Outstanding care every time

St George's University Hospitals NHS Foundation Trust

Trust Board Meeting in Public
Agenda

Date and Time: **Thursday 3 November 2022, 10:00 – 13:50**
Venue: **Hyde Park Room, 1st Floor, Lanesborough Wing, St George's Hospital, Tooting**

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 Learning from Deaths Report Q1 2022/23**	**GCMO**	Assure	Report
11:00	**2.2**	**Maternity Services: Perinatal Quality Surveillance Measures September 2022***	**GCNO**	Assure	Report
11:10	**2.3**	**Integrated Quality and Performance Report***	**MD-SGUH**	Assure	Report
11:20	**2.4**	**Winter Plan***	**MD-SGUH**	Assure	Report
3.0 CULTURE					
11:30	**3.1**	**People Committee-in-Common Report**	**Committee Chair**	Assure	Report
		3.1.1 Workforce Disability Equality Standard (WDES) and Workforce Race Equality Standard (WRES) Key Findings	**GCPO**	Assure	Report
		*3.1.2 Nursing Revalidation**	**GCNO**	Assure	Report
4.0 COLLABORATION					
12:10	**4.1**	**Audit Committee Report**	**Committee Chair**	Assure	Report
12:20	**4.2**	**Finance Committee-in-Common Report**	**Committee Chair**	Assure	Report
12:30	**4.3**	**Finance Report (Month 6)***	**GCFO**	Review	Report
12:40	**4.4**	**Corporate Objectives 2022/23**	**GDCEO**	Approve	Report
12:45	**4.5**	**Horizon Scanning Report**	**GCCAO**	Note	Report
12:55	**4.6**	**Board Assurance Framework Q2 (2022/23) Review**	**GCCAO**	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.

5.0 CLOSING ADMINISTRATION					
13:10	**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
	5.5	**Reflections on meeting**	**All**	Note	Verbal
13:20	**5.6**	**Patient Story**	**GCNO**	Inform	Verbal
13:50	**CLOSE**				

Date of Next Meeting: Thursday 12 January 2023

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

Outstanding care every time

St George's University Hospitals NHS Foundation Trust

Trust Board
Purpose, Meetings and Membership

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

Membership and Attendees		
Members	**Designation**	**Abbreviation**
Gillian Norton	Chairman	Chairman
Jacqueline Totterdell	Group Chief Executive Officer	GCEO
Ann Beasley	Non-Executive Director/Vice Chairman	AB
Stephen Collier	Non-Executive Director	SC
Paul da Gama	Group Chief People Officer	GCPO
Andrew Grimshaw	Group 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
Thirza Sawtell	Managing Director – Integrated Care	MD-IC
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
Patricia Morrissey	Head of Group Corporate Governance	HoGCG
Wendy Doyle	Head of Patient Experience and Partnership	HoPEP
Julian Ma	Governor, St George's University of London	JM
Apologies		
Quorum:	*The quorum of this meeting is a third of the voting members of the Board which must include one non-executive director and one executive director.*	

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

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

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

Thursday 1 September 2022

Putney and Roehampton 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	JH
Richard Jennings	Group Chief Medical Officer	GCMO
Stephen Jones*	Group Chief Corporate Affairs Officer	GCCAO
Peter Kane	Non-Executive Director	PKa
Parveen Kumar	Non-Executive Director	PKu
Pui-Ling Li*	Associate Non-Executive Director (from 11:00)	PL
James Marsh	Group Deputy Chief Executive Officer	GDCEO
Kate Slemeck*	Managing Director – St George's	MD-SGUH
Arlene Wellman	Group Chief Nursing Officer	GCNO
IN ATTENDANCE		
Wendy Doyle	Head of Patient Experience and Partnership	HPEP
Ralph Michell	Director of Strategy - GESH	DoS
Patricia Morrissey	Head of Corporate Governance Manager (minutes)	HoCG
OBSERVERS		
Richard Mycroft	Governor, South West Lambeth	RM
Ataul Qadir Tahir	Public Governor, Wandsworth	AQT
Joan Adegoke	Corporate Governance Officer	CGO
Natilla Henry	Site Chief Nurse - SGUH	SCN
Emily Sands	Deputy Head of Communications	DHC
Anna Wickins	Senior Business Manager to the GCEO	SBM

APOLOGIES		
Anna Macarthur	Director of Communications and Engagement	DCE
Thirza Sawtell*	Managing Director – Integrated Care	MD - IC
Tim Wright	Non-Executive Director	TW

** Non-voting members of the Board*

Feedback from Board Visits

Board members provided feedback from the visits conducted in the following areas:

- ITU – Chairman and MD-SGUH
- Neonatal Unit – Ann Beasley
- Cardiac Theatres/ Cath Lab – Stephen Collie, CCAO, GCMO
- Trevor Howell Ward – Jenny Higham
- Surgical Day Case unit and Gwynne Holford Ward Queen Mary's Hospital; and Trevor Howell ward, Kent ward and outpatients' area at St George's Peter Kane
- Emergency Department and Maternity – Parveen Kumar

Board members were delighted that regular Board walkabouts had resumed following a pause to the programme during the pandemic. Board to Ward communication sent a powerful message of Board member engagement across the Trust and the visits were very much appreciated by staff. The staff members involved in the visits were open and candid about the challenges being faced, impacting on morale in some areas, but nonetheless remained committed and passionate about providing high quality care to patients and to supporting their colleagues.

The Board noted the environmental challenges of the estate in some areas, where lack of space resulted in less-than-optimal ward design impacting on both patients and staff, and lack of storage caused issues with cluttering, impacting on ward accreditation outcomes. This was particularly evident with the contrast between General ICU and the much more modern capacity of Neuro and Cardiac ICU.

The reality of the pressures facing the NHS continued to be experienced and the Board noted the ongoing strain on capacity across the Trust. The number of patients requiring treatment had risen, patients were staying longer both due to acuity but also delays with discharge, and staff talked about feeling worn down by the constant pressure which was likely to become more challenging with winter approaching.

One area of the Trust's work that had not abated during the pandemic was the provision of maternity services and the power of strong nursing leadership within the Neonatal Unit was evident in the reflections of good staff morale and strong team working. The Board noted issues relating to the workstations on wheels with circa 30% of workstations out of service. Wifi and software issues regarding the sharing of patient notes were also shared by staff. Challenges in recruiting sonography staff were leading to increased pressure on the team and staff were trying to do their best in difficult circumstances.

Staff were delighted to share their pride in the Cardiac Cath Labs and the state-of-the-art technology available. In Cardiac Theatres the use of robotics was increasing and staff wished to relay their thanks to the Board for its support in bringing this technology to St George's. Not only was this a positive for patients but it also enhances the Trust's ability to attract and retain high quality staff. The Board noted concerns of senior staff regarding the pace of recruitment services offered by the SWL Recruitment Hub; and in turn their pleasure in seeing the return of cardiac surgical trainees.

The Board noted that the Surgical Day Case unit at Queen Mary's while not yet up to full capacity was a great addition to the hospital.

		Action
1.0	**OPENING ADMINISTRATION**	
1.1	**Welcome, introductions and apologies**	
	The Chairman welcomed everyone to the meeting and noted apologies.	
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. In addition, the Chairman noted her appointment to the UK Commission on COVID Commemoration.	
1.3	**Minutes of the Previous Meeting**	
	The minutes of the meeting held on 7 July 2022 were approved as a true and accurate record, subject to an amendment to note the apologies of Jenny Higham.	**HoCG**
1.4	**Action Log and Matters Arising**	
	The Board noted the following updates on the open actions: • PUBLIC220707.1: the Group Chief Medical Officer confirmed that there had been a drop in the early warning scores and that this had been due in part to the Trust's Covid response which had interrupted standard training and the Trust's ward accreditation programme. The Patient Safety and Quality Scrutiny Group had overseen a raft of actions to improve the scores, and the Integrated Quality and Performance Report later on the Board demonstrated the progress achieved. • PUBLIC220707.2: the MD-SGUH explained that SGUH was fully compliant with the 40-day response rate and that in general there was no issue with the Trust's complaints handling. However, on occasion due to the complexity of a case, or challenges with contacting complainants a delay had occurred. The Board was assured that the Quality Committee regularly scrutinised complaints data and this had not been flagged as an area of concern.	
1.5	**Group Chief Executive's Officer (GCEO) Report**	
	The Board received the report from the GCEO, who made the following points: • It had been a difficult month with heatwaves and operational	

challenges, including Covid absences affecting staffing, but Trust staff had risen admirably to the challenge.

- Winter preparation had commenced, including in relation to the vaccine programme for flu and Covid, surge capacity preparation and additional focus on supporting staff with the cost-of-living crisis. The Covid vaccine would be offered to:
  - Care home residents and staff
  - Frontline health and social care workers
  - All those 65 years plus
  - Adults aged 16-64 in a clinical risk group
- The Trust had launched its Values-Based Behaviours which underline the importance of 'how' staff work as well as what they do. Ensuring that staff treat each other in line with the Trust's values is crucial especially in terms of staff retention.
- As part of Black History Month, SGUH would be launching the 'See Me First' initiative, which would include the option to wear badge to demonstrate support for the commitment to combatting racism. Board members were invited to sign up to the statement and show leadership on the issue.
- The new Urgent Treatment Centre was now up and running and supporting greater capacity in the Emergency Department.
- Cath Labs three and four were also operational, also creating more capacity for diagnostics and efficient patient care.
- The Elective Care Recovery Programme continued to progress, with good activity over the last six weeks and a continued focus on addressing this issue.
- With regards to the Integrated Care System, David Williams had been appointed as the new Director for the Acute Provider Collaborative, an important element of integrated care.

The Board considered the phrasing of the 'See me first' statement and the use of the word 'non-judgemental' and in particular whether this was appropriate given that the provision of NHS services is based on staff making considered judgements. The Chairman reiterated that the statement had been prepared by the Staff BAME Network and that the term 'non-judgmental' should be seen within the specific context of the statement.

JH noted that racism among patients had been experienced by students on attachment in all specialties and that this was big problem for both students and staff. The GCMO explained that any incidents should be reported immediately to a senior member of staff who could speak with the patient concerned. The Board was reminded that the Chief Executive could also authorise the issuing of a 'yellow' card' to challenge and warn a patient abusing staff, including following a patient's discharge, although this was very rarely used. The GCMO offered to coordinate an all-staff message reiterating that staff do not have to tolerate abuse in any form and to provide staff with the confidence to respond to incidents and escalate, as required. **GCMO**

PKa asked for further detail on the support available to staff to help mitigate the impact of the cost-of-living crisis, including impacts relating to health. The GCPO provided a brief update on a range of support measures being

	considered, including a proposal to provide subsidised meals, better signposting of the staff benefits portal and discounts available to staff, bringing together comprehensive financial guidance into a single resource and support for local food banks. Further engagement would take place with staff over the coming month to find out exactly what measures staff would find most helpful, bearing in mind the financial constraints the Trust was facing. A further update would be provided to the Board at its meeting on 4 November 2022. The GCEO confirmed that staff would not be signposted to financial loan services. The impact of the crisis in terms of the increase in the number of sick people accessing Trust services would be addressed though the Trust's winter plan, although it was recognised that the Trust would not be able to solve all of the problems currently facing society. The Board noted the Group Chief Executive's report and signed up to the statement in support of the anti-racism agenda.	**GCPO**
2.0	**CARE**	
2.1	**Quality Committee-in-Common Report** The Chair of the Committee, Professor Dame Parveen Kumar, presented the report of the meetings held on 21 July and 18 August 2022. From the items contained in the report, the following key matters of note from the Committee were highlighted: • Basic life support (BLS), immediate life support (ILS) and advanced life support (ALS) training levels continued to be below target, despite improvements. • 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%. • More positively and linked to the action discussed earlier in the meeting, the 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 had been disseminated. • Datix, the current electronic incident reporting system across the Group is not compatible with the new Learning From Patient Safety Events (LFPSE) system which poses both financial and operational risks to the Group and will need to be factored into the capital plan for 2023/24. • There had been an unannounced inspection of mortuary services. While there had been a number of positive elements, a few areas were noted as requiring improvement. The full report would be considered by the Committee in due course.	

	AB requested further detail on the dissemination of learning from SIs and the GCMO outlined the dissemination routes including at departmental level, via morbidity and mortality meetings and other specific forums e.g., maternity, and the new patient safety newsletter. He acknowledged that there was always more that could be done and that learning between departments was an area where more robust processes could be put in place. Linked to the earlier discussion on the action log, the Chairman asked for clarification on the early warning scores and whether the action and the Quality Committee report were aligned. The GCMO explained that the scores had improved on the basis of 1 month's data but that the Committee was right to continue to place emphasis on the scores as a delay in recognising the deterioration in a patient's condition was a recurrent theme in patient safety incidents. The GCMO also noted that in future IPC reports the number of Covid deaths would align with those deaths where Covid was recorded on the death certificate. It was noted that the consequences of catching Covid in hospital were now much less severe. The Board noted the updates from the July and August 2022 Committee meetings.	
2.1.1	**Safeguarding Children and Adults Annual Report** The Board received and considered the Safeguarding Children and Adults Annual Report for 2021/22, which had been considered in detail by the Quality Committee at its meeting in August 2022. The Board noted the national problem related to children and young people's mental health. High numbers of young people continued to experience mental health crises and attend the emergency department and were admitted to the paediatric wards during 2021/22. The Chairman questioned whether the Looked After Children Service was best suited for delivery by a tertiary centre or whether this would be better provided elsewhere. The GCNO noted that a good service was being provided by the Trust but that a review would take place as the team was under-resourced. The Board noted and received assurance from the Safeguarding Children and Adults Annual Report for 2021/22 and noted the priorities in relation to safeguarding for 2022/23.	

2.1.2	**Infection Prevention and Control Annual Report** The Board received and considered the Infection Prevention and Control Annual Report for 2021/22, which had been considered in detail by the Quality Committee at its meeting in August 2022. The Board noted: • The on-going challenges faced by the Trust in response to SARS-CoV-2 and that the team continued to work well during the pandemic. • Two cases of Trust apportioned Meticillin Resistant Staphylococcus Aureus (MRSA) bacteraemia (blood stream infection). This compared 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 compared to 41 cases reported during 2020-21. The Trust was currently over trajectory for 2022/23. AB questioned whether the number of bypass graft site infections were higher than expected. In response, the GCNO confirmed that the team were looking at the issue. The GCMO explained that the Cardiac Surgery report considered by the Quality Committee included further detail and that close attention was being paid to rates of infection. As to whether the Trust was an outlier in terms of surgical site infection, the GCMO agreed to check statistical benchmarking data and provide an update to the Board.	**GCMO**
	The Board noted and received assurance from the Infection Prevention and Control Annual Report for 2020/21 and noted the priorities in relation to IPC for 2022/23.	
2.2	**Maternity Services** The GCNO presented a paper setting out the Trust's compliance with 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. The GCNO highlighted the following: • With regards to Perinatal Mortality for the period August 2021- July 2022 there were 42 deaths. • 2 Perinatal Mortality reviews were held. • There were 4 open cases referred to HSIB for review. • There were 2 overdue actions from 2021 which were expected to close soon. • Elements of mandatory training compliance had increased, including for PROMPT training which had increased from 61% to 95.9% for midwifery staff. • Minimum safe staffing remained the biggest challenge and the midwife to mother ration of 1:24 was not where it should be. While vacancy rates were low, the 75.5 % fill rate against the target of 94% made it very difficult for staff. The Board would receive an update on Nurse staffing at its meeting on 4 November 2022. AB suggested that it would be helpful to have the ethnicity data for perinatal mortality available and the GCNO agreed to provide this.	**GCNO**

	PKa asked about Serious Incidents and ethnicity and the GCNO stated that a high percentage of SIs related to overseas mothers. ESTH had a particular focus on this data and SGUH could learn from its approach. The Board noted the report and that future reports will include progress made towards meeting mandatory training performance targets.	
2.3	**Integrated Quality and Performance Report** The Board received and noted the IQPR for July 2022 (which included June data, as appropriate), which had been scrutinised at both the Finance Committee and Quality Committee prior to the Board meeting. The MD-SGUH introduced the report and highlighted the following: • It was one of the most challenging Julys for the Emergency Department and this was mirrored across London, with slow patient flow, high attendances, high staff sickness and gaps in rotas, and long waits for ambulance handover. • Patient flow into the new Urgent Treatment Centre was a priority and should decompress the ED waiting area. It was also expected that some ambulance patients would be suitable for handover there. • The Transfer of Care team were performing well and had brought the wait down for complex discharges, increasing the number of patients discharged from 5-10 to 25-30. • Capacity of the Hospital at Home service was expected to increase to 40 patients by December. • Diagnostic performance had slipped largely due to staff shortage in the ultrasound department. • Cardiac MRI would remain challenged until the additional MRI capacity comes online from September. • Outpatient performance was below the plan and there were still too many outpatient follow-up appointments. • The Outpatient Transformation Board had held its first meeting and the membership now included primary care colleagues. • There had been a reduction in the 52 week and 78 week waits since referral for treatment and recovery plans were in place for both. • With regards to Cancer performance in June, 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 2 week wait for breast cancer referral had deteriorated and a recovery plan was in place. • SGUH had maintained its rating of ‘excellent’ and scored 9/10 for care in the Cancer Experience Survey. PKu raised a query arising from her recent visit to the Emergency Department and asked whether there was a fast track through ED for those patients suffering from chest pain and possible myocardial infarction. The GCMO confirmed that there were lots of ways to pick up those patients with possible serious chest pain conditions and that he would contact PKu outside the meeting to clarify.	

	SC flagged the need to focus on referral and activity levels as these seemed to indicate an emerging problem and required an effective turnaround to prevent escalation and further issues down the line. The GDCEO noted the on-going challenges with responding to the volume of referrals and that solutions would require transformation of our work practices and also how we interface with primary care. The GCEO also noted that better use could be made of Patient Initiated Follow-up and that SGUH could learn from the experience at Hillingdon Hospitals NHS Trust.	
	PKa suggested that it would be helpful to have national figures for comparison so that the Board could understand where SGUH stands in relation to national wait list times, and it was agreed that this would be included across all metrics. It was noted that the SGUH ED was one of the best performing ED's in London and England, and that the Trust was mid-pack for ambulance handover.	**GDCEO/MD-SGUH**
	PKa also asked when the IQPR would include health inequalities data, and the GCMO committed to providing this before the end of the year, following discussions at People Committee and Quality Committee.	**GCMO**
	In relation to the data on our workforce, the Board noted: • The vacancy rate had improved with a reduction to 9% from 9.9% • There were 1000 live recruitment campaigns compared to an average of 850. • The time to hire had increased to 49 weeks. • The Trust's sickness rate was 5.0%, and above the target of 3.2% and a business case had been submitted for additional resource to support management of sickness absence. • Turnover had increased to 16.5% from 16.2% and was still higher than the target. The People Committee had received a detailed report on the reasons why staff leave the Trust	
	The Trust Board noted the IPQR and requested an update on outpatient transformation in 3 months' time.	**GDCEO/MD-SGUH**
3.0	**CULTURE**	
3.1	**People Committee-in-Common Report** Stephen Collier, Chair of the Committee, provided an update on the People Committee meetings held in July and August 2022 and highlighted the following: • Joint working as a Committee-in-Common continued to deliver positive benefits, allowing meaningful comparisons and identifying joint opportunities, such as the approach to a joint staff bank. • There had been progress made with Disclosure and Barring Service (DBS) checks and it was hoped that this would be closed as a risk in September. • The Trust's WRES data for the 12 months to March 2022 reflected good progress was being made across all indicators bar 1 relating to the % difference between the Board's voting membership and its overall workforce.	

	• Progress had been made on the Workforce Improvement Plan. • There would be a continued focus on medical revalidation deferral rates to ensure that an increase in the number of deferrals did not become a trend. The Board noted the report and the appendices Workforce Race Equality Standard (WRES) Indicator Overview for 2021-22 (appendix 1) and Workforce Disability Equality Standard (WDES) Indicator Overview for 2021-22 (appendix 2).	
3.1.1	**Medical Revalidation and Responsible Officer Report**	
	The Board considered the annual report from the Responsible Officer in respect of medical revalidation and noted that medical appraisal had improved to 82% but was below the target of 90% and not back to the pre-Covid level. The group with the lowest compliance is Trust Locally Employed Doctors and focused work was being undertaken to look at the specific needs of this group and to support them better. The number of recommendations to the GMC for deferral had increased as in many cases there was insufficient information on which to base a recommendation as appraisals had paused during Covid. The Board noted the annual report and the planned actions for the upcoming year.	
4.0	**COLLABORATION**	
4.1	**Audit Committee Report** Peter Kane, Chair of the Committee, provided an update on the meeting held on 28 July and highlighted the following: • The Consent Internal Audit had received limited assurance and was a cause for concern given the potential impact on patients and the interest the CQC would have in the matter. The timelines for implementing the audit recommendations were not pacey enough and the Committee had escalated this to the Executive for further consideration. In the meantime, the Trust was exposed to a level of risk. • Good progress was being made to protect the Trust from fraud and cyber threats, noting that cyber threats would continue to evolve. • All NHS organisations are required to undertake a financial sustainability self-assessment and have this audited by their Internal Auditors by 30 November 2022. While this was a standard audit it would also be helpful in terms of the forthcoming budget discussion and evidencing the rigorous financial processes and systems in place at the Trust. • The ESTH and SGUH Audit Committees had agreed that a Group-wide internal audit tender should commence and had agreed the process and timelines. It was expected that the tender would go live in August but this had been delayed pending further discussion on the option to proceed on a SWL basis. It was noted that further discussions would be taken off-line and that all relevant parties	

	would be included in these. An update on the internal audit tender arrangements would be circulated to the Board.	**GCCAO**
4.2	**Finance Committee-in-Common Report**	
	Ann Beasley, Chair of the Committee, provided an update on the meetings held in July and August 2022 and highlighted the following: • There was a path to green around activity performance which the Committee would continue to monitor. • A mock up of the new IPQR report had been shared with members. • There had been a fire at the St James' wing, due to the exceptional bravery by members of the Estates team the fire was contained. The fire was an unexpected impact of the exceptional hot weather and highlighted the range of challenges that the hot weather could result in. The Committee would receive a report on the fire in the coming months. • Progress was being made with big capital projects and the Committee awaited the business cases for the MRI and Cath Labs projects, so that the Trust could remain ready to take action should additional capital funding materialise. • Financial Performance was a continued focus and in particular the cash position. There was a sizable gap in the savings identified and the financial risks remained high. The Board noted the updates from the July and August 2022 Committee meetings and relayed its thanks to the members of the Estates team who had acted in response to the fire.	
4.3	**Finance Report (Month 4)**	
	The Board received and noted the Trust's financial performance at month 4 and the following points were made: • The Trust was reporting a deficit of £21.5m at the end of June, £4.5m adverse to plan. This position was largely due to the handling of ERF money as set out by NHSE, and was a challenge faced by all Trusts. • Efforts would continue to close the deficit gap but it would be a challenge to recover this in the second half of the year. • While there would be a focus on cash, there was no concern that the Trust would run out of cash. Additional support from DHSC could be called on, if required. The Board noted the month 4 financial position.	
5.0	**CLOSING ADMINISTRATION**	
5.1	**Questions from Governors and the public** No questions were received from the public. Richard Mycroft, Public Governor for South West Lambeth, asked about retention of staff and the GCPO outlined the measures to support staff retention, including:	

	• New starter interviews at 6 months to ascertain the risk of someone leaving the Trust and to attempt to fix things before someone decides to leave. • While there was currently no Talent Management policy, a new member of staff had been appointed to support developing our people and supporting their career progression. • Addressing areas of concern highlighted within the staff survey results, plans were in place to tackle these areas but this would take time. • The top 3 reasons for staff leaving were: Progression; vertical management and talent management. • Analysis of data from the exit interviews segmented staff into happy and unhappy leavers. SGUH had a higher proportion of happy leavers. • The wider cultural work being undertaken across the organisation on behaviours would also assist with making the Trust a better place to work.	
5.2	**Any new risks or issues identified** Winter planning would come through the Committees to Board in the next cycle of meetings.	
5.3	**Any Other Business** No other business was raised.	
5.4	**Draft Agenda for Next Meeting** This was not considered.	
5.5	**Reflections on meeting** Stephen Collier provided his reflection on the meeting and highlighted that the reports by Committee Chairs were helpful in concentrating the Board's focus on the areas of concern. He noted that the discussions at Board took place at a good pace and there were no timing issues, and having the opportunity to have side bar conversations was helpful. Being able to see and meet people face-to-face was a real advantage and much better than Teams meetings. There was an openness to discussion and the Executive was firm in its response without being defensive. The Executive was also good at flagging the areas within regulatory reports that required the Board's attention. Richard Jennings reiterated that it was great to have the chance to resume Board walkabouts and provided further reflection on the discussion of the racism statement, and in particular being conscious of how the Board's discussion could be perceived.	
5.6	**Patient Story** The Board welcomed Nicholas Low who relayed his patient experience of key-hole brain surgery. Nicholas was incredibly grateful to clinical staff for saving his life and for his after care, and to the spiritual team for their holistic approach to care. In terms of learning, while there had been delays to Nicholas's operation he noted that he had received timely apologies from staff, which had mitigated	

	his disappointment. Nicholas also highlighted an issue with maintaining a temperature on the ward suitable for all patients but noted that he had been allowed to bring in his own fan to ensure his comfort. Nicholas also reflected that the Trust could improve its branding and that upskilling staff could help to reduce turnover. The MD-SGUH apologised for issues with his discharge process. As a result of the quality care he received, recovery and follow up care, Nicholas noted his commitment to working with the Trust on a voluntary basis to improve patient experience. The Board noted Nicholas's enthusiasm and commitment to his role as an SGUH volunteer and member of the Patient Partnership and Experience Group The Board thanked Nicholas for sharing his story and his continued support for SGUH.	
	CLOSE	
Date of next meeting: Thursday, 3 November 2022, Wandsworth PDC, Burntwood Lane, SW17 0AQ		

The meeting closed at 12:50

Trust Board (Public) - 3 November 2022

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Action Log

ACTION REFERENCE	MEETING DATE	ITEM NO.	ITEM	ACTION	WHEN	WHO	UPDATE	STATUS
PUBLIC220901.1	1 Sep 2022	1.5	Chief Executive's Report	The GCMO offered to coordinate an all-staff message reiterating that staff do not have to tolerate abuse in any form and to provide staff with the confidence to respond to incidents and escalate, as required.	1 Sep 2022	GCMO		DUE
PUBLIC220901.2	1 Sep 2022	1.5	Chief Executive's Report	Further engagement would take place with staff to find out exactly what measures staff would find most helpful to support them during the cost of living crisis, bearing in mind the financial constraints the Trust was facing. A further update would be provided to the Board at its meeting on 4 November 2022.	1 Sep 2022	GCPO		DUE
PUBLIC220901.3	1 Sep 2022	2.1.2	Infection Prevention and Control Annual Report	GCMO to check statistical benchmarking data and provide an update to the Board as to whether the Trust was an outlier in terms of surgical site infection.	1 Sep 2022	GCMO		DUE
PUBLIC220901.4	1 Sep 2022	2.1.3	Maternity Services	GCNO to provide ethnicity data for perinatal mortality.	1 Sep 2022	GCNO	Oral update to be provided at meeting.	DUE
PUBLIC220901.5	1 Sep 2022	2.3	Integrated Quality and Performance Report	Include national wait list times for comparison so that the Board can understand where SGUH stands in relation to national wait list times, and it was agreed that this would be included across all metrics.	1 Sep 2022	GDCEO/MD-SGUH	Oral update to be provided at meeting.	DUE
PUBLIC220901.8	1 Sep 2022	4.1	Audit Committee Report	Circulate an update on the internal audit tender arrangements to the Board.	1 Sep 2022	GCCAO	An update on the internal audit tender is set out in the Audit Committee report to the Board. See agenda item 4.1	PROPOSED FOR CLOSURE
PUBLIC220901.6	1 Sep 2022	2.3	Integrated Quality and Performance Report	Following discussions at Quality Committee and People Committee, IQPR to include health inequalities data.	31 Dec 2022	GCMO	Not yet due.	NOT YET DUE
PUBLIC220901.7	1 Sep 2022	2.3	Integrated Quality and Performance Report	An update on outpatient transformation to be provided to the Board in 3 months' time.	12 Jan 2023	GDCEO/MD-SGUH	Not yet due.	NOT YET DUE

Outstanding care every time

St George's University Hospitals NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	3 November 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:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify)		
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.		
Committee Assurance:	The Committee is also asked that in considering contents of this report, its supporting documents and the discussion at the meeting which of the following assurance rating it would provide to the Trust Board. • **Substantial Assurance:** The report and discussions assured the Committee that there are robust systems of internal controls operating effectively to ensure that quality and safety risks are managed to deliver high quality services and care to patients. • **Reasonable Assurance:** The report and discussions assured the Committee that the system of internal controls is generally adequate and operating effectively but some improvements are required to ensure that quality and safety risks are managed to deliver high quality services and care to patients. • **Limited Assurance:** The report and discussions supported the Committee's conclusion that that the system of internal controls is generally inadequate or not operating effectively and significant improvements were required to ensure that the quality and safety risks are managed effectively to improve the position and ensure that high quality services and care is provided to patients. • **No Assurance:** The report and discussions led the Committee to conclude that there was a fundamental breakdown or absence of core internal controls and systems to enable the Trust to deliver high quality services and care to its patients.		
Supports			
Trust Strategic Objective:	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		

1

Previously Considered by:	N/A	**Date**	N/A
Appendices:	Appendix A: CEO's Report		

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

APPENDIX A

Chief Executive Officer's Report
Trust Board

Introduction

The economic climate, cost-of-living crisis, and ongoing capacity constraints are setting the scene for a challenging winter ahead. I am pleased to report that our teams here at St George's University Hospital have been working hard to prepare for the winter months, including activity to increase our capacity, maintain our quality, support our staff and continue with our flu and Covid-19 vaccination roll-out. Operationally, all our new Cath Labs are now up and running – including Cath Lab 5 since I last updated you. Our Major Trauma Ward is also in progress and although we have faced delays due to supply chain constraints, we are planning to open the ward with 18 new beds in the coming weeks, which will help tremendously to expand our capacity at this crucial time. In addition, whilst Covid-19 hospitalisation levels are low, the impact on staffing remains high given the isolation requirements. This is leading to a stretched workforce at a time when activity is very busy. Our teams are working hard to maintain their excellent performance, and we are taking opportunities to do things differently – for instance by trialling the 'Bristol Model' for ambulance handovers in the Emergency Department, as handover delays remain a key government priority. In addition, my Group Executive Team and I have a clear focus on maintaining quality whilst balancing capacity demands with budget management across the organisation. We continue to implement post-Covid recovery plans in all areas, ensuring that our capacity, quality and financial performances are managed appropriately.

We are also continuing to focus on ensuring St. George's remains an excellent place to work and successfully retains our valued staff – a key NHS agenda item. This month we launched our staff survey. We are actively encouraging participation so we can learn as much as we can from our staff about how we can continue to cultivate a working culture that reflects our values of Excellent, Kind, Responsible and Respectful.

Our teams are working harder than ever through these challenges, whilst continuing to deliver the outstanding services that our patients expect and deserve. And with these ongoing challenges in mind, I am delighted to update you that I attended one of our Long Service Awards on 19th October. Our Long Service Awards have made a triumphant return after a temporary pause during the pandemic. All three events in October have included live entertainment, and a chance to speak with long-serving staff about their experiences working at St George's for extraordinarily long times – from 25 years up to 40 years. The commitment and dedication of our staff is what enables us to continue to deliver excellent care, and it is genuinely inspiring to see. I am sure you will join me in thanking our longest serving staff for their unending commitment and service to the NHS, and to St George's in particular.

I am also pleased to share with you the success of our first ever Childhood Cancer Awareness event on 29th September. The event brought together former young cancer patients and their families, to raise awareness and celebrate their cancer journeys, and our staff who have treated them. It was especially heart-warming for our former and current patients to reunite with the staff who treated them, and for parents to connect and share experiences with other families to empathise and support each other. As you know, we are in the process of bidding to be the Principal Treatment Centre for Paediatric Cancer in South-West London, and I am passionate about providing the best care possible for our young patients. Our bid is due to be submitted on 14th November, and I will continue to keep you updated on this important work.

At our last Board Meeting, we also collectively signed up to the 'See ME First' initiative, an initiative led by our B.A.M.E. Staff Network which commits us to combatting racism and promoting Equality, Diversity and Inclusion within the organisation. We have just concluded our Black History Month,

which was a great success. I was delighted to take part in the launch event for the initiative, which was a joyous event with food, music and a great community spirit. I am hopeful that this initiative will support our organisation in combatting racism – thank you for showing the Board's support.

System Working: NHS England's Operating Framework

In addition to the focus on our internal operations, we are also continuing to manage our role within the wider system, including our work with the Integrated Care Board (ICB) of South-west London and with NHS England. On 12th October, NHS England published its new "Operating Framework". This operating framework delineates how the NHS will operate within the new statutory context created by the Health and Care Act 2022. This is a new system way of working, including organisational collaboration and closely linked responsibilities for NHS England, the Integrated Care Systems, and the Health Providers. The new framework seeks to articulate the interconnected relationships across the system, and the distinct areas of responsibilities, including the following select examples:

NHS providers will:

- Retain their statutory responsibilities for the delivery of safe, effective, efficient, high-quality services; and
- Continue to comply with the provider licence, Care Quality Commission (CQC) standards and NHS planning guidance requirements.

Integrated Care Boards (ICBs) will:

- Provide effective system leadership and oversee delivery of system strategies, plans and Long-Term Plan priorities;
- Commission and manage contracts, delegation and partnership agreements; and
- Oversee the budget for NHS services in their system.

NHS England will:

- Agree the mandate for the NHS with government and secure required resources;
- Shape and set national policy, strategy and priorities, and support systems and providers to achieve these – including via statutory intervention;
- Remain accountable to Parliament, via the Secretary of State;
- Oversee ICBs' delivery of plans and performance; and
- Directly oversee providers' delivery by exception and "generally in agreement" with ICBs.

At our recent Board Development seminar, we held excellent discussions regarding the Integrated Care System, our role as an Acute Provider and my role in particular as the lead for the APC on the ICB. I will continue to drive forward our part in this area, contributing to system working so that we, collectively, can tackle our biggest challenges within the NHS and work collaboratively to manage our responsibilities, continue to provide excellent health services for all and tackle health inequalities across our regions.

Group Strategy Development: Phases

I am pleased to update you that our strategy work continues, led by Group Deputy CEO James Marsh, to develop a new strategy for the Group. This work will shape our future, and is helping us navigate the changing landscape following the Covid-19 pandemic, advances in technology and innovation to tackle health challenges, closer collaboration between local health organisations within the community, and the creation of the Hospital Group of St. George's, Epsom and St. Helier.

Over the summer, a programme of consultation and engagement has taken place with individual clinical and corporate services, staff at both Trusts, patients and members of the public and external partners such as our local Integrated Care Systems, local place partnership boards, and General Practice leaders. Over 550 people have been engaged with so far. It is anticipated the five-year strategy will be launched in March 2023 which will be built upon our consultation and engagement, and I will keep you updated on this activity very closely.

Financial Update: Budget Deficit

Tackling the budget deficit continues to be a top priority. Our Group Chief Finance Officer Andrew Grimshaw will provide a full update on our recovery plans and Trust finances later on the agenda. I can assure you that this activity is of the utmost importance to me and, together with my Group Executive Team, I am tackling the significant challenges we face with regard to our deficit.

Elective Care Recovery Update

Our Elective Care Recovery continues to make good progress. We are performing well at a national level. I am pleased to report that our non-theatre specialties met planned volumes for outpatients and electives in recent weeks. Our theatre specialties were close to our planned volumes in October – particularly outpatients – and we will continue to move forward with plans to continue the positive progress in this area.

Industrial Action, Cost-of-living Crisis, and Staff Well-Being

The wider geopolitical and economic climate continues to drive a cost-of-living crisis. This crisis is worsening health inequalities and impacting staff welfare alike. Industrial action is also very likely across a number of staff areas, which we are managing safely and carefully, and will be maintaining patient safety at all times. Overall, these are turbulent times and we are doing all we can to support staff and make it easy for all to find the support they may need. We have pooled all the relevant information we have to offer staff seeking support and compiled an easy-to-access page on the intranet, highlighted on everyone's homepage. This intranet resource provides useful signposts towards a wide variety of financial well-being guidance and existing support that is on offer for staff, and it has been well received.

The Culture Programme at St George's continues in the third and final 'Deliver' phase. The Culture Equity and Inclusion Programme Board continues to meet every month, chaired by me, where we regularly review indictors of culture and inclusion, and progress of the various projects within the culture programme plan. Main topics of progress and discussion over the last 2 months include:

- Launch of our new Management Fundamentals toolkit to offer accessible and blended learning opportunities to all line managers;
- Embedding our recently launched values-based behaviours through workshops, induction, policies, appraisal and recruitment;
- Launch of a medical senior leadership development programme for all Care Group Leads and Clinical Directors, in partnership with the King's Fund;
- Continued development of our local OD service to provide focused team development, supporting leaders with team culture issues;
- Finalisation of WRES and WDES action plans; and
- Expansion of our Recruitment Inclusion Specialist scheme, to now cover Band 6 recruitments in addition to Band 7 roles upward.

Appointments

I am thrilled to announce that, this week, we have welcomed Tara Argent to St. George's as our new Chief Operating Officer. Tara is now in post, having joined us on Monday, 31st October. Tara has a wealth of experience working in operational leadership roles and has joined us from East Sussex Hospitals NHS Trust, an integrated care organisation providing acute secondary care and community services where she was Chief Operating Officer since 2020, helping to lead the organisation's response through and beyond Covid.

Prior to this, she worked as Divisional Director of Operations at Chelsea and Westminster NHS Foundation Trust, and Head of Operations at the Royal National Orthopaedic Hospital.

I want to also extend a big thank you to Julie Scrivens, Divisional Director of Operations for MedCard, who has acted as Interim Chief Operating Officer over the past several weeks. Thank you, Julie, for all your hard work - and welcome to the team, Tara.

Awards

I am very pleased to inform you that our staff and teams have recently been successful in a range of award programmes. Just a few of the success include:

- Juliann Welch (RCN London Black History Month Rising Star Award)
    - Juliann Welch, staff nurse on Gordon Smith ward, was recognised as a Rising Star by the Royal College of Nursing, for her work supporting international colleagues at St George's. Juliann is part of the Caribbean Nurses and Midwives Network, having moved to the UK from Barbados in October 2021, and was nominated by Marlene Johnson (Head of Nursing for Renal, Haematology and Oncology and Palliative Care) as part of the RCN's Black History Month celebrations.
- Estelle Le Galliot (BBC Radio London Make A Difference Key Worker Award)
    - Estelle Le Galliot, a Health and Wellbeing Co-ordinator in the Macmillan team based at St George's, was the recent winner of the BBC Radio London Make A Difference Key Worker Award. Most notably Estelle was awarded for her work during lockdown when she went above and beyond for our cancer patients by helping shielding patients by setting up a YouTube channel and Chemotherapy Comfort Kits.
- British Institute of Radiology (Make it Better Award)
    - A team of staff covering Medical Physics, Radiology and Trauma and Orthopaedics at St George's were recently presented with the 'Make It Better' award at the British Institute of Radiology (BIR) Annual Congress. The team was nominated for the creation of a new pathway which has improved the service for patients, which came about as a result of surgeon colleagues and our CT team in Radiology discussing how they could improve the imaging carried out on their post-surgical patients.

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	4 November 2022	**Agenda No**	**2.1**
Report Title:	**Quality Committee in Common Report**		
Lead Director/ Manager:	Richard Jennings, Group Chief Medical Officer Arlene Wellman, Group Chief Nursing Officer		
Report Author:	Prof. Dame Parveen Kumar, Chair of the Quality Committee in Common		
Presented for:	Assurance		
Executive Summary:	The report sets out the key issues covered by the Quality Committee at its meetings in September and October 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 September and October 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:	As set out in report.		
Legal/Regulatory:	CQC Regulatory Standards		
Resources:	N/A		
Previously Considered by:	N/A	Date:	N/A
Appendices:	N/A		

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Quality Committee Report
Trust Board, 3 November 2022

Matters for the Board's attention

The Quality Committee met on 22 September and 20 October 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 September 2022 meeting and the ESTH Chair chaired the October 2022 meeting.

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

September 2022	October 2022

• Quality Performance Report (M5)
• Serious Incidents Report
• Maternity Services Report
• Group Infection Prevention and Control Update
• Patient Safety and Quality Group Report
• Update from Pharmacy Team
• Learning from Deaths Quarter 1 2022/23
• Consent Internal Audit
• Seven Day Service Update
• Annual Reports
  ○ Learning Disabilities Services
  ○ Mental Capacity Act and Deprivation of Liberty Safeguarding Report
  ○ Research and Development
  ○ Patient Experience and Engagement
	• Quality Performance Report (M6)*
	• Serious Incidents Report
	• Maternity Services Report*
	• Group Infection Prevention and Control Update
	• Deep Dive on Resuscitation Training and compliance Action Plan
	• Winter Plan
	• Cardiac Surgery Update
	• Corporate Risk Register
	• Patient Safety and Quality Group Report

**These items are also presented to the Board for consideration at the November 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 5 and 6 2022/23

The Committee considered the key areas of quality and safety performance in months 5 and 6 and would like to highlight the following issues, recognising that the Board will discuss the performance data at month 6 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.
- Mental Capacity Act and Deprivation of Liberties (MCA/DoLs) Training Level 1 – In August and September performance saw a decline following a period of about six months when there was a steady improvement.
- There were 7 *C. difficile* infections during September 2022; with a total of 39 cases between April and September 2022. There is a NHSE trajectory of no more than 43 cases for 2022-23. This means the Trust remains significantly above trajectory. A focus on antimicrobial stewardship and cleanliness of medical devices continues.
- The birth rate continued to be higher than previous periods with obstetric and medical complexity also remaining high. Staffing remained extremely challenging across the months with vacancy's, sickness and Covid isolation continuing, along with extended lead time for recruitment start dates to fill band 5 and 6 midwifery posts. The Birth Centre had to close for significant periods to support the acute services.

Areas of good or improving performance:

- Friends and Family Test (FFT) - In Maternity and Emergency Department operational pressures and increased waiting time continue to impact FFT positive response. Positive responses for the ED increased to 78.5% which was an improvement on the last seven months. All other services achieved FFT targets where patients rated the services as "Good" or "Very Good".
- During the month of September, patients admitted on a non-elective pathway stayed in a hospital bed for on average 7.5 days. Although above the upper control limit, length of stay remains consistent with previous months. Daily non-elective admissions show a stable trend.
- Duty of Candour (DoC) was maintained at 100% in September.
- Response to formal complaints saw a drop in performance in September because all three contractors left with little notice. This had a huge impact on the management of cases and in meeting deadlines. In addition a brand new process was introduced, and some newly recruited staff joined the team. However the number of complaints per calendar day continued to show special cause variation with a decrease in the number of formal complaints received in September to 46. Percentage of complaints responded to within 25 working days was achieved with performance at 96%. Percentage of complaints responded to within 40 working days fell to 82% compared to 96% in September.

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. They provided an overview of the SIs reported by SGUH in July and August 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.

- Eight serious incidents were declared in July 2022 and five in August 2022.
- Four serious incident investigations were concluded in July 2022, and three in August 2022.

3. Infection Prevention Control

The Committee continued its monthly focus on infection prevention and control (IPC), through receiving a monthly update report.

Covid-19 continued to be the major focus of the IPC team. A total of 138 Covid-19 infections were detected in September 2022. There was a total of 15 deaths in September in patients who were Covid-positive during their admission. There had also been 31 nosocomial infections relating to Covid in the Trust over the month.

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 August there had been 6 cases, 5 of which were classified as Hospital Onset Healthcare Associated (HOHA). In September, there had been 7 cases, of which 5 were classified as HOHA. This meant that the year continued to be significantly above trajectory. A focus on antimicrobial stewardship continued. The Committee was assured that the IPC team were working well with the clinical teams to address this.

One case of *MRSA bacteraemia* was reported during August 2022.

On 14 October, the decision was made for SGUH to go back to wearing masks in clinical areas. The reason for this decision was to reduce the opportunities for confusion forpatients and staff attending other SW London Trusts where masks are worn in clinical areas. There will also be an increasing community prevalence of influenza as winter approaches. The position will remain under review.

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 currently non-compliant with safety action 2 regarding submitting data to the Maternity Services Data Set (MSDS) to the required standard. There were ongoing challenges with Euroking being able to support the relevant data submission.

Also, there was currently non-compliance with safety action 3 relating to whether the trust could demonstrate that they have transitional care services in place to minimise separation of mothers and their babies, and also to support the recommendations made in the Avoiding Term Admissions into Neonatal units programme. SUGH was only showing partial compliance as the local pathway was yet to be fully implemented.

5. Cardiac Surgery Report

The Committee received its regular quarterly report on cardiac surgery for the period July 2022 to September 2022. Based on the quality and safety data presented, the Committee was assured regarding the continued safe operation of the service.

Following the last update, it was confirmed that the NHSE Single Item Quality Surveillance Group had agreed with the Trust's proposal to lift the requirements outlined in May 2021 which were designed to support the service in transitioning to full functioning. However, the Trust had proposed that 3 monthly audits of outcomes and enhanced oversight of deaths through the Serious Incident Declaration Meeting would continue, in order to provide continuing assurance on safety and quality of care.

As requirements are lifted, the service requires support to meet current demand for elective and non-elective activity and increase capacity back to past levels. In September 2022, the Trust convened a Cardiac Surgery operational improvement programme, chaired by the Managing Director. This will aim to address the current challenges that are causing substantial numbers of patients to have their surgery

cancelled at short notice orpostponed. This programme will aim to minimise cancellations and delays and to optimise staffing, bed and theatre capacity to deliver elective work and to accept inter- hospital transfers.

6. Deep Dive

The Committee considered one deep dive: Resuscitation Training and Compliance Action plan

Resuscitation mandatory training compliance had not achieved the required performance target of 85% despite targeted improvement initiatives over the last 15 months. Advanced Life Support (ALS) and Basic Life Support (BLS) had shown some improvement but had failed to achieve and sustain 85%. Intermediate Life Support (ILS) training had been affected by a high Did Not Arrive (DNA) rate.

The report provided a high-level overview of training compliance trends over the last three years and assessed the impact of the 2021 Action Plan on improving compliance levels.

The following improvement actions are underway to address the identified ongoing and persistent challenges and to help the Trust to achieve and sustain the 85% performance target.

- Implementing a new Training Needs Analysis (TNA): A recent TNA had been undertaken and developed in conjunction with ESTH to establish a standardised system across the Group. It has been developed and benchmarked with most other London Trusts and would aim to elicit major positive changes by ensuring that all staff are given the training most appropriate to their care setting to optimise patient safety.

- New initiatives to tackle persistent high rates of DNAs: In 2021-22, the Resus service provided 21% more places than were required to achieve 100% compliance, However, DNA rates of 26% hindered the attainment of the 85% compliance target. New sanctions are currently under consideration for staff who repeatedly DNA, e.g. increasing the visibility of non- compliant staff members including introducing a process whereby staff level detail of non-compliance is highlighted at a range of meetings.

- Managing demand for training using the existing workforce: For SGUH the recommended number of Resuscitation Officers is 12 wtes compared with the actual number in post of 5.72. This will increase to 6.92 from December 2022. Following the launch of the new Training needs analysis additional training demands will be placed on the team as the number of 'in scope' staff will increase by 300. The recent innovation with online and self-assessment classes has increased the team's productivity.re Furthermore, the expected impact of the new TNA current staffing levels should deliver the required training with support from an additional interim administration resource. If high DNA rates persist, it is likely that additional training resources will need to be considered to manage the additional workload. The situation will be closely monitored, and workforce adjustments made accordingly.

7. Pharmacy Update

An Appreciative Inquiry was commissioned to understand the culture and leadership in the Pharmacy Department and this took place between August and October 2021. The overall conclusions showed many positive themes but also opportunities for improvement and development. In February 2022 the pharmacy

Deleted: (

department, with the support of the transformation team, had created a proposed approach for developing a management system based on improvement which supported and responded to themes raised in the Appreciative inquiry.

An MHRA inspection took place in June 2021 which identified deficiencies with the Radio pharmacy department. A post inspection letter was provided to the Trust detailing the MHRA's findings. The Trust provided a full response to the concerns raised by the MHRA with an action plan which was accepted in August 2021. In June 2022 all actions from the MHRA inspection were completed.

Medication safety continues to be a key focus of work within the Pharmacy department and across the Trust. The Trust continues to demonstrate a good reporting culture with regards to medicines safety. Within the service there was a focus on Quality Improvement and on joined up working supporting clinical trials.

Challenges within the Pharmacy Service at SGUH included the recruitment of sufficient Pharmacy Technicians.

8. Corporate Risk Register (CRR)

At both the September and October 2022 meetings, the Committee considered the risks on the Corporate Risk Register, that is those scored 15 and above, which related to quality and safety.

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.

There are also a further seven risks to do with quality at a corporate level, but relating mainly to operational performance and workforce, and these are overseen by other Committees,

A newly emerging risk was flagged for the Committee's attention following the 'amber alert' issued by NHS Blood and Transplant on the critically low availability of blood supplies. The Committee also reviewed the wider quality and safety risks across the Trust and noted the work underway to review these and escalate new quality and safety risks to the Trust's Corporate Risk Register, which would be presented to the Committee in November.

9. Seven Day Services Update

In October 2022 the Committee received its scheduled biannual update on the progress against 7 day services (7DS) clinical standards compliance.

A marked improvement in consultant presence at the weekends had been achieved through additional recruitment and changing job plans and patterns over the previous 18 months.

The report described variable performance in hospital discharge over 7 days, and it was noted that this was a focus for the non-elective flow improvement programme.

Although previously identified, some services still continued to report a gap in standard 5 (access to diagnostics) and particularly MRI scanning at weekends. In late 2021 recommendations were made to extend general MRI services across 7 days. This would be dependent on the provision of an additional MRI scanner on site and the employment of an additional Radiographer. At the current time the new

equipment was still to be installed and therefore this impacted the provision of the services over 7 days per week.

10. Winter Plan

The Committee received the details of the Winter 2022/3 plan for St George's University Hospitals NHSFT, as both a provider of local acute care, and of tertiary pathways.

Demand and capacity modelling indicate that adult medical general and acute bed capacity could be short of approximately 55 inpatient beds at peak in winter. This was despite the escalation 'winter ward' remaining open since the onset of the pandemic. This shortage is driven primarily by the increased length of stay for medical frailty patients (a consequence of increased decompensation post-Covid) and increase care needs upon discharge. This puts significant additional pressure on domiciliary and post-acute care capacity.

The Winter Plan is an operational document, designed to provide a coordinated oversight so that the Trust can reasonably balance elective recovery, seasonal pressures and a possible resurgence of COVID and or Flu during Quarter 3 and 4. Actions taken will be determined by the exact configuration of pressures as they occur in real time.

The plan includes the following elements:

- Use of Winter pressures funding from Merton and Wandsworth and how this will be aligned to frailty pathways
- Internal and external operational processes
- Quality improvement and governance to minimise avoidable admissions and optimise flow along non-elective pathways
- Actions in place to sustain elective and cancer recovery
- Workforce and staff-support plans

11. Annual Reports

The following Annual Reports were received and discussed:

- Learning Disabilities Services Annual Report**
- Mental Capacity Act and Deprivation of Liberties Safeguarding Annual Report**
- Research and Development Annual Report
- Patient Experience and Engagement Annual Report

**These reports will be made available in the Board reading room.

12. Recommendation

The Board is asked to note the updates from the October and November 2022 meetings.

Dame Parveen Kumar
Committee Chair
November 2022

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	3 November 2022	**Agenda No**	**2.1**
Report Title:	**Learning from Deaths and Mortality Monitoring Group (MMG) Report – Quarter 1 2022/23 (April – June 2022) - SGUH**		
Lead Director:	Dr Richard Jennings, Group Chief Medical Officer Dr Luci Etheridge, Site Chief Medical Officer		
Report Author:	Kate Hutt, Head of Mortality Services Mr Ashar Wadoodi, Lead for Learning from Deaths		
Presented for:	Discussion Update		
Executive Summary:	The paper provides an overview of the work of the Mortality Monitoring Group (MMG) and Learning from Deaths in Q1 2022/23. Updates against agreed objectives are outlined, encompassing all workstreams included in the local Learning from Deaths framework. A summary of progress related to the strengthening of Mortality & Morbidity (M&M) meetings across the Trust is included. Having established effective administrative support of M&M meetings the team are now focusing on supporting the implementation of the Learning from Deaths template which was agreed in June 2022. Details are provided regarding the expansion of the ME service to scrutinise all non-coronial deaths in Merton and Wandsworth. Key developments include initiation of a pilot in Merton, which will include 15% of the population and recruitment of 2 GPs to join the Medical Examiner Officer at St George's. Formal notification of the intention to move to a statutory service from April 2023 is also discussed. Established local mortality review processes and associated outcomes are reported, including a summary of the findings of structured judgement reviews over the last quarter. National mortality measures are also reported. Our summary hospital level mortality indictor (SHMI) is as expected, and our hospital standardised mortality ratio is lower than expected.		
Recommendation:	• To note the progress against the objectives for MMG and Learning from Deaths, particularly around the implementation of the Learning from Deaths template • To note the assurance provided by the TIAA review of mortality and to support the associated recommendations. • To note and support progress with the expansion of the ME service to include non-acute deaths in preparation for the move to a statutory system from April 2023.		
Committee Assurance:	The Committee is also asked that in considering contents of this report, its supporting documents and the discussion at the meeting which of the following assurance rating it would provide to the Trust Board. • **Substantial Assurance:** The report and discussions assured the Committee that there are robust systems of internal controls operating effectively to ensure that quality and safety risks are managed to deliver high quality services and care to patients.		

	• **Reasonable Assurance:** The report and discussions assured the Committee that the system of internal controls is generally adequate and operating effectively but some improvements are required to ensure that quality and safety risks are managed to deliver high quality services and care to patients. • **Limited Assurance:** The report and discussions supported the Committee's conclusion that that the system of internal controls is generally inadequate or not operating effectively and significant improvements were required to ensure that the quality and safety risks are managed effectively to improve the position and ensure that high quality services and care is provided to patients. • **No Assurance:** The report and discussions led the Committee to conclude that there was a fundamental breakdown or absence of core internal controls and systems to enable the Trust to deliver high quality services and care to its patients.		
Supports			
Trust Strategic Objective:	Care. Reducing avoidable harm.		
CQC Theme:	Safe and Effective (Well Led in implementation of new framework)		
Single Oversight Framework Theme:	Safe		
Implications			
Risk:	Work to clearly define and implement Care group and Trust (Learning from Deaths and governance) processes, and their interconnectivity, is progressing but is not fully mature. Finalising this will ensure governance is effectively managed and opportunities for learning are not missed.		
Legal/Regulatory:	'Learning from Deaths' framework is regulated by CQC and NHS Improvement, and demands trust actions including publication and discussion of data at Board level.		
Resources:			
Previously Considered by:	N/A	**Date**	N/A
Equality Impact Assessment:	N/A This is in line with the principles of the Accessible Information Standard		

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

1.0 PURPOSE

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

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

2.0 LEARNING FROM DEATHS

This quarter we have continued to liaise closely with our colleagues at Epsom & St Helier. We have established a regular meeting between their Associate Medical Director and Lead Mortality Reviewer and our Learning from Deaths Lead and the Head of Mortality Services. In the meeting we share our approaches to mortality governance with the aim of enhancing practices at both trusts and to move towards greater alignment.

Following approval by the Mortality Monitoring Group, the revised Learning from Deaths policy was ratified by the Patient Safety and Quality Group in June. The third version of the policy incorporates only minimal changes, which include clarification of the role of site and group Chief Medical Officers. The role that nurses, midwives and allied health professionals play in contributing to this important element of governance is also highlighted. In line with NHS England recommendations the categories of death in scope for structured judgement review has also been extended to include patients with a clinical diagnosis of autism. Greater detail is provided on which patients with a mental health diagnosis should be subject to case record review and how we will begin to identify deaths within thirty days of discharge.

The assurance review of mortality conducted by our auditors, TIAA, was completed this quarter and was reported to MMG in June. This review was linked to the key strategic risk that 'We are unable to provide outstanding care as a result of weaknesses in our clinical governance'. The scope of the project was to assess if systems and processes are in place for ensuring a consistent and coordinated approach for the review of deaths in hospital, including identification of key themes, learning points and reporting mechanisms, and if there is monitoring via appropriate key performance indicators and that outcomes are regularly reported. The review found reasonable assurance that adequate and effective governance, risk and control processes are in place for mortality.

The key findings resulted in five actions, all of which have been accepted. The management action plan which is summarised below was agreed by MMG in July 2022. The responsible officer for all actions is the Head of Mortality Services. Recommendations 1, 2 and 3 are graded as important; recommendations 4 and 5 are graded as routine and have already been completed.

Recommendation	Management Comments	Timeline
1. Ensure the Learning from Deaths Policy is updated following the rollout of the currently piloted adaptation of the Structured Judgement Review, and finalisation of key datasets and supporting documentation.	The policy will be updated to make the distinction between the use of the SJR for mortality reviews completed by the independent, corporate team and the standardised approach that will be adopted for care group level mortality reviews. The Learning from Deaths	31/12/22

	template and supporting Mortality & Morbidity Meeting Terms of Reference, are nearing finalisation and will be implemented over the coming 6 months.	
2. Establish a central log of actions and key learning points raised in each of the Care Group meetings to assist in carrying out trend analysis and identifying lessons learnt across the various Care Groups.	We will build on the work underway in individual care groups and work on formulating a database that can be used by M&M coordinators to record actions and learning in one system. We will use this data to support the triangulation of safety and governance intelligence and develop processes to share learning between and across divisions and the Trust as a whole. This will be reflected in the Terms of Reference for Mortality & Morbidity meetings.	30/06/23
3. Review the potential of moving to a web-based system for the Trust's mortality records, and develop a Business Case accordingly.	We will link with the Head of Patient Safety who is responsible for Datix and the development of a business plan to upgrade the Trust's version of the programme. We will ensure that we scope the potential for improving mortality review processes as part of the upgrade project and if appropriate that this is included as part of any Trust business plan. We will also liaise with partners in our hospital group to learn from their use of Datix to support mortality processes.	31/12/22
4. Update the Learning from Deaths Policy to include Nurses, Allied Health Professionals and other clinical staff, under "Roles and Responsibilities", at next update.	The policy was updated and presented to the Patient Safety and Quality Group on 15/06/22 for ratification. The policy was approved in principle, subject to closer consideration of this amendment by the Chief Nurse.	Complete
5. Update the Learning from Deaths Policy to reflect the change in name of the Mortality Monitoring Committee to the Morbidity and Mortality Group, at next update.	All references to the Mortality Monitoring Committee have been changed to the Mortality Monitoring Group. Care group/service level meetings are referred to as Mortality & Morbidity (M&M) meetings.	Complete

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

In February 2022 MMG agreed several priorities for the following six months. These objectives are designed to support continued improvement of processes around mortality monitoring, which in turn support greater learning and consequently, improvements to patient care. These cover each of the workstreams incorporated in our local Learning from Deaths framework and are summarised in the table below, alongside the action owner and progress to date. During the last two quarters there has been considerable progress in relation to

development of Mortality and Morbidity (M&M) meetings and the Learning from Deaths agenda. It is anticipated that progress with mortality investigations will be reported to MMG in August 2022 and will be reported in the next version of this report.

Mortality investigations to be concluded		
Acute myocardial infarction	The service is conducting a full investigation, which is scheduled for completion and reporting to MMG by August 2022.	Cardiology Clinical Governance Lead
Intracranial injury	This diagnosis grouping has not shown as an alert for several consecutive months. The Deputy Chief Medical Officer (Safety) and Learning from Deaths Lead are to meet with the Neurosurgery senior team to gather assurance that outcomes are being effectively monitored and assessed. They will agree an investigation process that can be rapidly implemented if any diagnosis or procedure groups have higher than expected mortality in the future.	Neurosurgery Clinical Governance Lead
Major trauma (TARN)	The Clinical Lead for Major Trauma will present a report to MMG in August 2022 which brings together key improvement streams and details the essential actions required to improve our service. To provide oversight MMG intend to monitor progress on a regular basis.	Major Trauma Lead
Mortality and Morbidity meetings development		
Continue pilot of M&M template, refine and implement more widely	Following feedback from pilot services and the palliative care team refinements have been made to the Learning from Deaths template and this was launched at the Clinical Governance Leads meeting in June 2022. The M&M coordinators are working with clinical teams to implement the agreed dataset, which is included as Appendix 1 to this report.	Ash Wadoodi & Kate Hutt
Define minimum standards for M&M meetings	Following consideration of the first draft of M&M Terms of Reference at MMG in May 2022 several revisions were made, and an updated version was provided to Clinical Governance Leads for review following the forum meeting in June. These are included as Appendix 2.	Ash Wadoodi & Kate Hutt
Engage with clinical governance leads to ensure that minimum standards are being met	KPIs and audit will be implemented following agreement of minimum standards as defined in the Terms of Reference. It is intended that the first audit of implementation and adherence to KPIs will be conducted in December 2022, following trust-wide implementation. A quarterly programme of audit will be in place until MMG is assured that a consistent approach is embedded. The frequency of audit will then be set out by MMG.	Ash Wadoodi & Kate Hutt
Explore ways to collate and share learning, possibly	Ad hoc sharing of learning takes place and divisions are expected to identify and share learning in quarterly reports to Patient Safety &	Ash Wadoodi & Kate Hutt

including development of a database and reporting to MMG	Quality Group. As recommended by TIAA we will research databases available, such as Datix Cloud IQ. The Head of Mortality Services has met with the Lead Mortality Reviewer at Epsom & St Helier to see how they are using Datix to support this work and a demonstration from Datix has been arranged for August. We will also explore the potential to develop an inhouse system which will make this learning more robust.	
Recruit to vacant posts	Complete. Two new team members took up post in June, bringing the M&M coordinators team to full capacity.	Kate Hutt & Maureen Ijomoni
Participate in TIAA evaluation of current status of service	Complete. The audit report was published in June and concluded that there was reasonable assurance of adequate and effective governance, risk and control processes in respect of mortality governance arrangements. Five recommendations were made and accepted.	Ash Wadoodi & Kate Hutt
Learning from Deaths agenda		
Train and induct new reviewers so that we have a full mortality review team	Complete. All reviewers are trained and are completing structured judgement reviews.	Ash Wadoodi
Define standard operating procedures for Learning from Deaths processes	Currently being drafted and scheduled for discussion at MMG in Q2.	Kate Hutt & Ash Wadoodi
Review MMG terms of reference	Complete. These have been updated and agreed at MMG in April.	Kate Hutt
Review Learning from Deaths policy	Complete. The policy has been reviewed with only minimal revisions required. MMG endorsed the policy in MMG in March and was presented to PSQG for ratification in June.	Kate Hutt

2.2 **Development of Mortality & Morbidity processes**

The Mortality & Morbidity (M&M) Coordinators Team has now been in place for a year. Individual performance reviews for all established coordinators have been completed with objectives and learning plans for the next year agreed which will support the continued development of the service. Two new coordinators joined the team in June 2022, returning the service to full establishment.

In addition to continuing to provide administrative support and facilitating M&M meetings the coordinators are currently working with clinical governance leads to implement the Learning from Deaths template which was agreed following the governance forum in June. The template is included in Appendix 1. Where services require further support with implementation this will be supported by the Clinical Lead for Learning from Deaths, and if

required the Deputy Chief Medical Officer (Safety). We intend to conduct the first audit of implementation in December, which will be reported in this paper subsequently.

Terms of Reference have been drafted. These define minimum standards, supported by evidence from sources such as the Royal College of Surgeons and the Royal College of Physicians. The draft, which has been shared with Clinical Governance Leads, is attached as Appendix 2. It is anticipated that these will be refined, in response to any feedback received and implemented in quarter 2.

2.3 **Medical Examiner Service**

NHS England sent an official letter to all NHS trusts, GP practices, integrated care boards and primary care networks on 11th July 2022. The letter clarifies the intention that the medical examiner system will be made statutory from April 2023 and sets out what local health systems need to do to prepare for this. The letter calls for positive engagement across all healthcare systems to overcome practical and logistical challenges. The most significant challenge to date has been around data sharing and we will continue to work with non-acute colleagues to find pragmatic solutions.

We have continued our work to extend medical examiner (ME) scrutiny to the non-acute sector, working collaboratively with leaders from primary care through our Merton and Wandsworth GP task and finish group. Following a visit to the Nelson Medical Practice to meet with GPs and their support team we have agreed our first pilot start date in July. This practice has a significant role in the local healthcare system, providing care to 30,000 patients, which is equivalent to 15% of the population of Merton. The learning from this pilot will be invaluable as we roll out the pilot to additional practices.

It is expected that the workload of our office will double when all non-coronial deaths are scrutinised. We have made significant progress with our mapping of GP practices and other healthcare providers in Merton and Wandsworth. With over 60 practices and several other providers there is a significant amount of work ahead of us. During quarter 2 we will be extending our pilots sites and compiling a timetable to bring all providers into the service by the April 2023 deadline. A number of other milestones have been agreed with our Regional Medical Examiner and we will report on those at the end of quarter 2. The Lead ME has identified to the Trust where executive support may be required, which includes finding solutions to data sharing issues, increased space for the expanded team and support to ensure that financial flows from NHS England into the Trust are clear and well understood.

We continue to build and develop the team. This quarter we successfully recruited two local GPs to our ME service. These new members of the team will take up post in September and will bring our establishment to 12 PAs. This increased resource, along with the specialist knowledge and skills of general practitioners, will be fundamental to successful expansion. Medical Examiner Officers have a key role to play in the service and this month two members of the team completed their mandatory training, delivered by the Royal College of Pathologists. To reflect the change in scope and clarify the independence of our service it has been agreed with our Regional Medical Examiner that our service will be known as the Merton & Wandsworth Medical Examiner Service, based at St George's.

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

DEATHS OCCURING AT THE ME OFFICE SITE THAT HAVE BEEN SCRUTINISED BY THE ME		
Number of in-hospital deaths scrutinised		**358**
Adult deaths		
Cases not notified to the Coroner and MCCD issued directly		268
Cases notified to the Coroner and MCCD issued following agreement by Coroner		31
Cases referred to the Coroner and taken for investigation		55
Child deaths		
Cases not notified to the Coroner and MCCD issued directly		3
Cases notified to the Coroner and MCCD issued following agreement by Coroner		0
Cases referred to the Coroner and taken for investigation		1
Timeliness and rejections by registration service		
MCCDs not completed within 3 calendar days (NB: no account of BH or weekend and requirement is 5 days)		60
MCCDs rejected by registrar		1
Urgent release of body is requested and achieved within requested time		24
Urgent release of body is requested and NOT achieved within requested time		2
Achieving communication with the bereaved		
Number of deaths in which communication did not take place		33
Reasons for no communication:	Declined	0
	No response	23
	No NOK	3
	Other	7
Detection of issues and actions		
ME referred for structured judgement review		28
ME referred to other clinical governance processes		1
ME referred to external organisation		0
Families referred to PALS		12

We are committed to trying to reach all those bereaved and having reflected on these data we will refine our processes to ensure we offer discussion from the ME service for all deaths that occur out of hours or outside of St George's. It should also be noted that the higher than normal number of medical certificates not issued within 3 calendar days reflects that there were two 4 day weekends this quarter.

3.0 MONTHLY INDEPENDENT REVIEW OF MORTALITY

3.1 During this quarter, independent reviews, using the structured judgement review (SJR), have been completed for 29 deaths. 28 of these were referred to the Learning from Deaths Lead by the Medical Examiner Office. The reasons for review are summarised below.

Triggers for review	
Confirmed learning disability	4
Significant mental health diagnosis	10
ME or clinical team detected possible learning or potential issue with care	5
Deaths following elective admission	4
Areas subject to enhanced oversight	3
Family raised significant concerns	2
Maternal death	1

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

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

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

3.2 **Overview of April 2022 to June 2022**

Between April and June 2022 there were 358 deaths. Members of the Mortality Review Team (MRT) reviewed 29 deaths, representing 8.1% of deaths. The findings from these structured judgement reviews are summarised below. It should be noted that all child deaths are reviewed locally by clinical teams and by the Child Death Overview Panel.

The structured judgement review methodology requires reviewers to identify problems in healthcare and to assess whether these have caused harm. Of the 29 deaths reviewed this quarter problems were identified in relation to 9 (31.0%) of the patients reviewed. Two patients experienced two problems in healthcare, resulting in 11 problems in total. None of the problems in healthcare identified were felt to have resulted in harm to the patient.

Problem in healthcare	No harm	Possible harm	Harm	TOTAL
Assessment	1	0	0	1
Medication	1	0	0	1
Treatment	0	2	0	2
Infection control	0	0	0	0
Procedure	2	0	0	0
Monitoring	0	1	0	1
Resuscitation	1	1	0	2
Communication	0	0	0	0
Other	2	0	0	2
TOTAL	7	4	0	**11**

An assessment of overall care is also provided for each death reviewed. In 5 deaths (17.2%) the care provided was rated as excellent. For most patients (18, 62.1%) care was evaluated as good; for 5 patients (17.2%) care was felt to have been adequate. In one case the reviewer judged there to have been poor care and raised a concern regarding the possibility of a missed diagnosis of a non-ST elevation myocardial infarction. This incident (DW171292) is currently being investigated by the division and will then be considered for discussion at the SI declaration meeting.

Overall care judgement	Number	Percentage
Excellent care	5	17.2
Good care	18	62.1

Adequate care	5	17.2
Poor care	1	3.4
Very poor care	0	0
Total	**29**	

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

Avoidability of death judgement	Number	Percentage
Definitely not avoidable	25	86.2
Slight evidence of avoidability	3	10.3
Possibly avoidable but not very likely (less than 50:50)	1	3.4
Probably avoidable (more than 50:50)	0	0
Strong evidence of avoidability	0	0
Definitely avoidable	0	0
Total	**29**	

3.3 **Learning disabilities**

All deaths that occur in patients with learning disabilities (aged 4 and over), and adults with a clinical diagnosis of autism, are reported to the national Learning Disabilities Mortality Review Programme (LeDeR). The LeDeR reviews are co-ordinated by the Clinical Commissioning Group and we have established effective liaison with these colleagues. We work closely together to share our local independent mortality reviews and in turn receive redacted copies of the completed LeDeR review.

Using our standard SJR methodology the mortality review team carry out local review of each death which meets the criteria for a LeDeR review. The table below summarises these deaths from the beginning of 2018/19 to the end of Q2 2022/23. In total there have been 72 deaths, with reviews completed for all.

This quarter there have been four deaths of patients with a learning disability. In three of the cases the death was judged to be definitely not avoidable. In the remaining case completion of the SJR suggested that there was slight avoidability and enquiries were therefore made of the clinical team. The query, which was regarding potential recruitment to a clinical trial within cardiology, was resolved by the clinical team's response which provided assurance that correct procedures had been followed. Overall care was judged to be excellent for 2 patients, and good for 2 patients.

LD DEATHS Avoidability of death judgement score	**2018/19**	**2019/20**	**2020/21**	**2021/22**	**2022/23 Q1**
TOTAL DEATHS	**9**	**16**	**22**	**21**	**4**
REVIEWS COMPLETED	**9**	**16**	**22**	**21**	**4**
Definitely not avoidable	9	16	22	18	3
Slight evidence of avoidability	0	0	0	3	1
Possibly avoidable (< 50:50)	0	0	0	0	0

Probably avoidable (> 50:50)	0	0	0	0	0
Strong evidence of avoidability	0	0	0	0	0
Definitely avoidable	0	0	0	0	0

4.0 LEARNING FROM MORTALITY: INVESTIGATIONS

Section 2.1 notes that there are three investigations ongoing: acute myocardial infarction, major trauma (TARN); and intracranial injury. The investigations of the first two of these areas are in progress with the Mortality Monitoring Group scheduled to receive an update in August 2022. The outcome will be reported in the Quarter 2 version of this report. It should be noted that each investigation must link with divisional governance processes. Divisional Governance Boards should receive updates on progress, which in turn should be reported by the division to Patient Safety and Quality Group (PSQG) until PSQG is satisfied that adequate assurance has been provided.

The intracranial injury diagnosis group is no longer observed as having higher than expected mortality, according to analysis of data generated via Dr Foster benchmarking tools. MMG has therefore concluded that no further investigation is required at this time. However, the Associate Medical Director (Safety) and the Clinical Lead for Learning from Deaths have arranged to meet with senior members of the neurosurgery team to gain assurance that outcomes are being routinely measured and assessed and to agree an investigation methodology that can be deployed should any mortality signal be observed in the future.

5.0 LATEST NATIONAL PUBLISHED RISK-ADJUSTED MORTALITY

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

The latest SHMI data, covering discharges from March 2021 to February 2022, was published on 14th June 2022. The Trust's overall mortality is categorised as 'as expected' at 0.91. We were one of 97 trusts in this category.

During the 12-month period there were 65,010 inpatient spells at the Trust, with 1,590 deaths observed, compared to 1,740 expected deaths. It should be noted that NHS Digital exclude Covid-19 activity from the SHMI publication in order to make the indicator values as consistent as possible with those from previous reporting periods. The SHMI is not designed for pandemic activity and the statistical modelling used to calculate the SHMI may not be as robust if such activity was included. Excluding Covid-19 activity means that, as far as possible, consistency is maintained and each SHMI publication can be interpreted in the same way.

NHS Digital provides a SHMI value for ten diagnosis groups, detailed below. The latest information is summarised in the table below and shows that our mortality is either lower than, or in line with what would be expected for all the diagnosis groups analysed.

Diagnosis Group	SHMI value	SHMI banding
Acute bronchitis	*	*
Acute myocardial infarction	1.30	As expected
Cancer of bronchus; lung	0.65	Lower than expected
Fluid and electrolyte disorders	0.87	As expected
Fracture of neck of femur (hip)	0.99	As expected
Gastrointestinal haemorrhage	1.15	As expected

Pneumonia (excluding TB/STD)	0.79	Lower than expected
Secondary malignancies	1.06	As expected
Septicaemia (except in labour), shock	0.85	As expected
Urinary tract infections	1.14	As expected

* Numbers are too low to disclose

5.2 **Hospital Standardised Mortality Ratio (HSMR)** [source: Telstra/Dr Foster]
For the most recent 12 months of data reported by Dr Foster (April 2021 to March 2022) our mortality is lower than expected. In contrast to NHS Digital, Dr Foster Intelligence has not excluded Covid-19 activity from their analysis.

HSMR analysis: April 2021 – March 2022	**Value**	**Banding**
HSMR (all admission methods)	83.5	Lower than expected
HSMR: Weekday emergency admissions	79.9	Lower than expected
HSMR: Weekend emergency admissions	91.6	As expected

Analysis of mortality at diagnosis and procedure group level is considered by MMG. This quarter one investigation was completed as summarised below. This investigation is considered complete, with no further scrutiny currently required, beyond ongoing monitoring.

Group	**Action**
Genitourinary symptoms & ill-defined conditions	This signal was first observed in the March MMG meeting. For the period December 2020 to November 2021 there were 5 deaths observed (out of 584 patients), against an expected 0.8. The clinical coding of these cases was reviewed, and it was found that the coding was incorrect in 2 of the cases. All of the cases were emergency admissions, with most treated within Acute Medicine. The patients were cared for on different wards, under different consultants. The patients died from a range of causes including cancer, acute renal failure and pneumonia. In no cases were concerns raised that required structured judgement review. In June MMG concluded that there were no themes or patterns in the data. In light of the small number, alongside coding errors, it was agreed that no issues of clinical concern were present that required further examination. The investigation is considered complete.

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Appendix 1: Learning from Deaths template

MRN	Click to enter text.		**Patient initials**	Click to enter text.	
Age	Click to enter text.		**Sex**	Choose an item.	
Date of death	Click to enter date.		**Date of admission**	Click to enter date.	
Datix	Yes ☐ No ☐		**Reference**		
Detail	Click here to enter text.				
Duty of candour	Yes ☐ No ☐ N/A ☐				
Reason for discussion	Choose an item.				
Brief case summary	Click here to enter text.				
Category of death	Expected death ☐ Unexpected death ☐				
DNACPR in place	Yes ☐ No ☐		**Appropriate TEP in place**	Yes ☐ No ☐	
Were 5 priorities of care for the dying person followed	Yes ☐ No ☐		*[Recognise, communicate, involve, support, plan & do]*		
Issues identified with End of Life care	Click here to enter text.				
Referral to coroner	Yes ☐ No ☐				
Cause of death (if MCCD issued)	1a	Click here to enter text.			
	1b	Click here to enter text.			
	1c	Click here to enter text.			
	2	Click here to enter text.			
Problems in care identified	**System factors**	Yes ☐ No☐	**Human factors**	Yes ☐ No☐	**Patient factors** Yes ☐ No☐
Please provide detail	Click here to enter text.				
Scoring of case	Choose an item.				
Key learning points identified	Click here to enter text.				
Good practice identified	Click here to enter text.				
Were staff supported appropriately	Yes ☐ No ☐		**If no, confirmation support now offered**	Yes ☐ No ☐	
Further review	**Escalation**	Yes ☐ No☐	**Datix**	Yes ☐ No☐	**Specialist input** Yes ☐ No☐
Detail	Click here to enter text.				

Outstanding care every time

St George's University Hospitals NHS Foundation Trust

Clinician completing review		Role		Date	Click to enter date.

Appendix 2: M&M Terms of Reference - DRAFT

Morbidity and Mortality (M&M) Meetings Terms of Reference DRAFT

1.0 Purpose

- To enable learning arising from the review of deaths and serious complications to be identified
- To ensure that any learning identified is shared across the care group and where appropriate to Divisional Governance board and/or the whole Trust
- To escalate to Serious Incident Decision Making (SIDM) group any incident or death that may meet the criteria for a serious incident if it has NOT previously been raised as a concern

2.0 Background

These terms of reference (ToR) have been written to provide a framework for M&M meetings across the whole Trust. There is already excellent practice in many areas but also some inconsistency and a lack of coordination and sharing of learning between groups. Most of these meetings will be based in care groups but the ToR also apply to directorates such as Major Trauma and Cancer.

These ToR use existing guidance from the Royal Colleges and other authoritative sources to set standards and expectations of all M&M meetings. The text boxes contain direct quotes from those sources to give a sense of the way in which these meetings should be conducted. Participants should always observe the Trust values. Those who do not behave in a reasonable, collaborative and constructive way should expect to be challenged.

The ToR have been developed by the Learning from Deaths (LfD) team with input from the clinical governance leads and support from the Medical Directorate to ensure they are fit for purpose and do not disrupt any existing good practice. They will be reviewed in xxx 2023 and updated to take account of any issues identified in practice.

3.0 Aims and objectives

> *"All participants in the M&M meeting share a responsibility for creating and maintaining an environment that is conducive to an objective, honest and non-judgemental review of adverse outcomes"*[1]

The aim of the discussion at the M&M meeting is to understand the cases and to identify if there is any learning that will improve future care for patients at St Georges. This will be done by:

- Using the LfD template to systematically review all aspects of care and reaching a consensus as to whether there are any areas that could have been improved
- Benchmarking the care provided against best practice guidance where available
- Identifying whether there are any themes arising from case reviews that require further attention
- Recording a summary of the discussion and completing and ensuring that the LfD template is fully completed and returned for every death discussed
- Agreeing any actions that should be implemented at care group (or directorate) level for the prevention of adverse outcomes in the future
- Identifying cases where there is learning that may be applicable to other settings in the Trust that should be escalated to the Divisional Governance team

4.0 Scope

4.1 Deaths that should discussed[2]

- All deaths of those with learning disabilities and with severe mental illness
- All deaths in a service specialty, or a particular diagnosis or treatment group where an 'alert' has been raised with the provider, e.g. Dr Foster, Standardised Hospital Mortality Indicators, Quality alerts, National audits, etc.
- All deaths in areas where people are not expected to die, for example after elective procedures
- Any death where concerns have been raised about the care including by family members or staff
- All deaths where learning will inform care group or the Trust's existing or planned improvement work
- All deaths where a Serious Incident has been declared
- All deaths where the LfD team has raised a concern
- All deaths where the Medical Examiners' Office has identified the need for further scrutiny

4.2 Complications/Morbidity to be discussed

- Morbidity as defined within the care group or according to national guidance
- All cases where serious complications have occurred even there is no perceived failing in care. A serious complication is defined as an unexpected worsening in severity of disease or the development of new signs, symptoms or unexpected pathological changes which may become widespread throughout the body and affect other organ systems (e.g. severe sepsis).
- Any case where concerns have been raised about the care including by family members or staff
- All cases as determined by local agreement/protocols
- All cases where learning will inform the care group or Trust's existing or planned improvement work.

"There are many ways to conduct ….. meetings, but it is useful to have some principles:

- *Hold regular meetings: sustainability is dependent on commitment by staff to be present at a regular time every week or month.*
- *Confidentiality: encourage open discussion inside the meeting, but no discussion of specific cases outside.*
- *Audits should not be an exclusive activity for medical staff, but require active and voluntary participation of all clinical staff and relevant technical staff.*
- *Feedback to and involvement of all staff is important.*
- *Be non-blameful and non-threatening, and welcoming to all staff.*
- *The team leader should be open about declaring his/her own failings. This can put junior staff at ease.*
- *Audit meetings should have a strong educational aspect; take the opportunity to teach on subjects that arise when they are relevant to quality of care.*
- *Use a team approach in identifying and solving problems: seek a wide spectrum of views on modifiable factors and solutions.*
- *Be respectful and acknowledge all health workers' efforts. Try to understand how they are feeling.*
- *Move from specific cases to general issues.*
- *Encourage good documentation, which is essential for accurate data collection and communication.*
- *Look for common patterns of avoidable events; do not just react to a single rare mistake or event.*
- *Do not single out individuals for blame. The team leader should emphasise system changes and the lessons from which everyone can learn. Modifiable factors should be viewed as offering opportunities for improvement.*
- *Consider the entire health system when trying to understand modifiable factors in deaths, not just referral-level hospital care."*[4]

5.0 Membership

5.1 Core members

- Clinical Governance Lead (Chair) - a deputy should be nominated so that meetings may proceed even if the Governance lead is absent. In some groups the clinical lead may be nominated as the chair for meetings where deaths are discussed.
- M&M Coordinator
- Medical Consultants
- Medical staff in training
- Senior Nursing Staff including Nurse Consultants and Nurse specialists as well as senior ward and theatre staff where appropriate
- Any other staff regularly involved in the delivery of patient care relevant to the cases to be discussed

5.2 Other Participants

Other members of staff may be invited to attend, such as Anaesthetists, Service Managers, Technical staff and other support staff where the Chair considers they can contribute to the discussion of a case

6.0 Schedule

- M&M meetings should take place regularly and be of sufficient length for discussion of all cases. The exact duration and regularity will be determined by the size and speciality of the service however meetings should not take place less that once per quarter. The program of meetings should be agreed locally and recorded centrally
- The meeting schedule should be reviewed if meetings routinely over-run or cases are regularly deferred
- The meeting should be held within regular working hours or at another time agreed by all parties to ensure all staff are able to attend
- All cases should be presented at the earliest opportunity after it is determined that a case meets the criteria for review.

7.0 Process

> *"Culture can play a significant influencing role on the speed, effectiveness and lifespan of improvement initiatives within organisations."*[3]

- Cases should be allocated sufficiently far in advance of the meeting to allow time for preparation
- M&M review form/slides should be completed prior to the meeting by either a registrar, or other substantive team member with support from a nominated consultant
- Preparing the presentation must involve gathering all relevant patient information and imaging.
- The M&M coordinator can support collection of non-clinical data
- The presentation should follow a standardised format to ensure consistency and understanding. This format should include the agreed Trust core data set for informing the LfD template with additions agreed locally
- Prepared materials should be sent to the meeting coordinator in advance of the meeting
- M&M review forms/slides should be presented by either a registrar, or other substantive team member
- Where cases involve critical input from another team, clinicians from other specialties should be invited to the M&M meeting

8.0 Roles and Responsibilities

8.1 M&M meeting Chair

> *"The chair of an M&M meeting should be able to demonstrate good leadership skills. Key attributes of good leaders that are also relevant when chairing an M&M meeting are:*
>
> - *Being honest, open and consistent;*
> - *Being accessible;*
> - *Being open to challenge and feedback;*
> - *Being decisive;*
> - *Being self-aware and mindful of their impact on others."*[1]

Prior to the meeting the M&M Group Chair should:

- Agree the agenda for the meeting
- Ensure the cases put forward for review meet the agreed selection criteria
- Prioritise the cases for review so that those with important learning points are not postponed
- If they will not be able to attend ensure a deputy is in place in order that the meeting can proceed

During the meeting the M&M Group Chair should:

- Ensure minutes and actions from the previous M&M meeting are agreed
- Ensure all planned M&M review forms/slides have been presented and cases are appropriately prioritised and timed
- Ensure there is an open and non-confrontational discussion of the cases
- Ensure that all participants in the meeting are given an opportunity to comment if they wish to do so
- Clearly articulate the learning and outcomes of discussions for summary by the minute taker
- Ensure that any actions arising are identified and recorded
- Ensure that any actions agreed are assigned to an appropriate individual with an agreed timescale
- Ensure the LfD template is completed for all deaths discussed.

Following the meeting the M&M Group Chair should:

- Ensure that the record of the meeting accurately reflects the outcome of the discussion and is circulated
- Follow up any cases that have been classified as meeting the agreed escalation criteria
- Ensure that a copy of any completed LfD templates are returned to the LfD office.
- Ensure the escalation of relevant cases to the Divisional Governance team
- Ensure other agreed actions are completed

8.2 M&M Coordinator

Key responsibilities include:

- Supporting the Chair to circulate an invitation prior to the M&M meeting
- If required, collect non-clinical data to contribute to preparation of M&M case reviews
- Provide a printed attendance log for attendees to sign and collect the attendance logs after the meeting
- Record minutes during the meeting and document all learning and action points and those to who the actions are assigned
- Submit the minutes, actions and learning points to the Chair for review and approval
- Disseminate approved minutes, actions and learning points
- Collect and store all M&M records including minutes, slides and LfD templates on the appropriate shared drive
- Update any relevant databases and support identification of recurrent themes
- Maintain an action tracker and systems to collate learning
- Consider any reasonable request for admin support, e.g., designing templates and supporting IT

8.3 Consultants

- Attend annually at least 75% of M&M meetings in their care group
- Support presenters to provide accurate and detailed summaries of cases that include enough information to facilitate meaningful discussion
- Contribute constructively and in a non-confrontational way to the discussion of cases
- Lead by example and create an environment which is conducive to learning

8.4 Others

- Senior Nursing Staff including Nurse Consultants and Nurse specialists should attend regularly when the discussion is about the patient cohort whose care they are involved in, and be willing to contribute to the discussion
- Any other staff regularly involved in the delivery of patient care relevant to the cases to be discussed and be prepared to engage in the discussion of cases as invited

9.0 Compliance

- The Governance lead should undertake a self-evaluation of their M&M meetings with respect to these ToR to identify any areas for improvement
- The Mortality Monitoring Group (MMG) will undertake an annual evaluation of M&M meetings to monitor compliance with these Terms of Reference, and effectiveness
- The Clinical Governance lead may be invited to present an overview of activity, learning and actions to the Mortality Monitoring Group on an annual basis

References (links)

1. Mortality and morbidity meetings: A guide to good surgical practice. *Royal College of Surgeons, 2014*

2. National Guidance on Learning from Deaths: A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care. National Quality Board, 2017

3. Implementing Structured Judgement reviews for Improvement. *Royal College of Physicians, 2018*

4. New WHO guidelines on paediatric mortality and morbidity auditing. *Archive of Disease in Childhood, 2019*

Appendix 3: National Quality Board Dashboard – data to 30th June 2022

St George's University Hospitals NHS Foundation Trust: Learning from Deaths Dashboard - June 2022-23

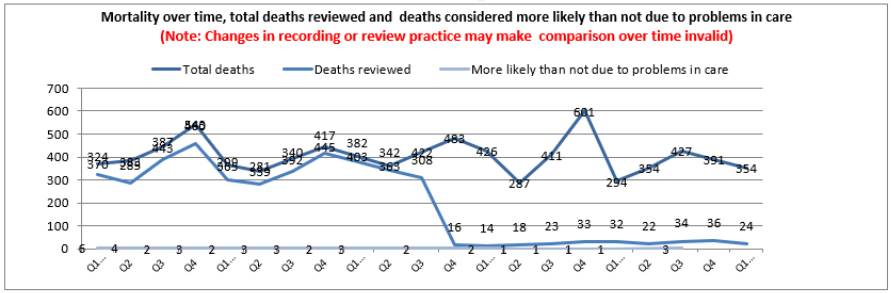
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

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

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

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered more likely than not due to problems in care PRISM Score<=3 or equivalent measure	
This Month	Last Month	This Month	Last Month	This Month	Last Month
113	107	10	6	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
354	391	24	36	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
354	1466	24	124	0	4

Time Series: Start date 2017-18 Q1 — End date 2022-23 Q1



Total Deaths Reviewed, categorised by SJR Avoidability Score

Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	1	10.0%	This Month	9	90.0%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	2	8.3%	This Quarter (QTD	22	91.7%
This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	2	8.3%	This Year (YTD)	22	91.7%

St George's University Hospitals NHS Foundation Trust: Learning from Deaths Dashboard - June 2022-23

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

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

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered more likely than not due to problems in care	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	1				
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
4	7				
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
4	21				

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

Time Series: Start date 2017-18 Q1 End date 2022-23 Q1

Meeting Title:	**Trust Board**		
Date:	3 November 2022	**Agenda No**	**2.2**
Report Title:	**Maternity Services: Perinatal Quality Surveillance Measures September 2022**		
Lead Director/ Manager:	Arlene Wellman, Group Chief Nurse and Director of Infection Prevention and Control		
Report Author:	Laura Rowe, Lead Midwife for Clinical Governance and Risk, Epsom and St Helier University Hospitals NHS Trust (ESTH) Jan Bradley, Director of Midwifery and Gynaecology Nursing, St George's University Hospitals NHS Trust (SGUH)		
Presented for:	Assurance		
Executive Summary:	**1.0 Purpose** The purpose of this report is to provide assurance on the compliance at ESTH and SGUH with 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 (see Appendix 1). A full CNST update report has also been provided for each Trust at Appendix 2 (ESTH paper not submitted for SGUH Board) and 3 respectively including an updated position statement for Continuity of Carer; these reports were shared externally with the LMNS in October 2022. **2.0 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. **On 11 October 2022 new technical guidance was released and the formal submission date for CNST has been revised to 5 February 2023.** **3.0 CNST MIS Safety Action 9 - Summary** Table 1 below details the CNST MIS reporting measures for both ESTH and SGUH and provides a comparison, where appropriate, on the quantitative data provided for Safety Action 9 for both Trusts.		

Safety Action 9 reporting measure (Quantitative information only)	ESTH	SGUH
1.Perinatal Mortality: Total number of deaths	10	53
2. Perinatal Mortality reviews held	2	9
3. Cases referred to HSIB for review	3 open cases 0 closed	4 open cases 0 closed
4. Incidents graded at moderate harm and above	1	5
5. Serious incidents completed	0	2
6. Overdue serious incident report actions	1 (from 2021)	2 (from 2022)
7.Mandatory training compliance	Performance across staff groups from 17% to 92%	Performance across staff groups from 75% to 94.33%
8. Minimum safe staffing	87%	91.2%
9. Service user feedback	N/A	N/A
10.Staff feedback to maternity safety champions	N/A	N/A

4.0 CNST Safety Actions - Summary

Table 2 below outlines the compliance for each Trust associated with the full CNST requirements as detailed in Appendix 2 (ESTH paper not submitted for SGUH Board) and 3.

In addition, with reference to Safety Action 1 both Trusts are required to submit a quarterly report to the Board to summarise compliance with the standards and provide a summary of perinatal death reviews together with any resultant action plans. The quarterly report is included in the Appendix 2 (ESTH paper not submitted for SGUH Board) and 3.

CNST Safety Actions	ESTH	SGUH
1.0 CNST Maternity Incentive Scheme		
1.1 CNST Safety Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard	Compliance: on track	Compliance: on track
1.2 Safety Action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Compliance: on track	Non-Compliant (Ongoing challenges with Euroking being able to support the relevant data submission: an exemption from this safety action has been requested)

	1.3 Safety Action 3: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal (ATAIN) units programme?	Compliance: on track	Partial Compliance: Local pathway not fully implemented
	1.4 Safety Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?	Compliance: on track (Neonatal team have confirmed full compliance, awaiting anaesthetic and nursing response)	Compliance: on track (Neonatal Team have submitted a business case to the board. The Neonatal Nursing team are developing an action plan to address deficiencies)
	1.5 Safety Action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Compliance: on track	Non-Compliant: Due to inability to retain 100% supernumerary status of the B7 shift coordinator
	1.6 Safety Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two?	Non-compliant due to not meeting the 80% target for CO monitoring and not meeting the 80% target of women given information regarding reduced fetal movements	Non-Compliant: Due to data upload and Euroking challenge as with Safety Action 2 above)
	1.7 Safety Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity service?	Compliance: on track	Compliance: on track
	1.8 Safety Action 8: Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your	Compliance: challenge due to ability to access and complete training	Compliance: challenge due to ability to access and complete training

unit training programme over the next 3 years, starting from the launch of MIS year 4? In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multi-professional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and newborn life support, starting from the launch of MIS year 4?		
1.9 Safety Action 9: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	Compliance: on track	Compliance: on track
1.10 Safety action 10: Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) Scheme from 01/04/2021 to 05/12/2022?	Compliance: on track	Compliance: on track

5.0 Continuity of Carer

5.1 ESTH: To continue with the implementation of MCoC as long as it remains safe to do so, and;

- The main focus will be that women from the Black, Asian and Mixed Ethnicity background and those from a vulnerable group will continue to be booked into the integrated teams
- To review the staffing levels within each of our present integrated teams (i.e. those teams booking women into a MCoC model
- We have paused on the implementation of a pilot 'Flexible' MCoC team.
- We have asked the integrated team leaders to pause submitting their teams KPI data, but we plan to re- introduce these submissions at a later date
- MCoC data will still be collected from our digital maternity system BadgerNet led by our maternity data manager

	5.2 SGUH: To continue to provide MCoC within the existing MCoC team provision and to pause implementation of further CoC teams until staffing levels improve and a realistic understanding of the impact extra scale up would have, and; • To continue to focus on women from the Black, Asian and Mixed Ethnicity background and those from a vulnerable group within our existing teams • The teams will continue to submit their KPI data • MCoC data will still be collected
Recommendation:	The Board is asked to note the report.
Committee Assurance:	The Committee is also asked that in considering contents of this report, its supporting documents and the discussion at the meeting which of the following assurance rating it would provide to the Trust Boards. • **Substantial Assurance:** The report and discussions assured the Committee that there are robust systems of internal controls operating effectively to ensure that quality and safety risks are managed to deliver high quality services and care to patients. • **Reasonable Assurance:** The report and discussions assured the Committee that the system of internal controls is generally adequate and operating effectively but some improvements are required to ensure that quality and safety risks are managed to deliver high quality services and care to patients. • **Limited Assurance:** The report and discussions supported the Committee's conclusion that that the system of internal controls is generally inadequate or not operating effectively and significant improvements were required to ensure that the quality and safety risks are managed effectively to improve the position and ensure that high quality services and care is provided to patients. • **No Assurance:** The report and discussions led the Committee to conclude that there was a fundamental breakdown or absence of core internal controls and systems to enable the Trust to deliver high quality services and care to its patients.
Supports	
Trust Strategic Objective:	All
CQC Theme:	All
Single Oversight Framework Theme:	Leadership and Improvement Capability (Well-led)
Implications	
Risk:	None
Legal/Regulatory:	Enforcement undertakings applicable to ESTH and SGH Compliance with the Health and Social Care Act 2008 (Regulations 2014) and CQC Registration Regulations

Resources:	N/A		
Equality and Diversity:	No issues to consider		
Previously Considered by:	Quality Committee	**Date**	20.10.2022
Appendices:	Appendix 1: Safety Action 9: Maternity Services Perinatal Quality Surveillance Measures August 2022 for ESTH and SGUH Appendix 2: ESTH CNST Quarterly Report to Board – (for ESTH Trust Board only) Appendix 3: SGUH CNST Quarterly Report to Board – updated		

gesh

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

Appendix 1

Maternity Services

Perinatal Quality Surveillance Measures September 2022

(CNST Maternity Incentive Scheme: Safety Action 9)

Arlene Wellman, Group Chief Nursing Officer and Director of infection Prevention and control

Trust Board

3 November 2022

Perinatal Mortality

Epsom and St Helier University Hospitals NHS Trust

Rolling Report - Time Period		October 2021 – September 2022
Total Number of Deaths		10
Type of Mortality	Antepartum Stillbirths	6
	Intrapartum Stillbirths	1
	Neonatal Deaths	3
Gestational Age	<24 weeks	1
	24-27 weeks	0
	28 - 31 weeks	0
	32 - 36 weeks	5
	37-41 weeks	3
	≥ 42 weeks	1

- 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 (stillbirth 2.93/1000, neonatal death 1.13/1000 and extended perinatal (both together) 4.06/1000). Our rates were similar to or lower than similar Trusts
- 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

How to deliver outstanding care.

Perinatal Mortality Reviews

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

- A PMRT panel was held on 16 September 2022 and two cases were discussed. In both cases there were no care or service delivery issues identified which directly contributed to the outcome. Other learning points were identified and action plans will be formulated when the reports are finalised
- A detailed report of PMRT cases and actions is submitted quarterly to the Quality Committee in Common (QCiC)
- There have been no clear themes identified, but there are currently 2 open actions relating to appropriate referrals and the management of intrauterine growth restriction (IUGR) and completion is monitored by the Risk Team. Updates on completion of actions have been requested from the leads as the actions were not completed by the end of quarter 2 as expected

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 3 open cases being reviewed by HSIB
- There were no cases closed by HSIB during September 2022
- Details of all HSIB cases are presented to the Trust Serious Incident Panel and the completion of actions are monitored
- There are currently 2 open actions; these relate to strengthening guidance around antepartum haemorrhage and triage. The first action is due to be completed at the next guideline group, and the management of triage is undergoing a wider conversation in relation to adopting the BSOTS system (Birmingham Symptom-specific Obstetric Triage System). These actions will be closed by the end of quarter 3
- 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 September 2022 which resulted in moderate or above harm.

- The patient had a c-section on 23 July 2022 (this was her second c-section) and Surgicel was used. She presented to the ED 1 month later on 27 August 2022 with a hard swelling of the lower abdomen which was found to be a large, infected collection. Management was initially with IV Tazocin, and subsequently with laparotomy and drainage of the collection and insertion of a Robinson's drain. There were dense adhesions noted during surgery. The patient was discharged with oral antibiotics on 9 September 2022.

Contributory Factors and Root Cause for Completed Serious Incident Reports

There were no Serious Incident Reports completed in August 2022

Progress against Serious Incident Action Plans

There is one action outstanding in respect of Serious Incident Reports:

- A review of the guideline in respect of counting swabs is also being undertaken (due 31/08/2021 and was expected to be completed by the end of September 2022). This outstanding action has been escalated to the Director of Midwifery and Gynaecology

Mandatory training compliance

Training compliance will be finally assessed in December 2022 and we are continuing to work towards the target of 90% compliance. We are returning to face to face to face training in September 2022 and anticipate an improvement in performance

Type of Training	Staff Group	August 22	September 22	In month performance	Staff number trained
PROMPT	Midwifery Staff	58%	87%	29%	Information expected to be available for this report - awaited
	Maternity Support Workers	14%	40%	26%	
	Consultant Obstetricians	58%	56%	2%	
	Trainee and Staff Grade Obstetricians	65%	56%	9%	
	Anaesthetics	21%	18%	3%	
CTG Training	Midwifery Staff	90%	92%	2%	
	Obstetricians	18%	17%	1%	
NLS (Newborn Life Support)		78%	78%	<>	

How to deliver outstanding care.

Minimum safe staffing

The fill rate in September 2022 was 87% against the target of 94%. The following actions were implemented to maintain safety:

- Matrons, managers and specialist midwives working clinically alongside staff

Staff group	Measure	**Aug 22**	**Sept 22**
Midwifery	Fill Rate (target >94%)	87%	87%
Obstetric	Expected vs fill	100%	100%
	Number of step downs/pull across	N/A	N/A

Service User Feedback

The themes identified, and actions, from the Quarter 1 Improving the Patient Experience (IPEC) report included:

- Communication (Risk Newsletter article and incidents shared with the team)
- Pain management
- Lack of information leaflets 3rd/4th degree tears (review of current information provided)
- Lack of physiotherapy appointments (vacant post now filled)
- Lack of de-brief appointments (being discussed through the MVP and options have been put forward e.g. pregnancy circles/mini de-briefs with CMW)
- Women needing to be diverted due to capacity/staffing
- Positive comments included infant feeding support, vaccination service, individual pregnancy planning, friendly and supportive staff

How to deliver outstanding care.

Staff feedback to Safety Champions

A staff engagement session was held on 23 September 2022. Items discussed are recorded on a separate Dashboard which is shared with all staff ahead of each meeting. Items raised included:

- Issues with delays in completing the NIPE examination (Newborn and Infant Physical examination)
- Concerns with the effectiveness of Staff bank
- Fetal growth surveillance after 36/40
- Translation services
- Lack of office secure/private office space for the Safeguarding Service
- Issues with increasing number of unresolved payroll issues

St George's University Hospitals NHS Foundation Trust

Perinatal Mortality

Rolling Report - Time Period	August 2021 – Sept 2022	
Total Number of Deaths		53
Type of Mortality	Antepartum Stillbirths	30
	Intrapartum Stillbirths	5
	Neonatal Deaths	18
Gestational Age	<24 weeks	23
	24-27 weeks	9
	28 - 31 weeks	6
	32 - 36 weeks	9
	37-41 weeks	9
	≥ 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 'more than 5% and up to 15% lower' 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 undergo a PMRT review and where applicable, a local/HSIB investigation

How to deliver outstanding care.

Perinatal Mortality Reviews

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

- 2 PMRT panels were held in September 2022. 9 cases were discussed: 6 Neonatal deaths and 2 Stillbirths and 1 IUD <24 weeks
- There have been no clear themes identified
- A detailed report of PMRT cases and actions is submitted quarterly to the Quality Committee in Common (QCiC)

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
- 2 cases are in final draft and 2 are at interview stage
- No cases were closed by HSIB in September 2022
- There are currently no open actions
- The senior management team meet quarterly with HSIB; the top 5 recommendation themes are: CTG management and interpretation; Escalation; Communication; Staffing Challenges; and Holistic Review

Incidents graded at moderate harm and above

There were 5 incidents reported in September 2022 which resulted in avoidable moderate harm:

- 3 incidents related to Maternity Unit Divert: choice of place of birth changed with no opportunity for patient engagement
- 1 incident related to the short term suspension of the Home Birth Unit: choice of place of birth changed with no opportunity for patient engagement
- 1 incident related to head entrapment during Breech delivery and admission to NNU: the baby is well

Contributory Factors and Root Cause for Completed Serious Incident Reports

There were 2 Serious Incident Reports closed in September 2022: 1 Serious Incident and 1 HSIB Investigation

Serious Incident: Unexpected admission to NNU.

- The root cause of the unexpected admission to the neonatal unit was severe meconium aspiration syndrome. The placental histology is suggestive of the meconium exposure taking place antenatally, the combination of hypoxia and infection create a situation in which meconium aspiration syndrome is more likely to occur
- Contributory Factors - Team: There were several junior members of staff present on this shift who required a lot of support from senior members of the team. Working Conditions - The delivery suite was very busy and both the Obstetric consultant and the midwife in charge were undertaking many tasks which meant they were unable to maintain direct oversight of this case

HSIB:

- The root cause identified early acute chorioamnionitis and evidence of intrauterine meconium discharge. No Contributory Factors but learning to ensure that all mothers have an assessment of fetal and maternal wellbeing at the time of admission.

How to deliver outstanding care.

Progress against Serious Incident Action Plans

There are 14 actions currently outstanding in respect of Serious Incident Reports:

- 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 3
- 12 actions not yet due 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 towards the target of 90% compliance.

		Aug 22	Sep 22	In month performance	Sep 22
Type of Training	Staff Group	%	%		Staff number trained
PROMPT	Midwifery Staff	90.26	90.21	**0.05**	176/195
	Maternity Support Workers	86.84	90.00	**3.16**	33/38
	Consultant Obstetricians	91.30	91.30	<>	21/23
	Trainee and Staff Grade Obstetricians	78.13	75.00	**3.13**	25/32
	Anaesthetics	85.45	88.40	**2.95**	22/26
CTG Training	Midwifery Staff	92.78	90.63	**2.15**	180/195
	Obstetricians	78.26	80	**1.74**	40/55
NLS (Newborn Life Support)	Midwifery Staff	96.41	94.33	**2.08**	188/195
	Maternity Support Workers	86.84	86.84	<>	33/38
	Consultant Obstetricians	91.30	91.30	<>	21/23
	Trainee and Staff Grade Obstetricians	78.13	75.00	**3.13**	25/32
	Anaesthetics	85.45	85.45	<>	26/31

How to deliver outstanding care.

Minimum safe staffing

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
- Increased RN presence in maternity HDU and on the postnatal ward

Staff group	Measure	**Aug 22**	**Sept 22**
Midwifery	Fill Rate (target >94%)	***80% filled (registrants)	91.2%
Obstetric	Expected vs fill	95%	100%
	Number of step downs/pull across	N/A	N/A

*** This data has been manually collated and awaits validated

How to deliver outstanding care.

Service User Feedback

Themes identified from complaints and compliments:

- Such great care from all the staff – I felt very well looked after
- Breast feeding services and also the combination of breast-feeding and giving contraceptive advice at same time is helpful

- Breastfeeding support on the ward could be improved
- Signage in Hospital is not great, particularly for the antenatal OPD

How to deliver outstanding care.

Staff feedback to Safety Champions

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

- Staffing levels and unit diverts in September were really hard
- Pro-active closures of the birth centre are frustrating for the women and the teams who work there. No birthing pool on Delivery Suite so this limits choice for type of birth (Even DGH maternity units will have a birth pool on the Delivery Suite)
- Skill mix of new starters puts additional pressure on the existing staff but we are glad to have them
- The changes in Bank rates of pay for midwives do not demonstrate the Trust values or reflect the high skill sets of the staff in a tertiary, high risk unit

How to deliver outstanding care.

APPENDIX 3

SGH MONTHLY MATERNITY REPORT - OCTOBER 2022 NEW TECHNICAL GUIDANCE RELEASED 11/10/2022

NEW REPORTING TIMEFRAMES ARE 08.08.21 - 05.12.2022 NEW SUBMISSION DATE OF 03.02.2023

Background	This report provides a monthly update to inform the Trust Board of the Maternity Service progress against compliance with the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS). This report will also highlight progress against any other identified safety issues/national requirements and will include details of all incidents reported to the Serious Incident Panel. The October 2022 report contains the following updates: • CNST Update
CNST Maternity Incentive Scheme (MIS)	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 small discretionary payment to assist them to make progress towards full compliance. On the 9th 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 with immediate effect in order to eligible recover the incentive element of the scheme contributions. Subsequent to this, on 23rd December 2021, the Trust received a letter confirming a pause to the majority of the reporting requirements in relation to CNST in recognition of the current pressures on the NHS and Maternity Services. Year 4 of the scheme was re-launched on 6th May 2022 with updated Technical Guidance. Due to some errors and inconsistencies in the Technical Guidance we are expecting a further iteration in the coming weeks. We are awaiting updated guidance from NHS Resolution following the announcement on the 6th Oct 2022 that the formal submission date for CNST has been revised to **5th Feb 2023.**

CNST Safety Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

We are required to submit a quarterly report to the Board to summarise compliance with the standards and also summarise the cases reviewed with any resultant action plans. The last report was submitted to PSQ in June 2022, therefore the next quarterly report; due in September 2022 is presented below. We are currently on track to meet all of the requirements of Safety Action 1 (listed below).

- **All perinatal deaths eligible to be notified to MBRRACE-UK from 6th May 2022 onwards must be notified to MBRRACE-UK within seven working days and the surveillance information must be completed within one month of the death.**

Since the last report in May 2022 there have been three eligible cases that have been reported to MBRRACE-UK within 7 working days, in accordance with the MIS Year 4 requirements.

- **A review using the PMRT of 95% of all deaths of babies, suitable for review using the PMRT, from 6th May 2022 will have been started, to the point that all factual questions have been answered on the PMRT, within two months of each death.**

- **At least 50% of all deaths of babies, suitable for review using the PMRT, who were born and died in your Trust from 6th May 2022 will have been reviewed using the PMRT by a multidisciplinary review team. Each review will have been completed to the point that at least a PMRT draft report has been generated by the tool within four months of each death and the report published within six months of each death.**

- **For 95% of all babies who died in your Trust from 6th May 2022, the parents will have been told that a review of their baby's death will take place, and that the parents' perspectives and any concerns they have about their care and that of their baby have been sought.**

A summary of all open, ongoing and closed cases since May 2022 has been included in the table below (the greyed-out cases will not count towards compliance in Year 4):

Case ID	Date of Death	Notified in 7 working days	Review started (2 months)	Draft review completed (4 months)	Review Published (6 months)	Parents Informed	Notes
81510	08/05/2022 35 weeks Neonatal death planned palliative care for congenital abnormalities	Yes	Yes	Yes	Yes	Yes	**Case closed**
81702	20/05/2022 31 weeks still birth known cardiac anomaly	Yes	Yes	Deadline not yet reached	Deadline not yet reached	Yes	**Case declared an adverse incident currently awaiting**

							PM report and genetic studies.
81774	24/05/2022 Twin pregnancy 27 weeks Neonatal death Twin two early onset growth restriction TTTS planned comfort care	Yes	Yes	Deadline not yet reached	Deadline not yet reached	Yes	
82045	15/06/2022 22 weeks extreme prematurity SROM	Yes	Yes	Deadline not yet reached	Deadline not yet reached	Yes	
82161	20/06/2022 39 weeks stillbirth presented at fully dilated no fetal heart found	Yes	Yes	Deadline not yet reached	Deadline not yet reached	To be done prior to review	**Case referred to HSIB but they declined investigation as parents did not consent.**
82257	26/06/2022 32 weeks reduced fetal movement Stillbirth	Yes	Yes	Deadline not yet reached	Deadline not yet reached	To be done prior to review	
82256	27/06/2022 34 weeks reduced fetal movement stillbirth	Yes	Yes	Deadline not yet reached	Deadline not yet reached	To be done prior to review	
82294	30/06/2022 37 weeks Stillbirth history of epilepsy on medication	Yes	Yes	Deadline not yet reached	Deadline not yet reached	To be done prior to review	
82368	05/07/2022 37 weeks emergency CS for fetal	Yes	Yes	Deadline not yet reached	Deadline not yet reached	To be done prior to review	**This case is being investigated by HSIB**

	distress Neonatal death						**and is therefore excluded.**
82408	10/07/2022 26 weeks extreme prematurity intrauterine growth restriction Neonatal death	Yes	Yes	Deadline not yet reached	Deadline not yet reached	To be done prior to review	
82583	15/07/2022 21 weeks extreme prematurity Neonatal death	Yes	Yes	Deadline not yet reached	Deadline not yet reached	To be done prior to review	
82712	26/07/2022 38 weeks born in poor condition following placental abruption Neonatal death	Yes	Yes	Deadline not yet reached	Deadline not yet reached		**This patient delivered at another Trust and the baby was transferred postnatally**
82720	27/07/2022 23 weeks extreme prematurity Neonatal death	Yes	Yes	Deadline not yet reached	Deadline not yet reached	To be done prior to review	**This patient delivered at another Trust and the baby was transferred postnatally .**
82902	04/08/2022 24 weeks stillbirth preterm labour	Yes	Yes	Deadline not yet reached	Deadline not yet reached	To be done prior to review	
82903	05/08/2022 25 weeks severe early onset pre-eclampsia and fetal growth restriction stillbirth	Yes	Yes	Deadline not yet reached	Deadline not yet reached	To be done prior to review	

83092	14/08/2022 39 weeks elective CS for breech no fetal heart stillbirth	Yes	Yes	Deadline not yet reached	Deadline not yet reached	To be done prior to review	
83153	18/08/2022 30 weeks NEC Neonatal death	Yes	Yes	Deadline not yet reached	Deadline not yet reached	To be done prior to review	**This patient delivered at another Trust and the baby was transferred postnatally .**
83215	22/08/2022 28 weeks fetal hydrops stillbirth	Yes	Yes	Deadline not yet reached	Deadline not yet reached	To be done prior to review	
83394	23/08/2022 38 weeks Neonatal death congenital diaphragmic hernia possible mediastinal lung tumour	Yes	Yes	Deadline not yet reached	Deadline not yet reached	To be done prior to review	**Not eligible for review by this Trust as did not die here.**
83379	02/09/2022 23 weeks extreme prematurity Neonatal death	Yes	Deadline not yet reached		Deadline not yet reached	To be done prior to review	**This patient delivered at another Trust and the baby was transferred postnatally .**

SGH is a tertiary referral centre.

The majority of these PMRT cases involve babies who were transferred with a poor prognosis or born extremely prematurely and that were known to have had underlying medical conditions prior to delivery.
We have one case involving a term neonatal death where immediate actions have been put in place following the identification of issues with staffing and fetal monitoring interpretation.
It is important to note that maternity staffing challenges are evidenced via our Datix system and red flag staffing.
This has been escalated on our risk register as extreme and has been recognised at divisional and board level as having a direct effect on patient safety.

Over previous reviews, there have been several actions identified through the PMRT review panel, and these have been detailed on the PMRT Board Report produced by MBRRACE (attached) covering the period 20/09/2021 to 21/12/2021 to date. Cases being reviewed by HSIB are excluded from the compliance figures as timescales for review are outside of our control.	
Safety Action 2 NOT COMPLIANT – EXTENSION REQUESTED	***Safety Action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?*** 1. ***By October 2022, Trusts are required to have an up-to-date digital strategy for their maternity services which aligns with the wider Trust Digital Strategy and reflects the 7 success measures within the What Good Looks Like Framework. The strategy must be shared with Local Maternity Systems and be signed off by the Integrated Care Board. As part of this, dedicated Digital Leadership should be in place in the Trust and have engaged with the NHSEI Digital Child Health and Maternity Programme.*** The draft digital strategy has been developed in conjunction with the national programme leads and is currently with the Head of Midwifery and Gynaecology Nursing. It was presented to the insights board on 4/10/2022. Once the above has been done, it will be presented at national level 2. ***Trust Boards to assure themselves that at least 9 out of 11 Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria in the "CNST Maternity Incentive Scheme Year 4 Specific Data Quality Criteria" data file in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2022. The data for July 2022 will be published during October 2022.*** *** We have continued reviewing and submitted our July Data (30th sept deadline). There have been some challenges with part of our MIS – EuroKing in being able to support the relevant submission and this has been formally escalated. Due to the above challenges, we have asked for exemption from this safety action. **This does pose a risk to full compliance.**
Safety Action 3 PARTIALLY COMPLIANT	***Safety Action 3: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations in the ATAIN programme?*** The Local pathway based on BAPM is partially implemented. SGUH have data available on transitional care, ATTAIN is a standing agenda item in senior meetings and, discussed in monthly surveillance report. The Neonatal Team have confirmed that there is no update to the previously presented action plan.

	The ATAIN leads will be putting together an action plan to address local findings from review.
Safety Action 4	***Safety Action 4: Can you demonstrate and effective system of clinical workforce planning to the required standard?*** We have shared the Technical Guidance with the Neonatal Medical and Nursing Team and the anaesthetic lead and asked for confirmation of compliance and where non-compliant, we have asked for an action plan for sign-off by the Board. Obstetric medical workforce - this is currently being reviewed and drafted by the management team. The Aesthetic medical workforce is compliant and have submitted their six-month rota from Feb – July 2022 to evidence compliance. The Neonatal Team have submitted a business case to the board. The Neonatal Nursing team are developing an action plan to address deficiencies. If the requirements are not met, Trust Board should evidence progress against the action plan developed in year 3 of MIS to meet the recommendations. The action plan and related progress, signed off by the Trust Board, should be shared with the Royal College of Nursing (cypadmin@rcn.org.uk) and Neonatal ODN Lead. This will enable Trusts to declare compliance with this sub-requirement.
Safety Action 5 NOT COMPLIANT	***Safety Action 5: Can you demonstrate and effective system of midwifery workforce planning to the required standard?*** SGUH are **at risk** with this safety action and remain partially compliant due to the inability to retain 100% supernumerary status of the Band 7 coordinator. We have a clear breakdown of BirthRate Plus to demonstrate the required establishment, midwifery planning and mitigations reports and this has been presented to board with detailed plans.
Safety Action 6 NOT COMPLIANT	***Safety Action 6: Can you demonstrate compliance with all five elements of the Saving Babies Lives Care Bundle Version 2?*** Whilst we are compliant with SBLCBv2, CNST year 4 has stipulated targets against each element which we have weaknesses in meeting. These are as follows: **Element 1. Reducing smoking in pregnancy by carrying out a Carbon Monoxide (CO) test at booking to identify (or those exposed to tobacco**

	smoke) and referring them to stop smoking service/specialist as appropriate 1a, 1b, 1c, 1d, 1e, 1f: All compliant. **Element 2. Identification and surveillance of pregnancies with fetal growth** 2a, 2b, 2c, 2d, 2e, 2f, 2g, 2h: All compliant **2i** – AT RISK; this is because the information uploaded by staff onto the current digital system is not accessible by NHSX via MSDS – EUROKING challenge **Element 3. Raising awareness amongst pregnant women of the importance of detecting and reporting reduced fetal movements (RFM) and ensuring providers have protocols in place. Based on best available evidence to manage care for women who report RFM.** 3a, 3b, 3c, 3d, 3e, 3f, All compliant **3g**. AT RISK; this is again because the information uploaded by clinical staff onto the current digital system is nota accessible by NHSX via MSDS – EUROKING challenge. **Element 4. Effective fetal monitoring during labour** 4a, 4b, 4c, 4d, 4e, 4f, 4g, 4h, All compliant **Element 5; Reducing preterm births** 5a, 5b, 5c, 5d, 5e, 5f All compliant.
Safety Action 7	***Safety Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your MVP to co-produce local maternity services?*** We are complaint with most elements of this safety action, evidence is required that the MVP work programme is shared with, and signed-off by, the LMNS. This will be done in October.
Safety Action 8	***Safety Action 8: Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next three years, starting from the launch of MIS Year 4?*** ***In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in-house', one –day, multi-professional training day which includes a selection of maternity emergencies, antepartum and intrapartum fetal surveillance and newborn life support, starting the from launch of MIS Year 4?*** A local training plan is in place and training compliance is reported monthly to the Board via the Perinatal Quality Surveillance Tool. Any gaps are escalated with the relevant clinical leads. The final compliance will be determined as at the end of January 2023.

Safety Action 9	***Safety Action 9: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?*** We are partially complaint with this action and are in the process of gathering evidence. SGUH previously prepared a detailed MCOC implementation plan, this has been presented to the board and has been approved although formal reporting has now been paused – see section on COC below.
Safety Action 10	***Safety Action 10: Have you reported 100% of qualifying cases to HSIB and to NHS Resolution ENS from 01/04/2021 – 05/12/2022?*** We are on track to be complying with this Safety Action. We have reported all relevant cases to both HSIB and ENS.
Continuity of care update ***SGH***	***On the 21st Sept 2022, NHS England sent out a letter to all trust chief nurses, directors of midwifery, medical directors and clinical directors of midwifery outlining essential and immediate changes to be made to the national maternity programme regarding the provision of continuity of carer.*** ***'There will no longer be a target date for services to deliver Midwifery Continuity of Carer (MCoC) and local services will instead be supported to develop local plans that work for them. There is no longer a national target for MCoC. Local midwifery and obstetric leaders should focus on retention and growth of the workforce and develop plans that will work locally taking account of local populations, current staffing, more specialised models of care required by some women and current ways of working supporting the whole maternity team to work to their strengths. We hope this will enable your services to improve in line with the evidence, at a pace that is right'*** ***This decision has been made in view of the challenges that maternity units have faced over the last 2 years, particularly around workforce.'*** SGH plans – • To continue with the MCoC teams we have. Willow – case loading - on calls to come into hospital Homebirth – case loading - on calls Juniper – shift-based team Maple – shift-based team • To pause implementation of further CoC teams until staffing levels improve and a realistic understanding of the impact extra scale up would have.

	• Continued focus on women from the Black, Asian and Mixed Ethnicity background and those from a vulnerable group within our existing teams • We have asked the teams to continue to submit their KPI data • MCoC data will still be collected

Meeting Title:	**Trust Board**		
Date:	3 November 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:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify)		
Executive Summary:	This report consolidates the latest management information and improvement actions across St George's Hospital productivity, performance, and workforce for the month of September 2022. This is an appendix to the Group IQPR. **Our Finance & Productivity** Outpatient performance is expected to be 97% after catch-up for September, which is behind the 100% plan. Catch up estimates include recodes between first/follow ups and procedure which has led to a reduction in attendances. Elective and Daycase performance is expected to be behind plan (after estimated catch up), with a percentage of 93%, below the 100% plan submitted for September. Improved theatre utilisation rates continue to be maintained i with the Theatres Transformation Board (TTB) continuing to drive improvements. QMH utilisation rose to 70% (+26% compared with September 2021). The unit also delivered the second highest number of cases ever (474), topped only by the previous month's total (510). This has been driven by improved booking volumes. Overall non-elective stay remains high but comparable to previous months however, patients staying 21+ days increased with on average 169 patients per day. High numbers of patients in the acute Trust who are considered medically optimised but are unable to move to their discharge destination in a timely way continues to impact capacity. Merton & Wandsworth Winter planning summit to be held on 17th Oct as well as a planned MADE event where a number of actions are on the agenda to mitigate current issues. Demand has also been impacted by a rapid increase in covid cases. **Our Patient Perspective** In September, Immediate Life Support (ILS) training rate was 67.7%; Basic Life Support rate (BLS) was 77.3% and Advance Life Support (ALS) was 73.4%, all against a target of 85% All areas of training continue to see a decline in performance. There were 22 Hospital Onset Health Associated (HOHA) COVID-19 infections and 9 Hospital Onset Probably Associated (HOPA) COVID-19 infections. A decrease of 28 nosocomial infections on last month. 23% of cases detected in hospital were nosocomial during September compared to 33% during August. Most Covid-19 cases remain mild or asymptomatic. The birth rate was 345 births with sustained obstetric and medical complexity remaining high. Staffing remained extremely challenging across the month with significant mitigation actioned and implemented. The Birth Centre was proactively		

closed for the whole month with women diverted and staff redeployed to Delivery suite.

In the Emergency Department operational pressures and increased waiting times continue to impact FFT positive response. Performance for Emergency Department was 75.9% a decrease on the last months performance. All other services achieved FFT targets where patients rated the services as "Good" or "Very Good ".

Our Process Perspective

Four Hour Performance in September was 79.1%, maintained performance was seen within the non-admitted pathway. In total 351 patients waited for more than 12 hours for a hospital bed following a decision to admit seeing a 42% reduction compared to August. Admitted performance continues to be a challenge. Exit block within the Department is the primary cause of the relatively poor admitted performance and also contributes to the ability to offload ambulances in a timely manner whilst maintaining space to see and treat other patients. Both of these situations improved in September but will remain an ongoing pressure. The Trust is exploring further measures to enable better flow out from the Department.

Performance against the 14 day cancer standard deteriorated in the month of August with 74.6% of patients seen within 14 days of referral compared to 79.6% in July. Decrease in performance is driven by Breast who have a recovery plan in place looking at workforce and WLI spend and Skin where demand has increased across the sector, RMP funding will support WLIs for backlog and capacity management. At the end of August 161 patients were waiting more than 62 day, whilst meeting trajectory this is an increase of 37 patients compared to July. The Cancer improvement Programme 2023/24 overseen by the Trust Cancer Group will continue to focus on a number of workstreams which will support backlog reductions including but not limited to review of current processes to support referral management, clinical capacity and workforce gaps impacting services including diagnostics where significant delays in Skin, Breast, Lower GI and Urology is affecting 62 day performance. FDS (Faster Diagnosis Standard) performance for was 69%, this has fallen from a compliant position of 77% in July and is driven by increasing referral volumes and capacity issues in Breast

At the end of September, the Trust reported that 11.6% of patients were waiting for more than six weeks to have a diagnostic test against a national recovery target of 5%. Increases have continued to be driven by Gynae Ultrasound and Endoscopy. Longer waits in Gynae have been impacted by Sonographer gaps as well as seeing an increase in demand, recovery plans in place have progressed and significant reduction in backlog is projected in October. Staffing within Endoscopy across Nursing, Clinical and Admin have been challenging and impacting the service's ability to staff lists at full capacity, the service are working through a short, medium and longer term workforce solution. Short term options are being working through (options include insourcing, outsourcing, in-house recovery programme).

The Trust continues to reduce the number of long waiting patients with 768 patients waiting longer than 52 weeks meeting trajectory and 35 patients waiting for more than 78 weeks. Revised trajectories for specialties with 78 week concerns

	being shared aiming to clear before March 23. The overall waiting list size continues to grow with patients waiting for first appointment increasing. There will be a PTL review of patients waiting over 18 weeks in specific specialties and patients contacted via DrDoctor and plans within some tumour groups to increase outpatient capacity and day case activity with the aim that by 25 November no patient will wait more than 52W on a non-admitted pathway without a first OPA scheduled within 4 weeks. **Our Workforce Perspective** Human Resources continues to support staff on short- and long-term sick leave to facilitate their return to work including due consideration for reasonable adjustment, and to better utilise the return-to-work meetings. A Turnover strategy is being developed to improve end-to-end recruitment and for vacancy focus is on the top vacancy hotspots and hard to recruit posts. The changes to the Resuscitation Training Needs Analysis has been implemented so some slight dips to the figures but the impact has not been significant. New topics coming onstream are Counter fraud Training and Disability Awareness/Essential Workplace Adjustments.
Recommendation:	The Committee is requested to note the report.
Committee rAssurance:	The Committee is also asked that in considering contents of this report, its supporting documents and the discussion at the meeting which of the following assurance rating it would provide to the Trust Board. • **Substantial Assurance:** The report and discussions assured the Committee that there are robust systems of internal controls operating effectively to ensure that quality and safety risks are managed to deliver high quality services and care to patients. • **Reasonable Assurance:** The report and discussions assured the Committee that the system of internal controls is generally adequate and operating effectively but some improvements are required to ensure that quality and safety risks are managed to deliver high quality services and care to patients. • **Limited Assurance:** The report and discussions supported the Committee's conclusion that that the system of internal controls is generally inadequate or not operating effectively and significant improvements were required to ensure that the quality and safety risks are managed effectively to improve the position and ensure that high quality services and care is provided to patients. • **No Assurance:** The report and discussions led the Committee to conclude that there was a fundamental breakdown or absence of core internal controls and systems to enable the Trust to deliver high quality services and care to its patients.
Supports	
Trust Strategic Objective:	Treat the Patient Treat the Person Right Care Right Place Right Time
CQC Theme:	Safe, Caring, Responsive, Effective, Well Led
Single Oversight Framework Theme:	
Implications	

Risk:	NHS Constitutional Access Standards are not being consistently delivered and risk remains that planned improvement actions fail to have sustained impact		
Legal/Regulatory:			
Resources:	Clinical and operational resources are actively prioritised to maximise quality and performance		
Equality and Diversity:			
Previously Considered by:	Quality Committee Finance & Investment Committee	**Date**	20/10/2022 21/10/2022
Appendices:			

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

gesh

Group Integrated Quality & Performance Report

September 2022

Presented by: James Marsh Group Deputy Chief Executive Officer
September 2022

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

Monthly Overview – Safe, high quality care (1)

gesh

Safe, High Quality Care	St George's							Epsom and St. Helier						
	Monthly Target	Jul-22	Aug-22	Sep-22	YTD Target	YTD Actual	13-Month Trend	Monthly Target	Jul-22	Aug-22	Sep-22	YTD Target	YTD Actual	13-Month Trend
Never Events	0	0	0	0	0	1		0	0	1	0	0	1	
Serious Incidents	8	8	5	3	96	23		TBC	5	2	2	TBC		
Number of Falls With Harm (Moderate and Above)	TBC	5	2	2	TBC	16		TBC	3	2	2	TBC	11	
Pressure Ulcers - Acquired catergory 3&4	0	15	17	9	0	82		0	0	2	1	0	9	
Dementia - Assessment & Investigation of Patients at risk of Dementia								90%	41%	46%	50%	90%	50%	
Nutrition														
Mental Capacity Act & Deprivation of Liberties - Level 1	90%	90%	89%	87%	90%	88%								
Mental Capacity Act & Deprivation of Liberties - Level 2	85%	72%	69%	70%	85%	70%								
Infection Control - Number of Cdiff - Hospital & Community	4	4	6	7	52	41		TBC	6	1	0	TBC	14	
Infection Control - Number of MRSA	0	0	1	0	0	1		0	0	0	0	0	0	
Infection Control - Number of E-Coli	9	5	10	4	111	33		TBC	28	23	21	TBC	121	
VTE Risk Assessment	95%	96.2%	96.5%	96.5%	95%	97%		95%	90.7%	88.5%	85.6%	95%	89%	
Mortality - HSMR	<1	83.5	89.2	88.5	<1	87.07		<1	108.31	111.74	113.12	<1	111.55	
Mortality - SHMI	<1	0.91	0.91	0.85	<1	0.89		<1	1.12	1.13	1.11	<1	1.10	

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

Monthly Overview – Safe, high quality care (2)

gesh

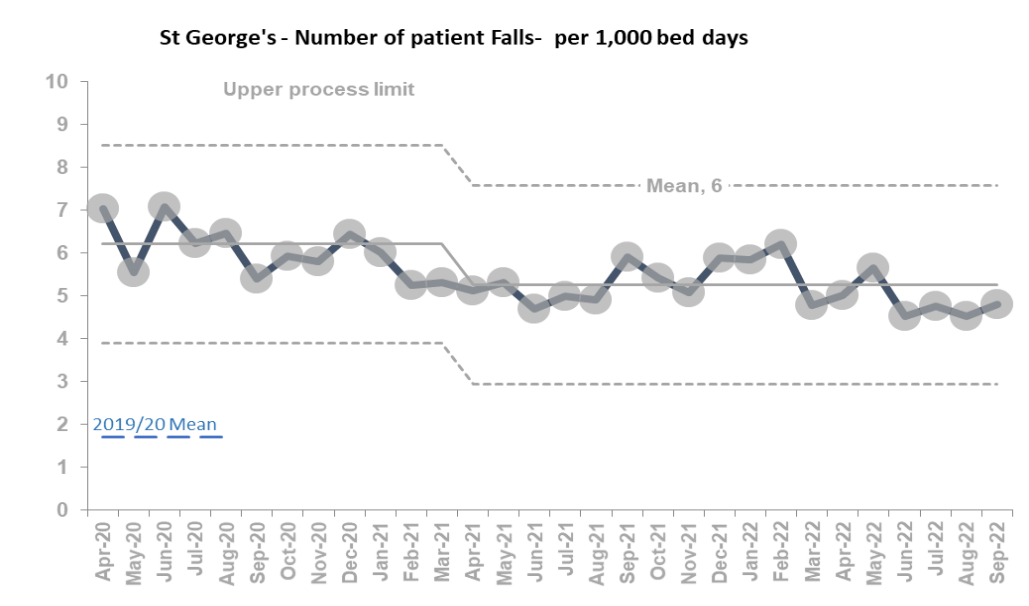
Safe, High Quality Care	St George's							Epsom and St. Helier						
	Monthly Target	Jul-22	Aug-22	Sep-22	2022_23 Target	YTD Actual	13-Month Trend	Monthly Target	Jul-22	Aug-22	Sep-22	2022_23 Target	YTD Actual	13-Month Trend
Number of Complaints Received	TBC	67	47	46	TBC	389		TBC	36	64	47	TBC	292	
Complaints responded to in 25 days	85%	93%	97%	95%	85%	96%		85%	52%	53%	58%	85%	55%	
Friends and Family Test - Inpatients Respose Rate	20%	30%	33%	25%	20%	34%		20%	33%	30%	30%	20%	30%	
Friends and Family Test - Inpatients Score	95%	98%	99%	99%	95%	99%		95%	93%	92%	93%	95%	93%	
Friends and Family Test - Emergency Department Respose Rate	20%	14%	13%	14%	20%	13.4%		20%	12%	13%	13%	20%	12.5%	
Friends and Family Test - Emergency Department Score	90%	71%	79%	76%	90%	72%		90%	77%	82%	83%	90%	79%	
Friends and Family Test - Maternity Respose Rate	20%	14.8%	7.7%	21.5%	20%	12.6%		20%	3.6%	7.9%	6.0%	20%	6.4%	
Friends and Family Test - Maternity Score	90%	91%	84%	90%	90%	87%		90%	86%	100%	100%	90%	96%	
Friends and Family Test - Community Respose Rate	20%	1.1%	1.6%	0.7%	20%	1.0%		20%	4.6%	6.6%	5.0%	20%	4.8%	
Friends and Family Test - Community Score	90%	93%	100%	92%	90%	95%		90%	98%	98%	98%	90%	97%	
Friends and Family Test - Outpatients Respose Rate	20%	4.4%	3.1%	3.4%	20%	3.9%		20%	6.3%	6.0%	6.0%	20%	6.8%	
Friends and Family Test - Outpatients Score	90%	91%	91%	91%	90%	91%		90%	93%	93%	93%	90%	93%	

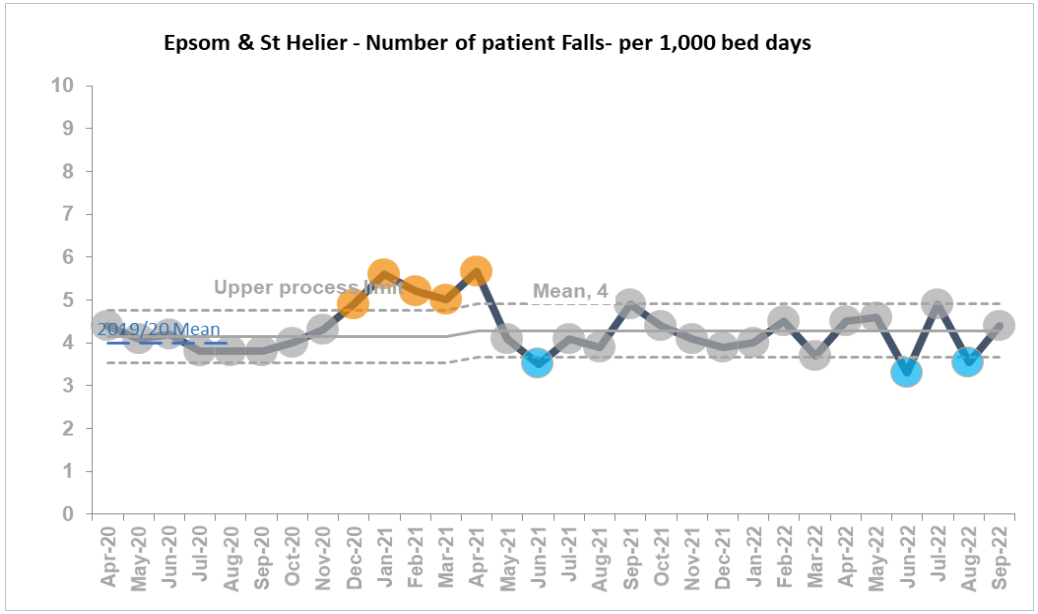
NHS
St George's, Epsom and St Helier
University Hospitals and Health Group

gesh

Falls
(Patient Falls- per 1,000 bed days)

Target: TBC	SGH: 4.8	ESTH: 4.4





SGH updates since last month

Overall fall rates remain lower than average, reporting 112 falls in September. Rates per 1,000 Occupied Bed Days are currently at 4.81 which is below the mean, an improving position with falls below the mean for 4 consecutive months. The vast majority of falls were of low or no harm, however, there were 2 Moderate harm falls reported this month

ESTH updates since last month

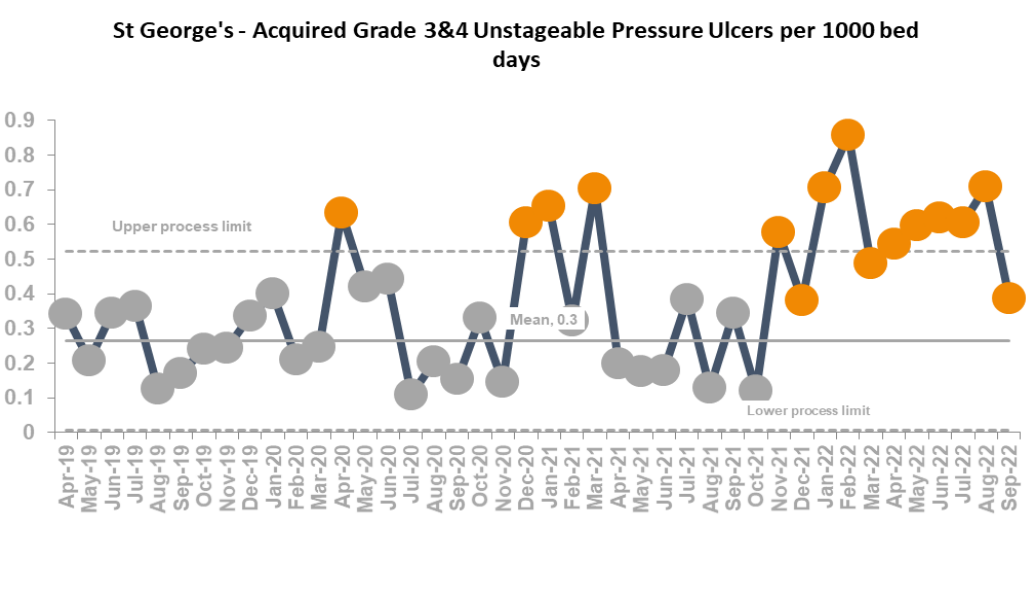
There were 84 falls in September, 15 less than last month previous. Rates per 1,000 Occupied Bed days are currently 4.4 an increase on last month when it was 3.4.

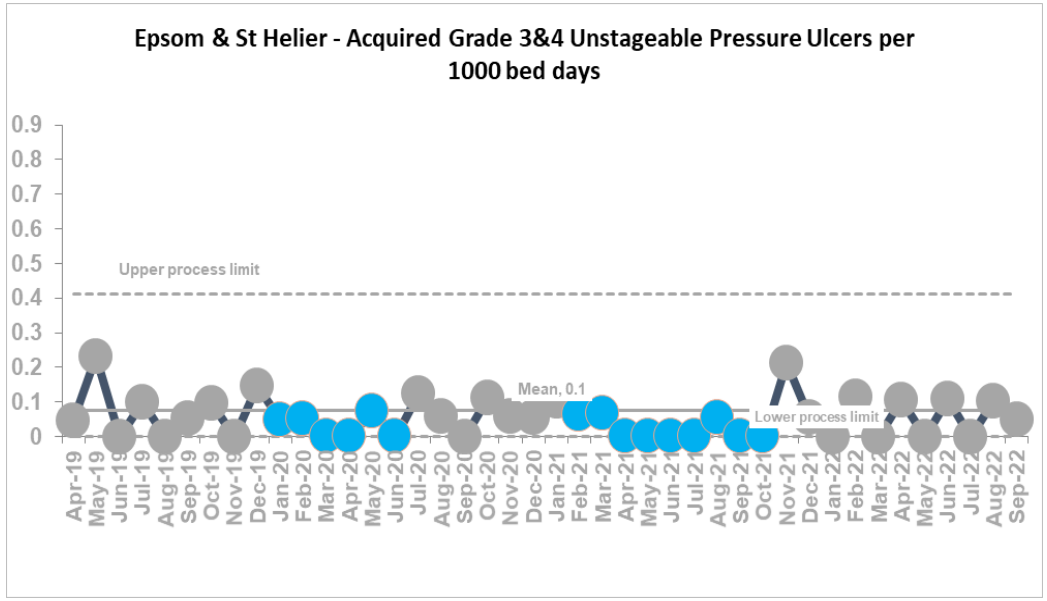
NHS
St George's, Epsom and St Helier
University Hospitals and Health Group

Pressure Ulcers - Grade 3 and above per 1,000 bed days

gesh

Target: TBC	SGH: 0.39	ESTH: 0.05





SGH updates since last month

There were a total of 9 Category 3&4 Unstageable Pressure ulcers this month. The rate per 1,000 bed days shows special cause variation with a deteriorating position and has for the last 11 months has been above the mean 8 of which have been above the upper control limits

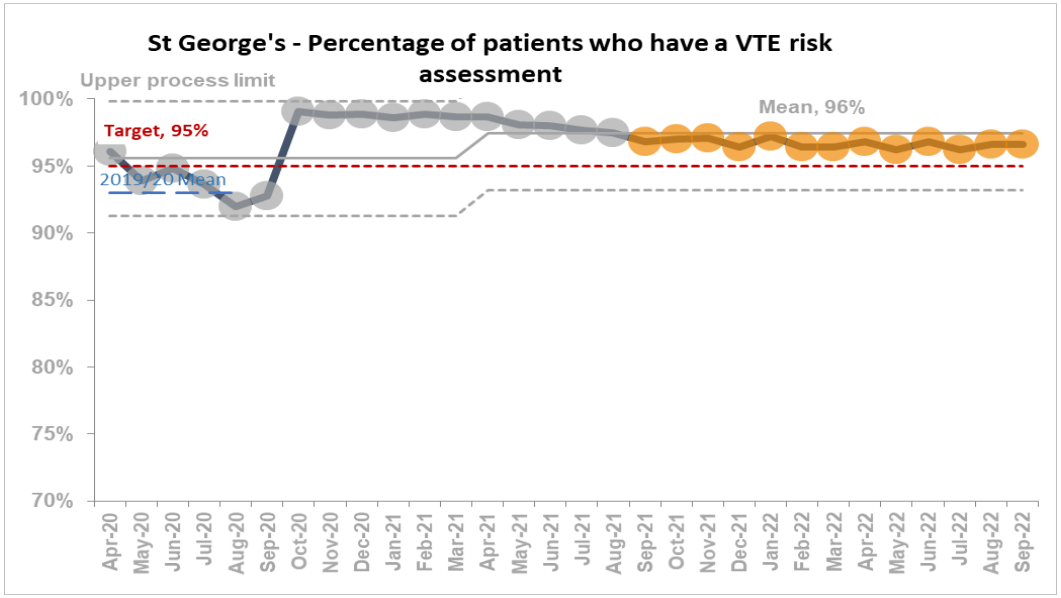
ESTH updates since last month

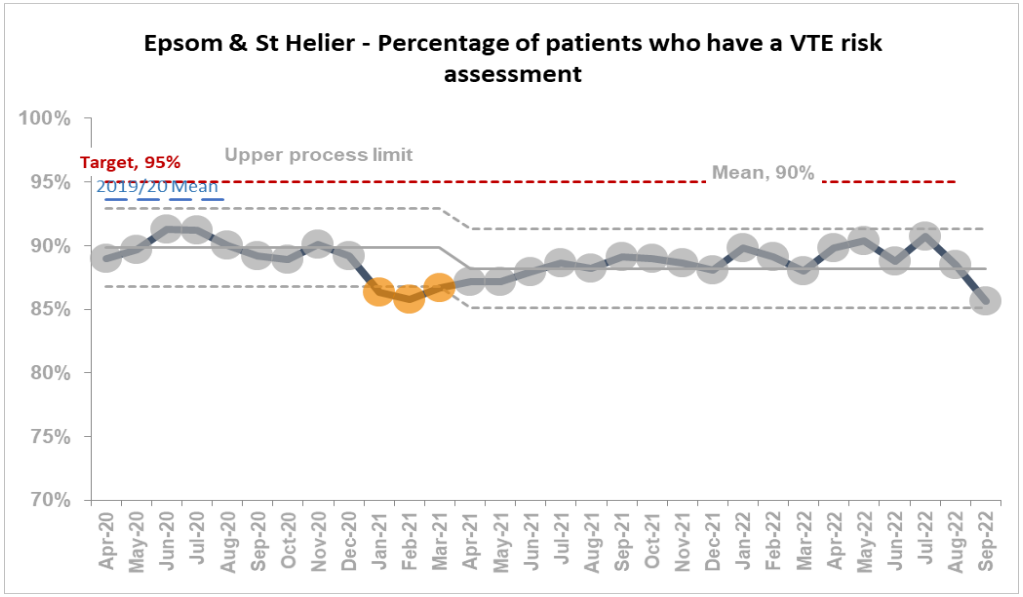
There were a total of 2 Category 3&4 Unstageable Pressure ulcers this month. The rate per 1,000 bed days is 0.05

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

Percentage of patients who have a VTE risk assessment

Target: 95%	SGH: 96.6%	ESTH: 85.6%





SGH updates since last month

In September 96.6% of patients had a VTE completed within the required time frame with performance continuing to be above the upper control limit.

The Hospital Thrombosis Group have recently updated the pharmacy VTE audit in line with NICE standards and the use of Tableau reporting to improve on accuracy. Mechanical and patient information audits are in progress with the findings being used to drive improvements across the Trust. Our portfolio for VTE Exemplar Centre revalidation is also being compiled, due in March 2023.

ESTH updates since last month

In September 85.6% of the patient had a VTE completed within 24 hours. Total completed was 88.7% (data validation ongoing)

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

Quality - Analysis and Action

gesh

SGH current issues –

- Infection control - 7 C. difficile infections during September 2022; 5 were classified as Hospital Onset Healthcare Associated (HOHA); and 2 were classified as Community Onset Healthcare Associated (COHA). There have been a total of 39 cases between April and September 2022. There is a NHSE 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 21 cases at end of September. This means the Trust remains significantly above trajectory. A focus on antimicrobial stewardship and cleanliness of medical devices continues.
- MCA & DoLS - Nursing Staff are at 87% compliance for Level 2 training, highlighting the value of ongoing work with Practice Educators, support from nursing colleagues and visibility of the MCA team in clinical areas. Meetings with Post Graduate Medical Education Lead and Site Chief Medical Officer to discuss how to improve MCA compliance for Medics and Dental (currently at 52%). Work underway to review induction period and the PGME team will support with engaging Educational Supervisors.
- Pressure Ulcers - There were a total of 9 Category 3&4 Unstageable Pressure ulcers this month. The rate per 1,000 bed days shows common cause variation with a deteriorating position and has for the last 11 months has been above the mean 8 of which have been above the upper control limits

SGH future action -

- Infection control - A focus on antimicrobial stewardship continues; a meeting is planned to discuss antimicrobials and *C. difficile.* Additional stewardship training to be given. The IPC Team continue walkabouts and spot checks of medical device and environmental cleanliness
- MCA & DoLS - Train the Trainer programme is being reviewed and content adjusted. This will be offered to Therapy team colleagues as well as nursing staff to build capacity within teams. The Risk Register is being updated regarding the MCA and compliance rates which is of increasing concern as LPS implementation draws closer. Strong consideration to an LPS Practice Educator as part of a risk reduction strategy in line with other major Acute Trusts needs to be given
- Pressure Ulcers - protected repositioning times and daily mattress checks, regular visits to QMH, senior nurse PUP workshop, development of poster for categories of PU in dark skin tones, teaching on preceptorship days, guidance to support senior staff investigating PU and development of a process to support regular deep dives.

ESTH current issues –

- Infection Control: 4 HOHA and zero COHA in September. There were 156 Covid-19 infections detected in September and 40 nosocomial infections. Covid RCA process is currently under review. There were 26 Covid-19 clusters which generated 78 contacts.
- Backlog of outstanding SI investigations and complaints due to loss of key resource earlier this year. Trust needs to ensure we have adequate workforce to facilitate these issues.
- Several outstanding PHSO enquiries due to Covid-19 pandemic, most cleared and remaining 2 outstanding cases on plan to be cleared.
- Performance lagging behind in some of the fundamentals of care metrics.
- Increase in Falls due to the complexity of patients we are seeing especially in the escalation area where patients require enhanced care.

ESTH future action –

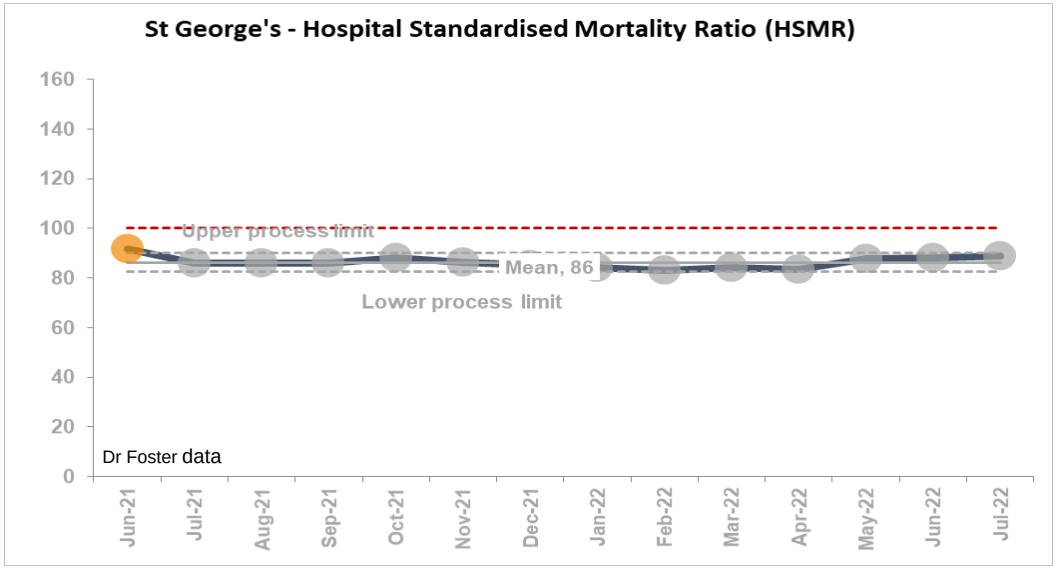
• Infection Control: New national screening guidance implemented across the Trust on 12th of September. There has been a PII on Buckley ward following 2 positive C.diff results within a period of 10 days of each other. RCAs are in progress for further investigations and meetings are to be arranged with staff involved. Unfortunately there will be no ribotyping to rule out cross infection, due to insufficient samples. The IPC team continues to support the ward staff during this period.
• Mandatory infection control training compliance overall improved to 77% for clinical staff groups and 86% for non-clinical groups. Divisional Leads will address training compliance issues. IPC team has arranged local bespoke training for different specialities with the aim of improving uptake. Assigned training requirements are being reviewed for some directorates listed below with incompliances.
• Incidents: Resource and structure review to clear the backlog and ensuring that we are investigating in a timely manner.
• New patient incident response framework coming into effect next year expected to reduce the burden of investigations.
• Pressure Ulcer: Where there's an increase seen, specialist experts will support the divisions with training and management to reduce the incident rate .Pressure damage prevention group that has been paused during the pandemic will restart in October. Stop the pressure campaign is scheduled in November to address the issue widely.
• Falls prevention group will be restarting in November to ensure the right support and focus and mitigation in place are adequate.

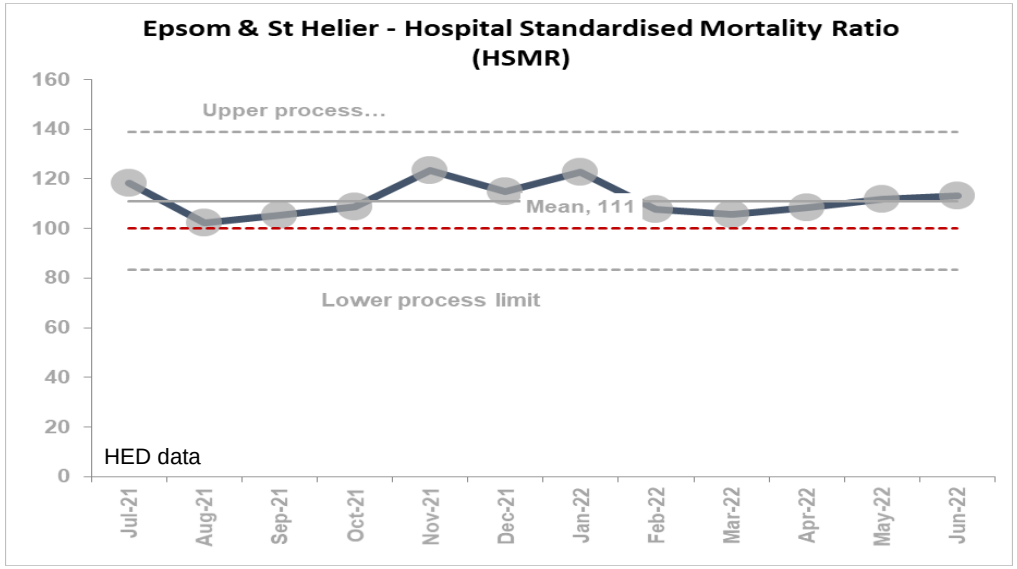
NHS
St George's, Epsom and St Helier
University Hospitals and Health Group

Mortality – HSMR

gesh

Target: <100	SGH: 88.5	ESTH: 113





SGH updates since last month
Latest HSMR, for the 12 months from August 2021 to July 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.

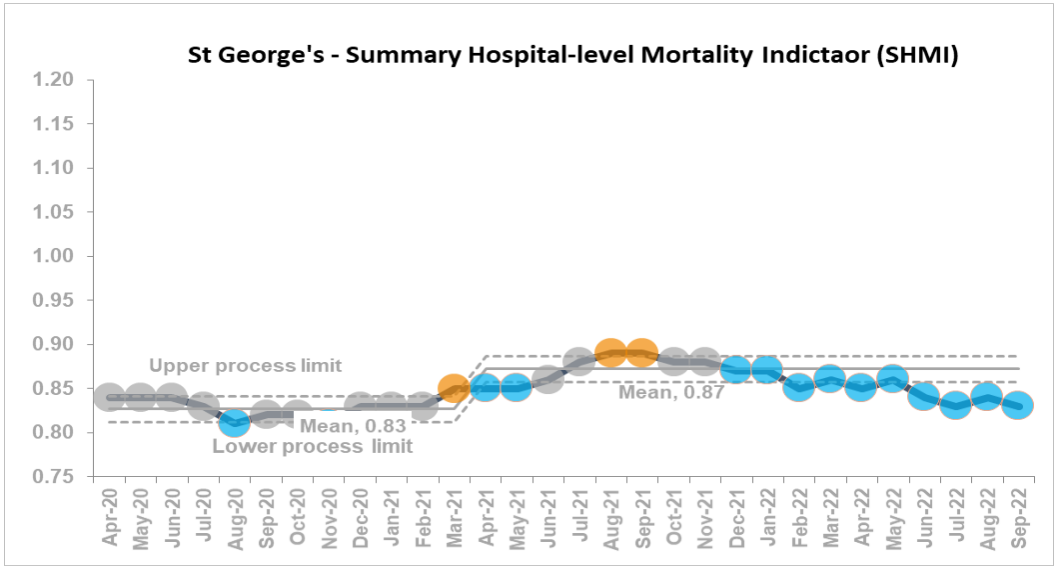
ESTH updates since last month
Latest HSMR for 12 month to June 2022 remains above expected level, but has dropped for the second month in a row. Difference between weekday and weekend is not significant.
As per previous months, elective HSMR is significantly lower than expected level at 31.9, and non elective HSMR dominates the trend at 114.3.

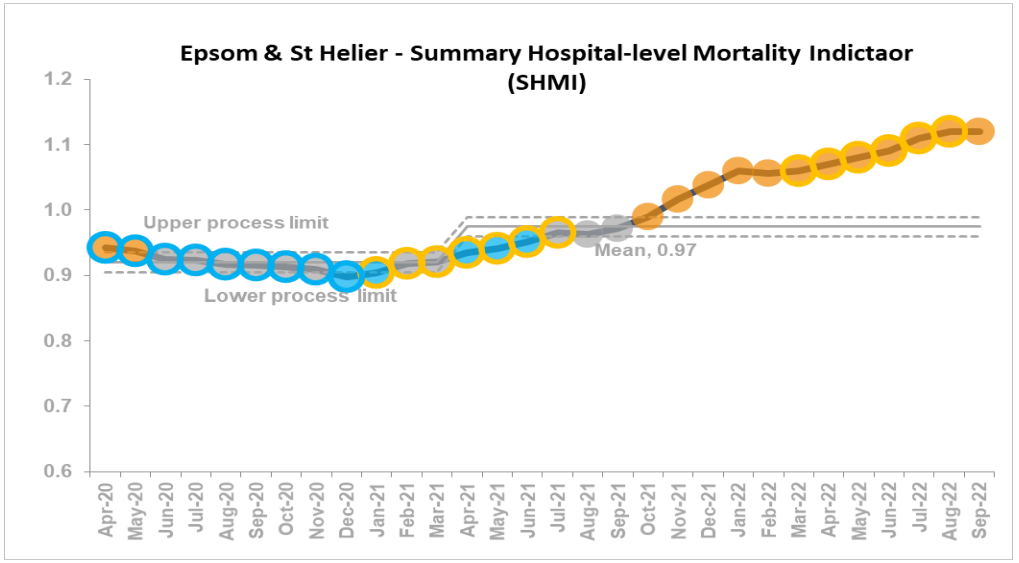
NHS
St George's, Epsom and St Helier
University Hospitals and Health Group

Mortality – SHMI

gesh

Target: <1	SGH: 0.85	ESTH: 1.11





SHMI data is based on a rolling 12 month period and reflective of period May 21 to April 22 published (September)

SGH updates since last month

The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures. For SGH performance was 0.93 and is as expected.

SHMI data is based on a rolling 12 month period and reflective of period May 21 to April 22 published (September 22)

ESTH updates since last month

12 month rolling SHMI continues to rise. Latest available data up to April 2022 (published in September 2022).
There is no material difference between the two sites, Epsom at 1.12 and St Helier at 1.14.

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

Mortality - Analysis and Action

gesh

SGH current issues –

In August TARN notified the Trust that we have been identified as a potential negative outlier alarm for the period April 2019 to March 2021.

The Mortality Monitoring Group consider mortality at diagnosis and procedure group level. Currently investigations of two diagnosis groups where our Dr Foster mortality data suggests that our mortality is higher than expected have been triggered, namely 'Acute Myocardial Infarction' and 'Crushing injury or internal injury'

SGH future action -

In line with their outlier policy TARN is working with the Trust to conduct a data quality review and a consultant orthopaedic surgeon is leading this work. There is already a wide-ranging improvement project underway and in August MMG received a detailed update from the Clinical Lead for Major Trauma. The action plan encompasses all elements of the improvement work: data quality and learning from deaths; infrastructure change; service configuration; and clinical quality. Progress will continue to be monitored by MMG, and it is noted that it will take time for changes in practice to be reflected in mortality statistics. Aligned to this we are considering how best to monitor and evaluate outcomes related specifically to neurotrauma. The need for increased assurance in this area is linked to both TARN data and previous specialty specific signals which are now resolved.

In August, the cardiology Clinical Governance Lead updated MMG on the investigation of mortality in 'Acute Myocardial Infarction'. Several actions are in progress with establishment of a dedicated shock team being the highest priority. Cardiology and the Cardiothoracic ICU are collaborating on this initiative and expect the team to be in place in the coming months. The team will be supported by training, defined roles and responsibilities, and protocols. Subsequent priorities include improvements to clinical documentation of presenting condition and diagnosis, and timeliness of assessment and/or procedure.

Mortality in the 'crushing injury or internal injury' diagnosis group is being investigated in the first instance by the Head of Mortality Services, drawing on existing reviews of the 12 deaths that contribute to the signal. This will be reported to MMG in October.

ESTH current issues –

Since July 2021 there has been a gradual increase in the HSMR and SHMI rates within ESTH. Trust Reducing Avoidable Death & Harm (RADAH) Committee review diagnosis level. The Trust comorbidity score is constantly below the national average.

A deep dive report presented in September examined factors which may be contributing to this increase and recommended further actions to take.

ESTH future action –

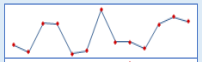
A focussed case notes review of patients who died and who had a prolonged stay in ED have been completed. No specific clinical issue has been identified. Mortality review and medical examiner teams will continue to triangulate the outcomes of their reviews

Following the internal deep dive, external audit is underway which will run during October and November to ensure clinical coding accurately captures the diagnosis and co-morbidities of patients who die after non elective admission and to confirm the reasons driving the reduction in deaths expected in the Trust.

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

Monthly Overview – Maternity

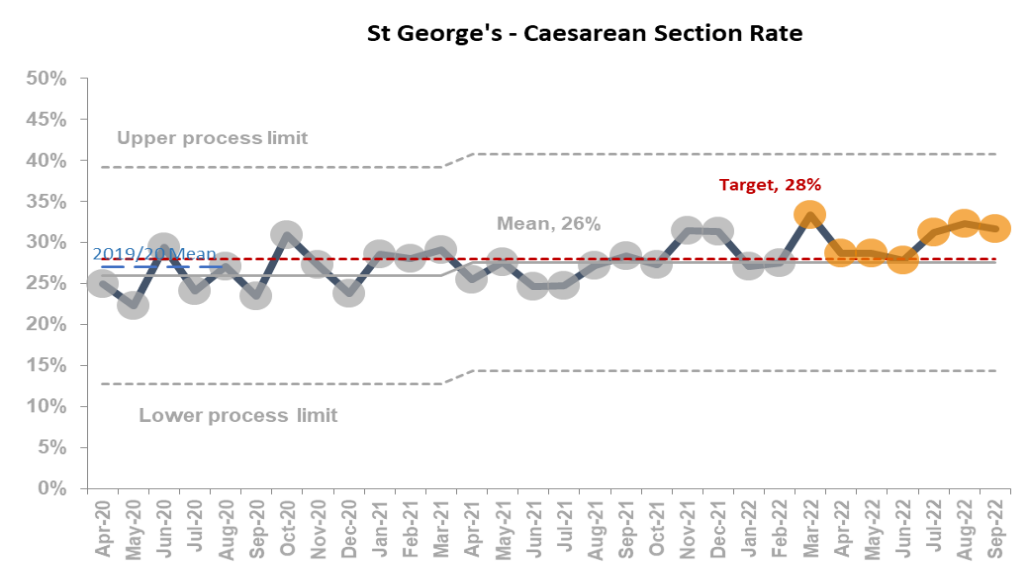
gesh

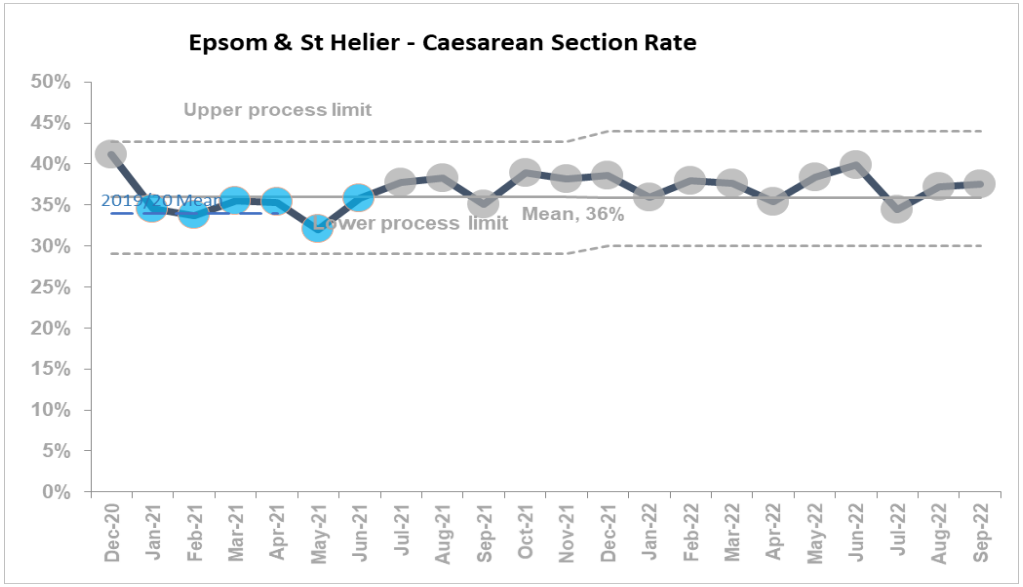
Maternity	St George's							Epsom and St. Helier						
	Monthly Target	Jul-22	Aug-22	Sep-22	YTD Target	YTD Actual	13-Month Trend	Monthly Target	Jul-22	Aug-22	Sep-22	YTD Target	YTD Actual	13-Month Trend
Caesarean Section Rate	<28%	31.2%	32.3%	31.6%	<28%	30.1%		TBC	34.4%	37.2%	37.5%	TBC	37.1%	
% Births with 3rd or 4th degree tear	<5%	1.7%	1.6%	1.2%	<5%	1.4%		TBC	4.0%	1.5%	3.0%	TBC	2.9%	
% Births Post Partum Haemorrhage >1.5 L	<4%	1.4%	2.8%	2.6%	<4%	2.7%		<3%	1.8%	2.5%	2.5%	<3%	2.8%	

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

Caesarean Section Rate

SGH Target: <28%	SGH: 31.6%	ESTH Target: TBC	ESTH: 37.5%





SGH updates since last month

Caesarean section rates fell slightly from 32.23% in August to 31.6% in September and shows performance above the mean for the last 7 months and above the target of 28%

ESTH updates since last month

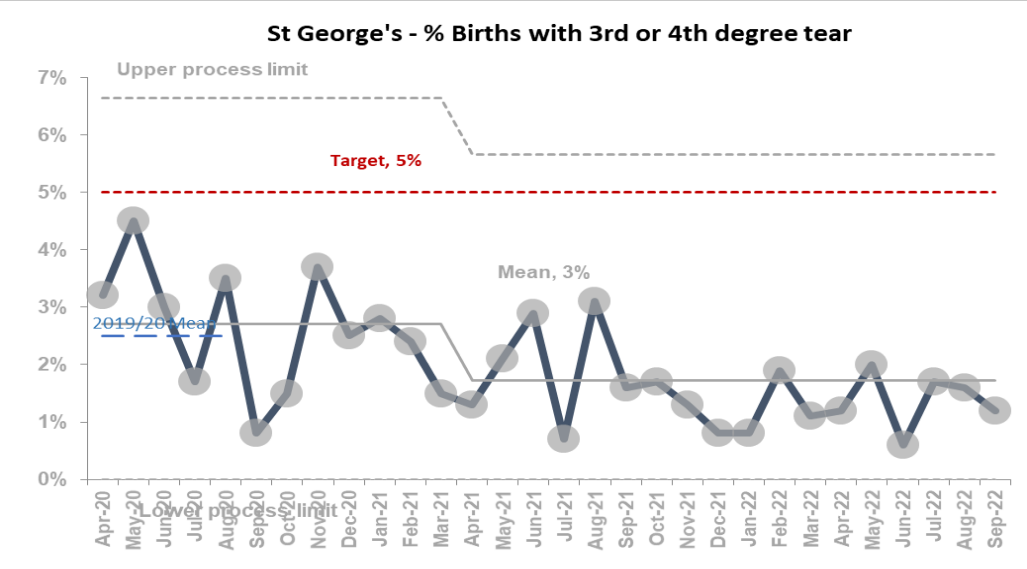
Caesarean section rate was 37.5% in September

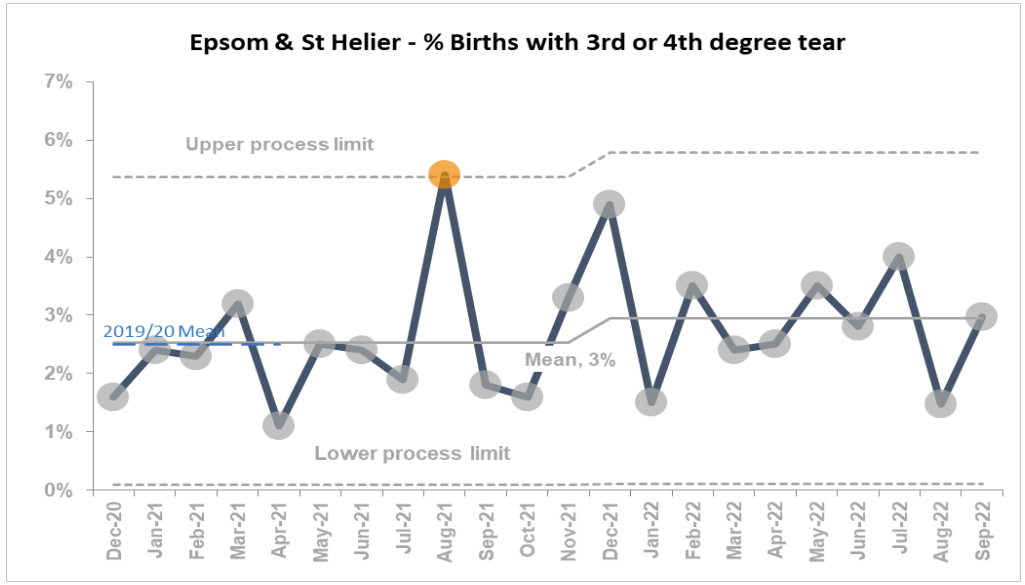
NHS
St George's, Epsom and St Helier
University Hospitals and Health Group

% Births with 3rd or 4th degree tear

gesh

SGH Target: <5%	SGH: 1.2%	ESTH Target: TBC	ESTH:2.9%





SGH updates since last month

The number of 3rd or 4th degree tears shows a steady decline over the last 3 months to levels seen prior to May 2022.

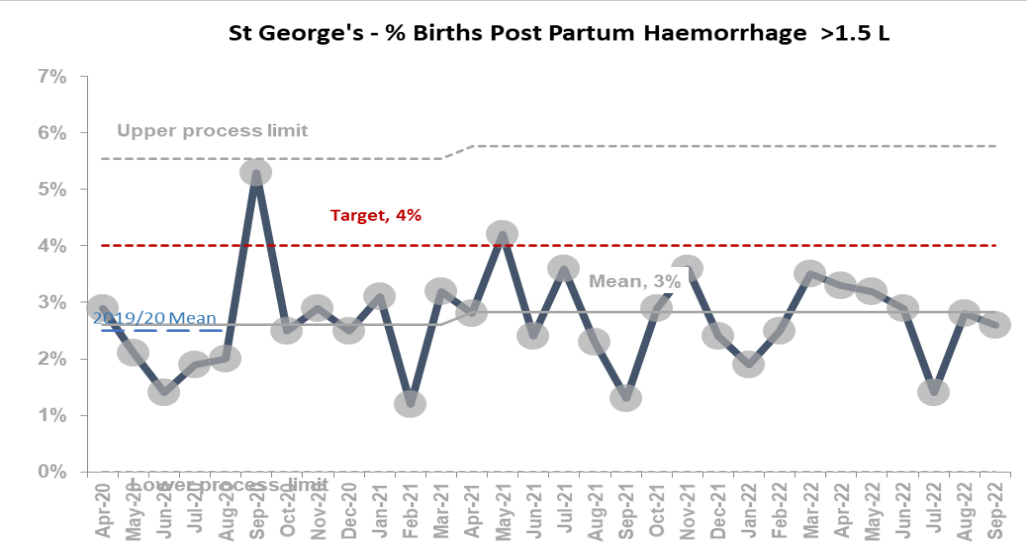
ESTH updates since last month

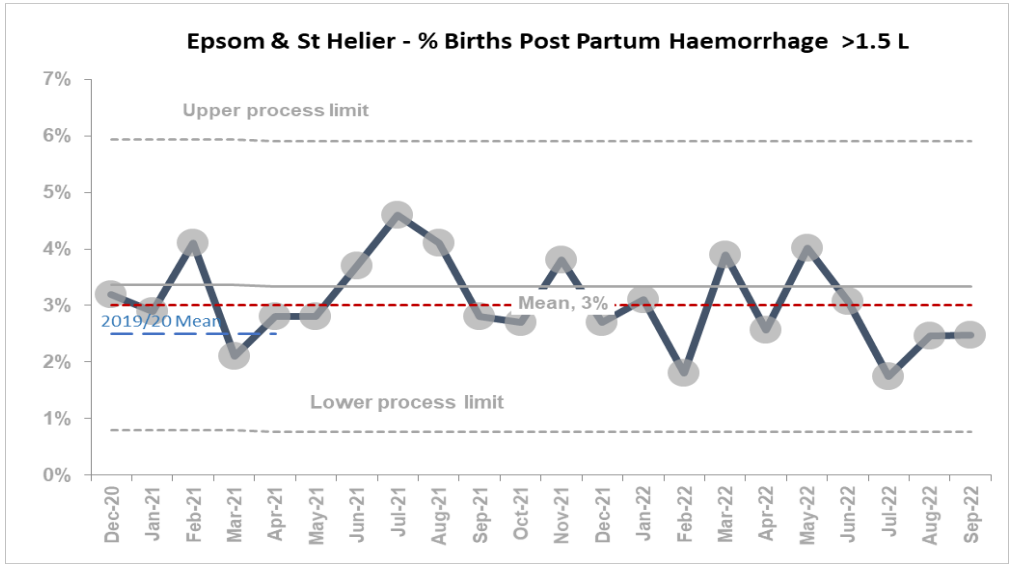
A slight increase in the number of births with 3rd or 4th degree tears from 1.47% to 2.97%.

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

% Births Post Partum Haemorrhage >1.5 L

SGH Target: <4%	SGH: 2.6%	ESTH Target: <3%	ESTH: 2.5%





SGH updates since last month

There was a continued low PPH rate >1.5L which is reassuring – this is the result of a QI project on Delivery Suite

ESTH updates since last month

The percentage of births with post partum Haemorrhage >1.5L was 2.5% in September. The trust met this target eight time in the last 12 months.

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

Maternity - Analysis and Action

gesh

SGH current issues –

September birth rate was 345 births with sustained obstetric and medical complexity remaining high. Staffing remained extremely challenging across the month with significant mitigation actioned and implemented. This was influenced by vacancy's at band 5 and band 6 level, short term sickness/absences and covid isolation continuing.

Due to activity and acuity that staffing levels could not safely support, the Maternity unit formally diverted on three occasions in September with support via the SWL Surge Hub. The Birth Centre was proactively closed for the whole month with women diverted and staff redeployed to Delivery suite. The Homebirth Service was suspended for two weeks and following additional 'lean in' from the team was subsequently reinstated.

ESTH current issues –

Concerns with high 3rd/4th degree tears

Caesarean section rate remains high.

SGH future action -

Formal reporting for Continuity of Carer targets have now been paused by the national teams. We will however continue to target our services and support for our most vulnerable women, both clinically and those in areas of high deprivation and those identified as being at risk including the influences of ethnic origin.

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.

Digital Strategy (as part of maternity digital transformation) This strategy defines a clear set of objectives and roadmap to March 2025 which builds upon the Trust's existing digital strategy to meet both patient and staff expectations. The implementation of the new Maternity EPR is a significant part of the strategy and will occupy a large part of this timeline, however, we set out additional objectives and indicate what lies ahead beyond 2025.

ESTH future action –

3rd/4th degree tears: ESTH continue to promote the OASI care bundle and review practice. All cases are subject to a 72 hour review which is shared for assessment and comment regarding practice and potential lessons learnt.

Case review is being carried out to identify pressure points and any outstanding issues. There is also an issue with the threshold for reporting across London and is in work in progress through the system.

PPH is subject to the same review process and continues to sit below target.

Caesarean section rates: following the Ockenden report, this metric has been removed nationally, with emphasis on both safety and women's choice. ESTH value the importance of limiting major surgical intervention, however continue to pride ourselves on positive pregnancy outcome in terms of both neonatal intervention and patient experience.

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

Monthly Overview – Elective Care (1)

gesh

Responsive and Productive Services - Elective Ca	St George's							Epsom and St. Helier						
	Monthly Target	Jul-22	Aug-22	Sep-22	YTD Target	YTD Actual	13-Month Trend	Monthly Target	Jul-22	Aug-22	Sep-22	YTD Target	YTD Actual	13-Month Trend
Outpatient activity	63,195	55,506	55,198	58,797	357,189	345,811								
Patient Initiated follow ups	TBC	268	272	252	TBC	1,842		TBC	903	817	897	TBC	5,260	
Advice and Guidance	TBC	1,312	1,316		TBC			TBC	1,248	1,332	1,301	TBC	7,444	
Outpatient DNA rates	TBC	11.8%	11.1%	11.0%	TBC	11.5%		TBC	5.3%	5.3%	5.2%	TBC	5.2%	
Outpatient % virtual	25%	23.0%	21.3%	21.4%	25%	22.7%								
New to follow up outpatient ratios	TBC	1.09	1.11	1.21	TBC	1.11		TBC	2.74	2.77	2.75	TBC	2.81	
Elective and day case activity	5,298	5,140	4,921	4,750	30,291	29,266		3,840	3,462	3,342	3,305	21,632	16,835	
Elective LOS	TBC	4.1	3.8	4.5	TBC	4.08		TBC	5.6	6.0	5.9	TBC	5.7	
Elective Day case rates	79%	78%	78%	78%	79%	79%		82%	89%	95%	90%	82%	90%	
Theatre Utilisation	85%	79%	79%	80%	85.0%	80.0%								
Theatre Average Cases per Session	TBC	1.64	1.63	1.70	TBC	1.666								
On the day cancellations for Non Clinical Reasons	TBC	23	34	27	TBC	157		TBC	82	75	98	TBC	368	
On the day cancellations for Non Clinical Reasons & Re-booked within 28 Day	100%	96%	97%	100%	100%	99%								

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

Monthly Overview – Elective Care (2)

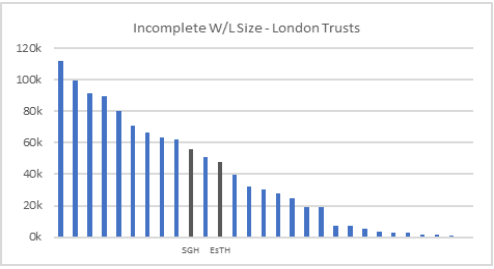
gesh

	St George's							Epsom and St. Helier						
Responsive and Productive Services - Elective Ca	**Monthly Target**	**Jun-22**	**Jul-22**	**Aug-22**	**YTD Target**	**YTD Actual**	**13-Month Trend**	**Monthly Target**	**Jun-22**	**Jul-22**	**Aug-22**	**YTD Target**	**YTD Actual**	**13-Month Trend**
RTT – total size of waiting list*	47,500	52,351	54,199	55,626				42,400	47,086	47,427	47,521			
RTT - Waits over 52 weeks*	830	914	877	768				175	259	271	275			
RTT - Waits over 78 weeks*	25	48	42	35				1	5	3	4			
RTT – Performance	92%	72.5%	71.2%	71.4%				92%	73.5%	71.6%	70.1%			
Cancer 14 Day Standard	93%	83.2%	79.6%	74.6%				93%	96.7%	96.7%	96.6%			
Cancer 14 Day Standard Breast Symptomatic	93%	50.0%	32.7%	27.6%										
Cancer 31 Day Diagnosis to Treatment	96%	92.0%	96.5%	94.7%				96%	98.9%	98.9%	100.0%			
Cancer 31 Day Second or subsequent Treatment (Surgery)	94%	98.0%	96.0%	91.0%				94%	100.0%	100.0%	100.0%			
Cancer 31 Day Second or subsequent Treatment (Drug)	98%	100%	100%	100%				98%	0%	100%	100%			
Cancer 62 Day Referral to Treatment Screening	90%	86.5%	82.0%	66.7%				90%	0.0%	100.0%	80.0%			
Cancer 62 Day Referral to Treatment Standard	85%	74.8%	73.8%	68.9%				85%	85.1%	87.4%	85.0%			
No. of patients over 62 days	175	117	124	161				70	60	56	63			
Cancer – 28 day Faster Diagnosis Standard	75%	78.6%	77.3%	69.1%				75%	76.5%	77.0%	80.5%			
	Monthly Target	**Jul-22**	**Aug-22**	**Sep-22**	**YTD Target**	**YTD Actual**	**13-Month Trend**	**Monthly Target**	**Jul-22**	**Aug-22**	**Sep-22**	**YTD Target**	**YTD Actual**	**13-Month Trend**
Diagnostic activity	TBC	15,651	15,638	15,568	TBC	219,127		TBC	15,712	16,463	16,821		219,360	
Diagnostic performance	5%	5.8%	10.9%	11.6%				5%	10.1%	13.6%	11.9%			

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

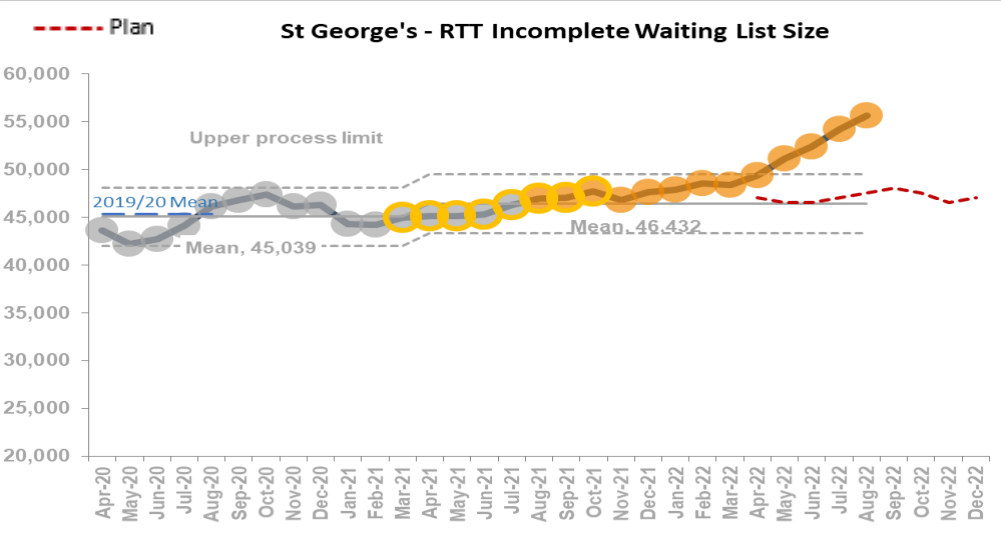
RTT – Total Waiting List Size

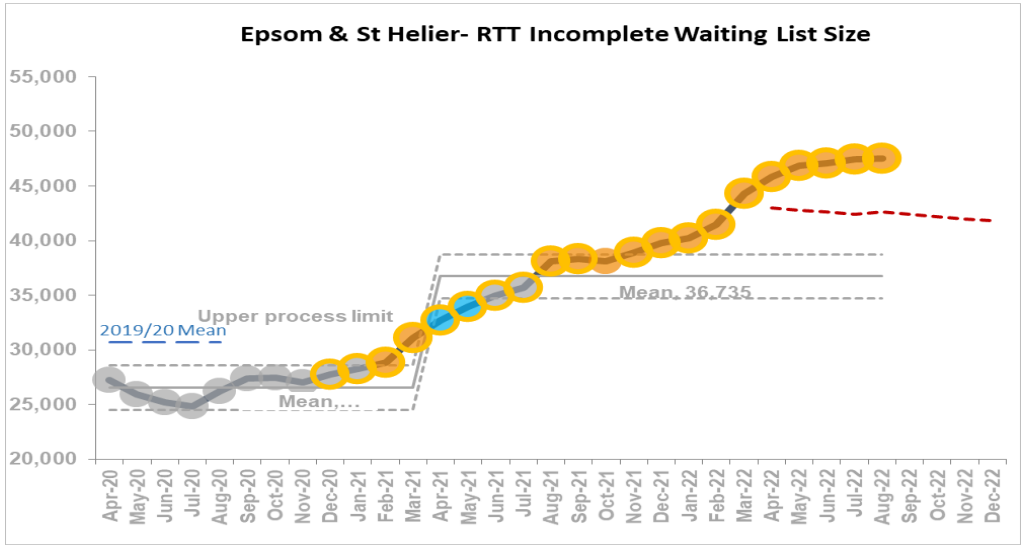
gesh



Aug-22

SGH Plan: 47,500	SGH: 55,626	ESTH Plan: 42,600	ESTH: 47,521



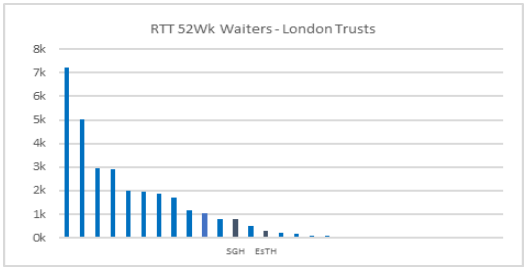


SGH updates since last month
The Trust continues to see the total PTL size grow with 55,626 patients waiting for treatment, above the upper control limit for the last three month period and not meeting plan. The increases continue to be driven by the non-admitted PTL with the volume of patient under 18 weeks rising by 2.8% compared to July and significantly higher than a year ago. Upward trends continue to be seen within Cardiology, Chest Medicine, Neurosurgery and Neurology. In total 71.4% of patients are waiting for less than 18 weeks.

ESTH updates since last month
The PTL volume has seen an increase for the tenth successive month (although slower than previously seen – less than 0.2%), with 18 week breach numbers increasing significantly resulting in drop in performance reporting 70% of patients waiting for less than 18 weeks. Largest proportion of patients waiting for more than 18 weeks is within the Gynae, Dermatology Gastroenterology and General Surgery.

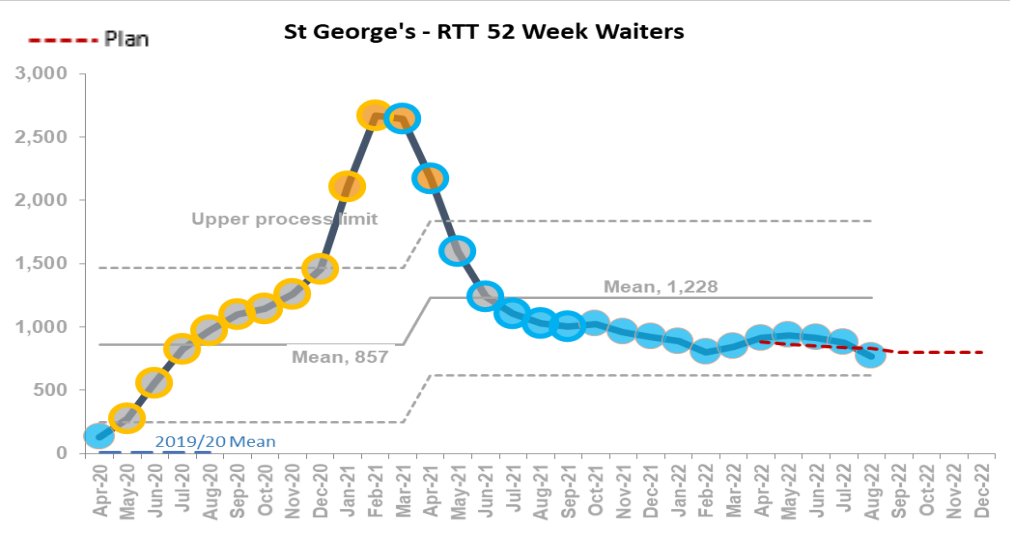
St George's, Epsom and St Helier University Hospitals and Health Group

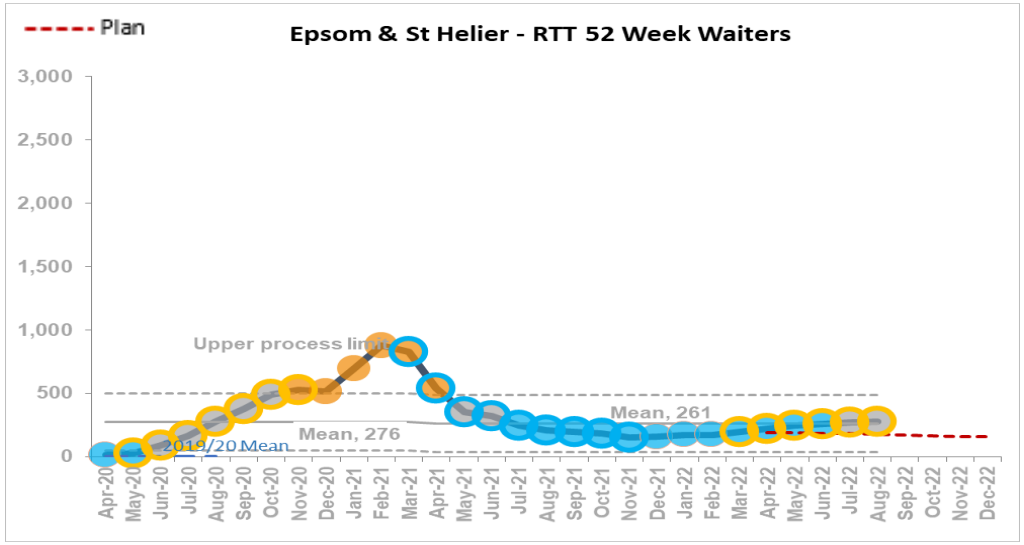
RTT – 52 Week Waiters



Aug-22

SGH Plan: 830	SGH: 768	ESTH Plan: 175	ESTH: 275





SGH updates since last month

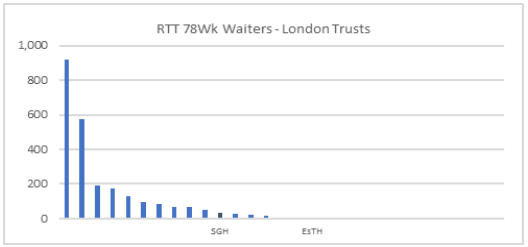
There has been a reduction of the Trust backlog of long waiting RTT patients in the month of August. The number of 52 week waiters has reduced from 877 patients in July to 768 patients, a decrease of 12.4% and now ahead of plan, this is driven by a reduction within the non-admitted PTL particularly within in the specialty of ENT. Highest proportion of 52 week waiters remains within the admitted pathway (69%) particularly within General Surgery, Cardiology and Plastics.

ESTH updates since last month

The month-end 52-week waits have increased to 275 pathways, an increase of four compared to July. The largest proportion of breaches are within Cardiology, Gastroenterology and Thoracic Medicine on the non-admitted PTL.

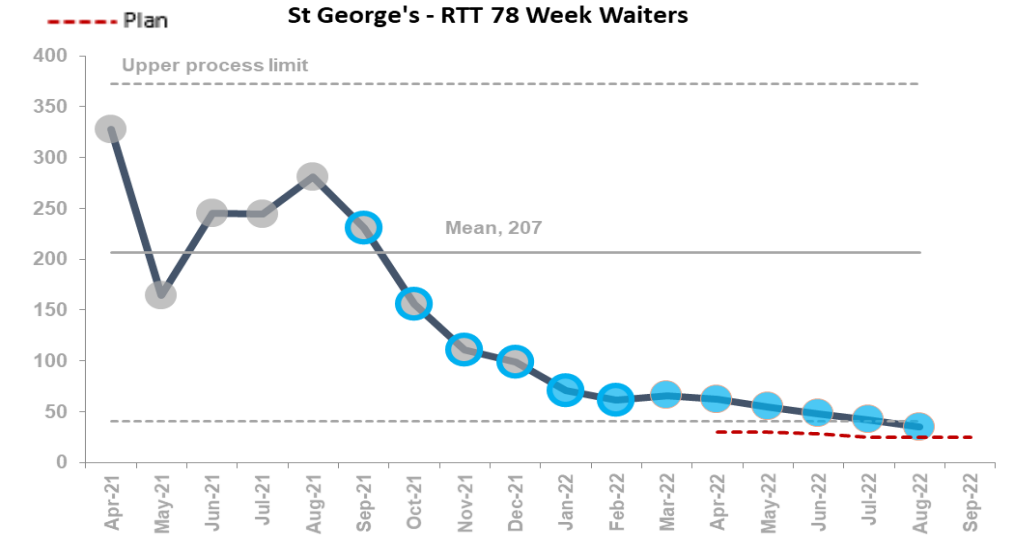
St George's, Epsom and St Helier University Hospitals and Health Group

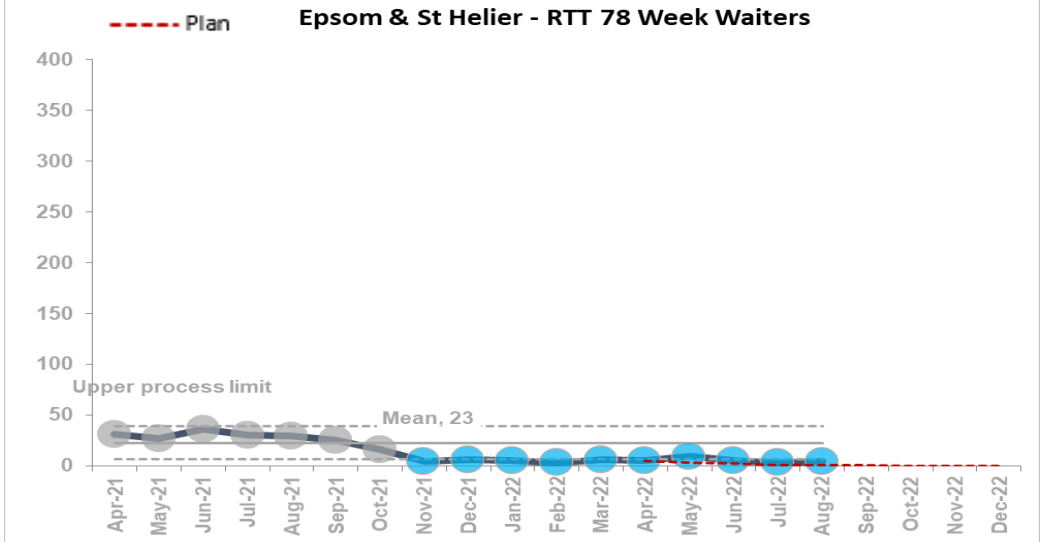
RTT – 78 Week Waiters



Aug-22

SGH Plan: 25	SGH: 35	ESTH Plan: 1	ESTH: 4





SGH updates since last month

The number of patients waiting for more than 78 weeks for treatment reduced from 42 patients in July to 35 patients in August with the highest proportion of patients within General Surgery and Cardiology on the admitted PTL.

.

ESTH updates since last month

At the end of August there were four pathways waiting for treatment above 78 weeks within the specialties of Trauma &Orthopaedics, Gastroenterology and Cardiology. There were no patients waiting for more than 104 weeks.

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

Elective / RTT Analysis and Action

gesh

SGH current issues –

The number of patients waiting for a first appointment continues to grow. There are 650 patients waiting over 40 weeks for a first appointment.

Recorded activity is below plan in a number of elective specialities.

The number of patients waiting over 52 and 78 weeks continues to fall and are on track to achieve year end targets.

SGH future action -

Patients waiting over 18W, in specific specialties, without an appointment, will be contacted via DrDoctor to confirm if they still require an appointment &/or moving to another provider with shorter waiting times. The same approach will be used for long waiting Breast 2WW patients.

Increasing activity, with speciality plans being developed to support additional OPAs & day case activity in QMH theatres. Aiming that by 25 November no patient will wait more than 52W on a non-admitted pathway without a first OPA scheduled within 4 weeks.

Reducing the volume of outpatient data quality issues that may be inflating the PTL. In addition there is focus on the cashing-up in a number of specialities where it is having an impact on clock stops & pathway progression.

Reviewing patients on the Non-RTT Admitted PTL to ensure that patients have not had active RTT pathways stopped in error to reduce the number of unexpected long waits reinstated onto the RTT PTL.

GMs are now providing weekly updates to SWL CCG for all patients waiting over 52W, including reasons for delay, next appointment & TCI dates.

Revised trajectories for specialties with 78 weeks concerns being shared to try and clear 78+ before March 23

ESTH current issues –

Total patients waiting for a first attendance currently 25k (an increase from 18k in Jun21). However, the total patients awaiting first appointment has remained static at 25k since Jun22. Referrals have remained significantly above BAU levels most months:

MRR (Monthly Referral Return)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
21/22 VS 19/20 (BAU)	95%	87%	115%	100%	109%	116%	107%	123%	121%	100%	119%	128%
22/23 VS 19/20 (BAU)	110%	114%	116%	100%	119%							

52 week waits increased slightly from 271 in July 2022 to 275 in August 2022. Community Paediatrics is now the most pressured speciality with children waiting over 52 weeks for first appointment (38 as of 07/10/22).

ESTH future action –

First waits are beginning to stabilise as the high referral demand is largely being mitigated by first outpatient activity also being above BAU. This is being achieved by increased efficiencies in clinic (reducing DNAs and unfilled slots following last minute cancellations), insourcing and additional internal clinic sessions.

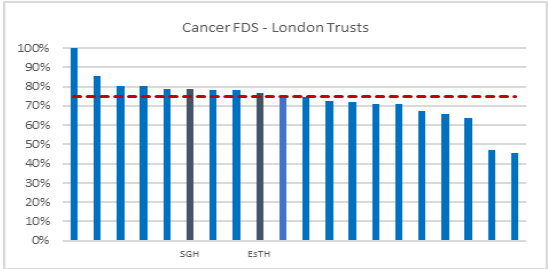
-Outpatient transformation plans are underway to further mitigate the high referral demand by increasing A&G/Specialist Advice opportunities and referral optimisation, as well as a number of other outpatient transformation work streams.

-Mutual aid is also being sought for a number of specialties to support with the referral demand but also to reduce the long waiting patients, especially Community Paediatrics (mutual aid being requested from CHS and SGH for this service, but numbers still to be agreed).

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

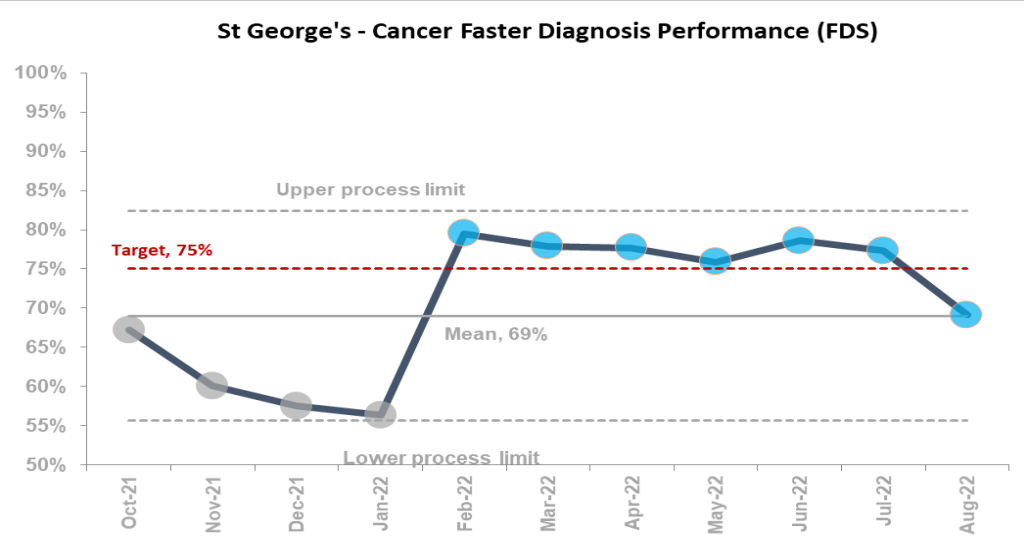
Cancer – Faster Diagnosis Standard

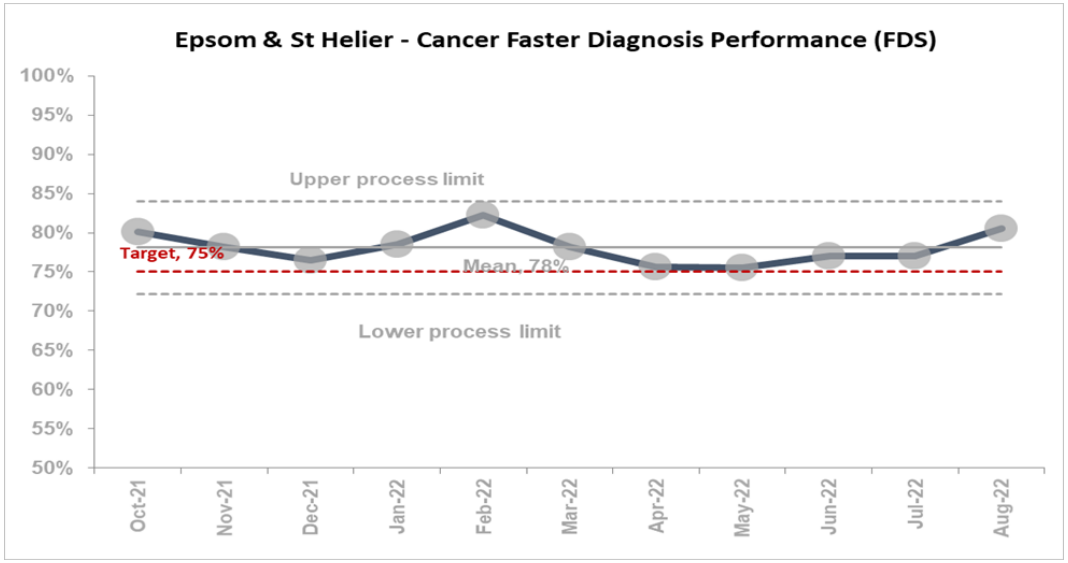
gesh



Aug-22

Target: 75%	SGH: 69.1%	ESTH: 80.5%





SGH updates since last month

FDS performance in August was non-compliant for the first time since January 2022 at 69.1%. The highest volume of patients are within Skin who remained compliant with a performance of 87%. Gynae and Lung also met the target. Breast and Head & Neck moved to a non-compliant position.

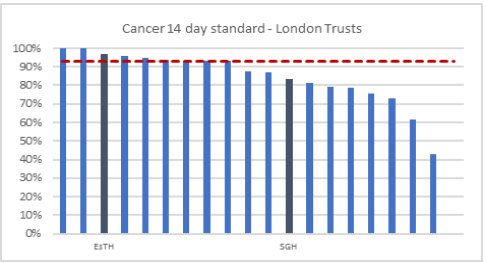
ESTH updates since last month

Performance against the FDS standard remains stable achieving 80.5%.

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

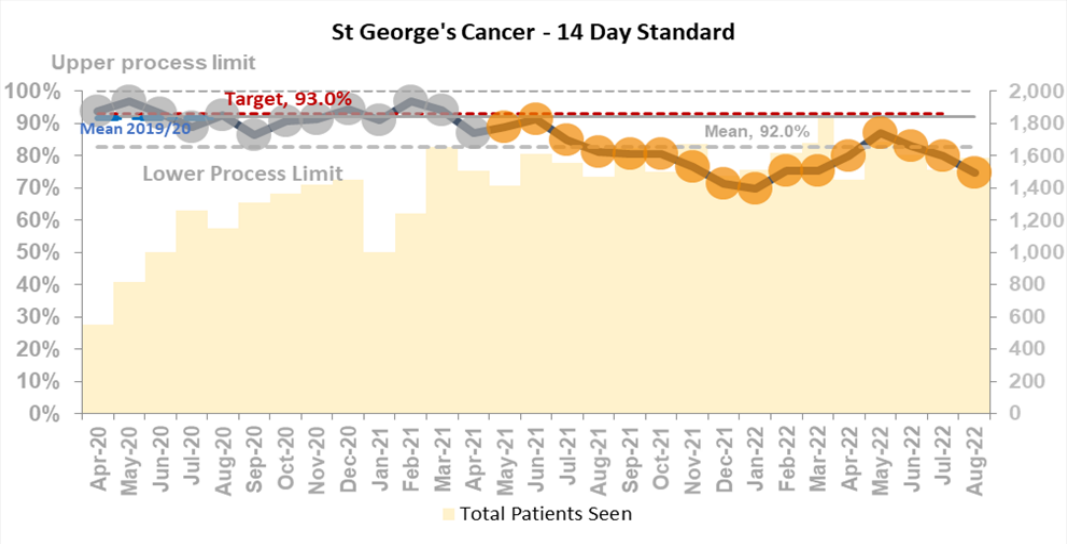
Cancer – 14 Day Referral to Seen Standard

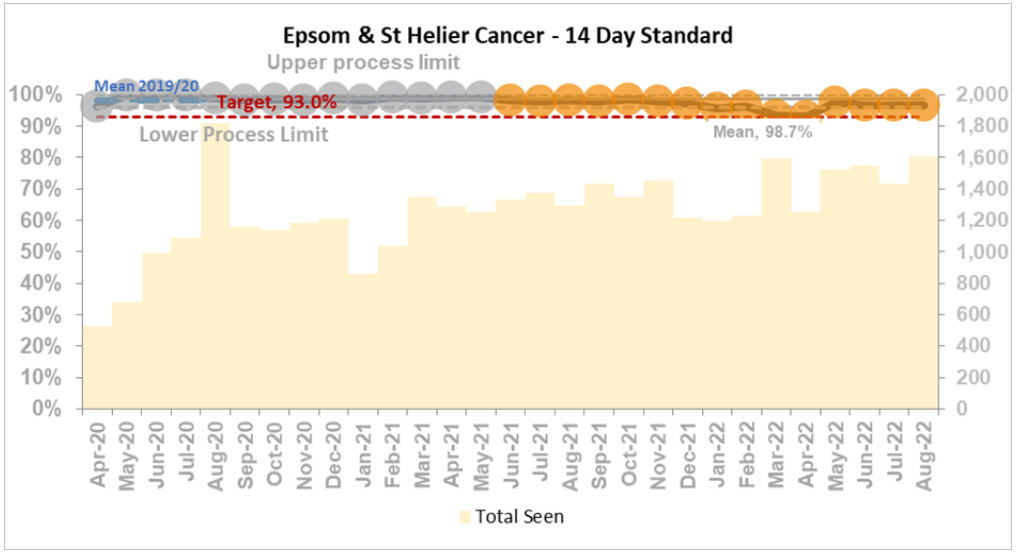
gesh



Aug-22

Target: 93%	SGH: 74.6%	ESTH: 96.6%





SGH updates since last month

Performance deteriorated in August reporting 74.6% this is compared to 79.6% in July The overall number of referrals received into the Trust remains consistent with previous months although 11% higher compared to August 19 (pre covid) Breast performance improved by over 10% although significantly under target with a performance of 44.8%. Gynae and Skin tumour groups reported a in performance of over 15% compared to July. Positively, Haematology and Head and Neck remained compliant for a consecutive month.

ESTH updates since last month

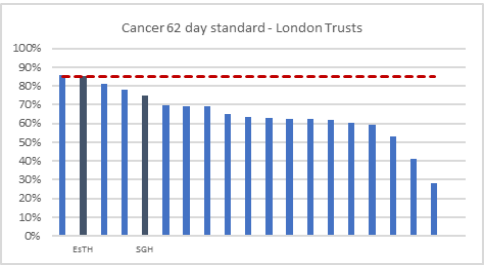
Performance remains above target reporting 96.6% in August.

Total number of referrals received in August was 1,606 which is an increase of 12.2% from July.

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

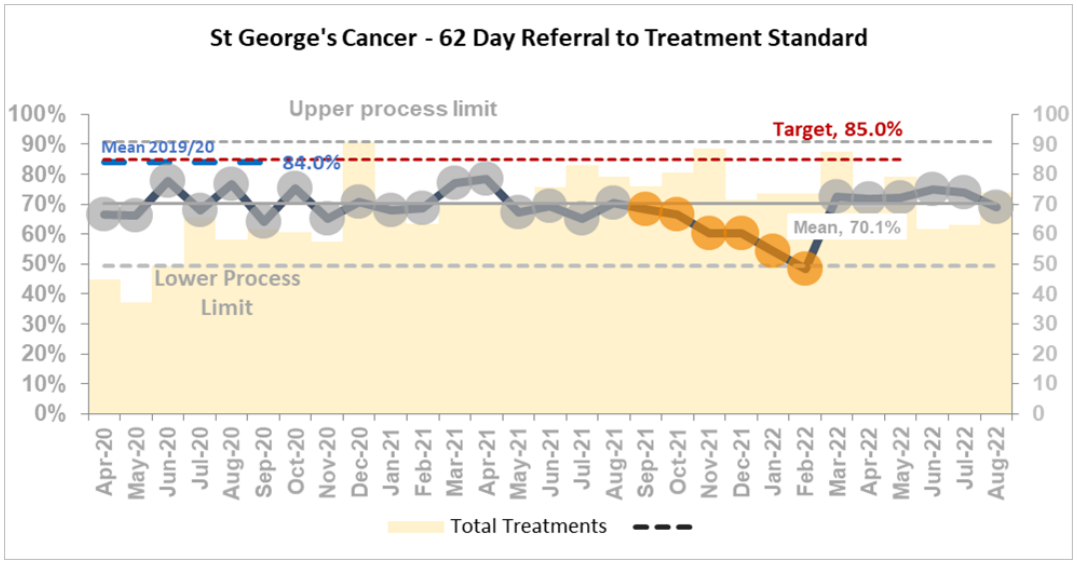
Cancer –62 Day Referral to Treatment Standard

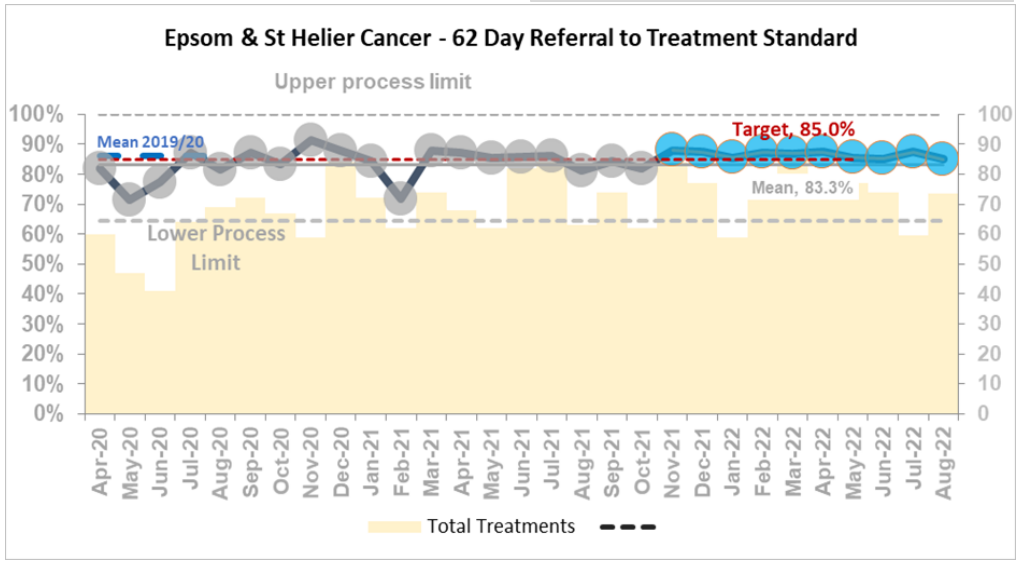
gesh



Aug-22

Target: 85%	SGH: 68.9%	ESTH: 85%





SGH updates since last month

In August, there were 74 accountable treatments on the 62 day GP pathway, an increase of 17% compared to July. At Trust level 68.9% of patients were treated within 62 days compared to 73.8% in August, however performing above the London average. Seven tumour groups were complaint. Skin, Lung, Urology with the largest cohort of treatments in the month continue to be non-complaint against the 85% standard.

ESTH updates since last month

Target of 85% continues to be achieved reporting 85% in August
Compared to August the number of treatments have increased by 23.5%

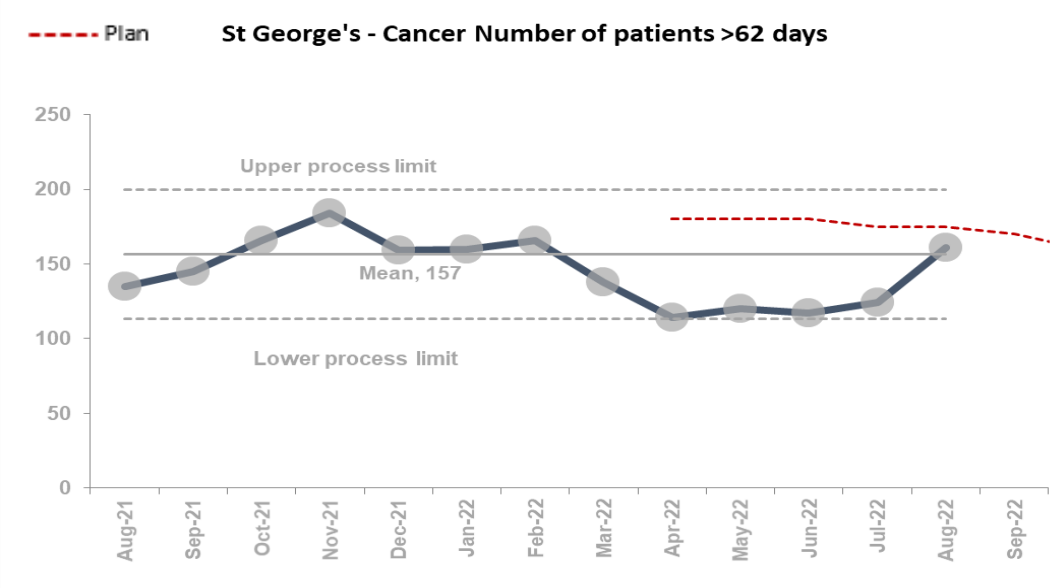
NHS
St George's, Epsom and St Helier
University Hospitals and Health Group

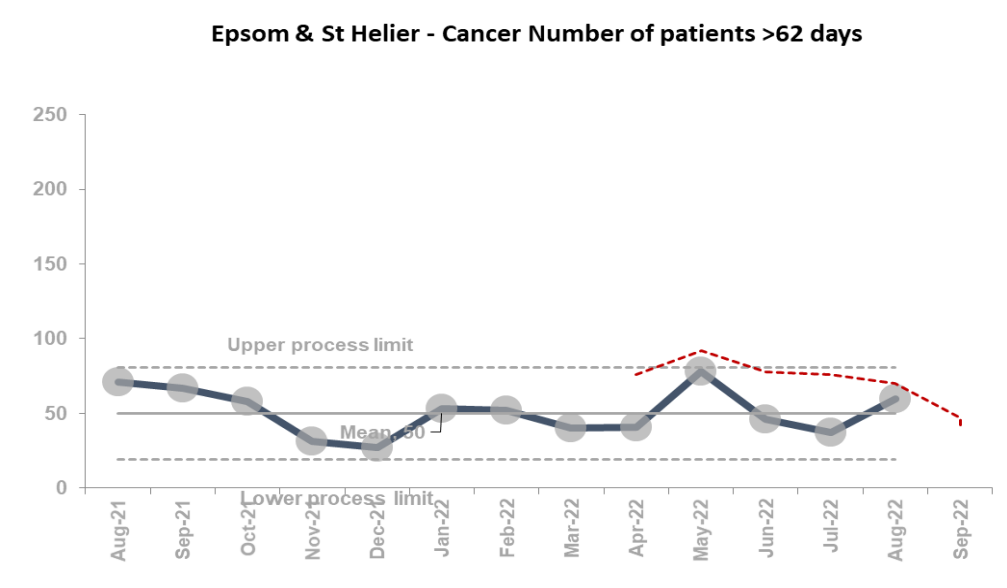
Cancer – Number of patients > 62 days

gesh

Aug-22

Trajectory: 175	SGH: 161	Trajectory: 70	ESTH: 60





SGH updates since last month

The trust set a trajectory of 62 backlog volumes which is being currently being delivered. At the end of August 161 patients were waiting more than 62 day, this is an increase of 37 patients compared to July however below trajectory of 175. Skin, Lower GI and Breast have the largest proportion of patients within the backlog however are better than plan. Head & Neck and Urology are behind plan.

ESTH updates since last month

The Trust set a trajectory of 62 backlog volumes which is currently being delivered. At the end of August, 60 patients were waiting for more than 62 days which is below trajectory of 70.

EStH has implemented processed to maintain and improve the backlog

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

Cancer Performance Analysis and Action

gesh

SGH current issues –
Skin continues to see increases in referrals across the sector.
FDS Performance driven by increasing referral volumes and capacity issues in Breast.
Gynaecology have challenges with hysteroscopy capacity and urology have delays in diagnostics (template biopsy) and access to theatre for prostate.
Increase in 62 day backlog is the result of delays relating to capacity in in Dermatology, Urology and Breast.
Urology has significant challenges in workforce and capacity

ESTH current issues –

Endoscopic Ultrasound (EUS) at Royal Marsden Hospital (RMH) capacity continues to be challenging – current wait is up to 4-5 weeks.

Endobronchial Ultrasound (EBUS) capacity is also challenging throughout the network, currently our lung cancer patients are referred to UCLH where the average wait is 4-5 weeks turn around.

SGH future action -
The Cancer improvement Programme 2023/24 workstreams ongoing to support backlog reductions.
Urology - significant challenges in demand, workforce & capacity. A recovery plan developed targeting theatre capacity & pre-op access, plus a demand and capacity review.
H&N – pathway navigator now in post & a 0.4 WTE CNS funded to support risk stratified triage; ongoing discussions with KUH/ CUH for a joint post.
Skin/ Plastics - recovery plan in progress to support referral management, clinical capacity & workforce gaps.
Lung - RMP approved £199,227 for an additional weekly EBUS list = additional 192 cases per year in line with GIRFT & EBUS within 5 days of referral. Delivery has been postponed to Q4; discussions in progress to support commissioning.
Service engagement – services have daily access to their 62 day & 104 day backlog data. All patients discussed at PTL assurance, PPC huddle & escalation to pathology and radiology. Services review & complete all actions by Friday 12 PM weekly. Senior engagement via the bi-weekly access committee.
Clinical Harm Review - all TWW 62 day and 104 day breaches have a RCA to assess harm.

ESTH future action –
On going work with RM Partners to provide EBUS service within the network.

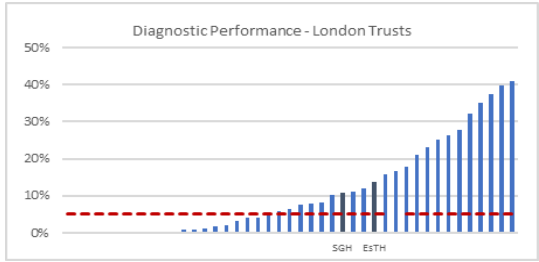
RM Partners recognises the challenge in providing EBUS for our patients and investment is ensuring to create additional capacity at St George's Hospital.

ESTH is in liaison with RMH via RM Partners to improve the EUS service.

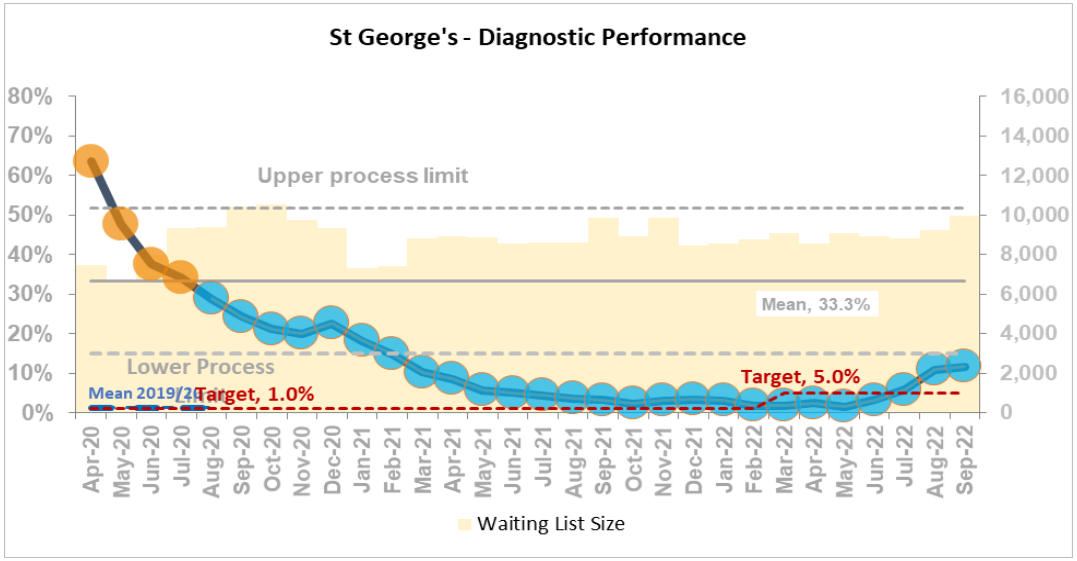
NHS
St George's, Epsom and St Helier
University Hospitals and Health Group

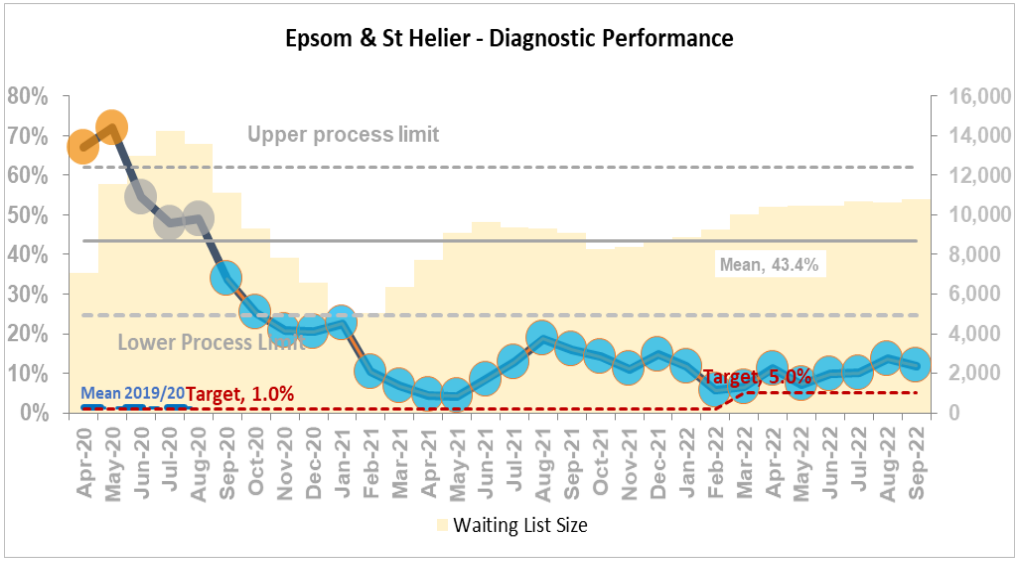
Diagnostic Performance

gesh



Target: 5%	SGH: 11.6%	ESTH: 11.9%





SGH updates since last month

Deterioration in performance seen in September with 11.6% of patients breaching the six week diagnostic target (1,151 patients) compared to 10.9% at the end of August. Largest proportion of long waiters are within Gynae Ultrasound and Endoscopy. The waiting list size has grown by 7.7%.

ESTH updates since last month

In September there was an improvement in diagnostic waiting times with 11.9% patients waiting for more than six weeks compared to 13.6% in August. In total, there were 1,285 patients >6Wks. The largest proportion of breaches are within Non-obstetric ultrasound and Echocardiography.

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

Diagnostic Performance Analysis and Action

SGH current issues –

Vacant Sonographer posts in Gynae US and increase in demand has led to increased waits, current capacity and demand profile suggests 39 additional clinics are needed per month.

Staffing within Endoscopy across Nursing, Clinical and Admin have been challenging and impacting the service's ability to staff lists at full capacity. Bookings for Urgent and Cancer referrals taking priority as per guidance.

SGH future action –

Gynae Ultrasound – 1 WTE vacancy, postholder commences in January 23. Continuing to utilise bank and agency as much as possible and a proportion of activity has been shifted to General Radiology to support. Backlog and waiting list has been cleared through October therefore improved performance will be seen from November.

The Endoscopy service are working through a short, medium and longer term workforce solution. Short term options are being working through (options include insourcing, outsourcing, in-house recovery programme). The service have had provisional approval to recruit 2.0 WTE Band 8b Nurse Endoscopists and 3.0 WTE Band 5 Registered Nurses to support service delivery in the medium to longer term. Longer term plan also likely to include upskilling of nursing workforce to train as JAG accredited nurse endoscopists – this a national priority and is supported by the ICS.

Cardiac MRI adding weekly additional day of scanning and backlog is starting to reduce, a further additional day starting in November will bring the service into compliance within Q3.

ESTH current issues –

Total DM01 breaches reported in September 2022 was 1,285 (down from 1,446 in Aug 22), with a performance of 11.9% High number of breaches in NOUS and Echo.

ESTH future action –

Radiology team is undertaking deep dive of NOUS vetting , demand for radiologists list and scheduling management. We have also got two new radiologists started in September 2022 which will help with additional capacity for radiologists lists.
We are using outsourcing and insourcing to clear the backlog both in NOUS and echo.

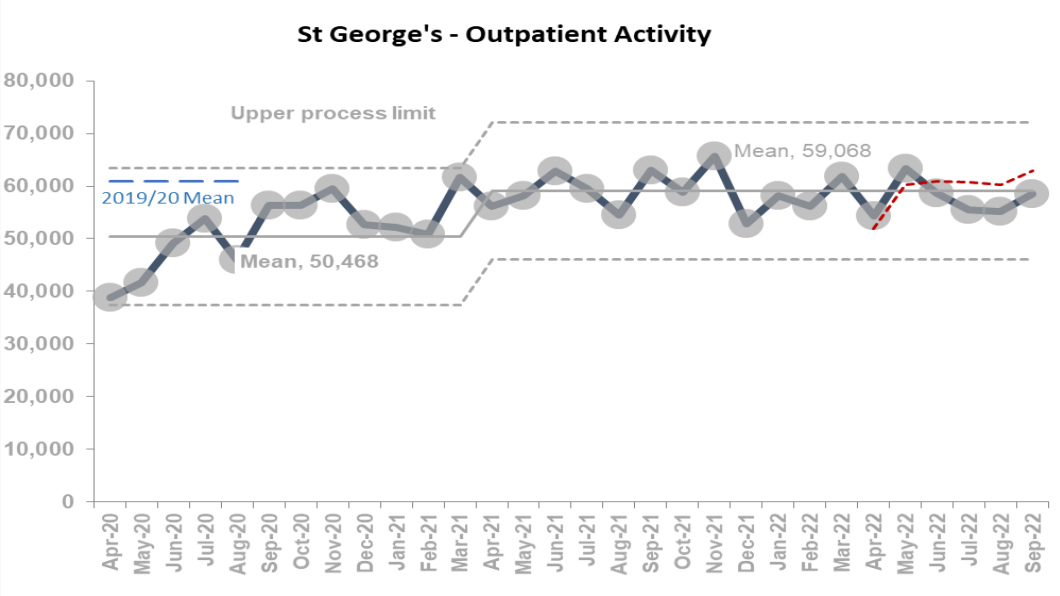
NHS
St George's, Epsom and St Helier
University Hospitals and Health Group

Outpatient Activity

gesh

Sep-22

Target: 63,195	SGH: 58,797



Apr-22	May-22	Jun-22	Jul-22
49,609	58,803	53,833	52,321

Data source: SLAM OP activity freeze data
Awaiting data for longer time period for charting.

SGH updates since last month

Total outpatient activity is currently at 93% of plan. This is expected to increase to 97% once data catch up is completed. First attendances are expected to be above plan by 3%, Follow-up activity -2% and procedures
-15%. Note that no working day adjustment has been made for the additional bank holiday in September 2022 to stay consistent with current South West London methodology.

ESTH updates since last month

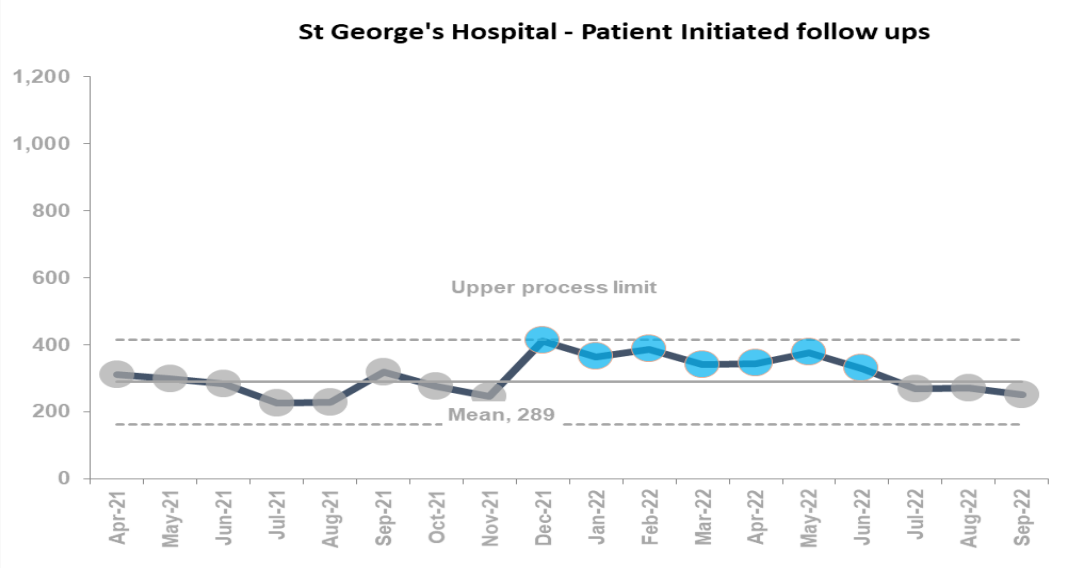
St George's, Epsom and St Helier University Hospitals and Health Group

Patient Initiated Follow-up (PIFU)

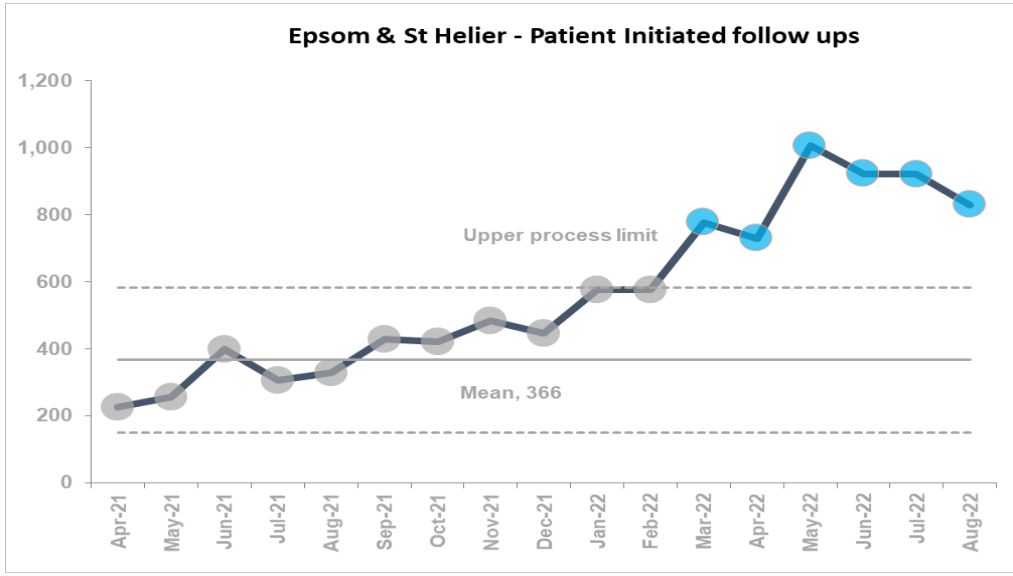
gesh

Sep-22

Target: TBC	SGH: 252



Target: TBC	ESTH: 926



SGH updates since last month

The Trust is piloting PIFU with a number of engaged services. Currently data recording functionality is limited. Cerner is preferred solution and is currently in testing. The data shown above will be significantly limited.

ESTH updates since last month

In October, the following plans are underway to further increase the uptake of PIFU. 1) PIFU for long term conditions – 3 month pilot started 3 Oct in Gastro for stable IBD patients seen by the Epsom clinicians. 2) Launched PIFU to discharge for fracture clinic patients revised discharge time frame of 3 months. 3) Urology - targeted clinical education sessions on PIFU for SPRs led by the Urology Clinical Lead, Miss Tharani Nitkunan. 4) Currently working towards implementing a revised PIFU to discharge timeframe for Orthotic patients.

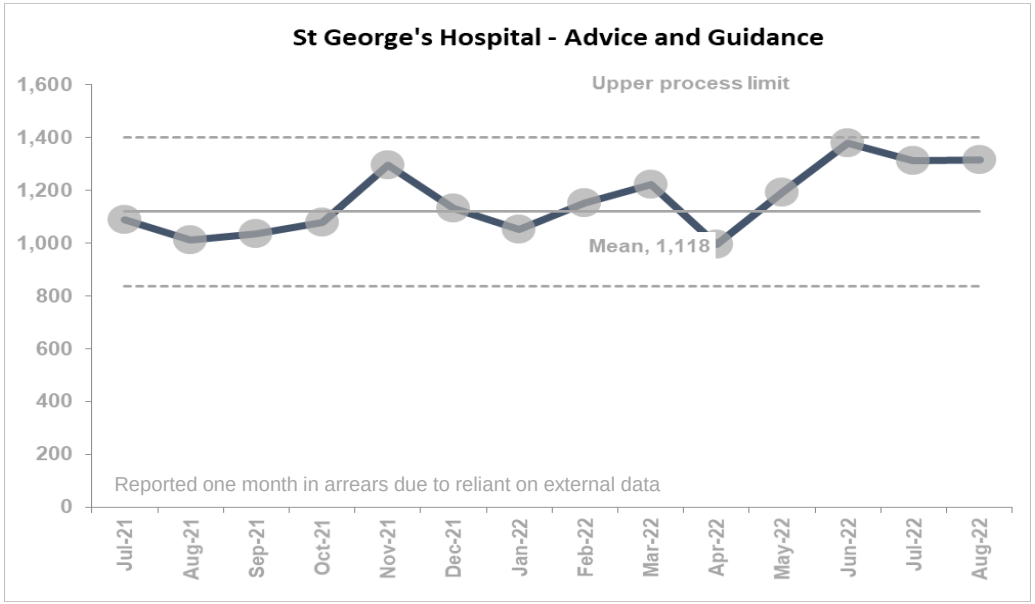
NHS
St George's, Epsom and St Helier
University Hospitals and Health Group

Advice & Guidance

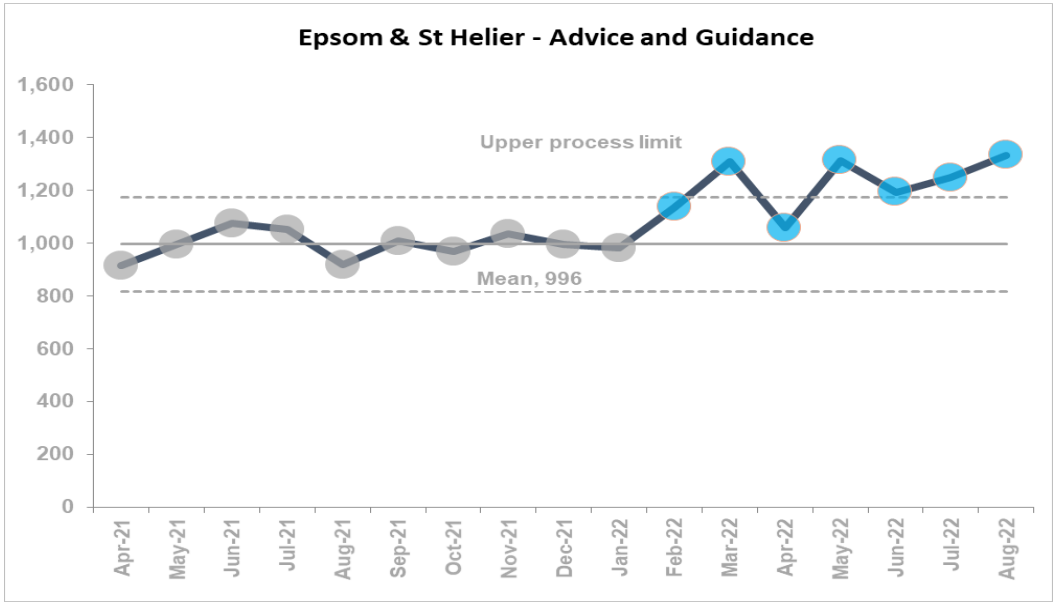
gesh

Sep-22

Target: TBC	SGH: 1,316



Target: TBC	ESTH: 1,332



SGH updates since last month

A&G activity is above the mean for the last four month period. Key clinicians are engaged and willing to act as pilot with next steps to agree and roll out plan to increase activity numbers. Steering Group' and 'Task and Finish Group' in place

ESTH updates since last month

Increase in A&G activity continues to be seen with recent activity above the upper control limit.

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

Outpatient Activity - Analysis and Action

gesh

SGH current issues –

PIFU data collection restricted within system – Cerner functionality in testing which is preferred solution. Some services delivering PIFU but through 'Open Access' policy.
A&G - Anxieties from GPs regarding response times

SGH future action -

PIFU - Engaged with services to review and map patient pathways together with production of comms & literature in preparation for progressing once Cerner solution in place. Have engaged with EsTH PIFU programme team who've shared PIFU general clinical briefing, examples of clinical protocols and patient letters. Project manager to be assigned.
A&G - engaging with the SWL clinical lead to ensure we have clear routes of communication regarding implementation dates. Training packages created and to be rolled out to services. Next steps to agree roll out plan with commissioners with Dermatology, Urology and Gynaecology possible pilot services.
Increasing activity, with speciality plans being developed to support additional OPAs

ESTH current issues –

PIFU – some clinicians concerned about capacity for PIFU'd patients to request an appointment. Mitigation – using examples of successful implementation and data to discuss likely scale of requests. Using Referral Optimisation work to work towards reducing demand on capacity and optimising use of capacity.
A&G – some clinicians concerned about time required to return with advice. Mitigation – supporting teams to develop common text that can be edited for specific patient needs, including useful links for GP's. Some anxieties about potential increased GP pushback. Mitigation – collaborative working with both Sutton and Surrey ICS' so that pathways and approaches are agreed locally with GPs.

ESTH future action –

PIFU – Monitor PIFU for long Term conditions in Gastro and support as they a review of their waiting lists to see if PIFU can be retrospectively applied for patients. Suitable patients will be booked in to a telephone clinic for a joint clinical decision-making discussion. Launch PIFU to discharge in Orthotics. Continue to link in with the NHS E contact for the proposed national round table discussions for PIFU and waiting lists.
A&G - Specialist advice tab now on the ESTH OP dashboard. Expansion and update of the public "Referring to Our Services" webpage is also underway with some updates already live. Neuro and Urology Quick views are drafted. Rheum, Derm, Gynae Gastro and Cardio are in development. Urology - Paed Foreskin GP and parent advice guides drafted and being proposed to GP clinical groups in Sutton and Surrey 13 Oct. A&G guidance for GP's from Dermatology and an educational session on A&G shared by Dr Juliet Williams to primary care colleagues. Advice and Refer – local approach agreed with SWL. Socialised Gynae and Urology pathways, engaged relevant teams. Awaiting ENT Rhinitis pathway from SWL to progress from initial contact with ENT. Discussions between A&R leads and Sutton GP's continue.
Referral Optimisation – Finalise Neuro and Urology Referral Quick views, socialise these widely and implement triage to these. Finish first drafts of Rheum, Gynae, Derm, Gastro and Cardio quick views.
GP Peer to Peer Referral reviews – consider and socialise findings once released, identify key actions from these.
TWW – discussions regarding high referral but static diagnosis rates.
Pending local agreement, launch, socialise and triage to the Paed Foreskin advice.

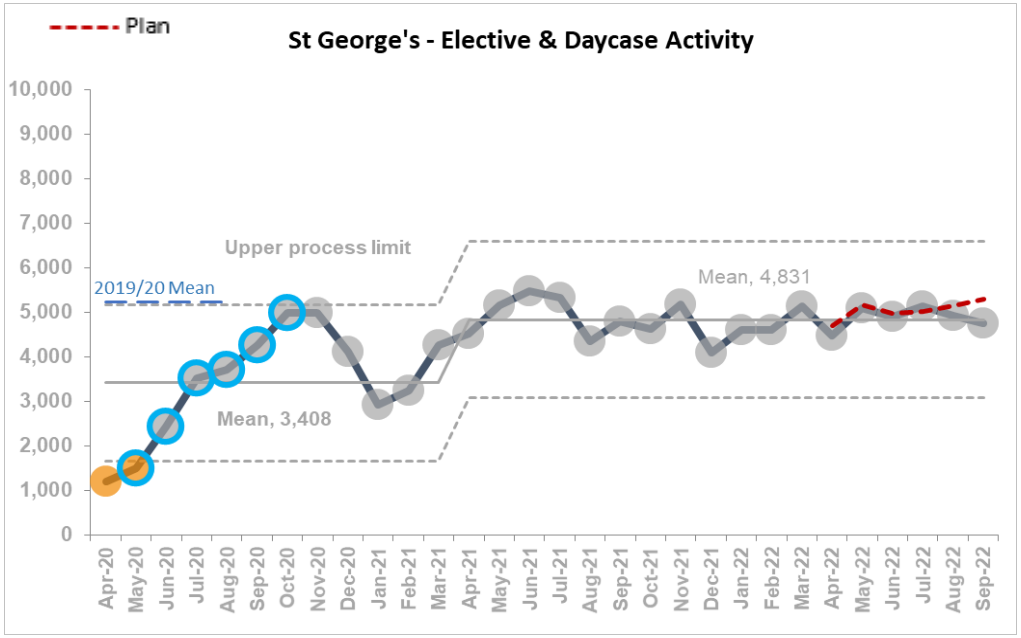
NHS
St George's, Epsom and St Helier
University Hospitals and Health Group

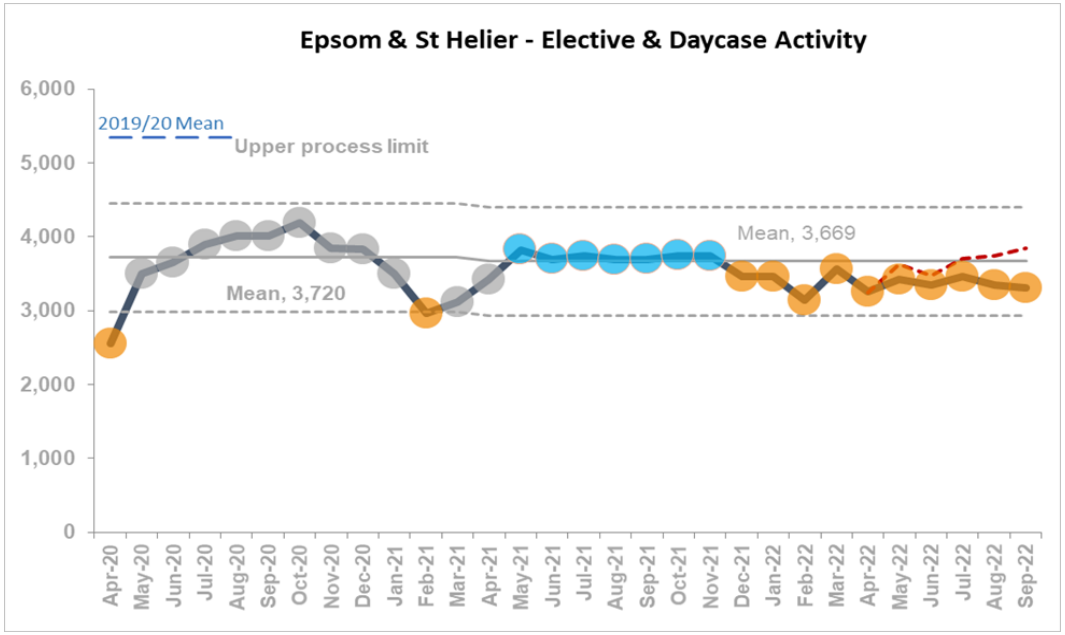
Elective & Daycase Activity

gesh

Sep-22

SGH Plan: 5,298	SGH: 4,750	EStH Plan: 3,840	ESTH: 3,305





SGH updates since last month

Elective performance remains within the upper and lower confidence limits although below the mean, Across the month of September there were on average 227 elective treatments per day. Elective and Daycase performance is currently at 88% but is expected to increase to 93% after data catch up, below the 100% plan submitted for September.

ESTH updates since last month

Elective activity is currently below plan. Across the month of September there were on average 157 elective treatments per day.

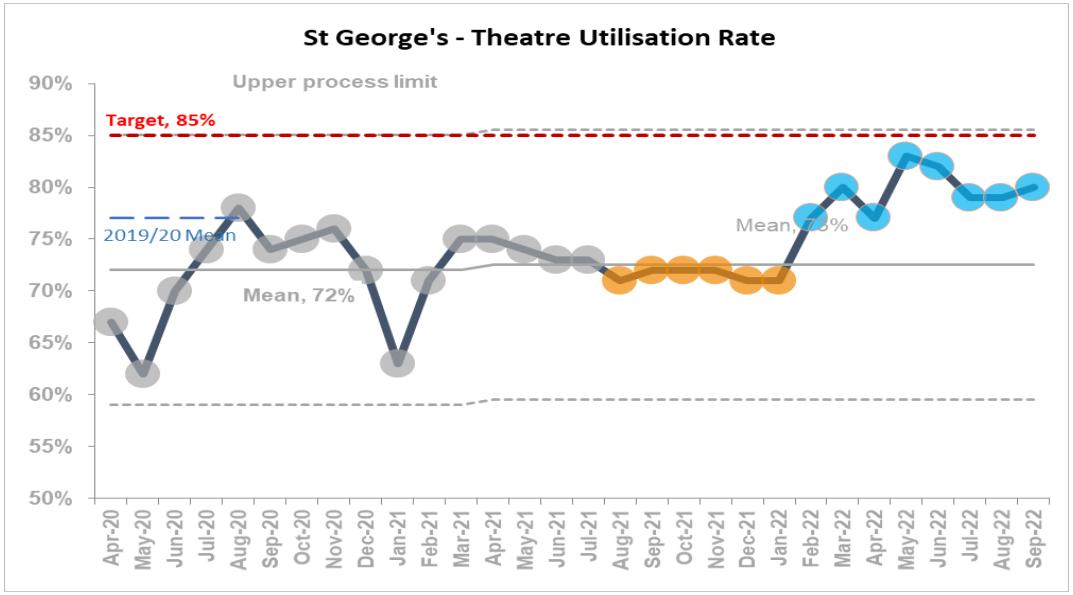
NHS
St George's, Epsom and St Helier
University Hospitals and Health Group

Theatre Productivity - Utilisation

gesh

Sep-22

Target: 85%	SGH: 80%



Theatre data in final validation to ensure criteria aligns with NHSE data.

SGH updates since last month

Theatre utilisation rates remain positive showing a sustained performance above the upper control limits reporting 80% utilisation rate in September.. This is driven by improved rates within Plastic Surgery, Trauma & Orthopaedics and Vascular Surgery.

ESTH updates since last month

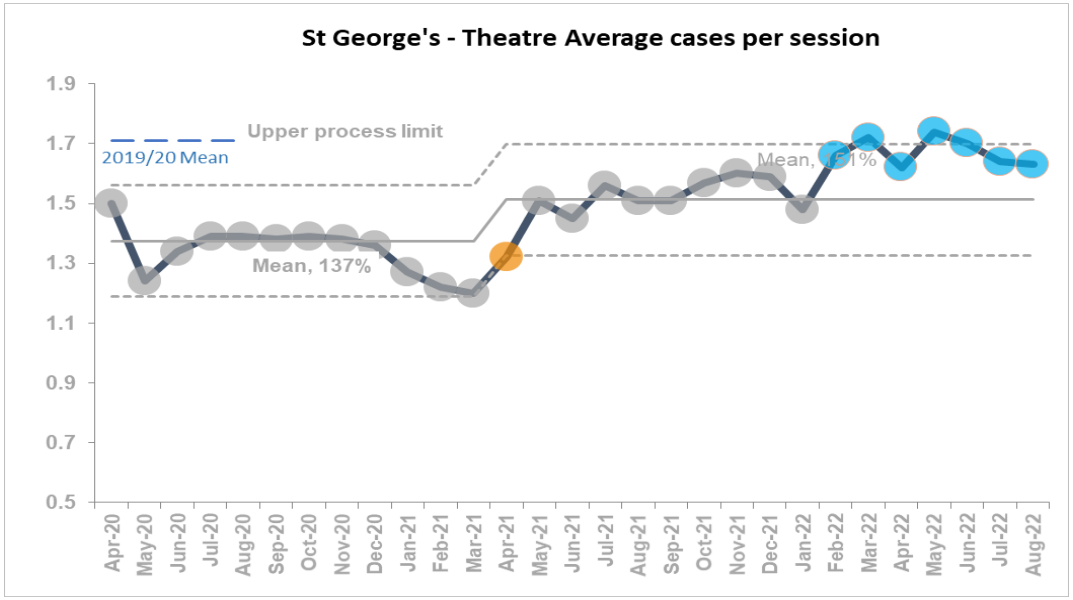
NHS
St George's, Epsom and St Helier
University Hospitals and Health Group

Theatre Productivity – Average Cases per Session

gesh

Sep-22

Target: N/A	SGH: 1.7



Theatre data in final validation to ensure criteria aligns with NHSE data.

SGH updates since last month

Theatre cases per session performance is stable showing only common case variation, Gen Surgery, Urology, Plastics and Vascular Surgery performing positively above the upper control limit. Theatres ran a total of 1,605 theatre lists (elective and non elective sessions), this is 11% higher compared to the same month in 2019

ESTH updates since last month

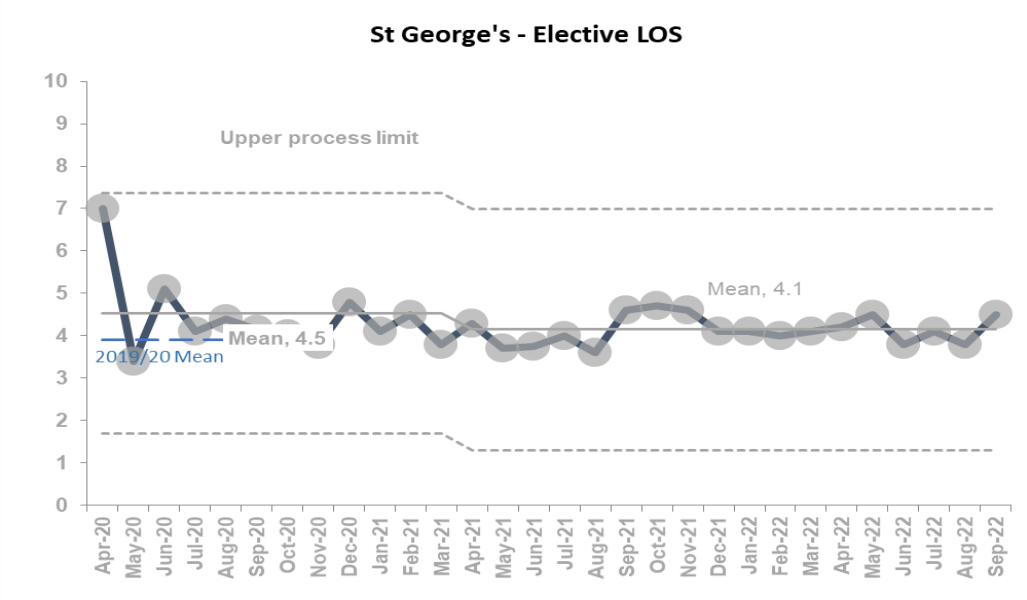
NHS
St George's, Epsom and St Helier
University Hospitals and Health Group

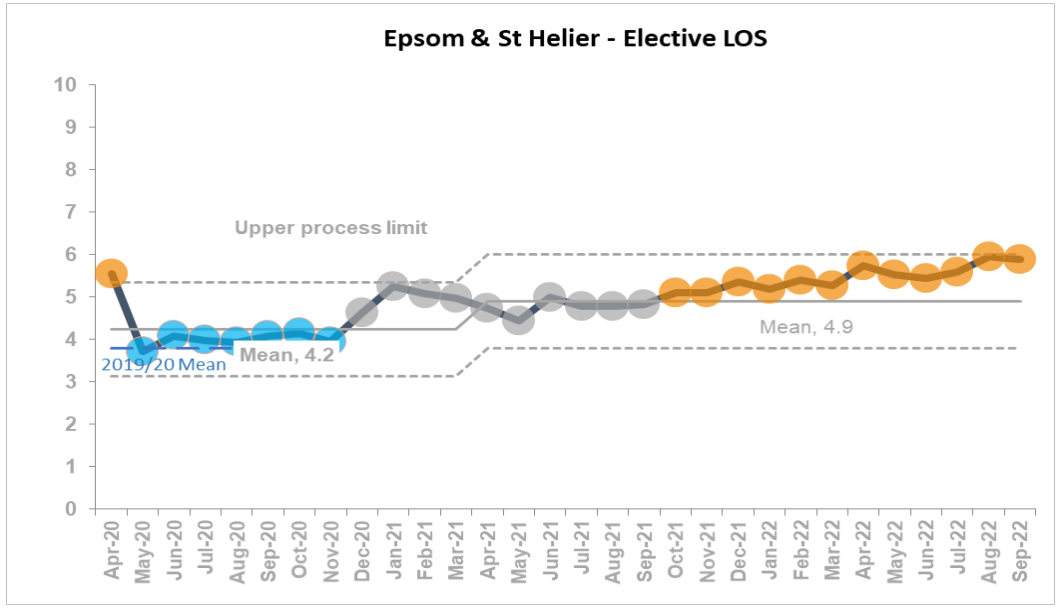
Elective Length of Stay

gesh

Sep-22

Target: N/A	SGH: 4.5	ESTH: 5.8





SGH updates since last month

Elective length of stay continues within the upper and lower control limits showing only common cause variation. Patients admitted electively stayed on average for 4.5 days through September.

ESTH updates since last month

Elective length of stay remains high but within the control limits.

.

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

Theatre Productivity - Analysis and Action

gesh

SGH current issues –

QMH STC utilisation rose to 70% (+26% compared with September 2021). The unit also delivered the second highest number of cases ever (474), topped only by the previous month's total (510). This has been driven by improved booking volumes.
Utlisation in both day surgery units is now high (78% average – the highest utlisation post-Covid) and now exceeds IP theatres.
IP theatre utilisation is being severely hampered by bed capacity (both ICU and ward beds) and resultant flow issues.
Without this disruption, theatre utilisation would have comfortably exceeded the 85% target in September.

SGH future action -

ASA1 Streaming for Adults under 60 was launched in Pre-Operative Assessment on 10th September: 35% of SGH surgeries in the last three months took place on ASA1 patients (DSU - 49%; 26% - IP). All of these patients have a nurse-led appointment (30 mins) and an HCA/ NPA F2F appointment
Phase 1: from 12th September all in cohort patients will be screened by a POA nurse using the ASA1 Streaming form. This means 35% of patients who would have been assessed as noted above will now be streamed in under 10 mins instead, delivering a huge efficiency saving. Phase 2: from start of November, referring surgeons will be able to specify whether patients are ASA1 using a new question on the eTCI (circled), delivering further efficiencies (~10,000 hours of saved POA capacity per annum). This will release capacity to enable earlier full POA for more complex patients reducing the risk of lists being cancelled due to the patient being unfit and enables more effective theatre planning.

CEPOD efficiency programme

A five point improvement plan has been agreed at Theatres Transformation Board (TTB). Stage 1 is focused upon repatriating CEPOD into St James Theatres and moving Orthopaedics back into Paul Calvert theatres (launched on 12th September). The next stage focuses on the CEPOD Booking process and stages 3-5 focus on: improving staffing; introducing 'Brief and Send'; developing fit-for-purpose IT.

ESTH current issues –

Late Starts caused by a lack of admitting capacity, as Surgeons, Anaesthetists & Nursing teams do not have adequate space to clerk patients. Continue to stagger patients due to space, meaning that when the list order changes (DNA's), we waste a portion of time until the next patient is ready. Underruns are being caused by short notice cancellations. There is often an insufficient window between POA and TCI, which is leading to there not being enough time to work a patient up for surgery. As a result, patients are being cancelled at short notice, and services do not appear to have a 'pool' of 'ready, fit and able' to pull from. POA capacity vs demand also requires a deep dive to ensure enough POAs are available for services to book into, and the right slots are also available (telephone/F2F). However, capacity for the POA team is an issue – as to increase capacity we require more rooms and more admin to support so our Nurses are being used to see patients

ESTH future action –

The Theatre Improvement Programme (TIP) launches again from October, with x3 workstreams being set up to target the current issues (POA, Late Starts/Underruns and Scheduling). Whilst deliverables are still being confirmed, we will target the current issues. The POA workstream will focus on reviewing the booking process, including the requirements of admin time, and a review of the current clinic design, as well as the process for referring patients to Anaesthetic Consultants for a high-risk review. This should support a better window between POA and TCI, so fewer patients are cancelled right before surgery. For late starts and underruns, this workstream will focus on introducing a new consenting/admitting/changing area for our patients (the Annex) to facilitate more space. As well as a focus on creating clear expectations ('The perfect morning') which will be about communicating team brief times, clarifying roles and responsibilities, and ensuring that the on the day cancellations SOP that was introduced, is being enforced – including calls to Senior Operational Managers if Surgeons/Anaesthetists are late. Going back to basics to ensure the theatre scheduling templates are accurate - i.e. reflective of later sessions due to weekly teaching meetings. Scheduling will focus on identifying a 'golden patient' that is locked in to go first, as well as creating a 'List Order SOP' to reduce changes on the day. focus on getting further booked out, creating 'pools' of patients able to be booked at short notice, reminder texts for surgery, and we will look into overbooking lists that consistently underrrun.

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

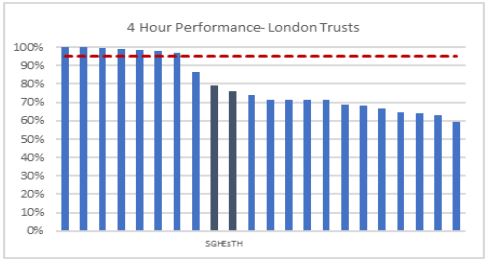
Monthly Overview – Non Elective Care

gesh

Responsive and Productive Services - Elective Ca	St George's							Epsom and St. Helier						
	Monthly Target	Jul-22	Aug-22	Sep-22	YTD Target	YTD Actual	13-Month Trend	Monthly Target	Jul-22	Aug-22	Sep-22	YTD Target	YTD Actual	13-Month Trend
4 Hour Operating Standard	95%	72.2%	79.8%	79.1%	95%	75.0%		95%	74.7%	75.6%	75.9%	95%	75.6%	
12 Hour Trolley Waits	0	579	612	351	0	2554		0	210	163	269	0	767	
Ambulance handover Performance 30 minutes	0	408	239	275	0	1583		0	318	371	337	0	1866	
Ambulance handover Performance 60 minutes	0	198	195	96	0	751		0	196	160	109	0	849	
Non elective length of stay	TBC	7.8	7.5	7.4	TBC	7.46		TBC	7.7	7.9	7.9			
Mental health delays 4 Hour Breaches	TBC	71	112	125	TBC	493								
Redamission Rate - Non Elective	TBC	8.7%	9.2%	8.1%	TBC	8.7%		TBC	5.2%	5.7%	5.2%	TBC	5.2%	
Length of stay > 7 days (stranded)	TBC	399	349	375				TBC	153	155	155			
Length of stay > 21 days (super stranded)	TBC	175	163	169				TBC	65	67	70			

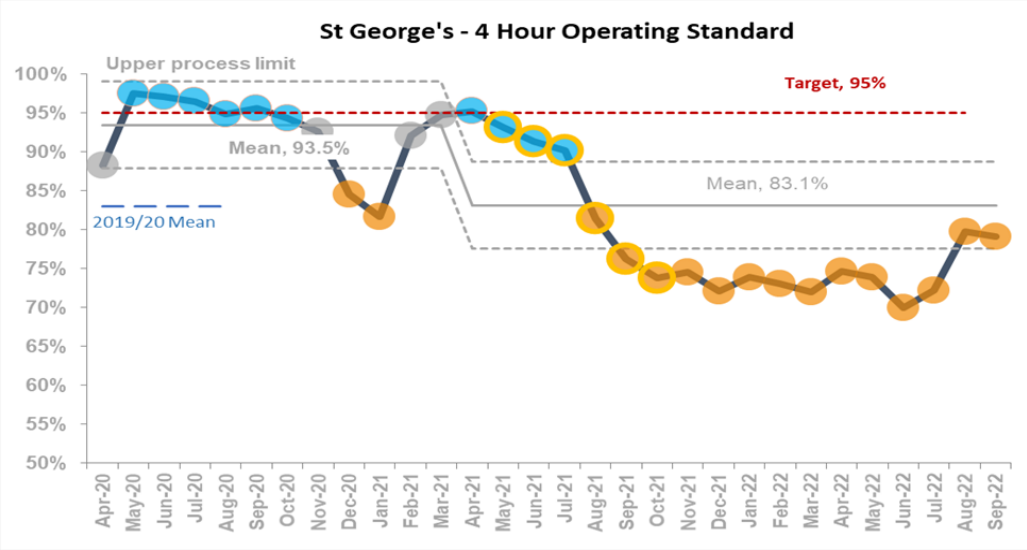
NHS
St George's, Epsom and St Helier
University Hospitals and Health Group

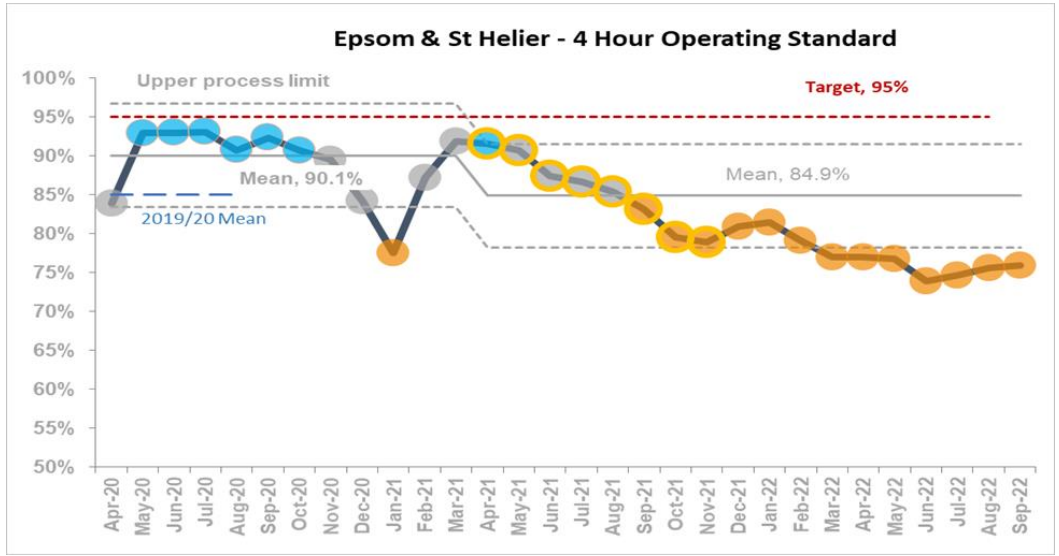
4 Hour Operating Standard



Sep-22

Target: 95%	SGH: 79.1%	ESTH: 75.9%





SGH updates since last month

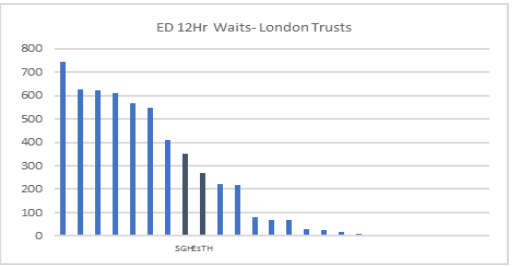
In September, 79.1% of patients attending the emergency department were either discharged, admitted or transferred within four hours of their arrival. Improvement in the non-admitted pathway seen in August was maintained and performance stays within the upper and lower control limits. On average across the month there were 400 attendances per day with 75 patients per day arriving by ambulance. Acuity remains varied with approximately 50% of patients triaged with a Manchester triage score between 1-3.

ESTH updates since last month

September performance improved for the fourth consecutive month with performance at 75.9%. Across the Trust there were on average 421 attendances per day of which 97% were type 1.

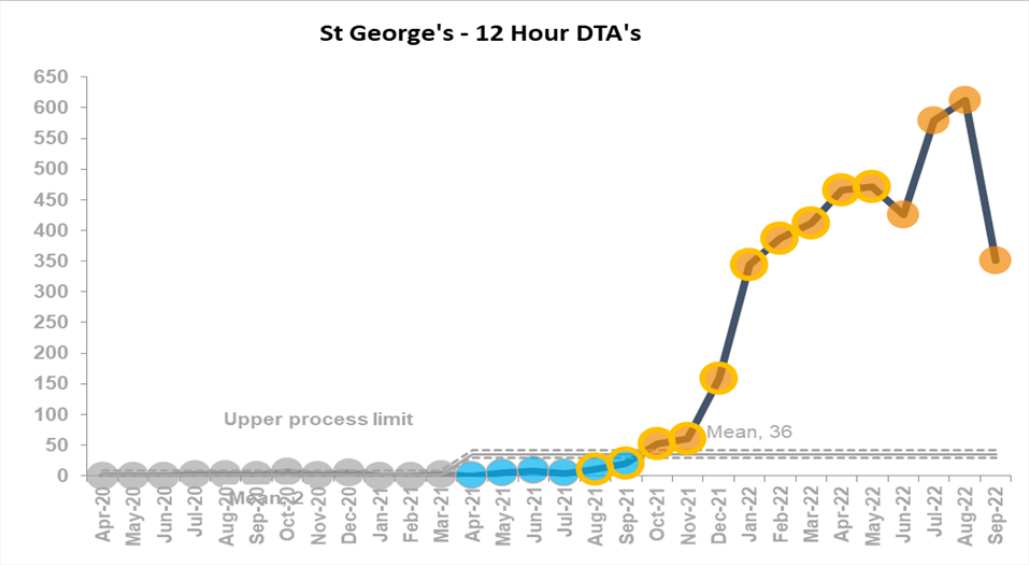
NHS
St George's, Epsom and St Helier
University Hospitals and Health Group

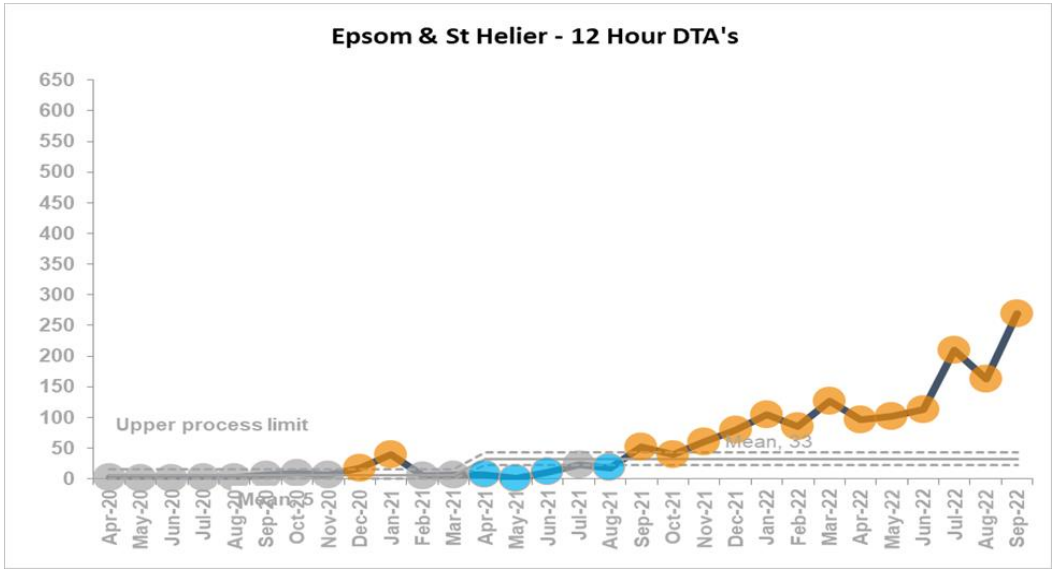
12 Hour DTA's



Sep-22

Target: 0	SGH: 351	ESTH: 269





SGH updates since last month

The number of patients in the department waiting to be admitted for more than 12 hours from decision to admit reduced by 42% compared to August, this was seen alongside an improvement in the number of ward discharges before 11am.

ESTH updates since last month

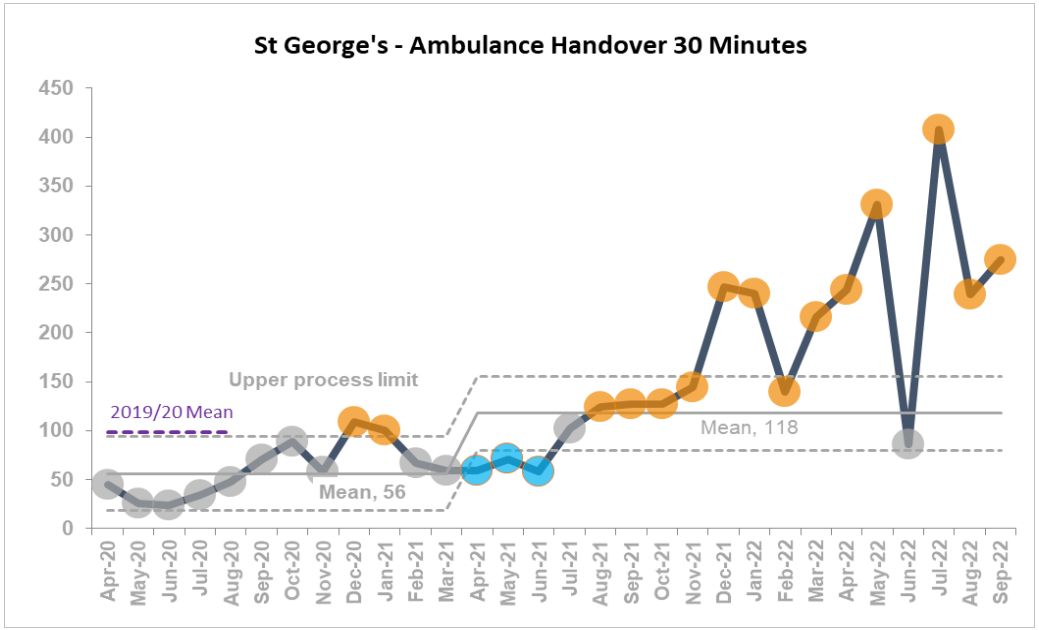
An increase in twelve hour breaches (from 194 to 269) was seen in September.

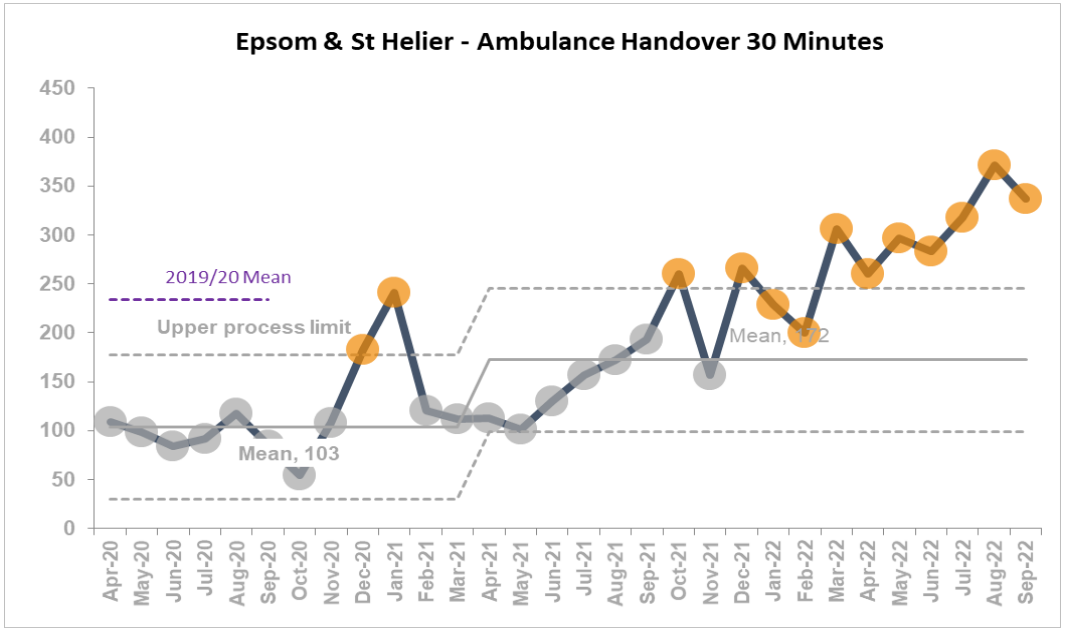
NHS
St George's, Epsom and St Helier
University Hospitals and Health Group

Ambulance Handover – 30 minutes

gesh

Sep-22		
Target: 0	**SGH: 275**	**ESTH: 371**





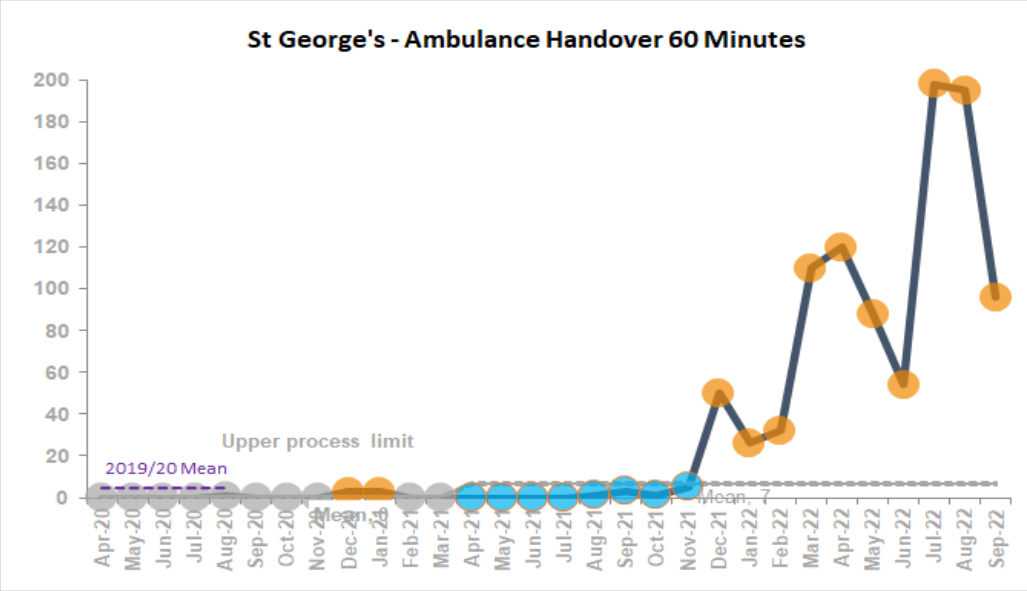
NHS
St George's, Epsom and St Helier
University Hospitals and Health Group

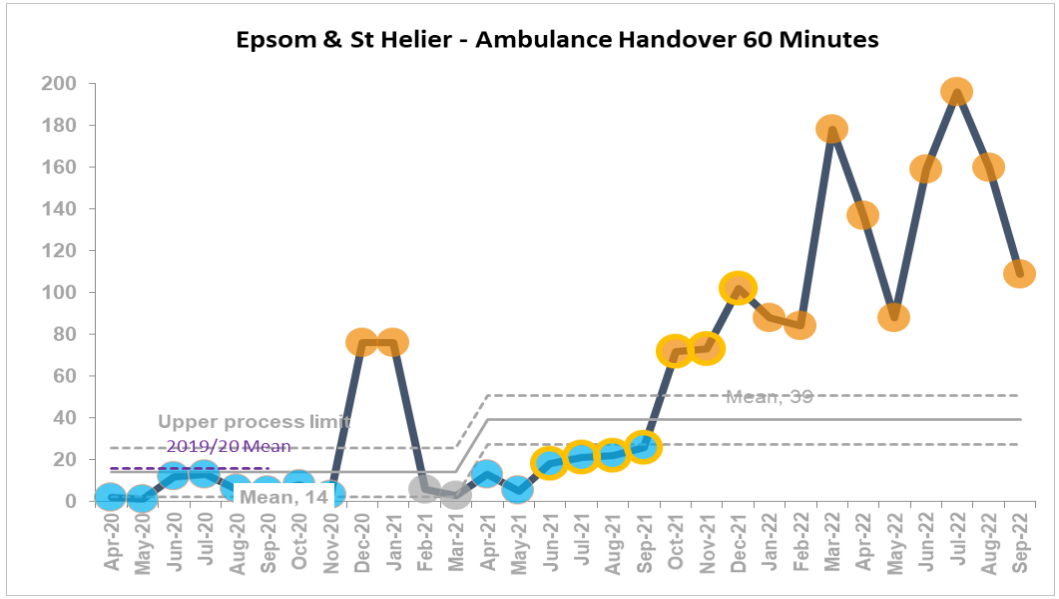
Ambulance Handover – 60 minutes

gesh

Sep-22

Target: 0	SGH: 96	ESTH: 109





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

Emergency Performance

SGH current issues –

Whilst overall 4 hour performance is still strong compared to peers, the admitted performance continues to be a challenge. Exit block within the Department is the primary cause of the relatively poor admitted performance and also contributes to the ability to offload ambulances in a timely manner whilst maintaining space to see and treat other patients. Both of these situations improved in September but will remain an ongoing pressure.

There are continued issues with nursing numbers caused by vacancies and sickness although this is improving.

SGH future action -

An internal ECDB has been established by the Managing Director and is meeting weekly with an initial focus on Frailty, Same Day Emergency Care and Internal Professional Standards.

The Trust is exploring further measures to enable better flow out from the Department referencing the model being used at North Bristol.

Omnicell pharmacy cabinets are being rolled out across the Department to improve efficiency and safety of dugs dispensing.

Winter funding has enabled further investment in to frailty within ED, further increased GP cover, ED surge capacity, additional pharmacy support for ED and surgical SDEC expansion.

LAS have received funding for a Hospital Ambulance Liaison Officer (HALO) who will be in post from the start of November.

Ambulance/UTC sub-group of ECDB meeting fortnightly to work on improvement plans with LAS.

The combination of the UTC working well and seeing more patients than the initial target with further expansion of patient cohort continuing and LAS being able to offload directly to the UTC are combining to relieve pressure on the main Department.

ESTH current issues –

We are experiencing on-going challenges from an emergency performance perspective on both hospital sites, largely driven by high numbers of patients requiring admission to an inpatient bed remaining in ED, therefore, compromising flow through the department.

Impact on 4-hour operational standard, reporting 75.9% performance in September.

An increase in the number of patients spending > 12 hours in the emergency department, reporting 269 patients in September 2022, which is an increase from 194 in August 2022

Challenges associated with ensuring timely ambulance handover, resulting in high numbers of > 60 minute ambulance off-load delays, reporting 109 > 60 minute delays in September 2022. This is an improved position compared to August 2022 where we reported 160 > 60 minute delays, however, remains very high.

ESTH future action –

Whole system winter planning work shop scheduled for Friday 14th October to discuss and agree additional actions required to support non-elective flow. This will include a review of trust, departmental, and whole system escalation triggers to ensure that we have effective and timely actions in place.

We continue to progress our patient flow and discharge work programme with a focus on 10 key work streams that will positively impact on the non-elective patient pathway. Examples include, implementing actions to support an increase in weekend discharge, development of fit for purpose discharge lounge facilities, and increasing the number of patients who can be supported at home via the virtual ward service.

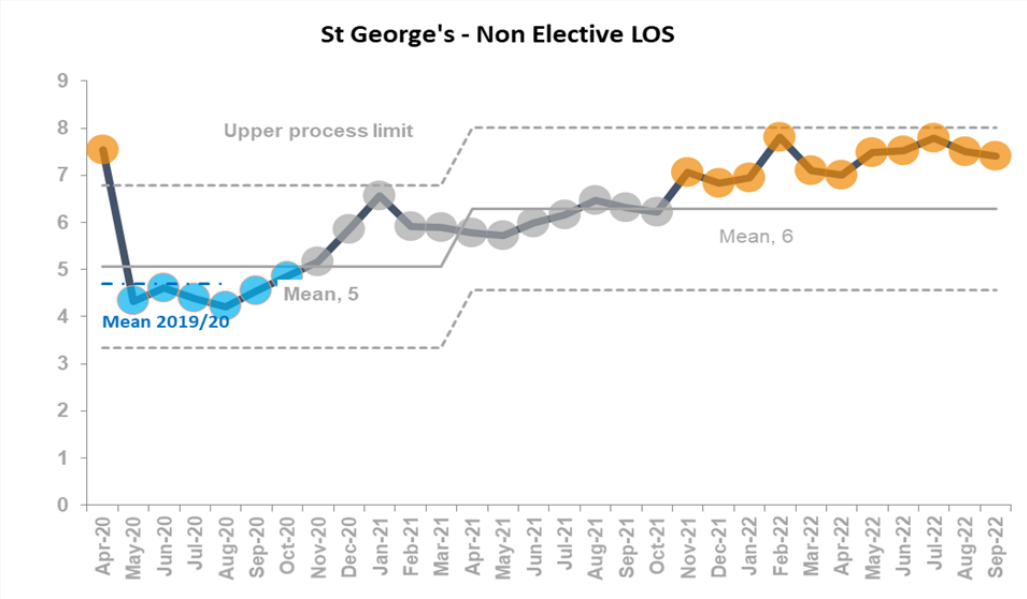
NHS
St George's, Epsom and St Helier
University Hospitals and Health Group

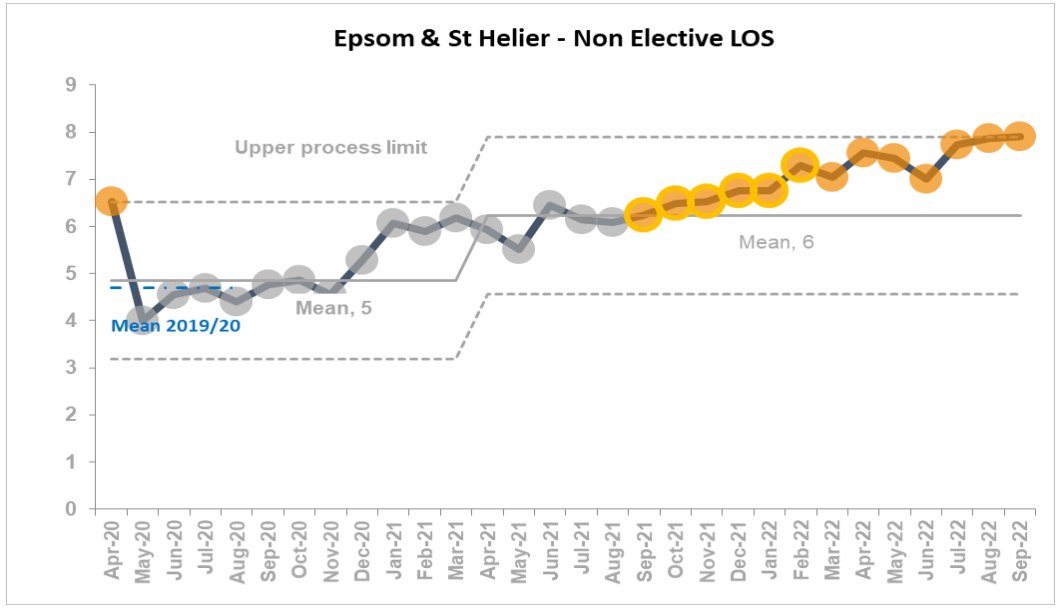
Non Elective Length of Stay

gesh

Sep-22

Target: TBC	SGH: 7.5	ESTH: 7.9





SGH updates since last month

LOS remains above average however seeing a slight decline over the last month with on average, patients staying in a hospital bed for 7.4 days. Admission rates are stable. Patients staying 14+ days reduced (seeing an increase in 7+ days) however patients staying 21+ days increased with on average 169 patients per day.

ESTH updates since last month

Average LOS showing an upward trend and above the mean.

Zero LOS NEL admissions for August 22 are 397, remaining below the ambition of 433, reflecting the impact of SDEC

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

Length of Stay Performance - Analysis and Action

SGH current issues –

The increase in Pathway 1 delays for Merton & Wandsworth and the lack of therapy capacity in Wandsworth
Early discharge and weekend discharges needs to be improved
Failed discharge due to transport failure
High numbers of patients in the acute Trust who are considered medically optimised but are unable to move to their discharge destination in a timely way.
Underutilisation of departure lounge

SGH future action -

M&W Winter planning summit (17th Oct) and a planned MADE event. Actions to mitigate current issues are on the agenda with the weekly M&W discharge forum.
The revised stranded patient weekly and daily discharge calls process is well embedded and working well, although M&W capacity constraints have limited the impact of this change
The Departure Lounge improvement project is underway with a view to increase the capacity and utilisation of the lounge
As part of the workstream on improving early discharges and to reduce risk of failed discharge due to transport failure, the Trust Transport Team are going to visit inpatient wards to raise awareness around the transport contract (booking ready on the day vs the day before), myth busting and also to share best booking practice.
The use of H@H is improving and an increase in capacity with additional funding approved for the service should have a positive impact once staff are in post
Focus on improving compliance with Red2Green to reduce internal delays for pathway 1-3 patients
The TOC team has received winter monies to enable retention of the staff
Focus on improving the number of weekend discharges continues
Covid numbers have increased rapidly, patients are being managed within division and speciality as far as possible instead of within dedicated Covid ward space.
NHS England GIRFT team are meeting SGH Acute/General Medicine on 25th November 2022

ESTH current issues –

We continue to see a month on month increase in the number of patients with a LOS of > 7, 14, and 21 days, resulting in increased bed occupancy across both hospital sites

We have increasing numbers of medically optimised patients, particularly for patients on pathway 1 and pathway 3

Increasing numbers of long stay patients alongside increased bed occupancy is resulting in daily unplaced patients in ED, impacting flow through the department

ESTH future action –

Development of a discharge performance dashboard providing more granular detail regarding patients on pathways 1, 2, and 3, including overall length of stay by pathway / locality. This information will support whole system engagement/escalation to support more timely discharge planning.

Development of whole system triggers/actions in relation to medically optimised patients, including length of stay performance from the time of medical optimisation to discharge.

Introduction of a medically optimised patient tracking list providing key information regarding required next steps to facilitate discharge. This includes acute trust focussed actions required.

A review of all ward based MDT/board rounds against best practice recommendations, and identification of actions required to ensure practice recommendations are met.

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

Monthly Overview – Our People

gesh

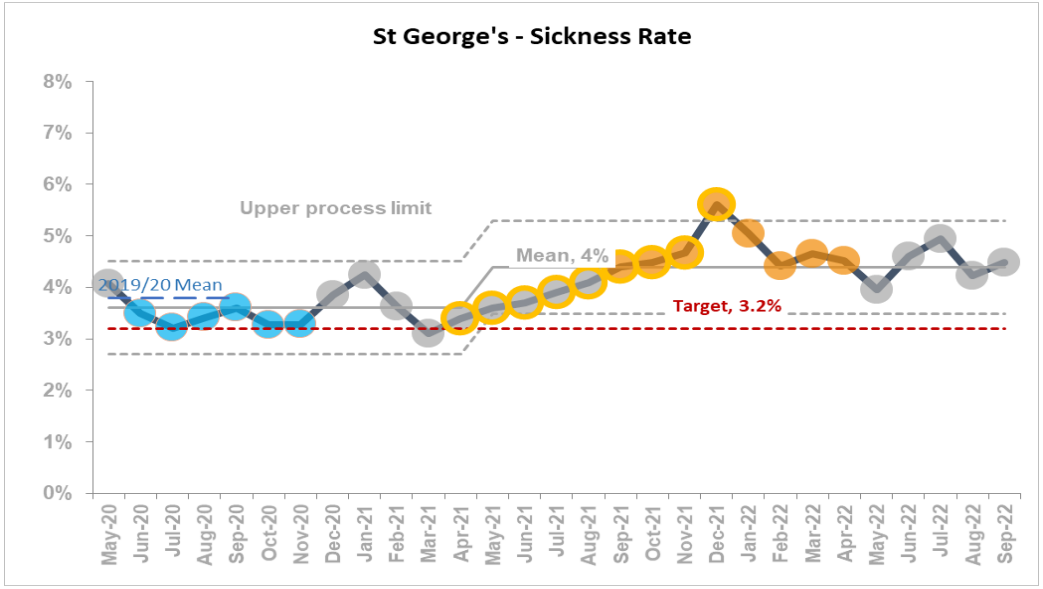
Our People	St Georges							Epsom and St. Helier						
	Monthly Target	Jul-22	Aug-22	Sep-22	YTD Target	YTD Actual	13-Month Trend	Monthly Target	Jul-22	Aug-22	Sep-22	YTD Target	YTD Actual	13-Month Trend
Sickness Rate	3.2%	5.0%	4.2%	4.5%	3.8%	4.5%		3.8%	6.6%	5.2%	5.0%	3.8%	5.5%	
Agency rates		3.2%	3.2%	2.7%	TBC	3.1%		TBC	3.7%	4.3%		TBC	4.0%	
MAST	85%	89.9%	89.1%	88.8%	91%	89.3%		85%	78.4%	79.0%	78.9%	85%	78.6%	
Vacancy	10%	9.0%	9.7%	9.7%	12%	9.4%		10%	14.1%	14.3%	13.8%	10%	14.0%	
Appraisal Rate Medical	90%	81.8%	80.7%	80.2%	84%	81.1%		90%	89.0%	88.0%	89.0%	90%	88.8%	
Appraisal Rate Non Medical	90%	70.6%	69.8%	70.9%	73%	70.4%		90%	53.0%	58.0%	62.0%	90%	55.7%	
Turnover	13%	16.5%	16.6%	16.4%	17%	16.3%		12%	16.0%	15.8%	16.2%	12%	15.9%	
Percentage BAME staff band 6 and above	TBC	43.4%	43.5%	43.7%	TBC	43.2%		TBC	35.8%	35.7%	35.7%	TBC	35.71%	

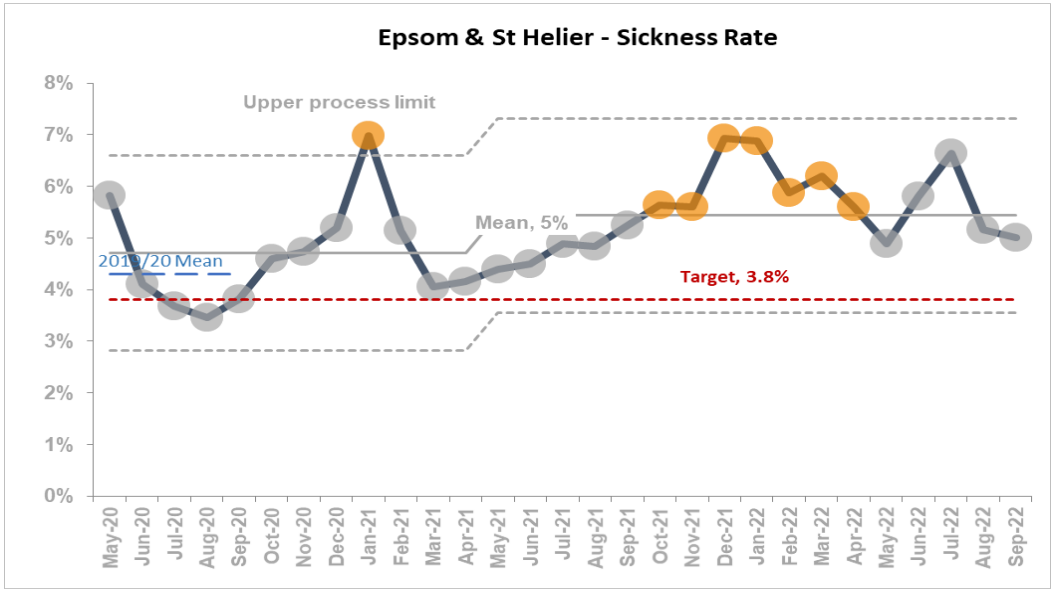
NHS
St George's, Epsom and St Helier
University Hospitals and Health Group

Sickness Rate

gesh

SGH Target: 3.2%	SGH: 4.5%	EStH Target: 3.8%	ESTH: 5.01%





SGH updates since last month

The Trust's sickness rate was 4.2%, and above the target of 3.2%. ' Cold, Cough, Flu - Influenza' and 'Infectious Diseases' - both of which includes covid-related sickness - were the highest cited reason for sickness.'. Long term sickness (episodes of sickness lasting 28 days or more) accounted for 13% of all sickness absence

ESTH updates since last month

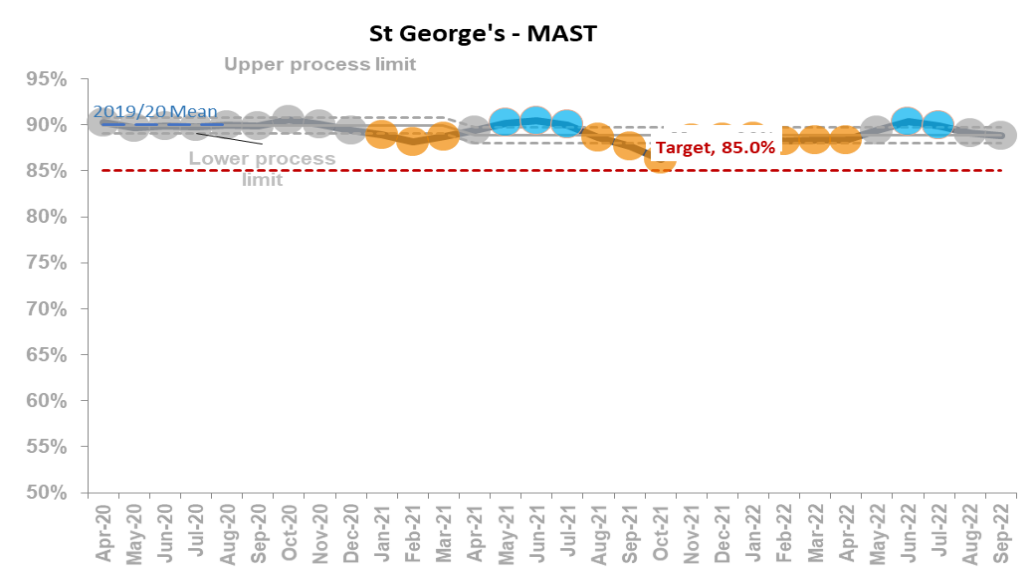
Sickness absence decreased by 0.15% % to 5.01% and remains significantly above the KPI threshold target of 3.8%. 'Other known causes', 'Cold, Cough, Flu - Influenza' and 'Infectious diseases' were the top 3 reasons for sickness absence. Long term sickness absence (episodes of sickness lasting 28 days or more) accounted for 13.8% of all sickness absence.

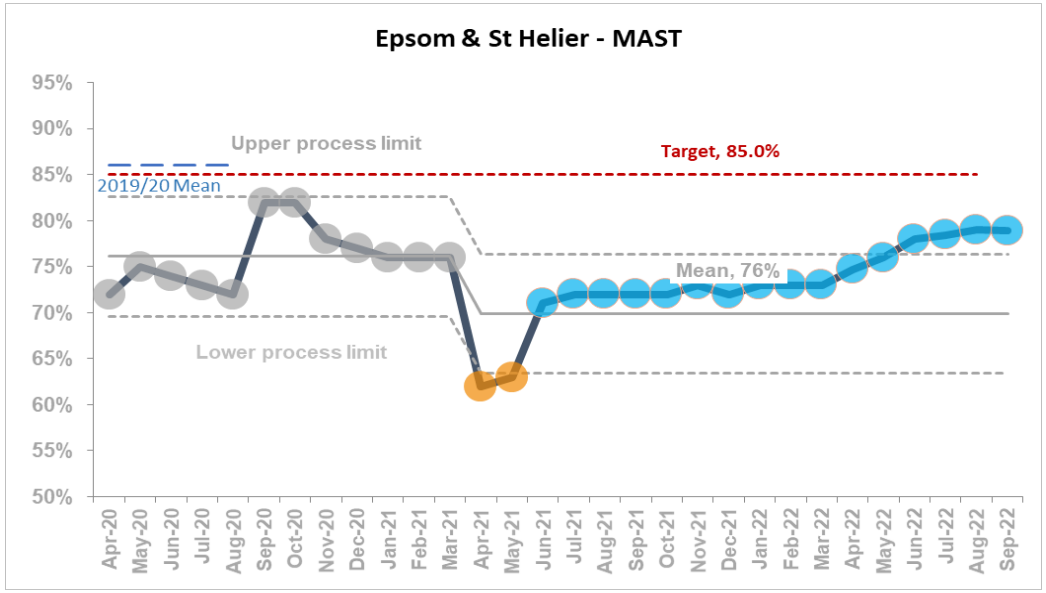
NHS
St George's, Epsom and St Helier
University Hospitals and Health Group

MAST

gesh

Target: 85%	SGH: 88.8%	ESTH: 78.9%





SGH updates since last month

Mandatory and Statutory Training (MAST) was 88.8% in September compared to 89.1% in August. The Mast Compliance rate is holding steady as it has done for the last year or so

ESTH updates since last month

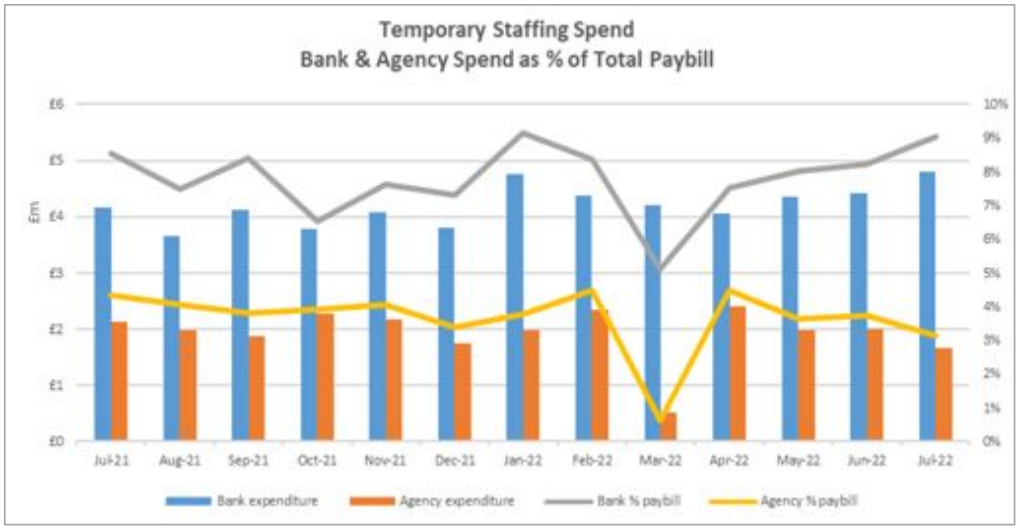
MAST training performance continues above the upper control limit however remaining below target of 85%.

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

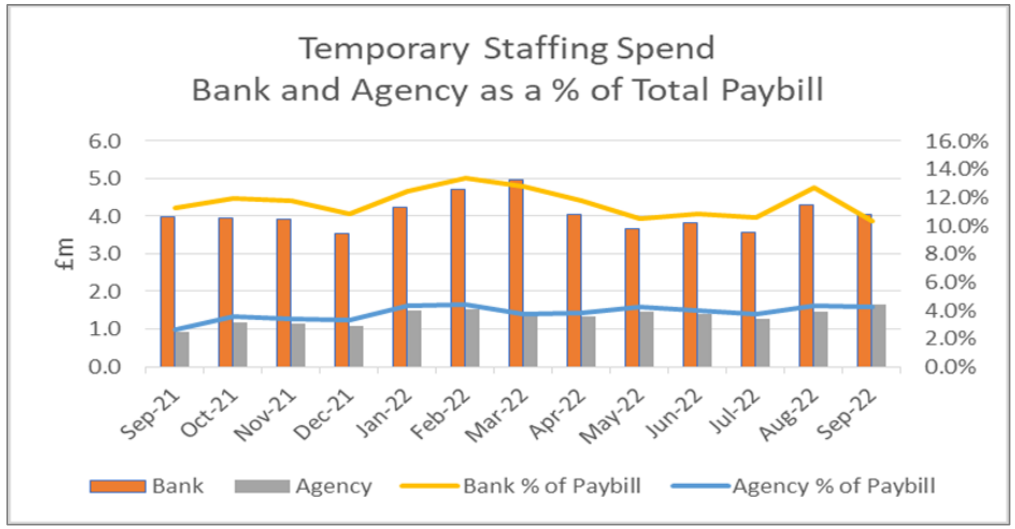
Agency and Bank Spend

gesh

St George's



Epsom & St Helier



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

Our People - Analysis and Action

gesh

SGH current issues –

The Trust vacancy rate has increased to 9.66%, with an increase of over 100 budgeted FTE and around 50 actual FTE. All staff group vacancy rates are below the 10% target except for Estates & Ancillary, Admin & Clerical, and Additional Clinical Services
Turnover has increased to 16.63%. Excluding the rotational staff, of all leavers in August, 66% of them were voluntary

ESTH current issues –

Compared to Month 5, vacancy rate for all staff types decreased with the exception of Estates and Ancillary (increase of 1.38 %) and Healthcare Scientists (increase of 1.18%)
Turnover in month was 1.55%, an increase on the previous month and is above the KPI target of 1%. 63% of leavers in month were voluntary

SGH future action -

Human Resources continues to support establish support for staff on short and long term sick leave to facilitate their return to work including due consideration for reasonable adjustment. It includes working with management to better utilise the return-to-work meetings and an engagement too to identify support for staff to enable them to improve the level of attendance

MAST - Focus will include applying a new training needs analysis for the clinical Resuscitation topics which should see some movements in rates for that topic.

ESTH future action –

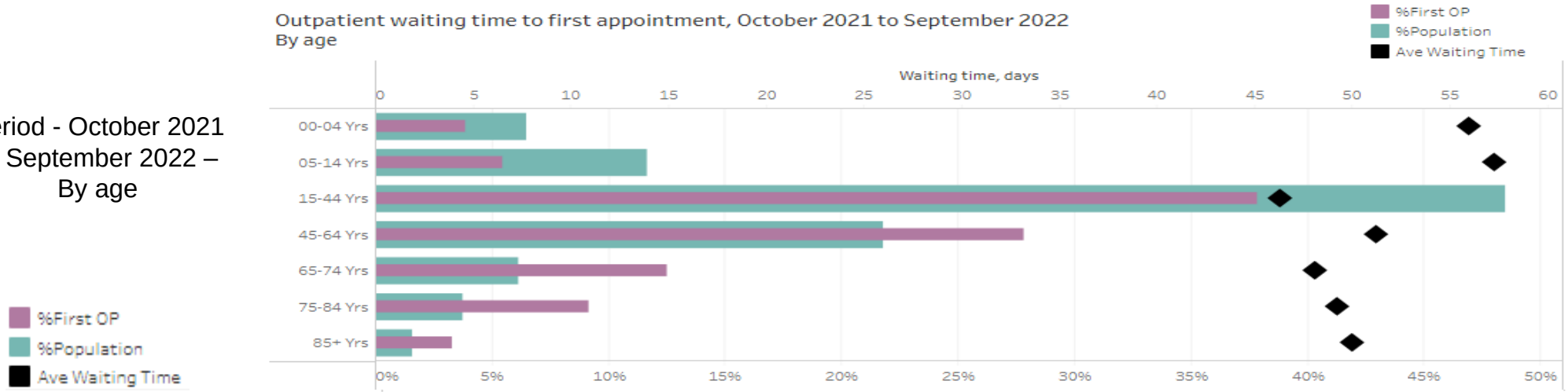
Training and Appraisal - The divisions performance against these two indicators are regularly discussed as part of their HR performance scorecard. The data is available to managers in ESR and also the compliance percentages per team and division are updated weekly and shared via the intranet. L&OD team will be sending weekly reports alternating between appraisal and Core Skills

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

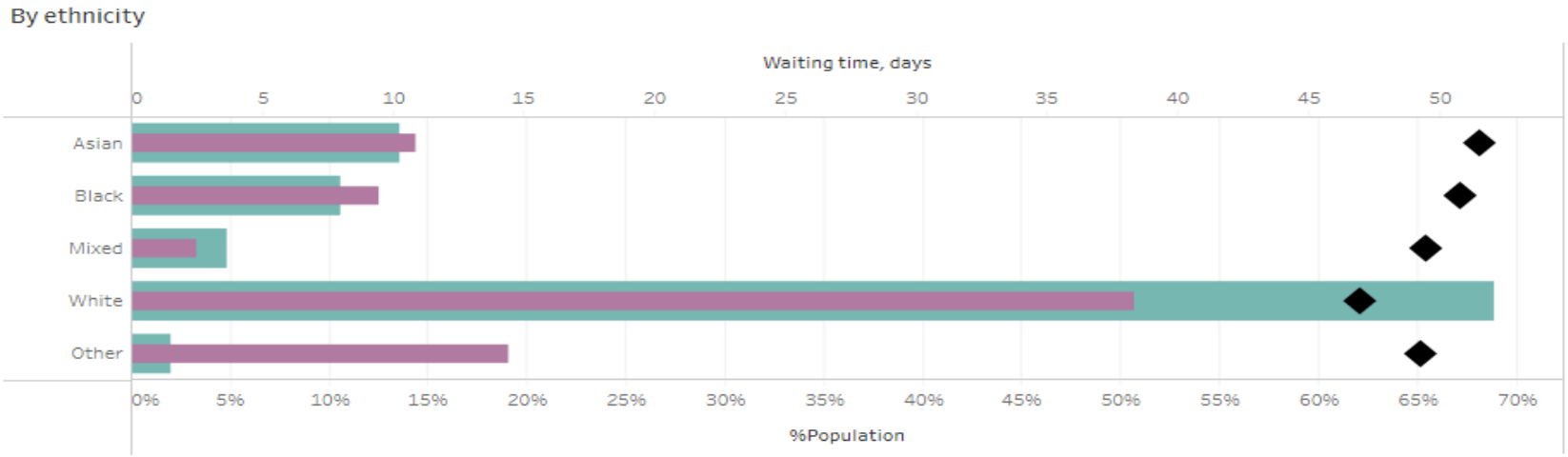
Outpatient waiting time to first appointment

St George's

Period - October 2021 to September 2022 – By age



Period - October 2021 to September 2022 – By ethnicity



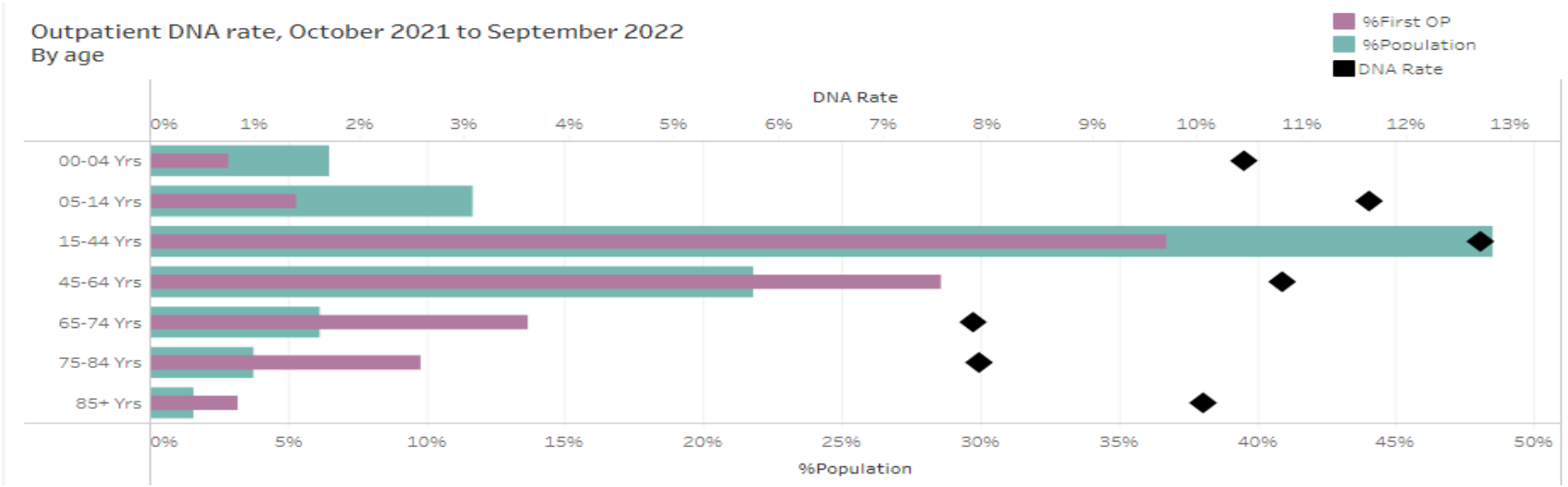
NHS
St George's, Epsom and St Helier
University Hospitals and Health Group

DNA Rate

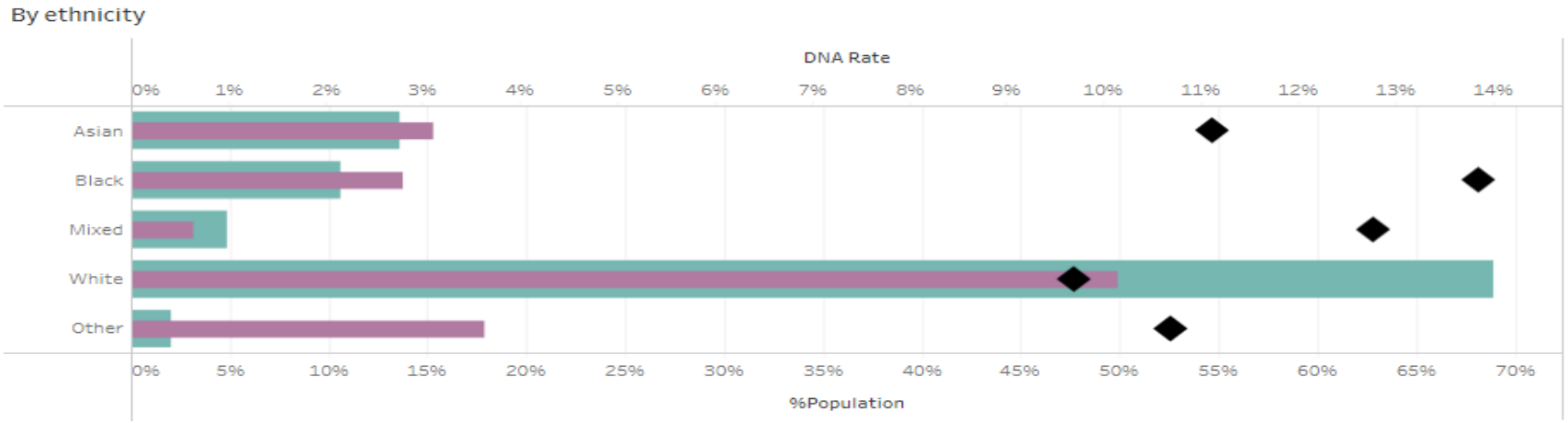
St George's

gesh

Period - October 2021 to September 2022 – By age



Period - October 2021 to September 2022 – By ethnicity



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

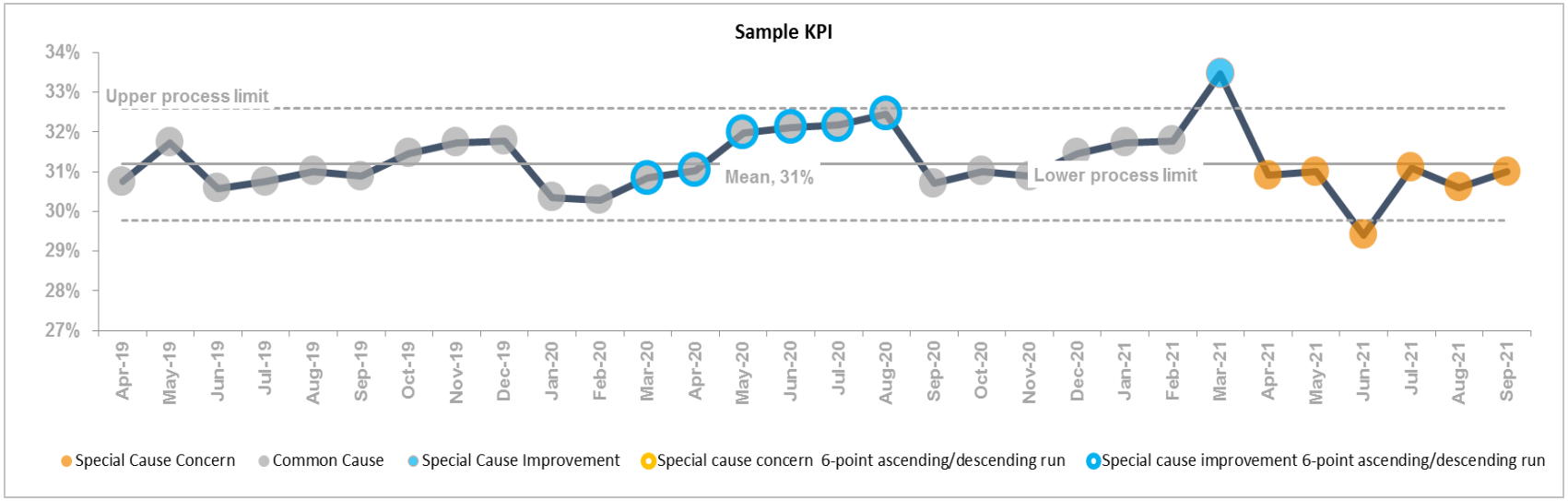
Appendix

gesh

- Overview of Assurance Process
- Glossary explaining source data, assumptions, and methodology
- Data Quality Assurance on the information presented
- Guide on interpreting statistical process control charts

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

Interpreting (Statistical Process Control) Charts



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

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

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

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	3 November 2022	**Agenda No**	**2.4**
Report Title:	**St George's University Hospitals NHSFT Winter Plan 2022/3**		
Lead Director/ Manager:	Kate Slemeck, Managing Director		
Report Author:	Julie Scrivens, Acting Chief Operating Officer Luci Etheridge, Site Chief Medical Officer Natilla Henry, Site Chief Nurse		
Presented for:	Assurance		
Executive Summary:	This document sets out the Winter 2022/3 plan for St George's University Hospitals NHSFT as both a provider of local acute care and of tertiary pathways. Demand and capacity modelling indicates that adult medical G&A bed capacity could be as high as 55 inpatient beds short at peak winter, even with our 'winter ward' remaining open since the onset of the Pandemic. This is driven primarily by the increased length of stay for medically frail patients (a consequence of increased decompensation post-COVID) and increased care needs upon discharge, which put significant additional pressure on already challenged domiciliary and post-acute care capacity. This is an operational document, designed to provide a co-ordinated oversight on how the Trust can reasonably balance elective recovery, seasonal pressures and a possible resurgence of COVID or Flu during Quarters 3 and 4. As such, it is neither a strategic document nor an operational protocol – the actions taken will be determined by the exact configuration of pressures as they occur in real time. The document includes: • Demand and capacity modelling, and alignment to the NHSE requirement for each ICS to generate the equivalent of 5% additional G&A beds for winter, together with the multiple NHSE initiatives and assurance required. • Merton and Wandsworth winter pressures funding allocation and deployment. • Internal and external operational processes, quality improvement and governance to minimise avoidable admissions and optimise flow along non-elective pathways • Actions in place to sustain elective and cancer recovery • Workforce and staff-support plans A number of the initiatives described in this document are a work in progress. We need to transform key elements of our emergency pathways in community and acute settings to meet the changed patients need presenting post-COVID. Doing more of the same is a disservice to our patients and our staff, but the challenge of transforming pathways whilst under continued demand pressure should not be under-estimated. Some of the actions outlined in this Winter Plan are high risk, for example, our local community provider achieving 40 hospital@home beds capacity by November/December 2022. Others, such as updating the Trust's OPEL framework simply require actions directly within our control to be completed in a timely manner.		

	This Winter Plan will be reviewed and updated as required to reflect the current readiness of winter delivery in November. It is presented to the Trust Board for information and assurance.		

Recommendation:	The Trust Board is asked to note:
	• The risks identified in sustaining sufficient capacity to meet all non-elective emergency need that presents to the Trust in a timely and effective manner
	• The Place-based approach to developing community-based frailty clinical pathways.
	• The actions underway within the Trust to
	  ○ maximise clinically appropriate admission avoidance
	  ○ sustain elective and cancer recovery
	  ○ support effective and timely flow of patients from the Emergency Department into hospital beds where needed and home when medically optimised and ready.		

Supports			
Trust Strategic Objective:	All		
CQC Theme:	Safe, Caring, Effective, Responsive, Well-led		
NHS System Oversight Framework Theme:	Well Led		
Implications			
Risk:	Principal risks are outlined in section 1 of this document		
Legal/Regulatory:	There is a high risk of: • underperformance against the ED 4-hour access standard • incidence of 12+ hours delay to patients waiting in ED for an inpatient bed • ambulance handover delays This paper sets out the actions taken to mitigate these risks so far as is possible.		
Resources:	N/A		
Previously Considered by:	Finance Committee	**Date:**	21 October 2022
Appendices:	Winter Plan 2022/23		

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

St George's Winter Plan 2022/23

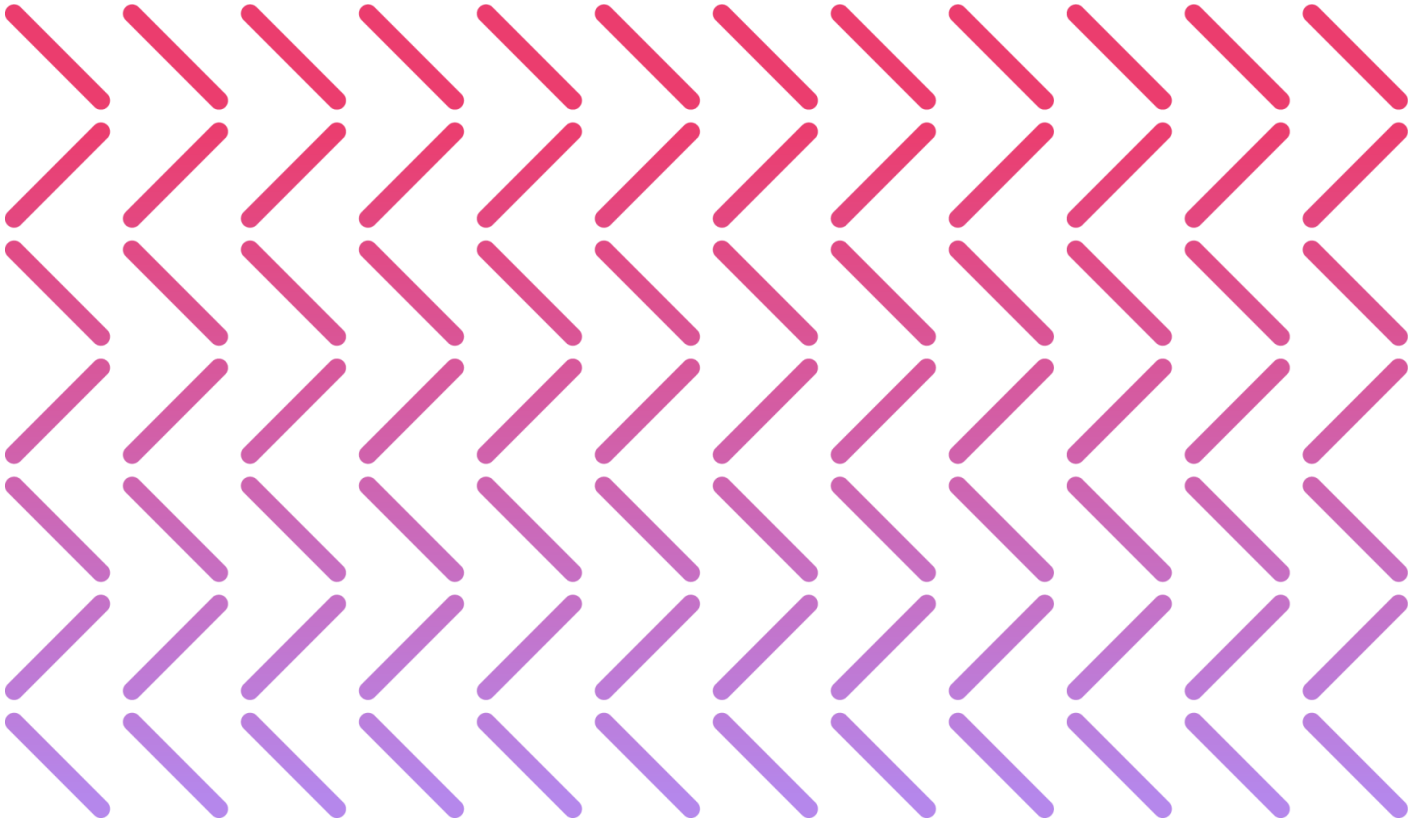
Including COVID-19, Flu, Elective Recovery, Children's Respiratory Conditions

Julie Scrivens, Acting Chief Operating Officer
Luci Etheridge, Chief Medical Officer
Stephanie Sweeney, Deputy Chief Nurse
Kate Slemeck, Managing Director

October 2022

Version 6

SECTION 1
Introduction



Outstanding care every time

Managing Director's Introduction

There is little doubt that the NHS has another tough winter ahead, following a year where the NHS has been under significant pressure. With patients waiting over 12 hours in Emergency Departments, 4-hour access standard and 60+ minute ambulance handover breaches of a magnitude not seen for nearly a generation, with seasonal demand, including flu and children's respiratory conditions expected to be high, and expected seasonal COVID surges, all while we continue to remain committed to maintaining our elective recovery, we ask our staff once again to dig deep this winter.

It's against this backdrop that we are working on robust plans to ensure we have appropriate capacity to meet winter demands. We have learnt a lot over the last 18 months and we continue to be innovative and agile as we respond to the challenges This includes work on a vaccine programme for flu and Covid-19 boosters, surge capacity preparation, and an additional focus on supporting staff who are facing the strains of a cost of living crisis and addressing associated health inequalities.

One of the key issues we are facing is driven by increased length of stay for medical frailty patients, which puts significant additional pressure on domiciliary and post-acute care and capacity. By adapting and working in new ways with our partners, we are able to ease some of the expected pressure so we can continue to provide safe and timely care to our patients. The focus for St George's will be to work existing capacity more effectively and to innovate, reducing admissions through increasing same day and next day emergency care pathways and accelerating discharge. We also have hospital@home in place with plans to significantly increase capacity, and are developing a response 7-day acute frailty pathway in our ED for the winter months and beyond. Working with Merton and Wandsworth has greatly reduced the number of 'bed days lost' for patients who are well enough to leave hospital but who await onward care, and we will continue to collaborate in this way.

In terms of increasing capacity for patients requiring urgent treatment, have recently opened a new Urgent Treatment Centre (UTC) that will relieve pressure on our ED. However, we need to transform key elements of our emergency pathways in community and acute settings to meet the changed patients need presenting post-Covid. Our innovative surgical centre at Queen Mary's will continue to offer day surgery to patients whose treatment had been delayed by the pandemic, together with improved utilisation of the 23 hour Day Surgery unit, both of which will run throughout winter. Our trauma ward is also undergoing refurbishment and is due to re-open by December providing a purpose built ward with the ability to cohort major trauma patients together, focus expertise and enhance processes, all of which are aimed at better outcomes.

We won't just be caring for our patients this winter, we will also continue to look after our staff. From wellbeing rooms and psychological counselling, to ensuring they have their rest breaks and easy access to vaccinations, our staff, and keeping them well, remain a continued focus of this winter plan.

I am confident our committed and talented staff will do their utmost to keep patients safe, and want to thank them for all they do day in, day out. Together we will continue to improve health outcomes for our patients and provide equitable care to our diverse communities throughout the coming winter.

Thank you
Kate Slemeck, Managing Director

Outstanding care every time

Contents

Outstanding care every time

Executive Summary

This document sets out the Winter 2022/3 plan for St George's University Hospitals NHSFT as both a provider of local acute care and as a tertiary provider.

Demand and capacity modelling indicates that adult medical G&A bed capacity could be as high as 55 inpatient beds short at peak winter, even with our 'winter ward' remaining open since the onset of the Pandemic. This is driven primarily by the increased length of stay for medical frailty patients (a consequence of increased decompensation post-COVID) and increased care needs upon discharge, which put significant additional pressure on domiciliary and post-acute care capacity.

This is an operational document, designed to provide a co-ordinated oversight on how the Trust can reasonably balance elective recovery, seasonal pressures and a possible resurgence of COVID or Flu during Quarters 3 and 4. As such, it is neither a strategic document nor an operational protocol – the actions taken will be determined by the exact configuration of pressures as they occur in real time.

The document includes:

- Demand and capacity modelling, and alignment to the NHSE requirement for each ICS to generate the equivalent of 5% additional G&A beds for winter, together with the multiple NHSE initiatives and assurance required
- Merton and Wandsworth winter pressures funding, and how this will be used; alignment to frailty pathways transformation programmes
- Internal and external operational processes, quality improvement and governance to minimise avoidable admissions and optimise Flow along non-elective pathways
- Actions in place to sustain elective and cancer recovery
- Workforce and staff-support plans

A number of the initiatives described in this document are a work in progress – we need to transform key elements of our emergency pathways in community and acute settings to meet the changed patients need presenting post-COVID. Doing more of the same is a disservice to our patients and our staff, but the challenge of transforming pathways whilst under continued demand pressure should not be under-estimated.

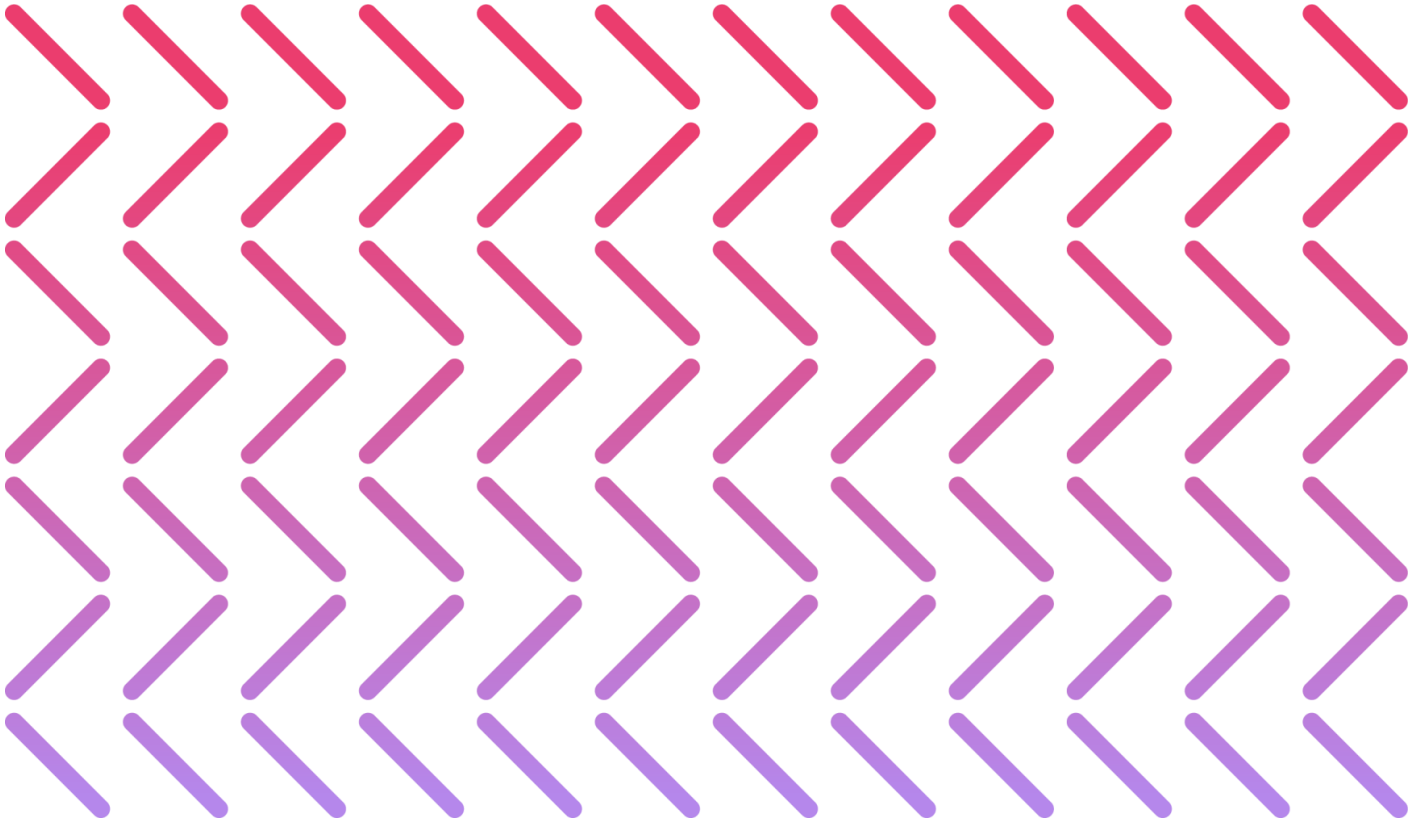
Some of the actions outlined in this Winter Plan are high risk, for example, our local community provider achieving 40 hospital@home beds capacity before the onslaught of winter. Others, such as updating the Trust's OPEL framework simply require actions directly within our control to be completed in a timely manner.

This Winter Plan will be updated to reflect the current readiness of winter delivery in November, and re-presented to Trust Board for information and assurance.

Summary of Principal Risks – Winter Plan 2022/3

Principal Risk	Mitigations	Controls	Original Risk (LXC)	Mitigated Risk (LXC)
Non-elective patient need & demand will outstrip Trust capacity	• 7/7 Transfer of Care (TOC) team to drive supported discharges • Provision of ambulatory frailty pathway (same day discharge) • Optimised use of Same Day Emergency Care Pathways (SDEC) and next day / urgent outpatient appointments	Trust and pan-SWL operational and clinical oversight, linking to Trust governance processes	4x5 = 20	4x4 = 16
Insufficient community capacity to meet local non-elective need	• Continuation with domiciliary care and community therapy capacity to meet increased care needs Pathway 1 D2A discharges • CLCH Hospital@Home to provide c. 40 virtual beds by December 2022 (up from 8) • Optimised use of intermediate care beds	Trust and pan-SWL operational and clinical oversight, linking to Trust governance processes	4x5 = 20	4x4 = 16
MH patients will routinely wait over 12 hours for a MH bed	• Pan-London actions to optimise use of existing section 136 capacity • Additional independent sector acute mental health inpatient capacity • Streamlined community access to crisis support • Rapid escalation for out-of-area MH patients requiring repatriation	Trust and pan-SWL operational and clinical oversight, linking to Trust governance processes	4x5 = 20	4x4 = 16
Elective recovery will be stalled by winter pressures	• Theatre utilisation programme in place (full lists, list productivity, GIRFT compliance on daycase) • Mutual aid in place for high volume / low complexity procedures • Green wards protected, and supported with dedicated PACU and ITU capacity	Weekly review of activity against trajectory at care group level, scrutiny at SWL and regional levels	4x4 = 16	4x3 = 12
Staff sickness absence will increase (COVID isolation and seasonal infections)	• Continued use of inpatient safer staffing huddles 2x daily • Extraordinary use of medical safer staffing huddles • Co-ordinated requests / deployment bank staff • Maximum uptake of flu vaccinations by staff • Maximum uptake of COVID boosters by staff	Trust and pan-SWL operational and clinical oversight, linking to Trust governance processes	4x4 = 16	4x3 = 12

SECTION 2
Operating Environment



Outstanding care every time

Current Operating Environment

The NHS has been under significant pressure over the last year with patients waiting over 12 hours in Emergency Departments and 4 hour access standard and 60+ minute ambulance handover breaches of a magnitude not seen for nearly a generation. Planning for seasonal winter pressures must be considered in light of this baseline operating environment, as we go into Winter 2022.

Many of the options previously used to alleviate winter pressures have been in place throughout 2022, such as the winter ward, which has not closed since March 2020, the start of the pandemic, and Better Care funding which has provided increased levels of reablement and domiciliary care throughout 2022. Reducing elective activity to free up resource for winter pressures is also not an option, given the importance of providing access to operations for patients who have already waited too long. Other limitations, such as physical space and workforce, where those willing to work extra shifts has understandably reduced post-covid, remain and further add to the winter challenge.

The focus for St George's will be **to work existing capacity more effectively** and **to innovate, reducing admissions and accelerating discharge**. These approaches are appropriate as the pressure on the emergency pathways experienced throughout 2022 is not caused, for adult services at least, by increased volumes of patients requiring non-elective admissions, which have yet to reach pre-pandemic levels. Nor can insufficient post-discharge care capacity be blamed for full inpatient beds, as our collaboration with Merton and Wandsworth has greatly reduced the number of 'bed days lost' for patients who are well enough to leave hospital but who await onward care.

The key issue driving the pressures on our ED is one of increased patient need. The baseline health of our frail population is substantively lower than pre-COVID. People's underlying long term conditions and general health is frequently described as 'more brittle'. There are not more patient requiring non0elective medical inpatient care, but those whoa re admitted are taking longer to become well enough to discharge and are requiring increased levels of support to return home. This can be seen in the increased length of stay for our medical non-elective patients.

We have three components in place; a **hospital@home** capable of managing sub-acute illness, **effective partnership pathways** across our health partners and an **acute ambulatory frailty pathway in the ED** that does not admit, but coordinates MDT support enabling the patient to return home.

The Trust is now an active partner in developing non-acute clinical pathways and the lynchpin of the winter 2022 plan will be the rapid development and expansion of these over the next quarter. It will include increased Same Day Emergency Care pathways, reducing admissions to AMU or Nye Bevan; more effective use of Mary Seacole ward at QMH for recovery, rehabilitation and reablement and enhanced multi-specialty post-acute follow-up.

There remain internal efficiencies to achieve such as the use of the new **Urgent Treatment Centre for 'non-blue' ambulances**; consistent use of Red to Green to optimise treatment time for inpatients; increased percentage of **patients discharged by lunchtime**; and discharging as many patients as are admitted every Sunday and Monday.

None of these actions alone will achieve the inpatient capacity needed to meet safely this year's winter pressures. The impact can only be achieved in the round if we build on everything we have learnt about team-working during COVID to deliver integrated and coordinated pathways of care.

Outstanding care every time

Winter 2022/23 Demand & Capacity Modelling

NHS England has asked acute Trusts to model winter demand for 2022/3 as a 5% increase in non-elective inpatient beds, predominantly medical. For St George's, this equates to 48 additional beds required, although it must be noted that our 'winter ward' has remained open and in full use since 2020.

Within the Trust we have modelled 4 scenarios, summarised below. Scenario 3 is the one considered most likely, and compared to 2019/20 inpatient bed demand, this requires:

Medical

An additional 33 non-elective medical beds, peaking at an additional 52 during January and February. This increase compared to 2019/20 winter pressures is not due to increased inpatient admissions, but:

- Increased length of stay, especially in acute medicine / senior health
- Increased delays in onward packages of care, driven primarily by the increase in care package sizes post-COVID
- Increased delays for post-tertiary repatriations awaiting a bed in their home DGH

These figures do NOT include those patients who wait in our Emergency Department for an inpatient medical bed, which over winter 2021 was persistently c. 25 acute medical patients. In effect, hospital occupancy levels have meant that daily flow through non-elective medical beds has run 12 hours behind demand, and thus the real-time impact of winter 2022/23 could be as high as 72 beds shortfall if timely flow from the emergency department to inpatient beds is to be achieved and sustained.

Surgical

The persistent trend in increased trauma inpatient admissions has been factored into this winter modelling as requiring an additional 5 beds. In reality, the refurbishment of Holdsworth as a major trauma ward is expected to reduce length of stay by a minimum of 1 day per patient (bringing the Trust back in line with other major trauma centres, as per TARN data), which will absorb the additional admissions.

Children's

Children's Respiratory Syncytial Virus (RSV) has been persistent through 2021/22, with no clear seasonal affect since COVID. The modelling indicates that the current pressures on children's inpatient beds will persist but not increase from current bed demands.

Critical Care

ITU demand may increase briefly after any spike in G&A admissions for COVID, requiring an additional 2-5 beds for a 2 week period. However, it is worth noting that most admissions now are for an alternative acute presentation, with patients also having COVID (not the reason for admission). This pattern has been seen in the most recent Omicron BA4/5 COVID surge.

Underpinning analytical detail for this modelling can be found at Appendix 1

Outstanding care every time

Bed Modelling – Executive Summary

Suggested Scenario – Scenario 3

Scenario 3: Plan for a Covid surge, additional RSV, additional beds used due to delayed discharges and LOS, additional beds used due to trauma and a normal winter pressure (see slide 6 for more info). Under these assumptions, we may see bed occupancy above 100% come January.

Med Card excl. Covid

Under scenario 3, we require a bed base of around 536 beds for Jan and Feb, peaking at 556. The rest of the year about 503 would be sufficient.

In 2019, around 438 beds were required for the rest of the year. This equates to an additional 98 beds this winter; around 32 for winter pressures, 1 to RSV and 65 beds to delayed discharges and LOS. Additional beds would be required for Covid.

SCNT

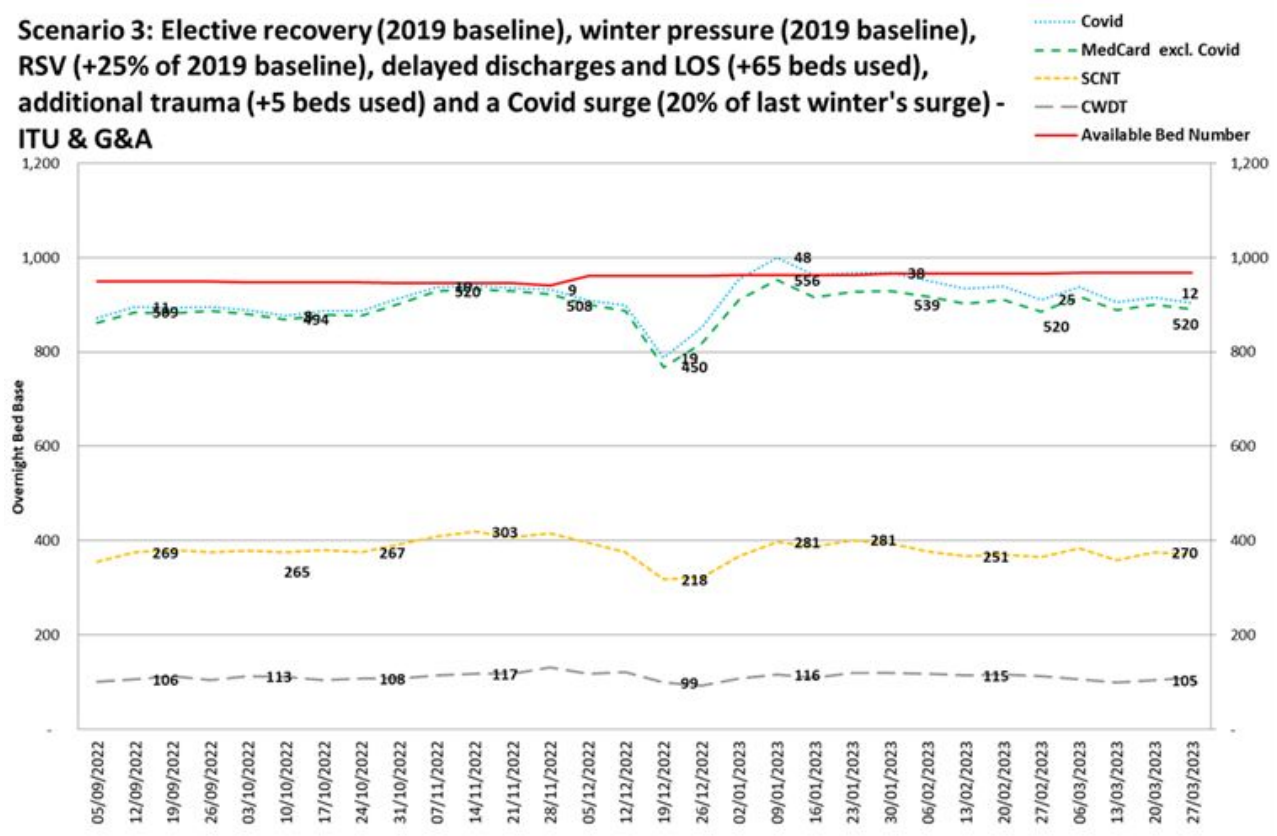
Under scenario 3, we require a bed base of around 266 beds for Jan and Feb, peaking at 281. The rest of the year about 266 would be sufficient.

In 2019, around 261 beds were required for the rest of the year. This equates to an additional 5 beds this winter; around 0 for winter pressures and 5 beds to additional trauma.

CWDT

Under scenario 3 , we require a bed base of around 115 beds for Jan and Feb, peaking at 120. The rest of the year about 107 would be sufficient.

In 2019, around 107 beds were required for the rest of the year. This equates to an additional 8 beds this winter; around 5 for winter pressures and 3 to RSV.



- *Max G&A space = 969, of which 508 Medcard, 128 CWDT (excluding maternity and neonatal), 334 SCNT.*
- *Increase in bed base due to re-opening of Holdsworth ward.*
- *No reduction to available bed numbers due to IPC covid distancing measures.*
- *These numbers are the weekly average bed demand – in reality, there will be peaks and troughs throughout the week and throughout the day of each week as part of the typical weekly cycle.*

Outstanding care every time

Bed Modelling

Scenario 3 – ITU & G&A

Plan for a Covid surge, additional RSV, additional 65 beds used due to delayed discharges and LOS (compared to 2019 baseline), additional 5 beds used due to increase in trauma (compared to 2019 baseline) and to expect normal winter pressure.

- We have assumed a **Covid surge of 20% of last winter's surge**, and we believe that a surge is possible, albeit smaller leading into Christmas.
- Due to this, we may see **bed occupancy above 100% come January.**

Planning is required to manage patients and maximise the availability of beds throughout Winter.

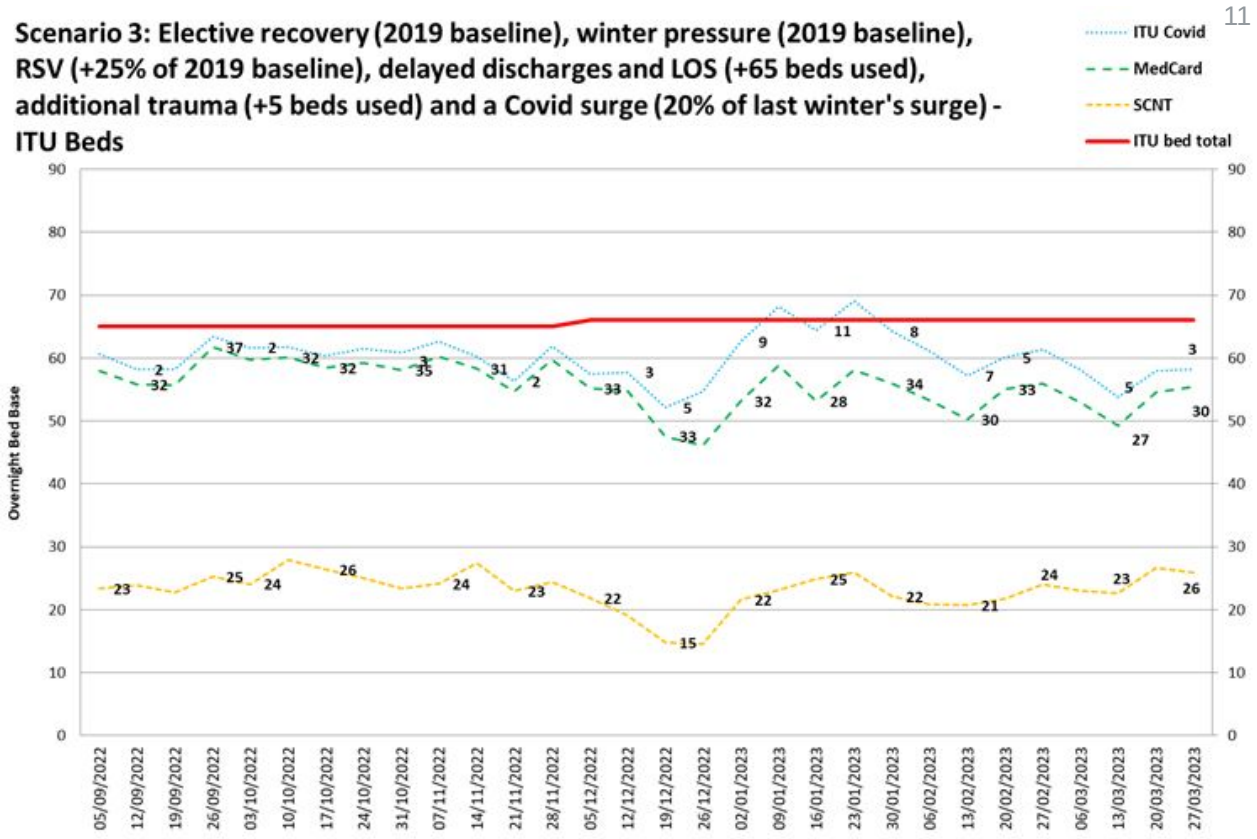
- We will need to **ensure that the maximum amount of bed space is available**, and will need to focus on ensuring we do everything to improve and **keep low, the numbers of patients awaiting discharge or repatriation.**
- We would need to work with SWL to better manage patients and think about temporary capacity solutions.
- Elective recovery effort will be affected due to lack of beds.

ITU may need additional beds throughout the Winter period.

- We will **not be free of Covid**, and there are still some that are un-vaccinated in the local population.
- We have based the ITU Covid forecast on a 3:1 ratio of G&A to ITU beds.

It is possible that ITU will need to expand approximately 1 week after the an initial increase in Covid G&A patients.

- The expansion if required ought to be only for a couple of weeks, but we could require **an additional 2-4 ITU beds** during that time.



- *Max ITU space = 66.*
- *Increase in bed base due to re-opening of Holdsworth ward (change in James Hope ITU to Brodie ITU).*
- *These numbers are the weekly average bed demand – in reality, there will be peaks and troughs throughout the week and throughout the day of each week as part of the typical weekly cycle.*

Outstanding care every time

Winter Funding

Winter funding for 2022/3 is calculated at 2021/2 levels, minus 23%. For Merton and Wandsworth (including St George's) this equates to £4.46m.

Discharge to Assess (D2A) capacity for community therapy and domiciliary care remains at previous levels. 7 day working for social care brokerage and community therapy is sustained.

St George's attracts 42% of the winter funding, focused on:

- ED surge capacity
- Same Day Emergency Care (SDEC) enhanced capacity
- Extended frailty ambulatory pathway in ED
- Sustaining the Transfer of Care hub driving supported discharge

Costed fully, at this stage there is a £185k cost pressure in the current Trust winter pressures capacity. This is expected to be resolved as more detailed operational staffing / modelling is completed.

Hospital@Home

In addition, Merton and Wandsworth has been allocated £1.08m recurring funding for virtual ward / hospital@home. This will be used by CLCH to provide up to 40 hospital@home beds, focused on admission avoidance:

- Prevention of conveyance to ED
- Ambulatory frailty pathway from ED
- Turnaround from AMU

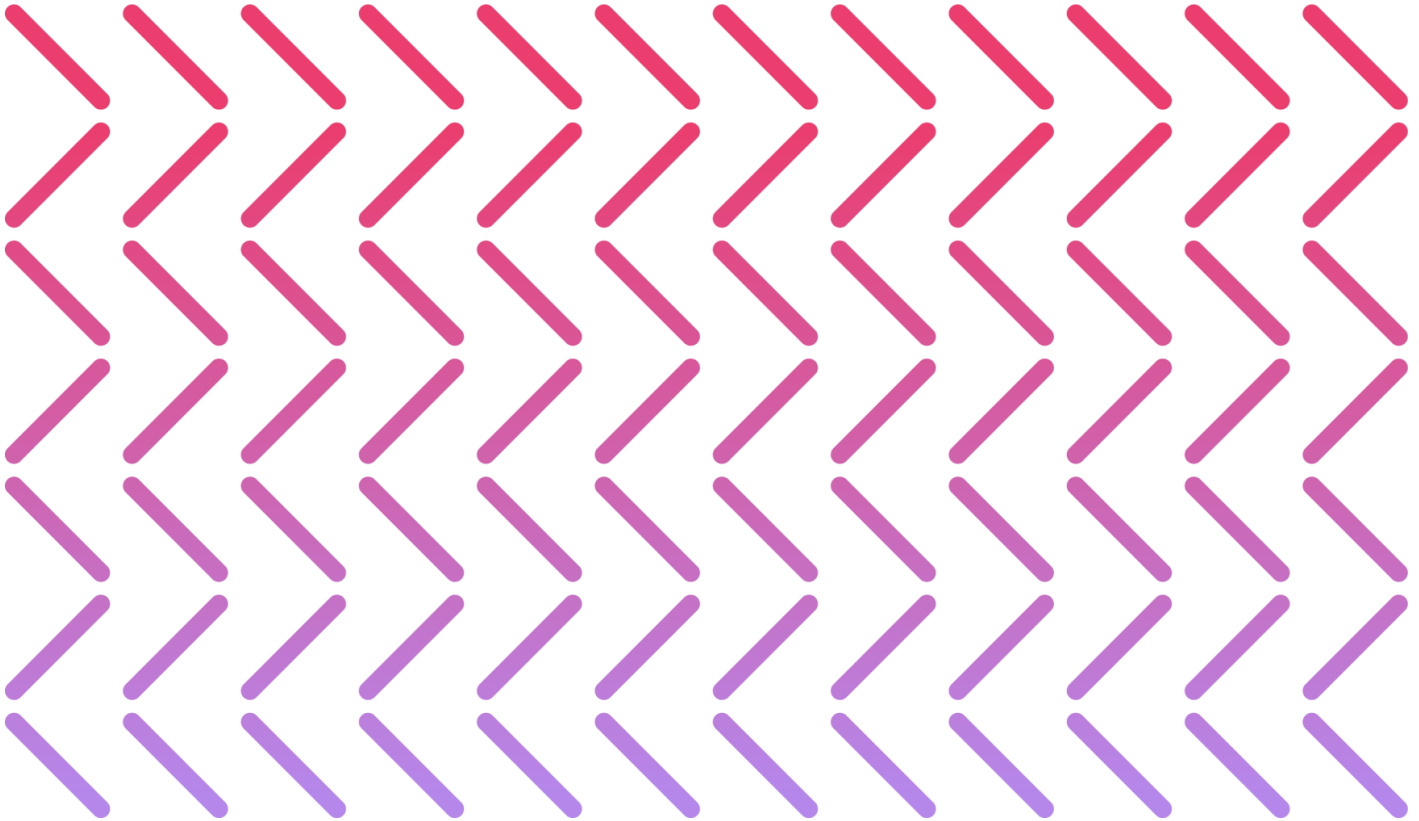
The intermediate care beds at Ronald Gibson House will be decommissioned from October 2022. This reflects rising acuity in this patient cohort, and subsequent low utilisation of these beds. Over this winter, this capacity will be reutilised to:

- Support the enhanced ambulatory frailty pathway in ED
- Spot purchasing of care home beds to support D2A

Lead Org	Scheme Description	Funding by Scheme	F
CLCH	D2A	£788,000	
LAS	LAS HALO	£70,000	
LBM	Mental Health Hospital Discharge pathway	£207,664	
	Reablement Capacity - Ensuring discharge capacity	£276,570	
	Volunteer Schemes to support discharges from ED	£71,400	
	Local Authority Extended brokerage eg to 7 days/longer working hours	£166,250	
	Local Authority Discharge Support	£153,125	
LBW	Sustaining 7 day and after 5pm working	£70,000	
	Cost of additional home care	£182,000	
	Volunteer Schemes to support discharges from ED	£60,000	
	Local Authority Schemes – Increasing Discharge Capacity	£250,000	
	Home first	£150,000	
SGUH	Prescribing pharmacist	£83,000	
	ED Majors	£1,256,000	
	Additional streamer	£87,000	
	SDEC	£185,000	
	Enhanced Transfer of Care hubs	£403,369	
	New Frailty zone, enhanced OPAL	£185,000	
TOTAL		**£4,644,378**	

Outstanding care every time

SECTION 3
Emergency Pathway Capacity



Outstanding care every time

Optimising the Emergency Floor – Right Care, Right Time

Our principal aims to deliver effective, safe care of our patients, and timely flow through our Emergency Floor this Winter, are:

1. **Timely off-load of ambulances** – maintaining Resus and Majors capacity for rapid ambulance handovers, including emergency tertiary pathways (stroke, neuro, major trauma, cardiac)
2. **Redirecting patients whose needs are best met elsewhere**:
   - Use of direct booking into GP practices / enhanced GP Hubs
   - Streaming minor illness / injuries to our urgent treatment centre
   - Optimal use of Same Day Emergency Care (SDEC)
   - Direct booking into speciality-specific urgent outpatients appointments
3. **Effective partnership working**
   - Ambulatory frailty pathway
   - Mental health needs

To achieve these aims, several actions are already in place and, will be further enhanced through the next quarter.

The following slides outline those actions, which will in turn be supported by programs of work to sustain Flow through our inpatient beds.

Together these actions meet the NHSE criteria set for emergency care delivery this winter. Delivery & Impact of these actions are overseen by the Trust's Emergency Care Delivery Board (ECDB), a sub-group of Trust Management Group.

Details of the following actions can be found in the appendices.

Outstanding care every time

Emergency Floor Surge Plan

The emergency floor surge and super surge plans are in place to maximise the capacity in the Emergency Department to offload ambulances, treat seriously unwell patients and continue to assess and treat walk-in attendances. When defined triggers are met measures include:

- Dedicating cubicles in Majors A and B for in and out assessment areas
- Using Extended Emergency Care Unit to place patients awaiting a ward bed
- Using secondary nurse assessment area as in and out doctors area
- Introduced a Treatment Pod to decompress Majors cubicles
- Splitting Resus 8 into two cubicles
- Splitting Majors A 18-21
- Use of Paediatric Majors for adult patients awaiting a ward bed

Note: All dependant on staffing levels

Same Day Emergency Care

Across all SWL Trusts we wish to provide a consistent and comprehensive model of SDEC & Frailty resulting in an increase in the proportion of patients treated and discharged on the day of attendance.

Direct bookings from 111 into SDEC (avoiding patients going to ED) are now live. We will continue to improve direct access from LAS, Primary and Community Care to SDEC services (avoiding patients going to ED) and grow the range of SDEC and Frailty services provision, embedding the gold standard pathways to meet the demand and changing needs. Specific services and actions underway include:

- Gynae SDEC pathway launched in June with a plan to roll out the pathway to 111 direct bookings
- 7 day paediatric SDEC service pilot began in May 2022 from the Blue Sky Unit and incorporates LAS direct access
- Medical SDEC operates as a 7 day service from AAA (Richmond Ward) and is reviewing further pathways to expand the medical offer
- The Vascular team are working collaboratively with the Nye Bevan Unit to provide a new vascular SDEC, supported by pharmacy and radiology
- Surgical SDEC plan to increase their operating hours in the Nye Bevan Unit, also supported by winter funding, developing further referral pathways, including the possibility of an ENT SDEC pathway (sore throat)
- Increased provision of Acute Frailty Services toward the 70 hour target

Next Day Speciality Outpatient Slots

Many specialties already offer a next day service in their outpatient clinics defined as available slots within 72hrs of patient contact with the Trust. The slots are bookable by the ED team, SDEC (Same Day Emergency Care), other in-patient specialties or via the GP. This Consultant led service enables timely decision making and planning and has several benefits including:

- Enabling ED to discharge a patient with a known plan to the relevant specialty. This in turn reduces pressure on ED and allows ED staff to focus on patients who need the specialist attention only ED can provide.
- Enables in patients in downstream wards to be discharged expediently, releasing bed capacity, whilst ensuring patients can continue their care in an ambulatory, outpatient approach
- Admission prevention through urgent access to specialist advice following primary care referral

We are currently mapping the services offering these 'hot slots' to raise awareness of existing clinic slots and specialities and will review current utilisation and whether to expand this offer moving into the winter months.

Ambulance Handovers

A plan is already in place to reduce the high number of long waits for ambulance handover and there is a fortnightly working group between SGUH and LAS that feeds in to M&W ECDB. Operational actions include:

- Hospital Ambulance Liaison Officer (HALO) to be allocated to SGUH by LAS as part of winter funding
- Review of all ambulance patients and patients in cubicles to identify those who are fit to sit
- Ambulance crews to wait in Majors with patients
- Patients to be assessed whilst on ambulance
- Cohorting to be considered to release some crews back on to the road

Ambulatory Frailty Pathway

Clinical audits indicate that around a third of patients presenting to our Emergency Department with frailty-related issues could be managed on an ambulatory pathway. Historically, this pathway provision has been limited by:

- Insufficient hospital@home capacity in the community to take this cohort home
- Challenges co-ordinating sub-acute medical needs with multiple social needs rapidly to support ambulatory care
- Trust's OPAL (Older People's Assessment Liaison) provided 5/7 days per week

The unintended consequence of this limited provision has meant:

- Patients are admitted to AMU, slowing flow from ED for patients with acute medical needs
- Patients may be admitted to 'down-stream' beds, risking extended admission and associated decompensation / increased care needs upon discharge

The implementation of Hospital@Home provided by CLCH, together with mature partnership working with health and care partners in Merton and Wandsworth means that this winter, the Trust will be able to provide a **dedicated Ambulatory Frailty Pathway in our Emergency Department**. The key interfaces will be **rapid access to Hospital@Home, Community Therapy, Reablement / Restart of domiciliary care, Place-based navigation to community support.**

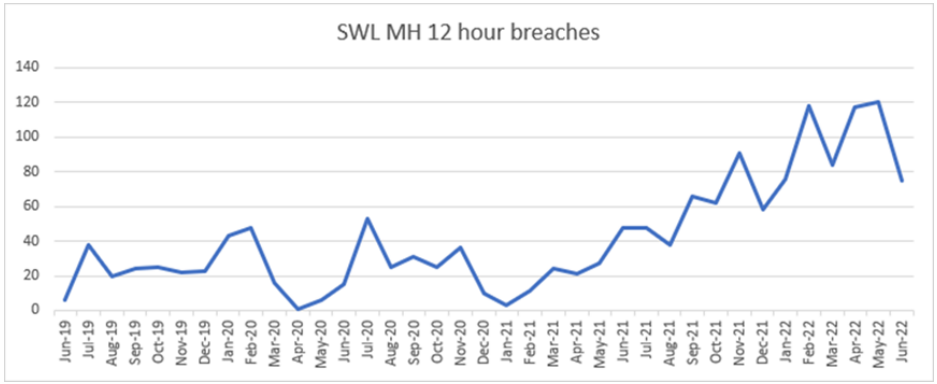
This will be funded in the first instance through Winter Pressures funding and will focus on:

- Frailty / complex co-morbidities
- Sub-acute medical needs
- Complexities in same day discharge to usual place of residence such as need for adaptive equipment, package of care restart, meals provision.

Mental Health Presentations – Current Position

As the time to complete a section 136 patient assessment has reduced, the numbers of people in acute mental distress being conveyed to Emergency Departments for assessment / access to MH treatment has increased. The number who subsequently have to wait over 12 hours for a mental health bed has also significantly increased across South West London.

This reflects pressures on acute MH beds, which are currently running at 105-110% occupancy. In turn, this is exacerbated by delays in securing onward care for patients ready for discharge from acute MH beds.



Right Care, Right Place – Mental Health Patients

The Trust is very well supported by our primary Mental Health partner provider, SWLSTG. Initiatives already in place include:

- Enhanced community access to crisis support
- Coral Suite
- Psychiatric liaison 24/7 in the Trust ED
- Close working between bed management teams to prioritise and allocate beds based on clinical acuity

For London, plans are in place to appoint section 136 capacity co-ordinators by April 2023 to ensure that this cohort of patients are taken to a 136 suite whenever appropriate and feasible; pan-London review of section 136 suite demand vs. capacity is underway. In South West London, planning is in place across MH providers to secure additional independent sector inpatient capacity – and work with local Boroughs / specialist providers on reducing onward care delays.

For the Trust, a local summit on the section 136 pathway identified opportunities to refine the local pathways:

- Consistency from LAS and Metropolitan Police in checking availability of section 136 suite capacity before conveyance to ED
- Immediate escalation to SWL Surge Hub for AWOL patients from out of area who are brough to ED to ensure rapid engagement with home hospital for repatriation
- Triggers added to OPEL Framework to prompt escalation to SWL Surge / LAS when a high number of MH patients are waiting in ED
- Joint best-practice clinical review between psychiatric liaison and ED on care for section 136 patients; update clinical pathways where appropriate

Further underpinning detail can be viewed in Appendix 2

Outstanding care every time

Urgent Treatment Centre

The new Urgent Treatment Centre opened in August 2022. It provides:

- An improved and expanded environment for the management of minor illness and injuries that present to our Emergency Department
- SDEC capacity for c. 10 ‘non-blue’ ambulances each day
- Improved co-location with the GP Out Of Hours Service provided at the Trust

The UTC is open at least 12 hours a day, 7 days a week and now treats an expanded cohort of patients:

- Shoulder dislocations
- Tonsilitis/Quinsy medical management
- Back Pain with red flag symptoms
- LAS patients who have had IV analgesia
- Minor Illness with a increased NEWS score
- Acute epistaxis
- Complex sports injuries for example tib-fib fractures
- Head injuries requiring possible CT Head

GP Out of Hours

SWL ICS commissioned a new contract for GP Out of Hours Service, which commenced early June 2022. This contract included increased clinical advisory capacity for 111, but reduced the GP capacity out of hours at the Trust’s IUC by 50%, with an immediate negative impact on performance against the 4 hour standard.

The Trust has worked with SWL ICS to quantify the gap in urgent primary care provision caused by this change in contract, which did not adequately factor Place-based GP out of hours legacy service provided at the Trust. A revised model has been scoped which co-locates with the new **Urgent Treatment Centre**, offering a full multi-disciplinary team to treat minor illness / injury and urgent primary care needs for people who walk into the Emergency Department, and who due to the day / time, cannot be booked into local GP enhanced hubs.

The staffing model is a hybrid one, extending in-house (directly contracted GPs) during weekday evenings and contracting with local GP partners at weekends. This model offers the optimal balance between continuity of service provision (no gap in IUC service in the early evening, as in current contract) and staffing resilience.

Paediatric Emergency Capacity

The modelling for Children's Respiratory Syncytial Syndrome (RSV) for this winter does not indicate spikes in demand that significantly increase bed pressures for children's emergency care. However, what it does suggest that there will be times when demand may marginally exceed existing inpatient and critical care capacity.

Our Paediatric Service proposes a flexible mini-surge capacity, as outlined right.

This is a maximum of 3 additional ITU / HDU beds, and 3 G&A beds, with staffing enhanced through use of bank shifts to sustain safer staffing standards.

If required, this is an unfunded cost pressure to the Trust. Deployment of this additional capacity will be as per the triggers for children's emergency inpatient / critical care capacity outlined in the updated OPEL framework (see section 7).

Inpatient therapy service to continue to support 7-day working, with on site physios available on the weekend. All other professions to provide in week service.

Specialist Feed Production Unit to continue to offer 6-day on site presence, with Sunday feeds prepared on Saturday.

BAU capacity

Current BAU
Viral Respiratory in Cubicles, or cohorted bays as per IPC standards

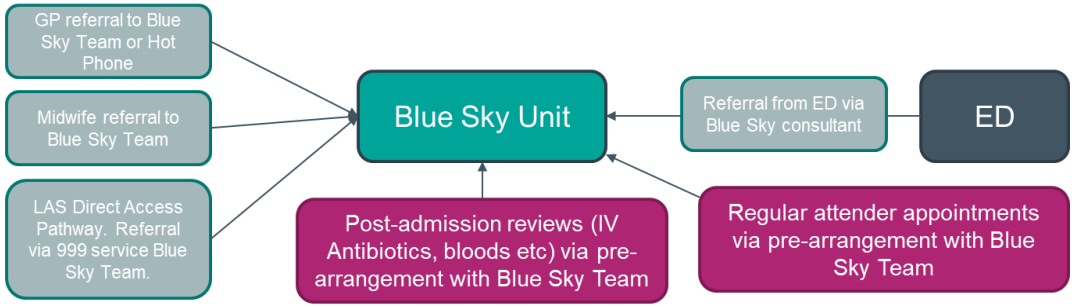
Increase in **ITU capacity (+3 beds** across ITU and HDU). Increase in **Enhanced Care beds (+2 on FH)-** requires 1 extra RN/shift (1:2 staffing ratio). Increase in 3 RN per shift for PICU- would normally be funded through some winter pressure funding from the STPN/ NHSL.

Increase in **Nicholls cubicles to 8** (conversion of admissions area). **Requires a minimum of 6 RNs and 2 HCAs as per NMC Guidelines**. It is noted that current acuity on the unit require 7 RNs LD and 6 overnight.

Increase in **Enhanced Care beds (+2 on Nicholls)-** requires 1 extra RN/shift (1:2 staffing ratio)

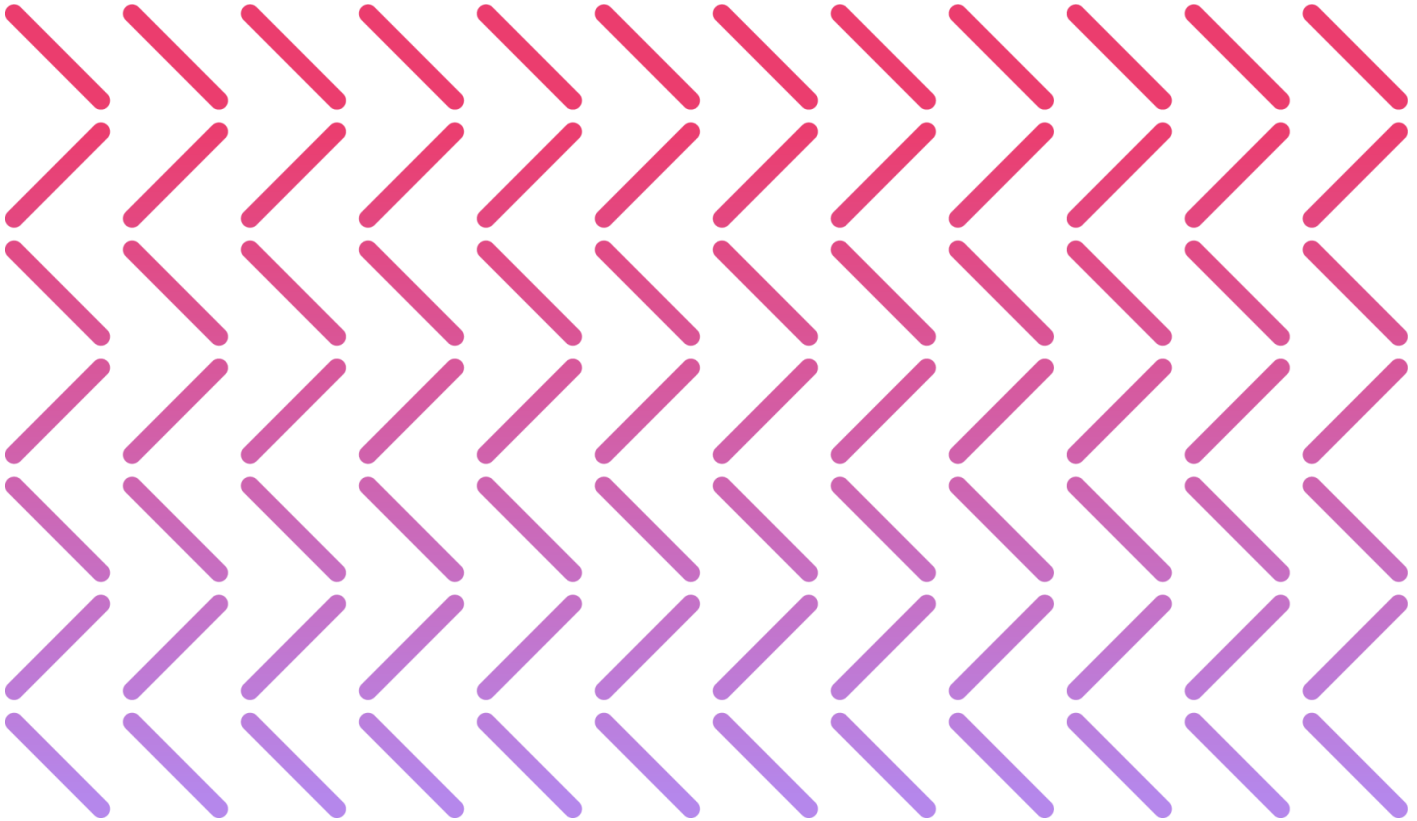
Maximum capacity within estate

Creation of **2 double cubicles** on Nicholls. Depending on acuity of babies, a double cubicle may need 1 RN or HCA, however based on NMC guidelines it is expected that these bed could be supported with 7RN and 2HCAs on a LD.



- Blue Sky to remain open as a 7 day service
- Direct access LAS Pathway has been agreed and implemented for children who are triaged pre-arrival with first attendance to the Blue Sky Unit if appropriate.
- Where appropriate Blue Sky to support early discharge and frequent attenders with scheduled appointments on the unit (e.g. those requiring IV antibiotics, bloods etc). It is expected this will reduce length of stay, improving flow as well as reducing attendances through ED.
- Referrals to Blue Sky taken as per usual criteria via the consultant Hot Phone to reduce ED attendances

SECTION 4
Elective Delivery and Enhanced Care



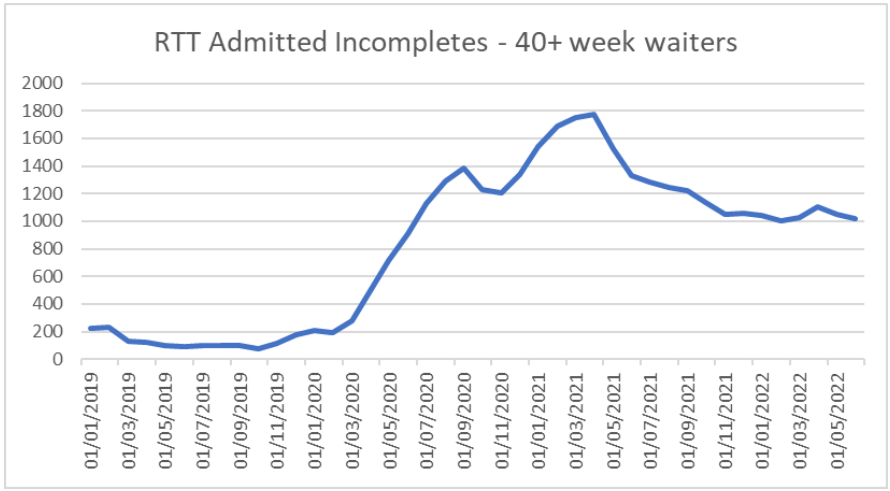
Outstanding care every time

Summary of Elective Plan

A major risk throughout winter is the impact of the increased demand on elective activity. As can be seen in the graph, the number of patients waiting over 40 weeks is significantly higher than pre-pandemic levels. This means that we cannot plan to reduce our elective activity to free up beds for ED admissions. We must, instead, look to continue our operating and maintain patient throughput to treat our long waiting patients, wherever possible.

Delivery will be optimised through greater use of day surgery and our operating theatres at QMH, reducing the need for inpatient beds. Enhanced elective theatre scheduling, where big theatre/ITU cases are streamlined across the week, will be used thus reducing controllable peaks in demand for specialty beds.

Focus will be applied to our key areas of risk where we have particularly long waiters. These include cardiology, ENT, general surgery, plastics and maxillo-facial.



To support this, clear plans for **diagnostics** (see appendix 3) will smooth the journey for patients, enhancing their discharge and reducing their length of stay. Additional capacity for this winter includes new MRIs coming on line in October 22 and mutual aid supporting additional sessions at QMH.

Outpatients, where there are also unacceptable waits across many specialties, have innovative plans in place to maximise the number of first OP appointments and to introduce patient initiated follow/ups, thus focussing capacity where patients need it most. An outpatient improvement board will provide oversight and governance for this and other elements of the plan which include:

- Consultant oversight of junior doctor repeat follow-ups
- Actions to reduce DNA rates
- Super Saturdays, providing increased capacity for high risk specialties

Good outpatient, diagnostic and surgical access are imperative for our patients on a **cancer pathway.** The cancer service has seen significant increases in demand and the focus on the above operational capacity will contribute to cancer recovery.

Outstanding care every time

Summary of Enhanced Care Plans

Critical care across St George's is made up of multiple small ITUs enabling a flexible approach to their use. These have all come under significant pressure over the last two years due to COVID and the learning from this experience will be applied through winter 22. The role of each unit will be flexed between COVID, elective and emergency capacity depending on the type of patient presenting.

Actions supporting efficient use of the critical care beds include:
- Timely step down from ITU
- Use of recovery areas if necessary, with clear protocols in place as to when that is appropriate

Staffing in this area, due to its specialist nature, present a risk, but the extra training of staff through the pandemic and the learning from how new teams formed and work together will mitigate this risk.

Internal Flow - within the Hospital

Whilst the number of non-elective medical admissions has NOT increased since 2019/20 (pre-COVID), length of stay of inpatients has, especially in those patients whose admission is 21 days plus. Some of this reflects the increased fragility and increased care needs for patient with complex co-morbidities since COVID lockdowns, reported across health and social care. However, some of it reflects the challenges in adapting our internal rhythm of the day to manage Flow through the hospital from the Emergency Floor through to timely discharge. Without effective Flow, a disproportionate level of clinical risk is held on the Emergency Floor.

The elective and enhanced care plans support improved flow within the hospital, but further actions are in place to optimise this.

For the Trust as a whole, the OPEL rating (NHS Operational Pressures Escalation Level) for the Trust is being revised to provide a clear reference point for all those involved in managing the bed pressures, providing much needed clarity on cross-divisional roles and decision making for changing OPEL levels in and out of hours.

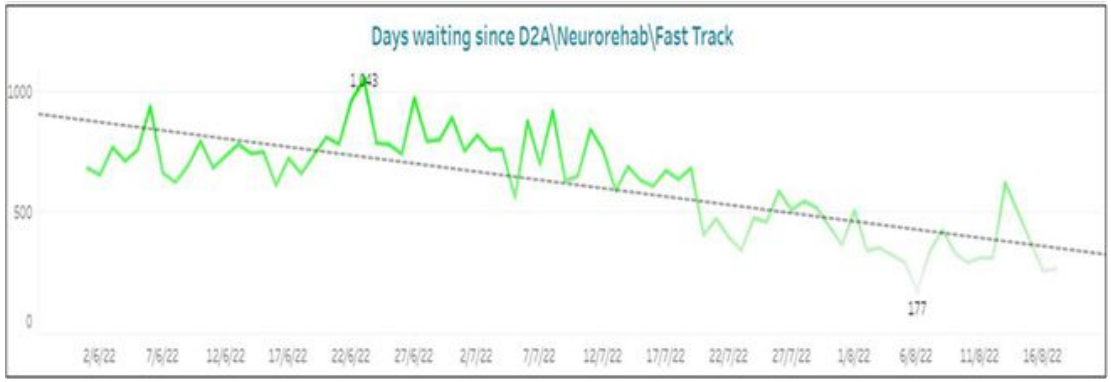
The **Clinical Site Management Team**, who coordinate Flow from the Emergency Floor through the complete patient journey and are key to optimising that patient Flow, will be greatly supported by this. As a team, they also have detailed protocols in place encompassing flow priorities, senior leadership on every shift, early escalation and clinical input for **Transfer of Care (TOC)**.

Since July 2022, the TOC service has been clinically-led through the Senior Health team. Changes have included:

- Case Management on behalf of the wards
- Robust validation process – improved quality of D2A referrals
- Regular face-to-face f/up with wards to support actions for discharge
- Sharpened decision-making with partners for complex patients
- Enhanced visibility of daily performance and escalation to the Clinical Site Management Team and COO

These changes have:

- Increased the daily discharges from an average of 13/ day to a range of 25-36/day
- Reduced average ‘days lost awaiting D2A placement’ across the Trust from c. 650 days to 200 days (see SPC charts)
- Reduced the number of ‘Super-stranded’ patients who have had multiple care home / nursing home assessments before being accepted to a suitable placement



Outstanding care every time

External Flow - Merton and Wandsworth Additional Capacity this Winter

Discharge to Assess Pathway 1 will continue to be funded at winter 2021-2 levels through the national winter pressures funding. This encompasses:

- Additional re-abling domiciliary capacity for post-acute patients to support them home, and determine their long term domiciliary care needs
- Additional community therapy capacity to ensure timely home assessment of patients on Pathway 1 post-discharge
- Weekend social worker capacity to support brokerage and flow 7/7, including to return to residential care homes

HALO – London Ambulance Service co-Ordinator present in the St George's ED, supporting ambulance handovers, and 'boots on the ground' for LAS informing ambulance flows across South West London

Mental Health – additional MH crisis clinicians, and independent sector inpatient capacity to support peaks in demand

Virtual Ward (national substantive funding)
Creation of 40 substantive hospital@home beds, providing sub-acute care for patients in their usual place of residence. This includes community admission avoidance, ambulatory frailty patients from ED and rapid turnaround patients from AMU. This service is commissioned from CLCH, and is expected to be at full capacity by January 2023.

Intermediate Care
In line with changing IPC regulations, no provision has been made this year for care home beds to care for post-acute patients until their post-COVID quarantine is completed allowing them to return to their usual care home.

As per the Merton and Wandsworth Frailty Strategy, the 8 intermediate care beds at Ronald Gibson House will be decommissioned in October. The specification / CQC registration of these beds means there are very few patients who meet the criteria who can't go home directly with support; utilisation is consistently poor accordingly.

This winter, additional care home beds will be spot-purchased to address any deficit; the strategic plan is to reinvest in Enduring Mental Illness (EMI) Discharge to Assess capacity. This will enable this cohort of patients' long term needs to be better assessed in a more therapeutic setting; and reduce the number of delayed patients awaiting in an acute hospital bed for an EMI placement.

Merton and Wandsworth Additional Capacity this Winter (cont.)

Support to Get You Home

Key safes - Weekend capacity commissioned to put in key safes for patients being discharge from hospital needing domiciliary care for the first time

Equipment

Additional funding for increased community equipment provision to support admission avoidance and supported discharge

Primary Care

The national specification for the GP Hubs commences in October 2022. Plans are in place to ensure that:

- ED streamers can book patients with primary care needs directly into local GP hubs
- GP Hubs can easily communicate with the Emergency Floor for advice in managing ?emergency patient presentations

In winter 2021-2, local GPs provided clinical advice to the 111 service for local patients during peak festive periods. This significantly reduced the number of primary care walk-in patients attending the Trust's ED. It is not yet clear whether:

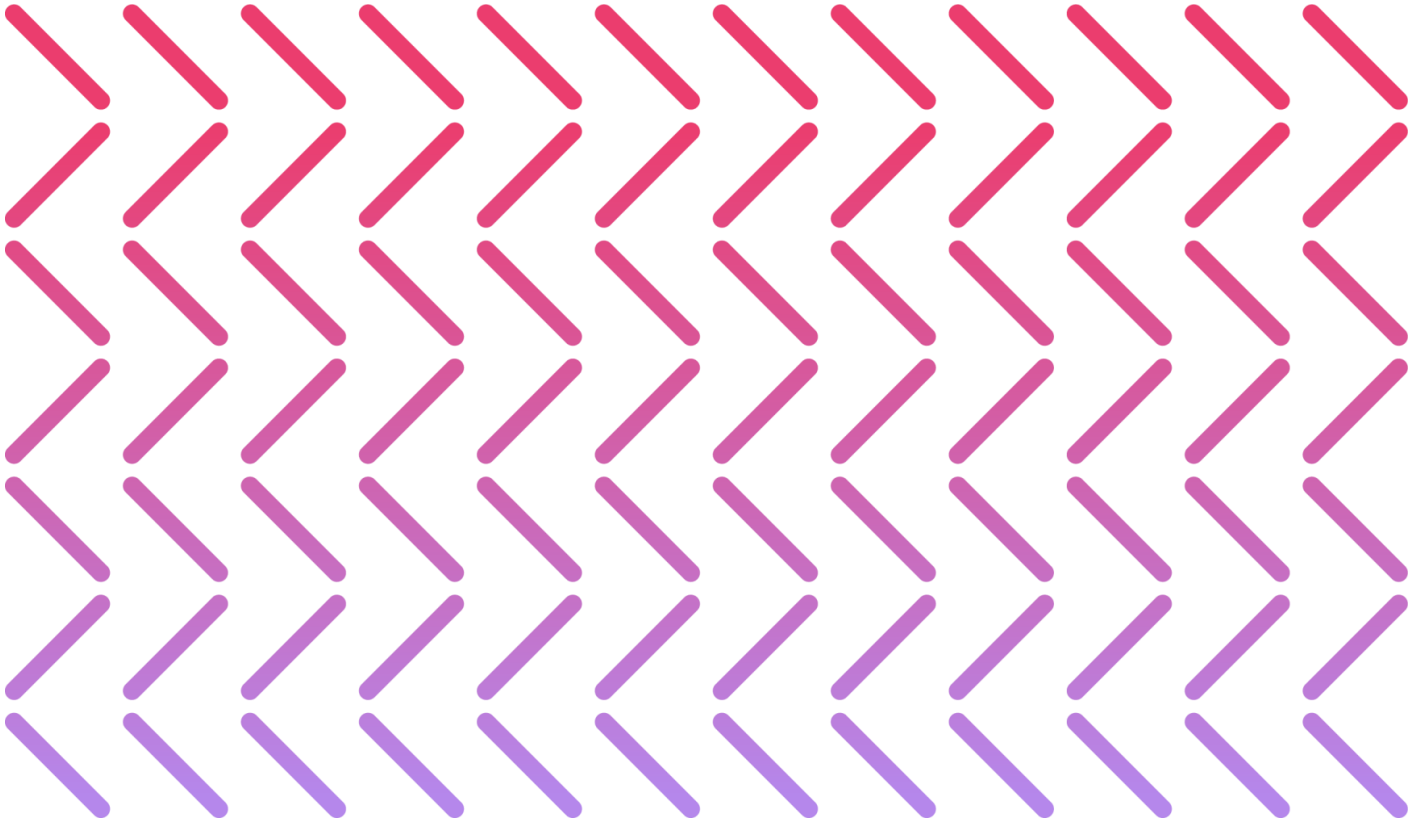
- The new GP OOH contract for South West London (including enhanced Clinical Advice Service) negates the need for this additional clinical capacity
- If not, whether dedicated winter funding for primary care will be put in place again to fund this

Winter Funding for St George's

Circa 48% of the national winter funding for Merton and Wandsworth in 2022/3 will be spent at the Trust, including:

- 7/7 Ambulatory frailty pathway in ED
- ED surge capacity
- Transfer of Care (TOC) team staffing
- Enhanced Surgical Same Day Emergency Care (SDEC) clinical capacity (Nye Bevan Unit)

SECTION 5
Business Continuity



Outstanding care every time

Business Continuity & Major Incident Preparedness

The Trust's Business Continuity and Major Incident Plans were last reviewed and updated end-to-end in October 2021. NHSE Assurance in autumn 2021 found the plans to be 'substantially compliant', with 2 actions recommended. Both have since been completed.

There have been a number of internal critical incidents declared during 2022, reflecting the pressure on the aging infrastructure of the estate. None of these resulted in harm to patients or staff, however each required a shift to business continuity arrangements whilst repairs were made in key clinical areas. A major incident training exercise was completed in June 2022.

Learning from business continuity events is overseen by the Business Continuity Steering Group, Chaired by the Chief Operating Officer. Post-incident debriefs have consistently found that teams directly involved in internal critical incidents feel well-supported; and that the control & command of actions works well.

However, there has been learning too, which has been cascaded throughout the organisation:

- Awareness of IT and telephony arrangements in place in clinical areas if power / server connectivity is temporarily lost ('red' computers, analogue telephones)
- Changes to Facilities protocol if power is lost (manual check that switches to generator have connected)
- Increased UPS duration in key medical equipment
- Need to update digital communication channels for targeted cascade in business continuity critical incidents / major incidents

This year's self-assessment against the NHS business continuity requirements is due for submission to NHSE on September 15th.

By November 2022, assurance of team-level readiness of the following business continuity plans will have been completed:

- Cold weather plan
- Full hospital protocol
- On-call requirements in relation to the revised OPEL framework for the Trust

Arrangements in place: System Mutual Aid for Emergency Pathways

System Escalation and Mutual aid are well-rehearsed in South West London for non-elective as well as elective care. Supported by South West London ICS Surge Hub and London NHS01, acute providers can:

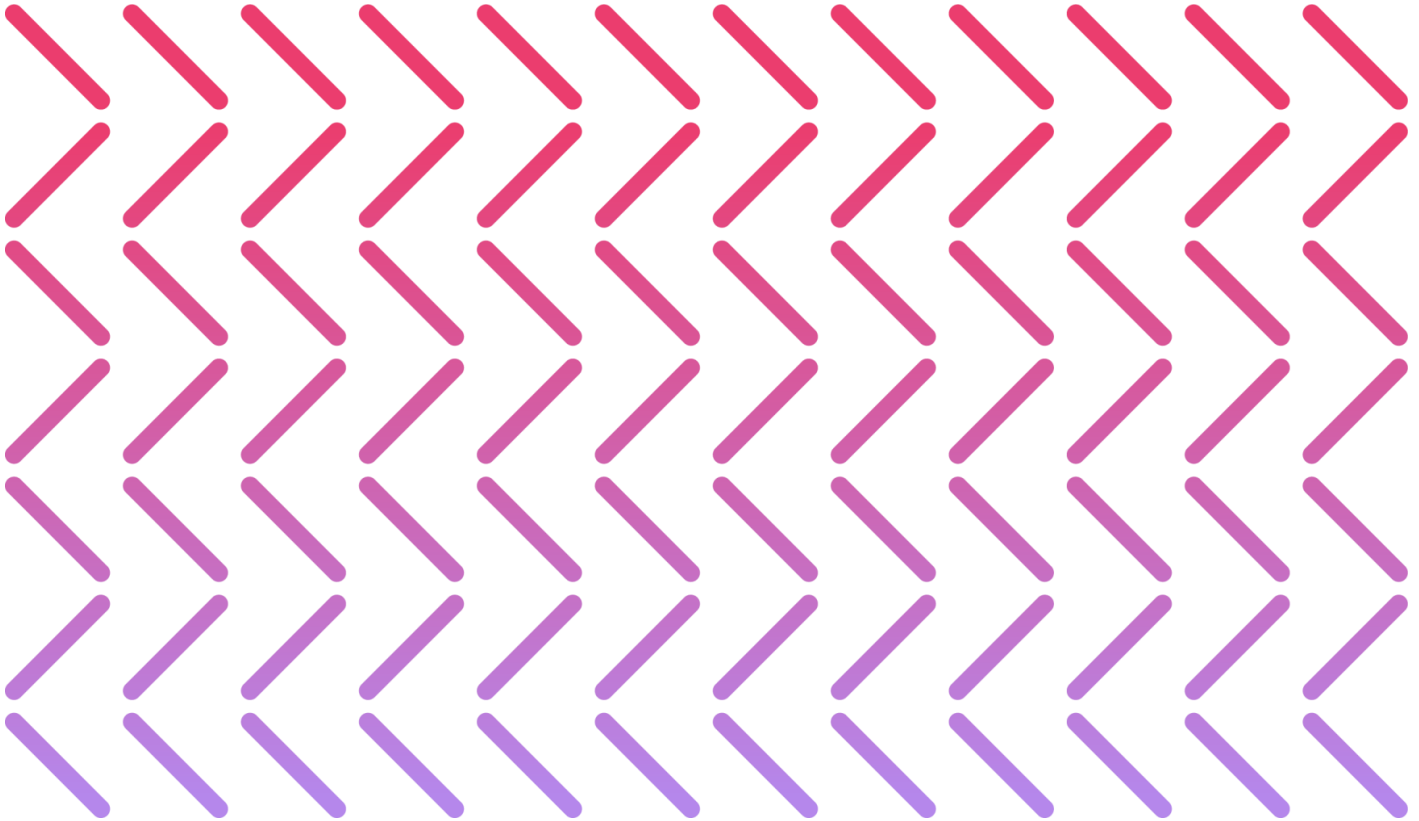
- Seek a partial redirect of 'non-blue' ambulances to other EDs less pressured within an ICS for a specified period of time, to allow delayed ambulance handovers to be prioritised and decompression actions in ED to be effected
- Seek a partial redirect on unplanned admissions across a clinical network in South West London, for example, maternity, children's or critical care
- Seek planned support to cover maintenance works that affect tertiary emergency pathways, for example to hybrid theatres, or essential works to a major trauma network helipad
- Seek co-ordinated support from local Place partners and ICS acute partners in instances of an internal critical incident or major incident
- Co-ordinate support to acute partners in Kent, Surrey and Sussex if their pressures require support from London ICS'

During winter 2022/3 this support network will be enhanced by:

- London Ambulance Service HALO presence in SWL EDs at peak times – co-ordinating intelligence on ED pressures within the EDs as well as delays to ambulance handovers. This allows more timely and proportionate use of partial diverts (pre-agreed) at Level 2 and Level 3 pressures
- SWL COOs calls, which occur as frequently as system pressures indicate (from 1/ week to daily)
- Support from mental health providers to co-ordinate section 136 capacity across South London;
    - Ensuring such patients are not conveyed to EDs if there is section 136 capacity available
    - More effectively distributing section 136 patients numbers across available EDs

Requests for mutual aid on emergency pathways (including mental health) are determined by the OPEL Framework. Decision-making to initiate (as per the Trust's Business Continuity Plan) rests with the COO (in-hours) or Strategic On-Call (OOH), and is facilitated by the Clinical Site Management Team.

SECTION 6
Infection Prevention and Control (IPC)



Outstanding care every time

IPC Approach

Flu and Covid-19 Vaccination Plan Autumn 2022

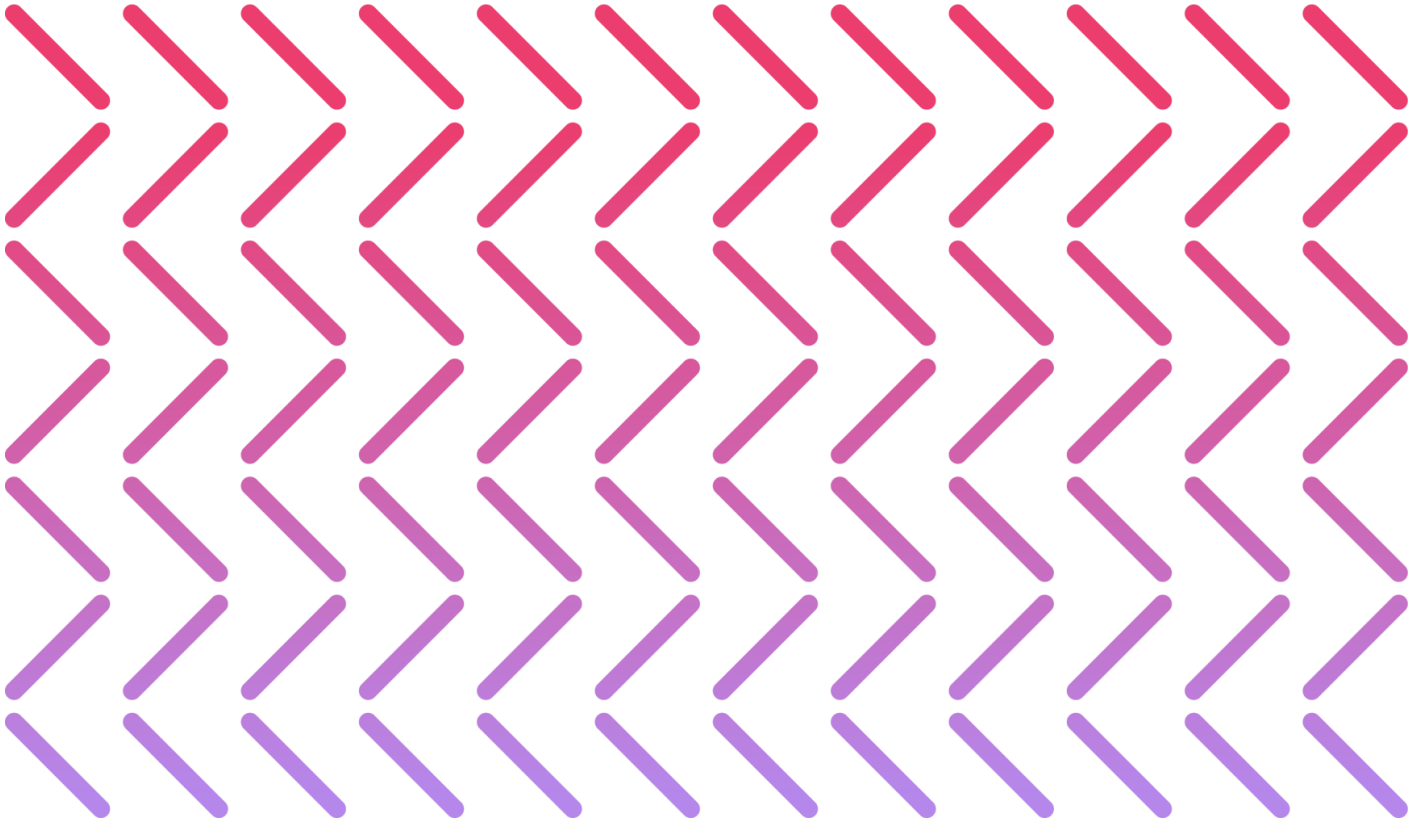
The Flu Vaccination clinic will run from 20 September 2022 to 28 February 2023.

- New booking system called Vaccination Track. Emails will/have been sent to all Trust staff, with a link to book in for their vaccinations (Covid and Flu)
- Two locations for Flu vaccinations this year: Cardiac gym in Atkinson Morley Wing and PALS office in Grosvenor Wing
- Peer vaccinators will also be visiting the wards and departments on a daily basis to offer flu vaccinations to staff in their place of work.
- Internal target for compliance for Flu update in our staff is 85%
- Clinic times are Monday to Friday 8am to 6pm
- Staff can book on vaccination track or they can walk in

The Autumn Covid-19 Booster Clinic will run from 28 September 2022 to 18 December 2022

- New staff booking system called Vaccination Track. Emails have been sent to all Trust staff with a link to book in for their vaccination.
- Staff can book an appointment for a Covid only, or a combined Flu and Covid, vaccination. Some walk ins will be accepted.
- The Booster Vaccine available at St George's this autumn is Pfizer Bivalent
- One location: The clinic will be based in the cardiac gym, cardiac outpatients, ground floor Atkinson Morley Wing
- Clinic opens on 28 September from 8am to 4pm and will run for seven days a week until the 16 October. From 21 October the clinic will run from 8am to 4pm , Friday to Sunday, until 18 December 2022. Opening times can be expanded if there is sufficient demand.
-
- Patient/Public access: St George's clinics are available on the National Booking System (NBS) for patients & public to book into.
- Headline update : Staff bookings opened on Friday 17 September – so far the combined clinics have the highest demand

SECTION 7
Workforce



Outstanding care every time

Winter Workforce Plan

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

Our focus is to:

- Build upon our existing workforce plans, and workforce improvement plans with our priority to focus on those areas which will support the wellbeing of our staff and strong, affordable staffing levels through winter.
- Move at pace and where we're introducing something new, the focus should be upon what we can do quickly (within a month or so, e.g. Cost of Living).
- Join system levels where we believe there are likely to be synergies, and this won't cause undue delays.

Staff Support	Occupational Health	Staff Health and Wellbeing	Recruitment	Absence Management
• To implement a stepped model of psychological care in developing the capacity of the service and meeting a range of psychological presentations in line with NICE Guidance. • Increasing staff capacity to meet the increase and demand on the Staff Support Service for Counselling, Manager Support, presence in clinical and non-clinical areas, Mediations and Conflict Resolution, De-Briefs, supporting staff and areas which experience aggression etc. with the recruitment of two fixed term WTE psychotherapists/counsellors. • To offer a wider range of evidence-based interventions in meeting the needs of those accessing the service. • To continue to promote the conflict and mediation service to help support the resolution of conflicts within teams and between individuals. • To contribute to study days and present on a range of common mental health and wellbeing challenges - supporting the prevention and recognition of presentations and symptoms of mental ill health and distress. • To continue to reach out and extend presence in clinical areas and undertake 'walkabouts' offering support and wellbeing tips and where possible, Reflective Practice sessions. • To seek to extend presence at St. John's and Queen Mary's to one full day a week. • To further promote information on suicide awareness and how to get support. • To continue to collaborate and support the Health and Wellbeing Team with projects. For example, cost of living and menopause sessions.	• OH Information to be easily accessible on the intranet – OH page currently being updated – to be removed from H&W page • Physiotherapy is available to staff (no self-referrals) • Long Covid Consultations ongoing with Covid Surge Team & OH Physicians • Covid urge Team still supporting staff with advice re covid positive results • Staff Support can refer to OH but manager needs to be aware of such referrals • Walk in available for Dermatitis and sharps/splash injuries • Priority clearance list sent every Tuesday by Recruitment • Immunity catch-up programme ongoing – ensure all staff have mandatory vaccines • New updated All staff Covid Risk assessment available on Intranet • Urgent referrals for stress are prioritised	• Developing and advertising a suite of resources to help staff with the Cost of Living throughout the winter period. • Launching and delivering Mental Health training for all line managers, designed to proactively help managers in supporting the mental health of their staff through winter pressures. • Working with managers to ensure they complete Wellness Action Plans for themselves and their team members. • Training Health and Wellbeing Champions to deliver local initiatives and adding staff wellbeing to agendas in local meetings and huddles. • Showcasing and promoting healthy working practices, including reinforcing the importance of regular breaks and usage of annual leave. • Providing staff with opportunities to develop their wellbeing through a range of training opportunities on mental and physical health topics. • Promoting support available to staff from the Staff Support team.	• Clearly identify divisions and departments which will face the greatest winter pressures • Leading up to winter pressures, establish priority service/processes for these identified areas • Regular monthly review of vacancy rates for each division (currently 481 WTE campaigns for 134 vacant nursing posts at Sept22) • Current nursing pipelines to also include all international recruitment via Capital Nursing, to be sent weekly to relevant leads • Provide future pipelines with expected start dates, to allow Nursing leads to accurately forward plan rota's/budgets • Continue with open day's and attraction events, 5 events since April have resulted in 61 offers (11 HCA's and 50 nurses) moving from virtual to face to face • HCA's pipelines have been identified as a risk, we are working closely with nursing leads to address this shortfall and Education team also ensuring no delays caused due to training capacity • As part of our widening participation work we are working closer with the Princes Trust and the JCP, especially with HCA recruitment • A further 5 open day events have been planned, with a dedicated event just for HCA's, to help support the incumbent newly qualified nurses • Support the education team with newly qualified inductions (to help ensure new staff are well supported) • IEN's in the pipeline – expecting 26 in September and a further 25 in October, we are anticipating delays to this pipeline due delays in visa's (caused by Ukraine conflict), flight cancellations as well as a significant increase to the cost of flights. • Liaise closer with Staff Bank to address shortfalls and build a talent pool • Advertising commenced in July specifically targeting former nurses to Return to Practice to increase the workforce from this previously qualified population, the course is HEE funded and a bursary is available. • Refreshing SWL website to drive candidate pool increase	• Introduction of Divisional Sickness Absence bureaus to ensure all cases are under management and to support managers / remove blocks • Approval of business case to employ 4 no. temporary HR Advisors to give direct support to managers in managing absence • Weekly sickness absence reporting, focusing on Covid-19 to track and respond to changes • National policy on sick pay post Covid implemented • Review of OH capacity to minimise delays in process • Implement annual leave comms plan and reporting with aim of minimising carry forward to 23/24 and maximising taking of annual leave

Staff Health and Wellbeing

The Current Picture

Cost of living
The cost of living crisis is going to put a strain on many households, contributing to stress levels of our staff, and making access to basic necessities, such as transport, food and heating less affordable.

Rates of pay
Though there has been an uplift of pay for NHS staff that offered a higher increase for staff on lower pay bands, it will not meet the rising inflation rates, compounding the cost of living pressures staff are feeling.

Workload
Operational areas continue to manage a backlog of activity created by the pandemic, therefore workload remains high and will add to the seasonal pressures. There is also a further risk of another Covid-19 wave this winter which will impact activity.

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

Staff sickness
Sickness rates remain high across the Trust despite the number of Covid-19 cases lowering. This can be related to high rates of stress and burnout.

Staff vacancy rates
The Trust vacancy rates rise during the winter period and, coupled with sickness absence, are expected to increase the pressure on staff.

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

Our Current Offer

Creating training and resources to support managers

Creating a culture that places wellbeing at its heart

Encouraging staff to take adequate rest breaks/annual leave

Increasing provision of wellbeing information to staff

Providing training on wellbeing to staff

Specialist group support from Staff Support service

Mediation

Facilitating specialist interventions

Health promotion to at risk groups

Encouraging conversations about mental health through Wellness Action Plan and Mental Health training options

Providing cover on wards at times of significant pressure

Promoting national specialist services

Supporting staff with return to work following a period of sickness absence

Referring staff into external services if required

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

Facilitating trauma debrief groups

Additional winter pressure support offer

Developing support resources to help staff through the Cost of Living crisis

Maximising affordable food provision

Reiterating the importance of scheduled rest breaks and working with staff groups to identify nominated leads for ensuring breaks are taken

Developing localised wellbeing plans by care group

Improving the Wellbeing Hub rest spaces

Targeted health and wellbeing relationship building with line managers

Identify at risk staff and develop targeted interventions

Regular reporting of key themes, with action plans developed in response

Fast tracking managers to access coaching support

Providing line managers with targeted wellbeing resources

Supporting Practice Educators in facilitating groups and mentoring

Peer to peer support groups

Staff Support:

Proactive outreach via email to staff when they go off sick for psychological reasons, (from Manager on behalf of Staff Support) with information about the Staff Support Service, resources and how to access support.

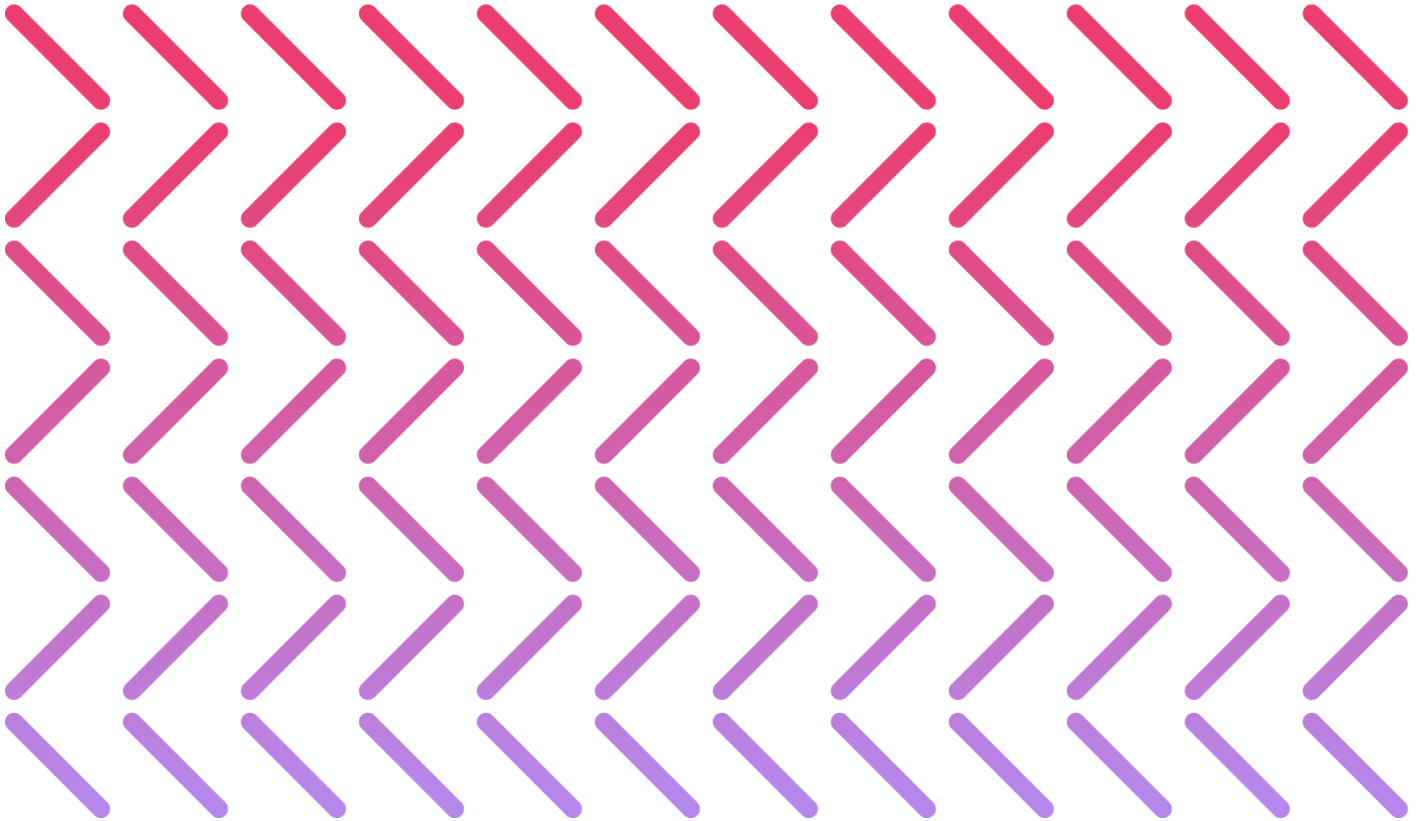
Ongoing Staff Support sessions whilst staff are off sick and during in the initial phase of returning to work.

We will:

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

Outstanding care every time

SECTION 8
Winter Communication Plan



Outstanding care every time

Communication Plan – St George's, Epsom and St Helier Hospital

This is a Group-wide communications campaign aligning with SWL, London and national campaigns, however, there will be some individual projects that apply to one Trust only.

We will share content across our channels from SWL, London and national campaigns with the same overarching objectives and messaging to show joined-up collaborative working, amplify our messages and demonstrate that we are one NHS team working together to support our local people.

While we can plan for certain dates and projects and look ahead for opportunities, we will be flexible and react to any periods of particularly increased demand or issues requiring particular management.

We will use our communications channels to highlight these challenges and encourage the public to use the most appropriate service for their healthcare need using a range of real data to support our messaging.

We also want to showcase the work we are doing to meet demand and share public health messaging on how to stay safe and well this autumn and winter.

We need to ensure our staff are supported during what is traditionally a challenging time – off the back of an already-very busy period – and will promote ways they can look after their health and wellbeing – from cost-of-living support and mental health, to getting their flu vaccines and Covid-19 boosters.

The full winter pressures plan for the group can be found in Appendix 2 of this document.

Meeting Title:	**Trust Board**		
Date:	3 November 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 September and October. The Committee is recommending a reduction in the current risk rating on compliance with Disclosure and Barring Service requirements from 16 to 8, and the Board is asked to endorse this The Committee has noted good progress on mitigating the Trust level risks (SR8 and SR9) allocated to the Committee for oversight. The Committee is not at this stage recommending a reduction in either risk from the present 'Extreme -16' rating to 'High-12', but if current progress on mitigation can be maintained, a reduction on risk is in prospect for the financial year-end. At its October meeting the Committee was briefed on seven new risks which are currently being evaluated by the executive. The Committee regarded this process as a normal part of good forward-looking risk-management practice, rather than a significant shift in the Trust's risk profile.		
Recommendation:	The Board is asked to: • Note the report. • Endorse the proposed reduction in the current risk rating on compliance with Disclosure and Barring Service requirements from 16 to 8. • Approve the Committee's decision to finalise the content of the Trust's WRES and WDES annual statements.		
Supports			
Trust Strategic Objective:	Culture		
CQC Theme:	Well Led		
NHS System Oversight Framework:	People, Well Led		

1. Introduction

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). The Committee in Common arrangements are working well in practice.

2. Risk Assurance

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. All active[1] staff have now engaged with the process, and only three staff have been unable to provide the documentation required to enable verification of their DBS status to be undertaken. This represents a significant improvement on where the Trust was four months ago. The Committee therefore agreed to recommend a reduction in the current risk rating from 16 to 8, and the Board is asked to endorse this.

At its October meeting the Committee was briefed on seven new risks which are currently being evaluated by the executive. The Committee regarded this process as a normal part of good forward-looking risk-management practice, rather than a significant shift in the Trust's risk profile. There will be a follow-on report to the Committee at its November meeting.

The Committee also noted a large number of risks captured on the Datix system, as well as noting good progress on mitigating the Trust level risks (SR8 and SR9) allocated to the Committee for oversight. The Committee is not at this stage recommending a reduction in either risk from the present 'Extreme - 16' rating to 'High-12', but if current progress on mitigation can be maintained, a reduction on risk is in prospect for the financial year-end.

At its September meeting the Committee reviewed a short report on the performance of the outsourced payroll service. Most performance standards and thresholds were being met by the service provider, and although some areas for improvement were identified and will be progressed, no material risk issues were identified.

3. Strategy

The Committee reviewed the Trust's progress against the 2019-2024 Education Strategy, noting solid progress as we move into the second half of the associated delivery plan. What was encouraging was how the Trust was pivoting its plans so as to incorporate new technologies (such as Car-T cells) into its learning and development objectives. The delivery plan was on track, and we took assurance from the processes in use and the clear commitment of the Education Strategy Implementation Group to keeping the Trust at the forefront of medical and clinical education, and to make this the everyday experience of a large number of Trust staff.

The Committee reviewed progress at the half-year by the Trust against its Workforce Strategy, and the key actions scheduled for Q3. Generally good progress was being made, and there were no areas of concern.

4. Internal Supply

The Trust's overall vacancy rate remains below 10% (although it has increased recently to 9.66%), which we regard as a generally positive position although the recent increase suggests that we will breach the 10% target by calendar year-end. Rolling 12-month turnover stands at 16.63%, which is above the target of 13% and has seen a small rise more recently. Particularly high turnover continues

[1] There are 15 non-active members of staff who are not currently working for whom a DBS check is not held. They will not be allowed to return to work until these are in place.

to be experienced in Clinical, AHP and Estates staff. On sickness absence – the last available data was 4.2% in September, which reflects a reduction on levels seen during the summer Covid wave. The Committee noted changed arrangements for the active management of sickness absence, and the benefits they are anticipated to deliver.

The Committee reviewed the Trust's Workforce Improvement Plan at its October meeting, and noted generally good progress being made on each of the six workstreams, although the workstream related to sickness absence was tracking behind plan due to internal staff shortages. The original estimated total potential benefit that was intended to be generated from these initiatives was originally estimated at c £6 million, but the Executive were clear that it is unlikely that this will be achieved in full and were asked by the Committee to review its estimates.

The Committee reviewed the data relating to the size of the Trust's Establishment. This had increased from 9,567 in April 2021 to 10,076 in August 2022 – an increase of over 500 staff, or 5.3%. Some of this has been a result of TUPE transfers into the Trust as it took on delivery or lead-employer responsibility for specific functions such as South West London Pathology. However, some was simply an increase in the size of the Trust workforce which, given current activity levels at the Trust as a whole, does raise a question about loss of efficiency. This is not something the Committee has yet had a chance to explore in detail, but will clearly need to be addressed by the executive.

The Trust's use of bank and agency staff through to July was noted, with increasing levels of bank staff utilisation and decreasing levels of (higher-cost) agency staff. We regard this as an indicator of active and successful management of contingent staffing spend, and noted the trends continue to move in the right direction here.

5. Culture Diversity and Inclusion , Organisational Development

Group WRES and WDES Action Plans – the Committee was briefed at its October meeting on the way that WRES and WDES initiatives were being jointly managed across the SGH/ESH group. This would require further alignment of the metrics and reporting structures in operation, and the first steps in this process were noted.

Trust WRES and WDES Reports - following reviews of earlier drafts by the Committee at its August meeting, final drafts of the Trust's WRES and WDES reports for 21-22 were circulated to the Committee in October for review on behalf of the Board pursuant to authority delegated at the Trust's September meeting. For update at the Board.

Culture Programme Update – at its September meeting the Committee received an update from the Culture, Equity and Inclusion Board, which continued to meet monthly. The Living our Values project had been launched and staff were being actively engaged on the Trust's and colleagues' expectations of them. Line manager training ('Management Fundamentals') was being scheduled for delivery to all new and existing managers from the end of September. A Leadership Development Programme had been launched for Clinical Directors and Care Group leads. RIS representation on recruitment panels had continued to increase and now stood at 72% of all panels. Consideration is being given to widening RIS training to all staff, rather than to those from minority racial groups.

Health and wellbeing – the Committee received and reviewed a Q2 update on the health, wellbeing and staff support activities in place. The take-up of therapeutic 1:1 sessions remains high.

Staff Engagement – The Committee received a report on the results of the Q1 and Q2 staff Pulse surveys. The survey base was now all staff (rather than the fixed 2,500 previously surveyed) and as a result response numbers had more than doubled. Of some concern was that the engagement score achieved had fallen between Q1 and Q2 (6.20, down from 6.36) as had the staff scores for motivation, involvement and advocacy. High workload and overwork were identified by staff as contributory factors, as was unsupportive management. The highest single rated suggestion for action by the Trust was

'Improve management'. Paul da Gama, the Trust's Chief People Officer, accepted the downturn in results (see Annex 1 below) and responded constructively – acknowledging the need for continued development of middle management, the provision of staff support and wellness, and the active management of operational pressure. He noted, and the Committee accepted, that the work being undertaken within leadership development (see Culture Programme Update, above) would contribute to this.

6. Trust Governance

Guardian of Safe Working – at its September meeting the Committee received the Q1 report from the Guardian of Safe Working, Dr Serena Haywood. There had been 128 exception reports, a material increase over the 79 in the prior quarter and Q1 in the two preceding years (98 and 32). Although no immediate safety concerns were raised the Committee was concerned to note the high number of exception reports, particularly in acute medicine. Feedback from trainees was that there has been a more recent improvement in service pressure in this area, and we will keep this under careful review in future reports. The Committee recognised the work being done by the Trust to help manage the operational pressures on doctors in training, and it is clear that this area is getting attention from senior medical leadership. Exception reporting for non-Consultant doctors (not in training) had been initiated. No exception reports had been received from this cohort. As this was Dr Haywood's last meeting in the Guardian role, she was thanked for the great contribution she had made to safe working at the Trust.

GMC's survey of postgraduate medical trainees - at the October meeting, the Committee received a full report on the GMC's survey of postgraduate medical trainees, in a paper prepared by Dr Luci Etheridge, our St George's site CMO. The GMC reported a major step forward since last year, and whilst there are still areas of action required in haematology and respiratory medicine, the overall picture was much improved, and the planned progress sustained. It was particularly pleasing to read the comments about the cardiac surgical consultants working together in team simulation, and to hear that the department is now taking trainees again, and to read the comments about improvements in acute medicine. The Trust team's self assessment of actions required and self-initiated intervention suggested a strong commitment to further improvement. It was also clear that there was good co-operation and joint working between the Trust and ESH.

The Committee also received a helpful paper from Dr Indranil Chakrovarti and Dr Joyce Popoola (respectively Director of Medical Education and Undergraduate Sub-Dean). The key point was that undergraduate assessment and feedback had improved materially over prior year, even in previously weak areas. Teaching and training space remained a challenge, and whilst some mitigations were available, the underlying issue would require to be addressed. A set of objectives had been set out for the following year, majoring on improving the quality of teaching.

Training and revalidation of nurses and AHPs. The Committee received a detailed and helpful paper from Arlene Wellman providing assurance on the processes in place to revalidate nurses and AHPs employed at the Trust. The Committee took assurance from the information provided, and the fact that there were no cases of revalidation lapses within the Trust nursing workforce of some 2,850 individuals.

People Policies Update – the Committee received a report on the planned policy update initiative. This was clearly a significant exercise, and was being approached on a risk-led basis. The Committee endorsed the proposed approach, and the prioritisation process to be used.

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. It is also an assurance to the Committee on the active management of the Trust's HR and people function of some challenging issues in a dynamic environment.

Stephen J Collier, Committee Chair, 27 October 2022

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

ANNEX 1

Pulse Survey, all staff

n = 972, Q2

n = 416, Q1

Staff Engagement

Detailed results

	Question	St George's			
		Staff Survey 2021 score	Q1 People Pulse score (April)	Q2 People Pulse score (July)	Improvement/ decline between Q1 and Q2
Motivation measures	I look forward to going to work	52.0%	40.4%	41.9%	↑ 1.5%
	I am enthusiastic about my job	64.7%	59.6%	56.6%	↓ 3.0%
	Time passes quickly when I am working	73.3%	72.1%	67.3%	↓ 4.8%
Involvement measures	There are frequent opportunities for me to show initiative in my role	72.4%	60.3%	59.1%	↓ 1.2%
	I am able to make suggestions to improve the work of my team/department	68.6%	61.5%	60.9%	↓ 0.6%
	I am able to make improvements happen in my area of work	51.3%	49.0%	46.4%	↓ 2.6%
Advocacy measures	Care of patients/service users is my organisations top priority	74.4%	66.7%	61.2%	↓ 5.5%
	I would recommend my organisation as a place to work	58.3%	47.1%	42.1%	↓ 5.0%
	If a friend or relative needed treatment I would be happy by the standard of care provided	71.2%	62.5%	61.9%	↓ 0.6%

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	3 November 2022	**Agenda No**	**3.1.1**
Report Title:	**Workforce Disability Equality Standard (WDES) and Workforce Race Equality Standard (WRES) Key Findings and Action Plans**		
Lead Director/ Manager:	Paul Da Gama, GCPO		
Report Author:	Joseph Pavett-Downer, D&I Lead		
Presented for:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify)		
Executive Summary:	**Introduction** Both the WRES and WDES are mandatory annual workforce equality reports that focus on a specific protected characteristic – WRES focuses on race and WDES on disability. Our 2022 Reports and Actions Plans have undergone extensive internal stakeholder engagement and have been developed in collaboration with our Staff Networks and with our counterparts at ESTH. Whilst there are several differences between SGH and ESTH we have been able to create a good degree of alignment which will support a more consistent approach across the group in the future and allow for improved monitoring and reporting via our shared committees. All reports and associated actions plans have been presented and discussed via EMT, PMG and Group People Committee. **To meet the publication deadline of 31st October, the Board delegated authority, to approve publication, to the Group People Committee. These reports and actions plans were approved at the Committee on 14th October and therefore the Board are being asked to note the plan.** **WRES Action Plan** This action plan has been developed following review of our WRES 2022 key findings. Whilst we have seen improvements in staff experience in several key areas, there is still a lot of work to be done to create a truly inclusive environment for all. Therefore, this action plan focuses on four key areas on improvement: • Improving Equal Representation in Leadership • Debiasing Recruitment • Improving Career Development Opportunities • Building an Anti-Discrimination Culture Specifically, this will see us introduce initiatives such as; Inclusive Talent Management and Succession Planning, Reciprocal Mentoring, Active Career Conversations for unsuccessful candidates, Management Fundamentals, Debiasing Recruitment and Disciplinary. **WDES Action Plan** This action plan has been developed following review of our WDES 2022 key findings. Positively, we have delivered on all actions set in our 2021 action plan, however, the impact on staff experience has been limited and there is still a significant amount of work needed to improve experiences and perceptions of staff with a disability. Therefore, are we will continue with three primary areas of focus.		

	• Improving Equal Representation of People with a Disability • Building an Anti-Discrimination Culture • Improving Managerial and Organisational Support for Staff with a Disability. Specifically, this will see us introduce initiatives / focus on areas such as; Recruitment Inclusion Specialists, Disability Advice Line, Workplace Adjustments, Guidance and Processes and improved psychological safety so staff feel able to declare and discuss their disability status.
Recommendation:	To meet the publication deadline of 31st October, the Board delegated authority, to approve publication, to the Group People Committee. These reports and actions plans were approved at the Committee on 14th October and therefore the Board is asked to note the plans.
Committee Assurance:	The Committee is also asked that in considering contents of this report, its supporting documents and the discussion at the meeting which of the following assurance rating it would provide to the Trust Board. • **Substantial Assurance:** The report and discussions assured the Committee that there are robust systems of internal controls operating effectively to ensure that quality and safety risks are managed to deliver high quality services and care to patients. • **Reasonable Assurance:** The report and discussions assured the Committee that the system of internal controls is generally adequate and operating effectively but some improvements are required to ensure that quality and safety risks are managed to deliver high quality services and care to patients. • **Limited Assurance:** The report and discussions supported the Committee's conclusion that that the system of internal controls is generally inadequate or not operating effectively and significant improvements were required to ensure that the quality and safety risks are managed effectively to improve the position and ensure that high quality services and care is provided to patients. • **No Assurance:** The report and discussions led the Committee to conclude that there was a fundamental breakdown or absence of core internal controls and systems to enable the Trust to deliver high quality services and care to its patients.
Supports	
Trust Strategic Objective:	Culture
CQC Theme:	Well led
Single Oversight Framework Theme:	
Implications	
Risk:	Our staff do not feel safe to raise concerns and are not empowered to deliver to their best because we fail to build an open and inclusive culture across the organisation which celebrates and embraces our diversity.
Legal/Regulatory:	
Resources:	
Equality and Diversity:	The WDES and WRES Action Plans are designed to close the gap in workplace inequalities.

Previously Considered by:		**Date**	
Appendices:	The Full Reports are available in the Board Reading Room		

St George's University Hospitals
NHS Foundation Trust

Workforce Race Equality Standard (*WRES*) 2022-23 Action Plan

Outstanding care every time

Last modified: 31/10/2022

Introduction

St George's is committed to building a workforce which is valued and whose diversity reflects the communities it serves, enabling it to deliver the best possible healthcare service to those communities.

Everyone who works in the Trust, or applies to work in the Trust, must be treated fairly and valued equally irrespective of age, disability, race, nationality, ethnic or national origin, gender, religion or belief; sexual orientation, marital status, pregnancy and maternity status, domestic circumstances, social and employment status, HIV status, gender reassignment, political affiliation or trade union membership. These are known as *protected characteristics* (see opposite).

The Trust is committed to enabling everyone in the Trust to achieve their full potential in an environment characterised by dignity and mutual respect.

Development of the WRES Action Plan

The following action plan has been developed in collaboration with our BAME Staff Network and following discussions at Executive Management and Trust Management meetings, and in response to issues raised by Black, Asian and Minority Ethnic staff.

This action plan is a 'living document' and will be further developed and refined over the next 12 months to reflect and integrate what we learn about the impact of our interventions, and through additional input from stakeholders around the Trust. This action plan includes actions that we are currently in the process of implementing and also actions that we are planning to implement in the next 12 months.

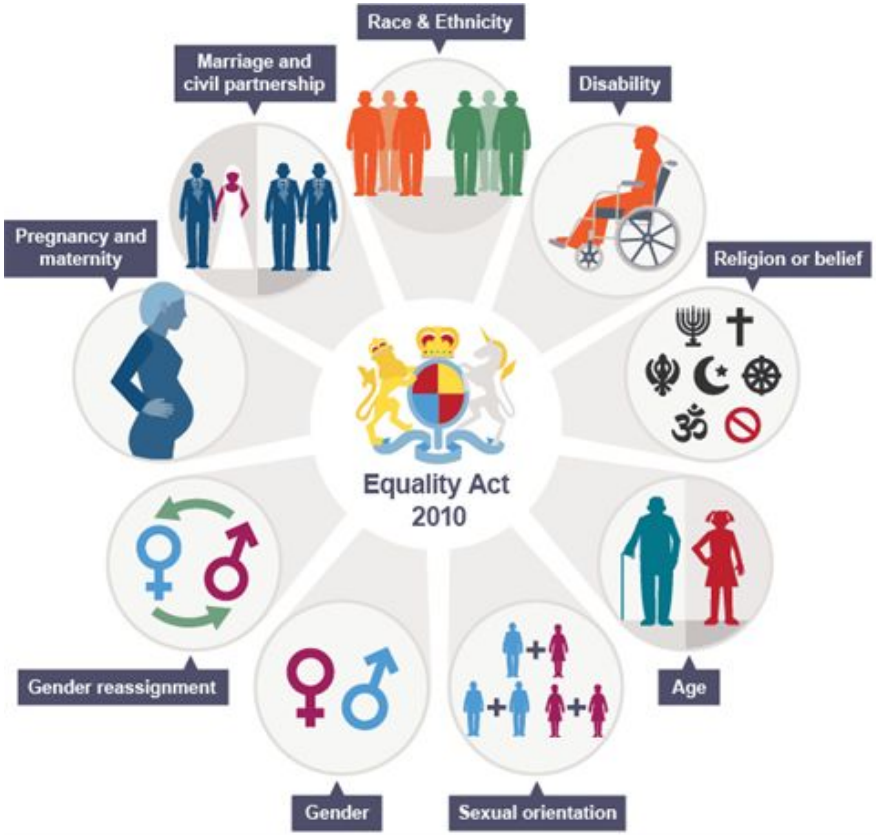


Figure 1: The 9 Protected characteristics enshrined in the Equality Act 2010

Structure of the Action Plan

The action plan will be delivered through a structured programme management approach. The specific actions have been grouped into 4 sections and linked to the relevant WRES indicator/s. Many of the planned actions will contribute toward more than one indicator, so primary and secondary indicators have been listed where relevant.

Section 1: Improving Equal **Representation** in leadership

- **Indicator 1:** % BAME staff in each of the AfC bands 1-9, medical & dental subgroups and VSM, including executive board members compared with the % of staff in the overall workforce
- **Indicator 9:** % difference between the organisation's board voting membership and its overall workforce

Section 2: Debiasing **Recruitment**

- **Indicator 2:** Relative likelihood of BAME staff being appointed from shortlisting across all posts

Section 3: Improving **Career Development** opportuties

- **Indicator 4:** Relative likelihood of staff accessing non-mandatory training and CPD
- **Indicator 7:** % staff believing that the Trust provides equal opportunities for career progression or promotion

Section 4: Building an **Anti-Discrimination** culture

- **Indicator 3:** Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation
- **Indicator 5:** % staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
- **Indicator 6:** % staff experiencing harassment, bullying or abuse from staff in last 12 months
- **Indicator 8:** In the last Percentage of staff who have personally experienced discrimination at work from manager/team leader or other colleagues in the last 12 months

Each section includes one or more projects with associated desired outcomes, actions, executive/operational leads, a projected delivery date and a measure/target.

Project	A title for the project, and the associated indicator. Secondary indicators are listed in brackets.
Desired Outcome	A statement of what the project will achieve or deliver for the trust
Actions	Each project is broken down into one or more key actions. These describe the main milestones, outputs, products or activities to be completed which will result in the desired outcome
Exec/Operational Lead	Each action will be associated with an overall exec level sponsor (SRO) and one or more operational leads who will usually deliver the work involved.
Delivery Date	A projected date for the completion of each action. Potential delays will be escalated and communicated, and dates may need to be adjusted as priorities shift and new ones emerge.
Measure & Target	The measure describes the factor that we will measure (e.g. number of staff trained, or % of BAME staff at Band 8a) and the target sets a goal of how many (e.g. 100 people, or 48%)

In addition, for each indicator, a RAG rating has been applied:

Rag Rating	Definition
Green	No variance between white and *BAME* staff experience
Amber	Some variance between white and BAME staff experience
Red	Significant variance between white and BAME staff experience

Targets and Success Measures

This action plan has been devised to address the challenge of achieving a sustainable difference in closing the gap in workplace inequalities between Black, Asian, Minority Ethnic, and white staff. How successful we are in meeting this challenge will be demonstrated via our progress against each NHS Workforce Race Equality Standard (WRES) indicator and our Staff Survey Results.

Monitoring

To support the delivery and success of this action plan and the desired outcomes, progress will be reported quarterly via our site Culture, Equity and Inclusion Programme Board and our Group People Committee.

Section 1: Improving Equal Representation in Leadership

Indicator 1: % BME staff in each of the AfC bands 1-9, medical & dental subgroups and VSM, including executive board members compared with the % of staff in the overall workforce

Green - Progress 2021/22 and Comparison to London Average	2021	2022	London Average
	47.7%	50.1%	48.1%

Project	Desired Outcome	Actions	Exec Lead	Operational Lead	Delivery Date	Measure / Target
Inclusive Talent Management Approach *Secondary indicator: 7*	Assessing, developing and retaining talent to improve representation of BAME groups	Develop an inclusive approach to talent management that incorporates the Trust's priority needs around the attraction, assessment, development, retention and movement of talent, including for our future leaders identifying as BAME. Ensuring collaboration with SWL partners throughout	G.CPO	HoLT	31/12/23	TBC with design of the talent management approach
		Implement and embed the talent management processes using a phased approach	G.CPO	HoLT, HRPBs	31/12/23	
Inclusive Succession Planning *Secondary indicator: 7*	An inclusive succession planning process where nominated successors are required to demonstrate a strong and authentic commitment to D&I and our values-based behaviours, in order to improve representation of BAME groups	As a strand of the wider approach to Talent Management, develop a succession planning approach, policies and processes for the Trust and trial the process	G.CPO	HoLT	31/12/23	TBC with design of the succession planning approach
		Succession planning to include commitment to D&I and valued based behaviours as core criteria.	G.CPO	HoLT	31/12/23	
		Implement the succession planning process across the Trust, through all Divisions	G.CPO	HoLT, HRBPs	31/12/23	

Indicator 9: % difference between the organisation's board voting membership and its overall workforce

Red - Progress 2021/22 and Comparison to London Average	2021	2022	London Average
	-33.1%	-31.4%	-26.1%

Project	Desired Outcome	Actions	Exec Lead	Operational Lead	Delivery Date	Measure / Target
Executive Team Pledges	The expectation of all staff to be involved in tackling exclusion and discrimination is role modelled	Group and Site Executive Team and Board members to share one personal SMART action which they will take to improve the working lives of those from minority groups	G.CEO	D&I Lead	31/12/22	**100%** of Exec team comply
Board Level Representation	Improved representation at Director and Board level (Band 9, VSM and NEDs)	Ensure that all recruitment activity at Board level considers appropriate means to increase *BAME* representation on the Board and to search from as wide a field as possible for suitably qualified candidates including from under-represented groups.	G.CPO	Deputy CPO (Workforce)	At each recruitment opportunity, reviewed regularly	Increased percentage of *BAME* at Bands 9 and above
Reciprocal Mentoring	Board members (and VSMs) build a stronger understanding of the issues faced by BAME staff	Board members and VSMs to start and maintain reciprocal mentoring relationships with BAME staff, with support around recruitment, pairing, training and sustaining quality mentoring relationships.	G.CPO	D&I Lead, HoCT	Sep 2023	No. of mentoring relationships; Feedback from mentors and mentees

Section 2: Debiasing Recruitment

Indicator 2: Relative likelihood of White applicants being appointed from shortlisting compared to BAME applicants

Amber - Progress 2021/22 and Comparison to London Average	2021	2022	London Average
	1.47	1.26	1.62

Project	Desired Outcome	Actions	Exec Lead	Operational Lead	Delivery Date	Measure / Target
Training for Interviewees *Secondary indicator: 1*	BAME staff have access to interview training to boost their performance when applying for roles.	Develop a short course and supporting written guidance on 'preparing for job interviews' and ensure it is routinely offered year round.	G.CPO	HoCT, HoLT	31/02/23	Increased internal hire rate / promotion of BAME staff and feedback via Assured Decision-Making reporting forms.
Debiasing Recruitment Process *Secondary indicators: 1,7*	Improved clarify and robustness within the interview process, via clear scoring metrics and model answers.	Review and update recruitment and selection (R&S) guidance, including R&S training, to ensure there is a clear and consistent approach to the application of scoring criteria/metrics within the interview process. Including example of model answers.	G.CPO	D&I Lead, SWL Hub	01/02/23	Measured via the results of RIS Post Interview Feedback Form
Recruitment Inclusion Specialist (RIS) Scheme	Improved candidate experience at interview and increased transparency in decision making, leading to increased representation at senior levels	Continue to manage and monitor the RIS scheme, with regular reporting on compliance via monthly reviews with the Recruitment Hub, and through the Culture, Equity and Inclusion (CEI) monthly Programme Board.	G.CPO	D&I Lead, SWL Hub	Ongoing	Maintain 85%+ compliance with the RIS scheme
		Expand the RIS scheme to include recruitments for Band 6 roles. This will include training additional RISs (and enabling wider participation as a RIS, including from white staff).	G.CPO	D&I Lead, SWL Hub	30/04/23	200 RIS members trained (in total)

Section 3: Improving Career Development Opportunities

Indicator 4: Relative likelihood of staff accessing non-mandatory training and CPD

Green - Progress 2021/22 and Comparison to London Average	2021	2022	London Average
	1.03	0.98	0.95

Indicator 7: % BAME staff believing that the Trust provides equal opportunities for career progression or promotion

Amber - Progress 2021/22 and Comparison to London Average	2020	2021	London Average
	41.1	42.1%	44.6%

Project	Desired Outcome	Actions	Exec Lead	Operational Lead	Delivery Date	Measure / Target
ACCs for unsuccessful candidates *Secondary indicators: 1,2*	Internal BAME staff who are not successful at interview are offered a formal 1:1 feedback session with panel chair	Pilot Active Career Conversations (ACC) – a supportive, action focused feedback session between panel chairs and unsuccessful BAME interviewees	G.CPO	D&I Lead, HoL&T	01/02/23	Successful pilot completed within one division
		Launch Active Career Conversations (ACC)– a supportive, action focused feedback session between panel chairs and unsuccessful BAME interviewees	G.CPO	D&I Lead, HoLT	01/04/23	By end of 2023, 85% of un-successful candidates offered an *ACC*
Coaching & Mentoring *Secondary indicators: 1,2*	BAME staff have greater access to coaching and mentoring	Develop and implement a career coaching and mentoring offer (including policies and processes) that is connected to the performance appraisal process, to be made available for BAME staff	G.CPO	HoCT,	30/06/23	By end of June 2023, 25 BAME staff are in coaching/mentoring relationships
		Create and build up list/bank of internal career coaches/mentors, and train new/existing coaches/mentors as necessary	G.CPO	HoCT	30/09/23	
Personal Development and Career Planning by Managers	Improved personal development and career planning for employees	Clarify line manager expectations and responsibilities (as part of a Management Fundamentals) in relation to supporting staff to develop meaningful PDPs as a part of the annual appraisal process (including updating appraisal training)	G.CPO	HoCT	31/03/23	By the end of 2023, **60%** of PDR records include evidence of career focused conversations (beyond the usual
		Revise Performance Development Review Process to ensure that there is a structured career development section in place	G.CPO	HoCT, HoLT	31/03/23	

		Develop guidance and training module for managers to conduct career planning discussions (which may be part of the performance review discussion, but not exclusively)	G.CPO	HoCT HoLT	31/12/23	'development conversation') *[Measurement will require new LMS functionality]*

Section 4: Building an Anti-Discrimination Culture

Indicator 3: Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation

Red - Progress 2021/22 and Comparison to London Average	2021	2022	London Average
	1.82	1.65	1.54

Project	Desired Outcome	Actions	Exec Lead	Operational Lead	Delivery Date	Measure / Target
Debiasing Disciplinary Process	Reduce the number of staff put forward for disciplinary action via improved understand of the thresholds for disciplinary action	Explore *Case Review Panel* data to better understand historic and emerging themes, and better support individuals involved. With a focus on; - Early interventions - Support based action, such as facilitated discussions / mediation - Building an increased organisational understanding of the disciplinary process and thresholds	G.CPO	HoER	TBC	Subject to ER Review Recommendations
Reduce Reliance on Disciplinary *Secondary indicator: 2* *(this links to the NHS National WRES strategy)*	Inappropriate managerial processes are replaced with person centred learning processes	Develop a new approach and process to respond to serious or chronic performance issues, thus reducing our dependency on formal disciplinaries (to be used only for extreme cases, e.g. theft, violence and patient safety breaches)	G.CPO	HoER,	31/02/23	25% reduction in number of formal disciplinaries by end of 2024
		Implement new approach and processes as designed	G.CPO	HoER	31/04/23	
		Review process for applying for and awarding secondments, ensuring that it is transparent, unbiased and links with successful planning framework.	G.CPO	D. GCPO (wkforce)	TBC	Delivery date and measure to be confirmed following D,GCPO starting in post.
		Implement any recommended changes, including effective staff engagement and communications plan.	G.CPO	D. GCPO (wkforce)	TBC	

Indicator 5: % staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

Green- Progress 2021/22 and Comparison to London Average	2020	2021	London Average
	27.3%	23.3%	31.1%

Indicator 6: % staff experiencing harassment, bullying or abuse from staff in last 12 months

Amber - Progress 2021/22 and Comparison to London Average	2020	2021	London Average
	30.1%	25.9%	29.8%

Indicator 8: % of staff who have personally experienced discrimination at work from manager or other colleagues in the last 12 months

Amber- Progress 2021/22 and Comparison to London Average	2020	2021	London Average
	18.0%	16.6%	17.3

Project	Desired Outcome	Actions	Exec Lead	Operational Lead	Delivery Date	Measure / Target
Embedding our Values Based Behaviours	Clear expectations of behaviour are communicated and understood by all staff, supporting development of more inclusive day to day behaviours and Trust culture	Values based behaviours are integrated throughout the employee lifecycle including: • Values based recruitment • Corporate and local Induction • Values based appraisal • Talent management	D.CPO (Culture)	AD. C&OD	31/10/23	Improved staff survey scores: feeling valued, discrimination, B&H, and engagement
		Incorporating our values-based behaviour into all management and leadership development interventions, including the Management Fundamentals Toolkit and our future Group-wide approach to multi-disciplinary leadership development.	D.CPO (Culture)	AD. C&OD	31/04/24	All existing and new management interventions are value-based
		Supporting priority local team interventions on culture development projects, including local translation and integration of our values-based behaviours	D. CPO (Culture)	OD Leads, HRBPs	Ongoing	Improvement in local staff survey results and other measures TBD for each intervention.
Supporting Staff to Raise Concerns	Empowering staff to report D&I concerns, and feel safe to do so	Regular review and triangulation of qualitative and quantitative data to identify emerging D&I related issues, e.g. working with FTSU, H&S and Security teams in response to incidents/Datix	G.CCAO	D&I Lead, F2SU Lead	Ongoing	Improved experience of staff as measured by relevant staff survey results
		Clarify and reinforce existing channels for raising concerns	G.CCAO	D&I Lead, F2SU Lead	Ongoing	

NHS
St George's University Hospitals
NHS Foundation Trust

Workforce Disability Equality Standard (WDES)

Action Plan 2022-23

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

Terminology

For the purposes of this report and in line with national metrics, the term ‘disabled staff’ and ‘non-disabled staff’ are used to describe the two groups of staff referred to in this report. St George’s and its staff encourages the use of ‘staff *with* a disability’ and ‘staff without a disability’ respectively as preferred terminology to foster better inclusion, reduce disability associated stigma and recognise the disability is not one’s identity but rather something people live with.

Disability is a Core Strand of Our D&I Agenda

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

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

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

Our Ambition

Serving a diverse population of 1.3 million and with over 9000 employees, St George's University Hospitals Trust is the largest healthcare provider in South West London. It is crucial that the diversity of our workforce reflects the diversity of the communities we serve, and we are pleased that in 2022 the number of Electronic Staff Record (ESR) declarations for people with a disability has increased. We will continue to reinforce the importance of declaring one's disability on ESR to ensure adequate representation, resource allocation and support and importantly, reduce stigma by building inclusion.

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

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

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

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

NHS
St George's University Hospitals
NHS Foundation Trust

Background

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

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

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

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

Looking Forward to 2022-23

Identifying Priority Themes

Based on our experiences of delivering last year's WDES Action Plan (2021/2022) as outlined in the main report, and the analysis of our WDES metrics within it, it is important that key foundations of support and awareness are laid to ensure continued development of staff and line management capacity in these areas as well as building on the success of last year.

In addition, increased visibility of this community will be critical to success in working towards workplace equality and a better experience of working at St George's.

Though our staff with a disability are recognised as a community that empowers and enriches our workforce, they often feel overlooked and misunderstood. Maintaining an open dialogue with our staff, responding appropriately and taking action will help ensure that progress is purposeful, and these staff members feel valued.

To better understand and tackle the workplace inequalities experienced by our staff with a disability, we must continue to work with key stakeholders to examine policies, practices and training provisions that affect them.

Monitoring

To support the delivery and success of this action plan and the desired outcomes, progress will be reported quarterly via our site Culture, Equity and Inclusion Programme Board and our Group People Committee.

Targets and Success Measures

This action plan has been devised to address the challenge of achieving a sustainable difference in closing the gap in workplace inequalities between people with a disability and those without a disability. How successful we are in meeting this challenge will be demonstrated via our progress against each NHS Workforce Disability Equality Standard (WDES) indicator and our Staff Survey Results

Structure of the Action Plan

The action plan will be delivered through a structured programme management approach. The specific actions have been grouped into 3 sections and linked to the relevant WDES indicator/s. Many of the planned actions will contribute toward more than one indicator, so primary and secondary indicators have been listed where relevant.

NHS
St George's University Hospitals
NHS Foundation Trust

Section 1: Improving Equal **Representation** of People with a Disability

- **Metric 1:** % Disabled staff in AfC pay-bands (or medical and dental subgroups and VSMs) compared with the percentage of staff in the overall workforce (for both clinical and non-clinical groups)
- **Metric 2:** Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts
- **Metric 10:** % difference between the organisation's Board voting membership and its organisation's overall workforce

Section 2: Building an **Anti-Discrimination** Culture

- **Metric 3:** Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure
- **Metric 4:** Staff Survey Q13: % Disabled staff compared to non-disabled staff: a) experiencing harassment, bullying or abuse from different groups; and b) saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it
- **Metric 5:** Staff Survey Q14: % Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion

Section 3: Improving **Managerial and Organisational Support** for Staff with a Disability

- **Metric 6:** Staff Survey Q11: % Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties
- **Metric 7:** Staff Survey Q5: % Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work
- **Metric 8:** Staff Survey Q28b: % Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work
- **Metric 9:** a) The staff engagement score for Disabled staff, compared to non-disabled staff; and b) Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard?

Each section includes one or more projects with associated desired outcomes, actions, executive/operational leads, a projected delivery date and a measure/target.

Project	A title for the project
Desired Outcome	A statement of what the project will achieve or deliver for the trust
Actions	Each project is broken down into one or more key actions. These describe the main milestones, outputs, products or activities to be completed which will result in the desired outcome
Exec/Operational Lead	Each action will be associated with an overall exec level sponsor (SRO) and one or more operational leads who will usually deliver the work involved.
Delivery Date	A projected date for the completion of each action. Potential delays will be escalated and communicated, and dates may need to be adjusted as priorities shift and new ones emerge.
Measure & Target	The measure describes the factor that we will measure (e.g. number of staff trained, or % of Disabled staff at Band 8a) and the target sets a goal of how many (e.g. 100 people, or 48%)

In addition, for each indicator, a RAG rating has been applied:

Rag Rating	Definition
Green	No variance between disabled and non-disabled staff experience
Amber	Some variance between disabled and non-disabled staff experience
Red	Significant variance between disabled and non-disabled staff experience

St George's University Hospitals NHS Foundation Trust

WDES Action Plan 2022/23

Section 1: Improving Equal Representation of people with a Disability

Metric 1: % Disabled staff in AfC pay-bands (or medical and dental subgroups and VSMs) compared with the percentage of staff in the overall workforce (for both clinical and non-clinical groups)

	2021	2022
Green - Progress 2021/22	2%	3%

Metric 2: Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts

	2021	2022
Red - Progress 2021/22	1.08	1.21

Metric 10: % difference between the organisation's Board voting membership and its organisation's overall workforce

	2021	2022
Green - Progress 2021/22	-2%	6%

Project	Desired Outcome	Actions	Exec Lead	Operational Lead	Delivery Date	Measure / Target
Increase Declaration Rates	Staff feel safe and supported to share their disability status in the workplace, leading to more accurate ESR declaration rates.	Develop a communications plan that amplifies the voices and experiences of staff with disabilities in the workplace. Highlighting the barriers that can be face and where successful adjustments and learning have taken place to improve staff experience.	SGH CN	D&I Lead	31/03/23	Increased declaration rate on ESR
		Work with Staff Engagement Lead to promote importance of declaration as part of the staff survey.	SGH CN	D&I Lead	31/03/23	Increased declaration rate on ESR

		Contact all staff to highlight the importance of ensuring their ESR is up to date and includes information in relation to protected characteristics.	SGH MD	D&I Lead	31/03/23	Increased declaration rate on ESR
Recruitment Inclusion Specialist Scheme	Improved candidate experience at interview and increased transparency in decision making, leading to increased representation at senior levels	Working with current RIS', SWL Hub and recruiting managers to reinforce that the RIS scheme is intended to drive inclusive recruitment practices and reduce bias **for all protected characteristics.**	SGH MD	D&I Lead	31/03/23	Maintain 85%+ compliance with the RIS scheme
		Review current RIS training material to reinforce emphasis on all protected characteristics, particularly disability. Specifically ensuring all newly trained RISs; • Are aware the Trust commitments in relation to the Disability Confident Scheme • Ensure adjustments are offered within the recruitment process as appropriate	SGH MD	D&I Lead	31/01/23	Feedback from participants on quality and relevance of training
		As part of the RIS criteria expansion, staff with disabilities and/or other protected characteristics will be encouraged and supported to become a trained Recruitment Inclusion Specialist.	SGH MD	D&I Lead	31/04/23	200 RIS members trained (in total), with a minimum of 5% with a declared disability

St George's University Hospitals NHS Foundation Trust

Section 2: Building an Anti-Discrimination Culture

Metric 3: Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure

	2021	2022
Green - Progress 2021/22 and Comparison to London Average	-	4.44

Metric 4: Staff Survey Q13: % Disabled staff compared to non-disabled staff: a) experiencing harassment, bullying or abuse from different groups; and b) saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it

	2021	2022
Amber - Progress 2021/22	a)35.8% / b)23.5%	a)34.8% / b)21.1%

Metric 5: Staff Survey Q14: % Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion

	2021	2022
Red - Progress 2021/22	42.7%	40.1%

Project	Desired Outcome	Actions	Exec Lead	Operational Lead	Delivery Date	Measure / Target
Disability Awareness for all staff	Improved awareness and support, leading to staff with disabilities feeling safe, supported, and valued colleagues and the organisation.	Promote new eLearning module to ensure embedded across organisation	D.GCPO (Culture)	D&I Lead	Ongoing	100% compliance by April 2023
		Complete annual review of feedback from Disability Awareness module	D.GCPO (Culture)	D&I Lead	31/12/24	Ideas and recommendations for improving the training
		Work with staff network and Freedom to Speak Up to conduct bespoke team discussions around disability inclusion; Attending local departmental meetings to promote disability inclusion and awareness	D.CPO (Culture)	D&I Lead, FTSU Guardian	31/03/23	Improved experience of staff as measured by relevant staff survey results

Individual Support	Staff with disabilities feel they have a safe space to share their experience and receive impartial, unbiased advice and guidance	Provide 121 support and guidance to staff members with disabilities in navigating complex processes in relation to their disability and workplace adjustments.	D.CPO (Culture)	D&I Lead	Ongoing	Improved experience of staff as measured by relevant staff survey results
		Working in collaboration with ESTH to explore introducing Disability Advice Line	D.CPO	D&I Lead	31/04/23	
Embedding our Values Based Behaviours	Clear expectations of behaviour are communicated and understood by all staff, supporting development of more inclusive day to day behaviours and Trust culture	Values based behaviours are integrated throughout the employee lifecycle including: • Values based recruitment • Corporate and local Induction • Values based appraisal • Talent management	D.CPO (Culture)	AD. C&OD	31/10/23	Improved staff survey scores: feeling valued, discrimination, B&H, and engagement
		Incorporating our values-based behaviour into all management and leadership development interventions, including the Management Fundamentals Toolkit and our future Group-wide approach to multi-disciplinary leadership development.	D.CPO (Culture)	AD. C&OD	31/04/24	All existing and new management interventions are value-based
		Supporting priority local team interventions on culture development projects, including local translation and integration of our values-based behaviours	D.CPO (Culture)	AD. C&OD	Ongoing	Improvement in local staff survey results and other measures TBD for each intervention.
Supporting Staff to Raise Concerns	Empowering staff to speak up and report D&I concerns, and feeling safe to do so	Regular review and triangulation of qualitative and quantitative data to identify emerging D&I related issues, e.g. working with FTSU, H&S and Security teams in response to incidents/Datix	G.CCAO	D&I Lead, F2SU Lead	Ongoing	Improved experience of staff as measured by relevant staff survey results
		Clarify and reinforce existing channels for raising concerns	G.CCAO	D&I Lead, F2SU Lead	Ongoing	

St George's University Hospitals NHS Foundation Trust

Section3: Improving Managerial and Organisational Support for Disabled Staff

Metric 6: Staff Survey Q11: % Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties

	2020	2021
Red - Progress 2021/22	35.1%	35.2%

Metric 7: Staff Survey Q5: % Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work

	2020	2021
Red - Progress 2021/22	34.9%	31.1%

Metric 8: Staff Survey Q28b: % Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work

	2020	2021
Red - Progress 2021/22	71.5%	63.0%

Metric 9: a) The staff engagement score for Disabled staff, compared to non-disabled staff; and b) Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard?

	2020	2021
Red - Progress 2021/22	6.6	6.2

Project	Desired Outcome	Actions	Exec Lead	Operational Lead	Delivery Date	Measure / Target
Guidance and Processes	Staff feel safe to access support, and our support teams provide clear and consistent guidance to staff in relation to disability and adjustments in the workplace	Work with OH and staff networks to identify gaps in support and reduce stigma with accessing OH and other support services.	G.CPO	D&I Lead, OH Team	31/07/23	Recording of reasonable adjustment requests; Feedback on experience from staff; Improved staff survey indicators
		Work with key teams that are involved in disability inclusion to ensure they are appropriately trained	G.CPO	D&I Lead, SGH HRD	31/07/23	
		Review and update current Employment of Disabled People policy	G.CPO	D&I Lead	31/12/22	

Calibre programme	Improved understanding and awareness of the types of disabilities and how these impact members of staff	Support Calibre 2022 graduates to use their influence to further the learning of non-Disabled staff and help raise awareness of disabilities in the workplace.	G.CPO	D&I Lead	28/02/23	Feedback on progress from graduates
Line Manager Training on Reasonable Adjustments	Improve staff satisfaction with the level of workplace adjustment(s) implemented to support them to carry out their work	Promote new eLearning modules to ensure embedded across organisation.	G.CPO	D&I Team	31/04/23	100% compliance by April 2023
		Complete annual review of feedback from Essential Workplace Adjustments e-Learning modules.	G.CPO	D&I Team	31/04/23	Ideas and recommendations for improving the training; Feedback on the quality of service form staff
		Review Essential Workplace Adjustments guidance pack and incorporate feedback/learn lessons from staff engagement with the content.	G.CPO	D&I Team	31/12/23	
Executive Team Pledges	The expectation of all staff to be involved in tackling exclusion and discrimination is role modelled	Group and Site Executive Team and Board members to share one personal SMART action which they will take to improve the working lives of those from minority groups	G.CEO	D&I Lead	31/12/22	**100%** of Exec team comply

Meeting Title:	**Trust Board**		
Date:	3 November 2022	**Agenda No**	**3.1.2**
Report Title:	**Nursing and Allied Health Professional (AHP) Revalidation: Governance and Monitoring**		
Lead Director/ Manager:	Arlene Wellman, Group Chief Nurse and Director of Infection Prevention and Control		
Report Author:	Lorna Bramwells, Director of Nursing and AHP for Cancer and Clinical Services (ESTH) Sharon Suggett, Head of Nursing for Workforce and Professional Standards (SGUH) Alison Benincasa, Director of Quality Governance and Compliance (Group)		
Presented for:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify)		
Executive Summary:	This report provides assurance in relation to the governance and monitoring mechanisms for the continuing registration of nurses, nurse associates, midwives and allied health professionals. There is a system in place at each Trust to monitor revalidation and renewal of professional registrations and revalidation for registered nurses, nursing associates and allied health professionals, although at SGUH the system for monitoring allied health professional registrations requires strengthening. In line with the Revalidation Policy for both Trusts the monitoring of revalidation and the renewal of professional registrations is managed through the Human Resources department and line managers and is supported by ESR. The current position for revalidation is as follows: ➢ ESTH: There are 2 current lapses in NMC registration; 1 RN on maternity leave and who will be leaving the Trust; and 1 AHP on a career break who will re-register prior to return to work ➢ SGUH: There is no current record of lapses in NMC registration. Information on revalidation and NMC pin expiry is overridden as the system is updated. The HR Workforce Information Team has been instructed to maintain monthly records. The review of the governance and monitoring processes for each Trust has identified the following improvement actions as set out in the table overleaf.		

	Issue	**Action Required**	**By who**	**By when**
	1. ESTH: Revalidation Policy requires review	1.1 Review ESTH Policy and align with SGUH to ensure there is one Revalidation Policy across the Group	ESTH Human Resources	30.11.2022
	2. ESTH and SGUH: Lack of standardised information for staff revalidation monitoring	2.1 For monitoring purposes show staff information of those who fail to revalidate by total number, band and profession, including allied health professionals for SGUH 2.2 Identify themes (if known) for reasons not to revalidate	ESTH and SGUH Human Resources	31.10.2022 and then monthly going forward
	3. SGUH: Lack of centrally held record on revalidation and NMC pin expiry	3.1 Maintain monthly information on revalidation and NMC pin expiry (as this information currently gets overridden as the system is updated) to provide accurate monthly reporting 3.2 Maintain central records of all nurses failing to re-register in addition to reasons for this, relevant action plans and NMC referrals in relation to non re-registration with the NMC	SGUH Workforce Information Team	31.10.2022 and then monthly going forward
Recommendation:	The Committee is asked to receive the Revalidation paper for assurance and make any necessary recommendations.			
Supports				
Trust Strategic Objective:	All			
CQC Theme:	All			
Single Oversight Framework Theme:	Leadership and Improvement Capability (Well-led)			
Implications				
Risk:	None			
Legal/Regulatory:	Enforcement undertakings applicable to ESTH and SGUH Compliance with the Health and Social Care Act 2008 (Regulations 2014) and CQC Registration Regulations			
Resources:	N/A			
Equality and Diversity:	No issues to consider			

Previously Considered by:	People Committee in Common	**Date**	14.10.2022
Appendices:	N/A		

gesh

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

Registrants Revalidation – Governance and Monitoring

Arlene Wellman, Group Chief Nursing Officer and Director of infection Prevention and control

3 November 2022

Executive Summary

This report provides assurance in relation to the governance and monitoring mechanisms for the continuing registration of nurses, nurse associates, midwives and allied health professionals.

There is a system in place at each Trust to monitor revalidation and renewal of professional registrations and revalidation for registered nurses, nursing associates and allied health professionals, although at SGUH the system for monitoring allied health professional registrations requires strengthening.

In line with the Revalidation Policy for both Trusts the monitoring of revalidation and the renewal of professional registrations is managed through the Human Resources department and line managers and is supported by ESR.

The current position for revalidation is as follows:

- ESTH: There are 2 current lapses in NMC registration; 1 RN on maternity leave and who will be leaving the Trust; and 1 AHP on a career break who will re-register prior to return to work

- SGUH: There is no current record of lapses in NMC registration. Information on revalidation and NMC pin expiry is overridden as the system is updated. The HR Workforce Information Team has been instructed to maintain monthly records.

Introduction

The Nursing and Midwifery Council (NMC) introduced a new process of revalidation in April 2016. Every registrant must complete the revalidation process every three years and pay for the annual retention fee every year (renewal date is yearly and dependent on registrants' entry to the NMC register) to remain on the NMC register.

The purpose of revalidation is to improve public protection by making sure that all registrants (registered nurse associates; midwives and registered nurses) remain fit to practice throughout their career. Revalidation builds on existing renewal requirements by introducing new elements which encourage nurses, nurse associates and midwives to reflect on the role of the Code in their practice and to demonstrate that they are 'living' the standards set out within it.

Nurses, nursing associates, midwives must fulfil the requirements of revalidation to maintain their NMC registration. Revalidation:

- reinforces the registrant's duty to maintain fitness to practice within their own scope of practice
- encourages registrants to incorporate 'the Code' in day-to-day practice and personal development
- encourages engagement in professional networks and discussions and can help to reduce professional isolation
- enhances employer engagement in NMC regulatory standards and increases access and participation in appraisals and continuing professional development.

Allied health professions have set times to renew throughout the year with Health and Care Professions Council (HCPC**)** which are profession specific. Registrants renew their registration online every two years and make a professional declaration. There is not currently a revalidation system in place as there is for nursing, nurses associates and midwives.

Revalidation Requirements

All registrants are notified directly by the NMC (with three months notice) of when the revalidation is due.

During the revalidation process, all registrants must;

- obtain five pieces of practice related feedback
- provide five written reflections
- complete 35 hours of continuous professional development (CPD) – including 20 hours of participatory CPD
- undertake a reflective discussion with another NMC registrant
- obtain confirmation that revalidation requirements have been met from an appropriate person
- complete 900 hours of practice (nurse and midwife)
- pay the annual NMC registration fee
- provide a declaration of health and character
- provide proof of professional indemnity

Allied health professions have set times to renew throughout the year with Health and Care Professions Council (HCPC**)** which are profession specific. Registrants renew their registration online every two years and make a professional declaration.

Failure to Maintain NMC/ HCPC Registration

- If a registrant's registration has lapsed, the relevant HR Advisor informs the Head of Nursing/Divisional Director of Nursing immediately

- The Revalidation Policy at each Trust will be followed if an individual fails to meet the requirements of their professional body to re-register or revalidate at the required time for all relevant parts of the register required

- The practitioner will cease working and will not be eligible for continued employment as a registered practitioner until confirmation of valid registration has been received. In addition, they will not be protected by their professional indemnity insurance or the Trust's Public Liability insurance

- The individual maybe suspended without pay or depending on the circumstances may be asked to work in an alternative role until registration is confirmed as renewed, which should not last longer than 48 hours

- Confirmation of renewal will be carried out by the manager telephoning, writing, or checking the details online

- Failure to maintain registration or revalidate correctly could result in disciplinary or capability action being taken. This could include suspension without pay and/or dismissal for gross misconduct depending on the circumstances. In accordance with the appropriate procedure, a senior manager will decide on the appropriate course of action

- Any breach must be brought to the attention of the Chief/Deputy Chief Nurse as soon as possible, as it is illegal to allow a nurse, nursing associate or midwife to work without all relevant registration and line managers will be held to account for any actions and omissions in this regard.

Headcount: Registered Nurses, Nurses Associates, Midwives and AHPs

ESTH		
Band	**AHP Headcount**	**Nursing Headcount**
Band 4	-	30
Band 5	75	674
Band 6	208	667
Band 7	186	483
Band 8a	62	148
Band 8b	2	22
Band 8c	7	14
Band 8d	-	10
Band 9	-	1
Other - non AfC	5	1
VSM	-	2
Grand Total	**545**	**2052**

SGUH		
Band	**AHP Headcount**	**Nursing Headcount**
Band 4	TBC	21
Band 5		1078
Band 6		1005
Band 7		537
Band 8a		147
Band 8b		21
Band 8c		22
Band 8d		8
Band 9		-
Other - non AfC		-
VSM		1
Grand Total		**2840**

Professional Assurance

The professional assurance process for ESTH is:

- A nominated Director of Nursing receives a monthly workforce report to review all cases where revalidation is not showing as being renewed. This is then sent to relevant to Directors of Nursing and to review, manage and follow trust policy accordingly
- The Corporate Nursing team holds a monthly assurance meeting (a sub-group of the monthly Nursing and Midwifery Committee) with Divisional Directors of Nursing, the Director of Midwifery to monitor cases referred to the NMC
- A quarterly meeting is held with Corporate Nursing, a nominated Director of Nursing and HR to review all disciplinary cases involving nurses and AHP to gain assurance of processes of capability and disciplinary management and all NMC referrals
- Quarterly meetings are held with the NMC, Corporate Nursing and nominated DoN to ensure that the relevant action has been taken on a case-by-case basis; to determine how the case is progressing and if there is further information that the NMC require

The professional assurance process for SGUH is:

- The Corporate Nursing team holds monthly 'Professional Standards Meetings' with Divisional Directors of Nursing, the Director of Midwifery and Human Resources, to monitor cases involving professional registration/ revalidation; capability; disciplinary and all NMC referral cases
- Bi-monthly meetings are held with the NMC to ensure that the relevant action has been taken on a case-by-case basis; to determine how the case is progressing and if there is further information that the NMC require.

Issues Arising and Actions Required

Issue	Action Required	By who	By when
1. ESTH: Revalidation Policy requires review	1.1 Review ESTH Policy and align with SGUH to ensure there is one Revalidation Policy across the Group	ESTH Human Resources	30.11.2022
2. ESTH and SGUH: Lack of standardised information for staff revalidation monitoring	2.1 For monitoring purposes show staff information of those who fail to revalidate by total number, band and profession, including allied health professionals for SGUH 2.2 Identify themes (if known) for reasons not to revalidate	ESTH and SGUH Human Resources	31.10.2022 and then monthly going forward
3. SGUH: Lack of centrally held record on revalidation and NMC pin expiry	3.1 Maintain monthly information on revalidation and NMC pin expiry (as this information currently gets overridden as the system is updated) to provide accurate monthly reporting 3.2 Maintain central records of all nurses failing to re-register in addition to reasons for this, relevant action plans and NMC referrals in relation to non re-registration with the NMC	SGUH Workforce Information Team	31.10.2022 and then monthly going forward

Meeting Title:	**Trust Board**		
Date:	3 November 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 27 October 2022.		
Recommendation:	The Board is asked to note the report of the Committee's meeting held on 27 October 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		

Outstanding care every time

St George's University Hospitals NHS Foundation Trust

Audit Committee Report
Trust Board, 3 November 2022

Matters for the Board's attention

The Audit Committee met on 27 October 2022 and agreed to bring the following matters to the attention of the Board.

1. Internal Auditors Reports

The Committee considered the Internal Audit Progress Report and Audit Recommendation Tracker and noted that there were 17 outstanding recommendations detailed in the actions tracker and that revised dates with updates had been provided in all cases except for actions relating to RTT and Temporary Staffing audit. The Committee noted its concerns with regards to:

- Delays with management responding to draft reports and set out that it expected to see progress in meeting the KPI of a 10-day response time.
- The lack of timely responses to IA regarding the progress on actions and the repeated revisions to some due dates.

The Committee also requested an update to its January meeting to follow-up on the actions taken in relation to the Consent Audit, and in particular its aspiration that recommendations are expedited, where feasibly possible. The Committee would also receive an update in the Financial Sustainability Audit at its January meeting and requested in the meantime that it be alerted if any issues arise from the review due to complete om 30 November 2022.

The Committee considered the following reports from internal auditors:

- DSP Toolkit Part 2 (2021/22) (Reasonable Assurance)
- Procurement (Limited Assurance)
- Rostering of Allied Health Professionals (Reasonable Assurance)
- Rostering of Junior Medical Staff (Reasonable Assurance)

Of the four internal audits reviewed, three were rated as '*reasonable assurance'*. With regards to DSP Toolkits and Rostering of Allied Health Professionals the Committee was assured that the management had reasonable plans in place to address any outstanding issues.

In relation to Procurement, the Committee noted that the key reason for the limited assurance rating was due to a lack of evidence that the tender or quotation process had been applied as per the policy. The Committee expressed concern that the management comments lacked a sense of urgency given the overall rating and requested an update at the January meeting to confirm that all actions have been undertaken. The Group Chief Finance Officer stated that a formal review would also be undertaken to understand the root cause of why evidence regarding competitive tendering was not available to the auditors at the time of request and noted that while it was not helpful if the evidence subsequently came to light, it would demonstrate that the control had not completely broken down. He also reminded the Committee that the timing of the audit may have contributed to the issue of missing evidence as the team were affected by the change to a new system. The GCFO informed the Committee that he would also share the report with his SWL Procurement peers.

With regards to Rostering of Junior Medical Staff, the Committee noted that the rostering team were doing well with the resources currently in place and that the overall assessment was fair in terms of current operations. However, it was noted that the arrangements within the Trust were not where they needed to be and that the impact on the experience of junior

doctors was unlikely to improve significantly until the electronic rota system was implemented. A wider discussion would be taken through the People Committee.

The Committee also considered a report setting out the themes arising from the review of governance-related recommendations from 2021/22, which had been undertaken by the GCCAO. The Committee noted that out of a total of 33 governance-related recommendations, 20 related to the need to update current policies either because the policy had passed its review date or to include specific new or additional relevant information, or to ensure that the content of existing policies were followed in practice. The Committee was assured that individual teams were taking actions to address the specific issues identified, and that wider work was in progress at SGUH by the Corporate Governance Team to monitor and track policies that were nearing the scheduled review date and that each of the Board Committees considered a bi-annual update report on the policies with its respective area. A wider piece of work looking at policies across the Group was currently being undertaken as part of the move to a single governance function for both Trusts. A number of HR policies were out of date across both Trusts and a prioritisation exercise was currently being undertaken to address the backlog by January 2023.

2. Counter Fraud Quarterly Report

The Committee considered its regular reports on progress with current counter fraud cases under investigation and noted that the Trust would be taking part in a data matching exercise called the National Fraud Initiative, which involves payroll data and personal identifiers such as contact details being provided to other NHS Trusts and bodies responsible for auditing and administering public funds.

3. Internal Compliance and Assurance

The Committee considered regular reports on:

- Breaches and waivers for Q2 2022/23, noting that breaches were down in the last quarter and that the number of waivers remained low.
- Losses and compensation payments.
- Aged debt, noting that the outsourced service to SBS was not working as it should be and that the matter had been escalated.

4. Corporate governance compliance

The Committee received its annual update on Trust compliance with the Managing Declarations of Interest Policy. The Committee noted the good work and progress to date, in particular, that:

- In 2021/22 the Trust achieved 54% compliance. This compared favourably to 25% compliance in 2020/21 (a year affected by Covid) and 45% compliance in 2019/20.
- The Trust was currently reporting 34% compliance at the mid-way point for 2022/23 which was an improvement compared to the mid-way point in the previous year. The new system now operating in SGUH meant that it was quicker and easier to comply.
- The intention was to have a Group wide declarations of interest policy and Committee members were invited to share any comments on the draft following the meeting. The Group-wide policy would be brought to the Committee for formal sign at its meeting in January 2023.

5. Joint Internal Audit Tender

The Committee received an update on the plans for procuring a common internal audit service across the Group, noting the change in context and developments since its last meeting. The Committee agreed:

- That the Trust should participate in a South West London-wide tender for both internal audit and counter fraud services and noted that the timings were challenging but manageable.

- to delegate authority to the Chair of the Committee to agree any final changes to the tender document which would be issued w/c 31 October 2022.
- the composition of the panel to review tenders which had been refined to comprise the Audit Committee Chairs of each of the Trusts, the executive lead for internal audit, and the executive lead for counter fraud.

Recommendation

The Board is asked to note the report of the Committee's meeting held on 27 October 2022.

Peter Kane
Audit Committee Chair, NED
November 2022

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	3 November 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 23rd September and on 21st October 2022.		
Recommendation:	The Board is requested to note the update.		
Supports			
Trust Strategic Objective:	Balance the books, invest in our future.		
CQC Theme:	Well Led.		
Single Oversight Framework Theme:	N/A		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A
Appendices:	N/A		

St George's University Hospitals NHS
NHS Foundation Trust

Finance Committee – September & October 2022

The Committee met on 23rd September 2022 & 21st October 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 forecasting for 2022/23 & planning for 2023/24;
- The HFMA Financial Sustainability self assessment;
- the quarterly update from SWL Pathology;
- Costing from both sites;
- The quarterly update from Procurement

As is its usual practice, the Committee discussed the Board Assurance Framework (BAF) risks on a rotating basis by deep dives, with consideration by exception in intervening months. In October members undertook a deep dive into all risks which are the responsibility of the committee; namely Finance, Estates, IDT & Operational risks. Discussion of the Finance risk focussed on whether a new strategic risk related to cash should be considered. Estates risk mainly focussed on the production of the Premises Assurance Model (PAM). Operational risk discussion focussed on the pressures of Emergency and Elective care at the site. IDT risks included Cyber Security. Members were assured that mitigations were receiving sufficient executive focus, and did not recommend any changes to current risk scores or levels of assurance..

The Committee discussed current financial performance, cash management and capital expenditure as the Trust reported M6 financial performance in 2022/23.

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

1.1 Board Assurance Framework Risks – Executive committee members updated the committee on their strategic risks, with score and assurance rating agreed as follows:

- SR3- Operational & IDT risk 20 - Partial Assurance
- SR5- Financial Sustainability risk 25 - Limited Assurance
- SR6- Financial investment risk 20 - Partial Assurance
- SR7- Estates risk 16 - Good Assurance

1.2 Estates Report –the SGH Director of Estates & Facilities (SGH DE&F) introduced the normal monthly updates, including progress being made with big capital projects such as MRI and the Cath Labs, and a review of the oil fire from earlier in the year, including recommendations.

1.3 Activity Performance – the SGH COO noted the expected performance against activity trajectories in September, where Daycase/ Elective performance is expected to be behind target (at 93% compared to 100% target) and Outpatient performance is expected to be behind target (at 97% compared to 100%).

1.4 Emergency Department (ED) Update – the performance of the Emergency Care Operating Standard was recorded at 75.9% in September. 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 11.6% of patients were waiting longer than six weeks to have a diagnostic test in September against a national recovery target of 5%, with main challenges in Gynaecology Ultrasound and Endoscopy.

1.6 Cancer Performance – the COO noted Cancer performance in August, where the Trust continues to be challenged in both 14 day and 62 day performance. Specialities affected most were Breast and Dermatology.

1.7 Referral to Treatment (RTT) Update – the performance against the RTT target was discussed, where the Trust continues to reduce the number of long waiting patients with 768 patients waiting longer than 52 weeks, meeting trajectory, and 35 patients waiting for more than 78 weeks. The Committee noted the underlying increases in the PTL and in average length of stay and recognised the challenges this would bring in the future.

1.8 Financial Performance– the Group Chief Financial Officer (GCFO) noted performance in M6 2022/23, where a YTD deficit of £29.6m was reported in line with the recently resubmitted plan, apart from a £6.8m adverse variance for ERF underperformance, which was being reported as such in line with system requirements.

He noted the cash balance as at 31st July 2022 was £60.8m, and that the capital position to date was an underspend of £1.5m, with total expenditure at £20.9m.

1.9 Cash update– the GCFO introduced a paper that outlined some scenarios for SGH cash balance in the coming months, which outlined a potential cash shortfall in January 2023 in a worst case scenario. The Committee noted that the expected outcome was for the Trust to have sufficient cash in the current financial year, but that cash requirements would continue to require careful monitoring.

1.10 Forecast 2022-23 – the GCFO noted the latest forecast I&E scenarios for 2022/23, including actions being taken to improve the position. Committee discussed the impact of inflation, non-recurrent benefits, and the position of the Trust with NHSE/I.

1.11 Planning 2023/24 – the GCFO introduced a first look at planning assumptions and a potential I&E deficit for the new financial year. Committee members noted that it was useful to see the scale of the challenge.

1.12 HFMA Financial Sustainability self-assessment– the Site CFO introduced the self-assessment and action plan circulated to committee members, which was noted.

1.13 SWL Pathology Report – the Site CFO noted the key highlights of the report, including the proposed changes to COVID testing.

1.14 Costing update – Committee members noted the submission of the National Cost Collection (NCC) return in accordance with national guidance, together with progress on the new costing database.

1.15 Procurement Report – the AD – SWLPP noted progress being made with CIP delivery and Breaches/Waivers.

St George's University Hospitals NHS
NHS Foundation Trust

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,
November 2022

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	3 November 2022	**Agenda No**	**4.3**
Report Title:	**SGH Financial Performance M6 2022/23**		
Lead Director/ Manager:	Andrew Grimshaw		
Report Author:	Tom Shearer		
Presented for:	Update		
Executive Summary:	The Trust is reporting a deficit of £29.6m at the end of September, which is £6.7m 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 £1.3m favourable to plan at Month 6. This is due to additional funding to cover COVID Testing and Vaccination costs. Expenditure is reported at £1.3m adverse to plan at Month 6. There are higher Junior Doctor and Nursing premium temporary costs, and additional COVID Testing and Vaccination costs. Only modest CIPs are planned for M6. However, pressures in the base budget and the scale of the challenge give cause for considerable concern Capital expenditure of £20.9m has been incurred year to date. This is £1.5m less than the budget of £22.4m At the end of Month 6, the Trust's cash balance was £60.8m. Cash resources are tightly managed and will continue to be monitored.		
Recommendation:	The Board is asked to note the M6 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:	Fin Comm In Common	**Date**	21st Oct
Appendices:	N/A		

M6 SGH Financial Performance

GCFO, SGH Site CFO & ESTH Site CFO

3rd November 2022

SGH
Summary metrics

Area	Key Issues	Current Month (YTD)	Previous Month (YTD)
Financial Position	The Trust is reporting a deficit of £29.6m at the end of September, which is £6.7m 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.	£6.7m Adv to Plan	£5.7m Adv to Plan
Income	Excluding ERF, income is reported at £1.3m favourable to plan at Month 6. This is due to additional funding to cover COVID Testing and Vaccination costs.	£1.3m Fav to plan	£1.1m Fav to plan
Expenditure	Expenditure is reported at £1.3m adverse to plan at Month 6. There are higher Junior Doctor and Nursing premium temporary costs, and additional COVID Testing and Vaccination costs.	£1.3m Adv to plan	£1.1m Adv to plan
Cost Improvement Programme	Only modest CIPs are planned for M6. 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 £20.9m has been incurred year to date. This is £1.5m less than the budget of £22.4m	£1.5m Fav to plan	£0.9m Fav to plan
Cash	At the end of Month 6, the Trust's cash balance was £60.8m. Cash resources are tightly managed and will continue to be monitored.	£60.8m £7.7m lower than Y/E	£80.0m £11.5m higher than Y/E

Month 6 Financial Performance

SGH

			Full Year Budget (£m)	M6 Budget (£m)	M6 Actual (£m)	M6 Variance (£m)	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)
Excluding ERF	**Income**	SLA Income	875.4	79.0	79.3	0.3	442.2	443.7	1.5
		Other Income	127.1	4.5	4.5	(0.0)	58.9	58.7	(0.2)
	Income Total		**1,002.5**	**83.5**	**83.8**	**0.2**	**501.1**	**502.4**	**1.3**
	Expenditure	Pay	(609.7)	(53.3)	(53.6)	(0.3)	(321.8)	(322.6)	(0.9)
		Non Pay	(347.8)	(29.9)	(29.8)	0.1	(182.0)	(182.4)	(0.4)
	Expenditure Total		**(957.5)**	**(83.2)**	**(83.4)**	**(0.2)**	**(503.7)**	**(505.0)**	**(1.3)**
	Post Ebitda		(71.1)	(5.5)	(5.5)	0.0	(33.3)	(33.3)	0.0
	Grand Total		**(26.1)**	**(5.1)**	**(5.1)**	**(0.0)**	**(35.9)**	**(35.9)**	**0.0**
ERF	**Income**		26.1	2.2	1.1	(1.0)	13.1	6.3	(6.8)
	Reported Position		**(0.0)**	**(3.0)**	**(4.0)**	**(1.0)**	**(22.9)**	**(29.6)**	**(6.8)**

Trust Overview

The in month reported position at **M6 is a £4.0m deficit, which is £1.0m adverse to plan. The YTD position is a £29.6m deficit, which is £6.8m adverse to plan**.

The Trust has received £6.3m of ERF income, which is £6.8m 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 £1.3m above plan, due to additional funding to cover COVID Testing and Vaccination costs.
- **Pay** is £0.9m overspent across Junior Doctor and Nursing staff groups due to premium temporary costs.
- **Non-pay** is £0.4m overspent due to additional COVID Testing and Vaccination costs.

Statement of Financial Position as at 30th September 2022

SGH

Statement of Financial Position	Note	M12 March-22 FY 21-22 Actual Audited Restated with IFRS16 (£m)	M06 Aug-22 FY21-22 YTD Plan (£m)	M06 Aug-22 FY22-23 YTD Actual (£m)	Movement Mar-22 vs YTD Aug-22 (£m)	Variance M06 YTD Plan vs Actual (£m)
Non current asset						
PPE	1	382.1	456.8	385.0	2.9	(71.8)
On SoFP PFI	1	51.2	48.7	50.2	(0.9)	1.5
Intangible Assets	1	43.5	16.8	39.1	(4.4)	22.3
IFRS16 ROU Assets	2	177.8	159.5	175.4	(2.3)	15.9
Other Non Current Asset	3	1.4	2.4	1.4	0.0	(1.0)
TOTAL NON CURRENT ASSET		**655.9**	**684.2**	**651.1**	**(4.8)**	**(33.1)**
Current assets						
Stock	4	15.1	19.4	16.7	1.7	(2.6)
Debtors	5	82.6	65.4	75.9	(6.7)	10.5
Cash	6	68.5	25.0	60.8	(7.7)	35.8
Total Current Assets		**166.2**	**109.7**	**153.4**	**(12.8)**	**43.7**
Current liabilities						
Creditors	7	(150.1)	(147.5)	(186.2)	(36.1)	(38.7)
Capital creditors	8	(32.6)	(26.5)	(17.2)	15.4	9.3
Int payable creditor	9	(0.1)	0.0	(0.1)	0.0	(0.1)
PDC div creditor	10	0.0	0.0	(0.4)	(0.4)	(0.4)
Provision<1 Year	11	(0.6)	(2.7)	(0.5)	0.1	2.2
Borrowings< 1 year	12	(18.8)	(20.5)	(18.9)	(0.1)	1.6
Total current liabilities		**(202.2)**	**(197.1)**	**(223.3)**	**(21.2)**	**(26.2)**
Net current assets/-liabilities		**(36.0)**	**(87.4)**	**(69.9)**	**(33.9)**	**17.5**
Provisions> 1 year	11	(2.2)	(4.8)	(2.2)	(0.0)	2.6
Borrowings> 1 year	12	(209.6)	(198.4)	(200.5)	9.1	(2.2)
Total Long-term liabilities		**(211.7)**	**(203.2)**	**(202.7)**	**9.0**	**0.5**
Net assets		**408.2**	**393.6**	**378.5**	**(29.7)**	**(15.1)**
Taxpayer's equity						
Public Dividend Capital		565.8	565.9	565.8	0.0	(0.0)
Revaluation Reserve		73.6	82.4	74.0	0.4	(8.3)
Other reserves		1.2	1.2	1.2	0.0	0.0
Income & Expenditure Reserve		(232.5)	(255.8)	(262.6)	(30.1)	(6.8)
Total taxpayer's equity	13	**408.2**	**393.6**	**378.5**	**(29.7)**	**(15.1)**

M06 FY22-23 YTD Statement of Financial Position Notes

Note 1: Fixed assets decreased by £4.8m (including IFRS16 assets) since March-22. This includes the impact of depreciation £25.4m, capital expenditure £20.9m and Grove reversionary interest of £103k.

Note 2: IFRS16 ROU leased assets present value of £178m added to fixed assets on 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 £1.7m compared to Mar-22 (slide 12g). This is due to increase in pharmacy, central store, perfusion, cardiac catheter and cardiac pacing stocks (slide 12g).

Note 5: Debtors has decreased by £6.7m since March 2022, this is due to increase in Non-NHS accrued income and NHS prepayments however there is a significant decrease in NHS accrued income which is the cause for decrease in debtors.

Note 6: The cash position is £7.7m lower than reported at year-end in March-22. YTD Sep-22 significant receipts received from NHS England £191m, NHS SW London ICB £219m, NHS SE London ICB £18.1m and NHS SU Heartland CCG £13.9m for the block payment, 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 £36.1m higher than the figures reported at year-end in March-22. There is a increase of £10.1m of trade payables since March-22. Other liabilities (deferred income) increased by £4.9m since March-22. March-22 creditors were low due to HMRC, and NHS Pension liability was paid in same period as compared to September-22.

Note 8: Capital creditors are £15.4m 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 trivial YTD outstanding loan value due for DHSC capital and LEEF loan.

Note 10: PDC dividend charge creditor increased to £0.4m since March-22. This is due to the M06 YTD PDC dividend charge accrual of £6.1m. This accrual is based on the FY22-23 forecasted PDC dividend charge of £12.1m. Trust made an interim PDC charge **dividend** payment of £5.6m in Sep-22. Next PDC dividend charge payment is on Mar-23.

Note 11: No significant movement in provision.

Note 12: No new borrowing since March-22. IFRS16 ROU lease liability of £167.3m added to the borrowings.

Note 13: Net taxpayer's equity decreased by £29.7m in M06 YTD. This is mainly due the I&E YTD M06 deficit of £30.1m and revaluation reserve increase of £0.4m. M06 YTD I&E deficit, includes finance expense and PDC dividend charges. No PDC drawdown made in respect of this YTD deficit.

Month 6 Cash Flow Statement

SGH

Statement of Cash Flow	M06 YTD FY22-23 Plan £m	M06 YTD FY 22-23 Actual £m	M06 YTD Variance
Opening Cash balance	**68.5**	**68.5**	
Income and expenditure deficit	(20.3)	(30.1)	(9.8)
Depreciation	21.2	25.4	4.2
Capital asset disposal	0.0	0.5	0.5
Interest payable	2.4	2.4	(0.0)
PDC dividend	4.9	6.1	1.1
Other non-cash items	0.0	(0.1)	(0.1)
Operating surplus/(deficit)	**8.2**	**4.0**	**(4.1)**
Change in stock	1.3	(1.7)	(3.0)
Change in debtors	(4.5)	6.7	11.2
Change in creditors	15.6	36.0	20.4
Change in provisions	0.6	(0.1)	(0.7)
Net change in working capital	**13.0**	**41.0**	**27.9**
PPE/Capital	(52.8)	(35.9)	17.0
Interest paid	(2.0)	(2.4)	(0.3)
PDC dividend charge paid	0.0	(5.6)	(5.6)
Net change in investing activities	**(54.9)**	**(43.8)**	**11.1**
PDC Capital Received	7.6	0.0	(7.6)
Accrued Interest YTD (DH & LEEF)	(0.0)	0.0	0.0
DH Capital £14.747m Loan repaid	(0.3)	(0.3)	0.0
LEEF Loan (Other Loan)	(0.7)	(0.7)	0.0
PFI	(0.6)	(0.7)	(0.1)
Finance lease payments	(8.8)	(7.2)	1.6
Net change in financing activities	**(2.9)**	**(8.9)**	**(6.1)**
Cash balance as at 30.09.22	**32.0**	**60.8**	**28.8**

M06 FY22-23 YTD cash movement

- The cumulative M06 22-23 I&E deficit is £30.1m. (*NB this includes the impact of donated grants and depreciation, which is excluded from the NHSI performance total).
- Within the I&E deficit of £30.1m, depreciation (£25.4m) does not impact cash. The charges for interest payable (£2.4m) and PDC dividend (£6.1m) 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 £4.0m.
- The net change in working capital has increased to £41.0m in Sep-22 compared to £35.5m in March-22. This is due to major movement in creditors of £36m, which is due to the increased trade payables, deferred income, HMRC and NHS Pension liability in Sep-22 compared to March-22.
- Stock value increased by £1.7m in Sep-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 Sep-22. LEEF loan repayment of £0.7m paid in YTD Sep-22. In addition, until Sep-22, Trust made a repayment of £0.7m for PFI and IFRS16 lease payment of £7.2m.
- No PDC funding received until Sep-22 for FY22-23.

Sep-22 cash position

- The Trust achieved a cash balance of £60.8m on 30th September 22.

M6 Capital

SGH

Spend Category	Current Month Budget £000	Current Month Actual £000	Current Month Variance £000	Year to Date Budget £000	Year to Date Actual £000	Year to Date Variance £000	Annual Budget £000	Annual Forecast £000	Annual Variance £000
Infrastructure	715	715	0	2,045	2,045	0	6,341	6,341	0
Information Technology	654	654	0	3,924	3,924	0	7,947	7,947	0
Medical Equipment / Leases & Others	615	615	0	3,690	3,690	0	7,893	8,295	-402
Capital Projects	2,181	1,581	600	12,731	11,231	1,500	23,800	23,800	0
Grand Total	**4,165**	**3,565**	**600**	**22,390**	**20,890**	**1500**	**45,981**	**46,383**	**-402**

The Trust has spent £20.890m to September 2022 on Capital schemes.

- 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.
- In the Infrastructure spend Audio Booth, Pinckney PPVL Rooms, Canteen heating and the Max Fax dental area flooring have all recently completed.
- Information Technology continues to progress well on the ICT Network and working through the activity. Currently working on Lanesborough Wing.
- Medical Physics is working on standalone assets and leases for the year. We expect a number of leases will come through in the following months.
- Capital Projects has handed over Cath Labs, which is now operational, and the MRI scheme is practically complete with arrangements well progressed for operational opening shortly. ITU continues to progress through pre-construction activities, although remains behind forecast, and the preferred PCSP is due to be announced shortly for the Renal scheme following a tender through the P23 framework.

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

gesh

Item 4.4

Corporate Objectives:

H2 22/23

St George's Trust Board

Date: 03 November 2022
James Marsh, Group Deputy Chief Executive

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

gesh

Introduction

Due to delays in the planning cycle this year, the Trust is currently working to a set of Corporate Objectives for 2021/22.

The Group and our system partners in our local ICSs are developing new Strategies, expected to be published at the end of this financial year. Objectives for 2022/23 will be we set based on those strategies.

There is therefore a need to refresh the Trust's 2021/22 objectives for the remainder of this financial year.

The Board is asked to agree the proposed H2 22/23 corporate objectives.

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

gesh

The landscape in which we operate has changed since objectives were set:

- The financial position for both Trusts has become significantly more challenging.
- The two Trusts launched a new Group (GESH) with a Group Executive Team, supported by Site Leadership teams at the two constituent Trusts.
- During H1 of 2022/23 we have seen the ongoing impact of Covid, significant pressures on the urgent and emergency care pathways and continuing challenges in the recovery of cancer and elective care pathways.
- The NHS 2022/23 priorities and operational planning guidance identifies key areas we need to contribute delivery of i.e. to support a system-based approach to planning and delivery aligned to the new ICS boundaries.

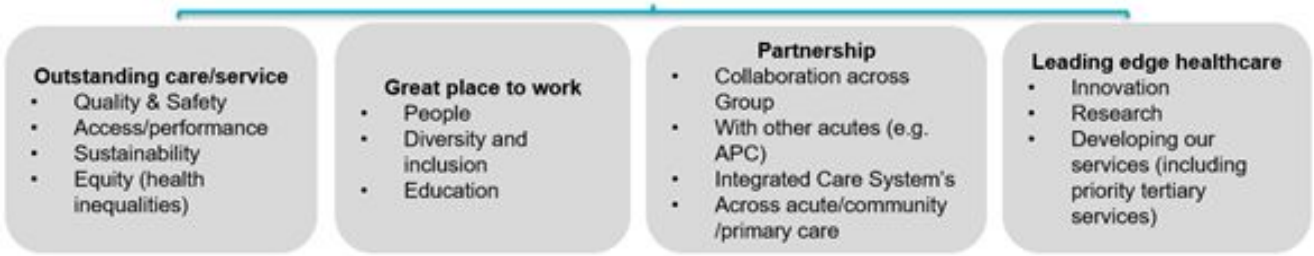
We are about to agree a new strategy, which will shape future objectives

The Boards at both Trusts are actively developing a new overarching Group Strategy to replace the existing five-year strategies at both St George's and Epsom and St Helier Trusts.

It is envisaged new Group corporate objectives for 2023/24 would be developed and agreed in line with the new Group Strategy by April 2023.

The emerging framework for the Group strategy is set out below. From April 2023, corporate objectives could be set against a framework like this.

Objectives for H2 2022/23 are for the period that take us to this point.



Proposed Corporate Objectives

Below are our existing corporate objectives from 2021/22, with proposed amendments underlined.

Care Patients and staff feel cared for when accessing and providing high quality timely care at St George's	**Culture** Transform our culture to create an inclusive, compassionate and enabling place to work where staff feel respected and understand their role in delivering high quality clinical care for our patients and service users	**Collaboration** We will engender an ethos of collaborative working across our teams within St George's, Epsom and St Helier and with our system partners to achieve the best outcomes for patients, building on the spirit of collaboration developed internally and externally through the Covid-19 response.
1. Improve patient safety by reducing avoidable harm in relation to: ➢ Learning from all local / SWL nosocomial Covid cases ➢ Treatment Escalation Plans agreed within 24 hours of admission ➢ Improving the practice of consent 2. Improve the clinical effectiveness and efficiency of all patient pathways 3. Embed a quality, safety and learning culture through monthly patient safety, mortality and morbidity meetings for every specialty	1. Deliver on our Health and Wellbeing promise to all staff by investing in Physical and mental health staff services and flexible working 2. Develop an environment where staff feel psychologically safe to speak up and use their voices to improve our services to patients 3. Taking action on our culture to ensure we are more inclusive and diverse, where discrimination, violence and bullying is not tolerated – improving the experience of BAME staff in particular 4. Develop and implement an inclusive talent management approach to ensure that we improve our opportunities for our staff	1. Continue to work in partnership and collaboration with the SWL Integrated Care System (ICS) and Acute Provider Collaborative (APC) 2. Delivering a transformational step change in use of resources at SGUH, across the Group and across South West London ICS, for the benefit of patients and the welfare of our staff 3. Explore and deliver opportunities for collaboration across the Group 4. Make best use of our resources at St George's and across South West London ICS, for the benefit of patients and the welfare of our staff

5

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

gesh

Recommendation

The Board is asked to agree the proposed H2 22/23 corporate objectives.

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	3 November 2022	**Agenda No**	**4.5**
Report Title:	**Horizon Scanning Report: Emerging Policy, Legislative and Regulatory Issues**		
Lead:	Stephen Jones, Chief Corporate Affairs Officer		
Report Author:	Stephen Jones, Chief Corporate Affairs Officer		
Presented for:	Note		
Executive Summary:	This report provides a regular update to the Trust Board on emerging policy, legislative, and regulatory issues that have relevance to the Trust. This report focuses on key developments between April and November 2022, highlighting particular developments relating to: the political and legislative environment; developments in the NHS policy and institutional landscape; system and professional regulation; reports from key stakeholders; and key appointments. The report is intended to support the Board in providing a regular and systematic review of national political, policy and regulatory developments. Key issues to highlight in the period April to November 2022: • The Health and Care Bill received Royal Assent in April 2022, and represents the biggest legislative reform to the NHS for the past decade. Among the most significant elements of what is a wide-ranging piece of legislation, the Act places Integrated Care Systems on a statutory footing and give the Secretary of State for Health enhanced powers over the NHS. • A review of healthcare leadership led by former Vice Chief of the Defence Staff, General Sir Gordon Messenger, was published in June and set out seven recommendations to Government to improve the quality of leadership in the NHS. All of the recommendations have been accepted by the Government, which has committed to producing an action plan to implement them. • NHS England published its new Operating Framework in October 2022 which sets out how NHSE will operate in the new structure created by the Health and Care Act 2022. It describes the roles that NHS England, Integrated Care Boards (ICBs), and NHS providers will now play, working alongside partners in the wider health and care system. It shows how accountabilities and responsibilities will be allocated to improve local health and care outcomes. • NHS England is currently undertaking a consultation on new NHS enforcement guidance. Revised and expanded enforcement guidance will be issued to ensure alignment with new legislation and NHSE's new responsibilities arising from the 2022 Act. The revised guidance will describe NHS England's intended approach to using its enforcement powers. There are no major changes expected in relation to enforcement in relation to providers, though the draft guidance emphasises how it will work with and through ICBs wherever possible and with an emphasis on systems working together to solve problems. The draft also sets out NHSE's approach to enforcement in relation to		

	Integrated Care Boards, and introduces an enforcement undertakings process to address identified issues. • NHS England has published new transactions guidance which sets out the way in which NHS England supports NHS Trusts or NHS Foundation Trusts and Integrated Care Systems undertaking statutory transactions, and assures trusts' proposals for them. The overall test is whether the deliverable benefits of the transaction materially outweigh the costs and risks. All transaction proposals are required to have patient and population benefits at their core and be underpinned by detailed plans for delivering those benefits. ICB support for a transaction is now a key test. The role of the Competition and Markets Authority has been amended with the 2022 Act, and NHS England will take a broader view of patient benefit than previously employed by the CMA. NHS Foundation Trusts' Councils of Governors will be required to take account of the benefit of the transaction to the ICS population as a whole, rather than the impact on the organisation individually. • The annual CQC State of Care report published in October 2022 highlights the "gridlock" in the health and care system and that "this is clearly having a huge negative impact on people's experiences of care", and states that at the heart of these problems are staff shortages and struggles to recruit and retain staff right across health and care. • A new Secretary of State for Health and Social Care (Steve Barclay MP) and wider ministerial team are in place following the formation of a new Government on 25 October 2022.
Recommendation:	The Board is asked to note the update.

Supports			
Trust Strategic Objective:	All		
CQC Theme:	Well-led		
NHS Oversight Framework Theme:	Leadership and Improvement Capability (Well-led)		
Implications			
Risk:	Horizon scanning is a key element in assisting the Board to understand emerging risks that could impact on the Trust's strategy and its operation.		
Legal/Regulatory:	N/A		
Equality, Diversity and Inclusion	N/A		
Resources:	N/A		
Previously Considered by:	N/A	**Date**	N/A
Appendices:	N/A		

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Horizon Scanning report

Emerging policy, legislative and regulatory issues

Stephen Jones
Group Chief Corporate Affairs Officer

November 2022

1. Executive Summary

This report provides a quarterly update to the Trust Board on emerging policy, legislative and regulatory issues that have relevance to the Trust. This report focuses on key developments in the year to date, highlighting particular developments relating to: the political and legislative environment; developments in the NHS policy and institutional landscape; system and professional regulation; reports from key stakeholders; and key appointments. The report is intended to support the Board in providing a regular and systematic review of national political, policy and regulatory developments.

Key issues to highlight:

- The Health and Care Bill received Royal Assent in April 2022, and represents the biggest legislative reform to the NHS for the past decade. Among the most significant elements of what is a wide-ranging piece of legislation, the Act places Integrated Care Systems on a statutory footing and give the Secretary of State for Health enhanced powers over the NHS.
- A review of healthcare leadership led by former Vice Chief of the Defence Staff, General Sir Gordon Messenger, was published in June and set out seven recommendations to Government to improve the quality of leadership in the NHS. All of the recommendations have been accepted by the Government, which has committed to producing an action plan to implement them.
- NHS England published its new Operating Framework in October 2022 which sets out how NHSE will operate in the new structure created by the Health and Care Act 2022. It describes the roles that NHS England, Integrated Care Boards (ICBs), and NHS providers will now play, working alongside partners in the wider health and care system. It shows how accountabilities and responsibilities will be allocated to improve local health and care outcomes.
- NHS England is currently undertaking a consultation on new NHS enforcement guidance. Revised and expanded enforcement guidance will be issued to ensure alignment with new legislation and NHSE's new responsibilities arising from the 2022 Act. The revised guidance will describe NHS England's intended approach to using its enforcement powers. There are no major changes expected in relation to enforcement in relation to providers, though the draft guidance emphasises how it will work with and through ICBs wherever possible and with an emphasis on systems working together to solve problems. The draft also sets out NHSE's approach to enforcement in relation to Integrated Care Boards, and introduces an enforcement undertakings process to address identified issues.
- NHS England has published new transactions guidance which sets out the way in which NHS England supports NHS Trusts or NHS Foundation Trusts and Integrated Care Systems undertaking statutory transactions, and assures trusts' proposals for them. The overall test is whether the deliverable benefits of the transaction materially outweigh the costs and risks. All transaction proposals are required to have patient and population benefits at their core and be underpinned by detailed plans for delivering those benefits. ICB support for a transaction is now a key test. The role of the Competition and Markets Authority has been amended with the 2022 Act, and NHS England will take a broader view of patient benefit than previously employed by the CMA. NHS Foundation Trusts' Councils of Governors will be required to take account of the benefit of the transaction to the ICS population as a whole, rather than the impact on the organisation individually.
- The annual CQC State of Care report published in October 2022 highlights the "gridlock" in the health and care system and that "this is clearly having a huge negative impact on people's experiences of care", and states that at the heart of these problems are staff shortages and struggles to recruit and retain staff right across health and care.
- A new Secretary of State for Health and Social Care (Steve Barclay MP) and wider ministerial team are in place following the formation of a new Government on 25 October 2022.

Outstanding care every time

2. Purpose

The NHS Leadership Academy identifies three essential 'building blocks' in helping NHS boards to exercise their roles of formulating strategy, ensuring accountability and shaping a healthy culture effectively. Effective boards are informed by the external context within which they operate. They are informed by and shape the intelligence on understanding local needs, trends and comparative information on organisational performance, and give priority to engagement with stakeholders and opinion formers. This report provides the Board with a regular update on key developments in the Trust's external environment at the national level, particularly in relation to:

- **Political and legislative developments**: Current and emerging political and parliamentary developments at a national level with direct or indirect implications, or potential implications, for the Trust; key changes, or potential future changes, to primary legislation and regulations.
- **NHS policy and institutional landscape**: Changes and developments in relation to significant new national policy as determined by the central NHS organisations, and changes to the national architecture and structures of the NHS and those organisations with which the Trust interacts.
- **System and professional regulation**: Changes and prospective changes to the regulatory landscape, of both system regulators and relevant professional regulators with potential relevance to the Trust.
- **Reports and updates from key stakeholders**: Topical reports from key national bodies and other stakeholders of relevance to the Trust, and highlights of recent Board meetings of key system partners.
- **Current inquiries**: Summary of key inquiries that are underway.
- **Appointments**: Key appointments to national bodies and other key stakeholders.

This report is intended to help ensure the Board receives a comprehensive quarterly update on key issues relating to these areas. It is distinct from the strategy horizon scanning report which focuses on regional and local issues.

3. Political and legislative developments

Health and Care Act 2022

- The Health and Care Act 2022 received Royal Assent on 28 April 2022. The Act contains the biggest legislative reforms to the NHS in a decade. The bulk of the Act focuses on developing system working with Integrated Care Systems (ICS) being placed on a statutory footing through the creation of Integrated Care Boards (ICBs). The Act also moves the NHS away from the focus on competition as set out in the Health and Social Care Act 2012,, including moving away from competitive tendering by default and towards collaborative local delivery.
- Key changes introduced by the Act:
    - **Integrated Care Boards and local systems:**
        - ICBs established on a statutory basis and clinical commissioning groups (CCGs) formally abolished from 1 July 2022.
        - ICBs to comprise, at a minimum, a chair, chief executive, and at least three other members. One of these members is jointly nominated by NHS Trusts and NHS Foundation Trusts, one by primary care services and one by local authorities providing services within the ICB footprint. Beyond this, local systems have flexibility to determine any further membership. NHS England will appoint the ICB chair and have the power to remove them. The ICB chief executive will be appointed by the chair, with NHS England approval.
        - ICBs have several duties including, but not limited to: improving the quality of services, reducing inequalities in access and outcomes; promoting integration between health, social care, and wider services; and having regard to the "triple aim" (see below).
        - Each ICB and its partner NHS Trusts and NHS Foundation Trusts must prepare a five-year forward plan to meet the local population's health needs
        - Each ICB must exercise its powers with a view to breaking even financially each year. In addition, each ICB and its partner NHS Trusts and NHS Foundation Trusts must seek to achieve financial objectives set by NHS England and operate with a view to ensuring that local capital and revenue use does not exceed the limits specified in directions by NHS England in each financial year. NHS England may give directions to an ICB and its partner NHS Trusts and NHS Foundation Trusts to ensure that they do not exceed these limits.
        - In addition, a separate power allows NHS England to set additional mandatory financial objectives specifically for trusts.
        - Integrated Care Partnerships (IPC) are established on a statutory basis, which brings together partners from across the system to address the health, social care and public health needs of the population. The ICP membership includes one member appointed by the ICB, one member appointed by each of the relevant local authorities, and any other members appointed by the ICP. The ICP has the power to determine its own procedures locally. Each ICP must prepare an 'integrated care strategy' building on the relevant joint strategic needs assessments to meet the assessed needs of the local population.

3. Political and legislative developments

Health and Care Act 2022 (continued)

- **Providers:**
  - The Act removes the exemption on NHS trusts to hold a licence from NHS England and required NHS England to treat any new NHS Trusts as if they had applied for a licence. In effect, this brings the provider licence in line with the approach for NHS Foundation Trusts.
  - All providers are now subject to the "triple aim" (see below).
  - NHS England may set financial objectives for trusts, and trusts must achieve those objectives. These objectives may apply to trusts generally, or to a particular trust or trusts of a particular description. NHS England has the power to apply a capital spending limit to an NHS Foundation Trust for a single financial year. NHS England is also given powers to give assistance and support to any provider of NHS services.
  - NHS Trusts and NHS Foundation Trusts have duties regarding climate change and the environment, and regulations are planned to eradicate slavery and human trafficking from supply chains
  - NHS Foundation Trusts are enabled to carry out their functions jointly with another organisation. The Act creates legal mechanisms to allow ICBs and NHS providers to form joint committees, of two or more providers, to make joint arrangements and pool funds.
  - The Act removes the requirement that an application to merge an NHS Foundation Trust with an NHS Trust must be supported by the Secretary of State. The Act also required NHS England to grant the application if it is satisfied that necessary steps have been taken to prepare for the dissolution and establishment of the new trust or acquisition and the Secretary of State approves the grant of application.
- **Secretary of State's (SofS) powers:**
  - SofS no longer has to set the mandate to NHS England for each financial year, and instead this can be set at any time and will remain in force until replaced by a new mandate
  - SofS gains a range of powers of direction, including intervention powers in relation to significant reconfiguration proposals. This includes a general power to direct NHS England in relation to its functions. There are exceptions to this power – the SofS cannot use the power in relation to the appointment of individuals by NHS England (including trusts and FTs), individual clinical decisions, or in relation to drugs or treatments that the National Institute for Health and Care Excellence (NICE) have not recommended or issued guidance on as to clinical and cost effectiveness. The SofS has been given power to veto any proposal from NHS England on the commissioning of specialised services. The SofS also has a new power to direct NHS England in the use of payments made to it for the purposes of integration. NHS England can make payments to ICBs in respect of integration. The SofS can set minimum standards for food and drink provided in hospitals.
  - New duty on SofS to report on the system for assessing and meeting the workforce needs of the health service in England at least once every five years.

3. Political and legislative developments

Health and Care Act 2022 (continued)

- **Regulatory powers, duties and statutory bodies:**
  - NHS England, Monitor and the NHS Trust Development Authority (operating as NHS Improvement) merged into a single organisation (the legal entity called NHS Commissioning Board formally renamed as "NHS England"). Monitor was abolished by the Act and its powers transferred to NHS England. NHS England has a duty to minimise the risks of a conflict between its regulatory and other functions, and to manage any conflicts that arise.
  - The national tariff is replaced with a new NHS payment scheme. The new payment scheme is to be published by NHS England, which will consult with ICBs and relevant providers. The intention is to give NHS England more flexibility in how prices and rules are set, to help support more integrated care at local levels.
  - The Act revokes existing procurement and competition requirements, as well as strengthening the rules around patient choice by making it mandatory for regulations to contain provisions about how NHS England and ICBs will allow patients to make choices about their care and providing NHS England with new powers to enforce patient choice requirements. The intention is to pave the way for a new NHS provider selection regime that moves away from competitive tendering by default in favour of a more collaborative approach to planning and delivering services. The role of the Competition and Markets Authority in mergers between NHS providers and in licensing is revoked, as are Monitor's competition functions.
  - NHS England given power to give directions to one or more ICBs in respect of any of the ICB's functions (including delegation arrangements) and payments.
  - NHS England given duties to reduce inequalities and to set out the powers of NHS bodies to assess inequalities.
  - NHS England required to prepare consolidated accounts for NHS Trusts and NHS Foundation Trusts and submit them to the Secretary of State and Comptroller and Auditor General, and then to Parliament.
  - The Care Quality Commission (CQC) will oversee and assess ICSs, and local authority adult social care duties. The assessment will take into account how the board, its partner local authorities and registers service providers work together, as well as how the system functions as a whole. The Secretary of State will set the priorities and objectives of ICS reviews. The Act specifies a focus on leadership, integration, quality and safety. The CQC will determine the indicators of quality, methods, period, and frequency of these reviews with Secretary of State approval.
  - The Healthcare Safety Investigation Branch (HSIB) is put on a statutory footing.
  - All NHS bodies are subject to the "triple aim" duty which requires the NHS to have regard to the wider effect of decisions on health and wellbeing, the quality of services, and efficiency and sustainability.
- The new legislative framework, particularly as it relates to the creation of the new ICS architecture, relates to Strategic Risk 4 (system working) on the Trust's Board Assurance Framework.

3. Political and legislative developments

House of Commons Health and Social Care Committee Report – Workforce: Recruitment, training and retention in health and social care

- On 20 July 2022, the House of Commons Health and Social Care Committee published the report of its inquiry into workforce in the NHS and social care. The Inquiry examined recruitment challenges and the steps needed to address these, the balance between domestic and international recruitment, changes to training of staff that could support increases in staff working in health and care, and the factors contributing to staff leaving health and care sectors.

- The Report underlined the scale of the workforce challenge, and the factors contributing to this. In particular, the Committee concluded that:
  - The Committee's report cited new research from the Nuffield Trust which indicated the NHS in England is short of 12,000 hospital doctors and more than 50,000 nurses and midwives. It also stated that evidence on workforce projections suggested an additional 475,0000 jobs would be needed in health and an extra 490,000 jobs in social care by the early part of the next decade. The Committee noted that the number of full-time equivalent GPs fell by more than 700 over three years to March 2022, and hard from the former Secretary of State for Health and Social Care that the Government was not on target to deliver its commitment of delivering 6,0000 additional GPs.
  - Maternity services were flagged as being under serious pressure, with more than 500 midwives leaving in a single year, and a Committee's earlier inquiry on maternity safety having concluded that there was a need for a further 2,000 midwives and almost 500 obstetricians.
  - The Committee identified that pay was a crucial factor in recruitment and retention in social care, with around 17,000 jobs in care paid below the minimum wage.
  - The Committee concluded: "The NHS and the social care sector are facing the greatest workforce crisis in their history". It stated that in the context of these challenges "the Government has shown a marked reluctance to act decisively" and noted that a workforce plan had not yet been published. The Committee concluded that "the persistent understaffing of the NHS now poses a serious risk to staff and patient safety both for routine and emergency care. It also costs more as patients present later with more serious illness. But most depressing for many on the frontline is the absence of any credible strategy to address it. It is time to stop photographing the problem and deal with it".

- A separate report by the Committee's panel of independent experts, published alongside the Committee's report, rated the Government's progress overall in meeting key commitments on workforce as "inadequate".

NHS Litigation Reform

- On 20 April 2022, the Health and Social Care Committee published a report on NHS Litigation Reform. Its report concluded that the current system for compensating injured patients in England was "not fit for purpose" and urged a radically different system to be adopted.

- The Committee observed that every year the NHS in England spends over £2 billion compensating patients who suffered harm during their treatment, and that the costs had grown at an "eye watering rate", with the total cost a decade ago being £900 million.

- The Committee observed that currently, litigation offers the only route by which those harmed can access compensation. As well as being "grossly expensive and adversarial", the existing system encourages individual blame instead of collective learning. It called for reforms to introduced an administrative scheme which would establish entitlement to compensation on the basis that correct procedures were not followed and the system failed to perform rather than clinical negligence which relied on proving individual fault.

3. Political and legislative developments

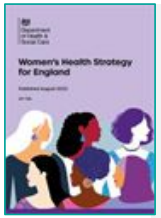
New Inquiries launched by the House of Commons Health and Social Care Committee

- The Health and Social Care Committee is currently undertaking the following new inquiries:
    - Integrated Care Systems: Autonomy and Accountability: The Committee's Inquiry considers how ICSs will deliver joined up health and care services to meet the needs of local populations. Among the areas being considered, the Inquiry will look at how ICSs will be able to operate with the flexibility and autonomy required tin order to tackle inequalities in the populations they service and whether the pursuit of central targets can be consistent with local autonomy.
    - Digital Transformation in the NHS: The Inquiry is exploring the current use of digital technology and how it needs to change in order to deliver improvements in services and outcomes for patients. The inquiry is considering key aspects of NHS digital transformation including digitising health and care records for interoperability, legacy systems in the NHS, and the interaction between digital transformation and clinical research.

Review of health and social care leadership

- On 8 June 2022, the Government published a review of leadership in health and social care led Vice Chief of the Defence Staff, General Sir Gordon Messenger. The review focused on the best ways to strengthen leadership and management across health and its key interfaces with adult social care in England. The Review made seven recommendations:
    1. Targeted interventions on collaborative leadership and organisational values: This would include a new national entry level induction for all who joint health and social care as well as a new, national mid-career programme for managers across health and social care.
    2. Positive equality, diversity and inclusion action: This would include embedding inclusive leadership practice as the responsibility of all leaders, committing to promoting equal opportunity and fairness standards, more stringently enforcing existing measures to improve equal opportunities and fairness, and enhancing the role of the CQC in ensuring improvement in EDI outcomes.
    3. Consistent management standards delivered through accredited training: This would include the introduction of a single set of unified, core leadership and management standards for managers, as well as training and development to meet these standards.
    4. A simplified, standard appraisal system for the NHS: This would include the introduction of a more effective, consistent, and behaviour-based appraisal system, of value to both the individual and the system.
    5. A new career and talent management function for managers: This would involve the creation of a new career and talent management function at regional level, which oversees and provides structure to NHS management careers.
    6. Effective recruitment and development of non-executive directors: This would involve the establishment of an expanded, specialist non-executive talent and appointments team.
    7. Encouraging top talent into challenged parts of the system: This would improve the package of support and incentives in place to enable the best leaders and managers to take on some of the most difficult roles.
- All seven recommendations have been accepted by the Government, which has committed to developing a plan to implement the recommendations.

3. Political and legislative developments



New Women's Health Strategy for England

- On 20 July 2022, the Government published a new Women's Health Strategy for England, with the aim of tackling the gender health gap. The strategy states that it sets bold ambitions to tackle deep-rooted, systemic issues within the health and care system to improve the health and wellbeing of women, and reset how the health and care system listens to women.

- The strategy includes key commitments around:
  - New research and data gathering
  - The expansion of women's health-focused education and training for incoming doctors
  - Improvements to fertility services
  - Ensuring women have access to high quality health information
  - Updating guidance for female-specific health conditions to ensure the latest evidence and advice is being used in treatment.

Plans to merge NHS Digital with NHS England accelerated to January 2023

- On 21 October 2022, the Department of Health and Social Care announced that the planned transfer of NHS Digital's functions to NHS England would be brought forward to January 2023. The move will create a single statutory body responsible for data and digital technology for the NHS. The aim is to help ensure that patients benefit from a streamlined experience due to a reduced need to repeatedly share information across the health system; the ability to make more informed choices about their care by providing information about length of wait for treatment, and making waiting lists by provider and specialty more accessible, and by easier access to electronic patient records through accelerated digital transformation services for patients.

New health in data strategy

- On 13 June 2022, the Department of Health and Social Care published a new health in data strategy, *Data Saves Lives: Reshaping Health and Social Care with Data*.

- The new strategy focuses on seven principles to drive transformation in health and care, creating a secure and privacy-reserving system: Improving trust in the health and care system's use of data; Giving health and care professionals the information they need to provide the best care; Improving data for adult social care; Supporting local decision-makers with data; Empowering researchers with the data they need to develop life-changing treatments and diagnostics; Working with partners to develop innovations that improve health and care; Developing the right technical infrastructure.

- The strategy commits t making sure that patient information is safe and that it never leaves a secure server and can only be used for agreed research purposes. It also contains commitments to give patients greater access to and control over their data, including by simplifying the opt-out processes for data sharing and improving access to GP records in the NHS App by November 2022.

4. NHS policy and institutional landscape

New NHS England Operating Framework

- On 12 October 2022, NHS England published its new Operating Framework. The Operating Framework sets out how NHS England will operate in the new structure created by the Health and Care Act 2022. It describes the roles that NHS England, Integrated Care Boards (ICBs), and NHS providers will now play, working alongside partners in the wider health and care system. It shows how accountabilities and responsibilities will be allocated to improve local health and care outcomes in a way that maximises taxpayer value for money. The Framework was developed with system leaders, organisations and stakeholders.
- The Operating Framework sets out the interconnected relationships across the revised health and care system in England:
    - NHS providers will: retain their statutory responsibilities for the delivery of safe, effective, efficient, high-quality services; and continue to comply with the provider licence, Care Quality Commission (CQC) standards and NHS planning guidance requirements.
    - Integrated Care Boards (ICBs) will: provide effective system leadership and oversee delivery of system strategies, plans and Long-Term Plan priorities; commission and manage contracts, delegation and partnership agreements; and oversee the budget for NHS services in their system.
    - NHS England will: agree the mandate for the NHS with government and secure required resources; shape and set national policy, strategy and priorities, and support systems and providers to achieve these – including via statutory intervention; remain accountable to Parliament, via the Secretary of State; oversee ICBs' delivery of plans and performance; and directly oversee providers' delivery by exception and "generally in agreement" with ICBs
- Although many of the formal powers and accountabilities that NHS England (and predecessor bodies) has in the new system are broadly similar, how NHS England plans to deliver those functions and how it will work will change under the new Framework, specifically:
    - Proportionate and streamlined approach: NHS England and ICBs will ensure that oversight and performance management arrangements are proportionate and streamlined, and do not create duplication or unnecessary bureaucracy and reporting requirements for providers. NHS England will describe a single set of national priorities, and metrics to track performance against them, in the Oversight Framework and oversee this through a single mechanism.
    - Devolution: For ICBs and their partner NHS providers the primary relationship with NHS England will be through the relevant regional team. Where national teams need to interact directly with ICBs and NHS providers, this will be done in conjunction with the relevant regional team, to ensure interactions are coordinated.
    - No surprises: Relationships between NHSE, ICBs and providers will be mature, respectful and colligate, underpinned by effective lines of communication and a 'one team' philosophy.
    - ICB annual assessments: NHS England has a duty to assess ICBs across a number of domains. The first annual assessment of ICBs will be completed in Q1 2023/24.

4. NHS policy and institutional landscape

Consultation on revised NHS Enforcement Guidance

- On 27 October 2022, NHS England published a consultation on revised NHS enforcement guidance.
- Under the Health and Care Act 2022, NHS England has statutory accountability for oversight of both Integrated Care Boards (ICBs) and NHS providers. With the abolition under the Act of NHS Improvement (Monitor and the NHS Trust Development Authority), NHS England has assumed responsibility for carrying out NHS Improvement's statutory functions, including the regulation of NHS providers, the exercise of enforcement powers, enforcement powers over ICBs in relation to compliance with patient choice provisions, and publishing and revising the guidance on the use of those powers.
- The current enforcement guidance was issued by Monitor (NHS Improvement) and relates primarily to providers. Monitor also issued enforcement guidance relating to its oversight role and enforcement powers over clinical commissioning groups and NHS England in relation to compliance with patient choice provisions. NHS England intends to issue revised and expanded enforcement guidance to ensure alignment with new legislation and its new responsibilities arising from the 2022 Act. The revised guidance will describe NHS England's intended approach to using its enforcement powers.
- The proposed revisions to the enforcement guidance focus on:
    - The changes required due to the abolition of Monitor and the NHS Trust Development Authority and the transfer of functions to NHS England
    - Alignment with new legislation and NHS England's new responsibilities under the NHS Act 2006 and the Health and Social Care Act 2012, as amended by the 2022 Act – specifically in relation to: the process for ICB enforcement; removal of references to enforcement action for breach of competition rules; revisions to the language to reflect the change from Monitor to NHS England as the regulatory body for NHS Foundation Trusts and the expansion of the provider licence to NHS Trusts; and NHS England's enforcement powers in relation to patient choice provisions.
    - Alignment with current policy including the NHS Oversight Framework and operational best practice, including: reducing the emphasis on investigations in the event of suspected provider licence breach, and removing the 'prioritisation framework' that Monitor used to inform its decisions on whether or not to begin or continue ongoing cases.
- In relation to provider enforcement, the basic processes that NHS England plan to follow have not changed. The revised guidance, however, sets out that NHS England will exercise its enforcement powers in line with the principles set out in the NHS Oversight Framework, working with and through ICBs wherever possible and with an emphasis on systems working together to solve problems.
- NHS England's powers to direct ICBs align with the powers NHS England may apply to providers that are in breach of their licence conditions (in particular the power to impose 'discretionary requirements'). The revised process would introduce an ICB undertakings process to be applied at a lower threshold than that required for directions. These undertakings would set out the actions the ICB agrees to take to resolve the identified issues. ICB undertakings will be agreed by NHS England and the ICB would set out the remedial actions to be taken, and the ICB would give a commitment that it will comply and carry out the relevant actions.
- The consultation asks for views on whether organisations agree with the changes and feedback on how the guidance can be further improved. The deadline for responses is 9 December 2022.

4. NHS policy and institutional landscape

Updated NHS Transaction Guidance

- In October 2022, NHS England published its new transactions guidance, *Assuring and supporting complex change: Statutory transactions, including mergers and acquisitions.* This followed a consultation undertaken in November 2021.

- The guidance sets out the way in which NHS England supports NHS Trusts or NHS Foundation Trusts and Integrated Care Systems undertaking statutory transactions, and assures trusts' proposals for them. Its purpose is to help ensure that a proposed transaction is the right solution to the issues it is addressing and that the intended benefit will be delivered. The overall test is whether the deliverable benefits of the transaction materially outweigh the costs and risks. All transaction proposals are required to have patient and population benefits at their core and be underpinned by detailed plans for delivering those benefits. In doing do, the new guidance reflects the changes introduced through the Health and Care Act 2022. It applies to all of the following statutory transactions: mergers, acquisitions, dissolutions, separations, and transfer schemes.

- The Key points are:
    - NHS England's overall test is whether the deliverable of a transaction will materially outweigh the costs and risks
    - Assessing benefits is a two-stage process, incorporating review of a strategic case and then full business case
    - NHS England takes a broad view of the term 'benefits', which may be contrasted with the historically tougher approach that the Competition and Markets Authority (CMA) applied to merger review
    - ICB support for a transaction is now a key test - trusts and system partners must work together constructively in the development of transaction proposals
    - CMA merger review will still apply to mergers or joint ventures involving an NHS provider and an independent provider (including GP practices)
    - Secretary of State approval is now required for all transactions
    - The draft new Council of Governors (CoG) guidance includes CoG approval for transactions that may not immediately benefit the NHSFT itself but is expected to benefit the wider ICS population
    - NHS England will apply its Risk Assessment Framework to determine whether the transaction is material or significant, and the overall level of risk will determine the process and timeline.

5. System and professional regulation

Care Quality Commission State of Care Report 2021/22

- On 21 October 2022, the CQC published its annual State of Care Report for 2021/22. The report provides an annual assessment of the state of health and social care in England and looks at the quality of care provided across the NHS and social care over the past year. The report concludes that: “Today, our health and care system is in gridlock and this is clearly having a huge negative impact on people’s experiences of care. People in need of urgent care are at risk of increased harm due to long delays in ambulance response times, waiting in ambulances outside hospitals and long waiting times for triage in emergency departments. Large numbers of people are stuck in hospital longer than they need to be, due to lack of available social care. And people’s inability to access primary care services is exacerbating the high pressure on urgent and emergency care services. At the heart of these problems are staff shortages and struggles to recruit and retain staff right across health and care.”
- Key findings of the report:
    - “People are struggling to access care”:
        - The impact of the pandemic continues to be felt by the population, in terms of access to appointments and delays in treatment, with many people waiting too long for treatment, and some people reporting that they did not feel well supported by health and care services.
        - There is significant variation across the country in waiting times for elective care and cancer treatment. People living in the worst performing areas were more than twice as likely to wait more than 18 weeks for treatment as people in the best performing areas.
        - People are struggling to access GP practices and NHS dental care.
    - “Inequalities pervade and persist”:
        - Inequality continues across large parts of health and social care, and health and social care providers need to do more to make their services accessible, especially to people with different communication needs.
        - The recording and use of demographic data by services generally needs to improve, to make sure data is complete, accurate, widely shared and used to bring about improvement.
    - “Depleted workforce”:
        - Providers are struggling to recruit and retain staff with the right stills and in the right numbers to meet the increasing needs to people in their care. Staff are being drawn to industries with higher pay and less stressful conditions.
        - Sickness, vacancy and turnover rates are having a deep impact. “Continuing understaffing poses a serious risk to staff and patient safety, both for routine and emergency care”.
    - “Challenges and opportunities in local systems”:
        - Local systems are starting to make a positive difference, but they must be focused on outcomes for people.
        - Good leadership is vital for local systems as they become established.
        - To maintain and develop the required workforce, as well as to plan for the future, providers and systems need to be clear about demands in the longer term, including the required workforce skillsets.
    - Specific concerns:
        - “The quality of maternity care is not good enough. Action to ensure all women have access to safe, effective and truly personalised maternity care has not been sufficiently prioritised to reduce risk and help prevent tragedies from occurring. Furthermore, women from ethnic minority groups continue to be at higher risk of dying in pregnancy and childbirth than white women, and more likely to be readmitted to hospital after giving birth”

5. System and professional regulation

General Medical Council Workforce Report 2022

- In October 2022, the General Medical Council (GMC) published its annual workforce report (*The State of Medical Education and Practice in the UK)*.
- Key messages:
    - While the number of doctors joining the workforce overall has grown by around 17% over the last five years, that growth is not consistent. It varies considerably between different groups of doctors, leaving a shortfall in primary care that puts at risk patients' ability to access GP services.
    - The UK medical workforce headcount is growing, with large increases in international medical graduates (IMGs) whose primary medical qualification is from outside the UK and European Economic Area (EEA). The number of IMGs has increased 40% in the last 5 years at a time when the number of UK graduates in the workforce has increased by 10%. Of the doctors who joined the workforce in 2021, 50% were IMGs and 39% were UK graduates. The workforce will grow by a third by 2030 compared with 2021 if current trends continue. But if the rate of IMGs joining goes back to pre-2017 levels, there will be 23,000 fewer doctors in 2030. The growth in IMGs has driven a shift in the composition of the workforce in terms of register types. In particular, specialty and associate specialist (SAS) and locally employed (LE) doctors have grown at almost six times the rate of GPs in the last five years and a little under four times the rate of specialists. SAS and LE doctors are a valuable asset but the system does not make the most of their talents.
    - Many SAS doctors reported they want better working environments, more support with better career development and progression, and more flexibility in positions available to them, but instead too many of them encounter barriers that hinder their development.
    - In addition to the relatively low growth in the number of licensed doctors on the GP register, there has been a reduction in the number of GPs working full time. Over half of GPs reported working beyond their hours and feeling unable to cope with their workload.
    - The medical workforce is increasingly female and is moving closer to parity with males. More of the UK graduates joining are female and more of those leaving are male, especially those at retirement ages. This is largely being counterbalanced by the large increases in IMGs joining, more of whom are male.
    - Poor working environments have been a key factor in driving doctors away, Burnout, stress, lack of flexible working arrangements and poor organisational and team cultures were cited repeatedly by doctors across all groups as reasons for leaving the profession.

General Medical Council Standards on Physician Associates and Anaesthesia Associates

- On 29 September, the GMC published new standards outlining what is expected from course providers and students learning to become physician associates (PAs) and anaesthesia associates (AAs). In 2019, the DHSC announced that AAs and PAs would be regulated by the GMC, to reinforce their growing role in the multi-disciplinary healthcare workforce. Regulation is expected to begin no earlier than late 2024. It will mean that anyone practising as an AA or PA must be registered with the GMC and will be subject to its regulatory requirements. Their education, must meet certain standards to maintain the trust placed in both professions. Included in the new standards are a core set of expectations course providers must ensure students can satisfy, known as PA and AA generic and shared learning outcomes.

5. System and professional regulation

Whistleblowing disclosures report 2022, Healthcare professional regulators

- On 28 September 2022, the regulators of healthcare professionals published their annual report on whistleblowing disclosures. The report covers the period from April 2021 to March 2022 and was published jointly by the General Medical Council, Nursing and Midwifery Council, General Dental Council, General Optical Council, General Osteopathic Council, General Pharmaceutical Council, and the Health and Care Professions Council. All prescribed bodies are required by law to publish an annual report on whistleblowing disclosures made to them:
    - General Medical Council: The GMC received a total of 62 whistleblowing disclosures, 59 of which were regarding fitness to practise and 3 regarding registration and revalidation. Of all the disclosures received by the GMC, 34 were made by doctors, 14 by other healthcare professionals, and 14 were made anonymously. The GMC reported that the complaints covered a wide range of allegations, including staffing structures at particular locations, professional misconduct and individual dishonesty. There was a 44% increase in the number of whistleblowing concerns raised compared with the previous year alongside a drop in the number of anonymous concerns potentially indicating people feeling more able to report a whistleblowing concern.
    - Nursing and Midwifery Council: The NMC received a total of 152 whistleblowing disclosures in 2021/22, of which 137 related to fitness to practise, 2 relating to registration and revalidation, and 8 relating to education. The number of concerns fell in 2021/22 compared with the previous year. The most common themes of the disclosures remained consistent: patient safety and care; leadership and management; health and safety; and behaviour (including bullying, intimidation and harassment of colleagues).
    - General Pharmaceutical Council: The GPC received a total of 25 whistleblowing disclosures in 2021/22. Regulatory action was taken in 19 cases, three cases were referred onwards to an alternative body, and 3 concerns continued to be investigated.
    - Health and Care Professions Council: The HCPC received a total of 4 whistleblowing concerns, and regulatory action was taken in all 4 cases. All 4 concerns were raised by healthcare professionals. The reports regarded scope of practise, arrangements for service provision during the Covid pandemic, training, and conflicts of interest.

6. Reports from key stakeholders

NHS Providers – *Realising the benefits of provider collaboratives*

- In August 2022, NHS Providers published a new report on providers collaboratives, and the emerging benefits, risks and enablers. Key messages:
    - Trust leaders see significant opportunities in working collaboratively to benefit patients and service users, given that no single organisation can tackle the systemic issues in the sector. Trusts and system partners have been developing these collaborative arrangements for some time, but these have only recently been formalised in the Health and Care Act 2022 and guidance, including on provider collaboratives and place-based partnerships.
    - Overall, Trust leaders welcome the permissive national policy framework which enables them to develop collaborative arrangements based on local contexts. This flexibility means that provider collaboratives vary in their purpose, membership, model and role within their systems. There is no one size fits all model.
    - NHS England has identified several potential benefits of provider collaboration, including reducing unwarranted variation in outcomes and access, maximising economies of scale, and improving recruitment and retention of staff.
    - Many of the ambitions and priorities of ICSs will be delivered through trusts collaborating with each other and wider partners.
    - Over time, ICB budgets and functions could be delegated to provider collaboratives, with some already seeing potential to take on traditional commissioning functions, including redesigning services and allocating funding.
    - Trust leaders have identified several key enablers that support provider collaboration at different stages of development. These include the importance of building trust between partner organisations, focusing on shared priorities rather than models and form, and ensuring changes are led by clinicians and driven by realising benefits for local communities.
    - The novel, complex nature of provider collaborative arrangements also creates risks for trust boards to manage. These include ensuring strategies align with those of provider collaboratives, ICB, ICP and places; avoiding recreating silos and reinforcing a provider/commissioner dynamic; and understanding how collaborative arrangements could be assessed and how that will interact with trust boards' ongoing duties and liabilities.

NHS Providers – Regulation, Reform and Services Under Pressure

- In July 2022, NHS Providers published a new report which found that while NHS trusts strongly support the shift in approach NHS England and CQC aim to take in line with system working, this has yet to be translated in practice. Both Care Quality Commission (CQC) and NHS England and NHS Improvement (NHSE/I) have recently updated their regulatory frameworks to signal a shift in approach in line with the move to system working.

- Trusts expressed strong support for the policy direction being taken by regulators. An overwhelming majority supported CQC's planned shift towards a more risk-based approach, data monitoring, and its intention to update ratings more frequently. Similarly, a large majority of trusts were supportive of the collaboration and system focus seen in NHSE/I's new system oversight framework (SOF) and its oversight metrics. However, trusts did not report experiencing the benefits of this shift in strategic direction in practice. Trust leaders reported an increase in the regulatory burden and the number of ad-hoc requests from regulators over the past year. Many felt that regulators were not mindful of the ongoing pressures they were facing linked to the COVID-19 pandemic and its after-effects. This was especially true for mental health and learning disability trusts. While they support CQC's new approach, trust leaders did not feel that the benefits of their most recent inspection justified the cost in terms of time and resource. Many commented on the need for CQC to develop further its approach to assessing systems and pathways of care, rather than individual providers in isolation, as well as the need for it to focus on supporting trusts to improve and collaborate. Although positive about the direction of the new SOF, trusts still perceive it as a performance management, rather than a support tool. They expressed concerns over the number of metrics, the justification of segmentation decisions, and the clarity of criteria for moving between segments.

7. Key appointments

Appointment of new Secretary of Stats for Health and Social Care and new DHSC Ministerial Team

- **Steve Barclay MP** was appointed Secretary of State for Health and Social Care on 25 October 2022, having previously held the same role between 5 July 2022 and 6 September 2022. He was previously appointed Chancellor of the Duchy of Lancaster and Minister for the Cabinet Office between 15 September 2021 and July 2022, and before this served as Chief Secretary to the Treasury from 13 February 2020 to 15 September 2021 and Secretary of State for Existing the European Union from 16 November 2018 to 31 January 2020. He was elected as MP for North East Cambridgeshire in May 2010.
- Alongside the appointment of a new Secretary of State for Health and Social Care, there have also been changes in the wider DHSC Ministerial Team:
    - **Helen Whately MP** was appointed as Minister of State at DHSC on 27 October 2022. She was previously Exchequeur Secretary to the Treasury between 16 September 2021 to 8 July 2022, and Minister of State (Minister for Care) at DHSC from 13 February 2020 to 16 September 2021. She was elected as MP for Faversham and Mid Kent in May 2015.
    - **Will Quince MP** was appointed as Minister of State at DHSC on 7 September 2022. He was previously Minister of State (school standards) at the Department for Education between 7 July 2022 and 7 September 2022, and before this served as Parliamentary Under Secretary of State at the Department for Education between 16 September 2021 and 7 July 2022. He was elected as MP for Colchester in May 2015.
    - **Neil O'Brien MP** was appointed Parliamentary Under Secretary of State at DHSC on 7 September 2022. He previously served as Parliamentary Under Secretary of State at the Department for Levelling Up, Housing and Communities between 19 September 2021 and 6 July 2022. He was elected as MP for Harborough in June 2017, having previously acted as special adviser to Prime Minister Theresa May on the economy and industrial strategy and special adviser to Chancellor of the Exchequer George Osborne.
    - **Lord Markham** was appointed Parliamentary Under Secretary of State at DHSC on 22 September 2022, having been appointed to the House of Lords the same month. He previously served as lead non-executive director at the Department for Work and Pensions and was Deputy Leader of Westminster Council.

Appointment of first Patient Safety Commissioner for England

- Dr Henrietta Hughes OBE was appointed the first ever independent Patient Safety Commissioner for England in July 2022 and began her role on 12 September 2022. The Patient Safety Commissioner is responsible for acting as a champion for patients and leading a drive to improve safety of medicines and medical devices. Dr Hughes' role is to act as an independent point of contact for patients, giving a voice to their concerns to make sure they are heard. The appointment of a commissioner was in response to the recommendations of Baroness Cumberledge's review into patient safety (First Do No Harm) published in 2020. Dr Hughes previously served as National Guardian for Freedom to Speak Up.

Outstanding care every time

Outstanding care every time

St George's University Hospitals NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	3 November 2022	**Agenda No**	**4.6**
Report Title:	**Board Assurance Framework (BAF) Quarter 2 2022/23 Review**		
Lead Director/ Manager:	Stephen Jones, Group Chief Corporate Affairs Officer		
Report Author:	James Brind, Head of Risk, SGUH Maria Prete, Risk Manager, SGUH		
Presented for:	**Assurance**		
Executive Summary:	This paper presents the Trust Board with the Board Assurance Framework as at Q2 2022/23. With the exception of Strategic Risk 4, which is reserved to the Board, the information set out for each strategic risk has been reviewed by the relevant Board Committee. There are no proposed changes to the risk scores or assurance ratings for the strategic risks on the BAF at Q1 2022/23, though there are a number of changes to actions to address gaps in control and mitigation which are referenced in the report. The risk on the Corporate Risk Register related to Disclosure and Barring Service checks has been reduced from 16 to 8 in light of the actions taking to mitigate the risk over the past four months. In relation to the strategic risk reserved to the Board: **SR4 – *'As part of our local Integrated Care System, we fail to deliver the fundamental changes necessary to transform and integrate services for patients of South West London'*** • There are no changes to the risk score, which remains at 12 (4c x 3l) or to the assurance rating which remains as 'good'. • This is on the basis that the position at Q2 is not materially different in practical terms from the position at Q1 2022/23.		
	The Board is asked: a) For the Strategic Risk (system working) reserved to itself (SR4): o Agree the proposed score of 12 (4C x 3L) (no change) o Agree the proposed assurance rating of 'good' (no change) b) For the remaining 9 strategic risks assigned to its Committees to: o Agree the proposed risk scores, assurance ratings and statements from the relevant assuring committee o Note the progress in mitigating identified gaps in control and assurance.		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	Well led		
Single Oversight Framework Theme:	Quality of Care Leadership and Improvement Capability		

Implications			
Risk:	The strategic risk profile		
Legal/Regulatory:	Compliance with Heath and Social Care Act (2008), Care Quality Commission (Registration Regulations) 2014, the NHS Act 2006, NHSI Single Oversight Framework, Foundation Trust Licence		
Resources:	N/A		
Previously Considered by:	Quality Committee Finance Committee People Committee	**Date**	20.10.2022 21.10.2022 14.10.2022
Equality and diversity:	The BAF reflects agreed risks in relation to quality and diversity and the actions being taken to address these.		
Appendices:	Board Assurance Framework Q2 2022/23		

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Board Assurance Framework 2022/23

Trust Board
BAF Report – Q2 2022/23

Stephen Jones
Group Chief Corporate Affairs Officer

3 November 2022

Executive Summary

1. Purpose
This paper presents the Trust Board with the Board Assurance Framework as at Q2 2022/23 and sets out the proposed risk scores and assurance ratings, as well as the actions being taken to address identified gaps in control and assurance. With the exception of Strategic Risk 4, which is reserved to the Board, the information set out for each strategic risk has been reviewed by the relevant Board sub committee, following review by the responsible sub-Group of the Trust Management Group and by the Executive Management Team.

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

The Board approved the current risks on the Board Assurance Framework (BAF) at its meeting in May 2020. The Board Committees are assigned the Strategic Risks as follows, with Strategic Risk 4 (system working) reserved to the Board:

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

3. Update at Q2 202223:

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

- **Assurance ratings:** Six of the ten strategic risks currently have a 'good' assurance rating; three have 'partial' assurance rating, and one has a 'limited assurance rating.

Executive Summary

- **Target risk scores:** Target risks were initially defined by the Board in September 2020. Draft target risk scores are set out for each strategic risk and on the summary slides on page 4. In summary these are:

  - SR1 Patient Safety – 12: This reflects the 2021/22 year-end target risk position and was considered to be realistic on their basis that as the pandemic eases it is likely to be able to reduce the risk score from 16.
  - SR2 Clinical Governance – 8: This reflects the current risk score position. A stretching target risk score would be to reduce the risk further by reducing the likelihood score from 2 currently to 1 at year end, producing an overall risk score of 4. In an organisation of our scale and complexity, and with the clinical governance implementation plan having recently been implemented, it may be considered too ambition to have a risk score of 4 for clinical governance by year-end.
  - SR3 Access to care; ICT – 16: this reflects the 2021/22 year-end target risk position and is considered to be realistic, if challenging.
  - SR4 System working – 8: The 2021/22 year-end target risk was 12. the question is whether, given the inherent risks within the system, a reduction to 8 by year end is achievable. It is proposed that a target of 8 is adopted on the basis that from July ICBs have been established on a statutory basis and will further bed in during the year and that during the year we will further strengthen our new group arrangement with ESTH.
  - SR5 Financial sustainability – 16: The 2021/22 year end target risk was 12 was not met and at Q1 2022/23 the risk score was increased to 25. Given the scale of the financial challenge and delivering the balanced plan, a stretching year-end position was proposed as a score of 16, though it is recognised that this will be challenging to meet.
  - SR6 Capital – 16: The 2021/22 uear-end target risk score was 12 and was not met (the year finished with the score at 20). Given the overcommitment of available capital means there are a significant number of risks that are unaffordable within the current allocation, and there are many schemes and projects required to be delivered within the year 2 to 5 plan that are unaffordable within allocations within SWL, it is proposed that the target year end position is set at 16, recognising that it may not be possible within current allocations to significantly reduce the risk in relation to capital during 2022/23.
  - SR7 Estates – 16: The 2021/22 target year end risk score of 16 was achieved. It is questionable whether given the scale of estates risks and the constrained capital available, it will be possible to move the overall risk score down to 12 by year end. As a result maintaining a score of 16 doe the year is proposed.
  - SR8 Culture – 12: This reflects the 2021/22 year-end target risk score and is proposed to roll forward for 2022/23..
  - SR9 Workforce – 12: This reflects the 2021/22 year-end target risk score and is proposed to roll forward for 2022/23.
  - SR10 Research – 6: This reflects the 2021/22 year-end target risk score and is proposed to roll forward for 2022/23.

- **Progress in mitigating risks:** Included in the summaries of each strategic risk are overviews of the actions completed to address identified gaps in control and assurance. This is intended to demonstrate the progress achieved in mitigating the strategic risk even where this has not progressed to the point where a change in the risk score can be recommended. assurance for SR2, SR7 and SR9.

Strategic Risk 4 (system working) is reserved to the Board: The Board is asked to review and confirm the risk score and assurance level for this risk. When the Board reviewed the risk score in May 2022, it considered that while the Trust had made significant progress in establishing the new group with ESTH and working as part of SWL ICS, the inherent risks around system working that went beyond the Trust's control warranted the risk score being maintained at 12. In July there has been the commencement of Integrated Care Boards on a statutory basis, the appointments to roles within the SWL ICB, and the further progress the Trust and ESTH have made in developing the group model. Given the position at Q2 is not materially different in practical terms from the position at Q1, it is proposed the risk score is maintained at 12(4c x 3l) and the assurance score maintained at 'good'.

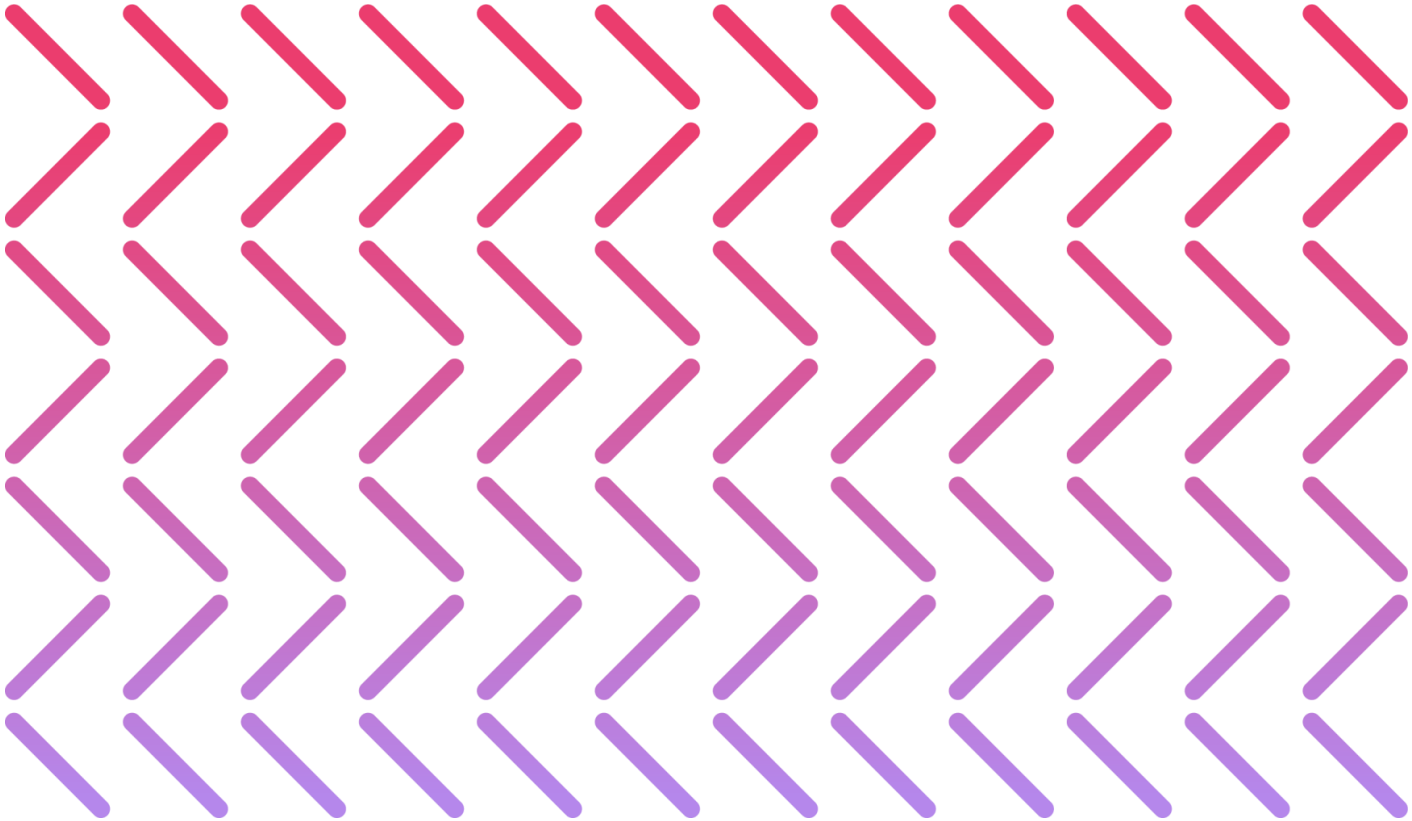
Strategic Risks: High Level Summary – Assurance Rating and Risk Score at Year End

Strategic Objective	Corporate Objective	Risk Reference	2021/22 Strategic Risks	ASSURANCE RATING		RISK RATING		TARGET RISK SCORES	
				Year start (April 2022)	Q2 position 2022/23	Year start (April 2022)	Q2 position 2022/23	Target to year end (Mar 23)	Target Met
1. Treat the patient, treat the person	Care	SR1	Our patients do not receive safe and effective care built around their needs because we fail to build and embed a culture of quality improvement and learning across the organisation	Partial	Partial	Extreme 16	Extreme 16	High 12	-
	Care	SR2	We are unable to provide outstanding care as a result of weaknesses in our clinical governance	Good	Good	Moderate 8	Moderate 8	Moderate 8	-
2. Right care, right place, right time	Care	SR3	Our patients do not receive timely access to the care they need due to delays in treatment and the inability of our technology and transformation programmes to provide accessible care built around our patients' lives	Partial	Partial	Extreme 20	Extreme 20	Extreme 16	-
	Collaboration	SR4	As part of our local Integrated Care System, we fail to deliver the fundamental changes necessary to transform and integrate services for patients in South West London	Good	Good	High 12	High 12	Moderate 8	-
3. Balance the books, invest in our future	Collaboration	SR5	We do not achieve financial sustainability due to under delivery of cost improvement plans and failure to realise wider efficiency opportunities	Partial	Limited	Extreme 20	Extreme 25	Extreme 16	-
	Collaboration	SR6	We are unable to invest in the transformation of our services and infrastructure, and address areas of material risk to our staff and patients, due to our inability to source sufficient capital funds	Partial	Partial	Extreme 20	Extreme 20	Extreme 16	-
4. Build a better St George's	Care	SR7	We are unable to provide a safe environment for our patients and staff and to support the transformation of services due to the poor condition of our estates infrastructure	Good	Good	Extreme 16	Extreme 16	Extreme 16	-
5. Champion team St George's	Culture	SR8	We fail to build an open and inclusive culture across the organisation which celebrates and embraces our diversity because our staff do not feel safe to raise concerns and are not empowered to deliver to their best	Good	Good	Extreme 16	Extreme 16	High 12	-
	Culture	SR9	We are unable to meet the changing needs of our patients and the wider system because we do not recruit, educate, develop and retain a modern and flexible workforce and build the leadership we need at all levels	Partial	Good	Extreme 16	Extreme 16	High 12	-
6. Develop tomorrow's treatments today	Collaboration	SR10	Research is not embedded as a core activity which impacts on our ability to attract high calibre staff, secure research funding and detracts from our reputation for clinical innovation.	Good	Good	Moderate 9	Moderate 9	Low 6	-

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

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

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



Strategic Objective	Treat the patient, treat the person	*Corporate Objective 2022/23:*	*Care*

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

Risk Appetite / Tolerance

LOW

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

Assurance Committee	**Quality Committee**
Executive Group	Patient Safety and Quality Group
Executive Lead(s)	Group Chief Medical Officer Group Chief Nursing Officer
Date last Reviewed	20 October 2022

Current risk and assurance assessment

Risk score:
The risk score remains at 16

Assurance rating:
The assurance rating remains at Partial. No changes are proposed a Q2 2022/23

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

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

During Q2 the trust has achieved
Quality Recovery Plan rolled out in the Trust, looking at Quality, Patient Experience and Safety. Currently in Pause and Reflect Module, the next phase is presentation of findings to the Trust management team and actions going forward.

Level of training for Resus approved and ARIS system updated

Three MR scanners are in place and will be functional from October 2022 which will improve the compliance with the 7 Day Service standards

Overall SR Rating – Quarterly Scores

Period 2022/ 2023	Risk Score	Assurance Strength	Change (last reporting period)	Inherent Risk Score	Target Risk Score 2022/23
Q1	16(4c x4L)	Partial	⟷	20 = 4(C) x 5(L)	12= 4(C) x 3(L)
Q2	16(4c x4L)	Partial	⟷		
Q3					
Q4					

Emerging risks

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

Future opportunities

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

Strategic Objective	Treat the patient, treat the person	*Corporate Objectives 2022/23:*	*Care*
SR1	**Our patients do not receive safe and effective care built around their needs because we fail to build and embed a culture of quality improvement and learning across the organisation**		

Key risk controls in place	Control effectiveness				Key sources of assurance	Lines of assurance (positive/ negative)		
	Q1	Q2	Q3	Q4		1	2	3
Quality and Safety Strategy in place and approved by the Trust Board (January 2020) supported by an implementation plan	S	S			• Trust removed from Quality Special Measures in March 2020 following improvements documented in CQC inspection report published in Dec 2019 • Quarterly update reports to QSC re delivery against Quality and Safety Strategy year 2 implementation plan		X X	X
Serious Incident reporting and Investigation Policy including electronic incident reporting system (Datix) in place	S	S			• Weekly review of serious incidents at serious incident declaration meeting and monthly report to PSQG and QSC (Note the Trust is currently awaiting the new -Patient Safety Incident Reporting Framework) • Internal Audit report/internal management action plan: rated substantial assurance		X X	X X
Complaints Policy in place	G	G			• Quarterly complaints report to Patient Safety Quality Group identifying emerging themes and learning • Internal Audit report including internal management action plan: rated reasonable assurance • Learning from complaints included in divisional governance reports		X X X	X
Friends and Family Test – *SMS feedback method in place for virtual and face to face outpatient appointments* - Text messaging – SMS surveys for inpatient surveys setup. Ward display of FFT report 'You siad, we did'.	G	G			• Friends and Family Test: Monthly performance reports to QSC via IQPR		X	X
Infection Control Policy including Root Cause Analysis (RCA) for all C. Diff cases to ensure learning in place	S	S			• Infection control audit reports identifying emerging themes and improvement actions • Ward round monitoring to ascertain that infection control requirements are in place and followed and periods of increased Surveillance and Assessment (PISA)	X X	X X	
Early Warning Score training in place	G	G			• nEWS assurance audit	X	X	
Treatment Escalation Plans in place for all non-elective adult patients within 24 hours of admission	R	R			• Report to PSQG,		X	
Sepsis tool live on iClip	R	R			• Sepsis tool on iClip in place	X		
COVID-19 measures: patient testing, masks, and facilities	G	G			• Covid testing carried out on day 0, 3 and 7 of admission; Masks wearing for in-patients; Emergency floor development increased number of single isolation facilities • Daily compliance performance report for PCR testing	XX		
Governance structure – new positions all recruited to	G	G				X		
Life support training - Programme to increase the numbers of staff who have undertaken required life support training is in place . ARIS system updated	R	R			• March 2022 BLS 76 %, ALS 74% and ILS 69%, • Trajectory and action plans being drawing up to set when compliance will be achieved in all of the 3 domains above. Will be shared and discussed in November2022 at Quality Committee	XX		

Strategic Objective	Treat the patient, treat the person	*Corporate Objectives 2022/23:*	*Care*
SR1	**Our patients do not receive safe and effective care built around their needs because we fail to build and embed a culture of quality improvement and learning across the organisation**		

Gaps in controls and assurances	Actions to address gaps in controls and assurances	Complete by (date)	Progress
Appropriate level of training for Resus	Implementation of training needs analysis to support RNs undertaking BLS training instead of ILS TNA approved at DMB level – presented at PSQG. MAST team have implemented the changes on the ARIS system	Complete	
Seven day clinical services standards (also see SR3)	**Implementation of Divisional action plans to achieve seven day clinical service standards compliance.** All Care Groups have updated their risk assessment. Directorates have defined plans to address all non- compliance and provide assurance that the quality of care is not compromised by the lack of 7 day services. All three MR scanners are in place and will be fully functioning by the middle of October 2022. Two of the scanners will run 7days a week 12/14 hrs and the third will run 9-5, 5 days a week. Budget setting and job planning for 2022/23 will address a number of gaps in 7 day services.	~~Feb 2022~~ Aug 2022	
Early Warning Score electronic devices not reliable due to IT issues as patient observations are not visible by the bedside. Lack of handheld devices to facilitate nurses' awareness of vital signs	**Improve Early Warning Score electronic device availability in the wards through Wi-Fi and address cold spot** *Wi-Fi will be addressed through the ICT Network improvement Project which is expected to run until the end of 2022*	~~Dec 2021~~ Dec 2022	

Strategic Objective	Treat the patient, treat the person	*Corporate Objectives 2022/23:*	*Care*

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

Risk Appetite / Tolerance

LOW

We have a **low appetite** for risks that affect the robustness of our clinical governance structures, systems and processes as these can impact directly on the quality of care patients receive.

Assurance Committee	**Quality Committee**
Executive Group	Patient Safety and Quality Group
Executive Lead(s)	Group Chief Medical Officer Group Chief Nursing Officer
Date last Reviewed	20 October 2022

Current risk and assurance assessment

Risk score:
It is proposed for the risk score for SR2 to remain at 8 as agreed at the March 2022 Quality Committee.

Assurance rating:
The assurance rating of good was agreed at the March 2022 Quality Committee meeting. This is on the basis of progress achieved in implementing the clinical governance improvement plan.

Changes since last quarter:
No changes in Q2 2022/23

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

During Q2 2022/23
The trust continue to make progress against the Clinical Governance Improvement programme.

M&M minimum dataset is being rolled out in further care groups.

In preparation for LPS, the safeguarding team have all received training as a 'best interests' assessor, in anticipation for its roll out.

Overall SR Rating – Quarterly Scores

Period 2022/ 2023	Risk Score	Assurance Strength	Change (last reporting period)	Inherent Risk Score	Target Risk Score 2022/23
Q1	**8 (4c x 2L)**	**Good**	⟷	**20 = 4(C) x 5(L)**	**8= 4(C) x 2 (L)**
Q2	**8 (4c x 2L)**	**Good**	⟷		
Q3					
Q4					

Emerging risks

- Impact of any further Covid-19 waves
- Impact of operational pressures on clinical governance meetings

Future opportunities

- IT developments to support new ways of working e.g. care group meetings and communication

Strategic Objective	Treat the patient, treat the person	*Corporate Objectives 2022/23:*	*Care*

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

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

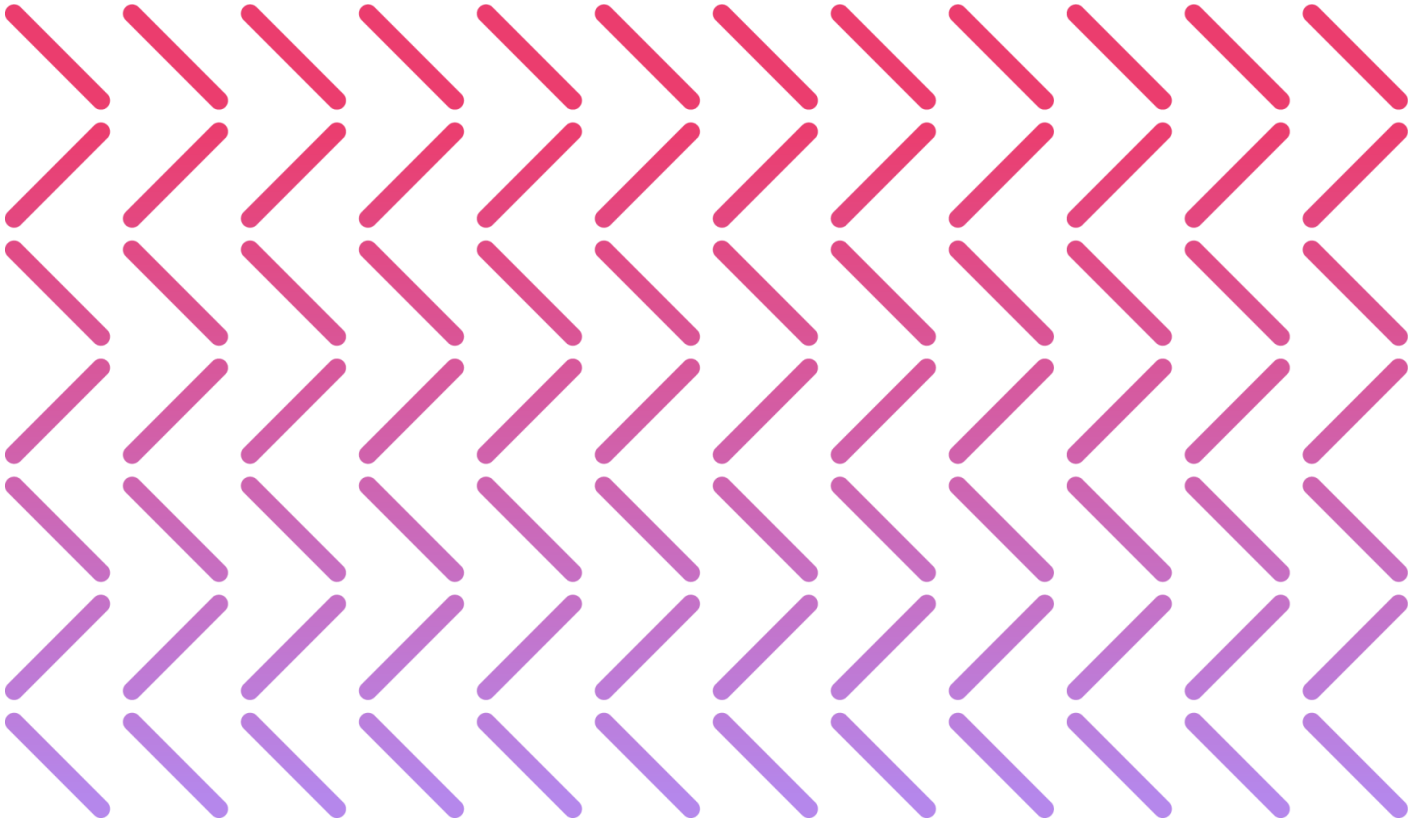
Strategic Objective	Treat the patient, treat the person	*Corporate Objectives 2022/23:*	*Care*
SR2	**We are unable to provide outstanding care as a result of weaknesses in our clinical governance**		

Gaps in controls and assurances	Actions to address gaps in controls and assurances	Complete by (date)	Progress
Full implementation of the Cardiac Surgery action plan to address all recommendations from the reviews	**Implement the Cardiac Surgery action plan** One remaining action left to be completed regarding medical staffing within CTICU out of hours, due to covid-19 pandemic this has not yet been addressed.	~~Oct 2021~~ Dec 2022	
MCA level 3 training module	**Develop and implement MCA level 3 training module. Level 3 / Champions programme** *The development of a level 3 MCA training programme has been paused. The programme will be developed as part of the preparation for the implementation of the Liberty Protection Safeguards.*	~~April 2022~~ April 2023	
OrderComms catalogue not kept up to date therefore not all results are reported via Cerner	**Update Cerner OrderComms catalogue:** *Delayed as resources diverted to set up COVID vaccine hub* The SWLP LIMS project is working through each discipline in terms of order comms and completing end to end testing of the orders between Clinisys WinPath Enterprise and all of the order comms systems in the sector including SGH's iCLIP.	~~Dec 2021~~ Dec 2022	
Liberty Protection Safeguards (LPS) process not yet issued by DoH	**Trust to implement LPS from April 2022 following DoH guidance.** Consultation completed and we have submitted our update with risks and concerns in April 2022. Next phase is for the release of how this will be rolled out nationally, the training required for staff and the workforce required to meet this new standard for our vulnerable patients.	April 2023	

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

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

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



Outstanding care every time

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

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

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

Assurance Committee	**Finance Committee**
Executive Lead(s)	Managing Director – St George's Group Chief Finance Officer
Date last Reviewed	21 October 2022

Current risk and assurance assessment

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

Assurance rating:
It is proposed that the assurance rating remains unchanged at 'Partial' to reflect the grip, focus monitoring and assurance on mitigations for both operational delivery and IT.

Changes since last quarter:
No changes are proposed to the overall risk score or to the assurance rating at Q2 2022/23

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

During Q2 2022/23 the Trust has

Continued to demonstrate consistent delivery for Priority 1 patients (cancer and non-cancer, treat within 72 hours) and Priority 2 patients (cancer and non-cancer, treat within 28 days). There is confidence we we are treating patients with urgent clinical needs in a timely way.

Continued to demonstrate consistent delivery for Priority 1 patients (cancer and non-cancer, treat within 72 hours) and Priority 2 patients (cancer and non-cancer, treat within 28 days). There is confidence we are treating patients with urgent clinical needs in a timely way.

The Flow Improvement Programme commenced with specific actions in QI namely RedtoGreen, morning discharges, timely completion of D2A referrals. Flow programme has been re cast and resourced to accelerate this programme and re focus into the most challenged areas. Deputy CNO is the clinical lead and workstream reports into Emergency Care Delivery Board

Overall SR Rating – Quarterly Scores

Period 2022/ 2023	Risk Score	Assurance Strength	Change (last reporting period)	Inherent Risk Score	Target Risk Score For 2022/23
Q1	20(4c x 5L)	Partial	⟷	25 = 5(C) x 5(L)	16 (4x4)
Q2	20(4c x 5L)	Partial	⟷		
Q3					
Q4					

Emerging threats

The combination of increased patient acuity, and placement of COVID patients in appropriate beds slows the flow; together with challenges in onward capacity in care homes / nursing homes / Package of Care arrangements means that there has been a fundamental mismatch between admission rates / length of stay and discharge rates on medical non-elective inpatient pathways, with significant deleterious impact on flow through the ED. This has caused 12 hour breaches for patients awaiting an inpatient bed and 60+ minute ambulance handover breaches.

Staff sickness during Covid surges remains and challenges to secure additional shifts also creates capacity challenges.

Future opportunities

Additional focus and reframing of flow progamme to be more targeted at wards and services with increasing length of stay. Emergency Care delivery board has recommenced and will coordinate and drive improvement action plans both within ED and across the wider trust to reduce the time patients spend in ED. Programme of work underway to support our community health partner to expand the Hospital@Home service, which takes patients home for treatment and care once the patient has been assessed, diagnosed and a treatment plan implemented by AMU.There is potential with re allocated funding from Integrated care beds that are underutilised to triple the capacity of the H@H service commencing in October/November 2022.
Actions underway to expand the capacity and resilience of medical and surgical (to weekends) Same Day Emergency Care pathways (SDEC) which divert patients away from ED to speciality 'hot' clinics that can best meet their need and minimise numbers in ED.

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

Key risk controls in place	Control effectiveness				Key sources of assurance	Lines of assurance (positive/ negative)		
	Q1	Q2	Q3	Q4		1	2	3
Clinical Safety Strategy	S	S			Clinically driven plan agreed at Operational Management Group and approved at Quality and Safety Committee		X	
Insourced company to manage adult and paediatric ECHO. Lead paediatric cardiographer with accreditation in congenital heart disease to oversee the service and train more staff	P	R			Performance included in Integrated Quality and Performance Report (IQPR)	X	X	
Digital strategy - ICT Work plan aligned to Digital strategy	R	R			Digital strategy aligned to clinical strategy and outpatient strategy		X	
VDI	S	S			VDI project updates to IGG – project has completed	X	X	
Virtual clinics – video conferencing system with patients (Attend Anywhere) in use with supporting laptops, webcams and headsets installed; operational management by Corp OPD	R	R			Informatics Governance Group		X	
New workflow in iClip for Referral Assessment Service (RAS) clinics as part of Covid19 changes and rolled out to Trust as BAU	S	S			ICT Outpatient Project Steering Group and the Trust Communications news story published in Staff Bulletin 26 June 2020	X		
Provision of iCLIP clinic documentation for physical or virtual OPA available.	S	S			Trust Communications news story published in Staff Bulletin 26 June 2020	X		
Provision of Office365 and Microsoft Teams to support MDT cancer and orthopaedic meetings and further roll out in progress	S	S			ICT Covid-19 Service Management Report presented to IGG in April 2020 10,000 staff migrated to Office 365 with access to teams presented to IGG Oct 2020		X X	
Provision of MDT conferencing rooms	R	R			5 out of 6 completed	x		
ED rapid assessment and triage process in place	S	S			Clinical pathway and Standard Operating Procedure (SOP)	X		
Direct access pathways	S	S			Clinical Pathway and SOP	X		
Partnership working between ED and local Mental Health organisations to improve care and waiting time for patients attending the ED with mental health needs	R	R			Clinical Pathway, Memorandum of Understanding/ COMPACT, and local service performance metrics	X		
UCC direct pathways	S	S			Clinical Pathway and SOP	X		
Clinical Decision Outcome Form (CDOF) incorporated within iClip	P	P			eCDOF Tableau report showing operational non-compliance	XX		

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

Gaps in controls and assurances	Actions to address gaps in controls and assurances	Complete by (date)	Progress
Seven day clinical services standards	**Implementation of Divisional action plans to achieve seven day clinical service standards compliance.** All Care Groups have updated their risk assessment. Directorates have defined plans to address all non- compliance. Capital works to install 2 static MRIs has been completed. Budget setting and job planning for 2021/22 focussed on addressing a number of gaps in 7 day services.	Complete d	
Cyber security	Implement recommendation to improve cyber security - The network is segmented via VLAN, migration from N3 to HSCN done, password policy implemented. Forcepoint and IPS in place. Agresso replaced by SBS Oracle. Added Heimdal patching software to improve compliance with mandatory patching. Added back up appliances to increase resiliency and additional Rubrik recovery solution. Implementing multi-factor authentication. Decommissioning of Win7 licenses so that devices are unable to connect to trust network.	Dec 2022	
ICT disaster recovery (DR) plan – require solution for 2nd data centre	Design ICT disaster recovery (DR) plan to include provision for second data centre Draft plan for hybrid model approved by IGG in Dec 2020; Site for a 2nd physical onsite data centre will be longer term depending on internal build such a renal unit, or availability in community or sites in SW London. Cloud solution for partial DR now purchased and being configured. Current phase is implementation, moving suitable systems across to cloud solution with view to reducing score when complete so due date modified but awaiting high speed VPN - delays due to resourcing constraints but new ICT Head and Deputy Head of Infrastructure now in post to complete the work. Funding yet to be secured during 22/23 for the second data centre	~~Mar 2021~~ Oct 2023	
MDT teleconferencing for SWLP, equipment not yet provisioned; workflows changed due to Covid-19	ICT Project Plan 2020/21 to improve hardware and workflow for MDT teleconferencing. 5 rooms out of the original requirement for 6 rooms have been delivered. Delay completing as 1 further room needs to be identified by organisation.	~~Apr 2022~~ Dec 2022	
Data warehouse capacity - not built to deal with current volume of data / continue use of paper based records. Cerner nightly extracts being terminated.	Project to improve data warehouse in capital plan 20/21 delayed due to Covid and now in flight and scheduled to complete Nov 2022	Nov 2022	
Multiple clinical systems which do not interoperate leading to fragmented clinical records (use of standalone systems not using patient MRN as single identifier)	Anaesthesia project to roll out Anaesthesia Module and retire paper charts during 2022 Funding secured for upgrade of Viewpoint and integration to iCLIP during 2022/23 and to replace the current maternity solution with iCLIP maternity solution which will be a 1year project. The risk will decrease after maternity project completes Funding to be secured for integration projects of smaller standalone systems e.g. Auditbase and Optimum	~~Sept 2022~~ Dec 2023	

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

Gaps in controls and assurances	Actions to address gaps in controls and assurances	Complete by (date)	Progress
ICT network infrastructure is old and not sufficiently resilient or able to meet today's demands for Wi-Fi and video-conferencing	Replacement of network core completed in Q2 2021/22; additional requirements to implement DMZ being resourced; followed by campus network and Wi-Fi completing Q4 2022/23. Phased improvement over this time period. Operationalisation of DMZ deferred until early 2023. Delays due to services giving up space for new comms rooms.	~~Mar 2022~~ Mar 2023	
Single view across all patient G&A flow	**Steps to be taken at individual ward level initially focussing on medical wards to get ownership and feedback loop in place on key metrics of flow:** • Consistent use of Red to Green to aid discharge planning • Benchmarking on length of stay and feedback loop by clinical speciality • Consistent volume of pre-11am discharges • Ward flow improvement programme roll out across medical wards	Dec 2022	
Cerner resource to implement Digital Bed Management Tool in iClip	Cerner resource identified to implement Digital Bed Management Tool in iClip Training needs assessment and roll out plan being developed for implementation in March 2023	Mar 2023	
Emergency Department capacity	Expand sub-acute Hospital@Home to take patients home from ED / AMU (once worked up), avoiding inpatient admission for frail patients where this additional resource prevents need for acute admission Extend Surgical SDEC to weekends Increase SDEC pathways and access to 'hot' clinics to prevent admission for patients who can be managed in an ambulatory setting. Re-introduce internal professional standards Agree an in department improvement plan to improve patient turnaround times in ED and delivery of the new ED standards Open new UTC with additional capacity and capability to take patients directly from ambulances when UTC suitable. Enhance front door frailty model with expanded capacity Adopt North Bristol Flow Programme UTC opened with additional capacity and capability to take patients directly from ambulances when UTC suitable	Dec 2022	

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

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

Risk Appetite / Tolerance

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

Assurance Committee	**Trust Board**
Executive Lead(s)	Group Deputy Chief Executive
Date last Reviewed	7 July 2022

Current risk and assurance assessment

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

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

Changes since last quarter:
No changes to risk scores or assurance ratings proposed at Q2.

Gaps in control and assurance addressed year-to-date:
The risk has been mitigated by the establishment of new controls :

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

Overall SR Rating – Quarterly Scores

Period 2022/ 2023	Risk Score	Assurance Strength	Change (last reporting period)	Inherent Risk Score	Target Risk Score For 21/22
Q1	12(4C x3L)	Good	⟷	16 = 4(C) x 4(L)	12= 4(C)x3(L)
Q2	12(4Cx3L)	Good	⟷		
Q3					
Q4					

Emerging risks

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

Future opportunities

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

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

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

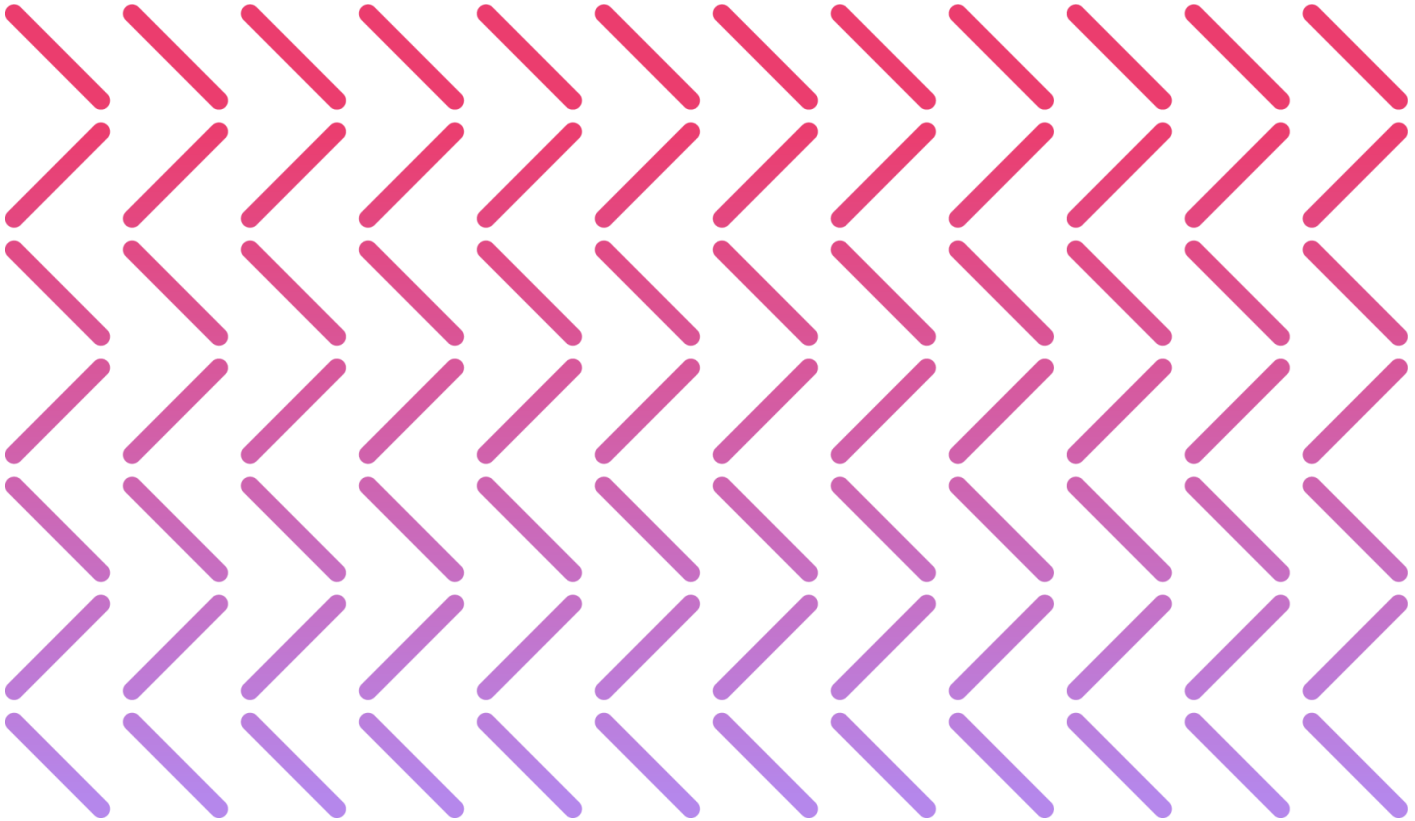
Strategic Objective	Right care, right place, right time	*Corporate Objectives 2021/22*	Collaboration
SR4	**As part of our local Integrated Care System, we fail to deliver the fundamental changes necessary to transform and integrate services for patients in South West London**		

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

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

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

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



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

Risk Appetite / Tolerance	**LOW**	We have a low appetite for risks that will threaten the Trust's ability to deliver services within our financial resources	**Assurance Committee**	**Finance Committee**
			Executive Lead(s)	Group Chief Finance Officer
			Date last Reviewed	21 October 2022

Current risk and assurance assessment

Risk score:
The current risk score for SR5 of 25 continues to reflect the level of financial uncertainty and risk the Trust faces in year, particularly in relation to the H2 position.

Assurance rating:
The assurance rating remains as Partial

Changes since last quarter:
No changes are proposed to the overall risk score or to the assurance rating at Q2 2022/23

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

- c£35m of unidentified CIP remains in the Trusts financial position, with limited opportunities identified against this gap to close it.
- A material financial gap exists within the ICS position, so it is unlikely additional funds from the sector will be available to close this financial gap.
- Further actions to close this gap are being reviewed by both site, and group teams.
- Divisional financial performance is being picked up through a monthly financial improvement Trust Management Group meeting chaired by the MD.
- Divisions are being met on a bi-weekly basis by the Site CFO to review overspends, and underspends. Equal attention is being given to both as ensuring underspends on areas of lower activity due to the pandemic will form a material part of the financial recovery plan.
- Increased financial governance has been introduced through Thursday focussed sessions aimed at delivering financial improvement, efficiency, and control.

The Trusts financial plan is currently breakeven. However, with the overall scale of the CIP needed to reach breakeven, the material level of unidentified CIP and the fact we are at the end of September the current forecast indicates that breakeven cannot be delivered.
The lack of visibility of a clear path to breakeven and the level of concern within the Executive Group and discussions at the last Finance Committee it is proposed to score this risk as 25; at this time it is certain the trust will fail to achieve breakeven, a score of 5 and the impact is above the threshold to score a 5.

Overall SR Rating – Quarterly Scores

Period 2022/ 2023	Risk Score	Assurance Strength	Change (last reporting period)	Inherent Risk Score	Target Risk Score
Q1	25(5c x 5L)	Partial	⟷	25= 5(c) x 5(L)	12 4(c) x 3(L)
Q2	25(5c x 5L)	Partial	⟷		
Q3					
Q4					

Emerging risks

- Financial envelopes for 23/24 materially lower than current expenditure levels.
- Increasing workforce challenges
- Competing priorities within divisions meaning finance isn't prioritised due to extreme operational pressures.

Future opportunities

- Financial improvement/mitigation through further collaboration within the SWL ICS
- Addition actions to be considered and approved through site and group meetings.

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

Key risk controls in place	Control effectiveness				Key sources of assurance	Lines of Assurance (positive / negative)		
	Q1	Q2	Q3	Q4		1	2	3
Monthly divisional finance meetings with in place with DCFO to discuss areas for escalation (underspends/overspends)	S	S			Monthly divisional finance reports	x		
Monthly reporting of financial issues through to TMG, FIC and Trust Board	S	S			Monthly Trust finance reports		x	
Financial plan in place, with monthly performance being scrutinised vs budget	S	S			Monthly report to Finance and Investment Committee		x	
South West London FAC continued to develop system financial management processes in support of delivery of control totals.	G	G			SWL Monthly Finance Report			x
Financial forecast in place for 22/23 at divisional level		G				x		
Thursday meeting structure in place to escalate issues to the site leadership team		S					x	

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

Gaps in controls and assurances	Actions to address gaps in controls and assurances	Complete by (date)	Progress
South West London financial performance management structure in place to drive and ensure financial performance and best practise within sector	- Trust to lead development of financial governance with SWL ICB ahead of 22/23alongside change in governance structure at SWL level. - Framework agreed by CFOs and CEOs - Further work required to ensure full benefit realised from SWL working.	Sept 20	
Large value of unidentified CIP	- Thursday focus meetings in place to identify and drive improvement - CIP half day sessions for idea generation planned.	Dec 22	
Capacity plan not fully developed inline with new working environment post COVID	- Ongoing operational changes within the hospital are meaning this work is ever evolving and fluid. - Capacity plan to be agreed in line with financial forecasts and performance trajectories through TMG - Capacity plan agreed as part of activity trajectory's. Still a work in progress - Further work required on theatres, beds, and outpatient demand and capacity plans.	Nov 21	
Lack of accountability within services for financial performance and delivery	- Ongoing operational challenges have delayed the implementation of this mitigation. - Finance to be included within objectives of all leadership posts with financial responsibility within the organisation	Nov 21	
Current forecast predicts material risk against current levels of funding	- Thursday meetings to focus on control and improvement - Issues to be raised through SWL ICS to NHSEI regarding funding shortfalls	Dec 22	
Plan for 23/24 beginning to be worked up, but very likely to show material and increasing financial risk	- Plan to be developed internally within the Trust ahead of 23/34 - Plan to be developed alongside SWL ICS plans and financial envelopes - Planning guidance to be received, digested, and built into assumptions.	Apr 23	

Strategic Objective	**Balance the books, invest in our future**								
SR6	**We are unable to invest in the transformation of our services and infrastructure, and address areas of material risk to our staff and patients, due to our inability to source sufficient capital funds**								
Risk Appetite / Tolerance	**LOW**	Due to the importance of securing investment in the Trust's ageing estates infrastructure, we have a low appetite for risks that could impact on the availability of capital	**Assurance Committee**	**Finance Committee**					
			Executive Lead(s)	Group Chief Finance Officer					
			Date last Reviewed	21 October 2022					
Current risk and assurance assessment	**Risk score:** The current risk score of 20 reflects the challenges the Trust faces in relation to capital funding. **Assurance rating:** The assurance rating remains at Partial. **Changes since last quarter:** No changes in risk score or assurance rating. **Gaps in control and assurance addressed year-to-date:** • Current capital funding available (CDEL) to SWL has now been confirmed, with all element of the 22/23 plan now funded. • Weekly reviews taking place with site CFO to ensure limited funds are prioritised and risks articulated from funding shortfalls. • Mitigations to risks currently being worked through including reviewing timings of projects between years, as well as revenue funding sources for some projects. • Trusts capital plans for 23/24 and beyond do not have sources of funding confirmed against them. • Significant shortfall currently in existence across South West London when comparing essentially plans to CDEL allocation for 23/24 and beyond. Mitigation being worked through in the ICS, but has a material impact on St George's. Whilst the Trust currently has a capital plan that remains within allocations for 22/23, there are significant number of risks that are unaffordable within the current allocation. In addition, there are many schemes and projects required to be delivered within the year 2 to 5 plan that are currently unaffordable within allocations within SWL. Further risk is emerging in relation to the ability to spend capital due to global supply chain issues. It is unlikely that the Trust will be able to undertake all the investments it would like over the next 5 years, however, the trust will have access to significant sums of capital meaning that it will be possible to address critical issues.								
			Overall SR Rating – Quarterly Scores	**Period 2022/ 2023**	**Risk Score**	**Assurance Strength**	**Change** (last reporting period)	**Inherent Risk Score**	**Target Risk Score**
				Q1	**20(4c x 5L)**	**Partial**	⟷	**20 = 4(c) x 5(L)**	**12 4(c) x 3(L)**
				Q2	**20(4c x 5L)**	**Partial**	⟷		
				Q3					
				Q4					
			Emerging risks				**Future opportunities**		
			- Inflationary pressures causing cost risk to projects - Supply chain issues are pushing prices of goods up				- Emergency capital funding made available from NHSE/I - Further prioritisation within SWL to move money to address material and urgent risk at St George's.		

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

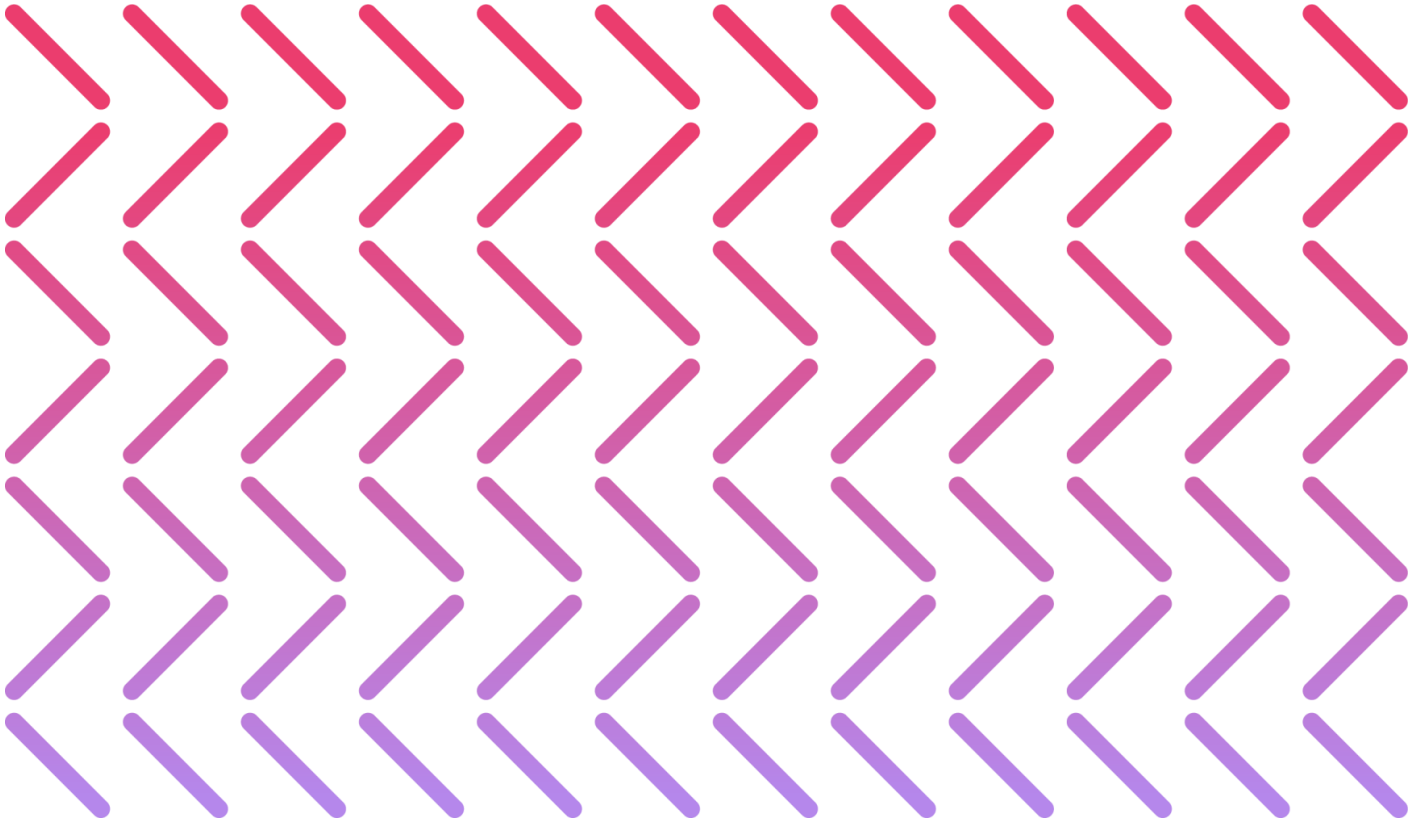
Key risk controls in place	Control effectiveness				Key sources of assurance	Lines of Assurance (positive / negative)		
	Q1	Q2	Q3	Q4		1	2	3
Monthly reporting to FIC and Trust Board on key areas of risk, both financially, and due to non-investment.	S	S			Monthly finance reports		X	
Weekly Capital funding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

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

Gaps in controls and assurances	Actions to address gaps in controls and assurances	Complete by (date)	Progress
No formal agreement of sources of funding for Trust strategic projects (renal, paed cancer etc.)	Pursue national funding streams for strategic projects Pursues additional regional funding with the London team for projects Work with ICS team on SWL capital prioritisation	March 23	
No alternative means of financing identified to fund programme	Alternative methods of financing current programme to continue to be reviewed Further work is ongoing to ensure all options are explored for projects in the pipeline	March 23	
Confirmation of funding for 23/24 programme in place	Capital prioritisation with SWL to be worked through	March 23	
Confirmation of funding for 24/25 programme and beyond in place	Further work required through ICS to ensure funding for 5 year capital plans are in place	March 23	

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

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



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

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

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

Assurance Committee	**Finance Committee**
Executive Lead(s)	Managing Director, St George's
Date last Reviewed	21 October 2022

Current risk and assurance assessment

Risk score:
The risk score remains at 16, following the lowering of the score from 20 in Q4 2021/22.

Assurance rating:
Based upon our most recent Premises Assurance Model submission to NHSE, we believe our level of assurance remains Good. With planned investment in a cloud base tool to measure PAM, we would suggest that on successful implementation our assurance level would be substantial.

Changes since last quarter:
No changes are proposed at Q2 2022/23

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

Progress during Q2 2022/23
The Trust have successfully secured all of SWL's green capital investment this year, and have been given £0.5m to complete 4 projects

The cath labs project is now complete and in full clinical use. The MRI building has been handed over and is now in Trust ownership. We are completing operational testing and commissioning and should be fully operational by the time of the meeting.

Unprecedented supply chain disruption in our capital projects for ventilation and electrical systems due to EU cutting production; as well as manpower resource constraints from sub-contractors

Overall SR Rating – Quarterly Scores

Period 2022/ 2023	Risk Score	Assurance Strength	Change (last reporting period)	Inherent Risk Score	Target Risk Score For 2022/23
Q1	16(4c x 4l)	Good	⟷	25 = 5(C) x 5(L)	12 = 4(c) x 3(l)
Q2	16(4c x 4l)	Good	⟷		
Q3					
Q4					

Emerging risks

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

Future opportunities

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

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

Key risk controls in place	Control effectiveness				Key sources of assurance	Lines of Assurance (positive / negative)			
	Q1	Q2	Q3	Q4		1	2	3	4
Risk adjusted backlog maintenance programme informed by Authorised Engineer reports and independent condition surveys	S	S			The most recent independent reports have shown good levels of assurance Safety working groups are now all meeting again PAM now provides enhanced assurance, this has now been assessed externally and improvements being implemented.. CQC report 2019 - technical assurance has been provided on the key areas of concern where reactive maintenance could potentially impact patient care		x x x x	x x x x	x x x x
Investment profile provides plans to manage backlog maintenance investment	W	W			Longer term capital planning is still a concern but is due to be addressed in the next financial year		x		
Governance systems in place to provide oversight on critical estates issues	P	S			Our 21/22 PAM submission has shown a marked improvement in our performance.			x	
Estate Assurance Group to review all key assurance and activities	S	S			The Group is now meeting regularly to review key assurance activities		x x		x
Green Plan	S	S			A first Green Committee has been held and more detailed action planning is underway		x	x	
Estates Strategy	S	S			Estates strategy is now being developed into a Strategic Business Case which will provide further details on options and implementation		x		x

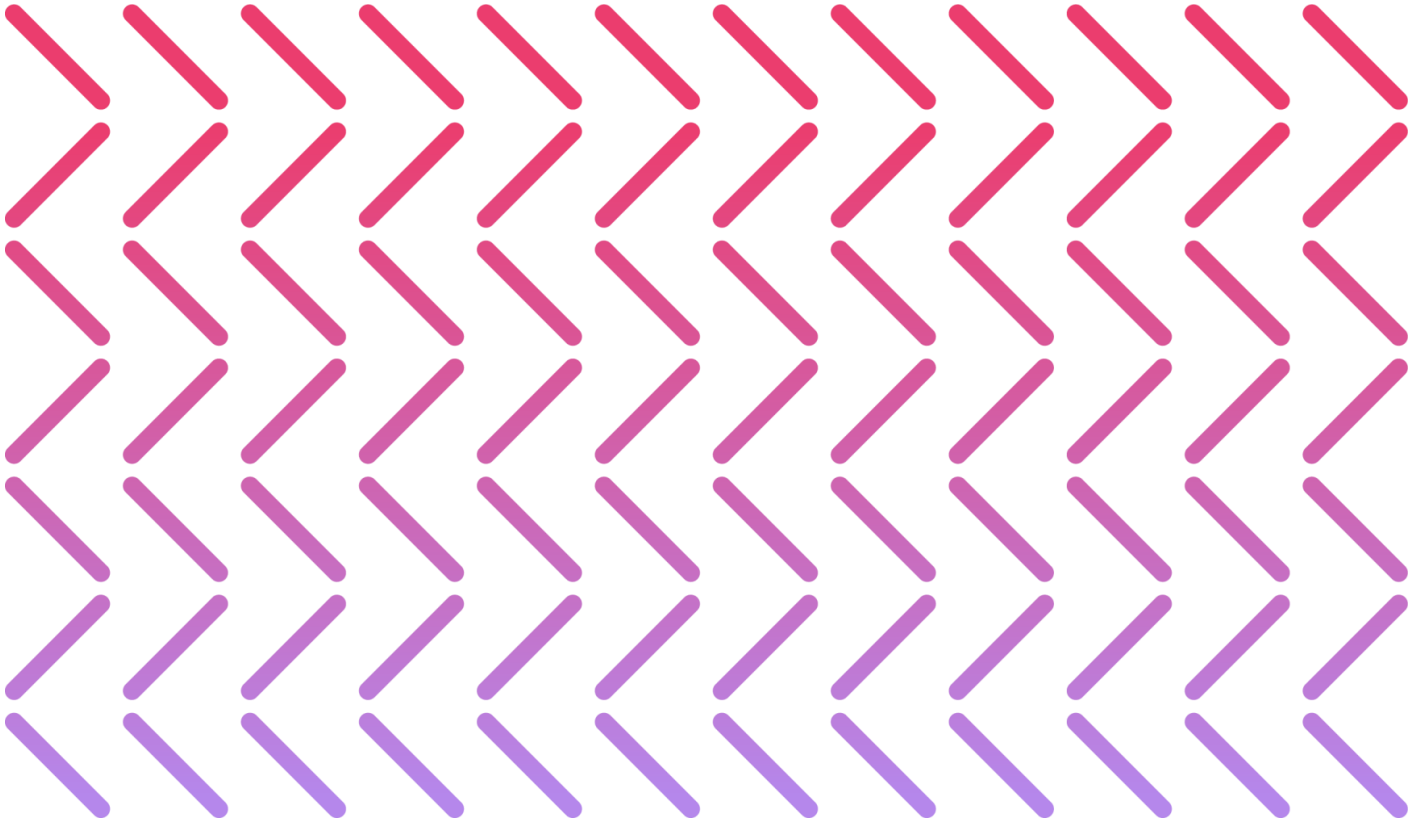
Strategic Objective	Build a better St George's	*Corporate Objectives 2021/22:*	Care
SR7	**We are unable provide a safe environment for our patients and staff and to support the transformation of services due to the poor condition of our estates infrastructure**		

Gaps in controls and assurances	Actions to address gaps in controls and assurances	Complete by (date)	Progress
No centralised data management system in place to ensure all required information is available and coordinated	We are now out to tender for automated ERIC and PAM submission systems. These are relatively new products but the market is now maturing and a number of providers are available. These systems will provide better data management, reduced administrative burden and better real time data on assurance	Dec 2022	
Estates restructure	We have completed the first phase of the restructure by moving assurance activities to the Health and Safety team. We are now preparing a business case for the second phase of restructuring the operational teams.	Dec 2022	

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

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

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



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

Risk Appetite / Tolerance	**LOW**	Due to concerns around bullying and harassment and the ability of staff to speak up without fear, we have a low appetite for risks that could impact on the culture of the Trust	**Assurance Committee**	**People Committee**
			Exec Review Group	People Management Group
			Executive Lead(s)	Group Chief People Officer
			Date last Reviewed	14 October 2022

Current risk and assurance assessment

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

Assurance rating:
It is proposed that we maintain the assurance rating of Good for Q2 to reflect the progress the Trust has made in mitigating the risk but also the challenges the Trust still faces as shown in our previous staff survey.

Changes since last quarter:
No changes in Q2 2022/23

Gaps in control and assurance addressed year-to-date:
During Q2 22/23 the risk has been mitigated by the completion of a number of identified gaps in controls:

- There is clear governance and reporting through the Culture, Equity and Inclusion Programme Board
- Delivery against the D&I action plan continues and is monitored via PMG
- Staff Survey 2021 priorities were developed into the new Big 5 and successfully rolled out across the Trust in Q1 and Q2
- Quarterly Pulse Survey has been implemented, and the results reported on via PMG
- Management Fundamentals training has been designed, with roll out initiated in Q2
- The Head of Talent Management role has been appointed and a Talent Management Strategy will be developed in Q3 and Q4 for 2022/23
- The Values and accompanying Behaviours have been refreshed and rolled out

Overall SR Rating – Quarterly Scores

Period 2022/ 2023	Risk Score	Assurance Strength	Change (last reporting period)	Inherent Risk Score	Target Risk Score For 2022/23
Q1	16 (4C x 4L)	Good	⟷	20 = 4(C) x 5(L)	12 = 4(C) x 5(5L)
Q2	16 (4C x 4L)	Good	⟷		
Q3					
Q4					

Emerging risks

- Impact of operational pressure on staff health and well-being.
- Cost of Living Crisis and the impact upon the health and wellbeing of our staff.
- Risk that culture programme does not deliver anticipated changes / improvements
- Length of time in resolving concerns raised via FTSU impacts on staff confidence in speaking up

Future opportunities

- Continuing delivery of the culture change programme
- Learning from Trusts with positive FTSU cultures and from NHSE&I's ongoing support on FTSU

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

Key risk controls in place	Control effectiveness				Key sources of assurance	Lines of Assurance (positive /negative)		
	Q1	Q2	Q3	Q4		1	2	3
Workforce strategy in place and approved by the Trust Board	S	S			Workforce Strategy refreshed and approved by Trust Board.		X	
Culture change programme established with clear timelines for delivery.	S	S			Culture plan reviewed and endorsed by the Trust Board. Delivery of plan overseen at Board level by the People Committee and on the management side by the Culture, Equity and Inclusion Programme Board and People Management Group Trust Values and Behaviours refreshed and rolled out		X	
Culture, Diversity and Inclusion Programme Board established	S	S			CEI Programme Board meets monthly, chaired by the Group CEO	X	X	
The Diversity and Inclusion action plan agreed by the Trust Board in July 2020	S	S			Progress of D&I action plan delivery reviewed at PMG and People Committee	X	X	
Trust D&I lead recruited and in place	S	S			D&I Lead in post.	X	X	
Staff networks in place to support particular groups	R	R			Networks in place and meeting regularly. Positive early engagement from staff in staff network groups. Network chairs in place, TORs agreed	X	X	
Big 5 launched in order to address issues raised by staff in NHS Staff Survey 2021	S	S			Detailed plan for each themes Big 5 month in place. This is updated with results from the quarterly Pulse Survey and delivery overseen by CEI Programme Board, PMG and People Committee		X	
Freedom to Speak Up Strategy and Vision in place	S	S			FTSU vision and strategy approved by Trust Board in Sept 2020 and delivery is overseen by People Management Group and People Committee.		X	
Freedom to Speak Up function established with dedicated Guardian in place	R	R			Temporary additional resource in place, but further permanent resource through Deputy and Champions required.		X	
IT software package to record FTSU concerns	P	P			Case management solution in place to support FTSU case tracking and reporting	X		
Policy framework in place (EDI, Dignity at Work, Raising Concerns)	P	P			Approved by PMG and available on intranet.		X	
Leadership and Management Development Programmes in place	P	R			Kings Fund and Matron programme now in place.		X	
Board visibility through Board visits and Chairman and CEO monthly TeamTalks	P	P			Executive and Board visibility assessed through staff survey and Culture diagnostic review.		X	
Inclusion of BAME Recruitment Inclusion Specialists (RIS) on panels at Bands 8a+	R	R			Percentage of 8a+ panels that include a RIS monitored DI Dashboard	X		
Software system (ER Tracker) in place to manage employee relations data	S	R			ER Tracker implemented on 22 February 2021 and due further review	X	X	
OD team established and posts recruited into (including Head of Talent Management	P	P			Divisional OD plans will be developed and signed off by site divisional teams		X	

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

Gaps in controls and assurances	Actions to address gaps in controls and assurances	Complete by (date)	Progress
Current leadership programme does not cover all leaders within the Trust	Develop Leadership skills programme for all team leaders, leadership programme for consultants and medical staff Management Fundamentals has been rolled out in Q2 for all line managers. Leadership programme for Clinical Leads and Medical Chairs to be delivered in Q3 in collaboration with the King's Fund.	~~Mar 2022~~ ~~May 2022~~ March 2023	
Staff do not feel safe to raise concerns and lack confidence that actions will be taken where concerns are raised, and concerns raised through FTSU take too long to investigate / address	New Group-side FTSU policy to be developed by end Q2 2022/23 based on new national policy framework published in late June 2022. FTSU Charter and Raising Concerns triangulation group to be launched in Q2 2022/23. August 2022 is the Big 5 'speaking up, speaking out' month	Jan 2023	
Produce Equality Delivery System (EDS2) report	The Trust is required to produce and publish a summary of our EDS2 implementation.	Mar 2023	
Divisional OD plans	Divisional OD plans will be developed and signed off by site divisional teams	Mar 2023	

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

Risk Appetite / Tolerance	**LOW**	Due to concerns regarding quality and diversity in our workforce, we have a low appetite for risks relating to workforce. However, in relation to developing future roles and recruitment and retention strategies our risk appetite is higher	**Assurance Committee**	**People Committee**
			Exec Review Group	People Management Group
			Executive Lead(s)	Group Chief People Officer
			Date last Reviewed	14 October 2022

Current risk and assurance assessment

Risk score:
The current risk score for SR9 of 16 reflects the level of risk in relation to our ability to effectively recruit, educate and retain our workforce culture across the organisation.

Assurance rating:
An assurance rating of 'partial' was agreed by People Committee for Q1 2022/23.

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

Gaps in control and assurance addressed year-to-date:
During Q2 2022/23 the risk has been mitigated by the completion of a number of identified gaps in controls:

- The Workforce Strategy is in place, with the implementation plan reviewed and communicated to PMG and People Committee;
- Divisional workforce plans have been developed and launched within Divisions for 2022/23
- Our Workforce Improvement Programme for Recruitment has been developed and reported on regularly as part of our Workforce Improvement Steering Board, PMG and TMG
- A Retention Working Group has been established to review opportunities for improved retention of our workforce
- A Learning from Leavers task and finish group established to identify opportunities to introduce best practice to specifically tackle retention
- A Head of Talent Management appointed to lead in the development of a Talent Management Strategy for 2023/24

Overall SR Rating – Quarterly Scores

Period 2022/ 2023	Risk Score	Assurance Strength	Change (last reporting period)	Inherent Risk Score	Target Risk Score For 2021/22
Q1	16(4c x 4L)	Partial	⟷	20 = 4(C) x 5(L)	12 = 4(c) x 3(L)
Q2	16 (4c x 4L)	Partial	⟷		
Q3					
Q4					

Emerging risks

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

Future opportunities

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

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

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

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

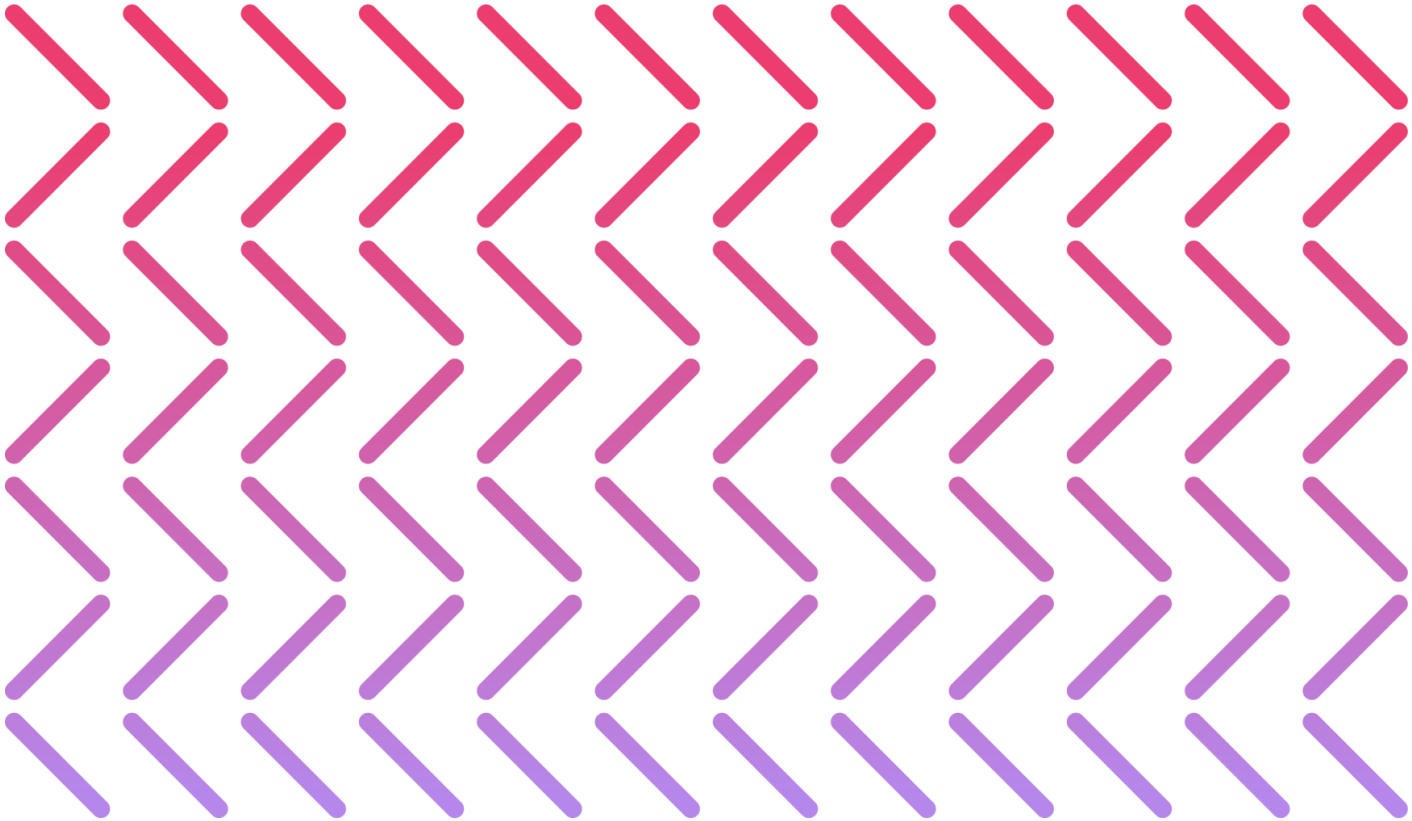
Key risk controls in place (continue)	Control effectiveness				Key sources of assurance	Lines of Assurance (positive / negative)		
	Q1	Q2	Q3	Q4		1	2	3
Divisional Workforce Plans in place (including International Recruitment Plans)	NA	S			HRBPs have developed and cascaded workforce plans for each of the divisions		X	
Home Working Policy reviewed and ratified in September 2022	NA	S			On intranet, available to staff		X	
Recruitment Workforce Improvement Plan in place for 2022/23	R	R			Progress reported to the Workforce Improvement Programme Steering Board and updates reported to PMG and People Committee		X	
Working groups established to understand opportunities for improved retention; learning from leavers and a retention working group	R	R			Actions/updates reported to PMG		X	

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

Gaps in controls and assurances	Actions to address gaps in controls and assurances	Complete by (date)	Progress
Trust-wide workforce plan that sets out recruitment requirements	Divisional workforce plans to be produced by HR Business Partners and these will lay out clear workforce planning. Divisional workforce plans have now been finalised and rolled out within service areas. Workforce plans have also been developed with Corporate Nursing in respect of international recruitment.	Complete	
International Recruitment Strategy for hard to recruit to posts	HRBPs to identify hard to recruit to posts. International recruitment strategies have been included as part of the corporate workforce plans which are now being implemented.	Complete	
Governance process for existing extended roles – ACPs and PA	Deploy new roles on relevant patient pathway – for ACPs and PAs. Developing the Physician Associate Workforce for the Future was presented at PMG in January 2022 and agreement was given to recruit a Chief PA at 8b. Consultant Job plans are being reviewed to ensure appropriate clinical supervision for PAs and an education programme/CPD budget - applied for WFD funding from ICS to support partial CPD requirements. Application and recruitment process in place for advanced practitioner programmes, and all existing staff mapped to the national advanced practice framework. Recruitment to trainee advanced practitioner posts needs strengthening to ensure appropriate authorisation for all posts.	~~Sept 2021~~ ~~May 2022~~ December 2022	
Structured identification and development of new roles required to deliver patient care	Develop governance process for the identification of new roles and required funding. Deputy COP due to commence with the Trust in November 2022, who will coordinate the wider workforce plans, including governance arrangements for newly created roles. The Vacancy Authorisation process has been developed to ensure a procedural framework for the authorisation of new roles and associated funding which was launched in Q2.	~~Sept 2021~~ ~~July 2022~~ March 2023	
Trust-wide workforce plan that sets out education & development needs to upskill existing and future workforce	Develop Trust-wide workforce plan that sets our Education & Development needs: A Training Needs Analysis for each Division has not yet been completed, and will need to be undertaken to identify divisional needs.	~~Sept 2021~~ ~~May 2022~~ December 2022	
No minimum CPD funding allocated for non-NMAP staff	Funding for 2022/23 was agreed with Finance as part of the business planning process, £400k agreed and programmes will be agreed/finalised and rolled out in line with this agreed funding for 22/23.	~~Jul 2021~~ Mar 2023	
Senior leadership that reflects the diversity of the workforce	Develop inclusive talent management, succession planning and career planning pathways. Further embed fair and equitable recruitment & selection process at senior level (further intervention over and above a RIS on every recruitment panel is needed. Leadership and Talent Management lead post has now been appointed, and they commenced in September 2022. The Talent Management strategy will be developed over Q3 and Q4. RIS compliance is corporately reported on as part of PMG and further training is due to be delivered to increase the pool to ensure compliance of 90% can be met.	~~Oct 2021~~ ~~Mar 2022~~ ~~Aug 2022~~ March 2023	
Inadequate ICT infrastructure, hardware and software to access on-line learning	Established Education Delivery IT (EDIT) Group to review current position on training delivery technology, future design and gap analysis. The group includes representatives from IT. 2022/23 review is being planned. Group has been established. Premises are a challenge, and therefore capital plans are being reviewed.	~~Oct 2021~~ Dec 2022	

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

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



Strategic Objective	Develop tomorrow's treatments today	*Corporate Objectives 2022/23:*	Collaboration

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

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

Assurance Committee	**Quality Committee**
Executive Group	Patient Safety and Quality Group
Executive Lead(s)	Group Chief Medical Officer
Date last Reviewed	20 October 2022

Current risk and assurance assessment

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

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

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

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

Overall SR Rating – Quarterly Scores

Period 2022/ 2023	Risk Score	Assurance Strength	Change (last reporting period)	Inherent Risk Score	Target Risk Score For 2022/23
Q1	9 (3c x 3L)	Good	⟷	16 = 4(c) x 4(L)	6= 3(C) x 2(L)
Q2	9 (3c x 3L)	Good	⟷		
Q3					
Q4					

Emerging risks	Future opportunities
• Restrictions on funding/ investment to extend research activities, with consequent inability to exploit research opportunities in full	• National Institute for Health Research call for core Clinical Research Facility funding – outcome of application • Opportunity for a greater research leadership role in SW London / partnership with other Acute Provider Collaborative Trusts • Build on current profile related to Covid-19 research activity/ studies • Develop closer collaboration between St George's and St George's University

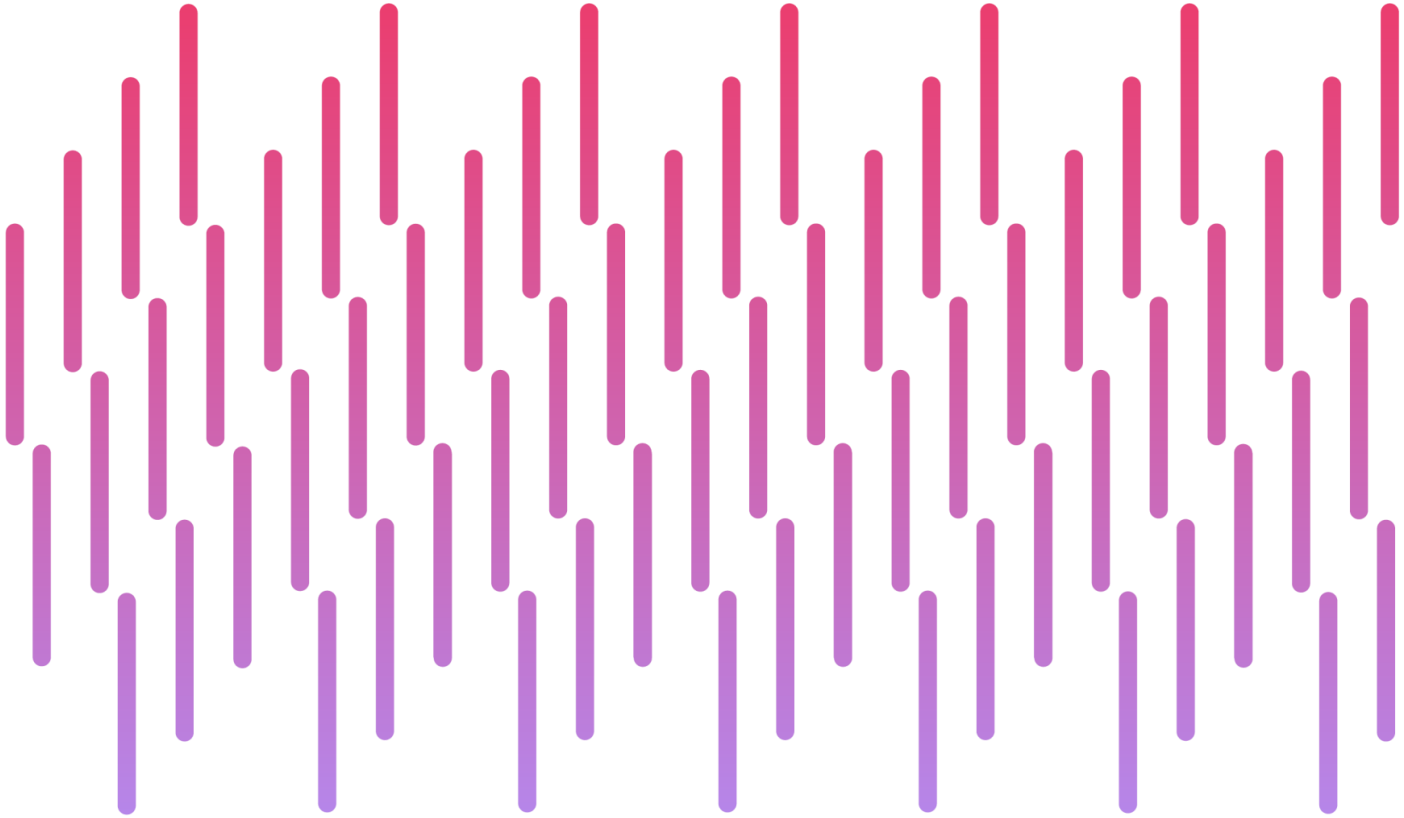
Strategic Objective	Develop tomorrow's treatments today	*Corporate Objectives 2022/23:*	Collaboration
SR10	**Research is not embedded as a core activity which impacts on our ability to attract high calibre staff, secure research funding and detracts from our reputation for clinical innovation**		

Key risk controls in place	Control effectiveness				Key sources of assurance	Lines of Assurance (positive / negative)		
	Q1	Q2	Q3	Q4		1	2	3
Research Strategy 2019-24 : approved by the Trust Board in December 2019 and supported by an implementation plan for the research strategy	S	S			• Increased numbers of clinical research studies led from St George's	x		
Partnership between St George's and St George's University London	S	S			• Partnership in place. TACRI and all four Clinical Academic Groups, which are joint Trust/University structures, have been set up. Reports from CAGs were received by Joint Strategy Board in March 2022.	x	x	
Key role in south London Clinical Research Network (chaired by CEO)	S	S			• Leadership positions in the Clinical Research Network - St George's CEO now chairs the CRN Partnership Board.		x	x
Implementation of process of horizon scanning clinical studies, including 'easy win' studies to balance portfolio against lower recruiting more intensive studies	S	S			• We have increased the numbers of patients recruited to clinical trials, which doubled over 3 years.	x	x	
Regular research resource and portfolio review meetings with research teams	S	S			• JRES holds regular meetings with research teams to review patient recruitment and troubleshoot any problems.	x		
Joint Research and Enterprise Services review and ratify (with researchers) all study targets and resources required	S	S			• There is annual target setting process for patient recruitment which is monitored and supported by JRES	x	x	x
Translational and Clinical Research Institute (TACRI) Steering Committee set up	S	S			• Steering Committee in place and reports to Patient Safety Quality Group and QSC	x	x	
Funding to implement 2019-24 research strategy approved for 2022/23	G	G			• £200K funding to implement the research strategy agreed for 21/22. and 500K for 2022/23 Statistical support for TACRI commenced, along with 7 fellowships for research nurses.		x	
Four Clinical Academic Groups formerly established	S	S			• Four CAGs have been established, and a CAG Director has been appointed for each.		x	

Strategic Objective	Develop tomorrow's treatments today	*Corporate Objectives 2022/23:*	Collaboration
SR10	**Research is not embedded as a core activity which impacts on our ability to attract high calibre staff, secure research funding and detracts from our reputation for clinical innovation**		

Gaps in controls and assurances	Actions to address gaps in controls and assurances	Complete by (date)	Progress
Few clinical academics - Many areas of Trust activity are not reflected in St George's University London research	**Seek investment to allow more clinical academic appointments** Investment will be needed from the Trust if new clinical academic posts are to be appointed (or new Trust consultants with protected time for research). Investment in the research strategy of £500K has been confirmed for 2022/23 and we are planning on launching schemes to support clinicians to undertake research in 2023	~~Dec 2021~~ ~~Dec 2022~~ Apr 2023	
Poor research IT infrastructure	**Seek investment /work with IT to set up research data warehouse** A working group has been set up to look at how the Trust can develop a research data warehouse, comprising Prof Dan Forton, IT and researchers across St George's. A proposal has been generated to develop and implement a research platform to be used by researchers, academics and external organisations. This would take the form of a Trusted Research Environment, which is a secure platform that provides remote access to data held in the hospital, for approved researchers or organisations to use. The timeline is for this to go live from October 2023.	~~Dec 2021~~ ~~Dec 2022~~ Oct 2023	

Appendix 1: Operational risks linked to strategic risks



Operational risks linked to strategic risk 1

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

Operational risks linked to strategic risk 2

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

Operational risks linked to strategic risk 3

Risk short form title	CRR Ref	Description	Open Date	Inherent Score	Current Score Sep 2022
Strategic Risk 3	Our patients do not receive timely access to the care they need due to delays in treatment and the inability of our technology and transformation programmes to provide accessible care built around our patients' lives			20	20
Network outage	CRR-1395	Infrastructure - Risk of further major network outages due to out-dated, unreliable, and prone to failure network, as a result of a lack of investment and maintenance in the Trust's ICT Network Infrastructure	Sec 2017	25 (5x5)	20 (5x4)
ICT Disaster Recovery Plan	CRR-803	In the event of an ICT disaster, there is a RISK this would result in delays or a complete failure in the Trust's ability to recover its ICT systems.	Feb 2011	20 (5x4)	20 (5x4)
Emergency care 4hr operating standard	ED-2449	Failure to deliver and sustain the 95% Emergency Care Operating Standard	Jan 2022	20 (4x5)	20 (5x4)
Patient flow	COO-2393	Risk of inadequate patient flow in the Trust (and across the health care system) for emergency admission	Nov 2021	20 (4x5)	20 (5x4)
Telephony	CRR-1292	Infrastructure - Potential failure of the Trust's central telecoms system (ISDX) (1), radio tower system (DDI) (2), and/or VoIP platform (500 handsets) (3) due to aged telecoms infrastructure	Jul 2017	20 (5x4)	16 (4x4)
Data Warehouse/ Information Management Fragmentation	CRR-1312	Information - Risk of poor daily operational performance reporting due to difficulties to retrieve data stored on multiple storage	Aug 2017	20 (4x5)	16 (4x4)
Wrong blood in tube	RHO-1626	Misidentification of patient or of the blood sample at venepuncture for transfusion samples, leading to wrong blood in tube (WBIT).leading to ABO incompatible blood transfusion	Aug 2018	20 (5x4)	15 (5x3)
Management of RTT	COO-2371	Failed to meet the constitutional standard of 92% of patients being treated within 18 weeks from referral due to COVID-19 and insufficient capacity	July 2020	20 (4x5)	12 (4x3)
Exposure to Cyber or Malware attack	CRR-0013	Infrastructure - Risk of potential successful malware / cyber attack due to weakness in the ICT infrastructure. This could lead to loss of data and operational disruption	Apr 2016	20 (4x5)	12 (4x3)
Fragmented Clinical Records	CRR-1398	Unavailability of all the correct and up to date clinical information at point of care due to fragmented patient records as a consequence of: Cerner implementation, multiple clinical system running in parallel but separate from Cerner,	Dec 2017	20 (4x5)	12 (4x3)
Diagnostic findings	MD1526	Acting on diagnostic findings	Jul 2016	16 (4x4)	12 (4x3)
7 day services	MD1118	Failure to be compliant with 4 of the Seven Day Services clinical standards	Nov 2016	12 (3x4)	12 (3x4)
Virtual by Design	IT-2157	There is a risk that IT Audiovisual/infrastructure are not met by IT resources, impacting on patient care	Sep 2020	20 (4x5)	4 (2x2)

Operational risks linked to strategic risk 4

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

Operational risks linked to strategic risk 5

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

Operational risks contributing to strategic risks 5 & 6

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

Operational risks linked to strategic risk 7

Risk short form title	CRR Ref	Description	Open Date	Inherent Score	Current Score Sep 2022
Strategic Risk 7	**We are unable provide a safe environment for our patients and staff and to support the transformation of services due to the poor condition of our estates infrastructure**			**20**	**16**
Inability to address infrastructure backlog maintenance to maintain safe site	762	Inability to address infrastructure backlog maintenance to maintain safe site due to lack of capital	Jul 2016	**20 (4x5)**	**20 (4x5)**
Risk of fire starting in Lanesborough and St James Wing developing into a major fire	2036	Risk that an undetected and immediately extinguished fire could develop into a major fire resulting in area evacuation	Feb 2020	**20 (5x4)**	**20 (5x4)**
Lack of UPS/IPS power supplies	2061	Lack of UPS/IPS power supplies	Mar 2020	**20 (5x4)**	**15 5x3)**
Data Centre	810	Risk that a fire, flood, power failure in the Data Centre could cause loss of data due to having a single data centre hosting all on-site critical systems	Mar 2014	**20 (5x4)**	**15 (5x3)**
Electrical Infrastructure - Risk of non-compliance	1311	Risk of electrical non-compliance with Electricity at Work Regulations and BS7671 due to lack of regular testing	Aug 2017	**16 (4x4)**	**12 (4x3)**
Bacterial contamination of water supply	793	Risk from exposure to potential pathogenic bacteria in water	May 2014	**20 (5x4)**	**12 (4x3)**

Operational risks linked to strategic risk 8

Risk short form title	CRR ID no.	Description	Open Date	Inherent Score	Current Score Sep 2022
Strategic Risk 8	Our staff are not empowered to deliver to their best and do not feel safe to raise concerns because we fail to build an open and inclusive culture across the organisation which celebrates and embraces our diversity			20 (4x5)	16 (4x5)
Organisational culture	2178	There is a risk that we fail to achieve a significant shift in culture to support the delivery of the Trust strategic objectives	Sep 2020	20 (4x5)	16 (4x4)
Diversity and Inclusion	1967	There is a risk that we are unable to deliver our Diversity and Inclusion Strategy or that it does not have the required impact	Jul 2019	20 (4x5)	16 (4x4)
Raising Concerns	1978	There is a risk that our staff a) don't know how to raise concerns at work b) don't know who to raise concerns with c) are not confident the concerns will be properly address and d) don't feel safe in raising concerns	Nov 2019	20 (4x5)	16 (4x4)
Bullying and Harassment	881	There is a risk that our staff continue to report high levels of bullying and harassment compared with peers and that we have not taken adequate measures to address this	May 2010	20 (4x5)	16 (4x4)
Effective Engagement	1364	There is a risk that we fail to engage effectively with our staff	Apr 2016	15 (3x5)	12 (3x4)
Organisational Development	1360	There is a risk that we do not ensure that our senior managers are developed to have the right leadership skills to be able to deliver our vision of outstanding care every time	Nov 2017	12 (3x4)	12 (3x4)
Recognise good practice	1361	A risk that we do not recognise success or good practice amongst our workforce.	Nov 2017	12 (3x4)	12 (3x4)

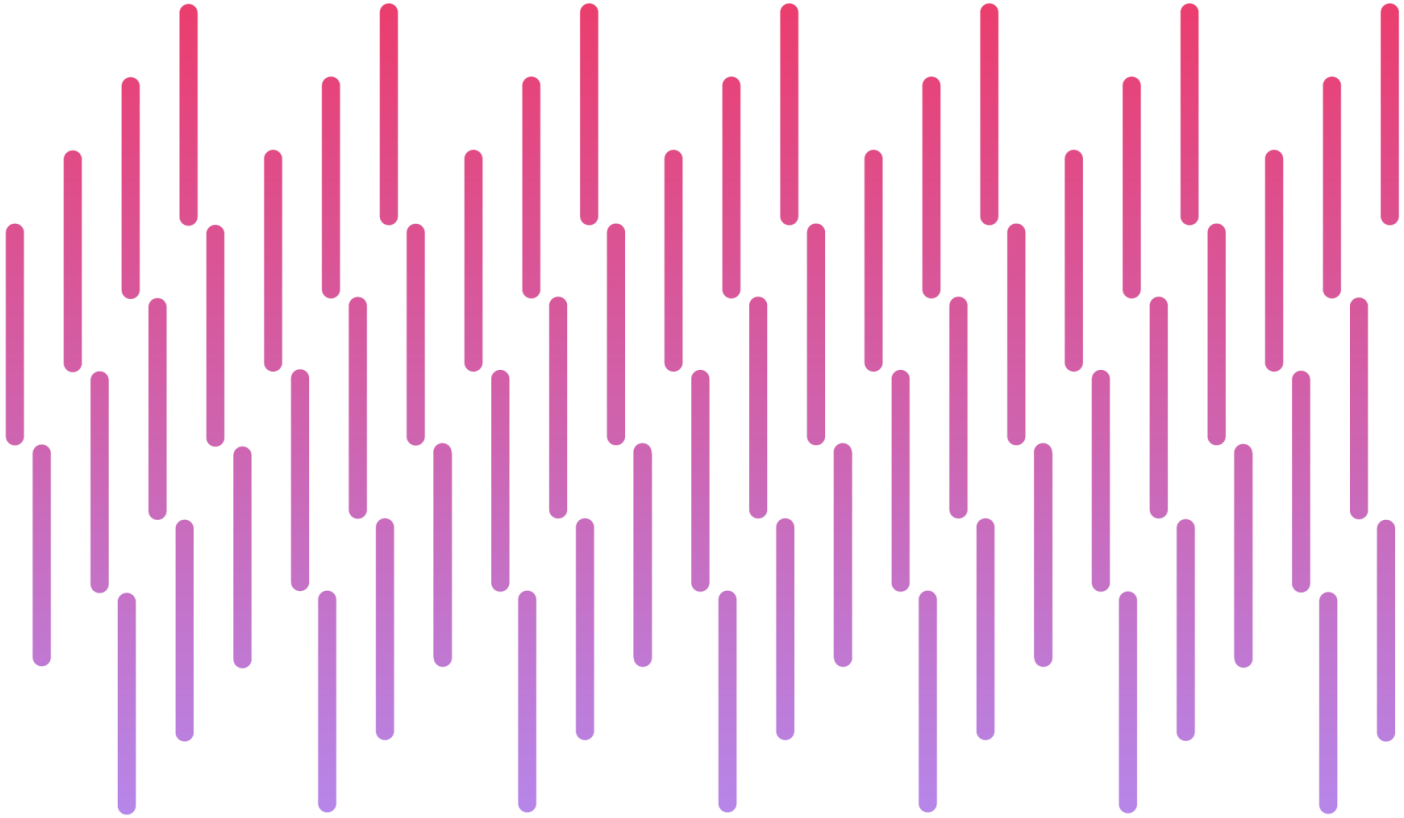
Operational risks linked to strategic risk 9

Risk short form title	CRR ID no.	Description	Open Date	Inherent Score	Current Score Sep 2022
Strategic Risk 9	We are unable to meet the changing needs of our patients and the wider system because we do not recruit, educate, develop and retain a modern and flexible workforce and build the leadership we need at all levels			20	16
Junior Doctors vacancies	1684	There is a risk that we are unable to fill Junior Doctor rota vacancies, leading to rota gaps which may impact on patient safety	Oct 2018	20 (4x5)	16 (4x4)
Recruitment and Retention	739	There is a risk that we fail to recruit and retain sufficient and suitable workforce with the right skills to provide quality of care and service at appropriate cost	Jan 2015	16 (4x4)	16 (4x4)
Disclosure and Barring Service Checks	2479	Staff are working with vulnerable adults and /or Children without the appropriate check of their criminal records	Jun 2022	20 (4x5)	16 (4x4)
High quality appraisals	1363	Risk that we do not ensure all of our staff have a high quality appraisal.	Nov 2017	12 (3x4)	12 (3x4)
Health and Wellbeing	2242	There is a risk that health and wellbeing is not embedded in the organisation.	Apr 2021	12 (3x4)	9 (3x3)
Education Strategy	2179	Failure to deliver the Education Strategy due to potential lack of organisational engagement and financial constraints	Oct 2020	9 (3x3)	9 (3x3)
Workforce Strategy	2038	There is a risk that the identified priorities in the Workforce Strategy do not produce the improvements or changes desired.	Feb 2020	9 (3x3)	9 (3x3)

Operational risks linked to strategic risk 10

Risk short form title	CRR Ref	Description	Open Date	Inherent Score	Current Score Sep 2022
Strategic Risk 10	**Research is not embedded as a core activity which impacts on our ability to attract high calibre staff, secure research funding and detracts from our reputation for clinical innovation**			16	9
The profile of research in SGHT being low	MD-1133	There is a risk that insufficient focus is given to research in SGHT. This could lead to a lack of investment in research, impacting on research delivery, income, reputation and ability to recruit and retain high calibre staff	Nov 2016	**15 (3x5)**	**12 (3x4)**
Clinical Research recruitment reduction	MD-1132	Risk of Clinical Research recruitment reduction. could result in a significant shortfall in overall (CRN and Commercial) recruitment and therefore reduction in research funding and income	Nov 2016	**12 (3x4)**	**9 (3x3)**
MHRA accreditation of the research department	MD-1405	There is a risk that the research department does not retain its MHRA accreditation due to poor infrastructure/ compliance	Dec 2017	**16 (4x4)**	**8 (4x2)**
Research partnership with St George's University	MD-1495	There is a risk that if research priorities are not aligned across SGUH and SGUL we will miss opportunities to translate academic research in to improved patient outcomes	Mar 2018	**12 (3x4)**	**6 (3x2)**

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



Outstanding care every time

Scoring the Board Assurance Framework

Risk Assessment and tracking of actions to address gaps in controls

Calculating Risk Scores

Risk Grading (Scoring)

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

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

Risk scoring matrix

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

Calculating Strength of Controls

Strength of controls

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

Scoring the Board Assurance Framework
Assurance sources and descriptors

Sources of Assurance

Sources of Assurance

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

Progress on actions to address gaps in control / assurance

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

Calculating Ratings of Assurance

Assurance Levels

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

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Draft Agenda 12 January 2023

HEADING	ITEM NO.	ITEM	LEAD	ACTION	FORMAT
OPENING ADMINISTRATION	1.1	Welcome and Apologies	Chairman	Note	Verbal
OPENING ADMINISTRATION	1.2	Declarations of Interest	All	Note	Verbal
OPENING ADMINISTRATION	1.3	Minutes of previous meeting	Chairman	Approve	Report
OPENING ADMINISTRATION	1.4	Action Log and Matters Arising	All	Review	Report
OPENING ADMINISTRATION	1.5	Chief Executive Officer's Report	GCEO	Inform	Report
CARE	2.1	Quality and Safety Committee Report	Committee Chair	Assure	Report
CARE	2.2	Integrated Quality and Performance Report*	MD	Assure	Report
CARE	2.3	Emergency Preparedness, Resilience and Respor	MD	Assure	Report
CULTURE	3.1	Workforce and Education Committee Report	Committee Chair	Assure	Report
CULTURE	3.2	Freedom to Speak Up Guardian Report*	GCCAO	Assure	Report
COLLABORATION	4.1	Finance and Investment Committee Report	Committee Chair	Assure	Report
COLLABORATION	4.2	Finance Performance Report*	GCFO	Assure	Report
COLLABORATION	4.3	Board Assurance Framework Q3 Report	GCCAO	Assure	Report
CLOSING ADMINISTRATION	99.1	Questions from Governors and the Public	Chairman	Note	Verbal
CLOSING ADMINISTRATION	99.2	Any Other Business	Chairman	Note	Verbal
CLOSING ADMINISTRATION	99.3	Any New Risks or Issues Identified	Chairman	Note	Verbal
CLOSING ADMINISTRATION	99.4	Draft Agenda for Next Meeting	All	Note	Verbal
		CLOSE			