maximum impact, benchmark comparisons to the rest of London’s

breast screening service and actions to tackle health inequalities and follow-up with women who do not respond to their invitation to attend screening.

With regards to Bowel screening the Committee was pleased to note the confirmation that this service is fully recovered.

8. New Patient Safety Framework

The Committee received a high-level briefing and update on the new Patient Safety Incident Reporting Framework (PSIRF) outlined in the NHSEI Patient Safety Strategy. The Committee noted that NHSE/I have statutory duties to collect patient safety information from all NHS-funded providers, and to provide advice and guidance on reducing patient safety risks. Currently, NHSE/I relies on the National Reporting and Learning System (NRLS) and Strategic Executive Information System (StEIS). These systems are now recognised as outdated and without the capability of modern IT / technology this produces many challenges to national data collection and reporting. The new Learning From Patient Safety Events (LFPSE) system is described as “A single port of call for recording, accessing, sharing and learning from patient safety events, in order to support improvement in the safety of NHS-funded services at all levels of the health system”. LFPSE uses Government Digital Service (GDS) design principles which are user-led and iterative. There are currently 4 LRMS providers who can support automatic uploads and reporting to the LFPSE platform. Datix, the current electronic incident reporting system across the Group is not compatible with the new LFPSE which poses both financial and operational risks to the Group and will need to be factored into the capital plan for 2023/24. Discussions have commenced within both Trusts and across SW London with reference to the potential IT solutions to mitigate this risk.

9. Safeguarding

The Committee received and considered the annual Safeguarding Children and Adults Annual Report April 2021 – March 2022, and noted that the Safeguarding Teams at the Trust continued to be extremely busy over the past year.

There had been key risks and challenges which had featured in 2021/22; including:

• Children and young people’s mental health: High numbers of young people experiencing mental health crises attending the emergency department and being admitted to the paediatric wards during 2021/22

• Liberty Protection Safeguards: The Mental Capacity Amendment Act (MCAA) received Royal Assent in May 2019, with the introduction of Liberty Protection Safeguards (LPS) which will replace the current MCA/ DoLS system. The LPS implementation does not have a date as yet, but its introduction has operational and financial implications for the Trust.

• Patient discharges: Increasing numbers of high-risk complex discharges particularly relating to self-neglect and disengagement, alongside significantly increasing numbers of referrals to the safeguarding team; Increasing numbers of concerns and enquiries being raised by the Adult Social Care in relation to discharge processes; and Delays in discharging patients to suitable settings due to lack of community provision is of increasing concern.

Training: Due to pressures with the service and across the wider Trust there were issues with staff being able to complete the necessary different levels of Safeguarding Training.

Detailed action plans were in place to try and deal these issues and other priorities within the service.

10. Quality Strategy Implementation Update

The Committee received an update on progress made towards the delivery of the three quality and safety priorities in Q1.

11. Corporate Risk Register

At its August 2022 meeting, the Committee considered the risks on the Corporate Risk Register, that is those scored 15 and above, which related to quality and safety. The Committee welcomed this opportunity to review the risks that sit below the BAF:

Risk 1626: 'Wrong blood in tube' was opened in August 2018 and escalated to the CRR in 2022. The current risk score is assessed as 15. Through the controls identified, it is expected that this risk will be de-escalated within the midterm.

Risk 2108: 'Lack of Trust capacity (physical capacity, equipment, and workforce) to effectively manage COVID-19' agreed to be closed.

Risk 2051: 'Risk of exposure to COVID-19 virus', is to be de-escalated from the CRR and rescored from the current 15 to 9.

The Committee requested to take risk as an early item on its agenda going forward to ensure the appropriate level of scrutiny and asked the Executive to consider any gaps in the risk register triangulated with evidence in e.g. the IPQR and links with the local risk register.

12. Mortuary Services

The Committee also received an update on an unannounced inspection of mortuary services. A verbal report from the inspection had been received ahead of the written report on the inspection outcome, which was expected within 28 days. While there had been a number of positive elements, a few areas were noted as requiring improvement. The Trust was criticised for not taking bodies out of the mortuary in a timely way as this impacted on capacity. It was noted that work had already started to rectify the situation and ensure that such occurrences do not happen in the future**.** A report would be brought to the Committee.

13. Reflections on the meeting

The timeliness of papers remained a critical issue as late papers were impacting on effective meeting preparation. The length of the meeting pack and the use of a single Committee software solution will be considered.

14. Recommendation

The Board is asked to note the updates from the July and August 2022 meetings.

Dame Parveen Kumar
Committee Chair
September 2022

Meeting Title:	**Trust Board**		
Date:	1 September 2022	**Agenda No**	**2.1.1**
Report Title:	**Safeguarding Children and Adults Annual Report April 2021 – March 2022**		
Lead Director/ Manager:	Arlene Wellman, Group Chief Nurse and Director of Infection Prevention and Control		
Report Author:	Daisy Tate, Safeguarding Lead		
Presented for:	Assurance		
Executive Summary:	**Purpose** In line with Statutory Requirement this report provides an overview of the work undertaken by the safeguarding team in 2021/22 and demonstrates compliance with the statutory and mandatory requirements relating to safeguarding and promoting the welfare of adults, children, and young people, including the safeguarding response to the ongoing Covid-19 global pandemic. **Statutory and Mandatory Responsibilities** As outlined on page 6 this report demonstrates that the Trust is meeting its responsibilities under statutory Section 11 duties of the Children Act, and under the Care Act, and details how the Trust is assessed on its performance both internally and externally regarding safeguarding adults, children, and young people. **Key achievements 2021/22** During this reporting period we have: • Identified and managed increasingly complex presentations as children, young people and adults re-present at hospital post Pandemic. • Retained a visible presence throughout the Trust to provide safeguarding leadership and support to clinical areas. • Implemented bi-monthly Safeguarding Seniors and Divisional Governance Leads meetings to monitor risks relating to safeguarding, compliance with training and improve information sharing. • Built close links with local Police to improve pathways for patients detained by Police, and those who abscond from hospital. • Improved reporting to embed and assure? our Quarterly Safeguarding Committee. • Begun to review the Domestic Abuse policy to ensure inclusion of provisions of the Domestic Abuse Act 2021. • Offered a variety of training opportunities to improve MCA MAST compliance, including regular Teams ‘drop in’ sessions. • Adjusted MCA training content to support staff competence and fluency in documentation underpinning care for our patients. • Updated Ward Accreditation questions to identify more detailed elements of MCA and Safeguarding frameworks.		

- Strengthened partnership working with Wandsworth and Merton Local Authorities.
- Produced a quarterly Child Safeguarding Newsletter. This will be extended to include adult safeguarding during 2022-23.
- Welcomed new leadership to the Safeguarding Adults team.

Key risks and challenges 2021/22

There have been key risks and challenges which have featured in 2021/22 which are provided in more detail in section 9 of this report together with the appropriate development or improvement actions and are summarised as follows:

- **Children and young people's mental health:** High numbers of young people experiencing mental health crises attending the emergency department and being admitted to the paediatric wards during 2021/22
- **Liberty Protection Safeguards:** The Mental Capacity Amendment Act (MCAA) received Royal Assent in May 2019, with the introduction of Liberty Protection Safeguards (LPS) which will replace the current MCA/ DoLS system. The LPS implementation does not have a date as yet but its introduction has operational and financial implications for the Trust
- **Patient discharges:** Increasing numbers of high-risk complex discharges particularly relating to self-neglect and disengagement, alongside significantly increasing numbers of referrals to the safeguarding team; Increasing numbers of concerns and enquiries being raised by the Adult Social Care in relation to SGH discharge processes; and Delays in discharging patients to suitable settings due to lack of community provision is of increasing concern
- **Absconding:** Increasing numbers of vulnerable patients absconding from hospital or leaving without being seen due to delays in accessing treatment due to patient acuity, length of wait in ED, challenge in managing patient exit and lack of beds throughout the system and increasing delay in accessing mental health beds for patients detained under the Mental Health Act, 1983
- **Looked After Children:** SGUH delivers a LAC service to children in the care of Wandsworth Local Authority. The service is challenged by being small, specialist and embedded in an organisation for which the provision of community services is not a primary business function. However, despite this, the team continue to perform to a high level. Key risks for this team include the take up of immunisations and accurate reporting amongst the LAC cohort. There is also an expected increase in the demand for review Health Assessments with impact on team capacity.

Priorities for 2022/23

The following areas are a priority for 2022/23 and form the basis of the safeguarding workplan:

	• Embed whole team working across Adult Safeguarding to maximise capacity within the team; this reduces duplication and overlap between teams whilst recognising specialist input. • Further improve quality of data collection to reflect the variety and scope of work undertaken. • Review Standard Operating Procedures to ensure that there is clear understanding of case work requirements and processes for the Adults team. • Create a Single Point of Contact for all telephone calls across Adults and Children's Safeguarding. • Strengthen relationships across the Trust with a more visible ward presence across Care Groups. • Implement an annual audit plan for each team. • Build capacity within Safeguarding Supervision to support staff managing complexity. • Implement the Liberty Protection Safeguards in line with Government timelines. • Develop our Intranet sites to allow for ease of access and operability. • Implement the planned Level 3 training in Adult Safeguarding, including Level 3 MCA training. • Support the Trust delivery of Oliver McGowan's training, the first mandatory Learning Disability training within the NHS once this published. • Recruit a new permanent Named Nurse within Children's to cover the Acute services. • Continue to provide flexibility in delivery of MCA training to support specific clinical area need and improve Level 2 MAST compliance • Implement clinical supervision across adult services, and build capacity within children's • Ensure the voice and views of individuals at risk of abuse or neglect and those who support them is heard and applied to ensure good personal outcomes and improve the outcomes for individuals.
Recommendation:	The Board is asked to receive the report and note the priorities for 2022-23.
Supports	
Trust Strategic Objective:	Treat the patient – treat the person Right care, right place, right time
CQC Theme:	Safe / Caring / Well Led
Single Oversight Framework Theme:	
Implications	
Risk:	If proper systems, process, and governance are not in place, there will be failure to meet statutory requirements and potentially put children, young people, and adults at risk.
Legal/Regulatory:	Compliance with:

	• Heath and Social Care Act 2008 • The Care Act 2014 • Children's Act 2004 • Working Together 2018		
Resources:	N/A		
Equality and Diversity:	No issues to consider		
Previously Considered by:	Patient Safety and Quality Group Quality Committee (in Common)	**Date**	20.07.2022 18.08.2022
Appendices:			

St George's University Hospitals NHS Foundation Trust

Safeguarding Annual Report 2021/22

Daisy Tate
Head of Nursing Adult Safeguarding

Date: July 2022

1. Summary Paper

The St George's University Hospitals NHS Foundation Trust (SGH) Annual Safeguarding Report details the systems and processes in place to safeguard children, young people and adults receiving SGH services. The Safeguarding Adults team work also includes the Mental Capacity Act team, Learning Disability Liaison Service and Domestic Violence & Female Genital Mutilation Clinical Nurse Specialist. The report demonstrates the Trust's commitment to the safeguarding of children, young people, and adults, in line with its statutory responsibilities, and covers the period from 1st April 2021 until 31st March 2022.

Statutory Responsibilities and Assurance:

- Lead adult and child safeguarding professionals were in place, meeting the statutory requirements as identified in Section 11 of the Children Act 2004, Working Together to Safeguard Children (2018), the Care Act (2014), NHS England Accountability and Assurance Framework (2019) and the Mental Capacity Act (2005).
- The Chief Nurse and Director of Infection, Prevention and Control is the SGH Board Executive Lead for safeguarding. Alongside the Deputy Chief Nurse and Head of Safeguarding they provide strategic leadership and over-sight of safeguarding.
- Moving to the Group Model partway through the reporting year, the Group Chief Nurse is the SGH Board Executive Lead for Safeguarding. Alongside the Site Chief Nurse and Head of Safeguarding, they provide strategic leadership and oversight of Safeguarding.
- Safeguarding governance arrangements have been established and embedded, with oversight from the Joint Safeguarding Committee (JSC), chaired by the Site Chief Nurse. The CCG is in attendance and provides support and challenge to SGH governance processes.
- There is active SGH involvement with the Local Safeguarding Adult and Children Partnership Boards in both Wandsworth and Merton, with SGH membership of a range of Board sub-groups.
- SGH has contributed to several learning reviews across the local boroughs, incorporating Safeguarding Adults Reviews (SAR) and Child Safeguarding Practice Reviews (CSPR).
- There is a safeguarding training programme in place to ensure SGH staff have received the requisite 'essential-to-role' safeguarding training, including Safeguarding Adults, Safeguarding Children, Mental Capacity Act (MCA)/Deprivation of Liberty Safeguards (DoLS) and Prevent training. Virtual training was created as a response to the Covid-19 pandemic; this has worked well and is now an embedded element of our educational offering.
- Policies, protocols, and processes are in place to support the assessment of need and vulnerability of children, young people and adults accessing SGH services.
- Safeguarding supervision, (mandatory and ad hoc) is delivered by the safeguarding team to support staff in decision making and prioritising the needs and wishes of children, young people, and adults, where there is a high level of complexity, risk, and vulnerability.
- Robust recruitment processes are in place, with pre-employment clearance for all new staff. SGH complies with guidance in relation to modern day slavery and human trafficking and undertakes enhanced Disclosure and Barring (DBS) checks for staff working with children and adults.

Key Achievements

During this reporting period we have:

- Identified and managed increasingly complex presentations as children, young people and adults re-present at hospital post Pandemic.
- Retained a visible presence throughout the Trust to provide safeguarding leadership and support to clinical areas.
- Implemented bi-monthly Safeguarding Seniors and Divisional Governance Leads meetings to monitor risks relating to safeguarding, compliance with training and improve information sharing.
- Built close links with local Police to improve pathways for patients detained by Police, and those who abscond from hospital.
- Improved reporting to embed and assure? our Quarterly Safeguarding Committee.
- Begun to review the Domestic Abuse policy to ensure inclusion of provisions of the Domestic Abuse Act 2021.
- Offered a variety of training opportunities to improve MCA MAST compliance, including regular Teams ‘drop in’ sessions.
- Adjusted MCA training content to support staff competence and fluency in documentation underpinning care for our patients.
- Updated Ward Accreditation questions to identify more detailed elements of MCA and Safeguarding frameworks.
- Strengthened partnership working with Wandsworth and Merton Local Authorities.
- Produced a quarterly Child Safeguarding Newsletter. This will be extended to include adult safeguarding during 2022-23.
- Welcomed new leadership to the Safeguarding Adults team.

Priorities for 2022/23

The following areas are a priority for 2022/23 and form the basis of the safeguarding workplan:

- Embed whole team working across Adult Safeguarding to maximise capacity within the team; this reduces duplication and overlap between teams whilst recognising specialist input.
- Further improve quality of data collection to reflect the variety and scope of work undertaken.
- Review Standard Operating Procedures to ensure that there is clear understanding of case work requirements and processes for the Adults team.
- Create a Single Point of Contact for all telephone calls across Adults and Children’s Safeguarding.
- Strengthen relationships across the Trust with a more visible ward presence across Care Groups.
- Implement an annual audit plan for each team.
- Build capacity within Safeguarding Supervision to support staff managing complexity.
- Implement the Liberty Protection Safeguards in line with Government timelines.
- Develop our Intranet sites to allow for ease of access and operability.
- Implement the planned Level 3 training in Adult Safeguarding, including Level 3 MCA training.
- Support the Trust delivery of Oliver McGowan’s training, the first mandatory Learning Disability training within the NHS once this published.
- Recruit a new permanent Named Nurse within Children’s to cover the Acute services.

- Continue to provide flexibility in delivery of MCA training to support specific clinical area need and improve Level 2 MAST compliance
- Implement clinical supervision across adult services, and build capacity within children's
- Ensure the voice and views of individuals at risk of abuse or neglect and those who support them is heard and applied to ensure good personal outcomes and improve the outcomes for individuals.

Table of Contents

2. Introduction

This Annual Report highlights the work undertaken by St George's University Hospitals NHS Foundation Trust (SGH) in respect to its commitment and responsibilities in maintaining the safety and protection of children and safeguarding adults at risk of abuse and neglect.

SGH has a statutory responsibility for ensuring that all services have safe and effective systems in place to safeguard adults and children at risk of abuse, neglect, and exploitation. To be effective, this requires staff members who recognise their individual responsibility to safeguard and promote the welfare of adults and children, and are equipped to fulfil this task, and the commitment of the Trust to support them in this. All NHS trusts must assure that safeguarding is embedded at every level in their organisations.

SGH responsibilities include ensuring staff have access to appropriate training, advice, support, and supervision in relation to Section 11 of the Children Act (2004), The Care Act (2014), the Mental Capacity Act (2005), and the Prevention of Terrorism Act (2005).

These place a duty on key people and bodies, including NHS Trusts, to make arrangements to ensure that their functions are discharged with regard to the need to safeguard and promote the welfare of children and adults with care and support needs.

This report covers the period from April 2021 to March 2022 and provides assurance that systems are in place to ensure that our service users are effectively protected, and that staff are supported to respond appropriately where safeguarding concerns arise. The safeguarding team supports SGH in fulfilling its statutory duty to safeguard service users and staff.

The purpose of this report is to:

- Provide an overview of the SGH safeguarding activity in 2021/22
- Provide assurance that SGH is compliant with its safeguarding duties
- Outline the key safeguarding priorities for 2022/23

3. Governance Arrangements

The SGH Chief Executive has overall responsibility for the safeguarding of children, young people, and adults at risk. The Chief Nurse and Director of Infection Prevention and Control has been the executive lead for safeguarding with responsibility to ensure that the Trust contribution towards safeguarding is discharged effectively throughout the organisation. Moving to our Group Model from January 2022, this is the Site Chief Nurse with overview from the Group Chief Nurse.

The Site Chief Nurse is responsible for:

- Strategic leadership on all aspects of the Trust's contribution to safeguarding
- Ensuring the Trust is represented at local safeguarding adult and children's Partnerships
- Ensuring that appropriate safeguarding processes are in place, including compliance with all legal, statutory, and good practice requirements

Safeguarding governance and assurance is monitored at the Joint Safeguarding Committee (JSC), chaired by the Site Chief Nurse. The JSC has been established as a permanent sub-committee of the Patient Safety Quality Group.

The purpose of the JSC is to provide a corporate overview of the safeguarding systems and processes at SGH and ensure that this agenda remains core to the Trust's business and purpose and that the Trust remains compliant with all statutory and regulatory requirements.

JSC meets quarterly and seeks assurance that all safeguarding commitments and responsibilities for both adults and children are met. It oversees the work of the Safeguarding Senior Management Team and seeks assurance that there are suitable processes in place to ensure that safeguarding arrangements are reviewed and updated on a regular basis.

The South West London CCG Designated Safeguarding Leads for adults and children at Wandsworth and Merton have a standing invitation to the JSC ensuring oversight of the Trust's safeguarding work.

The Head of Safeguarding provides a quarterly overview report which includes:

- Mandatory training and supervision performance
- Partnership working update
- Adult and child safeguarding activity
- Policy development
- Audit planning
- Risk management

The meetings in place to inform the JSC and ensure actions are completed consist of:

- Safeguarding Senior Management Team meetings (Adults, Children's, Maternity and Looked After Children's Named Professionals)
- Safeguarding Children team meeting
- Safeguarding Adults team meeting

Practitioners within the team attend the London Named Nurse Forum and South West London Safeguarding Adults forum. This provides the opportunity to share information and practice with a wide professional network. They also attend the Mental Capacity Act London Leads Forum, and Safeguarding Adults National Network meeting.

The Head of Safeguarding attends the NHS England London Region Safeguarding Sub-cell, chaired by the NHS England London Safeguarding Lead.

4. Safeguarding at SGH

4.1 Safeguarding Children

"Safeguarding and promoting the welfare of children and young people is defined as protection from maltreatment and abuse, preventing impairment of health and/or development and ensuring children are growing up in circumstances consistent with the provision of safe and effective care." Working Together (2018)

The Trust Board has agreed a Safeguarding Children's Statement which is publicly available on the Trust website. The statement can be accessed online at the following link and at Appendix 1 of this report.

https://www.stgeorges.nhs.uk/about/living-our-values/safeguarding-children/

SGH, including all staff and volunteers, have important and distinct duties to ensure that children and young people receiving services, experience safe and dignified care, and that they are safeguarded from harm, abuse, and neglect. This includes ensuring that appropriate action is taken when staff become aware of concerns taking place outside of the Trust.

Safeguarding activity may be enacted in the context of the administration of patient care directly, or by the Trust participating in multiagency safeguarding practice, such as sharing information with a local authority or attending a strategy meeting relating to a specific child.

It is extremely important to note that the Trust's safeguarding duties also extend to children and young people who are not patients at the Trust (and who may not be physically seen by the staff member or clinical team providing treatment to the adult). Most commonly, this will occur when an adult patient is receiving treatment, and potential risks to children or young people are identified. For example, if an adult attends for issues related to domestic abuse, substance misuse or poor mental health. We refer to this as a 'Think Family' approach, and this duty applies to all Trust staff including those who seldom or never work with children as part of their day-to-day duties.

The Trust's duties principally relate to sharing information with relevant agencies and participating in multiagency safeguarding processes. In the case of children and young people who are inpatients, or who receive direct and on-going care from the Trust, practitioners are likely to play a more active and substantial role in safeguarding service provision.

SGH complies with its legal duty under the Children Act 2004, by having in place a Named Doctor and Named Nurses for Safeguarding Children with responsibilities for both acute and community services. Named Nurses have statutory responsibilities, as identified in Working Together to Safeguard Children (2018), to support staff in recognising and championing the needs of children, including responding to possible abuse or neglect.

The Named Doctor provides support, advice, and leadership to medical staff, primarily to senior paediatricians. The Named Doctor delivers and leads a number of safeguarding supervision sessions with medical and multi-disciplinary teams.

As senior practitioners, the Named Nurses are experts in child development, child maltreatment and managing safeguarding concerns in a multiagency forum. The Named Nurses are supported by

Clinical Nurse Specialists (CNS) for Safeguarding Children. These practitioners have enhanced skills and knowledge in relation to all aspects of safeguarding children work.

The child safeguarding team work together to:

- Ensure that all children and young people are protected from significant harm
- Ensure the welfare of the child is paramount and the voice of the child is central to all interventions
- Ensure compliance with the London Child Protection Procedures (2020)
- Implement national and local guidance in relation to safeguarding
- Play an integral part in Wandsworth and Merton Safeguarding Children Partnerships and subgroups
- Promote best practice throughout the organisation

Child Protection Information Sharing (CPIS) System:
This national information sharing system connects the local authority, children's social care, IT systems with the NHS Spine Summary Care Records to identify children who are on a child protection plan (CPP), who are Looked After (in the care of the local authority) or pregnant women whose unborn baby is on a CPP. Access is via a code on the NHS Smart Card. NHS Digital is planning a wider roll out to health settings including outpatients.

4.2 Redthread

Redthread is a youth work charity providing support to young people with a range of vulnerabilities. Redthread's Youth Violence Intervention Programme is funded by The Mayor's Office of Policing and Crime, and several trusts and foundations. They also partner with SOLACE domestic abuse charity to provide a youth Independent Domestic Abuse Advisor (IDVA) who works with young women affected by domestic violence, and a Comic Relief funded young women's worker who supports young women affected by gang activity.

Whilst Redthread has developed a significant public profile in respect of their work in relation to knife crime, and this forms an important part of their work at SGH, they work with young people aged 11-25 attending SGH for any reason associated with youth violence including domestic violence, sexual violence, exploitation, and non-weapon related assaults.

The team work proactively and flexibly with young people who have been admitted to SGH and seek to make use of the 'teachable moment' when a young person is hospitalised, to co-produce a longer-term intervention with them.

There is a separate annual report detailing the work of the Redthread service.

4.3 Safeguarding Adults

The Trust Board has agreed a Safeguarding Adult's Statement which is publicly available on the Trust website. The statement can be accessed online at the following link and at Appendix 2 of this report.

https://www.stgeorges.nhs.uk/about/living-our-values/safeguarding-adults/

SGH complies with the Care Act (2014) and the Mental Capacity Act (MCA) (2005) by having in place a Lead Practitioner for adult safeguarding to ensure the Trust fulfils its legal duty towards adults at risk of harm or abuse. They are supported by a specialist practitioner.

Safeguarding duties apply to an adult who:

1. Has need of care and support (whether or not the Local Authority is meeting any of those needs).
2. Is experiencing, or at risk of abuse or neglect: and
3. As a result of those care and support needs, is unable to protect themselves from either risk of, or the experience of abuse and neglect.

The safeguarding adults' team work together to:

- Ensure the Trust has safeguarding arrangements in place as defined by the Care Act (2014)
- Ensure that the process of protecting adults with care and support needs is integral to all health care provision within the Trust
- Ensure that 'making safeguarding personal' is central to the way the SGH staff respond to people with care and support needs who may be in vulnerable circumstances and at risk of abuse or neglect by others
- Implement national and local guidance to safeguard adults and play an integral part in the Wandsworth and Merton Safeguarding Adults' Boards
- Ensure SGH is compliant with its duties towards people under the statutory legislation including the Mental Capacity Act (MCA) 2005 and Care Act (2014)

4.4 Mental Capacity Act

SGH has a Lead Nurse for the MCA, supporting by a Clinical Nurse Specialist, who provides advice and support regarding the delivery of lawful care in line with the requirements of the Mental Capacity Act (2005). These clinician's work closely with the Adult Safeguarding team as many adults with care and support needs may require support with decision making. The MCA team work to Make Safeguarding Personal and support clinical teams to identify and amplify the voice of the person at the centre.

There is a separate Annual Report detailing the work of the MCA team.

4.5 Learning Disability Liaison Service

The Learning Disability Liaison Service experienced a total staff change in this calendar year, with 2 Nurse's leaving for promotion posts elsewhere. The Clinical Lead also retired after 8 successful years at SGH. The LD team were very under-resourced for at least the final 6 months of 2021/22 reporting year, however, were supported by the wider Adult Safeguarding team.

The service had significant challenges in recruitment however a new Band 6 Liaison Practitioner started in March 2022, with the new Senior Practitioner appointed prior to year-end. While interviews for a Band 6 Nurse were undertaken twice, the decision was made to adjust this role to a development post for a Band 5 RN. They are due to start later in the year.

There is a separate Annual Report detailing the work of the Learning Disability Liaison Service.

4.6 Domestic Abuse

Domestic abuse comprises of any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence, or abuse between those aged 16 or over, who are or have been intimate partners or family members regardless of gender or sexuality. This includes forced marriage, honour-based abuse and abuse relating to gender identity or sexuality. Abuse can be perpetrated by partners, ex-partners, and family members, including children under the age of 18, adult children or siblings.

The Trust employs a Clinical Nurse Specialist for Domestic Abuse and FGM, alongside a specialist midwife for Domestic Abuse and a Domestic Abuse link practitioner within the Emergency Department.

These specialists work with 2 independent Domestic Abuse Advisors (IDVAs)

- Redthread Youth IDVA is employed by Solace Women's Aid and offers domestic abuse support to people aged 16 years to 25 years.
- The Hospital IDVA is employed by Victim Support and offers domestic abuse support to people from the age of 26 years upwards. The Victim Support IDVA post was vacant from December 2020, however our new IDVA started in February 2022.

Whilst the prevalence and impact of domestic abuse amongst patients is acknowledged, it must not be forgotten that these issues also affect our own staff. the Hospital IDVA is available to support them as well as patients. The Domestic Abuse Policy will reflect the impact of domestic abuse on our staff and is currently being reviewed to ensure that new legislation is included.

The Domestic Abuse Bill was passed in April 2021. Included within the Bill is an important new clause that acknowledges that children who see, hear, or experience the effects of domestic abuse, who are related to the person being abused or the perpetrator, are also to be regarded as victims of domestic abuse.

4.7 Maternity services

Pregnant mothers, unborn babies and young infants are particularly vulnerable to abuse. The Maternity Safeguarding Team (MST) recognises the potential for the perinatal period to exacerbate vulnerability and abuse for mothers and babies alike. As a maternity service there is an ongoing commitment to ensuring the antenatal period is viewed as a 'window of opportunity'. The Trust employs an experience Named Midwife who leads on child safeguarding support and supervision for midwives. The maternity safeguarding team consists of the Named Midwife and 3 specialists in safeguarding, mental health, and substance misuse.

There is a monthly multi-disciplinary maternity safeguarding meeting, attended by colleagues from Wandsworth and Merton Children's Social Care and Health Visiting Teams. At this meeting, information is shared regarding high-risk women to inform safety planning.

The maternity safeguarding team continue to advocate and liaise on behalf of vulnerable women and families with a particular emphasis on sharing safeguarding information with internal and external partners. Priority has been given to the provision of dedicated full time administrative support which will improve pathways of communication and data collection.

The MST strive to promote the integration of maternity care, adult and children's social care services, health visiting and GP services. Other examples of working together include working with nationally recognised charitable organisations such as Little Village in Wandsworth. The charity's generous collaboration with the maternity service means there is a preparedness to support mothers and families seeking refuge and asylum in the UK.

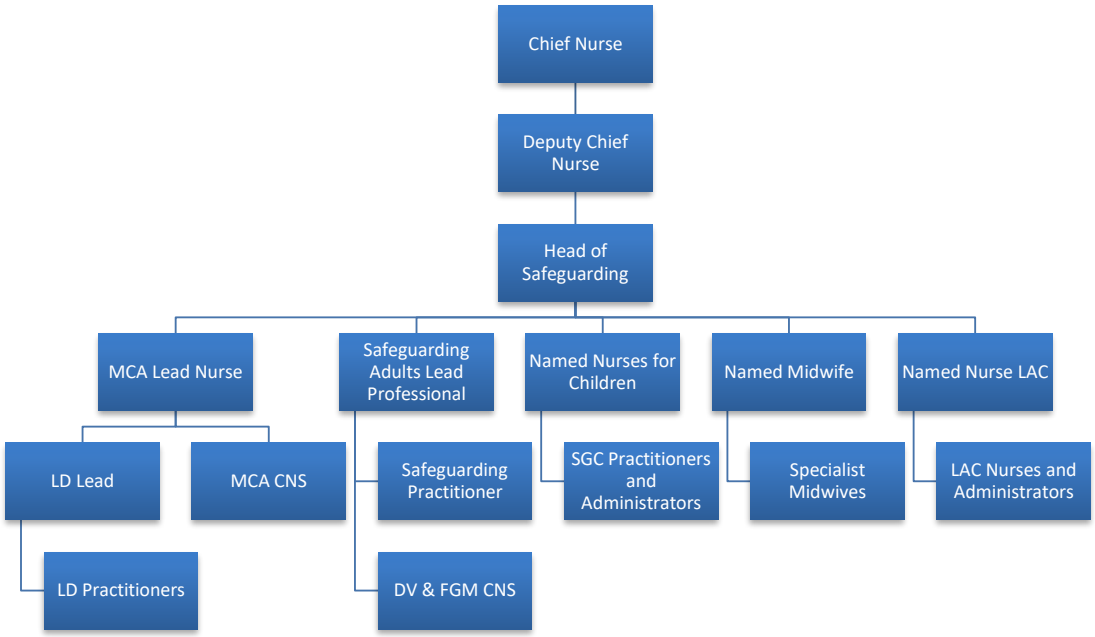
Safeguarding vulnerable mothers and babies requires a 'whole service' approach and the key message Safeguarding is 'Everyone's Business' prevails in the maternity department.

4.8 Looked After Children Services

SGH provides a Looked After Children (LAC) Service for children and young people in the care of the London Borough of Wandsworth, with a team comprised of 1 Named Nurse for LAC, 2 Clinical Nurse Specialists and a Named Doctor appointed in March 2022. The service is managed within paediatric services with clinical supervision and support from the Head of Safeguarding.

There is a separate annual report detailing the work of the Looked After Children service.

4.9 SGH Trust Safeguarding Team Structure



5. Assurance

5.1 Safeguarding during the ongoing Covid-19 pandemic

Since March 2021, we have noted a significant increase in the numbers of children attending the ED where there are safeguarding concerns. There has also been a 14% increase in adult safeguarding referrals, with a marked increase with self-neglect and domestic abuse referrals. A core part of the role of all members of the safeguarding team is to advocate for patients, manage risk, support interface with the Local Authority and encourage external partners back to face to face patient work and professionals meeting to improve outcome and understanding amongst stakeholders. This is a key aspect of our supporting delivery of safe, effective care.

Due to the ongoing nature of the pandemic with Omicron and other variants further impacting capacity with the teams, multiple workstreams planned for 2021/22 were paused as we managed with isolation, sickness, and increased referral rates. As a Trust, the increasing referral rates, while concerning in the context of our patients circumstances, highlights Trust commitment to identifying concerns.

5.2 Prevent Duty and training compliance

Prevent is part of the Government's counter-terrorism strategy 'Contest' and focuses on working with vulnerable individuals who may be at risk of being exploited by radicalisers and subsequently drawn into terrorist related activity. The Counter-Terrorism and Security Act 2015 contains a duty on specific authorities to have due regard to prevent people from being drawn into terrorism. This is also known as the Prevent Duty and is designed to protect people in a similar way to other processes that safeguard people from modern day slavery or sexual abuse.

The training is available online and works to support the understanding of the 'pre-criminal space', to prevent people from people drawn into terrorism. The training seeks to ensure that staff are aware that Prevent activity is not exclusive to adherents of any specific religion or ideology and highlights the growing importance of the far-right terrorist threat.

The Lead Practitioner for Adult Safeguarding is the Trust Prevent lead and the contact person for referrals. There was 1 Prevent referral during this Reporting year.

5.3 Learning, Development and Training

Safeguarding training for both adults and children is underpinned by an Intercollegiate Document published by the RCN on behalf of multiple stakeholders; the Intercollegiate Document for Children & Young People (2019) and Intercollegiate Document for Safeguarding Adults (2018). The documents describe roles and responsibilities detailing the level of training required. Each level of training requires that staff need to complete a minimum number of hours training over a three-year period and that these training hours can be met by undertaking a variety of different training interventions.

Children

There are up to 9,000 staff members who are required to undertake level 1 child safeguarding training via an e-learning training package every 3 years. 4,500 staff are required to complete the level 2 e-learning package. Compliance for both levels 1 and 2 is good and meets the Trust mandatory compliance target.

There are just over 1,000 staff requiring level 3 training which, in line with the intercollegiate guidance, is routinely delivered face to face. All staff new to Level 3 training attend a full day introduction to level 3 session and have guidance on how to achieve the additional hours needed over the next 3 years so that they can maintain compliance. Half-day updates cover a variety of topics to support this process, alongside free access to training provided by the local authority.

The Covid-19 response with clinical acuity and social distancing impacted the provision of face-to-face Level 3 training. During the initial phases, virtual training was offered however due to the complexity of breakout rooms and facilitation, it was decided that this was not the most effective use of valuable training time. As an adjunct to the local training, NHS England approved and uploaded a level 3 child safeguarding package to the e-Learning for Health portal. Enquiries have been made with the Trust e-Learning team to have the Level 3 modules imported to the Trust portal to support staff learning and development. Child Safeguarding training remains at circa 90%, showing good levels of compliance.

Maternity services returned to face-to-face Level 3 Safeguarding training in April 2021. Level 3 training uptake is consistently good, with over 93% of Midwives compliant by March 2022. The aim of training within maternity is to develop and grow a culture of child and family centered safeguarding that encourages professional curiosity and centres the ‘voice of the unborn baby/infant’.

Domestic Abuse training is delivered by the CNS for Domestic Abuse & FGM, Specialist Midwife for Domestic Abuse and IDVA’s as half day sessions as part of a Level 3 Children’s Safeguarding refresher training. Outside specialists are brought in for specific teaching, including GALOP, specialists in providing support for the LGBT+ communities. The compliance for this is captured within Children’s Level 3 figures.

The CNS for Domestic Abuse & FGM and Specialist Midwife for FGM provide half day training to support staff to understand how to use the FGM Assessment Tool, as well as Witchcraft and Breast Binding. Attendance at these sessions has been poor with the ongoing clinical pressures across the Trust continuing to impact staff being released to attend training. The FGM Steering Group will be meeting in Q1 2022 to discuss Terms of Reference and agree attendees. The full Group will then meet in Q2 and will support the delivery of more formal education. Ad hoc and bespoke training sessions are ongoing to targeted areas.

Adults

There has been an ongoing delay to the implementation of the planned Safeguarding training at the levels required in the Intercollegiate document; Level 3 training for staff where this is required in their roles. While this has been due to capacity within the team (referral rates, complexity of referrals, staff sickness and vacancies across the wider team), we have now recruited to all roles. Ensuring compliance with the Intercollegiate guidance and building capacity within safeguarding knowledge to optimise patient care is a core aspect of 2022/23 work.

For Levels 1 (all staff) and Level 2 (all staff with patient contact), there will be no immediate change to training, as existing compliance has been benchmarked at Level 2. New starters will be allocated to the correct level and compliance will be built in via usual cycle of compliance, building capacity with no impact on rates. Current training compliance is 91%; as noted however, staff are not yet allocated to Level 3 training due to team capacity issues above. The Lead Practitioner for Adult Safeguarding has mapped key meetings in Q2 to finalise training levels for Band 7+ staff and Junior

Doctors. The team is due to be fully staffed in September 2022 with the implementation of the planned re-allocation of training Level and communication plan at end Q2.

Level 3 training is likely to be 1500/2000 members of staff based on numbers in Children's training at the same level. An online programme has been identified for inclusion in MAST and face to face Level 3 training will include ongoing Safeguarding Supervision and the development of a 'training passport' in 2022/23.

Prevent training remains online and compliance is above NHS England mandated 85%, at 87% for Levels 1-2, and 93% for Level 3.

There is no mandatory Domestic Abuse training for staff working with adults, although the CNS delivers ad hoc training to multiple staff groups, including Foundation Year Trainee's, ED new starters and in response to specific requests from clinical team.

Training Data for 2021-22 (85% target)

	Level	Q1	Q2	Q3	Q4
Children	1	92%	90%	90%	89%
	2	91%	90%	91%	90%
	3	81%	78%	81%	81%
	4 *	100%	100%	100%	100%
Adults - incl FGM & modern slavery	1	92.7%	91%	90.3%	91%
MCA	1	86.6%	84.7%	84.5%	85.9%
	2	80.1%	76%	72.2%	69.7%
Prevent	1/2	84.6%	83%	85.6%	87%
	3	93.2%	86%	92.1%	93%

Child safeguarding level 3 training topics

To highlight the variety and depth of content within the L3 training, the content is noted below:

- Safeguarding policies, procedures and guidelines
- Signs of abuse
- Learning from Serious Case Reviews and Individual Management Reviews
- Child Sexual Exploitation (CSE) and Human Trafficking
- Role of the Local Authority Designated Officer
- Domestic Abuse
- Female Genital Mutilation
- PREVENT
- Managing Allegations against Staff
- Mental Health
- Private Fostering
- Documentation
- Referrals

5.4 Supervision

Children

Child safeguarding supervision is a requirement for all staff who have face to face contact with children and young people. It is accessed via the Named Nurses and Clinical Nurse Specialists. All safeguarding children supervision undertaken is reported to the Safeguarding Children Team so that compliance can be monitored.

The introduction of remote Supervision introduced in the initial Covid-19 response has proved popular amongst community practitioners as it allows for greater flexibility in attendance. Community staff are independent with specific caseloads and have more flexibility to manage their own diary; this supports greater levels of supervision uptake as they are better able to plan around commitments. The team have worked with Therapy staff and have created more sessions to offer increased flexibility with an additional offer of 1:1 sessions and additional end of quarter sessions. This is reflected in the ongoing trajectory over time within community services.

There is significantly more challenge within the acute setting, where releasing staff to access child safeguarding supervision has been extremely difficult. The uptake of safeguarding supervision across the acute paediatric services has traditionally been low. This has been made worse by the demands on services during the pandemic response and recruitment challenges as we move to living with Covid. It should be noted that the Paediatric teams have been working to improve this, and there is an improvement from the previous year as highlighted in the Safeguarding Supervision table below. Please note that the italicised figures are the 2020/21 figures and illustrate the trajectory.

In conjunction with the senior nursing team within Paediatric services, staff are being identified who could undertake Clinical Supervision training to build capacity and flexibility within Safeguarding Supervision. They would need to be senior staff with the ability to manage a clinical caseload, with protected time to facilitate and support Supervision. This change in approach is an attempt to increase the opportunity for Paediatric services to fulfil the supervision requirement for their staff. Oversight and support will be provided by the Children's Safeguarding team and is in direct response to challenges being experienced in releasing staff for supervision.

Safeguarding Supervision in Paediatric Services

2021/22	Q1	Q2	Q3	Q4
Acute	30%	22%	30%	23%
2020/21	*(6%)*	*(4%)*	*(14%)*	*(17.8%)*
Community	81%	70%	68.5%	78%
2020/21	*(36%)*	*(56%)*	*(74%)*	*(64.5)*

A Safeguarding Supervision Audit is underway to identify the barriers staff face in accessing the service and their understanding of the process.

Maternity

From January 2022, the Maternity Safeguarding Team have been able to provide face-to-face group supervision sessions for maternity staff as part of mandatory updates. Previously maternity staff have not had access to safeguarding supervision. Once this becomes embedded in maternity services emerging themes and trends can be noted, however at this juncture, there appears to be a positive trajectory to take up.

	January 2022	February 2022	March 2022
Safeguarding yearly update/Group Supervision	51.55%	59.49%	67.68%

Adults

Until recently safeguarding supervision for practitioners working with adults who have care and support needs has not been universally adopted or required. The supervision process and the associated benefits to the organisation and individuals has been widely acknowledged and recognised. As services recover from Covid-19, it is recognised that increased levels of support, practical guidance and reflection opportunities will build capacity and resilience within teams and work to promote optimal patient care.

All staff already have access to informal support plus expert advice from the safeguarding team. The safeguarding team also offers teams the opportunity to both informally and formally debrief when experiencing challenging cases. Part of the workplan for 2022/23 involves training the existing Safeguarding Adults team (including MCA & LD Practitioners at Band 7+) to facilitate Clinical Supervision. This will support a wider roll out of clinical supervision and support the implementation of Level 3 training across Safeguarding and MCA. We plan that there will be a requirement for at least annual Safeguarding Supervision, in addition to the existing support offered.

The adult safeguarding team has regular supervision meetings and the leads for each of the safeguarding disciplines meet monthly to share learning and concerns around complex cases. External supervision for the safeguarding leads has been trialled however due to the clinical backgrounds of the Leads, further work needs to be undertaken. The Professional Nurse Advocate role may be useful in taking this forward, and the Staff Support team may also be able to facilitate.

5.5 Managing Safeguarding Allegations Against SGH Staff

The Trust has a statutory duty to investigate allegations against staff working with children and this includes allegations relating to a staff member's work or in their private life.

The Head of Safeguarding and the Named Nurse for Safeguarding Children work closely with the Wandsworth Council Local Authority Designated Officer (LADO). The Trust has a duty to report to the LADO any instances in which it is alleged that a person who works with children has:

- behaved in a way that has harmed, or may have harmed a child
- possibly committed a criminal offence against or related to a child
- behaved towards a child or children in a way that indicates they may pose a risk of harm to children

This duty applies to allegations relating to the workplace, or in the employee's/volunteer's personal life. This is a complex and sensitive area of the Trust's work and involves close liaison between the Human Resource department and the safeguarding team. We are not aware of any LADO referrals during the period of this Report.

A new Trust Policy to manage allegations against staff relating to adults has been created and sent for initial approval by the Joint Safeguarding Committee. This will escalate via Trust internal Governance process.

There have been 12 allegations against staff (relating to adults) within the Trust and we have worked with Police and the Local Authority to support ongoing investigations. We are also aware of the emotional impact on staff accused and are able to signpost them to appropriate support while ensuring that we have a robust system in place to protect our patients.

5.6 Policies and Guidance

The following Safeguarding policies were ratified in 2021/22:

- Mental Capacity Act Policy: this has been renewed for another year due to impending changes with Liberty Protection Safeguards.

- The Managing Allegations Against Staff was approved by the JSC, however is awaiting sign off at Patient Safety & Quality Group.

5.7 Audit

There has been more limited Audit work in 2021-22 due to the ongoing Covid-19 pandemic and capacity issues within the teams. No formal audit was carried out within Adult Safeguarding, and the planned audit within Children's was delayed due to issues with the RATE system (now resolved).

Adults

No formal audit has been undertaken in 2021/22. This is key to the 2022/23 workplan and the initial audit will look to capture how often patients' views are recorded within the safeguarding process.

Questions relating to Safeguarding Adults, Children and Mental Capacity Act theory and practice remain integrated into ward accreditation assessments.

Children

Section 11 of the Children Act 2004 requires each person or body to which duties apply to have regard to any guidance given to them by the Secretary of State and places a statutory requirement on organisations and individuals to ensure they have arrangements in place to safeguard and promote the welfare of children.

The Wandsworth Safeguarding Children Partnership (WSCP) assesses the effectiveness of local safeguarding arrangements in various ways, including Section 11 safeguarding self-assessments. Currently the WSCP discharges this function by carrying out a section 11 assessment on an annual basis.

The Audit was undertaken in 2021 and this found that:

- Agencies were able to show how they listened to children and young people and the importance of their involvement in their care plans and service development.
- There was evidence across the agencies that leadership and accountability was high on the agenda and how senior managers were able to influence strategic planning and thinking.

- Information sharing and communication across all agencies was reflected in the various policies and procedures that were available and agreements that they were signed in line with local and national arrangements.
- Agencies have a plethora of guidance and policies on safeguarding children including linking in with London and national procedures.
- Dealing with allegations of abuse and making complaints was shown across all agencies with all necessary procedures and guidance.
- The importance of staff induction, training is available for all staff and each agency was able to show single and partnership responsiveness in this area.
- For Wandsworth anti discriminatory practice and working with diversity and disproportionality is particularly important across all agencies and they were able to supply a range of examples and practice developments to improve service delivery.
- All agencies reflected that understanding impact and outcomes of service delivery through various quality programmes and links with the WSCP
- The findings from the survey and interviews were a snapshot of staff representation, which supported the findings from the self-assessments by frontline staff. Individual agencies will manage following up areas in their service where feedback would be expected to be one hundred percent. e.g., 2 staff from the survey did not know what to do if they had a concern about a colleague or volunteer's behaviour towards a child.

6. Attendance information and activity

6.1 Safeguarding children

There are a wide range of concerns that lead to an internal referral to the safeguarding children team, including:

- Children attending A&E following self-harm
- Children admitted to hospital due to safeguarding concerns
- Alcohol / substance misuse
- Children attending following attempted suicide
- Physical injuries resultant from violence inflicted by other young people
- Attendances related to mental health
- Non-accidental injuries

The safeguarding team record all referrals made to a local authority children's services department and can report on the numbers of children attending with safeguarding concerns per borough. In addition, the team can identify the presenting concern, providing a more nuanced and detailed picture highlighting specific issues related to safeguarding, or areas for wider review.

Following a review of the referral process, the safeguarding team instigated a central secure email to ensure that they receive all copies of referrals made to children's social care services, for data collection and quality assurance purposes.

It is important to note that in the Emergency Department referrals to the Local Authority may essentially be notification i.e., informing them of the nature of the admission and the source of concern following an ED attendance and subsequent discharge. Referrals in relation to children or young people who are inpatients or outpatients are likely to be more detailed, and in general the Trust will expect to be part of the safeguarding plan for as long as the child is a patient and where appropriate, beyond.

Most referrals from the Trust to local authorities originate from the Emergency Department, with whom the safeguarding team holds regular operational meetings, and has an excellent working relationship. The weekly information sharing meetings benefit from the attendance of Wandsworth Children's Services, enabling easy access to information and updates regarding Wandsworth children who have attended SGH. This mechanism is highly valued by Emergency Department staff who otherwise might not know the outcome of their referral. The safeguarding team are seeking to engage other local authorities in this process.

Activity for the safeguarding has increased as we learn to live with Covid. Complex cases are being identified and these require detailed planning for safe discharge to the community. There has been a significant increase in mental health attendance and admission which has brought challenges to the clinical teams. The paediatric team have worked together with South West London CCG and St George's Mental Health Trust (SWLStG) to overcome the difficulties and find workable solutions. This work continues as paediatric ward staff balance the needs of children and young people in mental health crises, alongside their other patients.

Between April 2021 and March 2022, 860 children were referred to their local authority children's service having attended SGH ED where safeguarding concerns had been identified. To illustrate the level of increase, there were 632 children requiring onward referral in 2020/21 and 557 in 2019/20.

The referral and detailed breakdown of reasons for attendance for those children and young people then referred on to their local authority children's service highlights the multiple impacts on this population. Of particular concern is the over 100% increase in attendance for children and young people who have self-harmed. There is also a 61% increase in the number of children and young people attending following attempted suicide.

Referrals to local authority children's service having attended SGH ED

2021/2022	Q1	Q2	Q3	Q4	Total
Wandsworth	85	76	85	87	333
Merton	68	55	62	69	254
Others	74	69	68	62	273
Total	227	200	215	218	860

133 of those attending ED were subject to a Child Protection Plan

2021/22	Q1	Q2	Q3	Q4	Total
Wandsworth	13	14	15	14	56
Merton	15	14	9	4	42
Others	8	9	4	14	35
Total	36	37	28	32	133

62 children and young people had concerns which were linked to adult domestic violence:

2021/22	Q1	Q2	Q3	Q4	Total
Wandsworth	4	7	5	6	22
Merton	10	8	3	1	22
Others	4	4	4	6	18
Total	18	19	12	13	62

168 children and young people had risks identified where the risk was linked to adult mental health:

2021/22	Q1	Q2	Q3	Q4	Total
Wandsworth	16	18	13	13	60
Merton	17	12	13	15	57
Others	15	14	9	13	51
Total	48	44	35	41	168

61 children and young people attended where the risk was linked to adult drug and alcohol misuse:

2021/22	Q1	Q2	Q3	Q4	Total
Wandsworth	4	9	9	2	24
Merton	7	0	7	1	15
Others	5	8	6	3	22
Total	16	17	22	6	61

168 children and young people attended the Emergency Department having been assaulted/bullied

2021/22	Q1	Q2	Q3	Q4	Total
Wandsworth	15	19	19	22	75
Merton	11	7	10	12	40
Others	12	14	11	16	53
Total	38	40	40	50	168

159 children and young people attended the Emergency Department Number due to self-harming

2021/22	Q1	Q2	Q3	Q4	Total
Wandsworth	16	14	19	15	64
Merton	14	14	11	12	51
Others	7	5	24	8	44
Total	37	33	54	35	159

194 children and young people attended the emergency department following attempted suicide.

2021/22	Q1	Q2	Q3	Q4	Total
Wandsworth	24	22	17	21	84
Merton	20	13	12	14	59
Others	13	13	11	14	51
Total	57	48	40	49	194

105 children and young people attended with alcohol or drug misuse:

2021/22	Q1	Q2	Q3	Q4	Total
Wandsworth	15	9	10	9	43
Merton	11	7	10	6	34
Others	11	9	3	5	28
Total	37	25	23	20	105

Looked After Children

209 children who were in the care of their local authority, attended the Emergency Department

2020/21	Q1	Q2	Q3	Q4	Total
Wandsworth	8	14	18	8	48
Merton	6	9	10	6	31
Others	29	31	39	31	130
Total	43	54	67	45	209

Breakdown of referrals made from ED to external partners
Safeguarding Notification for child known to social care, Health Visitor and or School Nurse

2021/22	Q1	Q2	Q3	Q4	Total
Referral	227	200	215	218	1860
Notification	283	266	280	296	1125
HV/SN Ref	322	588	406	428	1744
Total	832	1055	901	942	3730

Total Emergency Department Paediatric Attendances

2021/22	Q1	Q2	Q3	Q4	Total
Total	8272	8254	8713	8136	33375*

* 11% of all paediatric ED attendances required onward referral to children's social care or health services

Hospital In-patient Data: these figures do not include referrals completed in ED

	Q1	Q2	Q3	Q4	Total
CYP admissions with safeguarding concerns	253	203	135	139	**730**
CYP admissions due to injuries	15	15	10	24	**64**
Referrals to Children's Social Care	25	11	17	32	**85**
CYP admissions for Child Protection Plan cases	12	2	3	3	**20**
CYP referred to CAMHS	14	12	6	15	**47**
Total	319	243	171	213	**946**

6.2 Domestic Abuse

Prior to Q3 2021/22, referral numbers to the Domestic Abuse team appear significantly higher than expected. On interrogation of the numbers, this is due to the way that figures were recorded in Q1 & Q2 where referrals were double counted, ie a referral for the Independent Domestic Violence Advocate (IDVA) was counted as separate to the Domestic Abuse CNS or MARAC. To bring this in line with safeguarding adults reporting, this has been amended so that only each new referral is recorded, rather than the specific interventions for an individual.

The referrals to the Domestic Abuse CNS within SGH have increased from 244 in 2020/21 to 643 in this year. However, as noted above, how referrals have been captured changed mid-year as the Domestic Abuse CNS moved to management within the adult safeguarding team. The Domestic Abuse CNS receive referrals within iClip so clearer data capture will support identification of ongoing themes. There have been several changes of Administrator supporting the CNS which may also impact data capture.

While victims of domestic abuse did not attend ED during lockdown, there was a marked increase in cases discussed at MARAC, the Multi Agency Risk Assessment Conferences, outside a usual trajectory. This is due to the increase in Police referrals to MARAC if attending a household x 3 in one year for a domestic disturbance with no crime committed. The CNS attends MARAC for Merton and Wandsworth, and also provides information on SGH attendances for Lambeth. Across the 3 Boroughs there were 1,247 cases discussed in 2021/22, however in 2020/21 there were 3,557 adults with 1,650 children discussed. Data capture has changed to include children with their relevant adult as a single case, rather than as separate victims.

While moving to living with Covid and the after effects of the pandemic, attendance rates to ED have increased and this continues to be a core referrer to the CNS. The Children's Safeguarding team and Maternity Services also link closely to ensure that these individuals, and families, are identified and supported. The Children's Safeguarding team noted that there had been at least 4 cases recently which were picked up by wards and then referred directly onto Social Care or other services without our internal teams. Work is being undertaken to maintain team presence in Paediatrics and the additional capacity being built into safeguarding supervision which will work to prevent recurrence.

Victim Support have a presence within the hospital and the new IDVA started in February 2022 after a vacancy of 13 months. This is a very specialist role, directly adding capacity to the team and in supporting people experiencing Domestic Abuse. They work directly with victims of domestic abuse while in hospital and to support post discharge to ensure their safety. IDVA's can only work with the victim of domestic abuse once consent has been obtained.

Local authority	Q1	Q2	Q3	Q4	Total
Wandsworth	101	127	12	18	
Lambeth	19	15	7	3	
Croydon	16	14	7	9	
Merton	62	58	13	11	
Surrey	13	7	2	5	
Sutton	14	16	4	0	
Richmond	NA	NA	1	0	
Kingston	9	6	2	0	
Other	28	32	4	8	
Total	**262**	**275**	**52**	**54**	**643**

6.3 Safeguarding adults

The safeguarding team collate data on all contacts to the team. In general, these contacts are raised by a member of Trust staff, although referrals are also made to the team by other agencies, for example, when a patient is admitted to the Trust and the local authority is already involved in a safeguarding matter, or whereby a patient is transferred between hospitals.

All referrals from SGH to a local authority are completed by the Safeguarding Adult Team to ensure referral consistency and quality. This supports monitoring trends in presentation and ensures that we are able to collate risk specific detail, such as the increase in patients presenting with self-neglect (162 compared to 117 in 2020/21) and support clinical teams. Due to the nature of services that SGH provides, it is common to be working with 14+ Local Authorities managing safeguarding concerns. There is no consistency in referral routes, thresholds or content required to refer to Local Authority's which adds complexity and barriers to efficient care.

The involvement of the Safeguarding Adult Team varies considerably from case to case and work will be undertaken in 2022/23 to synthesise this and create a clear threshold SOP. Engagement may be brief advice, or considerable case management and coordination with partnership agencies. As external partners, such as Social Work, are only recently coming back to site, the team have provided vital interface to support complex assessments. The team also attend the local monthly high risk Panel meeting with representation from the Local Authority, Fire and Police services, LAS, mental health, substance misuse, housing, and community health.

The Safeguarding Adults service received 1094 referrals from SGH clinical services and others in 2021/22. This evidences a continued year on year increase in referrals to the team.

Year	2012 /13	2013 /14	2014 /15	2015 /16	2016 /17	2017 /18	2018 /19	2019 /20	2020 /21	2021 /22
Referrals to the SGA team	602	825	855	971	841	813	882	825	961	1094

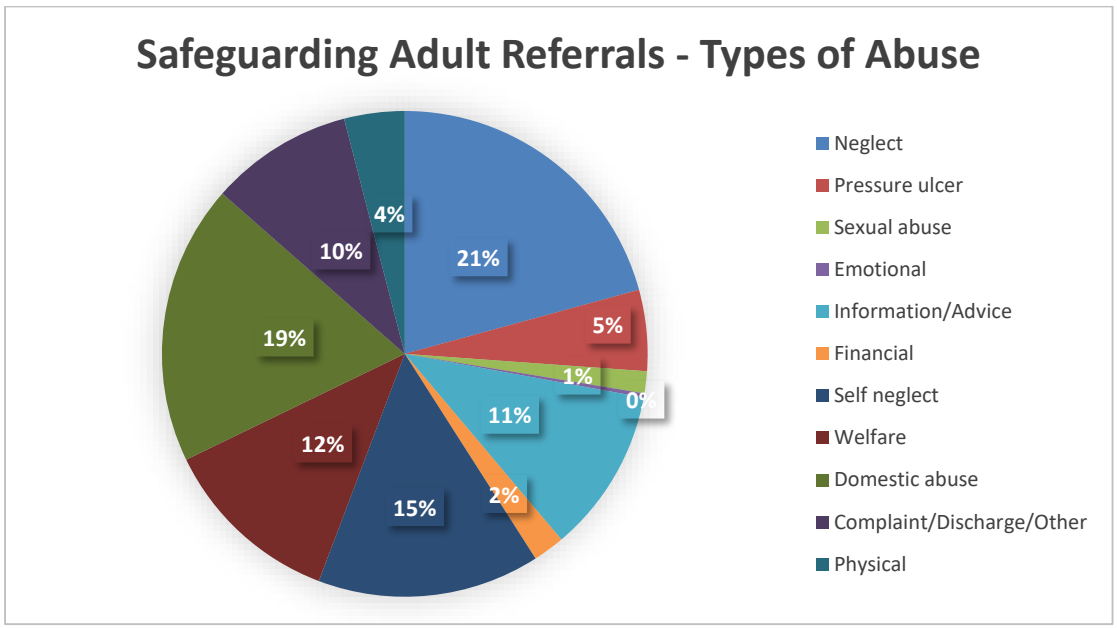
Number of safeguarding adult contacts by primary presenting concern for 2021/22.

Type of Abuse	Q1	Q2	Q3	Q4	Totals
Neglect	52	57	65	53	227
Domestic abuse	38	70	59	37	201
Self - neglect	47	37	32	46	162
Welfare	33	24	41	34	132
Info/Advice	28	36	27	29	120
Pressure ulcer	13	9	19	18	59
Physical	8	8	15	13	44
Financial	0*	0*	13	10	23
Sexual Abuse	0*	0*	7	9	16
Emotional Abuse	0*	0*	3	0	3
Total	262	275	296	261	1094

These categories are based on the initial screening when referrals are made into the SGH Safeguarding team. Neglect is broad and can relate to patients presenting in ED where there are concerns about community care packages including inadequate provision or carers not attending,

patients being left with a long lie. Domestic Abuse appears as second most common cause for referral, and this is where there is domestic abuse as well as a safeguarding concern and is not captured in the Domestic Abuse referral. Prior to Q3 of this year, separate data on financial, sexual and emotional abuse was recorded as part of neglect or 'other' in previous years.

There is an increasing trend in referrals for self-neglect which is a particularly challenging to support in an acute setting. The Care Act makes clear that self-neglect is a form of abuse if the person has care and support needs, and there is a very challenging balance to manage individual autonomy and the duty to protect. While self-neglect can usually be managed under the Care Act with assessment and planning, capacity to consent (or decline) interventions is core to this. This can often be a challenging area to assess due to the complexity of managing executive functioning and can be best undertaken in a community setting. Work is undergoing with local Safeguarding Adults Boards to share knowledge and best practice.



Please note that these categories are based on initial screening when referrals are made to the SGH's safeguarding team. Approximately a third of the referrals were converted into external referrals to Adult Social Care services for consideration under Section 42 of the Care Act. The Local Authorities hold the statutory data around safeguarding adults and make final decision around categories of abuse.

Safeguarding concerns regarding SGH care:
Section 42 of the Care Act (2014) establishes the process of local authority led Safeguarding Adults Enquiry, which may be in relation to concerns about abuse or neglect within a vulnerable adult's family, within the community or within a health or care setting.

The section applies where a local authority has reasonable cause to suspect that an adult in its area:

a. Has needs for care and support (whether or not the authority is meeting any of those needs),
b. Is experiencing, or is at risk of, abuse or neglect, and
c. As a result of those needs, is unable to protect himself or herself against the abuse or neglect or the risk of it

The threshold for raising safeguarding concerns about care is deliberately low to ensure that adults in need of care and support are appropriately safeguarded. Given the size of the organisation, it would be expected that some queries regarding care would be received. Close working with Wandsworth Local Authority ensures that a quick response to any concerns with areas for investigation is a fundamental aspect of joint work.

There were 118 concerns raised about care given by SGH during 2021/22. This is a 59% increase on 2020/21 where 70 concerns were noted. While most causes were closed following a preliminary investigation, or with no concern substantiated post Enquiry, 18 allegations of abuse were substantiated against SGH during the reporting period.

Of the total concerns raised regarding SGH care, 57 were closed at screening or after the initial S 42 planning phase. 18 were substantiated. This is a significant increase from 2020/21 where 70 concerns relating to our care was raised, with only 1 upheld from the 6 that went to formal S. 42 enquiry. This is likely to be multifactorial in nature, however thematic analysis will need to be undertaken on and reported at JSC in Q2.

2021/22	Q1	Q2	Q3	Q4	Total
Substantiated post S42 Enquiry	6	3	4	5	18
Closed at Screening or post S42 Enquiry with no concerns substantiated	16	9	15	17	57
Ongoing – awaiting outcome	0	0	1	4	5
Complaints/not safeguarding/learning opportunities	5	9	17	7	38
Safeguarding concerns regarding SGH care	27	21	37	33	**118**

All enquiries and concerns regarding SGH care are treated very seriously, and robust investigation and reporting processes have been implemented. Emerging trends are identified, and work is undertaken with the Local Authority and ward teams as appropriate. An example is the ongoing, increasing trend of patients absconding from ED who should have been kept at SGH either with Mental Capacity Act 2005 or Mental Health Act, 1983. A dedicated workstream is underway to look at each element in conjunction with the Police.

Whilst the preliminary investigations and enquiries have not raised concerns that reach the threshold of abuse or neglect, there is often important learning for the Trust. Recurrent issues include:

- Poor information on discharge summaries
- Lack of communication with care homes or families
- Inadequate information on district nursing referrals

The safeguarding team is working closely with nursing leadership and the discharge coordinators to improve information sharing and record keeping. A new discharge summary has been launched and work has been undertaken to improve the Discharge to Assess (D2A) referral paperwork.

6.4 Analysis

The ongoing impact of the Covid-19 pandemic on the safety and well-being of children, young people and adults with care and support needs is emerging over time. National evidence tells us that that mental health and domestic abuse are areas of particular concern, and this is reflected in our data. The team has received increased referrals from clinical areas relating to concerns regarding SGH staff and their wellbeing. While these are often outside the realm of safeguarding, it highlights the societal impact of Covid-19, lockdowns, subsequent 'waves' and learning to live with Covid has had.

Of particular concern to children's services has been the ongoing impact of 'lock-down' on children and young people's mental health. Rising referral rates to the safeguarding team from ED highlights the challenges that many of the children and young people are facing. Anecdotal evidence also suggests an increase in the number of non-accidental injuries to young children, and a retrospective audit is planned to review data and themes.

Significant work has taken place between paediatric services and South West London and St George's Mental Health Trust to put safeguards in place for young people on the paediatric wards, in particular for those with Eating Disorders. Given the continuing demand on Child and Adolescent Mental Health Services, both locally and nationally, it is likely that the demand for mental health interventions in the acute setting will continue to increase.

Within the SGH safeguarding adult services, the 14% increase in referrals reflects the wider increase in attendances and admissions, however also reflects an increased awareness of safeguarding adults locally and nationally. Discussions with partner organisations indicates that this is a trend across the sector. The increased complexity noted within referrals and casework showcases the valuable work undertaken by the team, and the need for further work in reinforcing the safeguarding adults team.

The increase can also be partially explained by reduced access to community services and support networks because of Covid-19. For example, increased isolation with a potentially abusive partner may lead to an increase prevalence an acuity of domestic abuse concerns. Reduced alcohol services and support from informal networks could lead to patients presenting to hospital with worsening unmanaged substance misuse problems. For St George's, there is ongoing work in how we can support community services to try and prevent increased attendance at hospital with these issues.

7. Partnership working

Partnership working, developing trusting relationships and high levels of communication are key to safeguarding children, young people, and adults with care and support needs.

The Wandsworth and Merton Safeguarding Children and Adult Partnerships are the bodies with responsibility for safeguarding children, young people, and adults across the respective boroughs. This partnership work involves the Police, Health (through CCG's) and Local Authorities, each with specific duties to secure safeguarding arrangements and responsibilities. The Trust is represented by the CCG at Wandsworth Adult and Child Safeguarding Partnerships, and at Merton Child Safeguarding Partnership, and is a member of the Merton Safeguarding Adult Partnership.

The overarching purpose of the Partnerships is to ensure that children, young people and adults with care and support needs are safeguarded from abuse and neglect. As part of the Trust's adult safeguarding responsibilities, we engage in the activities of the partnerships by membership of the sub-groups, participating in learning reviews, working on policy development and learning programmes.

Safeguarding Adults:

The Lead Practitioner for adult safeguarding attends the monthly 'CMARAP' – Community Multiagency Risk Assessment Panel for adults at risk across Wandsworth. This is an opportunity for teams across Wandsworth to present complex cases to senior operational leads from social services, mental health services, the police, housing, acute health and fire services with a view to mitigating risk.

Themes include self-neglect, hoarding, disengagement from services, drug and alcohol use and housing issues. There have been a number of successful outcomes for clients through this process.

Adults	Meeting	SGH attendee
Wandsworth	SAB Board SAR subgroup	HoS, SGA Lead
Merton	SAB Board (invitation) SAR subgroup Prevent Network	HoS, SGA Lead
SWL CCG	LeDeR	MCA Lead
	Clinical Reference Group LD & Autism	MCA Lead

Other meetings include fortnightly meetings with Wandsworth Hospital Team to review open safeguarding cases and complex discharges, safeguarding involvement in the monthly with EDPLOG (the ED mental health meeting with Police in attendance).

Domestic Abuse

DVA	MTG	SGH attendee	Frequency
Wandsworth	MARAC	DV Lead	Monthly
Merton	MARAC	DV Lead	Monthly
Lambeth (research)	MARAC	DV Lead	Monthly

Safeguarding Children

Children	MTG	SGH attendee
Wandsworth	Monitoring Quality & Performance	HoS
	SCIL	HoS/NN
	Training	NN
	Vulnerable Adolescents Group	NN
	Violence Against women & girls	CNS
Merton	Quality Assurance & Practice Review	HoS/NN
	Policy and Training	NN
	Early Help & Neglect	NN
	Promote and Protect Young People	NN
	Think Family and Domestic Abuse	CNS

8. Statutory Reviews

Child Safeguarding Practice Reviews (CSPR), Safeguarding Adult Reviews (SAR) and Domestic Homicide Reviews (DHR) form an essential part of the multi-agency partnerships safeguarding strategies. Safeguarding practitioners regularly attend meetings and workshops in relation to cases being considered or reviewed, to establish single and multiagency learning or changes in practice.

The extent of SGH involvement in the statutory review process will depend on the Trust's involvement in the case, and on our contribution to learning across the partnerships. Where SGH has had significant involvement in the case, we will provide a comprehensive chronology and Internal Management Review (IMR). Safeguarding leads and practitioners involved in the case may participate in practice review workshops and the Head of Safeguarding or Named Professional will be a member of the oversight panel.

Learning from local and national enquiries, CSPR, SAR and DHRs alongside case learning reviews are discussed at the JSC and are cascaded via scenario-based training, the Child Safeguarding Newsletter, and internal meetings. Action plans for any reviews with actions for SGH are monitored by the JSC.

Both Wandsworth and Merton adult and child partnerships are embracing the Learning Together model for practice reviews, developed by the Social Care Institute for Excellence. This approach uses systems thinking to gain a deeper understanding of current local practice and cultivate an open, learning culture. The aim is to build internal capacity by having staff trained and accredited in the Learning Together approach to reviewing. The Head of Safeguarding is currently undertaking the Learning Together training and is the Lead Reviewer for a Wandsworth CSPR.

Safeguarding Adult Reviews:
SGH provided information to 4 SAR's in 2021/22. The level of involvement varied depending on the nature of involvement SGH had to the person's care. The SAR processes have highlighted the challenges experienced in navigating systems for patients as well as discharge process and pathways. Learning will be brought back to the Trust and disseminated with senior staff to embed the change needed.

Child Safeguarding Practice Reviews:
Sadly, we have been involved in a number of CSPRs or IMRs in 2021/22, in relation to children and young people who have been killed or suffered significant harm. With changes in staff, and password protection on documents, we are unable to source the detail and this may need to be an additional report to JSC. All actions post CSPR or IMR are managed via the JSC.

Due to the nature of services provided at SGH, trauma and other high-risk cases will attend the hospital. For this reason, we are contributing to reviews in Wandsworth, Merton, Croydon, Lambeth, Lewisham and Surrey.

9. Key risks and challenges

Children and young people's mental health:
There have been high numbers of young people experiencing mental health crises attending the emergency department and being admitted to the paediatric wards during 2021/22. Young people with eating disorders and children and young people who are harming themselves is of particular concern, and the Trust is working with colleagues in the Mental Health Trust, CCG and local authorities to ensure that the right services are in place. A Paediatric Mental Health CNS post is planned to provide support to Paediatric wards, and this post will be managed within Children's.

Liberty Protection Safeguards:
The Mental Capacity Amendment Act (MCAA) received Royal Assent in May 2019, with the introduction of Liberty Protection Safeguards (LPS) which will replace the current MCA/DoLS system. The LPS implementation does not have a date as yet:

The introduction of the LPS has significant implications for SGH in terms of:

- The legislation applying to a wider range of care settings/individuals than current DoLS system
- SGH will become the Responsible Body rather than the Local Authority. This means that we will retain full legal responsibility for all patients deprived of their liberty at SGH.
- Increased financial costs to apply the LPS process and have staff trained in delivering the legislation across all divisions. There will also need to be dedicated provision for legal costs as we become responsible for completing all elements
- Initial scoping indicates that SGH could require at least 6 WTE Band 6 staff, potentially additional medical cover, as well as senior manager oversight and approval of all applications
- Introducing systems and processes. SGH will be legally required to anticipate and prevent individuals being deprived of their liberty, and to authorise and review the safeguards in place when SGH staff have applied a less restrictive intervention or deprivation in an individual's best interest, to safeguard and protect their health and wellbeing
- 16/17 year olds will come under this framework which will be a significant change for paediatric wards
- The LPS Consultation was launched in March 2022 with a closing date of 7th July. The Trust MCA team will be leading on the response and working with London partner organisations.

Patient discharges:
There are ongoing concerns regarding high-risk complex discharges particularly relating to self-neglect and disengagement, alongside significantly increasing numbers of referrals to the safeguarding team.

There are increasing numbers of concerns and enquiries being raised by the Adult Social Care in relation to SGH discharge processes.

Delays in discharging patients to suitable settings due to lack of community provision is of increasing concern. This is lead on by the Transfer of Care team who have robust escalation processes in place.

Absconding:
Increasing numbers of vulnerable patients absconding from hospital or leaving without being seen (they may have a cognitive impairment, confusion, mental health problem or frailty). This is due to

delays in accessing treatment due to patient acuity, length of wait in ED, challenge in managing patient exit and lack of beds throughout the system. There is also an increasing delay in accessing mental health beds for patients detained under the Mental Health Act, 1983.

Looked After Children:
SGH delivers a LAC service to children in the care of Wandsworth Local Authority. The service is challenged by being small, specialist and embedded in an organisation for which the provision of community services is not it's primary business. Despite this, the team continue to perform to a high level.
Key risks for this team include the take up of immunisations and accurate reporting amongst the LAC cohort. There is also an expected increase in the demand for review Health Assessments with impact on team capacity.

10. SGH Safeguarding priorities in 2022/23

The following areas are a priority for 2022/23 and form the basis of the safeguarding workplan:

- Embed whole team working across Adult Safeguarding to maximise capacity within the team; this reduces duplication and overlap between teams whilst recognising specialist input.
- Further improve quality of data collection to reflect the variety and scope of work undertaken.
- Review Standard Operating Procedures to ensure that there is clear understanding of case work requirements and processes for the Adults team.
- Create a Single Point of Contact for all telephone calls across Adults and Children's Safeguarding.
- Strengthen relationships across the Trust with a more visible ward presence across Care Groups.
- Implement an annual audit plan for each team.
- Build capacity within Safeguarding Supervision to support staff managing complexity.
- Implement the Liberty Protection Safeguards in line with Government timelines.
- Develop our Intranet sites to allow for ease of access and operability.
- Implement the planned Level 3 training in Adult Safeguarding, including Level 3 MCA training.
- Support the Trust delivery of Oliver McGowan's training, the first mandatory Learning Disability training within the NHS once this published.
- Recruit a new permanent Named Nurse within Children's to cover the Acute services.
- Continue to provide flexibility in delivery of MCA training to support specific clinical area need and improve Level 2 MAST compliance
- Implement clinical supervision across adult services, and build capacity within children's
- Ensure the voice and views of individuals at risk of abuse or neglect and those who support them is heard and applied to ensure good personal outcomes and improve the outcomes for individuals.

11. Conclusion

In the NHS Constitution the first principle that guides the NHS in all it does states:

> 'It has a duty to each and every individual that it serves and must respect their human rights'.

The SGH safeguarding team remain committed to ensuring that the Trust effectively executes its duties and responsibilities in child and adult protection and safeguarding. It is recognised that this is not achievable without the support and collaborative working of our partner agencies.

This report demonstrates continued significant progress against the statutory agenda, with good compliance to internal and external safeguarding standards. The team will continue to strive to ensure SGH safeguarding processes are robust and effective, building on existing systems to further improve and develop the Trust's response to safeguarding.

12. Reference links

London Child Protection Procedures, 2021 https://www.londoncp.co.uk

The Care Act, 2014 https://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

The Care Act Statutory Guidance, 2020 https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

The Human Rights Act,1998 https://www.legislation.gov.uk/ukpga/1998/42/contents

Mental Capacity Act, 2005 https://www.legislation.gov.uk/ukpga/2005/9/contents

Mental Capacity (Amendment) Act 2019 https://www.legislation.gov.uk/ukpga/2019/18/enacted

Safeguarding Adults – Intercollegiate Document, 2018 https://www.rcn.org.uk/professional-development/publications/pub-007069

Working Together to Safeguard Children, 2018 https://www.gov.uk/government/publications/working-together-to-safeguard-children--2

Safeguarding Children and Young People – Intercollegiate Document (2019)\
http://ndht.ndevon.swest.nhs.uk/wp-content/uploads/2012/08/Children-Intercollegaite-Doc-2019.pdf

Section 11, Children's Act (2004)
http://www.legislation.gov.uk/ukpga/2004/31/section/11

Learning Together
https://www.scie.org.uk/children/learningtogether/

Appendix 1

Safeguarding children and young people

St George's University Hospitals NHS Foundation Trust is fully committed to ensuring that all children and young people accessing acute and community services receive high quality care in a safe and secure environment. The Trust adheres to its statutory duties in line with Section 11 of the Children Act 2004 and the following safeguarding children arrangements are in place to support statutory duties:

- St George's University Hospitals NHS Foundation Trust meets the statutory requirements for safer recruitment with the Disclosure and Barring Service (DBS). All staff employed by the Trust will have a DBS check prior to employment and those working with children undergo an enhanced level of assessment.
- The Trust has Safeguarding Policies and Procedures in place which are up to date, reviewed regularly and approved by the Trust's Executive Lead for Safeguarding Children and Young People. All policies and procedures are accessible to staff via the Safeguarding Children page on the intranet.
- The Trust has a process to ensure children who are not brought to appointments are recognised and that decisions with regards to appropriate follow up are made taking into account the voice of the child and the impact on health and wellbeing.
- All staff members are required to undertake relevant safeguarding training; compliance is regularly reviewed via the training database and at the Trust Safeguarding Committee. The Trust has a training strategy in place for the delivery of safeguarding training.
- The Trust is involved in both local Safeguarding Children's Partnerships (Wandsworth and Merton) and is committed to interagency working and positively supports opportunities to work with other agencies.
- The Trust has a Trust wide Safeguarding meeting and governance structure in place which has overall leadership from the Chief Nurse and Director of Infection Prevention and Control, who is the Executive Safeguarding Lead. The Safeguarding Team structure is as follows:
-

Safeguarding Lead	Time allocated
Executive Lead for Safeguarding – Chief Nurse and Director of Infection Prevention and Control	As part of role
Head of Safeguarding for Adults and Children	1.wte
Named Doctor (acute)	3 programmed activities
Deputy Named Doctor (acute)	1 programmed activity
Named Midwife & Vulnerable Women Lead	1.wte
Specialist Safeguarding Midwife	1.wte

Named Nurse – (acute)	1.wte
Named Nurse (community services)	1.wte
Clinical Nurse Specialist (acute)	2.wte
Clinical Nurse Specialist Domestic Abuse & FGM (acute)	1.wte
Designated Doctor for LAC (acute)	1.wte
Specialist Nurse for LAC (community)	1.wte
Liaison Health Visitor (community based in acute)	1.wte

- The Trust Board takes accountability for Safeguarding Children and receives an annual report. The Safeguarding Committee (Children and Adults) reviews, scrutinises and oversees the Trust's safeguarding arrangements. The Trust will continue to review the arrangements in place and update in line with changing guidance and policy developments.

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St George's University Hospitals NHS Foundation Trust

Appendix 2

Safeguarding Adults

St George's University Hospitals NHS Foundation Trust works hard to ensure that all patients, particularly those that are vulnerable, are cared for in a safe, secure, and caring environment. In particular it is important that St George's protects patients from abuse, whether from within the hospital or from the community.

- The trust has a multi-agency policy and robust procedures in place for responding to and reporting alleged abuse
- The trust's adult safeguarding steering group reviews local and national guidance and legislation to ensure policies and procedures are relevant and updated
- All trust staff receive mandatory awareness (eLearning) training of adult protection as part of their induction
- The trust recognises that particular groups of people, such as those with dementia or a learning disability, can be at risk of abuse. Staff can make a significant difference to their care by treating all patients with respect and dignity
- The trust works closely with colleagues in local authorities in investigating allegations of abuse and ensures that adult safeguarding referrals are made promptly to the relevant local authority. The Trust works in partnership as required, with local authorities prior to, in the process of, and after referrals have been made.
- The Trust is a participant in the Safeguarding Adults Boards of both Wandsworth/Richmond and Merton to ensure that there is an effective multi-agency approach to protecting vulnerable adults. Through both NHS and partnership training and learning, the Trust Safeguarding team maintain an awareness of developments in practice and policy in relation to safeguarding, including in relation to specific areas of concern i.e., Modern Slavery and Human Trafficking.
- The Chief Nurse and Director of Infection Prevention and Control is the Executive Director for safeguarding.
- The trust board takes the issue of safeguarding extremely seriously and receives an annual report on adult safeguarding issues, whilst other Trust specific and partnership committees and boards receive information as required throughout the year. The bi-monthly Trust Safeguarding Committee meets monthly is and the body at which day to day Safeguarding operational information and pressures are considered.

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St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	1 September 2022	**Agenda No**	**2.1.2**
Report Title:	**Infection Prevention and Control Annual Report 2021-22**		
Lead Director/ Manager:	**Arlene Wellman, Group Chief Nursing Officer and Director of Infection Prevention and Control**		
Report Author:	David Shakespeare, Head of Infection Prevention and Control		
Presented for:	Assurance		
Executive Summary:	The Infection Prevention and Control (IPC) Annual Report presents a summary of activity pertaining to IPC during 2021-22 and sets out key priorities for the IPCT for 2022-23. **Key content of the report includes:** • Trust response to SARS-CoV-2 Performance of Healthcare Associated Infection (HCAI) against NHSI/E set trajectories including • Two Meticillin resistant *Staphylococcus aureus* (MRSA) bacteraemia • 43 cases of *C. difficile* against a NHSI/E target of no more than 52 cases • 65 *E. coli* bacteraemia against a NHSI/E improvement target of no more than 111 cases • 48 cases of *Klebsiella* bacteraemia against a NHSI/E improvement target of no more than 49 cases • 27 cases of *Pseudomonas aeruginosa* bacteraemia against a NHSI/E target of no more than 21 cases • There were 14 surgical site infections reported between April and December 2021 in Coronary Artery Bypass Graft (CABG) surgery which is higher than expected • The Trust achieved reasonable assurance of water safety following an external Authorising Engineer Audit • Hand hygiene audits across the Trust have shown a 99.5% pass rate		
Recommendation:	The Board is asked to receive the IPC Annual Report 2021-22; and to note the IPC priorities for 2022-23.		
Supports			
Trust Strategic Objective:	Build a Better St George's Treat the patient, treat the person		
CQC Theme:	Safe, Well Led		
Single Oversight Framework Theme:	Quality of Care		
Implications			

Risk:			
Legal/Regulatory:	The Health and Social Care Act (2008): The Hygiene Code - code of practice on the prevention and control of infections. (Updated 2015) https://www.gov.uk/government/publications/the-health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance Accessed July 2022 Health and Social Care Act 2008) Regulated Activities Regulations 2014: Regulation 12 Safe Care and Treatment		
Resources:			
Equality and Diversity:			
Previously Considered by:	Infection Control Committee PSQG Quality Committee (in Common)	**Date**	30/06/2022 20/07/2022 18/08/2022
Appendices:	Appendix 1 – IPC Annual Report 2021-22		

St George's University Hospitals
NHS Foundation Trust

Annual Report
Infection Prevention and Control
2021 – 2022

Contents **Page**

Executive summary

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

The Trust has been considerably impacted by the global pandemic of SARS-CoV-2, the virus that causes Covid-19. During 2021-22 a total 1946 patients required hospital admission, 1736 were subsequently discharged (89.21%) and sadly there were 185 deaths in patients who tested positive for SARS-CoV-2 (9.51%) between May 2021 and March 2022 inclusive. Of the 185 deaths, 93 deaths have COVID-19 listed on either Part 1A/B of their death certificate (4.78%). The year was predominantly affected by the Omicron variant wave of Covid-19.

The Trust responded to the pandemic by reducing normal business and increasing capacity in critical care and other ward areas to care for patients confirmed with Covid-19. Patient pathways were in place for suspected cases, and patients testing positive were housed in dedicated ward facilities and critical care where necessary. Despite this a number of nosocomial outbreaks occurred at the Trust, especially with the Omicron wave, though often typified by asymptomatic illness.

Guidance in the Trust was informed by nationally issued guidance from the United Kingdom Health security Agency (UKSHA) which formed the basis of all infection prevention decisions made during the pandemic. Following the creation of the St Georges', Epsom & St Helier University Hospitals Health Group, decisions around returning to normal business following the pandemic were taken in tandem across the Group.

During 2021-22 the Trust recorded two cases of Trust apportioned Meticillin resistant *Staphylococcus aureus* (MRSA) bacteraemia (blood stream infection). There compares to 3 during the previous year 2020-21.

There were 43 cases of Trust apportioned *Clostridium difficile* infection against an NHS Improvement target of no more than 52 cases. This compares to 41 cases reported during 2020-21.

There were 45 Trust apportioned cases of Meticillin sensitive *Staphylococcus aureus* (MSSA) bacteraemia during 2018-19 compared to 47 during 2020-21.

There were very low numbers of influenza cases reported during the winter season 2021-2022 which is thought to be a consequence of social distancing and wearing of face masks in response to the Covid-19 pandemic and the dominance of the Omicron SARS-CoV-2 variant. This reflects a national position of very low numbers of influenza cases.

There were no Norovirus outbreaks.

An excellent achievement has been the uptake of staff influenza vaccination, which at 72.3%, is once again among the highest uptake of hospitals in London.

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

A note of thanks to all our staff who continue to take seriously that prevention of infection at the Trust is everyone's business during a difficult time due to the Covid-19 pandemic. We once again continue look forward to further strengthening infection prevention and control practices at the Trust during 2022-23.

1. Infection Control Team and reporting arrangements

Head of Infection Prevention & Control	1.0 wte
Infection Control Doctor/ Consultant Microbiologist	4 PA's
Lead Nurse-Infection Prevention & Control	0.5 wte
Clinical Nurse Specialists- Infection Prevention & Control (Band 7)	3.0 wte
Infection Prevention & Control Nurse (Band 6)	3.0 wte
Infection Prevention & Control Nurse (Band 5)	1.0 wte
Infection Prevention & Control Support Worker	1.0 wte
Infection Prevention & Control Surveillance Scientist	1.5 wte
PA to infection Prevention & Control	1.0 wte

The *Trust Board* recognises and agrees their collective responsibility for minimising the risks of healthcare associated infection and agrees and supports the means by which these risks are controlled. The responsibility for Infection Prevention and Control (IPC) lies with the Director of Infection Prevention & Control (DIPC). For much of 2021-22 this responsibility sat with the Chief Nurse at St Georges. With the introduction of the St Georges', Epsom & St Helier University Hospitals Health Group, this responsibility now sits with the Group Chief Nurse. However, St George's retains a site Chief Nurse, who is supported by a Deputy Chief Nurse, an Assistant Chief Nurse, with delegated responsibility for Infection Prevention & Control, a Consultant Microbiologist as the Infection Control Doctor, and a Head of Infection Control.

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

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

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

The Infection Prevention & Control Committee (*IPCC)* is the main forum for governance and monitoring of action around IPC practice at the Trust. The membership of the IPCC includes representation from all Divisions at the Trust, plus a representative from the United Kingdom Health Security Agency via the South London Health Protection Team. The IPCC is chaired by the St George's site Chief Nurse. A quarterly report from the IPCC is received at the Patient Safety & Quality Group and the Trust Quality Committee, which is a subcommittee of the Board, where the IPC annual report is also received.

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

During 2021-22 the post of IPC Healthcare Surveillance Scientist has been established at the Trust and brings epidemiological skills to the IPCT.

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

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

2. Compliance with the Hygiene Code

The Trust is required to demonstrate compliance with The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (The Hygiene Code). Evidence of compliance to each section of the Hygiene Code was reviewed periodically during the year and was received at the Infection Prevention & Control Committee. The Trust declared compliance with all ten criteria of the Hygiene Code (listed below) during 2021-22.

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

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

A rolling programme of collation of evidence of compliance with the hygiene code will continue during 2022-23 as part of the calendar of business of the Infection Prevention & Control Committee.

3. Summary of Infection Prevention and Control Performance

Trusts are required to participate in six mandatory reporting schemes;

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

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

3.1 MRSA Bacteraemia

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

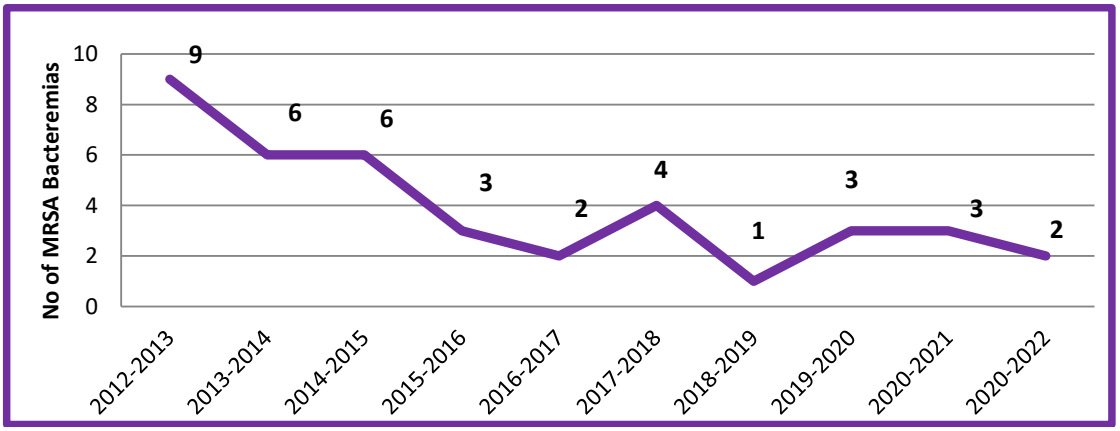
There have been two episodes of Trust-apportioned MRSA bacteraemia during the financial year 2021-22, compared to three during 2020-21.

Case 1: A MRSA bacteraemia in a blood culture taken from a patient on General Intensive Care Unit in September 2021. In this case the source of infection could not be clearly identified but was likely to be associated with the patient's chest, as aspiration pneumonia had been reported and the patient was positive for MRSA in sputum.

Case 2: A MRSA bacteraemia in a blood culture taken from a patient on Belgrave ward during October 2021. The likely source of infection in this case was via the peripherally inserted central cannula (PICC) line. The patient had a long history of MRSA colonisation.

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

Figure 1: MRSA bacteraemia St George's University Hospitals NHS Foundation Trust (SGH) 2012-2022

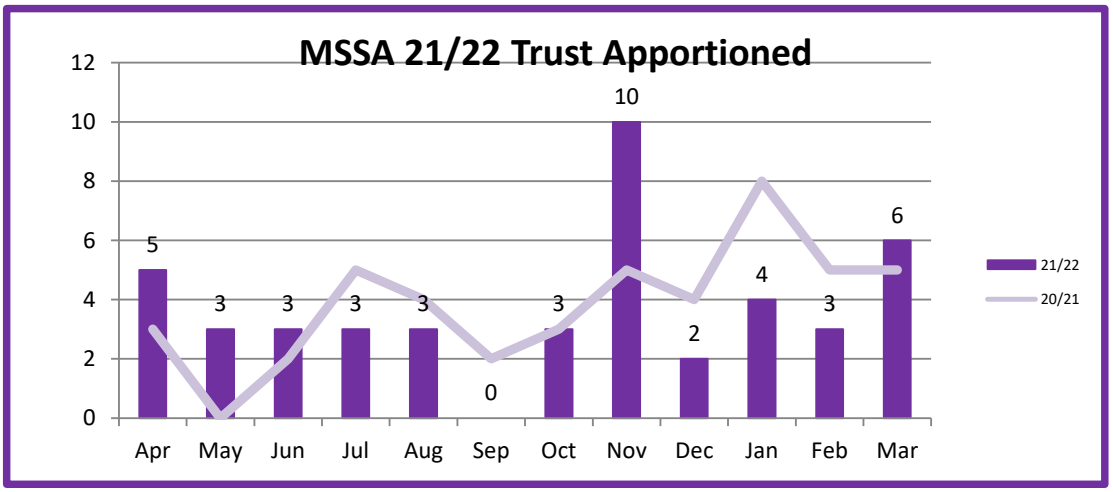


3.2 MSSA Bacteraemia

There were 45 episodes of MSSA bacteraemia during 2021-22 apportioned to the Trust, where the blood culture was taken after the second day of admission (Figure 2). This compares to 46 during 2020-21, 36 during 2019-20 and 27 during 2018-19. Of the 45 cases, 15 were thought to be associated with intravenous lines. Other key cause groups are respiratory and gastrointestinal infection.

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

Figure 2: MSSA bacteraemia SGUH 2021-22



3.3 *Clostridium difficile*

Clostridium difficile infection (CDI) is a major cause of antibiotic-associated diarrhoea Figure 3 shows CDI Trust apportioned 2012-22 against NHS Improvement set targets.

During 2021-22 St George's recorded 43 episodes of Trust apportioned *Clostridium difficile* infection against a presumed NHS England / Improvement target of no more than 52 cases. This compares to 41 cases during 2020-21, 51 cases during 2019-20.

The method of counting cases of CDI consists of

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

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

Of the 43 cases reported during 2021-22, 33 were classified as Hospital Onset Healthcare Associated (HOHA) and 10 were classified as Community Onset Healthcare Associated (COHA)

As per CDI standard operating procedure (SOP), episodes that were Trust-apportioned underwent root cause analysis (RCA). Identified lapses in care have been associated with links to antimicrobial agents and delays in taking a sample for testing.

Following the RCA review, feedback is given to the relevant Division and the outcomes of RCA are noted at the Infection Prevention & Control Committee.

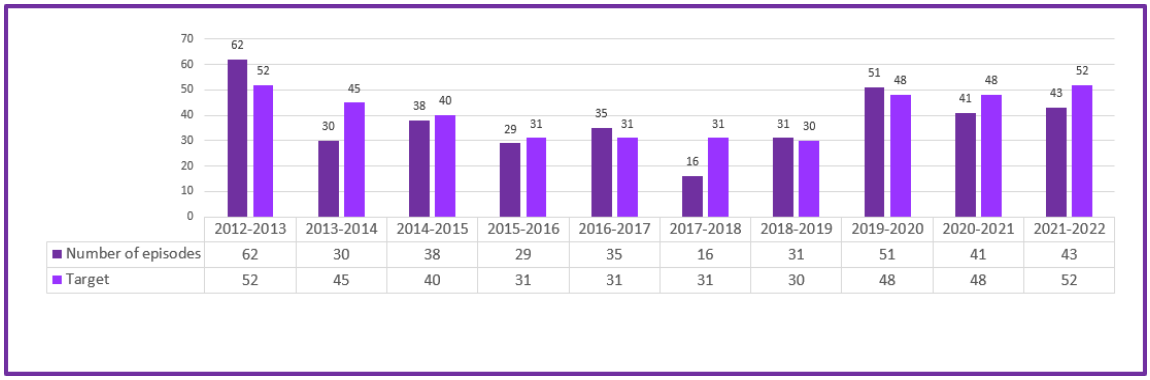
In addition, all isolates of *C difficile* were sent for ribotyping to look for any evidence of cross-infection.

One period of increased incidence, involving 3 patients on Cavell Ward was technically an outbreak as two of the cases had the same ribotype.

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

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

Figure 3: *Clostridium difficile* at St George's University Hospitals Foundation Trust 2012-13 to 2021-22



	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019	2019-2020	2020-2021	2021-2022
Number of episodes	62	30	38	29	35	16	31	51	41	43
Target	52	45	40	31	31	31	30	48	48	52

3.4 Gram-negative bacteraemia

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

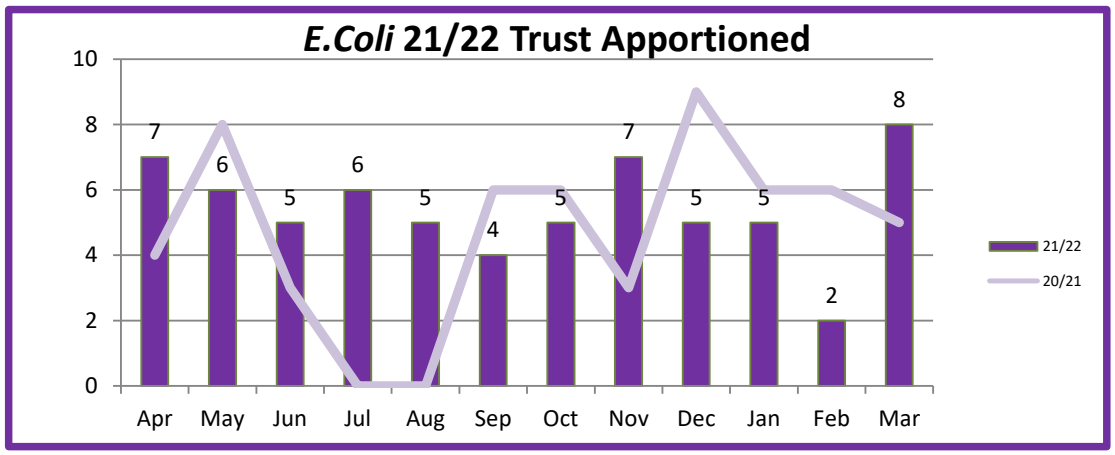
3.5 *E. coli*

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

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

For 2021-2 a total of 65 Trust apportioned *E. coli* bacteraemia were reported (Figure 4). This compares to 56 during 2020-21, 74 during 2019-20 and 47 during 2018-19. Predominant cause groups remain upper urinary tract and gastrointestinal tract. The total of 65 cases is set against a NHSI/E trajectory of no more than 111 cases. The Trust therefore completed the year within this trajectory.

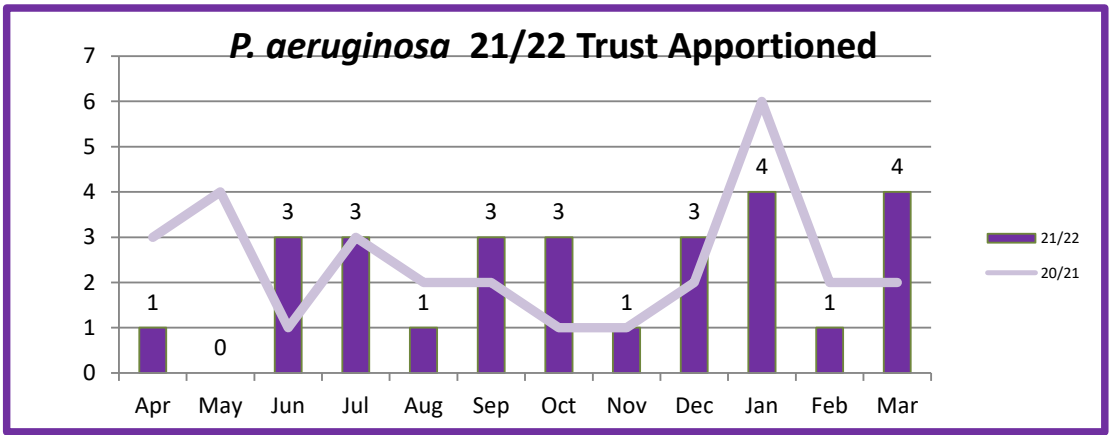
Figure 4: Trust apportioned *E coli* bacteraemia 2021-22 showing 2020-21 figures



3.6 *Pseudomonas aeruginosa*

There were 27 cases of Trust apportioned *Pseudomonas aeruginosa* bacteraemia during 2020-21 (Figure 5). This compares to 31 during 2020-21 19 cases during 2019-20, 16 during 2018-19 and 27 during 2017-18. The total of 27 cases is set against a NHSI/E trajectory of no more than 21 cases. The Trust therefore completed the year above this trajectory. This was a common position across other Southwest London acute Trusts.

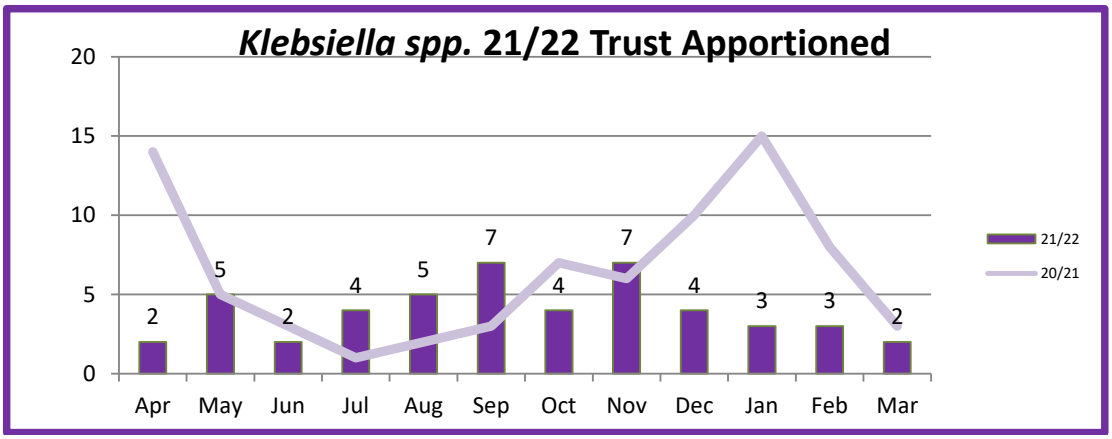
Figure 5: Trust apportioned *P. aeruginosa* bacteraemia 2021-22 showing 2020-21 figures



3.7 *Klebsiella*

There were 48 cases of *Klebsiella* bacteraemia reported during 2021-22, comparing to 78 during 2020-21, 38 during 2019-20 (Figure 6), 21 cases during 2018-19 and 29 cases during 2017-18 (Figure 6). The total of 48 cases is set against a trajectory of no more than 49 cases. The Trust therefore completed the year within this trajectory.

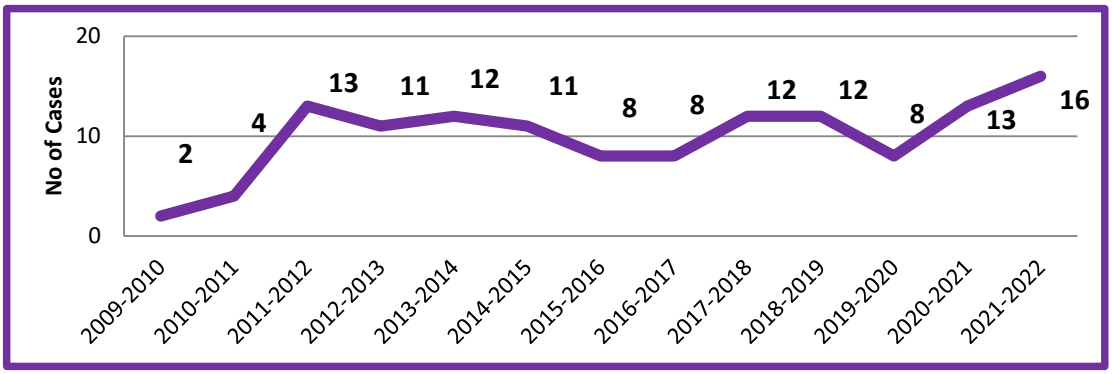
Figure 6: Trust apportioned *Klebsiella* bacteraemia 2021-22 showing 2020-21 figures



3.8 Glycopeptide resistant enterococcal bacteraemia (GRE)

St George's figures are illustrated below (Figure 7). There are no national thresholds. St George's has maintained low levels of GRE and 16 cases were reported during 2021-22.

Figure 7: GRE bacteraemia 2009-10 to 2021-2022



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

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

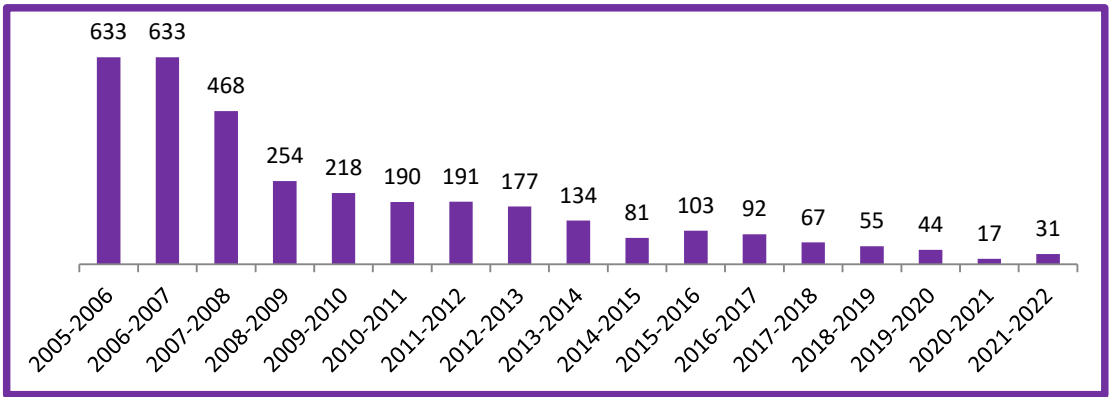
The Trust reports episodes to the voluntary PHE operated CPE database as well as submitting antibiotic resistance data to the PHE.

3.10 MRSA acquisitions

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

The acquisitions are shown 2005-22 in Figure 8.

Figure 8: MRSA acquisitions 2005-06 to 2021-22



Not all admissions are screened for MRSA, following guidance in 2014, indicating that MRSA screening could be reduced to “high-risk” patients only. The Trust Infection Control Committee therefore agreed to support targeted screening which has commenced for elective surgical patients via pre-assessment. This targeted screening will be expanded to low-risk emergency admissions. Patients who require critical care continue to be screened and high-risk surgical cases e.g., in orthopaedics or cardiac surgery will also continue to be screened.

4. Surgical Site Infection (SSI) Surveillance

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

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

The **Cumulative Incidence of SSI** is calculated from SSI detected during the inpatient stay and readmission with SSI. This rate is used for comparison against the national benchmark. Only SSIs identified by active surveillance in hospital are included in the main outcome measure for national surveillance because SSIs reported by patients cannot be verified. Table 3 shows cumulative incidence for Reduction of Long Bone 2021 and Table 6 shows cumulative incidence for Coronary Artery Bypass Graft (CABG) SSI at the Trust during 2021.

The **All-hospitals SSI** rate includes all SSIs detected during inpatient stay and readmission with SSI in addition to those infections detected in post-discharge surveillance and reported by patients up to 30 day's post-operation. Table 2 shows 'All hospitals' comparison for Reduction in Long Bone and Table 5 shows 'All hospitals' comparison for CABG SSI at the Trust during 2021.

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

Results are then submitted to UK Health Security Agency (UKHSA) that replaced Public Health England (PHE) in April 2021, so that comparison between hospitals can be made.

During 2021-22 the Trust participated in SSIS modules in reduction of long bone fracture and coronary artery bypass graft (CABG) surgery.

In 2021, due to the impact of the SARS-CoV-2 pandemic, no surveillance was conducted during the first quarter, January- March 2021.

4.1 Reduction of Long Bone Fracture

Data for 2021 (Table 1 as published by UKHSA are shown below). These are the figures for St George's Hospital all SSIS. The UKSHA reports SSI rates by calendar year, as opposed to financial year.

Table1: 2021 Reduction of Long Bone SSI data at St. George's

Year and Period	No. operations	Inpatient & readmission		Post discharge confirmed		No patient reported		All SSI*	
		No.	%	No.	%	No.	%	No.	%
2021 Q2	95	2	2.1%	0	0.0%	0	0.0%	2	2.1%
2021 Q3	109	0	0.0%	1	0.9%	1	0.9%	2	1.8%
2021 Q4	104	1	1.0%	3	2.9%	0	0.0%	4	3.8%

***All SSI = Inpatient & readmission, post-discharge** confirmed, **and patient reported**
This table refers to data collected over the selected periods for which data has been submitted and reconciled (Q2 April- June 2021, Q3 Jul-Sep 2021, Q4 Oct- Dec 2021).

(Source: UK Health Security Agency SSIS Service, Summary Reports Jan – Dec 2021)

In the period of **April- June 2021**, there were two SSI reported and were detected at readmission, classified as Organ space infections.

In the period **July – Sept 2021**, there were two superficial SSI's reported.one detected post discharge and the other patient reported.

In the period **October -December 2021**. There were four SSI reported. Two superficial detected post discharge follow up, one organ space detected post discharge follow up and one superficial during admission.

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

Table 2: 'All Hospitals' SSI for Reduction of Long Bone 2021

SSI period 2021	St George's	All hospitals
April- June	2.1%	1.4%
July - September	1.8%	1.4%
October- December	3.8%	1.4%

Table 3: Cumulative Incidence of SSI Reduction of Long bone 2021

SSI period 2021	St George's	All hospitals
April- June	2.1%	0.7%
July - September	0.0%	0.7%
October- December	1.0%	0.7%

The cumulative incidence of SSI (Table 3 above) are benchmark figures for the cumulative percentages for patient and readmission figures for 2021. The trust was not identified as an outlier in this module, being within an expected range.

By comparison, long bone SSIS modules were completed for January – March and July – September 2020. The rate of SSI was 2.6% during January – March 2020 (all hospital 1.6%) and 1.1% during July – September (all hospital 1.5%); and the cumulative incidence was 0.0% during January to March 2020 (all hospital 0.9%) and 1.1% during July – September 2020 (all hospital 0.8%).

All hospital comparison is an average of hospitals over the previous 5 years. UKHSA publishes SSI data by calendar year and not financial year.

4.2 Coronary Artery Bypass Grafts (CABG)

The cardio-thoracic Specialist Nurse in conjunction with Infection Prevention and Control Team undertook SSI surveillance of all CABG surgery. After the introduction of multiple measures following the high rates reported in the 2013-14 annual report the infection rate subsequently reduced significantly. However, recent surveillance has shown some increase. Tables 4-6 show figures for St. George's Hospital CABG SSIs 2021.

Table 4: 2021 CABG SSI Data at St. George's
(Source: UK Health Security Agency SSIS Service, Summary Reports Jan – Dec- 2021)

Year and Period	No. operations	Inpatient & readmission		Post discharge confirmed		No patient reported		All SSI*	
		No.	%	No.	%	No.	%	No.	%
2021 Q2	89	1	1.1%	3	3.4%	0	0.0%	4	4.5%
2021 Q3	80	1	1.3%	2	2.5%	1	1.3%	4	5.0%
2021 Q4	91	6	6.6%	0	0.0%	0	0.0%	6	6.6%

***All SSI = Inpatient & readmission, post-discharge confirmed, and patient reported**
This table refers to data collected over the selected periods for which data has been submitted and reconciled (Q2 April- June 2021, Q3 Jul-Sep 2021, Q4 Oct- Dec 2021).

In the period **April -June 2021** there were four SSIs reported. Four superficial SSI's. Three detected post discharge follow up and one on readmission.

In the period **July to September 2021** there were four SSIs reported. Three superficial and one deep incisional. The deep SSI was detected on readmission and the three superficial SSIs were detected post discharge follow-up.

In the period **October -December 2021** there were 6 SSI's. One patient had SSIs in sternum and donor site counting as two SSIS detected during admission. There were four superficial SSIs detected at readmission. The trust was identified as a high outlier among participating hospitals for CABG surgery for this period. Our inpatient and readmission SSI risk for CABG surgery was above the 90th percentile in this quarter at 6.6%. This compares to a 2.7% incidence of infection rate for all hospitals participating in this surgical category over the previous 5 years (Table 6).

Table 5: SSI 'All Hospitals' SSI for CABG 2021 (as published by PHE)

SSI period 2021	St George's	All hospitals
April- June	4.5%	5.7%
July - September	5.0%	5.6%
October- December	6.6%	5.5%

Table 6: Cumulative Incidence of SSI for CABG 2021

SSI period 2021	St George's	All hospitals
April- June	1.1%	2.8%
July - September	1.3%	2.7%
October- December	6.6%	2.7%

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

4.3 Actions

Coronary Artery Bypass Grafts (CABG):
At a meeting to discuss the trust's outlier position for **October -December 2021** the following actions were agreed:

- Liaise with cardiac surgeons regarding infections, discuss cases and review any root cause analysis findings
- Lookback at surgeons in 2020 and 2021 who have had infections to identify any trends in operators
- Identify theatres in which surgery took place, any anomalies, changes in practice or the theatre environment
- Undertake sternal and leg wound care audits to ensure standards are optimal; amend saving lives audit tool to ensure that it is fit for purpose and undertake a minimum of ten wound care audits on the cardiac surgery ward
- Undertake hand hygiene audits on the cardiac surgery ward, Cardiothoracic Intensive Care Unit (CTITU) and in theatres with escalation of any noncompliance
- Review SSI Saving lives audit scores (pre; peri and post-op), conduct additional audit after review and update of audit tools.
- Undertake nurse teaching on wound care management
- Review staff compliance with Antiseptic non touch technique (ANTT) competencies on the cardiac surgery ward and CTICU
- Review any accreditation or IPC walkabout findings that were undertaken October to December 2021 on the cardiac surgery ward, CTICU or cardiac theatres
- Support departments to implement any ongoing/unresolved improvements.
- Review patient education and teaching pre-and post-op on B. Weir to ensure the information is of a high standard and that education and teaching is routinely given to patients.

Additional Actions for the Trust

- Revise and adapt a SSI root cause analysis tool in collaboration with clinical teams to ascertain any lessons for future clinical practice with feedback to clinicians and Divisional Governance Teams.
- Continue to monitor compliance with standard NICE guidance regarding theatre procedures including sutures. Sutures have been discussed with theatres and they have moved from staples to sutures in orthopaedic and cardiac surgery. Triclosan (antimicrobial) coated antimicrobial sutures are currently in use
- Continue with feedback to surgical teams and other relevant stakeholders regarding infections, rates of SSIs and PHE reports
- IP&C walkabouts in theatres have been undertaken. Continued monitoring of theatres will be carried out with theatre staff with feedback
- Strengthen links with the T&O clinic to alert IPC when patients return with SSI or suspected SSI
- Review the method of finding post discharge and patient reported SSIs

5. Water Safety

The monitoring and preventative measures for control of *Legionella* and *Pseudomonas* in taps, showers and other water outlets continues in accordance with the Trust Water Safety Policy and Water Safety Plan. A system of filtering outlets remains in both St James wing and Lanesborough wing and water outlet testing remains in place. Detections in St James have reduced significantly, planned estates

works to improve the quality of water for St James Wing and Lanesborough are near completion. The Water Safety Team have implemented a continuous improvement strategy to manage existing estate, and water sampling during the year shows low levels of contamination across all areas, including both main Trust buildings housing the majority of wards, and other perimeter road buildings at the Trust.

The success of mitigating the risk of *Legionella* and *Pseudomonas* in St James wing has allowed the Trust to establish a 3-month trial which will allow the trust to remove Point of Use Filters from St James. The strategy implemented in St James is being implemented into Lanesborough with future projects planned to improve overall safety in the water services.

The Operational Water Management Group (OWSG) has led on management water safety and includes support from IPCT. The OWSG has met on a fortnightly basis and is led by the Head of Estates with representatives from Microbiology, Infection Control and contractor services in attendance. There is also a Strategic Water Safety Group chaired by the Chief Nurse / DIPC. An external audit by the Trust contracted Authorising Engineer for water concluded there was reasonable assurance of water safety at the Trust.

6. Outbreaks and incidents

6.1 Influenza infections and outbreaks

There were low numbers of influenza reported during the winter season 2021-22. This is thought to be due to the social distancing and wearing of face masks in response to the Omicron wave of the Covid-19 pandemic. This also reflects the position across southwest London and the national position of low numbers of influenza cases.

6.2 Staff Influenza vaccination

The Trust's staff influenza vaccination campaign for 2021-22 successfully led to an uptake of 72.3% by patient facing staff, ranking once again high in uptake for hospitals in London.

Table 7 shows uptake among a range of patient facing staff groups

Staff Group	Total flu jab
All Doctors	71%
Registered Nurses	67%
Midwives	48%
Clinical – Allied Health Professional	66%
Support to Clinical + Admin	73%
Patient facing students	100%
Total patient facing staff	72.3%

6.3 Norovirus infections and outbreaks

There were no Norovirus outbreaks during 2021-22.

6.4 SARS-CoV-2 pandemic (Covid-19) in St George's, 2021 - 2022

The SARS-CoV-2 (the virus that causes Covid-19) pandemic continued to overshadow the work of the IPCT and the wider hospital through 2021-22. At the

beginning of the financial year, we had emerged from the second wave of the pandemic, dominated by the Beta (Kent) variant of the virus; society, and the NHS, was also well underway with the COVID vaccination programme. Early in the summer, the Delta variant appeared, and caused a moderate peak in cases in August. This lasted into the autumn and was beginning to decline when in late November 2021 the Omicron variant appeared, leading to a very large fourth wave of infections nationally and locally in St George's. The Omicron wave prompted the COVID Vaccine Booster campaign. A vaccination centre was sited within St George's Hospital and was accessed by both staff and the local community.

The Omicron variant appeared to be more infectious than previous variants, with much greater numbers of cases nationally, and at least as many patients and staff affected as previously – but fortunately it appeared much less virulent, and the severity of disease was less.

SARS-CoV-2 cases are classified in accordance with the length of time post admission of the patient that they were detected. More than 72% of cases are detected on admission or within 3 days of admission, indicating acquisition in the community, see table 8 and figure 9.

Positive SARS Cov-2 April 2021 - March 2022 inclusive	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	% of TOTAL
Hospital onset healthcare associated (>14 days) HOHA	2	0	0	0	18	2	5	3	66	54	15	49	214	10.95%
Hospital onset probable association (8-14 days) HOPA	0	1	1	0	9	1	4	2	26	30	12	39	125	6.39%
Hospital onset indeterminate association (3-7 days) HOIA	0	0	1	2	8	15	6	8	44	44	22	53	203	10.38%
Community onset community associated (<3 days) COCA	7	4	26	89	143	89	80	83	240	291	138	223	1413	72.28%
TOTAL:	9	5	28	91	178	107	95	96	376	419	187	364	1955	

Table 8 – SARS-CoV-2 by classification of acquisition2021-22

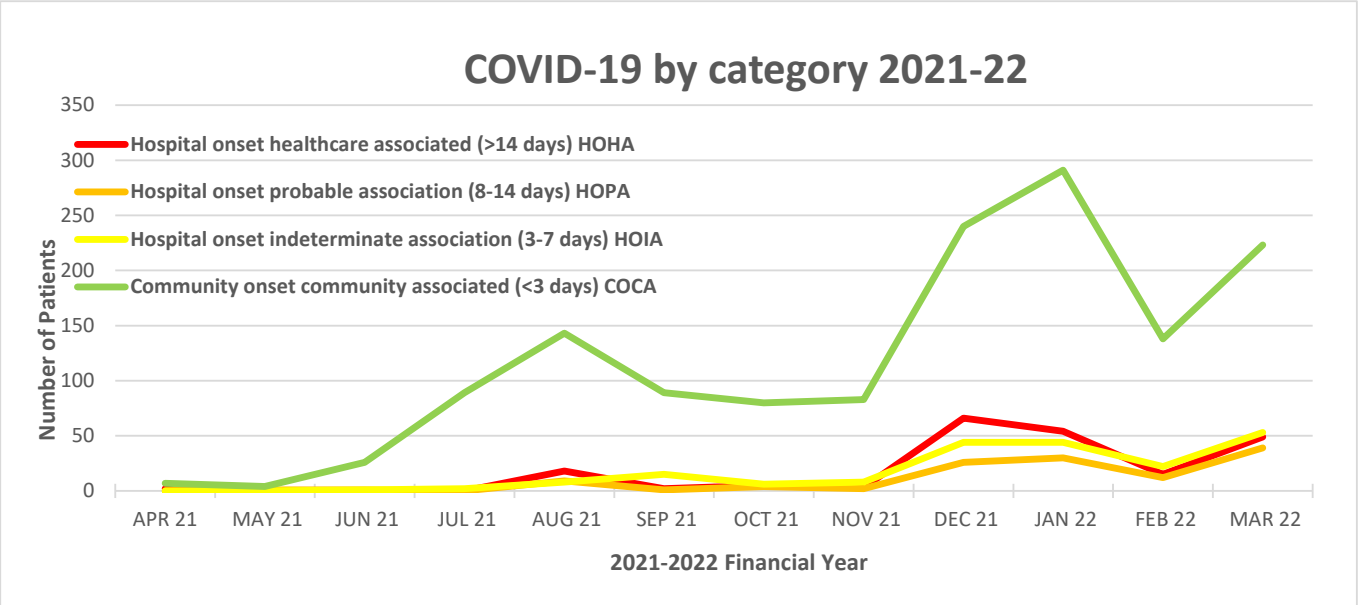


Figure 9: SARS-CoV-2 detections in inpatients by category 2021-22

In terms of nosocomial infections, the IPCT and Trust attempted to control, and limit spread of infection, with a range of measures as set out in national guidance, including screening of patients on admission and at intervals thereafter (frequency determined by local risk profile), prompt isolation of cases in dedicated COVID wards, isolation and screening of contacts, staff screening (intensified during outbreaks), mandatory mask-wearing by all staff, and molecular typing of isolates. The Emergency Department at St Georges is now all single cubicles which helped in the attempt to limit spread. The waiting area also was fitted with substantial Perspex screens between waiting chairs in a further effort to create a physical barrier between patients attending who might have had the infection and those who did not.

Despite these best efforts we still found that hospital spread of COVID occurred in proportion to community rates and over 20231-22, and 11% of cases were detected more than 14 days post admission to hospital. The control measures were themselves disruptive of patient pathways and the Trust was often compelled to balance the risks of COVID control measures against other problems such as delayed admission, overcrowding in ED, delayed or cancelled surgery, patients on dedicated COVID wards not receiving timely specialist care for their needs etc. The reasons for this inability to prevent all nosocomial COVID include the respiratory nature of spread, frequent asymptomatic infection in patients, visitors and staff, long incubation, and many wards with beds close together, in bays with no doors and no or minimal mechanical ventilation. There was also the issue that, as of 1/1/2022, 30% of local residents (> 12 years old) had not received any vaccine, compared to 7% unvaccinated people in the whole of England.

Fortunately, we found that the Omicron variant, while more infectious, was less severe; most cases we detected were asymptomatic, compared with most cases of previous variants being symptomatic. It is unclear whether this lack of severity was due to intrinsically lower virulence of Omicron, or the widespread population immunity we have developed through vaccination and/or prior infection.

IPCT Activities related to COVID-19

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

- Ongoing review of COVID-19 Infection Control and PPE guidance based on national guidance issued from UK Health Security Agency (UKHSA)
- Training and education for staff in PPE use and IPC precautions
- Hand hygiene training and audits
- Support for Staff Health Dept in managing COVID illness in staff. Staff testing continued to be offered through the Bence Jones Unit (the 'Pod') on the perimeter road at St George's
- Extension of IPC nursing service to 7-day cover during surges
- Liaison between laboratories and the clinical site management team regarding Covid-19 testing results
- Managing COVID incidents and outbreaks (in practice, during surges, this occupied most of the IPCT time)

COVID Recovery

As we emerged from the Omicron wave in early 2022, and the national COVID regulation were repealed, and the harm from COVID infection declined, the IPCT has supported the process of COVID recovery, and the replacement of restrictive COVID-related practices with more pragmatic policies designed to allow the NHS to function more normally and to clear backlogs and waiting lists. In particular, we have convened and led the St George's Hospital COVID Recovery Group, a forum of Surgeons, Physicians, Anaesthetists, senior nurses, and Microbiologists, with an agenda of reviewing existing COVID policies and agreeing on a safe process of moving to a post-pandemic NHS.

SWL Sector Work

The St George's IPCT contributes actively to the Southwest London IPC Forum, which exists to provide peer support to IPCTs, and a chance to compare practice and experience, and hopefully agree and harmonise policies and protocols.

Amyand Ward

An outbreak of healthcare associated Covid-19 occurred on Amyand Ward during August 2021. Amyand is a 32 bedded senior health ward in St James Wing on the St George's site. During the period 16/08/21 to 26/08/21, a total of 21 patients and 9 staff on Amyand Ward were found to have infection with SARS-CoV-2, the virus that causes Covid-19.

During this time nine patients died during their hospital admission. The first patient who was found to have Covid-19 died on 21/08/21, and the other deaths occurred between 29/08/21 and 11/09/21. 'Covid-19' was mentioned in Part 1 of the death certificate in six patients (generally referred to as 'died of Covid-19') and in Part 2 in one patient (described as 'died with Covid-19'). In two of the cases, Covid-19 was not mentioned on the death certificate.

The outbreak was the subject of a serious incident investigation which sought to address the following questions:

What was the cause of the outbreak, and could it have been prevented?
How was the outbreak managed?
What were the consequences of the outbreak?

Root cause

No single root cause of the outbreak could be identified. SARS-CoV-2 infection may have been introduced to the ward by the index patient, or possibly another patient identified in the

outbreak, or by a member of staff or a visitor. The ward environment is likely to have played a significant role in the dissemination of infection, notably poor mechanical ventilation achieving sub-optimal air changes per hour.

Despite high levels of vaccination in the patients, many were very frail and unwell from other illnesses and were therefore more susceptible to breakthrough infection and severe illness. Absence of day 1, 3 and 7 testing of patients was noted but is unlikely to have been the cause of the outbreak, though may have delayed the recognition of the outbreak by a short period. Vaccination levels in staff were low compared to the overall Trust rates and may have led to more staff becoming infected and possibly spreading infection, but this cannot be proven.

The cause of the outbreak cannot therefore be clearly identified. The single biggest factor for the widespread nature of the outbreak on Amyand Ward is likely to be the ward environment inclusive of sub-optimal mechanical ventilation, lack of doors on bays and general poor condition of the estate. However, the outbreak was recognised at a very early stage and infection prevention & control actions were found to have been implemented promptly and comprehensively.

7. Infection Control compliance and audit

7.1 Hand Hygiene

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

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

In 2021-2022 a total of 52,789 observations were recorded--reflecting less hand hygiene audits performed when compared to 2020-2021 (60,755 observations) --a 13.11% decrease. All audit scores of 0 were excluded during analysis yielding 99.59% hand hygiene compliance Trust wide--a 1.61% increase when compared to 2020-2021. The divisional figures below were adjusted to reflect 52,200 of the 52,789 observations. The remaining 589 observations were excluded as they come from areas such as Infection Control and Cardiology (QMH).

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

Figure 10: Hand hygiene compliance Trust wide 2021-22

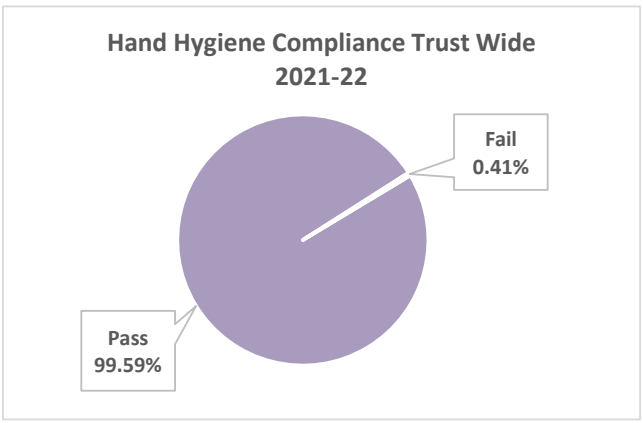


Figure 11: Hand hygiene compliance across all 3 Divisions 2021-22

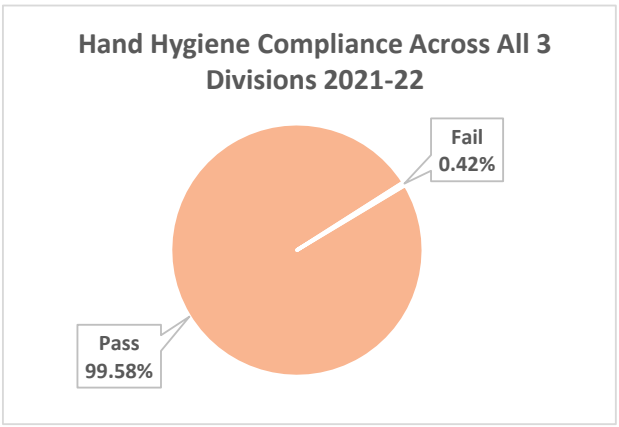


Figure 12: Hand hygiene compliance Division of Medicine & Cardiovascular Services 2021-22

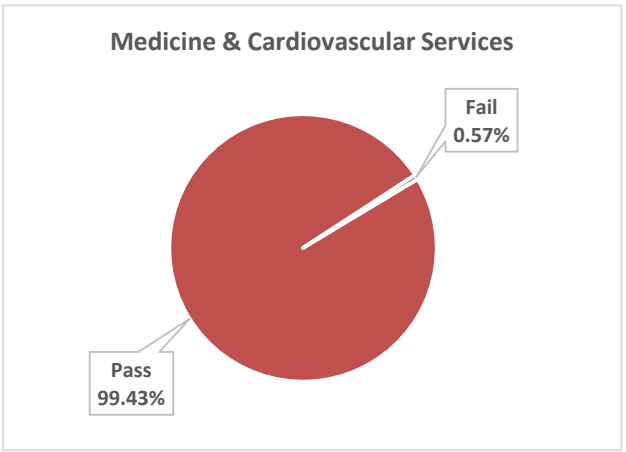


Figure 13: Hand hygiene compliance Children & Women's, Diagnostic & Therapy Services Division 2020-21

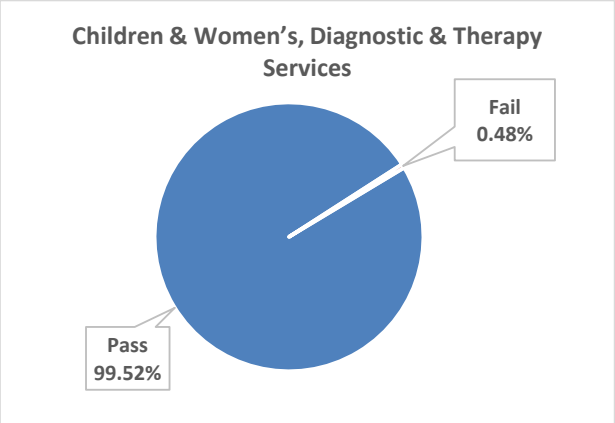
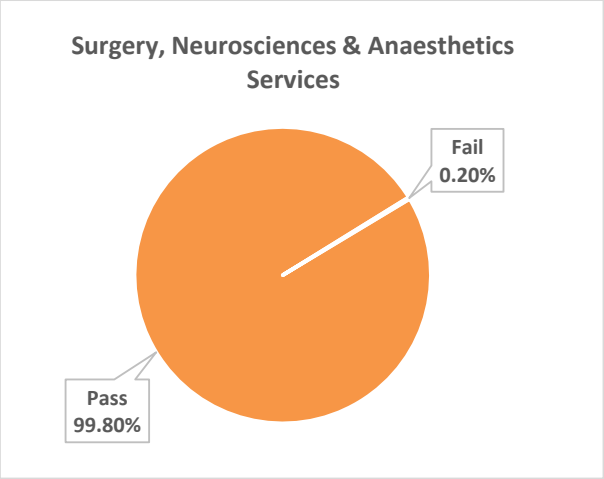


Figure 14: Hand hygiene compliance Division of Surgery Neurosciences and Anaesthetic Services 2021-22



7.2 Bare below the elbow (BBE)

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

7.3 Period of Increased Surveillance and Audit (PISA)

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

of clean linen and venous access devices (for MRSA) are also all audited during the PISA process.

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

There were two MRSA blood stream infections allocated to the trust for 2021-22 and the PISA process was carried for both cases.

31 wards were put on PISA out of 42 cases of Healthcare Associated cases of *Clostridium difficile*, this includes those with increased incidents and outbreaks. No PISA was carried out on cases that are community onset.

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

Feedback from PISA is given to the ward team at the time of the visit and is followed up in writing. Wards must maintain a total score of >95% for three consecutive weeks before stopping PISA.

During 2021-22 the average number of weeks that wards were on PISA was 7 weeks, the longest 15 weeks. Two wards were removed from PISA after the first week.

7.4 Saving Lives Audits

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

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

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

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

7.5 Estates and Facilities

The Estates and Facilities (E&F) team in conjunction with the nursing and Infection Prevention & Control Team (IPCT) conducted audits to assure the Trust of its obligation to provide a safe care environment. The Trust average score for cleanliness was 96%. For very high-risk areas including critical care the score was 99%.

In 2021-22 the E&F team also continued to be part of the audit teams for the ward accreditation programme. These included audits across the community sites, and Queen Mary's Hospital and actions were then taken to rectify any concerns when noted.

7.6 Cleanliness in Hospitals

Cleaning in hospitals has been governed by the National Specifications for Cleanliness in Hospitals (2007) and the NHS Cleaning Manual (2009) but have now been superseded by new National Specifications for Cleanliness in Hospitals in 2021. Each site has a target score which considers different risk categorisation and cleaning frequencies.
The Trust actual average score cleanliness for 2020-21 was 96%

By risk category	Average	Target	Variance
Very High	99%	98.0%	+1%
High	97%	95.0%	+2
Significant	95%	85.0%	+10%
Low	92%	75.0%	+17%
Overall 21-22	96%	88%	+3%

Throughout 2021-22 additional enhanced cleaning was in place in many areas of the trust to meet the challenge of Covid-19. This included additional cleaning hours in dedicated Covid-19 wards, and in high-risk areas such as the Emergency Department and in elderly care and surgical wards. Additional cleaning was also in place in high-risk areas such as oncology and haematology to help reduce the risk of nosocomial infection in vulnerable patients.

7.7 Ward and Department Accreditation Audits

The ward accreditation was designed to engage staff and empower leaders to improve and maintain standards and quality of patient care and staff experience. The accreditation framework is based around 13 standards that were developed in line with the CQC key lines of enquiry (KLOEs). The wards progress through four levels (Requires improvement, Bronze, Silver and Gold) following formal accreditation visits based on standards of performance against agreed metrics.

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

7.8 Infection Control Team walkabouts

In addition to formal audits the Infection Prevention & Control Team also undertake regular scheduled visits to clinical areas to observe cleanliness of medical devices, the environment and IPC practice. Feedback is given to the nurse in charge

following the visit and is followed up by communication to the Ward Manager, Matron and Head of Nursing.

8. Venous Access Service

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

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

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

9.1 IPC MAST Compliance

All wards and departments were encouraged to ensure that their compliance with MAST on-line training was greater than 85%. As at 23/06/2022, the compliance rate for IPC *clinical* on-line MAST was 83% (n= 5082) and for *non-clinical* on-line MAST was 89% (n=2675) compared to 20/21 when compliance was 87% and 91% respectively.

Medical and Dental non-clinical (67%) and Medical and Dental clinical (75%) where the least compliant groups.

9.2 Education and Training

The IPC nurses continued to deliver a range of training across the organisation throughout the year, including sessions via MS Teams. Due to Covid-19 restrictions and social distancing, Trust induction sessions remained cancelled (by the Education Department) during this period.

Training was delivered to the following groups, primarily nurses.
These included staff from the following locations and groups:

- Acute Medicine (including ED)
- Senior Health
- Renal
- Haematology/Oncology
- Surgery, Trauma and Orthopaedics
- Adult ICUs (GICU, CTICU, NICU)
- PICU
- NNU
- Paediatrics
- Nurse Induction/Overseas Nurses
- Nurse Preceptorship Programme
- HCA Induction
- Physician Associates
- Junior Doctors
- Medical Students

- Student Nurses
- Wheelchair Services
- Project Search Training

Hand hygiene training was also significantly impacted by Covid-19 so that it was not possible to take the Surewash machines to as many wards or departments as usual. Nevertheless, 278 staff were still able to practice their hand hygiene technique using Surewash. The IPC team now have 3 working Surewash machines, one of which is portable and can be taken to other trust sites.

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

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

10. Support from Public Health (South London Health Protection Team)

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

11. Priorities for 2022-23

A number of actions will be prioritised by the IPCT during 2021-23. Some actions are brought forward from 2021-22 which were not fully addressed due to focus on the Coronavirus pandemic

- Continue to implement national guidance to resume normal services following SARS-CoV-2 (Covid-19) pandemic and any new guidance in the event of a further wave or for any other respiratory infection
- Continue to aim for zero cases of MRSA bacteraemia
- Implement targeted screening for MRSA colonisation in low-risk elective surgery and low risk emergency admissions
- Improve learning from cases of MSSA, in particular, where cases may be line associated
- Audit the trust strategy for screening of carbapenem-resistant organisms to measure compliance
- Continue to work collaboratively within the Trust and with other local NHS organisations to reduce the incidence of *E. coli, Pseudomonas aeruginosa and Klebsiella* bacteraemia, in order to keep within NHSI/E set trajectories
- Continue to sustain high rates of compliance with hand hygiene and ‘Bare below Elbow’
- Further improve the process of investigation for surgical site infections and take opportunities to learn lessons and improve practice

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13. Glossary of terms

Bacteraemia / BSI	The presence of bacteria in the blood / blood stream infection
C *difficile*	A bacterium that is one of the most common causes of infection of the colon. It can sometimes produce a toxin leading to colitis
Colonisation	Germs in or on the body but which not make the person unwell
CPE	Carbapenemase producing Enterobacteriaceae are Gram-negative bacteria that are resistant to the carbapenem class of antibiotics, considered the drugs of last resort for such infections
E. coli	*Escherichia coli* form part of the normal intestinal microflora in humans with some strains having the ability to cause disease. These can include food poisoning e.g. E. coli 0157 or infections of the urinary tract and bacteraemia
GRE	Glycopeptide resistant enterococci are bacteria resistant to the Glycopeptide antibiotics (vancomycin and teicoplanin) and are sometimes known as Vancomycin Resistant Enterococci (VRE)
Gram staining	A common technique used to differentiate two large groups of bacteria based on their different cell wall constituents. The Gram stain procedure distinguishes between Gram positive and Gram negative groups by colouring these cells differently, thus affecting treatment options
Fit Testing	Fit testing is a method for checking that a specific model and size of tight-fitting facepiece matches the wearer's facial features and seals adequately to the wearer's face
HCAI	Healthcare Associated Infection: Any infection that develops as a result of receiving healthcare treatment
Influenza	A respiratory illness associated with infection with the influenza virus. Symptoms frequently include headache, fever, cough, sore throat, aching muscles and joints
MDT	Multi-disciplinary Team: A meeting of a range of specialists who are experts in different areas with different professional backgrounds, united as a team for the purpose of planning and implementing treatment programs for complex medical conditions
MSSA	Meticillin sensitive *Staphylococcus aureus*: a bacteria that commonly lives on the skin or inside the nose without causing problems, but which is capable of causing infections e.g. in a wound or blood stream
MRSA	Meticillin resistant *Staphylococcus aureus*: strains of *Staphylococcus aureus* which is resistant to a number of antibiotics
RCA	Root cause analysis: A process for identifying "root causes" of problems or events leading to an approach for responding to them
SGH	St George's Hospital (St George's University Hospitals NHS Foundation Trust)
Swabbing	Swabbing in order to test for Covid-19. This can be done using a PCR Test, which is processed in a laboratory or a Lateral Flow Test, which provides an instant response to the user. Swabbing involves rubbing the swab over both sides of the back of the throat and inside both nostrils
NHSI	NHS Improvement – an NHS body that oversees Trust driving quality improvement

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Meeting Title:	**Trust Board**		
Date:	1 September 2022	**Agenda No**	**2.2**
Report Title:	**Maternity Services: Perinatal Quality Surveillance Measures July 2022**		
Lead Director/ Manager:	Arlene Wellman, Group Chief Nurse and Director of Infection Prevention and Control		
Report Author:	Annabelle Keegan, Deputy Director of Midwifery, St George's University Hospitals NHS Foundation Trust (SGUH) Lisa Massey, Clinical Governance Matron, 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 Safety Action 9 of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS): the requirement for Trusts to complete the Perinatal Quality Surveillance Report and present this to the Board. **Background** The Maternity Incentive Scheme (MIS) aims to support Maternity Services to deliver safer maternity care through recovery of an incentive element built into the Clinical Negligence Scheme for Trusts (CNST) contributions, where trusts can evidence compliance with all ten safety actions. Trusts that cannot evidence that they have met all ten safety actions may be eligible for a discretionary payment to assist them to make progress towards full compliance. On 9 August 2021, NHS Resolution launched the fourth year of the CNST MIS with updated Technical Guidance, including a range of additional requirements that needed to be met to be eligible to recover the incentive element of the scheme contributions. With reference to CNST MIS Safety Action 9 Appendix 1 details the following reporting measures for July 2022: 1. Perinatal Mortality: the type of mortality by gestational age 2. Details of any Perinatal Mortality Reviews conducted in month and any associated immediate learning 3. The status of cases referred to HSIB (Healthcare Safety Investigation Branch) 4. The number of incidents graded at moderate harm and above 5. Contributory factors and the root cause for completed serious incident reports 6. Progress against serious incident action plans 7. Mandatory training compliance 8. Minimum safe staffing 9. Service user feedback 10. Staff feedback to maternity safety champions		

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<table>
<tr><td></td><td>Table 1 below provides a summary of the quantitative data provided for Safety Action 9.

<table>
<tr><th>Safety Action 9 reporting measure (quantitative information only)</th><th>SGUH</th></tr>
<tr><td>1.Perinatal Mortality: Total number of deaths</td><td>42</td></tr>
<tr><td>2. Perinatal Mortality reviews held</td><td>2</td></tr>
<tr><td>3. Cases referred to HSIB for review</td><td>4 open cases

0 closed</td></tr>
<tr><td>4. Incidents graded at moderate harm and above</td><td></td></tr>
<tr><td>5. Serious incidents completed</td><td>0</td></tr>
<tr><td>6. Overdue serious incident report actions</td><td>2 (from 2022)</td></tr>
<tr><td>7.Mandatory training compliance</td><td>Performance across staff groups from 61.03% to 95.9%</td></tr>
<tr><td>8. Minimum safe staffing</td><td>75.5%</td></tr>
<tr><td>9. Service user feedback</td><td>N/A</td></tr>
<tr><td>10.Staff feedback to maternity safety champions</td><td>N/A</td></tr>
</table>
</td></tr>
<tr><td>Recommendation:</td><td>The Board is asked to note the report and that future reports will include progress made towards meeting mandatory training performance targets.</td></tr>
<tr><td colspan="2">Supports</td></tr>
<tr><td>Trust Strategic Objective:</td><td>All</td></tr>
<tr><td>CQC Theme:</td><td>All</td></tr>
<tr><td>Single Oversight Framework Theme:</td><td>Leadership and Improvement Capability (Well-led)</td></tr>
<tr><td colspan="2">Implications</td></tr>
<tr><td>Risk:</td><td>None</td></tr>
<tr><td>Legal/Regulatory:</td><td>Enforcement undertakings applicable to ESTH and SGH

Compliance with the Health and Social Care Act 2008 (Regulations 2014) and CQC Registration Regulations</td></tr>
<tr><td>Resources:</td><td>N/A</td></tr>
<tr><td>Equality and Diversity:</td><td>No issues to consider</td></tr>
<tr><td>Previously Considered by:</td><td>Quality Committee (in Common) | Date | 18.08.2022</td></tr>
<tr><td>Appendices:</td><td>Appendix 1: Safety Action 9: Maternity Services Perinatal Quality Surveillance Measures July 2022</td></tr>
</table>

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Maternity Services

Perinatal Quality Surveillance Measures July 2022
(CNST MIS Safety Action 9)

Arlene Wellman, Group Chief nursing Officer and Director of infection Prevention and Control

Trust Board

1 September 2022

St George's

St George's University Hospitals NHS Foundation Trust

Perinatal Mortality

Rolling Report - Time Period	August 2021 - July 2022	
Total Number of Deaths		42
Type of Mortality	Antepartum Stillbirths	22
	Intrapartum Stillbirths	5
	Neonatal Deaths	15
Gestational Age	<24 weeks	11
	24-27 weeks	9
	28 - 31 weeks	5
	32 - 36 weeks	8
	37-41 weeks	8
	≥ 42 weeks	0 (+1 unknown)

- This data reflects the late miscarriages, antepartum stillbirths and neonatal deaths
- Annual figures published by MBRRACE-UK indicates that the 2019 stillbirth rate and the neonatal death rate is in the 'up to 5% lower and 5% higher than average for type of hospital' category. Since August 2021 SGUH averages 2.8/1000 for Neonatal deaths and 4.45/1000 for Stillbirths which is equal to other London tertiary referral centres
- A full review of all cases was undertaken and a report presented to the Board in November 2021
- All cases underwent a PMRT review and where applicable, a local/HSIB investigation

Perinatal Mortality Reviews

Details of reviews and learning from PMRT (Perinatal Mortality Review Tool

- A PMRT panel was held in July 2022. Two cases were discussed but no cases were finalised at this meeting.
- One case related to a known fetal abnormality and the other case is also undergoing and adverse incident investigation.
- A detailed report of PMRT cases and actions will be submitted quarterly to the Quality Committee in Common (QCiC).
- There have been no clear themes identified.

Cases referred to HSIB for review

HSIB are mandated to investigate cases of intrapartum stillbirth, neonatal death within 7 days of birth (not associated with a congenital abnormality) and incidences of severe brain injury, and focus on human factors.

- There are currently 4 open cases being reviewed by HSIB.
- There were no cases closed by HSIB during July 2022.
- There are currently no open actions.
- The senior management team meet quarterly with HSIB; the top 5 recommendation themes are: Staffing; Holistic overview and management of women ; CTG Interpretation; Escalation; and Communication

Incidents graded at moderate harm and above

There was one incident reported in July 2022 which resulted in avoidable moderate harm. This related to a baby born in unexpectedly poor condition following an emergency caesarean section for breech presentation. This case met the criteria for referring to HSIB, but the parent did not consent to HSIB involvement. This has also been reported as a Serious Incident.

Contributory Factors and Root Cause for Completed Serious Incident Reports

There were no Serious Incident Reports completed in July 2022.

Progress against Serious Incident Action Plans

There are 14 actions currently outstanding in respect of Serious Incident Reports related to investigations undertaken in 2022:

- 2 actions are overdue with reference to 2 separate investigations (the same action):
  - Implementation of the Birmingham Symptomatic-specific Obstetric Triage System (BSOTs) for Delivery Suite triage (All patients attending Delivery Suite for assessment will be triaged according to their condition, and there will be a clear triage pathway). This action is overdue due to the impact of staffing challenges during 2022 to date. A second triage room has now opened and is functioning in line with current triage processes. BSOTs will be implemented by the end of quarter 2
- 12 are not yet due and are with reference to 4 separate investigations and relate to post-operative unforeseen complications, stillbirth, hysterectomy and intrapartum intrauterine death

Mandatory training compliance

Training compliance will be finally assessed in December 2022 and we are continuing to work towards the target of 90% compliance.

Type of Training	Staff Group	%
PROMPT	Midwifery Staff	95.9%
	Maternity Support Workers	94.74%
	Consultant Obstetricians	90.48%
	Trainee and Staff Grade Obstetricians	78.13%
	Anaesthetics	80%
	ODPs	Not captured
CTG Training	Midwifery Staff	92.31%
	Obstetricians	66%
NLS		89%
Saving Babies Lives	Midwifery Staff	61.03%
Covid specific	Maternity Support Workers	N/A
	Consultant Obstetricians	N/A
	Trainee and Staff Grade Obstetricians	N/A
	Anaesthetics	N/A
	ODPs	N/A

Minimum safe staffing

The fill rate in July 2022 was 75.5% against the target of 94%. The following actions were implemented to maintain safety:

- Temporary closure of services (Birth centre, Homebirth or Delivery Assessment Unit)
- All specialist midwives working a minimum of 50% clinical
- Enhanced bank rates running through July
- Increased RN presence in maternity HDU and on the postnatal ward
- Registered Midwife agency usage

Staff group	Measure	Metric
Midwifery	Fill Rate (target >94%)	75.5%
Obstetric	Expected vs fill	100%
	Number of step downs/pull across	N/A

Service User Feedback

Themes identified from complaints and compliments:

- Positive induction of labour experience – all staff interactions were kind, professional and caring
- Poor communication – these have been addressed with individual staff members
- Inconsistent breastfeeding advice – added as subject on Maternity Update training day and all HCA/MSW attending full day training to ensure good level of knowledge and understanding

Staff feedback to Safety Champions

NED safety champion walk round in July spoke to staff in all areas:

- Staff feedback that short staffing on shifts is challenging – communication on recruitment and bank enhanced rates has been circulated to all staff
- Patient and partner feedback on the recent site fire response included they felt it was well organised, they were kept informed and felt safe throughout

Meeting Title:	**Trust Board**		
Date:	1 September 2022	**Agenda No**	**2.3**
Report Title:	**Integrated Quality & Performance Report**		
Lead Director/ Manager:	James Marsh, Group Deputy Chief Executive Officer		
Report Author:	Kaye Glover, Emma Hedges		
Presented for:	Assurance		
Executive Summary:	This report consolidates the latest management information and improvement actions across our productivity, performance, and workforce for the month of July 2022. **Our Finance & Productivity** Outpatient performance is expected to be 95% after catch-up for July, which is behind the 100% plan. First outpatient activity is estimated to be 12% below plan whereas follow-up activity 2% above plan. Additional clinics and WLIs continue within a number of the most challenged services. Elective and Daycase performance is expected to be ahead of plan (after estimated catch up), with a percentage of 101%, above the 100% plan submitted for July. This is driven by non-theatre specialties. **Our Patient Perspective** In July achievement of Life Support training rates remain challenged, Immediate Life Support (ILS) training rate was 72%; Basic Life Support rate (BLS) was 82.2% and Advance Life Support (ALS) was 82.9%, all against a target of 85%. Targeted training is in place to help improve uptake. There were no Never Event incidents reported in July, and for the period April 2022 to July 2022 there has been one incident. Nosocomial cases (HOPA & HOHA) have increased as a proportion of cases between June and July 2022, 36 of 204 (17.6%) detected in June; and 98 of 402 cases (24.4%) detected during July 2022. However, overall cases have declined towards end of July and into August 2022. The birth rate has plateaued, and obstetric and medical complexity remains high. Challenges with sickness and covid isolation, along with lead in times for recruitment start continues. The Labour Ward coordinator was supernumerary for 93.5% of the time. Excellent performance was seen in antenatal bookings with 98.2% of women referred being booked by 12 weeks and 6 days. Within the wider context, Hypoxic Ischaemic Encephalopathy (HIE) rates were 2.7 per 1000 births for Q1, a reduction on Q4 overall when it was 3.8%. In Emergency Department operational pressures and increased waiting times continue to impact the Family and Friends Test positive response. Performance for Emergency Department increase slightly to 70.9%, an improvement on the last		

two months performance. All other services achieved FFT targets where patients rated the services as "Good" or "Very Good ".

Our Process Perspective

In July, 72.2% of patients were ether discharged, admitted or transferred within four hours of their arrival. Admitted pathway performance continues to be impacted by flow across the Trust, this has been driven by a higher daily demand of non-elective admissions. Performance continued to be impacted by high levels of ED staffing absence during July, particularly in nursing. Times for ambulance handovers have dramatically increased in month as they have across London, the delays are caused by crowding in the department due to exit block, we continue to work with LAS colleagues to minimise the impact.

The 14 day standard saw a dip in performance in the month of June with 83.1% of patients seen within 14 days of referral compared to 86.9% in May and against a London average of 87.9%. The decrease in performance was driven by Breast, reporting a performance of 64% and Gynaecology at 76.5%. At Trust level 74.8% of patients were treated within 62 days, an increase of 2.6% compared to the previous month and above trajectory of 73%. The trajectory finishes in March 2023 with a predicted compliance of 80% against the 62 day national standard of 85%. FDS performance continues above target however, more work is needed so that all tumour groups hit the standard to ensure the required impact on timed pathways. The trust set a trajectory of 62 backlog volumes which is being delivered. At the end of June 117 patients were waiting more than 62 day against a trajectory of 180.

At the end of July, the Trust reported that 5.8% of patients were waiting for more than six weeks to have a diagnostic test against a national recovery target of 5%. A number of specialties have incurred challenges across the month and into August particular with staffing gaps coupled with increase in demand. Significant impact with long waits for Gynae ultrasound have driven poor performance.

At the end of June, 914 patients waiting longer than 52 weeks, a decrease of 22 patients compared to May and not meeting the agreed trajectory of 850 patients. The Trust continues to reduce the number of patients over 78 weeks with 48 patients waiting at the end of June and is on track to eliminate all patients waiting over 78 weeks by March 2023. Work continues with the network to redirect patients at the referral stage which is key to improving equity of access to timely healthcare across SW London.

Our Workforce Perspective

HR continues to support managers in the management of staff sickness by helping them to identify support for staff and developing a toolkit to support staff who are off sick'.

A resourcing strategy is being developed to improve the end-to-end recruitment and a refreshed appraisal drive is underway to work with divisions to increase the uptake of appraisals.

	Focus on the top 30 vacancy hotspots as well as targeted work on hard to recruit posts is continuing and HR have also launched the values and behaviours guide and summary as well as a values film and continue with our Big 5 campaign in response to the 2021 staff survey and will be providing an update at the next Group staff engagement event.		
Recommendation:	The Board is requested to note the report		
Supports			
Trust Strategic Objective:	Treat the Patient Treat the Person Right Care Right Place Right Time		
CQC Theme:	Safe, Caring, Responsive, Effective, Well Led		
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 Committee	**Date**	18 August 2022 19 August 2022
Appendices:			

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Integrated Quality and Performance Report – July 2022

Board 1 September 2022

James Marsh - Group Deputy Chief Executive Officer

12 August 2022

Our Outcomes

How Are We Doing?

July 2022

Daycase and Elective Surgery operations

Actual: 4,729
Plan: 4,852

Excludes estimated catch up 181

6 Week Diagnostic Performance

Actual: 5.8% **Target:** 5%

Four Hour Emergency Standard

Actual: 72.2%
Plan: 95%

Whole Trust Inpatient Friends and Family Test

Actual 98.1%
Target 95%

Outpatient Attendances

(inc outpatient procedures)

Actual 55,412
Plan: 60,709

Excludes estimated catch up 2,380

June 2022

Referral to Treatment Standard - Number of 52 Week Breaches

Actual: 914
Plan: 850

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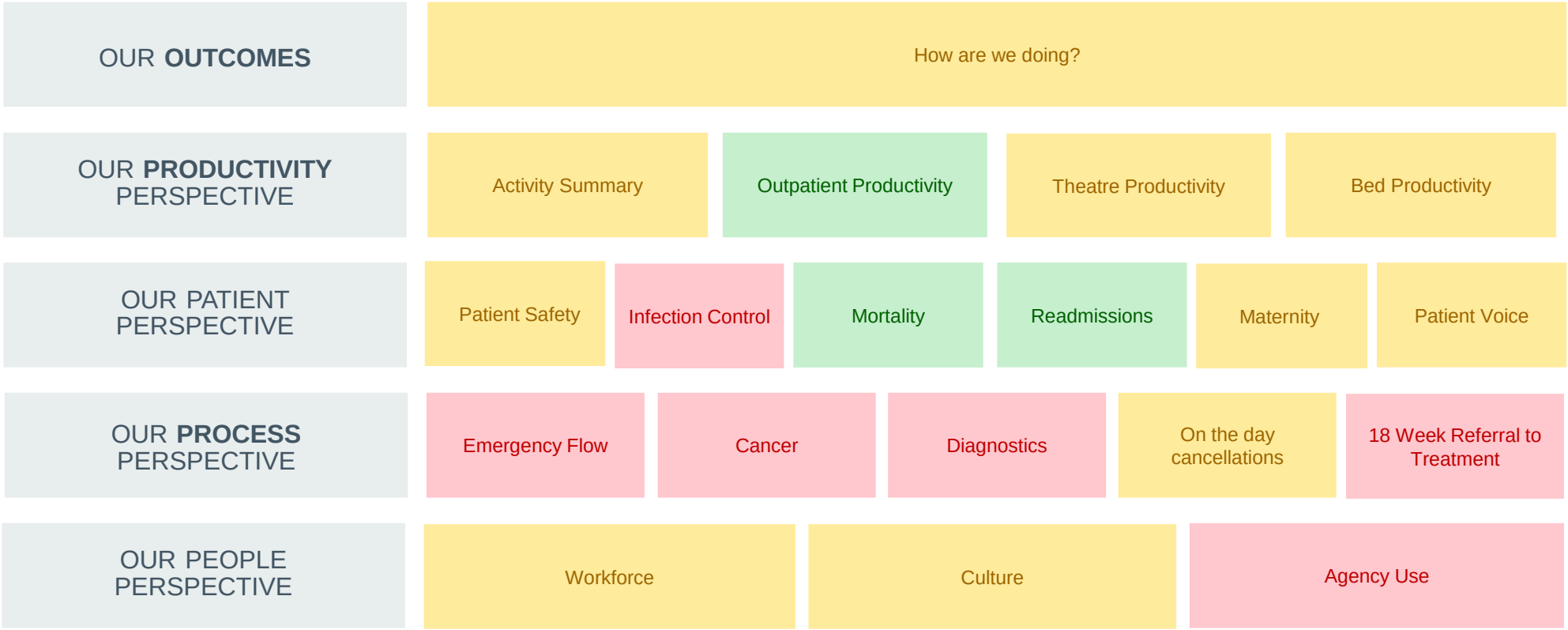
Balanced Scorecard Approach



Executive Summary – July 2022 (1 of 2)

	What the Information tells us	Actions and Quality Improvement Projects
Finance & Productivity Perspective	• Outpatient performance is expected to be 95% after catch-up for July, which is behind the 100% plan. • DNA rates remain within the upper control limits of the 2019/20 baseline however continues on an upward trend. In July 12% of patients did not attend their outpatient appointment • Elective and Daycase performance is expected to be ahead of plan (after estimated catch up), with a percentage of 101%, above the 100% plan submitted for July. This is driven by non-theatre specialties. Theatre utilisation rates remain positive. • Non-elective length of stay continues above the upper control limit with on average patients staying for 7.8 days. Increases this month driven by Intensive Care, Neurosurgery and Senior Health. Positively across the month the number of non-elective patients staying for more than 21 days reduced by on average three patients per day aided by a decrease in the number of patients awaiting discharge to due external delay particular in the later half of July.	Outpatients • Additional clinics and WLIs continue with a number of the most challenged services • Services to review text message templates to improve communication with patients and support reducing DNA rates Daycase & Elective activity • 27 Anaesthetic consultants and Specialty Doctors have been successfully recruited (or returned to work) over the last year, but the service still has a shortfall of ~15 consultants. • 10 more adverts will be going out in the next month. to cover vacant posts T&A have been making use of 9 agency locum consultants on Tooting site and Xyla insourced anaesthetists at QMH • OPD working Group implementing a range of recommendations to address high vacancy rates with progress across many workstreams Length of Stay • The TOC team management has transferred to MedCard and integrated with the SWAT discharge team • Work continues to optimise Discharge to Assess process with Merton and Wandsworth • Focus on improving compliance with Red2Green to reduce internal delays
Patient Perspective	• In July, Immediate Life Support (ILS) training rate was 72%; Basic Life Support rate (BLS) was 82.2% and Advance Life Support (ALS) was 82.9%, all against a target of 85% • There were no Never Event incidents reported in July, a total of one to-date for the period April 22 to July 22. • There were 66 Hospital Onset Health Associated (HOHA) COVID-19 infections and 32 Hospital Onset Probably Associated (HOPA) COVID-19 infections. An increase of 62 nosocomial infections on last month. • Maternity – The birth rate has plateaued, and obstetric and medical complexity remains high. Challenges with sickness and covid isolation, along with lead in times for recruitment start continues. The Labour Ward coordinator was supernumerary for 93.5% of the time. Excellent performance was seen in antenatal bookings with 98.2% of women referred being booked by 12 weeks and 6 days. Within the wider context, Hypoxic Ischaemic Encephalopathy (HIE) rates were 2.7 per 1000 births for Q1, a reduction on Q4 overall when it was 3.8% • FFT- In Emergency Department operational pressures and increased waiting times continue to impact FFT positive response. Performance for Emergency Department increase to 70.9% an improvement on the last two months performance. All other services achieved FFT targets where patients rated the services as "Good" or "Very Good“.	• Resus training compliance is still struggling to improve despite the team’s best efforts. Plans are in place to provide targeted training including taking the manikins out to departments to try and recover performance quickly. • All category 3 and above pressure ulcers undergo root cause analysis to identify any learning. Continued review of rapid response reports with wards and support of individualised action plans. • Senior nurse Pressure Ulcer Prevention workshops continue. • Continuing to work towards transforming our services in line with Continuity of Carer targets and have had ongoing input from the national Continuity of Care (CoC) midwifery team • Launch of the Maternity Telephone Helpline in March has been very positive taking in excess of over 98 calls per day to enable direct access to the service for advice and information and work in underway on the PDSA review of this activity. • Working towards transforming our services in line with Continuity of Care (CoC) targets. Introducing the Birmingham System of Obstetric Triage – widely used across maternity units in England to reduce harm and improve outcomes

Executive Summary – July 2022 (2 of 2)

	What the Information tells us	Actions and Quality Improvement Projects
Process Perspective	Four Hour Operating Standards for July • 72.2% of patients were ether discharged, admitted or transferred within four hours of their arrival. Admitted performance. Performance continued to be impacted by high levels of ED staffing absence during July. Times for ambulance handovers have dramatically increased in month as they have across London impacting flow within the department and the ability to surge into escalation areas. • 579 patients breached the 12-hour ED target June Cancer performance • The 14 day standard saw a dip in performance in the month of June with 83.1% of patients seen within 14 days of referral compared to 86.9% in May. Underperformance impacted by Breast and Gynaecology. • 74.8% were treated within 62 days, an increase of 2.6% compared to the previous month and above trajectory of 73%. • FDS Performance in June was compliant at 78.6%, above the national standard of 75%. More work is needed so that all tumour groups hit the standard to ensure the required impact on timed pathways. Six week diagnostic standard for July • At the end of July 5.8% of patients were waiting for more than six weeks for their diagnostic test compared to 3.2% in June this is against a national recovery target of 5%. Main increases driven by Gynae Ultrasound however all modalities are seeing challenges. Referral to Treatment for June: • 914 patients have been waiting over 52 weeks since referral for treatment, this is a decrease of 22 patients compared to May and currently not meeting trajectory. • 48 patients were on the PTL waiting over 78 weeks for treatment, seeing further improvement. • Increased waiting list size continues to be driven by an increase on the non-admitted pathway.	Four Hour Operating Standards actions • Internal Emergency Care Delivery Board introduced in July and chaired by Hospital Managing Director • Discussions with commissioners about a new model for out of hours GP to support ED • Continue to ring – fence assessment cubicles across Majors A & B whilst balancing the need to offload ambulances. Cancer Performance Actions • Introduce one stop clinics in gynae, and one stop pathways where appropriate in Head and Neck • Deliver the agreed improvements to the breast cancer pathway at 2 week wait and for 62 day delivery • Use the newly created Elective Delivery Group to monitor cancer performance and reduction in the backlog Diagnostics • Gynae – Challenges recruiting to 2 WTE sonographers (includes 1.2 additional funding secured), posts currently out to advert. Continue to utilise bank and agency where possible but with an increased demand this is proving challenging for the service. • Echo – Additional capacity through July has been provided to reduce waits for Stress Echo after seeing a spike in demand through May. Additional capacity throughout August. • Endoscopy – Staffing challenges mean a reduce service going into August with two room closures. All Cancer and Urgent referrals taking priority with reduced capacity within routine referrals. Increased demand in OGD. Referral to Treatment • Trust on track to eliminate all patients waiting over 78 weeks by March 2023. . • Work continues with the network to redirect patients at the referral stage which is key to improving equity of access to timely healthcare across SW London.
People Perspective	• The Trust's sickness rate was 5.0%, and above the target of 3.2% • Vacancy Rate this month was 9.0%, which is below the threshold of 10%. • Trust turnover rate in July was 16.2% and is adverse to the target of 13%. • Medical appraisal rates and non-medical appraisal rates was non-compliant against the 90% target, showing 81.8% and 70.6% respectively. • Mandatory and Statutory Training (MAST) was 90.3% in June and fell slightly to 89.9% in July. • Stability performance in July was 86.6% against a target of 85%	• **Sickness**- HR continues to support managers in the management of staff sickness by helping them to identify support for staff and developing a toolkit to support staff who are off sick • **Turnover**- A resourcing strategy is being developed to improve the end-to-end recruitment.. • **Appraisa**l-A refreshed appraisal drive is underway to work with divisions to increase the uptake of appraisals • **Vacancy**-Focus on the top 30 vacancy hotspots as well as targeted work on hard to recruit posts is continuing • **Stability** – We have launched the values and behaviours guide and summary as well as a values film, and continue with our Big 5 campaign in response to the 2021 staff survey and will be providing an update at the next Group staff engagement event.

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			

Activity Summary

		Activity compared to previous year			Activity against plan for month		Activity compared to previous year			Activity compared to 2019/20		
		Jul-21	Jul-22	Variance	Plan Jul-22	Variance	YTD 21/22	YTD 22/23	Variance	Jul-19	Jul-22	Variance
ED	ED Attendances	13,239	12,582	-4.96%	12,629	-0.37%	51,629	51,402	-0.44%	14,764	12,582	-14.78%
Inpatient	Non Elective	3,442	3,276	-4.82%	3,770	-13.10%	13,424	12,218	-8.98%	4,068	3,276	-19.47%
	Elective & Daycase	5,331	4,729	-11.29%	4,852	-2.54%	20,465	19,198	-6.19%	5,752	4,729	-17.79%
Outpatient	OP Attendances	59,479	55,412	-6.84%	60,709	-8.73%	253,599	231,816	-8.59%	66,491	55,412	-16.66%

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

Note: Figures quoted are as at 8/8/2022 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 July 2022 have been shown against activity levels reported in July 2021 and against 22/23 External Plan

For reference the grey boxes compare activity levels to July 2019 (Pre-Covid)

Note that first and follow-up Outpatient appointments are consolidated and this now includes Outpatient procedures

July Activity Performance v Plan – Elective, Daycase & OP Activity Volumes

The Trust has submitted a final activity plan for 2022/23; this is equivalent to 90% of 2019/20 levels adjusted for working days for April, 96% for May and 100% thereafter. An internal plan has additionally been approved based on bottom-up planning with individual clinical specialties. Therefore the internal and external plans do not reconcile.

Note: The below activity information is shown in 'SLAM' currency, as this is the currency the Trust is used to seeing and reporting.

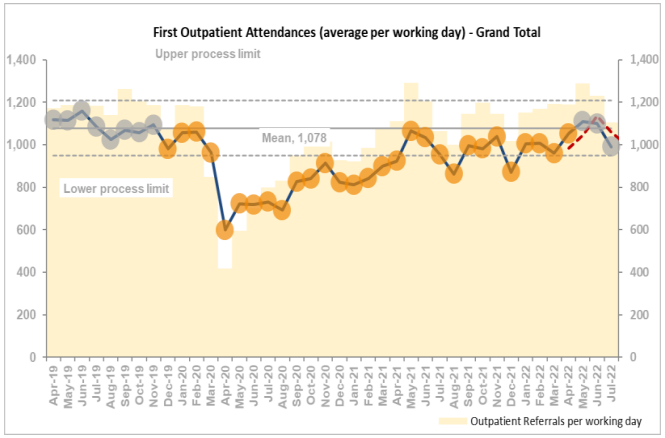
	ACTIVITY QUANTUMS - JULY						ACTIVITY %s vs 19/20			
Specialty	July WD Adj 19-20	Plan	Activity	Catch Up Estimate	Activity After Catch Up	Variance to Plan	Plan	Actual	Activity After Catch Up	Variance to Plan
Cardiac Surgery (172)	40	27	31	1	32	5	68%	77%	79%	11%
Colorectal Surgery (104)	55	58	7	0	7	-50	105%	13%	13%	-92%
Ear, Nose & Throat (ENT - 120)	170	159	103	1	104	-55	94%	61%	61%	-33%
General Surgery (100)	75	67	107	3	110	43	89%	143%	147%	57%
Gynaecology (502)	216	205	159	5	164	-41	95%	73%	76%	-19%
Neurosurgery (150)	135	150	128	0	128	-22	111%	95%	95%	-16%
Paed Surgery (171)	88	83	92	4	96	12	95%	105%	109%	14%
Plastic Surgery (160)	274	284	231	37	268	-16	104%	84%	98%	-6%
Thoracic Surgery (173)	61	58	51	2	53	-5	94%	83%	87%	-8%
Trauma & Orthopaedics (110)	129	108	66	4	70	-38	84%	51%	55%	-29%
Urology (101)	301	297	318	6	324	28	99%	106%	108%	9%
Vascular Surgery (107)	101	89	76	0	76	-13	88%	75%	75%	-13%
Total Theatre Specialties	**1,645**	**1,584**	**1,369**	**63**	**1,432**	**-151**	**96%**	**83%**	**87%**	**-9%**
Gastroenterology (301)	1,056	1,154	960	0	960	-194	109%	91%	91%	-18%
Cardiology (320)	254	227	259	3	262	36	89%	102%	103%	14%
Dermatology (330)	14	10	0	0	0	-10	71%	0%	0%	-71%
Neurology (400)	703	632	571	9	580	-52	90%	81%	83%	-7%
Paediatrics (420)	24	32	37	1	38	6	134%	156%	159%	26%
Clinical Haematology (303)	31	142	195	41	236	94	457%	628%	761%	304%
Medical Oncology (370)	79	96	93	1	94	-2	121%	117%	118%	-2%
All Other Specialties	1,046	1,117	1,245	62	1,307	190	107%	119%	125%	18%
Total Non-Theatre Specialties	**3,207**	**3,409**	**3,360**	**118**	**3,478**	**69**	**106%**	**105%**	**108%**	**2%**
Balancing Figure to Ext Plan		**-141**								
Total Daycase / Elective	**4,852**	**4,852**	**4,729**	**181**	**4,910**	**58**	**100%**	**97%**	**101%**	**1%**
Outpatient First Attendances	**29,894**	**29,894**	**25,352**	**963**	**26,315**	**-3,579**	**100%**	**85%**	**88%**	**-12%**
Outpatient Follow Up Attendances	**30,815**	**30,815**	**30,060**	**1,417**	**31,477**	**661**	**100%**	**98%**	**102%**	**2%**
Total Outpatients	**60,709**	**60,709**	**55,412**	**2,380**	**57,792**	**-2,917**	**100%**	**91%**	**95%**	**-5%**

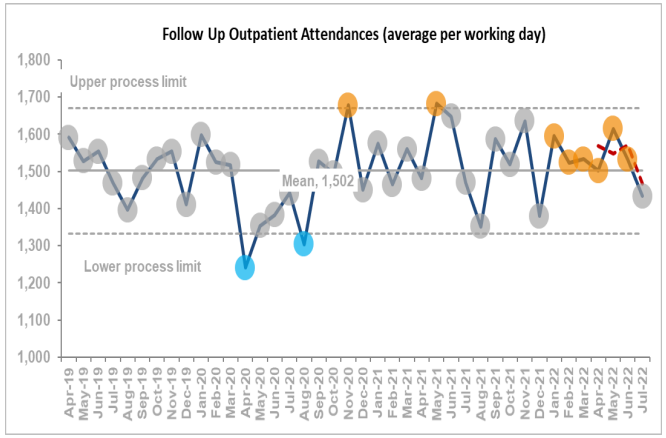
This table shows performance against the elective and day case activity plans split between theatre specialties and other specialties. It also shows Outpatient performance as a Trust. Diagnostic mapping to ascertain performance against trajectories is being worked through with commissioning colleagues.

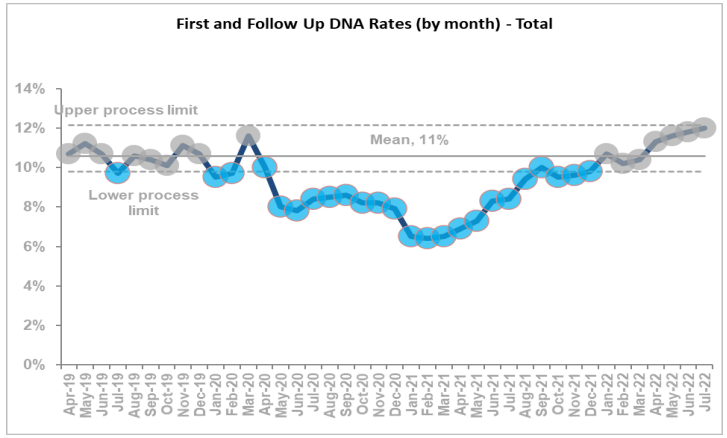
Elective and Daycase performance is expected to be ahead of plan (after estimated catch up), with a percentage of 101%, above the 100% plan submitted for July. This is driven by non-theatre specialties.

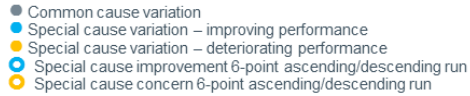
Outpatient performance is expected to be 95% after catch-up for July, which is behind the 100% plan. Note that Outpatient procedures are included, all within First Attendances.

Outpatient Productivity









What the information tells us

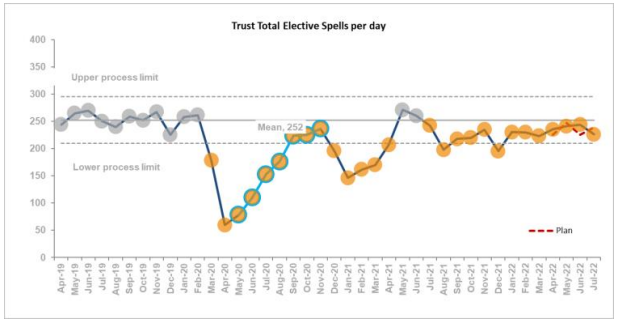
Outpatient performance is expected to be 95% after catch-up for July, which is behind the 100% plan.

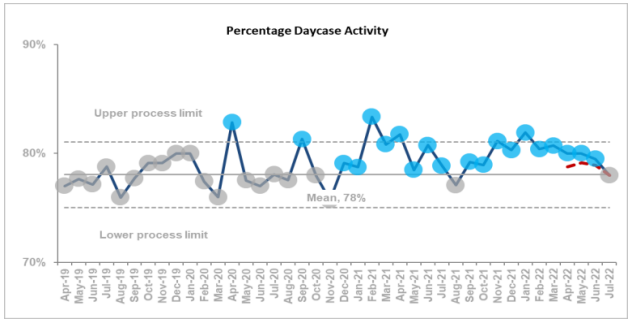
DNA rates remain within the upper and lower control limits of the 2019/20 baseline however continues on an upward trend. In July 12% of patients did not attend their outpatient appointment, this equates to on average, 375 patients per day compared to 352 per day in June.

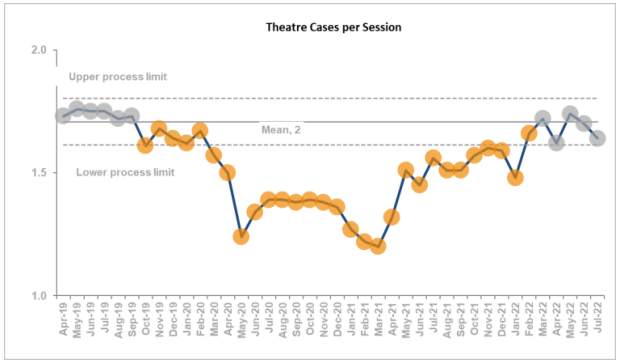
Actions and Quality Improvement Projects

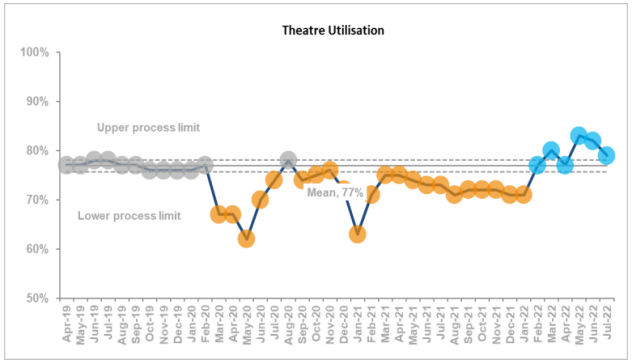
- Testing has commenced with IT to identify the kit appropriate for the delivery of effective virtual clinics and we are in discussion with Estates with regards the creation of a Virtual Clinic Hub. Services will need to start looking at their templates to separate out their virtual and F2F activity in to separate clinic templates.
- Additional clinics and WLIs continue with a number of the most challenged services.
- Services are being encouraged to review their text messages to help reduce the number of DNAs as some patients continue to receive contradictory communications and an audit is being planned to look at DNA rates and causes in Physiotherapy, Dermatology & Rheumatology.
- The Patient Portal phase 2 roll out will include cancel and rebook functionality as well as looking at how it will support the roll our of Patient Initiated Follow-up (PIFU). 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.
- Testing on the PIFU functionality in iCLIP has been on-going, but not yet complete, and it's hoped this functionality will make putting a patient on to a PIFU pathway an easy option and will therefore support greater buy-in and increase the number of services we roll-out to.

Elective Activity & Theatre Productivity









What the information tells us

Across the month of July there were on average 226 elective treatments per day. Elective and Daycase performance is expected to be ahead of plan (after estimated catch up), with a percentage of 101%, above the 100% plan submitted for July. This is driven by non-theatre specialties. Specialties behind plan include; ENT, Max Fax, Urology and Plastic Surgery.

The number of cases per sessions remains within the upper and lower control limits and theatre utilisation rates remain positively above the upper control limit with a rate of 78% in July. Gynae have specifically seen their utilisation rates increase in month higher than the previous 12 month period.

In July, Theatres ran a total of 1,552 theatre lists (elective and non elective sessions), this is 4% higher compared to the same month in 2019.

- 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

Anaesthetic recruitment

- Since July last year – 21 Anaesthetic consultants and Specialty Doctors (25% of the workforce) have resigned, retired or fallen LT sick, which has had a significant impact on our staffing.
  - The service was already under-established, and under-recruited to that establishment.
  - Previously, the service was reliant on staff picking up WLIs but post-Covid this model has faltered.
- Over 30 adverts have been put out to attract new recruits.
- 27 Anaesthetic consultants and Specialty Doctors have been successfully recruited (or returned to work) over the last year, but the service still has a shortfall of ~15 consultants.
- 10 more adverts will be going out in the next month.
- In the meantime, to cover vacant posts T&A have been making use of 9 agency locum consultants on Tooting site and Xyla insourced anaesthetists at QMH.

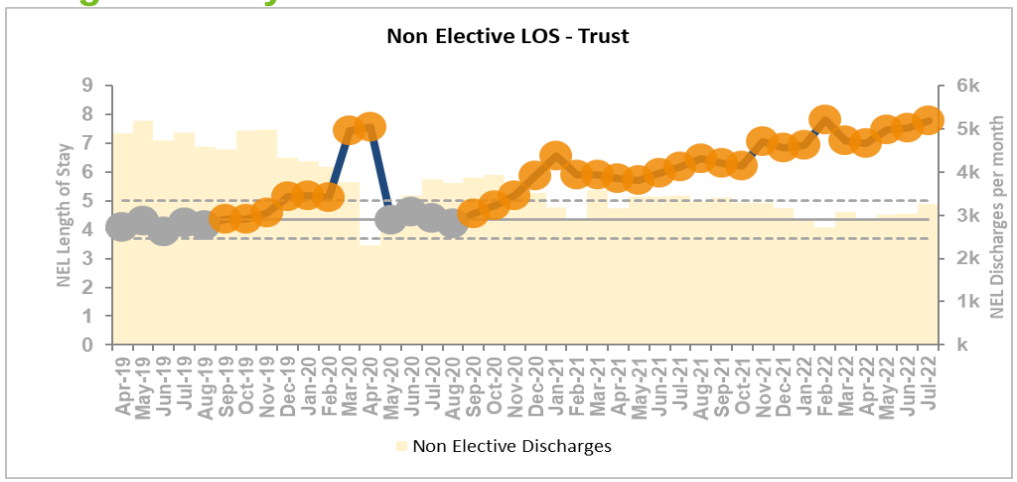
ODP Working Group

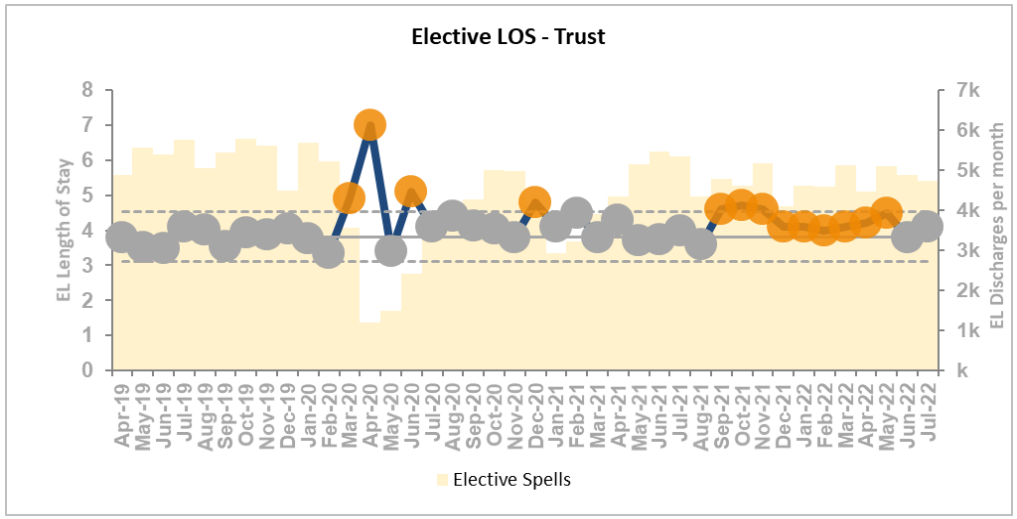
- High vacancy rates in our ODP workforce (35%) presents a growing risk to the Trust's ability to staff lists. Over the last three years the ODP substantive workforce has fallen substantially, with bank and agency filling the gap which has increased costs and created risks around 'on call' staffing etc.
- A working group was launched in October to tackle these issues and is now implementing a range of recommendations.
- Significant progress has been made across the six workstreams:
  - Recruitment and Retention incentives
  - Workforce Development
  - On call/ Night Shift rota
  - Payment, mis-payment issues
  - Lunch and rest period breaks
  - Culture

Culture and behaviours

- The long-term sustainability of our staffing depends on becoming an 'employer of choice', which will only be achieved through high levels of staff experience and wellbeing and positive word-of-mouth to support retention and recruitment.
- The Directorate launched a Culture and Behaviours survey in July to help us better understand the culture and behaviours within our theatres.
- This survey received over 185 responses and the T&A team are now working through this data – and conducting further research and listening events - to support the formation of an OD plan which aims to create a more positive and respectful working environment for all Theatre users.

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

Length of stay continues above the upper control limit and significantly higher than the 2019/20 mean. On average through July patients admitted on an emergency pathway stayed in a hospital bed for 7.8 days. Increases in the month were seen within Intensive Care, Neurosurgery and Senior Health. A reduction in length of stay within General Medicine was seen. Positively across the month the number of non-elective patients staying for more than 21 days reduced by on average three patients per day compared to June, this has been aided by a decrease in the number of patients awaiting discharge to due external delay particular in the later half of July where patients waiting was below average. The number of patients requiring non-elective admissions increase in July with on average five more patients admitted per day compared to June

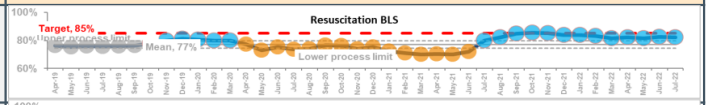
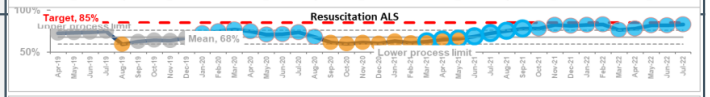
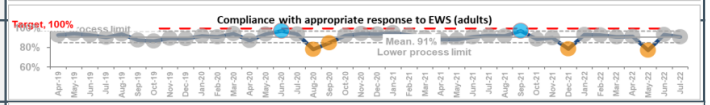
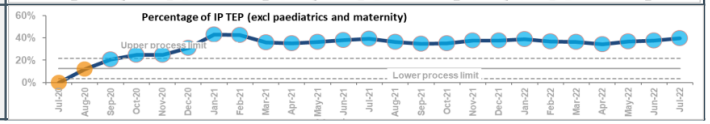
Elective length of stay continues within the upper and lower control limits showing only common cause variation. Patients admitted electively stayed on average for 4.1 days.

Actions and Quality Improvement Projects

- The TOC team management has transferred to MedCard and integrated with the SWAT discharge team. The team are now working as one team, led by a Head of Nursing, and new daily rhythm and case management has yielded the higher numbers of discharges and reduction in LoS seen in the data
- Work continues to optimise Discharge to Assess process with Merton and Wandsworth, led by Head of Nursing, to ensure there is a reduction in the number of rejected D2A's and effective use of care support, placements and rehabilitation beds. Form being developed to give partners early notification of D2A patients.
- New stranded patient weekly call underway with Merton and Wandsworth, fewer complex patients now requiring discussion.
- External interface flow work continues which includes three focal areas for Merton and Wandsworth: discharge, maximising community capacity and virtual frailty ward (Hospital at Home). Working with partners to increase Hospital at Home capacity.
- Focus on improving compliance with Red2Green to reduce internal delays for pathway 1-3 patients
- Covid numbers have stabilised and patients continue to be managed within divisions and speciality as far as possible instead of within dedicated Covid ward space.

Balanced Scorecard Approach

Quality Priorities – Deteriorating Patients

	Target	July-22	Var to target	Trend
Basic Life Support Training (BLS)	85.0%	82.2%	-2.8%	
Immediate Life Support Training (ILS)	85%	72.0%	-13.0%	
Advanced Life Support Training (ALS)	85%	82.9%	-2.1%	
Compliance with appropriate response to Early Warning Scores (Adults)	100%	90.9%	-9.1%	
Percentage of Inpatient Treatment Escalation Plans (excl paediatrics and maternity)	40%	39.7%	-0.3%	

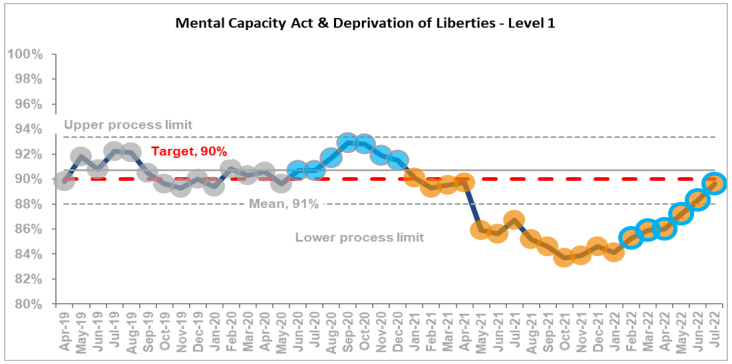
What the information tells us

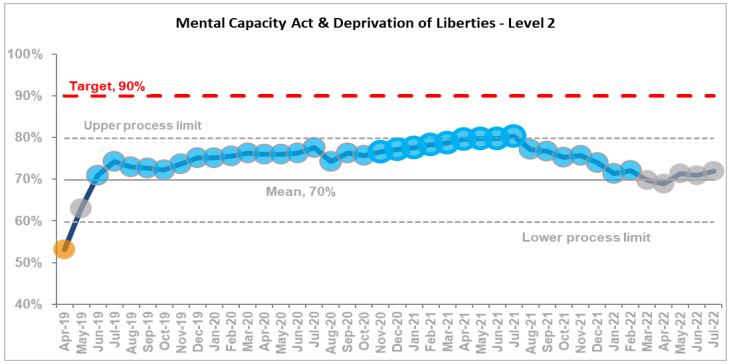
- BLS (Basic Life Support) training performance continues to shows special cause improvement , with performance at 82.2% and remains below target.
- ILS (Immediate Life Support) shows common cause, with performance slightly improved on last month at 72% this month.
- ALS (Advanced Life Support) training performance is 82.9%. And continues to show special cause variation with an improving position.
- Compliance with appropriate response to Early Warning Score (EWS), shows common cause variation with improvement remaining above 90%.
- 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.

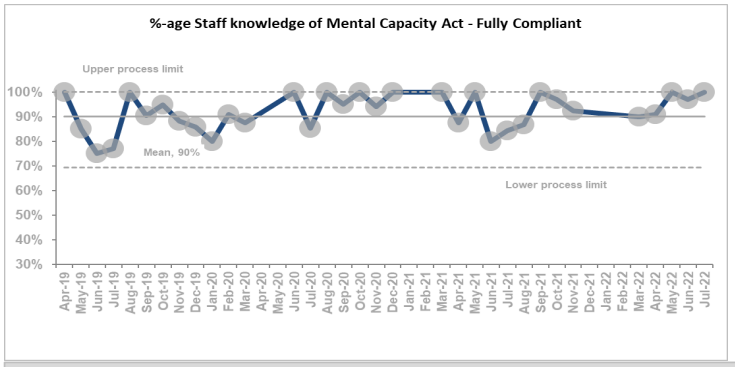
Actions and Quality Improvement Projects

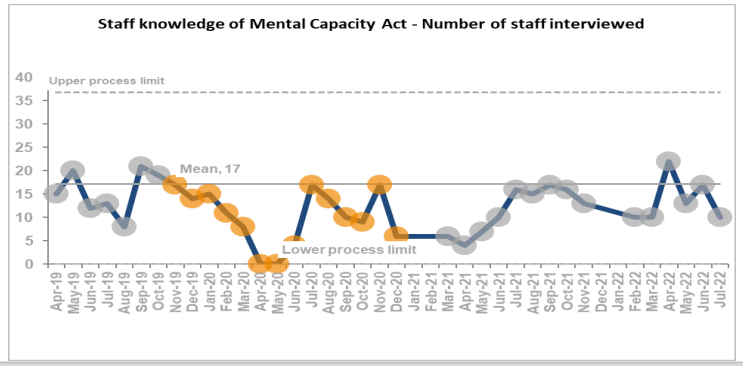
Resus training compliance is still struggling to improve despite the team's best efforts. Ongoing review of the Training Needs of all Trust staff to take place. The initial stage is completed. Its predicted that both ALS and ILS compliance will rise significantly following implementation but that BLS will drop. There is a plan to provide targeted training including taking the manikins out to departments to try and recover this drop quickly.
There will be the introduction of an enhanced BLS course for all Newly Qualitied Nurses, Band 5 nurses who do not take charge and Allied Health Professionals who are currently allocated ILS. Nursing Associates will also be assigned BLS+. This is a 4 hour course covering BLS with Automated External Defibrillation, Anaphylaxis, Choking, First Aid for fits/Faints/Falls etc (Recovery position). Critical Care Outreach Team will also provide a session on Deteriorating Patient and patients on Treatment Escalation Plans.
Nursing Staff will be expected to have an ILS before taking charge of the ward environment . Any Staff wishing to complete a higher level of training than allocated will be encouraged to do so if appropriate. This has been discussed with colleagues at Epsom and St Heliers who are considering a similar approach.

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 July for Level 1 shows a steady improvement with this month at 89.6%, however continues to shows special cause variation with a deteriorating performance. The past year has been below the 2019/20 average.
- Overall Level 2 compliance increased slightly to 71.9%, compared to 70.9% last month and continues to show common cause variation.
- Performance for the number of staff interviewed and their level of knowledge continues to show commons cause variation.

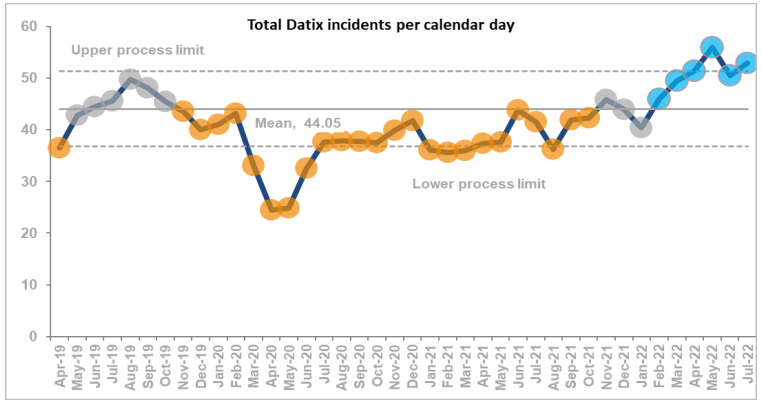
Actions and Quality Improvement Projects

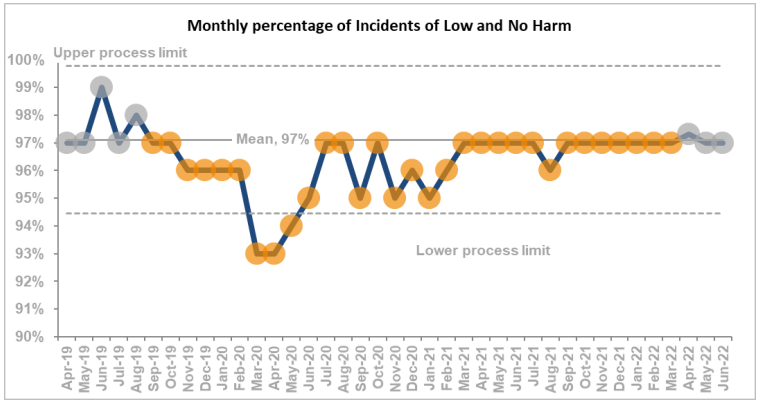
Despite ongoing contact with staff, the ability to organise bespoke sessions and easy online access to the requisite training, non-compliance for Level 2 continues to sit within the Medical Dental Group, mainly Specialty Registrars and Junior Doctors. The MCA team have emailed all Junior Doctor's however there has been minimal increase in compliance rates.. The MCA team offer ad hoc sessions, however these can be poorly attended unless made mandatory. The MCA team are seeking support from the CMO team and are working with the Divisional chairs and the divisional governance team to support focus sessions, and to ensure all non compliant staff are kept informed. The MCA team are aiming to join junior doctor induction to improve compliance.
A Pilot Level 3 MCA training is being undertaken in partnership with Neuro Rehab. This is part of our Liberty Protection Safeguards(LPS) preparation and will support seeding additional knowledge Trust wide, due to the Allied Health Professional rotation programmes.
The LPS Consultation response has been submitted. The MCA team have also been part of the SW London Response.

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	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
Monthly percentage of Incidents of Low and No Harm		97.0%	96.0%	97.0%	97.0%	97.0%	97.0%	97.0%	97.0%	97.0%	97.3%	97.0%	97.0%	data one month 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%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	94.0%	97.0%	88.0%	93.0%	data two months in arrears	
Total Datix incidents per calendar day		42	36	42	42	46	44	40	46	50	51	56	51	53





What the information tells us

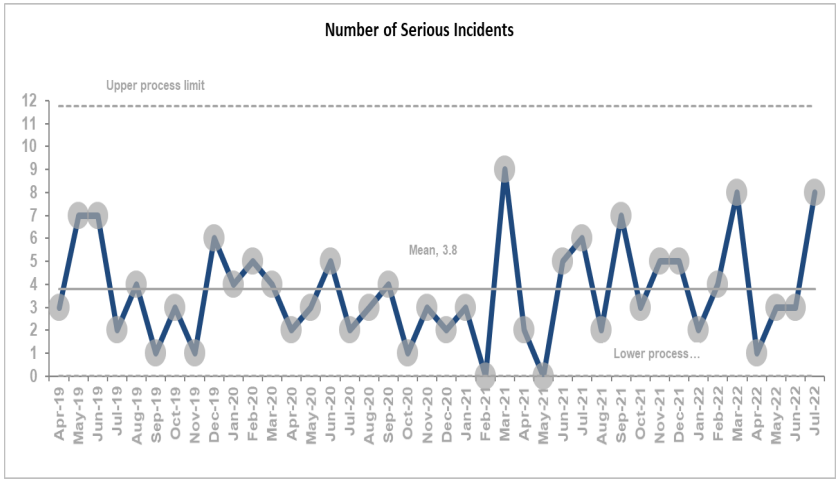
- All Open Serious Incident (SI) investigations are being completed in line with external deadlines of 60 working days.
- A 100% compliance with DOC within 20 working days was not achieved for the 4th consecutive month. Although an improvement was seen in March where performance improved to 97% May saw a further reduction to 88%. And June another increase to 93%.
- There were a total of 53 Datix incidents per calendar day this month.

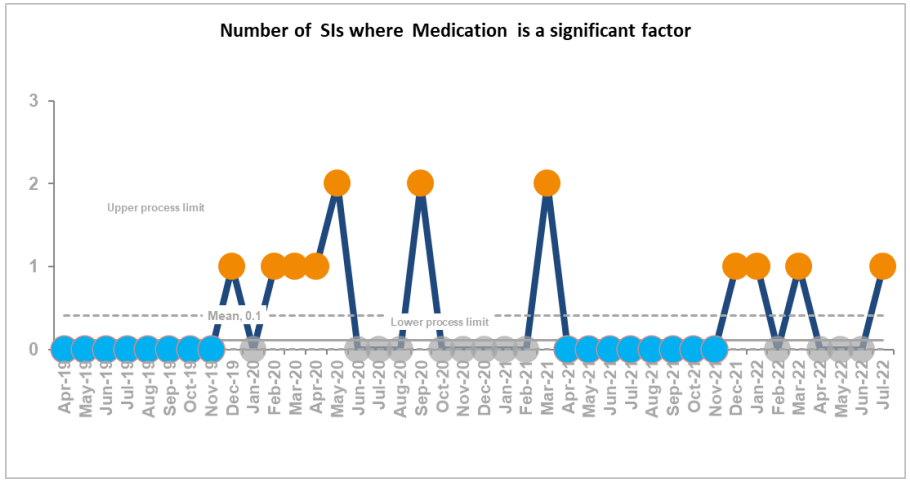
Actions and Quality Improvement Projects

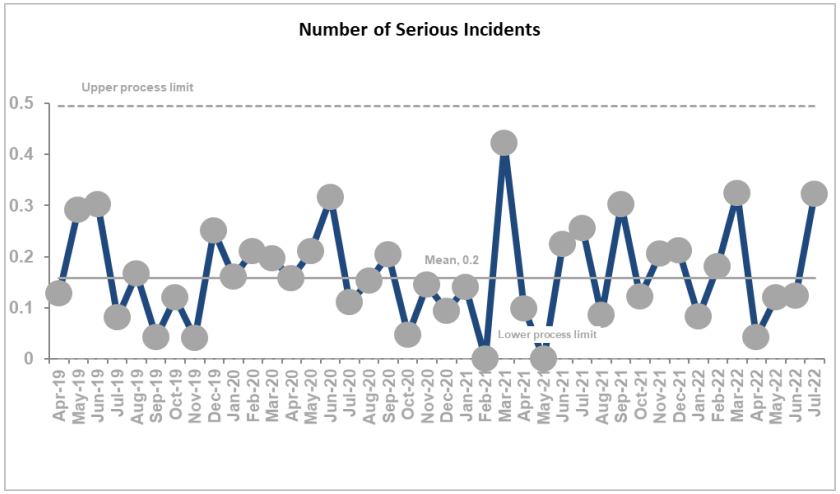
Duty of Candour (DoC) for January and March was 100% across the 3 Divisions. The non compliance from March continues due to a combination of illness and shortage of staff resulting in non-compliance at 94% and 97% respectively against the 100% target. However staff vacancies recruited to so improvement is anticipated.
DoC compliance continues to be monitored and support provided to the relevant departments in order to achieve compliance.

Patient Safety- Serious Incidents

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







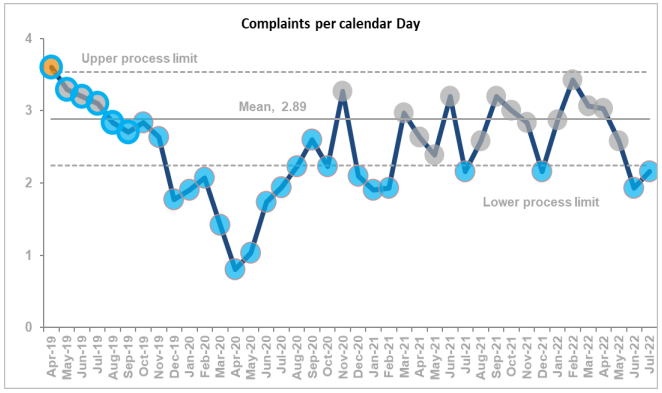
What the information tells us

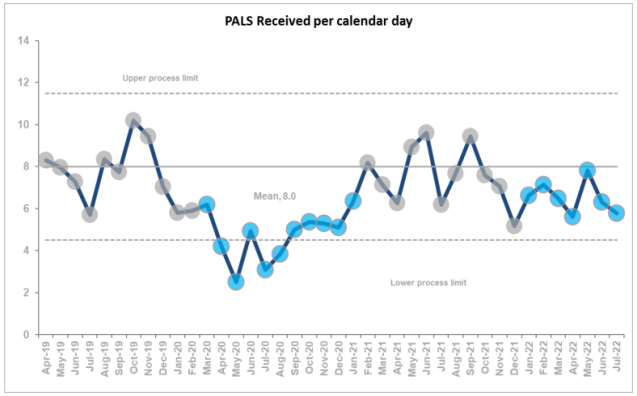
- Common cause variation is seen in the number of Serious Incidents and the number of Serious Incidents per 1,000 bed days.
- One Serious Incidents where Medication is a significant factor was recorded in July, now showing special cause variation with a deteriorating position..

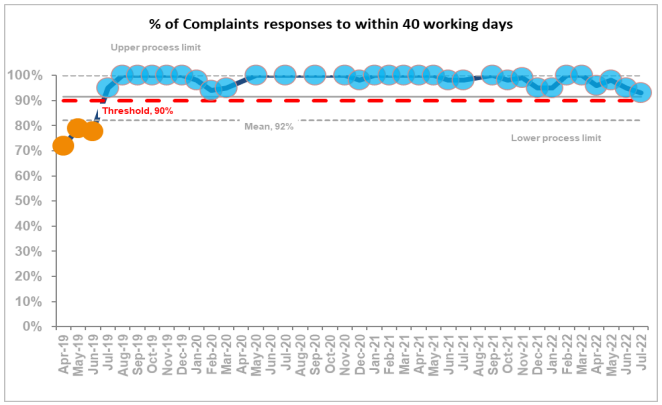
Our Patient Perspective

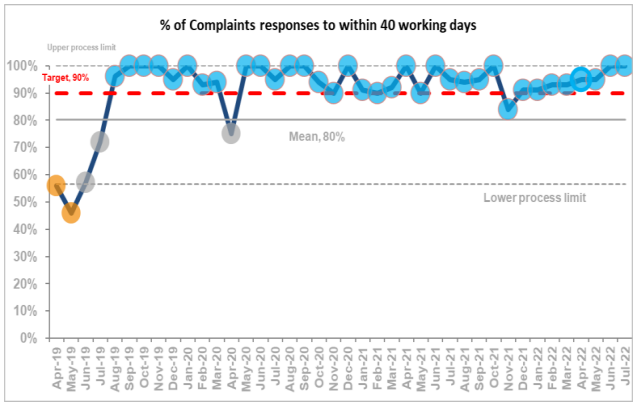
Complaints

Indicator Description	Target	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
Complaints Received per calendar day		2.2	2.6	3.2	3.0	2.8	2.2	2.9	3.4	3.1	3.0	2.6	1.9	2.2
% of Complaints responses to within 25 working days	85%	98%	98%	100%	98%	99%	95%	95%	100%	100%	96%	98%	95%	93%
% of Complaints responses to within 40 working days	90%	95%	94%	95%	100%	84%	91%	91%	93%	93%	95%	95%	100%	100%
% of Complaints responses to within 60 working days	100%	N/A	N/A	100%	N/A	N/A	67.0%	N/A	100%	100%	100%	100%	N/A	N/A
Number of Complaints breaching 6 months Response Time	0	0	0	0	0	0	0	0	0	0	0	2	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

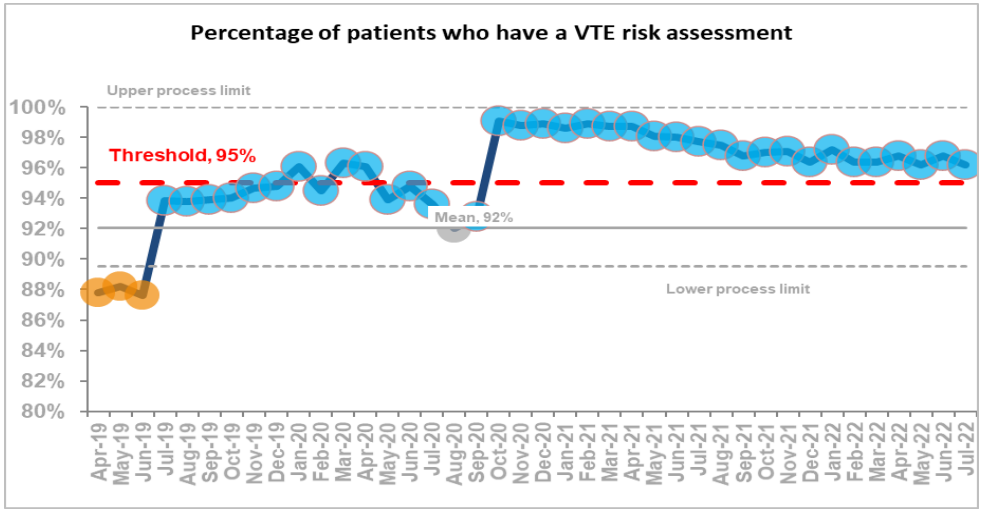
- The number of complaints per calendar day continues to shows special cause variation with an increase in the number of formal complaints to 67 in July.
- Percentage of complaints responded to within 25 working days was achieved with performance at 93%.
- Percentage of complaints responded to within 40 working days was achieved with performance at 100%.
- PALS received per calendar shows special cause variation with an improving position.

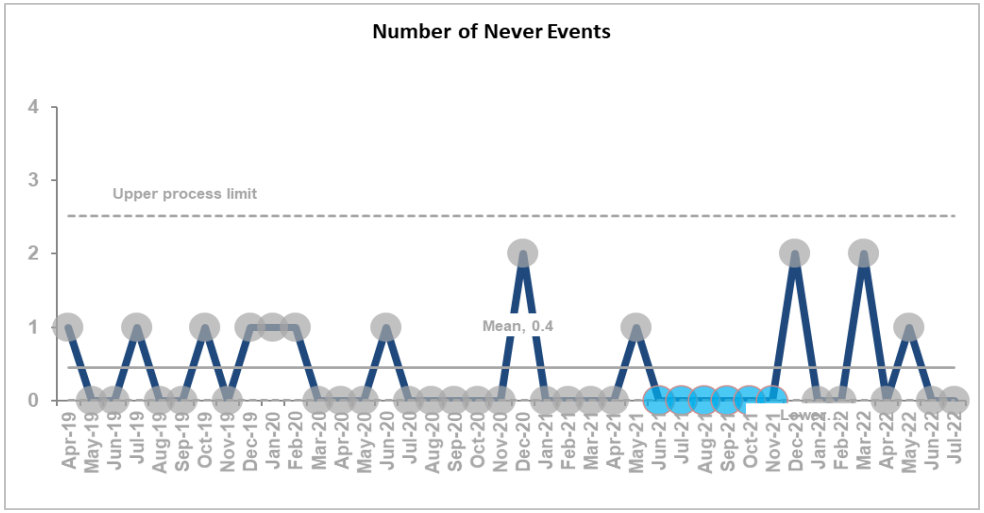
Actions and Quality Improvement Projects

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

Previous staffing issues are being resolved and permanent staff are coming into post and a new process is being implemented with the aim of making the process more straightforward for the Divisional leads

Patient Safety- VTE and Never Events





What the information tells us

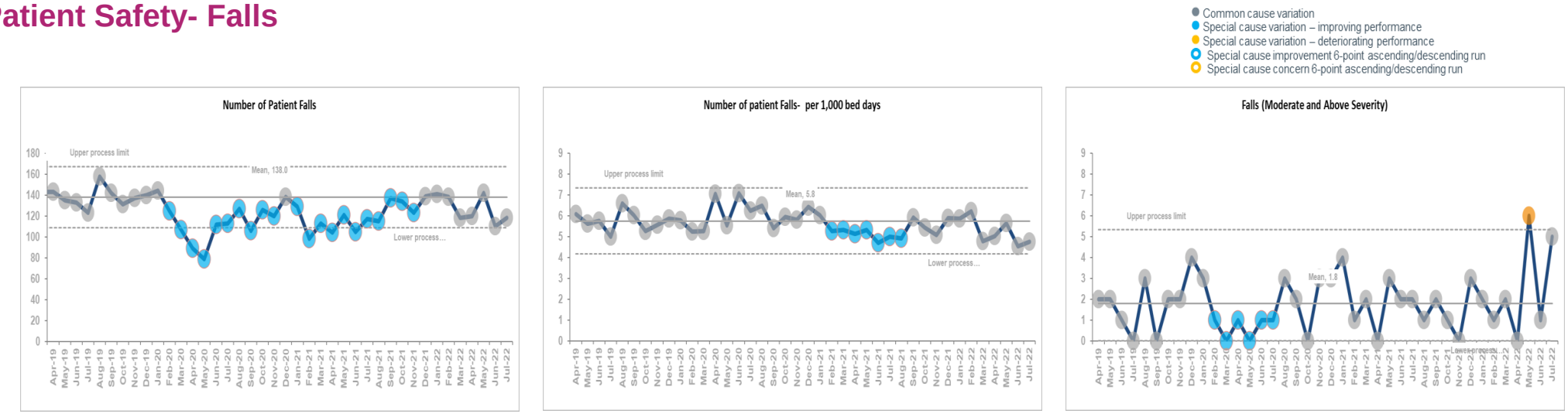
- In July 96.2% of patients had a VTE completed within the required time frame with performance continuing to be above the upper control limit.
- There were no Never Event declared in July 2022

Actions and Quality Improvement Projects

VTE The Hospital Thrombosis Group (HTG) continue to monitor VTE performance through Tableau reporting, the pharmacy VTE audit and hospital acquired thrombosis root cause analysis. Learning shared with divisions

Our Patient Perspective

Patient Safety- Falls



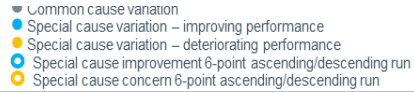
What the information tells us

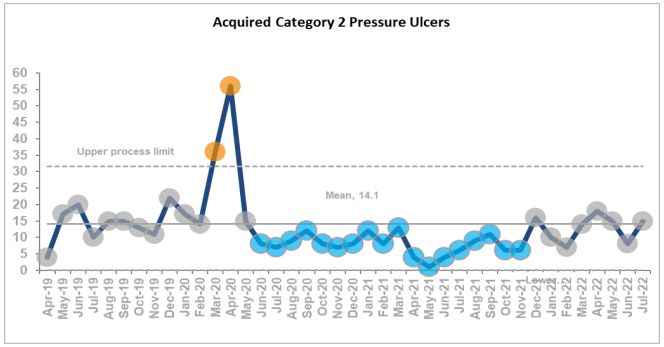
- Overall fall rates remain lower than average, reporting 118 falls in July.
- Fall rates per 1,000 Occupied Bed Days are currently at 4.75 which is below the mean with performance showing common cause variation
- There were 5 moderate fall reported this month.

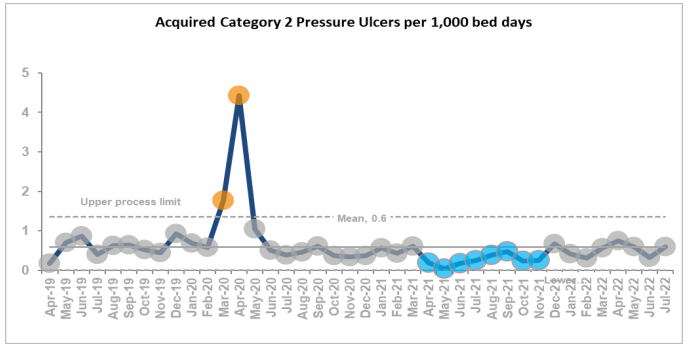
Actions and Quality Improvement Projects

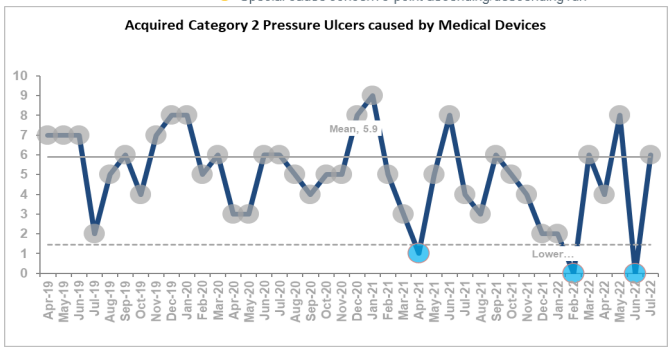
- Falls prevention measures continue to be implemented across inpatient wards
- Falls incidents continue to be monitored and reviewed locally by senior nursing teams with any learning identified and improvement actions implemented as appropriate.
- Wards identified as 'hot-spot wards` [due to reporting higher number of falls than usual], are working to improve falls prevention within their areas. The falls prevention coordinator continues to work with local leaders to try and understand contributing risk factors for falls with high harm.
- Fall incident deep dives are planned to be carried out by each division to better understand themes and help plan future action.
- No special causes have been identified to relate to the moderate and above harm falls however, the quality of falls related risk assessments, intrinsic, patient related, risk factors and staffing challenges/operational pressures are likely to have contributed to the increased number of falls with harm.

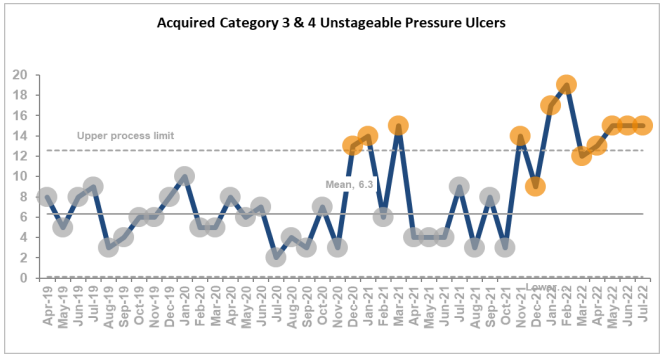
Patient Safety- Pressure Ulcers

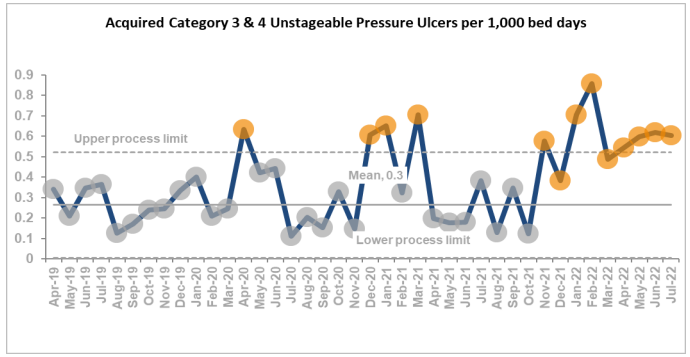


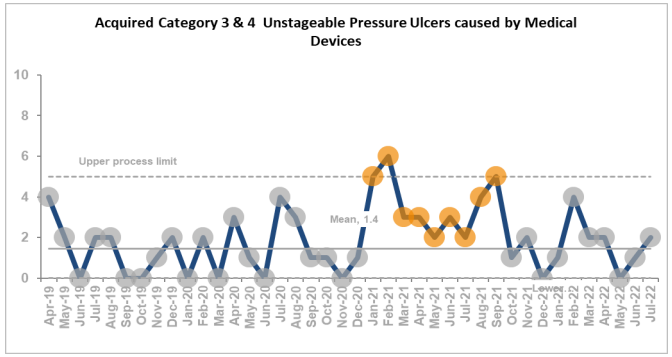












All PUs exclude Medical Devices except where stated

What the information tells us

- There were 15 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 15 Category 3&4 Unstageable Pressure ulcers this month. The rate per 1,000 bed days show special cause variation with a deteriorating position and those caused by Medical Devices 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
- Focus on Pressures at nursing back to floor planned in July.

Our Patient Perspective

Infection Control

Indicator Description	Threshold 2022-2023	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	YTD Actual
MRSA Incidences (in month)	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0
Cdiff Hospital acquired infections	52	0	3	4	4	5	5	3	2	1	10	5	5	3	28
Cdiff Community Associated infections		0	2	1	1	1	0	2	1	1	3	0	1	1	
MSSA	25	3	3	0	3	10	2	4	3	6	1	2	3	2	8
E-Coli	111	6	5	4	5	7	5	5	2	8	9	2	3	6	20
Covid-19 Nosocomial Infections Hospital Onset healthcare associated (>14 days) HOHA	N/A	0	18	2	7	4	69	61	14	47	30	15	25	66	136
Covid-19:Nosocomial Infections Hospital Onset Probable associated (8-14 days) HOPA	N/A	0	10	1	4	1	31	31	17	40	27	11	11	32	81
Pseudomonas Aeruginosa	29	3	1	3	3	1	3	4	1	4	2	2	2	2	8
Klebsiella spp. Bacteraemia	76	4	5	7	4	7	4	3	3	2	3	5	5	8	21

What the information tells us

- There were 4 *C. difficile* infections during July 2022; 3 were classified as Hospital Onset Healthcare Associated (HOHA), where the specimen was taken beyond admission day plus one day; and 1 was classified as Community Onset Healthcare Associated (COHA), where the specimen was taken within admission day plus one day (and where the patient had also been an inpatient in the previous 4 weeks). There have been a total of 28 cases between April and July 2022. There is a NHSIE trajectory of no more than 43 cases for 2022-23. This equates to no more than 3.5 cases per month or no more than 14 cases at end of July, This means the Trust is significantly above trajectory. However, following an inauspicious start to the year in April 2022, subsequent months have reflected a more expected and near monthly trajectory position. A focus on antimicrobial stewardship continues.
- There were 3 patients with a Trust apportioned MSSA blood stream infection during July 2022. There are no national or local trajectories for MSSA.
- There were 6 cases of Trust apportioned *E. coli* bacteraemia during July 2022. There is a NHSI/E trajectory of no more than 93 cases for 2022-23 or no more than 7.75 per month and no more than 31 at end of July. There have been 20 cases between April and July 2022. The Trust is therefore under this trajectory.
- There were 2 cases of *P. aeruginosa* bacteraemia during July 2022 (where the sample has been taken >48 hours beyond admission). There is a NHSI/E trajectory of no more than 29 cases for 2022-23, or no more than 2.4 per month or 9.6 cases for the period April to July 2022. There have been 8 cases between April and July 2022. The Trust is therefore under this trajectory.
- There were 8 cases of *Klebsiella spp.* bacteraemia during July 2022 (where the sample has been taken >48 hours beyond admission). There is a NHSI/E trajectory of no more than 76 cases for 2022-23, or no more than 6.3 per month. There have been 21 cases between April and July 2022. The Trust is therefore under this trajectory.
- There were 66 Hospital Onset Healthcare Associated cases (HOHA) of Covid-19 during July 2022, where the sample was taken >14 days after admission and 32 Hospital Onset Probable Associated (HOPA) cases where the sample was taken 8-14 days after admission

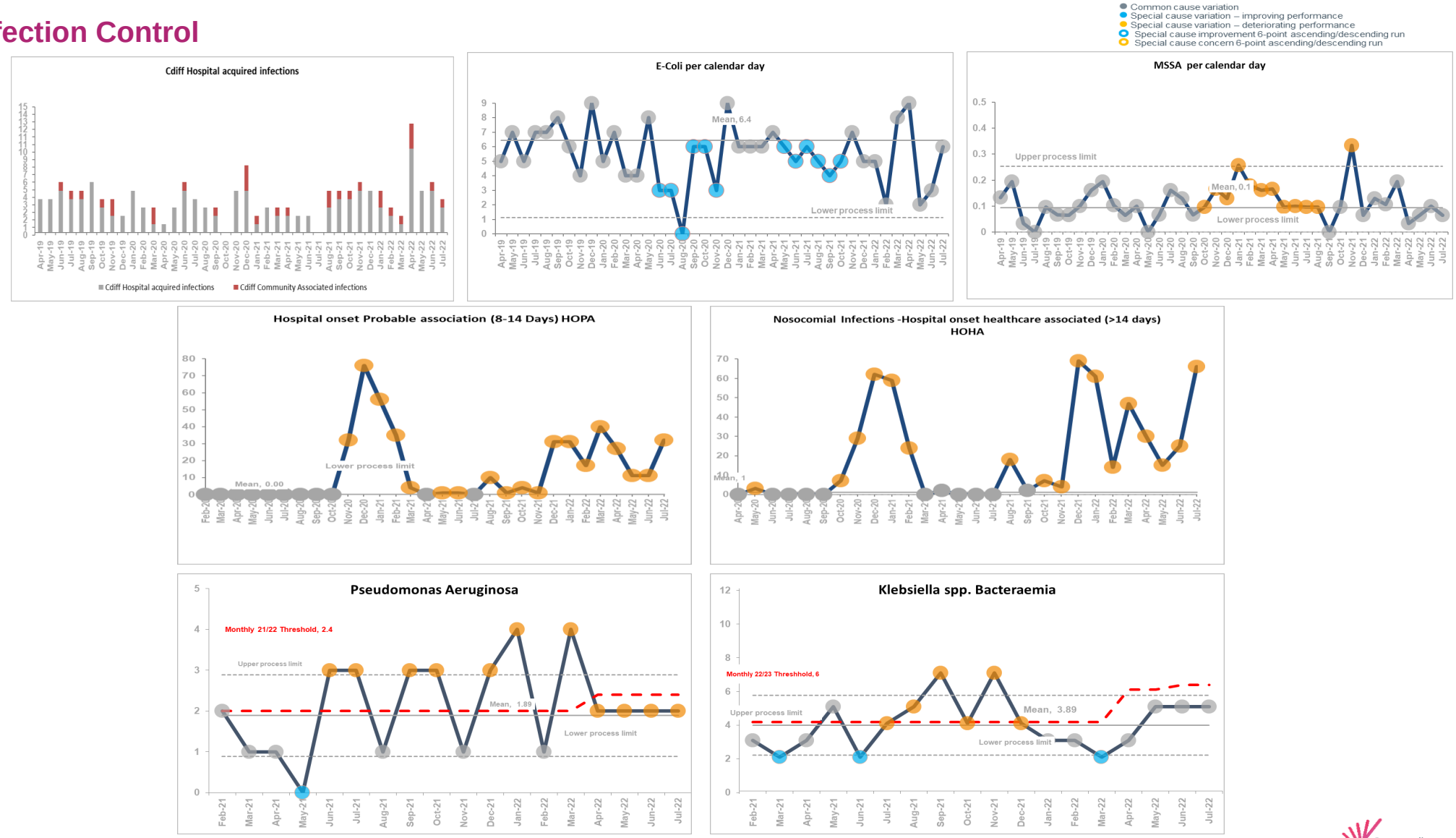
Actions and Quality Improvement Projects
C. difficile action:

- There is a focus on antimicrobial stewardship review with a presentation and discussion of trends due at August Infection Control Committee

Covid update July 2022:

- Situation now fundamentally different, reduced morbidity and mortality associated with Omicron wave (2021-22)
- Outbreaks, if still occurring are identified and managed. There were 14 Covid-19 outbreaks in July 2022, either continuing from June or new in month. 4 were in Surgery Division and 10 were in Medicine
- Most Covid-19 cases are now mild or asymptomatic
- Nosocomial cases (HOPA & HOHA) have increased as a proportion of cases between June and July 2022, 36 of 204 (17.6%) detected in June; and 98 of 402 cases (24.4%) detected during July 2022. However, overall cases have declined towards end of July and into August 2022.

Infection Control



Mortality and Readmissions

Indicator Description	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-22	Feb-22	Mar-22	Apr-22	Apr 21 to Mar 22
Hospital Standardised Mortality Ratio (HSMR)	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	82.6	83.7	76.2	65.0	83.5
Hospital Standardised Mortality Ratio Weekend Emergency	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	70.4	95.5	87.1	76.0	91.6
Hospital Standardised Mortality Ratio Weekday Emergency	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	84.1	83.7	75.7	63.5	79.9

Indicator Description	Jul-19-Jun-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	Jun-20-May-21	July-20-June-21	Aug-20-Jul-21	Sep 20-Aug 21	Oct 20-Sep 21	Nov 20-Oct 21	Dec 20-Nov 21	Jan 21-Dec 21	Feb 21-Jan 22	Mar 21-Feb-22
Summary Hospital Mortality Indicator (SHMI)	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	0.90	0.91	0.91	0.91

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	Mar-22	Apr-22	May-22	Jun-22
Emergency Readmissions within 30 days following non elective spell (reporting one month in arrears)	10.6%	10.0%	9.8%	10.3%	10.3%	10.1%	9.3%	9.0%	8.3%	7.2%	6.8%	9.1%	9.7%	9.4%	8.3%	8.5%	8.8%

Note: HSMR data reflective of period Apr 21–Mar-22 based on a rolling monthly published position. SHMI data is based on a rolling 12 month period and reflective of period Mar-2021 to Feb-2022 published (June 2022).
Readmission data excludes CDU, AAA and all ambulatory areas where there are design pathways

What the information tells us

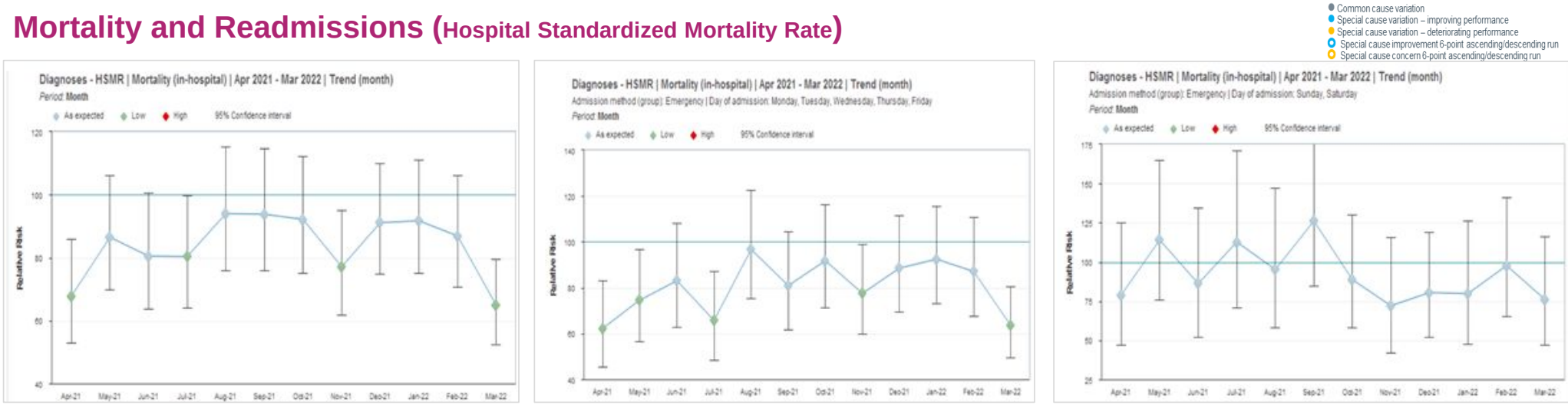
Mortality as measured by the summary hospital-level mortality indicator (SHMI) is as expected for the year March 2021 - February 2022. We are one of 97 trusts in this category. Our latest HSMR, for the 12 months from April 2021 to March 2022 shows our mortality to be lower than expected. Looking specifically 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 8.8% June 22. Performance shows special cause variation with an improving position.

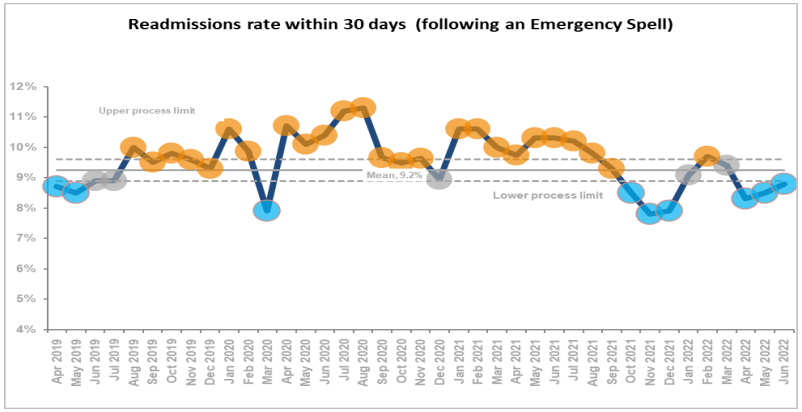
Actions and Quality Improvement Projects

We continue to monitor and investigate mortality signals in discrete diagnostic and procedure groups from Telstra/Dr Foster through the Mortality Monitoring Group (MMG). The group are expecting a final investigation report of mortality in the diagnosis group 'Acute Myocardial Infarction' to be presented at the August meeting. In the July meeting it was noted that the signal previously observed in the diagnosis group 'Intracranial injury' has not been observed for several months. The Deputy Chief Medical Officer for Safety and the Clinical Lead for Learning from Deaths have arranged to meet with leaders from the neurosurgery team to agree an approach to investigating any future signals

Mortality and Readmissions (Hospital Standardized Mortality Rate)

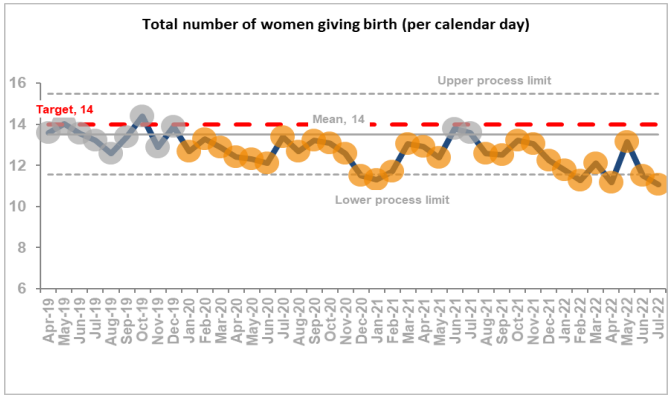


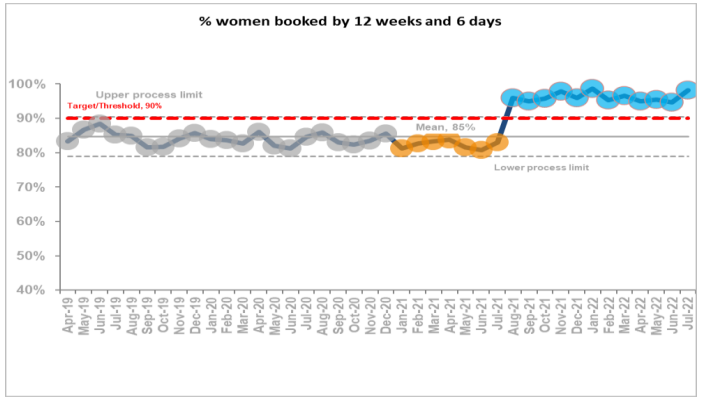
Inpatient Deaths (% of Discharges)

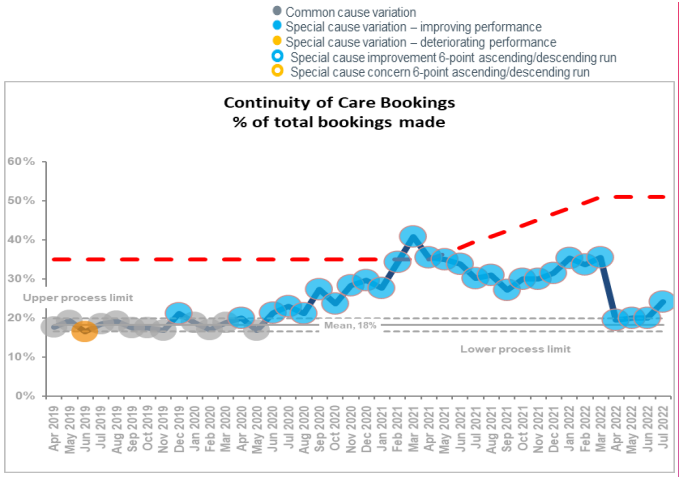


Our Patient Perspective

Maternity







What the information tells us

- July continues to see a plateaued birth rate with obstetric and medical complexity remaining high. Staffing remained extremely challenging across the month with high sickness and covid isolation continuing, along with lead in times for recruitment start dates to fill band 5 and band 6 midwifery posts. The Labour Ward coordinator remained supernumerary for 93.5% of the time which is not our aim. With mitigation in place over August for midwifery staffing there should be improvement in this important KPI although significant staffing challenges remain until October.
- Mitigation for staffing challenges continues included diverting birth centre and office based midwives to the Delivery Suite and in July with our Birth Centre closed 31% to support the acute inpatient areas when required.
- There were no stillbirths in month. There were 2.9 per 1000 neonatal deaths in July which remains below the target.
- Caesarean section rates were slightly increases at 31.2% in July which was driven by a small increase in elective caesareans and is always considered in the context of our other clinical outcome KPIs. Within the wider context, HIE rates were 2.7 per 1000 births for Q1, a reduction on Q4 overall.
- There was a marked reduction in our PPH rate >1.5L which is excellent – this is the result of a QI project on Delivery Suite.

Actions and Quality Improvement Projects

- We continue working towards transforming our services in line with Continuity of Carer targets and have had ongoing input from the national Continuity of Care (CoC) midwifery team. We aim to further increase CoC here at SGH in a number of waves with wave 1 now paused until January 2023 due to staffing challenges. We are liaising with and reporting into the National team confirming our planned trajectory in line with Ockenden recommendations and will continue to outline and confirm plans towards the safe implementation of wave1. This is targeted support for women in an area of deprivation and those identified as being at risk or BAME. The roll out and expansion will be in line with recruitment rates and plans.
- The work to launch the Digital Transformation programme across Maternity continues. The service supported IT to build a business case describing the additional requirements and resources required to build and roll out the end-to-end Maternity Information system. Once implemented this will mitigate and reduce the risk currently held on the risk register as high.
- The Maternity Telephone Helpline was successfully launched in late March 2022. The Helpline has enabled direct access to the service for advice and information and facilitates 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 very positive, from both women and staff. The Helpline has already been taking in excess of over 98 call per day and work in underway on the PDSA review of this activity.
- Birmingham System of Obstetrics Triage – Quality Improvement work is ongoing to improve clinical efficiencies and flow in the maternity Triage area on Delivery Suite (DS). We will be introducing the Birmingham System of Obstetric Triage – widely used across maternity units in England to reduce harm and improve outcomes. Simple reconfiguration of estates in DS reception is required to support this project and equally optimise safety in this area and DS. The aim is to commence in September 2022

Our Patient Perspective

Maternity

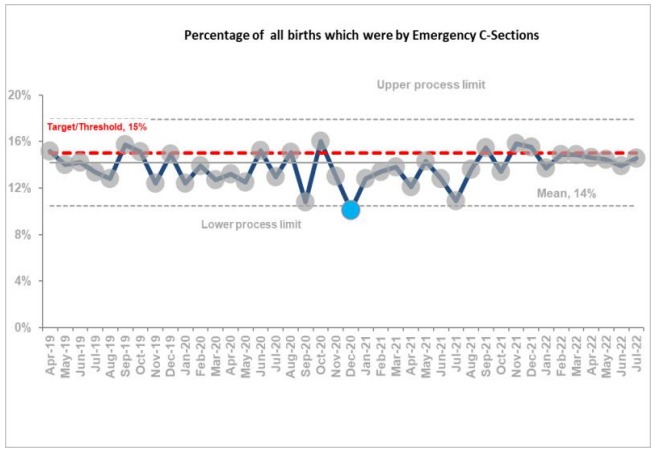
Maternity Dashboard

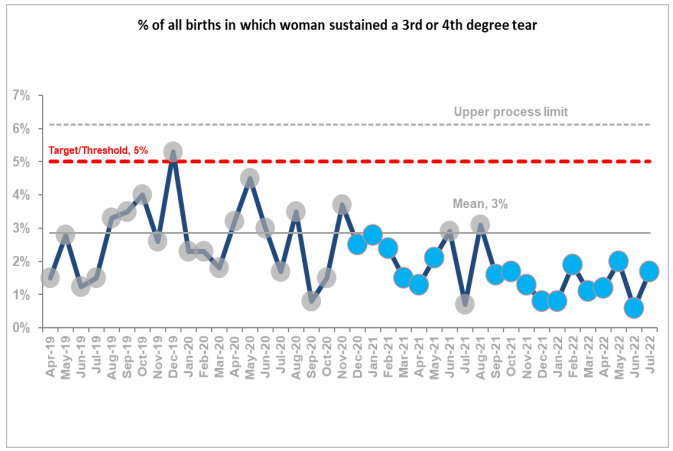
Definitions	Target	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
Total number of women giving birth (per calendar day)	14 per day	13.6	12.6	12.5	13.2	13.1	12.3	11.8	11.3	12.1	11.2	13.2	11.5	11.1
Caesarean sections (Total Emergency and Elective by Delivery date)	<28%	24.7%	27.2%	28.3%	27.3%	31.4%	31.3%	27.1%	27.5%	33.3%	28.7%	28.7%	27.8%	31.2%
% deliveries with Emergency C Section (including no Labour)	<8%	3.6%	2.6%	4.5%	4.4%	5.4%	5.0%	3.0%	5.7%	3.7%	3.9%	4.2%	3.8%	3.2%
% Time Carmen Suite closed	0%	30.6%	74.2%	56.0%	21.0%	15.0%	27.4%	12.9%	44.6%	35.5%	22.0%	17.7%	43.3%	31.0%
% of all births in which woman sustained a 3rd or 4th degree tear	<5%	0.7%	3.1%	1.6%	1.7%	1.3%	0.8%	0.8%	1.9%	1.1%	1.2%	2.0%	0.6%	1.7%
% of all births where women had a Life Threatening Post Partum Haemorrhage >1.5 L	<4%	3.6%	2.3%	1.3%	2.9%	3.6%	2.4%	1.9%	2.5%	3.5%	3.3%	3.2%	2.9%	1.5%
Number of term babies (37+ weeks), with unplanned admission to Neonatal Unit		13	16	13	12	12	10	11	13	13	5	13	13	15
Number of term babies (37+ weeks), with unplanned admission to Neonatal Unit as a percentage of deliveries	6%	3.1%	4.1%	3.5%	2.9%	3.1%	2.6%	3.0%	4.1%	3.5%	1.5%	3.2%	3.8%	4.4%
Supernumerary Midwife in Labour Ward	>95%	88.7%	90.3%	90.0%	88.7%	98.3%	98.4%	98.4%	92.9%	95.2%	100.0%	100.0%	100.0%	93.5%
Babies born with Hypoxic Ischaemic Encephalopathy / (1000 babies)		2.4 (Qtr2)			0.8 (Qtr3)			3.8 (Qtr4)			2.7 (Qtr1 2022)			
Still Births per 1000 Births	<3	7.1	0.0	2.7	9.8	10.2	2.6	0.0	0.0	0.0	9.0	4.9	11.6	0.0
Neonatal Deaths (KPI 72) per 1000 Births	<3	0.0	2.6	0.0	0.0	0.0	13.2	2.7	9.5	0.0	3.0	2.5	0.0	2.9
Continuity of Care Bookings- % of total bookings made (Target increases monthly by 1.5% towards a 51% target in Mar 22)	43.7%	30.1%	30.6%	27.2%	30.0%	30.0%	31.4%	35.3%	33.7%	35.5%	19.5%	20.0%	20.0%	24.2%
Percentage of all births which were by Emergency C-Sections (KP25+26)	15%	10.9%	13.6%	15.5%	13.4%	15.8%	15.5%	13.7%	14.9%	14.9%	14.6%	14.5%	13.9%	14.6%
% women booked by 12 weeks and 6 days	90%	83.0%	96.0%	95.0%	95.8%	97.9%	95.9%	98.7%	95.3%	96.6%	94.9%	95.5%	94.6%	98.2%

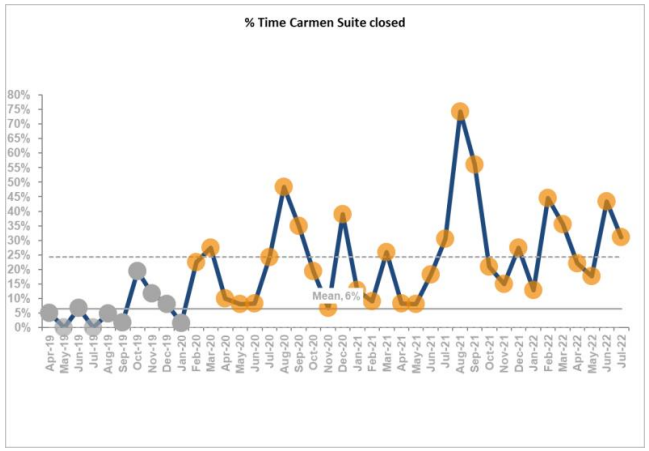
Our Patient Perspective

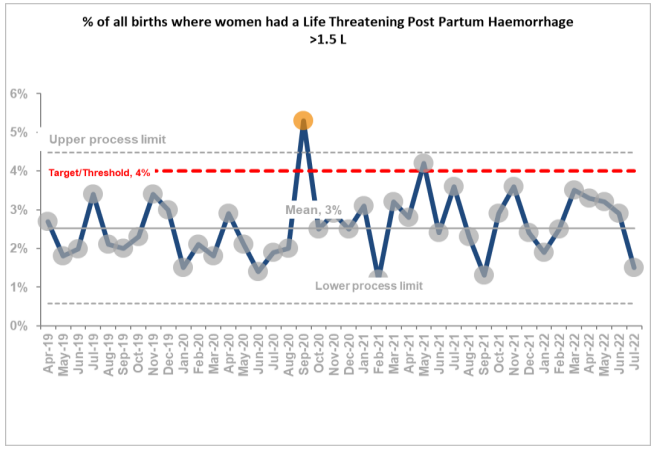
Maternity

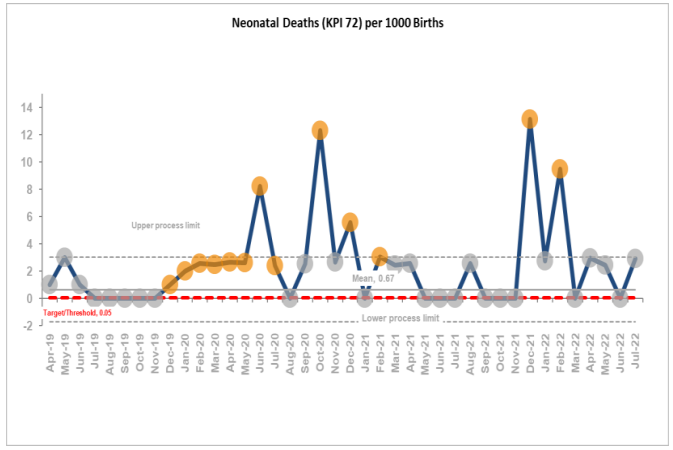
- Common cause variation
- Special cause variation – improving performance
- Special cause variation – deteriorating performance
- Special cause improvement 6-point ascending/descending run
- Special cause concern 6-point ascending/descending run

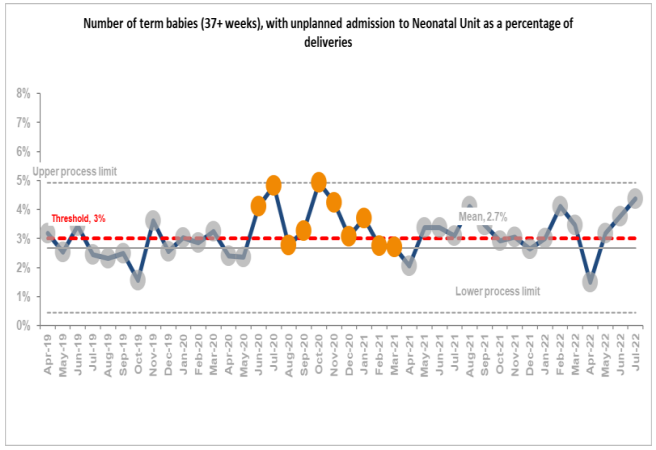












Friends & Family Survey

Indicator Description	Target	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
Emergency Department FFT - % positive responses	90%	81.6%	78.0%	73.6%	71.3%	75.5%	77.4%	80.2%	76.1%	72.0%	72.0%	68.3%	64.99%	70.9%
Inpatient FFT - % positive responses	95%	97.2%	98.4%	97.9%	98.9%	98.3%	96.0%	95.8%	98.2%	97.4%	98.4%	98.9%	98.6%	98.1%
Maternity FFT - Antenatal - % positive responses	90%	100.0%	50.0%	N/A	N/A	N/A	100.0%	N/A	N/A	N/A	N/A	50.0%	N/A	N/A
Maternity FFT - Delivery - % positive responses	90%	100.0%	N/A	100.0%	84.0%	86.8%	87.9%	85.0%	90.6%	92.5%	82.5%	79.2%	94.9%	90.9%
Maternity FFT - Postnatal Ward - % positive responses	90%	100.0%	0.0%	N/A	94.4%	100.0%	90.5%	100.0%	88.9%	100.0%	N/A	95.5%	93.3%	93.3%
Maternity FFT - Postnatal Community Care - % positive responses	90%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Community FFT - % positive responses	90%	100.0%	100.0%	92.9%	89.5%	94.1%	94.4%	100.0%	90.9%	96.0%	100.0%	92.9%	90.9%	93.3%
Outpatient FFT - % positive responses	90%	91.0%	89.8%	90.2%	90.3%	91.7%	91.9%	91.8%	92.5%	90.5%	91.1%	91.5%	91.5%	91.3%

What the information tells us

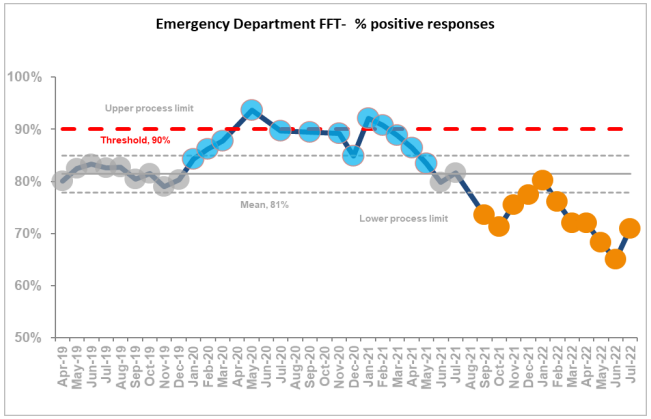
- Inpatient, Community, Maternity Delivery and Postnatal Ward, Outpatient and Community services all achieved FFT targets where patients rated the services as "Good" or "Very Good".
- Performance for Emergency Department (ED) fell to 70.9% compared to 64.9% last month and failed to meet the target of 90%. ED, Community and Maternity (Delivery) shows special cause variation with a deteriorating position and Inpatient and Outpatient shows special cause variation with an improving position.

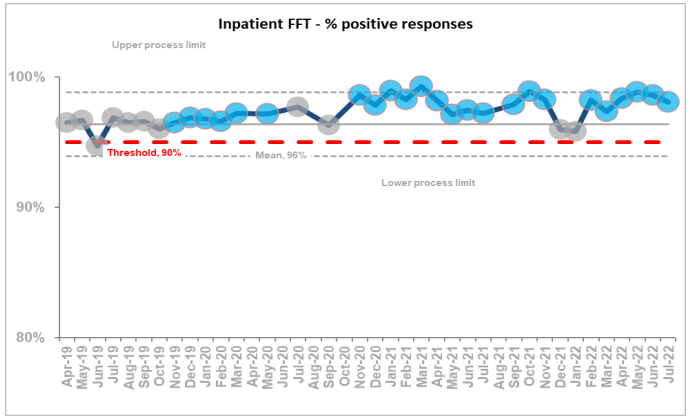
Actions and Quality Improvement Projects

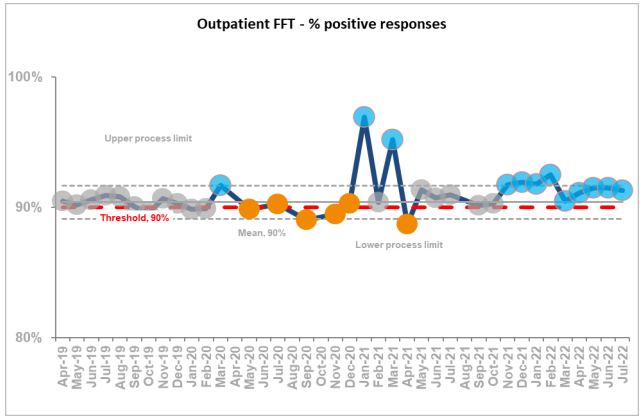
The FFT positive responses continue to be impacted by the current operational pressures in the Emergency Department and increased waiting times. The ED team are working with data team to ensure response rate is accurate. In addition to pressures further themes have been identified in relation to nutrition of patients along with cleanliness and overcrowding of the department. Action is being taken to address nutritional needs of patients waiting in the department, alongside the Mitie and catering team.

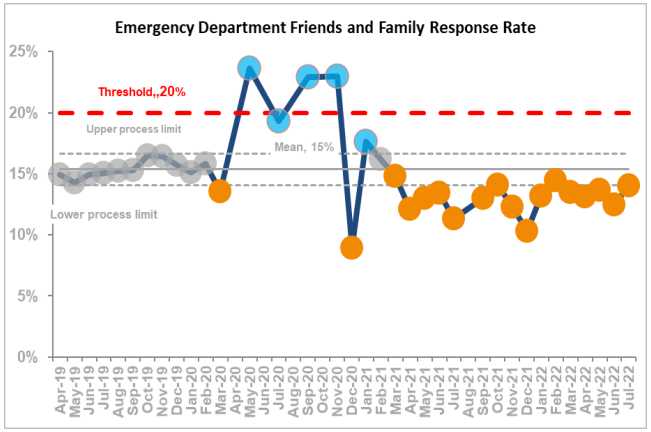
The ED senior nurse team are working with corporate nurses on the above themes and quality indicators

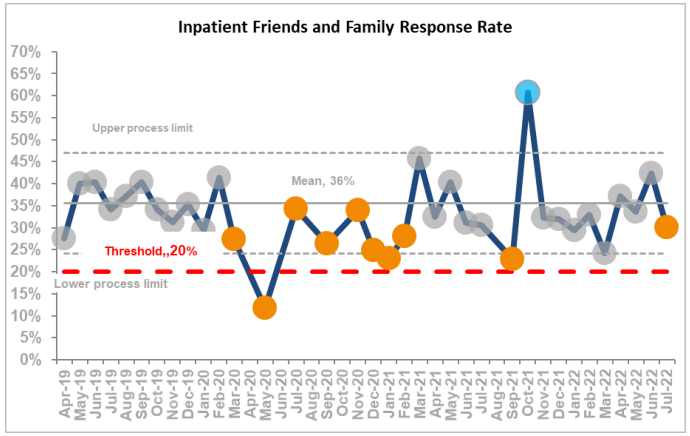
Friends and Family Test

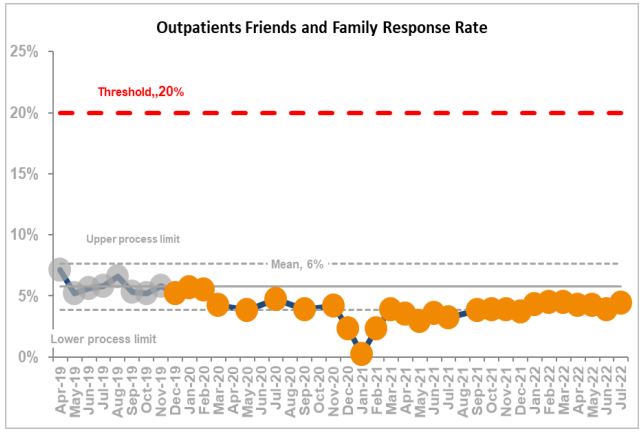












- Common cause variation
- Special cause variation – improving performance
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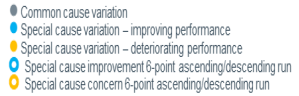
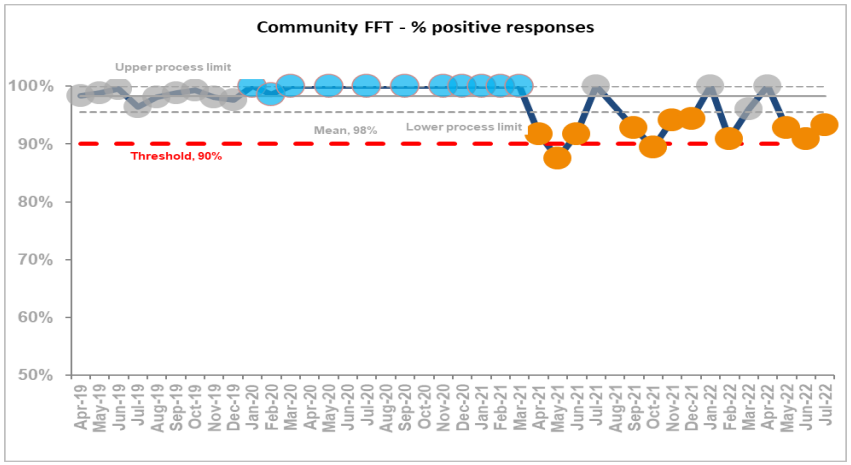
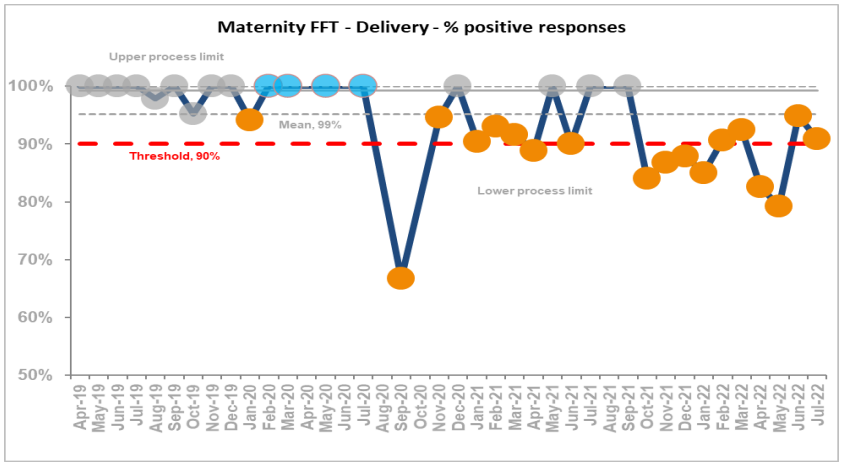
- Special cause concern 6-point ascending/descending run

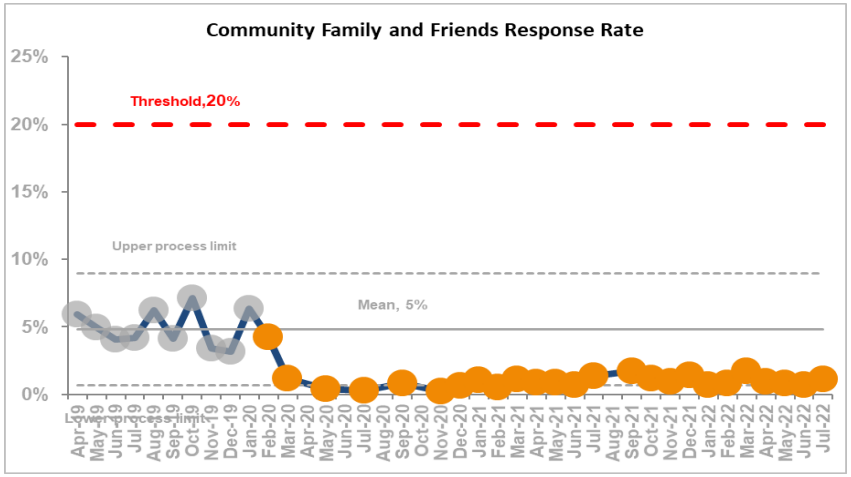
Our Patient Perspective

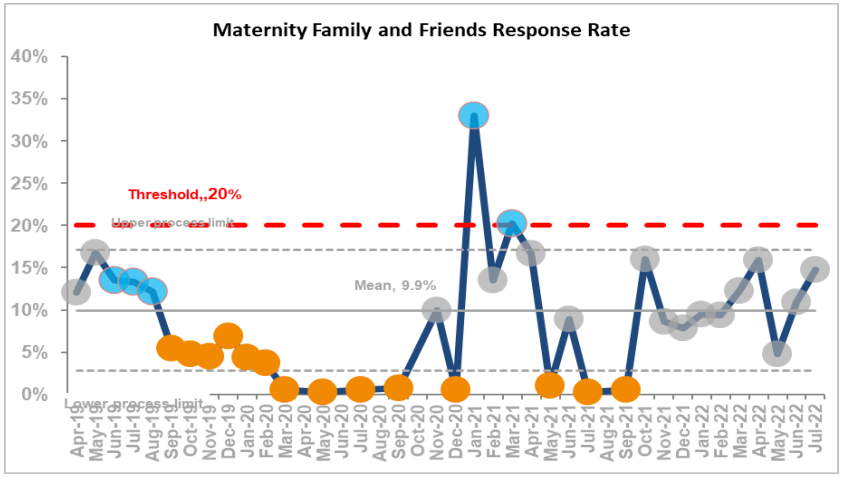
Friends and Family Test









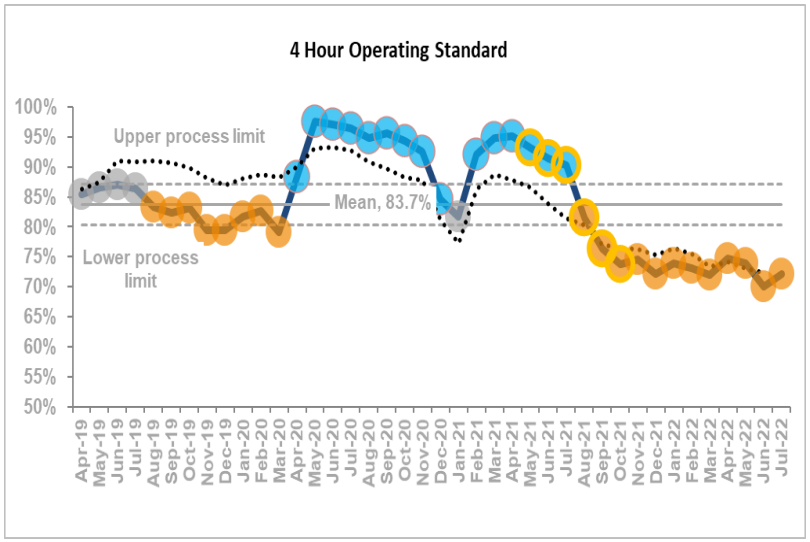


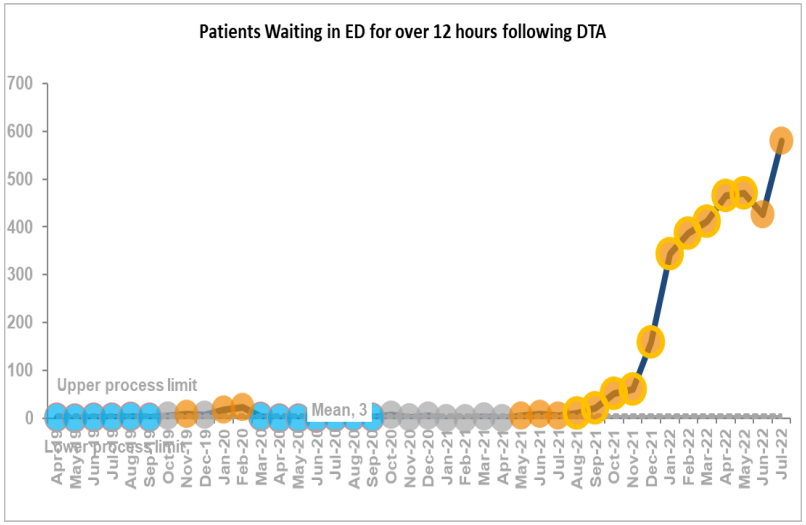
Our Patient Perspective

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			

Emergency Flow





What the information tells us

Performance against the Four Hour Operating Standard, although remaining challenged saw an improvement in July and is in line with the London average. Across the month 72.2% of patients were ether discharged, admitted or transferred within four hours of their arrival. Non-admitted performance shows a positive increase compared to the previous month however, admitted performance dropped. Admitted pathway performance continues to be impacted by flow across the Trust, this has been driven by a higher daily demand of non-elective admissions, with admissions outweighing the number of discharges on 18 days, and limited capacity resulting in a higher number of patients waiting for more than twelve hours to be place after a decision to admit, rising to 579 patients in July. This in turn limits capacity within ED with patients waiting longer for referral, specialist opinions and treatment decisions.

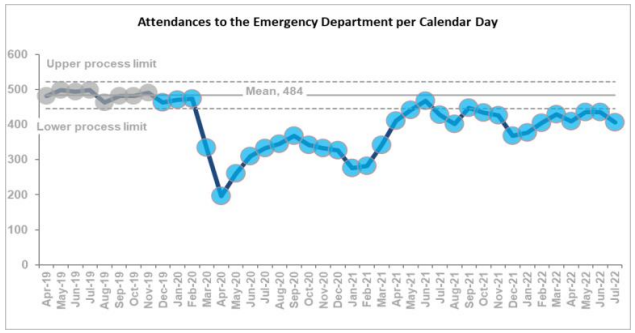
Performance continued to be impacted by high levels of ED staffing absence during July, particularly in nursing. Times for ambulance handovers have dramatically increased in month as they have across London, the delays are caused by crowding in the department due to exit block, we continue to work with LAS colleagues to minimise the impact. The out of hours GP service continues to face challenges in filling all shifts for the streaming GP resulting in extended waits into the evenings for this cohort of patients it is hope this service can be moved in house from end of September.

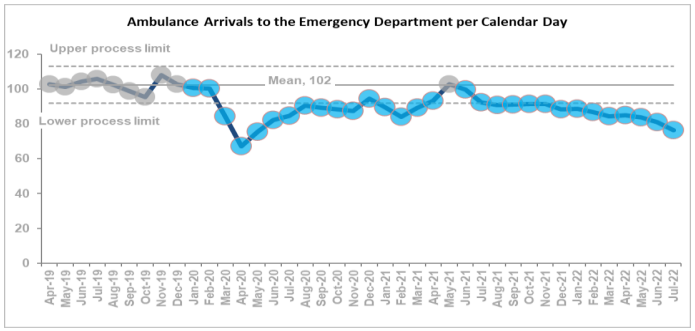
Actions and Quality Improvement Projects

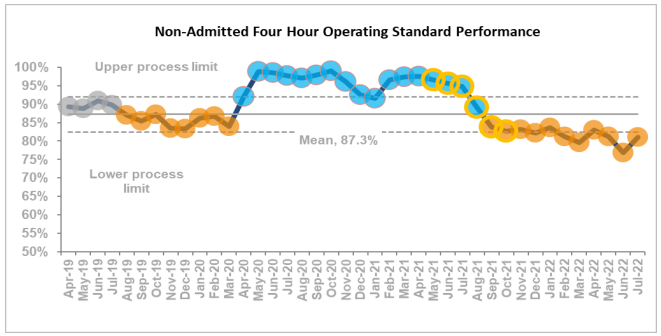
- The Trust is continuing to work seamlessly with system partners to reduce the number of patients waiting for social services
- Internal Emergency Care Delivery Board introduced in July and chaired by Kate Slemeck is meeting weekly and concentrating on 5 workstreams; ED and UTC, SDEC Direct, Flow, Diagnostics, Culture and Innovation.
- We continue in discussions with commissioners about a new model for out of hours GP to support ED, including the introduction of further navigator support to maximise re-directions bac to primary care..
- ED Length of Stay Reviews as well as Daily matron reviews being undertaken
- Exit Block is being added to Risk Register. Risks and safety issues are being reported on datix and discussed with COO / Exec daily
- Rounds of ED waiting room, to ensure safety of our patients waiting to be seen
- Continue to ring – fence assessment cubicles across Majors A & B whilst balancing the need to offload ambulances. This has led to improved access for patients on the non-admitted pathway.
- Inter Professional Standards meetings with Specialties to review existing guidelines and agreements regarding patient pathways and to deepen existing working relationships continue
- New AGM for Non-Elective flow appointed
- Stranded patient weekly reviews focussing on the most complex patients with extended LOS
- Omnicell drugs cabinets being introduced across the Department

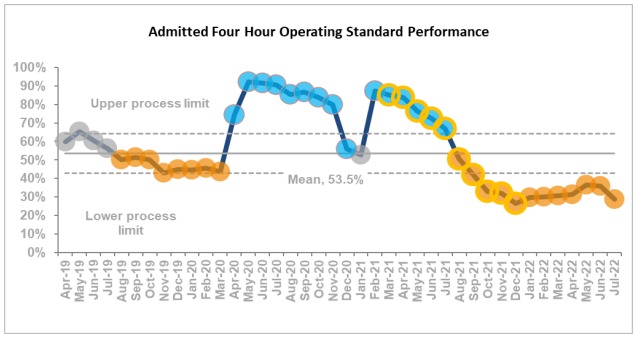
Our Process Perspective

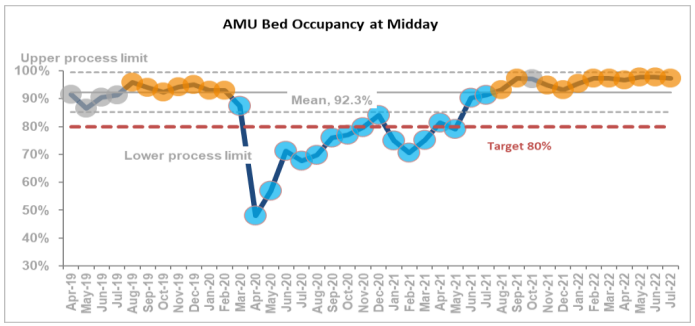
Emergency Flow

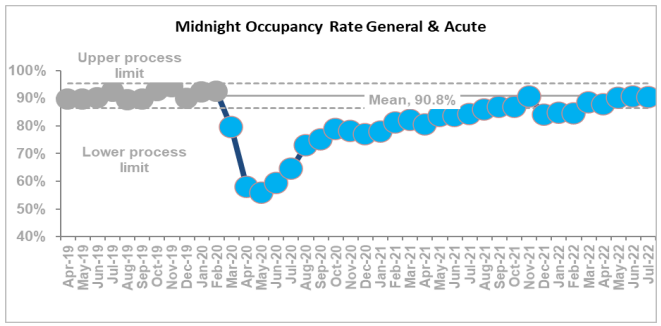


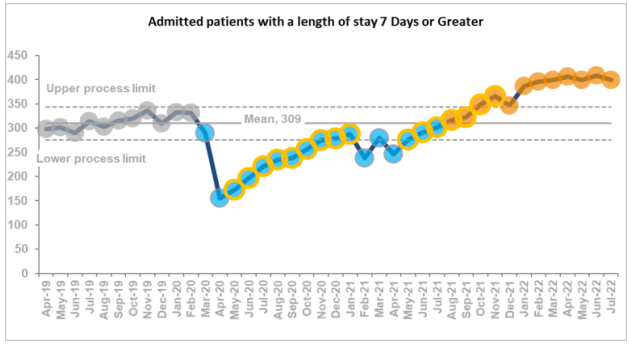


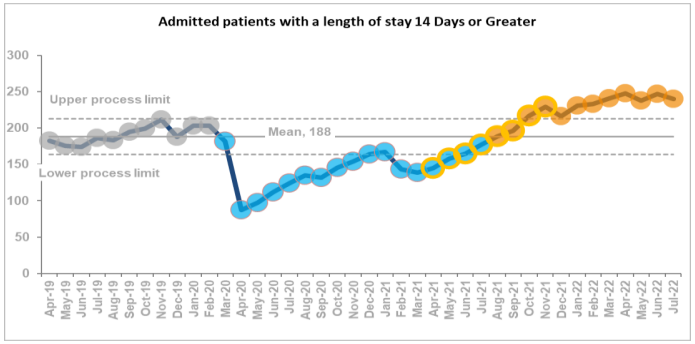


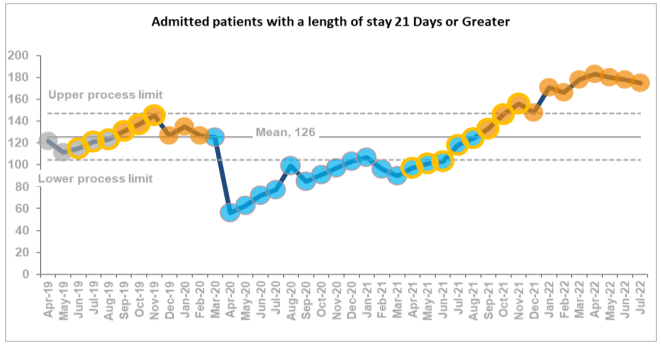






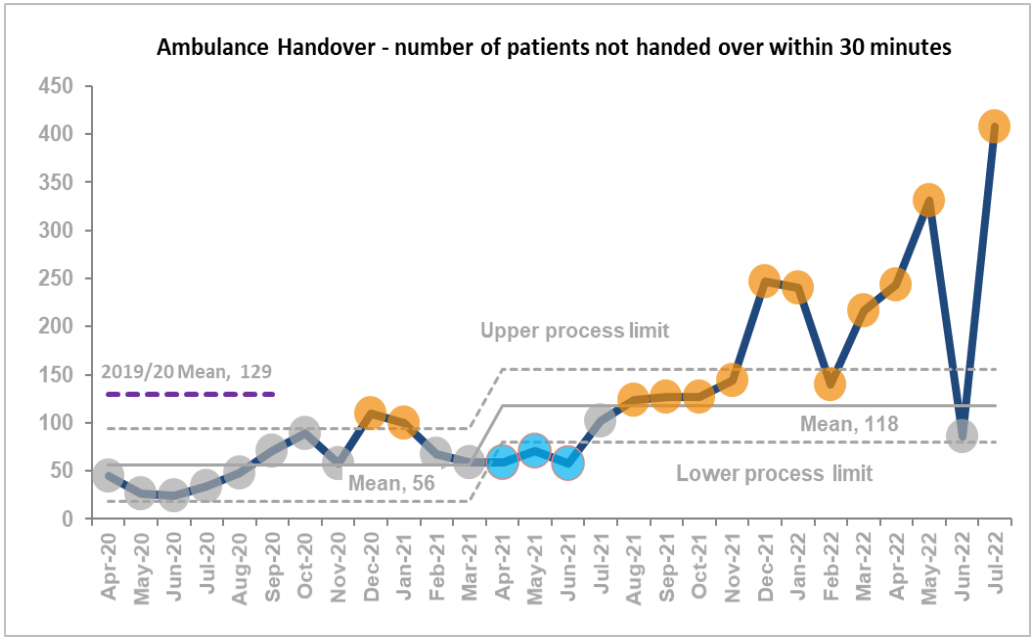


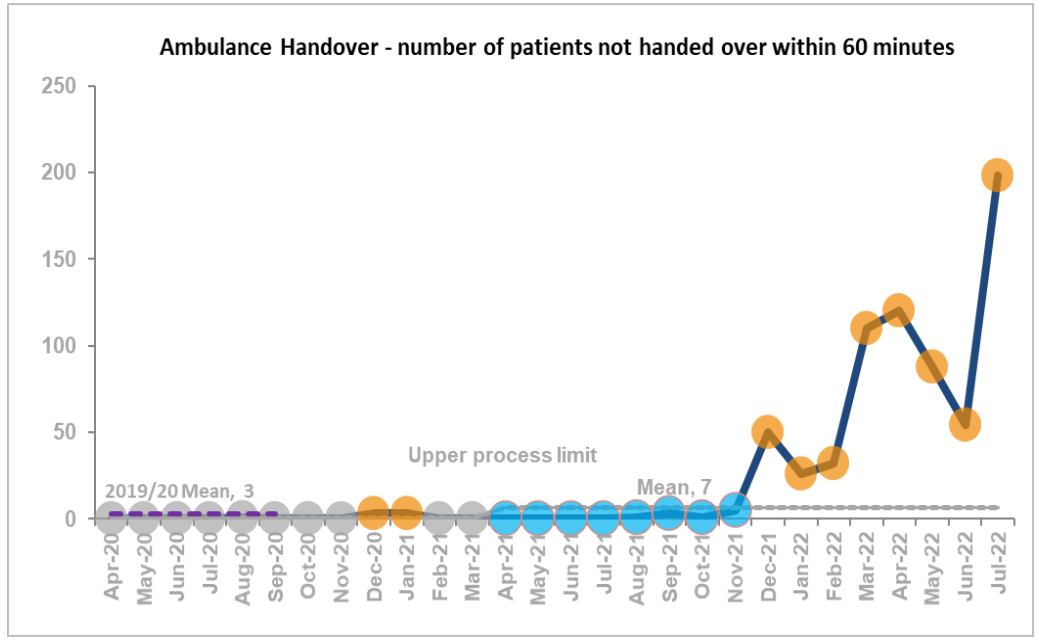




Our Process Perspective

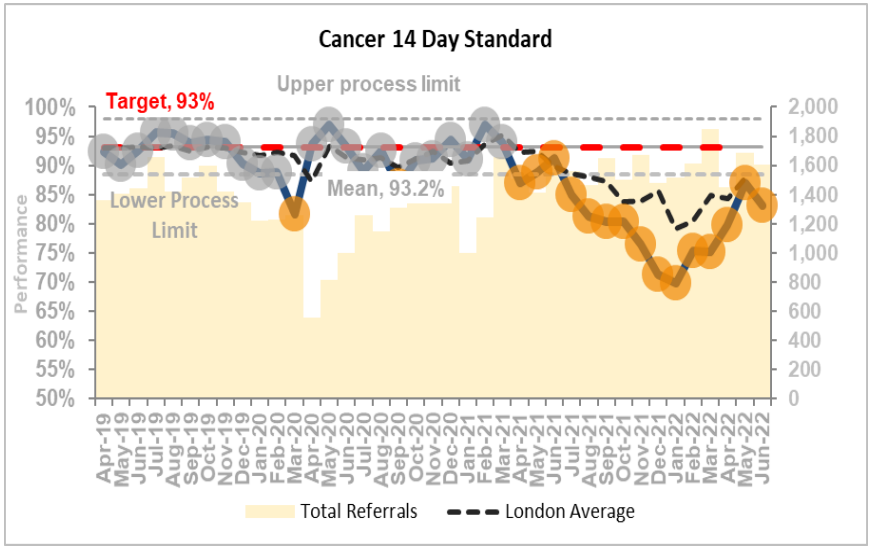
Emergency Flow – Ambulance Handover

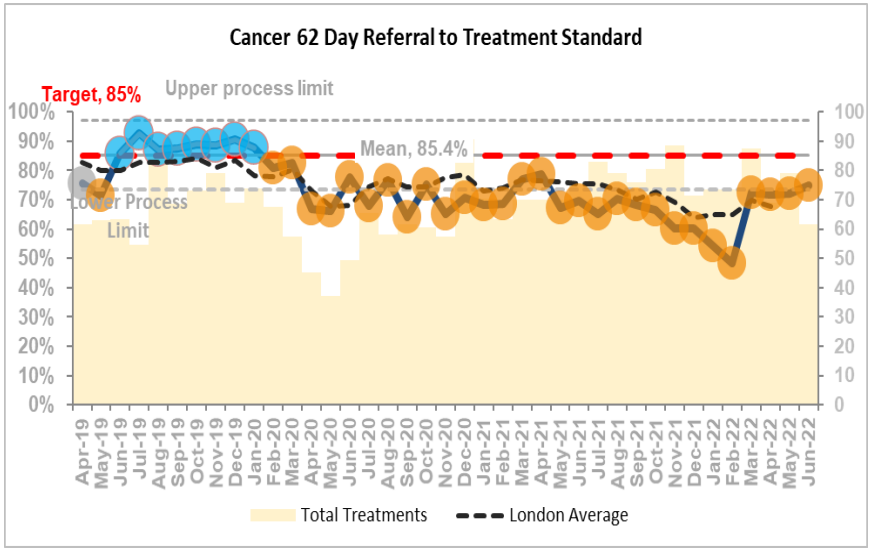




Our Process Perspective

Cancer





What the information tells us

The 14 day standard saw a dip in performance in the month of June with 83.1% of patients seen within 14 days of referral compared to 86.9% in May and against a London average of 87.9%. The decrease in performance was driven by Breast, reporting a performance of 64% and Gynaecology at 76.5%. Although the number of total seen remains consistent there was variation within tumour groups. Lower GI seeing a significant increase with 255 patients seen, the highest level since June 2021 and driving their performance into a compliant position whereas Breast saw a reduction of 90 patients compared to May with the lowest number of patients seen since August 2021.

In June there were 61.5 accountable treatments on the 62-day GP pathway falling below the mean of 2019/20 baseline. At Trust level 74.8% were treated within 62 days, an increase of 2.6% compared to the previous month and above trajectory of 73%. The trajectory finishes in March 2023 with a predicted compliance of 80% against the 62 day national standard of 85%. On average, the number of treatments each month since March 21 has been greater than before the covid pandemic. However, the number of patients treated more than 62 days along their pathway has also increased driving the deterioration in performance. All tumour groups, apart from Haematology and Urology are below the national target of 85%

The trust set a trajectory of 62 backlog volumes which is being delivered. At the end of June 117 patients were waiting more than 62 day against a trajectory of 180. This is still a significant number and has remained relatively constant for the last couple of months. This backlog needs to be reduced, as well as the average pathway length reduced, for the trust to hit compliance. This will take time due to the volume and complexity of the pathways. More focus will be given to the long waiting patients over the summer to ensure the backlog is further reduced.

FDS Performance in June was compliant at 78.6%, above the national standard of 75%. More work is needed so that all tumour groups hit the standard to ensure the required impact on timed pathways.

Actions and Quality Improvement Projects

The Cancer improvement Programme 2023/24 overseen by the Trust Cancer Group will continue to focus on a number of workstreams.

By delivering the pathway improvements and reducing the backlog, St George's will deliver compliance against the 62- day cancer standard in quarter 1 of 2023/24 in order to do this St George's will;

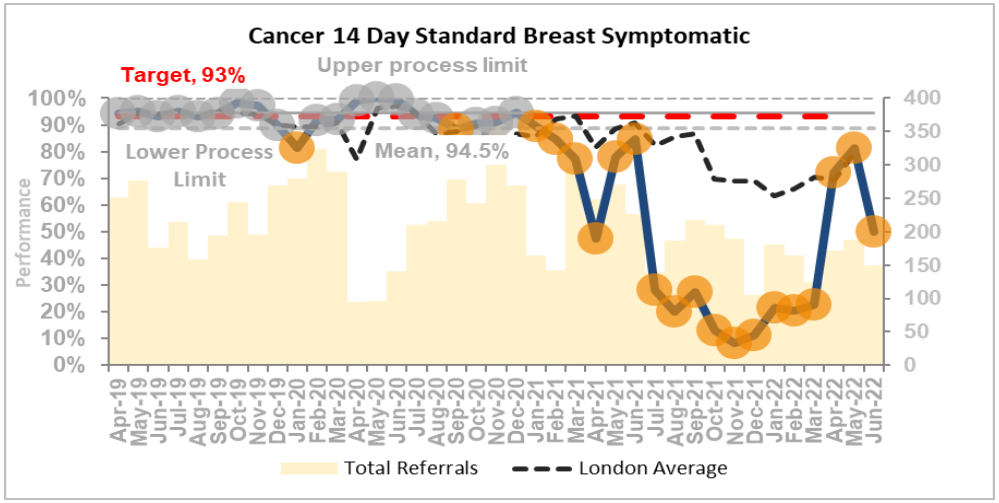
- Work to develop key milestones and detailed trajectories for all cancer improvement projects
- Deliver, through the improvement projects, the FDS standard across all tumour groups. This will need to fucus on two elements of timed pathways, first seen to diagnosis and from MDT to treatment
- Introduce one stop clinics in gynae, and one stop pathways where appropriate in Head and Neck
- Deliver the agreed improvements to the breast cancer pathway at 2 week wait and for 620day delivery
- Use the newly created Elective Delivery Group to monitor cancer performance and reduction in the backlog.
- Engage with all clinicians and teams to ensure focus and engagement

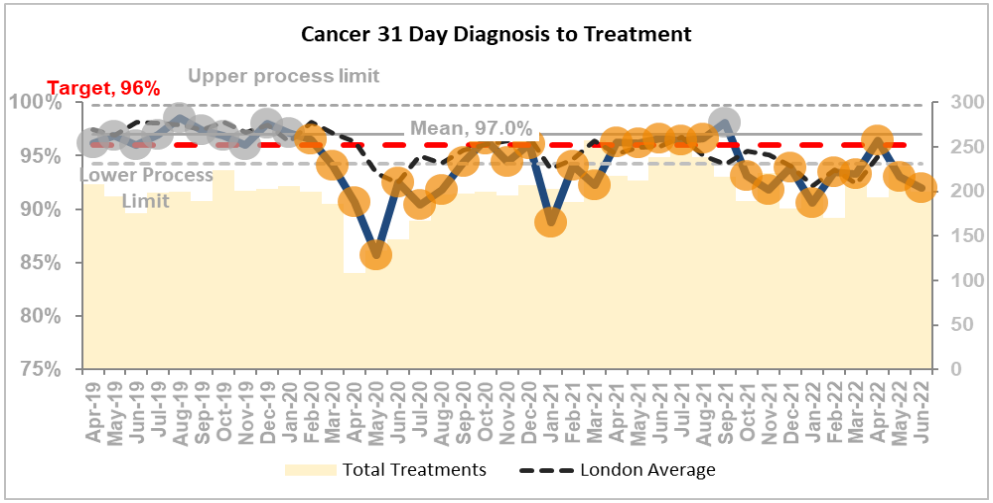
The following risks remain:

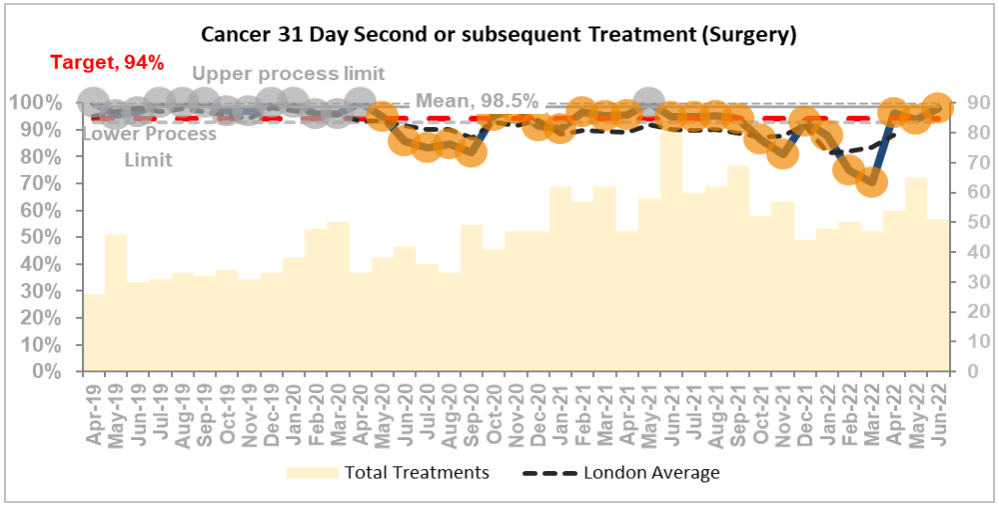
- The demand on radiology from cancer is at 140% of previous levels
- There will be a need for smarter working from our workforce who are already feeling under pressure
- Long term issues relating to IT infrastructure, clinical systems and processes is required

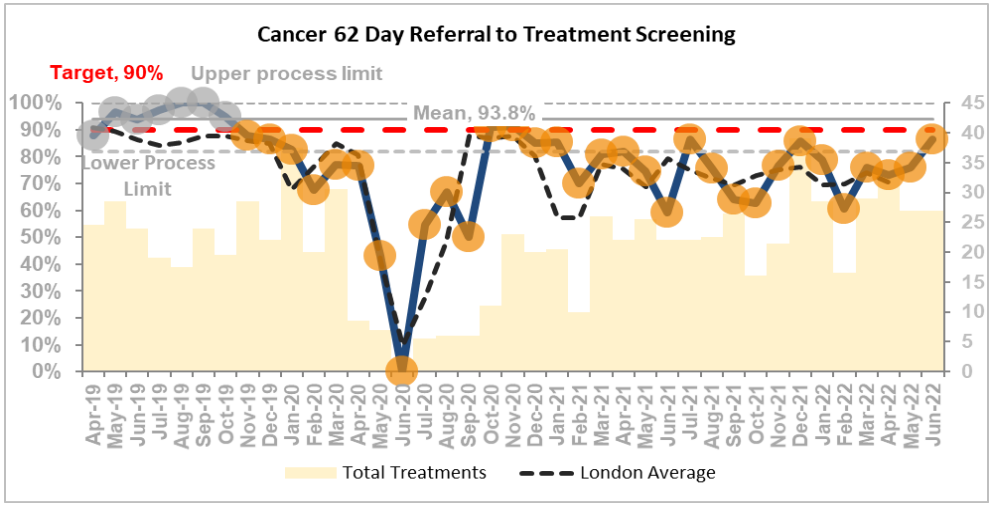
Our Process Perspective

Cancer



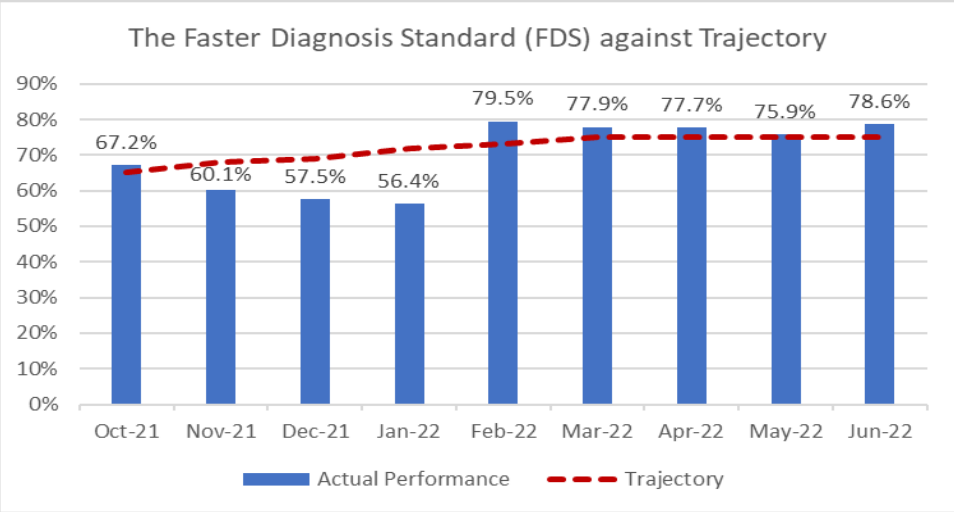


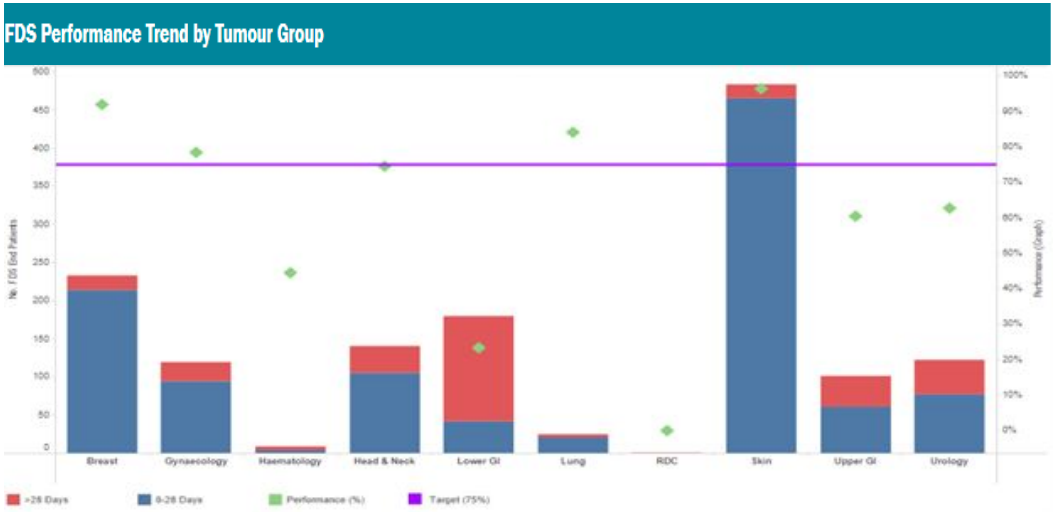




Our Process Perspective

Cancer – Faster Diagnosis Standard (FDS)





What the information tells us

In May, the Trust continued to meet the 75% standard with 76% 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 highest volume of patients are within Skin and Breast – both tumour groups are performing above 90% which is driving overall compliance. Lower GI are the lowest performing tumour group with 23% of patients receiving a communication within 28 days, this means that 159 patients did not. GI Services are the lowest performing group across the sector and part of the continued focus within the Cancer Improvement Programme.

Actions and Quality Improvement Projects

A number of projects at tumour level are being worked on in collaboration with RM Partners and SWL. St George's project meetings have been established in Breast, Upper GI and Lower GI. Work across tumour groups is underway with regard to pathology

FDS Projects:

- Capacity planning across tumour groups and identifying areas where additional actions are needed.
- Implementing straight to test
- Moving majority of gynae pathways to one-stop as part of the Community Diagnostics Centre.
- Increasing discharge at first appointment and expediting access to ongoing care as required.
- Introduction of a one stop head and neck pathway supported by triage

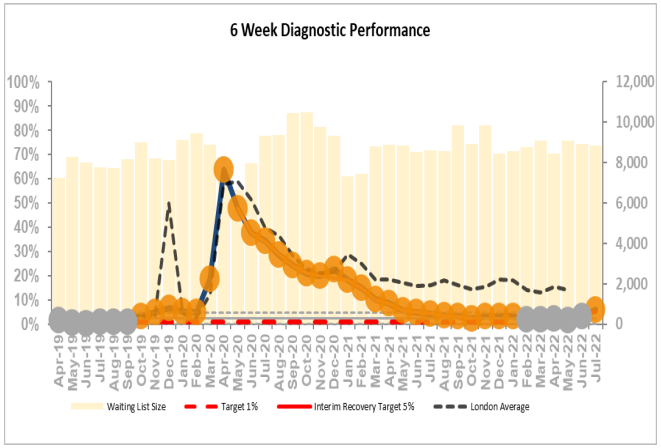
Progress Since June 22

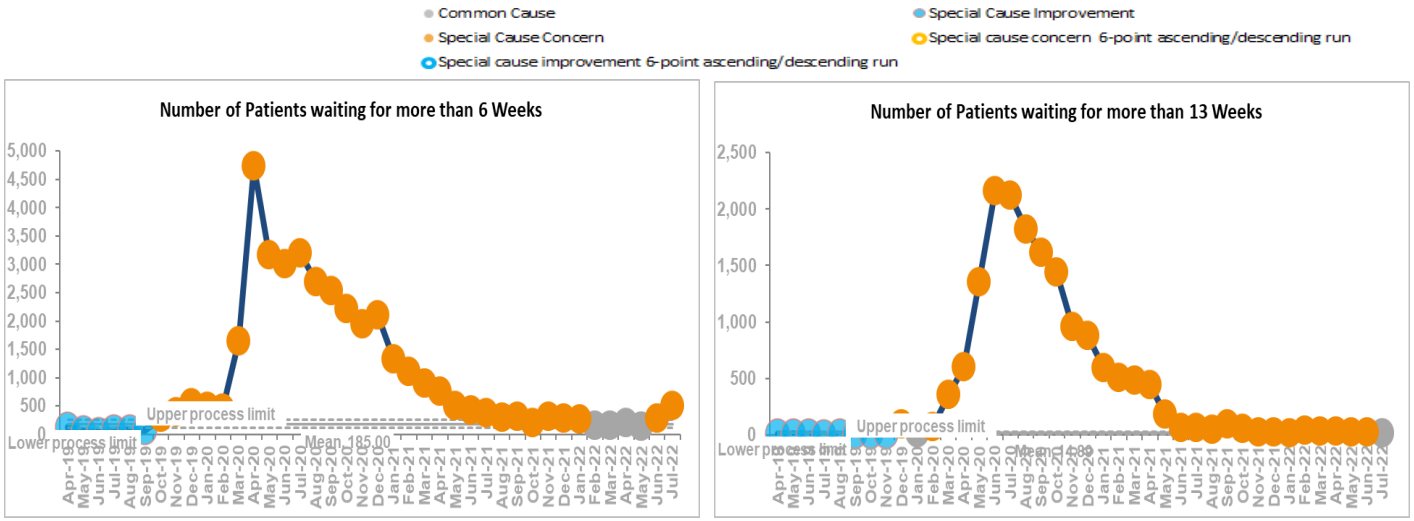
- 200K funding has been approved to set up an additional Lung EBUS service from September 22 to accommodate an additional 192 cases a year and improve Lung diagnostics across the sector
- RDC is now embedded as BAU
- Electronic Healthcare assessment has been rolled 3 areas in July 22

A number of these projects are complex, and multifaceted, and are not due to complete until March 2023. It is not felt that the 62-day standard can be met until these projects deliver.

Although the trust is currently hitting the FDS 75% standard, more work is needed to improve above 75% and so that all tumour groups hit the standard to ensure the required impact on timed pathways.

Diagnostics





What the information tells us

At the end of July, the Trust reported that 5.8% of patients were waiting for more than six weeks for their diagnostic test. This is a significant deterioration compared to the 3.2% reported at the end of June meaning that the Trust is not meeting the required national recovery target of 5%. In total there were 509 patients over six weeks and increase of 225 patients.

Increases have been driven by longer waits for Gynae Ultrasound impacted by both staffing gaps related to Sonographers coupled with an increase in demand. At the end of the month 295 patients were waiting for test accounting for 57% of the total breaches.

Whilst Cardiac MRI continue to report a high number of breaches performance is stable with the overall waiting list size decreasing, pressure will be elevated in September with expected improvement.

Echocardiology – The service saw a surge in demand throughout May particularly for Stress Echo increasing waiting times. The number of six weeks breaches reduced by 50% in July through additional sessions which is expected to continue throughout August.

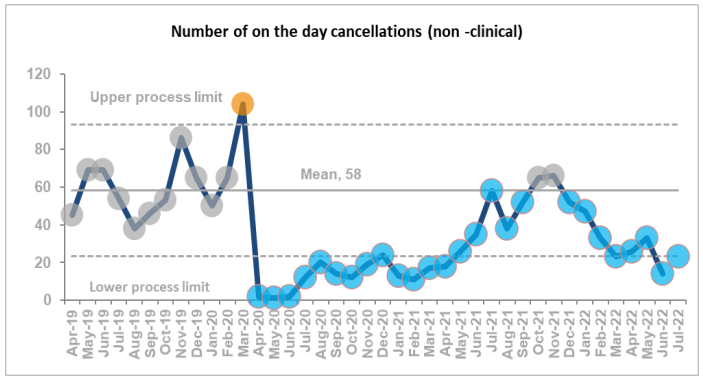
Endoscopy – In total 36 patients were waiting for more than six weeks and is expected to increase throughout August where gaps in staffing has impacted the ability to cover lists. Paediatric GA cover continues to impact ability to treat patients within target.

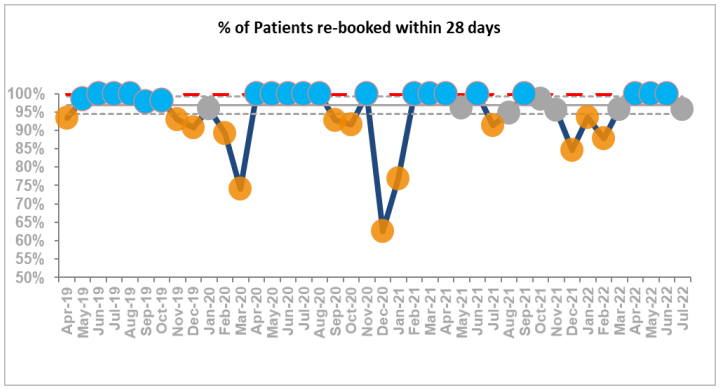
The Trust has still continued to focus on the longest waiting patients, those waiting for more than 13 weeks, and at the end of July 9 patients were reported a decrease of 60% compared to June.

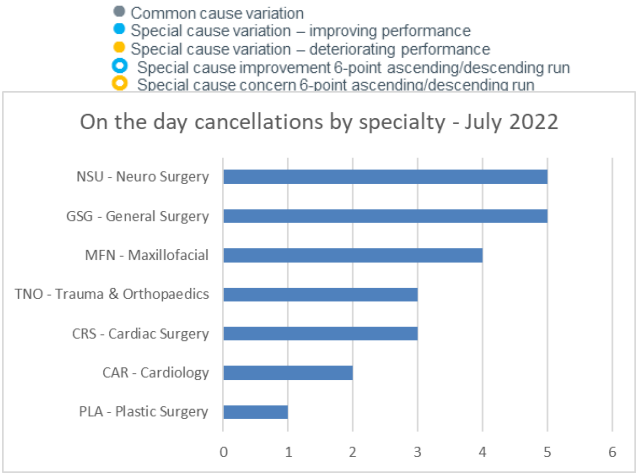
Actions and Quality Improvement Projects

- Cardiac MRI - Capacity challenges continue with additional MRI capacity coming online from September with new MRI unit, these sessions are now being booked into. The service continues to manage the waiting list affectively and are holding a stable position decreasing their overall waiting list size. ICS is looking at sector wide IS Cardiac MRI as St Georges not unique in challenges.
- Gynae Ultrasound – Challenges recruiting to 2 WTE sonographers (includes 1.2 additional funding secured), posts currently out to advert. Continue to utilise bank and agency as much as possible additional slots through July and August, however this is not meeting the demand. Additional support from General Ultrasound where possible.
- Paediatric Endoscopy - Capacity challenges are related to on-going GA availability - Paeds: 2 x Anaesthetic consultants posts out to advert
- Sleep Studies – Continuing to provide additional capacity where possible. Service completing a review of demand and capacity to identify where there are possible shortfalls.
- Endoscopy – staffing deficits has impacted the ability to open full capacity with two room closures whilst also seeing an increase in OGD demand. Cancer and urgent referrals will continue to take priority with reduced sessions for routine referrals.

On the Day Cancellations for Non Clinical Reasons(OTD)







What the information tells us

In the month of June the Trust cancelled 23 patients on the day of their procedure for non clinical reasons. Performance remains positively lower than the 2019/20 baseline seeing reductions being maintained in nearly all specialties particular within Vascular Surgery. This improvement has been driven decreases in cancelled ops due to bed availability and emergency cases taking priority where improved systems have been implemented.

Of the 23 patients cancelled one patient unfortunately was not offered a re-booking date within 28 days due to capacity in Neurosurgery.

Patients were cancelled for the following reasons in July;

- Timing - Emergency case took priority– 9
- Bed - No Critical Care bed available - 3
- Timing - Complication - previous case/-s– 3
- Staffing - Theatre Staff unavailable – 2
- Staffing - Anaesthetist unavailable – 1
- Bed - No Ward bed available-1
- Equipment/Theatre - Equipment Issues - 1
- Other – 4

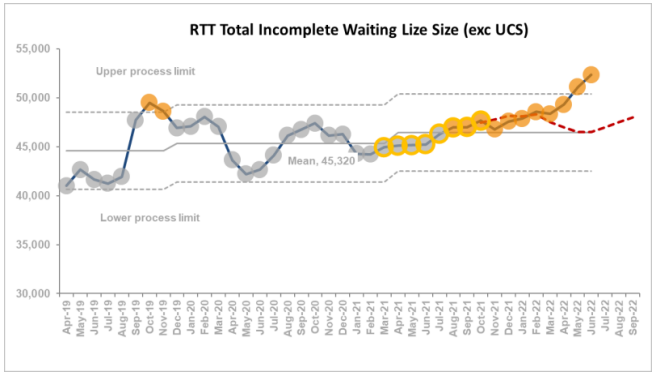
Actions and Quality Improvement Projects

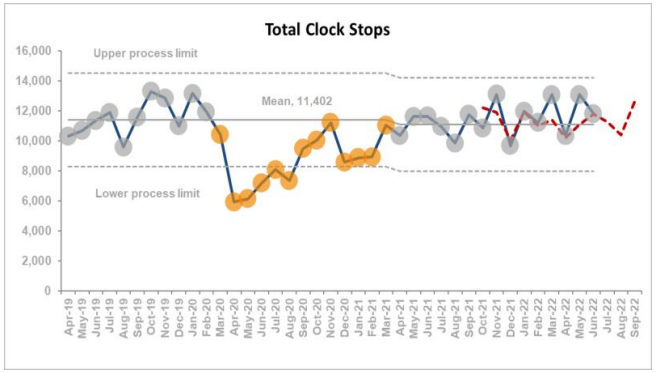
OTDC for non-clinical reasons increased slightly in July (by +7 patients) compared with June. This change was driven primarily by an increase in cancellations due to an 'Emergency case taking priority' (+4), and no bed availability (ICU beds +3) and ward beds +1 compared with June). Staffing gaps also accounted for 3 OTDC (+2 compared with June).

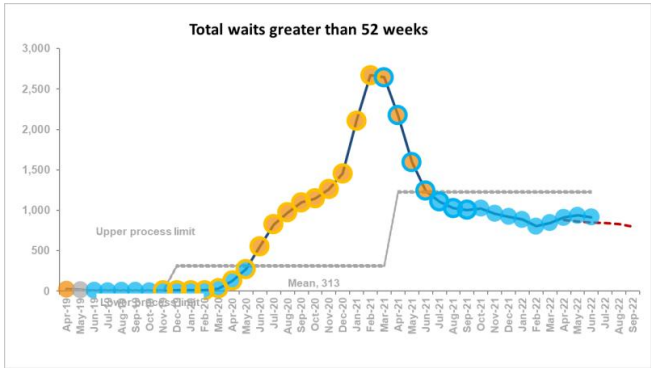
The continued very low rates of PPNCOs (i.e. DNAs and OTDC) – currently standing at just 3%, which is 7% less than the pre-pandemic SGH rate of 10%, and 2% below the national benchmark target of 5% – has been driven by:

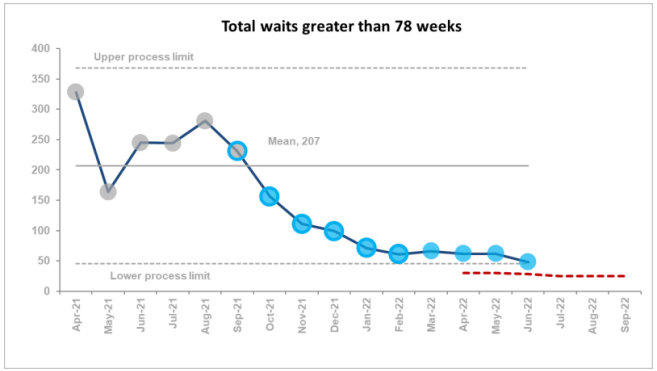
- **Better communication:** Launch of a revamped OTDC for non-clinical reasons SOP which focuses on raising awareness of the escalation process, to ensure that decisions are not being taken without consultation with all colleagues capable of avoiding a cancellation.
    - The relaunch has coincided with 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.
- **New pathways:** Creation of a 'Yellow' SDL Discharge pathway from SJW to DSU to improve flow in SJW Recovery, maximise SDLs and minimise failed SDLs. This SOP was then updated in April to include the discharge of 'Green' pathway patients and re-launched to ensure that all opportunities to transfer patients are taken:
    - Cancellations due to bed availability have fallen substantially.
    - This is partly attributable to the new 'Yellow' SDL Discharge pathway.
- **New processes:** T&A have developed a new process to improve the timely prioritisation of Urgent patients, to reduce the risk of cancellation due to POA issues (Inadequate POA has not been the cause of an OTDC for the last three months). This has been accompanied with joint work and comms with surgical teams to encourage more timely booking of patients for POA.

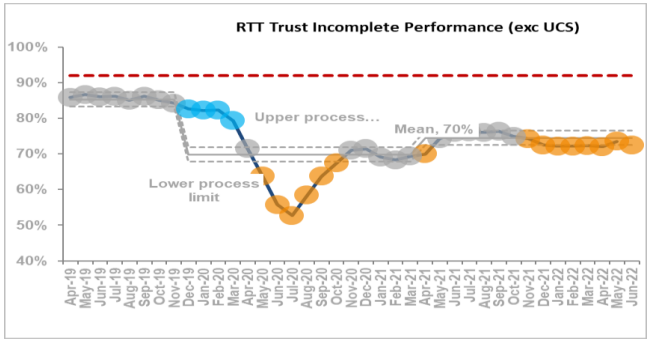
Referral to Treatment — June 2022











Note: Unknown Clock Starts (UCS) have been excluded from the above metrics.

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

What the information tells us

At the end of June there were 52,351 patients waiting for treatment on the RTT Incomplete PTL, an increase of 2.5 % compared to May.

Whilst the admitted PTL size is stable and within the upper and lower control limits the non-admitted PTL continues to grow with an additional 1,283 patients (+2.95%) compared to May and is above our trajectory by over 12%. Increases are driven by; Cardiology, Chest Medicine, ENT, Dermatology, Plastic Surgery.

The Trust reported 914 patients waiting for more than 52 weeks at the end of June, this is a reduction compared to the previous month by 2% however is above trajectory submitted of 850 patients. The largest cohort of patients is within General Surgery with 233 patients above 52 weeks, this is a reduction compared to 258 patients waiting at the end of May, ENT also saw a decrease of 17 patients. Cardiology, Plastics and Neurosurgery continued to see an increase. There were 48 patients in total waiting for more than 78 weeks, continue to see a downward trend but above trajectory by 20 patients.

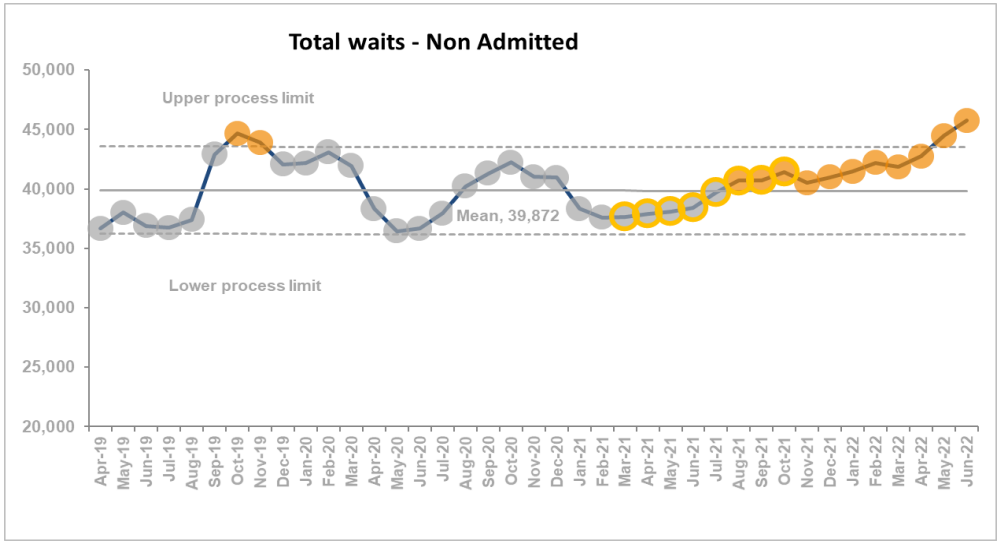
The number of clock stops in the month exceeded target.

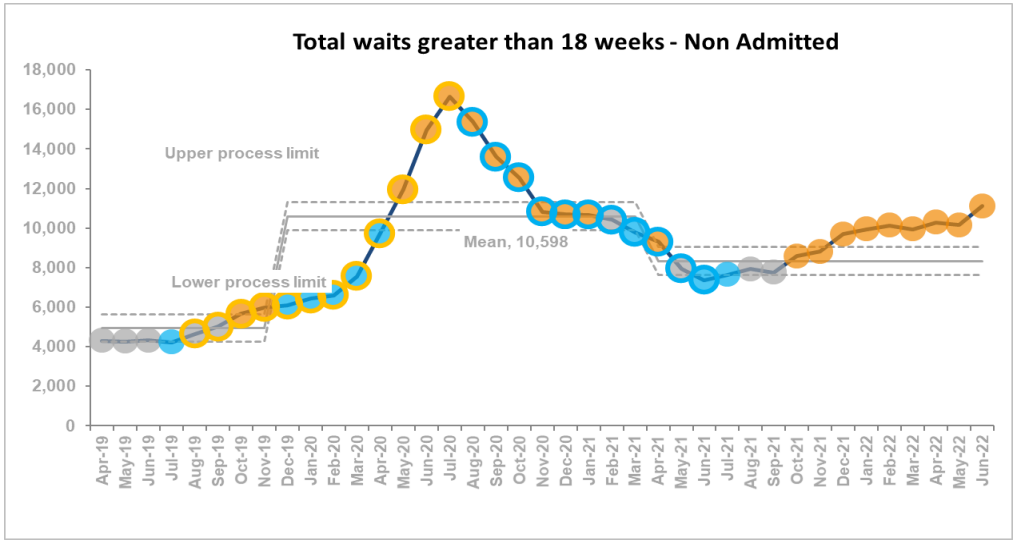
Actions and Quality Improvement Projects

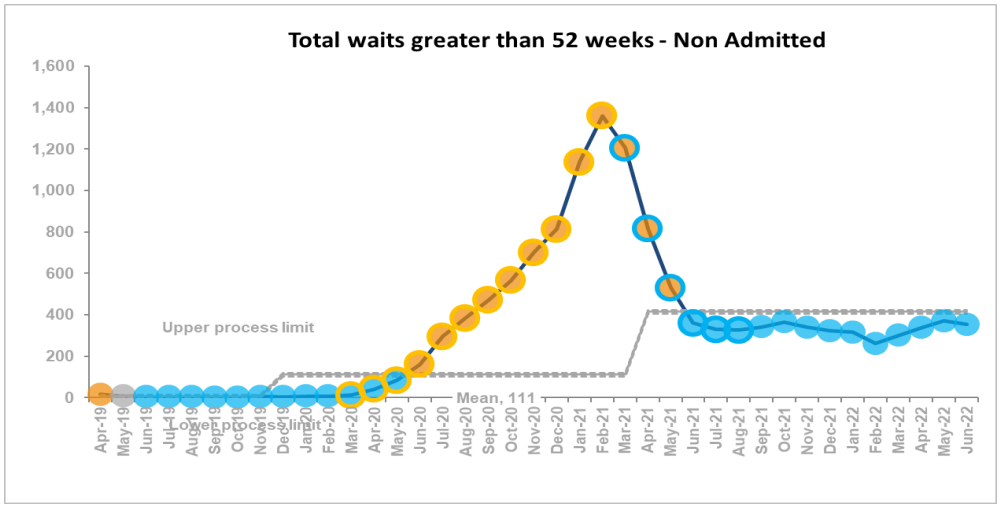
- Work continues with the network to redirect patients at the referral stage which is key to improving equity of access to timely healthcare across SW London.
- More General Surgery patients were sent via the Mutual Aid scheme to Kingston for treatment.
- The DoctorDr text messaging service will resume in July, now that the commercials have been completed.
- Scoping of Palantir project to improve theatre efficiency and maximise productivity.
- All services will reforecast 52 week breach position to understand the ongoing level of risk. Most significant challenges and growth in ENT, Plastics and Cardiology.

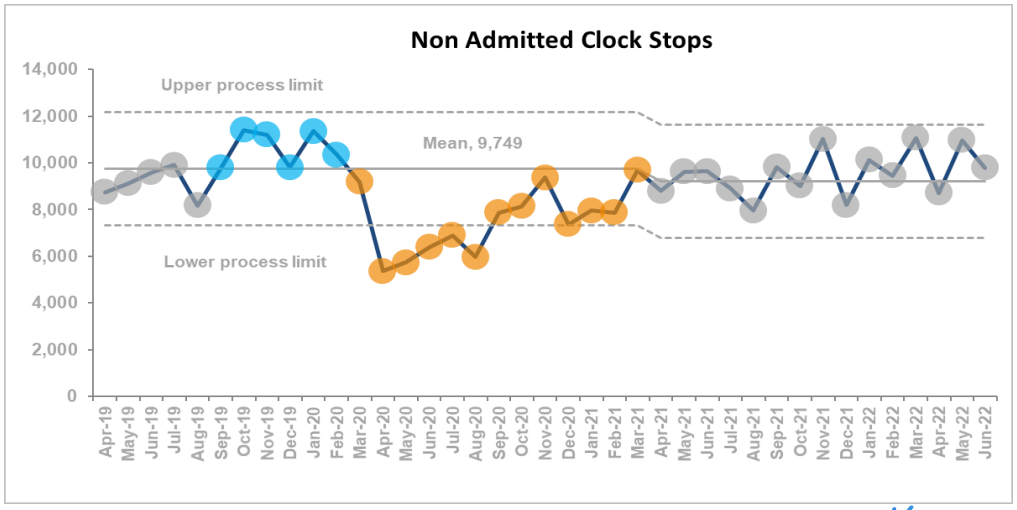
Our Process Perspective

Referral to Treatment Non-Admitted Pathway — June 2022



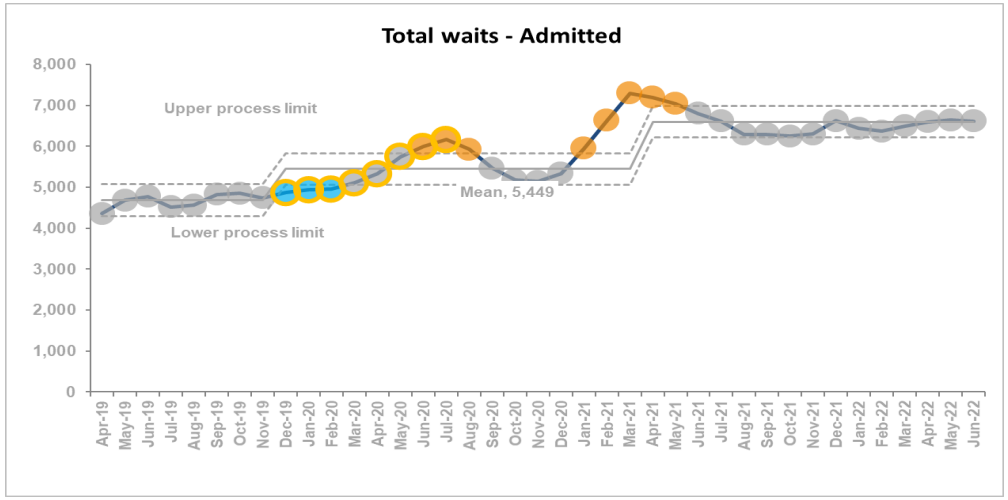


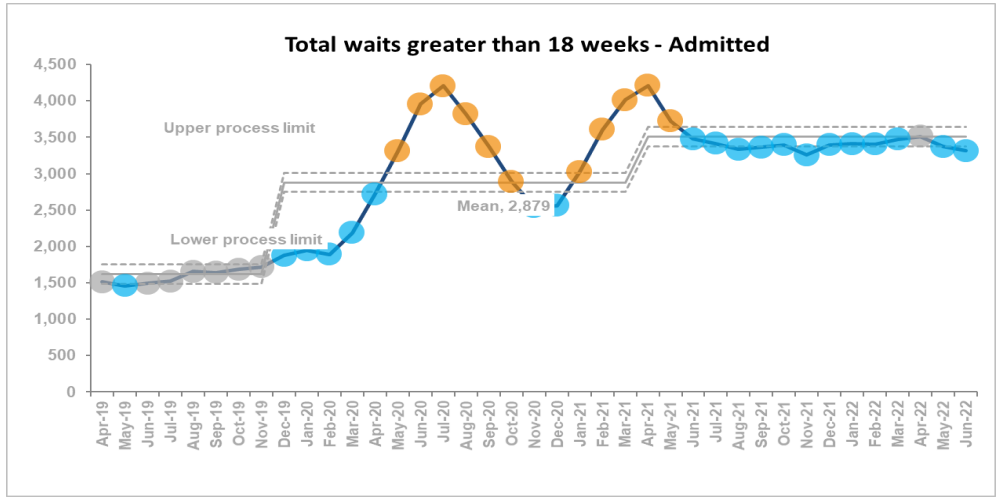


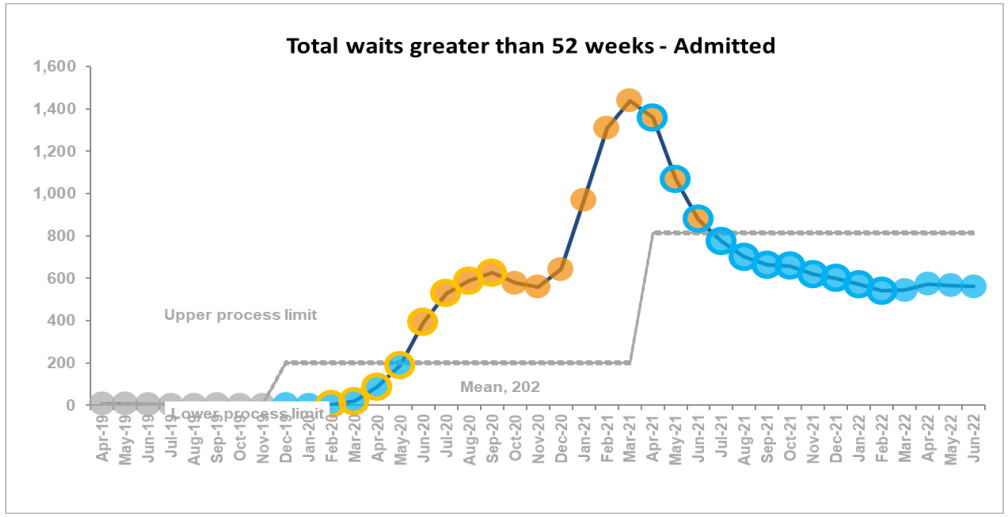


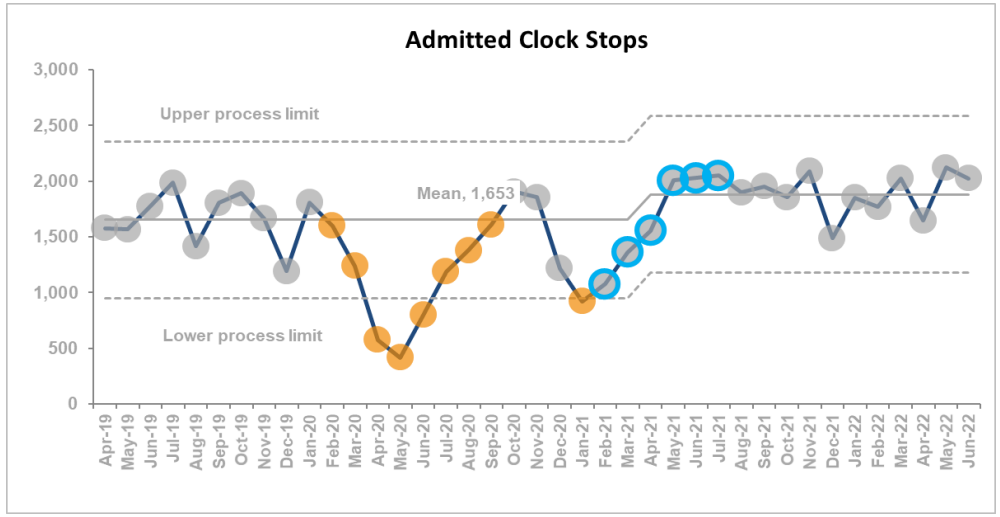
Our Process Perspective

Referral to Treatment Admitted Pathway — June 2022



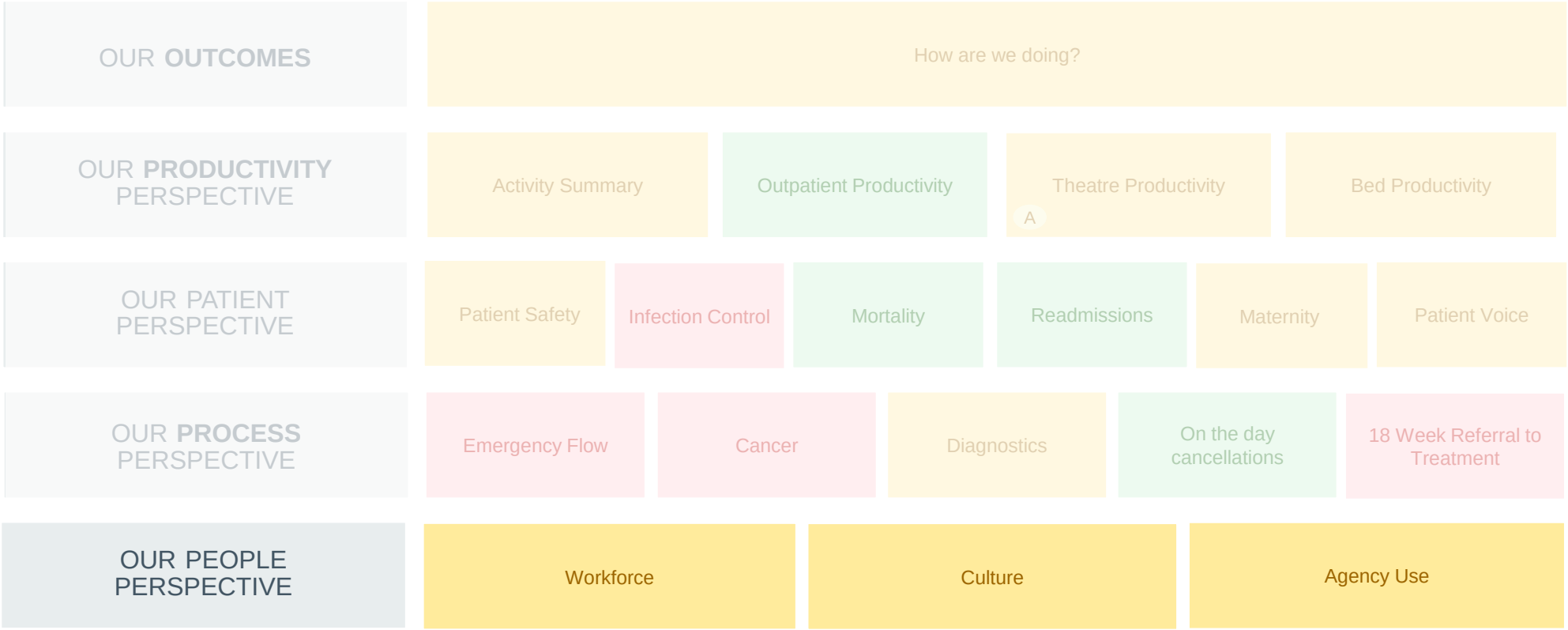






Our Process Perspective

Balanced Scorecard Approach



Workforce

Metric	Benchmark Average	Performance 12 months ago	Performance 3 months ago Apr-22	Current Performance July-22	Target	Distance to target	Current RAG Rating
Sickness	4.0%	3.9%	4.5%	5.0%	3.2%	-1.80%	✖
Vacancy	10.8%	9.5%	9.9%	9.0%	10.0%	+1.0%	✓
Turnover		12.5%	16.2%	16.5%	13.0%	-3.5%	!
Medical Appraisal		77.5%	80.3%	81.8%	90.0%	-8.2%	!
Non-Medical Appraisal	72.0%	73.9%	70.3%	70.6%	90.0%	-19.4%	!
MAST	85.7%	90.0%	88.3%	89.9%	85.0%	+4.9%	✓
Stability		90.4%	86.4%	86.6%	85.0%	+1.6%	✓

What the information tells us

- The Trust's sickness rate was 5.0%, and above the target of 3.2%
- Vacancy Rate this month was 9.0%, which is below the threshold of 10%.
- Trust turnover rate in July was 16.2% and is adverse to the target of 13% and shows special cause variation with a deteriorating position. Turnover figures have been revised, fixed term employees have been removed from our turnover and stability calculations and we are also now aligned with Epsom and St Heliers.
- Medical appraisal rates and non-medical appraisal rates was non-compliant against the 90% target. Showing 81.8% and 70.6% respectively.
- Mandatory and Statutory Training (MAST) was 90.3% in June and fell slightly to 89.9% in July.
- Stability performance in July was 86.6% against a target of 85%.

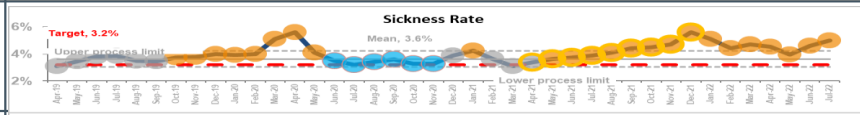
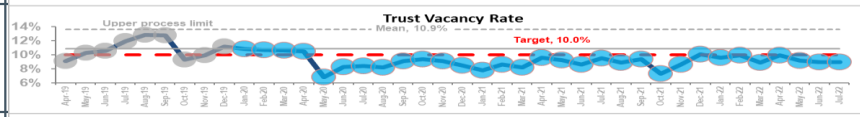
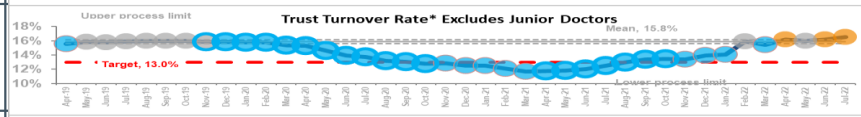
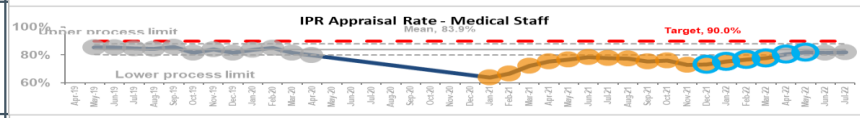
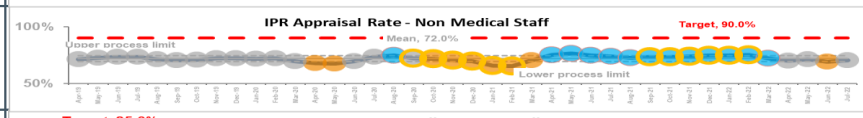
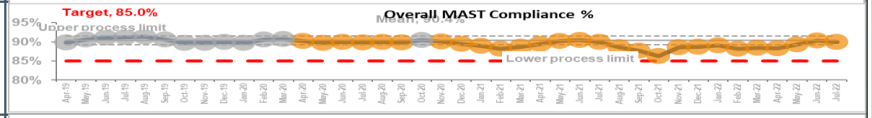
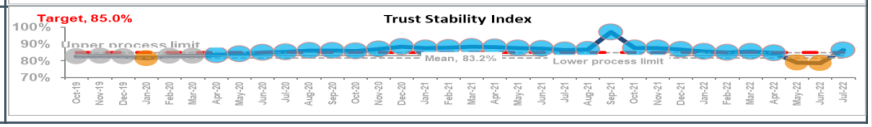
* Benchmark info is taken from Guy's & St Thomas', King's, Lewisham & Greenwich, Imperial, and UCLH.
* Turnover benchmarking isn't available as different Trusts calculate turnover in different ways

Actions and Quality Improvement Project

- **Sickness**- For all 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 continues to work 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. HR are building on the Big 5 Staff Recovery and Well being month. HWB Team continue to promote wellbeing resources and encourage healthy behaviour and deliver Mental Health Training
- **Turnover**- A resourcing strategy is being developed to improve the end-to-end recruitment and onboarding processes to include stay conversations and a wider look at staff retention and reasons for turnover.
- **Vacancy-Human:** Focus on the top 30 vacancy hotspots as well as targeted work on hard to recruit posts is continuing with tasks & finish groups set up involving working in partnership with the recruitment hub, service and HR to look at any barriers to recruitment and reasons for hotspots.
- **Appraisals**-A plan is being developed to stand up initiatives to support the increase in appraisal uptake to include health and wellbeing, talent management and driving up numbers undertaken. The summer period is where we see the lowest number of completed PDRs across the year.
- **MAST Compliance** –The overall Trust compliance remains steady. A focus for the next quarter will be applying a new training needs analysis for the clinical Resuscitation topics so may see some movements in rates for that topic**.**
- **Stability** – We have launched the values and behaviours guide and summary as well as a values film, and continue with our Big 5 campaign in response to the 2021 staff survey and will be providing an update at the next Group staff engagement event.

Workforce Metrics

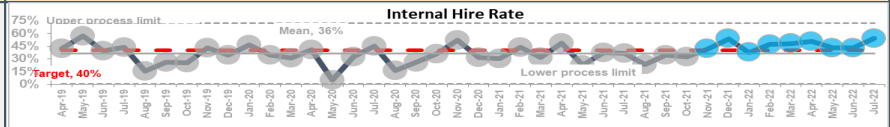
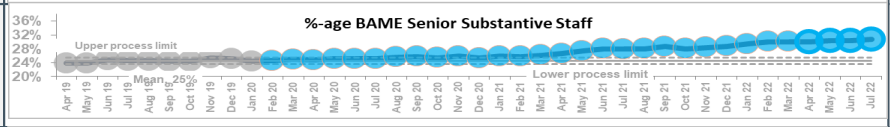
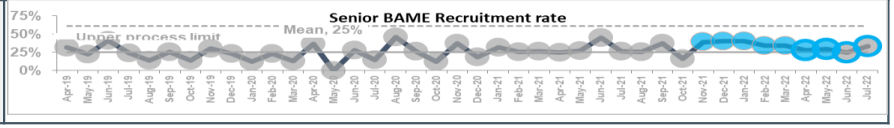
- Common cause variation
- Special cause variation – improving performance
- Special cause variation – deteriorating performance
- Special cause improvement 6-point ascending/descending run
- Special cause concern 6-point ascending/descending run

	Metrics	July-22	Target	Var to target	Trend
✖	Trust Level Sickness Rate	5.0%	3.2%	-1.80%	
✓	Trust Vacancy Rate	9.0%	10.0%	+1.0%	
!	Trust Turnover Rate* Excludes Junior Doctors	16.5%	13.0%	-3.5%	
!	IPR Appraisal Rate - Medical Staff	81.8%	90.0%	-8.2%	
!	IPR Appraisal Rate - Non Medical Staff	70.6%	90.0%	-19.4%	
✓	Overall MAST Compliance %	89.9%	85.0%	+4.9%	
✓	Trust Stability Index	86.6%	85.0%	+1.6%	

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.	July-22	Target	Var to target	Trend
✓	Internal Hire Rate (all bands)	54.2%	40%	+4.5%	
NA	%-age BAME Senior Substantive Staff (Band 8 and up)	30.7%	N/A	-	
NA	Senior BAME Recruitment rate (Band 8 and up)	33.1%	N/A	-	

What the information tells us

- In July the Internal hire rate was 54.2% an increase of 4.5% on last month showing special cause variation with an improving position..
- Of the Senior substantive staff (Band 8 and above) employed in the trust, Black and Minority Ethnic staff represent 30.7% of that group. The Senior BAME recruitment rate for staff 8 and above was 33.1% in July.
- Covid-19 Staff vaccinations are no longer being monitored.

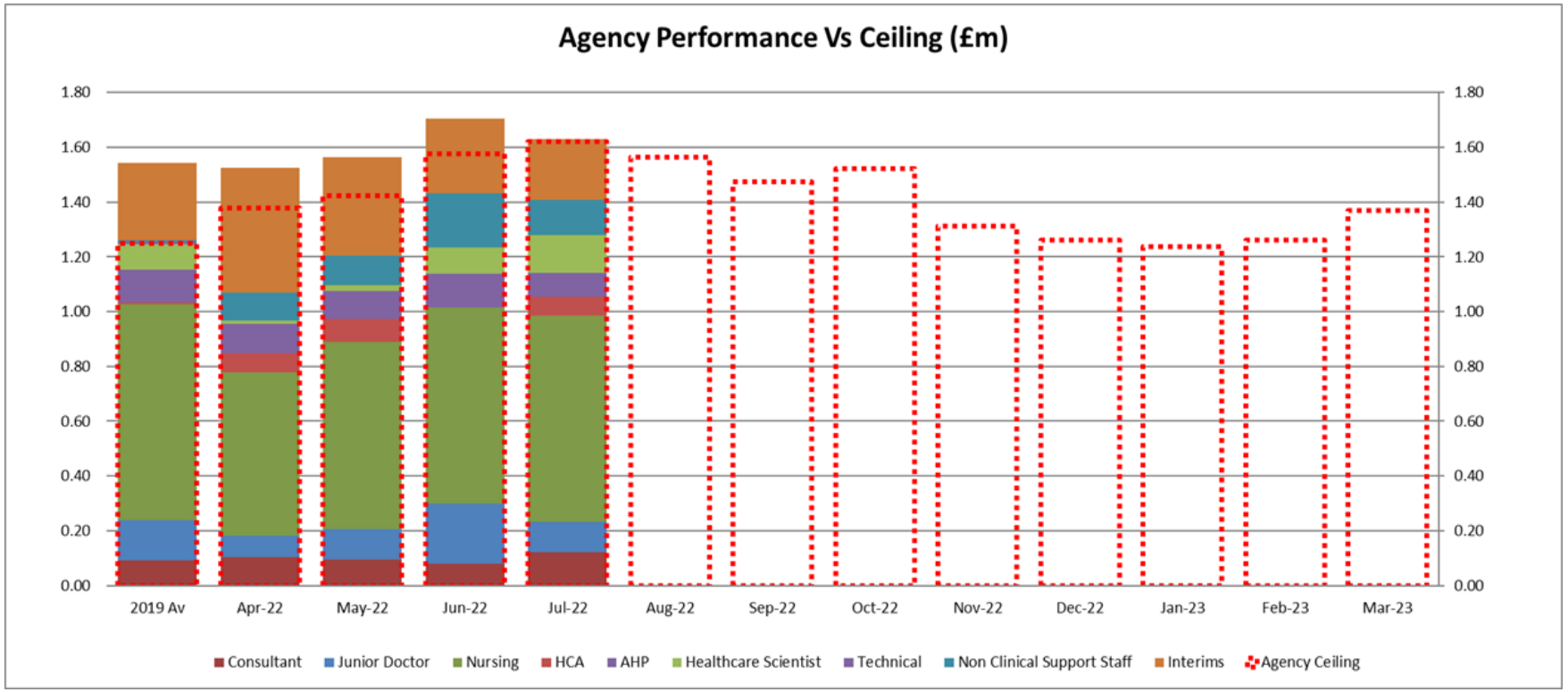
Actions and Quality Improvement Project .

- 163 starters in July. Adult nursing specific open day took place on 23rd July 2022. The next Trust recruitment open day is scheduled for Saturday 8th October and dates have been scheduled for 2023. We are working closely with Maternity services, MedCard and Maternity providing a bespoke service to increase recruitment activity and reducing Time to hire. Our Non nursing division are conducting a collaborative piece of work with Diagnostics. We are beginning work on increasing the pipeline of HCA's

.

- We continue to monitor monthly and work closely with the SWL Hub to drive compliance. Compliance has improved, overall, from 38% in April to 54% June to 72% in July. Compliance for Band 8A panels in July was at 92%. Unfortunately due to the higher volume of Band 7 panels held in July compliance was only 42%.
- There is a communication plan promoting vaccinations for all staff.

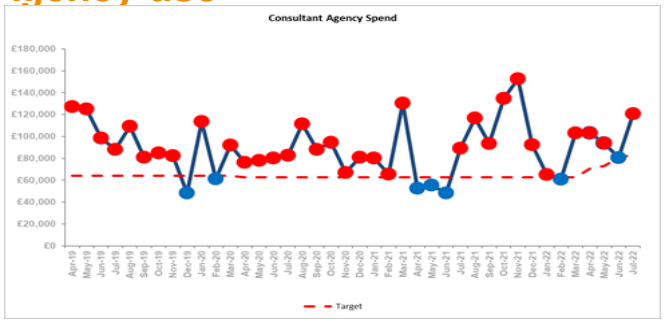
Agency use

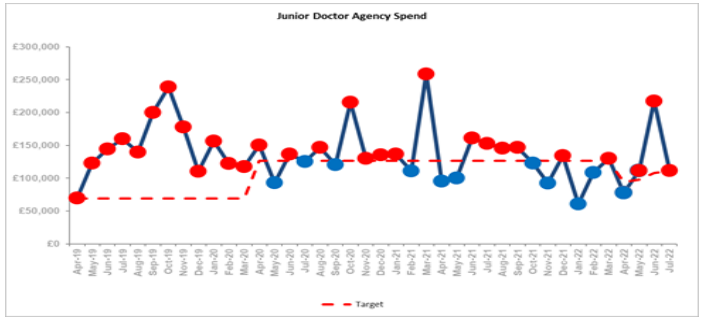


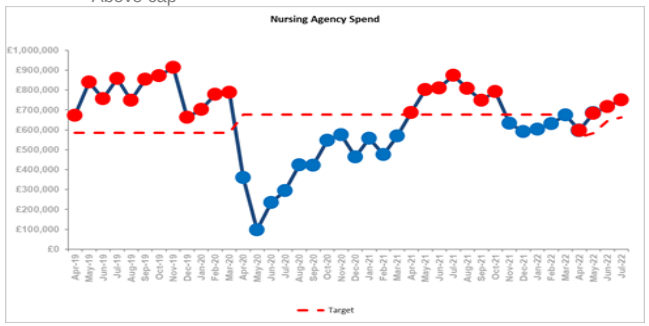
- The Trust's total pay for June was £53.10m. This is £0.20m favourable to a plan of £53.96m
- Agency cost for July was £1.63m and the monthly target set is £1.62m
- The total agency cost is worse than the target by £0.01m
- There is an internal annual agency target of £17.00m
- The biggest areas of overspend were Nursing (£0.09m) , HCA (£0.06m) and Non Clinical Support (£0.08m)

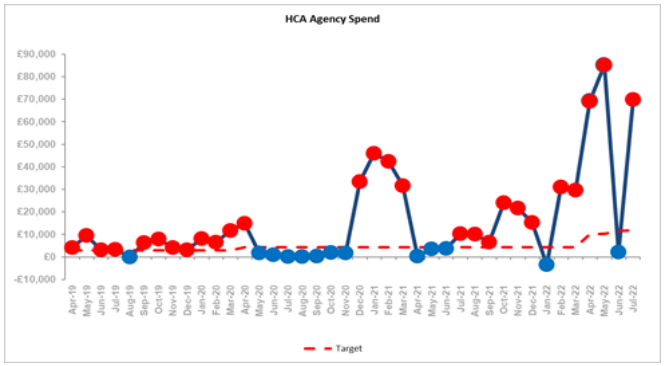
Agency use

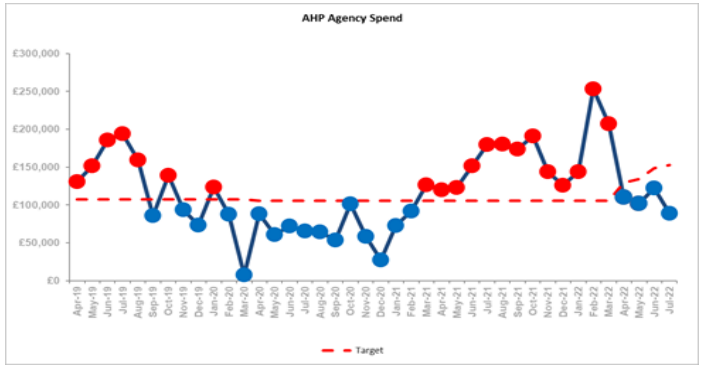
Below cap
Above cap

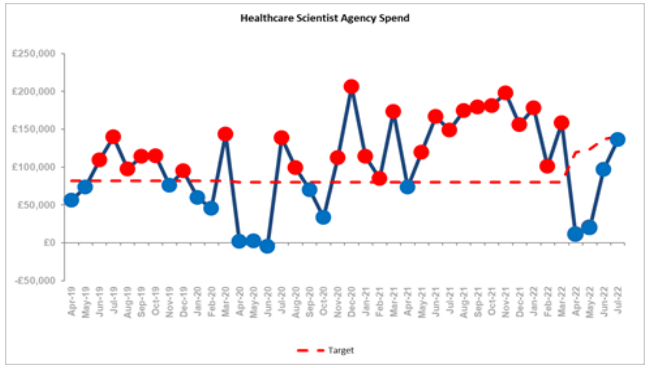


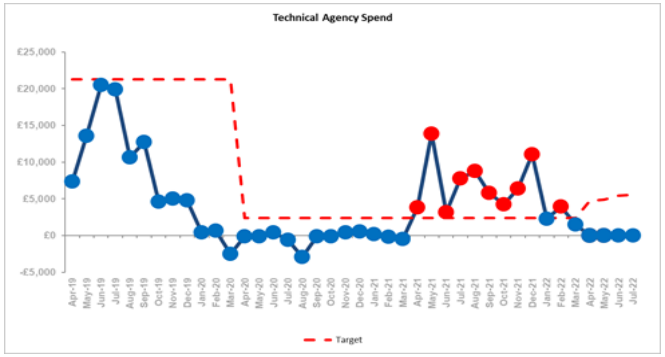


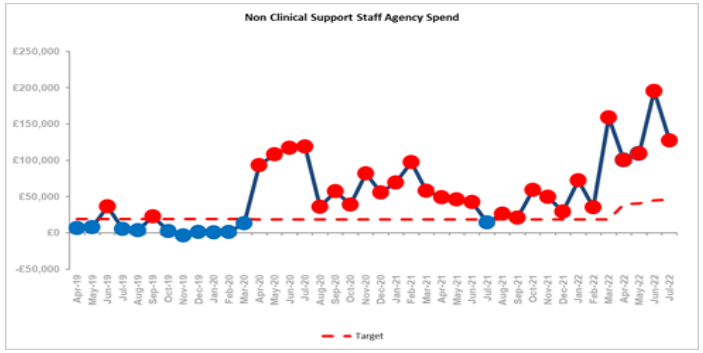


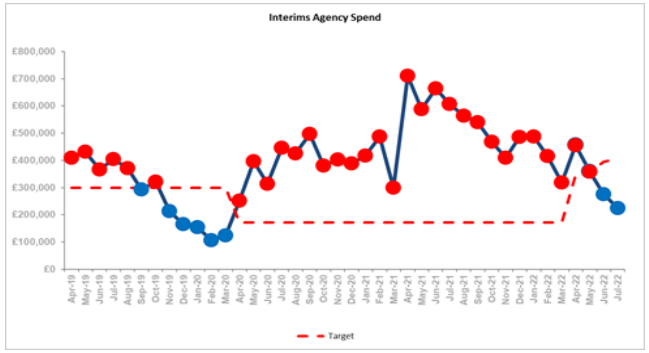






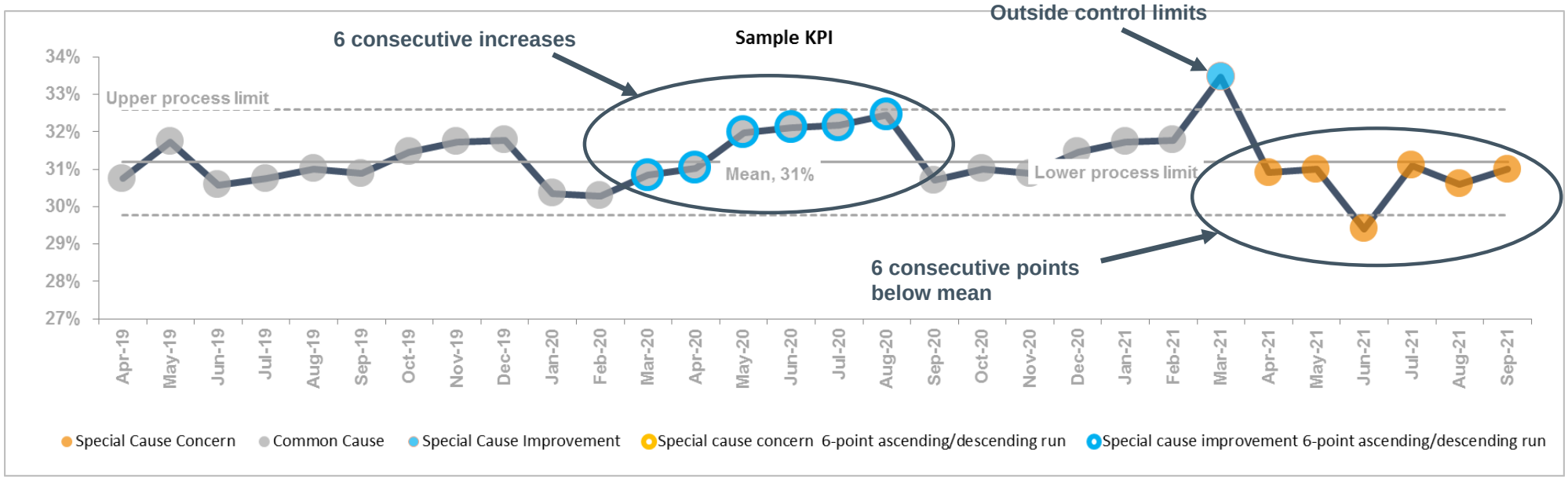






Appendix
Additional Information

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 – June 2022

14 Day Standard Performance by Tumour Site - Target 93%

Tumour Site	Target	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	No of Patients
Breast	93%	86.1%	26.9%	17.5%	30.1%	14.5%	10.3%	12.0%	25.3%	26.8%	33.3%	75.5%	87.8%	64.0%	239
Children's	93%	100.0%	100.0%	50.0%	50.0%	90.0%	100.0%	100.0%	50.0%	100.0%	100.0%	100.0%	100.0%	100.0%	4
Gynaecology	93%	91.7%	95.0%	94.5%	85.4%	88.7%	88.1%	91.3%	83.3%	79.2%	89.6%	78.6%	85.6%	76.5%	115
Haematology	93%	95.5%	79.3%	90.9%	100.0%	100.0%	95.8%	94.4%	87.5%	100.0%	100.0%	75.0%	100.0%	76.5%	17
Head & Neck	93%	93.4%	95.5%	88.1%	92.4%	93.8%	91.9%	95.3%	88.5%	89.7%	93.2%	78.4%	96.4%	96.8%	158
Lower Gastrointestinal	93%	82.2%	96.7%	95.7%	98.3%	98.3%	99.6%	100.0%	96.6%	95.4%	90.6%	89.5%	87.8%	93.3%	255
Lung	93%	93.9%	74.3%	68.2%	82.6%	85.7%	74.3%	31.3%	60.0%	76.1%	72.5%	92.5%	84.8%	84.4%	32
Skin	93%	94.5%	91.4%	94.8%	91.0%	93.7%	90.4%	88.8%	79.2%	94.4%	82.1%	76.5%	84.8%	83.3%	544
Upper Gastrointestinal	93%	97.4%	96.6%	97.2%	95.2%	96.8%	96.6%	93.4%	93.5%	94.6%	95.5%	91.1%	98.1%	97.3%	110
Urology (Suspected testicular cancer)	93%	98.3%	98.1%	88.6%	86.6%	94.4%	94.7%	92.1%	95.9%	95.7%	87.3%	75.5%	75.3%	74.6%	130

62 Day Standard Performance by Tumour Site - Target 85%

Tumour Site	Target	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	No of Treatments
Breast	85%	80.0%	83.3%	66.7%	81.3%	66.7%	54.5%	50.0%	61.5%	60.0%	61.5%	83.3%	76.5%	81.8%	11
Gynaecology	85%	60.0%	50.0%	100.0%	66.7%	40.0%	55.6%	16.7%	40.0%	40.0%	40.0%	75.0%	40.0%	28.6%	3.5
Haematology	85%	50.0%	80.0%	80.0%	100.0%	50.0%	42.9%	50.0%	55.6%	100.0%	75.0%	-	0.0%	100.0%	2
Head & Neck	85%	70.6%	50.0%	86.7%	58.3%	36.4%	56.5%	47.4%	25.0%	29.2%	82.2%	56.3%	69.2%	77.8%	9
Lower Gastrointestinal	85%	66.7%	18.2%	61.5%	70.6%	75.0%	75.0%	46.2%	50.0%	40.0%	66.7%	50.0%	28.6%	40.0%	5
Lung	85%	62.5%	25.0%	100.0%	66.7%	70.6%	70.0%	100.0%	55.6%	25.0%	80.0%	62.5%	81.8%	50.0%	3
Skin	85%	78.8%	76.5%	74.1%	89.5%	72.7%	77.5%	75.9%	70.0%	46.7%	87.5%	75.0%	74.1%	84.6%	13
Upper Gastrointestinal	85%	100.0%	100.0%	25.0%	0.0%	50.0%	0.0%	100.0%	50.0%	50.0%	30.0%	40.0%	-	0.0%	1
Urology	85%	47.8%	69.2%	55.6%	58.1%	81.3%	54.1%	62.9%	58.1%	54.5%	75.6%	85.7%	80.8%	88.0%	12.5
Other	85%	100.0%	50.0%	100.0%	100.0%	100.0%	66.7%	100.0%	100.0%	-	100.0%	80.0%	100.0%	100.0%	1.5

RTT Performance – June 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	393	27.5%	1,416	58.9%	942	867	1,810	52.1%	122	131
Urology Service	484	66.7%	2,092	83.4%	2,068	508	2,695	80.3%	21	26
Trauma and Orthopaedics Service	291	52.2%	2,222	81.8%	1,969	544	2,516	78.4%	23	4
Ear Nose and Throat Service	672	47.3%	4,777	66.7%	3,502	1,947	5,461	64.3%	203	199
Ophthalmology Service			100	78.0%	78	22	100	78.0%	0	0
Oral Surgery Service	234	44.9%	573	89.2%	616	191	828	76.3%	15	8
Neurosurgical Service	229	50.7%	2,757	61.4%	1,808	1,178	2,990	60.5%	118	66
Plastic Surgery Service	655	43.2%	845	83.8%	991	509	1,531	66.1%	88	93
Cardiothoracic Surgery Service	53	1	145	1	194	4	221	98.0%	0	0
General Internal Medicine Service			25	80.0%	20	5	27	80.0%	1	0
Gastroenterology Service	437	83.1%	2,684	71.3%	2,277	844	3,125	73.0%	53	11
Cardiology Service	1,387	39.7%	4,002	73.6%	3,496	1,893	5,427	64.9%	191	226
Dermatology Service	3	33.3%	2,950	86.9%	2,565	388	2,958	86.9%	15	2
Respiratory Medicine Service	6	100.0%	1,644	85.8%	1,416	234	1,652	85.8%	3	0
Neurology Service	51	76.5%	3,070	70.6%	2,205	916	3,153	70.7%	44	13
Rheumatology Service	6	1	1,111	91.1%	1,018	99	1,118	91.1%	6	0
Elderly Medicine Service			65	86.2%	56	9	65	86.2%	0	0
Gynaecology Service	262	60.3%	1,948	86.3%	1,840	370	2,210	83.3%	7	0
Other – Medical Services	184	77.2%	7,737	76.4%	6,055	1,866	7,989	76.4%	95	13
Other – Paediatric Services	646	44.3%	2,407	77.6%	2,153	900	3,084	70.5%	60	8
Other – Surgical Services	539	44.2%	2,470	76.3%	2,123	886	3,021	70.6%	102	110
Other – Other Services	88	68.2%	691	69.3%	539	240	809	69.2%	28	4
Grand Total	**6,620**	**50.0%**	**45,731**	**75.7%**	**37,931**	**14,420**	**52,790**	**72.5%**	**1,195**	**914**

Early Warning Score

Indicator Description	Threshold	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
Compliance with appropriate response to EWS (Adults)	100%	92.3%	91.6%	96.9%	88.5%	89.7%	78.5%	93.1%	92.9%	90.8%	91.5%	77.2%	93.2%	90.9%
Number of EWS Patients (Adults)		531	429	479	532	507	480	362	434	403	505	614	528	472

Meeting Title:	**Trust Board**		
Date:	1 September 2022	**Agenda No.**	**3.1**
Report Title:	**People Committee Report**		
Lead Director/ Manager:	Stephen Collier, Chair of People Committee		
Report Author:	Stephen Collier, Chair of People Committee		
Presented for:	Assurance		
Executive Summary:	This Report sets out a summary of the matters reviewed by the Committee at its meetings in July and August.		
Recommendation:	The Board is asked to: • Note the report • Workforce Race Equality Standard (WRES) Indicator Overview for 2021-22 (appendix 1) • Workforce Disability Equality Standard (WDES) Indicator Overview for 2021-22 (appendix 2)		
Supports			
Trust Strategic Objective:	Culture		
CQC Theme:	Well Led		
NHS System Oversight Framework:	People, Well Led		

Introduction

This is the second report from the Trust's newly constituted People Committee, following its adoption of Committee-in-Common working with Epsom and St Helier. We are making good progress on this and are now able to look across the experience and key performance indicators (KPIs) of both Trusts in order to assess performance and understand how the challenges of service delivery are being met. Of note is that increasingly these KPIs are common across both Trusts, which certainly helps the ease of comparison.

The Committee Chairs continue to alternate the chairing of meetings (rather than Chair their respective Trust's element in each meeting) and this arrangement works well in practice. Given the two-Trust coverage of meetings, time is a challenge. There also remain issues which are specific to one Trust (e.g. the HEE assessment of medical training at SGH), or where the perspective of the Trusts will differ (e.g. the SGH perspective on the Joint Bank proposal – see below) but both types of issue are being properly managed.

As previously, this Report summarises issues covered in the People Committee in Common, but reports only on matters relating to St George's University Hospitals NHS FT (unless otherwise indicated).

Risk Assurance

The Committee reviewed The Trust's Risk 1.6 and concluded that this should be segmented between the appraisal risk, and the mandatory training (MAST) risk, with a respective ratings of 16 and 12. The Board is asked to approve this segmentation of the risk, and the proposed risk ratings.

The Committee has continued to monitor progress on ensuring that all staff who are required to have been through the Disclosure and Barring Service check have been processed. There are now some 45 staff (of whom only 11 have not engaged with the process) at SGUH who either do not have a completed DBS check on file, or whose check is time-expired which represents a significant reduction on where the Trust was three months ago. Management continues to address this vigorously and the number of non-compliant staff is being reduced at pace. The Committee is not proposing to reduce the current risk rating of 16, although on present trends we would expect to be able to do so in the next two months or so. We have agreed a formal review of the position at the September meeting.

We were also assured by a Root Cause Analysis which identified systems factors and human factors which had led to the DBS failure and, critically, how changes made would prevent a recurrence.

Internal Supply

The Trust's overall vacancy rate remains below 10% (in fact in July it stood at 8.99%), which we regard as a positive position. However, vacancies in A&C and Estates remain at mid-teen levels. Rolling 12-month turnover stands at 16.15%, which is above the target of 13%. Particularly high turnover is being experienced in Clinical and AHP staff.

Sickness absence – the last available data was 4.6% in June, which is high and reflects the Covid wave then prevalent. The Committee was briefed on the change in sickness guidance from August for those with Covid, noting that new instances of Covid will be logged as sick leave, in line with other forms of sickness absence. The implications of this were discussed, against a background of a need to improve the management of sickness absence generally.

The Committee reviewed the Trust's Workforce Improvement Plan at its August meeting, and noted the progress being made in some areas. However, there remained a number of 'TBC' endorsements against some of the targets, which we understand will be completed in the next month.

The Committee discussed the need for clearer data on overall pay spend against budget and prior year as a means of tracking overall progress against the Trust's Workforce Improvement Plan, and the efficiency assumptions underpinning it. The executive has agreed to provide detailed analysis to the September meeting.

The Committee was briefed on the development of proposals for the future of the staff bank, including options for developing a joint bank across the Group. Further work is being undertaken in relation to the risks and benefits to both Trusts. A proposal will be presented to the Committee in due course.

The Committee undertook a (very) Deep Dive on the work of the South West London Recruitment Hub, and the contribution it was making to SGH. It was useful to have the ESH experience available, for comparison. It was clear that the Hub is a professional, planned and experienced unit, with a clear focus on service delivery – and uses industry standard KPIs to monitor its own performance. In discussion, it was clear that some challenges arose from hiring manager practices and delay, and the executive is addressing these so as to get best value from the Hub. It was also clear that retention is also getting focus from the executive, and they are acting on the feedback they are now getting from leavers. We took strong assurance from this Deep Dive. Although the healthcare staffing market is challenged, there were grounds for optimism in the way the Trust (and south-west London, more generally) is addressing this – and we look forward to future reports of progress in this area.

Culture Diversity and Inclusion, Organisational Development

WRES – at its July meeting the Committee reviewed the Trust's WRES data for the 12 months to March 2022. This affects potentially half of the Trust's workforce so is a critical measure of our culture and inclusion. Improvements had been realised in seven out of the nine indicators, although there had been a decline[1] in one indicator (Board composition vs workforce). The Committee noted that the gap was closing between white and BAME staff in relation to those who believed the Trust provides equal opportunities for career progression and promotion (indicator 5). In addition, the disciplinary Case Review Panel introduced in 2021 appeared to be having a positive impact on the numbers of cases entering formal disciplinary process. A snapshot of the indicators is attached in Annex 1.

The Committee also received a helpful report from the BAME Staff Network, which drew attention as a priority to the need to increase representation of BAME staff in AfC grades 8b-9. Concern with poor management practices remained a theme, and whilst it is clear that the Trust is trying to tackle this, overall progress is slow – and critically is not helping improve the experience of our staff.

WDES - the Committee reviewed the 21-22 WDES report. The Committee noted that 276 (3%) staff had self- identified as having a disability. In relation to the 13 indicators, improvements have been realised in five, no change in two and there had been a decline against six of the indicators. An action plan had been prepared to help ensure progress. Annex 2 sets out the position in 21-22, against prior years.

The Committee also received a helpful Q1 update on Diversity and Inclusion activity and initiatives at the Trust, much of which has now become business as usual. A new cohort of RIS advisors have been trained and will further expands the pool of individuals able to support recruitment and promotion interviews within the Trust.

Culture Programme Update – solid progress was being made with the Living our Values project. For

[1] There was some discussion on the accuracy of the data here, and a follow-on reassessment is being undertaken on this issue.

each of the four values, clear expectations had been set about behaviours what the Trust expected to see, loved to see, and didn't want to see. A structured delivery programme backed this up.

Health and wellbeing – the Committee received and reviewed a Q1 update on the health, wellbeing and staff support activities in place. The take-up of therapeutic 1:1 sessions remained high, and it was clear from staff feedback that these are an important part of the Trust's offering and support to staff, and much appreciated. The mediation and team conflict facility was gaining traction.

OD - We reviewed the Trust's approach to learning and development, particularly the development of our middle management tiers. We noted a broad range of management development offerings was available although the Trust had not developed clear expectations on capability for managers. We accepted that the new 'Management Fundamentals' project – which would be progressed at Group level - would go a long way to addressing this in a more systematic way. It was also noted that a number of Care Group Leads would receive Leadership Development training, as part of that Group-wide programme.

Trust Governance

Responsible Officer Report – we received a comprehensive report at the August meeting from Dr Luci Etheridge, our RO. This Report is in the Board papers for the September meeting. We noted the increasing number of deferred revalidations and, whilst not yet a problem, we agreed with Luci that we would need to turn this trend round over the next few months. We also noted the point flagged by Luci about the slightly lower than benchmark (but well up on prior year) levels of appraisals completed and the need to increase this. Against that background, we also agreed Luci's suggestion that a quarterly update from the RO to the People Committee (on an exception basis) would give an earlier line of sight on emerging issues. Joint working with ESH was providing opportunity for sharing good practice. Finally we noted Luci's promotion to Site CMO for St George's and thanked her for the excellent work done in the RO role (and also appreciated her confidence in the calibre of her successor, once appointed).

People Management Group - We continue to receive a report at each meeting from the Trust's People Management Group – this keeps us sighted on new and continuing operational issues and how the executive is managing them. It is an important part of the assurance process, in providing early warning of issues.

Stephen J Collier

Committee Chair, 24 August 2022

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NHS Foundation Trust

ANNEX 1

Workforce Race Equality Standard (WRES)
Indicator Overview

	Indicator	London Av. 2021	STG 2020	STG 2021	STG 2022	22 vs. 21
1	% of BAME staff in organisation	48.10%	46.40%	47.70%	50.10%	⬆
2	Relative likelihood of White applicants being appointed from shortlisting compared BAME applicants	1.62	1.47	1.47	1.26	⬇
3	Relative likelihood of BAME staff entering the formal disciplinary process, compared to that of White staff	1.54	2.54	1.82	1.65	⬇
4	Relative likelihood of White staff accessing non-mandatory training and CPD compared to BAME staff	0.95	1.05	1.03	TBC	
5	% of BAME staff experiencing harassment, bullying or abuse *from patients, relatives or the public* in the last 12 months.	31.10%	27.40%	27.30%	23.30%	⬇
6	% of BAME staff experiencing harassment bullying or abuse *from staff* in the last 12 months	29.80%	30.80%	30.10%	25.90%	⬇
7	% of BAME staff believing that organisation provides equal opportunities for career progression or promotion	65.40%	40.50%	41.10%	42.10%	⬆
8	% of BAME staff personally experiencing discrimination at work from *manager/leader/ or other colleagues*.	17.1	16.20%	18.00%	16.60%	⬇
9	% difference between the organisations' board voting membership and its overall workforce	-26.20%	-28.20%	-33.10%	-31.9	⬇

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ANNEX 2

2022 REVIEW: Indicator Overview

At the time of writing, St George's Hospital employs 9,606 staff, 276 of these staff members (3%) have formally declared themselves as living with a disability, while 754 (8%) did not disclose. In contrast, our 2021 Staff Survey results indicate that 15% of respondents consider themselves to have a disability. Data collected via the staff survey, Electronic Staff Records (ESR) and recruitment records have been compiled and used to report against the 10 WDES metrics below. The full set of data responses are set out in Appendix A.

		Staff with a disability				Staff without a disability		
Metric	Description	2019	2020	2021	20 vs. 21	2020	2021	20 vs. 21
1	% Disabled staff in AfC pay-bands (or medical and dental subgroups and VSMs) compared with the percentage of staff in the overall workforce (for both clinical and non-clinical groups)	2%	2%	3%	↑	90%	89%	N/A
2	Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts	1.09	1.08	1.21	↑	N/A	N/A	N/A
3	Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure	0	0	0	↑	N/A	N/A	N/A
4a.	Staff Survey Q14: % of staff experiencing harassment, bullying or abuse from patients/ service users	38.4%	35.8%	34.8%	↓	28.4%	25.4%	↓
4b.	Staff Survey Q14: % of staff experiencing harassment, bullying or abuse from managers	28.3%	23.5%	21.1%	↓	13.1%	10.0%	↓
4c.	Staff Survey Q14: % of staff experiencing harassment, bullying or abuse from other colleagues	33.5%	34.4%	31.6%	↓	20.9%	17.8%	↓
4.d	Staff Survey Q14: % of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	47.7%	49.2%	47.9%	↑	47.7%	46.2%	↑
5	Staff Survey Q15: % of staff believing that the Trust provides equal opportunities for career progression or promotion	42.4%	42.7%	40.1%	↓	50.1%	48.4%	↓
6	Staff Survey Q11: % of staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	34.0%	35.1%	35.2%	→	25.8%	23.9%	↓
7	Staff Survey Q4: % of staff saying that they are satisfied with the extent to which their organisation values their work	32.0%	34.9%	31.1%	↓	49.1%	42.2%	↓
8	Staff Survey Q28b: % of staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work	65.9%	71.5%	63.0%	↓	N/A	N/A	N/A
9	The staff engagement score for Disabled staff, compared to non-disabled staff	6.3	6.6	6.2	↓	7.1	6.9	↓
10	% difference between the organisation's Board voting membership and its organisation's overall workforce with a declared disability	-2.0%	-2.0%	-3.0%	↓	100.0%	100%	N/A

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Meeting Title:	**Trust Board**		
Date:	1 September 2022	**Agenda No**	**3.1.1**
Report Title:	**Medical Revalidation and Responsible Officer Report**		
Lead Director/ Manager:	Dr Luci Etheridge Responsible Officer		
Report Authors:	Dr Luci Etheridge Nicola McDonald, Revalidation support officer		
Presented for:	Assurance		
Executive Summary:	The Responsible Officer (RO) reports to the Board annually on progress in medical appraisal and revalidation of licensed doctors. In normal times the Trust makes a self-assessment return to NHSEI for the Annual Organisational Audit (AOA) in June. This is used to benchmark our processes and performance against other designated bodies. In March 2020 medical appraisal and all associated activities were paused. As a result, there has been no AOA in 2020 or 2021. No decision has yet been made on resumption of reporting to NHSE. However, the RO has continued to report to assure the board on activities related to revalidation of doctors. This paper is simply the Trusts self-assessment using the NHSE AOA proforma, even though this is no currently being reported to NHSE. Compliance with annual appraisal was 83% (899 connections) in 2018/19. In 2020 appraisal rates dropped to less than 50% due to the impact of the COVID pandemic. It is important to recognise that this fall was not through any lack of compliance; appraisal and revalidation was suspended nationally by NHSE and the GMC in March 2020. This Trust reinstated appraisal (before there was a national expectation to do so) in August 2020. It is now back to 82% (991 connections) but remains below the target of 90% and continues to benchmark around 5% below other similar NHS Trusts. The group with the lowest compliance is Trust Locally Employed Doctors and focused work is being done to look at the specific needs of this group, which contains a higher proportion of international medical graduates. 425 recommendations were made to the GMC in 2021/22, representing 42% of connected doctors, making 2021/22 an extremely busy year catching up after the pandemic. 129 (30%) of these were recommendations for deferral due to incomplete information. 7% of appraisals were approved missed appraisals due to either long term sickness or significant personal circumstances affecting ability to complete appraisal. Similarly, the number of second deferral requests to the GMC has risen due to sickness or circumstances preventing doctors from completing appraisals in the expected timeframe. Work is underway to support doctors to re-engage in appraisal and revalidation and reduce the high number		

	of deferrals in the next year. A key focus of the last year has been to support appraisers to work in line with the 2022 Medical Appraisal Guide. The essential principles of this are shortened written preparation, a prime focus on the appraisal as a catalyst of professional development, and an offer to the doctor to include a review of health and wellbeing as a component of professional development. To support this change in focus and ensure that emerging issues can be scrutinised, the People Committee has agreed to receive a shortened quarterly RO update on an exception basis that will highlight key trends, triangulate issues of concern and hold the RO to account for improving compliance and quality.		
Recommendations:	1. That the Board note the designated body annual board report. 2. That the Board note the planned actions for the upcoming year.		
Supports			
Trust Strategic Objective:	Right care, right place, right time Champion team St Georges		
CQC Theme:	Effectiveness and Well Led		
Single Oversight Framework Theme:	Workforce support and development		
Implications			
Risk:	Failure to ensure high quality appraisal and disciplinary processes for our doctors risks disengagement.		
Legal/Regulatory:	Failure to respond to feedback and reach an appropriate level of compliance risks scrutiny by NHSEI. Medical appraisal compliance informs the well led domain of the CQC.		
Resources:			
Previously Considered by:	PCiC	**Date**	Aug 22
Equality Impact Assessment:	N/A		
Appendices:			

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St George's University Hospitals NHS Foundation Trust

Designated Body Annual Report to the Board

Section 1 – General:

The board / executive management team of St George's University Hospitals NHS Trust can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: No action from last year. Comments: Dr Luci Etheridge continues as RO. However, a new RO will be appointed in the next 3 months as Dr Etheridge has taken up the post of site Chief Medical Officer. Action for next year: The board and GMC will be asked to approve the new appointee.

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Action from last year: Review administrative support required to ensure governance functions can be routinely met and integrated effectively with doctor engagement and development. Comments: Part time band 3 admin support since Feb 22 Action for next year: No action required

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: No action from last year. Comments: The Revalidation Support Officer regularly cross references the GMC Connect database with new starter and leaver reports. Action for next year: No action required

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: Ensure all doctors are able to access the Medical Appraisal Policy and resources to support appraisal and revalidation through the new intranet. Review the policy annually at the Responsible Officer Advisory Group.

Comments: Policy reviewed and updated. Medical appraisal intranet page built but not yet populated due to lack of time but content plan in place.

Action for next year: Admin team to populate medical appraisal intranet page with resources for appraisers and appraisees

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

Actions from last year No action from last year.

Comments: The Trust took part in the Higher Level Responsible Officer Quality Review Visit (NHSEI) in March 2020. The RO has had further contact with the HLRO team since taking up post to ensure progress against the recommendations in the action plan and it has been agreed that no further visit is required.

Action for next year: No action required

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: No action from last year

Comments: All doctors with a prescribed connection are supported with appraisal and revalidation and have access to the same governance systems. On request, the Revalidation Support Officer will complete a medical practice information transfer form for those who work at St George's but are connected to another organisation i.e. for their annual appraisal.

Action for next year: No action required

Section 2a – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes. For organisations that have adopted the Appraisal 2020 model, there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet used the Appraisal 2020 model may want to consider whether to adopt the model and how they will do so.

Action from last year: Embed Appraiser refresher training to ensure all appraisers challenge supporting information.

Comments: 115/150 appraisers have been through one of 6 available training sessions delivered by the RO team. Feedback has been sought and future training planned based on this and on results of the latest QA exercise. This year's training has been recorded for appraisers who have not been able to attend. All doctors are required to declare their full scope of work in their appraisal and should include supporting information that is proportionate to that, including information from all organisations in which they work, of any complaints and significant events they have been named in (or that they have not been named). The AaRG meet monthly and review information about doctors of concern or where additional support will be needed to ensure they meet requirements for revalidation.

Action for next year: Continue regular appraiser training linked to internal QA and feedback

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: Reassess quality in 2021/22 through annual QA exercise.

Comments: QA exercise led by Divisional Appraisal leads is ongoing, with sampling from each Division

Action for next year: Continue annual QA exercise to sample across all appraisers over 3 years

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: Publish/circulate updated Medical Appraisal Policy.

Comments: The policy has been ratified via PMG but has not yet been published online

Action for next year: Publish MAP online via the Trust intranet

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: Embed allocation of appraisers for all doctors and train new appraisers.

Comments: There are sufficient trained appraisers for 6 appraisals per year at the current number of connections. The number of connections continues to rise annually and new appraisers will be trained (jointly with ESTH to improve efficiency) in the coming year to continue to meet demand and ensure a pool of new and

diverse appraisers. Allocation is now established for senior doctors in the Trust to prevent potential COI. L2P is building a report to enable us to see when 3rd appraisals with the same appraiser are due so that we can start to actively address allocation for other doctors.

Action for next year: Begin to use L2P report and review at AaRG

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent).

Action from last year: Annual QA and review of Appraiser training attendance.

Comments: Appraiser update training is based around QA and attendance will be monitored. Going forward, appraisers are required to attend a training session every 2 years as a minimum and will be invited to review their role as appraiser if they do not attend.

Action for next year: Divisional appraisal leads will implement peer support groups for appraisers to discuss difficult appraisals. A key focus for the next year will be enabling appraisers to support wellbeing.

[1] http://www.england.nhs.uk/revalidation/ro/app-syst/

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: Report back on annual QA in the RO report to the board.
Comments: See RO annual report to PCiC for detail
Action for next year: Report back on annual QA in the RO report to the board.

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation:	
Total number of doctors with a prescribed connection as at 31 March 2021	**991**
Total number of appraisals undertaken between 1 April 2020 and 31 March 2021	**767**
Total number of appraisals not undertaken between 1 April 2020 and 31 March 2021	**225**
Total number of agreed exceptions	**73**

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: No action from last year
Comments: Continue with process for review through AaRG 3 months in advance of revalidation date. The number of revalidation recommendations between April 2020 and March 2021 **totalled 425.** 1 was submitted a day late due to an administrative error. The number of recommendations to revalidate **totalled 296** The number of recommendations to defer **totalled 129.**

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There were no recommendations of non-engagement.

Action for next year: Reduce deferrals and missed appraisals further by continuing active support through AaRG and tackling at risk groups eg LEDs

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: No action from last year

Comments: The Revalidation Support Officer will inform each doctor of what recommendation has been submitted. In the majority of cases where a deferral is necessary, the Revalidation Support Officer will communicate this to the doctor beforehand and the Divisional Appraisal Lead will give the doctor a clear action plan and timeframe to achieve by the next due date. The RO contacts the doctor directly in cases where they are deferred because they are subject to an ongoing process or where they are failing to meet the requirements of an action plan and are at risk of non-engagement.

Action for next year: No action required

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: Continue implementation of the action plan arising from the clinical governance review.

Comments: Actions from the first two parts of the governance review have been implemented. Outstanding areas from the 3rd part are mainly around the linking up of care group, Divisional and Trust governance:

- Insufficient support for clinical governance at care group level
- Clinical Governance leads are unable to attend key meetings because of clinical commitments
- Items on the local risk registers ae not escalated to Divisional level
-The outputs from LfD/MMG are not shared at Divisional level
- The Quality and Safety strategy does not drive improvement at Divisional, Directorate or Care group level

Action for next year: Work with the site and Group CMO and Divisional Chairs to continue implementation of the action plan arising from the clinical governance review.

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: Embed processes for review of performance of doctors through the Responsible Officer Advisory Group and recruit a lay representative to this group. Comments: Review of performance happens effectively through AaRG and the Trust Responding to Concerns group and policy supports this. PCiC has been asked to consider an alternative proposal this year to improve accountability of the RO to stakeholders for conduct and performance of doctors. Action for next year: Ensure a clear process is agreed for holding the RO to account

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: Review MHPS policy to include the RtC group and ensure clarity about its remit and function within the organisation. Comments: The MHPS policy is still in negotiation with the LNC. However, processes have been established with ER teams to support the response to concerns about doctors raised in any capacity and clinical lead development sessions have focused on this. Action for next year: Agree MHPS policy with the LNC to include the RtC group and ensure clarity about its remit and function within the organisation.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[2]

Action from last year: Finalise MHPS policy to include RtC group and agree and standardise steps and support for informal action within Divisions. Audit referrals to the RtC group, including for the impact of diversity and inclusion policies on referrals and outcomes. Comments: Audit completed from July 2021. Dido Harding template adopted when any decision is made about next steps. Processes have been established with ER teams to support the response to concerns about doctors raised in any capacity and clinical lead development sessions have focused on this. Action for next year: Agree MHPS policy with the LNC to include the RtC group and ensure clarity about its remit and function within the organisation.

[2] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[3]

Action from last year: No action from last year Comments: Where a doctor works for multi-organisations, information of note is transferred from RO to RO using a MPIT form. Action for next year: No action required

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: No action from last year Comments: Dido Harding template adopted when any decision is made about next steps. Action for next year: Ongoing monitoring of RtC referrals and outcomes and work with ESTH to agree shared action plan

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: No action from last year Comments: The Medical Staffing Team carry out the 6 NHS Employment Check Standards that outline the type and level of checks employers must carry out before recruiting staff into NHS positions. Action for next year: No action required

Section 6 – Summary of comments, and overall conclusion

[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

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Summary of last year's actions

Area of AOA	Action	Completion date	Progress
General	Improve the overall % of completed appraisals to achieve 90% category 1 completion, in line with the average for same sector designated bodies.	June 2022	82% inc from 67.58%
General	Review administrative support required to ensure governance functions can be routinely met and integrated effectively with doctor engagement and development.	March 2022	PT band 3 admin support since Feb 22
Effective appraisal	Ensure all doctors are able to access the Medical Appraisal Policy and resources to support appraisal and revalidation through the new intranet. Review the policy annually at the Responsible Officer Advisory Group.	March 22	Policy reviewed and ratified but intranet page not yet completed
Effective appraisal	Embed Appraiser refresher training to ensure all appraisers challenge supporting information.	March 22	Regular training established
Effective appraisal	Reassess quality in 2021/22 through annual QA exercise and report back to board on results	June 22	ASPAT used annually to sample across all appraisals
Effective appraisal	Embed allocation of appraisers for all doctors	March 22	All senior doctors and doctors in difficulty allocated appraiser, L2P building a report to highlight doctors completing 3rd appraisal with one appraiser
Medical governance	Review MHPS policy to include the RtC group and ensure clarity about its remit and function within the organisation.	March 22	New policy being reviewed with LNC, changes made to improve transparency of processes
Medical governance	Embed processes for review of performance of doctors through the Responsible Officer Advisory Group and recruit a lay representative to this group	June 22	See report for alternative recommendation
Medical governance	Audit referrals to the RtC group, including for the impact of diversity and inclusion policies on referrals and outcomes.	June 22	Audit completed, actions to be discussed as part of joint working with ESTH

This year's actions

Area of AOA	Action	Completion date	Progress
General	Admin team to populate medical appraisal intranet page with resources for appraisers and appraisees	**June 23**	
Effective appraisal	Continue regular appraiser training linked to internal QA and feedback.	**June 23**	
Effective appraisal	Continue annual QA exercise to sample across all appraisers over 3 years	**June 23**	
Effective appraisal	Publish MAP online via the Trust intranet	**June 23**	
Effective appraisal	Begin to use L2P report and review at AaRG	**June 23**	
Effective appraisal	Divisional appraisal leads will implement peer support groups for appraisers to discuss difficult appraisals. A key focus for the next year will be enabling appraisers to support wellbeing.	**June 23**	
Effective appraisal	Report back on annual QA in the RO report to the board.	**June 23**	
GMC	Reduce deferrals and missed appraisals further by continuing active support through AaRG and tackling at risk groups eg LEDs	**June 23**	
Medical governance	Work with the site and Group CMO and Divisional Chairs to continue implementation of the action plan arising from the clinical governance review.	**June 23**	
Medical governance	Ensure a clear process is agreed for holding the RO to account	**June 23**	
Medical governance	Agree MHPS policy with the LNC to include the RtC group and ensure clarity about its remit and function within the organisation.	**June 23**	
Medical governance	Ongoing monitoring of RtC referrals and outcomes and work with ESTH to agree shared action plan	**June 23**	

Section 7 – Statement of Compliance:

The Board / executive management team St George's University Hospitals NHS Foundation Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

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Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: _ _ _ _ _ _ _ _ _ _ _

Name: _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _

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Meeting Title:	**Trust Board**		
Date:	1 September 2022	**Agenda No**	**4.1**
Report Title:	**Audit Committee Report**		
Lead Director/ Manager:	Peter Kane, Chair of the Audit Committee		
Report Author:	Peter Kane, Chair of the Audit Committee		
Presented for:	Review		
Executive Summary:	The report sets out the key issues discussed and agreed by the Committee at its meeting on 28 July 2022.		
Recommendation:	The Board is asked to note the report of the Committee's meeting held on 28 July 2022.		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	Well Led		
Single Oversight Framework Theme:	Finance and use of resources, Leadership and Improvement capability (Well Led)		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A
Appendices:	None.		

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St George's University Hospitals NHS Foundation Trust

Audit Committee Report
Trust Board, 1 September 2022

Matters for the Board's attention

The Audit Committee met on 28 July 2022 and agreed to bring the following matters to the attention of the Board.

1. Internal Auditors Reports

The Committee considered the following reports from internal auditors:

- Internal Auditors Progress Reports and Recommendation Tracker
- Consent (Limited Assurance)
- Mortality (Reasonable Assurance)
- Board Assurance Framework (Reasonable Assurance)
- Freedom to Speak Up (Reasonable Assurance)

Of the four internal audits reviewed, three were rated as '*reasonable assurance'* and the management had reasonable plans in place to address any outstanding issues. In relation to Consent, the Committee expressed concern that the timings of the recommendations were not pacey enough and this was a particular cause for concern given the importance of this and the risk exposure presented. It was suggested that further consideration should be given to escalation to the Executive to explore if more support should be given to the DCMO to complete the actions required. The Committee noted that the Patient Safety and Quality Group would consider the audit findings at its meeting in August, and in addition it referred the matter for consideration at the Quality Committee at its September meeting and agreed that the Board should also be made aware of the risks presented.

With regards to the Board Assurance Framework, the Committee noted the findings of the audit which documented the improvements in the BAF that had been implemented over recent years. The Committee further noted work in progress to review the BAF and the CRR used as complementary elements within risk management, and that a common approach across the new hospital group was being developed and would be informed by an independent review of risk management.

The Committee noted that a number of improvements had been made with regards to Freedom to Speak Up since the previous *'limited assurance'* rating in this area. The report highlighted a number of areas of good practice demonstrated by the Trust, including in relation to the Board-approved strategy, governance and reporting arrangements to Board Committees, and oversight of internal controls. There remained scope for further progress on two key issues: the impact of staff perceptions in seeing the value in speaking up, and the delays with investigations into concerns raised through FTSU, particularly where these resulted in the commencement of formal HR processes.

2. Internal Compliance and Assurance

2.1. Breaches & Waivers

The Committee considered the regular breaches and waivers report for Q1 2022/23. Waiver usage had decreased in Q1 both in terms of frequency and value, while the number of breaches had increased.

It was reported that there was an on-going review of the contracts register to ensure that pre-emptive action was taken to mitigate the risk of potential breaches or waivers. Staff training and engagement activities were also continuing.

2.2. Counter Fraud Quarterly Report

The Committee considered a regular report on progress with current counter fraud cases under investigation. The Committee noted the progress on compliance with counter fraud training which was now included on the list of mandatory and statutory training. Roll out of the training had been arranged over three phases with high-risk departments (finance, estates and procurement) in the first tranche. 80% compliance across the three cohorts was expected by March 2023.

The Committee noted that the Counter Fraud Functional Standard return for 2021/22 had been submitted to NHSCFA. The overall Trust rating had been scored as Green.

The main area of on-going concern related to mandate fraud which was affecting every Trust. The Committee heard that SGUH has robust processes in place on the setting up of new suppliers and for changing bank details, which provided a robust defence.

2.3 Applying the Scheme of Delegation in the Group Structure

The Committee received an update on how the Trust had interpreted the new Group structure and roles and had mapped these into the existing financial limits within the Scheme of Delegation (SoD). A more comprehensive review of the SoD as a whole was planned for later in the year.

3 Information Governance

3.1 Information Governance Compliance Update and Annual Report

The Committee received the annual report for 2021/22 highlighting the Trust's compliance against the data security and protection toolkit requirements and noted that the Trust had reported itself compliant. In addition, work had continued at pace on Cyber Essential Plus accreditation even though it had become a non-mandatory requirement for 2021/22.

In the financial year 2021-22 there had been 831 IG incidents and it was suggested that benchmark data for similar Trusts would provide a useful comparison as it was difficult to know if the figure was high or reasonable for a Trust of this size and complexity.

3.2 Cyber Security Update

The Committee received an update report, which included the new cyber security dashboard and progress against the improvement summary and delivery plan. The Committee noted that patching remained a major concern and the Trust's exposure score was above 70% against the target of 40%. An automated patching solution had been deployed which avoided the need for manual patches and significant progress had been made since its implementation. The Committee heard that there was more work to be done to complete the upgrade to Windows10 and that this work was being monitored by NHS Digital, which was content with the plan for completion and implementation progress to date.

As both the infrastructure at SGUH and the cyber threat were changing at a fast pace, the Committee welcomed the development programme for IDT staff to ensure that staff remained as up to date as possible, accepting that in the fast-paced world of cyber security a very different threat could emerge very quickly.

4 Joint Internal Audit Tender

Committee agreed that a common tender for internal audit across the Group should be conducted and agreed the process and timelines for this, including approving the draft

tender document. The tender was due to go live in mid-August and recommendations for the award of a contract were scheduled to be considered by the Committee at its meeting on 27 October.

Recommendation

The Board is asked to note the report of the Committee's meeting held on 28 July 2022.

Peter Kane
Audit Committee Chair, NED
September 2022

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Meeting Title:	**Trust Board**		
Date:	1 September 2022	**Agenda No**	**4.2**
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 meetings on 22nd July 2022 and on 19th August 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		

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St George's University Hospitals
NHS Foundation Trust

Finance Committee – July & August 2022

The Committee met on 22nd July 2022 & 19th August 2022 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;
- Costing updates from both sites;
- Renal Business Case Update;
- Paediatric Cancer update;
- SGH Cancer performance update;
- Procurement quarterly update;
- A Group Cash update;
- A Big Projects review; and
- A CDC update;

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 July members undertook a deep dive into the IDT & Operational risks. Operational risk discussion focussed on the pressures of Emergency and Elective care at the site. IDT risks included Trust WIFI, Cyber Security, and Disaster Recovery. Members were assured that mitigations were receiving sufficient executive focus.

While no deep dive on Finance and Estates risks were presented at the meetings, exception reports highlighted the continued challenge of delivering the 2022/23 financial plan, and the generator fire that was dealt with effectively by Estates staff (of which the committee paid tribute to two in particular).

The Committee discussed current financial performance, cash management and capital expenditure as the Trust reported M4 financial performance in 2022/23.

- **The Committee wishes to bring the following items to the Board's attention:**

1.1 Board Assurance Framework Risks – the SGH Managing Director and SGH CIO both updated the committee on their strategic risks, with score and assurance rating agreed as follows:

  - SR3- Operational & IDT risk 20 - Partial Assurance

1.2 Estates Report –the Director of Estates & Facilities SGH (DE&F SGH) introduced the normal monthly updates, including progress being made with big capital projects such as MRI and the Cath Labs.

1.3 Activity Performance – the SGH COO noted the expected performance against activity trajectories in July, where Daycase/ Elective performance is expected to be slightly ahead of target (at 101% compared to 100% target) and Outpatient performance is expected to be behind target (at 95% compared to 100%).

1.4 Emergency Department (ED) Update – the performance of the Emergency Care Operating Standard was recorded at 72.2% in July. The Committee noted that the Trust continues to see significant challenges impacting waiting times from ambulance handovers.

1.5 Diagnostics Performance – the SGH COO noted that 5.8% of patients were waiting longer than six weeks to have a diagnostic test in July against a national recovery target of 5%.

1.6 Cancer Performance – the COO noted Cancer performance in June, where the Trust continues to be challenged in both 14 day and 62 day performance. **A deep dive report in July's Committee noted the expectation of delivering the 62 day performance target in Q1 of 2023/24.**

1.7 Referral to Treatment (RTT) Update – the performance against the RTT target was discussed, where the number of patients waiting over 52 weeks was 914 in June, 22 lower than May. 48 patients are waiting more than 78 weeks at June's end, with this expected to reduce to 0 by March 2023.

1.8 Financial Performance– the Group Chief Financial Officer (GCFO) noted performance in M4 2022/23, where a YTD deficit of £21.5m was reported in line with the recently resubmitted plan, apart from a £4.5m adverse variance for ERF underperformance.

He noted the cash balance as at 31st July 2022 was £70.6m, noting the potential challenge on cash should the savings targets later in the year not be delivered.

He also noted the capital position to date was an underspend of £0.4m, with total expenditure at £14.1m.

1.9 Cash update– the GCFO introduced a paper that outlined some scenarios for SGH cash balance in the coming months, dependent on the delivery of CIP. The Committee welcomed the update and low risk to accessing loan funding from NHSE/I should this be needed.

1.10 Planning 2022-23 – the GCFO noted the progress being made on planning for 2022/23, mainly focussed on CIP delivery and other risks. He noted the 4% CIP delivery achieved so far. The Committee noted the mitigations in place and risk profile of the Trust as the Trust forecasts a year end outturn.

1.11 Costing update – at July's Committee the SGH SCFO introduced the costing update for SGH, which noted delays in creating the new costing database in-house and the impact this could have on the annual submission (for which the deadline is 9th August). **The Committee noted their contentment that the submission be made in early September if needed, and gave delegated responsibility to the GCFO to make this submission.**

1.12 Procurement Report – the AD – SWLPP noted progress being made with CIP delivery and Breaches/Waivers.

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,
September 2022

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St George's University Hospitals NHS Foundation Trust

Meeting Title:	**TRUST BOARD**		
Date:	1 September 2022	**Agenda No**	**4.3**
Report Title:	**SGH Financial Performance M4 2022/23**		
Lead Director/ Manager:	Andrew Grimshaw		
Report Author:	Tom Shearer		
Presented for:	Update		
Executive Summary:	The Trust is reporting a deficit of £21.5m at the end of June, which is on £4.5m adverse to plan. The shortfall is due to lower ERF income as a result of the Trust not meeting its ERF target. This is consistent across South West London. Excluding ERF, income is reported at £1.0m favourable to plan at Month 4. This is due to additional funding to cover COVID Testing and Vaccination costs. Expenditure is reported at £0.9m adverse to plan at Month 4. This is due to higher Junior Doctor and Nursing premium temporary costs, and additional COVID Testing and Vaccination costs. Only modest CIPs are planned for M4. However, pressures in the base budget and the scale of the challenge give cause for considerable concern Capital expenditure of £14.1m has been incurred year to date. This is £0.4m less than the budget of £14.5m At the end of Month 4, the Trust's cash balance was £70.6m. Cash resources are tightly managed and will continue to be monitored.		
Recommendation:	The Trust Board notes the M4 position for 2022/23.		
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:	Group Fin Comm	**Date**	19/8/22
Appendices:	N/A		

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Trust Board: Public meeting
St. Georges Hospitals NHS Foundation Trust

Financial Performance to month 04 (July)

GCFO, SGH Site CFO

2th September 2022

SGH
Summary metrics

Area	Key Issues	Current Month (YTD)	Previous Month (YTD)
Financial Position (year to date)	The Trust is reporting a deficit of £21.5m at the end of June, which is on £4.5m adverse to plan. The shortfall is due to lower ERF income as a result of the Trust not meeting its ERF target. This is consistent across South West London.	£4.5m Adv to Plan	£4.5m Adv to Plan
Income	Excluding ERF, income is reported at £1.0m favourable to plan at Month 4. This is due to additional funding to cover COVID Testing and Vaccination costs.	£1.0m Fav to plan	£0.9m Fav to plan
Expenditure	Expenditure is reported at £0.9m adverse to plan at Month 4. This is due to higher Junior Doctor and Nursing premium temporary costs, and additional COVID Testing and Vaccination costs.	£1.0m Adv to plan	£0.9m Adv to plan
Cost Improvement Programme	Only modest CIPs are planned for M4. However, pressures in the base budget and the scale of the challenge give cause for considerable concern	To note risk against the scale of the ask	To note risk against the scale of the ask
Capital	Capital expenditure of £14.1m has been incurred year to date. This is £0.4m less than the budget of £14.5m	£0.4m Fav to plan	£0.3m Fav to plan
Cash	At the end of Month 4, the Trust's cash balance was £70.6m. Cash resources are tightly managed and will continue to be monitored.	£70.6m £2.1m higher than Y/E	£56.2m £12.3m lower than Y/E

Month 4 Financial Performance

SGH

			Full Year Budget (£m)	M4 Budget (£m)	M4 Actual (£m)	M4 Variance (£m)	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)
Excluding ERF	**Income**	SLA Income	858.4	75.0	74.4	(0.6)	290.3	291.1	0.9
		Other Income	144.1	8.5	9.2	0.7	43.8	44.0	0.1
	Income Total		**1,002.5**	**83.5**	**83.6**	**0.1**	**334.1**	**335.1**	**1.0**
	Expenditure	Pay	(609.7)	(53.3)	(53.1)	0.2	(215.2)	(215.3)	(0.1)
		Non Pay	(347.8)	(30.0)	(30.3)	(0.3)	(122.6)	(123.5)	(0.9)
	Expenditure Total		**(957.5)**	**(83.3)**	**(83.4)**	**(0.1)**	**(337.8)**	**(338.8)**	**(1.0)**
	Post Ebitda		(71.1)	(5.3)	(5.3)	(0.0)	(21.9)	(21.9)	0.0
	Grand Total		**(26.1)**	**(5.1)**	**(5.1)**	**0.0**	**(25.7)**	**(25.6)**	**0.0**
ERF	**Income**		26.1	2.2	2.1	(0.1)	8.7	4.2	(4.5)
	Reported Position		**0.0**	**(3.0)**	**(3.0)**	**(0.0)**	**(16.9)**	**(21.5)**	**(4.5)**

Trust Overview

The in month reported position at **M4 is a £3.0m deficit, which is on plan. The YTD position is a £21.5m deficit, which is £4.5m adverse to plan**.

The Trust has received £4.2m of ERF income, which is £4.5m under plan. This is due to the Trust not meeting its ERF target. This is consistent across South West London.

Excluding ERF income and costs:

- **Income** is £1.0m above plan, due to additional funding to cover COVID Testing and Vaccination costs.
- **Pay** is £0.1m overspent across Junior Doctor and Nursing staff groups due to premium temporary costs.
- **Non-pay** is £0.9m overspent due to additional COVID Testing and Vaccination costs.

Statement of Financial Position as at 31st July 2022

SGH

Statement of Financial Position	Note	M12 March-22 FY 21-22 Actual Audited (£m)	M04 July-22 FY22-23 YTD Actual (£m)	Movement YTD July-22 (£m)
Non current asset				
PPE	1	392.6	393.5	0.8
On SoFP PFI	1	51.2	50.5	(0.6)
Intangible Assets	1	43.5	40.6	(2.9)
IFRS16 ROU Assets	2	164.0	164.0	0.0
Other Non Current Asset	3	1.4	1.4	0.0
TOTAL NON CURRENT ASSET		**652.6**	**649.9**	**(2.7)**
Current assets				
Stock	4	15.1	17.1	2.0
Debtors	5	82.6	84.0	1.4
Cash	6	68.5	70.6	2.0
Total Current Assets		**166.2**	**171.6**	**5.5**
Current liabilities				
Creditors	7	(150.1)	(191.6)	(41.5)
Capital creditors	8	(32.6)	(19.5)	13.0
Int payable creditor	9	(0.1)	(0.1)	0.1
PDC div creditor	10	0.0	(4.0)	(4.0)
Provision<1 Year	11	(0.6)	(0.6)	0.0
Borrowings< 1 year	12	(18.8)	(18.8)	0.0
Total current liabilities		**(202.2)**	**(234.6)**	**(32.4)**
Net current assets/-liabilities		**(36.0)**	**(62.9)**	**(26.9)**
Provisions> 1 year	11	(2.2)	(2.2)	(0.0)
Borrowings> 1 year	12	(206.3)	(198.5)	7.8
Total Long-term liabilities		**(208.4)**	**(200.6)**	**7.8**
Net assets		**408.2**	**386.4**	**(21.8)**
Taxpayer's equity				
Public Dividend Capital		565.8	565.8	0.0
Revaluation Reserve		73.6	73.6	0.0
Other reserves		1.2	1.2	0.0
Income & Expenditure Reserve		(232.5)	(254.3)	(21.8)
Total taxpayer's equity	13	**408.2**	**386.4**	**(21.8)**

M04 FY22-23 YTD Statement of Financial Position Notes

Note 1: Fixed assets decreased by £2.7m since March-22. This includes the impact of depreciation £16.9m, capital expenditure £14.1m and Grove reversionary interest of £69k.

Note 2: IFRS16 ROU leased assets present value of £164m added to fixed assets from 01st April 2022.

Note 3: No movement in Other Non Current Asset and it relates to Clinical Tax Reimbursement provision.

Note 4: Inventory value increased by £2.0m compared to Mar-22. This is due to increase in pharmacy, central store, perfusion, cardiac catheter and cardiac pacing stocks.

Note 5: Debtors has increased by £1.4m since March 2022, this is due to increase in NHS trade receivables and NHS prepayments however there is a significant decrease in NHS accrued income.

Note 6: The cash position is £2m higher than reported at year-end in March-22. YTD July-22 payment received from NHS England £123m, NHS SW London ICB £146m, NHS SE London ICB £12m and NHS SU Heartland CCG £6.8m for the block payment, Covid-19 top-up and other invoices. Cash resources are tightly managed monthly to meet the £3.0m minimum cash target at the end of the year.

Note 7: Creditors are £41.5m higher than the figures reported at year-end in March-22. There is a significant increase in NHS and Non-NHS Accruals since March-22. Other liabilities (deferred income) increased by £1.8m since March-22. March-22 creditors were low due to HMRC, and NHS Pension liability was paid in same period as compared to July-22.

Note 8: Capital creditors are £13m lower than March-22. This decrease is due to FY 21-22 capital creditors paid in FY22-23.

Note 9: No Significant movement in interest payable movement due to small YTD outstanding loan value due for DHSC capital and LEEF loan.

Note 10: PDC dividend charge creditor increased to £4m since March-22. This is due to the M04 YTD PDC dividend charge accrual of £4m. This accrual is based on the FY22-23 forecasted PDC dividend charge of £12m. No PDC charge payment made to date.

Note 11: No significant movement in provision.

Note 12: No new borrowing since March-22. IFRS16 ROU lease liability of £164m added to the borrowings.

Note 13: Net taxpayer's equity decreased by £21.8m in M04 YTD. This is mainly due the I&E YTD M04 deficit of £21.8m. M04 YTD I&E deficit, includes finance expense and PDC dividend charges. No PDC drawdown made in respect of this YTD deficit.

Month 4 Cash Flow Statement

SGH

Statement of Cash Flow	M04 YTD FY 22-23 Actual £m
Opening Cash balance	**68.5**
Income and expenditure deficit	(21.8)
Depreciation	16.9
Impairment	0.0
Interest payable	1.6
PDC dividend	4.0
Other non-cash items	(0.1)
Operating surplus/(deficit)	**0.6**
Change in stock	(2.0)
Change in debtors	(1.4)
Change in creditors	41.5
Change in provisions	(0.0)
Net change in working capital	**38.0**
Capital spend	(14.1)
Capital Creditors	(13.0)
Capital additions Finance leases	0.0
Interest paid	(1.6)
PDC dividend charge paid	0.0
Net change in investing activities	**(28.8)**
PDC Capital Received	0.0
Accrued Interest YTD (DH & LEEF)	0.0
DH Capital £14.747m Loan repaid	(0.3)
LEEF Loan (Other Loan)	(0.7)
PFI	(0.5)
Finance lease payments	(6.4)
Net change in financing activities	**(7.9)**
Cash balance as at 31.07.22	**70.6**

M04 FY22-23 YTD cash movement

- The cumulative M04 22-23 I&E deficit is £21.8m. (*NB this includes the impact of donated grants and depreciation, which is excluded from the NHSI performance total).
- Within the I&E deficit of £21.8m, depreciation (£16.9m) does not impact cash. The charges for interest payable (£1.6m) and PDC dividend (£4.0m) are added back and the amounts actually paid for these expenses shown lower down for presentational purposes. This generates a YTD cash "operating deficit" of £0.6m.
- The net change in working capital has increased to £38m in July-22 compared to £35.5m in March-22. This is due to major movement in creditors of £41.5m, which is due to the increased NHS and Non-NHS accruals and HMRC and NHS Pension liability in July-22 compared to March-22.
- Stock value increased by £2.0m in July-22 compared to March-22. This is due to significant increase in central store, perfusion, cardiac catheter and cardiac pacing stocks .
- Trust paid DH Capital loan repayment of £0.3m YTD July-22. LEEF loan repayment of £0.7m paid in July-22. In addition, until July-22, Trust made a repayment of £0.5m for PFI and IFRS16 lease payment of £6.4.
- Capital creditors reduced by £13m compared to £32.6m in March-22.
- No PDC funding received until July-22 for FY22-23.

July-22 cash position

- The Trust achieved a cash balance of £70.6m on 31st July-22, £67.6m higher than the £3m minimum cash balance required by NHSI. This is due to the July-22 block contracts income including Covid-19 top-up received from CCG and NHS England.

M4 Capital

SGH

The Trust is planning to spend £45.98m on capital expenditure this financial year, including £4.5m on leases.

This spend is to be funded by Internal capital of £21.37m, leases of £4.5m, planned donated spend of £500k and new PDC allocation of £20.10m.

The spend is planned to cover a number of spending initiatives this year covering IT Medical Equipment and estate infrastructure.

The Trust has spent £14.09m YTD as at M04.

Trust continues to exert tight control over capital expenditure, approving requisitions for all projects.

Spend Category	YTD Budget £000	YTD Actual £000	YTD Variance £000
Infrastructure	1,064	1,848	-784
IT	2,616	3,970	-1,354
Medical Equipment & Other	2,372	176	2,196
Capital Projects	8,440	8,098	342
Grand Total	**14,492**	**14,093**	**399**