Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Council of Governors Meeting
8 December 2021

Agenda and papers

St George's University Hospitals NHS Foundation Trust

Council of Governors Meeting

Date and Time: Wednesday, 8 December 2021, 14:30 – 17:00
Venue: Virtual - MS Teams

Time	Item	Subject	Lead	Action	Format
1.0	**OPENING ADMINISTRATION**				
14:30	**1.1**	**Welcome and Apologies**	Chairman	Note	Verbal
	1.2	**Declarations of Interest**	All	Assure	Verbal
	1.3	**Minutes of meeting held on 16 September 2021**	Chairman	Approve	Report
	1.4	**Action Log and Matters Arising**	All	Note	Report
14:35	**1.5**	**Chief Executive Officer's Report**	DCEO/CFO	Update	Report
2.0	**CARE**				
15:00	**2.1**	**Covid-19 Update and Winter Planning**	CN	Update	Report
15:30	**2.2**	**Learning from Covid-19: Team St George's**	CPO	Update	Report
3.0	**COLLABORATION**				
16:00	**3.1**	**Finance and Financial Planning Update**	DCEO/CFO	Update	Report
4.0	**MEMBERSHIP ENGAGEMENT**				
16:15	**4.1**	**MEC Membership and Chair Confirmation**	CCAO	Update	Report
16:20	**4.2**	**Membership Engagement Committee Report**	CCAO	Update	Report
5.0	**ACCOUNTABILITY**				
16:30	**5.1**	**Questions to Non-Executive Directors**	All	Assure	Verbal
6.0	**CLOSING ADMINISTRATION**				
16:55	**7.1**	**Any Other Business**	All	Note	Verbal
	7.2	**Reflections on meeting**		Note	Verbal
17:00	**CLOSE**				
Date and Time of Next Meeting: 9 February 2022, 14:00-17:00					

Council of Governors Meeting

Council of Governors Purpose:	The general duty of the Council of Governors and of each Governor 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 Those in Attendance		
Members	**Designation**	**Abbreviation**
Gillian Norton	Trust Chairman	Chairman
Nasir Akhtar	Public Governor, Merton	NA
Adil Akram	Public Governor, Wandsworth	AAk
Afzal Ashraf	Public Governor, Wandsworth	AAs
Mia Bayles	Public Governor, Rest of England	MB
Alfredo Benedicto	Appointed Governor, Merton Healthwatch	AB
Kathy Curtis	Appointed Governor, Kingston University	KC
Jenni Doman	Staff Governor, non-clinical	JD
Sandhya Drew	Public Governor, Rest of England	SD
Sarah Forester	Appointed Governor, Healthwatch Wandsworth	SF
John Hallmark	Public Governor, Wandsworth	JH
Hilary Harland	Public Governor, Merton	HH
Marlene Johnson	Staff Governor, Nursing & Midwifery	MJ
Shalu Kanal	Public Governor, Wandsworth	SK
Basheer Khan	Public Governor, Wandsworth	BK
Sarah McDermott	Appointed Governor, Wandsworth Council	SM
Richard Mycroft	Public Governor, South West Lambeth	RM
Tunde Odutoye	Staff Governor, Medical and Dental	TO
Sangeeta Patel	Appointed Governor, Merton & Wandsworth CCG	SP
Alex Quayle	Staff Governor, Allied Health Professionals	AQ
Stephen Sambrook	Public Governor, Rest of England	SS
Khaled Simmons	Public Governor, Merton	KS
In Attendance		
Ann Beasley	Non-Executive Director	AB
Robert Bleasdale	Acting Chief Nurse	ACN
Stephen Collier	Non-Executive Director	SC
Paul De Gama	Chief People Officer	CPO
Andrew Grimshaw	Deputy Chief Finance Officer	DCFO
Richard Jennings	Chief Medical Officer	CMO
Stephen Jones	Chief Corporate Affairs Officer	CCAO
Peter Kane	Non-Executive Director	PK
Parveen Kumar	Non-Executive Director	PK
Layo Ossai	Corporate Governance & Engagement Administrator (Minutes)	CGEA
Geoff Stokes	Head of Corporate Governance	HCG
Tim Wright	Non-Executive Director	TW
Apologies		
Padraig Belton	Public Governor, Rest of England	PBe
Patrick Burns	Public Governor, Merton	PBu
Ataul Qadir Tahir	Public Governor, Wandsworth	AQT
Quorum:	*The quorum for any meeting of the Committee shall be at least one third of the Governors present.*	

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Minutes of the Meeting of the Council of Governors (In Public)
16 September 2021, via Microsoft Teams

Name	Title	Initials
Members:		
Gillian Norton	Trust Chairman	Chairman
Nasir Akhtar	Public Governor, Merton	NA
Adil Akram	Public Governor, Wandsworth	AAk
Afzal Ashraf	Public Governor, Wandsworth	AA
Padraig Belton	Public Governor, Rest of England	PB
Alfredo Benedicto	Appointed Governor, Healthwatch Merton	AB
Kathy Curtis	Appointed Governor, Kingston University	KC
Jenni Doman	Staff Governor, Non-Clinical	JM
Sarah Forester	Appointed Governor, Healthwatch Wandsworth	SF
John Hallmark	Public Governor, Wandsworth	JH
Hilary Harland	Public Governor, Merton	HH
Marlene Johnson	Staff Governor, Nursing & Midwifery	MJ
Shalu Kanal	Public Governor, Wandsworth	SK
Basheer Khan	Public Governor, Wandsworth	BK
Sarah McDermott	Appointed Governor, Wandsworth Council	SMD
Richard Mycroft	Public Governor, South West Lambeth (Lead Governor)	RM
Stephen Sambrook	Public Governor, Rest of England	SS
Khaled Simmons	Public Governor, Merton	KS
Ataul Qadir Tahir	Public Governor, Wandsworth	AQT
Alex Quayle	Staff Governor, Allied Health Professionals	AQ
In Attendance:		
Elizabeth Bishop	Non-Executive Director	EB
Robert Bleasdale	Chief Nurse (item 2.4)	CN
Stephen Collier	Non-Executive Director	SC
Paul Cuttle	Grant Thornton, External Auditor Partner (item 2.5)	PC
Paul Dossett	Grant Thornton, External Auditor Partner (item 2.5)	PD
Jenny Higham	Non-Executive Director	JH
Parveen Kumar	Non-Executive Director	PK
Richard Jennings	Chief Medical Officer	CMO
Stephen Jones	Chief Corporate Affairs Officer	CCAO
Pui-Ling Li	Non-Executive Director	PLL
Ralph Michell	Head of Strategy	HoS
Layo Ossai	Corporate Governance and Engagement Administrator	CGEA
Jacqueline Totterdell	Chief Executive Officer (item 2.1)	CEO
Apologies:		
Mia Bayles	Public Governor, Rest of England	MB
Ann Beasley	Non-Executive Director	AB
Sandhya Drew	Public Governor, Rest of England	SD
Tunde Odutoye	Staff Governor, Medical & Dental	TO
Dr Sangeeta Patel	Appointed Governor, Merton & Wandsworth CCG	DSP

		Action
1.0	**OPENING ADMINISTRATION**	
1.1	**Welcome and Apologies** The Chairman welcomed everyone to the meeting and noted the apologies as set out above.	
1.2	**Declarations of Interest** There were no new declarations of interests reported.	
1.3	**Minutes of the meeting held on 14 July 2021** In relation to item 3.1.2 (green plan), KS requested that the minutes be amended to state that he had asked non-executive directors how they had considered the green plan to be ready for board approval given that it lacked specific targets and timescales and depended on the development of further plans. Subject to this amendment, the minutes of the meeting held on 14 July 2021 were approved as a true and accurate record.	
1.4	**Action Log and Matters Arising** The Council of Governors reviewed the action log, which contained only one action relating to holding a seminar for Governors on infection prevention and control. This had been held on 7 September 2021 and the Council agreed the action could, therefore, be closed.	
2.0	**QUALITY, SAFETY & PEOPLE, PERFORMANCE**	
2.1	**Chief Executive Officer's Report** The Council of Governors received a comprehensive report from the Chief Executive Officer and the following points were noted in discussion: • The Trust continued to face significant operational pressures throughout the summer months. The pressure on the emergency department had been particularly high as the number of daily attendances had returned to – and often exceeded – pre-Covid levels. Elective and day case performance was ahead of trajectory, as was outpatient activity. The number of 52-week waits had gone down to just over 1,000. The number of diagnostic patients seen outside of the six-week target had also been reduced. The role of the new surgical treatment centre at Queen Mary's Hospital had been an important element of reducing the backlog. • While the overall number of Covid-19 cases had been low in the early summer, cases had risen in late July and remained relatively high, but this had not translated into significant increases in Covid-19 admissions to the Trust. However, in recent weeks the number of Covid admissions to the Trust's intensive treatment units (ITU) had gone up and it was notable that the vast majority of Covid ITU admissions were patients who had not received a Covid-19 vaccination. • The Trust was continuing to work hard to ensure all staff were vaccinated though there remained challenges. It was anticipated that a Covid booster programme would commence over the coming weeks, and the Trust would be having a big push to promote staff take up.	

		Action
	• The Trust continued to implement and enforce Public Health England guidance on infection prevention and control, and continuously reviewed its processes to keep patients safe. There had, however, been Covid-19 outbreaks in two of the Trust's wards recently and investigations had shown that there were shortcomings in swabbing at day 0, day 3 and day 7 and remedial action had been taken. The Trust was also working hard to ensure staff took twice weekly lateral flow tests. • As part of the Trust's response to the 2020 NHS staff survey, five key areas for improvement had been agreed on, and this 'Big 5' had driven staff engagement and communications over recent months. In May, the Trust had held a health and wellbeing month which was focused on supporting staff. In June, the Big 5 theme was "Let's talk", which was all about helping staff to feel safe to raise concerns and promoting awareness of how to speak up. In July, the Trust had focused on flexible working, urging staff and line managers to adopt a flexible by default approach. Fairer career progression was the theme of the Big 5 in August, focusing on building a culture where progression was based on merit and hard work. The current focus was on "creating a better workplace", which was concentrating on giving staff the tools and equipment, they needed to do their jobs effectively. In relation to operational performance, NA asked whether the 52 week waits position had improved compared with 2019 and whether plans had been put in place to accommodate how busy the Trust would likely be during winter. The CEO explained that considerable improvements had been made in reducing the number of 52 week waits, and while the numbers remained higher than the Trust would wish it was making good progress and was performing well compared with other trusts. The CEO also explained that the Trust was in the process of developing its winter plan, and this would be brought to the Board for review in November. HH asked whether plans were in place to move staff who were not vaccinated out of frontline roles. She also asked whether the Trust was clear about the vaccine status of contractors such as Mite staff. The CN explained that risk assessments had been undertaken for all staff and infection control measures were in place to mitigate the risks. Staff working in higher risk areas were required to undertake regular PCR testing. Education for staff on the benefits of the vaccine was ongoing. Regarding the vaccine status of Mite staff, the CN stated that it was difficult to retrieve that information due to GDPR and the time/people resources required because they are not direct employees of the Trust. JD added that a system was being put in place to get assurance from all partners of the Trust on Covid risk assessments and infection control. In response to a question from JH regarding 24 Hours in A&E, which was filmed at the Trust, the CEO explained that the Trust was no longer going to host the filming of the documentary and this was expected to move to a hospital outside London. In relation to the revenue generated by the programme, the CCAO explained that this was quite modest overall, with the income going to the Emergency Department and some to supporting the Trust's communications team in working with the production company. **The Council of Governors noted the report.**	

		Action
2.2	**Integrated Care System Update** The Council of Governors received the Integrated Care System update and noted the following key points in discussion: • There had been a large volume of new guidance from NHS England and NHS Improvement on both the devolution of specialised commissioning and the composition of Integrated Care Boards over the summer. The South West London Integrated Care System had been closely reviewing the new guidance and was progressing plans for appointments to the ICB. • The plans for ICSs remained subject to the Parliamentary passage of the Health and Care Bill. The Bill was currently going through its Committee Stage in the House of Commons. Royal Assent was anticipated during Q4 2021/22. • The significance of the changes being introduced through the Bill and associated guidance should not be underestimated. The changes represented a major set of changes to the way in which the NHS functioned at the local, regional and national levels. There was discussion about the impact of the changes for the role of Councils of Governors of NHS Foundation Trusts in the light of the movement towards closer integration and system working. The Chairman emphasised that the Bill in its current form made no changes to the statutory role of NHS Foundation Trusts or to the role and functions of Councils of Governors. Nevertheless, there were clear implications in the move to greater system working for individual organisations' sovereignty and the scope for individual autonomy in the way envisaged in the original Foundation Trust model. The Chairman noted that regular updates on the development of ICSs would continue to be brought to the Council of Governors. **The Council of Governors noted the report**.	
2.3	**Integrated Quality and Performance Report (Patient Safety)** The Council of Governors received an update on quality and safety and noted the following key points in discussion: • Action was being taken to address areas of non-compliance with life support training. Basic Life Support Training had increased to 83% from 70% and it was anticipated that all staff who required BLS training would have undertaken this by the end of September 2021. ALS (Advanced Life Support) training performance shows improvement at 75% from 64%, and ILS (Intermediate Life Support) shows special cause variation, with performance at 70% from 67% for this month. Both ILS and ALS training were expected to hit their targets by December 2021. • All services apart from the Emergency Department achieved their Friends and Family Test (FFT) targets of having over 90% of their users rate their service as "Good" or "Very Good". • Significant improvement had been noted with Duty of Candour compliance. This continued to be monitored and support provided to the relevant departments to continually sustain compliance. There was a discussion about the size of the Integrated Quality and Performance Report and it was suggested that the paper could be made shorter and easier to understand. It	

		Action
	was noted that a piece of work was currently being led by the Deputy Chief Executive and Chief Finance Officer to review the IQPR. **The Council of Governors noted the report**.	
2.4	**Patient Experience and Complaints Annual Review** The Council of Governors received the annual review on patient experience and complaints and noted the following key points in discussion: • During the first phase of the pandemic NHS England and NHS Improvement had relaxed their requirements on trusts' compliance with complaints timescales, but the Trust had decided to continue to uphold the previous timescales given the importance of swift resolution of complaints to patients and their families. • The Complaints Annual Report and the Patients Experience Annual Report had been taken to the Board and would be published on the Trust's website. • The family liaison service would continue to run and would be reviewed for effectiveness. • A Children and Young People's Council had been established to engage children and young people about the standard and quality of their care. • The homelessness project within the emergency department was initiated to help the staff provide support for individuals who were homeless, help patients navigate the system and access housing. • The performance targets on complaints continued to be met and there had been a 40% decrease in reopened complaints. PB highlighted that it would be more difficult to get responses from the patients with disabilities and more thinking could be done on how to deal with this challenge. He further highlighted that the ability to respond could also be a factor in low response rates and suggested that the carers could be engaged for feedback at the right time, which was not usually at the hospital. He advised that engagement should be undertaken with community groups that could help or advise on how to get responses from this group. Regarding learning from complaints, KS asked whether the learning identified in the report indicated why staff were not able to perform to acceptable standards. The CN responded by saying it was complex and down to many factors centred around a mix of stretched staff and temporary staff who were not familiar with the culture of the organisation. He also highlighted that leadership programmes within the organisation were being organised on values and professional standards. JH queried how many young people were on the Children's and Young People's Council and how they were recruited. The CN explained that there were eight people on the Council and were recruited following submission of personal statements and interviews by peers. MJ added that the Trust was providing a lot of support to staff in helping to understand complaints, communication, and documentation. **The Council of Governors noted the report**.	

		Action
2.5	**External Auditors Report – Value for Money Report** The Council received an update on the external auditor's value for money report which had also been made available to the public ahead of the Annual Members' Meeting. The following key points were noted in discussion: • The requirement for a value for money report was new this year, and followed changes in guidance by the National Audit Office. The assessment was undertaken against a set of measures including financial sustainability, governance and improving economy, efficiency and effectiveness. • The Trust's value for money arrangements have been assessed across the three key criteria and no material issues were identified. • Improvement recommendations had been provided, and target dates set for implementing these recommendations. The Chairman highlighted that the report had been reviewed by the Audit Committee and would be presented to the Board. EB suggested that the report had the potential to be a key assurance document and management tool. However, it had limited utility this year but it was hoped that it would be developed for future years. Several typographical errors were highlighted in the report and External Auditors agreed to correct these and reissue the report. **The Council of Governors received the report.**	
3.0	**MEMBERSHIP, INVOLVEMENT AND ENGAGEMENT**	
3.1	**Membership Engagement Committee Report (*Including terms of reference review)*** The Council received the report of the Membership Engagement Committee and noted the following key points which were presented by the Committee Chair: • A virtual Governor Constituency engagement event had been held on 23 August but attendance had been very low. The Committee had agreed that the programme should be reviewed in the context of attendance at the Annual Members' Meeting. • The Committee had reviewed its terms of reference and was proposing minor changes around the quorum for meetings, simplifying this to require a minimum of four members, the majority of whom should be public Governors. **The Council of Governors noted the report and approved the changes to the Committee's terms of reference.**	
4.0	**ACCOUNTABILITY**	
4.1	**Questions to Non-Executive Directors** The Chairman invited questions from Governors to non-executive directors. RM asked about how the £1 million budget for the culture programme would be allocated and asked what the key outcomes were for the project. SC responded by saying the spend on the project was around £994,000 spread across internal resources and external delivery. He highlighted the detailed measures of success set out in the	

		Action
	Workforce and Education Committee meeting. He further added that around half of the sum would be allocated to the programme in external support, with the remainder allocated to fixed term contracts and internal roles. KS asked whether there was an opportunity to further embed safety within the organisational culture. PK responded by saying there had been improvements with learning from incidents and the Trust was committed to the creation of a safety culture. SC added that there was an opportunity with the Patient First initiative to tackle this issue on a broader scale. The Chairman noted that there had been significant progress but there was further to go. KS asked for the views of NEDs about the role of governors in relation to public accountability. The Chairman responded by saying it was advantageous to have governors who were able to convey the public's views and priorities and bring different perspectives. At the same time, it could be problematic where Governors went beyond the remit of their powers and responsibilities.	
5.0	**CLOSING ADMINISTRATION**	
5.1	**Any other business** The Chairman reminded Governors that they do not need to wait for formal meetings of the Council of Governors to raise issues with any of the NEDs. If anyone wanted to speak to her, the Chairman was more than happy to meet Governors outside the confines of a formal meeting. The Chairman also encouraged Governors to participate in the new programme of visits across the Trust.	
5.2	**Reflections on meeting** The Chairman commented that she felt the meeting had been productive and that there was a feeling of unity. She reminded everyone of the details of the next Council of Governors meeting. The Chair thanked Elizabeth Bishop for her contributions and wished her the best for the future. EB in turn thanked everyone for their cooperation during her tenure. The Chairman concluded by thanking everyone for their contributions.	

Date of next Meeting
8 December 2021, 14:00-17:00

Council of Governors Public Action Log - 8 December 2021						
Action Ref	**Section**	**Action**	**Due**	**Lead**	**Commentary**	**Status**
There are no open actions on the Council of Governors Action Log						

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NHS
St George's University Hospitals
NHS Foundation Trust

Chief Executive's Report to Council of Governors
8 December 2021

Jacqueline Totterdell
Group Chief Executive Officer

To be presented at meeting by:

Andrew Grimshaw
Deputy Chief Executive Officer

8 December 2021

Introduction

Purpose

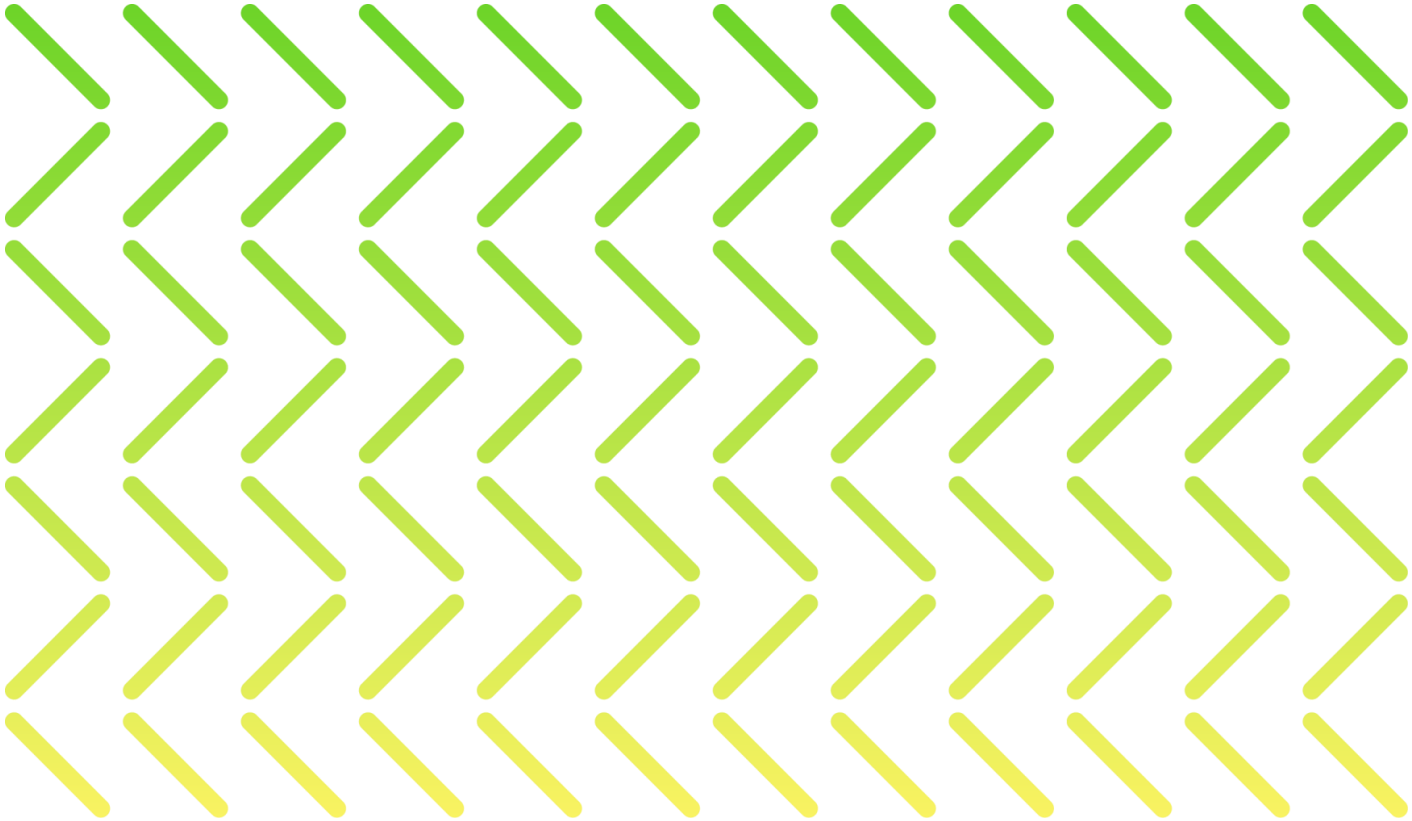
This report provides the Council of Governors with an update on key developments in the Trust and its wider external strategic and operating environment.

Recommendation

The Council is asked to receive and note the report.

CARE

Patients and staff feel cared for when accessing and providing high quality timely care at St Georges; in how the Trust starts to recovers from Covid-19 and in how we respond to any future wave



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Operational performance
Progress and pressures

- It has been two months since my last report to the Council of Governors and - like the rest of London - we are feeling some pressure across our Trust.
- We are however performing well in many areas. Less than 200 people are now waiting more than six weeks for routine diagnostics – just 2.3% of the waiting list compared with 24.6% this time last year. And we continue to manage ambulance hand overs in a timely way.
- But as the media reports, there is a great deal of pressure in the NHS - felt most keenly in our emergency pathways. The achievement against the four-hour standard in our Emergency Department (ED) is directly affected by patient flow through the hospital. We are working closely with our local health and social care partners to expand community capacity to support people at home, and ensure we discharge patients with ongoing needs in a timely way.
- Last month we worked with print and broadcast media to highlight the challenges we face, encourage take up of the Covid-19 vaccine, recognise the efforts of our staff and signpost people to alternatives to ED. I was pleased to see St George's featured on the front page of the Daily Express and on Channel 5 News.
- We know winter will be challenging as we respond to Covid-19, flu and children's respiratory viruses all while sustaining our elective recovery and supporting our tired teams. Our Winter Plan update to the Board last month set out the additional actions we have taken to maximise clinical capacity and support our NHS people through the coming months.

DAILY EXPRESS

CAMPAIGNING NEWSPAPER OF THE YEAR

OUR INDOMITABLE QUEEN

More rest for Her Majesty, but she WILL be at the Cenotaph

SPECIAL REPORT Anyone still hesitant about getting Covid jabs must read our graphic account of the daily battles faced by frontline health workers

STARK REALITY BEHIND 5.8M NHS BACKLOG

COMMENT

RICHARD JENNINGS

Chief Medical Officer, St George's Hospital

THERE has been no rest at St George's as staff deal with the very poorly and with Covid while ensuring routine surgery also takes place.

We are also looking after increasing numbers of Covid patients. Large numbers are unvaccinated and some end up in intensive care. They often regret not getting jabbed.

Many people who attend emergency have put off seeking help and are quite unwell. The NHS is here for you this winter, seek help as soon as you need it. If it's not an emergency, call NHS 111 or go online for advice.

If you attend A&E when it's not urgent you may well wait a long time. It's been a tough couple of years for NHS staff and I would like to thank them all.

I want to thank the Daily Express for visiting our hospital, speaking to staff and patients and hearing first-hand what it is like on the NHS frontline as we head into winter.

This paper took the time to hear from those working in our busy emergency department on the challenges of giving care to ever increasing numbers. Thanks also to readers who are getting jabbed and doing everything to keep well this winter.

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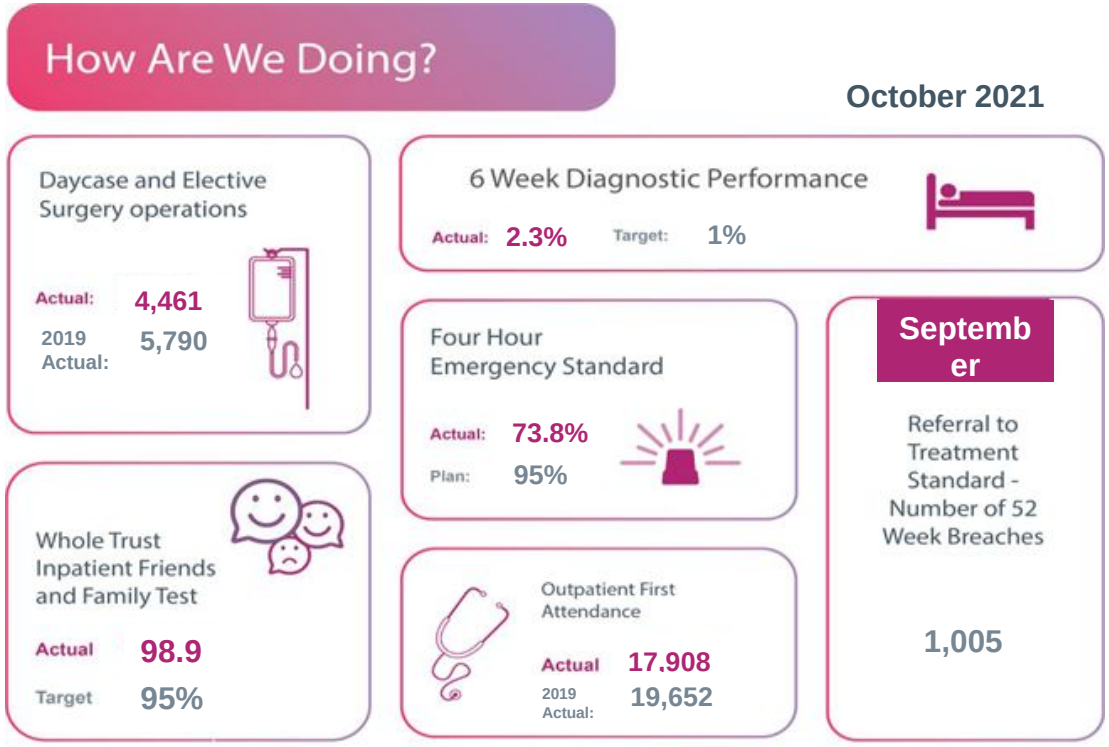
Operational performance
Surge and elective recovery

- **Four Hour Operating Standard**
  - 73.8% of patients either admitted, discharged or transferred within four hours of their arrival; the target is 95%
  - 52 patients breached the 12-hour ED target; no patient should wait longer than 12 hours before they are admitted to a ward.

- **September Cancer performance**
  - the Trust met the Cancer 31 Day Diagnosis to Treatment, 31-Day Second or subsequent Treatment (Drug), and the 31-Day Second or subsequent Treatment (Surgery) standards
  - 14 Day Performance was 80.4% decreasing from 81.3% reported in August
  - 62 Day Performance was 68.4% with a target of 85%

- **Six week diagnostic standard**
  - Improved to 2.3% from 3.2%
  - Capacity challenges remain in Cardiac MRI with 120 patients waiting more than 6 weeks.

- **Referral to Treatment for September:**
  - Waiting list has remained stable though the list has been growing slowly for the past six month
  - 1,005 patients have been waiting over 52 weeks since referral compared to the June plan number of 1,106.



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Operational performance
Winter Plan

The Council of Governors has a dedicated agenda item on the winter plan as part of its December meeting, but I wanted to draw out a few key points.

Our Plan for Winter 2021/22 aims to ensure that we continue to provide safe and timely care for all patients throughout this winter. During this year, we have sought feedback from teams, partners and patients about has what worked well in our pandemic response, and what we can improve as we continue to provide care to all our patients as well as treating COVID. This plan incorporates those lessons, in particular continuing to focus on our staff's health and well being.

We absolutely recognise the skill, professionalism and commitment that all of our staff continue to demonstrate, across emergency, cancer and elective pathways. Keeping our staff well and supported continues to be key and, in planning for this winter, we have invested in our workforce in key areas to minimise clinical risk and to reduce – as far as possible – the pressures felt by teams.

For this winter, we have looked at a 'most likely' scenario and developed a plan to help us deliver safe and timely care. We are not expecting to need to open as many ITU beds as last winter, which means less redeployment and more continuity for staff, and a better ability to continue with routine elective care for our patients. In line with GIRFT recommendations, we plan to do more elective care as day cases, to enable elective recovery to continue.

The plan describes how and when we will use our finite resources to gain the most from them, improving our internal processes to support staff in working smarter, not harder, and identifying specific areas where increases in demand are expected, such as a surge in children's respiratory conditions. In addition, our plans do not depend on repurposing our day surgery unit and endoscopy suites for COVID this winter. We have the benefit of our Elective Care Centre and Diagnostic Hub at QMH to protect our elective pathways, which have been running since this summer and we will take advantage of our strong partnership working in Merton and Wandsworth to develop a virtual frailty ward and MDT Transfer of Care hub to sustain flow, helping us to manage the clinical risk between patients arriving at the Emergency Department and patients ready for discharge on wards. These innovations will help us to make best use of our acute capacity to treat patients across all care pathways as we continue to focus on balancing the clinical risk across all these patient cohorts.

Patient safety, staff welfare and wellbeing are clear priorities for us in delivering this plan. The winter plan aims to keep us all protected from flu and COVID, with our flu vaccination programme's ambition to offer all frontline staff the flu vaccine, aiming for 95% of frontline staff being vaccinated by 1 December 2021; our COVID vaccination and booster programme, which continues in line with national guidelines. It also includes our winter planning, which sets out how we will manage services throughout this period – with patient safety and staff welfare as our top priorities.

We continue to be active partners in the Merton and Wandsworth and the South West London Integrated Care System Winter Plans in facing and responding to the unique challenges that this winter will bring, collaborating to best provide care to the patients we are here to serve.

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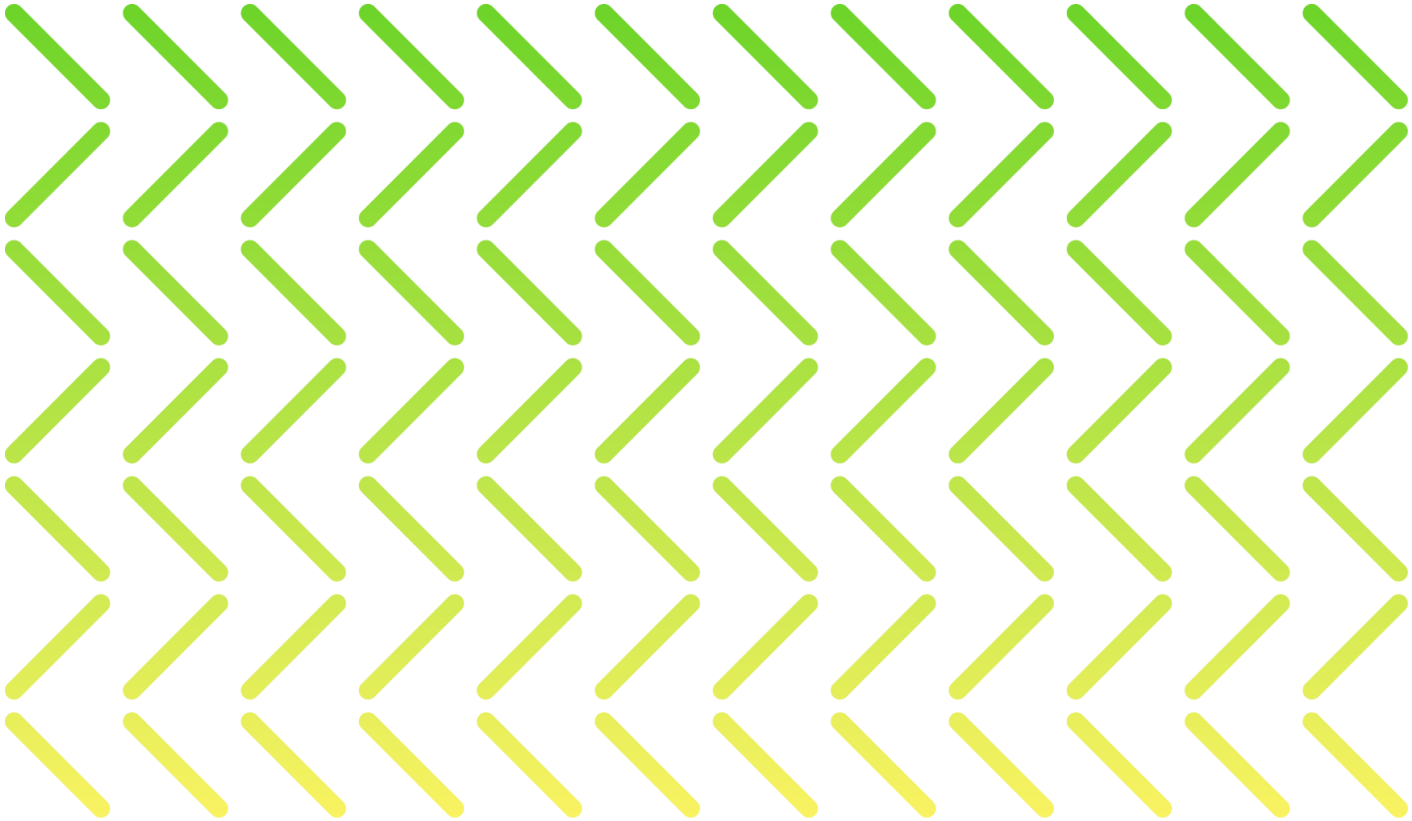
CULTURE

Transform our culture to create an inclusive, compassionate and enabling place to work where staff feel respected and understand their role in the delivery of high quality clinical care for our patients and service users.



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Corporate objectives 2021/22
Closer alignment and streamlining priorities

The Board approved an updated set of Corporate Objectives for the second half of 2021/22 at its meeting in September 2021. The new objectives remain grouped under the "3 Cs": Care, Culture and Collaboration. We have sought to reduce the number of objectives and provide greater focus on the key areas of focus. Staff have been asked to agree with their managers 3 objectives, from the Top 6 Corporate Objectives, to focus on and contribute to: one each from our Care, Culture and Collaboration themes. These are to be included in everyone's APDR (objectives) for the remainder of the year. This has the benefit of not being prescriptive, gives choice and lets individual members of staff and teams decide how best they can contribute to delivery of the chosen corporate objective.

Theme	**CARE**			**CULTURE**		**COLLABORATION**
Objective	**1**	**2**	**3**	**4**	**5 (old 6)**	**6 (old 9)**
Exec Lead	**CNO**	**COO**	**CMO**	**CPO**	**CPO**	**CFO**
Corporate Objective Description	**Improve patient safety by reducing avoidable harm in relation to:** **a) Learning from all local/ SWL nosocomial Covid cases** **b) TEPs agreed within 24 hours of admission** **c) Improving the practice of consent.** **d) Equality of access and outcome for BAME patients**	**Improve the clinical effectiveness and efficiency of all patient pathways.**	**Embed a quality, safety and learning culture through monthly patient safety, mortality and morbidity meetings for every speciality.**	**Deliver on our Health and Well Being (HWB) promises to all staff by investing in:** **a) Physical and mental health staff services** **b) Flexible working** **c) Well Being guardian appointment**	**Taking action on our culture to ensure we are more inclusive and diverse, where discrimination, violence and bullying is not tolerated – improving the experience of BAME staff in particular.**	**Make best use of our resources at St. Georges and across South West London ICS, for the benefit of patients and the welfare of our staff.**
Improvement Measures	• Reduction in the number of Covid nosocomial cases compared to 2020/21. • 90% of adult admissions have Treatment Escalation Plans (TEPs) agreed with a reduction in the number of cardiac arrests compared to 2020/21. • Improvement in consent audit performance compared to December 2020. • Identify areas of differential outcome for BAME patients and agree actions to improve within Maternity.	• Improved GIRFT performance for all specialities. • Delivery of 7 day clinical services (with CMO and CNO) • Deliver 4 hour A&E, cancer, RTT and diagnostics pathway trajectories. • Deliver agreed elective recovery trajectories. • Deliver Covid and winter plans in collaboration with APC and ICS partners. • Improve discharge planning and delivery to help maintain flow within the hospital.	• All specialities run, record and act upon learning (including Trust wide) from monthly patient safety, mortality and morbidity meetings. • Maintain SHMI at "below expected" level • Improvement in safety culture score compared to 2020/21.	• Deliver Covid and flu vaccination programme for all staff. • Appoint a HWB guardian. • HWB assessments for all staff completed and implemented. • Flexibility by default recommendations implemented. • Improvement in HWB staff survey score compared to 2020/21.	• Implement the priorities agreed in our Culture, Equity and Inclusion Programme plans. • Improvement in our engagement, diversity and inclusion staff survey scores compared to 2020/21. • Further improvement in representation of BAME staff and the local community in our leadership (Bands 7 and above).	• Implement the staff passport to promote best use of ICS/ APC capacity and staff expertise. • Support ESTH EPR replacement programme. • Financial balance achieved (Trust & SWL ICS) within the resource envelope agreed.

every time

Thank You George's
Thanking staff for their role during the pandemic

- The last two years has tested staff at St George's and taken a toll on families and our local communities. I am so proud of everyone who works at our Trust and who has kept going, putting patients and colleagues first, despite being tired and worn down. Their response continues to be phenomenal.

- To show our appreciation for everything staff have given throughout the pandemic, we started a three-month season of thanks on 1 October - 'Thank You George's'. Every member of staff has been given a £40 gift voucher to treat themselves, their families, or their colleagues. We ran a weeklong food festival where every member of staff was given a free hot meal and we have other great events planned, as well as a chance to learn, reflect, and share their experiences of responding to Covid-19.

- I'm pleased to report that Thank You George's has been a big hit with staff and we have received lots of emails and comments from colleagues who say they appreciate that all their hard work is being recognised.

- On 26 November, we sent out letters to local organisations, businesses and community groups who did so much to support and champion our staff throughout the pandemic. Whether donating food, helping us to spread vital information to our community, or volunteering to lend a hand– it has all made a huge difference during a difficult time. This story was picked up by some of our local media - spreading our message of thanks even further, which was fantastic to see!

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Thank You George's
Portraits to a life of dedication

Following the success of the outdoor exhibition Portraits to a Life of Dedication earlier this year, a new display featuring 132 portraits is now on show in the ground floor of Lanesborough Wing as part of Thank You George's. The photographs were taken by the Trust's very own Derek Francis, Assistant Legal Services Manager.

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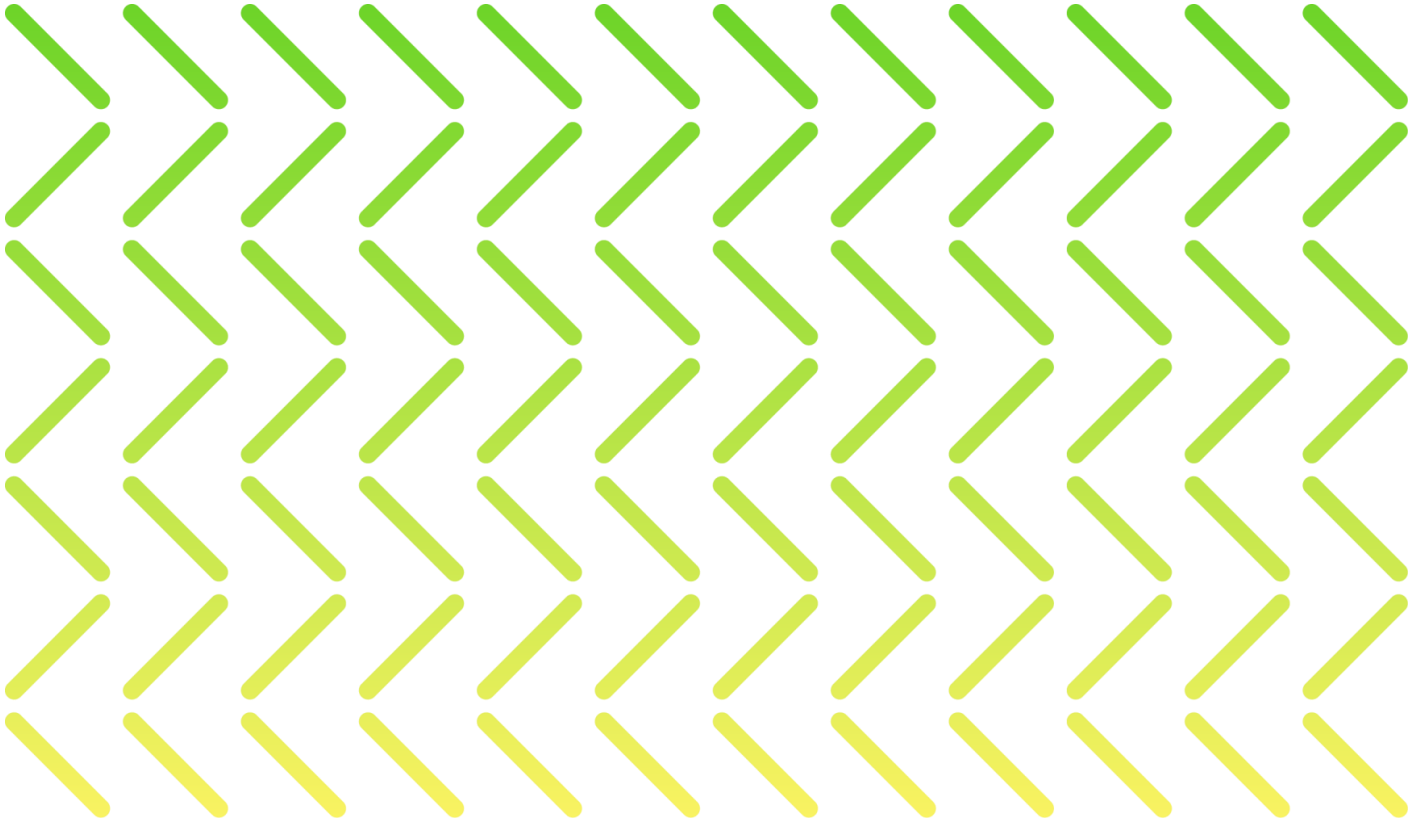
COLLABORATION

We will engender an ethos of collaborative working across our teams within St George's and with our system partners to achieve the best outcomes for patients, building on the spirit of collaboration developed internally and externally through Covid-19 response.



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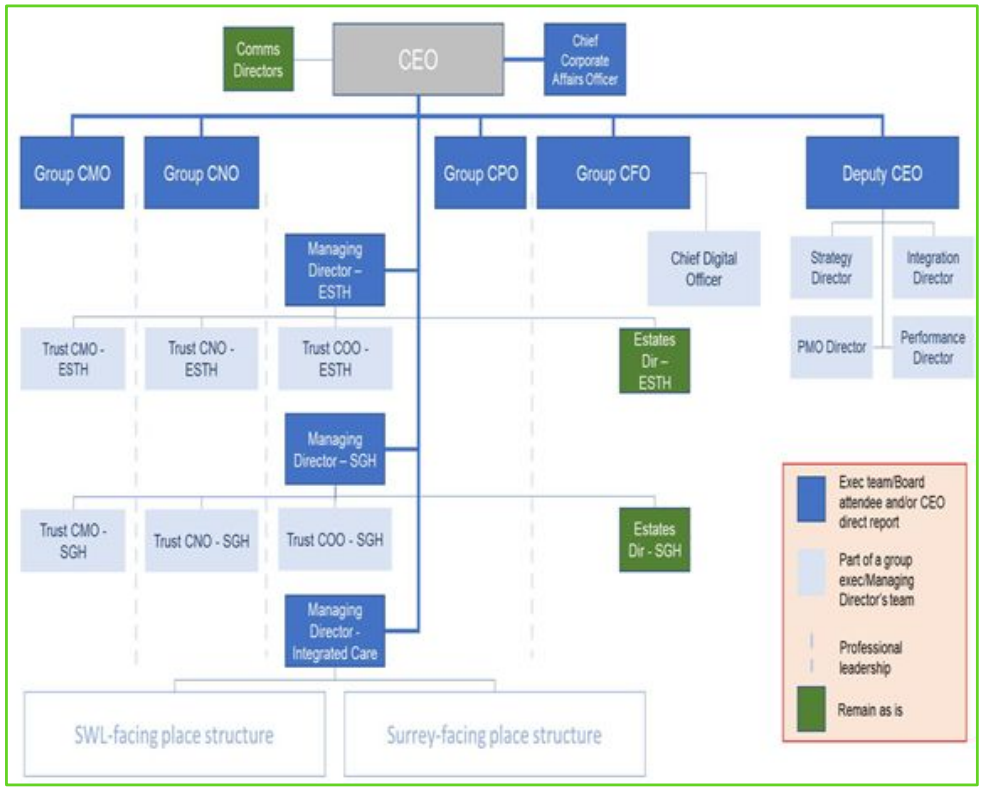
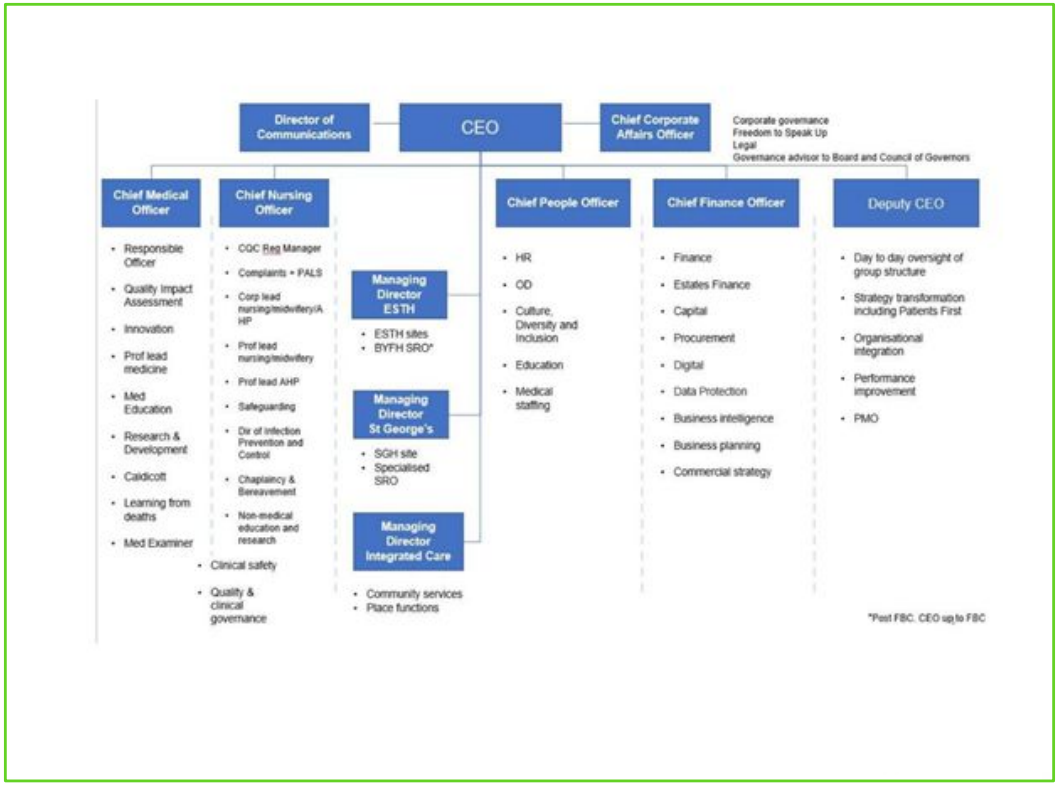
Developing our hospital group with Epsom and St Helier

New group executive structure

I have recently marked my 100th day as Group Chief Executive of St George's and Epsom and St Helier hospitals. Our hospitals are now formally working together to improve patient care, bolster our workforce and share our expertise. The next phase in us working together as a hospital group is to create a single executive team to provide leadership for both organisations as well as the operational management of our hospitals and community services. Following a consultation process, we finalised our new structure, which creates a number of group executive posts as well as site-based managing director and clinical roles. The diagram opposite explains what that will look like. My new blended executive team will be made up of directors across both hospitals and will reflect the wealth of knowledge, expertise and skills of both leadership teams. A transparent and competitive recruitment process has begun to appoint to these roles and I expect most directors will be in post by early January.





Development of the South West London Integrated Care System

Overview

St George's has shown throughout the pandemic that collaboration with our partners gives us the best outcomes for patients. This is evident in our sustained reduction in people waiting a long time for routine surgery, which is ahead of our plan, and SWL is an exemplar in London. Work continues to develop a new statutory Integrated Care System for SWL which will be made up of three parts: SWL ICS (South West London Integrated Care System) places; SWL ICS Provider Collaboratives; and SWL level ICS.

The Council of Governors has been briefed before that the South West London ICS is being put on a statutory footing from April 2022:

South West London Health & Care Partnership

An **Integrated Care Board (ICB)** will be established: a unitary board accountable for the NHS commissioning budget. Its members will be drawn from across the local NHS. It will be guided by an **Integrated Care Partnership,** drawing in a wider membership (including local authorities and stakeholders such as the voluntary sector). In South West London, it is expected that some of the ICS budget will be delegated to ICS Board subcommittees at 'place' or borough level (see below), and that in time some budget could be delegated to the Acute Provider Collaborative.

APC

Acute Provider Collaboratives are seen by NHSE/I as a core delivery vehicles for ICSs. It has been agreed that the Trust's CEO will be the lead chief executive for the SWL APC. Initially, it is expected that the ICS will commission individual acute providers separately – but in time the APC might receive a delegated budget to manage jointly.

At **'place' or borough level**, there will be formal arrangements for partnership working across NHS, local government and voluntary sector partners. The proposal from South West London has been that these partnership arrangements should be constituted as subcommittees of the SWL Integrated Care Board.

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Development of the South West London Integrated Care System

Recent developments

A wide range of guidance documents were published by NHSEI in the summer, which Council of Governors was briefed on at its last meeting on 16 September 2021.

Since then a number of listening events were hosted in September and October 2021 by Sarah Blow, Senior Responsible Officer, South West London Health and Care Partnership and Ian Thomas SWL ICS Local Authority lead, around developing the South West London Integrated Care Partnership and Place-based Partnerships. The listening events have concluded and are summarised below.

Summary of listening event themes:

- ICP membership needs to be small to be effective- having wider groups to discuss and agree on priorities and then a smaller ICP board to take it forward and ensure delivery. To enable a small membership, the ICP Board could create wider involvement by establishing specific task and finish groups or committees to ensure subject matter experts across the partnership could be involved in areas where they can make the biggest impact on outcomes. The ICP Board would then monitor progress against these priorities and demonstrate impact.
- The ICP must have a tight focus and also work transparently. There was agreement that the scope of the ICP should be limited to delivering a small number of priorities where partners can make a difference and not try and do everything. In creating the new structures, partners were keen to avoid duplication of multiple meetings to share information and work jointly
- The voice of people and communities needs to be central to all levels of the ICP's work.
- ICP priorities need to be built up from Place, recognising the importance and role of Health and Wellbeing Boards. Using Health and Wellbeing Board strategies and JSNAs to help set Place strategy and influence the priorities and scope of ICP.
- The primacy of Place and recognising that each is unique. Partners expressed that the ICP should exist to add value to Place, and the focus should be on getting Place to work well to help with discussions about the ICP. Therefore, flexibility is needed so existing Place partnerships can design what works for them so they can continue and be strengthened. It was felt that the maximum financial delegation to Place was required to make a real impact with local communities.
- The ICP is an opportunity to do something different, focusing on innovation and transformation to manage demand for health and care services. The ICP should commit to improving population health and reducing health inequalities -recognising that most health determinants lie outside the NHS - poverty, housing, environment, community, and education. There was agreement that this may have implications for ICP membership.

Following further feedback from partners on the themes, a proposals will be produced for the SW London Integrated Care Partnership and Place-based Partnerships and shared with partners over the coming weeks. Council of Governors will continue to be briefed on these developments as they emerge.

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Other key updates

St George's Staff at International Climate Change Conference

Staff at St George's are not only passionate about patient care but also the environment and we continue to take steps to be more sustainable. St George's, which aims to be carbon neutral by 2040, is the first Trust in England to introduce a carbon neutral patient menu which has helped us cut 23 tonnes of carbon, the equivalent of planting 30 acres of forests. Healthcare Assistant Marsha Lord was one of just nine NHS workers chosen to appear in a photographic exhibition at the climate change conference taking sustainable action to help achieve net zero carbon emissions. The exhibition, entitled "Care for the future: delivering the world's first net zero health service", celebrated the NHS staff who are supporting the transformation to greener healthcare. We have already introduced a range of recycling, energy saving, and carbon reduction programmes and I shall continue to update the Board on our efforts to become carbon neutral.

St George's Staff at International Climate Change Conference

We continue to welcome high profile visitors to St George's. Her Royal Highness Princess Michael of Kent officially opened a new Maternity Memorial Garden at St George's Hospital in October. The garden, which will serve as a quiet place for reflection for anyone affected by pregnancy or baby loss, as well as a permanent memorial to those mothers who have died during and after pregnancy, was opened to coincide with Baby Loss Awareness Week. The maternity service employs a team of three midwives to provide dedicated bereavement care, and with support from a psychotherapist to provide counselling for anyone affected by pregnancy loss, or who lost a partner during pregnancy. B&Q funded the garden which was built by St George's head gardener, John Greco, as well as volunteers from B&Q, and supported by St George's Hospital Charity.

Black History Month

We celebrated the achievements of our Black staff in October and hosted a series of events to mark Black History Month. The Trust's Black Asian and Minority Ethnic staff network and the hospital charity teamed up to create a month-long celebration which kick started with African drummers performing outside the Grosvenor and Atkinson Morley wing entrances of St George's Hospital. The Chairman and I wrote to everyone working at the hospital reaffirming our commitment to create an inclusive culture at St George's where all staff can thrive and deliver outstanding care every time. Like many organisations, St George's was forced to take a long hard look at itself following the death of George Floyd last year. This much needed review was guided by many of our staff sharing their realities of what it feels like to work at St George's, particularly when from a minority or marginalised group. Their feedback helped changed the way we work.

Visits from NHS England leaders

I was also pleased to welcome the Chief People Officer, Prerana Issar, and the Chief Operating Officer, Mark Cubbon, of NHS England to St George's recently. They both visited our surgical hub at Queen Mary's while Prerana also spent time in ED and on the wards at St George's. When leaving Prerana said she felt 'energised' and that she will take learning back with her, not least, the practical steps the Trust has taken to help support staff.

Awards

In the last month, I was delighted to hear about a number of our staff who have been recognised for their outstanding work with award nominations.

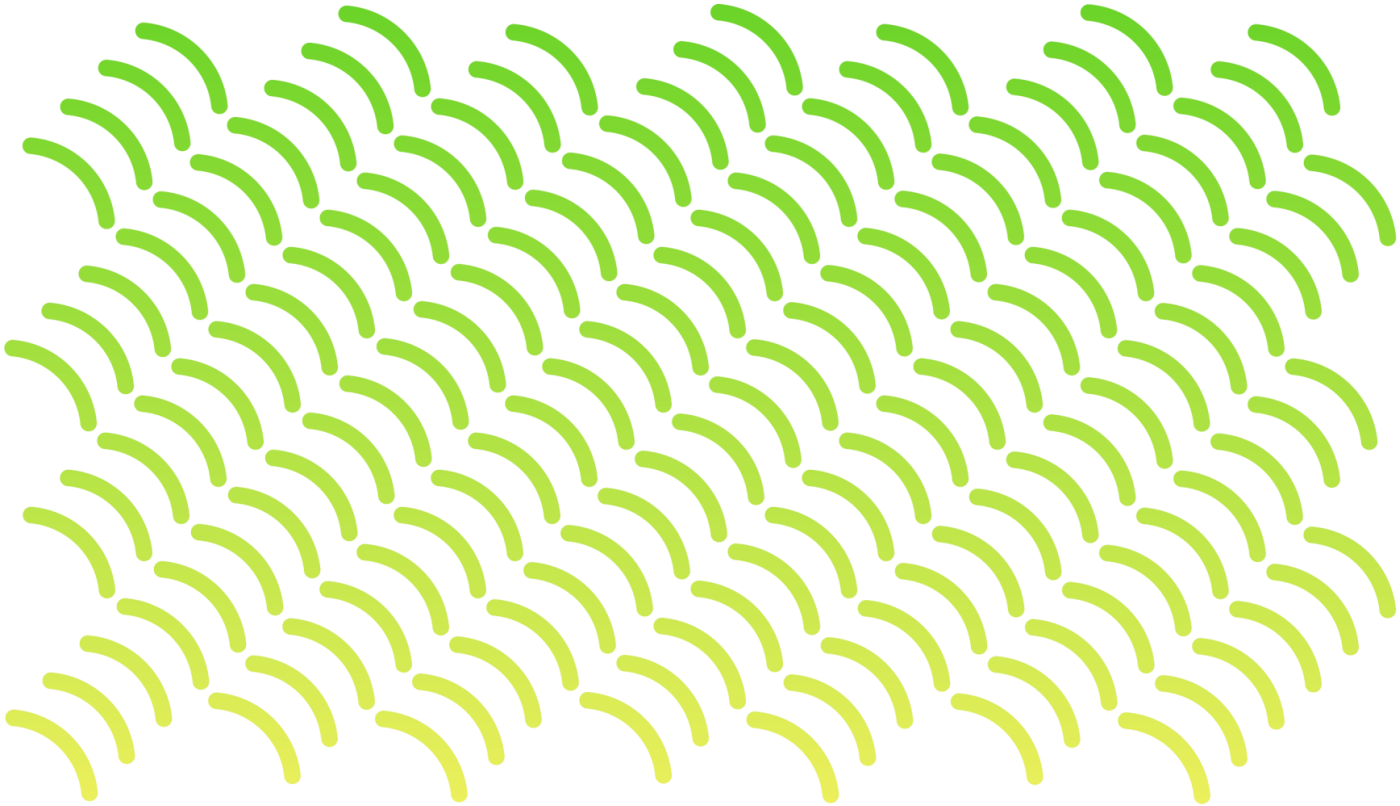
- Sheron King, Clinical Nurse Specialist for children with neurodisability, has won a Royal College of Nursing Rising Star Award.As part of Black History Month celebrations, RCN London held a Rising Star awards ceremony which recognises nurses and healthcare support workers from London's Black, Asian, and Minority Ethnic (BAME) nursing community who have made an outstanding contribution to the capital's health and care system. Sheron is a highly experienced paediatric nurse who has been working at St George's since 1997, providing care and support to children with complex medical conditions. Congratulations Sheron.

- At the Nursing Times awards, our teams were nominated for four awards across a range of categories, from infection prevention and control to cancer nursing. Unfortunately, they missed out on the top prizes on the night, but nevertheless it is wonderful that our teams are being nominated for their innovative way of delivering care to our patients.

- Padraic Costello, Clinical Nurse Specialist, was also nominated at the recent National Learning Disability and Autism Awards, which celebrate excellence in support for people with learning disabilities. Padraic and his team work across the Trust to make adjustments for adult patients with learning disabilities, and we are extremely proud of the fact he was nominated for this national award.

- Finally, a team in our Emergency Department were shortlisted for an HSJ Award for their involvement in a project aiming to reduce waiting times for emergency patients needing a Covid PCR test. This project has reduced waiting times for test results from approximately 90 minutes down to 12 minutes and means patients can get the right care, in the right place, much more quickly.

Well done to all our staff who have been recognised with these prestigious award nominations.



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NHS
St George's University Hospitals
NHS Foundation Trust

Covid-19 and Winter Planning: Update to the Council of Governors

Robert Bleasdale
Chief Nurse & Director of Infection Prevention and Control

Anne Brierley
Chief Operating Officer

8 December 2021

Introduction

Purpose

This report provides the Council of Governors with an update on the Covid-19 position across London and at the Trust and also sets out the current take up of the Covid-19 vaccines among Trust staff. The paper also sets out the proposals announced by the Government in relation to making Covid-19 vaccination for frontline NHS staff a condition of employment from April 2022.

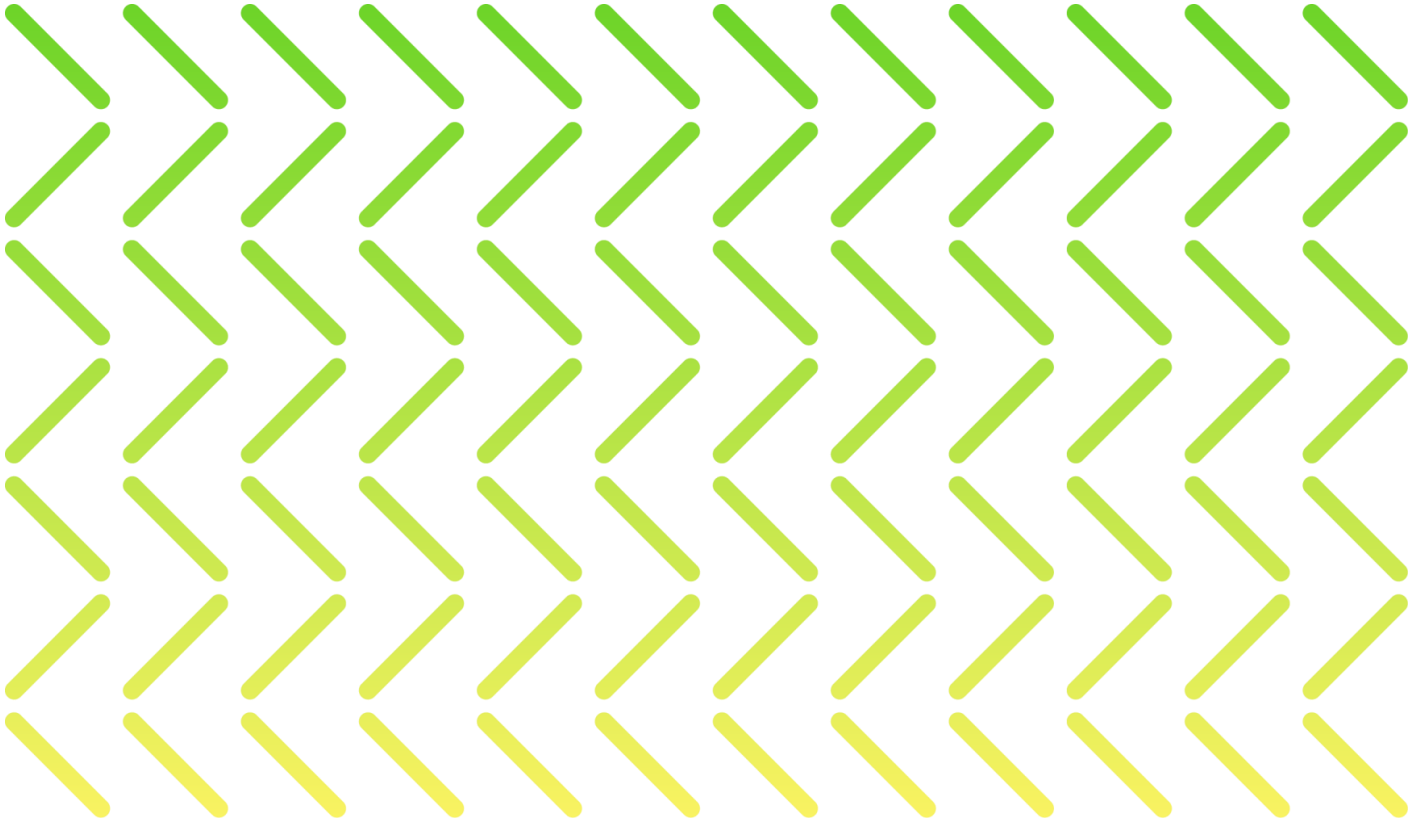
Alongside the Covid-19 update, the paper provides Governors with a high level overview of the Trust's approach to Winter Planning. This includes a summary of the modular approach the Trust is adopting, the operational capacity safety plan, and the Trust's approach to supporting staff health and wellbeing during what is expected to be a challenging winter. The Trust's full winter plan was reviewed and endorsed by the Trust Board at its meeting on 25 November 2021 and is available to review in the Board papers on the Trust's website.

Recommendation

The Council is asked to receive and note the report.

Covid-19 Position

Current Covid-19 position across London and at the Trust, vaccine take-up and vaccines as a condition of employment



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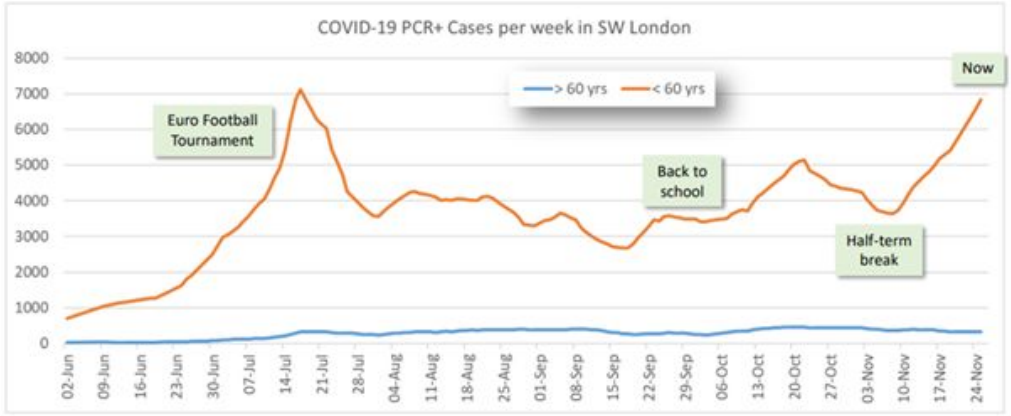
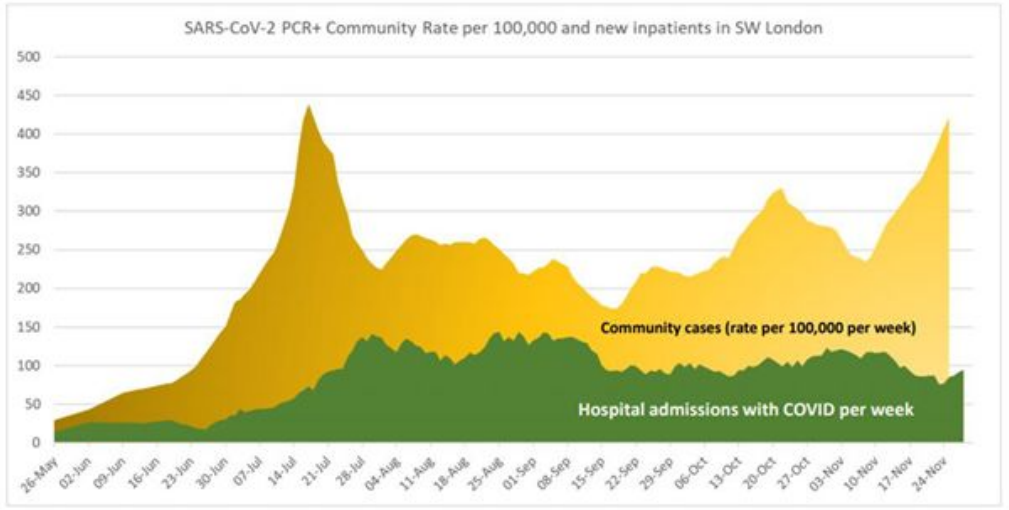
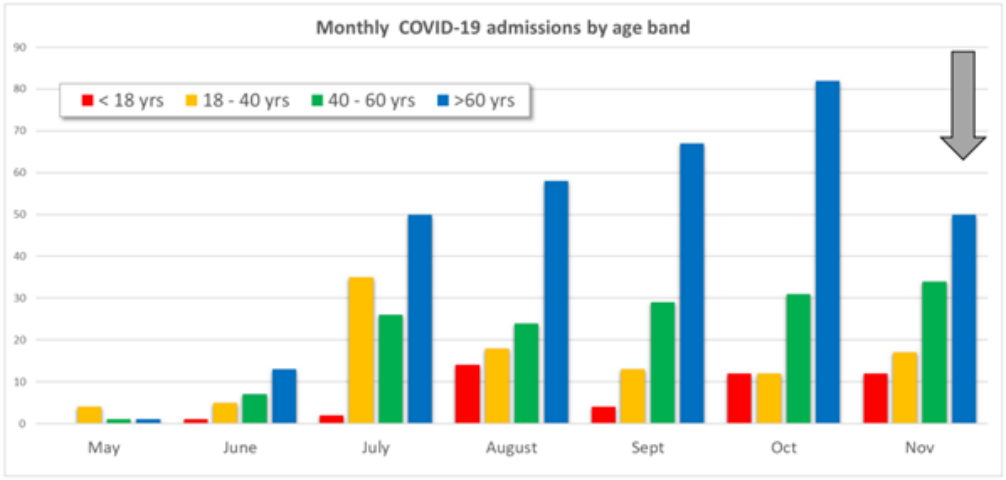
Covid-19 activity - South West London







COVID-19 cases in the community rose sharply in the summer (during the Euro Football Tournament), then fell, then rose again in the autumn when the children went back to school, then fell during the half-term break, and are now rising steeply again as we head into Winter.

Most infections are in the young – rates in the elderly (who contribute to most serious illness and deaths) are low, and steady.

Hospital admissions with COVID rose in July, lagging about 2 weeks after the community peak – but then the rates have been steady since August, fluctuating around 120 admissions per week.

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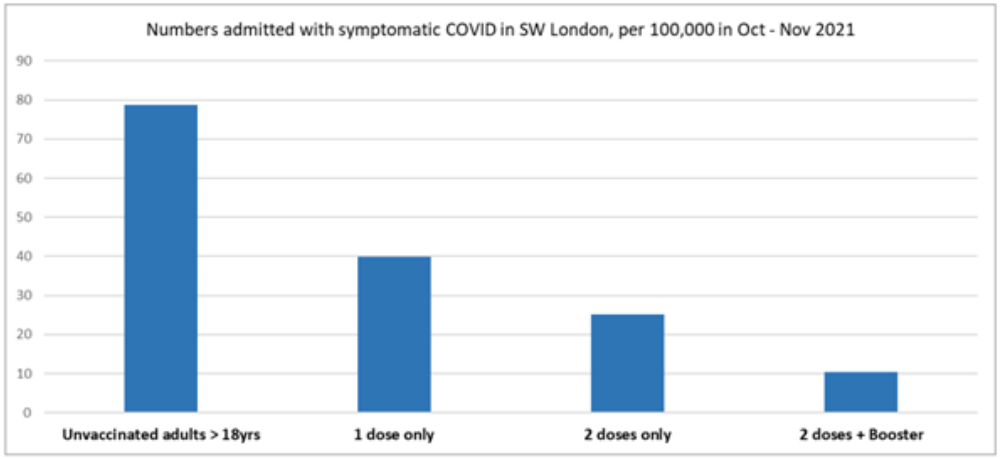
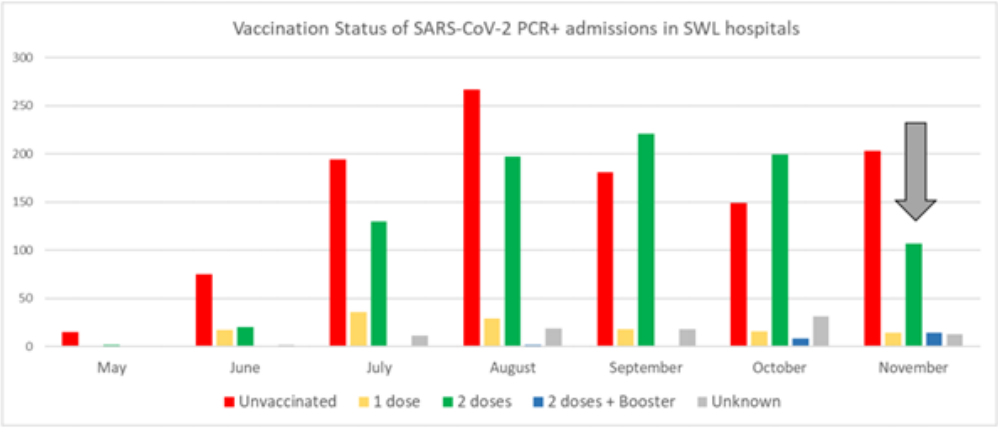
Covid-19 activity - South West London





Most admissions are of unvaccinated people (red below) , but a significant number are also in people with two doses of vaccine (green)

The number of breakthrough infections in vaccinated people increased slowly through the summer and autumn – but then fell in November, which was when the booster campaign really got going

Hardly any COVID admissions have been in boosted patients – 26 patients admitted, out of nearly 300,000 people boosted in SW London – and nearly half of these had been boosted in the previous fortnight, ie before you would expect an immune response

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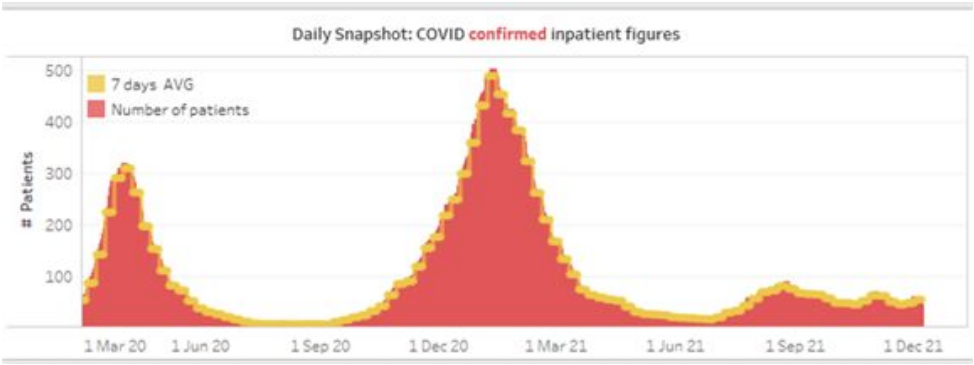
Covid-19 activity - St Georges

Ward	Inpatients	Ventilated	Unvaccinated	1 Vaccine	2 Vaccines	3 Vaccines
CTICU	4	3	3 (2 ventilated)	0	0	1
Ben Weir (ITU)	5	2	2 (1 ventilated)	0	2	1
Wards	26	0	8 (1 child)	1	14	3
Total	35	5	13	1	16	5



- As of the 6th December 2021 St Georges had 35 inpatients with a confirmed diagnosis of Covid-19.
- 9 Patients were in a critical care bed, of which 55.5% had not had a Covid vaccination
- 26 patients were in general and acute beds, and eight patients (30.7%) were unvaccinated
- Whilst the admissions of Covid-19 have remained relatively static, there has been an increase over the last week.
- Divisional teams have agreed to reopen the Trust Covid-19 cohort ward on Keate ward this week, with isolation facilities to be used on McEntee ward to support this
- Divisional teams agreeing additional areas that can be used as a flex capacity should this be needed as cases increase and decrease as part of the winter plan
- SWL IPC forum are continuing to meet to review cases across the sector and review new IPC guidance and any changes following the emergence of the new variant

Mandatory Covid-19 vaccinations

- Department of Health and Social Care formally announced on 9 November 2021 that individuals undertaking CQC regulated activity in England must be fully vaccinated by 1 April 2022
- This applies to all regulated activity, public and private funded
- The proposed regulation is currently going through parliament and full guidance is anticipated within the next week
- Staff will need to have received 1st dose of Covid vaccine by 3 February 2022 and both doses by 1st April 2022
- The regulation will apply to all staff that have social contact and direct face to face contact with patients, including cleaners, contractors, porters, volunteers and Students etc.
- The following exceptions apply:
  - Staff under 18 years old
  - Those clinically exempt from receiving the vaccine
  - Those who have taken part or are currently taking part in a clinical trial for COVID-19 vaccination
  - Those staff who have no face to face or social contact with patients
- The CNO and CPO will establish a weekly project group to work through the roles this applies to and HR implications
- CNO will write to all staff this week who we do not hold a vaccination record for informing them of the importance of vaccination, where to access more information and the upcoming changes to the regulations
- Additional staff Q&A sessions and 1-1 planned

Staff Group	Number of staff Trust	SWLP	Bank and Locum	Total
Add Prof Scientific and Technic	86	1	12	99
Additional Clinical Services (incl HCAs)	209	51	142	402
Administrative and Clerical	323	7	78	408
Allied Health Professionals	27		16	43
Estates and Ancillary	53		8	61
Healthcare Scientists	3	37	5	45
Medical and Dental	105		42	147
Nursing and Midwifery Registered	260		109	369
Totals	1066	96	412	1574

Mandatory Covid-19 vaccinations

Staff Group	1st Vaccine %	2nd Vaccine %	Booster %
Add Prof Scientific and Technic	87.4%	85.5%	37.4%
Additional Clinical Services	79.1%	76.1%	24.8%
Administrative and Clerical	83.9%	81.5%	34.7%
Allied Health Professionals	96.6%	96.3%	46.0%
Estates and Ancillary	82.1%	78.9%	34.3%
Healthcare Scientists	91.1%	90.2%	37.1%
Medical and Dental	94.4%	93.1%	53.7%
Nursing and Midwifery Registered	91.0%	89.2%	43.8%
Grand Total	**88.4%**	**86.5%**	**40.1%**

Band	1st Vaccine %	2nd Vaccine %	Booster %
Band 2	81.7%	77.8%	27.9%
Band 3	81.2%	79.4%	27.4%
Band 4	74.5%	71.8%	28.4%
Band 5	87.0%	84.6%	34.4%
Band 6	91.4%	90.2%	43.0%
Band 7	94.8%	93.7%	47.9%
Band 8a	94.5%	94.1%	46.8%
Band 8b	96.4%	95.0%	55.7%
Band 8c	97.1%	97.1%	61.4%
Band 8d	100.0%	100.0%	68.8%
Band 9	100.0%	100.0%	61.1%
VSM	100.0%	100.0%	61.1%
Medical	94.4%	93.1%	53.7%
Grand Total	**88.4%**	**86.5%**	**40.1%**

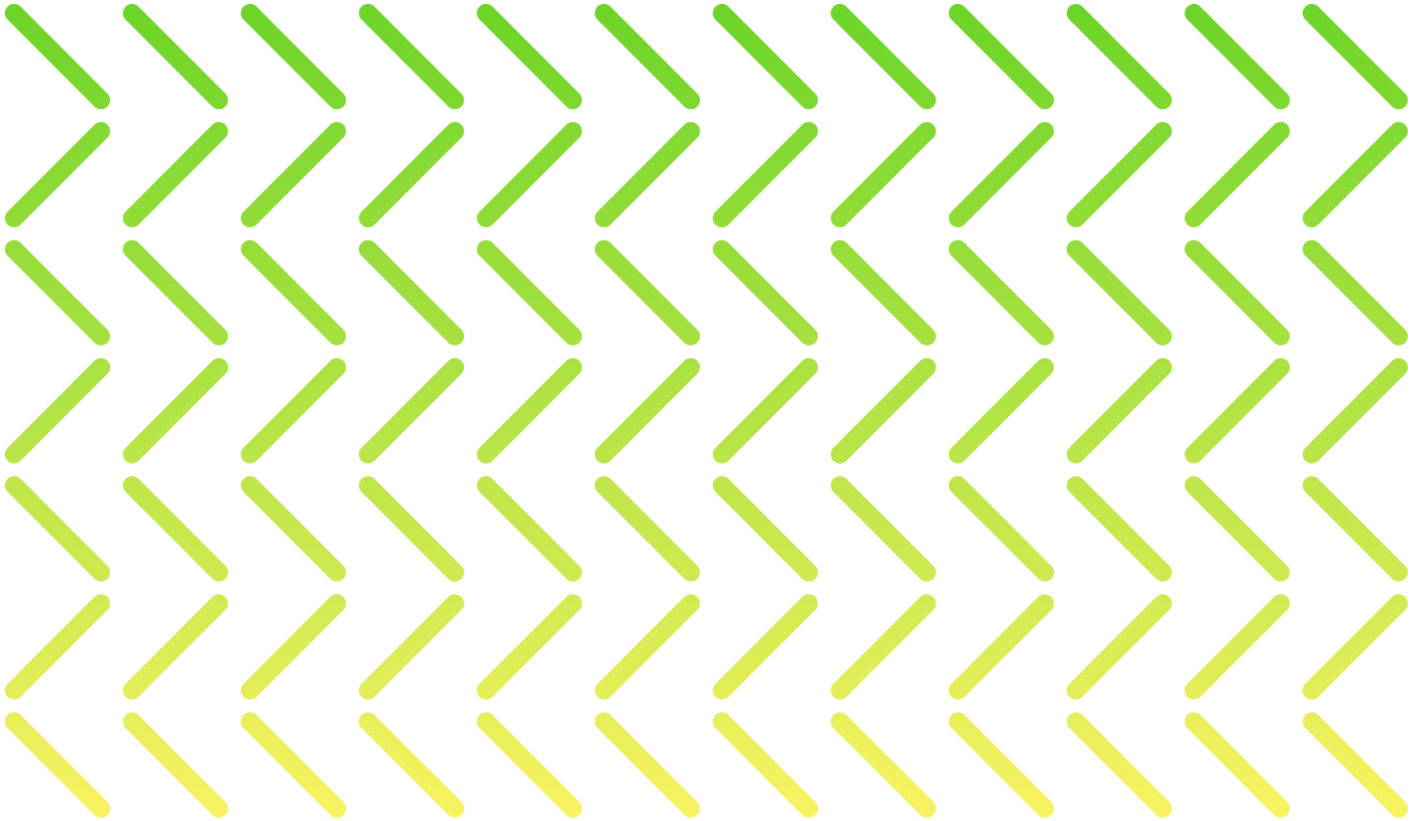
Ethnicity	1st Vaccine %	2nd Vaccine %	Booster %
Asian/Asian British	91.7%	90.0%	44.0%
Black/Black British	73.0%	68.9%	17.4%
Chinese/Other	89.5%	87.9%	46.5%
Mixed Race	83.3%	79.7%	32.3%
Not Stated	78.0%	77.4%	30.4%
White/White British	93.5%	92.4%	47.1%
Grand Total	**88.4%**	**86.5%**	**40.1%**

Ethnicity	1st Vaccine %	2nd Vaccine %	Booster %
BAME	84.2%	81.5%	34.0%
Not Stated	78.0%	77.4%	30.4%
White	93.5%	92.4%	47.1%
Grand Total	**88.4%**	**86.5%**	**40.1%**

Patient facing	1st Vaccine %	2nd Vaccine %	Booster %
No	85.3%	83.2%	33.0%
Yes	89.4%	87.6%	42.3%
Grand Total	**88.4%**	**86.5%**	**40.1%**

Winter Planning

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



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Winter Plan 2021/22
A Flexible Modular Approach

The scope, operating constraints and available options to mitigate patient need and demand in aggregate are expected to be greater than the available clinical and social care resources to meet all our patients' needs. Continuing to do more of the same will not be possible, nor will it be sufficient.

We will need to flex and adapt our care pathways, ways of working and our 'real-time' clinical prioritisation and oversight across all our patient cohorts to ensure that we:

- **effectively manage clinical risk across all clinical pathways; and are**
- **nimble and proactive in meeting changing challenges as they unfold over this Winter.**

There are 3 inter-dependent components driving this approach;

1) Scale and range of likely demand – usual winter pressures, plus COVID, plus flu, plus children's respiratory surge, plus on-going elective recovery

2) Workforce resilience and capacity – for staff within the Trust, and across system partners in primary, community, social care and mental health.

3) Limited additional mitigations to provide additional acute inpatient 'winter' capacity – the Trust (as with all SWL acute Trusts) has yet to close winter inpatient capacity, and hospital occupancy continues to run 'hot'; this position is replicated across all healthcare settings.

The Trust's Winter Plan is modular and dynamic, outlining multiple inter-dependent scenarios and actions to address, which we will use flexibly to meet changes in demand and capacity as winter unfolds. We will continue with executive flow huddles to make conscious and proactive decisions about patient flow.

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Operational Capacity Safety Plan

- Our winter plan is based on a Clinical Safety Strategy, developed by the Chief Medical Officer, Chief Nursing Officer, Chief Operating Officer, Divisional Management and Care Group leadership teams, the aim being to help us safely navigate winter by being proactive.
- The key elements are set out in the diagram below, balancing the needs of COVID, flu, elective recovery and the forecast increase in children's respiratory conditions. Put simply, we are planning to run as many services as possible at St. George's, across South West London NHS and independent sector - so that all patients can access the care they need, when they need it.
- This Operational Capacity Safety Plan is supported by care group risk assessments of patients and their needs, with treatment plans agreed and communicated with every patient and their GP where clinically appropriate.

COVID-19

- Designated COVID-19 ward(s) allocated, flexing with need
- Extra 6-14 ICU beds at peak demand
- Staff redeployed in teams
- Counsellors available to support staff in need and promote resilience
- Vaccination programme to continue
- Booster shots to be offered to all frontline staff

Flu

- Vaccination programme underway
- Staffed by peer vaccinators
- Availability of clinics – Mon-Fri
- Weekend and pop-up clinics to be advertised
- Aim for 100% flu vaccinations
- Flu patients allocated to side rooms, then bays, then a ward to be allocated according to demand
- Virus strains to be separated where possible

Emergency Floor

- Effective use of escalation
- Mental Health support 7/7
- POCT for COVID and Flu

New actions:

- Increased majors by 9 trolleys and 12 chairs
- POCT - joint testing for flu and COVID with winter funding to staff
- Expand same day emergency care pathways (SDEC), reflecting learning from ECIST visit

Elective Recovery

- Protect beds from surge
- Appropriately staff theatres
- Mega rota for outliers to protect patient flow

New actions:

- 4 QMH theatres with insourced theatres support
- Day Surgery Unit for adult and children (DSU and Jungle) move to 23 hours recovery to extend operating sessions
- Dedicated and protected green wards, ITU and PACU capacity
- Investment made in pre-operative team and training on outpatient EPR administration

Children's Respiratory

- Beds reallocated flexing with need
- Viral admissions in cubicles
- Increase ITU/HDU beds using PICU
- Place-based partners working together to optimise capacity

New actions:

- Incremental increase to a maximum **above** BAU of
  - 10 ITU
  - 6 Enhanced Care
  - 3 Ward
- Virtual respiratory ward in place with partners

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Staff Health and Wellbeing

The Current Picture

Increase in workload
NHS staff over the last 18 months have experienced an increase in workload due to COVID-19, winter pressures and a pressure to deliver elective procedures that have been delayed.

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

Staff sickness
Stress and burnout, coupled with the risk of contracting COVID-19 has also led to an increase in sickness levels across all staff within the Trust.

Staff vacancy rates
As a result of Brexit and other issues, staff vacancy rates have increased in this timeframe too, and so the Trust vacancy rate is higher than it was a year ago.

Redeployment
During the last 18 months, some staff have been redeployed to work in other areas that are not their speciality, and without the safety network that their team provides. This can lead to staff feeling under skilled and may lead to a negative impact on their wellbeing.

Rates of pay
Though there has been a 3% uplift of pay for NHS staff, recent announcements by the treasury regarding an increase to NI contributions and inflation mean that for many staff, their take home pay will be less than the pay award increase.

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

Our Current Offer

Working with local organisations to set up wellbeing hubs

Providing food to staff on wards

Encouraging staff to take adequate rest breaks/annual leave

Increasing provision of wellbeing information to staff

Creating training and resources to support managers

Creating a culture that places wellbeing at its heart

Providing training on wellbeing to staff

Increasing capacity of Staff Support Service to provide specialist groups

Mediation

Facilitating specialist interventions

Health promotion to at risk groups

Reinforcement of messaging 'its ok to not be ok'

Providing cover on wards at times of significant pressure

Increasing capacity of Staff Support Service

Promoting national specialist services

Supporting staff until they return back to work

Referring staff into external services if required

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

Facilitating trauma debrief groups

Additional winter pressure support offer

Scheduled Rest Breaks

Developing localised wellbeing plans by care group

Improving the Wellbeing Hub rest spaces

Targeted health and wellbeing relationship building with line managers

Liaising with line managers to identify at risk staff

Regular reporting of key themes

Fast tracking managers to access coaching support

Providing line managers with targeted wellbeing resources

Supporting Practice Educators in facilitating groups and mentoring

Targeting at risk groups

Peer to peer support groups

We will:

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

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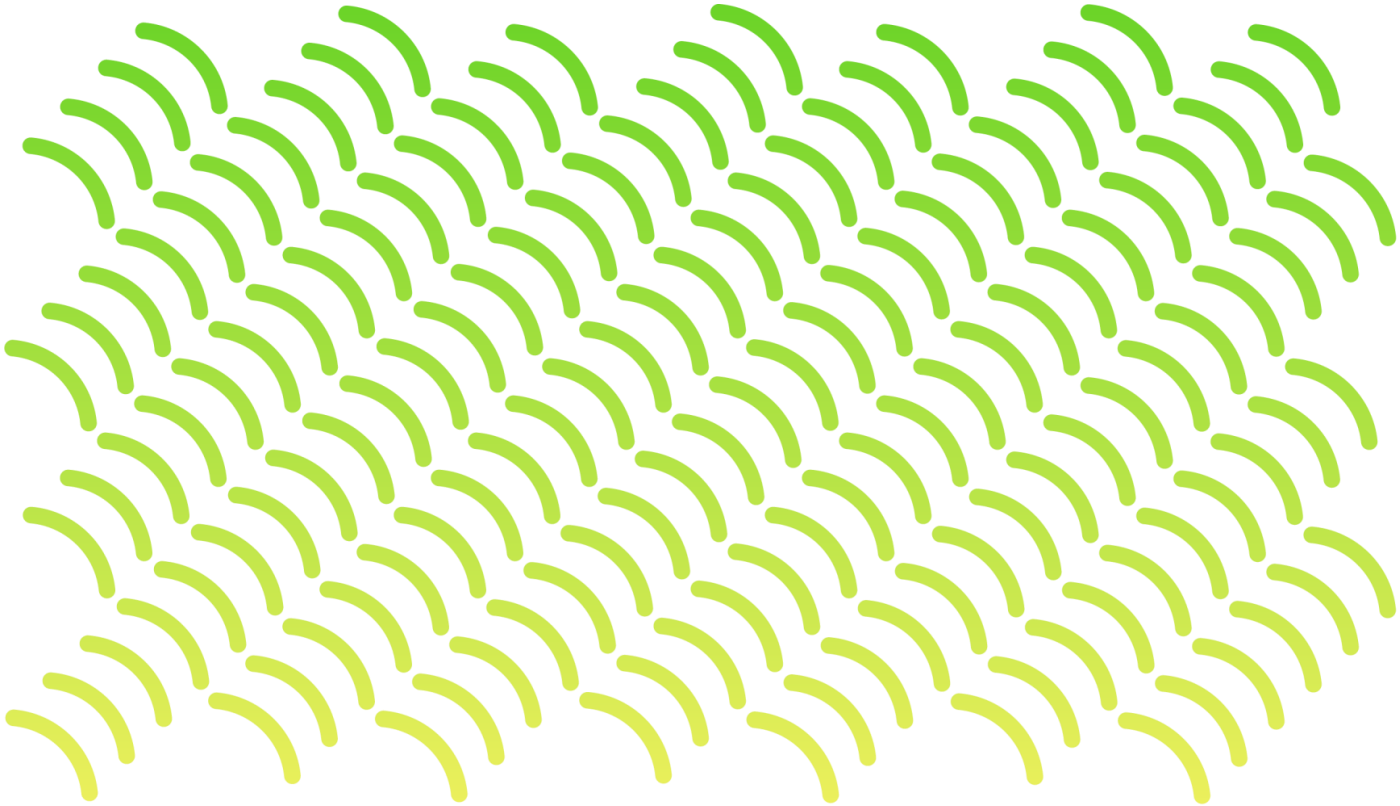

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NHS
St George's University Hospitals
NHS Foundation Trust

Learning from COVID

Workstream 1: Team St. George's

Report of Findings

Council of Governors
8 December 2021

Paul da Gama
Chief People Officer

8 December 2021

Introduction

Purpose

In March 2021, the Chief Executive Officer commissioned a project to review lessons learned throughout our organisation's COVID-19 journey to date. This report sets out the findings of one of the four workstreams within that project, which focused on how we supported and worked with each other during the pandemic.

The report was presented to the Board's Workforce and Education Committee earlier in the autumn. It is presented to the Council of Governors in full to set out both the approach we have adopted towards learning from the pandemic and to highlight the specific learning we have taken in relation to our people.

Recommendation

The Council of Governors are asked to discuss the findings of the report.

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Contents

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Summary of Main Lessons

Area of Focus	Lesson / Recommendation
Overall Methodology	• Plan to conduct a thorough 'second-cut' of lessons learned, with adequate time and resource to engage Operational Divisions, over a longer time period • Examine other sources of data (Datix, SIs, complaints) that will inform how we best deploy and manage our workforce in the event of another crisis/wave • Develop a toolkit for local teams to conduct their own lessons learned exercise which is considered an important part of recovery
Communications	• Define, refine and embed a repeatable crisis-model of staff communications which was overall deemed highly successful during COVID
Corporate Learning and Development	• Continue the adaptation of learning and training to a virtual or blended context – the shift will be at least semi-permanent. This will require investment in new equipment and developing new skills/roles.
Clinical Skills Training and Education	• Define and refine the training required for pandemic-related roles, building on already defines education/training pathways – This should include definition of and provision for developing new pandemic related skills, particularly new communication requirements (e.g. EOL) • Provide clearer communications around study leave and other disruptions to training/education proceedings
Remote / homeworking	• Develop policies, processes, skills and supporting cultures to enable remote and homeworking as a permanent feature of working at St George's
Staff Redeployment	• Establish a dedicated hub for all redeployed staff groups, and a detailed, fully supported end to end employee journey (informed from the experiences of other Trusts who did this more successfully) • Set ourselves up to work with volunteers in future times of crisis • Establish robust processes for determining workforce needs in crises (numbers, skills, locations etc)

Area of Focus	Lesson / Recommendation
E-Rostering	• Consult on what is possible to fulfil before committing to massive staff redeployment and subsequent e-rostering requirements
Medical Staffing	• Update recruitment processes to include virtual elements
Estates and Facilities	• Position and communicate H&S as a shared corporate responsibility as opposed to sitting with E&F (including mask enforcement) • Develop a strategy for appropriate distribution and allocation of free food.
Staff Risk Assessment	• Develop an electronic staff risk assessment process adaptable to align closely to NHSE reporting requirements
Health and Wellbeing (including Staff Support)	• Consult our HWB staff on designing the redeployment process for our staff • Maintain a central register of redeployed staff so they can be monitored and offered targeted support • Establish resilience as a core leadership and all staff competency and reflect this is our learning and training offer across the board
Employee experience	• Redeploy staff in whole teams to preserve sources of resilience, and plan redeployments to affect as few staff as possible • Develop clear recovery plans and pathways for individuals and teams post pandemic, including planned time off, similar to what some Trusts have done more comprehensively. • Increase the physical visibility of senior leaders in areas where staff are redeployed and other units working through the brunt of the crisis. • Follow up a crisis period with a target employee retention strategy
Staff Survey	• Our redeployed staff scored above average for both engagement and team working • Integrate remote people management skills into our leadership development training offer to counter the negative effects of remote/home working on engagement and other staff survey factors

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Workstream 1: Team St George's

- In March 2021, the Chief Executive Officer commissioned a project to review lessons learned throughout our organisation's COVID-19 journey to date.
- The project was divided into 4 workstreams, as illustrated below.
- This report is the first response to the requirement set out in Workstream 1: 'Team St George's'.

Aim

This aim of this workstream has been to review:

- *How we supported and worked with each other during the surges*

Within this broad theme, the 'Team St George's' workstream more specifically seeks to answer the following key questions:

- What worked well through the surge period, and why?
- What further opportunities to evolve can be identified for surge and non-surge times?
- For each implemented change, do we want to 'Restore, Retain or Reinvent'?

Two Main Parts

This workstream consists of two main parts:

Part 1:

a) Consulting providers of staff and people-related services

Part 2:

a) Collecting feedback and lessons from operational staff about their employee experiences during COVID, including and their experiences of teamwork

b) Reviewing results of the COVID specific questions from the 2020 staff survey

Methodology
Part 1: People-related services that support and serve our staff

- Involvement was secured from the following people-related functions/services across St George's:
    - Health and wellbeing, including Staff support
    - Staff risk assessment (Occupational Health)
    - Remote/home working
    - Recruitment and Induction
    - Education and training
    - Learning & Development
    - Redeployment of staff
    - E-rostering
    - Communications
    - Estates and facilities
- Temporary Staffing and Information Technology were also invited to offer input.
- A small number of representatives from each team were interviewed via MS Teams for approximately 1 hour and notes were taken by the interviewer.
- Interviews were structured around the following format:
    1. *What were the main changes implemented?*
        - Interviewees were asked to identify 2-5 of the main changes that were implemented (or attempted) throughout the pandemic period.
        - For each of these changes they were asked to consider:
    2. *What worked well? What should we keep doing?*
    3. *What worked less well? What would we do differently?*

- Notes of each meeting were written up using the grid depicted below, and each grid has been presented in full in Part 1 of this report.

Main changes implemented	What worked well? What should we keep doing?	What worked less well? What would we do differently?

- Many of those interviewed within Part 1 offered views *as employees generally*, in addition to participating *as providers of people-related services*. These views will be contained within Part 2:
    - Some of these functions shared valuable views on how they noticed teamwork was affected within their own teams (where this input was not specifically focused on the people-related services they provide)
    - Sometimes this group of interviewees were also well placed to represent the views of fellow employees generally, depending on their role (for example, Staff Support was an important source of data for the general employee experience during the pandemic).

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Methodology
Part 2a: Employee experience of operational staff during COVID

- Part 2a intended to capture a breadth of experiences, stories and most importantly learnings of our staff during the pandemic in terms of:

  (i) how they received the people related services listed in Part 1, and

  (ii) their experiences of teamwork and being supported more generally.
- At the advice of the COO, DMB meetings (SNTC, CWDT and MedCard) were attended to explain the purpose of this workstream and to ascertain how best to gather input from staff within Operational Divisions. The COO was particularly keen to collect input from ED and AMU in this process.
- DMB members were asked to share:
  1. *Existing reviews:* sharing existing write-ups of their own lessons learned reviews/workshops already conducted
  2. *Ideas on who in their Division to consult and how,* for example: Matrons, Consultants or other frontline staff who they felt would have useful learnings to share, and existing forums that could be engaged
  3. *Input by email:* responding to a few short questions which were sent around after each meeting

Part 2a Limitations

- All DMB meetings and members responded positively to the request for their participation in this workstream.
- Overall, there was a strong sentiment conveyed (particularly from CWDT and MedCard) that this review held great importance to the organisation – both to ensure we learned from successes and failures in what has been 'uncharted' territory, but also because of the opportunity to meaningfully reflect and learn on what has been a highly stressful and sometimes traumatic period. The potential for supporting the recovery of our staff from a reflective learning process was felt to be high.
- Despite high interest and importance placed by Operational Divisions on this process, **there have been few opportunities to gain meaningful input from the 3 Operational Divisions**. In following up with several DMB members to try and identify sources of input, a number of potential reasons for the lack of response have surfaced:
  1. *Perceived low-value and authenticity*: Some feel this is a tick-box exercise and the real value of participating is not felt. There is a degree of cynicism in this process meaning people may not be prioritising their participation.
  2. *Timing:* Assurances have been made that operational staff in these Divisions have many learnings and experiences to share, however there is widespread exhaustion and a 'lack of bandwidth' and energy to participate currently.
  3. *More effort required:* There is more that could be done to seek the input of frontline staff, and to make it easy for the them and their managers to coordinate this. To enable further conversations and data collection to take place, workstream 1 will need more resource (time and people) to identify the right stakeholders, set up and facilitate meetings, record data and write up the learnings and themes.

A 'First Cut' Only of Lessons Learned

Concern has been expressed from Operational Divisions about the potential 'conclusive' nature of this process, when there has not been what is perceived to be adequate time, space and effort in reaching and hearing from those who need to be involved.

The notion that this report (submitted end of April) is a 'first-cut' was acceptable, on the condition that a second and possibly third cut would actually happen. It is recommended that St George's resource a fuller review.

It has not been able to examine a number of areas that might fall under Workstream 1, including:

- Analysis of Greatix, Datix, complaints and SI data relevant to COVID-19.
- Analysis of workforce decisions and management (specially around 'flow', staffing numbers and skill requirements to do COVID-related work) – what will inform how we organise staff in the event of a third wave?

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Methodology
Part 2b: 2020 Staff Survey

- The 2020 staff survey involved data collection during October 2020.
- 5,107 staff completed the survey (a response rate of 59%).
- Respondents were asked four classification questions:
    1. **Have you worked on a COVID-19 specific ward or area at any time? (yes/no)**
    2. **Have you been redeployed due to the COVI-19 pandemic at any time? (yes/no)**
    3. **Have you been required to work remotely/from home due to the COVID-19 pandemic? (yes/no)**
    4. **Have you been shielding? (yes, for myself/yes, for a member of my household/no**)
- Section 2b contains charts that show the breakdown of theme scores for staff answering ‘yes’ to each of these questions, compared with the results of all our staff.
- ‘Top-line’ analyses have been proposed for each of these charts which may offer further insights into the experience of our staff during the pandemic.

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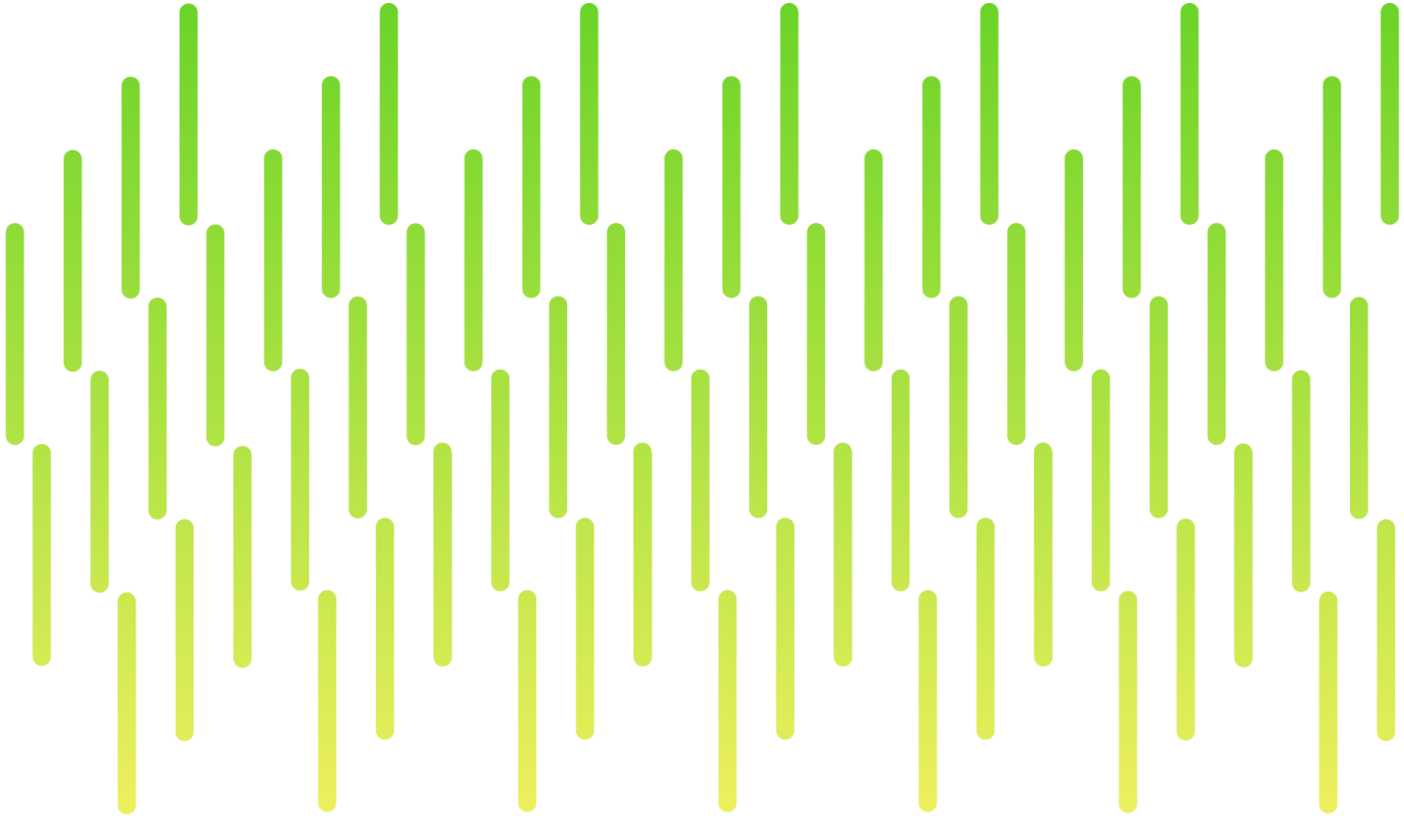
Part 1: Provision of people-related services during COVID

Views from colleagues who provided staff services and support



Communications
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Main changes implemented	What worked well? What should we keep doing?	What worked less well? What would we do differently?
Radically changed frequency and style of staff communications • Introduced daily all-staff bulletins between March-July 2020 and December 2020 -March 2021 (opened by 6,000 staff on average; rated extremely or very useful by 95.75% of staff in Jan 2021) • Ran regular senior leaders' briefing sessions, including thrice weekly sessions during January 2021 (rated extremely or very useful by 89.52% attendees in Jan 2021)	• Daily bulletins were well received in a time of crisis; timeliness of communications addressed staff desire for regular and rapid updates • More regular senior leaders' briefings gave staff chance to ask questions and raise concerns with executive team • Bulletins included Covid-19 related data which staff found helpful – however, only introduced during second wave • In future, it is essential to ensure all communication is as concise as possible – staff are busy.	• All-staff bulletins during the first wave were too long. • Getting correct Covid-19 data in real-time proved very difficult – so we were unable to share with all staff • During the first Covid-19 surge, we were having to get exec sign off on all-staff bulletins - which was time consuming and led to delays • We adapted our intranet to create a temporary Covid-19 hub, but were unable to launch the new intranet site until January 2021 – this made it difficult for staff to access key information and guidelines
Extensive media engagement to educate/inform the public about the impact on our services • Agreed early on to take a proactive approach to media engagement, with a focus on broadcast coverage • BBC London granted access to ITU in April 2020; July 2020; January 2021; and March 2021; Press Association granted exclusive access to ITU/ward areas in January 2021	• Broadcast coverage enabled us to convey (in pictures) the scale of the challenge our teams were facing; it also enabled us to communicate important public health messages (e.g. Hands, Face, Space). • We suspended filming of Channel 4's 24 Hours in A&E – scheduled for May – due to IPC guidelines, and to enable us to focus on Covid-19 communications activity	• Broadcast coverage is labour intensive, and the inevitable focus on ITU meant other teams got less exposure
Stakeholder engagement and greater use of social media • We created bespoke briefing documents and materials for key stakeholders (e.g. MPs) to ensure they were kept up to date about Covid-19, and the impact on St George's • We also devoted more time, energy and resource to social media content (including interviews with staff in various roles) than previously	• Engagement with our social media channels increased in last 12 months (March 2020-March 2021): for example, Twitter followers increased by 29% (+5,789)	

Learning & Development

Main changes implemented	What worked well ? What should we keep doing?	What worked less well? What would we do differently?
Converting induction to an online experience • Initially reduced from a 5-6 hour face to face event to a 1.5 hour version for smaller groups (March to November) • Redesigned the programme to an online event (to be in place from November 2020 onwards)	• Good feedback (average rating of 4 out of 5) for a programme based on video content • Saving of time and effort to have specialists/speakers do videos instead of attending every Monday • Leads were willing to engage in the process – good cooperation (despite video recording self not being a familiar process for some)	• 40% said they would prefer a F2F format and 39% would prefer a mixture of F2F and virtual. • We are likely to apply a more blended approach in future – mix of synchronous and asynchronous (self led), and this has accelerated our plans. • There will still be a physical F2F element as new staff need to provide ID and other paperwork etc, so we can't lose the F2F element altogether. • We have learned that we don't need to run 48 events a year – we will probably be able to reduce this by half. • Induction events will be still a physical event, but mainly for the social/affective elements, and to offer a warm and personal welcome
Regular face to face training programmes were paused or stopped during surges • We tried to quickly adapt to using online methods (because Covid 'room' restrictions) where possible, however the overall training offer was greatly reduced.	• For those midway a programme (e.g. King's Fund LDP), the pause allowed people to focus on the surge, and didn't add to the burden • Many did not have time to undertake training, so the pause in training was appropriate • Offered a chance to pause and review the courses – specifically: balance of training demand vs supply, assessing update requirements, assessing potential for adaptation to blended formats • People have had to find, experiment and innovate with new tools (e.g. Zoom, Mentimeter) to use in an online format	• Needed more capacity and skills to adapt courses to an online format • Need to introduce a train the trainer skills development offer to include blended approaches – a combination of facilitation and technology skills • Some team members didn't have hardware (e.g. laptop/camera) to do online training. • MS Teams was still fairly new – e.g. breakout functionality just launched and many can't use it • We have a low amount of e-learning content which would have been valuable at this time, and we are still very underfunded to do this • We need to partner more deeply with IT to strategically and sustainably adapt our L&D offer • New tools (e.g. Mentimeter, Zoom etc.) have been used in the absence of clear, aligned decisions around organisational endorsement and funding of subscriptions • Existing systems were not equipped to handle 'rich media' (e.g. 75% can't do a Teams call via VDI or even watch a video) – this has led to many disruptions and constant workarounds • Once we stopped some programmes, it was hard to resurrect them, and get people back in the headspace of learning.
Resourcing and budget needs have increased - and we were already under resourced • To respond to new ways of working, we have had to greatly adapt the work of the department, almost overnight.	• The need to modernise our L&D offer will accelerate this planned development	• Buying online content – but need to consider building in-house content development capacity • LMS requires adaptation (VDI is currently needed to access Totara) • Greater demand for e-learning content and design due to new ways of working • Large body of work ahead to build new partnerships/commissioning etc. • We need to invest to ensure we are prepared for future crises, and gain senior buy-in to upgrading our approach to L&D to be in line with expectations of a leading teaching hospital

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Clinical Skills Training (GAPS)

Main changes implemented	What worked well ? What should we keep doing?	What worked less well? What would we do differently?
Creation of new training programmes including 'Boot camp' • 733 staff trained in Boot camp • ICU Nurse Redeployment / Preparedness Programme - 285 Nurses Trained • ICU Medical & Ventilation Training – 245 Trained • CoVIDPACT – COVID-19 Palliative Communication Training – 37+ Trained (on-going) • Covid Resuscitation Update - 215 Trained (on-going)	• Boot camp has evolved so much because we now know so much more than we did • We trained over 700 people in boot camp, over 6 days a week. • Establishment of an education / training pathway for second surge • PPE was a whole new language that was embedded into training quickly and effectively • Regular programme of training and courses was stopped	• We were asked to repeat boot camp in surge 2, but very few people came. • Feedback from staff throughout the pandemic was that they needed so much training – but that they could also never be released to go and do necessary training. HCAs and Nurses were never being released by their seniors because of a fear of being understaffed. • Guidelines around PPE were changing rapidly and sometimes conflicting which made deciding what to tell people difficult.
Conversion of the GAPS centre into a staff 'hub'	• We 'colonised' the medical school because they had vacated the 4th floor. • The floor became a huge space where people were able to meet, talk, support each other, share issues and anxieties.	• Communications around redeployment, what people might expect, and what they would be doing was weak (possibly because no one knew). • People needed to talk about it, and the GAPS training area became an important kind of hub for staff • It was chaotic and unplanned. There were people pouring out of the lifts and there was no process or system to manage the flow. • There were far too many people in the space at a time, mostly without masks s(we did not have PPE at the time) and without distancing measures in place.
'Moral' skills around prioritising cases and sensitive communication became paramount	• Training plans were adapted quickly. • Every simulation/training session began with a direct conversation about prioritising cases – because staff would be working in situations where they may have to prioritise one patient's life over another.	• Staff were required to have 'moral' dialogues including DNR and end of life discussions with families, and many were unprepared and not well equipped to do so. • Previously, it was only doctors who would have these conversations with families whereas now it was a much greater group of less experienced and less qualified staff. • Deeply sad 'goodbye' conversations were happening on tablets less than a metre away from a joyful recovery conversation – it was an emotionally charged atmosphere and difficult to enable respectful conversations. • There were seriously challenging situations around communicating updates to families, and whether staff could feedback that a patient was 'stable' or not. The virus meant patients could deteriorate extremely quickly and this put great pressure on our staff in supporting patient–family communications and trying to give appropriate updates. • The family liaison service mushroomed and we were not prepared for this need.

Education

Main changes implemented	What worked well ? What should we keep doing?	What worked less well? What would we do differently?
Clinical skills training was prioritised on a huge scale	• High numbers of staff trained in a short space of time • We need a dedicated clinical skills training area – we had to rely on the medical school for some space and it was challenging as offers and cooperation were not always forthcoming	• 'Drop in' format meant that many slots were not utilised. • It was hard to keep track as it was unclear as to who was administering the processes – we really needed a dedicated staff member in charge
Medical/PA students were trained as HCAs	• The continuous energy and enthusiasm of the team	• Poor communication from Nursing in daily workforce meeting about what their role would be and therefore training needs • Better communication was required, and we are also conscious of the limitations on this during a pandemic
Attendance at daily workforce meeting	• It was really positive to have a joined up approach between workforce and education • Returning to 'business as usual' means that we are no longer as well connected with workforce, including strategy	• As above – would escalate in future
Study leave cancelled in first wave	• Clear comms from CPO	• During the second wave there were no comms and lack of clarity on this despite seeking it. This resulted in lots of confusion and staff not released to attend commissioned courses
Training of staff who were redeployed to ITU	• Team members supported this training well	• Lack of information from corporate nursing

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Remote / Homeworking
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Main changes implemented	What worked well ? What should we keep doing?	What worked less well? What would we do differently?
Introduced a remote/home-working roadmap, checklist and toolkit – for both staff and managers • Identified which parts of a role could be done onsite, from home or blend of the two. • Also included advice/guidance for managers.	• Removed the subjectivity of decision making around WFH from individuals and line managers, by helping them arrive on a decision objectively. • This made it easy, fair and avoidant of conflict in making decisions. • Conducted a pilot with SNTC first – we are really proud of this process that we designed and implemented. • It was thorough and comprehensive – considered all aspects of a role including materials and equipment • Worked with Health and Wellbeing, Health & Safety and IT on producing guidance for WFH – a great example of teamwork. We had all the right people on board in the working group. • Has helped us resolve grievances about people not being allowed to WFH – we now have a clear objective process. • Guidance for staff to care and look after themselves at home was well received.	• We had to go through a number of drafts as we built it from scratch which took longer than was ideal. • We could have promoted and communicated it more thoroughly after implementation – it seemed that not all staff and managers were aware. • We now need to look at developing permanent WFH policies and processed, as we know we will not simply move back to pre-COVID ways of working – a working group is already in place.
Provision of homeworking needs	• We sent out homeworking equipment to some staff where it was needed most (e.g. chairs, desks)	• Needed support for staff on facilities and equipment • Some staff didn't have Wi-Fi and other basic essential to help them WFH. • We did not have policy clarity around this, nor adequate resource or funding to provide things like Wi-Fi, heating, electricity, and lighting (we need to assess HMRC conditions around this first)

Staff Redeployment
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Redeployment is a key theme appearing in *Part B: Employee Experience during COVID*.

Main changes implemented	What worked well ? What should we keep doing?	What worked less well? What would we do differently?
Establishment of the Workforce (WF) Workstream • The Trust set up a WF workstream (working group) to coordinate everything to do with workforce during COVID		• The whole work of the WF group was reactionary, unplanned and chaotic. It worked – but it was painful for doctors, and especially for junior doctors. • Numbers were changing unexpectedly (e.g. bed numbers) and it was very hard to predict staffing needs. • We didn't have adequate infrastructure or process to ensure all the right expert input whenever needed, in order to establish exactly what staff were needed, when and where. • No one was clearly in charge for deciding what we needed (numbers of staff in which location) • In future, we need a much tighter and more robust process for determining what the workforce needs are as future crises unfold.

Many of our staff were redeployed to different roles/teams/units
• Basic systems and processes were created and put in place to enable this
• Staff were often sent to new teams at very short notice
	• The majority of staff were willing and able to be redeployed, and provided excellent care in extremely challenging circumstances – both professional and personal	• We did not have a dedicated redeployment hub
		  ○ Many other NHS organisations had one in place.
		  ○ Ideally we would have had a fully tested and robust redeployment hub
		  ○ It is important that we learn from other organisations who did this more successfully.
		  ○ We did have a basic hub for Doctors and Nursing, but not for admin staff
		• There were some very negative experiences for staff in being redeployed:
		  ○ Some turned up to work in a new team were told they weren't wanted because, for example, they lacked a particular skill (e.g. iclip). This was a demoralising experience.
		  ○ Many staff reported a lack of information about their redeployment which left them feeling confused and concerned.
		  ○ Some staff were very fearful and did not want to be moved to a new role, at a time when the nature of the virus and its transmission was very unclear. Many staff were asking to stay home instead.

Need for volunteers • Due to the unprecedented scale of the challenge, there was a strong need for additional workforce, including volunteers		• We weren't set up to use volunteers at a time when so much additional human resource was required • This meant staff had to carry extra burden of work, and all additional workforce has to be paid for.
Special pay rates as a COVID enhancement • Exec team agreed to special COVID pay	• Some staff received financial recognition for working in a modified and challenging environment	• These pay rates were inconsistent and presented many challenges for the HR department • Exec team agreed to special COVID pay rate – and we regretted this afterward because we had to reduce it – it wasn't sustainable • We needed a more robust system for enhanced pay that could be applied more consistently

E-Rostering

Main changes implemented	What worked well ? What should we keep doing?	What worked less well? What would we do differently?
Very fast creation of new templates and processes • Needed to fill many shifts and backfill accordingly to make all ITUs safe • Normally have a week to build a rota – but now had to complete the task in 3 hours • Introduced a very high chance of error	• New templates were successful • Having an electronic system was advantageous and it was adaptable • Existing relationships and knowing the matrons and what they need/want made it easy to create the new systems • For the second wave, we already had the rosters built, so the second wave was slightly easier	• In trying to make the ITU safe (there were 7, from the usual 3) we had to staff them appropriately and also backfill. There was resistance to people moving which made filling positions very difficult at times • Rising to the challenge relied heavily on individuals' knowledge, skills, and personal relationships. Systems alone would not have managed • There were more errors than usual
Much higher capacity of work in much shorter time frames, with no additional resource • Usually up to 75% more work to do • Used to transfer a few people in a day, now transferring 20 people per hour • Normally roster 3 months in advance, but it was being done 1 day in advance	• People still got paid • There were a few mistakes but people were very forgiving • We took responsibility for these errors which helped people to be tolerant • During the second wave it was all more staggered and measured which made it all more manageable to make the changes.	• We needed people to be more tolerant and understanding. • Some managers unreasonably expected a personal and instant service. • We needed people to have more awareness of the gravity of the situation and the additional workload and stressors on ***everyone's*** work and responsibilities. • Some people were quite rude, lacking patience and empathy. • There was a lack of understanding that we had no additional help. • This amounted to much more stress and anxiety than we were used to dealing with. • Because the function managed, the harm experienced and need for more resource may be overlooked. Like other teams, we may become a victim of our own success.
Decisions by Directors created unrealistic demands of the team • Promises around pay were made to staff that could not feasibly be fulfilled		• Some Directors were unaware of reasonable limits of what could be expected from the team. • What used to be an 8 week process was being asked for in a day or at best a week. • Seniors need to check that what they are asking for is actually achievable (e.g. that staff can actually get paid) before they promise it to the staff. It felt like they got swept up in crisis management but did not maintain realistic expectations of the function and failed to consult us.
Amended staff-move authorisation process • Amended so that it had to come from Chief Nurse office	• To manage the in flux of requests, we insisted they all came from the Chief Nurse's office – a decision which helped us to manage the work	• People automatically asked for their staff back when theatres reopened but the team has to insist on authorisation. There was not time to thoroughly communicate and embed new processes.

Outstanding care every time

Medical Staffing
Slide title second line

Main changes implemented	What worked well ? What should we keep doing?	What worked less well? What would we do differently?
Changing junior doctor work schedules • Normally, junior doctors get sent a work schedule for their rotation in advance – it is rare for it to change. • During COVID they were changed greatly and at very short notice	• During the second surge, people controlling the rotas had an understanding of the staffing they would need (capabilities, levels of staffing) to keep the unit safe, which they didn't have during the first wave.	• Adapting work schedules felt really 'knee-jerk' and unplanned. We had to work out the skill mix needed 'from scratch' in very new and ambiguous circumstances. • Some people reacted negatively, probably because they were frightened. Many of us were basing our potential needs on what we had seen in Italy (which was extremely daunting).
Online recruitment for consultants • First wave paused but we needed to find an alternative, so this was all done on Teams	• Made us think if we really need to fly someone in from overseas for interview in future • It has been really convenient for other interview panel members – made it easy to get better panel representation	• You don't get the best out of a candidate when they're online
General Team working • The Medical staffing team are very rarely in the same place at the same time any more.	• Homeworking benefits	• Has been a period of adaptation to establish new ways of working to optimise teamworking and performance – and we are still adapting.
Establishment of the Workforce Group / Workstream (Team St George's)	• Urgency of the need led us to make decisions quickly, to take action quickly • Able to recognised the work of teams and people I didn't previously recognise. Saw new sides of people who were lesser-known 'heroes' e.g. those with PPE expertise	• Despite sitting on the workforce group, I didn't have the info needed. • The daily meeting of the COVID Workforce workstream/working group involved 20-30 people in one room. At this point we had not yet established the importance of social distancing and mask-wearing was not yet common practice.

Estates & Facilities

E&F staff interviewed also shared significant learning on how they worked as a team - see also Part B.

Main changes implemented	What worked well ? What should we keep doing?	What worked less well? What would we do differently?
Enhancements to Services and physical estates Including: • Staff H&S non-clinical (e.g. cleaning and transport) • Capital projects – ED enhancements • Medical physics enhancements • Oxygen provision *(IPC discussed in different workstream)*	• Ramped up very quickly • Facilitated by strong, fast communications • H&S were more proactively included and involved • Managed to maintain oxygen levels, and developed a new approach to monitoring oxygen consumption levels and maintaining adequate provision	• Spent too long on H&S decision making • Uncertainty around what we were trying to achieve around H&S, guidance wasn't always implemented • H&S was sometimes seen as purely a Facilities issue instead of a Corporate one – it must be a shared responsibility • We need to assess sustainability – we can't operate at that pace/volume from now on permanently – risk of relying on goodwill and burning people out
Adaptations to workplace • Including screens, signage, meeting spaces		• There was an expectation that we had all the answers but information wasn't often available from the Divisions so that we could determine and issue guidance
Free car parking • Offered to staff throughout the pandemic	• This was well received by staff and helped them get to work safely.	• We've probably now doubled the number of staff who drive into work and there is little to no indication that this will reduce. • Meeting carparking expectations and requirements is unsustainable
Mask management • More Security in entrances and ED • Policing of mask wearing		• Steep learning curve about messaging, managing tricky situations, and dealing with conflict • No sense of ownership from the Trust more widely – it was an E&F issue to police mask wearing and took about 2 months to get Senior leadership support • E&F were criticised for all mask wearing shortfalls • Security staff received poor behaviour from our staff when challenged to wear masks
Provision of free food	• Surge 1 was very stressful in relation to food, but this was noticeably different in surge 2, implementing what we had learned. • People became more understanding.	• Assumptions and expectations of free food – really difficult to manage and distribute fairly, how to prioritise teams for free food, and to explain/communicate all of these decisions. Not possible to please everyone. • Demoralising and demotivating for catering teams

Outstanding care every time

Staff Risk Assessment
Slide title second line

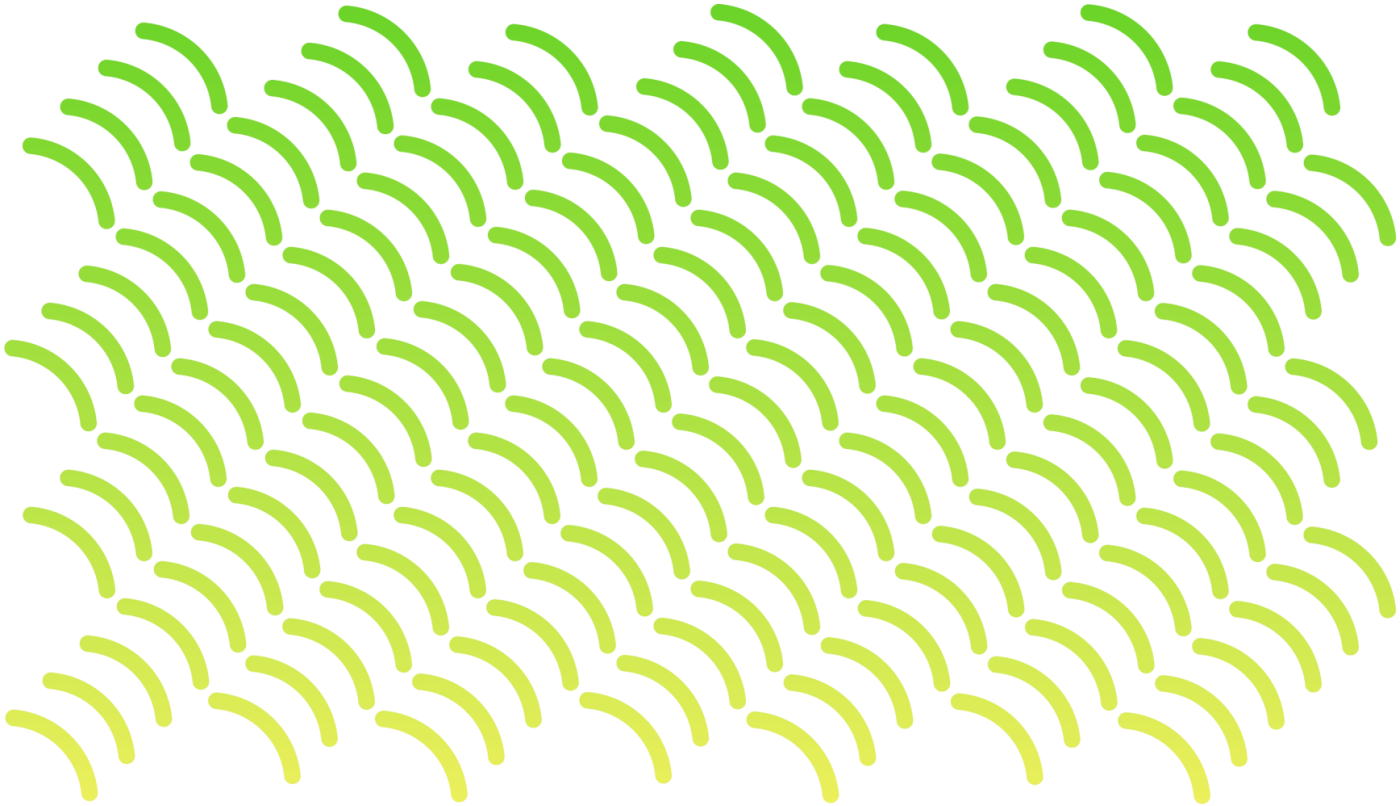
Main changes implemented	What worked well ? What should we keep doing?	What worked less well? What would we do differently?
Developed and implemented a staff COVID Risk Assessment process • Included a process for data collection, and conducting, analysing and logging the Risk Assessments • Developed a template	• Piloting it was helpful - in pharmacy and acute medicine – from which we got helpful, constructive feedback (on content and process, including technical aspects) • Able to make improvements and address issues • OH medical consultants were involved and linked in with lead microbiologist and Deputy CMO on the clinical elements, which resulted in a stronger product • The quality of the end result made reporting on vaccinations very simple – this meant the effort has somewhat 'paid off'	• Sheer administrative workload was significantly underestimated • Strongly under-resourced to administrate the process (6-700 per day needed for manual processing) – including verification, printing, transcription, adding to Excel spreadsheet – • All of these steps were crucial for NHS reporting which was not made clear at the beginning • Process was extremely manual – we had 26 temp staff working on it – it was confidential and had to be done by HR staff – all other HR work was paused. We were not able to bring in support form non-HR staff. • It was extremely stressful on individuals and relationships within the team. • We really needed an electronic form, but it was too late once we realised. Going forward we need to automate this process in an electronic format. We must do this for future waves. • Daily reports were required which involved extensive manual counting. • Targets were set by NHSI/E – 90% target for all Trusts. ○ We need to ensure all the data fields that are logged reflect what we need – NHSI/E brought in new data fields (i.e. actions) – we didn't have this so we had to go back and complete this retrospectively.
Procurement of Additional OH Services • Staff evaluated as high risk or very high risk had to be seen by OH (referred to see an OH clinician) • To fulfil this, we needed to procure additional OH services. • NHSE had created a framework with DPS – we procured Cordell Ltd. We worked with procurement to get a contract in place quickly.	• Procuring the extra OH services was fast and straightforward. • We immediately redirected all 6,000 bank workers to this external OH service which worked well • The NHSE framework that was set up for procuring additional services was very helpful to us.	• We could have engaged information governance earlier to comply with GDPR and associated rules and guidelines – this is part of the process that slowed things down.

Health and Wellbeing (including Staff Support)
Slide title second line

As a major interface with the challenges of operations staff during the pandemic, the Staff Support (and health and wellbeing team shared views and lessons on their own service provision (see below), as well as sharing the experiences and concerns of our operations staff (see Part B)

Main changes implemented	What worked well ? What should we keep doing?	What worked less well? What would we do differently?
Overall higher level of recognition of staff health and wellbeing throughout the pandemic	• Feels like as an org we have started to value the importance of wellbeing	• Wellbeing is still mostly seen as an 'add-on', and we need to keep striving to culturally ingrain H&WB as a core pillar of our work and organisational identity • The pandemic has highlighted our tendency to thrive on crisis management. • Our heritage is 'the poorest but friendliest' – we don't seem to prioritise our health and needs and as an organisation we are finding it hard to change.
Consulting H&WB on redeployment and other strategies		• We need to be asking the right questions with foresight and involving the right people • If we were consulted about redeploying staff we could have advised that this be done by teams and not individually.
Identifying and reaching redeployed staff to offer support		• We need to keep and maintain a list of redeployed people so that we can communicate with and target them. We tried really hard to ask others in the organisation to identify who was redeployed so we could make contact with them. This was unsuccessful and we had to identify them ourselves by physically visiting clinical areas.
Need to provide more psychological support to Senior clinical staff		• We need to offer more support to senior clinical staff – particularly matrons and HONS. • How we do this in the middle of a crisis we are not sure; We have offered group support but got very little response. • We need to try and establish this now while we are not in a surge so that we can support them through any future surge.
Need to build capacity and skills in stress management and resilience among staff		• The theme of uncertainty came up a lot when providing psychological support. Our people need more skill and ability to deal with it. • We need to more thoroughly build stress management and resilience into our competencies and training offers; We need to build our org and team capacity and capability to support resilience and wellbeing • How do we proactively build resilience instead of relying on reactive support?
Increased resilience requirements of the Staff Support function	• We have learned to self reflect, self preserve and build resilience as we go.	• We haven't had adequate offices for a whole year - We were moved out of the Willow with 2 hours notice. We were going to go to Blackshaw but no longer since it got demolished. • We don't have the adequate space and facilities to do our role. So much is expected from us but we have been excluded from decisions. • We question whether we can do this again, like many of the staff we have been supporting.

Part 2a: Employee experience during COVID
Views of colleagues working through the pandemic



Themes emerging from operational and other staff
As captured by Staff Support

Our Staff Support team led support groups in ITU and on wards. They also continued to provide one-to-one psychological support to staff throughout the pandemic. They heard many perspectives from staff about their experiences during the pandemic. Many of these staff were redeployed, often thrown together in new teams with strangers.

Staff support have strongly noted their admiration and praise for staff who have pulled together, worked hard, learned so much, and matured as individuals and collectively.

Managing redeployment of staff	• There was a lack of communication to all parts of the hospital, redeployed or not, on the rationale for the Trust disrupting virtually every team in the hospital. It is still not understood. • A series of connected backfills meant all levels and groups were affected. We need to properly think through how to minimise disruption instead of disrupting everyone. • People should have been moved in teams to preserve the supportive relationships and networks that take years to develop.
Communications and clarity of information around redeployment	• This issue is above matron level. • Staff needed clear explanations why they were being moved. The lack of information added to the confusion, fear and trauma. • We had redeployed nurses into ITUs who had to report to work every day to find out which unit they would work in. The sheer worry of not knowing where you'd be next – literally the following morning. • 20 mins before, staff would be told where they would be needed to create new clinical areas. One example relates to groups of dental nurses who received information at 6pm the night before having to work 12 hour shifts. • At the end of March, 15-20% of redeployed staff are still in ITUs (including community staff, physios, outpatient nurses etc.) Comms around repatriation is still unclear. • Comms for managers have also been low, and (new) responsibilities have been high. The stress of managers has passed down to team members and affected morale greatly.

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Themes emerging from operational and other staff
As captured by Staff Support

Demonstrating compassion and support from Senior Leadership	• This issue is above matron level • At late notice, people are being moved still with very short notice. After just forming a team and acclimatising, they are then being thrust into a new role where they may or may not have the skills needed. • People have felt used. They still have no idea when they are going back. No one has the courtesy to say why they need to stay. If people have the rationale it can help them make sense of their situation. • Really need the most senior staff to be seen to be caring. It's not just about throwing more resources at it – we need a personal expression of care, and visibility. • EMT need to go to the ITUs and say thank you and this should have happened routinely throughout. Thanks are repeated in writing but it needs a personal presence. To our knowledge, only the Director of Culture and OD and the CMO has visited. • Visibility of leaders would make a big difference – it may mean they attend on their days off.
More personal and emotional nature of the work	• Because families have been denied access, staff are fulfilling the roles of families too. • The care became more personal, and then they've had to deal with the effects of so many patients dying
Recovery Plans and allowances	• Staff should have been offered structured time off/debriefs/decompression periods afterwards. This is what happened in other hospitals and we should have done the same. • We must push for mental health 'me' days which are paid for. Other Trusts have done this. • Overall, allowances at St George's and the perception of 'care' from the organisation has been meagre, especially in relation to other Trusts
Training for new roles staff are redeployed to	• People weren't shown the basics. Training procedures were not thorough – some were available but they weren't communicated, people didn't access them when needed. • People were thrown into ITU with no training or information (they didn't access bootcamp because often didn't know about it) • People were told to do training in days off!
Current retention risk	• There is a strong and widespread feeling of exhaustion and depletion. • There is now a strong risk of many staff leaving. • The pandemic has made them rethink their career choice, and their employer.

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Themes emerging from a Schwartz Round
‘How my team weathered the storm’

A Schwartz Round was organised and facilitated on 20th April 2021, supported by our Clinical Psychology staff. This is an event for staff of all professions and levels.

A list of themes emerging from that session were shared, while preserving anonymity. This list of key themes from that session is included below.

- Holding tensions (being ok, not being ok / counsellor vs. scientist)
- Sense of purpose / the need for a structure / routine when many things feel out of control
- Surges of energy
- Feelings of disconnection, reconnecting
- The team as a family
- Growth for the future
- The manager can’t carry everyone
- Reforming teams post COVID - different people have different needs / how to energise and re-motivate
- Expectations of how we should behave and respond – and the impact when we can’t live up to these
- Scientists have feelings too
- Holding trauma
- Hearing, listening, being heard, being seen – the value of sharing experience
- Redeployment – the shock of very different work / facing death

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Themes around Teamwork

- In addition to sharing learnings around the provision of their own people-related services, several of these teams also noted how the pandemic affected teamwork within their own teams and also across usual team boundaries.
- It would also be important to secure input around the theme of teamwork from Operational Divisions.

	Positive	Negative

Autonomy and engagement	• Some teams described how the increase in responsibilities due to the crisis created a stronger sense of autonomy. With so much work to do in a little space of time, there was no time to micromanage.
	• People had to 'figure out for themselves' which creates a sense of achievement and importance and builds personal confidence
	• Work tasks were adapted down to only what really mattered and what was important.
	• All of the above in turn, for some – certainly not all - built engagement and satisfaction at work, which is reflected in the staff survey results also.
	• People were able to step up and shine, and show what they're capable of, and this is not always possible in normal times.
	• The forced speed of decision making, despite the risks involved, was experienced as highly positive.
		• There is a strong desire from teams not to 'let us go back to the way things were'
		• People are afraid of going back to:
		  ○ too many meetings,
		  ○ losing our action-orientation, and
		  ○ doing the things we really need to be doing

Recognition and inclusion of functions	• The pandemic has strengthened profile of what some teams do, and how critical they are to organisation – particularly for teams like H&S or E&F more widely • Some teams enjoyed being more engaged and involved from the beginning, whereas normally it was hard to get a 'seat at the table'. • It felt as though the value of our expertise was being noticed.	
Communication and collaboration	• Boundaries between teams and across divisions were often seen to be smaller, if not altogether absent during the crisis. • Some teams started 'daily huddles' at various levels to deal with the rapidly changing context and calls to action. These get togethers were seen as not only effective but highly engaging for team members and some teams have kept these huddles in place permanently. • Several teams noticed an increased willingness to cooperate among stakeholders, with far less resistance experienced than usual. • A noticeable improvement in interpersonal 'morale'	• There was so much information being shared, much of which was important and appreciated. What it resulted in however was a significant task of identifying and pulling out anything that may be relevant to a specific function. • Communicating plans for the second surge was delayed and some felt they were 'on the back foot' • Lack of community sites planning and consideration. Some felt they had to press for clarity and decisions.

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Themes emerging from a Divisional Management Board
Minutes of a pandemic reflection discussion

Four main questions were considered at a DMB meeting of SNTC in March 2021, where members were asked to reflect on their experiences over the pandemic.
It is important to note that the views from these senior leaders are quite different (and seemingly more positive) to the views of staff, particularly those themes shared by Staff Support.

What are you proud of?

- the amount of activity that was achieved this time and how patients on the list were effectively allocated.
- The service developments that were achieved in spite of Covid.
- Learning lessons from the 1st wave - organisational learning and working well as a team.
- The way the team worked really hard, incredible team work, the second surge was more on course, proud of what was achieved, phenomenal how much had been done.
- This surge was harder because everything was moving faster, the wards as an example but despite that this time everything felt much happier and this was put down to better communication coming from the top so people knew what they were doing.
- The redeployment was better handled (junior doctors) and there were consultants looking after wards.
- No one complained about PPE.
- During the ward changes the communication was good.
- It felt calmer this time, less panic because people knew what to expect this time.
- People were happier because disruption on their lives wasn't so much.
- SGH reputation as an organisation who can do things and do them well. The response to the private sector was managed well, and with others sector. An example was set to others.

What have we learnt about ourselves and the system

- Communication is about the right level of communication.
- No matter how bleak it is there is always a way just so long as you stay calm and think it through.

What should we have done differently? / what do we want to leave behind?

- The process of starting up activity from ITU could have been done better.
- As a team we were generous and flexible but we need to be tougher for our patient's sake. We need to protect our own patients.
- Nursing was still not exactly right. More information needs to be given on how many nurses are needed, etc.
- Staff need kindness as their heads are fried.
- There should be some capital for ourselves and the patients in our care.
- The impact on our patients should not be underestimated. We have given a lot, patients have had pathways delayed, risk had been held within this division, we need support from ITU and the medical division to kick-start that recovery as soon as possible and we need to ask for that support rather than waiting for it to be offered.

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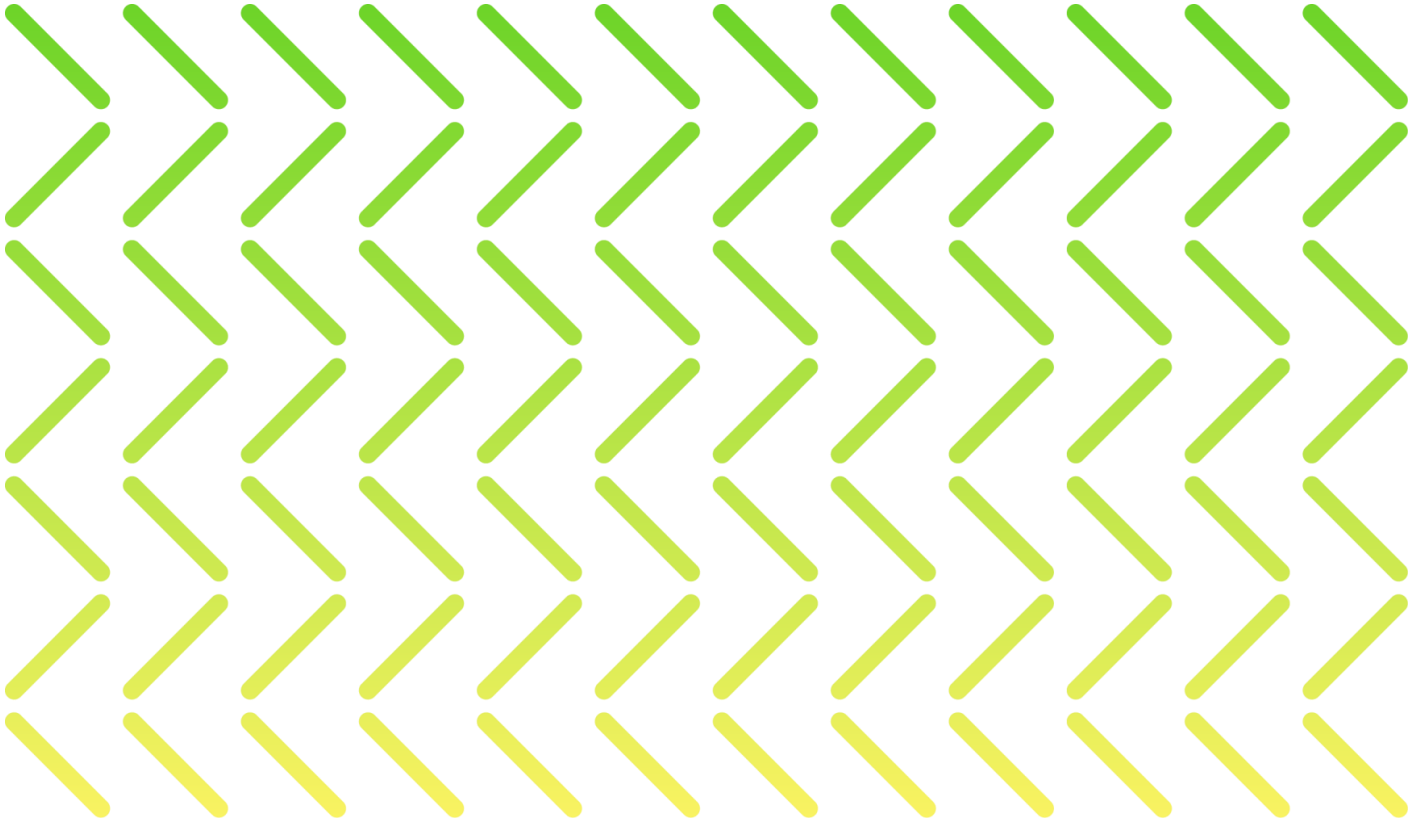
Part 2b: Employee experience during COVID
Staff survey COVID-specific findings



Staff Survey Questions

- The 2020 staff survey involved data collection during October 2020.
- 5,107 staff completed the survey (a response rate of 59%).
- Respondents were asked four classification questions, listed below:
- Charts on the following pages show the breakdown of theme scores for staff answering ‘yes’ to each of these questions, compared with the results of all our staff, which is represented by the first pair of columns in each image.

Have you worked on a COVID-19 specific ward or area at any time? (yes/no)	Have you been redeployed due to the COVI-19 pandemic at any time? (yes/no)
Have you been required to work remotely/from home due to the COVID-19 pandemic? (yes/no)	Have you been shielding? (yes, for myself / yes, for a member of my household/no)

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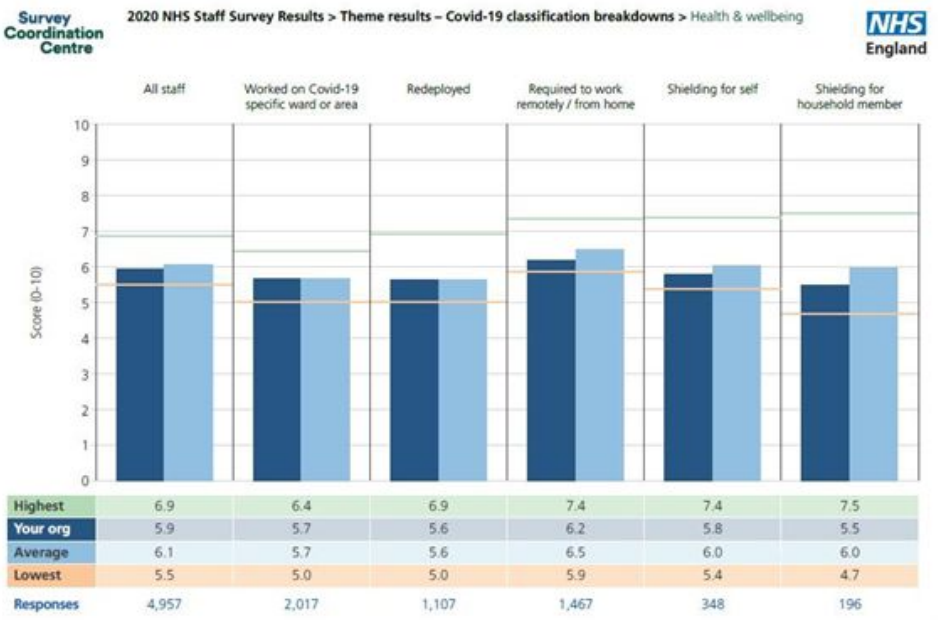
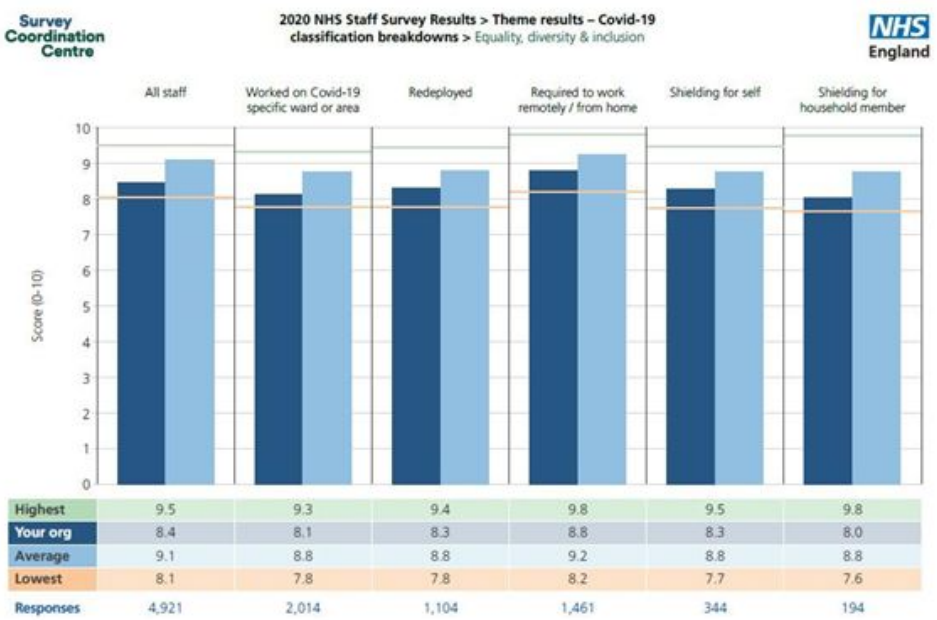
Staff Survey
COVID related insights





Health and Wellbeing

- Staff who identified as working on COVID-19 wards or areas, or as redeployed, rated health and wellbeing higher than staff who identified as remote workers or shielding.

Equality, Diversity and Inclusion

- Staff perceptions of EDI appear similar across all groupings.
- Staff identifying as home/remote workers appear to have slightly more positive perceptions of EDI in our organisation that the other groups.

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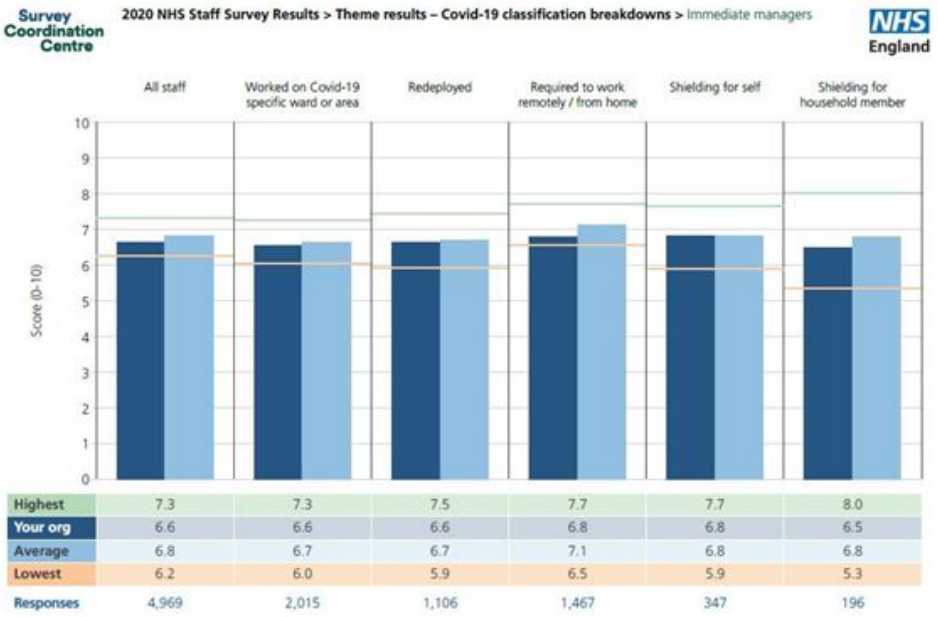
Staff Survey
COVID related insights



Immediate Managers

- Staff identifying as remote/home workers appear to have a greater variance than the average in experience of their immediate managers.
- Managing staff remotely will be a new challenge for many of our managers and the they may not yet have the required capabilities.
- We might therefore consider including remote management skills in our management and leadership development offer.

Morale

- Although scores for morale were very similar across all staff groups, our staff were more notably behind the sector average for the remote/home working groups.
- This might suggest that we rely on face to face contact for maintaining morale more than other organisations.

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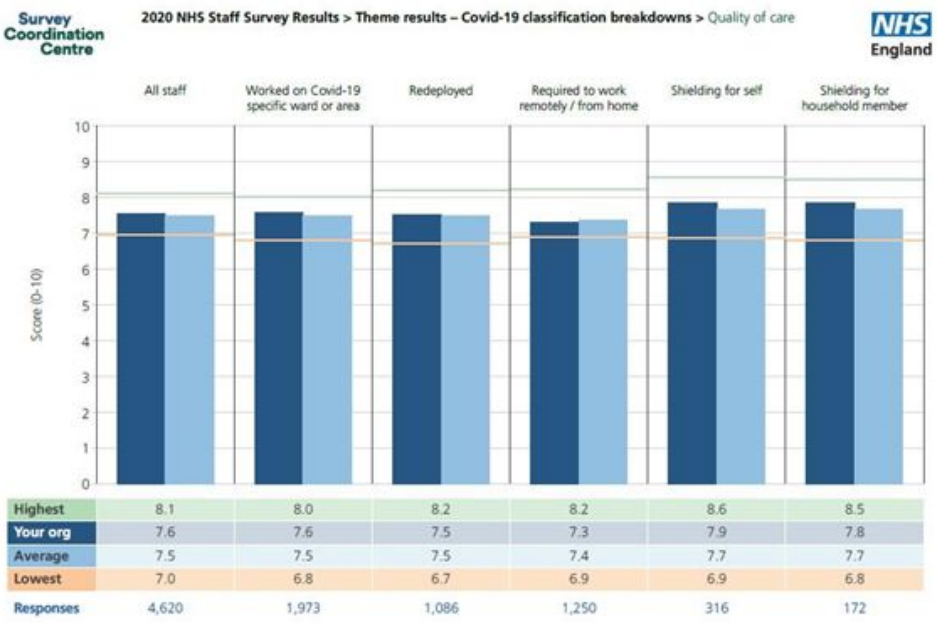
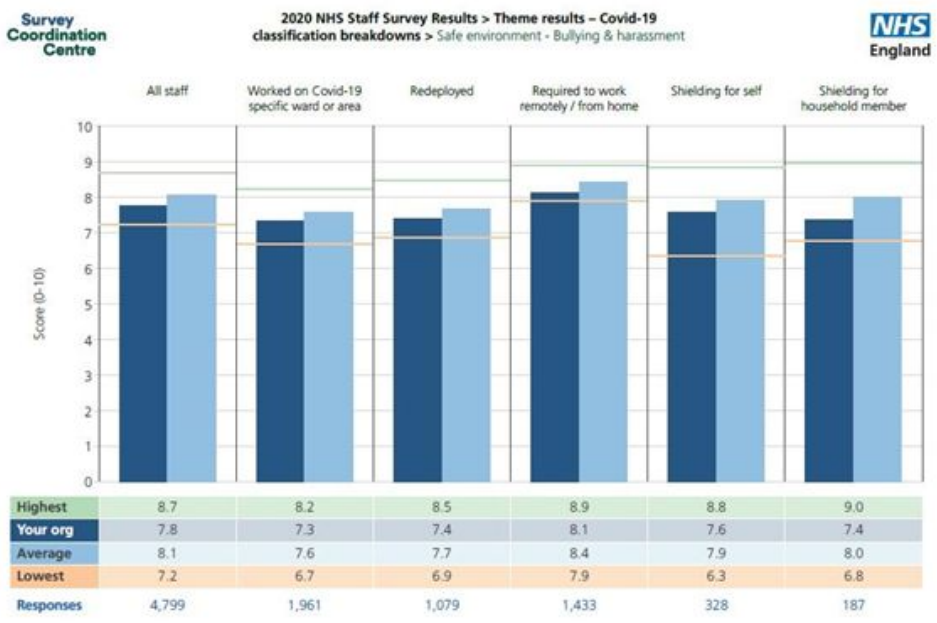
Staff Survey
COVID related insights



Quality of Care

- Apart from remote/home workers (who are less likely to be clinical workers), 'quality of care' was one of the few areas of the staff survey where we scored *above* the sector average.



Bullying & Harassment

- Although in line with the pattern in other Acute Trusts (the 'average'), staff who worked on COVID-19 areas or redeployed staff had a poorer experience of bullying and harassment than staff who were shielding or home/remote working.

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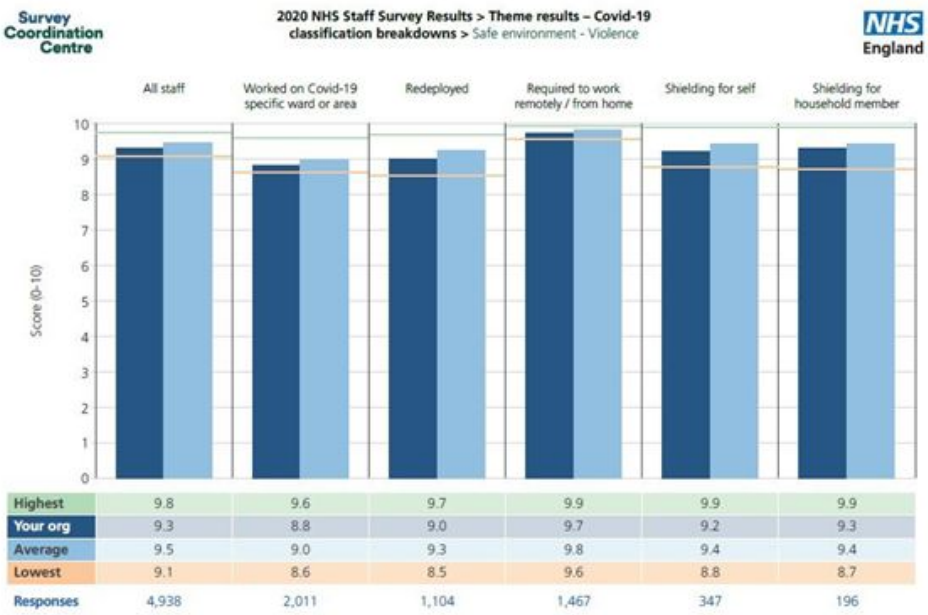
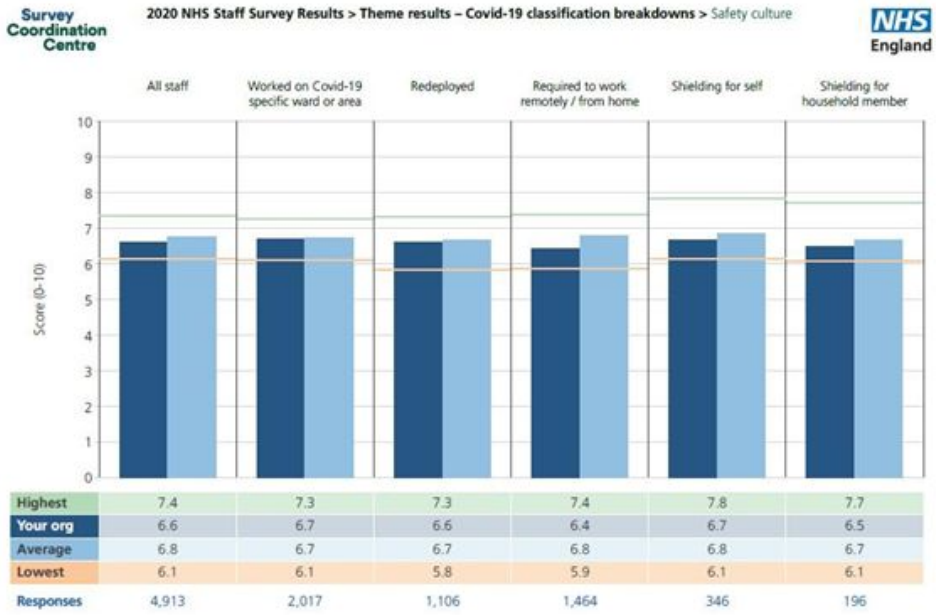
Staff Survey
COVID related insights



	All staff	Worked on Covid-19 specific ward or area	Redeployed	Required to work remotely / from home	Shielding for self	Shielding for household member
Highest	9.8	9.6	9.7	9.9	9.9	9.9
Your org	9.3	8.8	9.0	9.7	9.2	9.3
Average	9.5	9.0	9.3	9.8	9.4	9.4
Lowest	9.1	8.6	8.5	9.6	8.8	8.7
Responses	4,938	2,011	1,104	1,467	347	196

Violence

- Although in line with the pattern in other Acute Trusts (the 'average'), staff who worked on COVID-19 areas or redeployed staff had a poorer experience of experiencing violence than staff who were shielding or home/remote working.



	All staff	Worked on Covid-19 specific ward or area	Redeployed	Required to work remotely / from home	Shielding for self	Shielding for household member
Highest	7.4	7.3	7.3	7.4	7.8	7.7
Your org	6.6	6.7	6.6	6.4	6.7	6.5
Average	6.8	6.7	6.7	6.8	6.8	6.7
Lowest	6.1	6.1	5.8	5.9	6.1	6.1
Responses	4,913	2,017	1,106	1,464	346	196

Safety Culture

- When compared to the average scores for Acute Trusts, staff working in COVID 19 areas rated our safety culture slightly higher than other staff groups.

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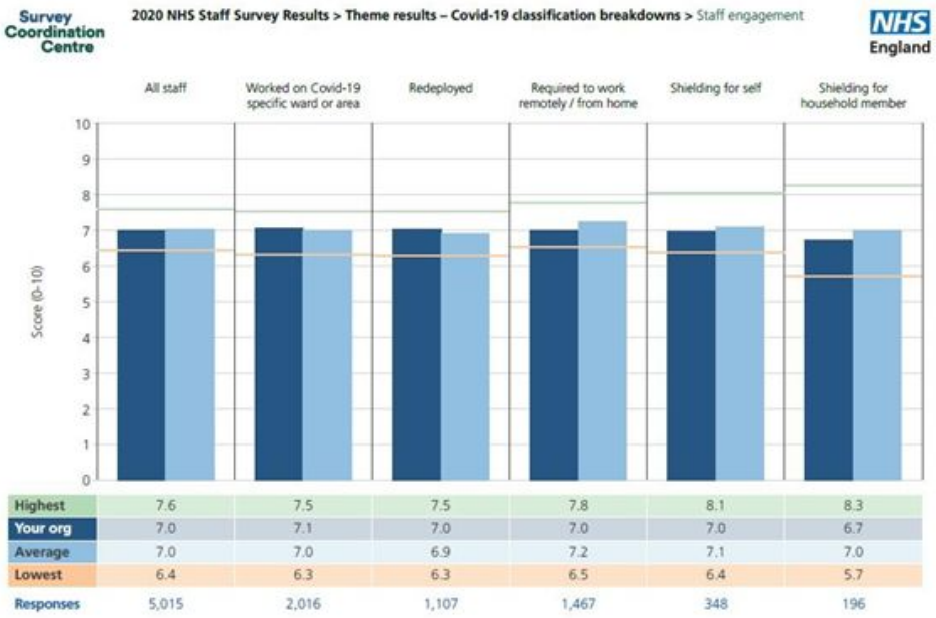
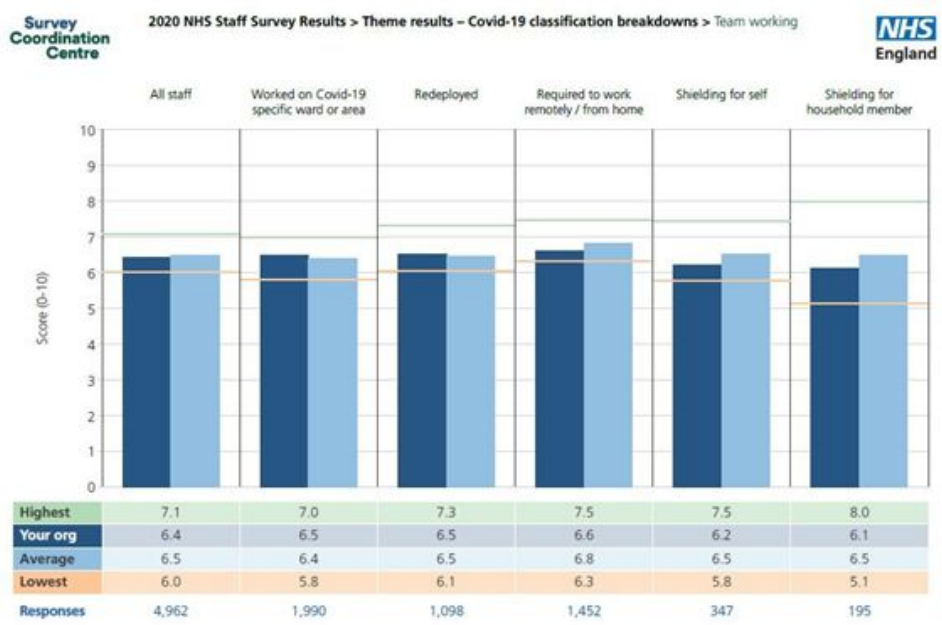
Staff Survey
COVID related insights



Engagement

- Redeployed staff and staff working on COVID-19 areas rated overall engagement as slightly above the average for Acute Trusts, whereas all other staff groups rated it slightly below the average.



Team working

- Similar to scores for engagement - redeployed staff and staff working on COVID-19 areas rated team working as slightly above the average for Acute Trusts, whereas all other staff groups rated it slightly below the average.

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NHS
St George's University Hospitals
NHS Foundation Trust

Financial update for Governors

Andrew Grimshaw
Chief Financial Officer

08th December 2021

Executive Summary – Month 7 (October)

Area	Key Issues	Current Month (YTD)	Previous Month (YTD)
Financial Position	The Trust is reporting a deficit of £2.6m at the end of October, which is on plan. This includes £16.3m of ERF income and £11.4m of ERF costs, both of which are £7.7m higher and lower than plan (and so offset).	On Plan	On Plan
Income	Excluding ERF, income is reported at £1.4m adverse to plan at Month 7. This is due to a shortfall in COVID testing income, which is offset in non-pay.	£1.4m Adv to plan	£0.6m Adv to plan
Expenditure	Excluding ERF, expenditure is reported at £1.4m favourable to plan at Month 7. This is due to lower COVID testing and Commercial Pharmacy costs, partially offset by higher staffing costs related to COVID.	£1.4m Fav to plan	£0.6m Fav to plan
ERF	The Trust has received £16.3m of ERF income, which is £7.7m over plan. The Trust has incurred £11.4m of associated costs, which is £7.7m under plan.	On Plan	On Plan
Capital	Capital expenditure of £28.8m has been incurred year to date. This is to £0.5m favourable to a plan of £29.2m.	£0.5m Fav to plan	£0.5m Fav to plan
Cash	At the end of Month 7, the Trust's cash balance was £70.9m, which is £67.9m higher than the £3m minimum cash balance required by NHSE&I. The Trust is actively ensuring suppliers are paid in good time.	£67.9m Fav to plan	£59.6m Fav to plan

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Forecast for 2021/22 H2 and full year

	£m
H1 reported	(0.6)
H2 Forecast	(16.6)
Cumulative trust position	**(17.3)**
ERF expected earnings	7.7
Funding from SWL	2.6
Run rate improvements/Savings	2.0
Total Deficit	**(5.0)**

- FIC reviewed, and the Trust Board approved this planning assumption for H2 in November.

- Reflects pressure on SGH, SWL and nationally
  - Higher CIP requirement.
  - Reduction in covid funding.

- Need to focus on the actions to support delivery;
  1. Deliver or beat the H2 Forecast
  2. Deliver the Elective trajectory.
  3. Identify improvements to the run rate

- This will be challenging in relation to the pressures the trust is under.
- But this reflects the national direction of travel to return to Long Term Plan assumptions.
- Establish actions and way of working for H2 that will roll into 2022/23 planning. Seek to deliver more in H2 to support 22/23.

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How do we deliver?

- Focus on recovering activity, productivity and better ways of working.
- We ensure we use everything we have well.
- Expenditure is an output, lets manage the inputs.
- Focus on systems and processes that underpin this.

- Recognise that some of the funding we have received over the last 18 months will be withdrawn. Adjust our behaviour to reflect that. But also recognise this is not a flat reduction across the board.

- Put the triumvirates at the heart of this.
- Link the wider exec group around to support; CPO workforce systems, CNO/CMO professional compliance etc.

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Planning for 2022/23

- Planning guidance has not yet been issued by NHSI.
- However, some headlines have been signalled;
  - 50% reduction in covid funding.
  - 100% reduction in non-NHS income support.
  - Improvement trajectories will be identified for trusts to aid a return to pre-covid Long Term Financial Planning assumptions.
- 2022/23 is expected to be a very challenging year as the NHS returns to normal planning processes.
- Detailed guidance is expected “before Christmas”
- Pending receipt of national guidance the Finance Department is scoping scenarios and starting planning for the new year. The first draft of this will be reported to the Finance and Investment Committee in December.

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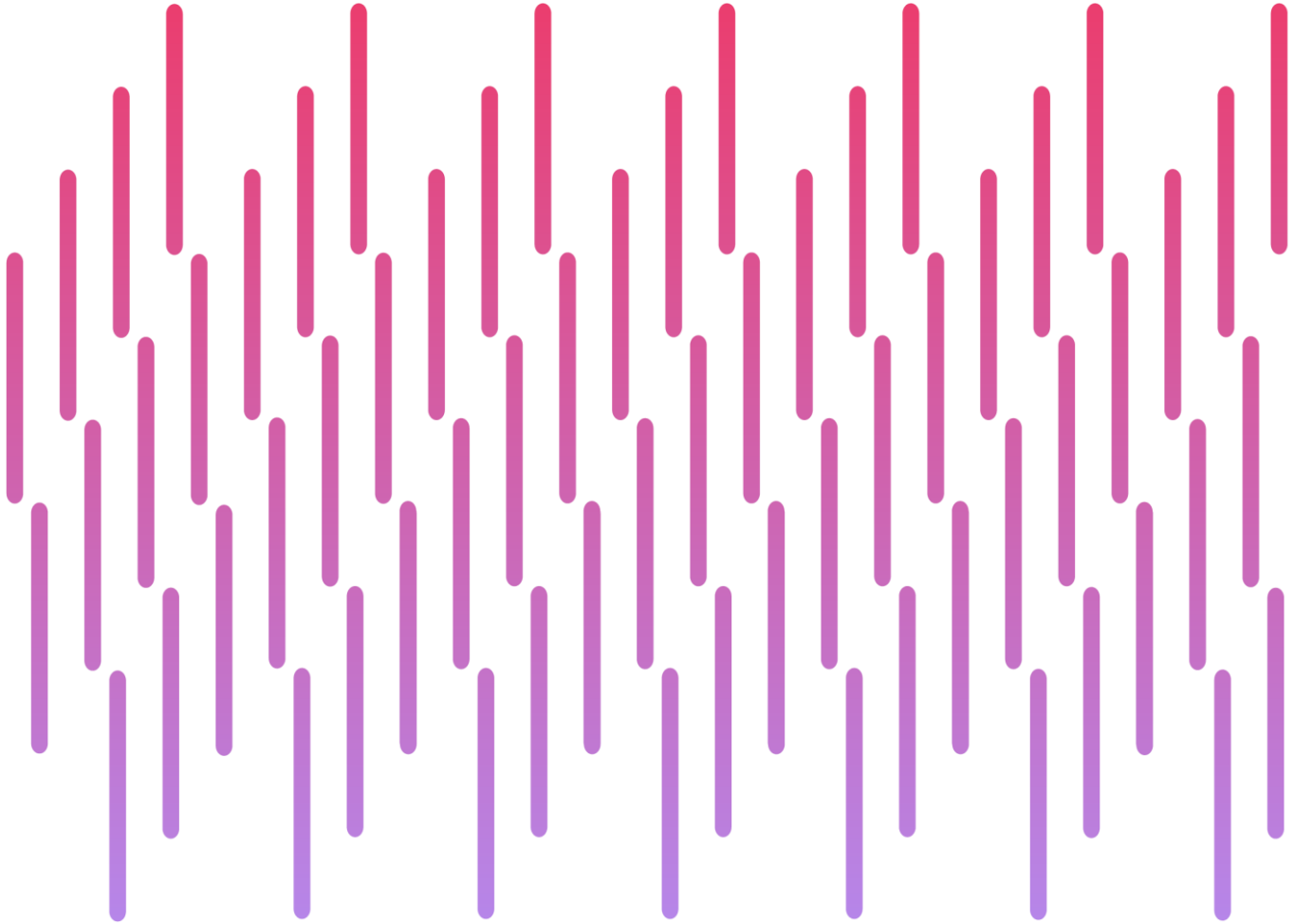
Supporting information

- Detailed income and expenditure account
- Balance sheet
- Cashflow
- Capital expenditure



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1. Month 7 Financial Performance

			Full Year Budget (£m)	M7 Budget (£m)	M7 Actual (£m)	M7 Variance (£m)	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)
Excluding ERF	**Income**	SLA Income	856.9	78.4	77.8	(0.5)	503.1	500.8	(2.3)
		Other Income	136.3	11.5	11.3	(0.2)	78.8	79.7	0.9
	Income Total		**993.2**	**89.9**	**89.1**	**(0.8)**	**581.9**	**580.5**	**(1.4)**
	Expenditure	Pay	(595.6)	(57.9)	(58.2)	(0.3)	(349.1)	(351.0)	(1.9)
		Non Pay	(374.7)	(31.4)	(30.3)	1.1	(215.5)	(212.2)	3.3
	Expenditure Total		**(970.2)**	**(89.3)**	**(88.5)**	**0.8**	**(564.6)**	**(563.2)**	**1.4**
	Post Ebitda		(44.1)	(3.7)	(3.7)	(0.0)	(24.7)	(24.7)	0.0
	Grand Total		**(21.2)**	**(3.1)**	**(3.1)**	**0.0**	**(7.4)**	**(7.5)**	**(0.0)**
ERF	**Income**		14.3	1.2	1.2	0.0	8.5	16.3	7.7
	Expenditure		(3.5)	0.0	0.0	(0.0)	(3.7)	(11.4)	(7.7)
	Total		**10.8**	**1.2**	**1.2**	**(0.0)**	**4.9**	**4.9**	**0.0**
	Reported Position		**(10.4)**	**(2.0)**	**(2.0)**	**0.0**	**(2.6)**	**(2.6)**	**(0.0)**

Trust Overview

The in month reported position at **M7 is a £2.0m deficit, which is on plan. The YTD position is a £2.6m deficit, which is on plan**.

Excluding ERF income and costs:

- **Income** is £1.4m under plan, due to a shortfall in COVID testing income.
- **Pay** is £1.9m overspent across Junior Doctor and Nursing staff groups due to additional costs related to COVID, such as sickness.
- **Non-pay** is £3.3m underspent due to lower COVID testing costs and Commercial Pharmacy.

The Trust has received £16.3m of ERF income, which is £7.7m over plan. The Trust has incurred £11.4m of associated costs, which is £7.7m under plan.

2. Balance Sheet as at 31st October 2021

Statement of Financial Position	M12 March-21 FY 20-21 Actual Audited (£m)	M07 September-21 FY21-22 YTD Actual (£m)	Movement YTD October-21 (£m)
Fixed assets	**470.7**	**483.6**	**12.9**
Current assets			
Stock	**13.2**	16.2	3.0
Debtors	**83.3**	58.5	(24.8)
Cash	**36.6**	70.9	34.3
Total Current Assets	**133.1**	**145.6**	**12.5**
Current liabilities			
Creditors	**(110.8)**	(151.3)	(40.5)
Capital creditors	**(36.0)**	(19.9)	16.1
PDC div creditor	**0.0**	(4.7)	(4.7)
Provision<1 Year	**(0.9)**	(0.9)	0.0
Borrowings< 1 year	**(5.1)**	(5.5)	(0.4)
Int payable creditor	**(0.1)**	(0.1)	0.0
Total current liabilities	**(152.9)**	**(182.4)**	**(29.5)**
Net current assets/-liabilities	**(19.8)**	**(36.8)**	**(17.0)**
Provisions> 1 year	**(3.3)**	(3.2)	0.1
Borrowings> 1 year	**(57.4)**	(56.4)	1.0
Total Long-term liabilities	**(60.7)**	(59.6)	1.1
Net assets	**390.2**	**387.2**	**(3.0)**
Taxpayer's equity			
Public Dividend Capital	**531.9**	531.9	(0.0)
Income & Expenditure Reserve	**(225.2)**	(228.3)	(3.1)
Revaluation Reserve	**82.4**	82.4	0.0
Other reserves	**1.2**	1.2	0.1
Total taxpayer's equity	**390.2**	**387.2**	**(3.0)**

M07 YTD Statement of Financial Position

- Fixed asset values have increased by £12.9m since March-21. This includes the impact of depreciation £16.1m, capital expenditure £28.8m and Grove reversionary interest of £115k.
- The Inventory value has increased by £3.0m compared to Mar-21 (slide 10h). This is due to increases in central store stock, pharmacy, cardiac catheter and cardiac pacing stocks (slide 10h).
- Debtors has decreased by £24.8m since March 2021, and this is due to high accounts receivables turnover by the Trust from NHS debtors. There has been significant reduction in the NHS Debtor accrual, as well as NHS CCG and NHS FT receivables.
- The cash position is £34.3m higher than reported at year-end in March-21, owing to timing differences on payments at year end that have now reversed.
- Cash resources are tightly managed monthly to meet the £3.0m minimum cash target at the end of the year.
- Creditors are £40.5m higher than the figures reported at year-end in March-21. There is a significant increase in Non-NHS Non-Pay accruals since March-21. March-21 creditors were low due to HMRC and NHS Pension liability paid in advance compared to September-21. Other liabilities (e.g. deferred income) have decreased by £2.4m since March-21.
- Capital creditors are £16.1m lower than March-21. This decrease is due to 2020/21 capital creditors paid in 2021/22.
- Provisions have decreased by £0.1m which is due to the utilisation of the early retirement provision.
- There has been no new borrowing since March-21, except the increase in capital finance lease borrowing of £3.4m M07 YTD.
- PDC dividend charge creditors have increased to £4.7m since March-21. This is due to the M07 YTD PDC dividend charge accrual of £7.4m. This accrual is based on the 2021/22 forecasted PDC dividend charge of £12.6m. In September-21, the Trust paid a PDC dividend charge payment of £2.3m and also received a PDC dividend charge refund of £362k for 2021/22.
- No PDC capital has been received between April-21 and October-21.
- Taxpayers equity reduced by £3m in M07 YTD. This is mainly due the I&E deficit of £3.1m in M07 YTD. M07YTD I&E deficit, includes finance expense and PDC dividend charges.

3. Month 7 Cash Flow Statement

Statement of Cash Flow	M07 YTD FY 21-22 Actual £m
Opening Cash balance	**36.6**
Income and expenditure deficit	(3.1)
Depreciation	16.1
Impairment	0.0
Interest payable	1.9
PDC dividend	7.4
Other non-cash items	(0.2)
Operating surplus/(deficit)	**22.1**
Change in stock	(3.0)
Change in debtors	24.8
Change in creditors	40.5
Change in provisions	(0.1)
Net change in working capital	**62.2**
Capital spend	(28.8)
Capital Creditors	(16.1)
Capital additions Finance leases	3.4
Interest paid	(1.9)
PDC dividend charge paid	(2.7)
Net change in investing activities	**(46.1)**
PDC Capital Received	0.0
Accrued Interest YTD (DH & LEEF)	0.0
DH Capital £14.747m Loan repaid	(0.3)
LEEF Loan (Other Loan)	(0.7)
PFI	(0.8)
Finance lease payments	(2.2)
Net change in financing activities	**(4.0)**
Cash balance as at 31.10.2021	**70.9**

M07 FY21-22 YTD cash movement

- The cumulative M07 21-22 I&E deficit is £3.1m. (*NB this includes the impact of donated grants and depreciation which is excluded from the NHSI performance total).
- Within the I&E deficit of £3.1m, depreciation (£16.1m) does not impact cash. The charges for interest payable (£1.9m) and PDC dividend (£7.4m) are added back and the amounts actually paid for these expenses shown lower down for presentational purposes. This generates a YTD cash "operating surplus" of £22.1m.
- The net change in working capital has increased by £62.2m in October-21 compared March-21. This is due to major movement in creditors of £40.5m, which is due to increased NHS and Non-NHS accruals, and increased HMRC and NHS Pension liability in October-21 compared to March-21.
- Stock value increased by £3.0m in October-21 compared to March-21. This is due to significant increase in central stores stock.
- The Trust made a DH Capital loan repayment of £0.3m in May-21, and LEEF loan payment of £0.7m was made in June-21. In addition, as at October-21, the Trust has made YTD repayments of £0.8m and £2.2m for PFI and Finance leases, respectively.
- Capital creditors reduced by £16.1m compared to March-21 and new capital finance lease additions of £3.4m have been made YTD as at October-21.
- There has been no capital or revenue support PDC funding received between April-21 and October-21.

October-21 cash position

- The Trust achieved a cash balance of £70.9m on 31st October-21, £67.9m higher than the £3m minimum cash balance required by NHSI.

4. M7 Capital

- The Trust is planning to spend £56.6m on capital expenditure this financial year, including £3.5m on finance leases
- This spend is to be funded by Internal capital of £20.5m, leases of £3.5m and new PDC allocation of £32.6m
- The spend is planned to cover a number of spending initiatives this year covering IT Medical Equipment and estate infrastructure
- The Trust has spent £28.8m YTD as at M07
- Trust continues to exert tight control over capital expenditure, approving requisitions for all projects

Spend category	FY Budget £000	YTD budget £000	YTD exp £000	*YTD var £000*
MRI	9,900	9,900	7,423	2,477
Cath Labs	6,700	6,700	4,866	1,834
Estates	6,200	2,102	8,663	-6,561
IT	6,600	2,302	3,053	-751
Lease Renewals	3,500	3,500	3,450	50
SWLP BAU Capital	500	0	0	0
SWLP 4TTP	700	0	0	0
Total St George's Schemes	**34,100**	**24,504**	**27,455**	**-2,951**
SWL Schemes				
Critical Care Expansion	27,400	3,668	892	2,776
SGH Emergency Floor	3,070	512	45	467
SWL LCHR (host TBC)	2,000	333	0	333
SWL PACs	1,300	217	429	-212
Community Diagnostics Hub	2,000	0	0	0
Total SWL Schemes	**35,770**	**4,730**	**1,366**	**3,364**
Total Expenditure	**69,870**	**29,234**	**28,821**	**413**
Mitigations required in year	-15,691	0	0	0
SWL contingency held at STG	2,400	0	0	0
Expenditure as per PFR	**56,579**	**29,234**	**28,821**	**413**

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Meeting Title:	**Council of Governors**		
Date:	8 December 2021	**Agenda No**	**4.2**
Report Title:	**Membership and Engagement Committee Report**		
Lead Director/ Manager:	Stephen Jones, Chief Corporate Affairs Officer		
Report Author:	Stephen Jones, Chief Corporate Affairs Officer		
Presented for:	Council of Governors is asked to note the attached update.		
Executive Summary:	This report updates the Council of Governors on the meeting of the Governors' Nomination and Remuneration Committee held on 6 December 2021. The Committee has recently re-formed with many Governors attending the meeting for the first time. There was a wide-ranging discussion about the means by which governors can and should engage with their members, noting the different methods that may be needed for 'local' public members, public members from the rest of England and staff members. Using existing groups (e.g. Healthwatch) may be helpful. It was felt important to find ways of gaining members' views and from a practical point of view, focus groups were suggested. It was also noted that there may be a mis-match between the topics the Trust would want to engage members on (such as local NHS re-organisations) and those that may be of more interest to members. These might include issues relating to specific conditions which might appeal to a specific cohort of members. The annual members meeting was discussed and it was noted that attendance was disappointing but this may be due to novelty of online meetings having worn off. Finally, the Committee heard of the work of the Patient Partnership Experience Group which has been inevitably curtailed due to the pandemic but for which further developments are planned.		
Recommendation:	The Council of Governors is asked to the update from the Membership and Engagement Committee.		
Supports			
Trust Strategic Objective:	All objectives		
CQC Theme:	Well-Led		
Single Oversight Framework Theme:	Leadership and improvement capability		
Implications			
Risk:	Performance of the Chairman and Non-Executive Directors is fundamental to the effective leadership of the Trust		
Legal/Regulatory:	*Foundation Trust Code of Governance* section B.6		
Resources:	As set out in the paper.		
Previously Considered by:	N/A	**Date**	N/A
Appendices:	N/A		

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Membership Engagement Committee Report

Council of Governors, 8 December 2021

1.0 PURPOSE

1.1 This paper provides an update on the issues considered at the Membership Engagement Committee meeting held on 6 December 2021.

2.0 BACKGROUND

2.1 The role of the Membership Engagement Committee is to develop and implement the Trust's Membership Strategy, identify key actions for supporting effective engagement with members of the Trust and facilitate mechanisms and activities which ensure the Trust's membership is representative of the communities it services. The Committee plays a key role in ensuring that all members of the Council of Governors participate in activities which improve engagement and involvement with members. The Committee provides assurance on these matters to the full Council of Governors.

2.2 The Council of Governors has a collective statutory duty to represent the interests of members and the public. While the Committee acts as a working group for the delivery of the Membership Strategy, effective membership engagement is an issue for which the Council has collective responsibility.

2.3 Since the last meeting of the Membership Engagement Committee on 8 September 2021, the membership of the Committee has been refreshed, with the following Governors indicating their interest in being members of the Committee:

- Adil Akram, Public Governor (Wandsworth)
- Afzal Ashraf, Public Governor (Wandsworth)
- Alfredo Benedicto, Appointed Governor (Merton Healthwatch)
- Jenni Doman, Staff Governor (Non-Clinical)
- John Hallmark, Public Governor (Wandsworth)
- Hilary Harland, Public Governor (Merton)
- Marlene Johnson, Staff Governor (Nursing and Midwifery)
- Richard Mycroft, Public Governor (South West Lambeth), Lead Governor
- Khaled Simmons, Public Governor (Merton)

2.4 The Committee has not yet selected a chair to recommend to the Council of Governors for approval.

3.0 ISSUES DISCUSSED

3.1 As the Committee meeting on 6 December 2021 was the first of the newly constituted Committee, with a substantial turnover in Governor membership, the meeting was largely devoted to taking stock of the current Membership Strategy and engagement activities in the

context of the need to develop a successor to the current Membership Strategy, which runs to July 2022.

3.2 The key issues discussed and considered included:

- Update on implementation of current Membership Strategy: The Committee received an update on the implementation of the year three commitments in the current membership strategy. It noted that the planned constituency engagement event in South West Lambeth had been deferred pending a review by the Committee of engagement activities.

- Taking stock of current membership activity: With a view to developing thinking about a new membership strategy, there was a wide-ranging discussion about the means by which governors can and should engage with their members, noting the different methods that may be needed for 'local' public members, public members from the rest of England and staff members. Using existing groups (e.g. Healthwatch) may be helpful. It was felt important to find ways of gaining members' views and from a practical point of view, focus groups were suggested. It was also noted that there may be a mis-match between the topics the Trust would want to engage members on (such as local NHS re-organisations) and those that may be of more interest to members. These might include issues relating to specific conditions which might appeal to a specific cohort of members.

- Annual Members' Meeting (AMM): The Committee considered a paper reflecting on the September 2021 AMM, and the learning that could be applied to planning the 2022 meeting. Overall, the meeting had been delivered well and to a professional standard, and it involved a large number of Board members. However, attendance by members and the public had been a disappointment, with the meeting attracting approximately a quarter of the number which had attended the virtual AMM the previous year. While recognising that it was early to start the planning for the Annual Members' Meeting for 2022, Governors suggested consideration be given to holding the meeting at different times of the day, and potentially holding two meetings; one during the day principally aimed at staff, and another in the evening.

- Patient Partnership and Engagement Group (PPEG): The Committee received an update on the work of the PPEG, the Trust's principal strategic forum for engaging patient representatives. The work of PPEG had been somewhat curtailed due to the pandemic and as a result of recent operational pressures. The Committee heard that the Trust's previous Head of Patient Experience had left the Trust and the Trust had decided to separate responsibilities for patient experience and patient complaints, and would be making two separate appointments. Sarah Forrester, Appointed Governor for Healthwatch Wandsworth, offered to attend meetings of PPEG on behalf of Governors to help ensure the PPEG and membership work of Governors were coordinated effectively.

4.0 RECOMMENDATION

4.1 The Council of Governors is asked to the update from the Membership and Engagement Committee.