Trust Board Meeting in Public
Agenda

Date and Time: Thursday 2 March 2023, 10:00 – 12:50
Venue: Hyde Park Room, Lanesborough Wing, St George's Hospital

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 Report	Committee Chair	Assure	Report
10:55	2.2	Maternity Services Report*	GCNO	Assure	Report
11:05	2.3	Healthcare Associated Infection Report*	GCNO	Assure	Report
11:15	2.4	Integrated Quality and Performance Report*	MD-SGUH	Assure	Report
3.0 CULTURE					
11:25	3.1	People Committee-in-Common Report	Committee Chair	Assure	Report
11:35	3.2	Freedom to Speak Up Guardian Report, Q3 2022/23*	GCCAO / FTSUG	Assure	Report
4.0 COLLABORATION					
11:45	4.1	Audit Committee Report (SGUH)	Committee Chair	Assure	Report
11:55	4.2	Finance Committee Report	Committee Chair	Assure	Report
12:05	4.3	Finance Report (Month 10)*	GCFO	Assure	Report
12:15	4.4	Board Assurance Framework Q3 2022/23	GCCAO	Note	Report
5.0 CLOSING ADMINISTRATION					
12:25	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	Reflections on meeting	All	Note	Verbal
12:35	5.5	Patient Story	GCNO	Inform	Verbal
12:50	CLOSE				

Date of Next Meeting: 5 May 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.

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
Lucinda Etheridge	Site Chief Medical Officer – SGUH (*Deputising for GCMO)*	Site CMO
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
Stephen Jones	Chief Corporate Affairs Officer	GCCAO
Peter Kane	Non-Executive Director	PK
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		
Deirdre LaBassiere	Deputy Director – Corporate Governance	DD-CG
Apologies		
Richard Jennings	Chief Medical Officer	GCMO
James Marsh	Group Deputy Chief Executive Officer	GDCEO
Andrew Murray	Non-Executive Director	AM
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.

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

Thursday 12 January 2023

Hyde Park Room, 1st Floor, Lanesborough Wing, St George's Hospital, Tooting

PRESENT		
Gillian Norton	Chairman	Chairman
Jacqueline Totterdell	Group Chief Executive Officer	GCEO
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	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		
Shazia Khan	Nurse SGUH (Patient Story)	NSGUH
Wendy Doyle	Head of Patient Experience and Partnership (Patient Story)	HPEP
Carolyn Cullen	Interim Corporate Governance Project Officer (minutes)	HCGPO
OBSERVERS		
John Hallmark	Governor, Wandsworth	JH
Hilary Harland	Governor, Merton	HH
Julian Ma	Appointed Governor, St George's University	JM
Adil Akram	Governor, Wandsworth	AA
Joan Adegoke	Corporate Governance Officer	CGO
Anna Macarthur	Director of Communications and Engagement	DCE
Anna Wickins	Senior Business Manager to the GCEO	SBM
APOLOGIES		
Ann Beasley	Non-Executive Director/Vice Chair	AB
Tim Wright	Non-Executive Director	TM
Thirza Sawtell*	Managing Director- Integrated Care	MD-IC

** Non-voting members of the Board*

Feedback from Board Visits

Board members provided feedback from the visits conducted in the following areas: McKissock Ward (SNCT neurosurgery), Thomas Young Ward (SNCT neurology) Pinckney Ward (CWDT Paediatric medicine), Benjamin Weir Ward (Cardiac surgery) and Cheselden Ward (vascular surgery).

McKissock Ward (Neurosurgery) - Stephen Collier and GDCEO

The ward was well run, well organised and tidy. Although it was clear that there was pressure, ward was calm. Staff were using “WhatsApp” and had set up a ward group to exchange real time information. Both observed that was clear leadership of the ward. Three issues were highlighted to the Board:

- Ring-fencing Covid patients (used during the surge) had been beneficial;
- consistency of decision to discharge: it was stated that different consultants had different thresholds. The GDCEO added that the challenge was to support people following acute illness and discharge in a timely way and support recovery at home.
- strong reliance of overseas nurses on the ward, and whether there was learning on how to integrate and support these nurses to improve retention.

Thomas Young Ward (Neurology) – Pui-Ling Li and GCNO

The impression of the ward was that it was calm, tidy and peaceful. Length of stay was longer than the hospital average, at approximately three months. Nurses were trained in rehabilitation and were passionate about their work. Shift patterns on the ward were longer with two twelve-hour shifts being used. There had been complaints from patients about other patients, mostly relating to behavioural problems. Issues highlighted to the Board:

- Staff were highly trained and expert in this speciality; there was a high proportion of long serving nurses on this ward.
- The twelve-hour shift pattern was welcomed by staff but handover and not meeting colleagues to discuss issues emerging issues on previous shift was a concern.
- Managing violent behaviour was difficult, particularly as such incidents unsettle other patients on the ward.

Pinkney Ward (Paediatrics) - Parveen Kumar and GCPO

The sense of pride in the ward by staff was clearly clear. Estates had refurbished the ward and this had been welcomed by staff but one door had not been painted and it had proved difficult to get this rectified. Staff were particularly proud of the garden, the result of a bequest, which they found a useful space for parents and children to be together, away from the ward.

Staff stated that it was difficult to discharge patients with mental health needs, although the ward reported good relationships with South West London and St George’s Mental Health NHS Trust. There were currently nurse vacancies on the ward. Staff typically left to secure higher pay rates and promotion elsewhere. Staff also reported that there was limited internal scope for progression.

Benjamin Weir Ward (Cardiac Surgery) – Gillian Norton, GCMO and GCCAO

The ward was visibly well managed and very clean. Of note was that the fire wardens of the day were highlighted on the white board, which was good practice. Constraints on managing lists for planned surgery were raised, particularly the lack of ITU beds post-surgery. Currently, intensive care beds were required for patients from the emergency department as well as a higher number of patients suffering from Covid and respiratory conditions. Together, this was having a significant impact on planned surgery. The Chairman had spoken to a patient who was extremely complimentary about the care she had received; despite the pressures the ward was facing.

Cheselden (Vascular Surgery) – Peter Kane and MD-SGUH

The ward appeared busy but well managed with strong leadership. Nursing staff spoken to had been with the Trust for between 15 and 20 years. Nurses were very complimentary about the opportunities for learning and development as well as regarding this as an interesting area to work in. The fragility of the hybrid theatre was a concern.

An issue raised was with Pharmacy and how quickly medicines were delivered to allow discharge.

The Board welcomed and noted the updates.

		Action
1.0	**OPENING ADMINISTRATION**	
1.1	**Welcome, introductions and apologies**	
	The Chairman welcomed everyone to the meeting and noted apologies. The Chairman thanked Patricia Morrissey, outgoing Interim Head of Corporate Governance, for all her work for the Board and the Trust.	
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.	
1.3	**Minutes of the Previous Meeting**	
	The minutes of the meeting held on 3 November 2023 were approved as a true and accurate record.	
1.4	**Action Log and Matters Arising**	
	The Board noted the following updates on the open actions: • **PUBLIC220901.1:** The GCMO confirmed that a message to all staff not to tolerate abuse had been prepared and would be sent out shortly. • **PUBLIC221103.01:** The GCNO confirmed that the performance of the complaints service in November 2022 had improved. This was noted in the report from the Quality Committee on agenda. Item closed. • **PUBLIC2201103.05:** The GCNO confirmed that Board visit protocol would remain unchanged, with visits across SGUH being known to staff in advance. Item closed. The Board agreed all items on Action Log proposed for closure should be closed.	
1.5	**Group Chief Executive's Officer (GCEO) Report**	

The Board received the report from the GCEO, who made the following points:

- The GCEO stated that the operational pressure currently facing St George's could not be understated. The Emergency Department (ED) had received record numbers of attendances, with over 12,000 patients seen in December 2022. The focus was on improving the flow through the hospital to ensure that beds and other capacity were released to help manage demand. Staff were working hard to ensure patients were managed safely as the hospital experienced rising levels of Covid and flu, as well as RSV and Group A Streptococcal infections.

- SGUH was trialling a new regularised patient flow system known as the Bristol model to improve flow through the hospital, this had been showing some benefits. The Trust had established a team to assess elderly and frail patients attending the ED to enable discharge home without admission. The Trust was also hosting multi-agency discharge events with stakeholders.

- In relation to elective care recovery performance, South West London was addressing performance concerns by setting up surgical hubs with protected theatre space to work through high volume/low complexity cases across SWL which will allow St George's to focus on specialist and complex cases.

- NHS England had recently published its Priorities and Operational Planning Guidance for 2023-24. NHS England was implementing a new target of seeing 74% of ED patients within four hours by the end of 2023/24. The guidance also set out a new payment by results system for planned elective care. The GCEO stated that the GCFO would be incorporating these goals and targets into the Trust business planning for the forthcoming year.

- Further to the strains on capacity, the Trust was also managing the impact of, and preparing for, multiple industrial actions including from the London Ambulance Service and the Royal College of Nursing. The GCEO stated that she was humbled by the hard work and commitment of staff who managed to steer a pathway through this difficult time. A daily communication bulletin had been launched which provided key daily statistics on activity and wait times across the group and gave staff increased awareness of pressures in different parts of the hospital.

Jenny Higham agreed that staff were working through a particularly difficult time and that it was important to recognise their commitment. Stephen Collier added that appreciation should be extended to the management team.

The Board noted the Group Chief Executive's report

2.0 CARE		
2.1	**Quality Committee Report** The Chair of the Committee, Parveen Kumar, presented the report of the meetings held on 17 November and 15 December 2022. The following matters from the Committee were highlighted: • Quality performance report, Months 7 and 8 2022/23: Areas of challenge included increased number of Influenza A cases, low compliance (54%) with Mental Capacity Act & Deprivation of Liberty Level 2 Training and more deaths than expected in the fracture neck of femur diagnosis group. This was highlighted from the SHMI (Standard Hospital Mortality Indicator). Parveen Kumar highlighted complaints performance had improved to 86% despite significant operational pressures. • The Committee had considered and noted a new style serious incident (SI) report which provided assurance on learning from SI investigations. This focus on learning would help to improve patient safety and was a welcome enhancement. The Committee had noted three serious incidents had been declared in September and one in October. • A deep dive on the major trauma service had been undertaken which had been prompted by the Trauma Audit and Research Network identifying the Trust as a negative outlier for case-mix adjusted mortality outcomes for the period April 2019 to March 2021. The Committee had noted, overall, some improvements had been made, but some degree of investment was required, including employing more specialist trauma consultants. The Committee had also agreed that to recommend to the Board that the ongoing development of the major trauma service should be a focus for discussion at the group strategy meeting taking place in January 2023. Parveen Kumar emphasised that it was important that the consultants who managed trauma patients had job plans focussed on trauma. Stephen Collier stated that it would be disappointing not to make a trauma consultant appointment during the current year. The Board noted the updates from the November and December 2022 Committee meetings.	
2.1.1	**Learning from Deaths Q2 (July – September) 2022/23** The GCMO introduced the learning from deaths report. The total number of deaths for this period was 372 with 11% (42) needing Structured Judgement Reviews. One death was classified as probably avoidable in this quarter; this related to hospital acquired Covid infection. The GCMO informed the Board that a new standardised approach to Morbidity and Mortality meetings had been introduced, including a new template to identify all unexpected deaths within care groups. This process had already highlighted higher incidents of DVT prophylaxis, and which triangulated with recent Serious Incident data. The GCMO stated that DVT prophylaxis would now be reviewed specifically in SJR reviews. The Board noted the report.	
2.1.2	**Healthcare Associated Infection (Infection Control) update report**	

	The Group Chief Nurse and Director of Infection Prevention and Control (GCNO), introduced the report and highlighted the following to the Board: • There were 46 cases of *C.difficile* Infection (CDI) between 1 April and 30 November 2022, two of which were cases identified as having a lapse of care. These cases were under investigation. This was against a national threshold of 43 *C.difficile* cases for the year as a whole. • 47% of staff at SGUH had received the flu vaccine as at December 2022 compared with 55% of staff at ESTH. 34% of SGUH staff had taken the Covid-19 vaccine compared with 43% of staff at ESTH. The GDCEO expressed disappointment with the lower levels of vaccination amongst St George's staff and stated that the data on take-up by profession and ethnic group gave a useful insight into behaviour and could inform how next year's vaccination campaign could be targeted. The Board noted the update and noted the vaccination position of staff across the Trust.	
2.2	**Maternity Services** The GCNO introduced the report which provided a high-level gap analysis of the Trust's position in relation to the Kirkup report, assurance on the Perinatal Quality Surveillance Measures for November 2022, and compliance with the Maternity Incentive Scheme. The GCNO drew the Board's attention to the findings of MBRRACE-UK 2020 which indicate that the 2020 stillbirth rate and the neonatal death rate at SGUH had changed since the last published figures and was now in the category of 'more than 5% higher than average for type of hospital'. The GCNO explained that the SGUH team would continue to review all stillbirths and neonatal deaths and report all findings via the peri-natal mortality tool. The Quality Committee had requested further assurance on these findings in the form of an external review. The outcome would be received in quarter 4 2022/23. The Chairman expressed concern at the Trust's MBRRACE-UK score and welcomed the external review. Due to the timing of the Maternity Incentive Scheme submission, it was requested that the sign off for the SGUH Maternity Incentive Scheme CNST submission be delegated to the Quality Committee at its meeting on 19 January 2023. The GDCEO stated that there were lessons to be learnt with the CNST compliance as the Trust had been assured that they were compliant until the technical guidance changed. The GCNO replied that other Trusts had faced the same issue. The Board: • Noted the report and the suggestions for service improvement • Noted the Quality Committee in Common had requested further assurance on the MBRRACE-UK 2020 findings in the form of an external review which will be received in quarter 4 2022/23 • Delegated sign-off of the Trust's Maternity Incentive Scheme CNST submissions to the Quality Committee.	

2.3	**Integrated Quality and Performance Report (IQPR)** The IQPR for November 2022 had been scrutinised at both the Finance Committee and Quality committee prior to the Board meeting. The GDCEO introduced the report and highlighted the following: • The number of RTT patients waiting more than 52 weeks continued to fall and was now meeting plan. The Trust was on track to deliver against year-end targets for both 52+ and 78+ week waits. Diagnostic waits above six weeks had reduced; in particular there had been a 50% reduction in waits for cardiac MRI scans. • Problems remained with the RTT PTL: 526 patients waited over 40 weeks for a first appointment. Breast continued to have a significant backlog with 352 patients waiting for a first outpatient appointment with the next clinic availability in eight weeks. • The Trust was not meeting cancer standards both for the 14-day target to see cancer specialist and the 62-day target to have a confirmed diagnosis and start treatment. Specialties affected most were Breast, Dermatology and Urology; recovery plans had been put in place. • Productivity in theatres continued to be a challenge. This was caused by limited ward and ICU bed capacity which had led to cancellations. The Trust was introducing a weekly elective access meeting to reduce cancellations. • Four-hour ED wait performance in November was 81.1% and SGUH was the second best performing Trust in London. However, its performance was less good with regards to patients waiting for more than 12 hours for a hospital bed following a decision to admit. A further area of concern is the fall in ED nursing numbers caused by vacancies and sickness. The Group Chief People Officer (GCPO) informed the Board that sickness rates for nursing staff in ED are improving. The Board noted the IPQR, including the detailed scrutiny of the performance data that had been undertaken by both the Finance and Quality Committees.	
2.4	**Emergency Preparedness, Resilience and Response (EPRR) Annual Submission** The results of the 2022 EPRR assurance process, and the action plan to address areas for improvement, were presented to the Board. The assurance process, which judged the Trust against NHS England's core standards, identified areas for improvement in the Trust's arrangements. The Trust would submit an assessment which rated the Trust as "partially compliant". Overall, the Trust had 56 green ratings, eight amber ratings but no red ratings. The Trust was prioritising the following tasks to improve performance: • Increase the EPRR resource in order to update plans in line with legislation and guidance. • Re-establish the SWL EPRR Trauma Network. • Hold a major incident plan review and develop mandatory training for all on-call staff. Peter Kane asked why performance in this area had declined. The MD-SGUH stated that that there had been vacancies over the last year amongst key	

	personnel in this division; however, the SGUH Chief Operating Officer was focussing on improving emergency resilience and will drive this area forward over the coming year. The Board noted the NHS England EPRR assurance update and action plan and approved the submission noting the "partially compliant" rating.	
3.0	**CULTURE**	
3.1	**People Committee Report** Stephen Collier, Chair of the Committee, provided an update on the People Committee meetings held in November and December 2022 and highlighted the following: • The Committee had reviewed the people risks on the Corporate Risk Register and decided that the single risk addressing staff recruitment and retention should be divided into two separate addressing recruitment and retention separately to bring greater focus to the mitigating actions on each. • A South-West London staff bank was being evaluated by the South West London ICB; the Committee would review the results. • A deep dive into reasons for increased nurse staffing turnover was being undertaken; key findings would be reported to the Committee and the Board. • The nurse establishment had increased by 24.3 WTE's at a net additional cost of £850k. While the rationale for the increase in the number of posts was fully endorsed by the Committee, the financial impact was of real concern. • 37 staff had participated in the Trust's leadership programme and satisfaction with the programme was rated highly. This was a key part of the Trust's talent management programme to ensure the quality and capability of senior functional management. Peter Kane welcomed the inclusion work that the Committee undertakes and expressed confidence this would bear dividends with staff retention. The GCEO underscored the importance of the leadership programme but stated that her principal concern was improving leadership training for service managers in Bands 6 and 7. The GCEO hoped that the current programme could be tailored for this important group. The Board noted the update.	
4.0	**COLLABORATION**	
4.1	**Finance Committee Report** In the absence of the Committee Chair, Stephen Collier introduced the report and following points were highlighted from the Finance Committee meetings held on 18 November 2022 and 16 December 2022: • The Committee had noted progress with major capital projects such as MRI and Cath Labs. Both projects had been completed and were now open and in use. It was agreed that regular reporting on estate capital projects would be undertaken.	

	• Outpatient performance was expected to fall below the 100% target (currently at 95%); however, day case and elective performance was on trajectory to meet its target. • The cash balance at 30 November 2022 was £42.4m and the capital budget had an underspend of £3.8m. The Board noted the update.	
4.3	**Finance Report (Month 8) 2022/23**	
	The Board received and noted the Trust's financial performance at month 8 and the following points were made: • Overall, the Trust was reporting a deficit of £34.2m, which was £19.4m adverse to plan. • The Trust had received £8.7m of Elective Recovery Fund (ERF) income, but this was under plan, as the Trust did not meet its ERF target. • Pay was £15.2m overspent, with particular overspends on junior doctor and nursing staff groups as temporary costs were charged at a premium. The GCFO stated that although the Trust was reporting a deficit; the level of deficit was what was predicted. Managers were, on the whole, managing their budgets as expected. The Board noted the month 8 financial position.	
5.0	**CLOSING ADMINISTRATION**	
5.1	**Questions from Governors and the public** No questions were received from the public. Hilary Harland, Public Governor for Merton, asked about resilience plans during the current industrial action. John Hallmark, Public Governor for Wandsworth, asked whether the Trust had declared a serious incident or an Opel 4 incident. The GCEO explained that plans were in place to ensure that services were safely maintained during the industrial action; staff groups involved in taking strike action were willing to provide support, if requested. However, on strike days the Trust would stand down all meetings and activities, such as training, so staff can focus on clinical priorities. A number of nationally and locally agreed derogations were also in place. The MD-SGUH stated that critical incidents and Opel 4 incidents were not often called and would typically last for under 12 hours, if called. Neither a critical incident, nor an Opel 4 incident, had been called during the current strike action. John Hallmark welcomed the discussion and focus on trauma services and noted that the Trust wanted to employ a specialist trauma consultant. He asked whether more beds would be specifically designated for trauma patients. The GCEO stated that the Board would give further consideration to the priority of trauma, and resources allocated to it, at the Board discussion on priorities in the coming weeks.	
5.2	**Any new risks or issues identified** The risk related to industrial action was being considered for escalation to the Corporate Risk Register.	

5.3	**Any Other Business** The Chairman informed the Board that this was the last Board meeting that both Parveen Kumar and Pui-Ling Li would attend as they had reached the end of their terms of office. The Chairman thanked Parveen Kumar and Pui-Ling Li for their contributions to the Board and their work for the Trust since January 2020. Parveen Kumar stated that it had been a privilege working with such dedicated staff who remained so caring under so much pressure. It was also a pleasure to work with such dedicated Board members. Pui-Ling Li stated that she had enjoyed being the first associate non-executive director at the Trust for some time. Pui-Ling Li felt this role had worked well for her and the Board. The Chairman replied that having someone who was both a GP and a public health professional had been of enormous value to the Board. There was no other business.	
5.4	**Draft Agenda for Next Meeting** The draft agenda was noted.	
5.5	**Reflections on meeting** Pui-Ling Li provided her reflections on the meeting and highlighted: • How welcome it was to be back on site for face-to-face Board meetings. • The Board had adjusted to working online during the pandemic and she commented on how seamless this transition had been. A new Board etiquette of raising the electronic hand had focussed exchanges and led to ordered debate. • As this was her final Board meeting, Pui Ling Li wanted to thank her executive colleagues for their patience and support and their professionalism. • Pui Ling Li stated that the chairing and leadership of the Board was exemplary; Board members had a chance to air views in a forum that respected all contributions.	
5.6	**Patient Story** The Board welcomed Deborah, mother of baby Connie who had been born in July 2022 with a dead bowel. On discovery of this, a multi-disciplinary meeting (MDT) was arranged, and the paediatric team holistically considered Connie's treatment options. Connie was extremely unwell, with a very poor prognosis. Mr CK Sinha, and Mr Z Mukhtar, Consultant Paediatric Surgeons attended the Board and described the treatment options open to Connie. Also in attendance were Neonatologist, Paediatric gastroenterologist, and members of the neonatal nursing team. **Innovative treatment** Connie had a very poor prognosis. Most of her bowel was dead, which became apparent very soon after birth. The MDT considered all the possible scenarios including accepting that Connie's diagnosis was unlikely survivable and letting Connie die with dignity, and attempting an innovative surgical technique, with a minimal likelihood of success, but giving Connie a small chance of survival. The first of two surgical procedures on Connie effectively inserted a GJ tube (gastro-jejunal), made by the team, to bypass the dead bowel and support the regeneration and development of the remaining viable tissue. Two surgeries and	

four challenging months later, Connie was very well. Surprisingly, 40 cm of the dead-looking bowel prior to surgery had now regenerated. Connie's recovery had been far quicker than anticipated.

The team and Deborah, Connie's mother, explained the experience of a family, including communication, involvement in decision making, managing expectations, how potential outcomes were addressed and survived by a very determined baby.

Key points for learning

1) Teamwork was crucial to Connie's success story. The surgeons, Neonatologist, Paediatric gastroenterologist, and the neonatal nursing team were all critical in delivering outstanding care.
2) Managing the expectations of Connie's parents was crucial in terms of the small chance of success of surgery.
3) Medical science was evolving – bringing new challenges and opportunities – but this came with risk. The team considered the balance of on the edge surgery and the gains to knowledge this gave with the likelihood of success. The team agreed that going ahead with this treatment option was made possible by Connie's parents being so central to decision making. Their acceptance of risk was of considerable support to the team.
4) The team were considering how best to share their learning as this was a very innovative procedure.

Consent: Deborah gave permission to share her story with the Board and volunteered to present herself. Baby Connie was also present – all Board members agreed it was a delight to see Connie, a very heathy, smiley five-month-old.

The Chairman summed up by saying that seeing Connie, and hearing about such ground breaking surgery, performed by such a capable multidisciplinary team, had helped the Board lift their attention from the day-to-day and focus on what mattered most: team working and excellence.

The Board thanked Deborah and Connie for sharing their feedback.

CLOSE

Date of next meeting: 10 am on 2 March 2023, Hyde Park Room

The meeting closed at 13:30

Trust Board (Public) - 2 March 2023

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	**Update on 12 January:** An all staff message reiterating that staff do not have to tolerate abuse in any form had been prepared and would be issued in the coming weeks.	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	**Update on 3 November:** The GCMO confirmed that it was already in the public domain that St George's was not an outlier in respect of surgical site infection. However, he was still considering other data and a further update would be provided at the Board's January meeting. The action would remain open. GCMO to confirm.	DUE
PUBLIC221103.06	3 Nov 2022	4.6	Board Assurance Framework Q2 (2022/23) Review	The Board agreed that it would be premature to increase the score of SR4 at the present time. Consider options as to the score and wording of SR4 as part on next BAF discussion in light of discussions around ICS and the risk environment in part II of the meeting.	3 Mar 2023	GCCAO	On Agenda. See item 4.4.	PROPOSED FOR CLOSURE

Meeting Title:	**Trust Board**		
Date:	2 March 2023	**Agenda No**	**1.5**
Report Title:	**Group Chief Executive Officer's Report**		
Lead Director/ Manager:	Jacqueline Totterdell, Group Chief Executive Officer		
Report Author:	Jacqueline Totterdell, Group Chief Executive Officer		
Presented for:	Inform		
Executive Summary:	A summary of key events over the past two months to update the Board on strategic and operational activity at SGUH.		
Recommendation:	The Trust Board is asked to note the update.		
Supports			
Trust Strategic Objective:	Well-led		
CQC Theme:	Leadership and improvement capability (well-led)		
Single Oversight Framework Theme:			
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Equality and Diversity:	N/A		
Previously Considered by:	N/A	**Date**	N/A
Appendices:	N/A		

Group Chief Executive Officer's Report
Trust Board, 2 March 2023

Introduction

Since I last provided an update for you, here at St. George's we have experienced ongoing, challenging circumstances in the form of continued pressures of high demand, and the additional need to manage industrial action safely. But I am proud to say we have still delivered a strong performance despite these pressures – and with every development we continue to learn, adapt and embed new ways of working to make our performance ever stronger and more sustainable.

Operationally, we are stable and whilst there is always more we can do, we continue to deliver positive progress towards our performance targets, which is testament to the hard work and inspirational commitment of our teams at every level in the Trust. I want to take this opportunity to thank them all, for everything they do.

The Royal College of Nursing (RCN) strikes on the 6th and 7th February were impactful, but through the sheer hard work of our teams the Trust was able to maintain services and keep patients safe. The largest impact – as you would expect – was felt in planned care. We managed derogations, and carefully organised our workforce to prioritise patient safety throughout. As you will have seen in media reporting, the forthcoming RCN strikes – due to take place this week – have been paused as the Government engages in talks with the RCN. As you will also have seen, the British Medical Association has announced that junior doctors have voted overwhelmingly for industrial action, likely to take place in March. This is a live and dynamic issue, and I will continue to keep you updated on St. George's plans and actions to manage the impact of any forthcoming industrial action, and to keep patients safe.

Public services are going through testing times. I, along with my Group Executive Team, continue to prioritise financial planning and deficit management, working closely with regional colleagues and system leaders, as we navigate the challenges of post-covid recovery and business planning – including adapting to new innovative collaborations across broader geographic footprints to support sustainability and tackle health inequalities. We will provide an in-depth update later on this agenda on our financial planning as we move towards the new financial year.

My focus is also, as ever, on staff well-being and welfare. Throughout the past two months I have continued to prioritise visiting teams, talking to staff and hearing about their work. We have recently introduced newly branded 'Executive Question Time' sessions each month, and in April, I will also be putting in place monthly Site visits called 'Chat with the Chief' where I will be available for all staff to come and see me, ask questions in an informal setting, and chat about whatever may be on their minds. We are also looking forward to receiving our Staff Survey results back soon, and I look forward to updating you on this important diagnostic work, including actions that we will be taking forward in response.

And finally, demonstrating my daring dedication to St. George's, I wanted to inform you that I will be taking part in a skydive in late April, alongside Amerjit Chohan, CEO of St. George's charity, to raise money for the 'Time for a Change' appeal! This appeal seeks to raise £5 million to deliver facilities that are fit for purpose for the world-class paediatric service that we deliver here at St. George's. I'm so committed to this brilliant appeal, and I will share updates as we proceed towards the big day.

Group Strategy Update

Our Group Strategy is nearing its final approval date. You have all been sighted on the progress we have made on our Group Strategy, and we have been pleased to involve you in discussions

regarding our key priorities and initiatives. Our strategy is fundamental to the future for St. George's, Epsom and St. Helier Group and will define how we allocate our resources over the forthcoming five-year period to realise our vision.

As you know, our strategy is built upon an extensive programme of engagement and consultation, which involved 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.

The Group Strategy is due to be submitted for approval at our next Board Meeting in April, and I look forward to keeping you closely informed of this work, going forward.

NHS England – New Developments

We continue to work closely with our system partners and leaders at NHS England, to ensure that our strategy and activity aligns with the long-term strategic goals of the NHS as a whole, as we seek to tackle budget management and explore innovative ways of working. This includes new, pioneering use of 'hospital at home' measures and virtual wards, which supports management of incoming patient flow and bed capacity. Through our activity with our Community teams, we will continue to support this way of working – particularly in frailty services.

NHS England has also launched a Joint Working Agreement to legally underpin the collaborations between multi-ICBs and NHS England for certain specialised services. This includes collaborations across regions for specialised commissioning over larger geographical footprints to support efficiencies in delivery, and to support tackling health inequalities in response to local public health needs. We, as part of the Group of St. George's, Epsom and St. Helier, will be working closely with relevant ICBs on this area to support innovations in specialised commissioning delegation, in order to continue providing excellent health services to our population and to support financial sustainability. I am delighted to work on these innovative developments, and I will keep you informed of developments in this area.

Principle Treatment Centre for Children's Cancer

I also wanted to provide an update on the process for the Principle Treatment Centre for Children's Cancer. As you are aware, NHS England is deciding the future of children's cancer services. The NHS England programme board met in January 2023 to discuss an options appraisal for the Evelina and St. Georges Hospital following bid submissions. Both options will now be taken through a public consultation phase, which begins in June 2023, and will involve a range of NHS clinicians, parents, patients, and stakeholders.

No decision will be made by NHS London about the children's cancer centre until after the period of public consultation has taken place.

Paediatrics at St. George's is rated outstanding by CQC and we have been caring for children with cancer for over 25 years. The obvious solution is to consolidate the service onto a single site at St. George's, where the expertise already exists and we expect the consultation process will demonstrate that this would be the best outcome for patients and their families. I will continue to keep you updated.

Staff Welfare & NHS England Racial Equality Standards

I also wanted to report that NHS England published its Workforce Racial Equality Standards (WRES) report on 22 February 2023, and is due to publish its related equality, diversity and inclusion improvement plan in the coming weeks. Here at St. George's, we remain committed to supporting

diversity, and combatting racism, throughout the organisation, to support racial equality in the NHS. Through our own WRES reports and Trust-based action plans, as well as our overall programme of work for Culture, Equality and Inclusion, which I Chair, we are allocating resources and senior management time to tackling this area.

Paul Da Gama, our Group Chief People Officer, will be leading our work on this important area, to tackle race inequality as part of our overall staff welfare programme.

Elective and Non-Elective Care Recovery Performance

Whilst there is always more we could do, I am also pleased to be able to share some successes in our progress towards elective and non-elective care recovery targets.

In elective care, the number of patients waiting over 52 weeks continues positively towards its year-end target. Our Cancer 62-day backlog also continues to decrease, and our performance in this area is currently tracking ahead of our agreed plan.

In non-elective care, I am also pleased to report to you that we have maintained a strong performance despite extremely challenging pressures. Our four-hour performance increased to 81.5% in January, meaning that St. George's is in the top ten in the country for performance. The Trust continues to embed the regularised flow programme which I informed you of at our last Board, to support faster exits from the Emergency Department and to enable timely ambulance handovers.

I look forward to keeping you updated on further successes over time, but also how we are addressing challenges so we can continue to deliver a strong performance within the most challenging circumstances.

Awards

Our staff and teams have recently been successful in a range of award programmes. Just a few of the successes include:

- National MyPorter Awards: Seamus McMahon
  - We're very excited to see one of our porters, Seamus McMahon, has been shortlisted for the National MyPorter Awards. These awards are organised by NHS England and are a great way to bring some national recognition to NHS facilities teams for the wonderful work they do. Seamus has been nominated as 'Porter of the Year' which is really fantastic and we are all very proud.
- Lt Col Jeyasankar Jeyanathan honoured with an OBE
  - We were delighted to see that Lt Col Jey Jeyanathan, one of our consultants in Anaesthetics and Intensive Care, received an OBE in King Charles' first New Year's honours. Jey Jeyanathan was first placed here at St. George's as a Defence Senior Registrar in 2011. He is now a consultant in intensive care medicine and anaesthesia. The OBE was presented in recognition of his hugely commendable service, and more recently his major role in developing transfer services for critically ill patients to manage bed shortages across the Southeast.

Events

We have held some wonderful events at St. George's recently, below are a few examples.

- Neonatal Unit receive donation of new equipment

- Our Neonatal team were presented with new equipment by The Ickle Pickles Children's Charity. The Lifestart Resuscitaire Unit allows the resuscitaire (equipment used to stabilise the baby after birth) to be brought right up to where the baby is delivered, supporting delayed cord-cutting compliance. We were delighted to hold an official handover event where members of the charity were able to meet and speak with members of our NNU, who were very pleased by the benefits the equipment will bring to our babies.

- Elective recovery success of our surgical super-hub

    - NHS England recently marked the one-year anniversary of the launch of their elective recovery plan, which aims to address the increase in waiting lists for non-urgent surgery following the pandemic. I was really proud that our surgical 'super-hub' at Queen Mary's Hospital was at the forefront of the celebrations, as an example of a highly successful facility which is really making a difference to our patients. The hub started treating patients in June 2021, and since opening we have undertaken more than 7,000 operations. A huge well done to everyone who has been involved in this fantastic achievement. The Times newspaper also visited the hub and spoke to staff, including Shami Umarji who is our clinical director for surgery, and who gave a brilliant interview covering the pressures that are being felt at our hospital and across the NHS, and how our surgical hub is helping.

- Supporting our staff through industrial action

    - The start of the year has seen strike action taking place across the healthcare sector, including nurses, physiotherapists and ambulance staff. We of course support the right of our staff to strike, and have been holding a series of question and answer sessions for those who may have questions or concerns about the implications of the strikes on our services. We have also created a digital hub on our intranet with FAQs and resources so that we can ensure we have a way for staff to stay up to date with all the key information relating to the various strikes going on. I've been really impressed by the amazing teamwork I have seen around preparing for the strikes and making sure that we can continue to provide safe care for our patients while supporting our staff's right to strike.

Meeting Title:	**Trust Board**		
Date:	2 March 2023	**Agenda No**	**2.1**
Report Title:	**Quality Committee Report**		
Lead Director/ Manager:	Dr Andrew Murray, Chair of the Quality Committee		
Report Author:	Dr Andrew Murray, Chair of the Quality Committee		
Presented for:	Assurance		
Executive Summary:	This report sets out the key issues considered by the Quality Committee at its meetings in January and February 2023 and sets out the matters the Committee wishes to bring to the attention of the Board. The key issues the Committee wishes to highlight to the Board are: • Industrial action: The Committee was assured that the steps put in place by the Trust to maintain safety during this period had worked effectively. • Fundamentals of care: The Committee held a deep dive on nutrition and hydration, pressure ulcers and falls, and identified issues with the consistency with which risk assessments were being applied and with the completion of documentation. • Maternity services: The Committee reviewed the Maternity Incentive Scheme prior to submission to NHS Resolution, noting that 4 of the 10 Safety Actions were non-compliant. The Committee heard that the Trust is bidding to NHS Resolution for £800,000 in funding from the Maternity Incentive Scheme fund to help achieve compliance against Safety Actions 3, 5, 6 and 8. • Cardiac surgery: The Committee noted that outcomes continued to be within the expected range. The service faced operational pressures in relation to access to ITU beds, access to theatres, and the availability of cardiac anaesthetists.		
Recommendation:	The Trust Board is asked to note the issues escalated to the Board and the wider issues on which the Committee received assurance in January and February 2023.		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	All CQC domains		
NHS System Oversight Framework Theme:	Quality of care, Operational Performance, Leadership and Improvement Capability		
Implications			
Risk:	Relevant risks considered.		
Legal/Regulatory:	CQC Regulatory Standards		
Resources:	N/A		
Previously Considered by:	N/A	Date:	N/A
Appendices:	N/A		

Quality Committee Report
Trust Board, 2 March 2023

1.0 PURPOSE

1.1 This report sets out the key issues considered by the Quality Committee at its meetings in January and February 2023 and sets out the matters the Committee wishes to bring to the attention of the Board.

1.2 The Committee meets as a Committee-in-Common with the Quality Committee for Epsom and St Helier University Hospitals NHS Trust, however this reports sets out those matters that relate to St George's University Hospitals NHS Foundation Trust.

2.0 ITEMS CONSIDERED BY THE COMMITTEE

2.1 At its meetings on 19 January and 16 February 2023, the Committee considered the following items of business:

January 2023	February 2023
• Quality Performance Report (M9) • Serious Incidents Report • Maternity Services Report* • Group Infection Prevention and Control Update* • Fundamentals of Care Deep Dive (Nutrition and hydration, pressure ulcer prevention, falls) • Cardiac Surgery Report • Inpatient Survey Results • Quality Priorities 2022-23, Q2 and Q3 Update Report • Caldicott Guardian Report • Corporate Risk Register	• Quality Performance Report (M10)* • Serious Incidents Report • Maternity Services Report* • Group Infection Prevention and Control Update* • Nursing Industrial Action Report • Pharmacy Report • Seven Day Services Report • Patient Experience and Engagement Report • Board Assurance Framework (Quality Risks)*

** Items marked with an asterisk are on the Trust Board agenda as stand alone items in March 2023.*

2.2 The Committee was quorate for both meetings. The meeting held on 19 January 2023 took place during the industrial action taken by the Royal College of Nursing, and, as a result, a number of site directors did not attend the meeting in order to support colleagues in the delivery of safe and effective care during this time.

3.0 KEY ISSUES FOR ESCALATION TO THE BOARD

3.1 The Committee wishes to highlight the following matters for the attention of the Board:

a) Trust response to industrial action by the Royal College of Nursing:

The Committee considered a report summarising the impact of the industrial action taken by the Royal College of Nursing on 18 and 19 January 2023, focusing principally on the quality and safety of care provided during this period, and the learning identified by the Trust which will be factored into planning for anticipated future days of industrial action. The Committee was assured that the steps put in place by the Trust to maintain safety during this period had worked

effectively. The Committee heard that patient and staff safety had been monitored by Operational Heads of Nursing, experienced leaders who visited areas at regular intervals throughout each day to assess the safety of patients and staff, and that clear escalation measures were in place to ensure safety concerns were raised immediately with the Deputy Chief Nurse. The Committee was assured that there were no Adverse or Serious Incidents reported on 18 or 19 January 2023, and there were no observed increases in the number of pressure ulcer, falls and medication incidents.

The Committee was briefed on the three services where a significant number of staff withdrew labour and the agreed derogated staffing numbers or required nursing skills were problematic to rectify: the Emergency Department; Gunning Ward; and Nicholls Ward. Staffing shortfalls had been addressed through redeployment of staff not involved in the industrial action. Areas were also supported by upskilled non-clinical staff from across the organisation who were trained to undertake a range of appropriate non-clinical support to teams. One incident report was submitted where staff were unable to take a break (on Brodie Ward) and this is currently being investigated.

In relation to learning, the Committee was assured that the Trust had undertaken a prompt and comprehensive review of the key lessons learnt during these two days of industrial action by nursing staff, and it commended the approach to identifying learning that had been undertaken. This was particularly important given that further industrial action by health care professionals appears likely in the coming weeks and months. The key areas of learning highlighted to the Committee were: (i) preparation, in terms of early engagement and communication with staff affected, planning from outpatient and theatre services in terms of cancellations and rescheduling of patients; (ii) ensuring safety through a multi-disciplinary control room worked well; (iii) working with the RCN through the strike committee worked effectively; (iv) redeployed staff, both clinical and non-clinical, worked well together to keep patients safe and to support each other; and (v) staff health and wellbeing support was well utilised and feedback from staff was positive, though many staff reporting feeling an acute professional dilemma, whether taking industrial action or not.

b) <u>‘Fundamentals of care’ deep dive:</u>

The Committee held a deep dive on the ‘fundamentals of care’ at its meeting in January 2023 which explored the Trust’s position in relation to nutrition and hydration, pressure ulcers and falls.

In relation to nutrition and hydration, the Committee were concerned that audits had demonstrated that some basic elements were not being applied consistently, that risk / MUST assessments were not being consistently undertaken, and that not all patients had food charts completed throughout admissions. The Committee was assured to note that an action plan was in place to address these issues and that there were ongoing monitoring arrangements in place, including ward checks.

On pressure damage, there were themes around documentation not being completed and a lack of compliance with the pressure damage prevention bundle, and the Committee heard there was a particular issue with malfunctioning of pumps for pressure relieving mattresses. The Committee heard that half of the stock had not been replaced and there was a plan in place to replace the remainder.

In relation to falls, the Committee heard that risk assessments were not being consistently completed within 24 hours, and there were concerns regarding the number of unwitnessed falls relating to patients with cognitive impairment as well as unwitnessed falls within the Emergency Department. The Committee heard

that operational pressures on the Trust was a likely factor in this, and was assured that an action plan was already in place to improve the position.

Overall, the Committee found that holding a deep dive in relation to the fundamentals of care had enabled it to draw together and triangulate some key themes both from a quality, safety and patient experience perspective and in terms of regulatory compliance. The Committee was assured that with the introduction of the new Patient Safety Incident Response Framework a single overarching Group-wide improvement plan was being developed, with site-specific actions, to address the points raised.

c) Maternity services:

The Committee continues to review the quality and safety of the Trust's maternity services as a standing item at each meeting.

In January 2023, with the agreed delegation by the Board, the Committee reviewed and approved the Trust's Maternity Incentive Scheme (MIS) submission to NHS Resolution. The Committee has monitored the Trust's position against the 10 safety actions throughout the year-to-date, but remained concerned that on 4 of the 10 safety actions the Trust was reporting a non-compliant position. While the Committee recognised that the measured had changed for 2022/23, this was disappointing given the Trust had, in previous years, achieved compliance against all 10 safety actions. The Committee was assured that the Trust had developed plans to ensure full compliance for 2023/24, which included assigning clinical leads for each safety action who would attend the MIS CNST update meetings throughout the year, and appointing a dedicated project manager across the Group to support compliance monitoring and reporting.

In February, the Committee reviewed the Trust's position against Safety Action 9 of the MIS, the requirement for Trusts to complete the Perinatal Quality Surveillance Report. As this report is on the Board's agenda for this meeting (see agenda item 2.2), this report highlights the key points the Committee would wish to highlight to the Board: the MBRRACE data for the Trust indicates that the 2020 stillbirth rate and the neonatal death rate is in the 'more than 5% higher than average for type of hospital' and, as the Board is aware, an external review will consider what improvement actions may be required; there were two incidents graded moderate harm and above in January 2023; mandatory training compliance in certain areas is improving but remains below target in some areas; and the Trust is bidding to NHS Resolution for £800,000 in funding from the Maternity Incentive Scheme fund to help achieve compliance against Safety Actions 3, 5, 6 and 8.

d) Cardiac Surgery:

The Committee received a regular update on quality and safety within the Cardiac Surgery service at its meeting in January. The Committee was assured that outcomes within the service continued to be within the expected range, that there had been no adverse or serious incidents in the reporting period, and that the enhanced oversight of quality and safety in the service continued, with all deaths being reviewed by the Serious Incident Declaration Meeting.

The key issues facing the Cardiac Surgery service, which the Committee wishes to highlight to the Board, relate to access to intensive care beds, access to theatres, and the availability of cardiac anaesthetists. The Committee heard that, together, these posed significant operational challenges for the service. It was recognised that South West London, as a whole, had fewer ITU beds generally, and the pressures on the Emergency Department meant that a number of specialties faced challenges with ITU bed availability. The Committee was briefed on, and endorsed, plans to turn four beds on Benjamin Weir Ward into enhanced care beds which would help alleviate pressure, and that the Trust was engaging

across the SWL system in relation to ITU bed provision. The recent departure of a number of cardiac anaesthetists was a particular concern, and this had been escalated to the Corporate Risk Register. The Committee also heard that the Trust continued to explore options for putting in place appropriate leadership for the service following the planned retirement in March 2023 of Steve Livesey, Care Group Lead and Associate Medical Director for Cardiac Surgery. The Committee was assured the Trust had developed an operational improvement plan for the service and that practical steps were being taken to mitigate the risks posed by operational and staffing challenges.

4.0 KEY ISSUES ON WHICH THE COMMITTEE RECEIVED ASSURANCE

4.1 The Committee wishes to report to the Board the following matters on which it received assurance:

a) Serious Incidents:

The Committee continues to receive monthly reporting on Serious Incidents, with commentary about immediate actions taken or relevant information about planned investigations, and learning from completed SI investigations. While the details of individual SIs are of course concerning, the Committee is assured that the Trust has in place robust processes for identifying, investigating and reporting on SIs. A total of 29 SIs had been reported in 2022/23 to date, which compared with 39 over 2021/22 as a whole. There are currently no overdue SI investigations at the Trust. A Never Event had been declared by the Trust in December 2022, which related to a misplaced nasogastric tube. An investigation was ongoing, but as an immediate step a communication had been issued to all clinical staff at the Trust (and also to clinical staff at Epsom and St Helier) by the Group Chief Medical Officer and Group Chief Nursing Officer regarding the importance of checking imaging not just the imaging reports when confirming the placement of NG tubes.

b) Infection prevention and control:

The Committee receives a comprehensive monthly report on infection prevention and control, and this reporting provides substantial assurance to the Committee that the Trust's governance of IPC is effective. As this report is also submitted to the Board in full (see agenda item 2.3), the Committee would simply highlight its concern with the number of *C.difficile* infections, which stands at 51 for the year-to-date against a national threshold of 43, and with the uptake among staff of the Covid-19 and influenza vaccines, which at the time of the Committee's meeting stood at 49.4% (flu) and 35.7% (Covid-19). The Committee sought assurance on the steps the Trust was taking to analyse the reasons for the low uptake, which it heard was in part linked to vaccine fatigue among staff, and the lessons that could be learnt to inform planning for winter 2023/24.

c) Quality Priorities:

The Committee reviewed progress against the agreed Quality Priorities for 2022/23. Overall, the Committee was assured that good progress was being made but the number of 'amber' rated actions demonstrated that there remained work to do prior to the year-end to achieve the targets set. One area in which the Committee expressed concern was in relation to the 'amber' rated progress on equity and access in relation to learning disabilities, which had previously been an area of strength. The Committee heard that there had been some staffing gaps which had impacted on the service, including the departure of a long-serving senior member of the team. Despite the 'amber' ratings at Q3, the Committee considered that it had substantial assurance both on the progress made to date and the plans to align quality priorities across the Group for 2023/24.

d) Seven Day Services Compliance:

The Committee received a biannual report setting out the Trust's compliance with the Seven Day Services (7DS) Clinical Standards. The Committee was assured that planned consultant presence over 7 days is sustained throughout the Trust. Where the few remaining services do not meet the standards, mitigations are in place which have been deemed sufficient by an established divisional review process. Benchmarked SITREP data shows that non-elective length of stay is consistent across the week, and is not dependent on day of admission and discharge activity across 7 days is in line with London and national benchmarking. The Committee welcomed the Trust's approach in undertaking deep dives into services and wards which show variation in these metrics, which are focused on understanding the barriers to effective 7-day flow.

One area where the Trust had previously struggled to meet the 7DS standards was in relation to emergency diagnostic tests, and specifically availability of MRI 7-days a week with a turnaround within one hour for critical patients and 12 hours for non-critical patients. The Committee heard that MRI scanning and reporting is limited to specific presentations only at the weekend. The Trust's new MRI capacity came online in autumn 2022. A business case to recruit an additional radiographer would support scanning across 7-days, and this is scheduled to be considered by the Trust's Operations Management Group in the spring.

e) Pharmacy:

The Committee received its regular quarterly report on the pharmacy service and the implementation of agreed improvement actions. The most recent progress update in implementing improvements in response to the MHRA's inspection findings of 2021 had been submitted to the regulator in December 2022. A number of improvements had been made to radiopharmacy and quality management systems and processes had been strengthened. The next inspection by the MHRA was due in Quarter 1 2023/24.

f) National Adult Inpatient Survey 2021:

The Committee received a report at its January meeting on the results of the National Adult Inpatient Survey 2021, and heard that there were 4 indicators where performance was somewhat worse than expected (cleanliness of room/ ward; enough to drink; confidence in nurses treating you; everything done to control pain), 1 indicator which was worse than expected (hospital food), and 24 questions on which there had been a statistically significant decrease in scores compared with 2020 (overall experience; assistance to eat meals; communication; discharge; noise at night; respect and dignity). The Committee reviewed and received assurance regarding the action plan developed to address the areas of deteriorating performance. The issue of pain management was a theme identified at both St George's and Epsom and St Helier and would be incorporated into the 2023/24 Quality Priorities for the Group. While the results were disappointing, the Committee recognised the impact of the operational pressures on the Trust and that there had been areas of positive performance.

5.0 OTHER ISSUES CONSIDERED BY THE COMMITTEE

5.1 During this period, the Committee also received the following reports:

a) Patient Engagement and Experience:

The Committee received a biannual report on patient engagement and experience, covering the period May to November 2022, and was pleased to note the steps taken by the Trust to relaunch the Patient Partnership and Engagement Group (PPEG) in September 2022, and the work undertaken to increase the number of volunteers at the Trust, with 44 new volunteers recruited in the year to

the end of November 2022. The Committee was assured that the Trust was implementing actions to address the control issues identified in the internal audit report on patient experience, particularly in relation to recording of protected characteristics to identify areas for improvement.

b) Caldicot Guardian Annual Report:

The Committee felt assured that the Caldicot Guardian function was working as it should. The Guardian function had a good relationship with the information governance team and information governance was embedded in the Trust's programme of Mandatory and Statutory training. The Committee heard that consideration was being given to establishing a single Caldicot Guardian function for the Group in order to facilitate a Group-wide, strategic approach to dealing with national trends and challenges.

6.0 REVIEW OF RISKS

6.1 The Committee considered the quality and safety risks on the Corporate Risk Register at its meeting in January 2023 and the strategic risks within the Committee's remit on the Board Assurance Framework at its meeting in February.

6.2 On the Corporate Risk Register, the Committee wishes to highlight:

a) The following new risks had been added: decision-making within the Mental Capacity Act legal framework (Risk score: 16); Consent (16); Infusion pumps (15); Maternity staffing (15); and shortage of anaesthetic consultants (16).

b) Consideration was also being given to adding and / or updating the following risks: Access to ITU beds, particularly in relation to cardiac surgery; and the quality and safety dimensions of industrial action.

6.3 On the Board Assurance Framework, the Committee reviewed the risks within its remit: Strategic Risk (SR) 1 (patient safety and learning culture); SR2 (clinical governance); and SR10 (research). The Committee agreed that no changes to risk scores or assurance ratings were appropriate at the Q3 2022/23 position.

7.0 RECOMMENDATION

7.1 The Trust Board is asked to note the issues escalated to the Board and the wider issues on which the Committee received assurance in January and February 2023.

Dr Andrew Murray
Committee Chair
March 2023

Meeting Title:	**Trust Board**		
Date:	2 March 2023	**Agenda No**	**2.2**
Report Title:	**Maternity Services Report: Perinatal Quality Surveillance Measures**		
Lead Director/ Manager:	Arlene Wellman, Group Chief Nurse and Director of Infection Prevention and Control		
Report Author:	Jan Bradley, Director of Midwifery and Gynaecology Nursing, St George's University Hospitals NHS Trust (SGUH) Laura Rowe, Lead Midwife for Clinical Governance and Risk, Epsom and St Helier University Hospitals NHS Trust (ESTH)		
Presented for:	**Assurance**		
Executive Summary:	see below		

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).

2.0 CNST MIS Safety Action 9 – Monthly Summary

Table 1 below details the CNST MIS safety action 9 reporting measures for both ESTH and SGUH and provides a comparison on the quantitative data provided for both Trusts.

Safety Action 9 reporting measure (Quantitative information only)	**ESTH**	**SGUH**
1.Perinatal Mortality: Total number of deaths (rolling report year)	9	39
2. Perinatal Mortality reviews held	3	2
3. Cases referred to HSIB for review	2 open cases 1 closed	3 open cases 1 closed
4. Incidents graded at moderate harm and above	2	2
5. Serious incidents completed	4	1
6. Overdue serious incident report actions	1	0
7.Mandatory training compliance	Performance across staff groups from 21% to 88%	Performance across staff groups from 73.95% to 95.12%
8. Minimum safe staffing	90%	85.6%
Bid to NHS Resolution for CNST funding	£500K	£800K

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

Recommendation:	The Committee is asked to note the report and make suggestions for any further action.		
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-in-Common	**Date**	16.2.23
Appendices:	Appendix 1: Safety Action 9: Maternity Services Perinatal Quality Surveillance Measures January 2023 for ESTH and SGUH		

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

Appendix 1

Maternity Services

Perinatal Quality Surveillance Measures January 2023

(CNST Maternity Incentive Scheme: Safety Action 9)

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

Quality Committee in Common

16 February 2023

Internal and External Assurance Processes

Epsom and St Helier University Hospitals NHS Trust

The safety of Maternity Services is monitored on an internal and external perspective and has seen increased scrutiny at both National and local level in response to the Ockenden enquiry.

Internal Governance and Monitoring

- Monthly Division Risk Report monitored by Women's Health DMT
- Quarterly Quality Report to QCAC
- Attendance at RADAH and SI Panel
- Monthly Maternity update to QCiC including CNST compliance, Serious Incident Update, Perinatal Quality Surveillance data and other updates
- Maternity Specific Risk Management Policy and Guideline
- Weekly programme of risk and governance meetings and Quality Half Day

External Governance and Monitoring

- CQC (including the Maternity Survey)
- HSIB
- MBRRACE-UK (PMRT)
- CNST
- LMNS (Surrey Heartlands and SWL)
- Maternity Voices Partnership
- NHS Resolution (ENS scheme)

How to deliver outstanding care.

Perinatal Mortality

Rolling Report - Time Period	February 2022 – January 2023		Ethnicity
Total Number of Deaths		9	2 White British 2 Indian 2 Black Caribbean 1 Bangladeshi 1 Other Asian 1 Other
Type of Mortality	Antepartum Stillbirths	4	
	Intrapartum Stillbirths	0	
	Neonatal Deaths	4	
Gestational Age	<24 weeks	3	
	24-27 weeks	0	
	28 - 31 weeks	0	
	32 - 36 weeks	3	
	37-41 weeks	3	
	≥ 42 weeks	0	

- This data reflects the late miscarriages, antepartum stillbirths and neonatal deaths
- Annual figures published in November 2022 by MBRRACE-UK indicates that the 2020 extended perinatal mortality is comparable to similar Trusts. The neonatal death rate was higher than similar Trusts, however none of the six babies died in the Trust (they were born in the Trust and transferred out). A detail analysis of the report in partnership with the LMNS is currently being undertaken
- All cases underwent a PMRT review and where applicable, a local/HSIB investigation
- This month’s data shows 78% of deaths were from the global majority population; this has been shared with the Equality and Diversity Lead Midwife who is undertaking a programme of work in partnership with the MVP

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 13 January 2023 and 3 cases were reviewed.
- A detailed report of PMRT cases and actions is submitted quarterly to the Quality Committee in Common (QCiC) due in March 2023.
- Of the 3 cases reviewed, there were no factors identified that directly contributed to the outcome. In one case poor use of interpretation services were identified as a non-contributory factor.
- 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. There is 1 additional action related to the Call a Midwife Advice Line. Completion has been impacted by the long-term sickness absence of our Bereavement Midwife. Updates on completion of actions are requested regularly from the leads and escalated to the Clinical Director and the Director of Midwifery as appropriate.

How to deliver outstanding care.

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.

- Details of all HSIB cases are presented to the Trust Serious Incident Panel and LMNS and the completion of actions are monitored through both.
- There are currently 2 open cases being reviewed by HSIB; 1 case was closed by HSIB during January 2023 with safety recommendations relating to neonatology.
- There are currently 3 open actions; these relate to strengthening guidance around antepartum haemorrhage and triage. 1 action is completed and the guideline is awaiting upload to VICTOR by communications; the management of triage is undergoing a wider conversation in relation to adopting the BSOTS system (Birmingham Symptom-specific Obstetric Triage System).
- 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

How to deliver outstanding care.

Incidents graded at moderate harm and above

There were 2 incidents graded as moderate harm and above in January 2023. One related to an intrapartum stillbirth following placental abruption and has been referred to HSIB for investigation. The 2nd incident related to a baby born in poor condition, likely secondary to maternal sepsis.

Contributory Factors and Root Cause for Completed Serious Incident Reports

There was one SI completed in December 2022 and this will be presented to the SI panel in February 2023. There were a further 2 Sis completed in January 2023 presented to the February SI panel and a further HSIB report presented (4 in total). These have been summarised on the next slide.

How to deliver outstanding care.

Completed Serious Incident Reports

HSIB MI – 00643 – This case related to an intrapartum stillbirth at full term. There was an abrupt loss of the fetal heart followed by maternal collapse. As HSIB did not review the maternal collapse we asked the Chief Obstetrician for London to Lead an external review and the conclusion was that the fetal demise and maternal condition was secondary to Amniotic Fluid Embolism; HSIB concluded that this was due untreated maternal infection. The Medical Director is currently discussing with RCOG as the degree of coagulopathy in this case is not in accordance with HSIB findings.

HSIB recommendations were around escalation when there are CTG concerns (which did happen in this case) and CTG training – the CTG in this case did not show any signs of evolving hypoxia and according to national guidance did not meet the criteria for immediate escalation, therefore these findings were contested.

How to deliver outstanding care.

Completed Serious Incident Reports

HSIB MI – 010548 – This case related to an intrapartum stillbirth at full term. The woman had the majority of care overseas and booked with us the third trimester. On admission in advanced labour there was no fetal heart. HSIB made no safety recommendations in this report.

INC – 105148 – This was related to a screening test (Newborn Blood Spot Test) where adult blood was found to be on the card. The panel included representation from NHSE/I and a look back and re-testing exercise was undertaken. Recommendations included reviewing the management of avoidable repeats to ensure the process is not punitive, to strengthen the recording of NBBS and to review the SOP.

INC – 118946 – This related to a baby who was readmitted with bilirubin induced neurological dysfunction; the baby is doing well but will continue to be followed-up. There is a recommendation to strengthen the current jaundice guideline with reference to the issues identified in the investigation.

How to deliver outstanding care.

Progress against Serious Incident Action Plans

- The new actions with reference to the previous completed serious incident reports have not been included.
- We are awaiting completion of an audit by the Clinical Matrons to assess that swab counts are being recorded on the delivery room whiteboard. The DoM has reminded the matrons of the importance of completing these actions as soon as the clinical situation allows.
- The Standard Operating Procedure in relation to the newborn blood spot (NBBS) which will address the process for raising concerns and sharing KPI data has been drafted and is awaiting approval.

How to deliver outstanding care.

NHS
Epsom and St Helier
University Hospitals
NHS Trust

Mandatory training compliance

We were not compliant with CNST year 4. An additional 8 study days are being planned for PROMPT and NLS and the low compliance amongst medical staff has been escalated to the Director of Women's Health. Although an improveemt in training compliance has been reported this month training continues to be impacted by sickness and staff being taken off mandatory training to support the acute clinical area.

Type of Training	Staff Group	December 22	January 23	In month performance	Staff number trained (rolling year total)
PROMPT	Midwifery Staff	84%	85%	+1%	276 for PROMPT 222 for CTG training
	Maternity Support Workers	62%	65%	+2%	
	Consultant Obstetricians	72%	79%	+7%	
	Trainee and Staff Grade Obstetricians	32%	52%	+20%	
	Anaesthetics	17%	21%	+4%	
CTG Training	Midwifery Staff	85%	84%	-1%	
	Obstetricians	34%	88%	+54%	
NLS (Newborn Life Support)		79%	82%	+3%	

How to deliver outstanding care.

Minimum safe staffing

The fill rate in January 2023 was 90% against the target of 94%. The following action was implemented to maintain safety:

- Matrons, managers and specialist midwives working clinically alongside staff

Staff group	Measure	**Nov 22**	**Dec 22**	**Jan 23**
Midwifery	Fill Rate (target >94%)	87%	82%	90%
Obstetric	Expected vs fill	100%	100%	100%
	Number of step downs/pull across	N/A	N/A	N/A

How to deliver outstanding care.

Service User Feedback

The themes identified and improvement actions from the Quarter 2 Improving the Patient Experience (IPEC) report included:

- Respecting privacy and dignity
- Evidence based information sharing
- Issues with the BadgerNet App
- Women feeling hot during the heatwave
- Lack of virtual tour on the website
- Women needing to travel cross site to access specialist consultant care
- Positive comments included infant feeding support, friendly and supportive staff, women feeling at ease and evidence-based information sharing

How to deliver outstanding care.

Staff feedback to Maternity Safety Champions

A staff engagement session was held on 30 November 2022. Items discussed are recorded on a separate Dashboard which is shared with all staff ahead of each meeting. Items raised and updates on previous issues included:

- Issues with delays in completing the NIPE (Newborn Infant Physical Examination)
- Lack of office secure/private office space for the Safeguarding Service
- Issues with increasing number of unresolved payroll issues
- Poor state of back life corridor on Labour Ward STH
- Challenges with clinic space in the community
- Poor state of repair of the delivery beds (with several out of commission)

Update on actions undertaken:

- Bid submitted for bed replacement

How to deliver outstanding care.

Bid to NHS Resolution for CNST Funding

- We have submitted a bid for £500,000 from the Maternity Incentive Scheme fund to help us to achieve compliance with Safety Actions 5 and 8 (co-ordinator supernumerary status and mandatory training.

  - backfill funding for a pilot to introduce a maternity bleep holder 24/7 (in common with most other units)
  - backfill funding increase for the uplift for mandatory training due to the increased training needs.

How to deliver outstanding care.

Internal and External Assurance Processes

The safety of Maternity Services is monitored on an internal and external perspective and has seen increased scrutiny at both National and local level in response to the Ockenden enquiry.

Internal Governance and Monitoring

- Local Maternity Governance team, supported by Divisional Governance and Corporate Patient Safety team.
- Escalation and Education on Datix management with mandatory training for all staff.
- Quality, Safety and Assurance in incident management communicated weekly/monthly to disseminate learning for staff.
- Monthly Maternity Governance Meeting ~ Business Guidelines, Audit, Risk Management, Themes and Trends supported by QI team.
- Bi monthly Maternity Governance case meeting ~ Root Cause analysis for moderate or low grade harm that has identified learning.
- Serious Incident Decision Meeting Weekly for escalation of incidents that reach moderate harm or above.
- Monthly Risk Surgery Meetings with Divisional Team for discussion of Risk Register and level of harm with mitigating actions in place.
- Ensure that Confidential Enquiries and other national reports and guidelines are reviewed and acted upon where necessary.
- Divisional Board Governance Meetings for escalation of risk locally and shared learning across division.
- Governance presence in all local meetings across maternity to discuss learning and outcomes.
- PSQG Divisional board governance surveillance on quality and risk management.
- Maternity Dashboard Review Monthly

How to deliver outstanding care.

External Governance and Monitoring

SGUH is reporting to the following External Bodies:

- Integrated Care Board notification and escalation with Serious Incidents escalated at Trust board level.
- LMNS governance and structure – Transformation Project
- Ockenden compliance and review, national standard and compliance required and evidence based.
- South West London LMNS Serious Incident Meeting Quarterly to discuss cases and share learning.
- Health Safety Investigation Branch Investigations escalated in accordance with criteria.
- CNST monitored and measured against 10 safety requirements
- PMRT – national requirement for mortality review of all deaths. The aim of the PMRT programme is introduce the PMRT to support standardised perinatal mortality reviews across NHS maternity and neonatal units in England, Scotland and Wales
- MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK
- UKOSS A national system to study rare disorders of pregnancy
- NHSR escalation by legal team in conjunction with maternity services and governance investigations. NHS Resolution is an arm's length body of the Department of Health and Social Care. We provide expertise to the NHS on resolving concerns and disputes fairly, sharing learning for improvement and preserving resources for patient care.
- Better Births, adherence to the BB policy and transformation project commenced in 2016
- Infectious diseases in pregnancy screening: data and outcomes

ROLLING YEAR Perinatal Mortality

Rolling Report - Time Period	January 2022 – January 2023		Ethnicity
Total Number of Deaths	39		20 White 7 Asian/Asian British 4 Mixed 4 Black/black British 3 Missing or declined 1 Other
Type of Mortality	Antepartum Stillbirths	22	
	Intrapartum Stillbirths	3	
	Neonatal Deaths	14	
Gestational Age	<24 weeks	12	
	24-27 weeks	8	
	28 - 31 weeks	5	
	32 - 36 weeks	6	
	37-41 weeks	8	
	≥ 42 weeks	0	

- This data reflects the late miscarriages, antepartum stillbirths and neonatal deaths
- Annual figures published by MBRRACE-UK indicate that the 2020 stillbirth rate and the neonatal death rate has changed since the last publication and is in the 'more than 5% higher than average for type of hospital' category (stillbirth 3.92/1000, neonatal death 2.52/1000 and extended perinatal (both together) 6.41/1000) – an external review will look further at this position to highlight any areas for improvement
- All cases undergo a PMRT review and where applicable, a local/HSIB investigation and learning is shared locally and at the SWL LMNS Serious Incident meetings

How to deliver outstanding care.

Perinatal Mortality Reviews

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

- A detailed report of PMRT cases and actions is submitted quarterly to the Quality Committee in Common (QCIC)
- There were 2 PMRT panels held in January 2023. Issues were identified with Ex utero transfers including maintaining temperature of infants during transfer in to SGUH from other Trusts, management of intrapartum and post delivery care of extremely premature infants at level 2 Trusts, bereavement follow up for parents when several Trusts are involved, postnatal follow up after neonatal death and missed antenatal appointments with GP

- The issues outlined above were not felt to have contributed to the outcome for the baby.

How to deliver outstanding care.

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 were no referrals to HSIB in January 2023
- There are currently 3 open cases being reviewed by HSIB; one case was closed by HSIB during January 2023 and the safety recommendations are described on the next slide
- Details of all HSIB cases are presented to the Trust Serious Incident Panel and LMNS and the completion of actions are monitored through both
- There are currently no open actions. The management of triage is undergoing a wider conversation in relation to adopting the BSOTS system (Birmingham Symptom-specific Obstetric Triage System).
- 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

How to deliver outstanding care.

Incidents graded at moderate harm and above

There were two incidents graded as moderate harm and above in January 2023.

One involved a delay in patient care due to staffing pressures and the other related to a staff accident where the colleague fell.

How to deliver outstanding care.

Contributory Factors and Root Cause for Completed Serious Incident Reports

There was one SI completed in January 2023. This related to woman who required an instrumental delivery due to an abnormal CTG. The baby was born in poor condition and required therapeutic cooling. The investigation was undertaken by HSIB. As HSIB use a systems-based approach they do not identify a route cause or contributory factors. Following review, they identified the following safety recommendations:

1. The Trust to ensure there is a system to enable effective escalation to the obstetric team when an abnormal CTG is identified.

2. The Trust to ensure that there is a robust system to support a shared understanding of how central monitoring is used within the MDT.

Progress against Serious Incident Action Plans

- Every HSIB case has an action plan drawn up at an MDT meeting which is presented and signed off at SIDM.
- All Serious Incident actions have all been completed.

How to deliver outstanding care.

Mandatory training compliance

The Technical Guidance for CNST was published on 11 October 2022 and Maternity services were asked to evidence training performance a month earlier and over a shorter period of time; any continuous 12 month period between 9 August 2021 and 5 December 2022. Previously the ask was to demonstrate 90% compliance for 12 months within any 18 month timeframe period and evidence the position as at 05 January 2023.

NHS resolution has since revised the Technical Guidance further and training completed up to 3 January 2023 can now be included therefore the training planned in December 2022 is included below.

		Dec 22	Jan 23	In month performance
Type of Training	Staff Group	%	%	%
PROMPT	Midwifery Staff	90.09	90.59	**+ 0.50**
	Maternity Support Workers	90.91	95.12	**+ 4.21**
	Consultant Obstetricians	95.65	91.30	**- 4.35**
	Trainee and Staff Grade Obstetricians	97.8	85.29	**- 12.51**
	Anaesthetics	83.9	73.95	**-9.95**
CTG Training	Midwifery Staff	90.48	90.95	**+0.47**
	Obstetricians	79.3	82.5	**+ 3.2**
NLS (Newborn Life Support)	Midwifery Staff	90.09	91.58	**+1.49**
	Maternity Support Workers	86.84	86.84	**<>**
	Neonatal Obstetricians	100	100	**+8.7**
	Trainee and Staff Grade Obstetricians	100	85	**- 15**
	Neonatal Nurses	95	91	**-4**

How to deliver outstanding care.

Minimum safe staffing

The following actions are considered to mitigate against risk and to maintain safety:

- Temporary closure of services (Birth centre or Homebirth)
- All specialist midwives working some clinical shifts
- Increased RN presence in maternity HDU and on the postnatal ward
- Use of agency Registered Midwife to support workforce on the wards
- Robust sickness management and support
- Moving of Antenatal ward to be based on postnatal ward for safety of patients and staff

Staff group	Measure	**Nov 22**	**Dec 22**	**Jan 23**
Midwifery	Fill Rate (target >94%)	82%	78%	85.6%
Obstetric	Expected vs fill	100%	100%	100%
	Number of step downs/pull across	N/A	N/A	N/A

How to deliver outstanding care.

Service User Feedback

Themes identified from complaints and compliments:

- Many positive comments for postnatal ward continue
- Overwhelmingly positive feedback for clinical staff on Delivery Suite
- Kind, compassionate and considerate care from all on Delivery Suite
- Communication on discharge from postnatal ward could be improved
- We are working to reduce any variance between care during the day and at night

How to deliver outstanding care.

Staff feedback to Maternity Safety Champions

NED and Exec Maternity Safety Champion walk around in December 2022 and spoke with staff in all areas:

- Antenatal Clinic redecorating has not been completed to a high standard with external aspects of doors and corridors not painted – this has been escalated to estates
- Delivery Suite activity had been high with significantly complex and challenging cases over the Christmas weekend which have been highly commended
- MDT working has been excellent – Maternity/ED/ICU/neonates

Update on actions undertaken:

How to deliver outstanding care.

Staff feedback to Maternity Safety Champions

Our new NED Maternity Safety Champion Dr Andrew Murray is walking around Maternity and the Neonatal unit on 22 February

- Antenatal Clinic (ANC) redecorating has not been completed to a high standard with external aspects of doors and corridors not painted – this has been escalated to estates
- Bereavement Suite refurbishment almost complete – snagging being undertaken
- Delays in completing the Bereavement Suite works have delayed full roll out of the revised Maternity Triage in Delivery Suite (DS)
- Abduction Drill on Wards identified significant gaps in security systems

Update on actions undertaken:

- Estates chased to complete works in ANC and DS
- Estates chased to support addressing identified gaps in security systems onto wards. CCTV, lighting, intercom system, double locked doors to increase security bay, cost pressure to support 7/7 security presence

How to deliver outstanding care.

Bid to NHS Resolution for CNST Funding

We have submitted a bid for £800,000 from the Maternity Incentive Scheme fund to help us to achieve compliance with Safety Actions 3, 5, 6 and 8 related to:

- Transitional care - A work stream to investigate increasing our transitional care capacity to further reduce admissions and mother-infant separation; HEE e-learning package, targeted education of labour ward midwives and neonatal medical staff and purchase and promote use of handheld transcutaneous bilirubinometers in the community
- Workforce planning - Commission a full BR plus staffing review to determine current midwifery requirements and support development of workforce business case
- Saving babies lives care bundle – Quarterly audit of 20 sets of case notes and pre-delivery questionnaire for CO monitoring compliance at 36 weeks
- Mandatory training – commission additional training sessions for MDT new starters

How to deliver outstanding care.

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

Meeting Title:	**Trust Board**		
Date:	2 March 2023	**Agenda No**	**2.4**
Report Title:	**Healthcare Associated Infection (Infection Control) update Report**		
Lead Director/ Manager:	Arlene Wellman, Group Chief Nurse and Director of Infection Prevention and Control		
Report Author:	Prodine Kubalalika, Director of Nursing/ Deputy Director of Infection Prevention and Control (ESTH) Kristina Hager, Senior Nurse, Infection Prevention and Control (SGUH)		
Presented for:	Assurance		
Executive Summary:	This paper provides a monthly update of key issues/ concerns arising in Infection Prevention and Control (IPC) at site level summarised in table 1 below. The paper supplements the Ies and summary contained in the Integrated Performance Reports for both Trusts.		

Table 1: IPC issues/ concerns at site

IPC Issue/ Concern	**ESTH**	**SGUH**
C. *difficile* infection	Oct: 1 HOHA, 2 COHA Nov: 3 HOHA, 3 COHA Dec: 3 HOHA, 0 COHA Jan: 2 HOHA, 0 COHA **YTD: 32** **National threshold: 50**	Oct: 3 HOHA, 0 COHA Nov: 3 HOHA, 1 COHA Dec: 2 HOHA, 0 COHA Jan: 3 HOHA, 0 COHA **YTD: 51** **National threshold: 43**
Covid-19	YTD total cases: 1960 YTD deaths: 346 Total cases Jan: 129 Total deaths Jan: 28 Nosocomial deaths Jan: 2	YTD total cases: 2065 YTD deaths: 173 Total cases Jan: 137 Total deaths Jan: 19 Nosocomial deaths Jan: 7
MRSA bacteremia	YTD = 0	YTD = 1 (Aug 2022)
Aspergillus	April: 5 Aug/ Sept: 3 November: 2 December: 0 January: 1 (community case)	Zero
Carbapenemase-producing Enterobacterales (CPE)	2 CPE cases: previously known carriers	CPE ward outbreak in December 2022: 2 linked cases, 0 cases in Jan 2023
Pseudomonas aruginosa	Zero	Zero
Influenza	Oct-Dec: Reporting not started Jan: 52	Oct: 27 Nov: 55 Dec: 231 Jan: 50
Fit Testing	Dec: 55% Jan: 55%	Dec: Reporting not started Jan: 67%

There have been no changes in guidance/updates from the IPC weekly meetings. Covid guidance and in particular wearing of face masks, will be reviewed in March 2023 to allow winter respiratory infections to subside.

Dr Matt Laundy has been appointed as the SGUH IPC Lead Doctor.

In addition, the following points are drawn to the attention of the Committee:

1.0 ESTH

1.1 CPE Carbapenemase-producing Enterobacterales: In December 2022 there was an NDM (New Delhi metallo-β-lactamase) CPE outbreak on CCU St Helier involving 4 patients. An outbreak incident meeting was held on 11 January 2023 and the following findings/actions:

- Source of infection/outbreak/index case remains unclear, however further swabbing of the secondary contacts were negative which demonstrated no onward transmission.
- Following the initial positive case, the bay remained open to admissions due to unprecedented bed pressures not only at the Trust but across the region at the time. However despite the capacity pressures, the situation should have been escalated to the site leadership team to ensure a safe pathway was developed to reduce the risk of onward transmission.
- Although this would not have changed the outcome for the contacts/subsequent new admissions, there was an initial delay of 48 hours to swab identified contacts.
- No dedicated equipment and facilities for CCU on AMU which poses the challenge and a blur of shared responsibilities for cleaning equipment and keeping the environment clutter free.
- One of the patients was having regular podiatry input and it was highlighted that this is a group of staff that had not been included in the roll out of the Trust Aseptic Non Touch Technique (ANTT) strategy to assess and monitor competencies. The IPC team will be delivering the training to podiatrists on both sites in February 2023.

At the time of writing this report, all patients had been discharged and one had died as reported in the last report (CPE not included on death certificate) . The incident is now closed.

1.2 Legionella, 2nd floor Langley wing, Epsom Hospital: As part of the capital programme, a major refurbishment is being undertaken to create a 20 bedded ward in the space that was used for medicine clinical administration on the 2nd floor in Langley wing. In December 2022, as the project was nearing completion, water samples were taken for routine testing on two outlets on the new Croft ward where high legionella counts were identified.

Following the remedial works, all the water sample results are now clear and Croft ward relocated to the new the ward area in January 2023.

1.3 Influenza: As of 10 January 2023 patient influenza levels are now reported with 52 cases in January 2023.

2.0 SGUH

2.1 Influenza: The number of Influenza cases has fallen significantly in January 2023 to 50 cases, in comparison to the December cases of 225. In view of this there is no longer a dedicated flu ward in the Trust.

2.2 Fit Testing: As of 30 January 2023, fit testing at St George's Hospital and Queen Mary's Hospital including staff based in the Community is now reported with 67% of eligible staff now fit tested.

2.3 Norovirus: There has been one inpatient outbreak in January 2023 (the first outbreak this winter), on a Senior Health ward, commencing 2 January 2023. The ward was closed between 5 to 26 January 2023 with 13 patient affected. Several outbreak meetings were held. There have been no new cases.

2.4 Hepa Filters: A trial has been in place at SGUH following successful use of air filters at ESTH and a reduction in nosocomial covid-19 infection. The outcome of the trial at SGUH is currently inconclusive due to hepa filters not being used consistently. On occasions the hepa filters were switched off due to patient complaints of noise and feeling cold. Further discussion re next steps is underway.

3.0 Flu and Covid-19 Staff vaccination

Flu Vaccination: ESTH performance is 56.25% (54.96% in the previous reporting period) against the 70% CQUIN target and SGUH performance is 49.4% (47.1% in the previous reporting period) against the 80% CQUIN target.

Table 1 Flu vaccination by staff group

Staff Group	ESTH		SGUH	
Add Prof Scientific and Technic	171	59.65%	726	48.3%
Additional Clinical Services	1276	46.87%	1244	38.3%
Administrative and Clerical	1335	56.78%	1969	40.5%
Allied Health Professionals	521	62.38%	736	57.1%
Estates and Ancillary	471	39.07%	282	42.2%
Healthcare Scientists	66	62.12%	433	35.6%
Medical and Dental	879	68.15%	1551	64.2%
Nursing and Midwifery Registered	1911	58.87%	2917	53.3%
Students	10	30.00%		
TOTAL	**6640**	**56.25%**	**9858**	**49.4%**

Table 2 Flu vaccination by ethnicity (staff)

Staff Group	ESTH		SGUH	
Asian/Asian British	1453	60.50%	2336	49.9%
Black/Black British	872	36.01%	1679	26.3%
Chinese/Other	292	60.96%	600	57.5%
Mixed Race	245	49.80%	452	41.4%

Not Stated	543	42.36%	290	40.3%
White/White British	3235	62.19%	4501	58.1%
TOTAL	**6640**	**56.25%**	**9858**	**49.4%**

Covid Vaccination: ESTH performance is 41.95% (43.05% in the previous reporting period) and SGUH performance is 35.7% (34% in the previous reporting period).

Table 3 Covid vaccination by staff group

Staff Group	ESTH		SGUH	
Add Prof Scientific and Technic	86	50.29%	726	38.4%
Additional Clinical Services	390	30.56%	1244	20.3%
Administrative and Clerical	669	50.11%	1969	34.2%
Allied Health Professionals	258	49.52%	736	43.1%
Estates and Ancillary	125	26.54%	282	26.2%
Healthcare Scientists	32	48.48%	433	35.3%
Medical and Dental	451	51.31%	1551	49.0%
Nursing and Midwifery Registered	773	40.45%	2917	34.6%
Students	1	10.00%		
TOTAL	**2785**	**41.94%**	**9858**	**35.7%**

Table 4 Covid vaccination by ethnicity (staff)

Staff Group	ESTH		SGUH	
Asian/Asian British	615	42.33%	2336	34.2%
Black/Black British	175	20.07%	1679	14.7%
Chinese/Other	128	43.84%	600	44.5%
Mixed Race	88	35.92%	452	28.1%
Not Stated	172	31.68%	290	28.3%
White/White British	1607	49.68%	4501	44.4%
TOTAL	**2785**	**41.94%**	**9858**	**35.7%**

The national Flu Campaign comes to a close on 28 February 2023, however vaccinations will still be provided after this date on request.

In previous years the static Flu clinic at SGUH has closed on 31 January. However, this year the static clinic located in the PALs office will remain open for one session a week on a Wednesday between 10-2. This is in addition to the weekly occupational health clinic (Monday, all-day) for new starters and overseas recruits.

Recommendation:

Board is asked to:

1. Receive for assurance the Healthcare Associated Infection (Infection Control) Report from a site and Group perspective and make any necessary recommendations

	2. Note the vaccination position for staff at site and across the Group		
Supports			
Trust Strategic Objective:	Build a Better St George's Treat the patient, treat the person		
CQC Theme:	Safe, Well Led		
Single Oversight Framework Theme:	Quality of Care		
Implications			
Risk:			
Legal/Regulatory:	The Health and Social Care Act (2008): The Hygiene Code - code of practice on the prevention and control of infections. (Updated 2015) https://www.gov.uk/government/publications/the-health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance Health and Social Care Act 2008) Regulated Activities Regulations 2014: Regulation 12 Safe Care and Treatment		
Resources:	N/A		
Equality and Diversity:	N/A		
Previously Considered by:	Quality Committee in Common	**Date**	16.02.2023
Appendices:	N/A		

Healthcare Associated Infection (Infection Control) Update Report: January 2023

1.0 Group wide initiatives/ developments

This paper provides a monthly update of key issues/ concerns arising in Infection Prevention and Control (IPC) at site level. The paper supplements the IPC key performance measures and summary contained in the Integrated Performance Reports.

1.1 Group Delivery Model: Infection Prevention and Control

Terms of Reference are in place for the weekly Group Infection Control meeting. The Team is made up of the GCNO & DIPC (Chair) GCMO, Site Chief Medical Officers, Site Chief Nurses, Site lead for Infection Prevention and Control – Nursing and Site lead for Infection Prevention and Control – Medical.

This forum has the authority to make decisions on the application of national IPC guidance and to implement changes as appropriate across the Hospital Group or at site level (ESTH and SGUH) in regard to the application of universal standards for Infection Prevention and Control (IPC).

Members of the Group IPC forum have responsibility for delivery of any changes to IPC practice and to take the required actions through the normal operational management reporting lines.

The Infection Prevention and Control Meeting in Common will be operational by the end of Quarter 4 2022-23. It is anticipated that this meeting will be held bi-monthly and will be chaired by the Group Clinical DIPC.

IPC leads continue to work collaboratively across St George's, Epsom and St Helier University Hospitals and Health Group, with all Covid-19 guidance issued from June 2022 onwards having been agreed and published as guidance for the Group. The IPC Leads also continue to be proactive members of the weekly South West London IPC group where all Covid-related issues and other IPC issues are discussed to ensure consistency in guidelines and methods across SWL.

There have been no changes in guidance/updates from the weekly meetings, Covid guidance and in particular wearing of face masks, will be reviewed in March 2023 to allow winter respiratory infections to subside. Dr Matt Laundy has been appointed as the SGUH IPC Lead Doctor.

2.0 Epsom and St Helier University Hospitals NHS Trust

2.1 Covid-19 position

The IPC team continues to lead and ensure robust IPC control measures are in place including prompt identification and segregation of suspected cases of Covid-19 and minimising the risk of healthcare acquired Covid-19 infections.

A total of 129 Covid-19 infections were identified in January. Of these, 99 cases were detected within 2 days of admission; 2 cases between 3 and 7 days of admission; 9 cases between 8 and 14 days post admission and 19 cases detected 15 or more days post admission.

- YTD Covid-19 positive cases = 1960
- YTD Covid-19 deaths = 346
- Total Covid-19 positive cases this month= 129
- Total Covid-19 deaths this month = 28
- Nosocomial Covid-19 Infections this month = 28

ESTH has implemented the new nosocomial process with RCAs that meet the new criteria back dated to the 1 October 2022. In January, there were only two RCAs that met the criteria.

2.1.1 Covid-19 guidance and updates: There has been no change to national guidance. ESTH continues to adhere to published guidance and monitor if changes are required to meet local needs.

The following is a summary of the current Covid-19 guidance used across the Trust:

- All patients with a decision to admit are swabbed in A&E
- Swabbing can be undertaken for patients who develop new onset of symptoms.
- Swabbing is undertaken for patients being discharged to care facilities. (new nosocomial infections are often picked up in this group of patients).
- No swabbing or self-isolation required for elective admissions, no impact on theatre lists/positive cases identified since guidance was introduced in August 2022.
- All staff wear masks in clinical areas including outpatients. National guidance does not require the public to wear in healthcare settings, however patients/relatives are requested to wear masks in areas with ongoing clusters/outbreaks.
- Staff who test positive are required to self-isolate for 5 days and undertake a lateral flow test on day 5 and 6. Staff can return to work if both tests are negative and if positive isolate for 7 days and come back to work on day 8 from the day of positive result/onset of symptom.

2.1.2 Covid-19 Outbreaks/Clusters: There were 17 Covid-19 clusters in January 2023. Combined, these clusters generated a total of 57 contacts. As per new guidance, screening of Covid contacts was discontinued across the Group and only those who become symptomatic are to be swabbed. However, due to the number of positive cases on some of the wards, screening of contacts was undertaken to inform practice and reduce the risk of onward transmission.

The IPC team continues to monitor and follow up contacts up to day 5 following the exposure date.

2.2 Influenza A and B

In January we continued to see increased flu activity as reflected in the community prevalence. There were 4 influenza A clusters in January. Combined these clusters generated a total of 33 contacts. Contact bays were closed to new admissions and transfers for 3 days, unless all contacts were prescribed and given prophylaxis as per guidance. IPC team monitored exposed patients for symptoms over the 3 days, and any that became symptomatic were swabbed and isolated.

There were no Influenza B clusters.

2.3 Mpox Virus (MPV) national outbreak: There were no confirmed Mpox cases reported in January 2023.

2.4 Surgical Site Infections (SSIs): Due to concerns raised around surgical site infections following bowel surgery, the IPC team will undertake a three-month surveillance for large bowel surgical patients commencing in January 2023. Results and outcomes will be shared in future reports.

2.5 FFP3 Mask Fit Testing: NHS England has advised Trusts that it is now a national requirement to upload staff fit testing data/competencies onto the ESR national competency database. The fit testing team have been working with the Trust ESR team to move historical data to the new database and it is expected that the migration will be completed in the next few months.

As of 31 January 2023, **2947** staff (clinical and non-clinical) across the Trust and community have been fit tested. It is a national requirement for staff to be fit tested for a minimum of two different models of masks and the current compliance is as follows:

- Staff who have passed on one type/model of FFP3 mask - 1293
- Staff who have passed on two or more types/models of FFP3 masks - 1631
- Percentage of staff passed on 2 or more masks is 55%

Attendance for fit testing continues to be a challenge; the Fit Testing team is actively contacting divisional leads to encourage uptake. The team offers block bookings for areas as requested as well as a daily walk-in service on both sites 5 days per week.

2.6 PPE Audit Compliance: Monthly PPE compliance audits are being undertaken in all clinical areas. A total of 82 inspections over 66 areas yielded a PPE compliance score of 97%. 25 areas have not had an inspection (73% completion compliance).

2.7 Hand Hygiene Compliance: Monthly hand hygiene compliance audits are being undertaken in all clinical areas. A total of 99 inspections over 72 areas yielded a hand hygiene compliance score of 98%. 19 areas have not had an inspection (79% completion compliance).

In cases of outbreaks, bay/ward closure, additional PPE and hand hygiene audits are undertaken by the ward staff and spot checks by the IPC team.
Action reports from the divisional nurse leads are requested for areas of non-compliance and feedback to the site chief nurse.

2.8 MRSA Bloodstream Infections: There were no Trust attributed MRSA bloodstream infections in January 2023. YTD = 0.

***2.9 C diff* Infections:** In January there were 2 Trust attributed C diff cases, (2 Healthcare Onset Healthcare Associated). The IPC team have collaborated with clinical staff to complete and review RCAs within 5 days of result. On review of the cases, there were no lapses in care identified with all cases. YTD C diff cases is 32 against a national objective of 50 cases.

Table 1: *C diff* Trust Acquired Cases 2022/3

C difficile	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Lapse in Care**
Cumulative Internal Trajectory	7	11	15	18	21	23	27	31	36	40	45	50	4
HOHA	0	3	2	5	1	4	1	3	3	2			
COHA	1	0	1	1	0	0	2	3	0	0			
Total Trust C diff cases YTD	**1**	**1**	**7**	**13**	**14**	**18**	**21**	**27**	**30**	**32**			

Table 2: Healthcare Associated Infections – Surrey Downs Inpatient Wards 2022/3

HCAI	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
MRSA Bloodstream Infection*	0	0	0	0	0	0	0	0	0	0		

C difficile*	0	0	0	0	1	0	0	0	0	0		
Hospital Acquired Covid-19	0	0	1	9	1	0	7	1	1	1 (Alex)		

2.10 Carbapenemase-producing Enterobacterales (CPE): There were 2 CPE case identified in January 2023 from rectal screens collected for known previous CPE patients. On admission both patients were isolated in single rooms. There were no contacts assigned to these cases.

2.11 Aspergillus: There was one case isolated with Aspergillus fumigatus in ITU. The samples were sent when the patient arrived on the Unit, therefore not hospital acquired case. No other cases on the Unit have been identified.

2.12 Legionella: 2nd floor Langley wing, Epsom Hopsital: Following the high legionella counts on the newly refurbished Croft ward reported in the last report, all the water sample results are now clear and Croft ward relocated to the new the ward in January 2023.

2.13 Delivery Suite Operating Theatre, Epsom General Hospital: During routine servicing of the Air Handling Unit (AHU) in delivery suite theatre in Epsom it was highlighted that the unit was dust covered and was growing mould. The theatre was temporarily shut down, whilst the AHU was cleaned and the filters changed. The investigation is now complete and the Estates team concluded that this was caused by heavy rain entering the air intake (occurrence is very rare). The filters for the AHU have since been changed and the internals of unit have been cleaned. The Estates team has now introduced a new system of checking air intakes for ingress following heavy rain.

2.14 Mandatory infection control training: Table 3 below shows mandatory infection control training compliance per Division as of 31 January 2023. IPC team have 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 poor compliance.

Table 3: Mandatory Infection Control Training – January 2023

DIRECTORATE	NHS|CSTF| Infection Prevention and Control Level 1 Non-clinical	NHS|CSTF| Infection Prevention and Control Level 2 Clinical
343 3 Board	64%	
343 3 Chief Nurse	90%	82%
343 3 Clinical Operations	91%	78%
343 3 Clinical Services	85%	79%
343 3 Communications & PR	75%	
343 3 Corporate Affairs	92%	
343 3 Digital Services	90%	
343 3 EOC	88%	91%
343 3 EOC - Consultant		53%
343 3 EOC - Perioperative Care	94%	86%
343 3 EOC - Theatres	90%	83%
343 3 Estates & Facilities	91%	
343 3 Finance	91%	
343 3 Human Resources	89%	80%
343 3 Integrated Care Services	84%	85%
343 3 Medical Director	93%	57%
343 3 Medicine	83%	73%

343 3 Planned Care	88%	77%
343 3 Private Patients	88%	100%
343 3 Renal Services	77%	78%
343 3 Surrey Downs Health & Care	95%	86%
343 3 Sutton Health & Care	94%	83%
343 3 Transformation Director	88%	
343 3 Women & Children's Services	88%	72%
Total Compliance	**88%**	**77%**

85%-100%
60%-84%
0-59%

2.15 ESTH IPC Activity Summary

- Trust MRSA bloodstream infections in January 0. YTD = 0
- C diff in January = 2 HOHA, 0 COHA. YTD 32 against a national objective of 50
- There were 129 Covid-19 infections detected in January and 28 nosocomial infections.
- Two IPC polices have been reviewed and approved at PRG, Infection Control in the Built Environment and PATS policy.
- There were 17 Covid-19 clusters which generated 57 contacts.
- As of 31st January, 2924 staff have passed fit testing, 1293 on one type/model of FFP3 mask and 1631 on two or more types.
- Mandatory infection control training compliance overall 77% for clinical staff groups and 88% for non-clinical groups. Divisional Leads are responsible for monitoring training compliance.

2.16 Surrey Downs and Sutton Health & Care

- There were no Trust apportioned C diff cases reported in Alexandra Frailty ward. Community hospitals do not have nationally set objectives for MRSA or C diff.
- Surrey Downs hand hygiene audits compliance was 100% (11 of 11 service areas submitted).
- Sutton Health & Care hand hygiene audits compliance reported as 100% (18 of 18 service areas submitted).
- Mandatory infection control training compliance for Surrey Downs Health & Care was 86% for clinical and 95% for non-clinical staff.
- Mandatory infection control training compliance for Sutton Health & Care was 83% for clinical and 94% for non-clinical staff.

3.0 St George's University Hospitals NHS Foundation Trust

This report reflects the monthly position for SGUH as of January 2023.

3.1 Influenza: The number of Influenza cases has fallen significantly in January 2023 to 50 cases (46 Type A and 4 Type B) in comparison to December's number of cases at 225 cases (Figure 1) reflecting a decrease in community prevalence. Influenza A is still the predominant strain. There has been one inpatient outbreak in January 2023 (a decrease from four in December). Cavell ward is no longer our Influenza ward and is currently being used for positive COVID cases (A Bay).

Symptomatic staff can be tested by PCR via Occupational Health.

3.2 Covid-19 position (Data as of 02 February 2023): Covid-19 is showing a decrease in community prevalence, reflected in decreasing numbers of both patients testing positive when first admitted to hospital and in existing hospital patients.

A total of 137 Covid-19 infections were detected in January 2023. Of these, 87 cases were detected within 2 days of admission; 6 cases between 3 and 7 days of admission; 11 cases between 8 and 14 days post admission and 33 cases detected 15 or more days post admission.

- YTD Covid-19 positive cases = 2065
- YTD Covid-19 deaths = 173
- Total Covid-19 positive cases in January = 137
- Total Covid-19 deaths in January = 19
- Nosocomial Covid-19 Infections in January = 7

The following five figures give an indication of the decreasing trend of Covid-19 detected at St George's during January 2023 reflecting a decrease in community prevalence.

Figure 1: Monthly Distribution of Nosocomial Covid-19 Infection by HOHA and HOPA

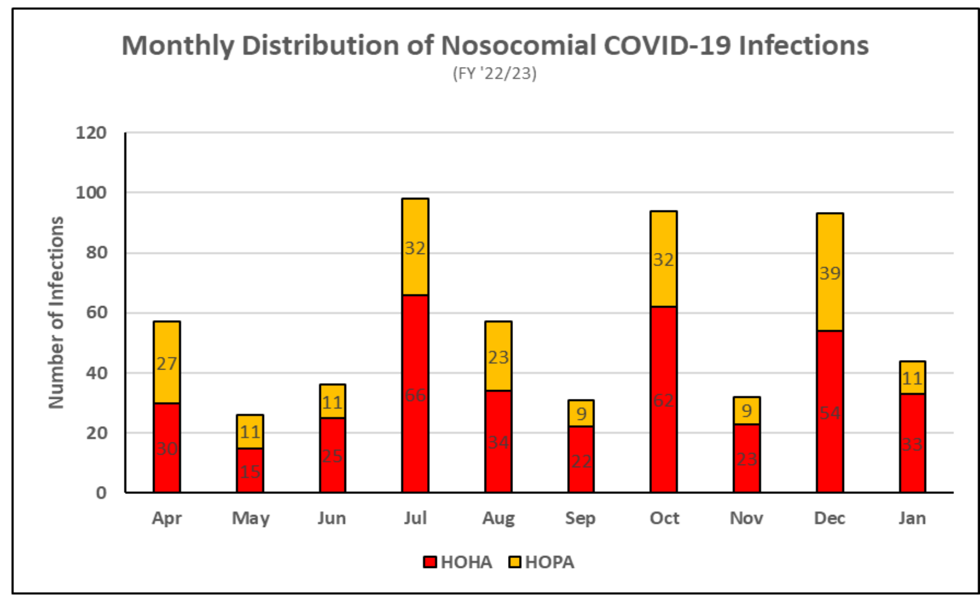
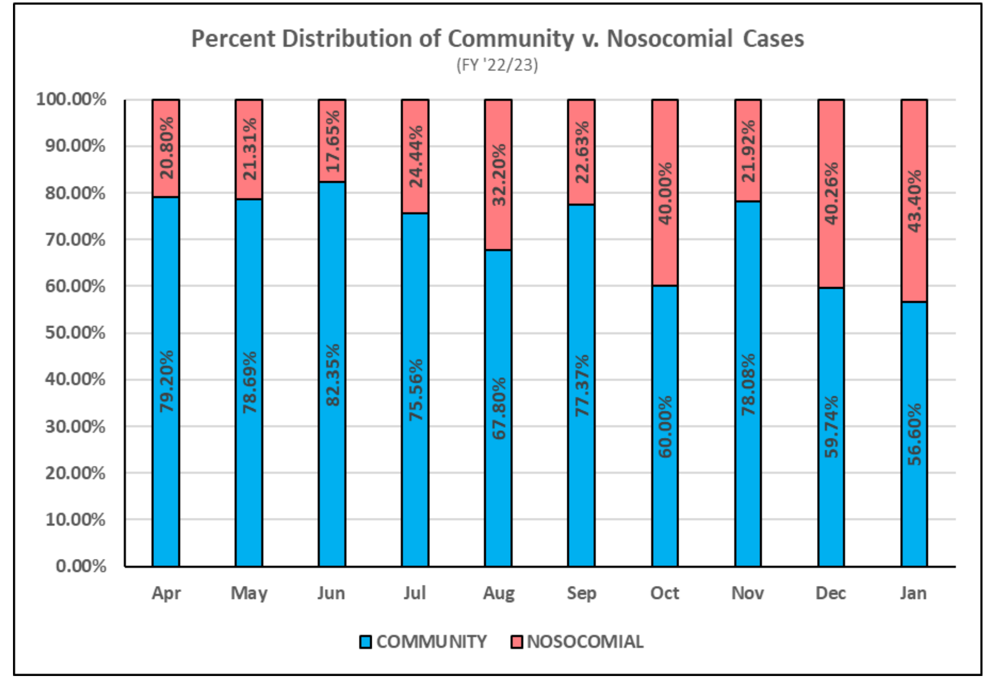
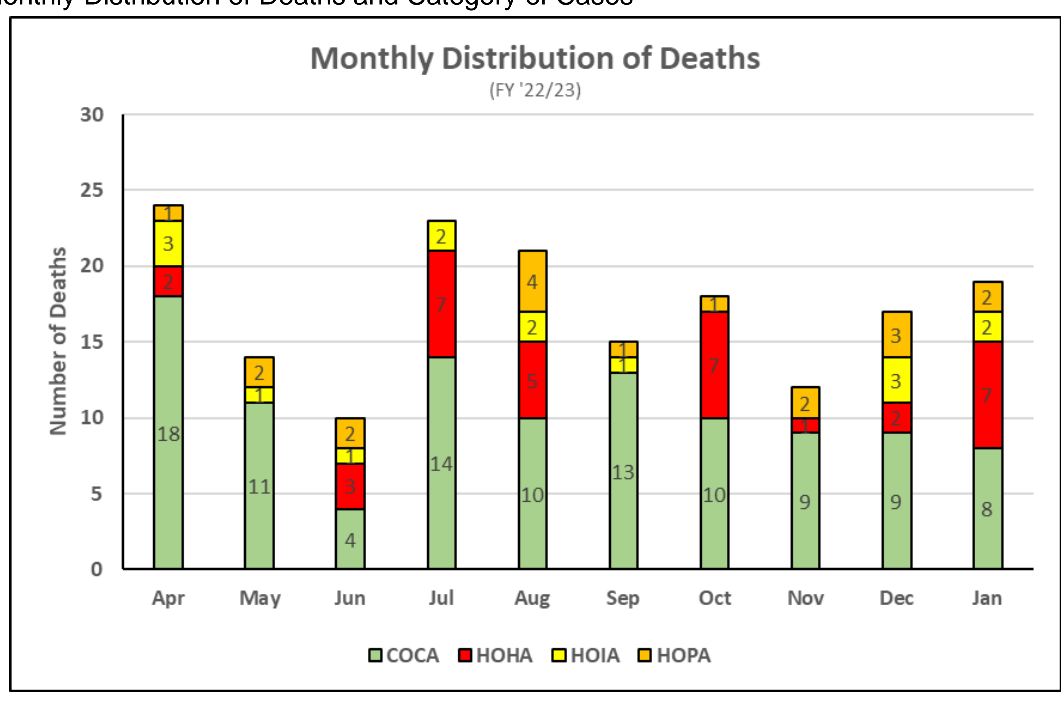


Figure 2: % of Nosocomial Cases April 2022 – January 2023



Deaths from Covid 2022-23: There have been a total of 173 deaths between April 2022 and January 2023 in patients with a positive Covid-19 diagnosis during their admission (Figure 8).

Figure 3: Monthly Distribution of Deaths and Category of Cases



During January 2023 there were 19 deaths from Covid-19 where the patient was positive during the admission. Table 1 shows how the deaths were categorised.

Table 4: Deaths from Covid-19 During January 2023

Deaths in January 2023			
#	**Class.**	**COVID on Death Certificate?**	**Date of Death**
1	HOHA	NO	01/01/2023
2	HOHA	CORONER INQUEST	24/01/2023
3	HOHA	NO	08/01/2023
4	HOHA	PART 2	06/01/2023
5	HOPA	NO	09/01/2023
6	HOHA	NO	01/01/2023
7	HOIA	CORONER INQUEST	23/01/2023
8	HOHA	NO	08/01/2023
9	COCA	NO	26/01/2023
10	COCA	CORONER INQUEST	08/01/2023
11	COCA	PART 1B	04/01/2023
12	HOIA	PART 2	16/01/2023
13	COCA	CORONER INQUEST	06/01/2023
14	COCA	CORONER INQUEST	18/01/2023
15	COCA	CORONER INQUEST	14/01/2023
16	HOPA	CORONER INQUEST	14/01/2023
17	COCA	CORONER INQUEST	12/01/2023
18	COCA	NO	24/01/2023
19	HOHA	Part 1A	29/01/2023

Of the 19 deaths recorded during January 2023, 7 were HOHA and 2 were HOPA Covid-19 acquisitions. Of the 7 HOHA cases and 2 HOPA cases, one case had COVID listed contributing to death on Part 1A of their death certificate. All other causes of death are either being investigated by the coroner or do not have COVID listed on Part 1A/B of their death certificate. Therefore, 1 of the 19 cases in January 2023 have been subject to Rapid Response Review and referred to the Serious Incident (SI) review process at the Trust. However, four deaths that have occurred between October-December 2022 were subject to a Rapid Response Review in January 2023 and referred to the Serious Incident review—the outcome is still pending.

Overall, there has been a slight increase in the number of deaths when comparing January 2023 to December 2022—more specifically with the number of HOHA deaths. However, April 2022 remains our highest month with regard to deaths (24).

3.2.2 Covid-19 Outbreaks/Clusters: In January 2023, there were 2 ongoing outbreak which commenced in December 2022, and 6 new outbreaks (on 6 wards) which commenced in January 2023.

During extreme bed pressures, Covid-19 recovered patients should be prioritised to closed bays. If not possible, other patients (who are not in a vulnerable group) can be admitted but it must be recognised that this may just prolong the outbreak. This decision must be sanctioned by the DIPC/clinical director/ IPC doctor/Chief nurse or deputy and must be documented. Patients and/or relatives being admitted to a contact ward/bay must be told that there have been cases of COVID on the destination ward before transfer.

3.2.3 Covid-19 Key Issues

HEPA Filters

As agreed at the Group IPC meeting 26/10/2022 the trust is conducting a trial of hepa filters on Rodney Smith medical ward to assess if (a) they are acceptable (noise and space) and (b) if it is possible to demonstrate a lower incidence of nosocomial Covid-19. ESTH colleagues reported that they had a ward on the Epsom site with repeated outbreaks; they installed hepa filters (Redair), one unit per bay and have had no outbreaks since.

The St James Wing wards at SGUH do not have any demonstrable air changes so any air changes, but preferably 6 or above, would be a great improvement. The trial commenced on 28/10/2022 with one hepa filter in a bay on Rodney Smith. The scrubber was deemed acceptable from a noise and space perspective; therefore, one scrubber was placed in each bay and the ward monitored for nosocomial COVID rates.

Two months after the first hep filter was installed on Rodney Smith a comparison to a comparable ward (Marnham) was made with regard to HOHA, HOPA or HOIA cases as shown in Figures 4-6. From this, there appears to be a lack of sufficient evidence to support the use of hepa filters as a method to decrease the rate of nosocomial cases/outbreaks. However, this is under the assumption that the hepa filters have been running continually as intended.

Unfortunately, the hepa filters have *not* been running continuously in the bays. Ward staff have attributed this to patients requesting them to be turned off or lowered due to feeling cold. Therefore, it is not entirely reasonable to say that the use of hepa filters has not currently demonstrated a lower incidence of nosocomial Covid-19 as reported by our colleagues at ESTH.

It should also be noted that the hepa filters now pose a potential IPC risk due to the collection of dust and patients using them as a resting place for their belongings.

Figure 4: HOHA/HOPA/HOIA (Day6 and Day7) Covid-19 Cases on Rodney Smith and Marnham

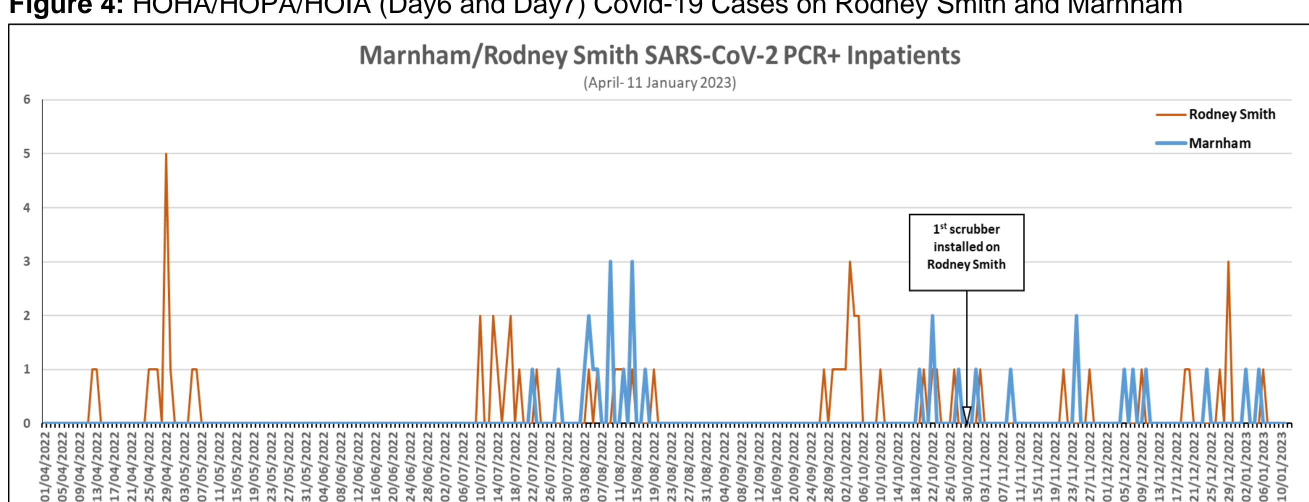


Figure 5: HOHA/HOPA/HOIA (D6 and D7) Covid-19 Cases on Rodney Smith

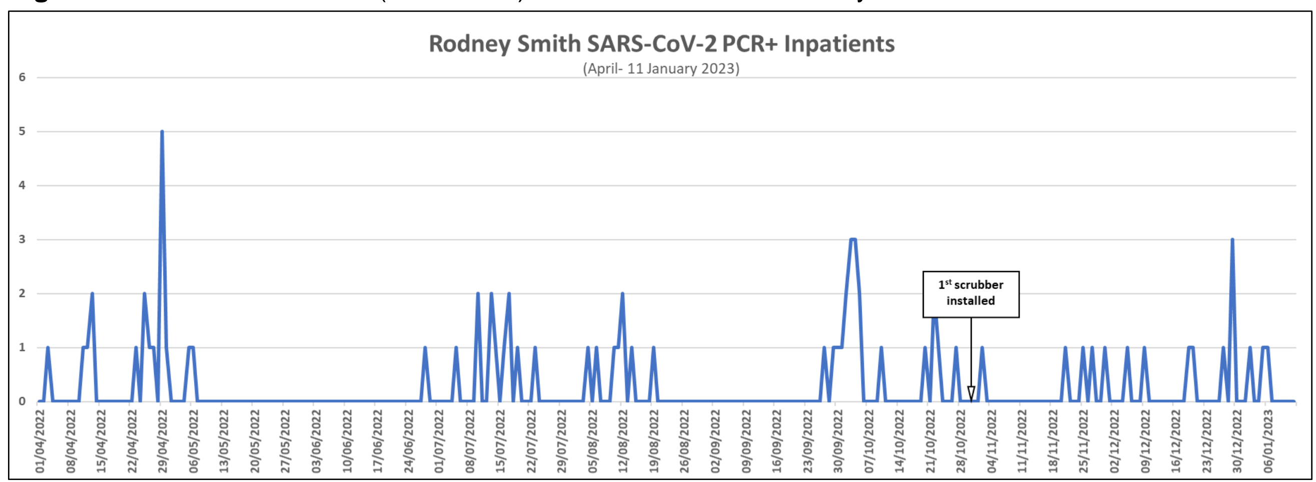
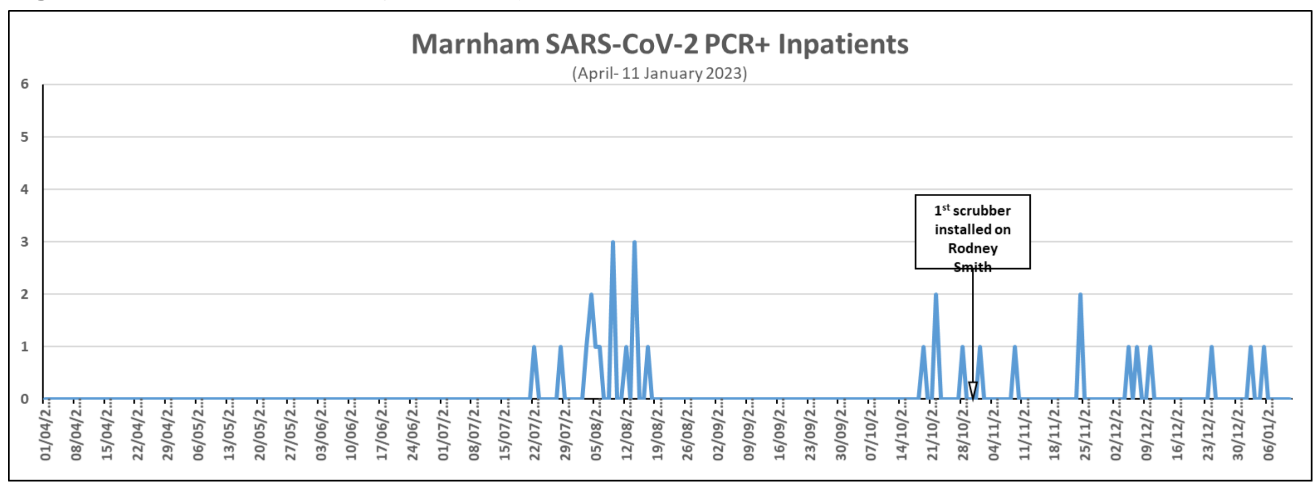


Figure 6: HOHA/HOPA/HOIA (D6 and D7) Covid-19 Cases on Marnham



3.2.4 Fit Testing

Current as of 30 January 2023. The below figures demonstrate the fit tests carried out at St George's Hospital and Queen Mary's Hospital and will include staff based in the Community. The method of testing at St George's is Quantitative fit testing to ensure we have an objective method of testing that provides a numerical result called fit factor.

Total number of tests – 7700
Total number of passes – 5838
Total number of staff tested – 4391
Total number of staff with a pass result on a current mask model - 2967
Total number of records added to the ESR system under competencies – >4500

The Fit Testing team are reviewing the figures to show the number of staff tested to 2 or more current mask models.

The team will be working with departments to ensure the information on ESR is up to date. A large number of tests have been completed from a centralised base in the Trust with the rest completed through bespoke visits at ward level.

67% of eligible staff are now fit tested.

3.3 Norovirus: There has been one inpatient outbreak in January 2023 (the first outbreak this winter), on a Senior Health ward, commencing 2 January 2023. The ward was closed 5 January 2023 and re-opened on 26 January 2023. It was a large outbreak (n=13). Several outbreak meetings were held. There have been no new cases.

3.4 MRSA Bacteraemia: There were no MRSA BSI cases in January 2023, 1 case YTD on 19 August 2022.

3.5 Mandatory Reporting - *C. difficile* Infection (CDI): There were 3 C.*difficile* infections during January 2023 and all three cases were classified as Hospital Onset Healthcare Associated (HOHA) and 0 were classified as Community Onset Healthcare Associated (COHA). There has been a total of 51 cases of *Clostridioides difficile* between April and January 2023. 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 35 cases at end of January. This means that the Trust has breached the threshold of 43 cases. The 51 cases between April and January 2023 consist of 41 HOHA cases and 10 COHA cases.

The CDI cases have been predominantly in MedCard Division, 31 cases. There were 11 cases in the Division of Surgery and 9 cases in Children & Women's Division. CDI cases have occurred in 24 different locations across the trust, many being sporadic by location. There has been one period of increased incidence (PII) in January (ribotyping still awaited), but no CDI outbreaks identified.

2.5.1 RCA Case Reviews and Lapse in Care: As per CDI standard operating procedure (SOP), cases of *Clostridioides difficile* meeting the criteria for external reporting are subject to a root cause analysis (RCA). All isolates of *C difficile* are also sent for ribotyping to look for any evidence of cross-infection and outbreaks. Following an RCA review, feedback is given to the relevant Division and the outcomes of RCA are noted at the Infection Prevention & Control Committee.

Most CDI cases have now been reviewed (45/51) to ascertain if there were any causative lapses in care e.g., inappropriate antimicrobial prescribing or serious lapses in environmental or medical devices cleaning which may have led to the acquisition of the case. However, most cases are likely to be attributable to the administration of appropriate antibiotics to patients with infections which were not preventable, and potentially life threatening if not treated with antibiotics.

Lapses in Care - Three CDI cases were noted to have a possible lapse in care, which may have potentially been causative of the infection. The lapse was in relation to prescribing antimicrobial therapy to a microbiology result and not necessarily to the clinical picture of the patient. Multidisciplinary meetings for two of these have been held.

3.6 *E. Coli* Bacteraemia : There were 12 cases of *E. coli* bacteraemia during January 2023: 10 were classified as Hospital-onset healthcare-associated (HOHA) where the specimen date is ≥3 days after the current admission date (where day of admission is day 1); 2 were classified as Community Onset Healthcare Associated (COHA), where the specimen was taken within admission day plus one day (and where the patient had also been an inpatient in the previous 4 weeks).

There is a NHSE trajectory of no more than 93 cases for 2022-23 or no more than 7.75 per month and no more than ~78 at end of January 2023. There have been 80 cases between April 2022 and January 2023. The Trust is therefore over this trajectory.

3.7 Other mandatory Reporting: *Klebsiella spp*. and *Pseudomonas aeruginosa* bacteraemia remain within NHSI/E set trajectories.

3.8 IPC Mandatory Training performance (SGUH): Infection Prevention and Control MAST data (as 03/02/2023) by Division.

Table 7: MAST IPC compliance by Division

Division	Compliance
Children &Women's, Diagnostic and Therapy Services Division	**89%**
Medicine and Cardiovascular Division	**86%**
Surgery and Neurosciences Division	**87%**

3.9 Invasive Group A Streptococcus (iGAS): The UKHSA is reporting increasing cases of invasive group A streptococcus (iGAS). Updated summary guidance has been written and is to be published on the intranet.

3.9.1 Incident 1 (concluded)

3.9.2 Incident 2 (follow up): A fifth maternity case of group A streptococcus was identified. Due to the high number of cases identified in the community at present it is likely that the infections were not acquired in St. George's hospital (SGH).

- **Case 1:** iGAS in blood culture 30 October 2022. Post-delivery at SGH on 26/10/22; Gwillim ward same day, later admitted to Croydon hospital with 2-day history of fever, rigors, headache, nausea. Baby developed severe iGAS infection 23 November 2022. Mother and baby are now fully recovered.
- **Case 2:** HVS positive on 30 October 2022. Delivery at SGH on 24 October 2022, 2nd degree tear, sutured. Went to Gwillim ward, discharged 25 October 2022 and re-admitted 30 October 2022 with fever requiring 3/7 IV antibiotics. Mother and baby are now fully recovered.
- **Case 3:** Wound swab positive 27 November 2022. Caesarean section in SGH theatres on 16 November 2022. Went to Gwillim ward for 24 hours before being discharged home. 26 November 2022 presented to ED with 3-day history gradual onset lower abdomen pain/pain around incision site, radiating into right groin. Afebrile.
- **Case 4:** iGAS in blood culture 18 December 2022, Strep pyogenes. SVD and manual removal of placenta on Carmen suite 15 December 2022. Home on 16 December 2022. Readmitted 18 December 2022, presented tachypnoeic, tachycardic, pyrexia. septic, with vaginal discharge. 19 December 2022, went to theatre for ERPC, uterine infection noted. Baby well, seen and assessed by paeds. Mum given IV antibiotics. Was in isolation since admission, no other patient contacts. Subsequently noted that husband had sore throat the week before.
- **Case 5:** iGAS in blood culture 09 January 2023 post-delivery. SVD 07 January 23 at SGH; 2nd degree tear which was sutured; transferred to Gwillim, discharged home same day. Re-admitted two days later 09 January 2023 via triage feeling generally unwell and with abdominal pain, temp 38, shivers and feeling unwell previous night. Offensive PV discharge since 08 January 012023. Minimal lochia wound discharge. Started IV Augmentin and Gentamycin; 10/01/23 started Co-Amoxiclav. HVS and Vulva swab also positive GAS 09 January 2023. Mother and baby well and discharged home.

Actions

1. Isolate sent for typing
2. 4 staff screened by throat swab for GAS (all swabs negative)
3. Any staff members with active/ongoing symptoms, to be referred to OH
4. Delivery suite to continue to monitor any re-admissions and send HVS, swab any wounds, as appropriate

5. Incident meetings held 30 November 2022, 21 December 2022 and 5 January 2023

Outcome: Staff screening complete. No staff cases identified to-date. No further incident meetings planned. Typing results were only available on 4 of the 5 cases. They are all different types, suggesting we have **not** been dealing with single point-source outbreaks.

3.10 Pseudomonas aeruginosa – NNU: In December 2022 there was a *Pseudomonas aeruginosa* bloodstream infection in a baby on the NNU and the observation that there had been a possible increase in the numbers of babies with positive microbiology results indicating infection or colonisation with sensitive strains of *Pseudomonas aeruginosa.*

A look back exercise identified 8 other babies with positive microbiology results for *Pseudomonas aeruginosa* since April 2022. Details have been obtained from neonatal staff who noticed a possible increase in numbers as well as from microbiology records.

All taps on NNU are filtered. Initial environmental screening of filters and basins resulted in one positive swab from a filter in HDU 2. The basin was taken out of use. Hand hygiene audits and environmental cleaning passed on the unit; this is generally at a good standard. An incident meeting was held on 9 December 2022.

In 2022 there had been 13 babies so far with *Pseudomonas aeruginosa* infection/colonisation. In 2016 there had been 14 babies with positive results; in 2019 there were 13; in 2020, 9 babies and in 2021 there were also 9 babies. Most of these babies had colonisation and none had bloodstream infection. Thus, the current total number of babies was not higher than had been seen in most recent years, but the bloodstream infection was a serious finding.

In 2016 there had been a thorough investigation, but it had not been possible to determine if the infections were related. There had been no evidence that water from the unit had been the source.

In March 2022 there had been a discussion about the water usage on the unit when there were two babies identified with *Pseudomonas aeruginosa* colonisation/infection. In March 2022 some environmental screening for *Pseudomonas aeruginosa* was performed and was negative.

Babies are washed with tap water (nappy changes). There was discussion around the use of sterile water instead. The wording in guidance around this is somewhat ambiguous but sterile water is used at many other hospital units.

Actions

- Isolates sent for typing (older samples will likely not be available)
- Water testing results obtained from Water Safety Team (WST)
- Water sample of CHWB (where filter was positive) followed up
- Continue to monitor hand hygiene and cleaning on the unit
- Records of cot spaces and incubators reviewed by IPC and nursing staff for any overlap
- Maintain the switch to sterile water for nappy changes
- Continue to monitor for any new cases and send for typing

Outcome: There have been no new cases. The filter that returned a positive result was disinfected and water sampling and further swabbing of that filter came back clear. Unit based domestic staff spoken to and demonstrated understanding of cleaning for CHWB. Water testing obtained from WST; any samples that had come back positive had remediation and negative samples on re-testing. The NNU (main unit has switched over to sterile water for nappy changes, however, for bathing babies they are still using tap water.

Typing results: unfortunately, only 3 clinical specimens were available for typing, but VNTR analysis has shown that the isolates are unique – they are different. The environmental sample from the filter was also sent for typing and was different from the clinical typing results.

Subsequent to the last committee report, one of the babies we had previously not been able to get any typing on had pseudomonas in the sputum later in December so the isolate was sent for typing. It has come back as a close match with the baby who had the positive blood culture but they differ by one locus in the STS typing.

Both these babies were in ICU 3 between the 19 November and 5 December 2022, diagonally across from each other. The timing of the isolates (one month apart) makes it a bit difficult to work out any potential dynamics. If they are the same then we do not know which baby acquired it from the other. Also, the antibiograms were possibly different - the isolate that was typed was not actually tested.

Plan: Micro to ask the lab to do sensitivities on the latest isolate; also to speak to the Reference lab to see if they can use a different technique which may provide a more accurate result.

No further incident meetings have been planned for the moment.

Meeting Title:	**Trust Board**		
Date:	2 March 2023	**Agenda No**	**2.3**
Report Title:	**GESH Integrated Quality and Performance Report**		
Lead Director/ Manager:	James Marsh, Group Deputy Chief Executive Officer		
Report Author:	Tara Argent, Chief Operating Officer, SGUH Alex Shaw, Chief Operating Officer, ESTH		
Presented for:	**Assurance**		
Executive Summary:	This report consolidates the latest operational management information and improvement actions across both St George's Hospital and Epsom & St Helier for the month of January 2023. **SGUH January 2023:** **Elective Care** **Successes** The number of patients waiting over 52 weeks continues on a downward trajectory and is on track to achieve year end target. Waits for a diagnostic test decreased through January with 4.4% of patients waiting over 6 weeks compared to 6.5% in December, decrease has been driven by Radiology specialties. Cancer 62 day backlog continues to reduce and performance ahead of plan. Theatres have seen the highest utilisation in the last 6 months in January at 81%, this is still 2% under our pre covid level, however our average cases per lists have surpassed our pre covid level and is currently 1.68. **Challenges** The Trust continues to see the total RTT PTL size there is an internal data quality focus that should support reduction in the over all number once fully validated. Staffing within Endoscopy across Nursing, Clinical and Admin continue to be challenged. This is leading to significant numbers of procedures being booked outside of their 6 week breach date. The service have been running additional Saturday lists since Nov 2022, however the positive impact of this has not been fully realised due to the pause in the Christmas break and RCN industrial action not permitting derogation to deliver the full service. Breast continues to be the main driver of Two Week Wait low performance with a booking profile of 2/3 weeks. Services have been further impacted by the nursing strike and the derogation not permitting the delivery of out patient services. Further impacts to all modalities were seen over December / January due to lost capacity during the festive period, theatre cancellations due to flow and a number of industrial strikes, this is set against a closed ward in the SNCT G&A bed base. To support productivity Theatres are relaunching a robust 6-4-2 process whereby theatre lists are micromanaged to ensure we are optimising capacity, whilst adhering to GIRFT & Model Hospital metrics.		

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

<table>
<tr><td></td><td colspan="3">Non-Elective Care

Successes
Four Hour performance increased to 81.5% in January, performance is still strong compared to peers. The Trust continues to embed the regularising flow programme to support exit from the Emergency Department and enable timely ambulance handovers. This has seen the introduction of boarding on the wards against daily predicted discharge numbers

Lead Nurse for Discharge and Flow for SGH appointed and will be developing the substantive workforce plan for the Transfer of Care (ToC) hub. In addition, winter funding from SWLICS to support with discharge from emergency pathway. Departure Lounge capacity and utilisation has increased across medical and surgical specialties. The use of Hospital at Home service is increasing referrals due to joint working with CLCH and growing confidence in what the service can deliver amongst consultants.

Challenges
The inability of the department to admit patients to downstream wards continues to impact on capacity, It continues to be difficult to discharge patients with the additional combined result of the RCN and CSP strikes, adversely impacting LoS.
The increase in Pathway 2 and 3A delays for Merton & Wandsworth due to a lack of bed availability and lack of homes willing to take complex patients (housing issues). Pathway 1 delays for M&W which are escalated on a daily basis. An increased focus is being placed on accurately recording the patients that no longer meet the criteria to reside (CtR) and the time waiting until Medically Ready for Discharge (MRD) to identify schemes to share risk and streamline pathways in conjunction with place partners.</td></tr>
<tr><td>Recommendation:</td><td colspan="3">The Trust Board is asked to note the report.</td></tr>
<tr><td colspan="4">Supports</td></tr>
<tr><td>Trust Strategic Objective:</td><td colspan="3">All</td></tr>
<tr><td>CQC Theme:</td><td colspan="3">All</td></tr>
<tr><td>Single Oversight Framework Theme:</td><td colspan="3">Leadership and Improvement Capability (Well-led)</td></tr>
<tr><td colspan="4">Implications</td></tr>
<tr><td>Risk:</td><td colspan="3">None</td></tr>
<tr><td>Legal/Regulatory:</td><td colspan="3">Enforcement undertakings applicable to ESTH and SGH
Compliance with the Health and Social Care Act 2008 (Regulations 2014) and CQC Registration Regulations</td></tr>
<tr><td>Resources:</td><td colspan="3">N/A</td></tr>
<tr><td>Equality and Diversity:</td><td colspan="3">No issues to consider</td></tr>
<tr><td>Previously Considered by:</td><td>Quality Committee in Common
Finance & Investment Committee</td><td>Date</td><td>16.2.23
17.2.23</td></tr>
<tr><td>Appendices:</td><td colspan="3"></td></tr>
</table>

Group Integrated Quality & Performance Report

January 2023

Presented by: James Marsh Group Deputy Chief Executive Officer
January 2023

Executive Summary
Safe, high-quality care

St George's Hospital

Successes

Complaints performance was 88% in January 2023 despite significant operational pressures.

Latest HSMR, shows our mortality to be lower than expected. Looking specifically at emergency admissions, mortality is lower than expected for those patients admitted during the week and as expected for those admitted at the weekend. SHMI 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 based on England average figures. For St Georges' performance was 0.92 and is as expected.

Challenges

Analysis provided by NHS Digital of SHMI data indicates that in June 2022 a run of more deaths than expected in the fractured neck of femur diagnosis group was observed. The SHMI for this group of patient is as expected.
Structured judgement reviews (SJRs) completed in recent months for a small number of deaths have indicated a potential issue with VTE prophylaxis.

With sustained obstetric and medical complexity, staffing remained challenging across the month with significant mitigation actioned and implemented. This has been influenced by vacancies at band 5 and band 6 level, short term sickness/absences and covid isolation continuing.

There was an increase to 17 Grade 3 & 4 pressure ulcers in January 2023 Engagement between Corporate Nursing and senior nursing leaders similar to that in August 2022 is planned for February 2023.

Epsom & St Helier

Successes

No never events at ESTH in January.

Pressure Ulcers: reduction in hospital acquired pressure ulcers in inpatient setting for the fourth consecutive month. Purchase of additional cushions for all inpatient areas.

Nutrition:. Rollout of E- Must to 7 areas .

Dementia and Delirium – Work on 9 areas cross site including window murals, signage , a bust stop and large murals in progress.

Falls Prevention and Management :

Provision of Crashmats of all inpatient and Community Inpatient areas.

The percentage of unwitnessed falls as a reduction in January, 58 % compared to 71%

Details of Infection Control updates are in the separate report presented to the Quality Committee in Common.

Challenges

VTE screening - This continues to fluctuate below the monthly target .

Pressure Ulcers- Over 300 referrals in the last month, more work is required to ensure appropriate referrals and review resources

Analyses on mortality ratio continues, with detailed actions summarised in the Mortality section.

Executive Summary
Elective Care

St George's Hospital

Successes

The number of patients waiting over 52 weeks continues on a downward trajectory and is on track to achieve year end target.

Waits for a diagnostic test decreased through January with 4.4% of patients waiting over 6 weeks compared to 6.5% in December, decrease has been driven by Radiology specialties.

Cancer 62 day backlog continues to reduce and performance ahead of plan.

Theatres have seen the highest utilisation in the last 6 months in January at 81%, this is still 2% under our pre covid level, however our average cases per lists have surpassed our pre covid level and is currently 1.68.

Challenges

The Trust continues to see the total RTT PTL size there is an internal data quality focus that should support reduction in the over all number once fully validated.

Staffing within Endoscopy across Nursing, Clinical and Admin continue to be challenged. This is leading to significant numbers of procedures being booked outside of their 6 week breach date. The service have been running additional Saturday lists since Nov 2022, however the positive impact of this has not been fully realised due to the pause in the Christmas break and RCN industrial action not permitting derogation to deliver the full service.

Breast continues to be the main driver of Two Week Wait low performance with a booking profile of 2/3 weeks. Services have been further impacted by the nursing strike and the derogation not permitting the delivery of out patient services.

Further impacts to all modalities were seen over December / January due to lost capacity during the festive period, theatre cancellations due to flow and a number of industrial strikes, this is set against a closed ward in the SNCT G&A bed base.

To support productivity Theatres are relaunching a robust 6-4-2 process whereby theatre lists are micromanaged to ensure we are optimising capacity, whilst adhering to GIRFT & Model Hospital metrics.

Epsom & St Helier

Successes

Total PTL reduced for the second consecutive month from 47341 in Nov22 to 46859 in Dec22, following twelve successive months of increases.

Outpatient first activity remains significantly above 104% of BAU levels with 108% in Dec22. Total patients awaiting a first outpatient attendance has reduced from ~22k in Dec22 to ~21.7k in Jan23 which suggests the high referral demand is mainly being mitigated with increased activity.

Specialist advice requests delivered per 100 outpatient first attendances in Dec22 was 9.6, an increase from 9.1 in Nov22.
Cancer performance achieved against the key standards in December 2022.

Challenges

GP referrals remain significantly above BAU levels. GP referrals for Dec22 were 10% higher than the volume received in Dec19.

52 week waits continue on an upward trend each month with an increase from 270 in Nov22 to 309 in Dec23. Community Paediatrics remains the most pressured speciality with 129 children waiting over 52 weeks for a first appointment (as of 08/02/23), an increase from 92 (as of 04/01/23) and 50 (as of 01/12/22).

Patient initiated follow-up reduced from 2.7% in Nov22 to 2.4% in Dec22 although this is expected in a lower activity month where routine activity is cancelled over urgent activity i.e. Dec, Apr, Aug.

DM01 (diagnostics) remains pressured with 2393 patients waiting more than 6 weeks in Jan23, an increase from 2008 in Dec22. The increase is mainly within radiology modalities (MR, CT and NOUS). ECHO has remained static (although still pressured) with ~500 waiting more than 6 weeks.

Cancer Endoscopic Ultrasound (EUS) at Royal Marsden Hospital (RMH) capacity continues to be challenging – current wait according to RMH is just over 2 weeks. An internal audit is being undertaken to support further liaison with RMH and RM Partners to improve turnaround times.

Executive Summary
Non-Elective Care

St George's Hospital

Successes

Four Hour performance increased to 81.5% in January, performance is still strong compared to peers. The Trust continues to embed the regularising flow programme to support exit from the Emergency Department and enable timely ambulance handovers. This has seen the introduction of boarding on the wards against daily predicted discharge numbers.

Lead Nurse for Discharge and Flow for SGH appointed and will be developing the substantive workforce plan for the Transfer of Care (ToC) hub. In addition, winter funding from SWLICS to support with discharge from emergency pathway.
Departure Lounge capacity and utilisation has increased across medical and surgical specialties. The use of Hospital at Home service is increasing referrals due to joint working with CLCH and growing confidence in what the service can deliver amongst consultants.

Challenges

The inability of the department to admit patients to downstream wards continues to impact on capacity, It continues to be difficult to discharge patients with the additional combined result of the RCN and CSP strikes, adversely impacting length of stay.
The increase in Pathway 2 and 3A delays for Merton & Wandsworth due to a lack of bed availability and lack of homes willing to take complex patients (housing issues). Pathway 1 delays for M&W which are escalated on a daily basis. An increased focus is being placed on accurately recording the patients that no longer meet the criteria to reside (CtR) and the time waiting until Medically Ready for Discharge (MRD) to identify schemes to share risk and streamline pathways in conjunction with place partners.

Epsom & St Helier

Successes

- The percentage of beds occupied by COVID positive patients is at 3.5% in January 2023, and has remained below the ambition for the last two months.
- Readmission rates remain low at 4.4% for January 2023
- Zero length of stay non-elective admissions for January 2023 are 345, remaining below the ambition of 439, reflecting the impact of SDEC.

Challenges

- The percentage of patients spending 12 plus hours in ED is 9.8% in January 2023, an improvement compared to December 2022 where we were reporting 14%
- Mean daily super stranded numbers over 134 for January 2023 and a de-terioration compared to December 2022 (130).
- 60-minute plus ambulance handover delays of 145 in January 2023, an improving position compared to December 2022 (274)

Executive Summary
Our People

St George's Hospital

Successes

Our HR teams across both SGUH and ESTH came together with senior Finance colleagues for two workshops to redesign our approach to workforce planning. The process is frequently exclusively led by finance decisions, but our approach will in future be to align HR and Finance Depts in working with managers groupwide.

Using the staff survey data we are in the process of determining the areas of focus for this year's Big 5. We are working with clinical divisions to ensure that the Big 5 will be ready to have executive sponsorship and then ready for a communication campaign in the Spring.

Vacancy rates continue to be well controlled overall and at 8.3% are below our target level of 10%. Children's, Women's Diagnostics & Therapies has particular success in managing its vacancy levels.

Challenges

Sickness has fallen back from a high level of December, but continues to consistently run above target.

Staff turnover levels at 16% rather than our desired target level of 13% are an area of focus. We are using an external, independent provider to send out exit questionnaires to leavers and to analyse the results to "learn from leavers". This work is being conducted across both Trusts in addition to working with recent joiners to identify those considered to be potential "flight risks" .

Epsom & St Helier

Successes

Starting in Q3 our new Culture Champions conducted a widespread engagement programme with all staff invited to attend a culture focus group to share their lived experiences at the Trust and make recommendations to help improve our culture. The results of this first phase were reported to the senior leadership team and the next phase is to merge these findings with the recent staff survey outputs building further on our RESPECT work.

Our Occupational Health Dept have begun to roll out health checks for members of staff who are over 40 with the first group of employees receiving their invitation to a screening session in February.
We continue on our journey towards ensuring that the concept of "A Just Culture" is fully embedded in our decisions on Employee Relations issues and senior members of the team have attended external training to help us move further towards our goal.

Challenges

ESTH has been fortunate this far to avoid having nurses strike, but the proposed 72 hour walkout in March by junior doctors will have an impact on our services.
Appraisal rates are below our target and have tailed off further during the winter pressures. We have decided to begin detailed monthly reporting to the senior team with a view to ensuring that managers make time to carry out quality appraisals for their teams.

Monthly Overview – Safe, high-quality care (1)

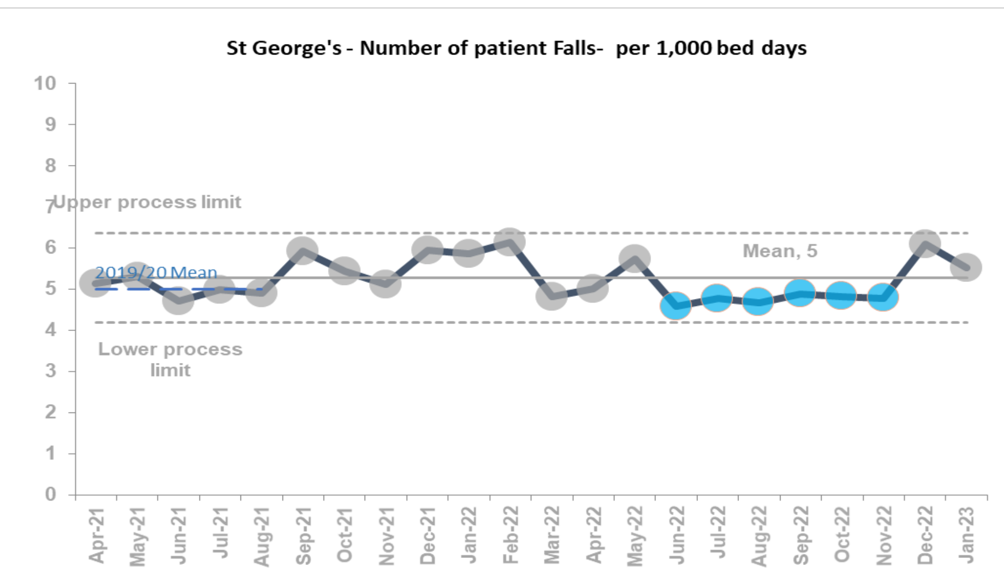
Safe, High Quality Care	St George's							Epsom and St. Helier						
	Monthly Target	Nov-22	Dec-22	Jan-23	YTD Target	YTD Actual	13-Month Trend	Monthly Target	Nov-22	Dec-22	Jan-23	YTD Target	YTD Actual	13-Month Trend
Never Events	0	0	1	0	0	2		0	0	0	0	0	1	
Serious Incidents	8	4	1	1	96	30		TBC	3	2	2	TBC	31	
Number of Falls With Harm (Moderate and Above)	TBC	2	3	2	TBC	29		TBC	6	1	1	TBC	18	
Pressure Ulcers - Acquired catergory 3&4	0	9	12	17	0	126		0	2	2	0	0	14	
Dementia - Assessment & Investigation of Patients at risk of Dementia		NA	NA	NA	NA			90%	38%	71%	58%	90%	51%	
Mental Capacity Act & Deprivation of Liberties - Level 1	90%	89%	89%	89%	90%	88%			NA	NA	NA	NA	NA	
Mental Capacity Act & Deprivation of Liberties - Level 2	85%	73%	73%	75%	85%	71%			NA	NA	NA	NA	NA	
Infection Control - Number of Cdiff - Hospital & Community	4	4	2	3	43	51		TBC	6	3	2	TBC	32	
Infection Control - Number of MRSA	0	0	0	0	0	1		0	0	0	0	0	0	
Infection Control - Number of E-Coli	9	2	4	7	111	67		TBC	22	22	12	TBC	208	
VTE Risk Assessment	95%	96.8%	96.9%	96.8%	95%	97%		95%	87.6%	85.8%	82.9%	95%	88%	
Mortality - HSMR	<100	88.4	88.7	87	<100	86.1		<100	113.96	115.60	114.64	<100	112.57	
Mortality - SHMI	<1	0.92	0.92	0.92	<1	0.92		<1	1.15	1.14	1.16	<1	1.12	

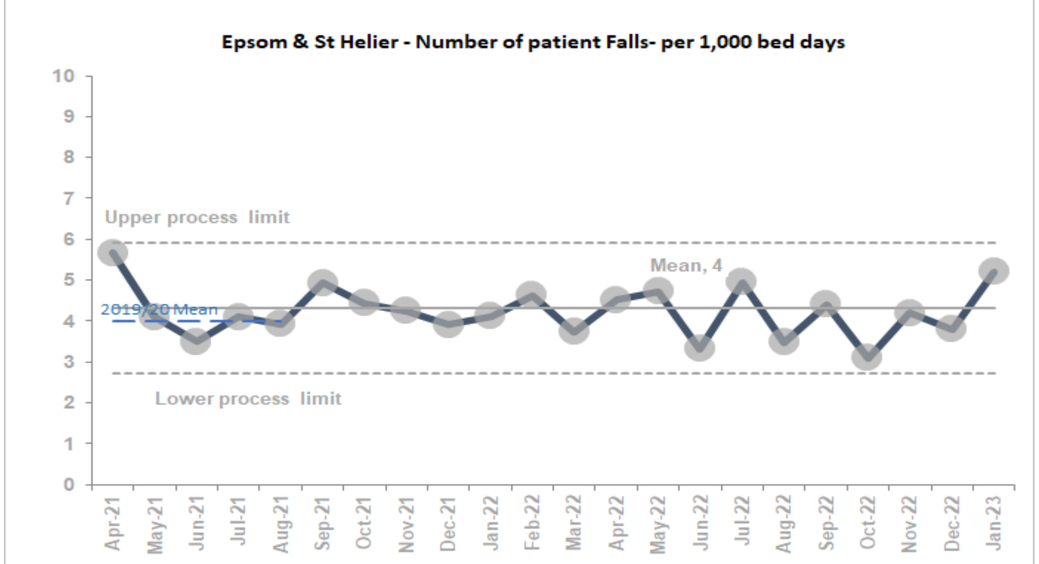
Monthly Overview – Safe, high-quality care (2)

Safe, High Quality Care	St George's							Epsom and St. Helier						
	Monthly Target	Nov-22	Dec-22	Jan-23	2022_23 Target	YTD Actual	13-Month Trend	Monthly Target	Nov-22	Dec-22	Jan-23	2022_23 Target	YTD Actual	13-Month Trend
Number of Complaints Received	TBC	51	44	30	TBC	567		TBC	39	35	42	TBC	461	
Complaints responded to in 25 days	85%	80%	88%	88%	85%	92%		85%	69%	64%	62%	85%	58%	
Friends and Family Test - Inpatients Respose Rate	20%	24%	27%	32%	20%	31%		20%	21%	16%	17%	20%	26%	
Friends and Family Test - Inpatients Score	95%	99%	98%	98%	95%	99%		95%	96%	94%	94%	95%	94%	
Friends and Family Test - Emergency Department Respose Rate	20%	11%	11%	12%	20%	12.6%		20%	7%	7%	7%	20%	10.9%	
Friends and Family Test - Emergency Department Score	90%	74%	73%	87%	90%	74%		90%	79%	78%	89%	90%	80%	
Friends and Family Test - Maternity Respose Rate	20%	13.1%	7.6%	11.0%	20%	11.9%		20%	7.7%	4.0%	4.0%	20%	6.1%	
Friends and Family Test - Maternity Score	90%	81%	93%	91%	90%	87%		90%	98%	100%	97%	90%	97%	
Friends and Family Test - Community Respose Rate	20%	0.6%	0.0%	0.1%	20%	0.7%		20%	0.8%	1.1%	1.1%	20%	0.8%	
Friends and Family Test - Community Score	90%	100%	0%	100%	90%	85%		90%	97%	98%	96%	90%	97%	
Friends and Family Test - Outpatients Respose Rate	20%	3.8%	4.9%	4.7%	20%	4.3%		20%	3.0%	2.4%	3.5%	20%	3.1%	
Friends and Family Test - Outpatients Score	90%	92%	92%	93%	90%	92%		90%	94%	95%	93%	90%	94%	

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

Target: TBC	SGH: 5.5	ESTH: 5.2





SGH updates since last month

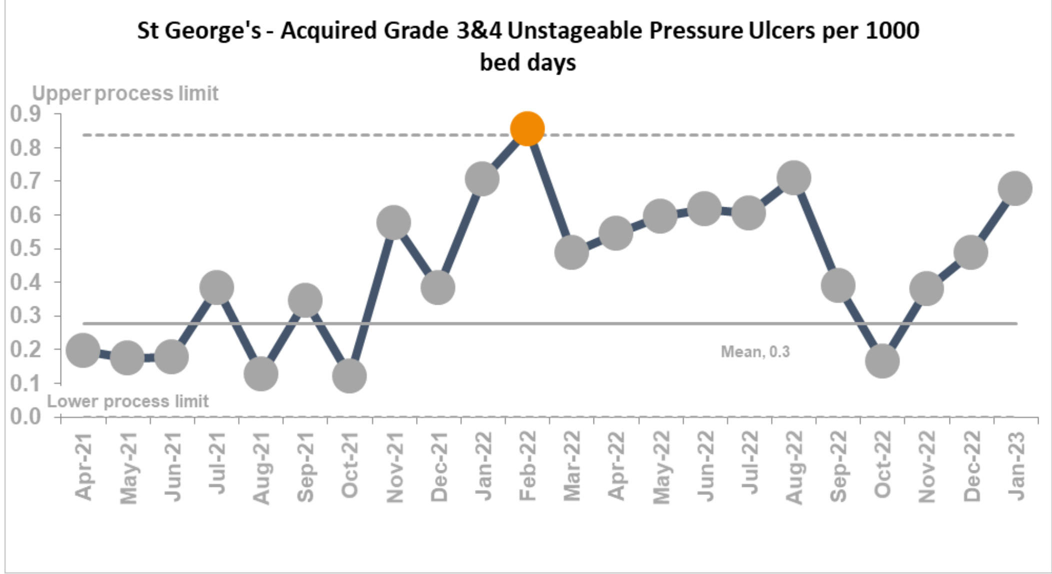
There were a total of 137 falls in January 2023, this very similar to January 2022 (140) and down from December 2022 (149). Rates per 1,000 Occupied Bed Days were 5.5, also down from 6.1 in December. The vast majority of falls were of low or no harm, however, 1 moderate harm fall occurred on Gunning (Surgical) Ward resulting in a wrist fracture, this patient has been treated and is recovering. An extreme harm fall occurred on Gordon Smith (Haematology/ Oncology) Ward resulting in an Acute on Chronic Subdural Haemorrhage, sadly the patient died. This case has been referred to the coroner and is being investigated internally.

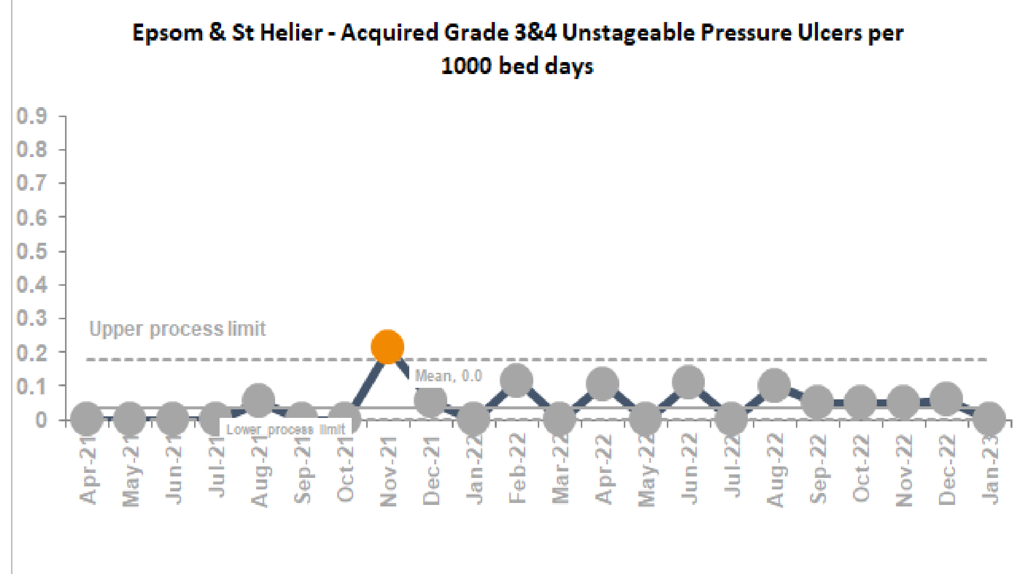
ESTH updates since last month

In January the overall Trust data saw a reduction in falls with 5.2 falls per 1000 bed days. The Acute Hospitals remained fairly static, with 4.4 falls per 1000 bed days, however, there was a slight reduction in falls reported in the inpatient areas, but this was offset with an increase in the number of falls reported in non-inpatient areas. The Community Hospitals saw a 54% reduction in the number of falls reported compared to December. There was 1 severe harm incident equating to 0.05 harms per bed days

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

Target: TBC	SGH: 0.68	ESTH: 0.00





SGH updates since last month

There were a total of 17 category 3, 4 and unstageable pressure ulcers reported in January 2023. This is an increase from December (12) and November (9) but remains below the upper process limit. Engagement between Corporate Nursing and senior nursing leaders similar to that in August 2022 is planned for February 2023.

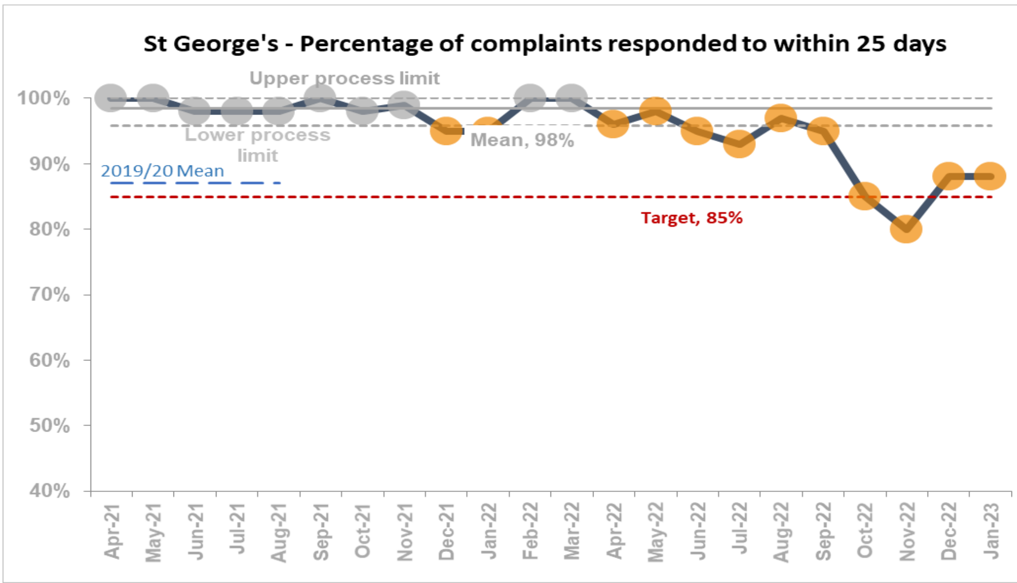
The number of medical device related pressure ulcers continued to trend downward in January 2023 with 17 (compared to 20 in December and 23 in November), this is likely to be due to QI work focused on this aspect of nursing care in intensive care areas.

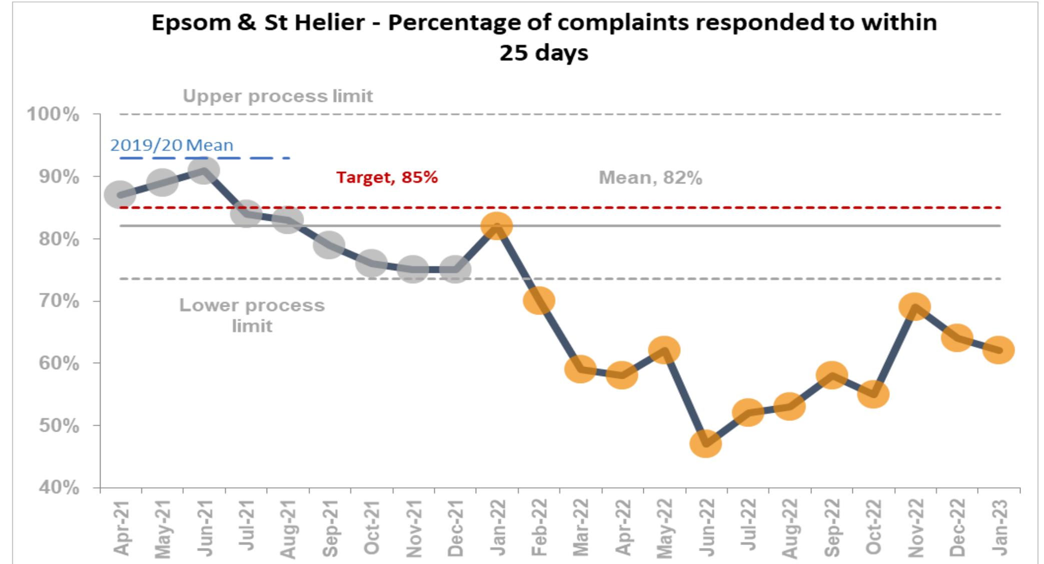
ESTH updates since last month

10 acquired pressure damage cases were reported in January, a decrease compared to January cases. There were no grade 3 & 4 unstageable pressure ulcers for this month

Complaints

Target: 85%	SGH: 88%	ESTH: 62%





SGH updates since last month

There were 30 complaints in January 2023 with 88% of them being responded to within 25 days. Capacity issues in the team continues to impact performance and the coming weeks should see improvements. However there continues to be a compliant position despite operational challenges.

ESTH updates since last month

42 formal complaints were received during the reporting period, 62% of these met the 25 days response timeframe. Good progress is being made in reducing the backlog reported previously, supported by 3 new members of staff who joined the team in September. 1The team is in a better position to manage complaints and policy changes which will streamline the overall complaints process. The GCNO and GMD are actively supporting the responses.

Quality - Analysis and Action

SGH current issues –

Infection control – 3 C.difficile infections during January 2023; all three were classified as Hospital Onset Healthcare Associated (HOHA) There have been no periods of increased incidence (PII) or CDI outbreaks January 2023. There have been a total of 51 cases between April and January 2023. 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.

MCA & DoLS - Nursing Staff are at 88% compliance for Level 2 training, highlighting the value of ongoing work with Practice Educators and the MCA team supporting the clinical areas. Meetings with Post Graduate Medical Education Lead and Site Chief Medical Officer to take place in February 2023 to discuss how to improve MCA compliance for Medics and Dental (currently at 59% a slight increase from 57% in December 2022).

Pressure Ulcers- There has been an increase from 12 (December 2022) to 17 (January 2023) Category 3 & 4 pressure ulcers. The senior team will meet with corporate nursing team to understand themes and learning. There has been a reduction of Medical Device Related Pressure Ulcers from 30 October 2022 to 17 in January 2023.

SGH future action -

Infection control - A focus on antimicrobial stewardship continues; a deep dive of current CDiff cases has been completed and an Antimicrobial audit paper has also been compiled and will be presented in a future Quality Committee. The IPC Team continue walkabouts and spot checks of medical device and environmental cleanliness

MCA & DoLS -Work has been agreed with the Local Authority to support qualified Trust Best Interests Assessors to undertake assessments in preparation for LPS.

Pressure Ulcers- Continue to review all incidents related to Category 2 and above by senior nurses and TVN team. A Pressure Ulcer Prevention E-Learning module has been developed and will be available on EMAST to support education of staff.

ESTH current issues –

Infection Control: There were no Trust attributed MRSA bloodstream infections in January 2023. YTD = 0. In January there were 2 Trust attributed C diff cases, (2 Healthcare Onset Healthcare Associated). The IPC team have collaborated with clinical staff to complete and review RCAs within 5 days of result. On review of the cases, there were no lapses in care identified with all cases. YTD C diff cases is 32 against a national objective of 50 cases. In January we continued to see increased flu activity as reflected in the community prevalence. There were 4 influenza A clusters. Combined these clusters generated a total of 33 contacts. Contact bays were closed to new admissions and transfers for 3 days, unless all contacts were prescribed and given prophylaxis as per guidance. IPC team monitored exposed patients for symptoms over the 3 days, and any that became symptomatic were swabbed and isolated. There were no Influenza B clusters.

Pressure Ulcers: There are no grade 3 or grade 4 pressure ulcers this month.

ESTH future action –

Infection Control: In cases of outbreaks, bay/ward closure, additional PPE and hand hygiene audits are undertaken by the ward staff and spot checks by the IPC team.

Action reports from the divisional nurse leads are requested for areas of non-compliance and feedback to the site chief nurse. Details of Infection Control updates are in the separate report presented to the Quality Committee in Common.

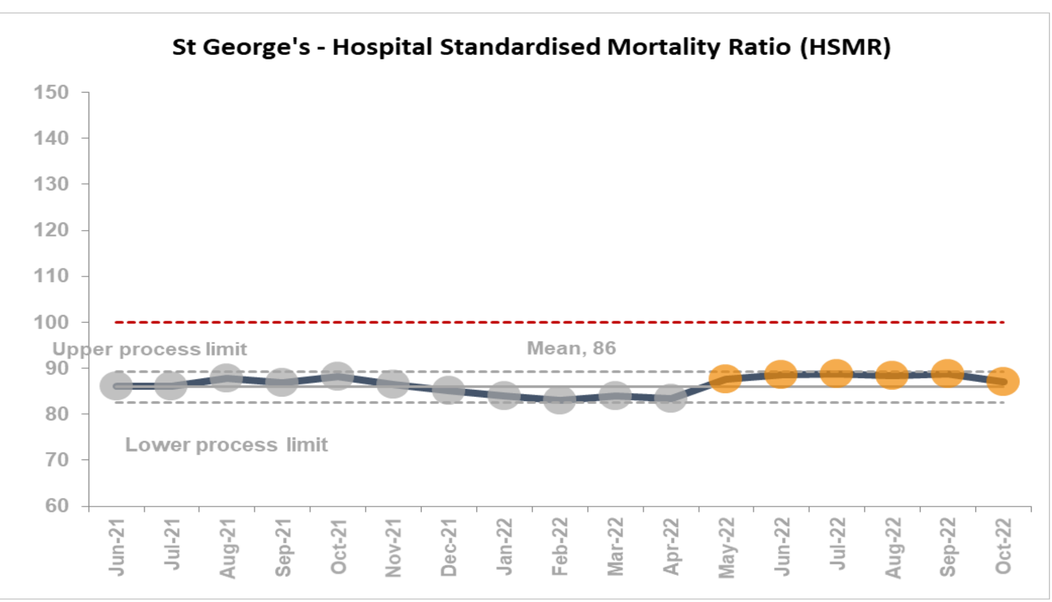
Launch of Fundamentals of Care Study Day in April to incorporate (Falls, Nutrition, Sepsis, VTE, Continence).

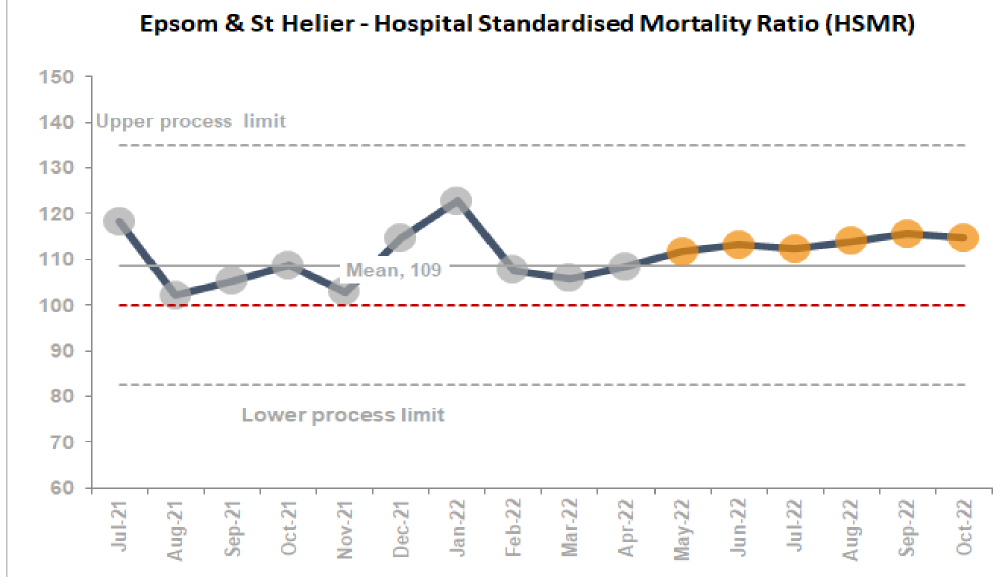
Focussed work on VTE Assessment and implementation

Falls Prevention- Continued engagement to support bank staff to utilise available training.

Mortality – HSMR

Target: <100	SGH: 87.0	ESTH: 114.6





SGH updates since last month

Latest HSMR, for the 12 months from November 2021 to October 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.

Data source: Dr Foster

ESTH updates since last month

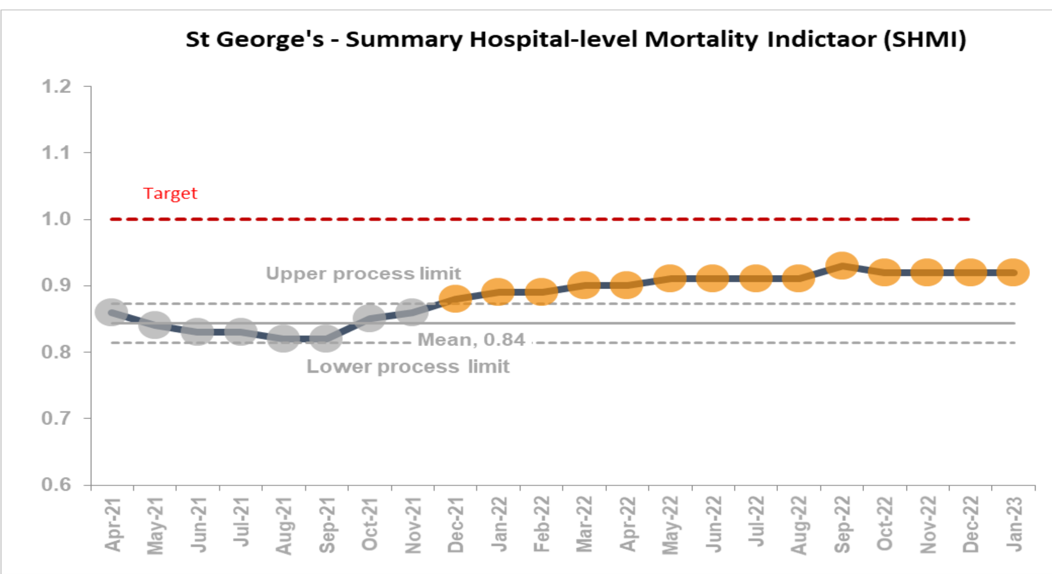
Latest HSMR, for the 12 months from November 2021 to October 2022 remains above expected level. As per previous months, elective HSMR is significantly lower than expected level at 66.8, and non-elective HSMR dominates the trend at 116.3.

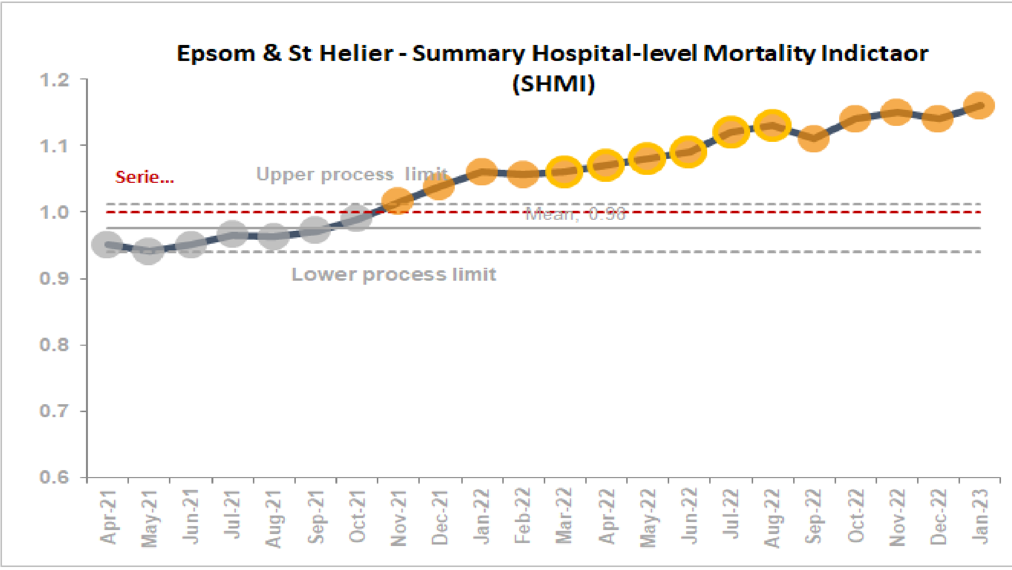
Mortality ratio is slightly lower for those patients admitted during the week than over the weekend, but both cohorts remain above expected level.

Data source: HED

Mortality – SHMI

Target: <1	SGH: 0.92	ESTH: 1.16





SHMI data is based on a rolling 12-month period and reflective of period September t21 to August 22 published (January 23)

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 remains at 0.92 and is as expected.
SHMI data is based on a rolling 12month period and reflective of period September 21 to August 22 (published January 23)

Source NHS Digital

ESTH updates since last month

SHMI includes all inpatient mortalities that occur within a hospital and deaths up to 30 days post acute trust discharges are considered using ONS data.

12 month rolling SHMI continues to rise at ESTH. Latest available data up to August 22 (published in January 23). There is no difference between the two sites.

Source NHS Digital

Mortality - Analysis and Action

SGH current issues –

The Mortality Monitoring Group consider mortality at diagnosis and procedure group level. No new signals have been identified for further review and an update on existing investigations is given below.

In a small number of cases structured judgement reviews (SJRs) completed in recent months have indicated a potential issue with the documentation of DNACPR and treatment escalation plan discussions and decisions. The SJR template has been adapted to prompt more detailed examination of any such issues. It is anticipated that in addition to flagging any learning on a individual case that this information can be collated and contribute to wider improvement work in this area.

SGH future action -

Clinical review of deaths related to perinatal diagnosis groups in Dr Foster was completed and reported previously. Work is now underway to review coding practices and to benchmark our outcomes against a similar peer group. This work involves colleagues from clinical coding, strategic business intelligence and specialist midwives.

We have previously investigated cardiology diagnosis groups where higher than expected mortality had been observed. Currently there are no cardiology related signals seen in the Dr Foster data; however, work continues to improve clinical pathways and clinical coding practices. The cardiogenic shock team is now fully operational Monday-Friday 9-5. There has also been a productive meeting between acute medicine, cardiology and clinical coding to initiate changes in practice to improve the specificity of diagnosis outside of cardiology, which will in turn improve the value of mortality benchmarking data.

ESTH current issues –

Trust Reducing Avoidable Death & Harm (RADAH) Committee review diagnosis level along with crude mortality rates. As reported previously, there has been a gradual increase in the HSMR and SHMI rates within ESTH since Summer 2021 although HSMR has dropped slightly in the recent reporting month.

Work continues to identifying the cause, including deep dive into clinical outliers, ED prolonged stay, SDEC recording impact and clinical coding audit.

ESTH future action –

The Trust continues to review all unexpected deaths via mortality review and SJR processes. Work continues such as deep dive into bowel cancer continues and review of all ward based cardiac arrests.

The audit completed in November demonstrated an opportunity to capture and improve comorbidity which is expected to impact on SHMI and HSMR. The Trust will be piloting enhanced clinical input into trust coding to improve the quality of reporting starting with the Renal division.

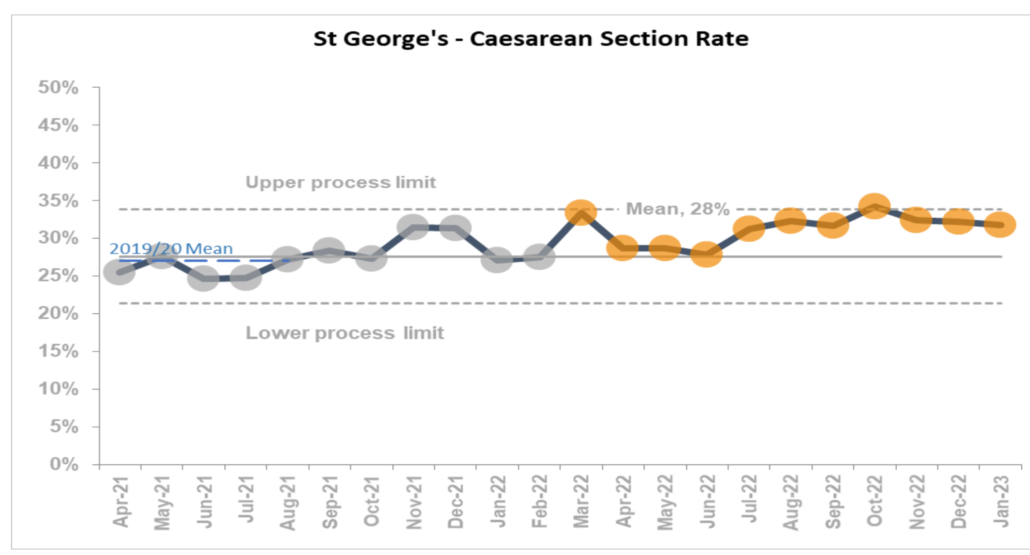
Divisional clinical quality leads will also be reviewing areas and develop actions to provide assurance.

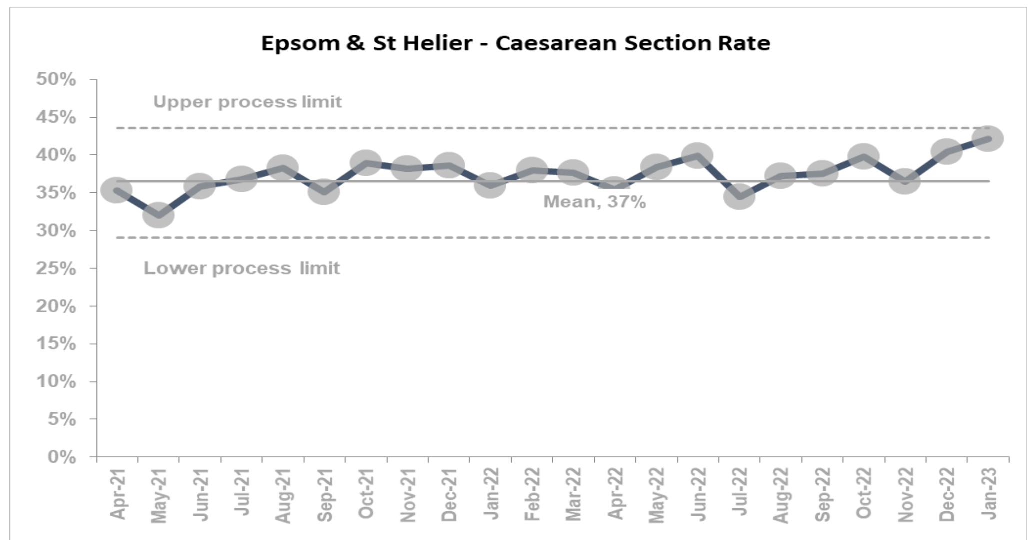
Maternity

Maternity	St George's							Epsom and St. Helier						
	Monthly Target	Nov-22	Dec-22	Jan-23	YTD Target	YTD Actual	13-Month Trend	Monthly Target	Nov-22	Dec-22	Jan-23	YTD Target	YTD Actual	13-Month Trend
Caesarean Section Rate	N/A	32.4%	32.2%	31.7%		31.1%		N/A	36.5%	40.4%	42.1%		38.2%	
% Births with 3rd or 4th degree tear	<5%	1.4%	4.1%	3.8%	<5%	1.9%		<3%	2.2%	1.7%	3.3%	<3%	2.5%	
% Births Post Partum Haemorrhage >1.5 L	<4%	2.3%	3.5%	1.9%	<4%	2.7%		<4%	3.2%	2.7%	0.7%	<3%	2.4%	
Booking Volumes (Number of Births)	>433	349	339	372	5000	3599			290	306	309		3173	
Birth Rate - Vaginal	>60%	55.4%	54.5%	52.8%		59.1%			63.5%	59.6%	58.6%		56%	
Birth Rate - Instrumental	14%	16.9%	13.3%	16.7%		14.4%			10.9%	9.9%	11.0%		12%	
Screening - booked before 9+6 weeks	>90%	39.2%	50.9%	49.2%		56%			88.0%	86.8%	76.7%		86%	
Screening - booked before 12+6 weeks	>90%	85.9%	87.9%	99.3%		93.4%		>90%	99.7%	98.1%	94.7%		98.4%	
1:1 support in labour	>80%	97.7%	97.3%	95.0%		90.3%		>95%	99.7%	99.3%	99.4%		99.3%	
Continuity of Care		23.0%	27.0%	26.3%		23.0%			77.0%	76.5%	77.8%		80%	

Caesarean Section Rate

Target: NA	SGH: 31.7%	ESTH: 42.1%





SGH updates since last month

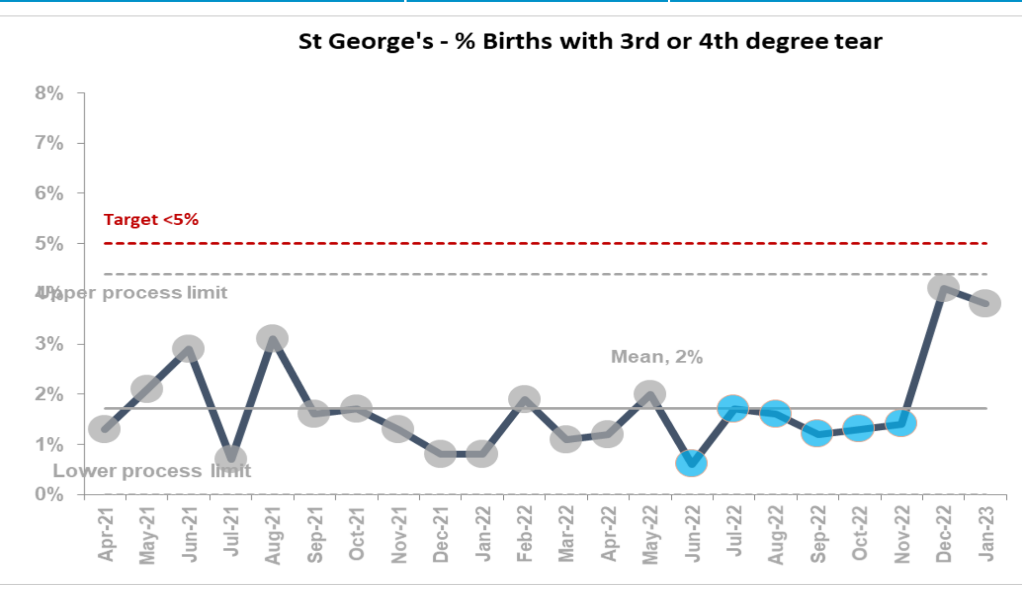
Caesarean section rates decreased from 32.2% in December to 31.7% in January.
This was split between 16% emergency and 14.2% elective procedures.
There were no admissions to NNU for active cooling in January and no HIE (hypoxic ischaemic encephalopathy cases.

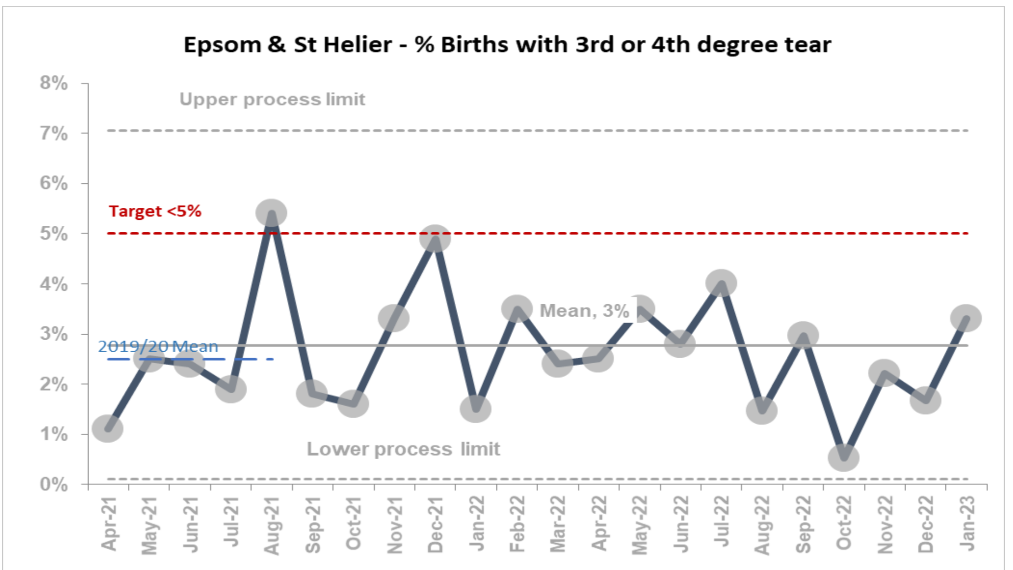
ESTH updates since last month

Caesarean sections rates- 42.1%. Following the Ockenden report, this metric has been removed nationally, with emphasis on both safety and women's' choice.

% Births with 3rd or 4th degree tear

SGH Target: <5%	SGH: 3.8%	ESTH Target: N/A	ESTH: 3.3%





SGH updates since last month

The number of 3rd or 4th degree tears shows a steady but persistent performance over the last few months, however there was an increase over December and January when that increased to 4.4% and 3.8% respectively.

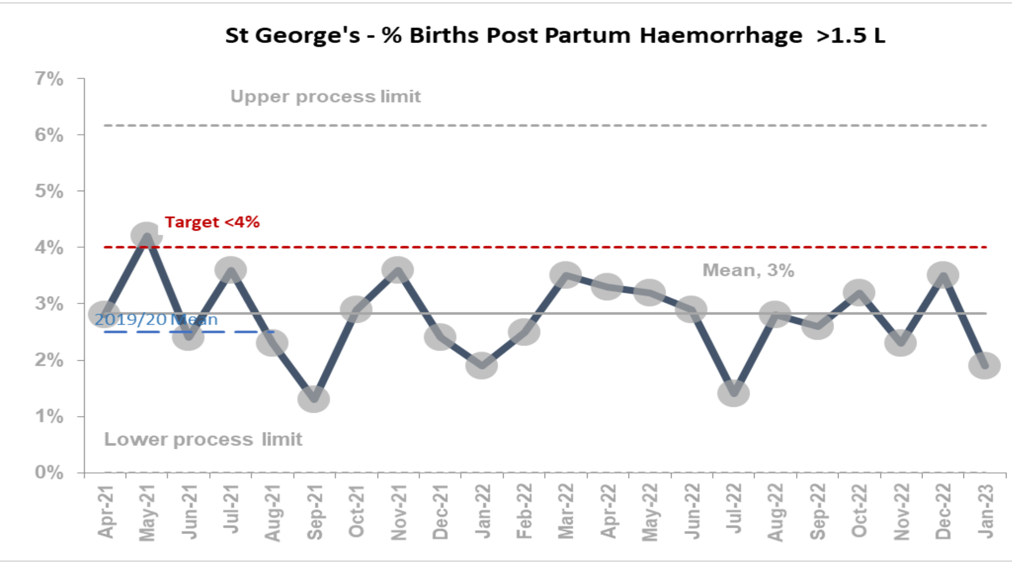
This is a continuous drive and point of discussion and education across the MDT groups

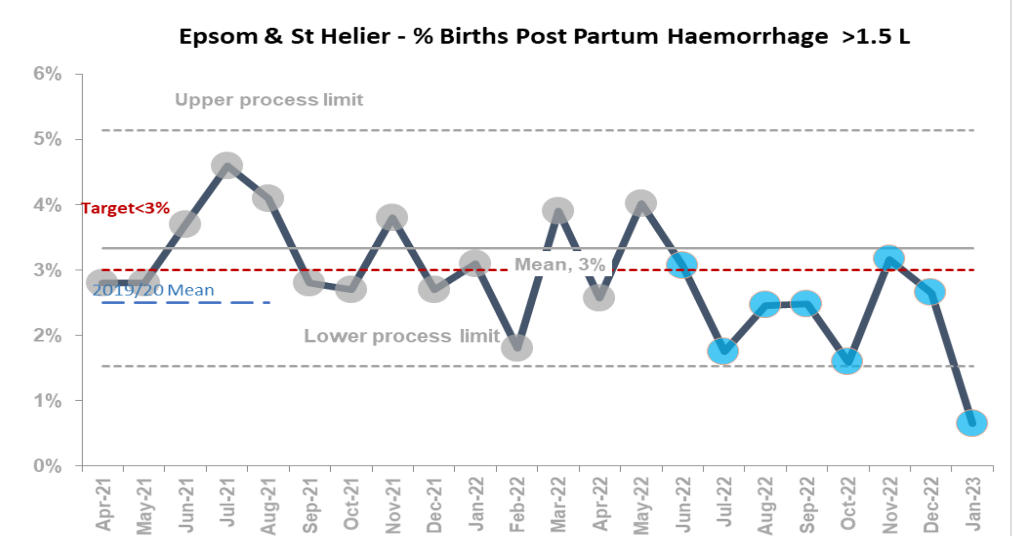
ESTH updates since last month

Percentage of births with 3rd/4th is up in January at 3.3% and below ceiling target of 5%.

% Births Post-Partum Haemorrhage >1.5 L

SGH Target: <4%	SGH: 1.9%	ESTH Target: <3%	ESTH: 0.7%





SGH updates since last month

There has been a continued low PPH rate >1.5L in January of 1.9% which is reassuring given the complexity of the women – this is influenced by an ongoing MDT QI project spanning the intrapartum areas to sustain the reduced blood loss for our women.

ESTH updates since last month

The percentage of births with post-partum Haemorrhage >1.5L was 0.7% in January, remaining below Trust ceiling target. StHelier site was high at 3.7%.

Maternity - Analysis and Action

SGH current issues –

January birth rate was 372 with high levels of obstetric and medical high complexity throughout. Staffing remained challenging across the month with significant mitigation actioned and implemented. This has been influenced by vacancies at band 5 and band 6 level, short term sickness/absences and covid isolation continuing.
CNST declaration has been submitted demonstrating that we have not met compliance in 4 of the 10 safety actions for 22/23.
We continue to respond to and plan for complex and multiple clinical scenarios using an MDT training approach and feedback from our women via FFT and the MVP.
We are utilising our Recruitment and Retention Lead midwives to support Preceptorship midwives and newly recruited midwifery colleagues complete their inductions and orientation to SGH. This is in recognition of the disproportionate skill mix within our workforce during some shifts.
We have introduced the Birth Rate Plus Acuity staffing tool on DS to capture the real-time profile of care provision. The data is captured every four hours to give a total picture over time - this provides information for SGH but also includes access across SWL maternity units – Croydon, ESTH, Kingston.

SGH future action -

We continue to work with our governance teams and HSIB colleagues to learn all we can from incidents that reach referral and investigation thresholds to influence service delivery.
The Women's Health Teams are piloting two NHSE workstreams to explore and support Health and Wellbeing along with Culture and Leadership within Maternity Services and the staff delivering them.
Continued recruitment and retention programmes to bolster the workforce deficits and improve clinical outcomes. Business cases being re-submitted to seek support with remaining recommended staffing gaps.

ESTH current issues –

Percentage of births with 3rd/4th tear is back up in January at 3.3% but consistently well below ceiling target of 5%.

The percentage of births with post-partum Haemorrhage >1.5L dropped significantly in January to 0.7%, below Trust ceiling target for the last 8 months and achieving the standard.

Note that following the Ockenden report, Caesarean section metric has been removed nationally, with emphasis on both safety and women's' choice.

ESTH future action –

Maternity reporting is led by GCNO. ESTH continues to promote the OASI care bundle and review practice.

All 3rd / 4th degree tears are reviewed by a specialist midwife and any learning point identified are shared. Following an observed spike last year, all the 3rd and 4th degree notes were reviewed which found no themes or trends.

In addition, the following changes have made as part of the OASI trial: introduction of Epi- scissors; all midwives and junior/ middle grade doctors receive training on OASI care bundle.

A retrospective review of all our 4th degree tears over the last 5 years and including the women's perspective is being conducted to understand their expectations and our deficiencies and to better manage them in future.

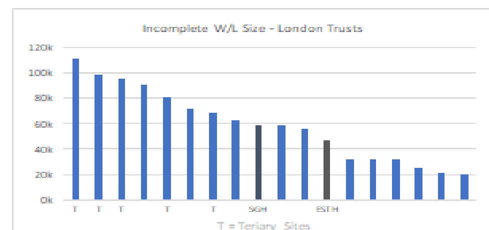
Monthly Overview – Elective Care (1)

Responsive and Productive Services - Elective Care	St George's							Epsom and St. Helier						
	Monthly Target	Nov-22	Dec-22	Jan-23	YTD Target	YTD Actual	13-Month Trend	Monthly Target	Nov-22	Dec-22	Jan-23	YTD Target	YTD Actual	13-Month Trend
Outpatient activity	62,955	60,903	48,745	58,553	620,031	583,873		57,263	59,945	46,811	56,563	551,609	543,172	
Patient Initiated follow ups	TBC	192	154	171	TBC	2,574		TBC	1,701	1,163	1,507	TBC	10,923	
Advice and Guidance	TBC	1,326	1,022		TBC	11,062		TBC	1,488	1,222	1,490	TBC	13,088	
Outpatient DNA rates	8%	10.4%	11.4%	10.7%	8%	11.3%		TBC	5.1%	5.5%	5.0%	TBC	5.3%	
Outpatient % virtual	25%	22.2%	21.0%	21.6%	25%	22.2%		TBC	6.5%	5.8%	5.2%		5.8%	
New to follow up outpatient ratios	TBC	2.08	2.02	2.06	TBC	2.34		TBC	2.65	2.65	2.63	TBC	2.75	
Elective and day case activity	5,023	5,096	4,192	4,536	49,646	49,395		3,387	3,964	3,400	3,836	36,697	36,674	
Elective LOS	TBC	3.8	4.8	3.9	TBC	4.1		TBC	6.0	5.9	6.1	TBC	5.7	
Elective Day case rates	79%	78.8%	80.0%	80.1%	79%	79%		82%	80.9%	82.4%	82.8%	82%	83%	
Theatre Utilisation	85%	80%	80%	81%	85.0%	79.9%		TBC	81.4%	84.0%	82.3%	TBC	82.6%	
Theatre Average Cases per Session	TBC	1.67	1.59	1.63	TBC	1.65		TBC	3.62	3.69	3.76	TBC	3.63	
On the day cancellations for Non Clinical Reasons	TBC	41	38	37	TBC	300		TBC	93	89	84	TBC	815	
On the day cancellations for Non Clinical Reasons & Re-booked within 28 Days	100%	87.8%	78.9%	83.8%	100%	92%								

Monthly Overview – Elective Care (2)

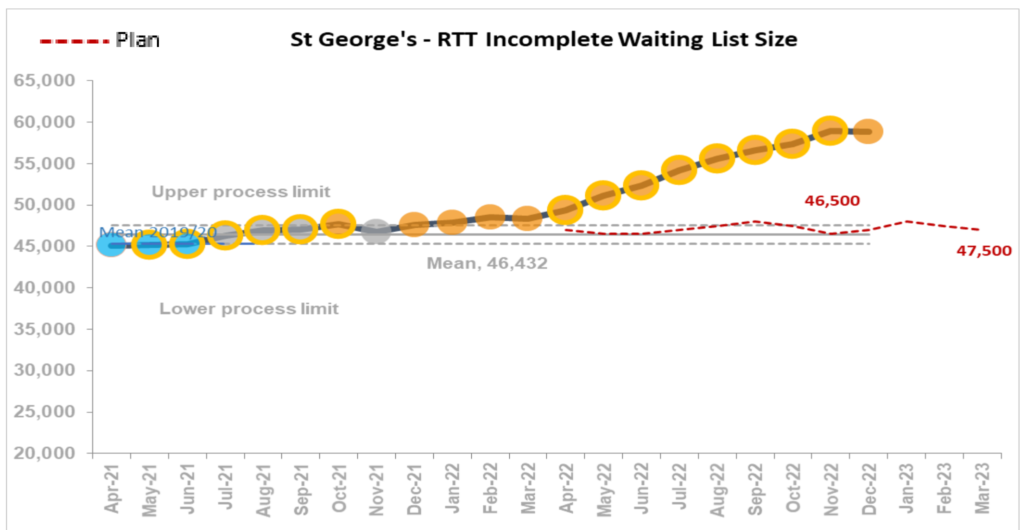
	St George's							Epsom and St. Helier						
Responsive and Productive Services - Elective Care	**Monthly Target**	**Oct-22**	**Nov-22**	**Dec-22**	**YTD Target**	**YTD Actual**	**13-Month Trend**	**Monthly Target**	**Oct-22**	**Nov-22**	**Dec-22**	**YTD Target**	**YTD Actual**	**13-Month Trend**
RTT – total size of waiting list*	47,000	57,348	58,904	58,835				4,200	48,204	47,341	46,859			
RTT - Waits over 52 weeks*	800	679	612	612				160	265	270	309			
RTT - Waits over 78 weeks*	20	19	33	39				0	6	6	5			
RTT – Performance	92%	70.5%	70.0%	67.4%				92%	69.2%	69.1%	66.5%			
Cancer 14 Day Standard	93%	68.9%	74.6%	69.9%				93%	93.4%	93.6%	94.2%			
Cancer 14 Day Standard Breast Symptomatic	93%	3.2%	5.0%	8.8%										
Cancer 31 Day Diagnosis to Treatment	96%	94.7%	96.2%	96.8%				96%	100%	100%	100%			
Cancer 31 Day Second or subsequent Treatment (Surgery)	94%	88.2%	100.0%	94.6%				94%	100%	100%	100%			
Cancer 31 Day Second or subsequent Treatment (Drug)	98%	100%	96%	100%				98%	100%	100%	100%			
Cancer 62 Day Referral to Treatment Screening	90%	59.5%	70.9%	58.1%				90%	66.7%	100%	0.0%			
Cancer 62 Day Referral to Treatment Standard	85%	64.7%	71.6%	65.6%				85%	86.6%	88.5%	88.0%			
No. of patients over 62 days	160	135	115	95				42	49	48				
Cancer – 28 day Faster Diagnosis Standard	75%	60.5%	60.7%	60.1%				75%	79.3%	79.1%	79.9%			
	Monthly Target	**Nov-22**	**Dec-22**	**Jan-23**	**YTD Target**	**YTD Actual**	**13-Month Trend**	**Monthly Target**	**Nov-22**	**Dec-22**	**Jan-23**	**YTD Target**	**YTD Actual**	**13-Month Trend**
Diagnostic activity	TBC	18,051	14,838	16,676	TBC	160,256		TBC	16,998	14,112	17,057		160,230	
Diagnostic performance	5%	5.1%	6.5%	4.5%				5%	11.1%	17.9%	19.8%			

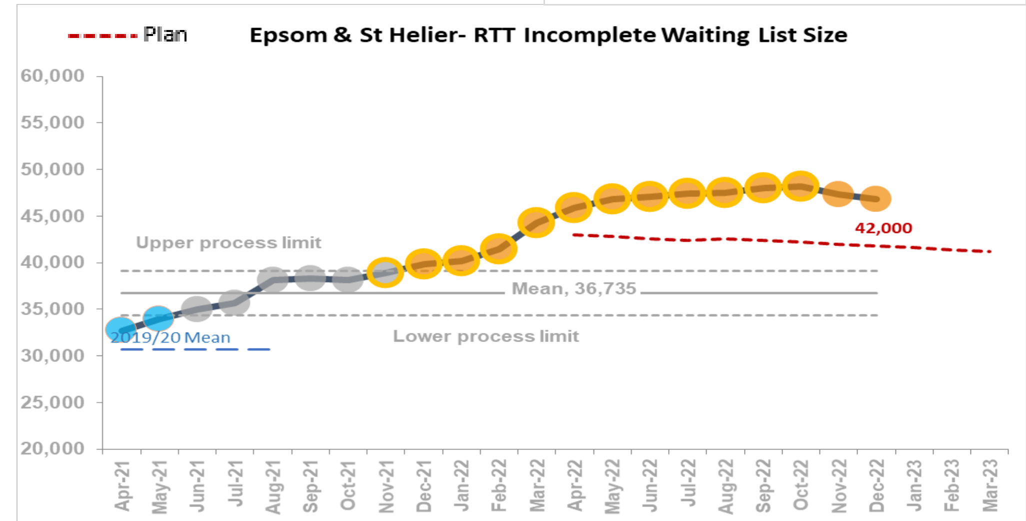
RTT – Total Waiting List Size



Dec-22

SGH Plan: 47,000	SGH: 58,835	ESTH Plan: 41,800	ESTH: 46,859





SGH updates since last month

Total PTL volume at the end of December was 58,835, seeing a slight decrease of 0.1% following a consistent upward trend. 88% of the total PTL size is attributable to the non-admitted PTL with the largest proportions of patients waiting are within ENT, Cardiology and Neurology who also hold the highest proportions of 18 week breaches.

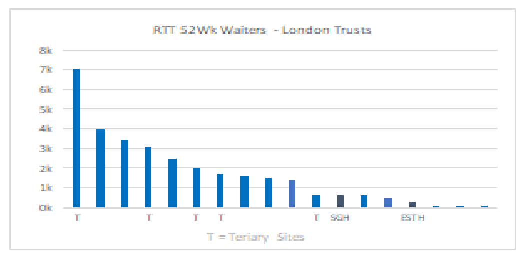
At the end of December 7,207 patients were waiting on the admitted PTL, the highest proportion of 18 week waits are within; Cardiology, ENT and Plastics.

ESTH updates since last month

PTL volume has seen a decrease (1.8%) following twelve successive months of increases, with (18w) breach numbers also dropped (249 pathways, 1.7%). With both these numbers dropping at a very similar rate, 18w performance has remained very consistent with last month (from 69.2% to 69.1%).

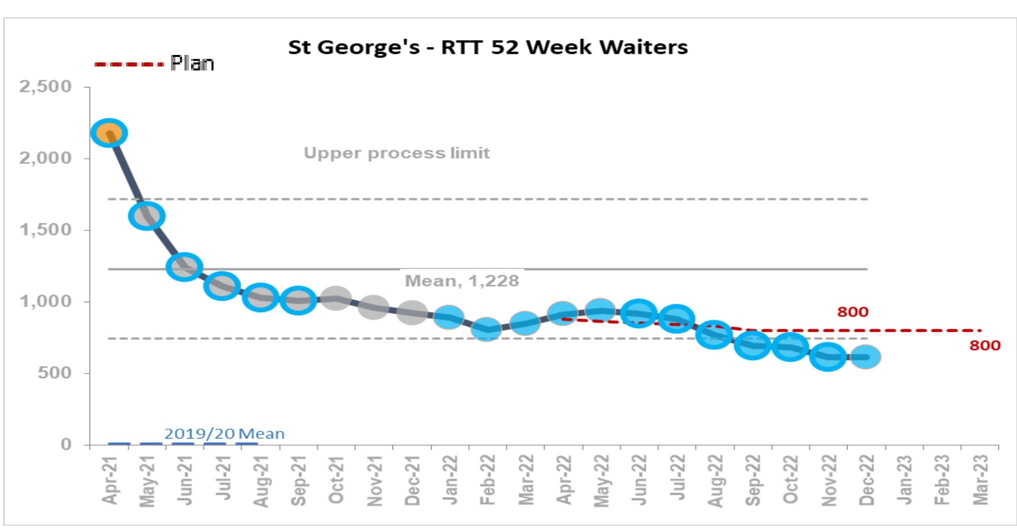
The largest proportion of 18 week breaches are within General Surgery, Gastroenterology and Gynaecology.

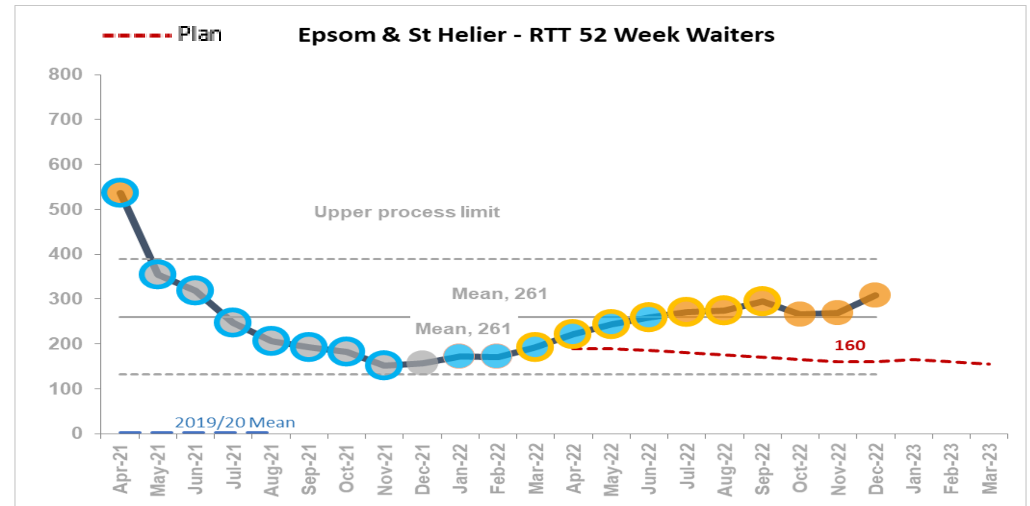
RTT – 52 Week Waiters



Dec-22

SGH Plan: 800	SGH: 612	ESTH Plan: 160	ESTH: 309





SGH updates since last month

At the end of December 612 patients were waiting for treatment for more than 52 weeks, this is below plan of 800.
The largest cohort of patients are on the admitted PTL (419 patients) the highest proportion within Cardiology. There are 193 patients waiting for more than 52 weeks on the non-admitted PTL the largest proportion within Neurology and Neurosurgery

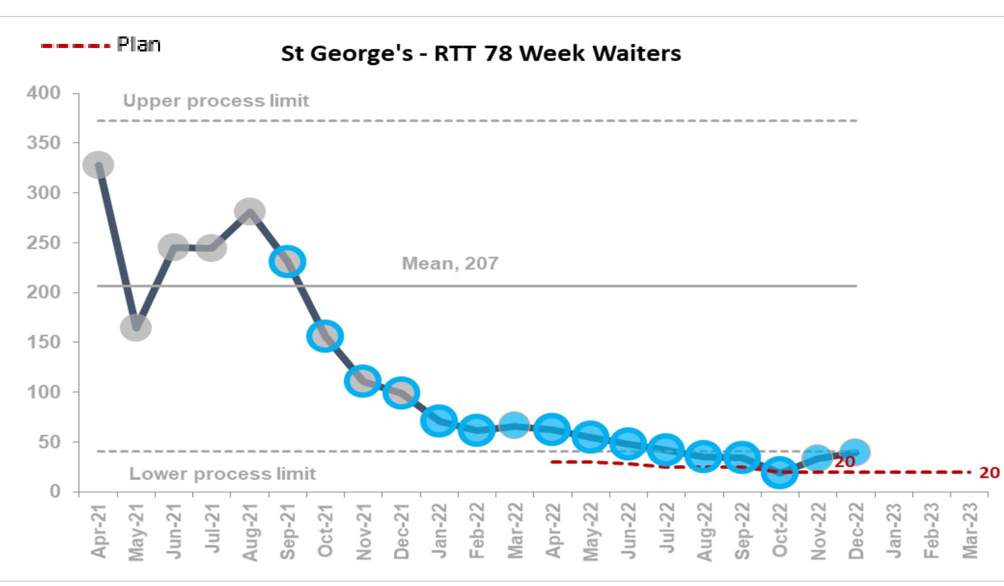
ESTH updates since last month

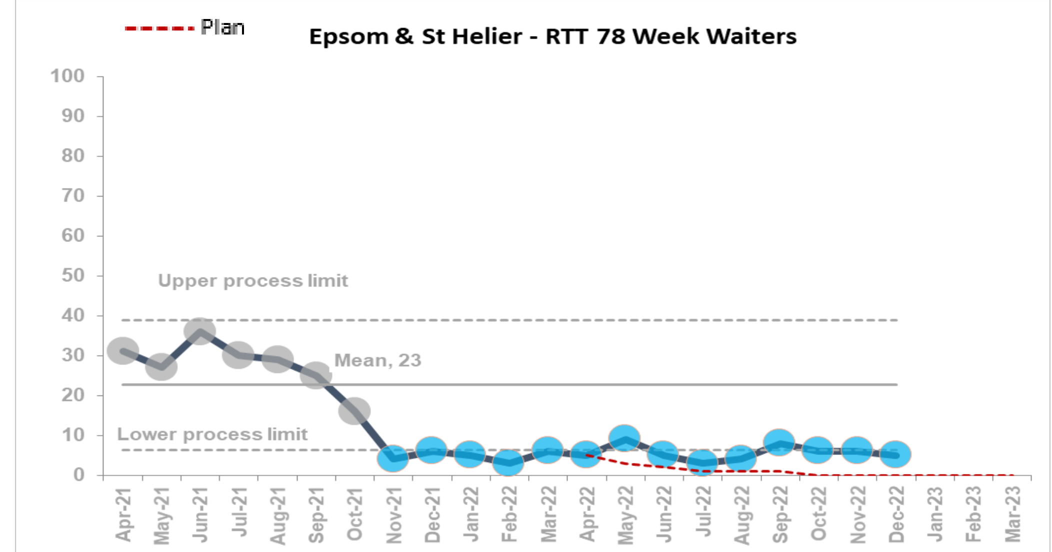
The month-end 52-week waits have increased slightly (by 39 pathways with no 104+ week waits. The largest proportion of patients waiting in this cohort are within, Gastroenterology, Paediatric Specialties and Gynaecology.

RTT – 78 Week Waiters

Dec-22

SGH Plan: 20	SGH: 39	ESTH Plan: 0	ESTH: 5





SGH updates since last month

The number of patients waiting for more than 78 weeks increased over December with 39 patients compared to 33 patients in November. The largest proportion of patients are within Cardiology (43.6%), Plastics (23%) and General Surgery (15.4%).
All patients within the 78-week cohort have a next event, with the Trust on track to have no patients waiting over 78 weeks by March

ESTH updates since last month

At the end of December, five patients were waiting for more than 78 weeks for treatment with 60% within Gastroenterology.

Elective / RTT Analysis and Action

SGH current issues –

There are 542 patients waiting over 40 weeks for a first appointment. The largest numbers are in Neurosurgery, the elective access meeting is focusing on reducing these waits and ensuring that the PTLs are validated and the access policy is being appropriately applied..
Elective Day case activity is in line with plan, however inpatient elective activity is at 85%
The number of patients waiting over 65 and 52 weeks continues a downward trajectory and is on track to achieve year end targets

SGH future action -

Focus on reducing the volume of outpatient data quality issues that may be inflating the PTL size.
In addition, there is a focus on cashing-up in several specialties where it is having an impact on clock stops and pathway progression. Neurology and Gynecology have the largest volumes.
The MBI AI driven document reader will begin to support validation of the RTT incomplete pathways, identifying errors, DQ and opportunities.
The document reader will also begin reviewing the non-RTT first and continuing PTLs, which will reduce the risk of patients being lost to follow-up.
The number of patients at risk of breaching 78 weeks is being monitored weekly and expected to deliver against the national ask. Any breaches will be as a result of patient choice.

ESTH current issues –

- Total PTL reduced for the second consecutive month from 47341 in Nov22 to 46859 in Dec22, following twelve successive months of increases.
- Outpatient first activity remains significantly above 104% of BAU levels with 108% in Dec22.

ACTIVITY	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
Outpatient First	108%	120%	118%	107%	105%	110%	120%	119%	108%

- Total patients awaiting a first outpatient attendance has reduced from ~22k in Dec22 to ~21.7k in Jan23 which suggests the high referral demand is mainly being mitigated with increased activity.
- Specialist advice requests delivered per 100 outpatient first attendances in Dec22 was 9.6, an increase from 9.1 in Nov22.

ESTH future action –

- GP referrals remain significantly above BAU levels. GP referrals for Dec22 were 10% higher than the volume received in Dec19.
- 52 week waits continue on an upward trend each month with an increase from 270 in Nov22 to 309 in Dec23. Community Paediatrics remains the most pressured speciality with 129 children waiting over 52 weeks for a first appointment (as of 08/02/23), an increase from 92 (as of 04/01/23) and 50 (as of 01/12/22).
- Patient initiated follow-up reduced from 2.7% in Nov22 to 2.4% in Dec22 (although this is expected in a lower activity month where routine activity is cancelled over urgent activity i.e. Dec, Apr, Aug)
- DM01 (diagnostics) remains pressured with 2393 patients waiting more than 6 weeks in Jan23, an increase from 2008 in Dec22. The increase is mainly within radiology modalities (MR, CT and NOUS). ECHO has remained static (although still pressured) with ~500 waiting more than 6 weeks.

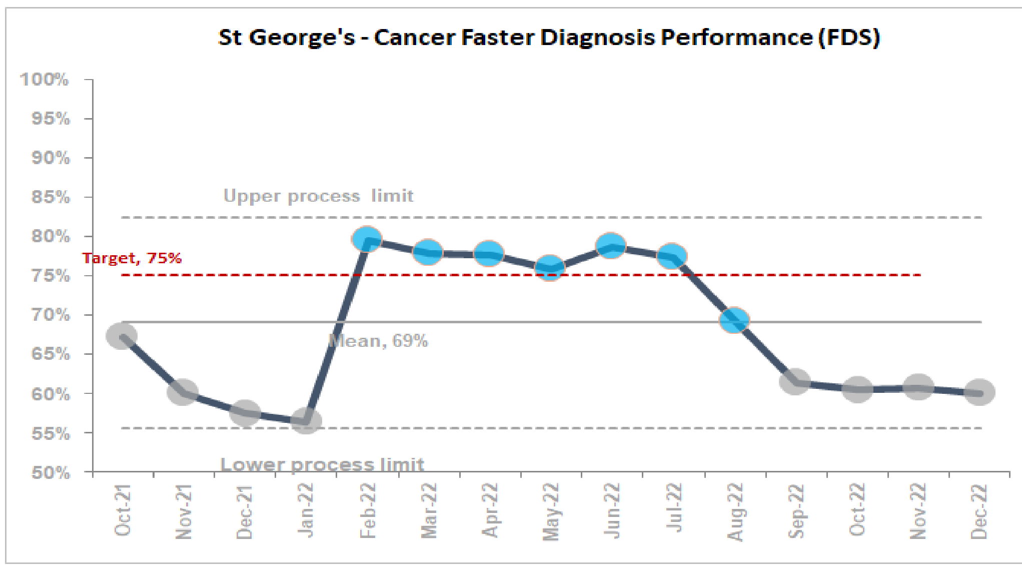
Cancer – Faster Diagnosis Standard

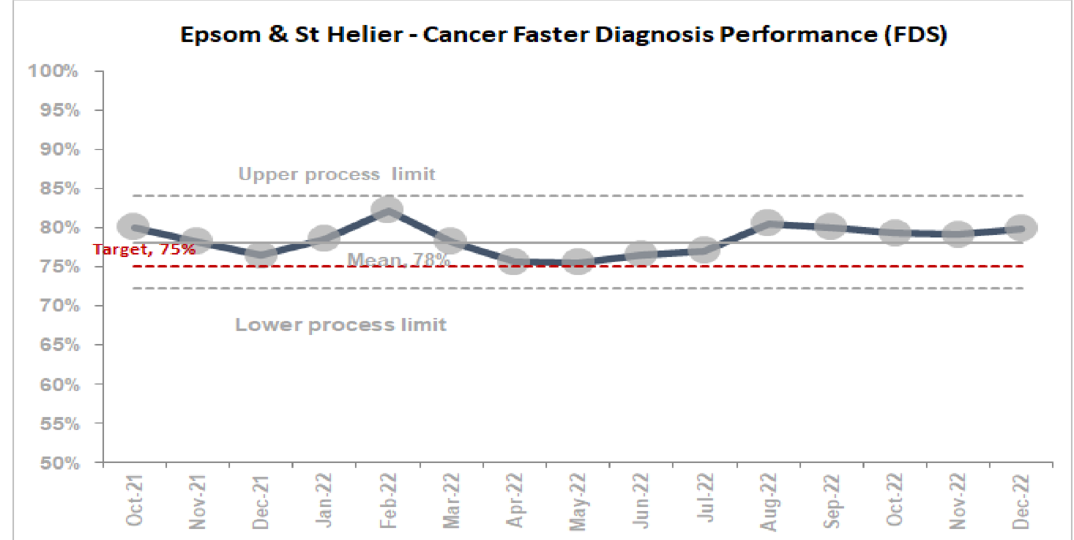
Cancer FDS - London Trusts

T = Tertiary Sites

Dec-22

Target: 75%	SGH: 60.1%	ESTH: 79.9%





SGH updates since last month

FDS performance at the end of December was 60.1%, a slight decrease compared to November. The largest volumes of patients are within Skin who are complaint with a performance of 89.2% however Breast and Lower GI remain challenged with a performance of 31% and 54.7% retrospectively. We are now working closely with pathology to monitor and improve TATs to support improvement

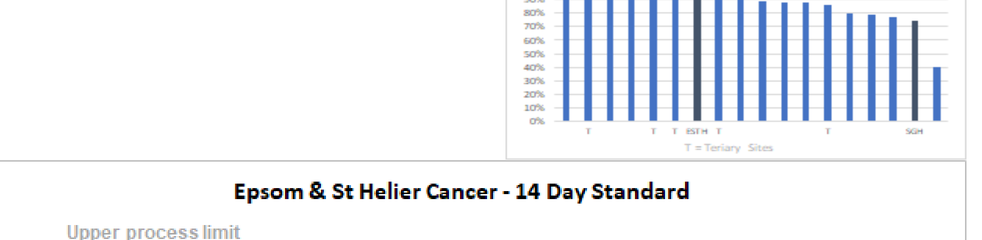
ESTH updates since last month

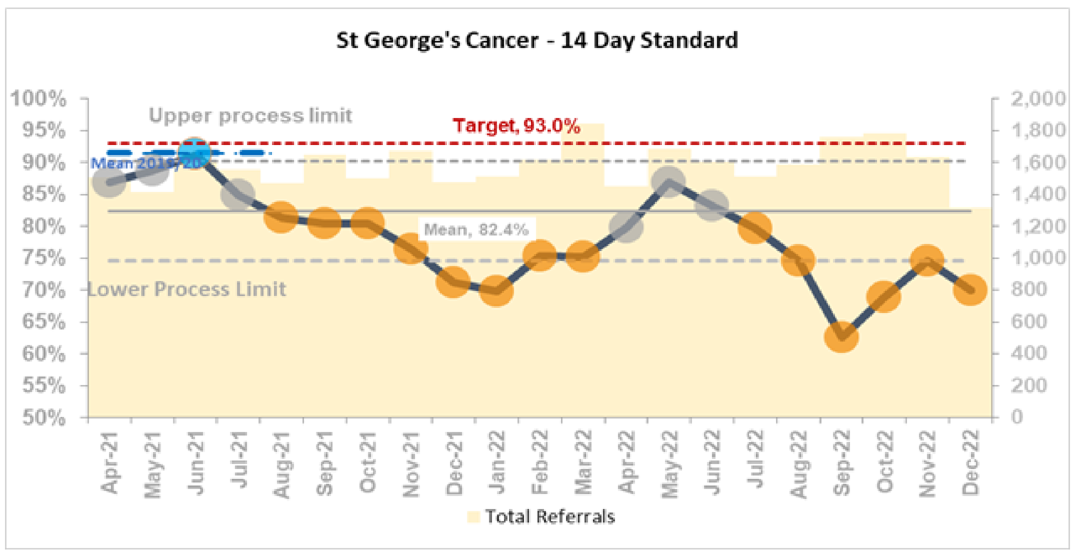
The Trust expects to continue delivering FDS performance throughout the year despite the significant increase in GP referrals in specialities such as Skin.

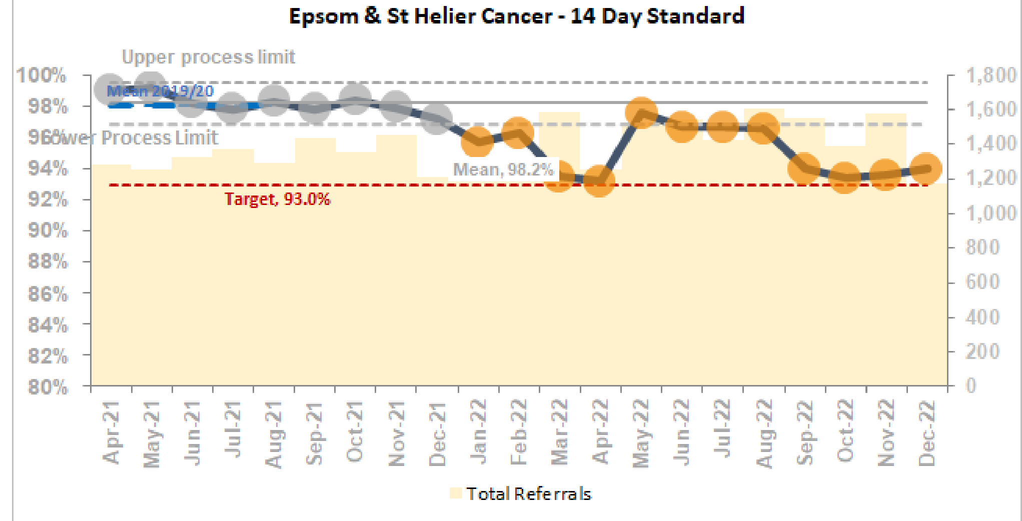
Cancer – 14 Day Referral to Seen Standard

Dec-22

Target: 93%	SGH: 69.9%	ESTH: 94.2%







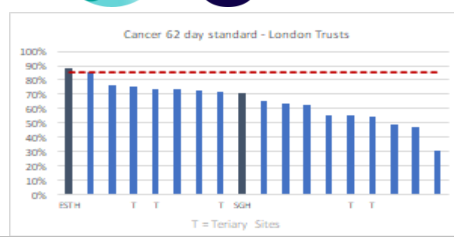
SGH updates since last month

Trust performance against the 14 day standard was 69.9% in December compared to 74.6% in November. All tumour groups with the exception of Upper GI are non-compliant. Breast remains extremely challenged with a performance of 6.9%. Gynae saw a fall in performance with 70.1% of patients seen within target. Skin performance increased to 86.8% compared to 77.6% in November. Some of this can be attributed to RCN strikes, patients availability and slot availability.

ESTH updates since last month

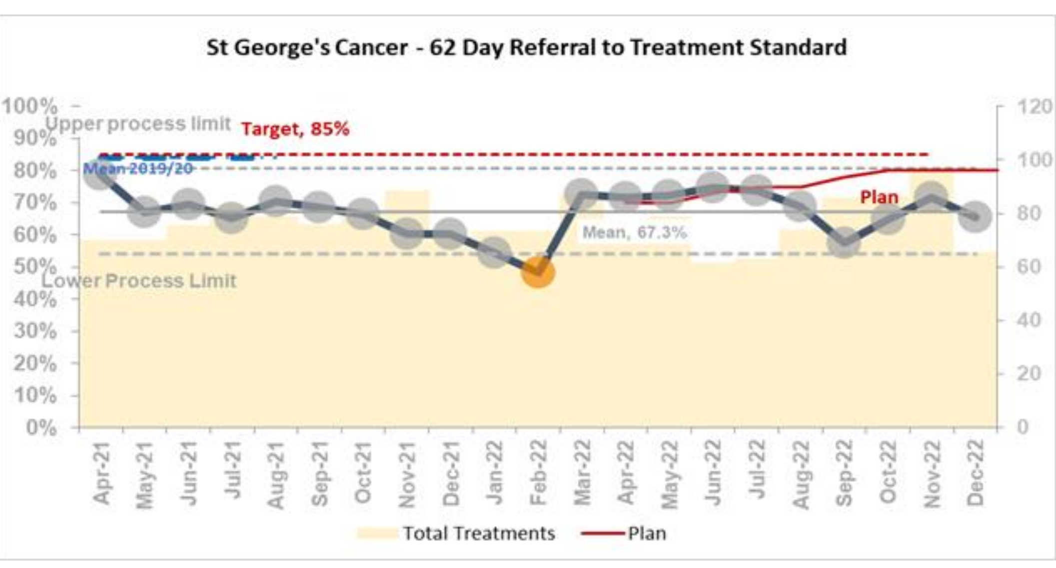
As articulated above, the increase in referrals makes the challenge of delivering 14 day performance much greater. ESTH has always aimed to deliver 14 day performance within 7 days, what is noted is that due to the increase in referrals, the average wait for an a first appointments is closer to 14 days. Whilst compliant with compliant with the 14 day standard, its impact is felt more acutely when reviewing 62 day breaches.

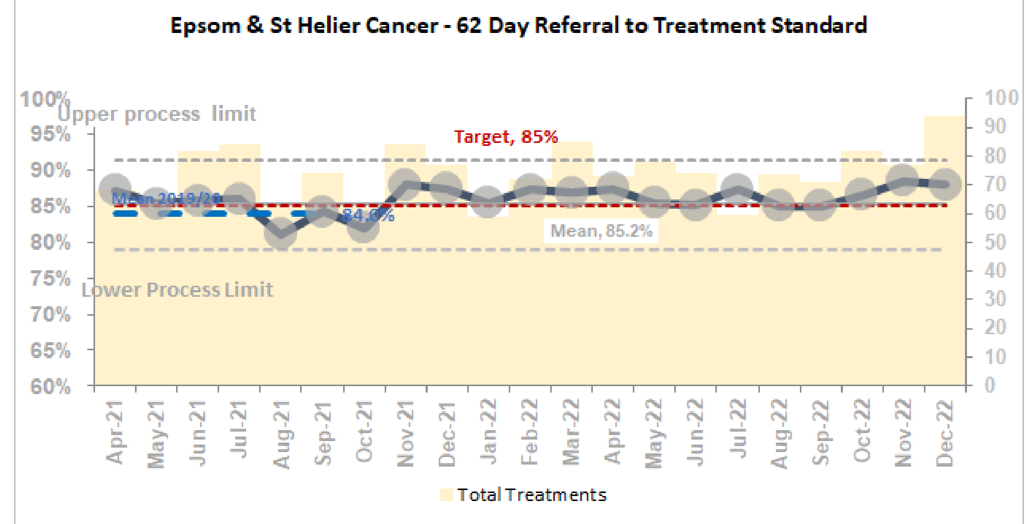
Cancer –62 Day Referral to Treatment Standard



Dec-22

Target: 85%	SGH: 65.6%	ESTH: 88.3%





SGH updates since last month

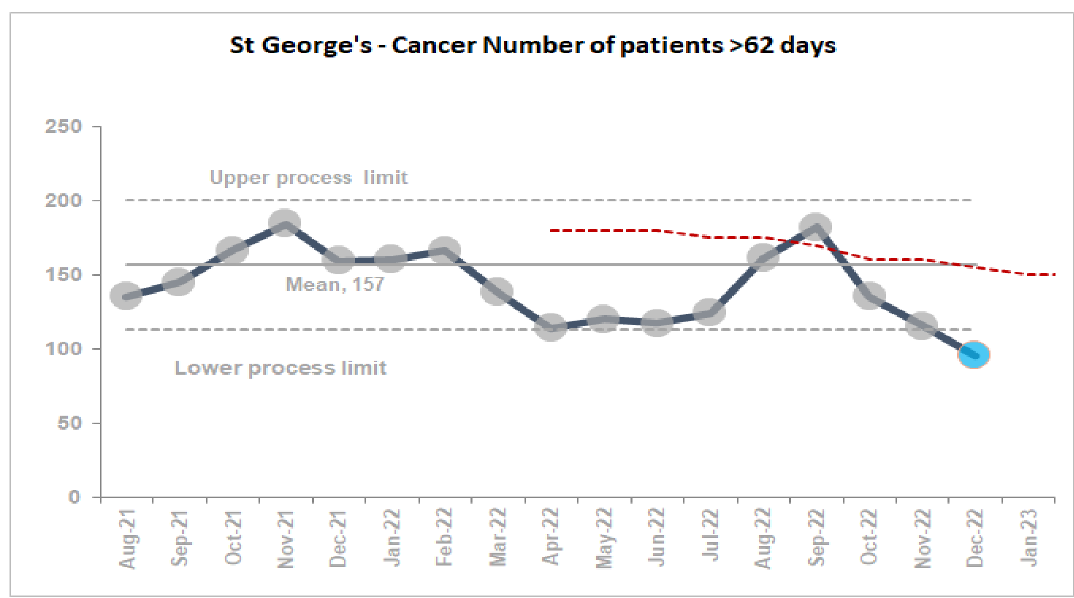
In December 65.6% of patients received treatments within 62 days of referral compared to 71.6% in November. Urology with the highest proportion of treatments were compliant with a performance of 89.5%, Skin was also compliant at 88.9%. All other tumour groups were non-compliant, the lowest performing tumour group being Breast at 14.3%. However this is an increase in the breast activity as per recovery trajectory

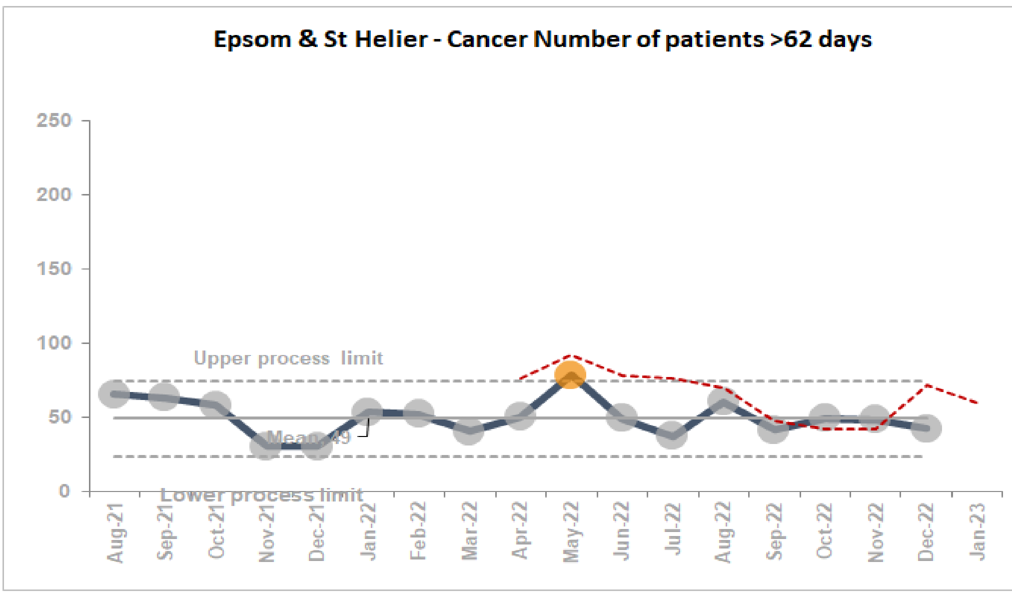
ESTH updates since last month

We show consistently high performance and this has been aided by a significantly high number of patients treated during the month of December (93.5 patients). Breaches occurred in Haematology, H&N, LGI, Lung, Skin and Urology.

Cancer – Number of patients > 62 days

Dec-22			
Plan: 155	SGH: 95	Plan: 42	ESTH: 42





SGH updates since last month

The 62 day backlog remains ahead of plan seeing a decrease of 17% compared to November. All tumour groups are meeting their plans with Skin and Breast have the largest proportion of the back log.

ESTH updates since last month

The Trust has signed up to a trajectory backlog reduction which has been consistently met. On average, we run a backlog of around 50 patients. The Trust ensures clinical impact review is frequently carried out on those patients by the clinical leads for cancer in the relevant tumour site.

Cancer Performance Analysis and Action

SGH current issues –

TWW: Breast continues to be the main driver of TWW with a booking profile of 2/3 weeks. Services particularly breast, LGI were further impacted by the nursing strikes.

FDS: FDS Performance is driven by capacity for one stop clinic in Breast. Gynae, Skin and Lung have consistently achieved this standard in the past 3 months. Haematology and LGI are amongst the lowest performance due to capacity and delays in the pathway to diagnosis. Skin is in recovery from previous backlogs impacting Minor Ops capacity and pathology delays are seen with 40% of patients waiting more than 3 weeks for processing and reporting of samples. Patients in the urology prostate pathway are waiting a median time of 10 days to MRI and 30 days to template biopsy from referral.

62 Day Backlog: Whilst reductions in 62-day backlog were seen challenges are seen in a number of areas. Urology theatre capacity for penile, prostate and renal and late inter trust transfers. Radiology capacity is impacting CT guided biopsy and 2+ weeks reporting for all modalities.

Further impacts to all modalities were seen over December / January due to lost capacity during the festive period, theatre cancellations due to flow and a number of industrial strikes.

SGH future action -

Breast - funding agreed to extend insourcing with Xyla until the end of the financial year

Endoscopy - has expanded lists to cover six days/week until Feb 23 .

Lower GI – electronic triage to live in December 22.

Pathology – There is a bi-weekly pathology board with SWL pathology, ICS and RMP to address pathology challenges, and align cellular pathology cancer escalation protocol across the sector.. Pathology is now also a member of the cancer access meeting to ensure greater communication and action.

Lung - RMP approved £199,227 for an additional weekly EBUS list resulting in an additional 192 cases per year in line with GIRFT & EBUS within 5 days of referral. The first list is planned for March 24, with recruitment in progress.

Cancer Access Meeting – A weekly access meeting has been in place since January 2023, enabling better collaboration and accountably of cancer pathways.

ESTH current issues –

Endoscopic Ultrasound (EUS) at Royal Marsden Hospital (RMH) capacity continues to be challenging – current wait is up to 3-4 weeks.

Delivering Telephone assessment clinics in 3 days is achievable in UGI and Urology, however, H&N and Lung TAC delivery is challenging.

No current issues in CNS. Pending business planning to increase CNS workforce.

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. We are hoping for capacity to be agreed at St George's for this work.

IR diagnostics are challenged due to competing acute pressures and limited IR consultants.

The wait for GA diagnostics is typically 2-4 weeks across all areas. Meeting the Rapid Prostate Pathway (Ref to TPPB) within 9 days by default is also challenging. ESTH working with urology and radiology teams to look at ways of increasing capacity, implement local anaesthetic template biopsy by putting a Trust capital programme bid for additional equipment.

ESTH future action –

RMH EUS capacity is under focus at group meetings and additional lists have been added. Anecdotally, this is reducing the wait, but it had been noted that RMH stratifies EUS requests into different urgency categories and the team has been advised to ensure requests are allocated a TWW priority which aligns with the patient pathway priority.

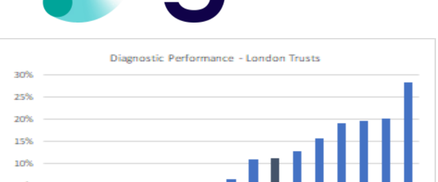
New CQUIN admin and monitoring processes have been created to deliver improvement in CQUIN performance by Q4.

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.

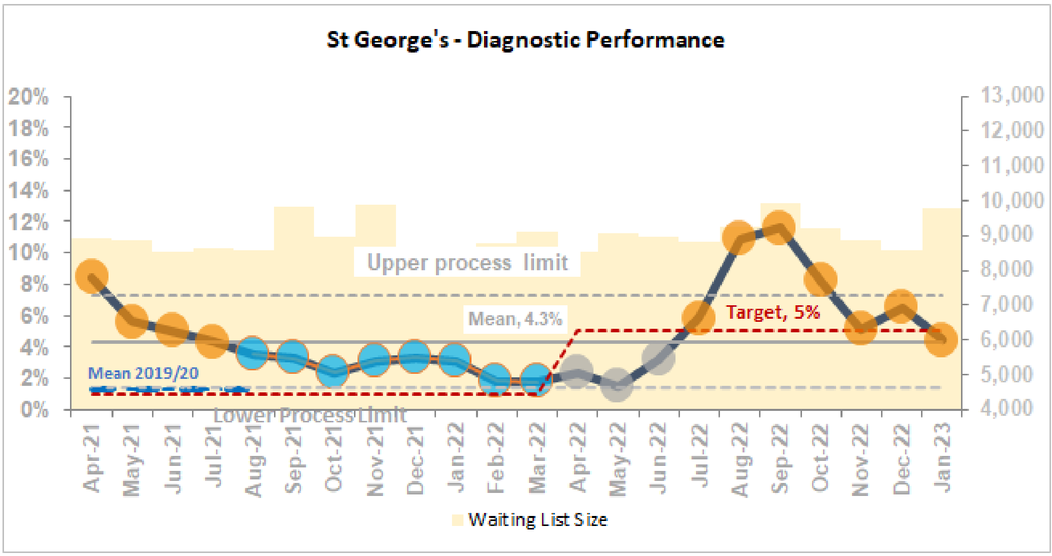
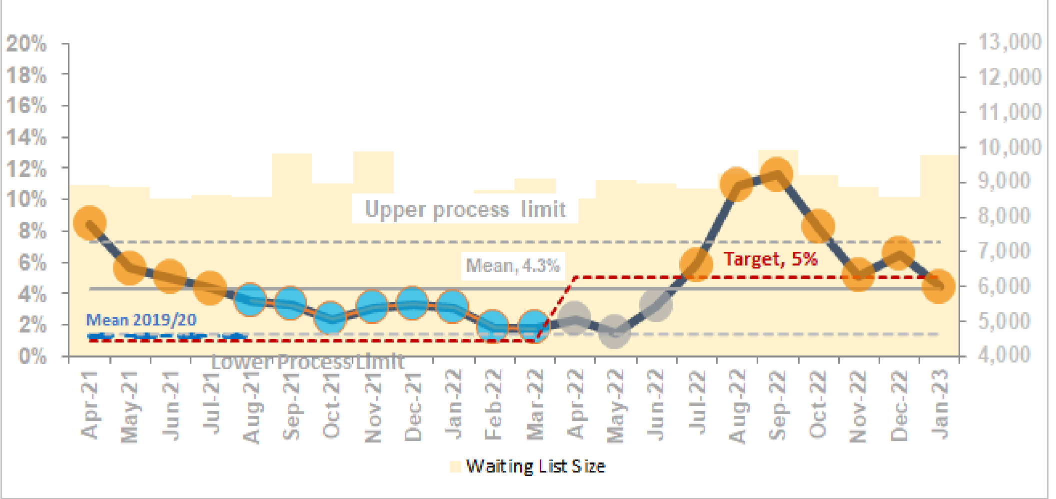
Template biopsy (TPPB) service provision is planned to change from a clinician led GA to Nurse led LA. This will bring ESTH in line with other hospitals in the sector. Finalising Reporting TAT KPI.s within Radiology to expedite patient pathways.

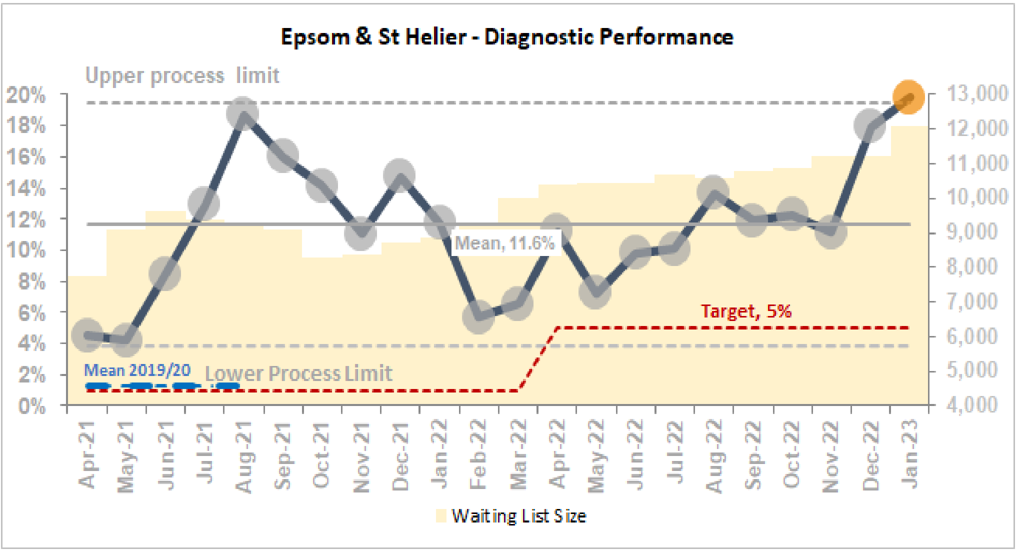
Diagnostic Performance



Jan-23

Target: 5%	SGH: 4.4%	ESTH: 19.8%



SGH updates since last month

At the end of January 4.4% of patients were waiting for more than 6 weeks for their diagnostic test, this is compared to 6.5% seen in December meaning that there are 117 less patients waiting over 6 weeks. Decrease has been driven by Radiology specialties after seeing a number of breaches in December due to equipment failure. Cardiac MRI have returned to compliance.
Challenges within the month continued to be impacted by Endoscopy modalities

ESTH updates since last month

At the end of January the Trust are reporting 2,393 patients waiting for over six weeks for a diagnostic test, which is an increase of 385 from the volume of breaches at the end of December (and close to double the number from the end of November). Largest proportion of breaches are within Echo and MRI. The PTL size has also increased since the end of December by nearly 8%.

Diagnostic Performance Analysis and Action

SGH current issues –

Staffing within Endoscopy across Nursing, Clinical and Admin continue to be challenged. This is leading to significant numbers of procedures being booked outside of their 6 week breach date. Additional sessions has been partially limited due to the pause in the Christmas break and RCN industrial action

SGH future action –

The Endoscopy service have been running additional Saturday lists since Nov 2022 running between 3 and 4 rooms all day (6-8 lists, 60-80 points) where there has been uptake from nursing and medical staff. The positive impact of this additional weekend capacity has been partially limited due to the pause in the Christmas break and RCN industrial action. Plans to increase nurse endoscopist establishment with two Band 8b nurse endoscopist posts established a trainee nurse endoscopist post. Re-opening room 5 at St George's will commence mid Feb-23.
Respiratory Sleep Studies have continued to be challenged with capacity. Service has created additional substantive slots (30 per month) to support recovery and match demand. The service expects to be complaint by M12'.
All modalities have submitted recovery trajectories and these are being reviewed and monitored through the weekly diagnostic performance meeting.

ESTH current issues –

Total Imaging diagnostics breaches reported in January 2022 were 1502. Out of which 593 MRI, 181 CT, 722 US and 6 Dexa.

This is higher than seen previous reporting months. The main contributing factors were:

Breakdown of MRI at Epsom leading to scanner downtime

a higher number of unplanned absences due to staff sickness than considered as part of winter planning measures.

Continued high activity and winter pressure in non-elective demand leading to majority of resources prioritise for acute.

Radiology recovery plan has been challenged due to complex scans in the backlog as the capacity received from St George's for MRI is for straight forward MRI on Wilson scanner.

High number of annual leave in radiology medical team due to extra leave carried over from pandemic.

Additional funding 82k for Echo secured from SWL for backlog clearance

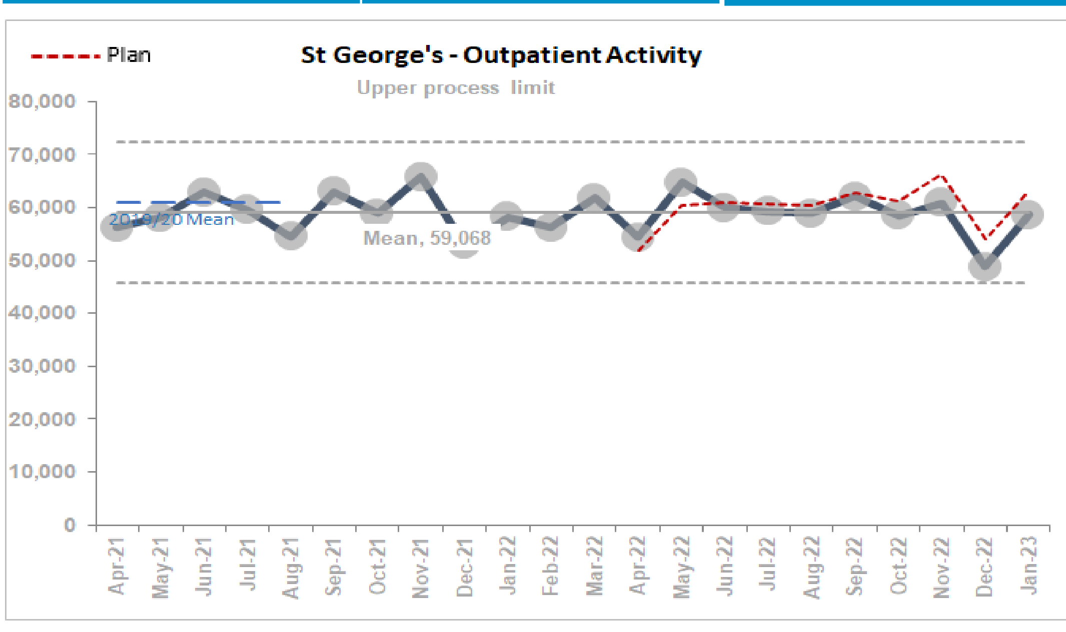
ESTH future action –

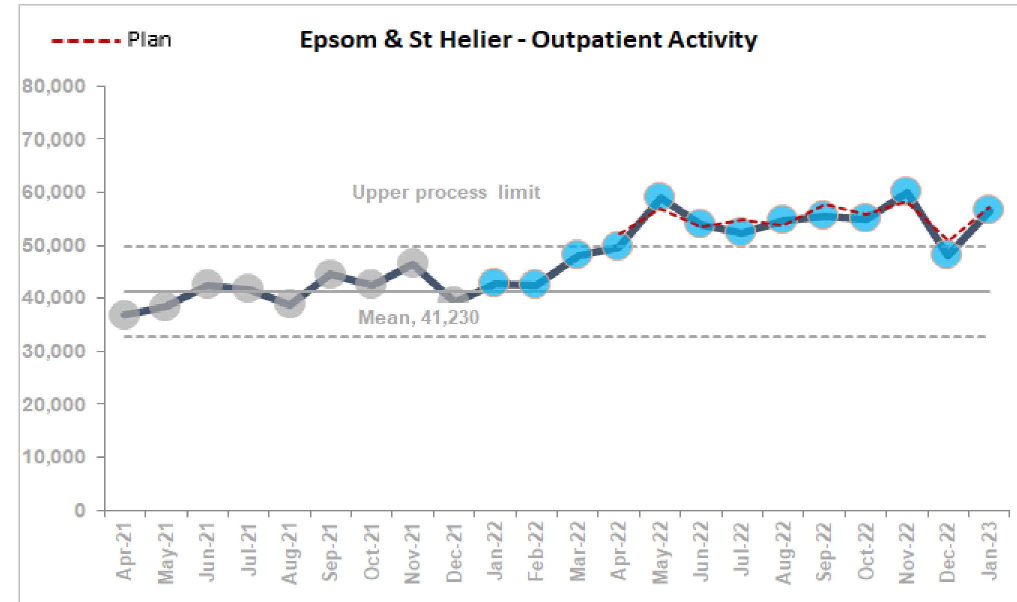
- Increase booking staff and utilise weekend lists;
- Increase breach validation resource and prioritise true demand during extended access Monday to Friday;
- Daily utilisation monitoring and 6 weeks rolling, forward view will improve timing of "pull-back" efforts and escalations.
- Additional capacity on wilson scanner taken.
- Review of radiology job plans and annual leave currently being reviewed by new radiology clinical leads.

Outpatient Activity

Jan-23

Plan: 62,955	SGH: 58,553	Plan: 57,263	ESTH: 56,563





SGH updates since last month

Outpatient performance is expected to be 97% after catch-up for January, 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. Outpatient performance is expected to be 94% after catch-up YTD, which is behind the 100% plan.

ESTH updates since last month

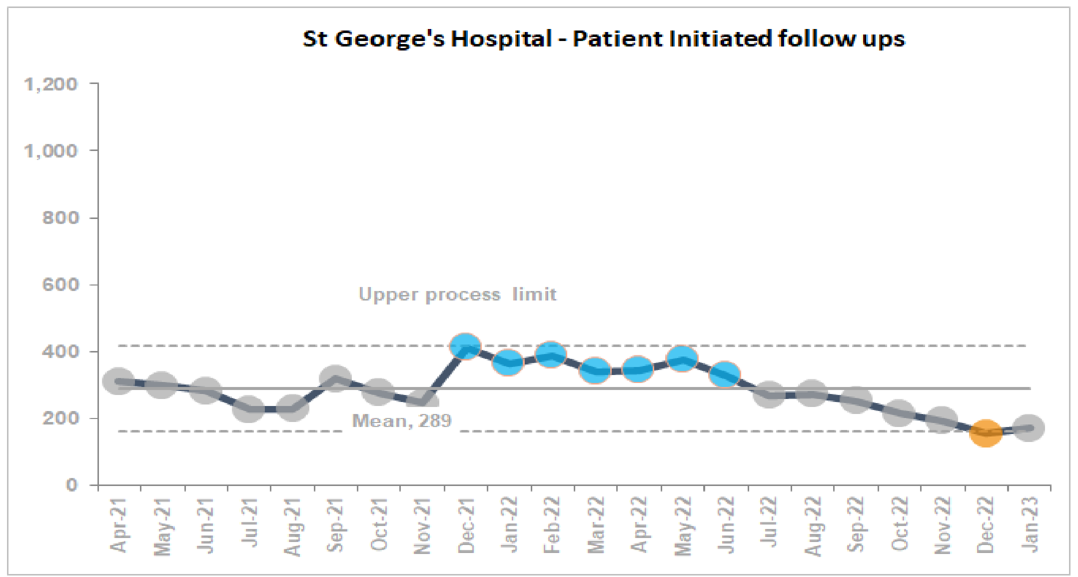
Outpatient performance is slightly below plan in the month of January however performing above the upper control limit.. This is expected to increase once data coding is complete.

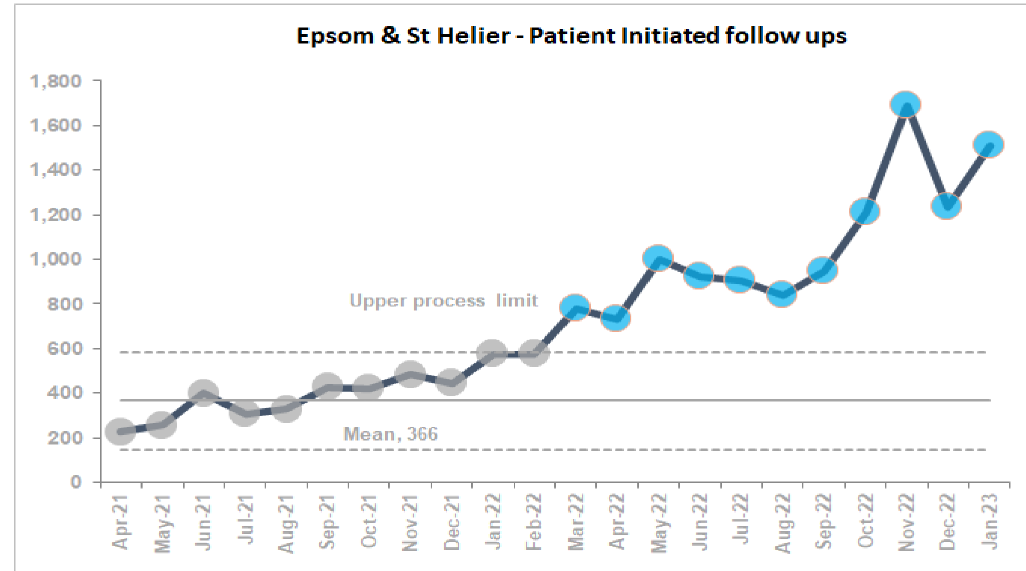
Patient Initiated Follow-up (PIFU)

Jan-23

Target: TBC | SGH: 171

Target: TBC | ESTH: 1,507





SGH updates since last month

Plastic Surgery is the only specialty recording this activity, data recording is being pursued with a number of services engaged with pilots. Data collection and assurance processes are currently being reviewed.

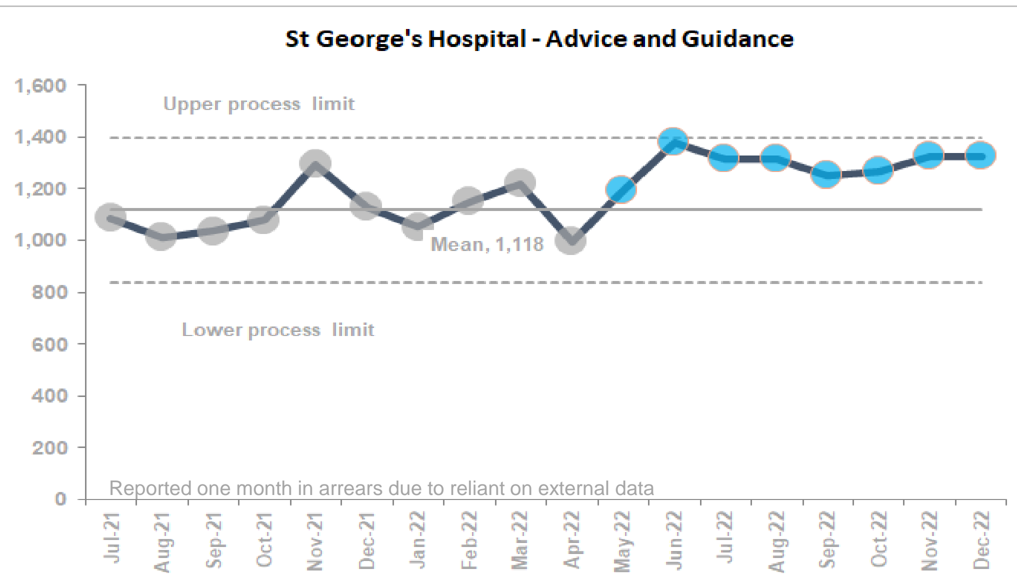
ESTH updates since last month

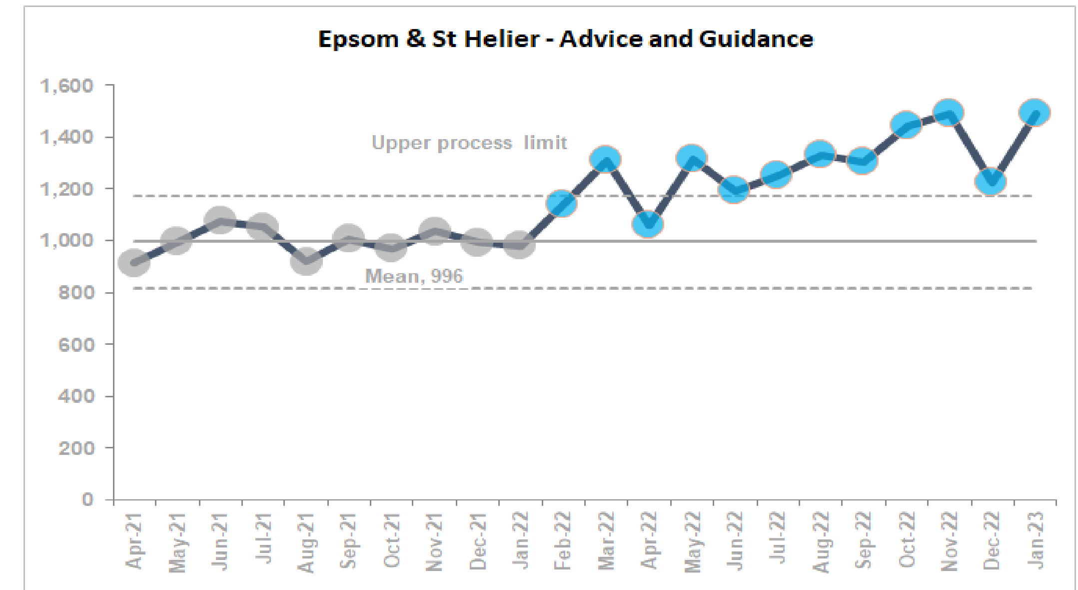
The number of patient initiated follow ups are as expected and in line with overall outpatient activity with 1,507 patients.

Advice & Guidance

Dec-22	
Target: TBC	SGH: 1,022

Jan-23	
Target: TBC	ESTH: 1,490





SGH updates since last month

A&G activity continues above the mean. Key clinicians are engaged and willing to act as pilot with next steps to agree and roll out plan to increase activity numbers. Successful pilot with Dermatology and Urology.

ESTH updates since last month

Activity levels remain positively above the upper control limit.

Outpatient Activity - Analysis and Action

SGH current issues –

PIFU data collection restricted within system – There have been recording issues with PIFU across all specialities, this is being addressed via iCLIP and will also be part of the Outpatient "back to basics" workshop being held in February to determine the programme for the remainder of the year.

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A&G – Pilot continues with Dermatology and Urology as we prepare others services to migrate. All services have now been contacted with regards the transition and the requirement for clinicians to complete eLearning training, but uptake slow. Performance in pilot services improving and they report no problems. Cerner solution for integration into iCLIP Powerchart now has no release date.

SGH future action -

PIFU – Continue to engage with services to review and map patient pathways together with production of comms & literature in preparation for progressing once Cerner solution in place. PIFU administrative resourcing modelling has been completed and will be looking to recruit 2x Band 4 PIFU PPCs once timelines for programme are clearer. Clarity required for the Daycase PIFU pathway, still TBC with services

A&G – Cut-over plan to roll our to medical specialities on 6th March and then Surgical and Paediatrics 20th March with Kinesis turnoff 31st March 2023.

Virtual working – Virtual OP hot desk area have been designed and in test stage with clinicians. We are aiming to ensure that our clinical space is being fully optimised by moving activity from clinic rooms to the virtual pods. Space only appropriate for 100% virtual activity

Outpatient KPIs – DNA rates currently 11.7%, reduction from 13.5% in mid November. Most significant improvement in Audiology from 28.6% to 8% within 3weeks. Supporting Genetics waiting list validation via DrDoctor over the next month – approx. 1400 patients that predicted to be removed from waiting list.

ESTH current issues –

PIFU – no current issues – ranking between 1st and 4th position in London in a number of specialties.

A&G – Escalated to SWL that our A&G figures do not include A&G via CAS, (currently CAS excluded but RAS included), therefore our A&G figures are not a true reflection of performance. Also this means there is variation in the reporting methodology across the 4 SWL acutes. ESTH are taking part in an exercise to remedy this.

ESTH future action –

PIFU – Continue to monitor and review at Outpatient Performance meetings, to troubleshoot and offer further support and shared learning. Continued Peer to Peer learning to identify targeted specs to consider expansion of PIFU – Cardiology (Kingston 3.4%), Rheumatology (Kingston 3.8%), Respiratory, Endoscopy, General Surgery day case, Audiology . Roll out PIFU patient Survey

A&G/Pathway review/Referral Form

Agreed governance route and quick view roll out schedule developed for Sutton Place.

Development and launch of the Neurology and Urology Quick View Guides and the SWL Menopause referral guidelines.

Launch of Patient and GP paediatric foreskin guidance leaflets and the Dermatology advice and guidance top tips.

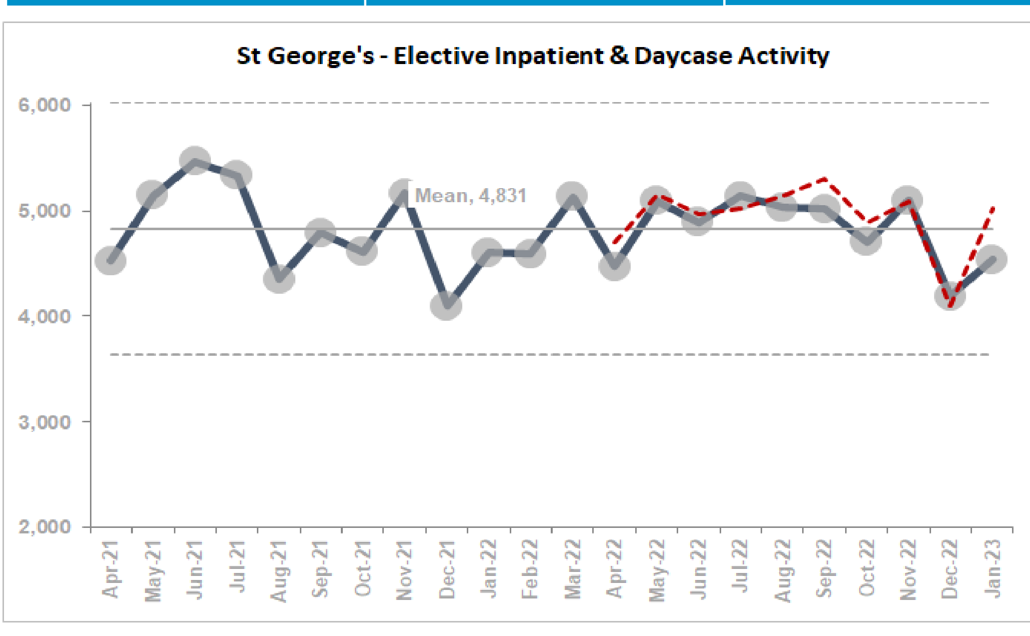
Following discussions and sign off of the initial referral optimisation schemes across Neurology, Dermatology, Urology we have begun to see a slight reduction in the average wait for routine 1st Outpatient appointment and the beginnings of a downward trend in the reduction of routine referrals. We will continue to monitor as these schemes are fully implemented.

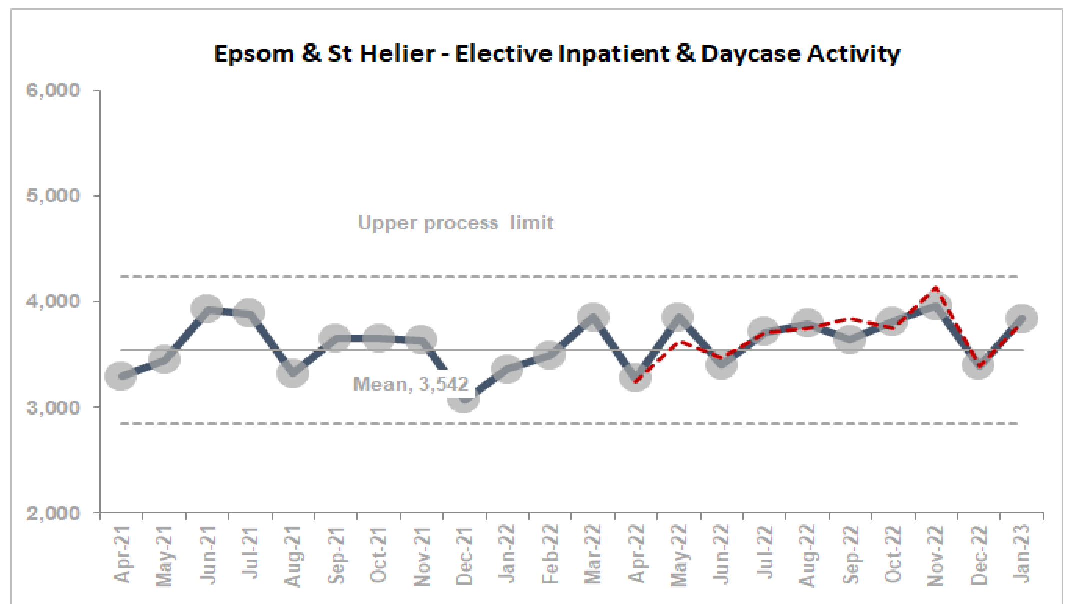
OPWL initiative (Dr Doctor) – Business case to be developed with a view to roll this out further followings successful pilots in a number of specialties.

Elective Inpatient & Daycase Activity

Jan-23

SGH Plan: 5,023	SGH: 4,536	ESTH Plan: 3,800	ESTH: 3,836





SGH updates since last month

Elective and Daycase performance is behind plan (after estimated catch up), with a percentage of 94% submitted for January. Performance is 100% YTD.

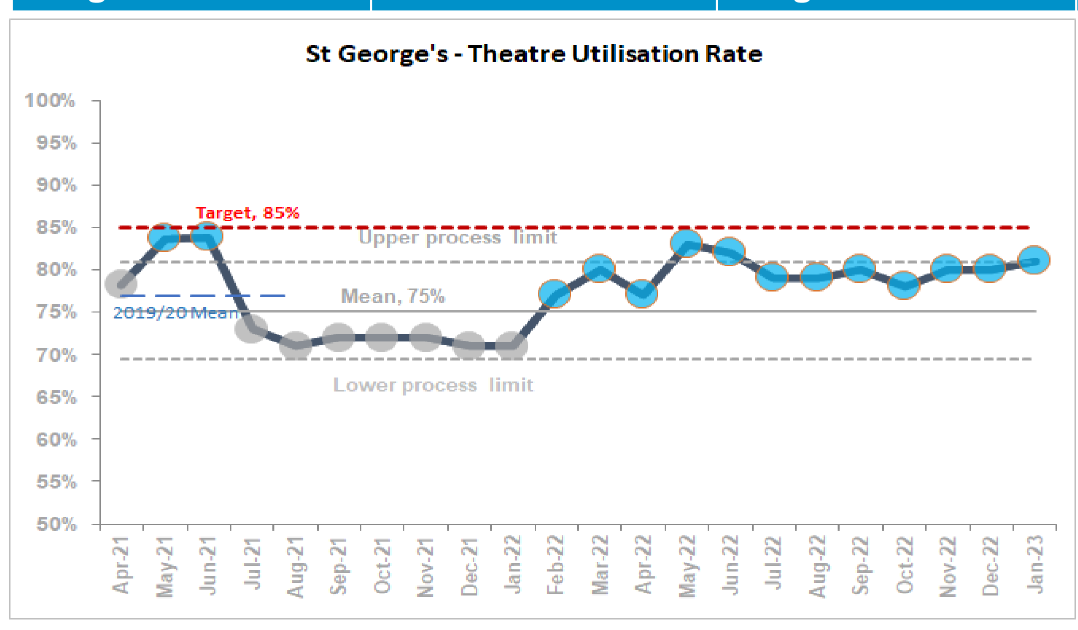
ESTH updates since last month

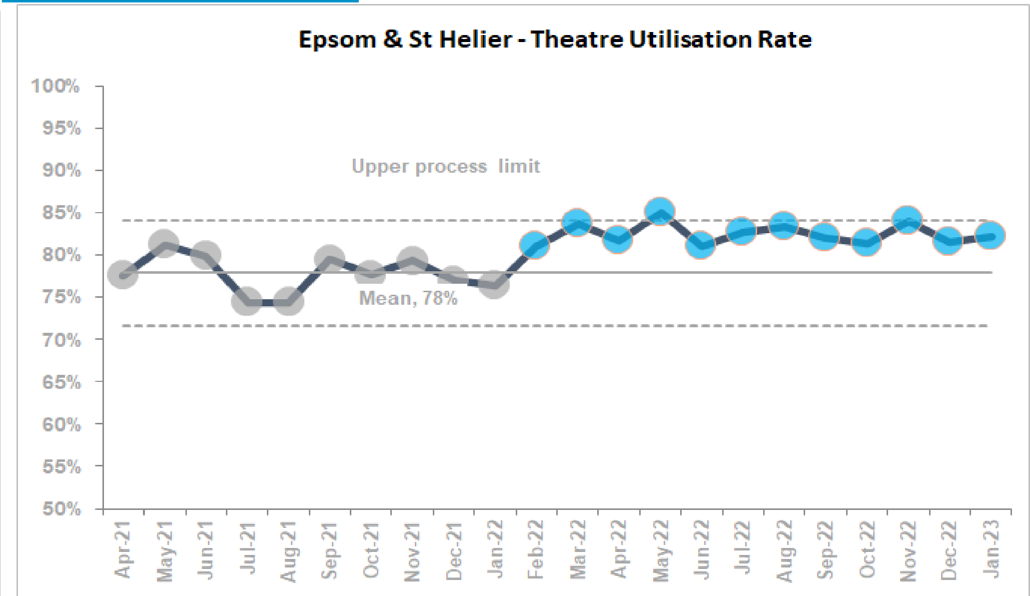
For the month of January elective activity was above plan.

Theatre Productivity - Utilisation

Jan-23

Target: 85%	SGH: 81%	Target: TBC	ESTH: 82.1%





SGH updates since last month

Theatre utilisation remained at around 81% in January, however this is below the aim of 85%.

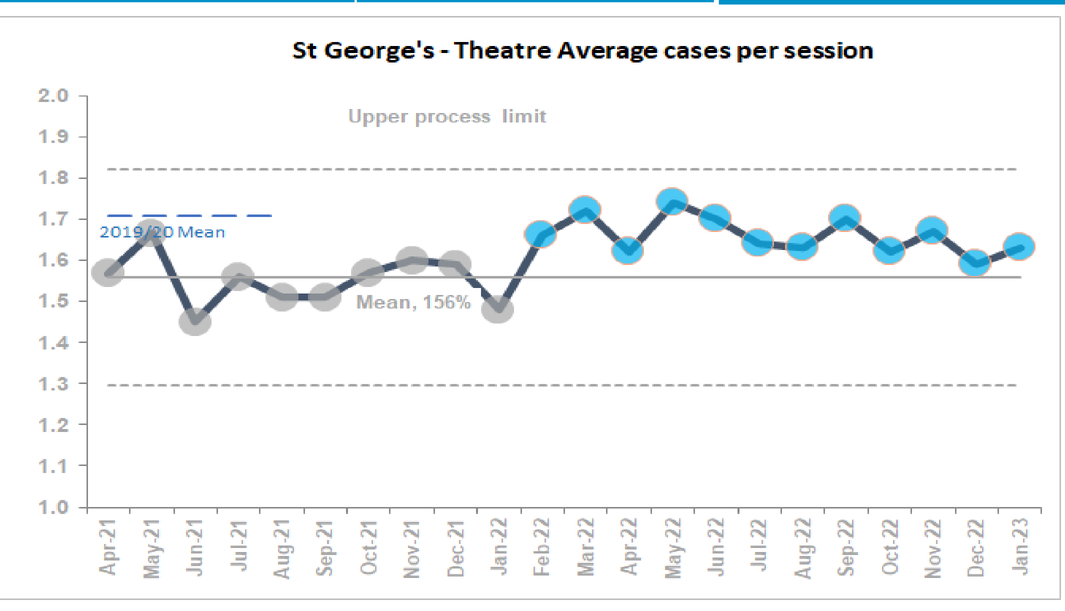
ESTH updates since last month

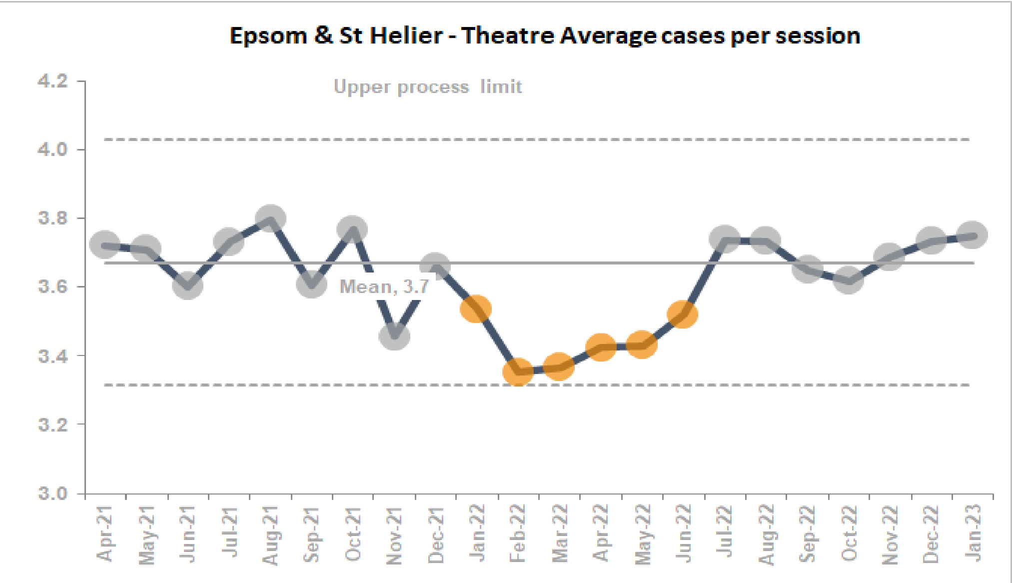
Theatre utilisation rates remain above the mean, averaging 83%

Theatre Productivity – Average Cases per Session

Jan-23

Target: TBC	SGH: 1.63	Target: TBC	ESTH: 3.75





SGH updates since last month

Theatre cases per session performance remains above the mean of the 2019/20 baseline, with on average through January 1.63 average cases per session.

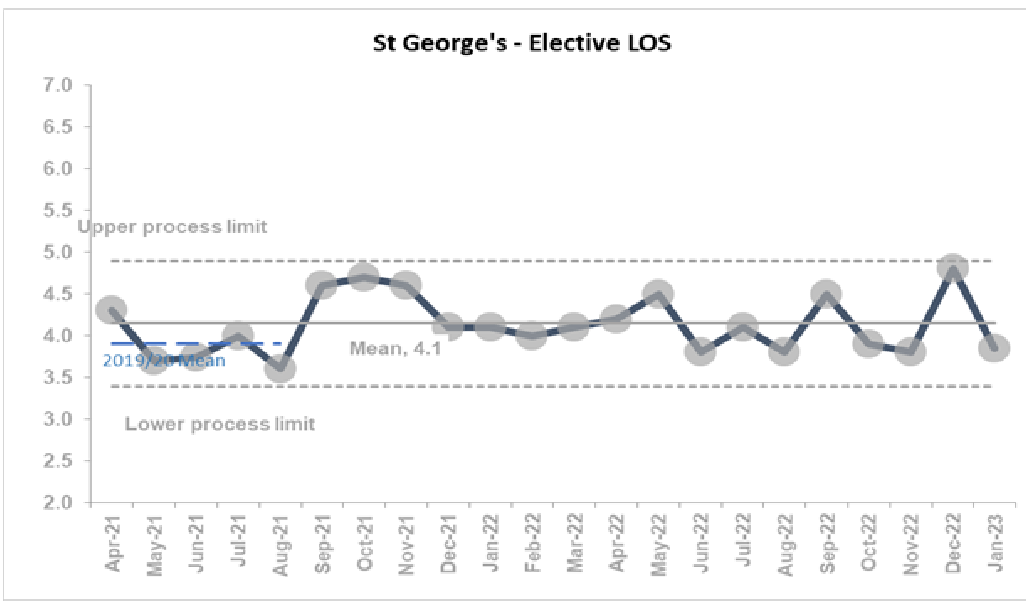
ESTH updates since last month

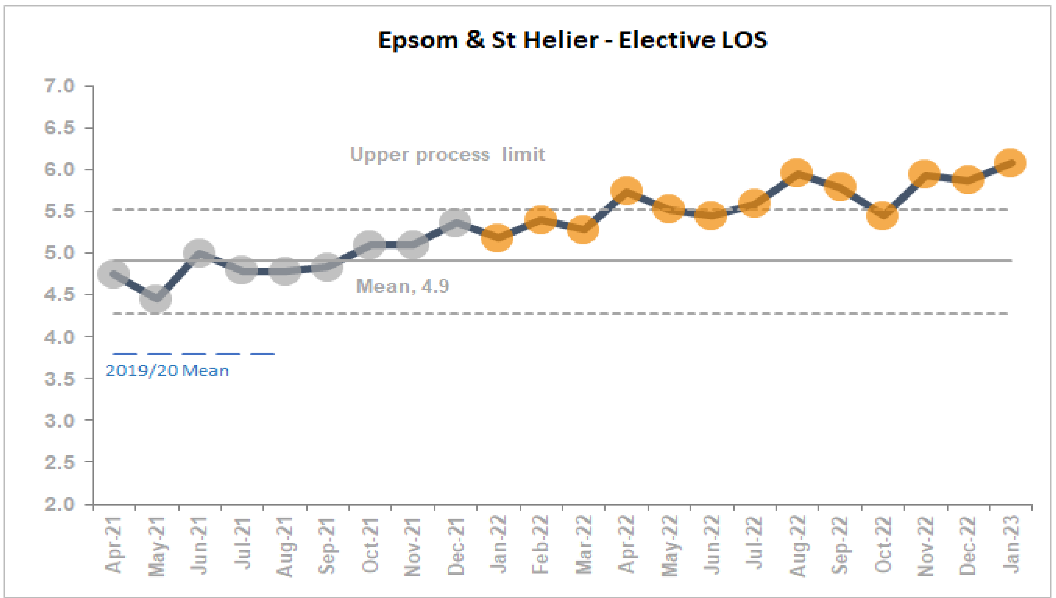
Average case per session has increased above the mean over the past three month period showing only common cause variation.

Elective Length of Stay

Jan-23

Target: N/A | SGH: 3.85 | ESTH: 6.0





SGH updates since last month

Elective length of stay continues within the upper and lower control limits showing only common cause variation.

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ESTH updates since last month

Average length of stay for patients admitted on an elective pathway continues above the upper control limit, across January an average length of stay of six days.

Theatre Productivity - Analysis and Action

SGH current issues –

Productivity - Challenges remain around flow caused by limited ward and ICU bed capacity leading to cancellations.

To support productivity we are relaunching a robust 6-4-2 process whereby theatre lists are micromanaged to ensure we are optimising capacity, whilst adhering to GIRFT & Model Hospital metrics.

Recruitment - We currently have 12.8 WTE consultant anaesthetist vacancies due to resignations and maternity. Five of these posts have successful candidates in the pipeline to start in Q4, 1 and 2. Our current area of concern is anaesthetic cover for Cardiac and Thoracic surgical lists due to a high volume of resignations within this specialist area. We plan to mitigate the risks of the gaps with locum and agency. All vacancies are being worked up with the workforce team in collaboration with our Care Group Leads to ensure the posts reach a wider audience. The BMJ will be featuring the vacancies when they are live on Trac.

The Xyla contract has been extended for 6 months to support us in covering vacancies, retirement and increased sickness. There will be a decrease in the use of Xyla as our substantive posts are filled.

Kingston are no longer operating at the QMH site within the modular theatres, however these vacant sessions have been backfilled with SGH specialities.

SGH future action -

We have seen the highest utilisation in the last 6 months in January at 81%, this is still 2% under our pre covid level, however our average cases per lists have surpassed our pre covid level and is currently 1.68.

A robust 6-4-2 plan has being launched this month to support theatre productivity. The new process will ensure SDL patients (same day leavers) are first on the list which will support with the onsite bed pressures and avoid failed SDL's. The new process will also ensure there is an accurate average time per case and surgeon to assist our scheduling team when they are booking cases.

There is currently ongoing workstreams to ensure there is consultant oversight to theatre lists.

The Surgical Division (SNCT) are prioritising the implementation of a Neuro PACU to mitigate the pressures of ITU and continued cancellations of Neuroscience cases, this work should be completed by the end of March, in view of opening the PACU for four patients in Q1 23/24. this is linked to the reopening of Holdswoth ward. Recruitment - To support the reduction of Xyla, we are reviewing all of the outreach areas that are covered by anaesthetics that are not currently funded and rolling additional requests. The team are micromanaging anaesthetic recruitment to ensure there are clear recruitment time lines.

Anaesthetic recruitment to ensure there are clear recruitment time lines.

ESTH current issues –

Productivity

January was a challenging month for elective theatres, due to the loss of our elective ward to support emergency medicine admissions on our Epsom site. In addition, a change in the payment rates for nursing staff has resulted in some staffing challenges, alongside an increased sickness absence rate. In spite of these challenges, through the use of spare SWLEOC ward capacity, and through flexibility and hard work from our theatre teams we were able to maintain our elective program.

The impact from these challenges on productivity however, is increased late starts (70-% of our lists started late) and increased numbers of on the day cancellations due to running out of theatre time. As each day was managed on a day by day basis depending on bed capacity, this resulted in delays to sending for the first patient.

ESTH future action –

Agreed use of QMH Roehampton HVLC theatres for General Surgery. Will reduce the need for high cost weekend theatre lists and also ensure patients are treated in the right place at the right time.

Review of on the day (OTD) cancellations and process of validation to ensure OTD cancellation data is accurate.

Renew POA theatre productivity workstream to ensure that is aligned with recent Anaesthesia Clinical Services Accreditation (ACSA) visit. Scope to transform service and subsequently improve theatre productivity.

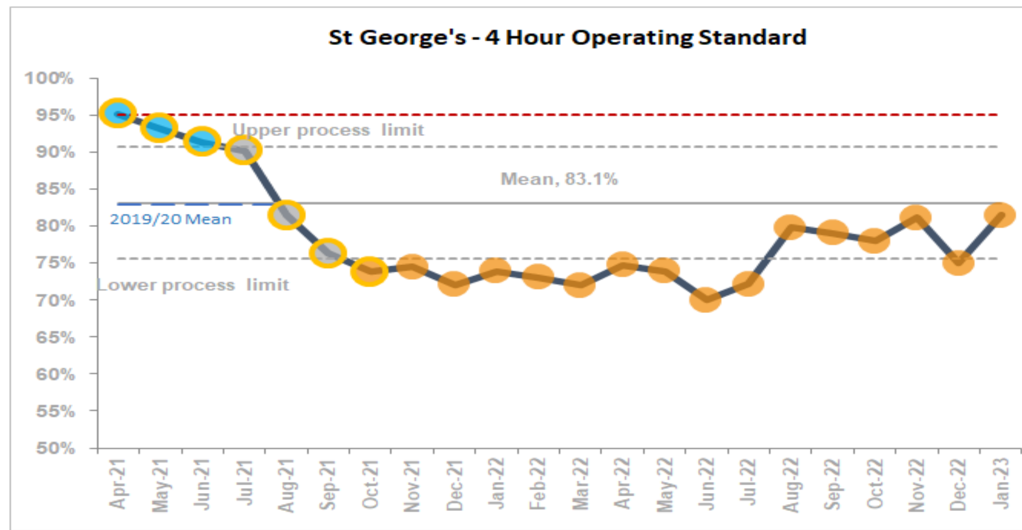
Monthly Overview – Non Elective Care

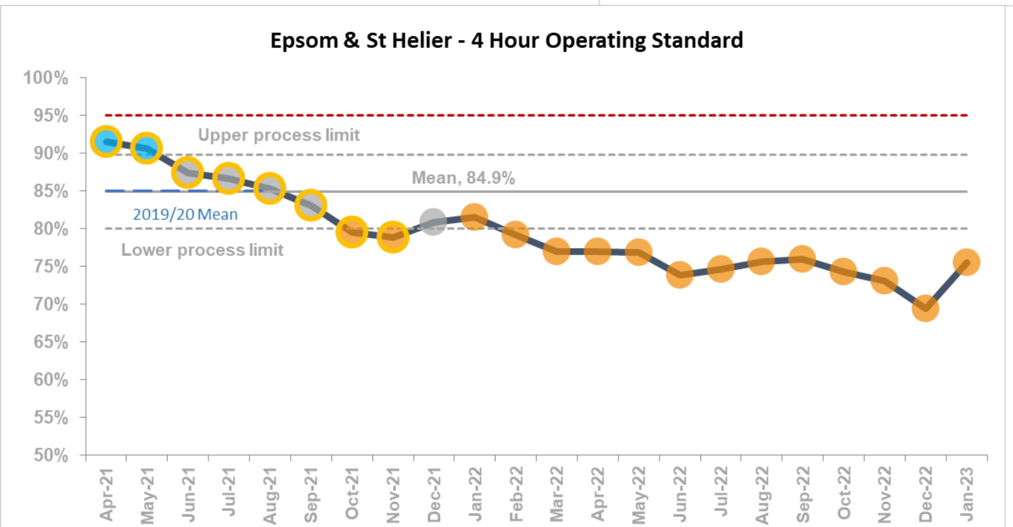
Responsive and Productive Services - Non Elective Care	St George's							Epsom and St. Helier						
	Monthly Target	Nov-22	Dec-22	Jan-23	YTD Target	YTD Actual	13-Month Trend	Monthly Target	Nov-22	Dec-22	Jan-23	YTD Target	YTD Actual	13-Month Trend
4 Hour Operating Standard	95%	81.1%	75.0%	81.5%	95%	76.5%		95%	73.1%	65.5%	75.6%	95%	74.2%	
12 Hour Trolley Waits	0	697	734	755	0	5782		0	375	574	501	0	2794	
Ambulance handover Performance 30 minutes	0	106	41	49	0	1864		0	336	391	312	0	3226	
Ambulance handover Performance 60 minutes	0	198	177	108	0	1469		0	220	274	145	0	1734	
Non elective length of stay	TBC	7.6	8.3	7.3	TBC	7.49		TBC	7.8	7.6	8.1	TBC	7.62	
Mental health delays 4 Hour Breaches	TBC	103	80	107	TBC	1006								
Redamission Rate - Non Elective	TBC	8.0%	8.7%	7.7%	TBC	8.4%		TBC	5.8%	5.4%	5.4%		5.6%	
Length of stay > 7 days (stranded)	TBC	386	389	415	TBC			TBC	306	308	319	TBC		
Length of stay > 21 days (super stranded)	TBC	230	161	189	TBC			TBC	125	130	135	TBC		
Number of patients not meeting criteria to reside	TBC	203	228		TBC			TBC	170	153	154	TBC		
Number of patients not meeting criteria to reside % of occupied G&A beds	TBC	39%	39%		TBC			TBC	35%	33%	33%	TBC		

4 Hour Operating Standard

Jan-23

Target: 95%	SGH: 81.5%	ESTH: 75.6%





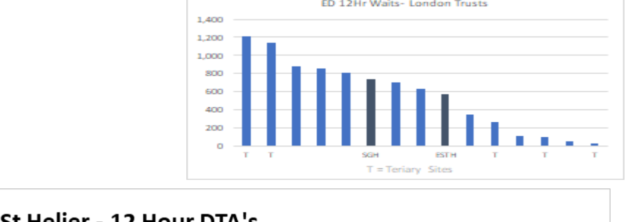
SGH updates since last month

Four Hour performance increased to 81.5% in January with on average 357 patients attending per day, on average 19 patients less compared to Jan 22, however data shows that acuity has increased with 51% of patients triaged with a Manchester Triage Score of between 1-3 with on average 29% of patients attending ED requiring hospital admission.

ESTH updates since last month

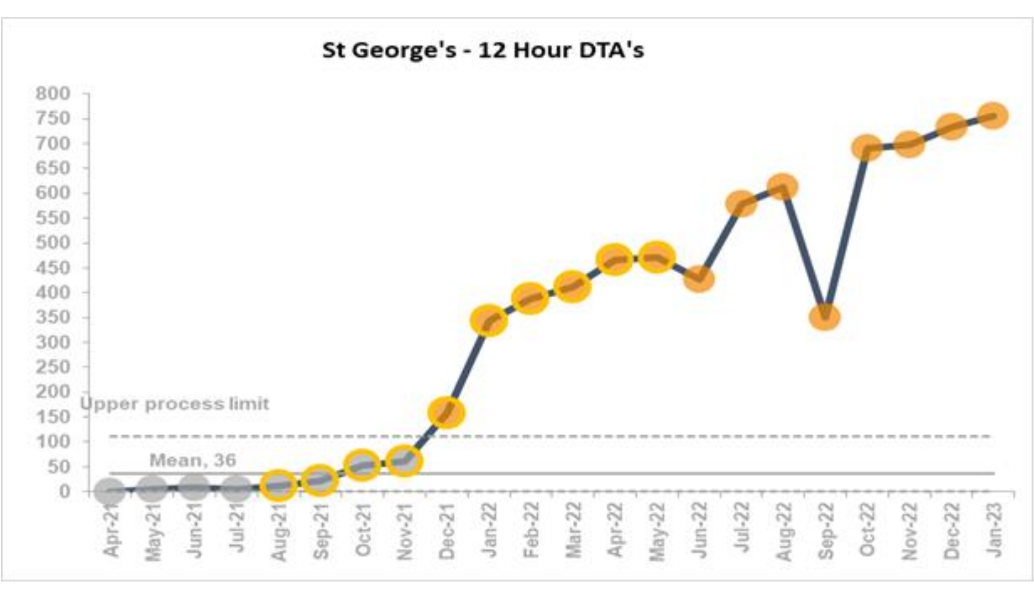
Performance improved in January following a drop in December.
The number of patients presenting to ED with confirmed covid/Flu A have reduced throughout January 2023 with the percentage of beds occupied by covid patients at 3.5%

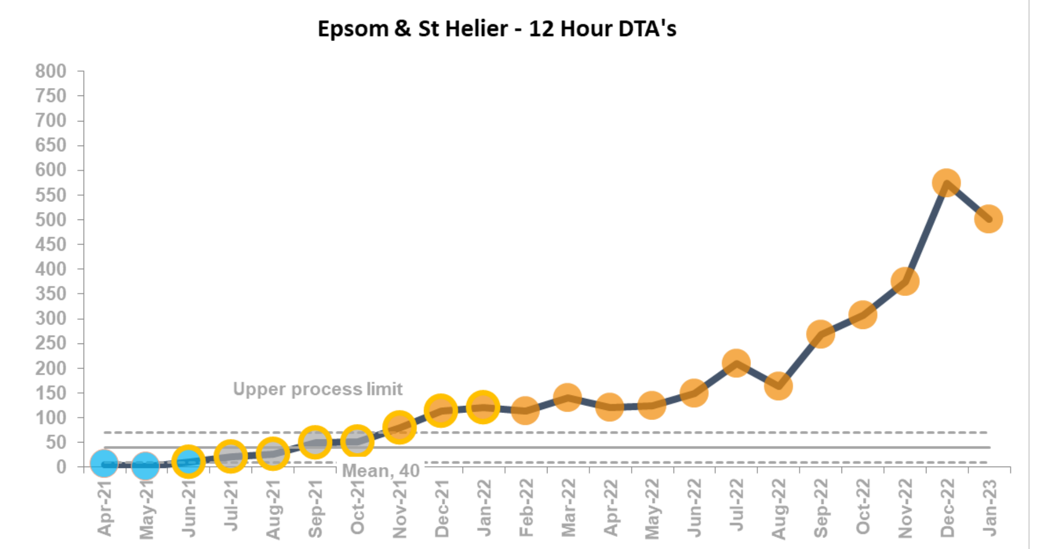
12 Hour DTA's



Jan-23

Target: 0	SGH: 755	ESTH: 501





SGH updates since last month

Through January a total of 755 patients waited for more than 12 hours for admission following a decision to admit, a daily average of 24 patients, a slight increase compared to December.

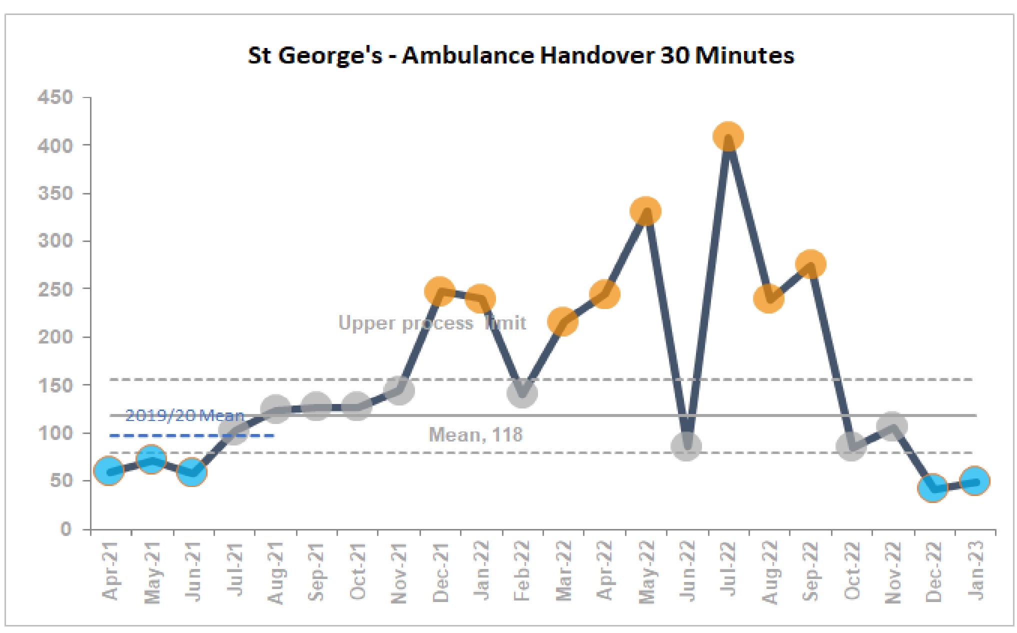
ESTH updates since last month

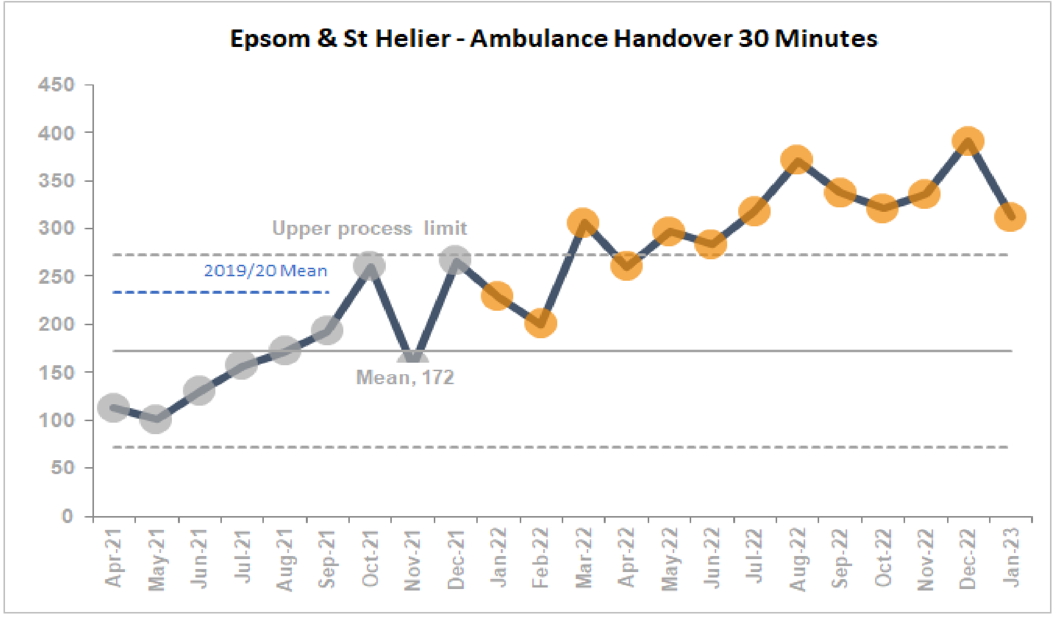
We have seen an improvement in the number of patients spending over 12 hours in ED reporting 9.8% of total arrivals in January 2023 compared to over 14% in December 2022.

Ambulance Handover Delays 30-60 minutes

Jan-23

Target: 0	SGH: 49	ESTH: 312





SGH updates since last month

LAS are now cohorting on an almost daily basis and this has led to a significant improvement in our LAS handover performance, however this masks the fact patients are now waiting in the corridor rather than with the ambulance.

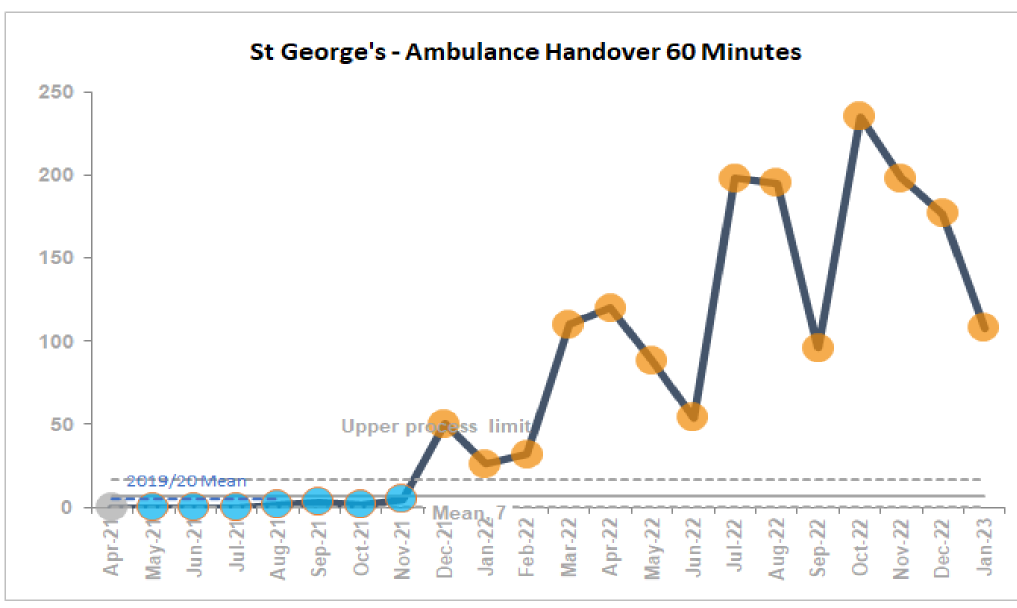
ESTH updates since last month

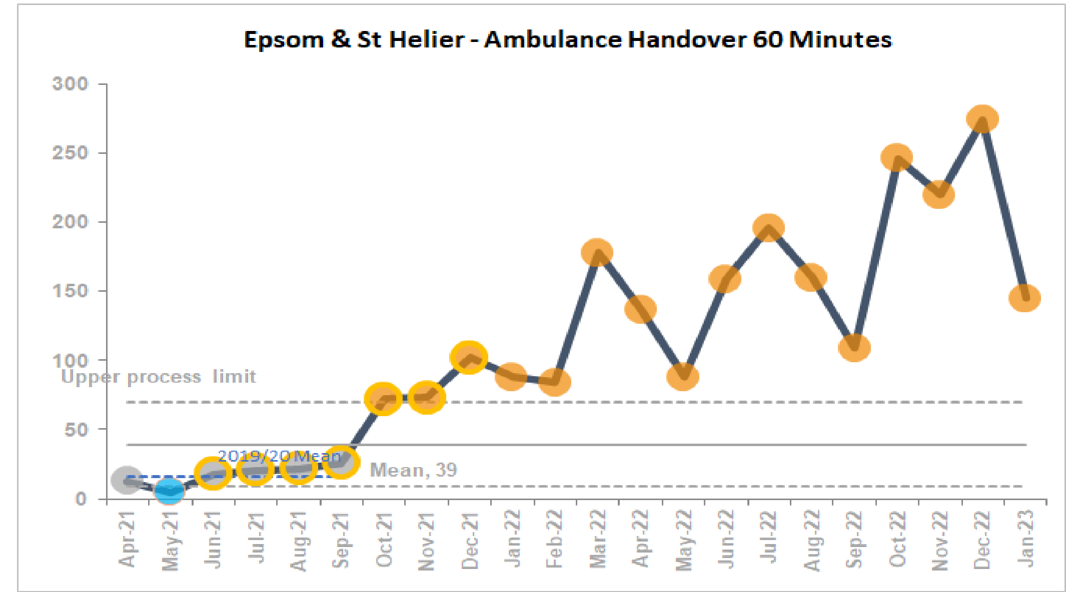
We have seen an improvement in January 2023 following a peak in December 2022.

Ambulance Handover Delays
60 minutes

Jan-23

Target: 0	SGH: 108	ESTH: 145





SGH updates since last month

LAS are now cohorting on an almost daily basis and this has led to a significant improvement in our LAS handover performance, however this masks the fact patients are now waiting in the corridor rather than with the ambulance.

ESTH updates since last month

Whilst over 60-minute ambulance handover delays remain high, we have seen good improvement reporting 145 in January 2023 compared to 274 in December 2022.

Emergency Performance

SGH current issues –

Overall 4 hour performance is still strong compared to peers, (consistently in top 12 nationally and top 2 in London). The inability of the department to admit patients to downstream wards continues to impact on capacity.
SGH ED have adapted operationally to respond to multiple LAS (London Ambulance Services) and Nursing strikes through January. LAS are cohorting on an almost daily basis and this has led to a significant improvement in our LAS handover performance, however this masks the fact patients are now waiting in the corridor rather than with the ambulance. An additional HALO has been appointed by LAS, start date onsite to be confirmed.
Medical staffing is in a good position and we have recently recruited 22 medical students to support as MAs, further recruitment is under way.

SGH future action -

The internal ECDB is continuing to focus on Frailty, Same Day Emergency Care, Internal Professional Standards, as well as Digital Service Improvement works.
Omnicell pharmacy cabinets are now fully rolled out across the Department, with the latest being installed in resus.
The Trust continues to embed the regularising flow programme to support exit from the Emergency Department and enable timely ambulance handovers. This has seen the introduction of boarding on the wards against daily predicted discharge numbers.
The frailty support within ED has begun and will continue to expand as the newly recruited practitioner and medical staff come on line, we are already seeing patients being enabled to return home on a daily basis who would previously been admitted.
There are 2 GPs supporting the UTC on weekdays until midnight.
The expansion of the Urgent Treatment Centre's ability to see paediatric patients from age 2 upwards is now embedded and is helping to relieve the pressure on the main Children's and Young Persons ED.
A ED/Acute Medicine FY2 position has been created to work with the medical team looking after DTA patients in the Majors B area.
Homelessness Inclusion Team has been awarded further money from St George's Charity to support step down accommodation and we are exploring closer links with Red Thread charity to enable them to support vulnerable patients aged over 25.

ESTH current issues –

Similar to last month, we remain challenged from an emergency care performance perspective, largely due to a high number of patients who require admission to an inpatient bed remaining in ED for a prolonged period of time, however, our 4-hour performance standard has seen a monthly improvement and we are reporting 75.6% performance in January 2023 compared to 69.4% in December 2022.

We have also seen an improvement in the number of patients spending > 12 hours in ED reporting 9.8% of total arrivals in January 2023 compared to over 14% in December 2022.

Whilst > 60-minute ambulance handover delays remain high, we are reporting 145 in January 2023 compared to 274 in December 2022.

The number of patients presenting to ED with confirmed covid/Flu A have also reduced throughout January 2023 with the percentage of beds occupied by covid patients at 3.5%

ESTH future action –

We continue to implement boarding in response to site pressures and are implementing our recently refreshed OPEL triggers and actions, which includes divisional level actions in place at each level of escalation.

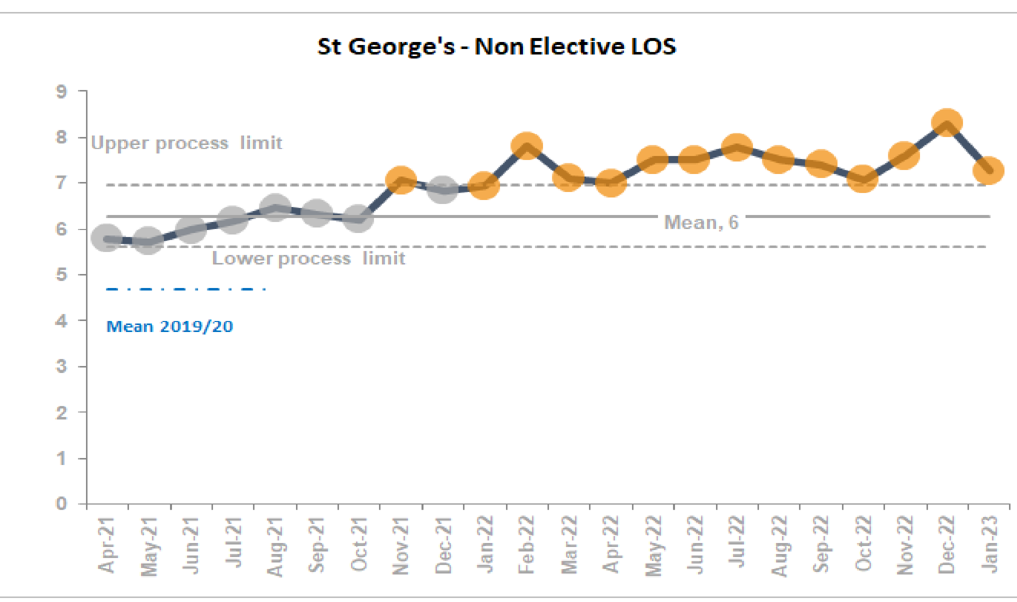
We continue to respond to ambulance service industrial action and have a monthly meeting in place with LAS and SECamb to review performance. We routinely implement the reverse queue and cohorting process to manage ambulance handover delays.

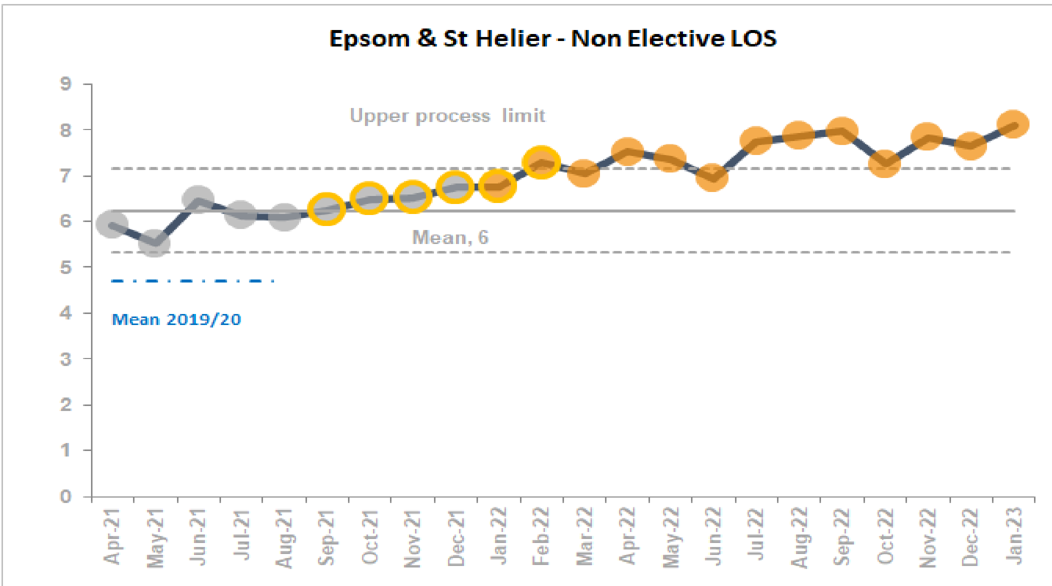
We have reviewed our patient flow and discharge work programme and are prioritising a number of key actions aimed at improving flow through the emergency department. These include specialty response to ED and changes to bed allocation processes via the emergency department.

Non Elective Length of Stay

Jan-23

Target: TBC	SGH: 7.26	ESTH: 8.1





SGH updates since last month

Length of stay although remaining above their upper control limit decreased through January with on average patients admitted on a non-elective pathway staying in a hospital bed for 7.26 days. However, the Trust saw an increase in the number of long length of stay patients, rising in both 7 and 21 day LOS.

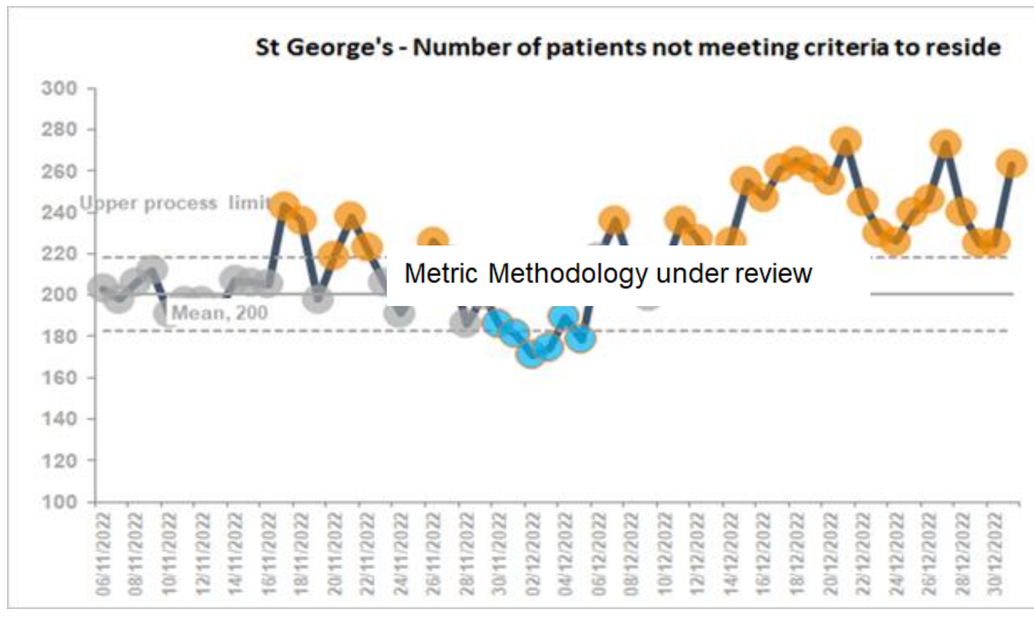
ESTH updates since last month

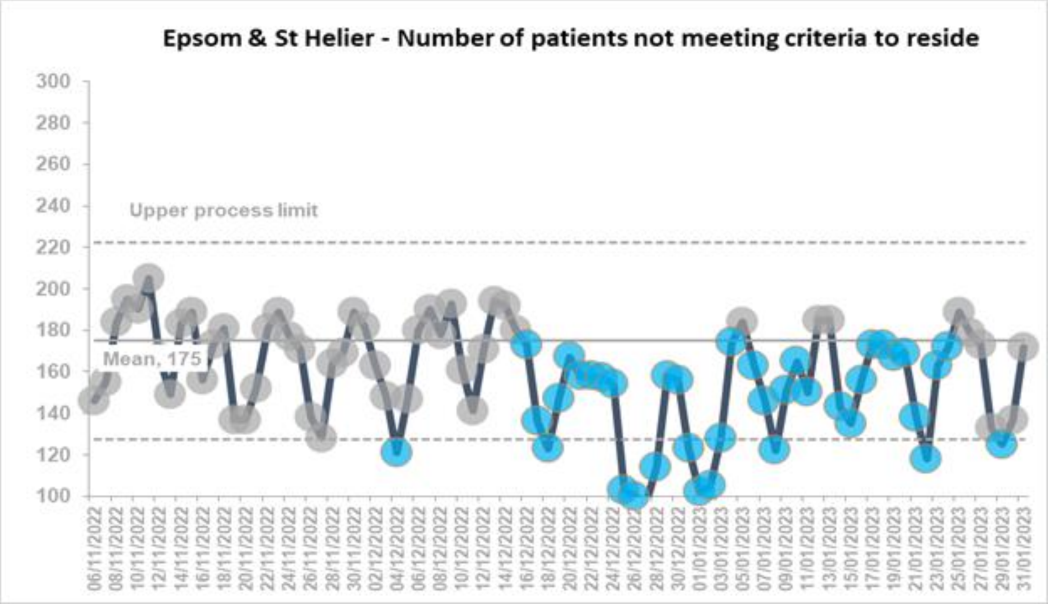
Non Elective length of stay remains above the upper control limit. On average across January patients admitted on a non-elective pathways stayed 8.1 days. Both the number of stranded and super stranded patients increased.

Patients not meeting criteria to reside

Jan-23

Target: TBC	SGH: TBC	ESTH: 154





SGH updates since last month

Methodology and reporting of this data has been reviewed and currently being revised to ensure accurate view of the numbers.

ESTH updates since last month

The number of patients not meeting criteria reside remains predominantly within the upper and lower control limits although throughout January the trend shows a lower trend.

Length of Stay Performance - Analysis and Action

SGH current issues –

It is going to be more difficult to discharge patients in February 2023 as a combined result of the RCN and CSP strikes, adversely impacting length of stay and lack of onward care capacity.

The increase in Pathway 2 and 3A delays for Merton & Wandsworth due to a lack of bed availability and lack of homes willing to take complex patients (housing issues). Pathway 1 delays for M&W which are escalated daily.

"Early bird" and weekend discharges to onward care continue to be a challenge as many homes do not accept patients over the weekend.

Whilst reducing and monitored closely, still high numbers of patients in the Trust who are considered medically optimised but unable to move to their discharge destination in a timely way.

SGH future action -

The Trust to continue to proactively workforce plan for further industrial action, with significant focus on the potential full 72hr BMA / junior doctor strike and the continued industrial action being undertaken by frontline staff on agenda for change contracts (RCN/CSP).

Lead Nurse for Discharge and Flow for SGH appointed and will be developing the substantive workforce plan for the Transfer of Care (ToC) hub.

The LAS to Medical SDEC pathway soft-launched in December 2022, as an alternative pathway to traditional ED attendance has been hampered by staffing levels.

The Trust is undertaking several pieces of work to improve length of stay, looking at the time it takes to discharge a patient on the day, accurately recording not meeting CtR and the pathway blocks that increase the LOS to the patient being medically ready for discharge. This requires partnership working with place to share the risk whilst becoming less risk adverse. Nurse led discharge also needs to be reinvigorated for weekend discharges.

ESTH current issues –

We have seen an increase in the number of patients with a length of stay of > 21 days in January 2023 when compared to the previous month, however, our daily medically optimised numbers are reducing, particularly for patients in the Sutton locality.

We continue to see high acuity patients presenting to both sites, with high occupancy levels in HDU/ITU which is driving the longer length of stay.

We remained challenged in progressing discharge for patients on pathway 3, and particularly for patients with challenging behaviour.

The development of our ward based patient tracking system and associated quality improvement programme has resulted in more robust and clinically led reporting of patients who no longer meet the criteria to reside. We are confident that our current reporting processes are resulting in a more realistic position, however, this has demonstrated an increase over recent months. A review of data quality in relation to criteria to reside is currently being undertaken by internal audit.

ESTH future action –

The PCN ward on the St Helier Hospital site is operating at full capacity and the standard operating procedure has been adapted to include additional patient cohorts. Length of stay on the PCN ward is 3-4 days, resulting in daily bed availability.

We continue to provide stretcher discharge lounge facilities on both hospital sites and are looking to develop more substantive arrangements going forward.

We are utilising additional support from our community therapy team to support therapy assessment/review for patients with on-going therapy needs on our acute inpatient wards.

We have also reviewed our medically optimised patient lists and are sharing more accurate information regarding individual patients with health and social care colleagues in order to progress discharge arrangements.

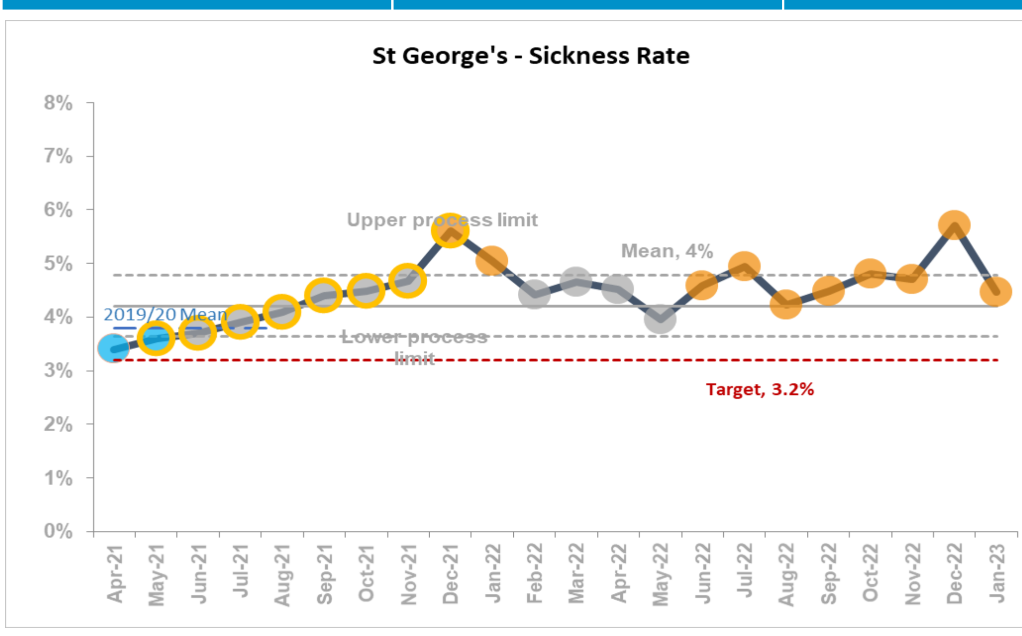
We have recently sourced additional support on the Epsom Hospital site via CHS to support self-funding patients source appropriate nursing home facilities.

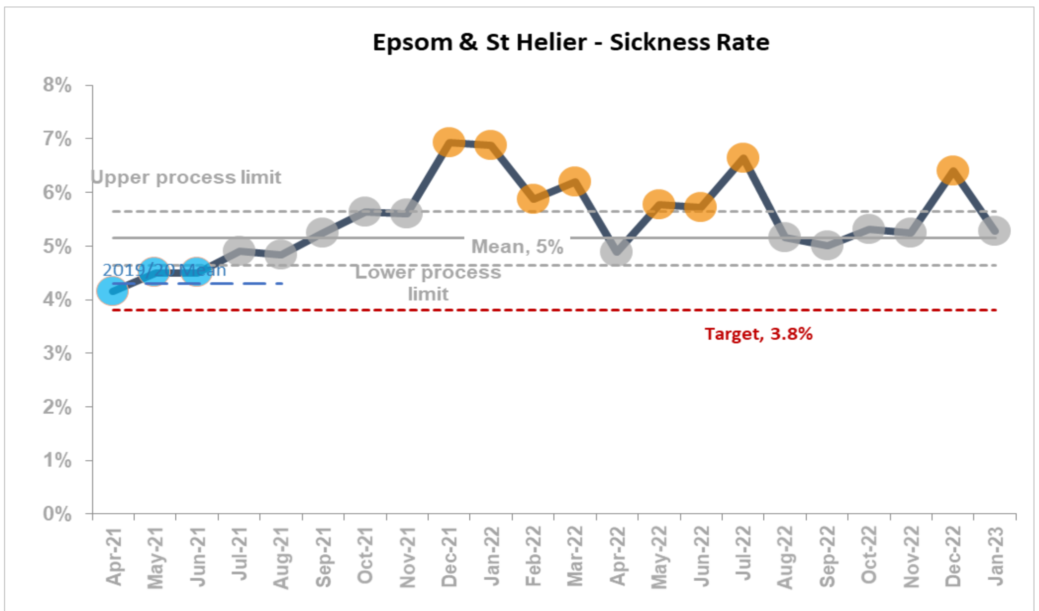
Monthly Overview – Our People

Our People	St Georges							Epsom and St. Helier						
	Monthly Target	Nov-22	Dec-22	Jan-23	YTD Target	YTD Actual	13-Month Trend	Monthly Target	Nov-22	Dec-22	Jan-23	YTD Target	YTD Actual	13-Month Trend
Sickness Rate	3.2%	4.7%	5.7%	4.5%	3.8%	4.6%		3.8%	5.2%	6.4%	5.3%	3.8%	5.5%	
Agency rates		2.6%	4.0%	2.3%	TBC	3.1%		TBC	5.4%	5.9%	4.3%	TBC	4.6%	
MAST	85%	89.0%	88.8%	88.6%	91%	89.0%		85%	79.9%	79.5%	80.8%	85%	79.2%	
Vacancy	10%	8.5%	8.7%	8.3%	12%	9.1%		10%	13.7%	13.9%	13.9%	10%	13.9%	
Appraisal Rate Medical	90%	77.8%	77.5%	76.4%	84%	79.4%		90%	85.0%	70.0%	69.3%	90%	83.5%	
Appraisal Rate Non Medical	90%	70.4%	70.2%	71.2%	73%	70.5%		90%	65.9%	67.5%	67.4%	90%	60.8%	
Turnover	13%	16.2%	16.1%	16.1%	17%	16.3%		12%	16.5%	16.3%	16.2%	12%	16.0%	
Percentage BAME staff band 6 and above	TBC	43.9%	44.0%	44.0%	TBC	43.5%		TBC	36.1%	36.6%	36.2%	TBC	35.96%	

Sickness Rate

SGH Target: 3.2%	SGH: 4.5%	ESTH Target: 3.8%	ESTH: 5.3%





SGH updates since last month

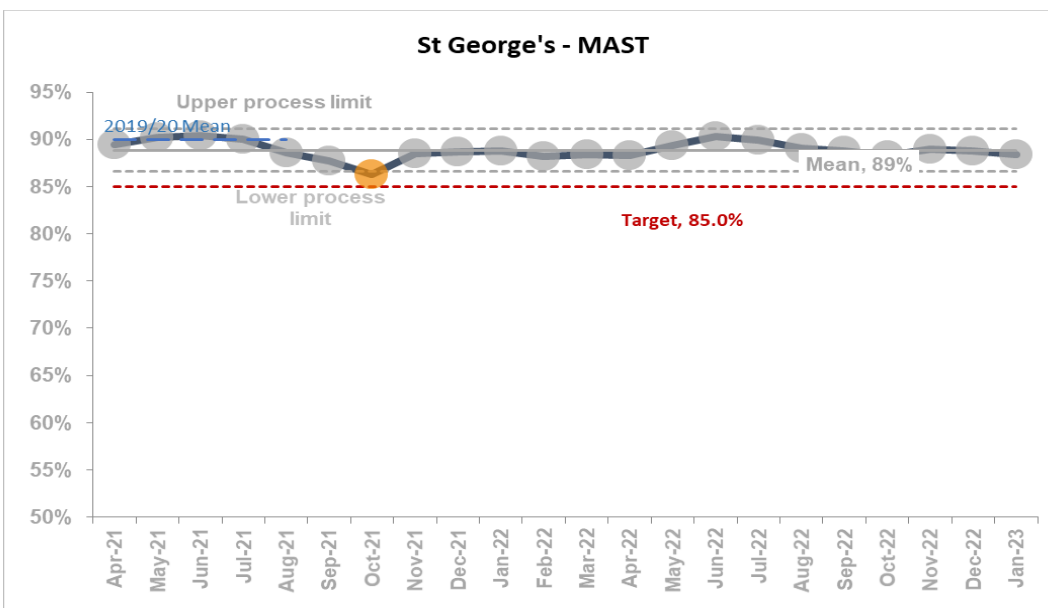
The Trust's sickness rate fell to 4.71% in January from 5.7% in December. This remains above the target of 3.2%. Colds, Cough, Flue-Influenza, Infectious Diseases (both of which included covid-related sickness) and Gastrointestinal problems, were the highest cited reason for sickness.

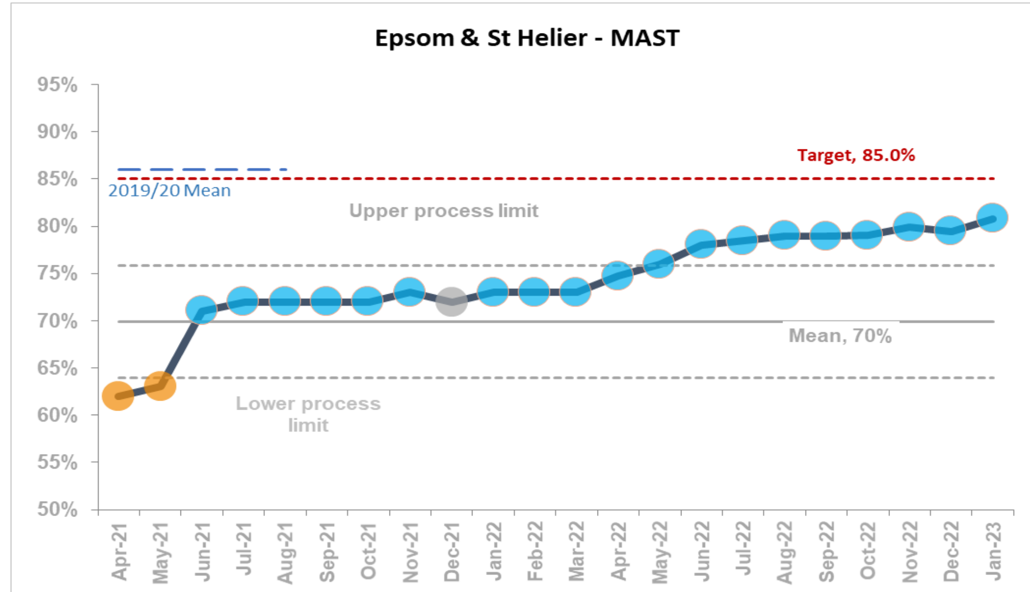
ESTH updates since last month

Sickness absence decreased by 1.12% t0 5.3% and remains significantly above the threshold of 3.80%. Cold, Cough, Flu-Influenza and Gastrointestinal problems were the top 3 reasons for sickness absence.

MAST

Target: 85%	SGH: 88.6%	ESTH: 80.8%





SGH updates since last month

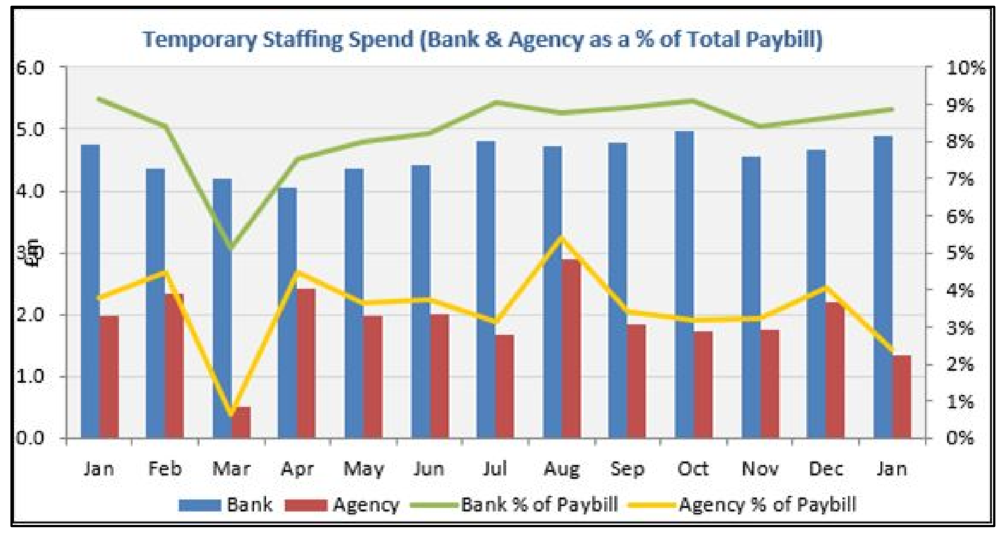
Mandatory and Statutory Training (MAST) was 88.6% in January with compliance remaining steady and has done so for the last year or so.

ESTH updates since last month

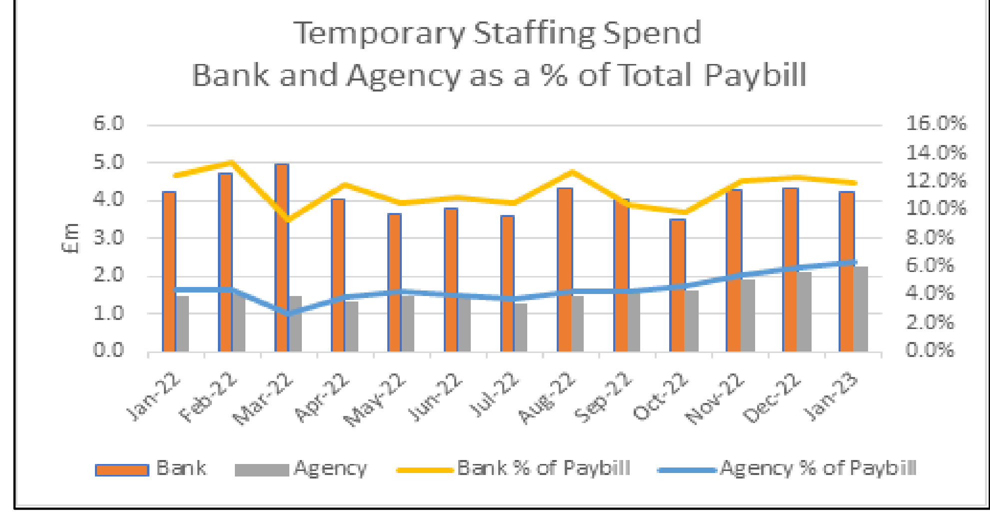
Performance against the MAST indicator is regularly discussed, however remains challenged. The data is available to mangers to keep managers abreast of performance. It will allow managers to track their trajectory by comparing their current percentage with their previous percentage to enable them the see clearly their rate of improvement or otherwise.

Agency and Bank Spend

St George's



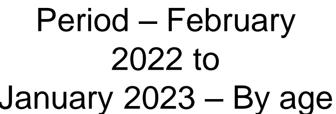
Epsom & St Helier

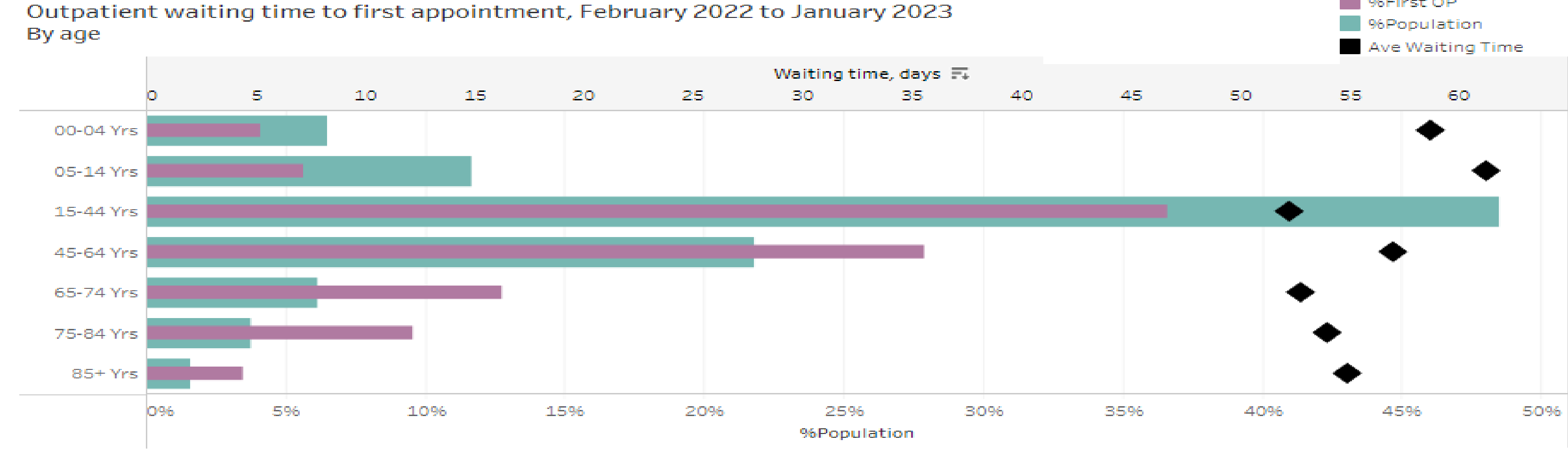


Outpatient waiting time to first appointment

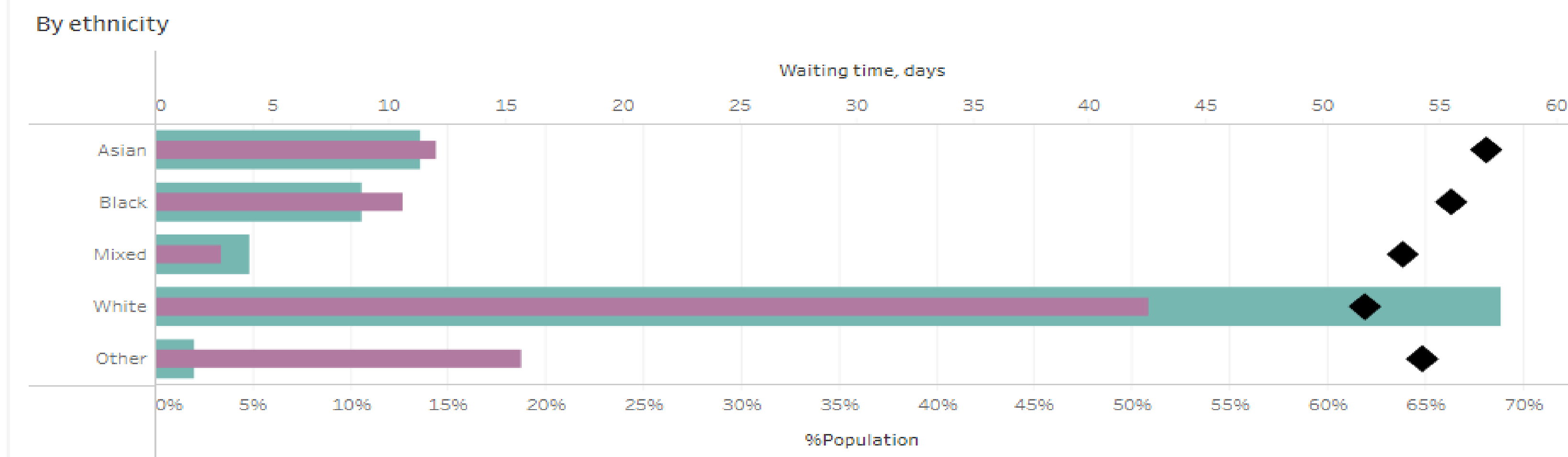
St George's

Period – February 2022 to January 2023 – By age





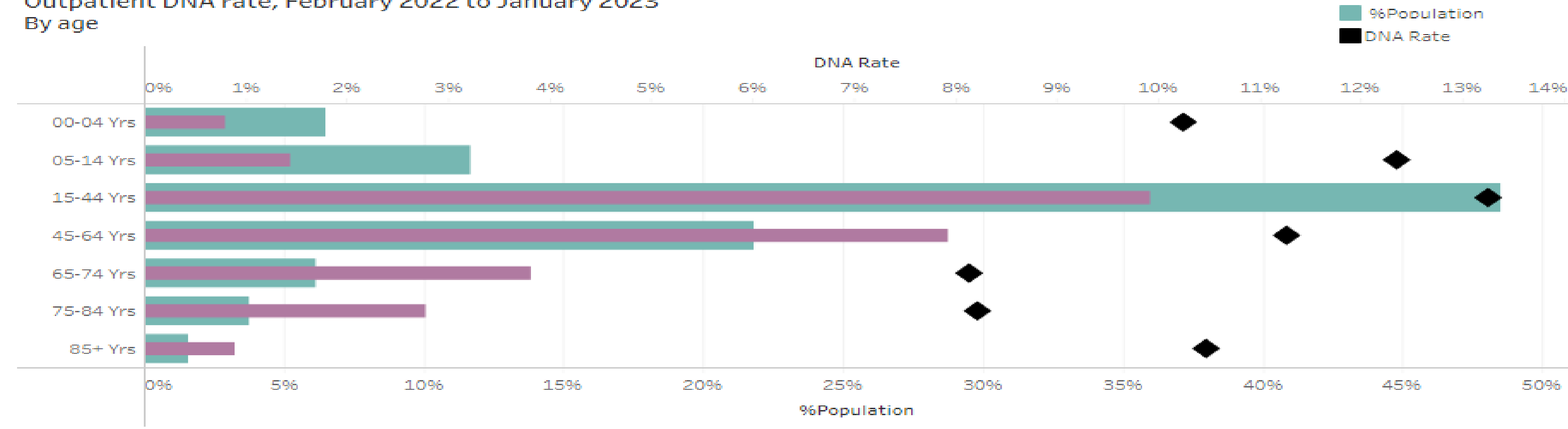
Period – February 2022 to January 2023 – By ethnicity



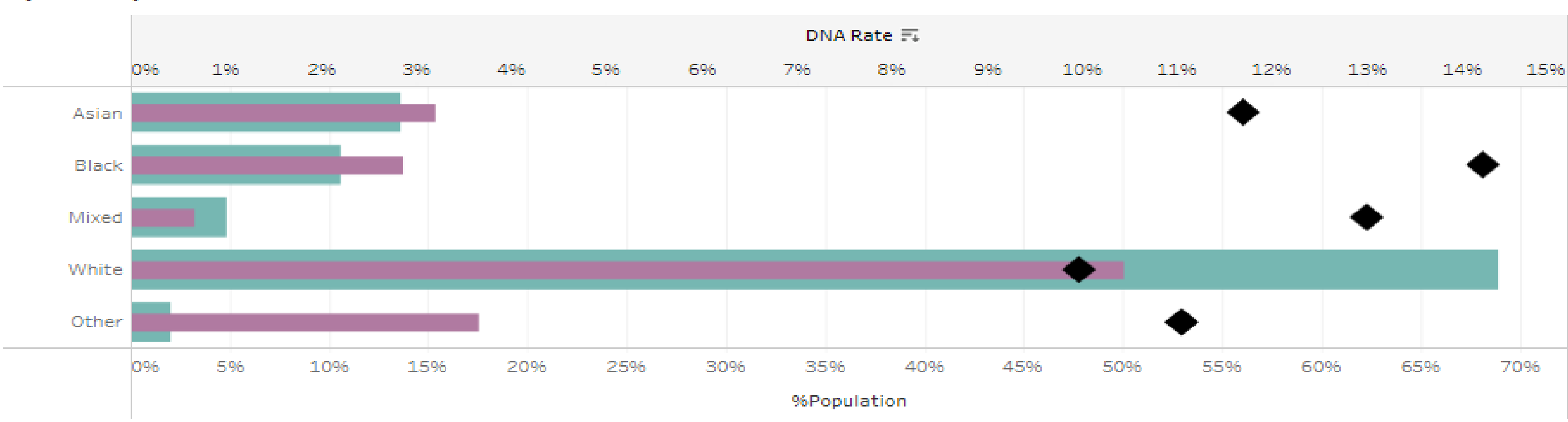
DNA Rate

St George's

Period – February 2022 to January 2023 – By age



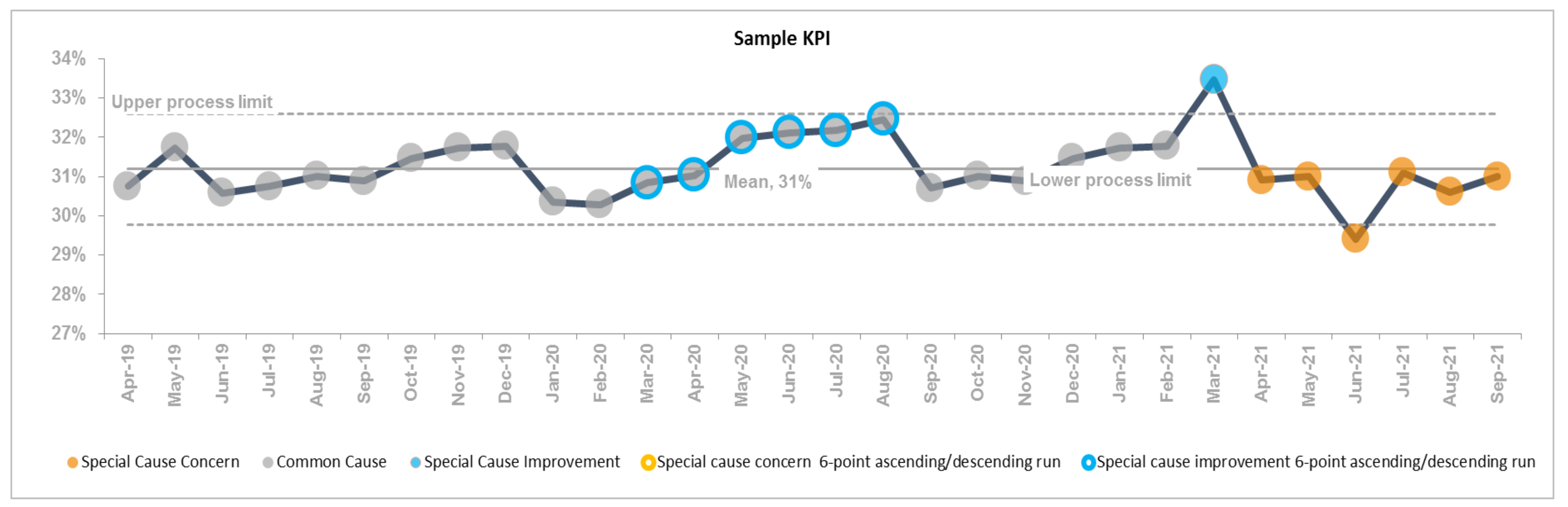
Period – February 2022 to January 2023 – By ethnicity



Appendix

- Guide on interpreting statistical process control charts
- ESTH Integrated Care Dashboard

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

Meeting Title:	**Trust Board**		
Date:	2 March 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 January and February 2023.		
Recommendation:	The Board is asked to: • Note the report. • Note in particular the adjustments made to the Corporate Risk Register.		
Supports			
Trust Strategic Objective:	Culture		
CQC Theme:	Well Led		
NHS System Oversight Framework:	People, Well Led		

People Committee Report

Trust Board, 2 March 2023

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 continue to work well in practice and allow for variance analysis across a wider performance base.

2. Risk Assurance

Industrial Action - the Committee continues to receive detailed updates at each meeting on the phasing of planned industrial action being taken by staff, and the contingency planning being undertaken to mitigate the impact of this as far as is achievable.

Corporate Risk Register - A number of adjustments to the Corporate Risk Register were reported to the February meeting. In summary:

> Risk 2178: Organisational Culture. This Risk has been closed as a specific risk on the Corporate Risk Register as the Committee agreed that this was best addressed through the existing strategic risk on the Board Assurance Framework (SR8).
>
> Risk 739: Recruitment and retention. This Risk has been closed and replaced by 'Risk 2533: Staff recruitment' and 'Risk 2534: Staff Retention'. The change was agreed in order to provide greater clarity and focus on the distinct gaps in control for recruitment and for retention, and specific actions to address each of them.
>
> Risk 1978: Raising Concerns. This Risk has been updated to make clear the risk had evolved from one of lack of staff awareness of how to raise concerns to that staff confidence that concerns would be addressed in a timely way.

A number of Corporate Risks were highlighted, and a request made that the People Management Group (executive) review the risk rating on these.

Trust Strategic Risks – the Committee reviewed continuing good progress by the executive on mitigating Strategic Risks 8 and 9.

Payroll performance – our payroll is delivered by NHS SBS and the overall service was reviewed at the January meeting. Performance was viewed as acceptable. Most errors arose as a result of incorrect information being received from the Trust, rather than as a result of adverse performance by SBS.

3. Internal Supply

KPIs - at our January meeting we reviewed data through to November on vacancies, retention and turnover, noting that at whole-trust level vacancies stood at 8.5% and had been steadily falling since the summer. The Committee noted that the Trust had grown its staff base by 170 FTEs since April last year, and that this would be reviewed as part of the 23-24 budget process. For planning and budgeting purposes, the HR team was working closely with finance. Staff turnover remained at c 16%. Appraisal compliance at 70% continued to be below target of 90%, in part driven by turnover and sickness.

Staff sickness - A Deep Dive was undertaken on staff sickness, which remained stubbornly above the target of 3.2%, at 4.7% in month, and 4.5% for the year to date. Long term sickness (episodes of sickness lasting 28 days or more) accounted for 11% of all sickness absence. An initial pilot (the 'sickness bureau') had been run within nursing to provide more intensive support to staff off sick and secure a timely return to work. The success of this had led to a decision to expand its remit to other

staff groups. A number of other strategies were being pursued to manage sickness absence, tailored to the particular staff group and or/directorate in question.

Bank and agency staffing levels were reviewed, noting that agency spend had been below 3% of total pay for the last three months, reflecting good use of the staff bank. Importantly, the 3% spend level is below next year's NHSE mandated target of 3.7%.

Workforce Improvement Programme - progress was reviewed at the January meeting. This programme has six streams, designed to improve specific areas across workforce availability and delivery. Of these, four were broadly on track but that related to Sickness Absence management had not yielded the improvement targeted. That related to Temporary Staffing was slightly behind, but the anticipation was that it would meet its target by the financial year end.

Take-up of Flu and Covid Vaccinations – on Flu, take-up had been 47.1% against the 80% CQUIN target. On Covid, take-up had been 34%. Although take-up was materially lower than in previous years, the Trust was in the top 5 for vaccinations in London.

4. Culture Diversity and Inclusion, Organisational Development

Culture, Equity and Inclusion (CEI) Programme Board Update – good progress was reported. The leadership development modules 1 and 2 had been successfully delivered. The Group Talent Strategy was discussed, as was the referesh of the Living our Values programme. .

National Staff Survey - the embargoed results of the 2022 Staff Survey were reviewed at our February meeting. These will be reported direct to Board in due course, and so will not be further commented on here - other than to note that 48.15% of eligible staff responded to the survey. This is lower than our previous response rate (55.1%), however, higher than the average for other Acute Trusts (45.55%).

Managers Briefing - we reviewed and endorsed a one page Managers Briefing on how diversity and inclusion play through into team leadership, and the expectations of the Trust of its managers.

Staff Wellbeing - at the January meeting we noted the continuing good work being done by the staff wellbeing team, and continued increase in the level of staff counselling offered.

WRES and WDES Action Plans – at the February meeting we reviewed progress against the Action Plans that had been formulated following completion of the full year reports. For WRES, the key areas where progress was being targeted were:

- Improving Equal Representation in Leadership
- Debiasing Recruitment
- Improving Career Development Opportunities
- Building an Anti-Discrimination Culture

Progress on these were reviewed, and where this was falling behind plan the corrective actions being taken were evaluated. Overall, progress was seen as solid, though with some risk to delivery which the team are doing their best to overcome.

For WDES, the targets were aimed at:

- Improving Equal Representation of People with a Disability
- Building an Anti-Discrimination Culture
- Improving Managerial and Organisational Support for Staff with a Disability

Progress here was generally on track, though the pause (and reasons for it) in securing Recruitment Inclusion Specialist (RIS) advisors with lived experience of disability was noted.

5. Trust Governance

Freedom to Speak Up Q3 Report – Karyn Richards-Wright, the Trust's Guardian, gave a comprehensive update on Speaking Up. Staff use of the process continued to increase, with the highest ever number of concerns raised in the quarter. There was an increasing level of concern being raised in relation to managers adhering to procedures, and an increase in collective concerns (those raised by a group of staff). There was an increased and positive use of informal resolution to concerns. The length of time taken to investigate and resolve concerns remained an issue but there were indications of an improvement here. Site management teams were now more involved in liaising with the Guardian, which was contributing to earlier and informal resolution. Overall, the Trust was providing better support to Speaking Up, and its senior leadership was appropriately focussed on it.

Responsible Officer Report – we received the Q3 Report from Dr Luci Etheridge (who had temporarily assumed this role, following the promotion of the previous incumbent). There had been a reduction in Appraisal Compliance on prior quarter but Luci stated that this was not of concern – in fact typical for the quarter, give the impact of increased holiday and winter pressures. There would be a catch-up in subsequent quarters. No medical practitioners had been referred to the GMC for non-compliance. Dr Elizabeth Rhodes will take on the RO role with effect from 20 March, and we look forward to working with her.

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, 26 February 2023

NHS
St George's University Hospitals
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	2 March 2023	**Agenda No**	**3.2**
Report Title:	**Freedom to Speak Up Report, Q3 2022-23**		
Lead Director/ Manager:	Stephen Jones, Group Chief Corporate Affairs Officer and Executive Lead for Freedom to Speak Up		
Report Author:	Karyn Richards-Wright, Freedom to Speak Up Guardian		
Presented for:	**Assurance**		
Executive Summary:	This report provides the Trust Board with a thematic analysis of concerns raised with the Trust's Freedom to Speak Up Guardian during the period Q1 to Q3 2022/23. It sets out key themes and trends in the number, type and origin of concerns and highlights cross cutting and emerging issues. This report was considered by the People Committee at its meeting on 10 February. Overall, between 1 April 2022 and 31 December 2022 a total of 118 concerns were raised with the Trust's FTSU Guardian, a 57% increase on the number of concerns raised at the end of Q3 the previous year. The staff groups which have raised the highest number of concerns over the first three quarters of the current financial year are nursing staff and administrative and clerical staff. The Children's Women's Diagnostics and Therapies Division, which is the largest Division, recorded the highest number of concerns over the period Q1 to Q3 2022/23, around 50% of the Trust-wide total. The dominant types of concern raised over the first three quarters of the year – which has been broadly consistent with the previous year – have been concerns around Trust systems and processes (cited in 24% of concerns in this period), staff safety (cited in 16% of concerns in this period), leadership (cited in 13% of concerns in this period), and patient safety (cited in 13% of concerns in this period). A total of 4,114 workers have undertaken the Speak Up training to date, which represents a very significant increase in the number of workers trained since the introduction of Speak Up training as part of the MAST programme. Timely resolution of concerns remains an issue. However, the Guardian is meeting regularly with the Site Managing Director, Site Chief Operating Officer and Site Chief Medical Officer to progress concerns, and a new case management approach is being developed by the Guardian and Executive Lead. In line with National Guardian's Office guidance, the report also highlights a number of recommendations from the Guardian to the Trust, based on learning from recent concerns.		
	The Board is asked to: • Note the number of concerns raised in Q1 to Q3 2022/23 • Note the themes emerging from FTSU cases in this period • Note the recommendations from the FTSU Guardian arising from recent concerns.		
Supports			
Trust Strategic Objective:	All		

CQC Theme:	Well led		
Single Oversight Framework Theme:	Quality of Care Leadership and Improvement Capability		
Implications			
Risk:	Failure to comply with the requirements around Freedom to Speak Up, a regulatory requirement, risks undermining staff confidence in the leadership of the Trust and would be a reputational risk to the organisation.		
Legal/Regulatory:	NHS England Freedom to Speak Up Policy for the NHS, April 2016.		
Resources:	As set out in report.		
Previously Considered by:	People Committee	**Date**	16 February 2023
Equality and diversity:	The report sets out concerns by protected characteristics.		
Appendices:	N/A		

Freedom to Speak up Update Report
Trust Board, 2 March 2023

1.0 PURPOSE

1.1 This report provides the Trust Board with a thematic analysis of concerns raised with the Trust's Freedom to Speak Up Guardian from 1 April 2022 to 31 December 2022. It sets out key themes and trends in the number, type and origin of concerns and highlights cross cutting and emerging issues.

2.0 BACKGROUND OR CONTEXT

2.1 In February 2015, the independent report into Freedom to Speak Up, by Sir Robert Francis QC set out 20 principles to guide the development of a healthy speaking up culture throughout the NHS. Among these was the recommendation that every NHS trust appoint a Freedom to Speak Up Guardians. As the report stated, "every organisation needs to foster a culture of safety and learning in which all staff feel safe to raise a concern…we need to get away from the culture of blame, and the fear that it generates, to one which celebrates openness and commitment to safety and improvement".

2.2 Freedom to Speak Up Guardians support workers to speak up when they feel that they are unable to in other ways. Workers can speak up about things such as but not limited to, unsafe patient care, a criminal offence maybe that has been, or is being committed, unsafe working conditions or other breaches of Health and Safety, inadequate induction or training for workers, lack of, or poor response to, a reported patient safety incident, suspicions of fraud, bullying and harassment.

2.3 The importance of speaking up has been reinforced in both the NHS Patient Safety Strategy, published in July 2019, which sees speaking up as a fundamental part of establishing effective patient safety cultures in NHS trusts, and in the new NHS People Plan, published in August 2020, which describes speaking up as essential to building a culture of belonging in the NHS, one in which patients and staff feel safe. The NHS People Plan stated that "making sure staff are empowered to speak up – and that when they do, their concerns will be heard – is essential is we are to create a culture where patients and staff feel safe."

2.4 In September 2020, the Board approved the Trust's first Freedom to Speak Up vision and strategy. It set out the following vision for raising concerns: "*We aim to create a culture of safety and learning in which all staff feel safe, supported and confident to raise concerns without fear or detriment and were speaking up is visibly championed as a core part of providing outstanding care every time to our patients, staff and the communities we serve. "We aim to become a leader in establishing a positive speaking up culture by encouraging and supporting staff to speak up, listening to their concerns and acting on them. Staff will not fear speaking up and will be thanked for doing so*".

It also set out five strategic priorities for Freedom to Speak Up:

1. We will support our staff to feel confident about speaking up
2. We will make it safe for our staff to speak up
3. We will investigate concerns promptly, fully, and fairly
4. We will ensure that speaking up makes a difference
5. We will support the positive development of our organisational culture

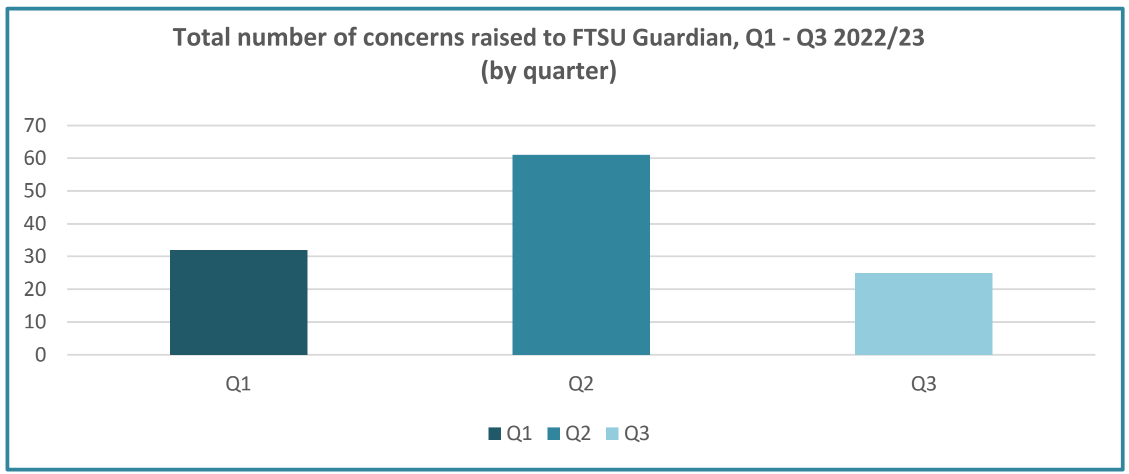
2.5 We will be releasing an updated Raising concerns at work policy in March 2023 following new guidelines from the National Guardians Office.

3.0 CURRENT FREEDOM TO SPEAK UP ACTIVITY AND THEMES

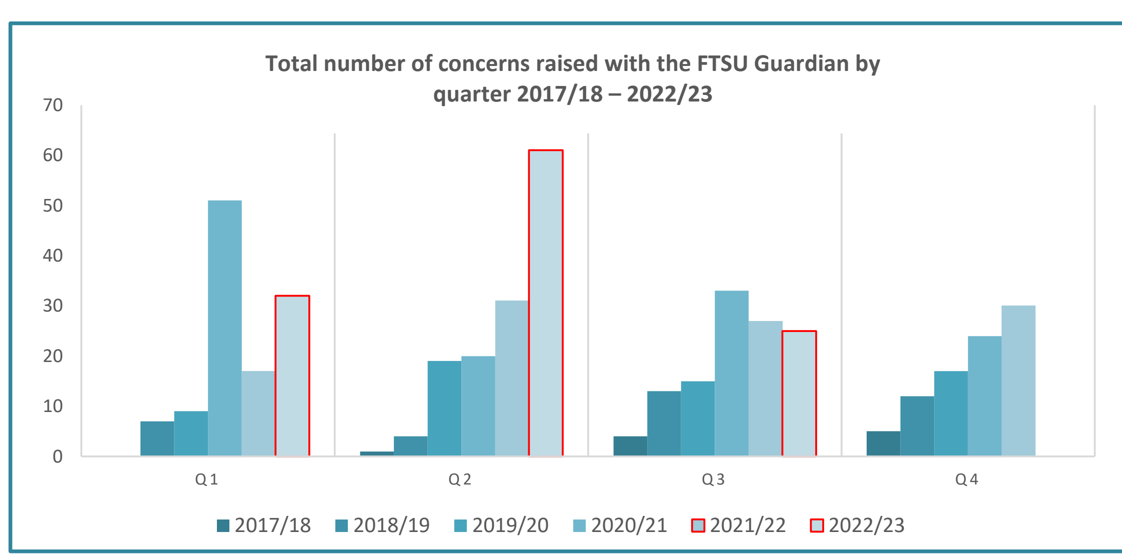
(a) Total number of concerns raised with the FTSU Guardian from 1 April 2022 to 31 December 2022 (Q1-Q3)

3.1 Between 1 April 2022 to 31 December 2022 (Q1-Q3 2022/23) the number of concerns raised with the Trust's FTSU Guardian was 118, over half of which were recorded in Q2. This compares with 75 concerns raised with the Guardian over the same period in 2021/2022, a 57% increase in the number of concerns compared with the same point last year, and a 13% increase over the previous level of concerns raised by the end of Q3 in 2020/21.

The following chart shows how the number of concerns received in 2022/23 was distributed over the first three quarters of the year:



The following chart gives a comparative perspective on the number of concerns raised, by quarter, over the past six years:



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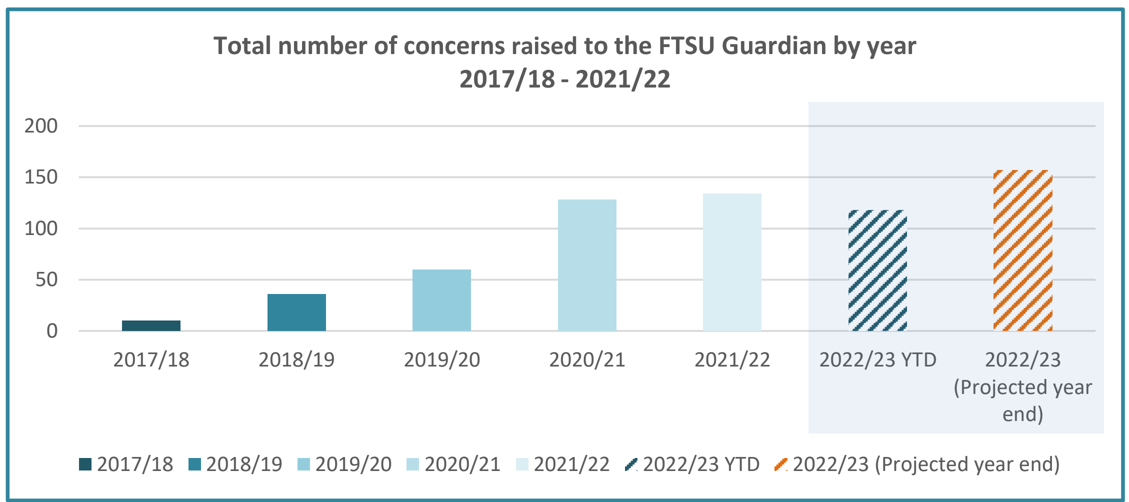
The following chart shows how the total number of concerns raised in each full year has changed over the past six years, including the Q3-Q3 data for the current financial year and a projection of the projected year-end total of concerns raised:



3.2 The above chart illustrates that more workers are accessing the FTSU service. This may be a combination of more workers feeling safe to approach the service combined with an increase in capacity with the new Deputy Guardian now in post and continued efforts throughout the year to raise the profile of the service including during the Big 5 and October's National FTSU month. You will see that Q2 had a sharp rise in concerns which also includes collective concerns raised through Midwifery and the Emergency Department.

3.3 Following the significant rise in concerns raised with the Guardian in 2020/21 compared with 2019/20 (128 in 2020/21 compared with 60 the previous year; a 113% increase), the upward trend in the number of concerns has continued albeit not at the same rate of increase. In 2021/22, a total of 134 concerns were raised, which represents a 4.7% increase over the previous high water point. In the current year, a total of 118 concerns have been raised over the first three quarters of the year, which represents 88% of the total of last year's concerns with one quarter still to go. Projecting forward to year-end based on the average number of concerns raised to date in the current year, it is possible that a total of over 150 concerns could be registered by the end of this financial year, which – if that were to materialise – would represent a 12% increase over 2021/22.

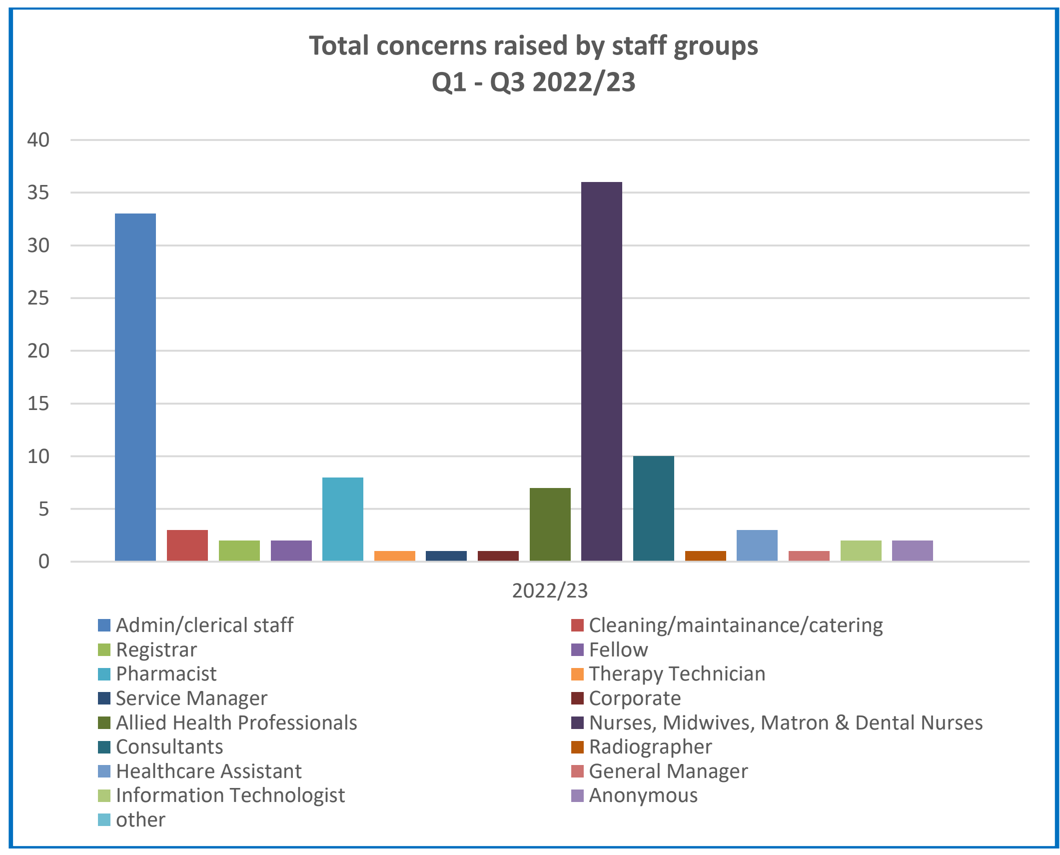
3.4 Although there is a continued increase in workers coming through FTSU to raise issues which is indeed positive, we encourage the organisation not to become complacent and to continue to support the FTSU Guardians in raising the profile of FTSU ensuring consistency and continued reassurance that the Guardians are reaching staff groups that historically did not access the service in such numbers, for example consultants. The Guardians will continue to raise FTSU awareness by working with managers and teams, attending departmental meetings, attending staff network meetings, and continuing to communicate with workers through trust communications and FTSU Champions.

3.5 Many workers contacting the Guardians have been at the Trust for two years or more and report that they like working in their departments, but also report that they have seen a decline in behaviours and accountability which is impacting workers feelings of wellbeing at work. Where culture and behaviours in teams are not in the right place, there is potential for this to impact on team effectiveness and, in some circumstances, on safety.

(b) Concerns raised by worker group in Q1 to Q3

3.6 An analysis of the worker groups who have raised concerns with the FTSU Guardian over the past year shows that:

a) **Nursing staff** including Matrons, Midwives and Dental Nurses are, by some margin, the staff group raising the most concerns during 2022/23 with 36 concerns.
b) **Administrative and clerical staff** are the staff group which raised the second highest number of concerns to the FTSU Guardian in the same timeframe. This mirrors the pattern seen in previous quarters with Administrative and Clerical Staff accounting for 33 of the of concerns raised.
c) **Consultants** were the third largest staff groups in terms of the number of concerns raised to the FTSU Guardian with 10 concerns raised. This is higher than in previous quarters and years
d) **Pharmacists** raised 8 concerns and 3 from **Healthcare Assistants**
e) There were 7 concerns from **Allied Health Professionals**
f) Two **anonymous** concerns raised in the same timeframe



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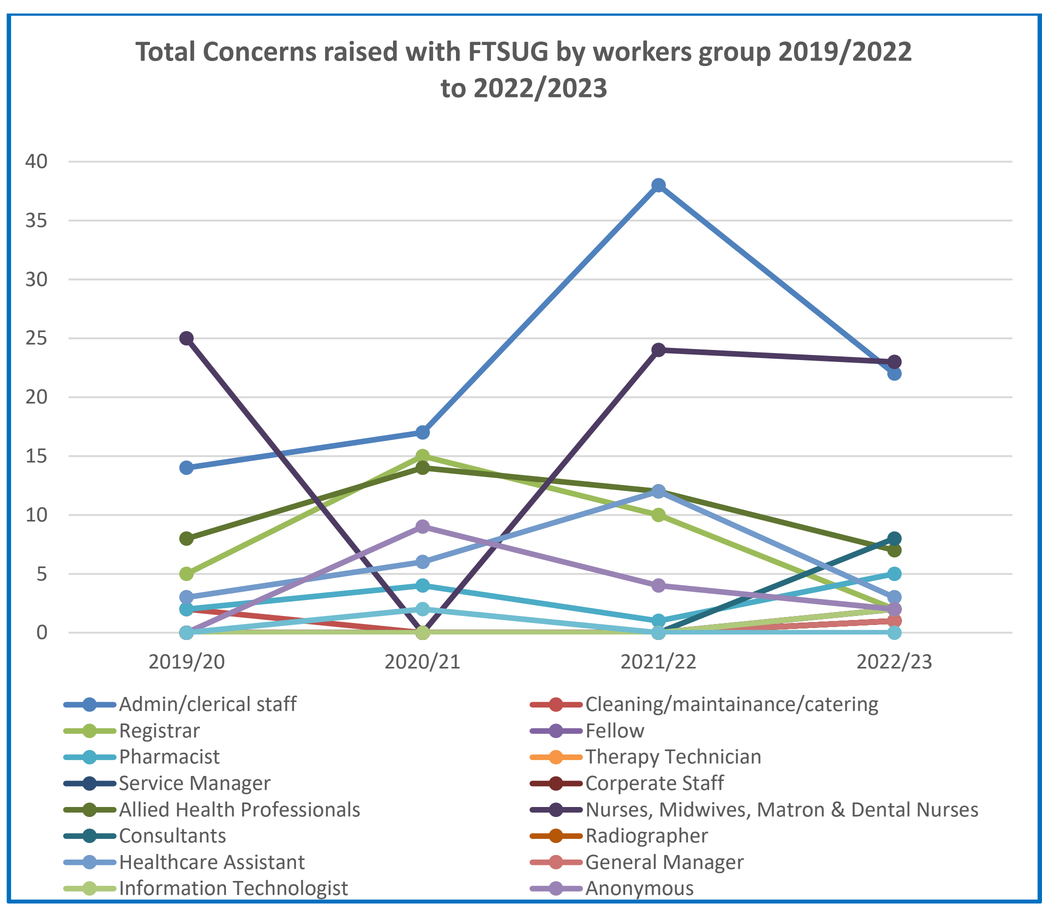
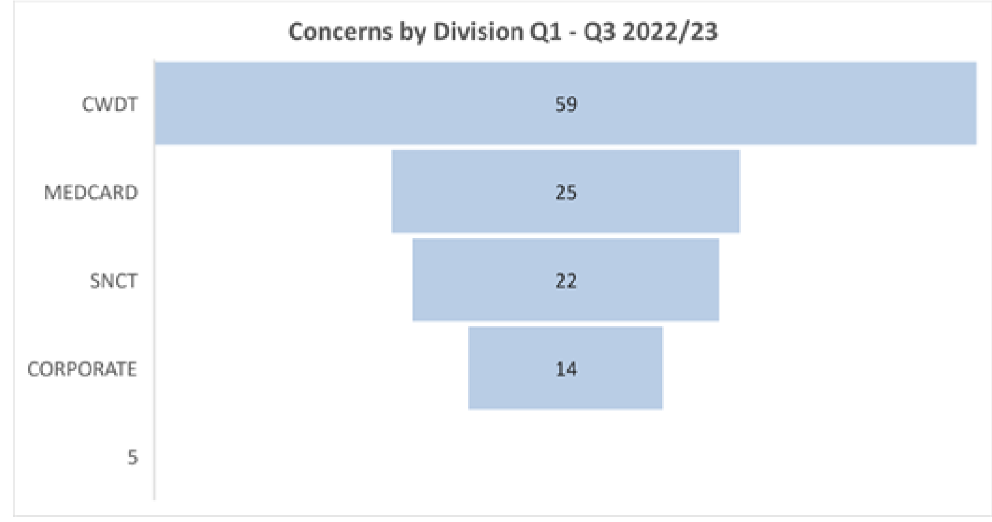


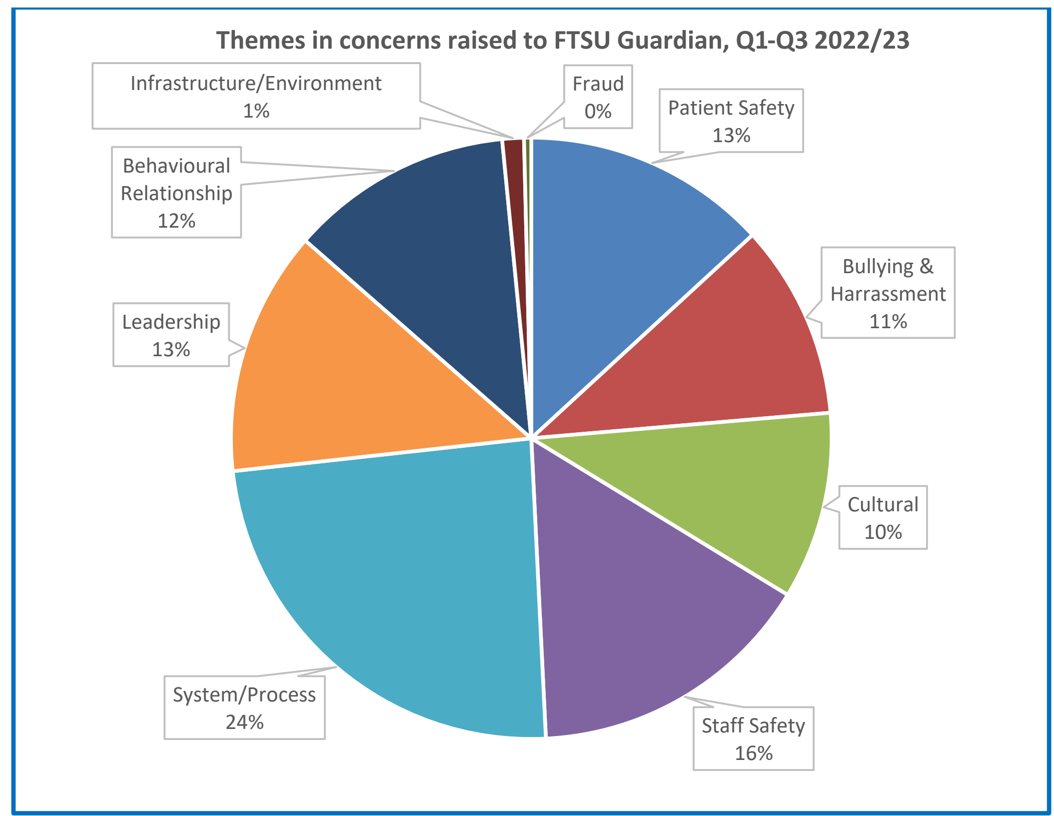
(c) Concerns raised to FTSU Guardian by Division, Q1-Q3 2022/23

3.7 The division with the highest concerns is CWDT with 59 concerns which is consistent with the size of the division being the largest, followed by MedCard with 25 concerns, SNCT with 22, Corporate with 14:



(d) Themes in concerns raised with the FTSU Guardian, Q1-Q3 2022/23

3.8 The Guardian would like to bring particular attention to the themes of concerns raised whilst asking for it to be noted that concerns often have more than one theme attached to the issue raised: patient Safety (34); staff safety (40); behavioural relationship (31); bullying & harassment (27); system/process (62); infrastructure/environment (3); cultural (26); leadership (34); and Fraud (1). The theme of System/Process is of concern as workers are regularly reporting that they feel that Trust processes are not being followed by their managers and that inconsistent management processes amongst teams is causing conflict between colleagues.



3.9 The vast majority of concerns raised with the FTSU Guardian are resolved informally and rapidly; however those concerns being escalated for formal investigation/response continue to be of concern to the Guardian due to the length of time it is taking to respond to the concerns. It is to be noted that the Guardian has recently starting working more closely with the Managing Director, Chief Operating Officer and Site Chief Medical Officer to facilitate better communication and faster resolution of concerns. The Guardian hopes that in future reports there will be a vast improvement in timely outcomes reported.

3.10 Out of the 118 concerns raised, 68% of concerns have or are currently being resolved informally. While a clear majority of concerns are resolved informally, such as through signposting, the proportion of concerns being resolved through a formal process has increase over recent years, from around 9% in 2020/21 to 32% in the year-to-date. To some degree, this reflects the significance and / or complexity of the issues being raised to the Guardian. The outstanding concerns awaiting final resolution are to be noted to be mainly collective

concerns from ED, Midwifery and Pharmacy whereby the Guardian is unable to close at this time.

3.11 The Guardians are able to resolve the FTSU aspect of the concerns informally through signposting to the appropriate route for handling the issue (e.g. a relevant HR process) or through raising with the relevant team to enable prompt action to be taken to address the concern raised. The Guardians continue to work closely with Staff Support, Organisational Development and the lead Guardian is also a trust mediator so is also able to facilitate resolution of concerns through transparent conversations and negotiation.

4.0 TIMELY RESOLUTION OF CONCERNS

4.1 The Guardian is hopeful that by working more closely and regularly meeting with senior leaders regarding breached concerns we will swiftly see an improvement in timely resolution. The FTSU Guardian and Executive Lead for FTSU are also developing a case management oversight process involving appropriate senior leaders to ensure early and ongoing review of concerns that are subject to formal investigation.

4.2 More workers including some who are quite senior are reporting to the Guardian that they are currently off sick or potentially due to go off sick due to anxiety regarding lengthy resolution of concerns which have been raised through HR.

4.3 The Guardian is concerned that workers are using the FTSU as a HR backup due to reports of workers raising some concerns with HR before approaching FTSU, but who are then coming to FTSU having become frustrated at the lack of HR response. The FTSU service is not resourced for this and the Guardians are concerned on what the impact of this continuing will have on the service. The Guardian has been meeting regularly with HR colleagues to advise of concerns relating to specific cases whereby staff are accessing FTSU due to the perceived lack of engagement from HR.

5.0 SPEAK UP, LISTEN UP, FOLLOW TRAINING

5.1 Following a national directive that all organisations should offer all workers regular mandatory training on how to speak up safely, how to respond to concerns and how to learn and reflect from these concerns. All 3 parts of the required training has now been released. It is important that all workers are given protected time to complete the required training to ensure that workers are aware of how to raise concerns and that managers are aware and confident in applying their responsibilities to concerns raised with them. In the year to 31 December 2022, a total of 4,144 workers at the Trust have completed the appropriate training. While the Guardian is of course keen to ensure that all staff complete the training, it is clear that the inclusion of Speak Up training as part of the Trust's MAST programme in late 2021 has resulted in far greater numbers of staff receiving training in speaking up. A training session in the Board-level Speak Up training is planned for the Group Board development session on 6 April 2023.

6.0 RESOURCES WITHIN FTSU SERVICE

6.1 A Deputy Guardian started in post at the beginning of July 2022 and this has had a positive impact on the service, offering more reach throughout the organisation, especially staff based at sites other than St George's which is where the Deputy Guardian has been tasked with

leading on. The function remains small, compared with other large Trusts, and requires some further administrative support as due to the increase of cases, clearly there has been an increase in administration of the same. The Guardian is in discussions as to ensure that the FTSU service is effectively resourced at St George's.

7.0 NEXT STEPS

7.1 The FTSU Guardian will be working closely with the executive lead and key stakeholders within the organisation with a view to supporting the organisation to spend protected time learning from concerns and publishing this learning so that steps can be taken to mitigate risk to our patients and staff which is a requirement from the National Guardian's Office.

8.0 RECOMMENDATIONS FROM FTSU GUARDIAN

8.1 Guidance from the National Guardian's Office requires local FTSU Guardian's to consider and make recommendations to their organisations about improvements that could be made, reflecting learning from FTSU cases. The FTSU Guardian makes the following recommendations to the Trust:

(a) **Workers appointed to lead investigations:** A theme in concerns raised to the Guardian relates to the training of staff who are appointed to lead formal investigations. Based on learning from recent cases, the organisation should prioritise reviewing its processes and training of workers responsible for investigations surrounding timely resolution of concerns, together with how workers responsible for the concerns will be supported to ensure that the trust abides by its own policies and good practise guidelines provided by NGO and NHSE for all Departmental, HR and FTSU concerns. The slow responses risk workers losing faith in internal processes and the organisation seeing a rise in concerns being raised externally.

(b) **Senior Leader training in speaking up:** The Guardian continues to recommend all senior leaders complete the Follow Up e-learning programme now released by the National Guardian's Office and is planning on presenting a training to senior leaders in April 2023. The focus of this training is on how senior leaders respond to concerns.

(c) **Concerns relating to Trust processes:** The Guardian continues to recommend the organisation pay particular attention to the issues and themes being raised by workers who are raising concerns through the Guardian, particularly those themes relating to trust processes not being followed which are on the increase.

(d) **Increase in collective concerns:** The Guardian recommends that particular note is taken to recognise the increase in collective concerns being raised in some areas. Whilst the Guardian is aware that work is underway with teams, communication with FTSU has been poor and this is a concern as the Guardian has a responsibility to feedback to workers who raise concerns directly with the FTSU Guardian.

(e) **Long-term sickness absence:** The Guardian recommends that work is undertaken by the organisation with support from the Guardian to triangulate themes including whereby

workers are off sick, many for lengthy periods of time as a result of no progression of concerns. The Guardian is concerned that these issues are not being identified and the link not being made between the lack of progression of cases and the well-being of workers together with the cost implication to the organisation of workers on long terms sick leave.

9.0 RECOMMENDATION

9.1 The Trust Board is asked to:

- Note the number of concerns raised in Q1 to Q3 2022/23
- Note the themes emerging from FTSU cases in this period
- Note the recommendations from the FTSU Guardian arising from recent concerns

Author: **Karyn Richards-Wright**
Date: **3 February 2023**

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Audit Committee Report
Trust Board, 2 March 2023

Matters for the Board's attention

The Audit Committee met on 26 January 2023 and agreed to bring the following matters to the attention of the Board.

1. Annual Report, Accounts and Quality Accounts Plan and Timetable

The Committee was updated on the processes and timelines for the production of the 2022-23 Annual Report and Accounts. Submission to NHS England is expected by 30 June 2023. The Communications team will lead on the preparation of the Annual Report, including the commissioning of content and drafting, with the GCCAO reviewing the compliance aspect of the report. Exemptions previously in place to ease reporting requirements during the Covid-19 pandemic are no longer in place. The expectation is that Trusts will be required to produce a standard Annual Report, recognising that the NHS Foundation Trust Annual Reporting Manual, which defines annual changes in regulatory requirements, has not yet been published by NHS England. Work to prepare the annual Quality Account, which would be incorporated into the Trust's final Annual Report, was being coordinated by the Corporate Nursing and would be presented to the Quality Committee for review prior to review by the Audit Committee and Board. The Committee will review the detailed timeline and high level messages to inform the preparation of the Annual at its meeting in April 2023.

The Committee also approved the accounting policies for the 2022-23 Annual Accounts.

2. External Audit Annual Plan

The Committee received the audit plan from the Trust's external auditors and was informed the initial work on the audit would start in February 2023 in preparation for the annual audit of Trust accounts. The Trust is engaging with external auditors on the approach with no concerns or issues raised in advance of commencement.

The Committee noted the differences in the scope of the 2022-23 audit requirement, which include:

- Trust financial reporting following the ending of Covid-19 emergency payments
- Changes to the General Ledger system and the move to NHS Shared Business Services
- Implementation of IRFS16
- The approach to value for money and the risks to financial sustainability and achieving a breakeven position

The Committee also noted an increase in external audit fees which reflects the current market position.

3. Internal Auditor Reports

The Committee received three final internal audit reports:

- NHS England Mandated Review: Healthcare Financial Management Association (HFMA) checklist - **Advisory assurance**
- ICT Project Management - **Substantial assurance**
- Payroll - **Limited assurance**

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The audit of the Trust's self-assessment of financial management had two recommendations; to assign leads to the actions identified from the HFMA self-assessment; and to ensure the actions to address gaps in controls and assurances are SMART with monitoring arrangements put in place going forward. The Trust has accepted and addressed both recommendations. The Committee was told the self-assessment process had provided assurance that existing day to day processes are conducted properly and much of the work of the assessment is already routinely tested as part of existing internal audits.

The Committee welcomed the rating of substantial assurance for ICT project management and was told the two minor recommendations on updating governance structures and project planning documentation; and defining reporting requirements for projects at the project initiation stage will be addressed by the incoming Head of Digital Projects.

The Committee expressed concern over the limited assurance given to the Payroll review, which had identified actions in relation to the adequacy and effectiveness of key controls over the payroll system and identified ten recommendations of which six were medium level actions. The Committee noted the actions to address the recommendations and the timeframe for the improvements to be implemented by the end of March, and it plans to review progress in addressing the recommendations at its meeting in April.

The Committee heard the internal auditors are on track to complete the 2022-23 plan by the end of the financial year, with remaining fieldwork and audits already in progress. The Committee noted the plan would be amended to show the Employee Relations audit has been postponed and replaced with an audit of the Fit and Proper Persons policy.

4. Counter Fraud Quarterly Report

The Committee considered its regular report on completed and ongoing counter fraud investigations. The Committee noted current national campaigns for raising fraud awareness and Trust initiatives for introducing the counter fraud team to new starters and overseas students, as well as local counter fraud proactive exercises undertaken to prevent and detect fraud and bribery.

The Committee received and approved the updated Anti-Fraud and Anti-Bribery Policy which now align with new NHS requirements as set out by the NHS Counter Fraud Authority and provides further guidance for Trust staff on the recognition and reporting of fraud.

5. Procurement

The Committee considered the breaches and waivers report, noting:

- One breach reported in Q 2022/23.
- A small increase in the number of waivers from seven to eight, a lower number than usually reported and leaves the Trust in a good position for end of year.
- Contracts management team proactively working through contracts database to identify contracts in need of renewal prior to expiry.
- Contracts teams building in additional scrutiny around CIPs and business planning for next year.
- Team continues to share weekly list of breaches and waivers and engage with divisions on reducing frequency of use.

The Committee was also updated on the work to address the recommendations following the limited assurance final internal audit report for procurement. The Director of Procurement is following up with the auditors and will be updating the Committee on progress.

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6. Cybersecurity and Information Governance Update

The Committee received and noted the update for Q3 2022/23 which reported the following key points:

- Data Protection Impact Assessments for South West London have been completed.
- The Data security and protection toolkit baseline audit scope has been agreed. The audit commences at the end of January with an interim submission of evidence at the end of February.
- A cybersecurity awareness campaign took place in November to alert staff to the dangers of phishing emails.
- The team is engaging with internal auditors in readiness for the audits of cybersecurity and Trust shadow IT systems

7. Managing Conflicts of Interest: Update on Compliance

The Committee received and approved the Group-wide policy for managing conflicts of interests. The policy was also presented to the Epsom and St Helier University Hospitals NHS Trust Audit Committee.

The Committee noted that, as at the end of Q3 2022/23, compliance with the policy, in terms of declarations made by decision-making staff, stood at 49% of all decision makers. The Trust's ambition was to achieve 70% compliance by end of the financial year. Targeted communications and engagement with Trust decision makers will carry through the next quarter in support of that aim.

8. Audit Committee Effectiveness Review 2022/23

The Committee noted the plan for undertaking the annual review of Audit Committee effectiveness in 2022-23 and agreed the questions to be used to inform the review subject to further review by the GCCAO. The review provides Committee members the opportunity to respond on the effectiveness of the Committee and to consider how the Committee might enhance its effectiveness in 2023-24.

9. SWL-wide Internal Audit Tender

The Committee received an update on the outcome of the joint tender for procuring a common internal audit service across South West London. The tender panel was unable to reach a common position on the award of a common supplier, and as a result a decision was made to set aside the tender and make a direct award. Successful and unsuccessful bidders have now been notified. There will be a common supplier of internal audit across the Group from 2023/24, and this will also include Croydon Health Services NHS Trust. Each Trust will, appropriately, have its own internal audit plan tailored to the evaluation of each Trust's internal control environment and internal audit needs. Within this, opportunities for alignment and learning across the Group will be sought, as will opportunities for learning across the SWL and Surrey Heartlands Integrated Care Systems.

Recommendation

The Board is asked to note the report of the Committee's meeting held on 26 January 2023

Peter Kane
Audit Committee Chair, NED
March 2023

DRAFT

Meeting Title:	**Trust Board**		
Date:	2 March 2023	**Agenda No**	**4.2**
Report Title:	**Finance Committee Report**		
Lead Director/ Manager:	Stephen Collier, On behalf of Chair of the Finance Committee		
Report Author:	Stephen Collier, On behalf of 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 20 January 2023 and 17 February 2023.		
Recommendation:	The Board is requested to note the update.		
Supports			
Trust Strategic Objective:	Balance the books, invest in our future.		
CQC Theme:	Well Led		
NHS System Oversight Framework Theme:	Use of Resources		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A
Appendices:	N/A		

Finance Committee – January & February 2023

The Committee met on 20th January 2023 and on 17th February 2023 as a committee in common with Epsom & St Helier University Hospitals NHS Trust. This paper focuses on agenda items that relate to St George's. In addition to the regular items on strategic risks, operational performance and financial performance, the committee also considered papers on:

- Financial planning for 2023/24;
- Costing;
- Quarterly update from SWL Pathology;
- Procurement update
- Productivity update
- Financial Policies
- Workforce patterns
- Payments update
- Joint Bank

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. The January committee undertook a deep dive of Estates and Facilities, and the February committee focussed on Finance, IDT and Operational Risk. There is significant financial risk with the challenge of maintaining sustainability and efficiency. Estates risk is mainly focussed on the increased challenges relating to completion of capital projects within the financial year. Operational risk discussion focussed on the pressures of Emergency and Elective care at the site. Both Finance and IDT are moving to an integrated update on risk for both ESTH and SGH. 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 M10 financial performance in 2022/23. Discussions continued for the Group annual planning for 23/24.

- **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 ratings 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 the Green plan.

1.3 Activity Performance – the SGH COO noted the expected performance against activity trajectories in January, where Daycase/ Elective performance is behind target with target (at 94%

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 81.5% for January. The Committee noted the good performance compared to peers, while downstream ward capacity remains a challenge. The role of social services in helping support the discharge process was noted.

1.5 Diagnostics Performance – the SGH COO noted that 4.4% of patients were waiting longer than six weeks to have a diagnostic test in January against a national recovery target of 5%, with main challenges in Endoscopy. Cardiac MRI has returned to compliance.

1.6 Cancer Performance – the Trust continues to be challenged and is currently not meeting the cancer standards in both 14 day and 62 day performance. However the backlog of patients has reduced.

1.7 Referral to Treatment (RTT) Update – the performance against the RTT target was discussed, where the Trust works to reduce the number of long waiting patients above 52 weeks and 78 weeks, remaining on track to deliver year end targets.

1.8 Financial Performance – the Group Chief Financial Officer (GCFO) noted performance in M10 is £20.4m adverse to plan driven by CIP performance shortfall. He also outlined latest progress with the financial forecast.

He noted the cash balance as at 31st January 2023 was £30.9m, and that the capital position to date was an underspend of £4.5m, with total expenditure at £50.9m.

1.9 Planning 2023/24 – The GCFO introduced the paper on 2023/24 financial planning. The Committee discussed proposed financial deficit and any mitigations that could be used. The uncertainty about income levels in 23/24 was noted,

1.10 Costing Update – the GCFO noted the continued challenge of COVID costs in the most recent cost benchmarking exercise.

1.11 SWL Pathology Report – the GCFO noted the progress being made with the Laboratory Inventory Management System (LIMS).

1.12 Procurement update– the AD-SWLPP noted progress being made with CIP schemes for 2023/24

1.13 Productivity Update – the SGH DFS introduced the paper outlining the conclusions that can be drawn from external benchmarking on productivity for the Trust. The committee discussed some of the data quality issues and analysis that would be useful following on from this.

1.14 Financial Policies Update – the GCFO noted the latest position with Trust financial policies in January and brought the updated Anti-Fraud and Anti-Bribery policy that had been approved at Audit Committee for information.

1.15 Workforce Update – the GCFO outlined some of the reasons for the increase in WTE at the Trust and controls in place moving forward for WTE increases. The Committee members welcomed the clarity of the report

1.16 Payments update – the GCFO highlighted the actions that will be taken to improve BPPC performance at the Trust.

1.17 Proposed Joint Bank - Update – The GCFO introduced the update on a joint Bank and committee members welcomed the work that has been undertaken to get to this point and, on the basis of the assurance provided, supported full implementation of the joint bank.

2.0 Recommendation

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

Stephen Collier
Acting Finance Committee Chair,
March 2023

NHS
St George's University Hospitals
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	2 March 2023	**Agenda No**	**4.3**
Report Title:	**SGH Financial Performance M10 2022/23**		
Lead Director/ Manager:	Andrew Grimshaw, Group Chief Finance Officer		
Report Author:	Tom Shearer, SGUH Site Chief Finance Officer		
Presented for:	Update		
Executive Summary:	The Trust is reporting a deficit of £27.1m at the end of January, which is £20.4m adverse to plan. The shortfall is mainly due to CIP under-delivery.		
Recommendation:	The Trust Board notes the M10 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:	Finance Committee	**Date**	17 February 2023
Appendices:	N/A		

Trust Board (Public) 2nd March 2023
Month 10 Finance Report

Group CFO and SGH Site CFO

SGH
Summary metrics

Area	Key Issues	Current Month (YTD)	Previous Month (YTD)
Financial Position	The Trust is reporting a deficit of £27.1m at the end of January, which is £20.4m adverse to plan. The shortfall is mainly due to CIP under-delivery.	£20.4m Adv to Plan	£25.1m Adv to Plan
Income	Income is reported at £8.3m favourable to plan at Month 10. This is due to additional funding to cover COVID Testing and Vaccination costs.	£8.3m Fav to plan	£5.4m Fav to plan
Expenditure	Expenditure is reported at £28.7m adverse to plan at Month 10, mainly due to CIP under-delivery. There are also higher Medical premium temporary costs.	£28.7m Adv to plan	£21.0m Adv to plan
Cost Improvement Programme	CIPs are reported as £20.4m adverse to plan YTD in M10.	£20.4m Adv to plan	£15.6m Adv to plan
Capital	Capital expenditure of £46.4m has been incurred year to date. This is £4.5m less than the budget of £50.9m	£4.5m Fav to plan	£4.7m Fav to plan
Cash	At the end of Month 10, the Trust's cash balance was £30.9m. Cash resources are tightly managed and will continue to be monitored.	£30.9m £37.7m lower than Y/E	£38.6m £30.0m lower than Y/E

Month 10 Financial Performance

SGH

			Full Year Budget (£m)	M10 Budget (£m)	M10 Actual (£m)	M10 Variance (£m)	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)
Excluding ERF	Income	SLA Income	884.9	75.5	76.6	1.1	743.3	747.0	3.7
		Other Income	117.5	8.1	9.9	1.8	94.2	98.8	4.6
	Income Total		**1,002.5**	**83.6**	**86.5**	**2.9**	**837.5**	**845.8**	**8.3**
	Expenditure	Pay	(609.7)	(48.3)	(55.2)	(6.9)	(513.1)	(541.2)	(28.0)
		Non Pay	(347.8)	(28.1)	(28.9)	(0.9)	(296.2)	(296.9)	(0.7)
	Expenditure Total		**(957.5)**	**(76.3)**	**(84.1)**	**(7.8)**	**(809.4)**	**(838.1)**	**(28.7)**
	Post Ebitda		(71.1)	(5.4)	(5.4)	0.0	(54.4)	(54.4)	0.0
	Grand Total		**(26.1)**	**1.9**	**(3.0)**	**(4.8)**	**(26.3)**	**(46.7)**	**(20.4)**
ERF	**Income**		26.1	2.2	11.6	9.5	19.6	19.6	0.0
	Reported Position		**(0.0)**	**4.0**	**8.7**	**4.6**	**(6.7)**	**(27.1)**	**(20.4)**

Trust Overview

The in month reported position at **M10 is a £8.7m deficit, which is £4.6m favourable to plan. The YTD position is a £27.1m deficit, which is £20.4m adverse to plan**.

The Trust has received £19.6m of ERF income, which is on plan. The in month position includes ERF income relating to prior months.

Excluding ERF income and costs:

- **Income** is £8.3m above plan, due to additional funding to cover COVID Testing and Vaccination costs.
- **Pay** is £28.0m overspent mainly due to CIP under-delivery, with overspends also across Medical staff groups due to premium temporary costs.
- **Non-pay** is £0.7m overspent mainly due to higher drug spend and also in Corporate areas.

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Meeting Title:	**Trust Board**		
Date:	2 March 2023	**Agenda No**	**4.4**
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 Q3 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 Q3 2022/23, though there are a number of changes to actions to address gaps in control and mitigation which are referenced in the report. 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'.*** While there have been areas of progress in relation to the risk identified in SR4, the system-wide risks presented particularly by the financial challenges, as well as the devolution of specialised commissioning from April 2024 mean that the external environment continued to hold significant risks. For this reason, it is proposed to maintain the risk score for SR4 at a 12 (4c x 3l) and the assurance score maintained at 'good', recognising the scale of these challenges.		
	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 and assurance ratings from the relevant assuring committee o Note the progress in mitigating identified gaps in control and assurance o Note that a new BAF will be developed to align with the forthcoming Group Strategy.		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	Well led		
Single Oversight Framework Theme:	Quality of Care Leadership and Improvement Capability		

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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**	16.02.2023 17.02.2023 10.02.2023
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 Q3 2022/23		

Board Assurance Framework 2022/23

Trust Board
BAF Report – Q3 2022/23

Stephen Jones
Group Chief Corporate Affairs Officer

2 March 2023

Executive Summary

1. Purpose

This paper sets out the Board Assurance Framework as at Q3 2022/23, including the proposed risk scores and assurance ratings, as well as the actions being taken to address identified gaps in control and assurance. With the exception of Strategic Risk 4, which is reserved to the Board, the information set out for each strategic risk has been reviewed by the relevant Board Committee prior to presentation to the Board.

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 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 culture), 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 Q3 202223:

- **Risk scores:** There are seven extreme risks, one high risks and two moderate risks. There are no proposed changes to the headline risk scores at Q3 2022/23. The most recent changes to the strategic risk scores were made as follows:
    - Increase in the risk score for SR5 (financial sustainability) from 20 to 25 in July 2022 following review by the Finance Committee.
    - Reduction in the risk score for SR2 (clinical governance) from 12 to 8 in May 2022, following review by the Quality Committee.

- **Assurance ratings:** Six of the ten strategic risks currently have a 'good' assurance rating; three have a 'partial' assurance rating,, and one has a 'limited' assurance rating. The most recent changes to the assurance ratings were made as follows:
    - Reduction in the assurance rating for SR5 (financial sustainability) from 'partial' to 'limited' in July 2022, following review by the Finance Committee.

- **Target risk scores:** As at Q3 2022/23, the following target risk scores have been met for the year-end 2022/23: SR2 (clinical governance) – 8; SR7 (estates) – 16. While changes are possible by the time of the Q4 review, at the present time, it appears likely that the following target risk scores will not be met in the current year:
    - SR3 – Operational performance and ICT: Current Score 20 against a year-end target risk score of 16. This reflects current operational pressures and ongoing ICT risks.
    - SR5 – Financial sustainability: Current Score 25 against a year-end target risk score of 16. This reflects the scale of the financial challenge acing the Trust and wider system.
    - SR6 – Capital: Current Score 20 against a year-end target risk score of 16. This reflects the ongoing position in respect of limited capital availability.
    - SR8 – Culture: Current Score 16 against a year-end target risk score of 12. This reflects the ongoing work to address known challenges around culture.
    - SR9 – Workforce: Current Score 16 against a year-end target risk score of 12. This reflects the scale of the workforce challenges facing the Trust and the wider system.
    - SR10 – Research: Current Score 9 against a year-end target risk score of 6. This reflects the mitigations needed to reduce this risk further will not now be completed until December 2023.

Executive Summary

- **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.

4. Strategic Risk 4 (system working) - 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, particularly in the context of the ongoing uncertainties around the formation of Integrated Care Boards on a statutory basis and the uncertainties around the delegation of specialised commissioning.

Areas of progress:
- ICBs were established on a statutory basis in July 2022 providing greater clarity and certainty about the position of ICBs in the system and their legal position.
- There have been the appointments to key roles within the SWL ICB a
- The St George's, Epsom and St Helier University Hospitals and Health Group has developed during the year. A single Executive team is in place, with sites teams established for each of the three sites. A MoU governs the operation of the Group, supported by an information sharing agreement. A Group Operating Model is in place, and a number of key Board Committees have been operating as Committees-in-Common during 2022/23, with the Boards scheduled to commence meeting as a Group Board from the start of the new financial year.

Areas of challenge:
- The scale of the operational performance and financial challenges across the SWL system present significant challenges.
- A sustainability review has been commissioned to explore financial sustainability across SWL, which could have significant implications for the system as a whole.
- Specialised commissioning devolution will now commence in April 2024. Devolution brings both risks and opportunities for the Trust and wider Group.
- Opportunities for the Trust to pursue a more active role at Place in Wandsworth and Merton.

Recommended position: While there have been areas of progress in relation to the risk identified in SR4, the system-wide risks presented particularly by the financial challenges, as well as the devolution of specialised commissioning from April 2024 mean that the external environment continued to hold significant risks. For this reason, it is proposed to maintain the risk score for SR4 at a 12 (4c x 3l) and the assurance score maintained at 'good', recognising the scale of these challenges.

5. Recommendation:

- For Strategic Risk 4 (system working) which is reserved to the Board, the Board is asked to maintain the current risk score of 12, and the current assurance rating of 'good' at Q3 – no change.
- For the nine Strategic Risks assigned to Board Committees, the Board is asked to:
  - Agree the proposed risk scores and assurance ratings at Q3 – no change
  - Note the progress being made in mitigating identified gaps in control and assurance
  - Note that a new BAF will be developed to align with the forthcoming Group strategy.

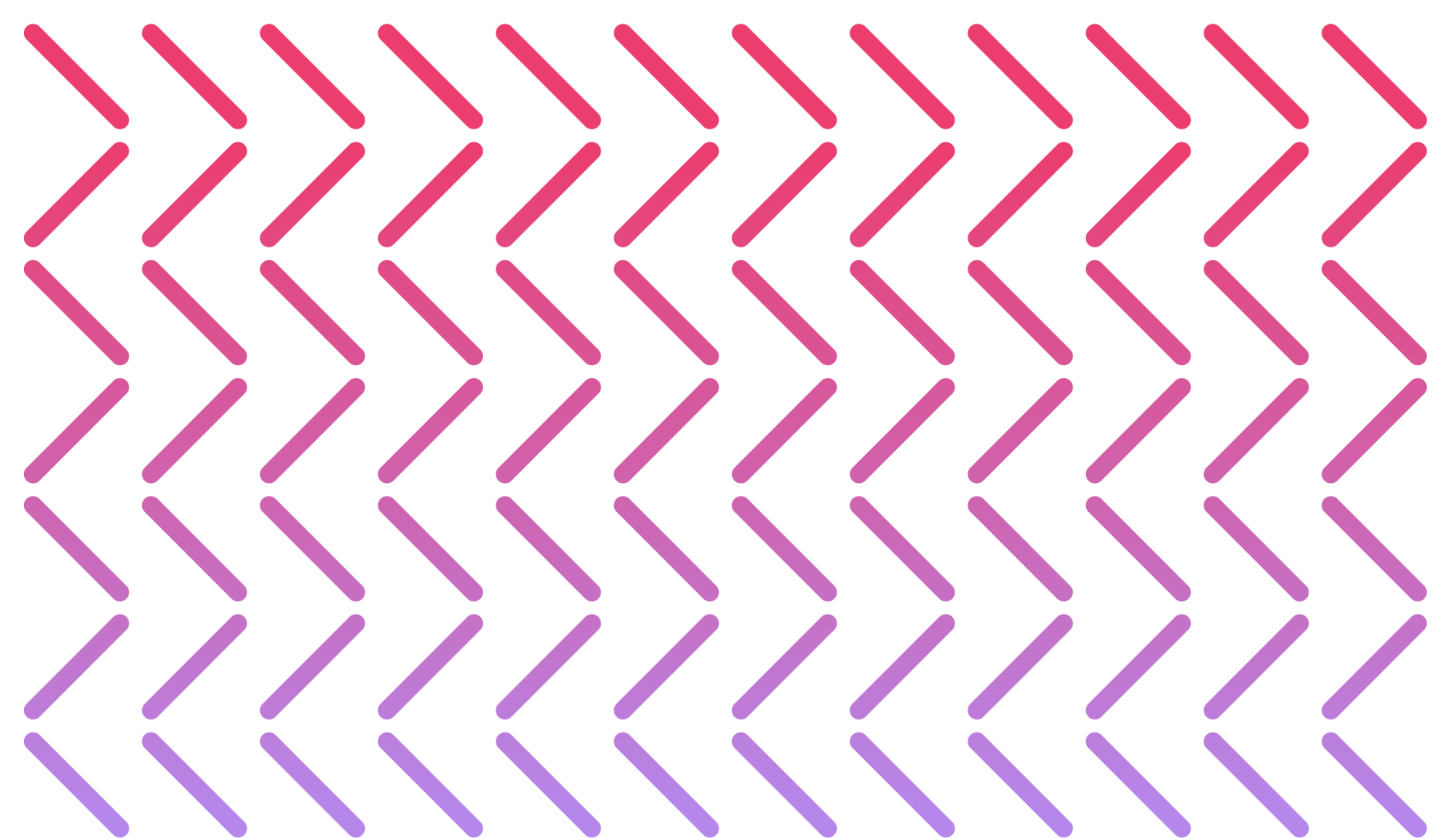
Strategic Risks: High Level Summary – Assurance Rating and Risk Score at Year End

Strategic Objective	Corporate Objective	Risk Reference	2021/22 Strategic Risks	ASSURANCE RATING		RISK RATING		TARGET RISK SCORES	
				Year start (April 2022)	Q3 position 2022/23	Year start (April 2022)	Q3 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	16 February 2023

Current risk and assurance assessment

Risk score:

The risk score remains at 16

Assurance rating:
The assurance rating remains at Partial.

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:

- Progress with the Quality Recovery Plan roll out in the Trust, looking at Quality, Patient Experience and Safety.
- Improvements have been made within the complaint process, 88% of complaints responded to within 25 days
- COVID-19 risks now reduced as we live with COVID
- Three MR scanners are in place and functional - which improves the compliance with the 7 Day Service standards
- Joint working with ESTH to share learning and best practice through SIDM, learning from deaths and maternity.

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	16(4c x4L)	Partial	⟷		
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
- Impact of any future pandemic 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
- Disconnect between divisional and corporate governance relating to pan-Divisional issues and how we ensure we embed learning across and between divisions and corporate functions.

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
- Cross site learning as part of the Group model

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	S		• Trust removed from Quality Special Measures in March 2020 following improvements documented in CQC inspection report published in Dec 2019 • Quarterly update reports to QSC re delivery against Quality and Safety Strategy year 2 implementation plan				X X	X
Serious Incident reporting and Investigation Policy including electronic incident reporting system (Datix) in place	S	S	S		• Weekly review of serious incidents at serious incident declaration meeting and monthly report to PSQG and QSC (Note the Trust is currently awaiting the new -Patient Safety Incident Reporting Framework) • Internal Audit report/internal management action plan: rated substantial assurance				X X	X X
Complaints Policy in place	G	G	S		• 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. 88% of complaints responded to within 25 day				X X X	X
Friends and Family Test – *SMS feedback method in place for virtual and face to face outpatient appointments* - Text messaging – SMS surveys for inpatient surveys setup. Ward display of FFT report 'You siad, we did'.	G	G	G		• Friends and Family Test: Monthly performance reports to QSC via IQPR				X	X
Infection Control Policy including Root Cause Analysis (RCA) for all C. Diff cases to ensure learning in place	S	S	S		• Infection control audit reports identifying emerging themes and improvement actions • Ward round monitoring to ascertain that infection control requirements are in place and followed and periods of increased Surveillance and Assessment (PISA)			X X	X X	
Early Warning Score training in place	G	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	R		• Report to PSQG,				X	
Sepsis tool live on iClip	R	R	R		• Sepsis tool on iClip in place			X		
COVID-19 measures: patient testing, masks, and facilities	G	G	S		• Covid testing carried out on admission; Masks wearing for in-patients; Emergency floor development increased number of single isolation facilities			XX		
Governance structure – new positions all recruited to	G	G	G		• TiAA Audit review			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	R		• February 2023 BLS 77.3%, ALS 71.1% and ILS 67.3%, Trajectory and action plans for compliance in all of the 3 domains above 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
Seven day clinical services standards (also see SR3)	**Implementation of Divisional action plans to achieve seven day clinical service standards compliance.** Reporting for 7 day services compliance has changed to reflect the framework published in Feb 2022 and is undertaken biannually. Hospital SITREP data shows a similar length of stay for admissions over 7 days, with no significant weekend disparity. Percentage of discharges occurring at the weekend are lower than weekday activity, this pattern for discharge activity is similar to regional and national benchmark data. Individual clinical areas showing variance are subject to deep dives and oversight by the hospital flow programme. The trust has increased weekend consultant presence across 7 specialties to improve performance against standard 2 and 8 (consultant review within 14 hours of admission, regular consultant review of high dependency patients). In the remaining 4 areas, a divisional review process has confirmed adequate mitigations for safety and hospital flow are in place and meet the requirements of the new standards. The trust is compliant with standard 5 (access to consultant delivered interventions) and to standard 8 except for 7-day equitable access to MRI scanning, which is currently available to a limited number of conditions. The new MRI scanner is now open giving 2 scanners running 7/7. Expansion of this service to all presentations depends on the recruitment of one additional member of staff - 1WTE radiographer to run 7/7 MRI across all pathways. This is being addressed in planning for 23/24.	~~Feb 2022~~ ~~Aug 2022~~ Aug 2023	
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 during 2023 although following 2 Wi-Fi failures in 2022, the timelines are being re-planned*	~~Dec 2021~~ ~~Dec 2022~~ Dec 2023	
Implementation of the new patient safety framework 'Patient Safety Incident Response Framework (PSIRF)'	Implementation of the Patient Safety Incident Response Framework (PSIRF) The Trust has set up fortnightly Group PSIRF Implementation meetings and monthly System checkpoint meetings in place to discuss and review readiness to begin implementation and actions to address associated challenges. A site implementation group is being set up. The Trust is developing an implementation plan on a page and an action plan. Recruitment for the Patient Safety Partners (PSPs) to commence in February 2023. Patient Safety Training e-learning module for all Trust staff (Level 1 – Essentials of patient safety) launched 2 February 2023, aim for completion by 31 May 2023. Assessment of resources for PSIRF implementation team being undertaken.	June 2023	

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	16 February 2023

Current risk and assurance assessment

Risk score:

It Risk score remains at 8

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 are proposed to the overall risk score or to the assurance rating.

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

During Q3 2022/23 the Trust has
The trust continue to make progress against the Clinical Governance Improvement programme.

M&M minimum dataset is rolled out in further care groups and all care groups now have minuted M&M learning outcomes

LfD process now well embedded across all groups and engagement in SJR process has improved, with additional reviewers including from nursing.

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	8 (4c x 2L)	Good	⟷		
Q4					

Emerging risks

- Impact of operational pressures on clinical governance meetings
- Lack of infrastructure to address pan-Divisional governance issues

Future opportunities

- IT developments to support new ways of working e.g. care group meetings and communication
- Review of the clinical governance lead role through the clinical governance leads group to support pan-Divisional governance and PSIRF implementation

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	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	G		• 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	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	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 • Consent lead identified to be MCA medical lead					XX	
MCA level 1 and level 2 training programme in place	R	R	R		• MCA level 1 and 2 training levels across all staff groups reported				X X	X X	
Electronic templates for the recording of Capacity Assessment and best interest decisions	G	G	S		• Electronic templates for the recording of Capacity Assessment launched on 2 November 2020				X		
Medical Examiner System in place	S	S	S		• Medical Examiner office reviewed all non-coronial inpatient deaths in May 2020					X	X
Mortality Monitoring OMP and Learning from Deaths lead in place	G	G	S		• Learning from Deaths report including SHMI and sources of individual mortality alerts e.g. NICOR					X	
eDischarge summary live on iClip	R	R	R		• Trust does not comply with NHSE Standard Contract for Discharge Summary. • Trust compliant with Professional Record Standards Body (PRSB)				X		X
Agreed methodology for Consent and Trust lead in place	R	R	G		• Bi-annual Consent audit included in Audit Committee agreed Clinical Audit Programme 2021/22				X	X	

Outstanding care every time

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**		

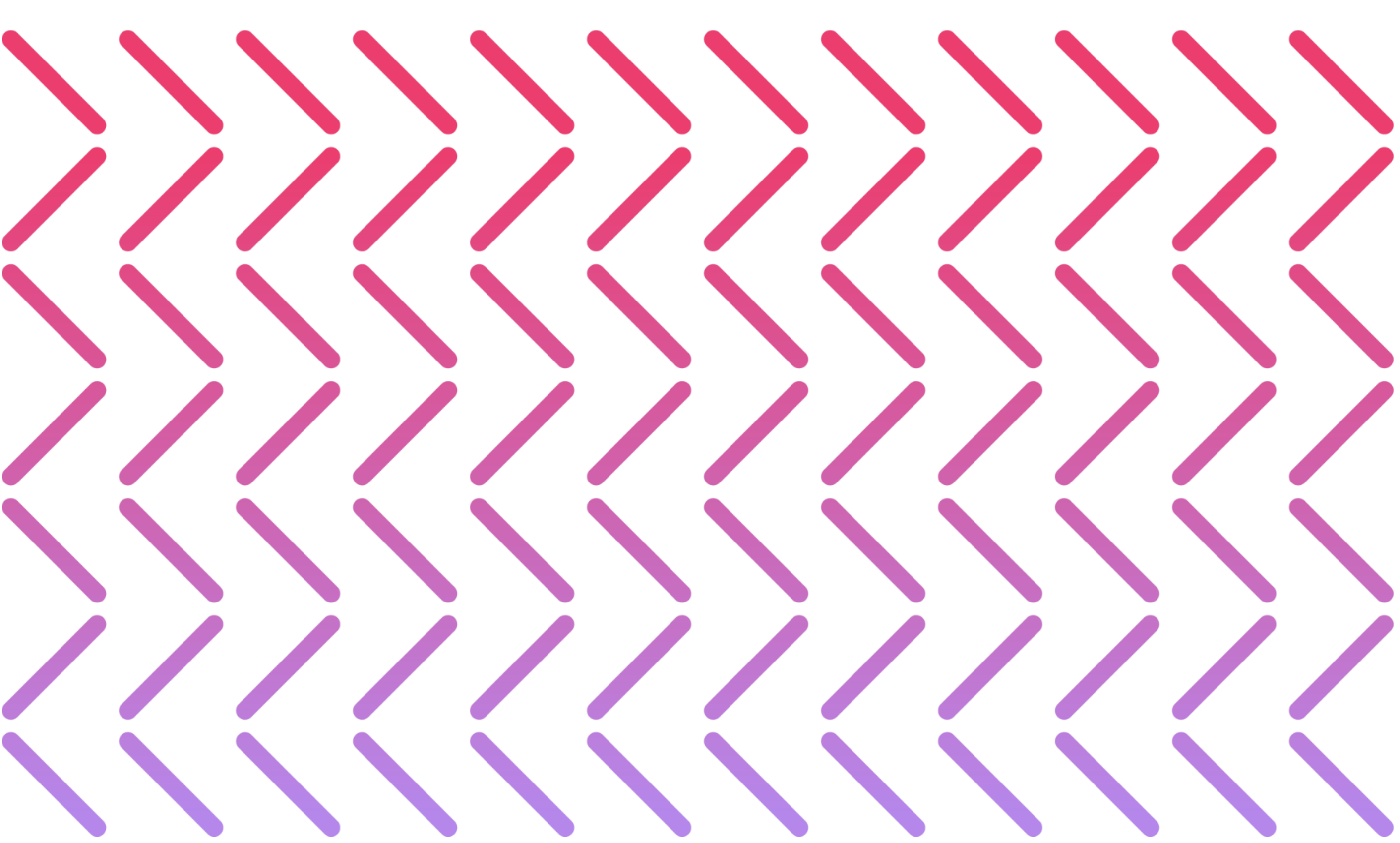
Gaps in controls and assurances	Actions to address gaps in controls and assurances	Complete by (date)	Progress
Full implementation of the Cardiac Surgery action plan to address all recommendations from the reviews	**Implement the Cardiac Surgery action plan** Medical staffing within CTICU out of hours has been addressed. *Currently we have two tiers of junior staffing both in-hours and out-of-hours (junior fellow or trainee and senior clinical fellow or trainee). We have a minimum of 1 senior level doctor/ 3 junior tier doctors per shift. The framework that judges which tier the junior staff are on are based on ICU competencies and not surgical competencies. These are based on recommendations by the faculty of intensive care medicine. To make sure our doctors are more comfortable with cardiac surgical patients we put them through a comprehensive induction programme, we invite all doctors on CALS courses (coordinated by Myrna Scott and Professor Madden), run in situ CALS sim, and have weekly teaching (junior, senior and journal club). The education programme includes bleeding management, pacing, management of specific types of surgery e.g. mitral valve surgery and cardiogenic shock. We also invite our junior staff to theatres to experience the intra-op environment. We have a number of echocardiography fellows (many approaching intermediate or advanced accreditation) who are often the first port of call when an urgent echo is required to aid diagnosis and management of patients. We have 2 consultants on during the day who will run 2 ward rounds per day and liaise any issues accordingly with the cardiac surgical consultant of the week. The on-call consultant will onsite in the evening and available for contact over the phone after they leave. They will usually call late in the evening to run through the patients on ICU. Out-of-hours the senior tier doctor will do a joint ward round with the surgical registrar/ senior fellow in the evening and will discuss any issues with the consultant on-call. If there are any issues which cannot be resolved with phone call advice the consultant on-call will come in. Our current staffing and seniority level currently meets the minimum standards outlined by the GPICS2 document.*	Completed	
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. Chempath LIMS go live Jan 23	Complete	
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	
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	
Strong process for the follow up and act on abnormal finding of diagnostic test	**Carry out GAP analysis for the follow up and act on abnormal finding of diagnostic tests.** Gap analysis commenced within Radiology department	30 Aug 2023	

Outstanding care every time

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

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

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



Strategic Objective	**Right care, right place, right time**			***Corporate Objectives 2022/23:***	**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	17 February 2023	

Current risk and assurance assessment

Risk score:

The 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 Q3 2022/23

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

During Q3 2022/23 the Trust has

Continued to schedule in accordance Priority 1 patients (and Priority 2 patients. We strive to treat patients with urgent clinical needs in a timely way.

The Regularising Flow Improvement Programme commenced with specific actions in QI namely RedtoGreen, early discharges, timely completion of D2A referrals.

Feb23: Failure of the Wi-Fi twice in 2022 has prompted a re-planning of the network replacement programme; VDI performance issues have emerged as user capacity has been exceeded and will require further investment

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	20(4c x 5L)	Partial	⟷		
Q4					

Emerging threats

Scheduling capacity
Onward care – ability to discharge patients has become even more problematic with increased delays and Length of Stay and Decision to Admit beds
Increase demand and acuity of admissions
Strike action – duration and impact unknown

Future opportunities

Additional focus and reframing of regularising 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.
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.
New 4 hour Emergency Care Operating Standards for ED which requiring 76% of patients being admitted

Strategic Objective	Right care, right place, right time					*Corporate Objectives 2022/23:*	Care	
SR3	**Our patients do not receive timely access to the care they need due to delays in treatment and the inability of our technology and transformation programmes to provide accessible care built around our patients' lives**							
Key risk controls in place	**Control effectiveness**				**Key sources of assurance**	**Lines of assurance (positive/ negative)**		
	Q1	**Q2**	**Q3**	**Q4**		**1**	**2**	**3**
Clinical Safety Strategy	S	S	S		Clinically driven plan agreed at Operational Management Group and approved at Quality and Safety Committee		X	
Insourced company to manage adult and paediatric ECHO. Lead paediatric cardiographer with accreditation in congenital heart disease to oversee the service and train more staff	P	R	S		Performance included in Integrated Quality and Performance Report (IQPR)	X	X	
ED rapid assessment and triage process in place	S	S	S		Clinical pathway and Standard Operating Procedure (SOP) SGHU ED is one of the highest performing trusts in London for the 4-hour. The Trust is expected to be fully compliant against the 76% standards	X		
Direct access pathways	S	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	R		Clinical Pathway, Memorandum of Understanding/ COMPACT, and local service performance metrics	X		
UCC direct pathways	S	S	S		Clinical Pathway and SOP	X		
Regularising flow	N/A	N/A	R		Weekly meeting - winter collaboration with NHSE	X	X	
UTC open	N/A	S	S		Performance will be monitored via ECDB	X		
Weekly elective access meetings for the delivery of RTT	N/A	N/A	S		Trust on track to deliver the reduction of patients waiting > 78 weeks to zero by 31 March 2023		X	
Luna system for monitoring RTT	N/A	S	S			X		

Strategic Objective	Right care, right place, right time					*Corporate Objectives 2022/23:*	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**
Digital strategy - ICT Work plan aligned to Digital strategy	R	R	R		Digital strategy aligned to clinical strategy and outpatient strategy			X	
VDI	S	S	P		VDI performance issues as user capacity exceeded so needs additional infrastructure			X	
Virtual clinics – video conferencing system with patients (Attend Anywhere) in use with supporting laptops, webcams and headsets installed; operational management by Corp OPD	R	R	R		Informatics Governance Group			X	
New workflow in iClip for Referral Assessment Service (RAS) clinics as part of Covid19 changes and rolled out to Trust as BAU	S	S	S		ICT Outpatient Project Steering Group and the Trust Communications news story published in Staff Bulletin 26 June 2020		X		
Provision of iCLIP clinic documentation for physical or virtual OPA available.	S	S	S		Trust Communications news story published in Staff Bulletin 26 June 2020		X		
Provision of Office365 and Microsoft Teams to support MDT cancer and orthopaedic meetings and further roll out in progress	S	S	S		ICT Covid-19 Service Management Report presented to IGG in April 2020 10,000 staff migrated to Office 365 with access to teams presented to IGG Oct 2020			X X	
Provision of MDT conferencing rooms	R	R	R		5 out of 6 completed		x		
Clinical Decision Outcome Form (CDOF) incorporated within iClip	P	P	P		eCDOF Tableau report showing operational non-compliance		XX		

Strategic Objective	**Right care, right place, right time**	***Corporate Objectives 2022/23:***	**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**
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~~ Dec 2023	
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. No funding secured for 22/23 to date. Improve back up resiliency further	~~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 and change of project manager	~~Apr 2022~~ ~~Dec 2022~~ Apr 2023	
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. Was scheduled to complete Nov 2022 but first phase delayed to Jan 23 due to technical issues and this pushes out the other phases.	~~Nov 2023~~ Apr 2033	
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 likely 2023/24 due to change in priorities for remainder of 22/23 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 circa Jul 2024 Funding to be secured for integration projects of smaller standalone systems e.g. Auditbase and Optimum	~~Sept 2022~~ ~~Dec 2023~~ Jul 2024	

Strategic Objective	Right care, right place, right time	Corporate Objectives 2022/23:	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; 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. Re-planning work following Wi-Fi incidents in 2022	~~Mar 2022~~ ~~Mar 2023~~ Dec 2023	
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, replanned around the ESTH shared domain	~~Mar 2023~~ Sept 2023	
Single view across all patient G&A flow	Steps to be taken on key metrics of flow: • Consistent use of Red to Green to aid discharge planning – work on-going • Regularising Flow – programme implemented • PTL – inpatient PTL accessible via Teams to have single view of beds • Work with Place to deliver onward care across pathway to expedite discharges and reduce length of stay / PoC to meet demand in different ways • Access meetings will have oversight of production planning - trajectories – development – delivery – PR management/access criteria - validation	~~Dec 2022~~ Sep 2023	
Emergency Department capacity	Expand sub-acute Hospital@Home to refer patients home from ED / AMU, 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. On-going Procure an electronic monitoring tool to view live data for the 4-hour performance Enhance front door frailty model with expanded capacity Regularising Flow –programme implemented UTC opened with additional capacity and capability to take patients directly from ambulances when UTC suitable	~~Dec 2022~~ Sep 2023	

<table>
<tr><td>Strategic Objective</td><td colspan="3">Right care, right place, right time</td><td colspan="3">Corporate Objectives 2022/23:</td><td colspan="2">Collaboration</td></tr>
<tr><td>SR4</td><td colspan="8">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</td></tr>
<tr><td rowspan="3">Risk Appetite / Tolerance</td><td rowspan="3">MODERATE</td><td rowspan="3">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.</td><td>Assurance Committee</td><td colspan="5">Trust Board</td></tr>
<tr><td>Executive Lead(s)</td><td colspan="5">Group Chief Executive Officer</td></tr>
<tr><td>Date last Reviewed</td><td colspan="5">3 November 2022</td></tr>
<tr><td rowspan="7">Current risk and assurance assessment</td><td colspan="2" rowspan="7"><u>Risk score:</u>

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

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

<u>Changes since last quarter:</u>
No changes to risk scores or assurance ratings proposed at Q3.

<u>Gaps in control and assurance addressed year-to-date:</u>
• ICBs were established on a statutory basis in July 2022 providing greater clarity and certainty about the position of ICBs in the system.
• There have been the appointments to key roles within the SWL ICB a
• The St George’s, Epsom and St Helier University Hospitals and Health Group has developed during the year.

<u>Areas of challenge:</u>
• The scale of the operational performance and financial challenges across the SWL system present significant challenges.
• A sustainability review has been commissioned to explore financial sustainability across SWL, which could have significant implications for the system as a whole.
• Specialised commissioning devolution will now commence in April 2024. Devolution brings both risks and opportunities for the Trust and wider Group.
• Opportunities for the Trust to pursue a more active role at Place in Wandsworth and Merton.</td><td rowspan="5">Overall SR Rating – Quarterly Scores</td><td>Period 2022/ 2023</td><td>Risk Score</td><td>Assurance Strength</td><td>Change (last reporting period)</td><td>Inherent Risk Score</td><td>Target Risk Score For 21/22</td></tr>
<tr><td>Q1</td><td>12(4C x3L)</td><td>Good</td><td>↔</td><td rowspan="4">16 = 4(C) x 4(L)</td><td rowspan="4">12= 4(C)x3(L)</td></tr>
<tr><td>Q2</td><td>12(4Cx3L)</td><td>Good</td><td>↔</td></tr>
<tr><td>Q3</td><td>12(4Cx3L)</td><td>Good</td><td>↔</td></tr>
<tr><td>Q4</td><td></td><td></td><td></td></tr>
<tr><td colspan="2">Emerging risks</td><td colspan="4">Future opportunities</td></tr>
<tr><td colspan="2">• System-wide financial pressures impacting on transformation opportunities

• Potential implications of the new SWL financial sustainability review</td><td colspan="4">• Opportunities that flow from the SWL financial sustainability review.

• 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</td></tr>
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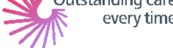


Strategic Objective	Right care, right place, right time	*Corporate Objectives 2022/23:*	Collaboration
SR4	**As part of our local Integrated Care System, we fail to deliver the fundamental changes necessary to transform and integrate services for patients in South West London**		

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

Strategic Objective	Right care, right place, right time	*Corporate Objectives 2022/23:*	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
Scale of financial challenge in SWL.	Engagement with the recently commissioned SWL financial sustainability review and implementation across the SWL system of recommendations accepted following the review.	TBC	
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 ahead of the devolution of specialised commissioning from the revised date of April 2024.	April 2024	

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	17 February 2023

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 Q3 2022/23

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

The Trusts financial plan was agreed as breakeven. However, with the overall scale of the CIP needed to reach breakeven meant delivery of breakeven was always seen as unlikely. Across the year the Trust has reported a firm risk to that breakeven position. This was reported monthly to the Finance Committee and to SWL. At month 10 a formal request to vary the forecast to £30m adverse has been submitted through SWL.

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	25(5c x 5L)	Partial	⟷	25= 5(c) x 5(L)	12 4(c) x 3(L)
Q2	25(5c x 5L)	Partial	⟷		
Q3	25(5c x 5L)	Partial	⟷		
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.
- SWL financial sustainability review

Future opportunities

- Financial improvement/mitigation through further collaboration within the SWL ICS
- Addition actions to be considered and approved through site and group meetings.
- SWL financial sustainability review

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	- Further work required to ensure full benefit realised from SWL working.	Apr 23	
Large value of unidentified CIP	- Recovery meetings in place to identify and drive improvement - CIP half day sessions for idea generation planned.	Mar 23	
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	Mar 23	
Current forecast predicts material risk against current levels of funding	- Recovery meetings to focus on control and improvement - Issues to be raised through SWL ICS to NHSE 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	17 February 2023

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:

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.

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 For 2022/23
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	20(4c x 5L)	Partial	⟷		
Q4					

Emerging risks

- Inflationary pressures causing cost risk to projects
- Supply chain issues are pushing prices of goods up
- Further risk is emerging in relation to the ability to spend capital due to global supply chain issues

Future opportunities

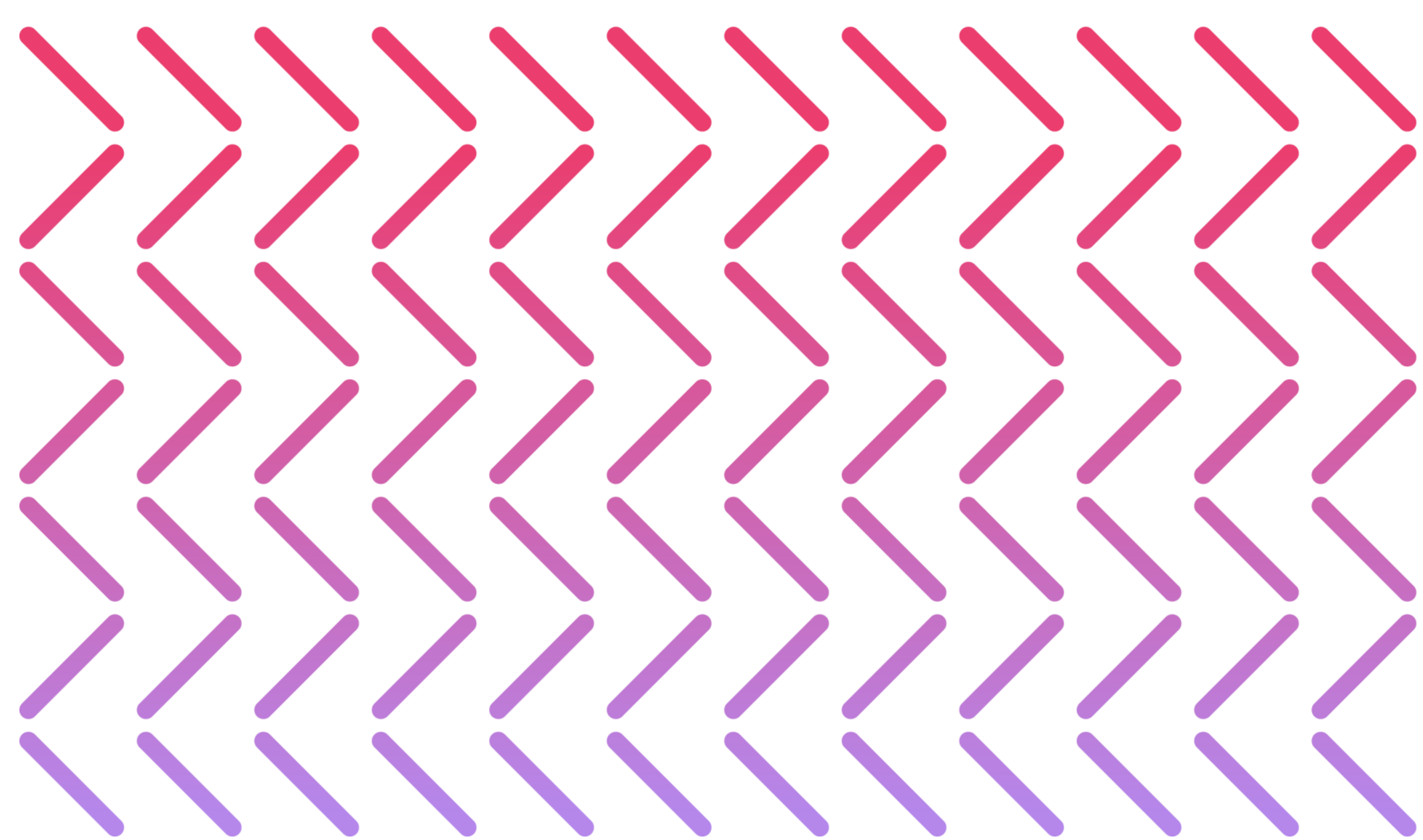
- Emergency capital funding made available from NHSE/I
- Further prioritisation within SWL to move money to address material and urgent risk at St George's.

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 Objectives 2022/23:	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	20 January 2023

Current risk and assurance assessment

Risk score:

The risk score remains at 16.

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 Q3 2022/23

Gaps in control and assurance addressed during Q3 2022/23:

Progress during Q3 2022/23
We have completed our procurement exercise to source a cloud based 'always live' tool to compile our Premises Assurance Model data. This tool will provide immediate dashboard reports on our assurance scores, store our evidence base in one place and provide action tracking for any gaps/risks as an audit tool.

The MRI building is now handed over and operational and a first draft of our HIP SOC is complete. However we continue to experience severe cost and resource issues in delivering capital projects.

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	16(4c x 4l)	Good	↔		
Q4					

Emerging risks	Future opportunities
• 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	• 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 Objectives 2022/23:***	***Care***
SR7	**We are unable provide a safe environment for our patients and staff and to support the transformation of services due to the poor condition of our estates infrastructure**		

Key risk controls in place	Control effectiveness				Key sources of assurance	Lines of Assurance (positive / negative)			
	Q1	Q2	Q3	Q4		1	2	3	4
Risk adjusted backlog maintenance programme informed by Authorised Engineer reports and independent condition surveys	S	S	S		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
Investment profile provides plans to manage backlog maintenance investment	W	W	W		Longer term capital planning is still a concern with no indication of improved capital availability in the long term		X		
Governance systems in place to provide oversight on critical estates issues	P	S	S		Our 21/22 PAM submission has shown a marked improvement in our performance, this will be enhanced by bringing in an online management system			X	
Estate Assurance Group reviews all key assurance and activities	S	S	P		The Group meets regularly to review key assurance activities, but flow / industrial action is dominating resources and assurance activities need wider Trust input		X X		X
Green Plan	S	S	S		A formal launch of our green plan delivery strategy is being planned for March 23		X	X	
Estates Strategy	S	S	S		Estates strategy approved. A first draft of our strategic business case is being reviewed and will be complete by the end of the financial year		X		X

Strategic Objective	Build a better St George's	*Corporate Objectives 2022/23:*	Care
SR7	**We are unable provide a safe environment for our patients and staff and to support the transformation of services due to the poor condition of our estates infrastructure**		

Gaps in controls and assurances	Actions to address gaps in controls and assurances	Complete by (date)	Progress
No centralised data management system in place to ensure all required information is available and coordinated	We have now completed procurement exercises for ERIC and PAM systems and have sought financial approval to proceed over the next 3-6 months	Dec 2022	
Estates restructure	We have completed the first phase of the restructure by moving assurance activities to the Health and Safety team. We have completed a first draft of the business case of the second phase of restructures as planned and will be submitting in Q4	Mar 2023	

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 Objectives 2022/23:*	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	10 February 2023

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 Q3 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 Q3 2022/23

Gaps in control and assurance addressed year-to-date:
During Q3 22/23 the risk has been mitigated by the completion of a number of identified gaps in controls:

- Continuing Governance and reporting through the Culture, Equity and Inclusion Programme Board
- Delivery against the D&I action plan continues and is monitored via PMG
- Quarterly Pulse Survey has been implemented, and the results reported on via PMG
- Management Fundamentals toolkit was launched in Q2, which supports each point of the employee lifecycle, and continues with implementation in Q3
- The Head of Talent Management has commenced in role and is developing the Trust's Talent Management strategy
- The Trust Values were refreshed and the values based behaviours were launched, including guides, workshops and e-learning.

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	16 (4C x 4L)	Good	⟷		
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 Objectives 2022/23:***	**Culture**
SR8	**We fail to build an open and inclusive culture across the organisation which celebrates and embraces our diversity because our staff are not empowered to deliver to their best and do not feel safe to raise concerns**		

Key risk controls in place	Control effectiveness				Key sources of assurance	Lines of Assurance (positive /negative)		
	Q1	Q2	Q3	Q4		1	2	3
Workforce strategy in place and approved by the Trust Board	S	S	S		Workforce Strategy refreshed and approved by Trust Board.		X	
Culture change programme established with clear timelines for delivery. Trust Values and Behaviours refreshed and rolled out	S	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		X	
Culture, Diversity and Inclusion Programme Board established	S	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	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	S		D&I Lead in post.	X	X	
Staff networks in place to support particular groups	R	R	S		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	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	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	S		Temporary additional resource in place, but further permanent resource through Deputy and Champions required.		X	
IT software package to record FTSU concerns	P	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	P		Approved by PMG and available on intranet.		X	
Leadership and Management Development Programmes in place	P	R	R		Kings Fund and Matron programme now in place.		X	
Board visibility through Board visits and Chairman and CEO monthly TeamTalks	P	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	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	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	S		Divisional OD plans will be developed and signed off by site divisional teams		X	

Strategic Objective	**Champion Team St George's**	***Corporate Objectives 2022/23:***	**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 delivered in Q3 in collaboration with the King's Fund. This is the first stage in the establishment of a wider overarching framework for leadership development in the Trust. Further communications planned for Management fundamentals training to increase completion.	~~Mar 2022~~ ~~May 2022~~ Mar 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 Q1 2023/24 based on new national policy framework published in late June 2022. FTSU Charter and Raising Concerns triangulation group to be launched in Q1 2023/24.	June 2023	
Produce Equality Delivery System (EDS2) report	The Trust is required to produce and publish a summary of our EDS2 implementation. Agreement was needed in respect of responsibilities for patient inequalities, which has now been reached and a Group approach will need to be taken, with a plan in place for end of the financial year.	Mar 2023	
Divisional OD plans	Divisional OD plans will be developed and signed off by site divisional teams. In Q3, high level plans for each division were developed that highlighted the Trust wide activities to ensure that the divisions are aware of these. OD leads provide quarterly high level updates to Divisional leads on local area OD work. In 2023, the divisional staff survey reports will be used to map division specific OD plans and these will be integrated with ongoing work and local priorities identified with HRBPs.	Mar 2023	

Strategic Objective	**Champion Team St George's**	***Corporate Objectives 2022/23:***	**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	10 February 2023

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 Q2 2022/23.

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

Gaps in control and assurance addressed year-to-date:
During Q3 2022/23 the risk has been mitigated by the completion of a number of identified gaps in controls:

- Beginning to develop our Group People Strategy that will focus on tension and creating a flexible workforce
- Our Workforce Improvement Programme for Recruitment continues to be reviewed and reported on regularly as part of our Workforce Improvement Steering Board, PMG and TMG
- Within Corporate Nursing, work has been initiated to review challenges with Nursing retention, and developing an organisational response to these
- The Head of Talent Management has commenced the discovery phase of their strategic planning and identified three main areas of focus; onboarding, employer brand and succession planning.
- Flexible working policies are being reviewed and will be updated in line with best practice and any legislative changes

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	16 (4c x 4L)	Partial	⟷		
Q4					

Emerging risks

- Staff remote working requirements and problems with IT infrastructure to support these flexible ways of working
- Scaling back of HEE funding
- Cost of Living pressures and the arising impact on staff
- Continuing industrial action, affecting staff and services, leading to burnt out and difficulties for staff achieving work life balance

Future opportunities

- Further collaboration with SWL ICS and the Acute Provider Collaborative
- Development of different roles
- Apprenticeships
- Developing our Group People Strategy that will focus on these issues

Strategic Objective	Champion Team St George's					*Corporate Objectives 2022/23:*	Culture		
SR9	We are unable to meet the changing needs of our patients and the wider system because we do not recruit, educate, develop and retain a modern and flexible workforce and build the leadership we need at all levels								
Key risk controls in place	Control effectiveness				Key sources of assurance	Lines of Assurance (positive / negative)			
	Q1	Q2	Q3	Q4		1	2	3	
Workforce Strategy in place and approved by the Trust Board (Nov 2019)	S	S	S		Refresh workforce strategy submitted to September WEC		X		
Workforce strategy implementation plan	S	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	S		Education strategy implementation progress report to People Committee		X		
Education implementation plan	S	S	S		Monthly Strategy group meeting to monitor progress with all key stakeholders		X		
Development of new roles (i.e. ACPs) to help fill the gaps in vacancies	S	S	S		Workforce report to PMG and WEC		X		
Advanced Clinical Practitioner Working Group established	R	S	S		Working group reports quarterly to PMG		X		
Recruitment open days for healthcare assistants and nursing now run by the Recruitment Hub.	S	S	S		Monthly Performance reports provided by the Recruitment hub		X	X (negative)	
Appraisal training sessions / ad hoc training in place	P	P	P		Training completion log in Education Centre booking system		X		
New compliant (section 1 update) contracts of employment templates on TRAC	S	S	S		New contract uploaded that is being issued to new starters (from 01/10/2020)	X			
Performance and Development Review (Appraisal) guidance reviewed and in place. Totara system upgraded	P	R	P		Appraisal completion monitoring via ESR, appraisal training available for all appraisers. PDR system transformation programme	X			
CPD funding system process	R	R	R		Funding established for NMAP staff. Progress review submitted to PMG and People Committee		X		
Apprenticeship Strategy being reviewed and developed	R	P	P		Apprenticeship plan reviewed and approved at PMG		X (negative)		
Disciplinary policy in place which includes 'Dido Harding' approach. Staff trained on the new approach to disciplinary cases	S	S	S		Policy in place and staff trained to support (completed Nov 2020)		X		
Flexible Working Policy/procedure implemented	S	S	P		On intranet, available to staff.		X		
Process to keep records for honorary contracts	S	S	S		New process established and list of honorary contract holders now reconciled with ESR	X			

Outstanding care every time

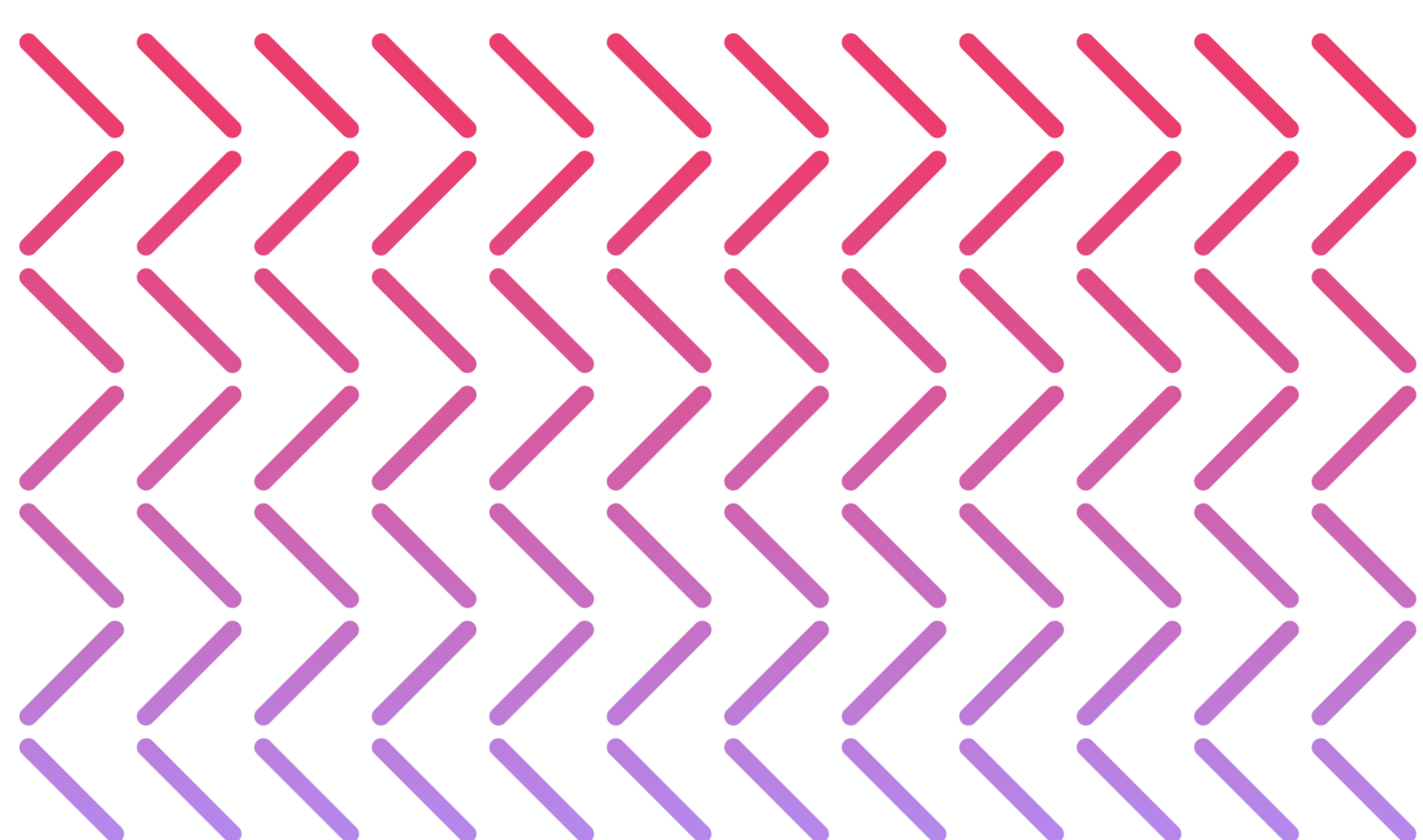
Strategic Objective	Champion Team St George's					*Corporate Objectives 2022/23:*	Culture		
SR9	**We are unable to meet the changing needs of our patients and the wider system because we do not recruit, educate, develop and retain a modern and flexible workforce and build the leadership we need at all 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	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	S		On intranet, available to staff			X	
Recruitment Workforce Improvement Plan in place for 2022/23	R	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	R		Actions/updates reported to PMG			X	
Application and recruitment process in place to apply for advanced practitioner MSc programmes.	NA	NA	S		Trainee advanced practitioner posts now approved by Trust lead for Advancing Practice.		X	X	

Strategic Objective	**Champion Team St George's**	***Corporate Objectives 2022/23:***	**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**
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. Application and recruitment process in place to apply for advanced practitioner MSc programmes. Trainee advanced practitioner posts now approved by Trust lead for Advancing Practice.	Complete	
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. Deputy CPO now in post and reviewing current governance arrangements in place for new roles and contributing to People Strategy for Group that will include the development of new roles	~~Sept 2021~~ ~~July 2022~~ Mar 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. TNAs will be undertaken on a divisional level, identifying core priorities to enable improvement in priority areas; leadership, talent management, inclusion, culture and civility. This work is now planned for March 2023 onwards.	~~Sept 2021~~ ~~May 2022~~ ~~Dec 2022~~ Mar 2023	
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. Funding has been allocated for the financial year, and expenditure continues to be monitored in line with agreed budgets.	~~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, with 3 priority areas now identified; onboarding, employer brand and succession planning. 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. If we can achieve compliance of 85% over 2/3 consecutive months, the RIS role will be expanded to Band 6 roles. Expansion to include other protected characteristics is pending survey results and engagement from BAME community.	~~Oct 2021~~ ~~Mar 2022~~ ~~Aug 2022~~ Mar 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. The Group has not been able to meet as originally intended, therefore the Terms of Reference for the Group will need further review with the new Deputy CPO.	~~Oct 2021~~ ~~Dec 2022~~ Mar 2023	

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	16 February 2023

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 in Q3 2022/23:
Two actions to address identified gaps in control and assurance were due for completion in Q3 2021/22 have been deferred for completion, the first to December 2023 and the second to October 2023. Appointing clinical academics is dependent on the Trust research strategy being fully funded on an ongoing basis – this is not yet confirmed and is being considered in the business planning process (there was support in principle at the Joint Strategic Board in December 2022). The set up of a research data warehouse is ongoing, with a planned timeline to establish a Trusted Research Environment (TRE) by October 2023.

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	9 (3c x 3L)	Good	⟷		
Q4					

Emerging risks

- Restrictions on funding/ investment to extend research activities, with consequent inability to exploit research opportunities in full

Future opportunities

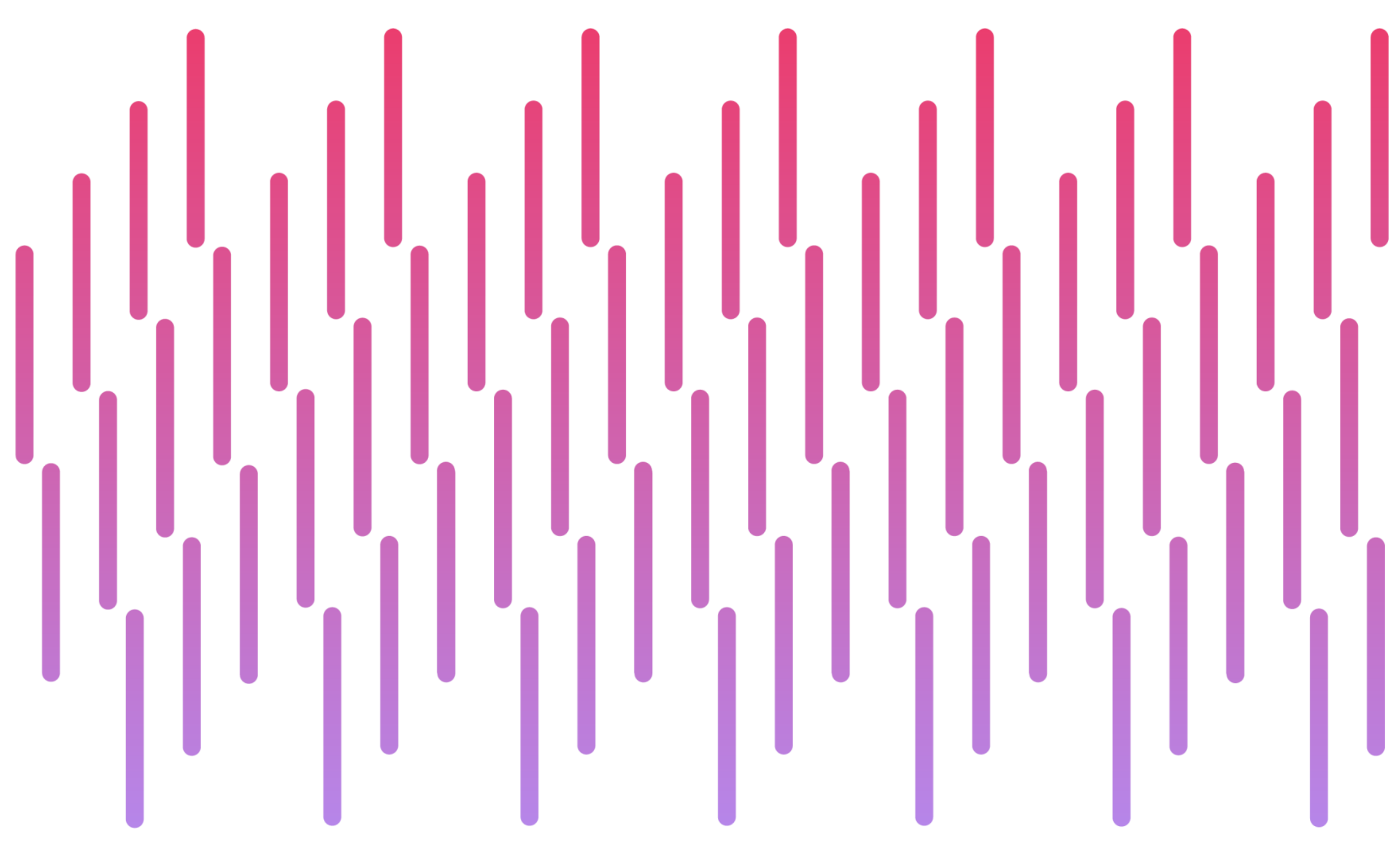
- National Institute for Health Research CRF capital funding call (January 2023) is an opportunity to seek capital investment following the award of the St George's NIHR CRF in 2022.
- Opportunity for a greater research leadership role in SW London / partnership with other Acute Provider Collaborative Trusts
- Build on current research activity/ studies profile
- 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	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	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	S		• Leadership positions in the Clinical Research Network - St George's CEO now chairs the CRN Partnership Board.		X	X
Implementation of process of horizon scanning clinical studies, including 'easy win' studies to balance portfolio against lower recruiting more intensive studies	S	S	S		• We have increased the numbers of patients recruited to clinical trials, which doubled over 3 years.	X	X	
Regular research resource and portfolio review meetings with research teams	S	S	S		• JRES holds regular meetings with research teams to review patient recruitment and troubleshoot any problems.	X		
Joint Research and Enterprise Services review and ratify (with researchers) all study targets and resources required	S	S	S		• There is annual target setting process for patient recruitment which is monitored and supported by JRES	X	X	X
Translational and Clinical Research Institute (TACRI) Steering Committee set up	S	S	S		• Steering Committee in place and reports to Patient Safety Quality Group and QSC	X	X	
Funding to implement 2019-24 research strategy approved for 2022/23 and under discussion for 2023/24	G	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	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 however ongoing investment is required to appoint clinical academic posts with the university (there was support in principle for this at the Joint Strategic Board in December 2022).	~~Dec 2021~~ ~~Dec 2022~~ Dec 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 Jan 2023
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 Update of the National Framework will mitigate this risk. 1 outstanding action in place and once completed we may be able to downgrade the risk.	Nov 2016	**12 (3x4)**	**9 (3x3)**
Infection control	CN2050	C Diff; MRSA; MSSA; E.Coli	Mar 2020	**12 (3x4)**	**8 (2x4)**
Learning from incidents	CN1166	Failure to learn from incidents	Nov 2016	**16 (4x4)**	**8 (4x2)**
Deteriorating patients	MD1527	Staff fail to recognise, escalate and respond appropriately to the signs of a deteriorating patient. This may happen because the Early Warning Score is inaccurately recorded or the escalation process is not applied correctly	Dec 2016	**16 (4x4)**	**8 (4x2)**
Learning from complaints	CN2009	Failure to learn from complaints	Dec 2019	**16 (4x2)**	**8 (4x2)**
Covid-19-Fit test	COVID-2106	Lack of fit test for FFP3 masks	Apr 2020	**12 (4x3)**	**Closed**

Operational risks linked to strategic risk 2

Risk short form title	CRR Ref	Description	Open Date	Inherent Score	Current Score Jan 2023
Strategic Risk 2	**We are unable to provide outstanding care as a result of weaknesses in our clinical governance**			20	12
Diagnostic findings	MD1526	Acting on diagnostic findings & Incidental findings	Jul 2016	**16 (4x4)**	**12 (4x3)**
Discharge	MD2052	Non-compliance with the eDischarge Summary Standard	Mar 2020	**16 (4x4)**	**12 (4x3)**
Patient Absconding	2482	Patient Absconding	Mar 2022	**16 (4x4)**	**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)**	**Closed**
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)**	**Closed**
Mental capacity Act	TBC	Decision-making within the Mental Capacity Act legal framework	Nov 2022	**20 (4x5)**	**16 (4x4)**
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. Pm-Divisional staff.	Sep 2019	**12 (4x3)**	**Closed**

Operational risks linked to strategic risk 3

Risk short form title	CRR Ref	Description	Open Date	Inherent Score	Current Score Jan 2023
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)**
Regularising flow	COO-2393	Risk of inadequate patient flow in the Trust (and across the health care system) for emergency admission Regularising flow – Place - onward	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)**
Breast Service RTT and Cancer	2421	Delivery of a sustainable Breast Service for RTT and Cancer demand	Feb 2022	**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)**
Elective cardiology waiting list	2240	Risk of long waiting patients for elective cardiology procedures	Apr 2021	**20 (4x5)**	**15 (3x5)**
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)**	**9 (3x3)**
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 Jan 2023
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	2132	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 Jan 2023
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	25
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)	25 (5x5)
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)	12 (4x3)
Identifying and delivering CIPs	CRR-1865	Risk that the Trust doesn't have sufficient capacity and capability to deliver CIPs at the level required to hit the financial plan.	Apr 2019	20 (5x4)	20 (5x4)
Future cash requirements are understood	CRR-1416	Risk that future cash requirements are not understood	Dec 2017	20 (5x4)	15 (5x3)
Manage commercial relation with non-NHS organisations	Fin-1856	Risk that the Trust does not have sufficient capacity, or skills to manage commercial relationships with non-NHS organisations procuring services from the Trust.	May 2019	12 (4x3)	12 (4x3)
Processes to manage cash and working capital	CRR-1417	Risk that the Trust does not have up to date processes to manage cash and working capital	Dec 2017	20 (5x4)	12 (4x3)
Understanding cost structures	Fin-1372	A risk that we do not understand our current cost and performance baseline and structures, or benchmark ourselves against others in this area to identify efficiencies and improvements.	Nov 2017	15 (5x3)	9 (3x3)
Maintaining a five year forward view	CRR-1413	The Trust has insufficient capacity to develop a five year long term financial plan that is aligned to an agreed clinical strategy.	Dec 2017	16 (4x4)	9 (3x3)
Maintaining an effective procurèrent environment	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 SWL	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)

Operational risks linked to strategic risk 6

Risk short form title	CRR Ref	Description	Open Date	Inherent Score	Current Score Jan 2023
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 Jan 2023
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
Estates infrastructure backlog maintenance	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)
Non-compliance with Electricity at Work Regulations and BS7671	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 (Legionella, Pseudomonas)	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 Jan 2023
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)
Senior Management Diversity	1967	lack of diversity in senior management roles across the protected characteristics impacts adversely on the ability of the Trust to recruit and retain a high quality and effective workforce	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)
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)

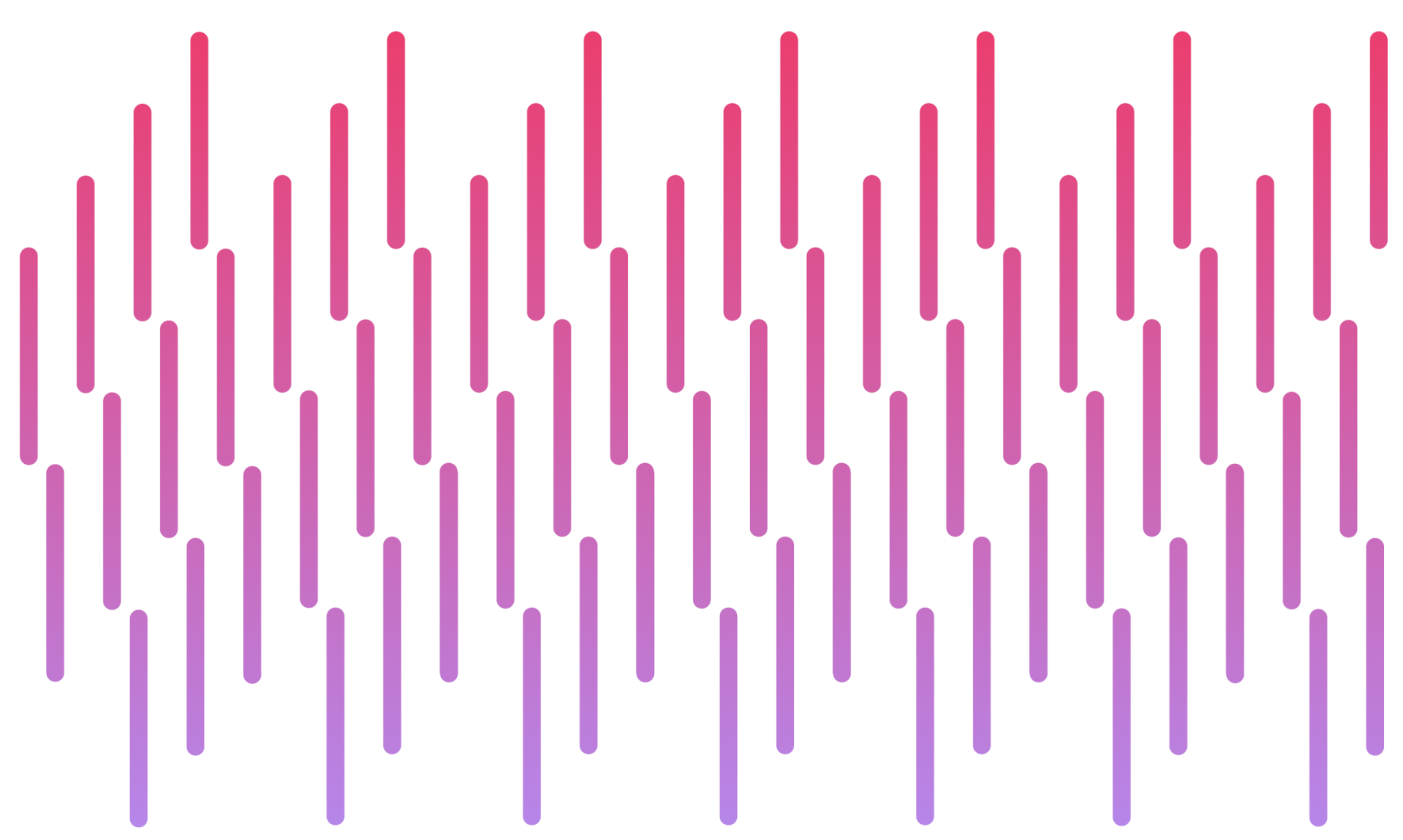
Operational risks linked to strategic risk 9

Risk short form title	CRR ID no.	Description	Open Date	Inherent Score	Current Score Jan 2023
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)**
Workforce Recruitment	2533	Due to national pressures in specialities, workload, demographics, work life balance post covid, competitiveness of NHS terms and conditions the Trust faces a challenge to recruit staff in sufficient numbers and skills	Nov 2022	**16 (4x4)**	**16 (4x4)**
Workforce retention	2534	Due to national pressures in specialities, workload, demographics, work life balance post covid, competitiveness of NHS terms and conditions the Trust faces a challenge in retaining the required workforce levels and skills	Nov 2022	**16 (4x4)**	**16 (4x4)**
Lack of Midwifery Staffing	2174	An insufficient number of registered staff to provide care in the antenatal intrapartum and postnatal period could lead to patient and staff harm, service delivery and maintaining standards	Nov 2020	**16 (4x4)**	**16 (4x4)**
Staff Appraisal Compliance	2530	The number of staff having their appraisal completed within the defined period may negatively impact staff retention and MAST training compliance	Oct 2022	**16 (4x4)**	**16 (4x4)**
Staff MAST compliance	882	Staff Mandatory and Statutory Training Compliance Low levels of engagement poses a risk to patient and staff safety and to regulatory compliance	Oct 2022	**16 (4x4)**	**TBC**
Staff Burnout	2531	Burnout and exhaustion among staff mean the Trust is unable to retain the workforce required	Oct 2022	**16 (4x4)**	**TBC**
Employee relations	2532	Due to staff shortage (sickness and vacancies) along with demands on the service which has become a one stop shop for all employment enquiries, the Employee relations service is not delivering the service to the Trust as envisaged	Oct 2022	**16 (4x4)**	**TBC**
Apprenticeship Levy	1036	By not recruiting enough staff on apprenticeships or support relevant training from monies raised by the Apprenticeship Levy on the Trust (£2.9million) the Trust may have to lose this money to central government and or transfer a portion to other organisations to support their training.	Oct 2022	**16 (4x4)**	**16 (4x4)**
Shortage of anaesthetic consultant	2344	Shortage of staff due to national shortages of specialists in Neuro & Obstetrics and cost of living in London	Nov 2021	**20 (4x5)**	**16 (4x4)**
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)**
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)	8 (4x2)

Operational risks linked to strategic risk 10

Risk short form title	CRR Ref	Description	Open Date	Inherent Score	Current Score Jan 2023
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



Scoring the Board Assurance Framework

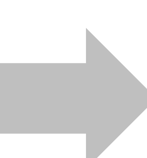
Risk Assessment and tracking of actions to address gaps in controls

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

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

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

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