Trust Board Meeting

Date and Time: Thursday 6 April 2017, 10:00 – 12:00
Venue: Hyde Park Room, 2nd Floor, Lanesborough Wing

PATIENT STORY
Robert Bieber who has experiences positive patient experience in the Urology Department talking to Health Care Professionals as part of the Continuing Education programmes, and supporting the Department's Patient Support Groups.

Time	Item	Subject	Action	Lead	Format
1. OPENING ADMINISTRATION					
10:15	**1.1**	**Welcome and Apologies**	-	Chairman	-
	1.2	**Declarations of Interest**	-	All	Oral
	1.3	**Minutes of Meeting held on 09.03.17**	Approve	Chairman	Paper
	1.4	**Action Log and Matters Arising**	Review	All	Paper
	1.5	**Update from Chair and CEO**	Inform	CEO	Oral
2. PATIENT SAFETY, QUALITY AND PERFORMANCE					
10:25	**2.1**	**Briefing on Learning from Patient Deaths**	Inform	Nigel Kennea	Paper
	2.2	**Quality Improvement Plan**	Assure	HoG	Paper
	2.3	**Performance & Quality Report**	Review	COO/CN	Paper
	2.4	**Report from Quality Committee**	Inform	Chair of Committee	Oral
	2.5	**Elective Care Data Quality Recovery Programme**	Update	ECRPD	Paper
	2.6	**Hospital Pharmacy Transformation Plan 2016 - 2020**	Inform	MD	Paper
3. FINANCE					
11:00	**3.1**	**Month 11 Finance Report**	Assure	DFPR/DFO	Paper
	3.2	**Report from Finance & Performance Committee**	Inform	Chair of Committee	Oral
	3.3	**Clare House – Demolition**	Approve	DFPR	Paper
4. WORKFORCE					
11:15	**4.1**	**Workforce Performance Report**	Inform	HRAB	Paper
	4.2	**Report from the Workforce and Education Committee**	Inform	Chair of Committee	Oral
5. GOVERNANCE & RISK					
11:30	**5.1**	**Corporate Risk Register**	Review	MD	Paper
	5.2	**Report from Audit Committee**	Inform	Chair of Committee	Paper
6. CLOSING ADMINISTRATION					
11:45	**6.1**	**Questions from the Public**	-	Public	Oral
	6.2	**Summary of Actions**	-	Co Sec	Oral
	6.3	**Any New Risks or Issues**		All	-
	6.4	**Items for Future Meetings** i. Communications Strategy and Annual Plan (June 2017) ii. ICT Strategy (May 2017) iii. Update on Outpatients Programme and Business Case (May 2017) iv. Update on Leadership Strategy (May 2017) v. Committee Terms of Reference & Annual Plans 2017-18 (May 2017) vi. Review of Trust's Insurance Arrangements (May 2017) vii. FOI Report (May 2017) viii. Update on Programme with Quality Special Measures Enforcement Actions (May 2017) ix. IPC Annual Report (June 2017)		-	-

		x. ICT Plans (June 2017) xi. Evaluation of Overseas Visitors and Migrant Cost Recovery Pilot (June 2017) xii. Safeguarding Report (July 2017) xiii. Charity and SGUL to attend Board (July 2017) xiv. Learning from Avoidable Deaths (July 2017)			
	6.5	**Any Other Business**	-	Chair	-
	6.6	**Reflection on Meeting**	-	All	Oral
12:00		**Close**			

Date and Time of Next Meeting: Thursday 4 May 2017, 10:00 – 13:00

Trust Board
Purpose, Membership and Meetings

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

Membership and Those in Attendance		
Members (Voting)	**Designation**	**Abbreviation**
Gillian Norton	Chair	Chair
Simon Mackenzie	Chief Executive	CEO
Ann Beasley	Non-Executive Director	
Stephen Collier	Non-Executive Director	Name/NED
Jenny Higham	Non-Executive Director (University Rep)	
Sir Norman Williams	Non-Executive Director	
Sarah Wilton	Non-Executive Director	
Avey Bhatia	Chief Nurse	CN
Iain Lynam	Chief Restructuring Officer & Acting Chief Financial Officer	CRO/CFO
Andrew Rhodes	Medical Director	MD
Thomas Saltiel	Associate Non-Executive Director	Name/NED
Executive Team		
Mark Gammage	HR Advisor to the Board	HRAB
Mark Gordon	Chief Operating Officer	COO
Richard Hancock	Director of Estates & Facilities	DE&F
Diana Lacey	Elective Care (Data Quality) Recovery Programme Director	ECRPD
Larry Murphy	Chief Information Officer	CIO
Divisions		
Alison Benincasa	Divisional Chair, CSD	DC/CSD
Tunde Odutoye	Divisional Chair, SCTN	DC/SCNT
Lisa Pickering	Divisional Chair, MedCard	DC/MedCard
Justin Richards	Divisional Chair, CWDT	DC/CWDT
NHS Improvement		
Steve Leivers	Financial Improvement Director	FID
Marie-Noelle Orzel	Quality Improvement Director	QID
Secretariat		
Fiona Barr	Corporate Secretary and Head of Corporate Governance	Co Sec

Trust Board Dates 2017-18 (Thursdays)		
04.05.17 10:00 – 13:00	08.06.17 10:00 – 13:00	06.07.17 10:00 – 13:00
10.08.17	07.09.17	05.10.17

10:00 – 13:00	10:00 – 13:00	10:00 – 13:00
09.11.17 10:00 – 13:00	07.12.17 10:00 – 13:00	11.01.18 10:00 – 13:00
08.02.18 10:00 – 13:00	08.03.18 10:00 – 13:00	

Trust Board (Public)
9 March 2017 – From 10:00
H2.5 Boardroom, 2nd Floor, Hunter Wing

Name	Title	Initials
PRESENT		
Sir David Henshaw	Non-Executive Director (Chair)	
Simon Mackenzie	Chief Executive	CEO
Ann Beasley	Non-Executive Director	NED
Stephen Collier	Non-Executive Director	NED
Jenny Higham	Non-Executive Director	NED
Gillian Norton	Non-Executive Director	NED
Sir Norman Williams	Non-Executive Director	NED
Sarah Wilton	Non-Executive Director	NED
Avey Bhatia	Chief Nurse	CN
Iain Lynam	Chief Restructuring Officer & Chief Finance Officer	CRO/CFO
Andy Rhodes	Medical Director	MD
IN ATTENDANCE		
Thomas Saltiel	Associate Non-Executive Director	NED
Mark Gammage	HR Advisor to the Board	HRAB
Mark Gordon	Chief Operating Officer	COO
Richard Hancock	Director of Estates & Facilities	DE&F
Larry Murphy	Chief Information Officer	CIO
Marie-Noelle Orzel	Improvement Director	ID
Alison Benincasa	Divisional Chair, CSD	DC – CSD
Tunde Odutoye	Divisional Chair, Surgery	DC - SNTC
Justin Richards	Divisional Chair, CWDT	DC - CWDT
Lisa Pickering	Divisional Chair, MedCard	DC – MedCard
Anna D'Alessandra	Director of Financial Planning & Performance	DFPR
Robert Flanagan	Director Financial Operations	DFO
Chris Rolfe	Associate Director of Communications	ADoC
Sharon Welby	Assistant Director – Capital Projects (on behalf of Richard Hancock)	AD-CP
APOLOGIES		
Diana Lacey	Elective Care (Data Quality) Recovery Programme Director	ECRPD
SECRETARIAT		
Fiona Barr	Interim Corporate Secretary & Head of Corporate Governance	Co Sec

STAFF STORY VIDEO
The Board was shown a video patient story in which Sara Watson, a patient with multiple conditions, explained why she had moved her care from St George's. She cited numerous problems with administration and general organisation though emphasized the quality of care she had received from staff at the Trust. The Board confirmed that the story was very disappointing though reflected that it echoed the findings of the Care Quality Commission report into the Trust's operations.

1. OPENING ADMINISTRATION

1A Welcome and Apologies

1.1	The Chair opened the meeting and welcomed everyone including Improvement Director Marie-Noelle Orzel to her first meeting of the Board. He also congratulated Gillian Norton on her appointment as Chair from 01.04.17.
1.2	The apologies were as set out above.
1B Declarations of Interest	
1.3	The Chairman asked for declarations of interest. None were made.
1C Minutes of Meeting held on 09.02.17	
1.4	These were accepted as a true and accurate record of the meeting held on 09.02.17.
1D Matters Arising and Action Log	
1.5	The Board received the Action Log and the NEDs asked the Executive to confirm dates for agreed actions to return to the Board. NED Sir Norman Williams also noted the requirement to learn from avoidable deaths and report this through the Board. He noted that this would be done through the Quality Committee, adding that the Trust did good work in this area and the lead clinician was presenting the Trust's work at a forthcoming national conference.
2. PATIENT SAFETY, QUALITY AND PERFORMANCE	
2A Quality Improvement Plan	
2.1	Paul Linehan (Head of Governance) presented an update on the Trust's Quality Improvement Programme (QIP) reporting that four workstreams (HR, Estates, Personalised Care and Safety Culture) had been rated 'red' overall due to the number of overdue actions. The Executive Director workstream leads were aware and the QIP Board had been briefed accordingly. An explanation for the slippage against each action was covered in the report and recovery plans had been agreed.
2.2	The Medical Director advised that the QIP was currently under review to evolve it from a task based plan to one which was geared towards outcome measures related to quality of patient care and patient experience. A narrative would also be developed to better engage staff in the delivery of the QIP. The Board discussed the importance of values and culture in achieving the behavioural change needed to underpin sustainable quality improvement and agreed that it had a key role to lead the changes. It was agreed that the Board would engage in a workshop on the QIP once it had been developed by the Executive.
TB.09.03.17/17	**Board to participate in an Away Day on the revised QIP.** **LEAD: All**
2.3	The Board received the report.
2B Performance & Quality Report	
2.4	The MD introduced the revised format of the Performance & Quality Report, advising that this was still "work in progress" and encouraged input from the NEDs to improve it further, particularly as the Executive was keen to produce information and reporting on performance in line with the NEDs' requirements.
2.5	The COO led the Board through the report noting that: i. Year on year, activity in all areas had increased. ii. Performance against the A&E four hour target had not reached 95% consistently in January 2017 but performance had been acceptable given demand and in

	comparison to other London hospitals, performance had been good. iii. The Trust held a Perfect Week in January and continued to apply the principles and learnings to subsequent weeks. iv. Cancer data for January 2017 was still being confirmed. Whilst it was expected to be on trajectory, it was unlikely to be on target though there were plans to achieve this by the end of April. A rising level of demand for endoscopy was cited as a reason affecting performance against Cancer standards. v. Nine per cent of elective activity in January had been lost in Surgery and Outpatients; this was largely due to the non-availability of anaesthetists following the implementation of changes to additional payments. vi. The number of 52 week breaches had plateaued at four weeks though could rise through the delivery of the Elective Care (Data Quality) Recovery Programme. vii. The Trust had breached its CDiff threshold of 31 cases in 2016-17, though this had been a tough target to achieve and had been based on historically low levels of CDiff in the Trust. viii. The Trust had also reported two cases of MRSA in 2016-17 against a threshold of zero.
2.6	The NEDs considered the performance information and expressed concern about the impact of the changes to additional payments on activity and income. For the next meeting, they requested greater understanding of the implications of the changes on income, activity and patient safety, by service line. The Executive assured the NEDs that the impact of the changes was being closely monitored and in future, the resource planning informed by the Demand & Capacity Model (DCM) should ensure that the normal delivery of elective care should not require additional premium payments.
TB.09.03.17/18	**Brief the Board on the implications of the changes to additional payments on income, activity and patient safety, by service line, at its next meeting.** **LEAD: COO**
2.7	NED Stephen Collier also drew attention to the decline in GP referrals which on the current run rate of 10-12% could have a significant impact on demand and therefore income. It was agreed that this would be considered more fully in the Finance & Performance Committee. Overall the NEDs welcomed the changes in the format of the Performance & Quality Report but confirmed that they needed greater explanation and less data and to see a written interpretation of the quality and performance information as part of the overall Report. In addition, the NEDs expressed a desire to see quality, performance and finance metrics being reported together in one integrated report, setting out outturn against plan each month and also predicted year-end outcome based on current performance. This was agreed and the Executive explained that this was being developed through the roll-out of DCM.
TB.09.03.17/19A	**Investigate at FPC.29.03.17 the impact of lower numbers of GP referrals.** **LEAD: COO and CRO/CFO**
TB.09.03.17/19B	**Provide a clear written narrative as a standard part of the Quality & Performance Report to explain performance.** **LEAD: COO and CN**
TB.09.03.17/19C	**Over time, produce an Integrated Performance Report which triangulates metrics on finance, quality and performance, with qualitative and quantitative analysis, and an assessment of outturn by month and year end position.** **LEAD: COO and CN**
2C Renal Services Update - Renal Dialysis Trailer Location	
2.8	This paper was presented to update the Board on steps being taken to manage and mitigate risks associated with the location of external dialysis "trailer" at the rear of Knightsbridge wing. The concerns about this remote location had been twofold: i. Dialysis patients requiring emergency care.

	ii. Welfare and safety of lone workers.
2.9	The Board was advised that the dialysis trailers provided additional capacity whilst the Trust finalised joint arrangements with Epsom & St Helier Trust for the effective management of renal patients in South West London. The concerns raised about treating acutely unwell patients and lone workers had been satisfactorily addressed.
2.10	In closing, the Chair reminded the Board of the forthcoming Board to Board with Epsom and St Helier Trust which would provide an opportunity to discuss progress with the development of joint renal services in South West London. The CEO noted for the record that the notice referred to in "Background" within the report was a Section 31 not a Section 29A.
2D Smoke Free Trust Paper	
2.11	Mary Prior, General Manager – Facilities, attended to present the paper reminding the Board that the NHS had been smoke-free since 2005 and whilst both the Trust and the University did not permit smoking in its buildings, car parks, grounds or gardens, there was still smoking, and vaping, on the sites.
2.12	The Board broadly supported the proposals set out in the paper and approved the £50k investment though accepted that there were certain circumstances, for example when relatives or patients received bad news, where the enforcement of a smoking/vaping ban would have to be done with care and compassion; fines in such instances would be inappropriate. There was strong support for increasing awareness and education through better signage to "nudge" smokers and vapers into making different choices.
3. FINANCE	
3A Month 10 Finance Report	
3.1	The Trust's month 10 financial position was reported as an in-month deficit of £6.6m against a £5.2m in-month deficit forecast. Reasons for the change between forecast and actual position included a reduction in income (there had been a nine percent reduction in elective activity which was linked to making fewer additional payments to clinicians), changes in the treatment of depreciation and lost rental income. The year to date deficit was £67.2m and against a year-end forecast outturn of £71m. It was noted that pay spend had remained stable since month 6 and capital expenditure was in line with forecast though this remained dependent on the monthly drawdown of emergency funding from NHS Improvement. The rate of capital expenditure was in large part due to a particularly proactive member of staff in the Estates Department who would be invited to a future Board meeting to explain his contribution to the delivery of the Trust's capital programme.
3.2	In accepting the report, the NEDs requested that the Executive present the 2017-18 budget at the April 2017 Board meeting.
TB.09.03.17/20	**Present the 2017-18 budget to the Board at its meeting on 06.04.17.** **LEAD: CRO/CFO**
4. WORKFORCE	
4A Workforce Performance Report	
4.1	The HRAB led the Board through the report, advising that: i. The Trust had achieved its highest ever levels of mandatory and statutory training (MAST) and thanked the Divisions for the priority and focus that they had given the. ii. Whilst appraisal rates were continuing to rise, 85% compliance was still low in

	comparison to other organisations. iii. Whilst pay spend remained stable and some progress had been made on reducing the paybill by 10%, there had been no discernible change in the staffing numbers and establishment since August 2016. This was now underway, through a review of the nursing workforce and the implementation of the DCM. iv. Proposals on leadership and engagement would be presented in April 2017.
4.2	The Board noted the workforce performance report and actions outlined within it.
5. GOVERNANCE & RISK	
5A Significant Risk Profile	
5.1	The Board briefly considered the Corporate Risk Report though discussion focused on the Board's oversight on the major risks facing the organisation and the extent to which they were guiding the Board's agenda. The Audit Chair noted that a Risk Management Committee had been established by the Executive which reviewed risks in detail each month though there was some debate about whether this Committee should be a Board, rather than an Executive Committee. Board members concurred that the overall management and visibility of risk had improved over the last six months. However they agreed that there was more work to be done, some of which should be led by the Board and influenced by its risk appetite, to agree how the principle risks should be overseen by and reported to the Board, for example through the Board Assurance Framework. The Chair Designate, Gillian Norton, would consider this further on taking up appointment.
5.2	For the next meeting, the Board wished to have a deep dive on the risks around disaster recovery both of which had the CIO as the risk owner: i. CRR-0009 IT storage: unrecoverable IT system downtime affecting critical clinical, web and email systems. ii. CRR-0013 Vulnerability to computer virus or attack 'Ransom ware'.
TB.09.03.17/21	**Undertake a deep dive on the risks around disaster recovery (CRR-0009 and CRR-0013) at the Board meeting on 06.04.17.** **LEAD: CIO**
5.3	The Board challenged the recommendations of the report advising that it as the Executive's responsibility to set out risk treatment and mitigation and present that for assurance to the Board - not for the Board "to satisfy itself that the current level of risk exposure is tolerable or acceptable". This was agreed by the Executive.
6 CLOSING ADMINISTRATION	
6A Questions from Public	
6.1	Members of the public welcomed the work being done on the outpatients project noting that this was a vital and successful part of Trust's transformation programme.
6B Any Other Business	
6.2	Before the meeting was closed, the Chair Designate led the Board in recording a vote of thanks to Sir David Henshaw for his leadership and commitment as interim Chair. Sir David wished the Trust the very best for the future noting that huge progress had been made, which would continue under Gillian's tenure, and that there were clear signs that the Trust was making a recovery.
6.3	There were no further items of business.

Date and Time of Next Meeting: Thursday 6 April 2017, 10:00 – 12:00

Trust Board Public - 06.04.17

Action Ref	Theme	Action	Due	Revised Date	Lead	Commentary	Status
TB.03.11.16/03	**Mortality Statistics**	Undertake a deep dive into mortality statistics at the Quality Committee every six months.	~~QC.29.03.17~~ QC.23.05.17		MD ~~& CN~~	The Committee briefly discussed rates of HMSR and SHIMI though given the introduction of new national guidance on learning from patient deaths, it resolved to arrange a briefing for the Board (for the meeting on 06.04.17) to ensure Board members were aware of the new requirements and for the Committee to look in more detail about how to implement the guidance at it meeting in May 2017.	Open
TB.05.01.17/08	**Overseas Visitors and Migrant Cost Recovery Pilot**	Board to receive an evaluation report on the pilot programme to recover costs in two clinical areas (maternity and an elective service) from overseas visitors and migrants who use NHS services but are not entitled to free care. Report to be received in June 2016.	TB.08.06.17		CRO	Not yet due.	Open
TB.05.01.17/11	**Leadership Development**	Present an updated report on leadership development to the March Board meeting (09.03.17).	~~TB.09.03.17~~	~~TB.06.04.17~~ TB.04.05.17	HRAB	Deferred to TB.04.05.17 on advice of the HRAB and as agreed at TB.09.02.17.	Open
TB.05.01.17/12	**Claims and Insurance**	Present an update report to the March Board meeting (09.03.17) on the Trust's insurance arrangements following the review by an external insurance specialist.	~~TB.09.03.17~~	~~TB.06.04.17~~ TB.04.05.17	HoG	Review not yet concluded. Item deferred to TB.04.05.17 though a verbal update will be given by the Trust Secretary at the meeting.	Open
TB.09.02.17/14	**RTT and Elective Care Recovery Programme**	Provide a detailed briefing to the Board to ensure there was full understanding on the rules and principles, the scale of the backlog as well as progress with the RTT project.	ASAP		ECRPD	Data Validation/RTT Workshop arranged for 24.04.17. The invitation to the workshop has been extended to the Divisional Chairs and Governors.	Proposed for Closure
TB.09.02.17/15	**Perfromance & Quality**	Involve the NEDs in the development of the new Performance and Quality Report.	On-going		COO & MD	Suggest that this action is closed as the NEDs have been providing feedback on the development of the report which is subject to regular revision to improve the format and layout of information.	Proposed for Closure
TB.09.02.17/16	**Local Escalation Plan**	Updated Local Escalation Plan to be circulated to the Board following its approval by the CEO and Chair on behalf of the Board.				Currently under development.	Open
TB.09.02.17/17	**Quality Improvement Plan**	Board to participate in an Away Day on the revised QIP.	06.04.17		All	The QIP has been revised in content and format and a briefing has been arranged for the Board on 06.04.14 which will pull together the various aspects of CQC, how and why the QIP has been revised and an overvriew of the Well-Led Domain. The presentation will also cover improvement methodology,culture and engagement.	Proposed for Closure
TB.09.03.17/18	**Additional Payments**	Brief the Board on the implications of the changes to additional payments on income, activity and patient safety, by service line, at its next meeting.	Board.06.04.17		COO	Item to be covered by the COO under the Performance Report at the Board.06.04.17.	Proposed for Closure
TB.09.03.17/19A	**GP Referrals**	Investigate at FPC.29.03.17 the impact of lower numbers of GP referrals.	FPC.29.03.17		COO and CRO/CFO	Item discussed at FPC.29.03.17.	Proposed for Closure
TB.09.03.17/19B	**Quality and Performance Report**	Provide a clear written narrative as a standard part of the Quality & Performance Report to explain performance.	Board.06.04.17		COO and CN	A revised front sheet has been included.	Propsed for Closure
TB.09.03.17/19C	**Integrated Performance Report**	Over time, produce an Integrated Performance Report which triangulates metrics on finance, quality and performance, with qualitative and quantitative analysis, and an assessment of outturn by month and year end position.	Under Development		COO and CN	This report is subject to regular revision and review to improve the format and layout and provide the information that the Board will find useful to oversee and challenge performance. However until it fully triangulates information it is suggested that this action remains open.	Open
TB.09.03.17/20	**2017-18 Budget**	Present the 2017-18 budget to the Board at its meeting on 06.04.17.	Board.06.04.17		CRO/CFO	On the Board agenda 06.04.17	Proposed for Closure
TB.09.03.17/20	**Disaster Recovery Risks**	Undertake a deep dive on the risks around disaster recovery (CRR-0009 and CRR-0013)	Board.06.04.17		CIO	On the Board agenda 06.04.17	Proposed for Closure

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	6 April 2017	**Agenda No**	**2.1**
Report Title:	National Guidance - Learning from Patient Deaths		
Lead Director/ Manager:	Andy Rhodes, Medical Director		
Report Author:	Nigel Kennea, Associate Medical Director		
Freedom of Information Act (FOIA) Status:	Unrestricted		
Presented for:	Information		
Executive Summary:	The National Quality Board has set out *A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care.* Following events in Mid Staffordshire, a review of 14 hospitals with the highest mortality noted that the focus on aggregate mortality rates was distracting Trust boards "from the very practical steps that can be taken to reduce genuinely avoidable deaths in our hospitals". This was reinforced by the recent findings of the Care Quality Commission (CQC) report *Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England*. It found that learning from deaths was not being given sufficient priority in some organisations and consequently valuable opportunities for improvements were being missed. The report also pointed out that there is more we can do to engage families and carers and to recognise their insights as a vital source of learning. Understanding and tackling this issue will not be easy, but it is the right thing to do. There will be legitimate debates about deciding which deaths to review, how the reviews are conducted, the time and team resource required to do it properly, the degree of avoidability and how executive teams and boards should use the findings. This first edition of *National Guidance on Learning from Deaths* aims to kickstart a national endeavour on this front. Its purpose is to help initiate a standardised approach, which will evolve as we learn. Following the Learning from Deaths conference on 21 March 2017 the guidance will be updated to reflect the collective views of individuals and organisations to whom this guidance will apply. The standards expected of Trust boards are set out at in Appendix 1 - Annex A. The Medical Director will be the Lead Director who will take responsibility for the learning from deaths agenda and Sir Norman Williams will be the Non-Executive Director who will take responsibility for oversight of progress.		
Recommendation:	Trust Board is asked to note the paper and action required going forward. The Quality Committee will keep under regular review in identifying, reporting, investigating and learning from deaths in care by the end of Q2, and ensuring		

	the Trust has a clear policy and approach and publication of the data and learning points from Q3 onwards.		
Supports			
Trust Strategic Objective:	Ensure the Trust has an unwavering focus on all measures of quality and safety, and patient experience.		
CQC Theme:	Safe, effective, caring, responsive and well-led		
Single Oversight Framework Theme:	Quality of Care		
Implications			
Risk:	As a Foundation Trust, St George's has to abide by all national all guidance and is therefore required to respond positively to the National Quality Boards frame work - *A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care.*		
Legal/Regulatory:	See above.		
Resources:	There are no specific resource implications associated with this.		
Previously Considered by:		**Date**	
Equality Impact Assessment:	Covered within the scope of the document.		
Appendices	**Appendix 1** – National Guidance on Learning from Deaths		

National Guidance on Learning from Deaths

A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care

National Quality Board

First edition March 2017

National Guidance on Learning from Deaths

Contents

Foreword

Following events in Mid Staffordshire, a review of 14 hospitals with the highest mortality noted that the focus on aggregate mortality rates was distracting Trust boards "from the very practical steps that can be taken to reduce genuinely avoidable deaths in our hospitals".

This was reinforced by the recent findings of the Care Quality Commission (CQC) report *Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England*. It found that learning from deaths was not being given sufficient priority in some organisations and consequently valuable opportunities for improvements were being missed. The report also pointed out that there is more we can do to engage families and carers and to recognise their insights as a vital source of learning.

Understanding and tackling this issue will not be easy, but it is the right thing to do. There will be legitimate debates about deciding which deaths to review, how the reviews are conducted, the time and team resource required to do it properly, the degree of avoidability and how executive teams and boards should use the findings.

This first edition of *National Guidance on Learning from Deaths* aims to kickstart a national endeavour on this front. Its purpose is to help initiate a standardised approach, which will evolve as we learn. Following the Learning from Deaths conference on 21st March 2017 we will update this guidance to reflect the collective views of individuals and organisations to whom this guidance will apply to ensure that it is helpful.

Professor Sir Bruce Keogh
National Medical Director
NHS England

Professor Sir Mike Richards
Chief Inspector of Hospitals
Care Quality Commission

Dr Kathy McLean
Executive Medical Director
NHS Improvement

On behalf of the National Quality Board.

Executive Summary

Introduction

1. For many people death under the care of the NHS is an inevitable outcome and they experience excellent care from the NHS in the months or years leading up to their death. However some patients experience poor quality provision resulting from multiple contributory factors, which often include poor leadership and system-wide failures. NHS staff work tirelessly under increasing pressures to deliver safe, high-quality healthcare. When mistakes happen, providers working with their partners need to do more to understand the causes. The purpose of reviews and investigations of deaths which problems in care might have contributed to is to learn in order to prevent recurrence. Reviews and investigations are only useful for learning purposes if their findings are shared and acted upon.

2. The following definitions apply for the purposes of this guidance:

(i) Case record review: The application of a case record/note review to determine whether there were any problems in the care provided to the patient who died in order to learn from what happened, for example Structured Judgement Review delivered by the Royal College of Physicians.

(ii) Investigation: The act or process of investigating; a systematic analysis of what happened, how it happened and why. This draws on evidence, including physical evidence, witness accounts, policies, procedures, guidance, good practice and observation - in order to identify the problems in care or service delivery that preceded an incident to understand how and why it occurred. The process aims to identify what may need to change in service provision in order to reduce the risk of future occurrence of similar events.

(iii) Death due to a problem in care: A death that has been clinically assessed using a recognised methodology of case record/note review and determined more likely than not to have resulted from problems in healthcare and therefore to have been potentially avoidable.

Governance and Capability

3. Learning from a review of the care provided to patients who die should be integral to a provider's clinical governance and quality improvement work. To fulfil the standards and new reporting set out in this guidance for **acute, mental health and community NHS Trusts and Foundation Trusts**, Trusts should ensure their **governance arrangements**

and processes include, facilitate and give due focus to the review, investigation and reporting of deaths, including those deaths that are determined more likely than not to have resulted from problems in care. Trusts should also ensure that they share and act upon any learning derived from these processes. The standards expected of Trust boards are set out at Annex A including having an existing **executive director** take responsibility for the learning from deaths agenda and an existing **non-executive director** take responsibility for oversight of progress. Guidance for non-executive directors is at Annex B.

4. Providers should review and, if necessary, enhance **skills and training** to support this agenda. Providers need to ensure that staff reporting deaths have appropriate skills through specialist training and protected time under their contracted hours to review and investigate deaths to a high standard.

5. Providers should have a **clear policy for engagement with bereaved families and carers**, including giving them the opportunity to raise questions or share concerns in relation to the quality of care received by their loved one. Providers should make it a priority to work more closely with bereaved families and carers and ensure that a consistent level of timely, meaningful and compassionate support and engagement is delivered and assured at every stage, from notification of the death to an investigation report and its lessons learned and actions taken.

Improved Data Collection and Reporting

6. The following minimum requirements are being introduced to complement providers' current approaches in relation to reporting and reviewing deaths:

A. POLICY ON RESPONDING TO DEATHS

- Each Trust should publish an **updated policy** by September 2017 on how it responds to, and learns from, deaths of patients who die under its management and care, including:

  i. How its processes respond to the death of an individual with a **learning disability** (Annex D) or **mental health needs** (Annex E), **an infant or child death** (Annex F) and a **stillbirth or maternal death** (Annex G).
  ii. **The Trust's approach to undertaking case record reviews**. Acute Trusts should use an evidence-based methodology for reviewing the quality of care provided to those patients who die. The Structured Judgement Review (SJR)

case note methodology is one such approach and a programme to provide training in this methodology for acute Trusts will be delivered by the Royal College of Physicians over the coming year (the current version of the SJR approach is available at https://www.rcplondon.ac.uk/projects/outputs/national-mortality-case-record-review-nmcrr-programme-resources Other approaches also exist, such as those based on the PRISM methodology. Methods like SJR were not developed for mental health and community Trusts but can be used as a starting point and adapted by these providers to reflect their individual service user and clinical circumstances. Annex J provides a case study of how SJR is being adapted for mental health Trusts. Case record reviews of deaths of people with learning disabilities by acute, mental health and community Trusts should adopt the methodology developed by the Learning Disabilities Mortality Review (LeDeR) programme in those regions where the programme is available (details of the programme are available from Annex D).

iii. **Categories and selection of deaths in scope for case record review:** As a minimum and from the outset, Trusts should focus reviews on in-patient deaths in line with the criteria specified at paragraph 14(ii). In particular contexts, and as these processes become more established, Trusts should include cases of people who had been an in-patient but had died within 30 days of leaving hospital. Mental Health Trusts and Community Trusts will want to carefully consider which categories of outpatient and/or community patient are within scope for review taking a proportionate approach. The rationale for the scope selected by Trusts will need to be published and open to scrutiny.

B. DATA COLLECTION AND REPORTING

- **From April 2017, Trusts will be required to collect and publish on a quarterly basis specified information on deaths. This should be through a paper and an agenda item to a public Board meeting in each quarter to set out the Trust's policy and approach (by the end of Q2) and publication of the data and learning points (from Q3 onwards).** This data should include the total number of the Trust's in-patient deaths (including Emergency Department deaths for acute Trusts) and those deaths that the Trust has subjected to case record review. Of these deaths subjected to review, Trusts will need to provide estimates of how many deaths were judged more likely than not to have been due to problems in care. The dashboard provided with this guidance shows what data needs to be collected and a suggested format for publishing the information,

accompanied by relevant qualitative information and interpretation.

- **Changes to the Quality Accounts regulations will require that the data providers publish be summarised in Quality Accounts from June 2018** (Annex L), including evidence of learning and action as a result of this information and an assessment of the impact of actions that a provider has taken.

Further Developments

7. In 2017-18, further developments will include:

- **The Care Quality Commission will strengthen its assessment of providers learning from deaths** including the management and processes to review and investigate deaths and engage families and carers in relation to these processes.
- **NHS England, led by the Chief Nursing Officer, will develop guidance for bereaved families and carers.** This will support standards already set for local services within the Duty of Candour[1] and the *Serious Incident Framework*[2] and cover how families should be engaged in investigations. Health Education England will review training of doctors and nurses on engaging with bereaved families and carers.
- **Acute Trusts will receive training to use the Royal College of Physicians' Structured Judgement Review case note methodology.** Health Education England and the Healthcare Safety Investigation Branch (Annex L) will engage with system partners, families and carers and staff to understand broader training needs and to develop approaches so that NHS staff can undertake good quality investigations of deaths.
- **NHS Digital is assessing how to facilitate the development of provider systems and processes** so that providers know when a patient dies and information from reviews and investigations can be collected in standardised way.
- **The Department of Health is exploring proposals to improve the way complaints involving serious incidents are handled** particularly how providers and the wider care system may better capture necessary learning from these incidents[3].

.

[1] Further information is available from: http://www.cqc.org.uk/sites/default/files/20141120_doc_fppf_final_nhs_provider_guidance_v1-0.pdf

[2] https://improvement.nhs.uk/resources/serious-incident-framework/

[3] This follows the Parliamentary and Health Service Ombudsman's report *Learning from Mistakes* (July 2016) and the Public Administration and Constitutional Affairs Committee hearings on this report.

Chapter 1 - Mortality Governance

Context

8. In December 2016, the Care Quality Commission (CQC) published its review *Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England.* The CQC found that none of the Trusts they contacted were able to demonstrate best practice across every aspect of identifying, reviewing and investigating deaths and ensuring that learning is implemented.

9. The Secretary of State for Health accepted the report's recommendations and in a Parliamentary statement[4] made a range of commitments to improve how Trusts learn from reviewing the care provided to patients who die. This includes regular publication of specified information on deaths, including those that are assessed as more likely than not to have been due to problems in care, and evidence of learning and action that is happening as a consequence of that information in Quality Accounts from June 2018.

Accountability

10. Mortality governance should be a key priority for Trust boards. Executives and non-executive directors should have the capability and capacity to understand the issues affecting mortality in their Trust and provide necessary challenge.

11. This *National Guidance on Learning from Deaths* should be read alongside the *Serious Incident Framework*. Trust boards are accountable for ensuring compliance with both these frameworks. They should work towards achieving the highest standards in mortality governance. However, different organisations will have different starting points in relation to this agenda and it will take time for all Trusts to meet such standards. Over time this guidance is likely to be updated to include wider providers of NHS care and whole healthcare systems.

Responding to Deaths

12. Each Trust should have a policy in place that sets out how it responds to the deaths of patients who die under its management and care. The standards expected of Trusts are set out at Annex C.

13. Boards should take a systematic approach to the issue of potentially avoidable mortality and have robust mortality governance processes. This will allow them to identify any areas of

[4] https://www.gov.uk/government/speeches/cqc-review-of-deaths-of-nhs-patients]

failure of clinical care and ensure the delivery of safe care. This should include a mortality surveillance group with multi-disciplinary and multi-professional membership, regular mortality reporting to the Board at the public section of the meeting with data suitably anonymised, and outputs of the mortality governance process including investigations of deaths being communicated to frontline clinical staff.

Death Certification, Case Record Review and Investigation

14. There are three levels of scrutiny that a provider can apply to the care provided to someone who dies; (i) death certification; (ii) case record review; and (iii) investigation. They do not need to be initiated sequentially and an investigation may be initiated at any point, whether or not a case record review has been undertaken (though a case record review will inform the information gathering phase of an investigation together with interviews, observations and evidence from other sources). For example, the apparent suicide of an in-patient would lead to a Serious Incident investigation being immediately instigated in advance of death certification or any case record review. The three processes are summarised below:

(i) Death Certification: In the existing system of death certification in England, deaths by natural causes are certified by the attending doctor. Doctors are encouraged to report any death to the coroner that they cannot readily certify as being due to natural causes. Reforms to death certification, when implemented in England (and Wales), will result in all deaths being either scrutinised by a Medical Examiner or investigated by the Coroner in prescribed circumstances. Additionally, Medical examiners will be mandated to give bereaved relatives a chance to express any concerns and to refer to the coroner any deaths appearing to involve serious lapses in clinical governance or patient safety.

(ii) Case Record Review: Some deaths should be subject to further review by the provider, looking at the care provided to the deceased as recorded in their case records in order to identify any learning. At a minimum, providers should require reviews of:

i. all deaths where **bereaved families and carers, or staff, have raised a significant concern about the quality of care provision**;
ii. all in-patient, out-patient and community patient deaths of those with **learning disabilities** (the LeDeR review process outlined at Annex D should be adopted in those regions where the programme is available otherwise Structured Judgement Review or another robust and evidence-based methodology should be used) and

with **severe mental illness**;

iii. all deaths in a **service specialty, particular diagnosis or treatment group where an 'alarm' has been raised** with the provider through whatever means (for example via a Summary Hospital-level Mortality Indicator or other elevated mortality alert, concerns raised by audit work, concerns raised by the CQC or another regulator);

iv. all deaths in areas where people are **not expected to die**, for example in relevant elective procedures;

v. deaths where **learning will inform the provider's existing or planned improvement work**, for example if work is planned on improving sepsis care, relevant deaths should be reviewed, as determined by the provider. To maximise learning, such deaths could be reviewed thematically;

vi. **a further sample of other deaths** that do not fit the identified categories so that providers can take an overview of where learning and improvement is needed most overall. This does not have to be a random sample, and could use practical sampling strategies such as taking a selection of deaths from each weekday.

The above minimum requirements are additional to existing requirements for providers to undertake specific routes of reporting, review or investigations for specific groups of patient deaths, such as deaths of patients detained under the Mental Health Act 1983 (Annex E).

Providers should review a case record review following any linked inquest and issue of a "Regulation 28 Report on Action to Prevent Future Deaths" in order to examine the effectiveness of their own review process.

Providers should apply rigorous judgement to the need for deaths to be subject to a Serious Incident reporting and investigation. For example, there may be instances where deaths clearly meet Serious Incident criteria and should be reported as such (whether or not a case record review has already been undertaken). Equally, problems identified in case record review may lead to the need for investigation whether this is an investigation under the Serious Incident Framework or other framework/procedure (see section iii)

(iii) Investigation: Providers may decide that some deaths warrant an investigation and should be guided by the circumstances for investigation in the Serious Incident Framework.

Some deaths will be investigated by other agents, notably the coroner. Indeed, the coroner has a duty to investigate any death where there are grounds to suspect that the death may have been avoidable. While care should be taken not to compromise such investigations, equally waiting until other investigations are completed may cause unacceptable delay. A good working relationship and close communication are needed to avoid problems.

Providers should review an investigation they undertake following any linked inquest and issue of a "Regulation 28 Report to Prevent Future Deaths" in order to examine the effectiveness of their own investigation process. If an inquest identifies problems in healthcare, providers may need to undertake additional investigation and improvement action, regardless of the coroner's verdict.

Consistency and Judgement in Case Record Review

15. All Trusts currently undertake some form of mortality review. However there is considerable variation in terms of methodology, scope, data capture and analysis, and contribution to learning and improvement. To generate learning for improvement in healthcare, clinicians and staff should engage in robust processes of retrospective case record review to help identify if a death was more likely than not to have been contributed to by problems of care.

16. The Structured Judgement Review (SJR) case note methodology is an approach being rolled out by the Royal College of Physicians. Other methodologies exist and Trusts may already be using them. Trusts need to be assured that the methodology they are using is robust and evidence-based, that it will generate the information they are now being required to publish and that their staff are trained and given sufficient time and resources to undertake case record reviews and act on what they learn.

17. Case record review assessment is finely balanced and subject to significant inter-reviewer variation. It does not support comparison between organisations and should not be used to make external judgements about the quality of care provided.

18. The judgement of whether a problem may have contributed to a death requires careful review of the care that was provided against the care that would have been expected at the time of death. Research has shown that when case record review identifies a death that may have been caused by problems in care, that death tends to be due to a series of problems none of which would be likely to have caused the death in isolation but which in

combination can contribute to the death of a patient[5][6]. Some of these elements of care are likely to have occurred prior to the admission and providers should support other organisations, for example in primary care, to understand and act on areas where care could be improved.

19. Trusts should acknowledge and cooperate with separate arrangements for the review (and where appropriate investigation) of certain categories of deaths, for example suicides, homicides, and child and maternal deaths.

Objectivity in Case Record Review

20. To ensure objectivity, case record reviews should wherever possible be conducted by clinicians other than those directly involved in the care of the deceased. If the specific clinical expertise required only resides with those who were involved in the care of the deceased, the review process should still involve clinicians who were not involved in order to provide peer challenge. Objectivity of reviews should be a component of clinical governance processes. Providers may wish to consider if their review processes should additionally be the responsibility of a designated non-executive director who could do this by chairing the relevant clinical governance committee.

Investigations

21. This *National Guidance on Learning from Deaths* and the *Serious Incident Framework* are complementary. This guidance sets out what deaths should be subject to case record review (paragraph 14(ii)), which is inevitably a wider definition than deaths that constitute Serious Incidents. Equally, when a death meets Serious Incident criteria there is no need to delay the onset of investigation until case record review has been undertaken. A review of records will inevitably be undertaken as part of an investigation process. However, immediate action to secure additional information and evidence to support full investigation should not be lost due an inappropriate requirement for all deaths (regardless of nature) to first undergo a case record review.

[5] Hogan et al. Preventable deaths due to problems in care in English acute hospitals: a retrospective case record review study. *BMJ Qual Saf2012*: 21: 737-45.

[6] Hogan et al. Avoidability of hospital deaths and association with hospital-wide mortality ratios: a retrospective case record *BMJ* 2015; 351:h3239.

22. Inquiries by the coroner[7] and investigations by providers are conducted to understand the cause of death and contributing factors. However provider investigations are not conducted to hold any individual or organisation to account. Other processes exist for that purpose including criminal or civil proceedings, disciplinary procedures, employment law and systems of service and professional regulation, including the General Medical Council and the Care Quality Commission. In circumstances where the actions of other agencies are required then those agencies must be appropriately informed and relevant protocols must be followed.

Medical Examiners

23. The introduction of the Medical Examiner role will provide further clarity about which deaths should be reviewed. Medical Examiners will be able to refer the death of any patient for review by the most appropriate provider organisation(s) and this new mechanism should ensure a systematic approach to selecting deaths for review, regardless of the setting or type of care provided in the period before a patient's death. NHS Improvement and the Department of Health are commissioning research to explore whether Medical Examiners are best placed to select which deaths need further review and ensure they do not inadvertently miss or over-refer certain types of cases. Prior to the implementation of the Medical Examiner system, Trusts are advised to allow for any doctors undertaking the certification of death to refer cases for case record review to the most relevant organisation.

Learning

24. Providers should have systems for deriving learning from reviews and investigations and acting on this learning. The learning should be shared with other services across the wider health economy where they believe this would benefit future patients, including independent healthcare services and social care services. Recommendations within any "Regulation 28 Report on Action to Prevent Future Deaths" from the coroner should also be integral to a provider's systems to support learning within and across their organisation and local system partners.

25. Regardless of whether the care provided to a patient who dies is examined using case record review or an investigation, the findings should be part of, and feed into, robust clinical governance processes and structures. The findings should be considered alongside

[7] Coroner investigations, A short guide (February 2014) is available from: https://www.gov.uk/government/publications/guide-to-coroner-services-and-coroner-investigations-a-short-guide

other information and data including complaints, clinical audit information, mortality data, patient safety incident reports and data and outcomes measures etc. to inform the Trust's wider strategic plans and safety priorities.

26. Where case record review identifies a problem in care that meets the definition of a patient safety incident (any unintended or unexpected incident which could have or did lead to harm to one or more patients receiving NHS care) then this should be reported via local risk management systems to the National Reporting and Learning System (NRLS).

27. All patient safety incidents reported as resulting in death or severe harm to a patient are clinically reviewed by the National Patient Safety Team at NHS Improvement to determine if there are implications for national learning and if a response is appropriate. Any deaths that are identified via case record review as due to problems in healthcare would meet the criteria for NRLS reporting. More information on the national process is available at https://improvement.nhs.uk/resources/patient-safety-alerts. All serious incidents that relate to patients should be reported to the NRLS for the same reason.

Cross-system Reviews and Investigations

28. In many circumstances more than one organisation is involved in the care of any patient who dies. Guidance in relation to cross-system reviews and investigations is at Annex H.

Roles and Responsibilities of National Bodies and Commissioners

29. Guidance is provided at Annex I. The lead roles with overall responsibility for the learning from deaths programme at each of the relevant national organisation are provided at Annex K.

Chapter 2 - Bereaved Families and Carers

Key Principles

30. Providers should engage meaningfully and compassionately with bereaved families and carers in relation to all stages of responding to a death and operate according to the following key principles below.

BEREAVED FAMILIES AND CARERS - KEY PRINCIPLES:

- bereaved families and carers should be treated as **equal partners** following a bereavement;
- bereaved families and carers must always **receive a clear, honest, compassionate and sensitive response** in a sympathetic environment;
- bereaved families and carers should receive a **high standard of bereavement care** which respects confidentiality, values, culture and beliefs, including being offered appropriate support. This includes providing, offering or directing people to specialist suicide bereavement support;
- bereaved families and carers should be informed of their **right to raise concerns about the quality of care** provided to their loved one;
- bereaved families' and carers' views should **help to inform decisions about whether a review or investigation is needed**;
- bereaved families and carers should receive **timely, responsive contact and support in all aspects of an investigation process**, with a single point of contact and liaison;
- bereaved families and carers should be **partners in an investigation** to the extent, and at whichever stages, that they wish to be involved, as they offer a unique and equally valid source of information and evidence that can better inform investigations;
- bereaved families and carers who have experienced the investigation process should be supported to work in partnership with Trusts in **delivering training for staff in supporting family and carer involvement** where they want to.

Context

31. Dealing respectfully, sensitively and compassionately with families and carers of dying or deceased patients within the NHS is crucially important. The principles of openness, honesty, and transparency as set out in the Duty of Candour should also be applied by

providers in all their dealings with bereaved families and carers. Yet the Care Quality Commission's report *Learning, candour and accountability* identified that NHS providers are continuing to fail too many bereaved families and carers of those who die whilst in their care.

32. When a patient dies under the management and care of a Trust, bereaved families and carers should be informed immediately after the death. People who are bereaved need others to recognise and acknowledge their loss. Recognition by professionals, appropriately expressed, may be particularly valued. Communication at the time of a death, and afterwards, should be clear, sensitive and honest. Bereaved families and carers should be given as much information as possible in line with the Duty of Candour for providers. Every effort should be made to hold these discussions in a private, sympathetic environment, without interruptions. Providers should ensure that their staff, including family liaison officers where available, have the necessary skills, expertise and knowledge to engage with bereaved families and carers. This includes recognising and dealing with common issues such as family members feeling guilty about their loss.

33. All too often the terms of the conversation people have with the NHS about a concern or complaint are set by the organisation. Organisations can often be too quick to dismiss or explain away concerns, compounding the grief of bereaved families and carers with obfuscation and a lack of openness. Paying close attention to what bereaved families and carers say can offer an invaluable source of insight to improve clinical practice. Listening to them goes hand in hand with the Duty of Candour. In particular, bereaved families and carers should be asked if they had concerns about the quality of care received by the deceased to inform decisions about the need to undertake a case record review or investigation.

34. When reviewing or investigating possible problems with care, involvement of bereaved families and carers begins with a genuine apology. Saying sorry is not an admission of liability and is the right thing to do. The appropriate staff member should be identified for each case, including to explain what went wrong promptly, fully and compassionately. This may include clinicians involved in the case but this may not always be appropriate and should be considered on a case by case basis.

35. Depending on the nature of the death, it may be necessary for several organisations to make contact with those affected. This should be discussed with the bereaved families and carers and a co-ordinated approach should be agreed with them and the

organisations involved. If other patients and service users are involved or affected by the death they should be offered the appropriate level of support and involvement.

36. The provider should ensure that the deceased person's General Practitioner is informed of the death and provided with details of the death as stated in the medical certificate at the same time as the family or carers. The GP should be informed of the outcome of any investigation.

Bereavement Support

37. Bereavement can influence every aspect of well-being. Providers should offer a bereavement service for families and carers of people who die under their management and care (including offering or directing people to suicide bereavement support) that offers a caring and empathetic service at a time of great distress and sadness. This includes offering support, information and guidance. This should include bereavement advisors to help families and carers through the practical aspects following the death of a loved one such as:

- arranging completion of all documentation, including medical certificates;
- the collection of personal belongings;
- post mortem advice and counselling;
- deaths referred to the coroner;
- emotional support, including counselling;
- collection of the doctor's Medical Certificate of Cause of Death and information about registering a death at the Registrar's Office;
- details of the doctor's Medical Certificate of Case of Death (this is needed to register a death at the Registrar's Office).

38. The following should also be considered:

- timely access to an advocate (independent of the Trust) with necessary skills for working with bereaved and traumatised individuals;
- support with transport, disability, and language needs;
- support during and following an investigation. This may include counselling or signposting to suitable organisations that can provide bereavement or post-traumatic stress counselling, with attention paid to the needs of young family members, especially siblings;

- further meetings with the organisations involved or support in liaising with other agencies such as the police.

Review

39. If the care of a patient who has died is selected for case record review providers should:

- have formed that decision based on the views of the family and carers. Providers should require reviews in cases where family and carers have raised a significant concern about the quality of care provision (paragraph 14 (ii)(i));
- communicate to the family and carers the findings of the review if any problems with care are identified and any lessons the review has contributed for the future.

Investigations

40. If a provider feels that an investigation into a death is needed, early contact should have been made with bereaved families and carers so that their views helped to inform the decision.

41. Bereaved families and carers will expect to know: what happened; how; to the extent possible at the time, why it happened; and what can be done to stop it happening again to someone else. If a provider proceeds with an investigation, skilled and trained investigators need to be able to explain to bereaved families and carers the purpose of the investigation which is to understand what happened. If problems are identified, the investigation should be clear why and how these happened so that action can be taken to prevent the same mistakes from occurring again.

42. Provided the family or carer is willing to be engaged with regarding the investigation, an early meeting should be held to explain the process, how they can be informed of progress, what support processes have been put in place and what they can expect from the investigation. This should set out realistic timescales and outcomes. There should be a named person as a consistent link for the families and carers throughout the investigation, for example a family liaison officer.

43. Bereaved families and carers should:

- be made aware, in person and in writing, as soon as possible of the purpose, rationale and process of the investigation to be held;

- be asked for their preferences as to how and when they contribute to the process of the investigation and be kept fully and regularly informed, in a way that they have agreed, of the process of the investigation;
- have the opportunity to express any further concerns and questions and be offered a response where possible, with information about when further responses will be provided;
- have a single point of contact to provide timely updates, including any delays, the findings of the investigation and factual interim findings. This may disclose confidential personal information for which consent has been obtained, or where patient confidentiality is overridden in the public interest. This should be considered by the organisation's Caldicott Guardian and confirmed by legal advice in relation to each case;
- have an opportunity to be involved in setting any terms of reference for the investigation which describe what will be included in the process and be given expectations about the timescales for the investigation including the likely completion date;
- be provided with any terms of reference to ensure their questions can be reflected and be given a clear explanation if they feel this is not the case;
- have an opportunity to respond on the findings and recommendations outlined in any final report; and,
- be informed not only of the outcome of the investigation but what processes have changed and what other lessons the investigation has contributed for the future.

Guidance

44. NHS England will develop guidance for bereaved families and carers, identifying good practice for local services on the information that families say they would find helpful. It will cover what families can expect by way of local support in relation to investigations and what to expect when services have identified the death as complex or needing an independent investigation so potentially involving longer timeframes and multiple agency involvement.

45. Public Health England has published guidance which provides advice to local authorities and the NHS on developing and providing suicide bereavement support[8].

8 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/590838/support_after_a_suicide.pdf

Annexes

Annex A - Board Leadership

BOARD LEADERSHIP - KEY POINTS

The board should ensure that their organisation:

- has an existing board-level leader acting as **patient safety director** to take responsibility for the learning from deaths agenda and an existing **non-executive director** to take oversight of progress;
- pays particular attention to the care of patients with a **learning disability or mental health needs**;
- has a systematic approach to **identifying those deaths requiring review** and selecting other patients whose care they will review;
- adopts a robust and **effective methodology for case record reviews** of all selected deaths (including engagement with the LeDeR programme) to identify any concerns or lapses in care likely to have contributed to, or caused, a death and possible areas for improvement, with the outcome documented;
- ensures **case record reviews and investigations are carried out to a high quality**, acknowledging the primary role of system factors within or beyond the organisation rather than individual errors in the problems that generally occur;
- ensures that **mortality reporting in relation to deaths, reviews, investigations and learning is regularly provided to the board** in order that the executives remain aware and non-executives can provide appropriate challenge. The reporting should be discussed at the public section of the board level with data suitably anonymised;
- ensures that learning from reviews and investigations is **acted on** to sustainably change clinical and organisational practice and improve care, and **reported in annual Quality Accounts**;
- **shares relevant learning** across the organisation and with other services where the insight gained could be useful;
- ensures sufficient numbers of **nominated staff have appropriate skills** through specialist training and protected time as part of their contracted hours to review and investigate deaths;
- **offers timely, compassionate and meaningful engagement with bereaved families and carers** in relation to all stages of responding to a death;
- acknowledges that an **independent investigation** (commissioned and delivered entirely separately from the organisation(s) involved in caring for the patient) may in

some circumstances be warranted, for example, in cases where it will be difficult for an organisation to conduct an objective investigation due to its size or the capacity and capability of the individuals involved; and,

- **works with commissioners to review and improve their respective local approaches** following the death of people receiving care from their services. Commissioners should use information from providers from across all deaths, including serious incidents, mortality reviews and other monitoring, to inform their commissioning of services. This should include looking at approaches by providers to involving bereaved families and carers and using information from the actions identified following reviews and investigations to inform quality improvement and contracts etc.

Annex B - Non-Executive Directors

Context

1. The board of directors of an NHS Trust or Foundation Trust is collectively responsible for ensuring the quality and safety of healthcare services delivered by the Trust, and in the case of a Foundation Trust taking into consideration the views of the board of governors.

2. Boards must ensure robust systems are in place for recognising, reporting, reviewing or investigating deaths and learning from avoidable deaths that are contributed to by lapses in care. Providers should ensure such activities are adequately resourced. Commissioners are accountable for quality assuring the robustness of providers' systems so that providers develop and implement effective actions to reduce the risk of avoidable deaths, including improvements when problems in the delivery of care within and between providers are identified.

3. All Trust directors, executive and non-executive, have a responsibility to constructively challenge the decisions of the board and help develop proposals on strategy. Non-executive directors, in particular, have a duty to ensure that such challenge is made. They play a crucial role in bringing an independent perspective to the boardroom and should scrutinise the performance of the provider's management in meeting agreed goals and objectives and monitor the reporting of performance. Non-executive directors should satisfy themselves as to the integrity of financial, clinical and other information, and that clinical quality controls and systems of risk management, for example, are robust and defensible.

Learning from Deaths

4. Executive and non-executive directors have a key role in ensuring their provider is learning from problems in healthcare identified through reviewing or investigating deaths by ensuring that:

    - the processes their organisation have in place are robust, focus on learning and can withstand external scrutiny, by providing challenge and support;
    - quality improvement becomes and remains the purpose of the exercise, by championing and supporting learning, leading to meaningful and effective actions that improve patient safety and experience, and supporting cultural change; and

- the information the provider publishes is a fair and accurate reflection of its achievements and challenges.

5. From April 2017, providers will start to collect and publish new data to monitor trends in deaths. Alongside this, they will need to establish an ongoing learning process. Board oversight of this process is as important as board oversight of the data itself. As a critical friend, non-executive directors should hold their organisation to account for its approach and attitude to patient safety and experience, and learning from all deaths, particularly those assessed as having been avoidable. The roles and responsibilities of non-executive directors include:

   i. **Understand the process: ensure the processes in place are robust and can withstand external scrutiny, by providing challenge and support. For example:**
      - be curious about the accuracy of data and understand how it is generated; who is generating it, how are they doing this, is the approach consistent across the Trust, are they sufficiently senior/experienced/trained?
      - seek similar data and trend information from peer providers, to help challenge potential for improvements in your own organisation's processes, but understand limitations of any direct comparisons;
      - ensure timely reviews/investigations (what is the interval between death and review or investigation?), calibre of reviewer/investigator and quality of the review or investigation;
      - is the Care Record Review process objective, conducted by clinicians not directly involved in the care of the deceased?
      - how was the case-record review selection done? For example, does selection reflect the evidence base which suggests older patients who die or those where death may be expected are no less likely to have experienced problems in healthcare that are associated with potentially preventable death? Does it ensure all vulnerable patient groups (not just those with learning disabilities or mental health needs) are not disadvantaged?
      - are deaths of people with learning disabilities reviewed according to the LeDeR methodology?
      - for coordination of responses to reviews/investigations through the provider's clinical governance processes, who is responsible for preparing the report, do problems in care identified as being likely to have contributed to a death feed into the organisation's Serious Incident processes?

ii. **Champion and support learning and quality improvement such as:**

- ensuring the organisation has a long-term vision and strategy for learning and improvement and is actively working towards this;
- understanding the learning being generated, including from where deaths may be expected but the quality of care could have been better;
- understanding how the learning from things going wrong is translated into sustainable effective action that measurably reduces the risks to patients - ensuring that learning and improvements are reported to the board and relevant providers;
- supporting any changes in clinical practice that are needed to improve care resulting from this learning;
- ensuring families and carers are involved reviews and investigations, and that nominated staff have adequate training and protected time to undertake these processes;
- paying attention to the provision of best practice and how the learning from this can be more broadly implemented.

iii. **Assure published information; ensure that information published is a fair and accurate reflection of the provider's achievements and challenges, such as:**

- ensuring that information presented in board papers is fit for publication i.e. it is meaningful, accurate, timely, proportionate and supports improvement;
- checking that relevant team are working towards a timely quarterly publication, in line with the Quality Accounts regulations and guidance;
- checking that arrangements are in place to invite, gather and act on stakeholder feedback on a quarter by quarter basis;
- ensuring the organisation can demonstrate to stakeholders that "this is what we said we would do, and this is what we did" (learning and action), and explain the impact of the quality improvement actions.

Annex C - Responding to Deaths

Trusts should have a policy in place that sets out how they respond to the deaths of patients who die under their management and care.

POLICY FOR RESPONDING TO DEATHS - KEY POINTS

The policy should include how providers:

- **determine which patients are considered to be under their care and included for case record review if they die** (it should also state which patients are specifically excluded);
- **report the death within the organisation and to other organisations who may have an interest** (including the deceased person's GP), including how they determine which other organisations should be informed;
- **respond to the death of an individual with a learning disability** (Annex D) or **mental health needs** (Annex E), **an infant or child death** (Annex F) **and a stillbirth or maternal death** (Annex G) and the provider's processes to support such deaths;
- **review the care provided to patients who they do not consider to have been under their care at the time of death but where another organisation suggests that the Trust should review the care provided to the patient in the past**;
- **review the care provided to patients whose death may have been expected**, for example those receiving end of life care;
- **record the outcome of their decision whether or not to review or investigate the death**, which should have been informed by the views of bereaved families and carers;
- **engage meaningfully and compassionately with bereaved families and carers** - this should include informing the family/carers if the provider intends to review or investigate the care provided to the patient. In the case of an investigation, this should include details of how families/carers will be involved to the extent that they wish to be involved. Initial contact with families/carers are often managed by the clinicians responsible for the care of the patient. Given that providers must offer families/carers the opportunity to express concerns about the care given to patients who have died, then the involvement of clinicians who cared for the patient may be considered a barrier to raising concerns. Providers should therefore offer other routes for doing this;
- **offer guidance, where appropriate, on obtaining legal advice for families,**

carers or staff. This should include clear expectations that the reasons, purpose and involvement of any lawyers by providers will be communicated clearly from the outset, preferably by the clinical team, so families and carers understand the reasons and are also offered an opportunity to have their own advocates.

Annex D - Learning Disabilities

Context

1. Since the 1990s, there have been a number of reports and case studies which have consistently highlighted, that in England, people with learning disabilities die younger than people without learning disabilities. The Confidential Inquiry of 2010-2013 into premature deaths of people with learning disabilities (CIPOLD) reported that for every one person in the general population who died from a cause of death amenable to good quality care, three people with learning disabilities would do so[9]. Overall, people with learning disabilities currently have a life expectancy at least 15 to 20 years shorter than other people[10].

2. A concerning finding from CIPOLD was that assumptions were sometimes made that the death of a person with learning disabilities was 'expected' or even inevitable, because that person had learning disabilities. As with the CQC report of 2016[11], CIPOLD also identified deaths that should have been, but were not, reported to mandatory review processes, including safeguarding reviews and to the coroner.

3. The lives of people with learning disabilities often involve a complex array of service provision with multiple care and support staff. If we are to improve service provision for people with learning disabilities and their families, and reduce premature deaths, we need to look wider than NHS-related circumstances leading to a person's death, in order to identify the wider range of potentially avoidable contributory factors to their death. A cross-sector approach to reviewing deaths of people with learning disabilities is imperative; one that includes families, primary and secondary healthcare, and social and third sector care providers. Such a balanced approach across acute and other settings is needed from the outset of a review process, in order to accurately determine if there are any concerns about the death, or to identify examples of best practice that could lead to service improvement.

---

[9] Heslop P, Blair P, Fleming P, Hoghton M, Marriott A, Needleman D, Russ L. (2013) Confidential Inquiry into premature deaths of people with learning disabilities. Bristol: University of Bristol.

[10] Glover G,et al, 2017. Williams R. Heslop P, Oyinlola J, Grey J. (2016) Mortality in people with intellectual disabilities in England. *Journal of Intellectual Disabilities Research, 61, 1, 62-74; Health and Care of People with Learning Disabilities, 2014-15*, NHS Digital, 9 December 2016.

[11] *Learning, candour and accountability: A review of the way NHS Trusts review and investigate the deaths of patients in England*, Care Quality Commission December 2016.

4. There is unequivocal evidence that demands additional scrutiny be placed on the deaths of people with learning disabilities across all settings. This work has already been started by the Learning Disabilities Mortality Review (LeDeR) programme, commissioned by Healthcare Quality Improvement Partnership (HQUIP) for NHS England. Once fully rolled out, the programme will receive notification of all deaths of people with learning disabilities, and support local areas to conduct standardised, independent reviews following the deaths of people with learning disabilities aged 4 to 74 years of age. These will be conducted by trained reviewers.

5. The purpose of the local reviews of death is to identify any potentially avoidable factors that may have contributed to the person's death and to develop plans of action that individually or in combination, will guide necessary changes in health and social care services in order to reduce premature deaths of people with learning disabilities.

Scope

6. A conceptual definition of learning disabilities is used in the Learning Disabilities White Paper 'Valuing People'[12] (2001).

7. At present, NHS England is working with NHS Digital to explore the options and potential of 'flagging' the records of people with learning disabilities on the NHS Spine[13]. Over time, this could provide an access point for identifying that a person who has died had learning disabilities.

8. The LeDeR programme currently supports local reviews of deaths of people with learning disabilities aged 4 years and over. The lower age limit is set at 4 years of age because before that age, it can be difficult to be sure that a child has learning disabilities as defined above.

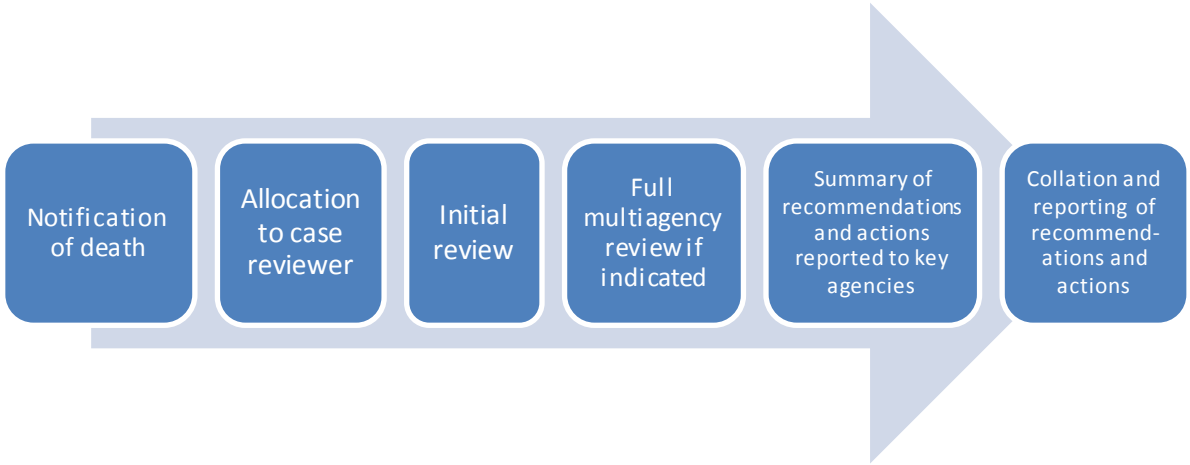
Operationalising Mortality Reviews of People with Learning Disabilities

9. The LeDeR programme has an established and well-tested methodology for reviewing the deaths of people with learning disabilities.

[12] Valuing People: A New Strategy for Learning Disability for the 21st Century, Department of Health, 2001. LeDeR briefing paper.

[13] Spine supports the IT infrastructure for health and social care in England, joining together over 23,000 healthcare IT systems in 20,500 organisations.

Current process



10. All deaths of people with learning disabilities are notified to the programme. Those meeting the inclusion criteria for mortality review receive an initial review of their death by an independent, trained reviewer.

11. The standardised review process involves discussing the circumstances leading up to the person's death with someone who knew them well (including family members wherever possible), and scrutinising at least one set of relevant case notes. Taking a cross-agency approach, the reviewer develops a pen portrait of the individual and a comprehensive timeline of the circumstances leading to their death, identifies any best practice or potential areas of concern, and makes a decision, in conjunction with others if necessary, about whether a multi-agency review is indicated.

12. A full multi-agency review is required if the criteria for the current themed priority review are met (death of a person from a Black and Minority Ethnic background or aged 18-24), or where an assessment of the care received by the person indicates deficiencies in one or more significant areas. A full multi-agency review is recommended if there have been any concerns raised about the death, if any 'red flag alerts'[14] have been identified in the initial review, or if the reviewer thinks that a full multi-agency review would be appropriate. The purpose of the multi-agency review is to gain further learning which will contribute to improving practice and service provision for people with learning disabilities, so the review process concludes with an agreed action plan and recommendations that are fed back to the regional governance structures for the programme.

[14] 'Red flag' alerts are those identified in the initial review that may suggest potential problems with the provision of care e.g. no evidence that an assessment of mental capacity has been considered when this would have been appropriate; delays in the person's care or treatment that adversely affected their health.

13. The LeDeR programme currently operates independently of, but communicates and cooperates with, other review and investigatory processes. This enables an integrated approach to initial reviews of deaths of people with learning disabilities to be taken whenever possible, so as to avoid unnecessary duplication but ensure that the specific focus of the different review or investigation processes is maintained.

14. Alignment of LeDeR with SJR for example will enable a balanced approach to be taken to reviewing deaths of people with learning disabilities that draws on contributions from across acute and other settings. Deaths of people with learning disabilities that occur in hospital settings should be subject to the LeDeR review process in order that insights from families, primary and secondary healthcare, and social and third sector care providers are all included in the mortality review.

15. The LeDeR programme provide annual reports on its findings, collating learning and recommendations at the regional and national level on how best to take forward the learnings across the NHS.

16. Because of the different methodology adopted by the LeDeR programme, it would not be appropriate to use the same definition of 'avoidable death' as used by the SJR, nor to compare rates of avoidable deaths across and between the two review processes. The LeDeR programme will continue to use the Child Death Review Process terminology of 'potentially avoidable contributory causes of death' and the Office for National Statistics definition of avoidable deaths using ICD-10 coding of the underlying cause of death[15].

Integration of the LeDeR Process into National Level Mortality Review Structures

17. When a death of a person with learning disabilities occurs, mandatory review processes need to take precedence, working with the LeDeR programme reviewers to ensure that a coordinated approach is taken to the review of the death in order to minimise duplication and bring in the learning disabilities expertise of the LeDeR reviewers, whilst recognising that some investigatory processes will be more focused than that of LeDeR which is cross-agency in nature and may require the provision of additional information.

[15] Office for National Statistics (2016) Revised Definition of Avoidable Mortality and New Definition for Children and Young People.
https://www.ons.gov.uk/aboutus/whatwedo/statistics/consultationsandsurveys/allconsultationsandsurveys/reviewofavoidablemortalitydefinition

18. Learning and recommendations from LeDeR reviews will identify opportunities for improvement at the local, regional and national level. Governance structures that can support the cross-agency implementation of recommendations from mortality reviews are required at all levels, but in particular for the reviews of deaths of people with learning disabilities. Such structures exist in the form of regional steering groups for the LeDeR programme, and these are usually best placed within the safeguarding framework. Not all deaths of people with learning disabilities are safeguarding issues; however the existing multi-agency framework and statutory responsibility mean that this is a natural 'home' for governance of mortality reviews.

Guidance for Providers

19. Key points to note are:

- All deaths of people with learning disabilities aged four years and older are subject to review using LeDeR methodology;
- The LeDeR programme is currently being rolled out across England. Full coverage is anticipated in all Regions by the end of 2017. If there is a death of a person with learning disabilities in an acute setting in an area that is not yet covered by the LeDeR programme, Trusts are recommended to use the SJR process or a methodology of equivalent quality that meets the requirements for the data that must be collected as an interim measure;
- If a Trust wishes to complete its own internal mortality review, it is recommended that it uses the LeDeR initial review process and documentation available at: http://www.bristol.ac.uk/media-library/sites/sps/leder/Initial%20Review%20Template%20version%201.2.pdf The provider can then submit that as an attachment to the LeDeR notification web-based platform once their internal review is completed;
- Once the LeDeR review has been completed, a copy will be sent to the relevant governance body at the Trust where the death occurred;
- Trusts are encouraged to identify appropriate personnel to undertake LeDeR training and review processes. Reviewers would be expected to conduct reviews independent of the Trust in which they work.

Annex E - Mental Health

1. Physical and mental health are closely linked. People with severe and prolonged mental illness are at risk of dying on average 15 to 20 years earlier than other people[16]. In addition, people with long term physical illnesses suffer more complications if they also develop mental health problems.

2. Reporting and reviewing of any death of a patient with mental health problems should consider these factors i.e. premature death of those with a mental disorder and the increased risk of complications for those with physical and mental health difficulties.

Inpatients detained under Mental Health Act

3. Regulations[17] require mental health providers to ensure that any death of a patient detained under the Mental Health Act (1983) is reported to the Care Quality Commission without delay. In 2015, the Care Quality Commission reported concern that providers were failing to make this notification in 45% of cases. The Commission has since updated its notifications protocols to ensure that providers ensure they report in a timely way.

4. Under the Coroners and Justice Act 2009, coroners must conduct an inquest into a death that has taken place in state detention, and this includes deaths of people subject to the Mental Health Act. Providers are also required to ensure that there is an appropriate investigation into the death of a patient in state detention under the Mental Health Act (1983).

5. In circumstances where there is reason to believe the death may have been due, or in part due to, to problems in care - including suspected self-inflicted death - then the death must be reported to the provider's commissioner(s) as a serious incident and investigated appropriately. Consideration should also be given to commissioning an independent investigation as detailed in the *Serious Incident Framework*.

People with Mental Health Disorders in Prisons

6. Evidence shows that there is a high incidence of mental health problems in prisons: 72% of adult male and 71% of female prisoners may have 2 or more mental disorders (e.g.

[16] *The Five Year Forward View For Mental Health* (NHS England, 2016) is available at: https://www.england.nhs.uk/wp-content/.../Mental-Health-Taskforce-FYFV-final.pdf

[17] Regulation 17, Care Quality Commission (Registration) Regulations 2009

personality disorder, psychosis, anxiety and depression, substance misuse); 20% have 4 or more mental disorders.

7. There have been large increases in the number of natural and non-natural deaths in prisons over the most recent five-year reporting period. The increase in recent years in non-natural deaths in prisons are due to a number of factors. Prisons contain a high proportion of vulnerable individuals, many of whom have experienced negative life events that increase the likelihood of suicide or self-harm. Issues that increase risk include drug/alcohol abuse, family background, social disadvantage or isolation, previous sexual or physical abuse, and mental health problems. The increase in part reflects an ageing prison population. Prisons are also very challenging environments particularly so for those prisoners who have a learning disability. Average estimates of prevalence of learning disabilities amongst adult offenders in the UK is thought to be between 2-10%. This figure is much higher for children who offend[18]. Prisoners with learning disabilities are also more likely than other prisoners to suffer mental ill health. As such, the mental wellbeing of prisoners with learning disabilities should be a key consideration for healthcare staff of NHS providers along with all other prison staff.

8. The *Serious Incident Framework* states that in prison and police custody, any death will be referred (by the relevant organisation) to the Prison and Probation Ombudsman (PPO) or the Independent Police Complaints Commission (IPCC) who are responsible for carrying out the relevant investigations. Healthcare providers must fully support these investigations where required to do so. The PPO has clear expectations in relation to health involvement in PPO investigations into death in custody. Guidance published by the PPO[19] must be followed by those involved in the delivery and commissioning of NHS funded care within settings covered by the PPO.

[18] *Equal Access Equal Care*, Guidance for Prison Healthcare Staff treating Patients with Learning Disabilities (2015) *available at* https://www.england.nhs.uk/.../equal-access-equal-care-guidance-patients-ld.pdf

[19] Guidance is available online: http://www.ppo.gov.uk/updated-guidance-for-clinical-reviews/

Annex F - Children and Young People

Infant and Child Mortality

1. Over the last 20 years, the UK has gone from having one of the lowest mortality rates for 0 to 14 year olds in Europe to one of the highest[1]. In 2014, 4, 419 children and young people aged 0 to 18 years old died in England and Wales. 24% of deaths in children and young people are thought to be preventable[2]. In the year ending March 2016, 68% of all deaths occurred in hospital, 22% in the home, 4% in a public place, and 4% in a hospice. In the year ending March 2016, 32% of all deaths occurred following a perinatal or neonatal event, 26% in children with chromosomal, genetic and congenital anomalies, 8% in children with 'sudden unexpected and unexplained' death, 7% in children with malignancy, 6% in children with acute medical or surgical illnesses, 6% in children with infection, 5% in children suffering trauma, 3% in young people taking their life, and 2% following deliberately inflicted injury, abuse or neglect[2].

2. In child mortality review, professionals have moved away from defining 'avoidability' to instead using the language of 'a preventable death' where the latter is defined as a death in which 'modifiable factors may have contributed to the death and which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths'[3]. In the year ending March 2016, 54% of deaths in hospital and 31% of death in the home were identified as having modifiable factors. Most modifiable factors are found in children dying from perinatal/neonatal events, followed by trauma, followed by those with chromosomal, genetic and congenital anomalies[2].

National Data on Causes of Death and International Comparisons[4]

3. The UK ranks 15 out of 19 Western European countries on infant (under one year of age) mortality and has one of the highest rates for children and young people in Western Europe[5]. There is a strong association between deprivation and mortality; for example infant mortality is more than twice as high in the lowest compared with the highest socio-economic groups[6].

Infants (under 1 year)

4. Around 60% of deaths during childhood occur in infancy. Infant mortality can be split into neonatal mortality (deaths 0–27 days) and post-neonatal mortality (28–365 days). Births without signs of life (stillbirths if after 24 weeks of pregnancy) do not contribute to infant mortality but are also an important indicator of maternal and child health. The Infant

Mortality Rate (IMR) is an indicator of both population health and the quality of healthcare service. It is also a key international indicator in the United Nation's Sustainable Development Goals and in UNICEF international comparisons.

5. Neonatal mortality accounts for between 70% and 80% of infant deaths. The great majority of neonatal deaths are due to perinatal causes, particularly preterm birth, and are strongly related to maternal health, as well as congenital malformations. The remainder of infant deaths are post-neonatal and are due to a broad range of causes including sudden infant death syndrome (SIDS). Stillbirths (defined in the UK as a baby born without signs of life after 24 completed weeks of pregnancy) account for half of all deaths during the perinatal period. In 2014, the IMR across the UK was 3.9 deaths per 1,000 live births. Although there has been an overall decline in the IMR across the UK over the past 45 years, in recent years the reduction in infant mortality in the UK has not equalled the gains observed in comparable countries. An international study of mortality in the UK compared with similar wealthy countries in Europe and elsewhere showed the UK to have IMR in 1970 similar to the average of the group, but that the UK had become among the worst performing 10% by 2008[7].

6. Social inequalities play a role in almost all the leading causes of infant death. The mechanisms underlying this social gradient are related to increased risk of preterm delivery in more deprived groups, as well as to maternal health during pregnancy (for example, smoking, poor nutrition, substance abuse) and uptake of recommended practices such as breastfeeding and safe infant sleeping positions[8]. Maternal age is also associated with infant mortality[6]. Many of the causes of infant mortality are preventable and necessitate actions at both a population and individual level[9]:

    - maximising the health and wellbeing of women before conception and during pregnancy (smoking cessation programmes, promotion of breastfeeding and promoting healthy weight in women of childbearing age)
    - protecting and supporting health promotion and early intervention services (universal midwifery and health visiting services for new mothers)
    - promoting evidence-based research into maternal and infant health, and translating findings into improved practice, standards of care, and ultimately policy
    - identifying best practice and reducing variations in outcomes across health care services

Children (1-9 years)

7. The main factors that contribute to death during childhood are different to those that contribute to death during infancy or adolescence. The common causes of death amongst 1 to 9 year-olds are cancer, injuries and poisonings, congenital conditions and neurological and developmental disorders. Injuries and poisonings from external causes are the leading cause of death in boys aged one to four years, whilst cancer is the leading cause of death in girls of the same age[5]. For both girls and boys five to nine years of age, cancer is the leading cause of death. Very early life also still has an impact on mortality in later childhood; children who were born preterm remain more likely to die before age 10 years compared to children born at term.

8. In the period 2012-2014, the mortality rate in children aged 1-9 years in the U.K. was 12.1 per 100,000 population. Although the mortality rate has declined across the UK since the 1970s, the UK's recent progress has been significantly lower than in other wealthy European countries, and concerningly the incidence of death due to diseases such as asthma and diabetes is higher than equivalent high-income countries. The scale of difference between the UK child mortality rate and the average suggests there are around 130 excess deaths of 1- to 9-year-olds each year in the UK[10].

9. Many childhood deaths are preventable. As with infants there is a strong association between deprivation, social inequality, and mortality. Causes amenable to interventions include environmental and social factors as well as health service factors and key actions include the following[9]:

    - creating safe environments, including access to information and safety equipment schemes to promote safety in the home;
    - reduce road speed limits in built-up areas to 20mph;
    - ensuring that clinical teams looking after children with long-term conditions such as asthma, epilepsy and diabetes deliver care to the highest standards, incorporating good communication, open access for patients and families, use of established tools such as the epilepsy passport and asthma plan, adherence to the components prevalent in the best practice tariff for diabetes, and address early the optimal conditions for safe transition to adult services. Implicit in this is teaching self-management and ownership of the condition;
    - increasing the provision of high-quality end-of-life care and access to appropriate palliative care;

- delivering integrated health systems across primary and secondary care; whilst providing the optimal configuration of specialist services for children with complex conditions needing tertiary care, such as cardiac, renal conditions and children's cancer.

Young People (10-19 years)

10. After the first year of life, adolescence is the life stage when children are most likely to die. The factors leading to death in adolescence are different to those in earlier childhood, and differ between males and females. The most common causes of death in this age group are injuries, violence and suicide, followed by cancer, substance misuse disorders and nervous system and developmental disorders.

11. Although the mortality rate in young people has decreased across the UK since the 1970s, progress recently has been slower than that seen in other wealthy countries[10]. The UK's 'average' adolescent overall mortality today is a mixed picture. Whilst our injury mortality rate is amongst the lowest, we have a higher rate of deaths due to 'non communicable diseases' such as asthma than other equivalent wealthy countries. Social inequalities are important since injury and illness are associated with poor environmental conditions and hazards such as smoking, alcohol, and drug use[8].

12. Many deaths are preventable and key actions include[9]:

- reducing deaths from traffic injuries through the introduction of graduated licensing schemes;
- improving adolescent mental health services;
- improving services for children with long term conditions, and especially those transitioning to adult care;
- increasing the involvement of young people and their families with rare and common long-term conditions in developing guidelines, measuring outcomes, service design and research trials.

13. Underpinning all efforts to reduce child mortality in England lies an urgent need to collect high-quality data to better understand the reasons why children die, to allow accurate international comparisons, and to inform health policy. This requires a national system for the analysis of child mortality data, as well as improved child death review processes.

Historical Background to the Process of Child Mortality Review

14. Since 1st April 2008, Local Safeguarding Children's Boards in England have had a statutory responsibility for Child Death Review (CDR) processes. The relevant legislation underpinning such responsibility is enshrined in the Children's Act 2004 and applies to all children under 18 years of age. The processes to be followed when a child dies are described in Chapter 5 of the statutory guidance document, *Working Together to Safeguard Children*[11]. The overarching purpose of child death review is to understand how and why children die, to put in place interventions to protect other children, and to prevent future deaths. *Working Together* describes two interrelated processes:

    i. a "Rapid Response" multi-professional investigation of an individual unexpected death; and,
    ii. a Child Death Overview Panel (CDOP) review of all deaths in a defined geographical area. The purpose of the CDOP is to establish the exact cause of death, identify patterns of death in community and remedial factors, and to contribute to improved forensic intelligence in suspicious deaths. The family should be kept central to the process.

Drivers for Change including new Legislation

15. The review of child deaths has been, to date, far more comprehensive than that for adults. However the following drivers for change exist:

    i. *Variation in process.* There is significant variation across the system in how child deaths are reviewed, which deaths are reviewed, and the quality of the review. Specifically:

        - 'unexpected' deaths in the community are generally reviewed as per the Sudden Unexpected Deaths in Infancy (SUDI) process. However there is variation in when a death is considered "unexpected" and in the timing of triggering investigations.
        - hospital deaths are usually reviewed at a Mortality and Morbidity (M&M) meeting. However there is wide variation, across the NHS, in how these meetings are convened, no standardisation on terminology, and a confused array of investigations (root cause analysis, serious incident inquiry, mortality review) that follow certain types of deaths.

- there is wide variation in CDOP processes (size, structure and functioning) and many CDOP panels are dislocated from governance processes within their local children's hospital.

ii. *The Wood Review*[12]. In 2016, Alan Wood recommended that national responsibility for child death reviews should move from the Department for Education to the Department of Health, that DH should re-consider how CDOPs should best be supported within the new arrangements of the NHS, and that DH should determine how CDOPs might be better configured on a regional basis with sub-regional structures to promote learning. He also recommended that child deaths be reviewed over a population size that allowed a sufficient number of deaths to be analysed for patterns and themes. He went further to recommend that the NHS consider the role CDOPs should play in the process for achieving a common national standard for high quality serious incident investigations. Finally, he supported the intention to introduce a national child mortality database, and urged DH to expedite its introduction.

iii. *The National Adult Case Review programme*[13]. This programme uses a very different structured judgment review (SJR) methodology to that used in child mortality review. It focuses on problems in heath care processes within an organization rather than trying to understand the cause of death. Cases in which care is judged to be poor are scored according to an 'Avoidability of Death' scale. It is important to recognise that many 16 and 17 year olds die in adult ITU's and therefore it is important to understand what processes should take precedence in the review of such patients.

iv. *Medical Examiner process*. The Medical Examiner will be introduced across England. This appointee will link with bereaved families as well as the Coroner and their involvement will affect all mortality review processes.

v. *CQC report: Learning, Candour, and Accountability*[14]. This report identified inconsistencies in: the involvement of families and carers; the process of identifying and reporting the death; how decisions to review or investigate a death was made; variation in the quality of reviews and investigations; and variation in the governance around processes and questionable demonstration of learning and actions.

vi. *Legislative change (Children and Social Work Bill 2017)*. The Wood Review recommendation that national responsibility for child death reviews should move from the Department for Education to the Department of Health is being enacted through

the Children and Social Work Bill 2017. Under the new legislation, local authorities and clinical commissioning groups are named as 'child death review partners' and must make arrangements for the review of each death of a child normally resident in the local authority area. They may also, if they consider it appropriate, make arrangements for the review of a death in their area of a child not normally resident there. The proposed legislation also states that the 'child death review partners' must make arrangements for the analysis of information about deaths reviewed and identify any matters relating to the death or deaths in that area a) relevant to the welfare of children in the area or to public health and safety and b) to consider whether it would be appropriate for anyone to take action in relation to any matters identified.

National Child Mortality Programme

16. NHS England is undertaking a national review of child mortality review processes both in the hospital and community. A key aim is to make the process easier for families to navigate at a very difficult time in their life. Central to the programme is the creation of a National Child Mortality Database, which is currently being commissioned. The effective functioning of the national database requires high-quality, standardised data arising from simplified and standardised local mortality and CDOP review processes. NHS England have therefore established 3 work streams:

- the simplification and standardisation of mortality review processes in the community and hospital;
- a review of the governance arrangements and standardisation of CDOP processes;
- the creation of the national child mortality database.

17. The goals of the NHS England's child mortality review programme are to:

- establish, as far as possible, the cause or causes of each child's death;
- identify any potential contributory or modifiable factors;
- provide on-going support to the family;
- ensure that all statutory obligations are met;
- learn lessons in order to reduce the risk of future child deaths;
- establish a robust evidence base to inform national policy across government to reduce avoidable child mortality across the UK nations.

18. NHS England, the Department of Health and the Department for Education are working together to produce new statutory guidance for child death review. This guidance will cover the processes which should take place following the death of a child, and in particular how the death should be reviewed at local mortality meeting and child death overview panel. This new guidance will be published in late 2017.

Reporting

19. The definitions used within the adult Case Review programme for record review and to identify problems in care are not recognised within *Working Together*. NHS England's work programme intends to identify best practice and standardise processes across deaths in hospital and the community, to improve the experience of families and professionals. The deaths of children who are treated in acute, mental health and community NHS Trusts should be included by Trusts in quarterly reporting from April 2017. The information should come from child death review processes, and should include reporting problems related to service delivery.

Board Leadership

20. Hospital Trust, Local Authority, Community Trust, Mental Health Trusts, and CCG boards should ensure that learning is derived from the care provided to children who die, by the appropriate application of the child mortality review process, and that learning is shared and acted on.

21. Many of the points around board leadership relating to adult deaths (set out in the main body of this guidance) also apply for child deaths. For example, providers must ensure that they have a board-level leader designated as patient safety director to take responsibility for the learning from deaths agenda (Annex A) and he or she should also have specific responsibility for the learning from child mortality processes. The director should ensure that the reviews are delivered to a high quality, with sufficient numbers of trained staff to lead the child mortality review process.

22. Particular attention should be paid to the deaths of children and young people with learning disabilities or mental health conditions, as these present with frequent co-morbidities and are often a more vulnerable group.

23. Providers should acknowledge that an independent investigation (one commissioned and delivered entirely separately from the organisation(s) involved in caring for the patient) may be required where the integrity of the investigation is likely to be challenged.

Best Practice in responding to Death of a Child who dies under a Trust's Care

24. All Trusts should have a policy in place that sets out how they respond to the deaths of children who die under their care. In doing this they should be mindful of current expectations described within *Working Together to Safeguard Children* (2015) and of NHS England's current review of child mortality review processes. New statutory guidance on child death review will be published in late 2017.

25. That policy should also set out how Trusts:

- communicate with bereaved parents and carers. This should include providing an honest and compassionate account of the reasons for death and knowledge of any potential problems in care that may need further review, ensuring initial contacts are managed by clinicians responsible for the care of the patient, and offering support to express concerns about the care given to patients who have died;
- achieve independence (where relevant) and objectivity in the child mortality review process, as well as lay membership within wider clinical governance systems.

Cross-system Reviews and Investigations

26. When the death of a child involves treatment across the health care pathway (primary: secondary: tertiary care) it is expected that child mortality review processes will not be duplicated and that a single overarching meeting will be convened. Child mortality review processes should interface with existing organisational governance systems. The NHS England child death review programme is mindful of expectations arising from the Serious Incident Framework, which sets out the circumstances in which further investigation is warranted in certain situations. It is therefore anticipated that when a review identifies a problem in care that meets the definition of a patient safety incident (any unintended or unexpected incident which could have or did lead to harm to one or more patients receiving NHS care) then this is reported via local risk management systems to the National Reporting and Learning System (NRLS). Regardless of the type of review, its findings must form an integral part of and feed into the organisation's clinical governance processes and structures. Review findings should be considered alongside other information and data including complaints, clinical audit information, patient safety incident reports and other outcomes measures to inform the Trust's wider strategic plans and safety priorities.

Bereaved Families and Carers

27. *Working Together* places the family at the heart of its processes. However it is recognised that the multitude of investigations that may unfold following a child's death can cause great confusion and distress to parents. The national bereavement group and bereavement charities are closely involved with developing NHS England's child death review programme – both in the co-design of systems and public guidance that explains processes.

28. The national Child Death Review programme recognises the following principles:

- bereaved families and carers should be treated as equal partners both in the delivery of care and following a bereavement;
- bereaved families and carers should receive a high standard of bereavement care, including being offered appropriate support;
- bereaved families and carers must always receive an honest, caring and sensitive response;
- bereaved families and carers should receive timely, responsive contact and support in all aspects of any review process, with a single point of contact and liaison.

Learning Disabilities and Mental Illness

29. NHS England's National Child Mortality Review programme fully recognises the unique challenge in reviewing the deaths of children with learning disabilities and mental health disorders. The Programme is working closely with the Learning and Disabilities Mortality Review (LeDeR) programme, and also aims to align itself with the Children and Young People's (CYP) Mental Health Programme and Specialised Commissioning particularly with regard to deaths in Tier 4 inpatient CAMHS Units. It will also work closely with the National Programme on Suicide in Young People. Going forward, the programme will ensure that there are appropriate mechanisms in place to allow data flows to occur unencumbered between all these systems and the national Child Mortality Database.

Conclusion

30. This section highlights the very different circumstances that pertain to the death of a child in acute, mental health and community organisations. Although infant and child mortality has declined in the UK, these improvements have not been sustained in comparison to other European countries. While poverty and inequality have a major impact on child mortality, we can nonetheless do much in front line service delivery to improve outcomes

for children, and experiences for both bereaved parents and the professionals who deliver care. Sadly, deaths in childhood are often an inevitable consequence of congenital malformations, birth events, and long-term conditions or chronic illness. Many, however, have preventable factors, and there is therefore an absolute imperative to scrutinise all deaths both locally and nationally to ensure that learning always occurs.

31. NHS England is seeking to address this by establishing a National Child Mortality Database to allow analysis and interpretation of child mortality data. The programme will also seek to improve, standardise and simplify the processes that follow the death of a child. This is predominantly to improve the experience of bereaved parents at such an overwhelming time, but also to enable uniformly robust data collection, to ultimately lead to a reduction in infant and child mortality in this country.

References

1. Viner RM, Hargreaves DS, Coffey C, Patton GC, Wolfe I. Deaths in young people aged 0-24 years in the UK compared with the EU15+ countries, 1970-2008: analysis of the WHO Mortality Database. Lancet. 2014 Sep 6;384 (9946):880-92
2. Department for Education. Child Death Reviews - year ending 31st March 2016. Available from: https://www.gov.uk/government/statistics/child-death-reviews-year-ending-31-march-2016
3. Government HM. Working Together to Safeguard Children. London. Department for Education. 2013
4. RCPCH. State of Child Health. Report 2017
5. Wolfe I, Donkin A, Marmot M et al. UK child survival in a European context: recommendations for a national countdown collaboration. Archives of Disease in Childhood. 2015
6. Office for National Statistics. Child Mortality in England and Wales: 2014; Available from: http://www.ons.gov.uk/peoplepopulationand community/birthsdeathsandmarriages/deaths/bulletins/childhoodinfantandperinatalmortalityinenglandandwales/2014
7. Eurostat.Infant mortality rate (tps00027). 2014. Available from: http://ec.europa.eu/eurostat/web/population-demography-migration-projections/deaths-life-expectancy-data//main-tables
8. Roberts J Bell R. Social inequalities in the leading causes of early death a life cause approach. 2015
9. Royal College of Paediatrics and Child Health, National Children's Bureau. A policy response to the report Why Children Die: deaths in infants, children, and young people in the UK (Part B). London. 2014
10. Viner RM, Hargreaves DS, Coffey C et al. Deaths in young people aged 0-24 years in the UK compared with the 15+ countries. 1970-2008. Analysis of the WHO mortality database. Lancet 2014: 384(9946): 880-892.\
11. Government HM. Working Together to Safeguard Children. London. Department for Education. A guide to inter-agency working to safeguard and promote the welfare of children. 2013
12. Government HM. Wood Report. Review of the role and functions of Local Safeguarding Children Boards. March 2016
13. Royal College of Physicians. National Mortality Case Record Review Programme. Oct 2016. Available at: https://www.rcplondon.ac.uk/projects/national-mortality-case-record-review-programme
14. Care Quality Commission. Learning, candour and accountability. 2016. Available at: https://www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf

Annex G - Maternity

1. In England, maternity care is generally safe and for the majority of women and their babies there is a good outcome. However, when things go wrong, the impact is devastating and has a profound effect on the parents, partners, siblings and extended family members.

2. Dr Bill Kirkup was tasked by the Secretary of State for Health to investigate and report on maternity services at Morecambe Bay NHS trust. The Report of the Morecambe Bay Investigation in 2015[20] highlighted a number of failures over a number of years at the Trust which resulted in poor care and the tragic deaths of mothers and babies. The report makes recommendations for mandatory reporting and investigation of serious incidents of maternal deaths, late and intrapartum stillbirths and unexpected neonatal deaths. It recommends a requirement that investigation of these incidents be subject to a standardised process, which includes input from and feedback to families, and independent, multidisciplinary peer review. In *Learning not Blaming*[21] the Government accepted this recommendation.

3. In October 2016, *Safer maternity care: next steps towards the national maternity ambition* was published setting out an action plan for the Government's vision for making NHS maternity services some of the safest in the world, by achieving the national ambition to halve the rates of stillbirths, neonatal deaths, brain injuries that occur during or soon after birth and maternal deaths, by 2030 with an interim measure of 20% by 2020. The plan details the actions needed at national and local level that build on the progress already made to improve the safety of maternity services.

4. Currently MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquires across the UK)[22], appointed by Health Quality Improvement Partnership and funded by NHS England, run the national Maternal, Newborn and Infant

[20] The report of the Morecambe Bay Investigation (March 2015): https://www.gov.uk/government/news/morecambe-bay-investigation-report-published

[21] The government response to the Freedom to Speak Up consultation, the Public Administration Select Committee report 'Investigating Clinical Incidents in the NHS', and the Morecambe Bay Investigation (July 2015).

[22] 'MBRRACE-UK' is the collaboration appointed by the Healthcare Quality Improvement Partnership (HQIP) to continue the national programme of work investigating maternal deaths, stillbirths and infant deaths, including the Confidential Enquiry into Maternal Deaths (CEMD). The aim of the MBRRACE-UK programme is to provide robust information to support the delivery of safe, equitable, high quality, patient-centred maternal, newborn and infant health services.

Clinical Outcomes Review to conduct surveillance of all late fetal losses, stillbirths and neonatal deaths, biennial topic-specific confidential enquiries into aspects of stillbirth and neonatal death or serious neonatal morbidity and surveillance and confidential enquiries of all maternal deaths.

5. Surveillance reports on stillbirths and neonatal deaths are published annually. Reports on maternal deaths are published on a triennial basis, because the number of maternal deaths from individual causes is small, and thus three years' worth of data is required to identify consistent lessons learned for future care and to maintain anonymity and confidentiality.

6. A maternal death is defined internationally as a death of a woman during or up to six weeks (42 days) after the end of pregnancy (whether the pregnancy ended by termination, miscarriage or a birth, or was an ectopic pregnancy) through causes associated with, or exacerbated by, pregnancy. Deaths are subdivided on the basis of cause into: direct deaths, from pregnancy-specific causes such as preeclampsia; indirect deaths, from other medical conditions made worse by pregnancy such as cardiac disease; or coincidental deaths, where the cause is considered to be unrelated to pregnancy, such as road traffic accidents. Maternal deaths are very rare. The MBRRACE-UK report 'Saving Lives, Improving Mothers Care highlights that for 2012-14, the maternal death rate was 8.5 per 100,000 women. Overall, 241[23] women among 2,341,745 maternities in 2012–14 died during or within 42 days of the end of pregnancy in the UK.

7. Better Births (2016)[24], the report of the NHS England commissioned National Maternity Review, set out a five year forward view for improving outcomes of maternity services in England. The report highlighted the lack of a standard approach to investigating when things wrong during before, during or after labour: Reviews and investigation are currently undertaken using different protocols and processes by different organisations. The Report recommended there should be a national standardised investigation process for when things go wrong, to get to the bottom of what went wrong and why and how future services can be improved as a consequence. Work has now begun on the development of a Standardised Perinatal Mortality Review Tool that will enable maternity

[23] Of these 41 deaths were classified as coincidental

[24] https://www.england.nhs.uk/wp-content/.../02/national-maternity-review-report.pdf

and neonatal services to systematically review and learn from every stillbirth and neonatal death in a standardised way.

8. Maternal deaths, neonatal deaths and stillbirths occurring in acute, mental health and community Trusts should be included by Trusts in quarterly reporting from April 2017.

9. It should be borne in mind that in addition to hospital obstetric units, maternal deaths can occur in a local midwifery facility (for example, a local midwifery unit or birth centre) or during home births. The definition also covers up to 42 days after the end of pregnancy.

Annex H - Cross-system Reviews & Investigations

1. In many circumstances more than one organisation is involved in the care of any patient who dies, with the most common combinations being primary care and acute care, ambulances services and acute care, or mental health services combined with any of these. Case record reviews typically have to rely on the records held by a single organisation, but even these records can provide indications of possible problems in earlier stages of the patient pathway.

2. Where possible problems are identified relating to other organisations, it is important the relevant organisation is informed, so they can undertake any necessary investigation or improvement. Most trusts already have effective systems to notify other organisations when concerns are raised via incident reports, and are likely to be able to adapt these to address potential problems identified in case record review.

3. Trusts should consider whether they can routinely arrange joint case record reviews or investigations for groups of patients where more than one organisation is routinely providing care at the time of death - for example, for older people with dementia and frailty receiving frequent input from their GP and from community mental health nurses. Commissioners have a role in encouraging appropriate routine collaboration on case record review.

4. Where the provision of care by multiple providers, and particularly the coordination of that care, is thought to have potentially contributed to the death of a patient, investing the significant resources required to coordinate major and complex investigations must be considered. For example, the Serious Incident Framework outlines the principles which underpin a serious incident investigation process and the relevant content is set out in paragraphs 5 to 10 below.

5. The organisation that declares the serious incident is responsible for recognising the need to alert other providers, commissioners and partner organisations as required in order to initiate discussions about subsequent action.

6. All organisations and agencies involved should work together to undertake one single investigation wherever this is possible and appropriate. Commissioners should help to facilitate discussions relating to who is the most appropriate organisation to take responsibility for co-ordinating the investigation process. Commissioners themselves should provide support in complex circumstances. For example, where no one provider organisation is best placed to assume responsibility for co-ordinating an investigation, the commissioner may lead this process. If commissioners do not have the capability or capacity to manage this type of activity this should be escalated to ensure appropriate resources are identified. This may be something to consider escalating through the relevant Quality Surveillance Group or through specific review panels and clinical networks. This should ensure the cumulative impact of problems with care can be resolved.

7. In some circumstances the local authority or another external body may be responsible for managing and co-ordinating an investigation process. Where this is the case, providers and commissioners must contribute appropriately and assure themselves that problems identified will be addressed.

8. Often in complex circumstances, separate investigations are completed by the different provider organisations. Where this is the case, organisations (providers and commissioners and external partners as required) must agree to consider cross boundary issues, such as gaps in the services that may lead to problems in care. The contributing factors and root causes of any problems identified must be fully explored in order to develop effective solutions to prevent recurrence. Those responsible for coordinating the investigation must ensure this takes place. This activity should culminate in the development of a single investigation report.

9. To determine oversight of an investigation, the RASCI (Responsible, Accountable, Supporting, Consulted, Informed) model supports the identification of a single 'lead commissioner' with responsibility for managing oversight of serious incidents within a particular provider. This means that a provider reports and engages with one single commissioning organisation who can then liaise with other commissioners as required. This approach is particularly useful where the 'accountable commissioner' is geographically remote from the provider (and therefore removed from other local systems and intelligence networks) and/or where multiple commissioners' commission services from the same provider. It facilitates continuity in the management of serious incidents, removes ambiguity and therefore the risk of serious incidents being

overlooked and reduces the likelihood of duplication where there is confusion regarding accountability and/or responsibility and general management of the serious incident process.

Healthcare Safety Investigation Branch

10. The Healthcare Safety Investigation Branch (HSIB) will provide capability at national level to offer support and guidance to NHS organisations on investigations, and to carry out up to 30 investigations itself per year where there is a deeper learning opportunity for the NHS. Through a combination of setting exemplary practice and structured support to others, the HSIB is expected to make a decisive difference to the NHS, promoting a culture of learning and a more supportive relationship with patients, families and staff.

11. Providers will benefit from the HSIB, and their expert advice on safety improvement. It should mean timely investigations, with a genuine commitment to openness, transparency and engagement with staff and patients and their families and carers that adopt an ethic of learning and continuous improvement. The HSIB will contribute strongly to the culture change that is needed in the NHS.

Annex I - Roles and Responsibilities of National Bodies and Commissioners

1. Each national organisation will have a single lead at executive level who has accountability, internally and externally for that organisation's support of delivering against the national programme on learning from deaths. This will include ensuring progress is reported to the National Quality Board and ensuring that learning from deaths remains a priority area in future developments. A list of the lead roles for each national organisation is at Annex K and will be made available on each organisation's website.

2. As the independent regulator of health and social care, the **Care Quality Commission** will use this national guidance on learning from deaths to guide its monitoring, inspections and regulation of services. Inspectors will use new key lines of enquiry in relation to safety and governance, set out in the Care Quality Commission's assessment framework, to assess learning from deaths, collect evidence and identify good practice. Where specific concerns are identified, the Care Quality Commission can use its powers to take action with individual providers and will report its findings of good and poor progress in individual inspection reports or national publications to help encourage improvement.

3. **NHS Improvement** will continue to provide national guidance for managing serious incidents. Local processes setting out what deaths should be subject to case record review will inevitably use a wider definition than deaths that constitute Serious Incidents. Equally, when a death clearly meets Serious Incident criteria there is no need for an initial stage of case record review to be completed before work to initiate and support a full investigation is undertaken. Serious Incident guidance provides the framework upon which the Care Quality Commission and commissioners (including CCGs and NHS England) will assess the quality of investigations undertaken across the NHS. NHS Improvement will, alongside the Healthcare Safety Investigation Branch and others, support implementation of best practice in investigations by Trusts.

4. As the revised inspection regime of the Care Quality Commission will assess providers' ability to learn from deaths as a key component of high quality care, work to address this will be factored into NHS Improvement's work to support providers in achieving good or outstanding Care Quality Commission care ratings. Regional teams will work with

providers, their commissioners and NHS England to identify areas where improvements can be made and the strategies which can help deliver the change required.

5. Nationally, NHS Improvement commissions (via the Healthcare Quality Improvement Partnership) the work of the Royal College of Physicians to develop and roll-out the Structured Judgement Review methodology, which will be providing a national training programme for acute Trusts to support them to carry out the methodology for adult inpatient deaths.

6. **NHS England** has a direct commissioning role as well as a role in leading and enabling the commissioning system. This national guidance on learning from deaths will guide its practice in both of these areas.

7. The **National Institute for Health and Care Excellence (NICE)** has produced best practice guidelines on the care of the dying, covering adults and children. These guidelines are supported by measurable quality standards that help Trusts demonstrate high quality care, and by information for the public describing the care that should be expected in the last days of life.

Annex J - Structured Judgement Review in Mental Health Trusts

Background

1. Some mental health providers have seen a missed opportunity in not learning more widely from deaths by reviewing the safety and quality of care of a wider group of people. This is despite research showing that people with mental health problems have greater health care needs than the general population and may suffer unnecessarily with untreated or poorly managed long-term conditions.

Where Next - Making a Decision on the Review Method

2. Since 2014 hospitals in Yorkshire and the Humber have been working together with the AHSN Improvement Academy to refine a mortality review method called Structured Mortality Review (SJR), a method proposed for all acute hospitals in England. The acute sector methodology reviews phases of care appropriate to their settings, such as initial assessment and first 24 hours, care during a procedure, discharge/end of life care and assessment of care overall. Written explicit judgements of care and phase of care scores form the basis of the reviews. This now forms the basis of the national acute hospitals mortality review programme.

3. This methodology and review format was seen as potentially valuable by three regional Mental Health trusts and they have individually worked to create phase of care headings more appropriate to mental health care, with the support of the Improvement Academy and Professor Allen Hutchinson. These three trusts are at different stages of implementation. In the early adopter trust the tool was also adapted to include a pen picture to enable the reviewer to understand both the life and death of the person, considering this fundamental to understanding areas for learning that may include review of physical health and lifestyle choices. In the same trust this approach was used within Learning Disability services prior to the introduction of the Learning Disability Review of Deaths (LeDeR) programme. In another trust both the mental health care and community care facilities have been using the methods.

Introducing the Review Process

4. Just as with the acute services, future reviewers require initial training in how to make explicit judgements of the quality and safety of care and how to assess care scores for

each phase of care. Assessments are made of both poor and good care and it is common to find that good care is far more frequent than poor care.

5. One of the findings from introducing the methods into mental health care is that many of the reviewers naturally have a focus on the mental health care component of the services. But review teams have found that using this review method they also identify common long-term conditions such as diabetes and heart disease that do not appear to have been well managed. For example, in one hospital it became evident that many people had a number of co-existing comorbid/long term conditions, yet it was unclear from the records whether or not the person was receiving support and or review from primary care and or secondary care services for their physical health. There is value, therefore, in also training up review staff who have an understanding of what good care looks like in long-term conditions within the context of mental health facilities.

6. Scoring of the phases of care is a new approach for many clinical staff in mental health care (just as has been the case in acute care) and scoring was initially felt to be very daunting by some reviewers. Nevertheless, as staff become more confident with its use, scoring can often be seen as a natural outcome of their judgements on the level of care provided. Some of the hospital teams have set up a mortality-reviewers support group to provide peer review and guidance. Feedback of the good care may be shared with both the individual staff and the wider teams - this is often well received. Of course, concerns also have to be discussed with services to identify areas for improvement.

Where Next

7. The use of the structured judgement method often receives very positive feedback from staff trained in this methodology and so in one centre SJR is being rolled out for wider use to review the quality of care being received whilst people are currently receiving services. Looking forward, it has been recognised that whilst services can learn from each case, more can be learnt from the aggregation of cases, where patterns of poor care and good care emerge. In one case study that has sought for such patterns it is of note that where patterns exist of poorer care, these have been in the main linked to the management of physical ill health within mental health and learning disability services.

8. For further details please contact Allyson Kent allyson.kent@nhs.net , or Professor Allen Hutchinson allen.hutchinson@sheffield.ac.uk Yorkshire and The Humber AHSN Improvement Academy.

Annex K - National Leads

The list below provides the lead role with overall responsibility for the learning from deaths programme at relevant national organisations:

- NHS Improvement - Executive Medical Director
- Care Quality Commission - Chief Inspector of Hospitals
- Department of Health - Director of Acute Care and Workforce
- NHS England - National Medical Director

Annex L - Background and Links

Learning Disabilities Mortality Review (LeDeR) programme

Background is available at http://www.bristol.ac.uk/sps/leder

Quality Accounts

Background is available at:
http://www.nhs.uk/aboutNHSChoices/professionals/healthandcareprofessionals/quality-accounts/Pages/about-quality-accounts.aspx

Healthcare Safety Investigation Branch

The new Healthcare Investigation Branch (HSIB) will offer support and guidance to NHS organisations on investigations, and carry out certain investigations itself. It is envisaged that the HSIB will be established to:

i. generate investigation findings and recommendations which drive action on the reduction or prevention of incident recurrence;
ii. conduct investigations and produce reports that patients, families, carers and staff value, trust and respect; and,
iii. champion good quality investigation across the NHS, and lead on approaches to enhance local capability in investigation.

The HSIB will be hosted by NHS Improvement and will undertake a small number of investigations annually. It will focus on incident types that signal systemic or apparently intractable risks in local healthcare systems. The HSIB and the role of Chief Investigator will play a crucial part in developing the culture of safety, learning and improvement in the NHS that will be one of the key elements of national policy and cross-system action in the years ahead.

Meeting Title:	Trust Board		
Date:	6 April 2017	**Agenda No:**	**2.2**
Report Title:	Quality Improvement Programme: Progress Report		
Sponsor	Avey Bhatia – Chief Nurse & Director of Infection Prevention and Control		
Report Authors:	Paul Linehan – Head of Quality Governance		
Freedom of Information Act (FOIA) Status:	Unrestricted		
Presented for:	Assurance		
Executive Summary:	This report provides assurance on the progress of the Quality Improvement Plan, and draws to the Board's attention (by exception) all actions that have breached their implementation deadline. The QIP Programme has shown significant improvement from the February position. The number of red actions has decreased from 7% to 3.2%, and the number blue action has increased from 25% to 33%. As at 23.03.17 • 33% (N=104) of actions have been embedded (Blue). In February there was 25% (N=79) • 57.6% (N=182) of actions are on target (Green). In February there was 63% (N= 198) • 6.3% (N=20) are at risk of breaching (Amber). In February there was 5% (N=16) • 3.2% (N=10) have breached target date for implementation (Red). In February there was 7% (N=23) The QIP programme is moving into a new phase whereby the actions will be related to the service delivery, and a new matrix is being developed to monitor the progress across the Trust. In addition a new narrative is being developed which will help staff understand the purpose of the QIP and their role in making improvements in patient safety. The reporting format for the refreshed QIP will change from April 2017 to replace the evolution of the QIP Programme.		
Recommendation:	The Board of Directors are invited to: 1. Note there has been some improvement on the planned delivery of the Quality Improvement Plan in March 2017. 2. Consider and discuss corrective actions for the 10 actions that have breached their target date. 3. Advise on any further action required by the Board.		
Supports			
Trust Strategic Objective:	Ensure the Trust has an unwavering focus on all measures of quality and safety, and patient experience.		
CQC Theme:	All CQC Domains		

Single Oversight Framework Theme:	(i) Quality of Care (ii) Operational Performance (iii) Leadership and Improvement Capability		
Implications			
Potential Risk:	I. Service users are exposed to unacceptable levels of harm arising from inadequate compliance with CQC fundamental standards of care; and II. The Trust fails to comply with NHSI enforcement undertakings and the provider licence.		
Legal/Regulatory:	Compliance with: (i) The Health and Social Care Act 2008 (Regulated Activities) Regulations (ii) 2014; (iii) The Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2015; (iv) Care Quality Commission (Registration) Regulations 2009; and (v) The Health & Social care Act 2012, the NHS Provider Licence General Condition 7 – Registration with the Care Quality Commission		
Resources:			
Previously Considered by:	Quality Improvement Project Board	**Date:**	22.03.17
Equality Impact Assessment:	No adverse impact identified.		
Appendices:	Workstream Overview Report for: (i) Personalised Care (ii) Safety Culture (iii) Governance (iv) Human Resources (v) Estates (vi) Operations (vii) Healthcare Informatics (viii) Leadership		

Quality Improvement Programme Update Report: March 2017
Trust Board, 6 April 2017

1.0 PURPOSE

1.1 The purpose of this paper is the ensure the Board of Directors are up to date on the progress of the Quality Improvement Plan, and to highlight to the Board, by exception, elements of the plan that are not on track.

2.0 BACKGROUND OR CONTEXT

2.1 The Quality Improvement Plan brings together the actions required to address the CQC compliance concerns identified following inspection in June 2016. The plan takes account of: (i) the Section 29A Warning Notice, served on the Trust in August 2016; (ii) all the 'must do' and should do' recommendations contained within the inspection reports; and (iii) a range of improvement interventions identified locally as quality priorities by the Trust.

2.2 The Quality Improvement Plan forms part of NHS Improvement's enforcement undertakings and, in this regard, the Board is required by November 2017 to: (i) provide NHSI with assurance that it has addressed the 'must do' actions to the CQC's satisfaction; (ii) is no longer considered by CQC to be inadequate in the well-led domain; and (iii) has improved against all domains rated as inadequate or requires improvement when compared to the CQC's inspection findings.

2.3 Following publication of the CQC report, the Quality Improvement Plan expanded and restructured into eight workstreams.

3.0 ANALYSIS

3.1 Within the 8 workstreams involved in the QIP there are 316 actions. Of those actions: 57.6% (n=182) are on track; 33% (n=104) have completed embedded actions; 3.2% (n=10) have breached the target date for implementation; and 6.3% (n=20) are identified as at risk of breaching target date for implementation.

3.2 The Board will note, that one workstream has been rated 'red' overall due to the number of overdue actions. The relevant Executive Director is aware; the QIP Board has been briefed accordingly. An explanation for the slippage is given against each action in the body of this report.

Personalised Care – Exceptions

3.3 Beds and bed rails. Delivery of the 844 electronic low-profiling beds with integrated bed rails are expected during April 2017. This will simultaneously improve quality, minimise the risk of falls from height, improve comfort for patients, minimise moving and handling risk.

3.4 Infection Prevention. The policy is currently being updated to ensure medical equipment across the Trust is cleaned prior to storage; it is predicted that this will be completed by 31st March, 2017.

3.5 Privacy, Dignity and Compassion – There are currently 13 wards with inappropriate curtains. A meeting was arranged for the 16 March to plan the decanting of patients from affected wards in order to lower curtain rails throughout St James Wing.

Safety Culture - Exceptions

3.6 The appointment of a Radiation Protection Advisor has been approved and the post has now gone to advert.

3.7 Venous-Thromboembolism prevention training. Nurses and other non-medical staff are currently not included in the training. The MD and CN are taking this forward to address shortfall.

3.8 Increasing insulin awareness. The diabetes inpatient training programme dates for 2017/18 for insulin awareness will be released in April 2017. The MAST programme for insulin will be uploaded and available for doctors, nurses and pharmacists by the end of May 2017.

Human Resources – Exceptions

3.9 Staff induction – A new induction pack has been produced and is with Corporate Communications to be turned into an App to be launched on 27th March 2017. A reminder in 'EG You' will apart monthly reminding staff to complete induction.

Estates – Exceptions

3.10 Replace/Install fire doors on the main access routes within Lanesborough Wing. The project will be completed in a phased approach, firstly it will consist of repairs to fire doors and secondly replacement of the extensively damaged fire doors, the overall completion date for this is the 18th August 2017.

3.11 Safe paediatric ward environment. Multiple tenders for various works have been circulated for quotes. Tender returns are expected by the end of April 2017.

Operations – Exceptions

3.12 Circulation of CAHS strategy. The CAHS service is currently out for tender. The final strategy document will not be circulated until the outcome of the tender is known which will be on the 14th April 2017.

Warning Notice

3.13 The Trust submitted its response to the Section 29A Warning Notice to the Care Quality Commission on 30/11/2016. CQC have acknowledged receipt of the Notice at a routine engagement meeting between the Trust and local CQC inspectors held on 9 December 2016. No further instructions have been received at the time of report in respect of the Section 29A actions.

4.0 IMPLICATIONS

4.1 Potential Risks

At a strategic level, there are two potential risks concerning the delivery of the Quality Improvement Plan:

I. The Trust may expose service users to unacceptable levels of harm arising from inadequate compliance with CQC fundamental standards of care;
II. The Trust may fail to assure the Regulator that: (i) it has addressed the S29A requirements and the 'must do' actions to the CQC's satisfaction; the actions set out in the Quality Improvement Plan are designed to mitigate these risks.
III.

3.2 Legal/Regulatory

3.3 Compliance with:

(ii) The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014;

(iii) The Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2015;

(iv) Care Quality Commission (Registration) Regulations 2009; and

(v) The Health & Social care Act 2012, the NHS Provider Licence General Condition 7 – Registration with the Care Quality Commission.

5.0 RECOMMENDATION

The Board of Directors are invited to:

a) Note there has been some improvement in the planned delivery of the Quality Improvement Plan in January 2017.
b) Consider and discuss this report
c) Advise on any further action required by the Board.

Appendix 1 Summary of QIP Workstream Ratings:

QIP Workstream	Total Actions	B	R	A	G	Overall Status	Comments
Personalised Care		39	3	5	52		Risks relate to • Sufficient and appropriate bed stock • Overall compliance of infection prevention and control training.
Safety Culture		19	3	6	53		Risks relate to: • Insulin awareness • Compliance with VTE training • Radiation Safety
Governance		10	0	1	17		• One of the eight QIP workstreams are currently off track
Human Resources		6	1	3	12		Risks relate to: • Induction
Estates		23	2	1	14		• Replacement of fire doors. • Completion of environmental work on Paediatric wards to ensure safe for MH patients.
Operations		5	1	2	24		• CAHS strategy • OPD: answering telephone within SLA of ≥ 95%
H/C Informatics		1	0	2	6		• Patient record systems • Roll out of clinical systems programmes
Leadership		1	0	0	4		• 5 actions remain within time scales thus rated green. • Recognised that stable leadership is fundamental to implementing improvements within the Trust.
Elective Care Recovery							Evidence presented to RTT Board for assurance. Opportunity to provide challenge at the QIP workstream.
Total		**104**	**10**	**20**	**182**	**316**	

Table 1: Summary of BRAG rating by workstream.

Overall workstream BRAG rating

Blue	Workstream completed, embedded and assured in daily practice
Red	≥ 5% actions in workstream have breached target date for implementation
Amber	≥ 20% of actions in workstream are either breached or at risk of breaching target dates
Green	< 20% of actions in workstream are either breached or at risk of breaching target dates

Executive Lead: Title: Head of Quality Governance Name: Paul Linehan						
Reporting Period: (March 2017)	**Action BRAG rating Analysis**					
	B	**R**	**A**	**G**	**Active Actions**	**Assurance Actions**
					212	**104**
	104	**10**	**20**	**183**	**Total Actions**	
					316	

Summary of progress against actions March 2017

Workstream	Sub Area	BRAG analysis				
		B	R	A	G	Total by WS
Personalised care						
1.1	EOLC	12	0	0	5	**17**
1.2	Gwynne Holford	14	0	1	7	**22**
1.3	Bedrails	3	1	1	9	**14**
1.4	MCA/DoLs/Safeguarding	2	0	0	4	**6**
1.5	Infection Prevention	0	1	1	3	**5**
1.6	Pain Management	2	0	0	6	**8**
1.7	Privacy & Dignity	4	1	0	5	**10**
1.8	Dementia Care	1	0	0	9	**10**
1.9	Paediatric Care	1	0	2	3	**6**
1.10	Fire wardens	0	0	0	1	**1**
Total for PC		**39**	**3**	**5**	**52**	**99**
2.Safety Culture						
2.1	Medicines Management	13	2	0	13	**27**
2.2	Radiation Safety	4	1	0	5	**10**
2.3	Deteriorating patient	2	0	6	24	**32**
2.4	WHO safer surgery	0	0	0	6	**6**
2.5	Clinical records security	0	0	0	6	**6**
Total for SC		**19**	**3**	**6**	**53**	**82**
3.Governance	N/A	**10**	**0**	**1**	**17**	**28**
4.Human Resources	N/A	**6**	**1**	**3**	**12**	**22**

5.Estates	N/A	**23**	**2**	**1**	**14**	**40**
6. Operations						
6.1	Patient Access	3	0	1	14	18
6.2	Equipment requirements	1	0	0	1	2
6.3	Community Adult Health Strategy	0	1	0	5	**6**
6.4	Divisional Trust Ops communications	0	0	1	2	**3**
6.5	Health Visiting	1	0	0	2	**3**
Total		**5**	**1**	**2**	**24**	**32**
7. H/C Informatics	N/A	**1**	**0**	**2**	**6**	**9**
8. Leadership	N/A	1	0	0	4	**5**
Total numbers		**104**	**10**	**20**	**182**	316

Table 2: Summary of actions and rating by workstream.

Appendices 1:8 Workstream Overview Reports

1: Personalised Care Workstream Overview report

Executive Lead Title: Chief Nurse Name: Avey Bhatia Reporting Period Date: March 2017		Overall BRAG	Action BRAG rating analysis			
			B	R	A	G
	March		39	3	5	52
	Feb		24	8	6	61

Key

Blue	Delivered and embedded so that it is now day to day business and the expected outcome is being routinely achieved. This has to be backed up by appropriate evidence
Red	Has failed to deliver by target date/Off track and now unlikely to deliver by target date.
Amber	Off track but recovery action planned to bring back on line to deliver by target date.
Green	Completed / On track to deliver by target date.

Off Track Issues Identified (Red actions) March 2017	**Original Target Date**	**Recovery Action Plan**	**Recovery Plan Target date**
Bed Rails 1.3.1a Ensure sufficient and appropriate bed stock and bed rails availability	**30/09/2016**	The provisional plan to replace in excess 800 beds across trust by end of financial year has now been rescheduled to April 2017. 844 new beds will arrive in March/April 2017. Once the roll out is complete all the beds in inpatient areas will have integrated bed rails.	**May 2017**

Infection Prevention 1.5.5 There are systems in place to ensure medical equipment across the trust is cleaned prior to storage and that the state of cleanliness of equipment returned to the ward is monitored.	**31/01/2017**	The "owners" of the policy have been advised of changes that need to be made. Permission to publish the amended policy is awaiting approval by the chair of the IPC.	**31/03/2017**
Privacy, Dignity & Compassion 1.7.1.a Review where the curtains or screens used to screen beds within clinical areas fit correctly.	**31/12/2016**	Meeting arranged for Thursday 16 March 2017 to plan decanting patients from affected wards in order to lower curtain rails throughout St James Wing. Batches of curtains will be ordered in parallel to the curtain rail work rather than waiting for the total amount to come into the trust.	**11/06/2017**

St George's University Hospitals NHS
NHS Foundation Trust

2: Safety Culture Workstream Overview report

Executive Lead Title: Medical Director Name: Andy Rhodes Reporting Period Date: March 2017		Overall BRAG	Action BRAG rating analysis			
			B	R	A	G
	March		19	3	6	53
	Feb		16	5	3	58

Key

Blue	Delivered and embedded so that it is now day to day business and the expected outcome is being routinely achieved. This has to be backed up by appropriate evidence
Red	Has failed to deliver by target date/Off track and now unlikely to deliver by target date.
Amber	Off track but recovery action planned to bring back on line to deliver by target date.
Green	Completed / On track to deliver by target date.

Off Track Issues Identified (Red actions) March 2017	Original Target Date	Recovery Action Plan	Recovery Plan Target date
Medicines Management 2.1.8.a Engage with Diabetes team to lead on programme of education and address poor insulin awareness through discussion with nursing staff as needed during ward Medication Safety Visits.	**31/12/2016**	Diabetes inpatient training programme is ongoing; the most recent training day was the 14th March 2017. New programme of dates for 2017/18 will be released in April 2017. Meeting with deputy chief nurse on 16/03/17 to discuss nursing staff groups for which training needs to be mandatory. MAST programme for insulin to be uploaded onto MAST website and available for doctors, nurses and pharmacists	**Ongoing training 2017/18** **31/05/2017**
Medicine Management 2.1.8.b 85% Compliance with VTE/anticoag training on MAST for all clinical staff. In addition develop bespoke and refresher training.	**31/12/2016**	Meeting with deputy chief nurse on 16/03/17 to discuss nursing staff groups for which training needs to be mandatory. Once this staff list is finalised and approved the MAST team can be informed and the VTE package can be added to the mandatory training record for those relevant staff groups. Bespoke and refresher training still being conducted as required.	**31/01/2017**
Radiation Safety 2.2.2b 'Appoint fulltime Band 8c Radiation Protection Advisor (RPA) (as supported by CEO). This position will also act as an Medical Physics Expert (MPE) or develop an alternative approach	**31/12/2016**	The RPA post was approved by the VCP on 22nd March and is just about to appear in advert.	**31/05/2017**

St George's University Hospitals NHS
NHS Foundation Trust

3: Governance Workstream Overview report

Executive Lead Title: Head of Quality Governance Name: Paul Linehan Reporting Period Date: March 2017	Overall BRAG		Action BRAG rating analysis			
			B	R	A	G
	March		10	0	1	17
	Feb		10	0	1	17

Key

Blue	Delivered and embedded so that it is now day to day business and the expected outcome is being routinely achieved. This has to be backed up by appropriate evidence
Red	Has failed to deliver by target date/Off track and now unlikely to deliver by target date.
Amber	Off track but recovery action planned to bring back on line to deliver by target date.
Green	Completed / On track to deliver by target date.

Off Track Issues Identified (Red actions) March 2017	**Original Target Date**	**Recovery Action Plan**	**Recovery Plan Target date**

St George's University Hospitals NHS
NHS Foundation Trust

4: Human Resources Workstream Overview report

Executive Lead Title: Director of HR Name: Mark Gammage Reporting Period Date: March 2017	Overall BRAG		Action BRAG rating analysis			
			B	R	A	G
	March		6	1	3	12
	Feb		6	5	5	6

Key

Blue	Delivered and embedded so that it is now day to day business and the expected outcome is being routinely achieved. This has to be backed up by appropriate evidence
Red	Has failed to deliver by target date/Off track and now unlikely to deliver by target date.
Amber	Off track but recovery action planned to bring back on line to deliver by target date.
Green	Completed / On track to deliver by target date.

Off Track Issues Identified (Red actions) March 2017	**Original Target Date**	**Recovery Action Plan**	**Recovery Plan Target date**
4.1.8 Ensure all staff are inducted into clinical areas.	**31/12/2016**	A new Induction pack has been produced and is with Corporate Communications to be turned into an App to be launched on 27th March 2017. An item will appear monthly in 'EG You' reminding staff to complete local induction and to complete the standard Trust checklist. A monthly email will be sent to all staff who attended induction in the previous month reminding them to complete local induction and to complete the checklist. Audits of local induction will be undertaken in April to check compliance.	**30/4/2017**

St George's University Hospitals NHS
NHS Foundation Trust

5: Estates Workstream Overview report

Executive Lead Title: Director of Estates Name: Richard Hancock Reporting Period Date: March 2017	Overall BRAG		Action BRAG rating analysis			
			B	R	A	G
	March		23	2	1	14
	Feb		20	3	0	17

Key

Blue	Delivered and embedded so that it is now day to day business and the expected outcome is being routinely achieved. This has to be backed up by appropriate evidence
Red	Has failed to deliver by target date/Off track and now unlikely to deliver by target date.
Amber	Off track but recovery action planned to bring back on line to deliver by target date.
Green	Completed / On track to deliver by target date.

Off Track Issues Identified (Red actions) March 2017	**Original Target Date**	**Recovery Action Plan**	**Recovery Plan Target date**
5.1.6.f Replace/Install Fire doors on the main access routes within Lanesborough Wing.	**31/03/2017**	The project will be completed in a phased approach. Phase 1 will consist of repairs to fire doors. Phase 2 will consist of the replacement of the extensively damaged fire doors due to the long lead time required to make and deliver the fire doors (approx. 8 weeks). The project will commence works in Grosvenor Wing first, possibly Lanesborough Wing next and finally St. James Wing. The commencement of works is subject to the approval of risk assessment and resolution of security issues. The programme of works provided by the	**18/08/2017**

		contractor can be forwarded once complete; discussions are presently underway with the contractor. The planned duration of works is 21 weeks from the contractor start date which is estimated to be 03 April.	
5.1.22b The paediatric ward environment is safe and suitable for treating and caring for children and young people with mental health conditions.	**31/01/2017**	Phase 1 – Multiple tenders for various works have been circulated for quotes. Tender returns are expected by end of April, it is planned that a review of tender returns will take approximately 2 weeks to choose and confirm a contractor. It is presumed a contractor will be on-site in May 2017. The team are currently finalising a detailed plan. Phase 2 – Phase 2 of Anti-Ligature works has been proposed in the EMT paper to run in tandem to Phase 1. It is likely the anti-barricade doors will require a longer lead time than 8 weeks due to the larger size of the order, additionally it is unknown whether this order will have to go through a tender process. Additionally, as this work will be carried out across 3 wards, discussion with the contractors and suppliers must first be held before estimations are made and planned to be installed with the least impact to services.	**31/07/2017** **31/08/2017**

St George's University Hospitals NHS
NHS Foundation Trust

6: Operations Workstream Overview report

Executive Lead Title: Chief Operating Officer Name: Mark Gordon Reporting Period Date: March 2017	Overall BRAG		Action BRAG rating analysis			
			B	R	A	G
	March		5	1	2	24
	Feb		2	1	1	28

Key

Blue	Delivered and embedded so that it is now day to day business and the expected outcome is being routinely achieved. This has to be backed up by appropriate evidence
Red	Has failed to deliver by target date/Off track and now unlikely to deliver by target date.
Amber	Off track but recovery action planned to bring back on line to deliver by target date.
Green	Completed / On track to deliver by target date.

Off Track Issues Identified (Red actions) March 2017	**Original Target Date**	**Recovery Action Plan**	**Recovery Plan Target date**
6.4.1.e 5. Sign off and circulate CAHS strategy.	**31/03/2017**	The CAHS service is currently out for tender. The final strategy document will not be circulated until the outcome of the tender is known which will be on the 14th April 2017.	**14/04/17**

St George's University Hospitals NHS
NHS Foundation Trust

7: H/C Informatics Workstream Overview report

Executive Lead Title: Director of IT Name: Larry Murphy Reporting Period Date: March 2017	Overall BRAG		Action BRAG rating analysis			
			B	R	A	G
	March		1	0	2	6
	Feb		0	0	0	8

Key

Blue	Delivered and embedded so that it is now day to day business and the expected outcome is being routinely achieved. This has to be backed up by appropriate evidence
Red	Has failed to deliver by target date/Off track and now unlikely to deliver by target date.
Amber	Off track but recovery action planned to bring back on line to deliver by target date.
Green	Completed / On track to deliver by target date.

Off Track Issues Identified (Red actions) March 2017	**Original Target Date**	**Recovery Action Plan**	**Recovery Plan Target date**

St George's University Hospitals NHS
NHS Foundation Trust

8: Leadership Workstream Overview report

Executive Lead Title: Chief Executive Name: Simon Mackenzie Reporting Period Date: March 2017	Overall BRAG		Action BRAG rating analysis			
			B	R	A	G
	March		1	0	0	5
	Feb		1	0	0	5

Key

Blue	Delivered and embedded so that it is now day to day business and the expected outcome is being routinely achieved. This has to be backed up by appropriate evidence
Red	Has failed to deliver by target date/Off track and now unlikely to deliver by target date.
Amber	Off track but recovery action planned to bring back on line to deliver by target date.
Green	Completed / On track to deliver by target date.

Off Track Issues Identified (Red actions) March 2017	**Original Target Date**	**Recovery Action Plan**	**Recovery Plan Target date**

excellent
kind
responsible
respectful

St George's University Hospitals NHS
NHS Foundation Trust

Integrated Quality and Performance Report for Trust Board

Board Meeting – 6 April 2017
Reporting period February 2017

Excellence in specialist and community healthcare

Quality and Performance Executive Summary

In this month (page 4)

February observed an increased level of GP referrals compared to previous month however, compared to the same period last year and year to date the level of referrals have dropped. All services continue to see higher levels of non elective admissions and elective treatments YTD.

Are we safe? (pages 5-11)

In February the Trust reported 4 cases of C. Diff taking the year to date total to 33 cases against a target of 31. The trust has had 2 MRSA bacteremia's reported year to date against a ceiling of 0. The second MRSA bacteremia that occurred in NICU in February 2017. There had been no MRSA bacteremia's acquired in NICU for at least 2 years prior to this. There has been 1 Never Event reported in February as a result of a retained swab post cardiac surgery, bringing the total of never events to 3 YTD. Harm Free care (All Harms) is better than the national target this month, and new harms remain above target and in line with the national average.

Are we effective? (pages 12-15)

The Trust continues to be better than the standard for weekday and weekend Hospital Standard Mortality ratio and also HSCIC. Total bed occupancy remains above the target of 85% , currently at 92.39% midnight occupancy. Length of stay remains consistent.

Are we caring? (pages 16-19)

The number of complaints received in February has decreased however we remain below the standard for 25 day response rate. This has been escalated through Divisions and challenged through Divisional Performance Reviews. There continues to be no same sex breaches reported year to date and response rates response times remain below target of 85%. Recommendation rates for Inpatients, A&E and outpatients remains above locally agreed target.

Are we responsive (pages 20-27)

Our performance against the 95% standard in A&E continues to perform below the national standard in February. We are working hard to improve this with a number of planned improvements to be implemented. Continued improvements are being made to improve treatment times for patients on a cancer pathway. All standards with the exception of Two week wait were met in January, recovery trajectories in place. Diagnostic 6 week performance remains below national standard for the third consecutive month, recovery actions in place which are having a positive impact.

Are we well-led? Pages (28-32)

Our staff friends and family test scores are poor both for a place to work and a place to be cared for at. This is a concern. Staff sickness remains above the trust target of 3%. There has been an improvement in Trust core MAST topics that are above the target of 85% with the exception of Information Governance which is currently 83%. MAST performance remains a concern across infection control, Resuscitation and VTE. Divisions have been asked to produce trajectories for improved performance

Appraisal rates remain below target for both medical and non-medical appraisals and Divisions have been asked to focus on IPR and MAST which is monitored through Divisional Performance Reviews.

Trust Overview

Domain	Ref	Theme	Management priority (last month)	Management priority (this month)	Forecast	Briefings
Safe	1.1	Patient Safety Incident Reporting	On Track	On Track	Stable	There has been 1 Never Event reported in February, shared SI between STN&C/M&C divisions. 3 YTD
	1.2	Patient Safety Harm free care	On Track	On Track	Stable	Harm Free care (All Harms) is 0.8% above target this month, new harms only remains above the target and national average at 98.02% for January
	1.3	Infection control and cleanliness	Moderate	Significant	At risk	C-Difficile 33 cases YTD against target of 31.
Effective	2.1	Mortality Indicators	Excellent	Excellent	Stable	The Trust continues to be below the standard for weekday and weekend Hospital Standard Mortality ratio and also HSCIC
	2.2	Length of Stay	On Track	On Track	Stable	
Caring	3.1	Admitted Patient Experience	Excellent	Excellent	Stable	
	3.2	ED Patient Experience	Excellent	Excellent	Stable	
	3.5	Single Sex Breaches	Excellent	Excellent	Stable	
	3.6	Complaints	Significant	Significant	Stable	Improved performance in December however remains below target, to be monitored through divisional performance reviews and weekly challenge meetings with complaints
Responsiveness	4.1	ED Access	Significant	Significant	At Risk	ED operational target remains below the national and STP target, however our position remains good against the national picture and February performance observed an increase of 3.96%
	4.2	Elective Care Access	Significant	Significant	At risk	This is mainly within a small collection of services: ENT, General Surgery with Recovery Plans in place.
	4.3	Cancer Access	Moderate	Moderate	Stable	All cancer standards met in January with the exception of Two week wait.
	4.4	Diagnostic Access	Significant	Significant	At Risk	6 week diagnostic performance remains below the target og 0.99% however decrease in the number of breaches have been observed
	4.5	Bed Capacity and Management	Moderate	Moderate	Stable	Bed Capacity reducing compared to previous months. The expansion of the Ambulatory Care model will further reduce occupancy and limit short-stay admissions over the next months.
	4.6	Cancelled Operations	Significant	Significant	At risk	Cancelled operations are recently high due to alterations in rotas. These are now rectified, and we should see a reduction in cancelled operations from March 2017.
Well Led	5.2	Staff Experience	On Track	On Track	Stable	
	5.3	Workforce Indicators	Significant	Significant	At risk	Division have been requested to set trajectories for MAST and appraisal as we remain below target
	5.4	Safe Staffing	Moderate	Moderate	Improving	
Operational Dependencies	6.1	Activity Volumes	Moderate	Moderate	At Risk	Activity volumes are recalibrating as that activity not requiring to come to a tertiary centre is
	6.2	Data Quality	Significant	Significant	At risk	Data Quality Project is improving overall validation, as well as delivery of training programme to improve the inputs within the PTLs, thus gradually improving the quality of data provided to management teams.

The trust is currently reviewing additional indicators for inclusion which will be incorporated in forthcoming reports

Scorecard Assessment Key

Management priority

Significant	An externally reported metric is below standard and therefore significant interventions are planned or in progress due to one or more factors
Moderate	An important internal metric is below agreed level and therefore moderate interventions are planned or in progress
Minor	Trends are adverse therefore some interventions are in place or in progress
On Track	All areas are on track
Excellent	Targets consistently met

Forecast

At Risk	Performance expected to worsen by next reporting period
Stable	Performance not expected to change significantly by next reporting period
Improving	Performance expected to improve by next reporting period

Statistical Process Control Charts

Performance against each indicator is shown as a Statistical Process Controls (SPC) chart. The purpose of these charts is to provide a simple view of performance over time, as well as an indicator of whether any variation in performance or activity is statistically important or not.
Each chart consists of four factors:

1) The run chart indicator, showing performance by month from April 2015 (blue line)
2) Average (mean) performance during the time period (green line)
3) Upper and lower control limits (UCL and LCL), which set out an expected range of variation for performance. Performance beyond these limits suggests a level of variation during the time period

In this month

	Feb-17	Compared to last Year: Same Month	Compared to last Year: YTD
The Trust received….			
 Referrals from GP	11,299	-15.8%	-5.2%
 Urgent Cancer Referrals	1,296	-18.8%	6.7%
The Trust treated….			
 ED Attendances	12,519	-10.1%	1.8%
 Non Elective Admissions	3,725	4.1%	9.4%
 Outpatient First Attendances	14,290	0.1%	3.1%
 Day cases	2,936	-5.2%	5.5%
 Elective Inpatients	1,258	-5.2%	1.2%

SAFE Domain Scorecard

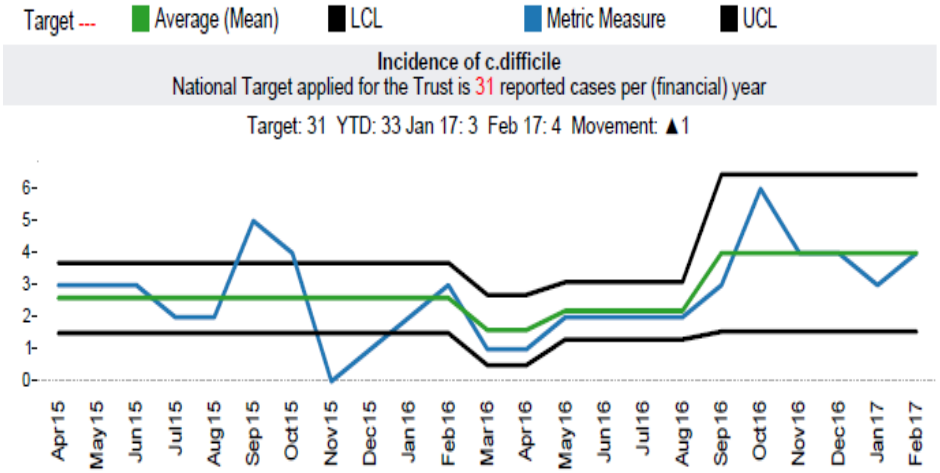
Executive Lead: Avey Bhatia, Chief Nurse

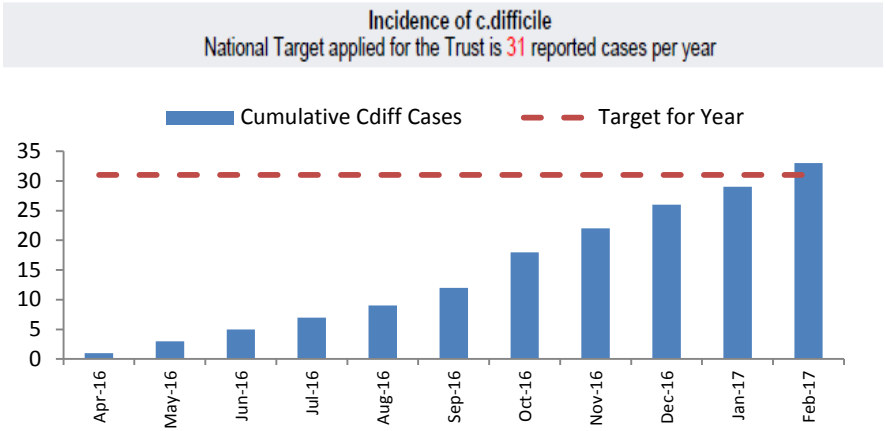
Theme	Indicator	Ref	Units	Period	Target	National or Local	Mth Rag Rating	Dec-16	Jan-17	Feb-17	Variance	YTD Total	Chart
Infection Control	Clostridium Difficile	76	Number	Feb-17	31	Local		4	3	4		33	Y
	MRSA bacteraemia cases	77	Number	Feb-17	0	National		0	0	1		2	N
	Incidences of E Coli	78	Number	Feb-17				2	6	3		57	Y
	Incidences of MSSA	56	Number	Feb-17				0	7	2		28	Y
	Cleaning & Decontamination Audit	238	%	Feb-17	100%	Local		94%	96.4%	97.70%		N/A	Y
	Hand Hygeine Audit	233	%	Feb-17	95%	Local		94.40%	97.0%	96.60%		N/A	Y
Incident Reporting	Total number of serious incidents reported	81	Number	Feb-17	TBC	TBC		4	8	7		86	Y
	Total number of Never Events	240	Number	Feb-17	0	National		0	0	1		3	Y
	Overdue CAS Alerts	115	Number	Feb-17	0	National		1	1	1		1	N
	Maternal Deaths	83	Number	Feb-17	0	National		0	0	0		0	N
	Medication errors causing serious harm	186	Number	Feb-17	0	National		0	1	0		8	Y
Harm Free Care	Number of falls per 1000 occupied bed days	1665	%	Feb-17	3.10%	Local		1.20%	1.20%	1.08%		N/A	Y
	Total number of patient falls	109	Number	Feb-17	TBC	TBC		160	161	137		1416	Y
	Attributable Grade 2 Pressure Ulcers per 1000 occupied days	242	%	Feb-17	0.22%	TBC		19	13	28		275	Y
	Attributable Grade 3 & 4 Pressure Ulcers per 1000 occupied bed days	243	%	Feb-17	0.02%	TBC		1	3	2		8	Y
	VTE Risk Assessments Completed	235	%	Feb-17	95%	National		95.80%	96.75%	96.46%		N/A	Y
	Bed Rails Audit	236	%	Feb-17	95%	Local		87.23%	92.99%	93.12%		N/A	Y

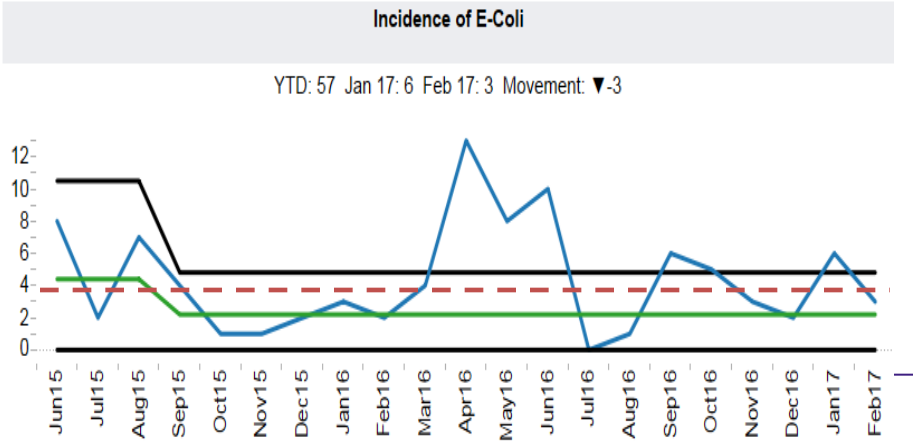
SAFE – Infection Control & Cleanliness

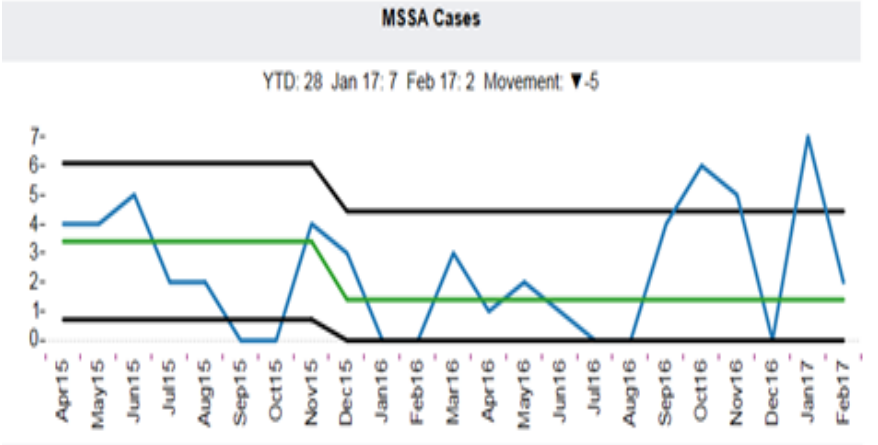
Briefing: The current number of Trust apportioned episodes for C.Diff is 33 against an end of year target of 31. A review and root cause analysis was completed for these cases which showed that few of these are likely to be adjudged as lapses in care and thus sanctions from the CCG would be unlikely. The results of this review have been shared with the CCG. The trust has had 2 MRSA bacteraemias reported year to date against a ceiling of 0. The second MRSA bacteraemia that occurred in NICU in February 2017. There had been no MRSA bacteraemias acquired in NICU for at least 2 years prior to this.

The patient had correct screening procedures completed when they were admitted to St Georges. The patient had a central line inserted on the 13th February 2017 and the patient became unwell and subsequently had cultures taken and antimicrobial treatment started. The blood cultures returned as MRSA positive on the 19th February 2017. The line tip had grown MRSA– consistent with a line associated infection, but it is debatable if the patient actually had a MRSA bacteraemia even though MRSA was isolated in blood cultures because they were taken through-line.





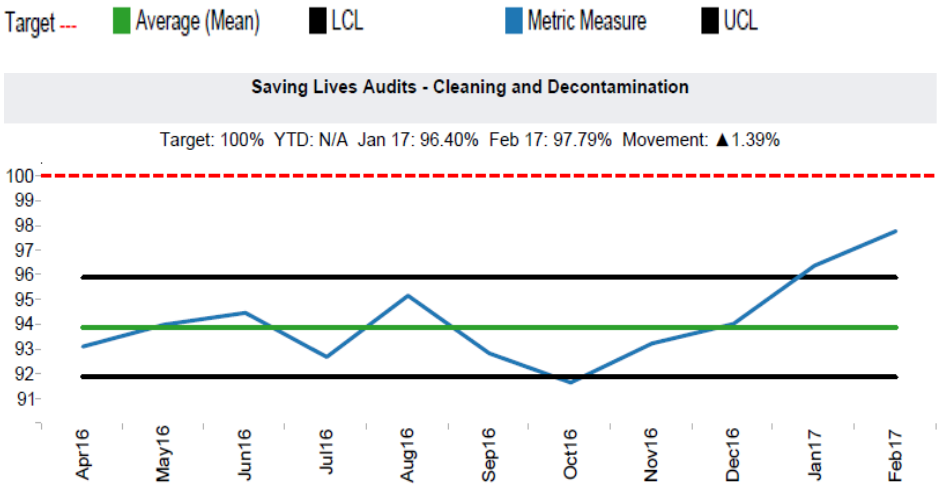


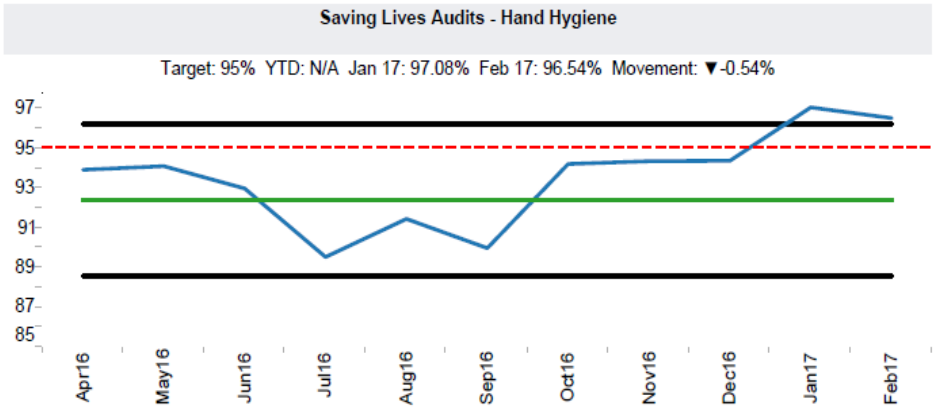


SAFE – Infection Control & Cleanliness

Briefing: For February the position for cleaning and decontamination is 97.79% against a target of 100% and Hand Hygiene 96.54%. The infection control team is currently reviewing the Saving Lives audits that are in place and reviewing supporting audit and assurance mechanisms for hand hygiene, such as use of soap/towels in clinical areas.

The infection Control team is currently recruiting a support nurse for 6 months to focus on Hand Hygiene compliance and education across professional groups.

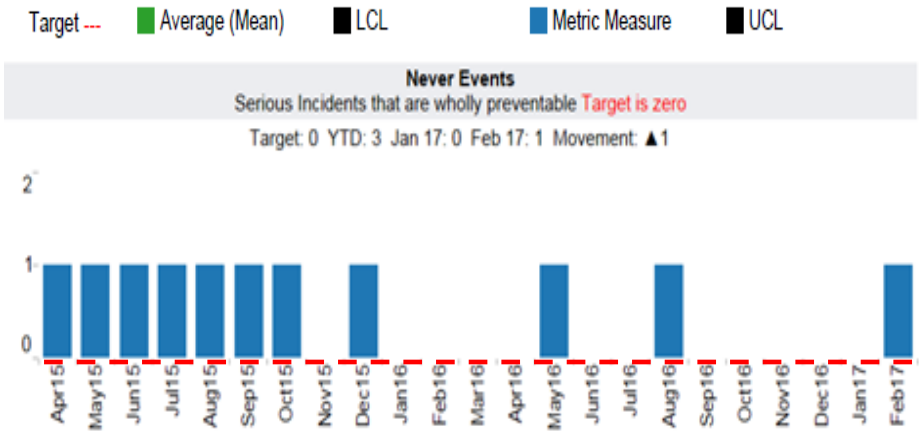


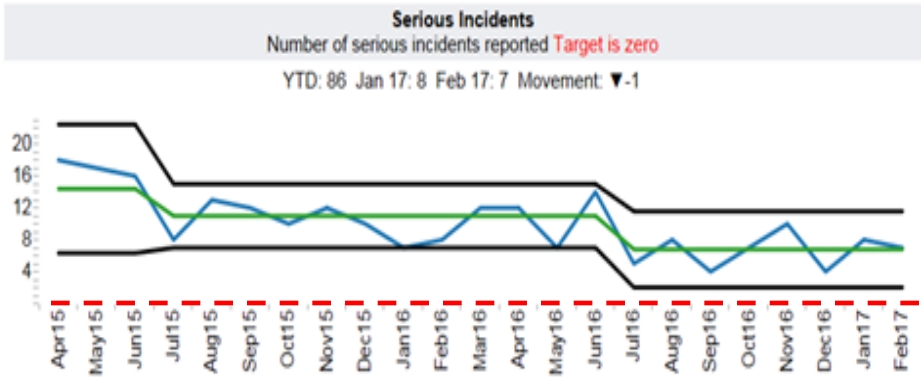


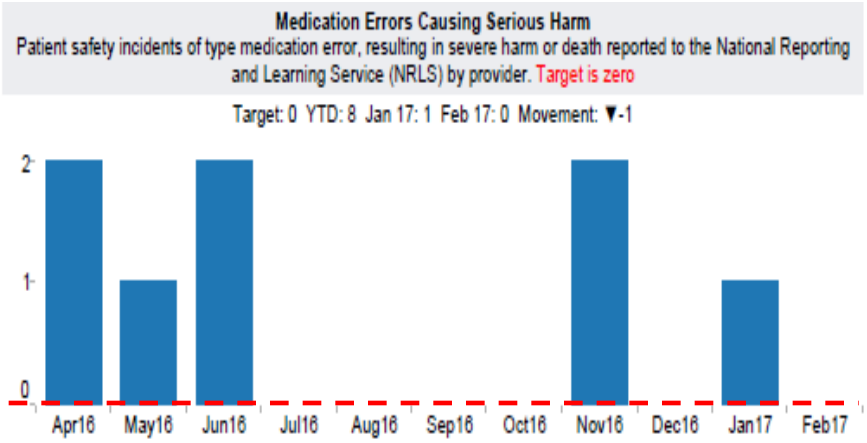
SAFE – Incident Reporting

Briefing:

Never Event: The Trust had a Serious Incident. An initial debrief and review with the team involved has taken place and a Serious Incident investigation is underway. The patient remains an inpatient and is in a stable condition.



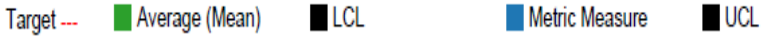




SAFE – Incident Reporting

Briefing:

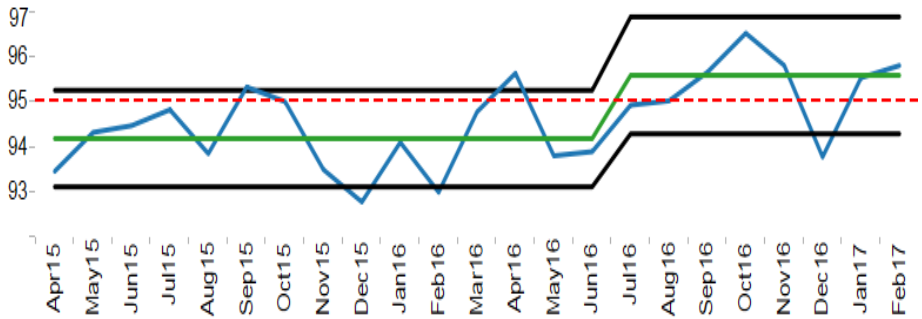
- February remains above the 95% target for delivering harm free care
- We have seen an increase in this metric this year as opposed to last which is a positive sign of improvements.



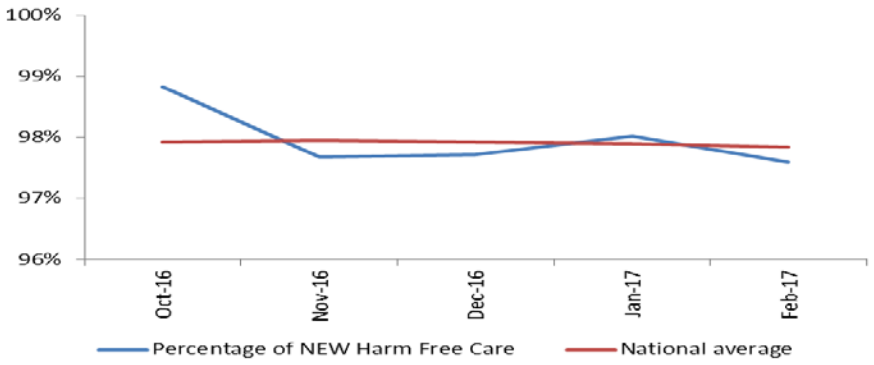
Percentage of Harm Free Care

Supporting Trusts in their aim to eliminate harm in patients from 4 common conditions; pressure ulcers, falls, UTI & VTE.
Target is 95%

Target: 95% YTD: N/A Jan 17: 95.53% Feb 17: 95.80% Movement: ▲0.27%



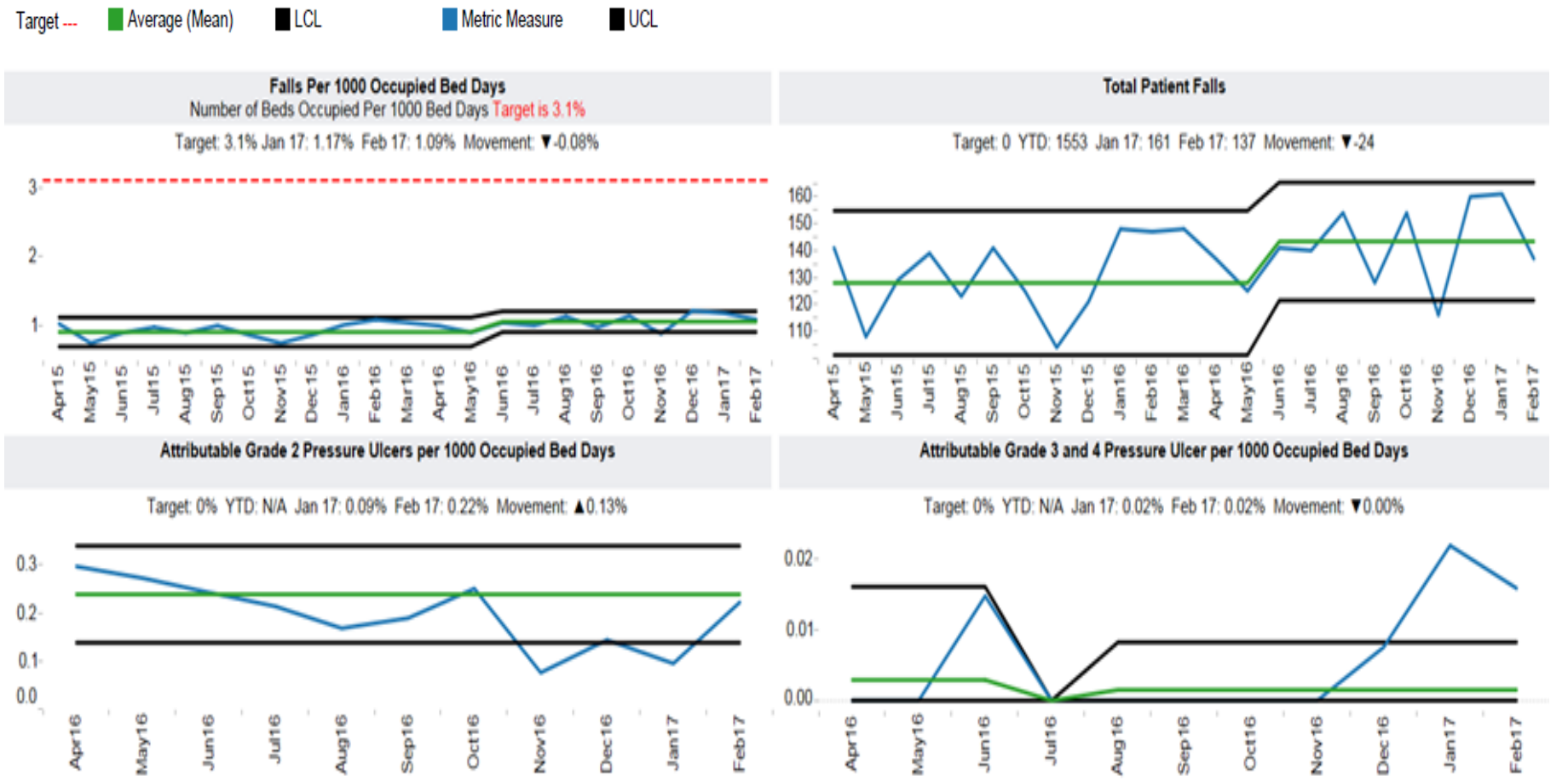
Percentage of NEW Harm Free Care



SAFE – Harm Free Care

Briefing:

The falls position for the trust remains below the national average. In order to support compliance against national guidance and review practice a falls lead is currently being recruited for the trust. The trust has seen a decline in grade 2 pressure ulcers that are attributable, however there has been a recent rise in grade 3 and 4 ulcers that are avoidable. These are being investigated as Serious Incidents and the Tissue Viability team will be reviewing them as a cluster to establish any wider learning



SAFE – Harm Free Care

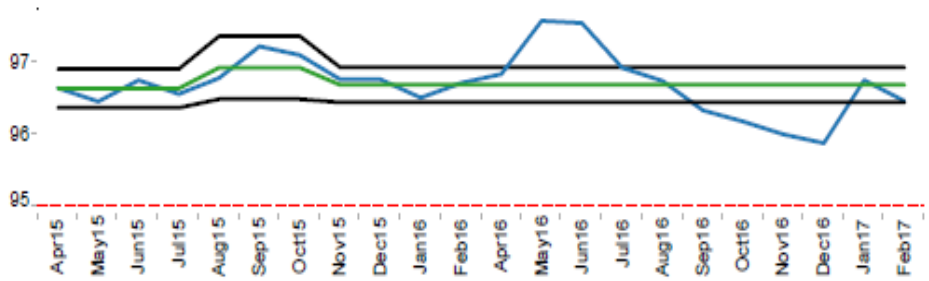
Briefing:

- VTE assessments continue to be performed above the national target of 95%.
- Bed rail audits suggest are compliance is slightly below the target.
- Work is being undertaken to triangulate these audits to ensure practice is as recommended.

Target --- Average (Mean) LCL Metric Measure UCL

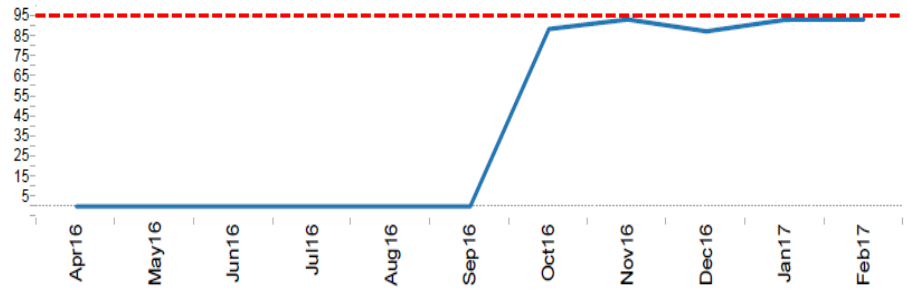
VTE Risk Assessments Completed

Target: 95% YTD: N/A Jan 17: 96.75% Feb 17: 96.46% Movement: ▼-0.29%



Bed Rails Audit

Target: 95% YTD: N/A Jan 17: 92.99% Feb 17: 93.12% Movement: ▲0.13%

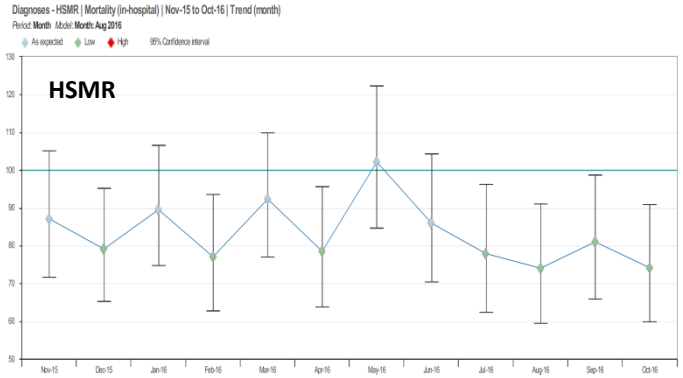


EFFECTIVE Domain Scorecard

Executive Lead: Andy Rhodes, Medical Director

Theme	Indicator	Ref	Units	Period	Target	National or Local	Mth Rag Rating	Dec-16	Jan-17	Feb-17	Variance	YTD Total	Chart
Mortality Indicators	Hospital Standardised Mortality Ratio (HSMR)	114	%	Feb-17	100	National		84.1	84.1	83		N/A	N
	Hospital Standardised Mortality Ratio Weekday Emergency		%	Feb-17	100	National		82.4	82	79.9		N/A	N
	Hospital Standardised Mortality Ratio Weekend Emergency		%	Feb-17	100	National		86.7	86.4	85.6		N/A	N
	Summary Hospital Mortality Indicator (HSCIC)	113	%	Feb-17	100	National		0.88	0.9	0.9		N/A	N
Length of Stay	Length of Stay Elective	153	Number days	Feb-17	TBC	Local		4.8	4.4	3.8		N/A	Y
	Length of Stay Non Elective	154	Number days	Feb-17	TBC	Local		4.2	4.2	4		N/A	Y
Occupancy	Bed Occupancy General & Acute		%	Feb-17	85%	Local		85.5%	88.2%	92.4%		N/A	Y

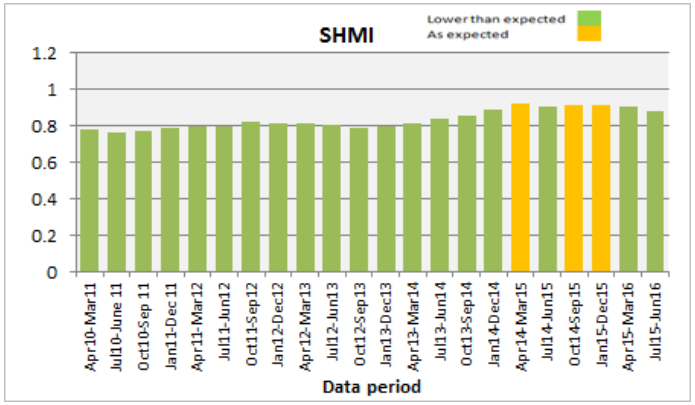
EFFECTIVE - Mortality



HSMR: hospital standardised mortality ratio

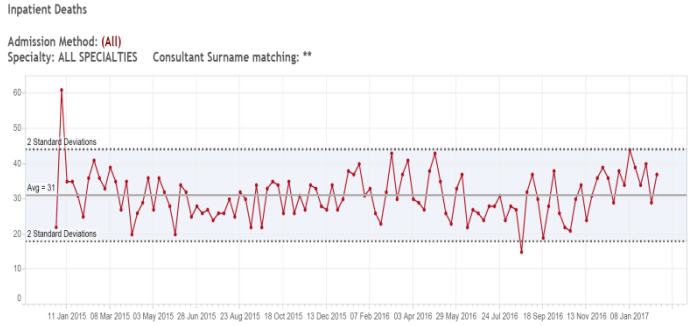
Basket of 56 diagnoses (around 85% of deaths). In-hospital deaths only

Adjusted for more factors, including palliative care



SHMI: summary hospital-level mortality indicator

All English acute non-specialist providers. All deaths in hospital and within 30 days of discharge



Risk-adjusted Mortality remains stable. HSMR remains better than expected: Nov 15 – Oct 16 = 83.3 with SHMI Jul 15 – Jun 16 = 0.88 – lower than expected (SHMI next published 23/3/17). Raw mortality is monitored daily and remains stable within usual limits.

The committee has 'real-time' monitoring of deaths by date and by day of admission; the committee reviews all deaths following elective admission, and scrutinises all deaths in mortality signals that arise in analysis of Dr Foster data. Recent completed reviews include analysis of deaths following #NOF, crushing injury, atherosclerosis, septicaemia, and CABG (other). Reviews are triangulated with the SI process and one death from this month's reviews was investigated as an SI. There has been learning including the importance of documentation of pre-operative assessment, the challenges of discussing operative risks in extremely ill patients, and improved interaction with coding teams in cardiology and GICU to improve information. The mortality monitoring committee has independently screened 34% of all deaths for learning, and to identify areas to strengthen this year.

Learning from Deaths https://www.england.nhs.uk/ourwork/part-rel/nqb/ (published 15/3/17).

The framework stipulates that board should ensure their organisation: has board-level leaders (exec and non-exec) to take responsibility for 'learning from deaths'; has a systematic approach to identifying deaths requiring review and selecting other patients whose care they will review including vulnerable patients; adopts a robust and effective methodology for case record reviews of all selected deaths ensures case record reviews and investigations are carried out to a high quality; ensures that mortality reporting in relation to deaths, reviews, investigation and learning is regularly provided to the board (a dashboard has been provided to support reporting); ensures learning is acted on to sustainably change practice and improve care and reported in Quality Accounts (from June 2018); ensures sufficient numbers of nominated staff have appropriate skills through specialist training and protected time to review and investigate deaths; offers timely, compassionate and meaningful engagement with bereaved families and carers in relation to responding to a death;

A number of immediate priorities for the next two months have been identified, which include:

- A nominated non-executive director to provide oversight of progress;
- collect and publish quarterly information on deaths, including those deaths subjected to case record review and how many were judged to have been due to problems in care;
- training of Divisional staff in the use of the RCP structured judgement review (SJR) and the implementation of learning disability (LeDeR) review process;
- ensure that our policy on responding to deaths is clear and supports the organisation to deliver its duties and meet the new requirements;
- To review governance arrangements and processes. This is underway and as a key first step we are finalising arrangements to ensure there is a dedicated full-time resource (person) available to support the AMD for mortality to deliver this broad programme of work, both in collating the data, facilitating the reviews and dissemination of learning; this is currently being negotiated.

Through addressing these urgent actions we will develop a plan for implementation of all aspects of the guidance.

Deaths following time in hospital, England, October 2015 – September 2016

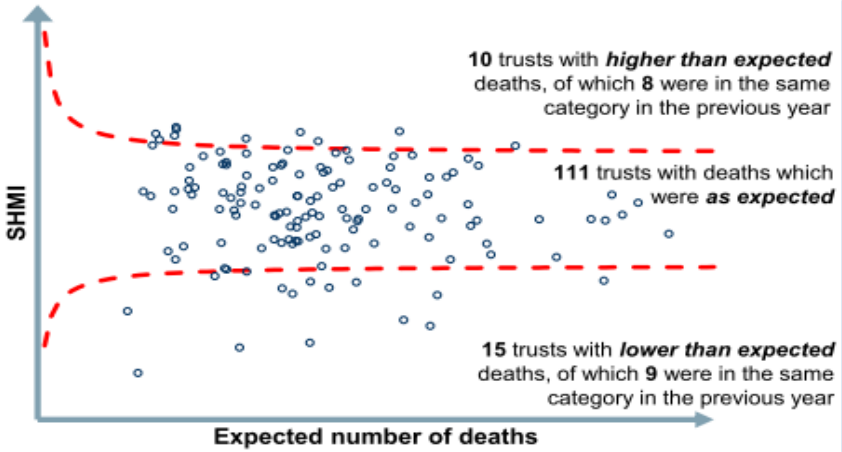
Quarterly statistics: Published 23rd March 2017

NHS Digital

This publication compares the actual number of deaths following time in hospital with the expected number of deaths, using the Summary Hospital-level Mortality Indicator (SHMI).

The expected number of deaths is estimated using the characteristics of the patients treated; age, sex, method of admission, current and underlying medical condition(s). It covers patients admitted to hospitals in England who died either while in hospital or within 30 days of being discharged.

Between October 2015 and September 2016, there were approximately 8.9 million discharges, from which 286,000 deaths were recorded either while in hospital or within 30 days of discharge for the 136 hospital trusts covered. This includes deaths from other causes as well as deaths related to the reason for the hospital admission.



The 10 trusts with a ***higher than expected*** number of deaths were:

- **Blackpool Teaching Hospitals NHS FT**
- **Dorset County Hospital NHS FT**
- **George Eliot Hospital NHS Trust**
- Gloucestershire Hospitals NHS FT
- Pennine Acute Hospitals NHS Trust
- **South Tyneside NHS FT**
- **Southend University Hospital NHS FT**
- **Weston Area Health NHS Trust**
- **Wrightington, Wigan and Leigh NHS FT**
- **Wye Valley NHS Trust**

The 15 trusts with a ***lower than expected*** number of deaths were:

- **Barts Health NHS Trust**
- **Cambridge University Hospitals NHS FT**
- **Chelsea and Westminster Hospital NHS FT**
- **Guy's and St Thomas' NHS FT**
- Homerton University Hospital NHS FT
- **Imperial College Healthcare NHS Trust**
- Kingston Hospital NHS FT
- London North West Healthcare NHS Trust
- Poole Hospital NHS FT
- Salford Royal NHS FT
- St George's University Hospitals NHS FT
- **The Whittington Hospital NHS Trust**
- **Torbay and South Devon NHS FT**
- **University College London Hospitals NHS FT**
- **West Suffolk NHS FT**

Trusts in **bold** were also in the same category in the same period in the previous year. 'FT' means 'Foundation Trust'.

The SHMI was developed in response to the public inquiry into the Mid Staffordshire NHS Foundation Trust.

It is used along with other information to inform the decision making of trusts, regulators and commissioning organisations.

The SHMI is not a measure of quality of care. A *higher/lower than expected* number of deaths should not immediately be interpreted as indicating poor/good performance and instead should be viewed as a '**smoke alarm**' which requires further investigation.

The SHMI cannot be used to directly compare mortality outcomes between trusts and it is inappropriate to rank trusts by their SHMI.

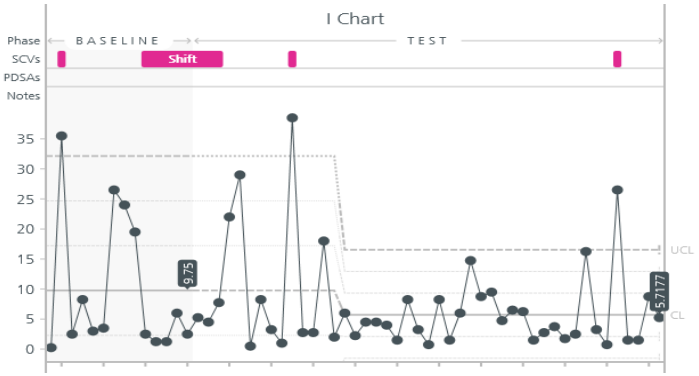
See the full release at http://digital.nhs.uk/pubs/shmioct15sep16 **0300 303 5678** **ISBN 978-1-78386-973-2**

Responsible Statistician: Sally Harrison **enquiries@nhsdigital.nhs.uk**

Audit performance- Feb-March 2017

Metric	CQC domain	Performance and comments
Case ascertainment- completion of audit data is assessed annually and RAG rated against HES data	Well led	2015- 13%, 2016- 128% (more cases recorded in NELA than HES) Consistent monthly performance ~80% data captured in perioperative period, other cases recorded retrospectively from notes review
Pre operative documentation of risk of death Patients should have objective risk scoring, to guide intra-operative and post operative management	Effective	40% patients in Feb- Mar meet this standard, improved from 20% in Jan. Theatreman booking form now amended to include risk scoring, training and awareness sessions
Access to theatres in appropriate timescale NCEPOD urgent classification cases- access in <6 hours, NCEPOD immediate- <2 hours	Responsive	See SPC chart. Outliers case notes and theatre schedule review underway. 70% patients currently meeting NCEPOD standard,
Cases >5% predicted mortality with consultant surgeon and anaesthetist present in theatres	Effective	90% cases meet this standard. This has been consistent over many months
Cases >10% predicted mortality) admitted to high dependency	Safe	GICU aim to take patients with risk of death >5%, 100% patients meeting admission internal standard
Length of stay	Not reported to CQC	See SPC chart, average >15 days, with significant proportion of patients staying >25 days.
Mortality	Effective	In hospital mortality 10.3% (awaiting risk adjustment), 2015 risk adjusted mortality falls within expected range, 11.3%

SPC chart of theatre access times- urgent cases



CARING Domain Scorecard

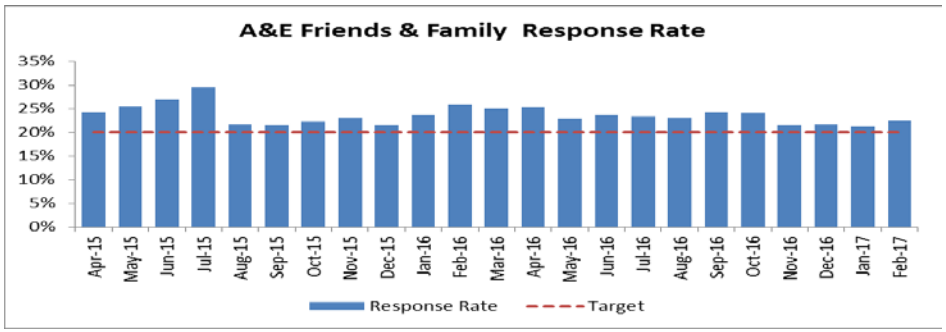
Executive Lead: Avey Bhatia, Chief Nurse

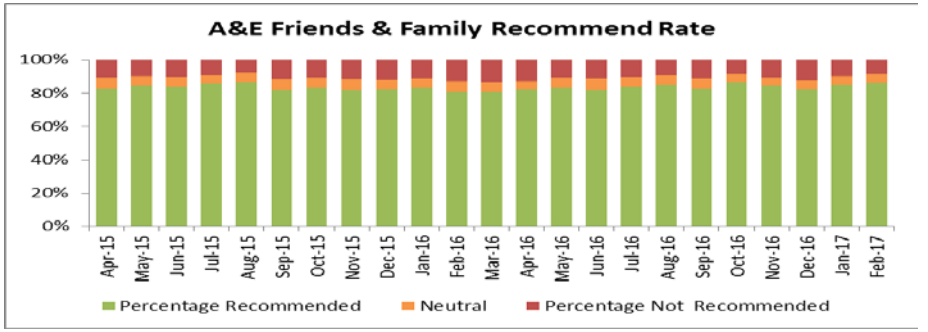
Theme	Indicator	Ref	Units	Period	Target	National or local	Mth Rag Rating	Dec-16	Jan-17	Feb-17	Variance	YTD Total	Chart
Mixed Sex Accomodation Breaches	Total Number of MSA breaches reported	91	Number	Feb-17	0	National		0	0	0		0	N
Friends & Family	FFT Response Rate A&E		%	Feb-17	20%	Local		21.80%	21.30%	22.43%		N/A	Y
	FFT Recommendation Rate A&E		%	Feb-17	90%	Local		82%	85%	86.28%		N/A	Y
	FFT Response Rate Inpatients		%	Feb-17	30%	Local		29.30%	44.70%	26.20%		N/A	Y
	FFT Recommendation Rate Inptients		%	Feb-17	95%	Local		96%	96%	97%		N/A	Y
	FFT Response Rate Outpatients		%	Feb-17	TBC	Local		1.10%	1.50%	1.30%		N/A	Y
	FFT Recommendation Rate Outpatients		%	Feb-17	90%	Local		92.0%	95.0%	93%		N/A	Y
Complaints	Complaints responded to within 25 days	92	%	Feb-17	85%	Local		58.70%	73.21%	69.41%		N/A	Y
	Number of complaints with agreed extensions	112	%	Dec-16	100%	Local		91.1%				N/A	Y
	Total Number of complaints received	111	Number	Feb-17	TBC	TBC		56	85	73		749	Y
	Total number of PALS received	248	Number	Feb-17	TBC	TBC		268	363	346		3496	Y

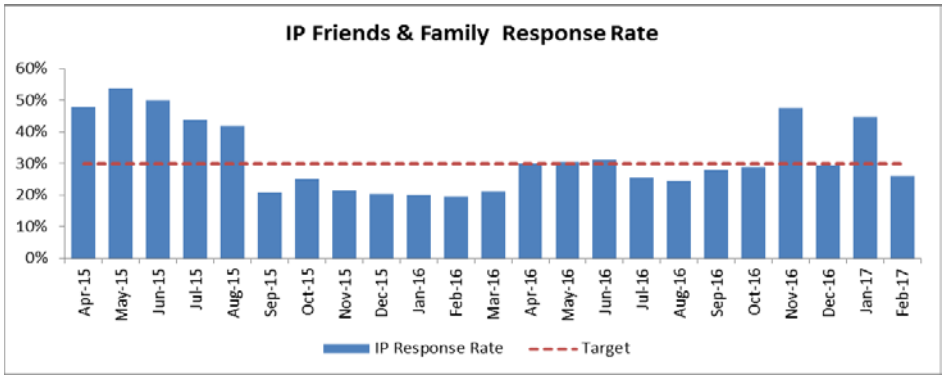
CARING – Friends and Family Test

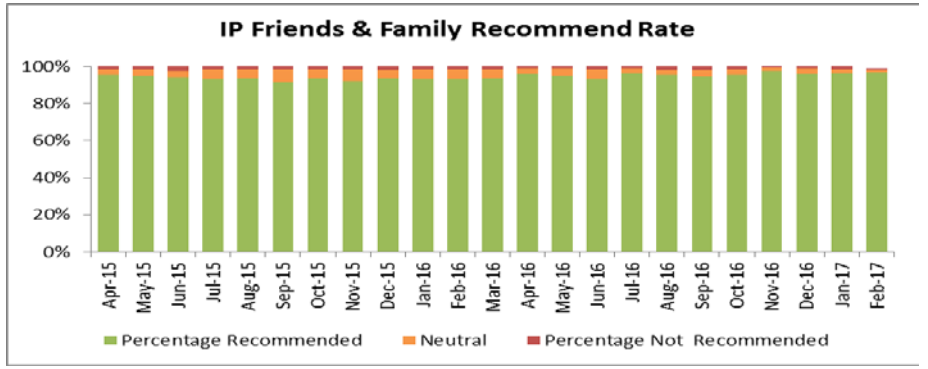
Briefing:

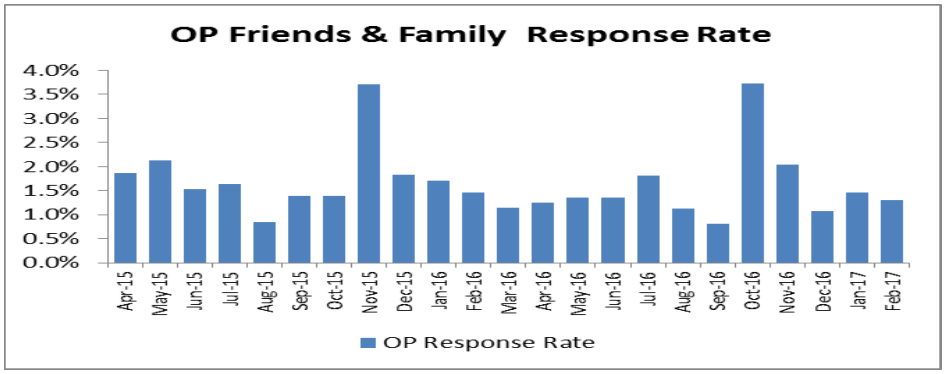
- We have set some quite challenging targets internally for the FFT
- Despite this we continue to perform well for inpatients and outpatients although are slightly beneath the target for A&E.

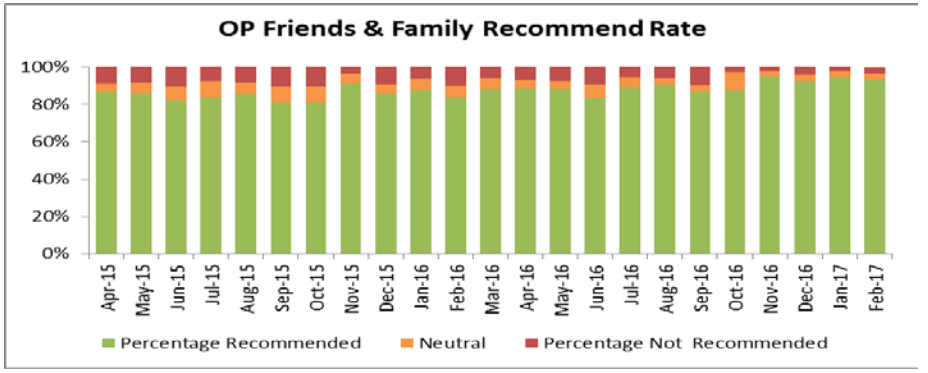












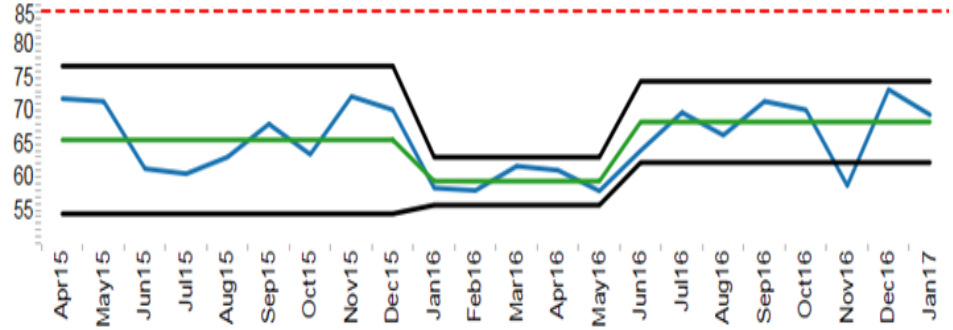
CARING –Complaints

Briefing:
We perform poorly in our ability to handle and respond to complaints in a timely fashion. This is being addressed by the DoQG through a root and branch review of the service.

Target --- Average (Mean) LCL Metric Measure UCL

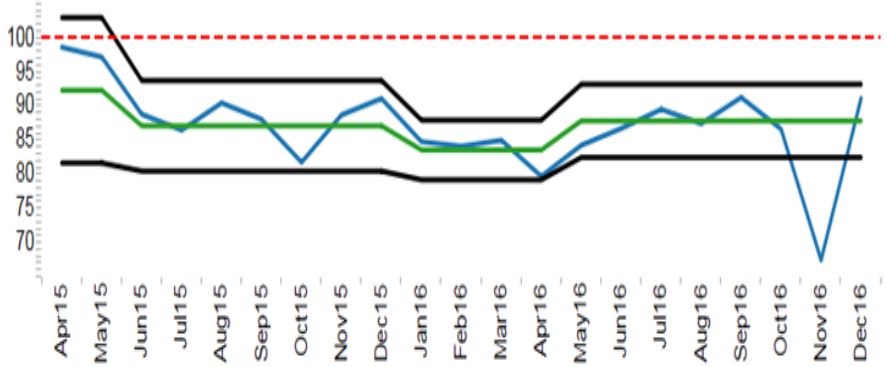
Complaints responded to within 25 days

Target: 85% YTD: N/A Dec 16: 73.21% Jan 17: 69.41% Movement: ▼-3.80%



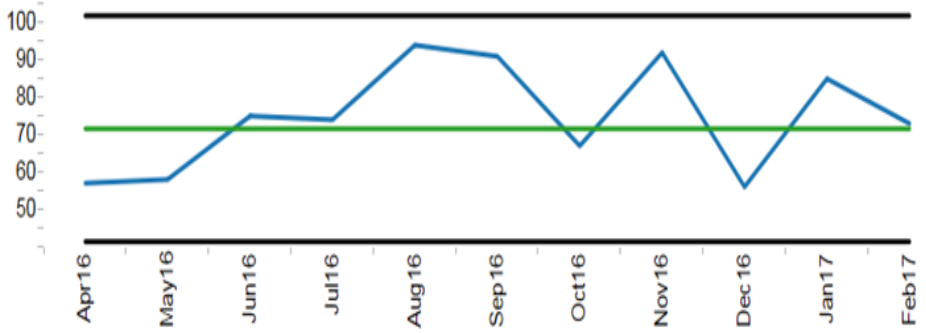
Number of Complaints With Agreed Extensions

Target: 100% YTD: N/A Dec 16: 91.07% Jan 17: 0.00% Movement: ▼-91.07%



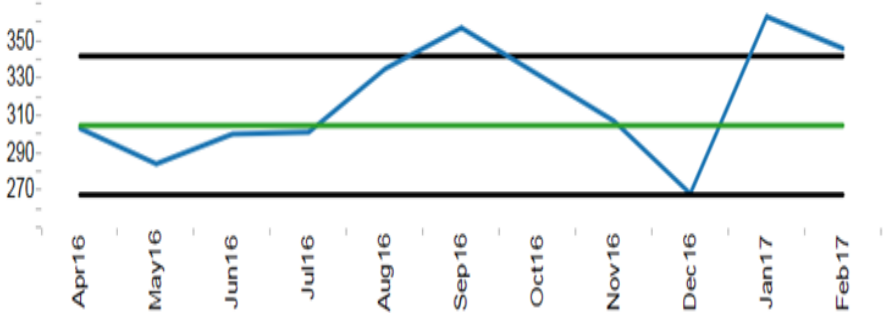
Total Number of Complaints Received

YTD: 822 Jan 17 85 Feb 17: 73 Movement: ▼-12



PALS by Directorate and Received

YTD: 3496 Jan 17 363 Feb 17: 346 Movement: ▼-17



RESPONSIVENESS Domain Scorecard

Executive Lead: Mark Gordon, Chief Operating Officer

Theme	Indicator	Ref	Units	Period	Target	Local or national	Mth Rag Rating	Dec-16	Jan-17	Feb-17	Variance	YTD Total	Chart
Waiting Times	A&E 4 hours waiting time	8	%	Feb-17	95%	National		89.14%	86.63%	90.59%		91.80%	Y
	LAS Handover times 15 minutes	120	%	Feb-17	100%	National		48.3%	46.9%	51.1%		N/A	Y
	LAS Handover times 30 minutes	121	%	Feb-17	100%	National		93.50%	96.40%	95.80%		N/A	Y
	LAS Handover times 60 minutes	122	%	Feb-17	0	National		0	0	0		N/A	Y
	18 Weeks RTT compliance: Incomplete	147	%	Feb-17	92%	National		81.70%	77.50%	75.00%		N/A	Y
	18 Weeks RTT number of 52 Wk breaches	75	Number	Feb-17	0	National		23	41	40		N/A	Y
	Diagnostic Waits over 6 Weeks	71	%	Feb-17	99%	National		97.80%	94.90%	97.20%		N/A	Y
	% of patients not treated within 28 days of last minute cancellation		%	Jan-17	0%	National		25.00%	11.50%	TBC		N/A	Y
								Nov-16	**Dec-16**	**Jan-17**	**Variance**		
	Cancer 14 Day GP Referral	162	%	Jan-17	93%	National		86%	93%	87.90%		91%	Y
	Cancer 14 Day Breast Symptomatic	163	%	Jan-17	93%	National		95%	93%	94.00%		94%	Y
	31 Day First Treatment	161	%	Jan-17	96%	National		97%	97%	96.40%		97%	Y
	31 Day First Subsequent Treatment Surgery	159	%	Jan-17	94%	National		96%	96%	95.10%		100%	Y
	31 Day First Subsequent Treatment Drug	160	%	Jan-17	98%	National		98%	100%	100.00%		97%	Y
	62 Day Referral	157	%	Jan-17	85%	National		80%	85%	87.70%		85%	Y
	62 Day Screening	158	%	Jan-17	90%	National		93%	93%	93.00%		93%	Y
	62 Day Consultant Upgrade		%	Jan-17	85%	National		88%	93%	93.00%		94%	Y

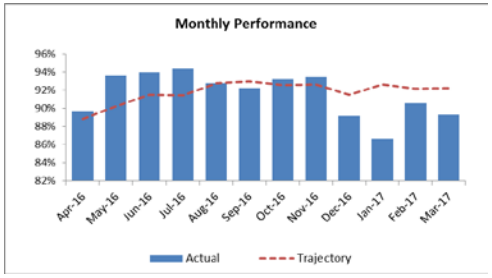
National submission deadline for Cancer standards is one month in arrears, therefore February performance will be submitted early April

RESPONSIVENESS – Emergency Department

Briefing: Emergency Department – Performance in February increased compared to January and four hour performance for the month was 90.59% (compared to 86.6% in January) YTD performance is currently 91.7%. ED attendances are 10% lower compared to the same month last year with a significant increase in performance (+7.50%), however non elective admissions remain above plan for the month (+32.7%). March to date performance is currently at 89.30% with attendances 2% higher for the same period last year with increased numbers of medical admissions and high patient acuity levels. This is evidenced by non elective activity continuing to be above plan. Majority of breach reasons being due to ED capacity and bed availability.

The Sustainability and Transformation Fund Performance against Trajectory 2016/2017

Monthly Actual	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Total Attendances	13,737	15,067	14,310	14,752	13,814	14,261	14,558	14,025	14,149	14,057	12,519	8,843
Attendances<4 Hours	12,321	14,105	13,448	13,923	12,811	13,154	13,569	13,114	12,612	12,178	11,341	7,897
Breaches >4 Hours	1,416	962	862	829	1,003	1,107	989	911	1,537	1,879	1,178	946
Performance Actual	89.7%	93.6%	94.0%	94.4%	92.7%	92.2%	93.2%	93.5%	89.14%	86.63%	90.59%	89.30%
Performance Trajectory	88.8%	90.2%	91.5%	91.4%	92.8%	93.0%	92.6%	92.6%	91.5%	92.6%	92.1%	92.2%
Meeting STF	✓ 0.87%	✓ 3.41%	✓ 2.49%	✓ 2.96%	✗ -0.04%	✗ -0.74%	✓ 0.65%	✓ 0.90%	✗ -2.33%	✗ -6.01%	✗ -1.55%	✗ -2.94%



Met STF not National
Not met STF or National
Met STF and National

Quarterly Actual	Q1	Q2	Q3	Q4
Total Attendances	43,114	42,827	42,732	35,419
Attendances<4 Hours	39,874	39,888	39,295	31,416
Breaches >4 Hours	3,240	2,939	3,437	4,003
Performance	92.5%	93.1%	91.96%	88.70%
Performance Trajectory	90.2%	92.4%	92.2%	92.3%
Meeting STF	✓ 2.3%	✓ 0.8%	✗ -0.3%	✗ -3.6%

Remaining Breach Tolerance (as of 19/03/2017)

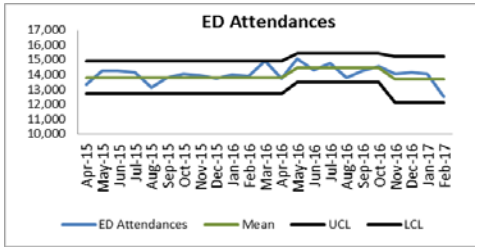
Breach Target Set		
Month	National	SFT
Jan-17	720	1,050
Feb-17	709	1,116
Mar-17	760	1,188
Q4	2189	3,354

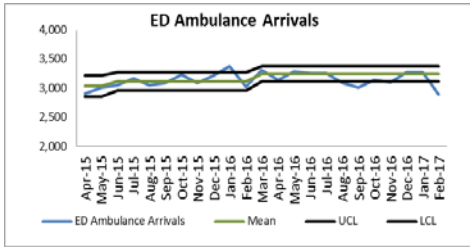
Breaches remaining for Month / Q4		
Month	National	SFT
Jan-17	-1,159	-829
Feb-17	-469	-62
Mar-17	-186	242
Q4	-1,165	-649

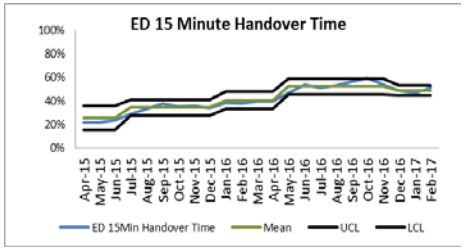
Breaches remaining for Month / Q4 per day		
Month	National	SFT
Jan-17	0	0
Feb-17	0	0
Mar-17	0	20
Q4	0	0

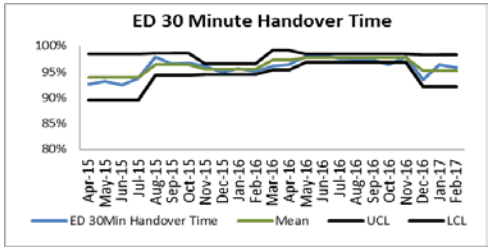
Breach Target Set - Number of breaches set to achieve National and STF
Breaches Remaining for Month - As of w/e how many breaches remain for the month to achieve target
Breaches Remaining per day - Breaches remaining for the month divided by days left to report
Attendances based on projections made as part of STF modelling

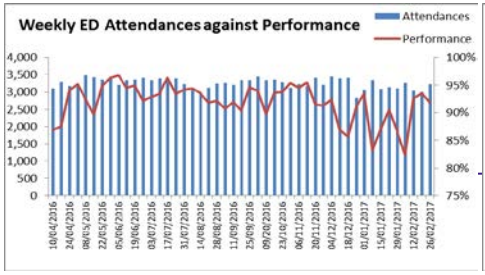
Weekly and Monthly Monitoring

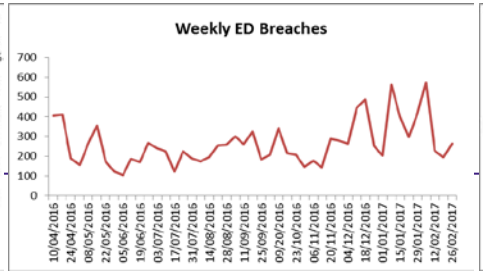


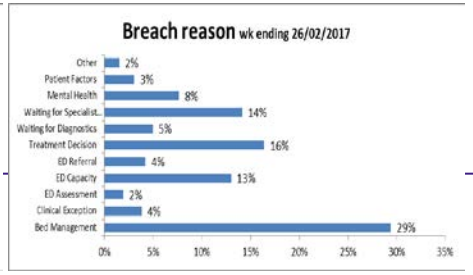


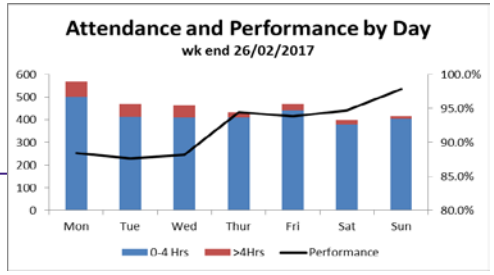












RESPONSIVENESS – Elective Care

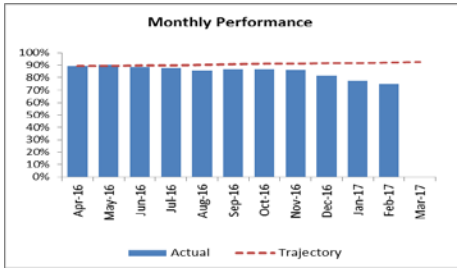
Briefing: 52 week waiters – 40 reported breaches for the month of February. Weekly performance meetings are in place for all specialties focusing on reduction of long waiters and prevention of 52 week breaches. As at the end of February elective Inpatient activity was only marginally below plan (-12%, 155 patients) in line with the winter plan to reduce bed occupancy, day case activity is currently 7% above plan.

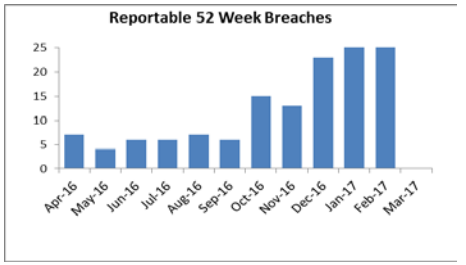
The Sustainability and Transformation Fund Performance against Trajectory 2016/2017

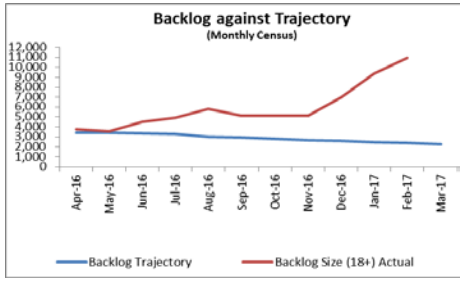
Monthy Performance	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17
Total Incomplete Waiting List	35,626	37,243	38,849	39,573	40,299	38,635	38,594	37,608	38,247	41,619	43,848
Total waits < 18 Weeks	31,873	33,668	34,309	34,635	34,498	33,487	33,454	32,450	31,259	32,269	32,902
Total waits > 18 Week Breaches	3,753	3,575	4,540	4,938	5,801	5,148	5,140	5,158	6,988	9,350	10,946
Performance Actual	89.5%	90.4%	88.3%	87.5%	85.6%	86.7%	86.7%	86.3%	81.7%	77.5%	75.0%
Meeting STF Trajectory	✗ -0.1%	✓ 0.8%	✗ -1.4%	✗ -2.4%	✗ -4.9%	✗ -4.1%	✗ -4.4%	✗ -5.1%	✗ -9.8%	✗ -14.3%	✗ -16.9%

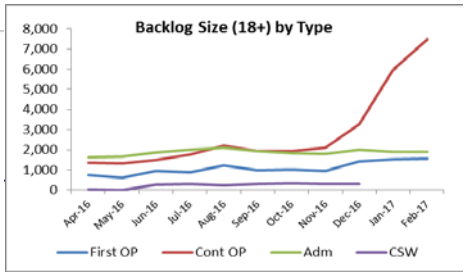
Reportable 52 Week Breaches	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17
Total Incomplete Waiting List	7	4	6	6	7	6	15	13	23	41	40

Met STF not National
Not met STF or National
Met STF and National





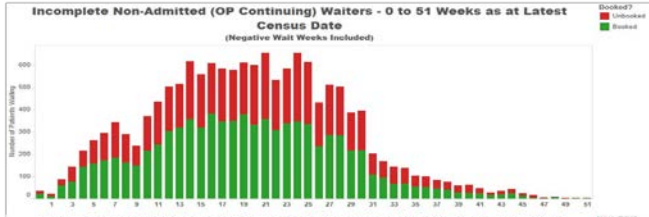


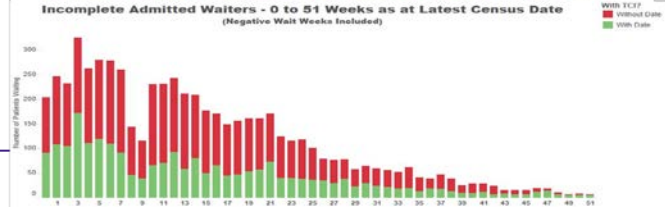


PTL Position (Unvalidated)

Monitoring the weekly PTLs for the number of patients who have been waiting 40+ week:

PTL: Booked Vs. Unbooked (unvalidated). An overview of the shape of the PTL's broken down by with / without an appointment booked



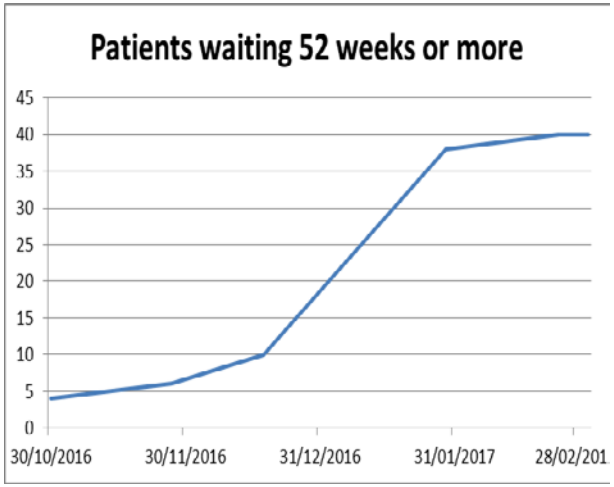


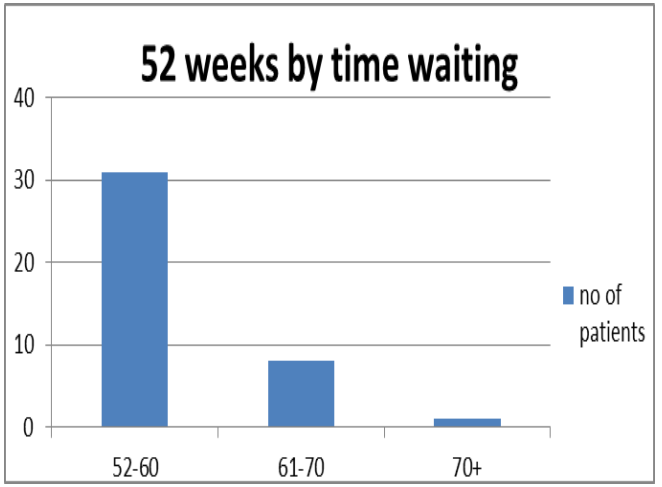
Patients waiting 52 weeks or more – validated position

last week	Tip in this week	removed in week	03/03/2017	No with admitted TCI date	No with Outpatient next event date	Removals other than treatment	Month end forecast
40	4	4	40	19	19	2	40

Prev weeks	30/10/2016	27/11/2016	18/12/2016	29/01/2017	24/02/2017	03/03/2017
52+	4	6	10	38	40	40

Specialty Breakdown	
Cardiac surgery	2
Ear, Nose & Throat	11
Gastroenterology	4
General Surgery	10
Neurology	1
Paediatrics Med & Surg	1
Plastic Surgery	3
Trauma & Orthopaedics	5
Urology	2
Vascular Surgery	1
Grand Total	**40**





The total number of patients waiting over 52 weeks, validated position, has remained at 40.
The current month end forecast is for a total waiting of 40.
The main areas of concern remain: ENT, 11 ; Gen Surgery , 10; T&O, 5.

RESPONSIVENESS – Cancer

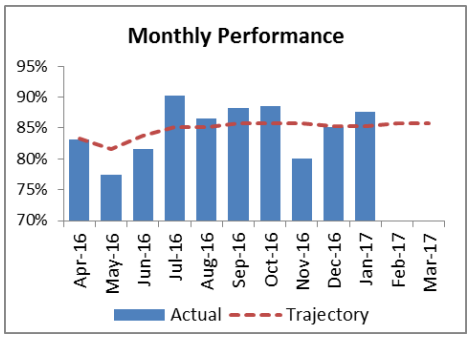
Briefing: National submission deadline for Cancer standards is one month in arrears, therefore February performance will be submitted early April. All Standards were met in January with the exception of Two Week Wait with performance at 87.9% (2.1% below target). 62 day performance achieved 87.7%. Above both national standard and STF trajectory for the month. Two Week Wait Standard fell below target due to a high number of breaches within Skin (60% of all breaches). This is a result of capacity pressures due to clinical vacancies. Recruitment is on-going and a recovery plan in place. Performance in other tumour sites that fell below target are within Gynae and Upper GI. 62 Day Standard –Performance increased in January to 87.7% against the target of 85%. The top three reasons contributing to breaches are: Delay in Diagnostics, Late ITT, Complex pathways.

The Sustainability and Transformation Fund Performance against Trajectory 2016/2017 - 62 Day Standard

Monthly Trajectory	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17
Total Treatments	60	60	74	74	74	63	70	63	68	68
Treatments <62 Days	50	49	62	63	63	54	60	54	58	58
Breaches >62 Days	10	11	12	11	11	9	10	9	10	10
Performance Trajectory	83.3%	81.7%	83.8%	85.1%	85.1%	85.7%	85.7%	85.7%	85.3%	85.3%
Total Treatments Actual	59.5	71	70.5	71.5	59.5	64	61.5	70.0	64.0	69
Total Treatments within 62 Days Actual	49.5	55	57.5	64.5	51.5	57	54.5	56.0	54.5	60.5
Total Breaches Actual	10	16	13	7	8	8	7.0	14.0	9.5	8.5
Performance Actual	83.2%	77.5%	81.6%	90.2%	86.6%	88.3%	88.6%	80.0%	85.2%	87.7%
Meeting STF	✗ -0.1%	✗ -4.2%	✗ -2.2%	✓ 5.1%	✓ 1.4%	✓ 2.6%	✓ 3.1%	✗ -5.7%	✗ -0.1%	✓ 2.4%

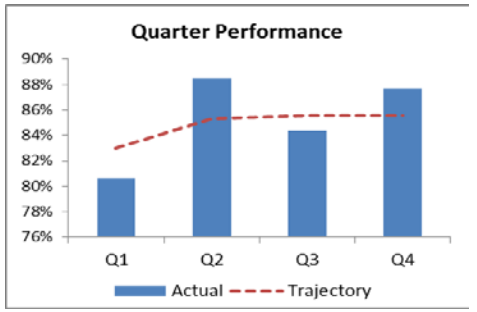
Quarterly Actual	Q1	Q2	Q3	Q4
Total Treatments	201	195	195.5	69.0
Treatments <62 Days	162	172.5	165	60.5
Breaches >62 Days	39	22.5	30.5	8.5
Performance	80.6%	88.5%	84.4%	87.7%
Meeting STF	✗ -2.4%	✓ 3.2%	✗ -1.2%	✓ 2.1%

Met STF not National
Not met STF or National
Met STF and National

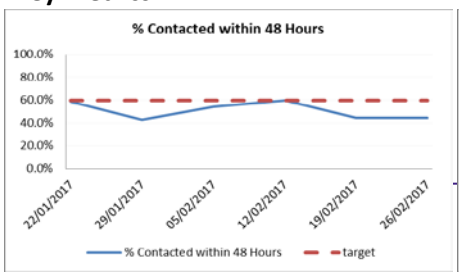


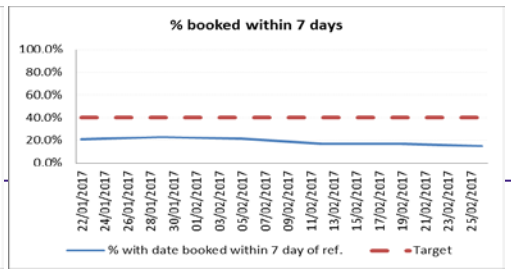
All Cancer Standards Performance Indicators

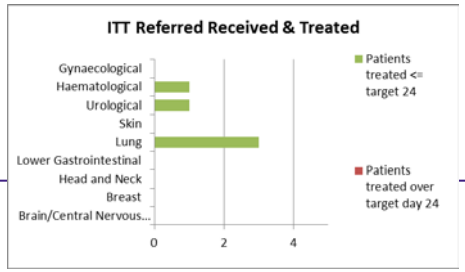
All Cancer Standards	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Trend
14 Day GP Referral (93%)	86.6%	87.3%	90.0%	93.1%	95.1%	94.2%	93.2%	85.7%	93.3%	87.9%	
14 Day Breast Symtomatic (93%)	94.8%	95.2%	85.9%	93.8%	94.2%	96.0%	98.9%	94.8%	93.2%	94.0%	
31 Day First Treatment (96%)	98.3%	96.3%	98.8%	97.6%	97.4%	96.2%	97.2%	96.9%	96.6%	96.4%	
31 Day Subsequent Treatment Surgery(98%)	100.0%	94.7%	96.6%	100.0%	100.0%	93.8%	98.8%	96.0%	96.0%	95.1%	
31 Day Subsequent Treatment Drug(98%)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.4%	100.0%	100%	
62 Day Referral (85%)	83.2%	77.5%	81.6%	90.2%	86.6%	88.3%	88.8%	80.0%	85.2%	87.7%	
62 Day Screening (90%)	93.9%	84.8%	94.8%	95.0%	95.8%	92.0%	96.2%	92.7%	92.7%	93.0%	
62 Day Consultant Upgrade (85%)	100.0%	100.0%	100.0%	90.0%	100.0%	100.0%	92.6%	87.5%	97.1%	100.0%	

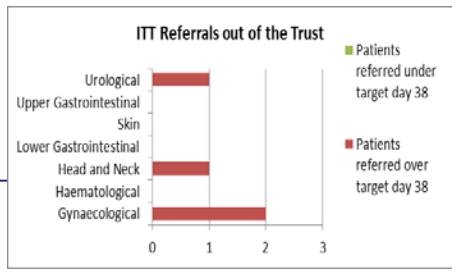


Key Metrics







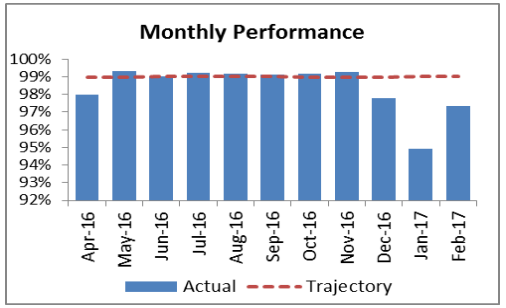


RESPONSIVNESS – Diagnostic Access

Briefing: Diagnostics 6 Week Wait – Diagnostic performance in December fell below national standard and the Trust did not achieve STF Trajectory within the last 3 months. In total 219 breaches were reported in February (97.2% performance) Nearly 70% of the 6 week breaches were within Imaging, particular within MRI and Non Obstetric ultrasound. Endoscopy reported 31% of all 6 week breaches reducing significantly compared to previous month. A recovery plan is in place and decreases in overall breaches continue to be observed within March.

The Sustainability and Transformation Fund Performance against Trajectory 2016/2017

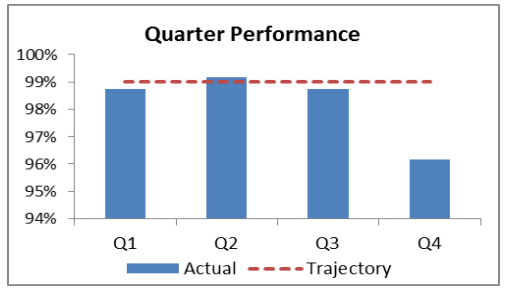
Monthly Trajectory	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17
Total Waits	5,788	5,386	6,046	5,718	5,429	5,750	5,803	5,860	5,776	5,813	5,816
Total Waits <6 Weeks	5,730	5,332	5,986	5,661	5,375	5,693	5,745	5,801	5,718	5,755	5,758
Total Waits >6 Weeks	58	54	60	57	54	57	58	59	58	58	58
Performance Trajectory	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%
Total Waits	7,290	6,588	6,977	6,436	6,085	6,258	6,834	6,878	6,906	7,358	7,871
Total Waits <6 Weeks	7,142	6,542	6,908	6,386	6,034	6,202	6,777	6,828	6,755	6,986	7,652
Total Waits >6 Weeks	148	46	69	50	51	56	57	50	151	372	219
Performance Trajectory	98.0%	99.3%	99.0%	99.2%	99.2%	99.1%	99.2%	99.3%	97.8%	94.9%	97.2%
Meeting STF	✗ -1.0%	✓ 0.3%	✓ 0.0%	✓ 0.2%	✓ 0.2%	✓ 0.1%	✓ 0.2%	✓ 0.3%	✗ -1.2%	✗ -4.1%	✗ -1.8%



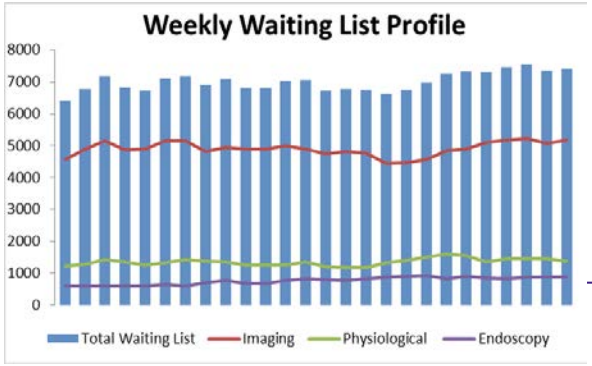
Met STF not National
Not met STF or National
Met STF and National

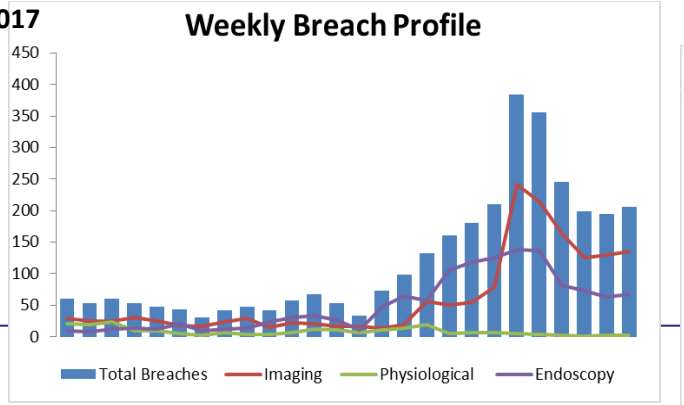
Quarterly Trajectory	Q1	Q2	Q3	Q4
Total Waits	17,220	16,897	17,439	11,629
Total Waits <6 Weeks	17,048	16,729	17,264	11,513
Total Waits >6 Weeks	172	168	175	116
Performance	99.0%	99.0%	99.0%	99.0%

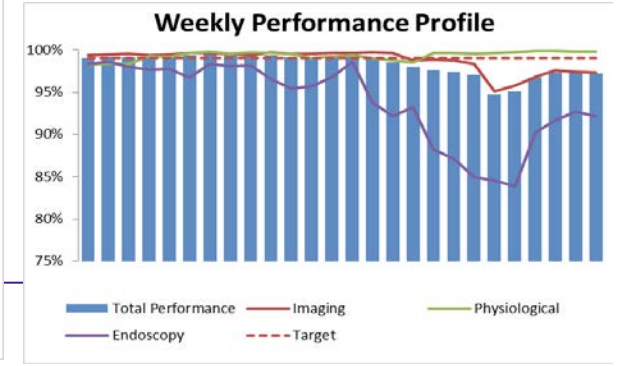
Quarterly Actual	Q1	Q2	Q3	Q4
Total Treatments	20,855	18,779	20,618	15,229
Treatments <62 Days	20,592	18,622	20,360	14,638
Breaches >62 Days	263	157	258	591
Performance	98.7%	99.2%	98.7%	96.1%
Meeting STF	✗ -0.3%	✓ 0.2%	✗ -0.25%	✗ -2.88%



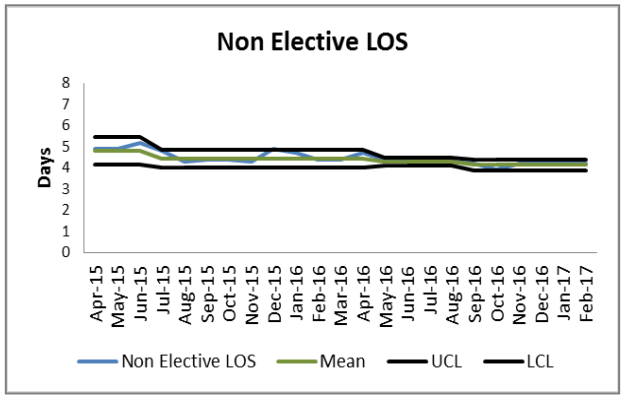
Weekly Performance Monitoring up to 05/03/2017

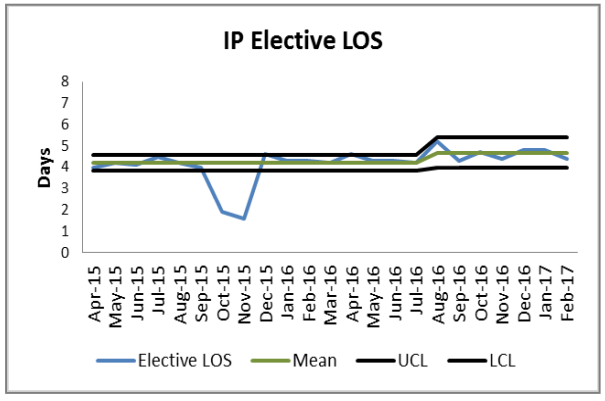


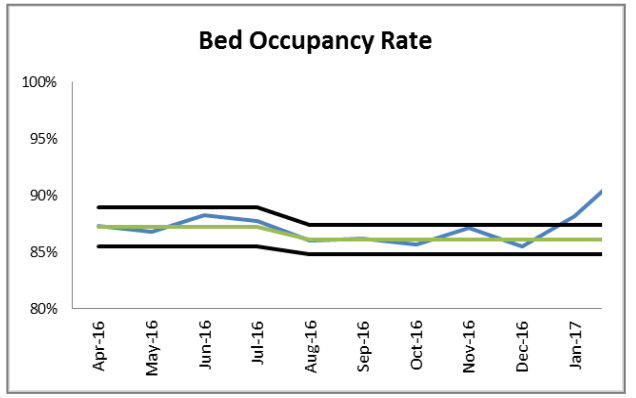


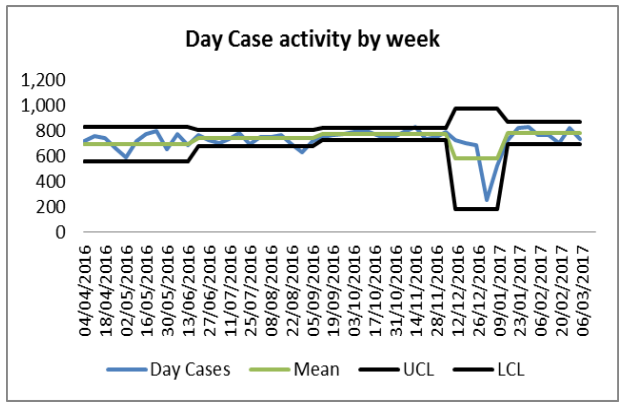


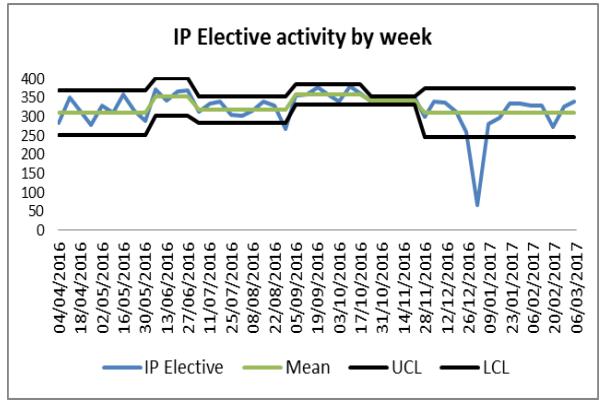
Operational Dependencies

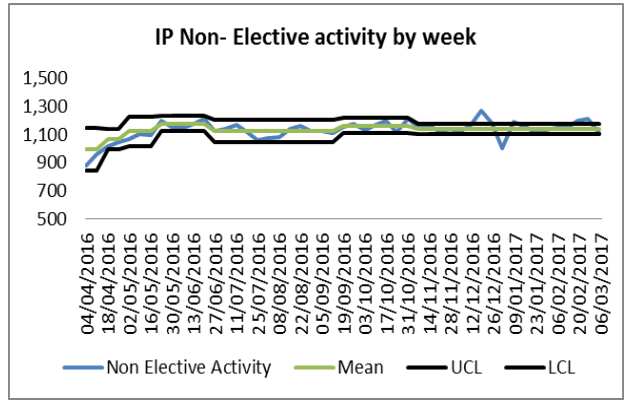


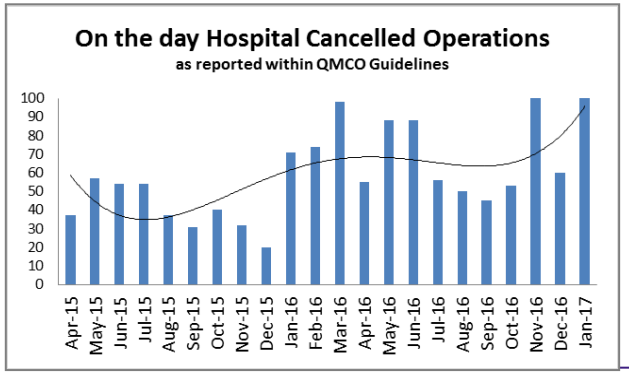


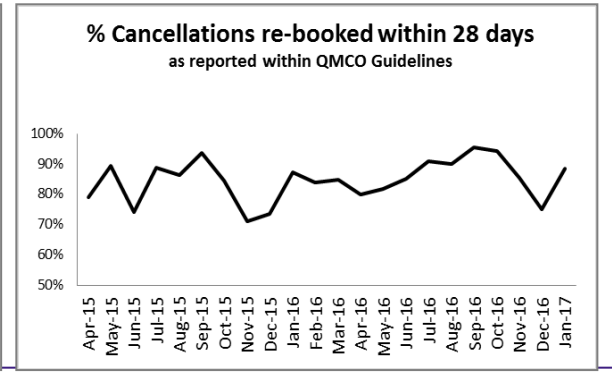


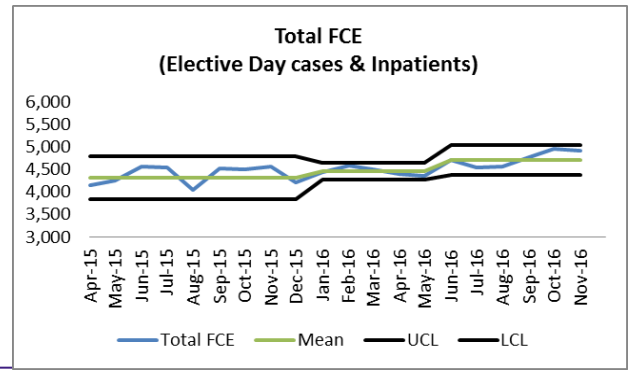




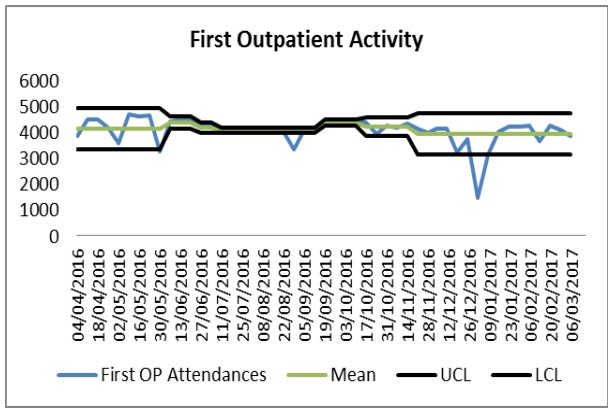


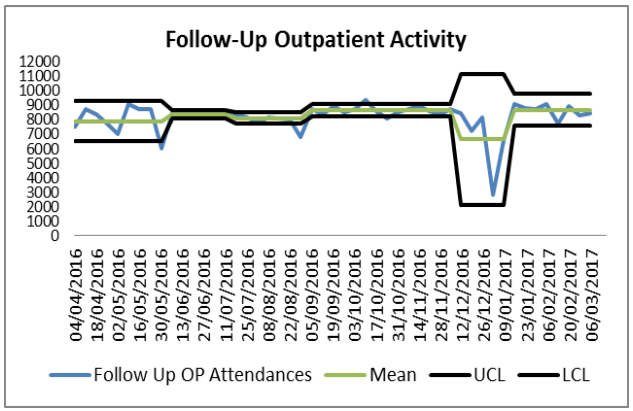


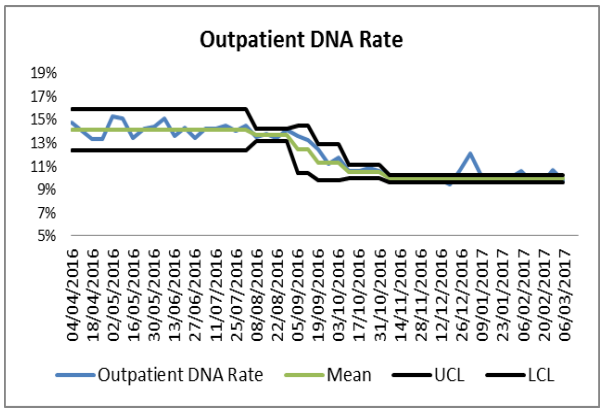


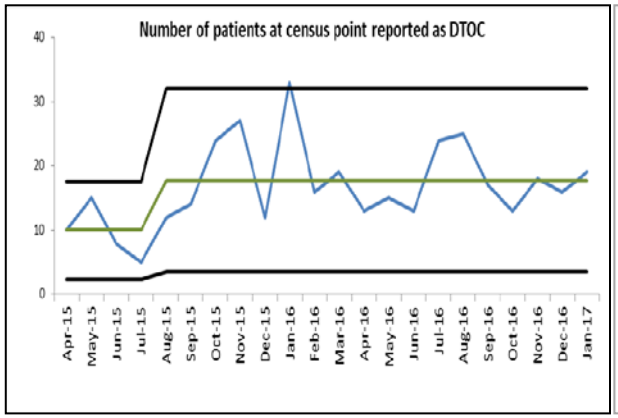


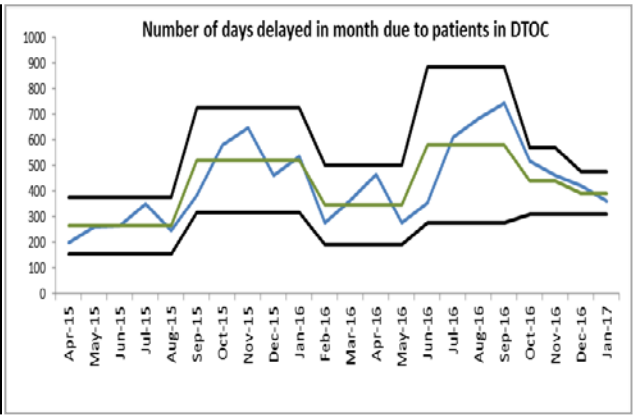
Operational Dependencies











Executive Lead: Mark Gammage, HR Advisor to the Board

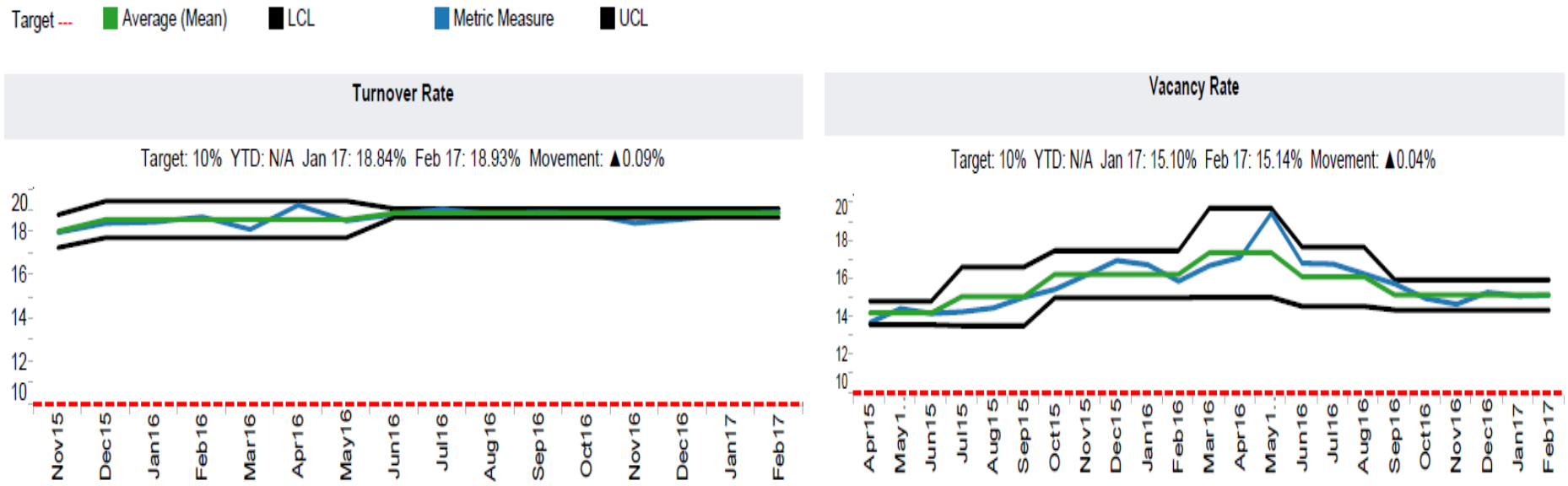
Theme	Indicator	Ref	Units	Period	Target	National or Local	Mth Rag Rating	Dec-16	Jan-17	Feb-17	Variance	YTD Total	Chart
Workforce	Trust Level Sickness Rate	101	%	Feb-16	3%	Local		3.70%	4.20%	3.80%		N/A	Y
	Trust Vacancy Rate	100	%	Feb-16	10%	Local		18.60%	18.80%	18.90%		N/A	Y
	Trust Turnover Rate	99	%	Feb-16	10%	Local		24.93%	23.65%	23.66%		N/A	Y
	IPR Appraisal Rate - Medical	103	%	Feb-16	90%	Local		76%	79.2%	81.37%		N/A	Y
	IPR Appraisal Rate - Non Medical	104	%	Feb-16	90%	Local		64.18%	67.5%	70.42%		N/A	Y
	Ward Staffing Unfilled Duty Hours	106	%	Feb-16	10%	Local		6.25%	4.6%	6.25%		N/A	Y
Safe Staffing	Safe Staffing Alerts	237	Number	Feb-16	0	Local		11	11	7		99	Y

								Q4 2015/16	Q1 2016/17	Q2 2016/17	Variance		
Staff Experience	Staff Friends and Family Test Response Rate		%	Q2	TBC	Local		6%	8%	7%		N/A	N
	Staff Friends and Family Test Recommend as a place to work		%	Q2	TBC	Local		50%	50%	37%		N/A	N
	Staff Friends and Family Test Recommend as a place for treatment		%	Q2	TBC	Local		75%	79%	73%		N/A	N

WELL LED – Workforce Indicators

Briefing:

- Turnover remains high (18.6%) and above our target for this year
- Vacancy rates continue to be high at 15.8% and above our 10% target. Some of this vacancy figure is an inflation due to unbudgeted vacant posts sitting in ESR which we are working with managers to remove.



WELL LED – Workforce Indicators

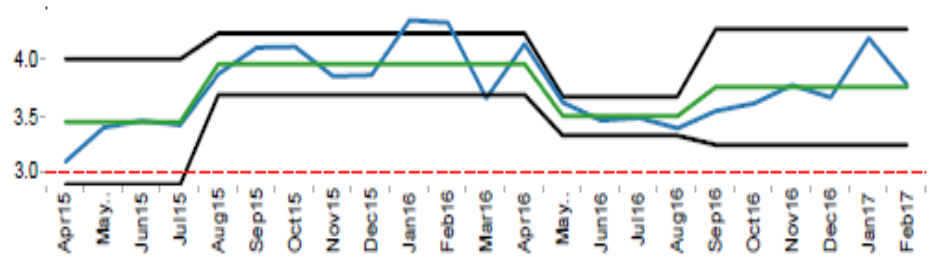
Briefing:

- Sickness absence has remained fairly constant throughout the year although is above the expected local target.
- We continue to have safe staffing levels on the wards despite the sickness, although this is often mitigated through the use of premium cost staff.

Target --- Average (Mean) LCL Metric Measure UCL

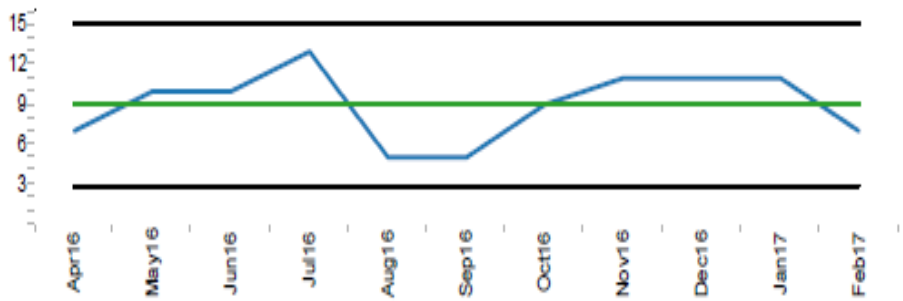
Sickness/Absence Rate

Target: 3% YTD: N/A Jan 17: 4.18% Feb 17: 3.78% Movement: ▼-0.40%



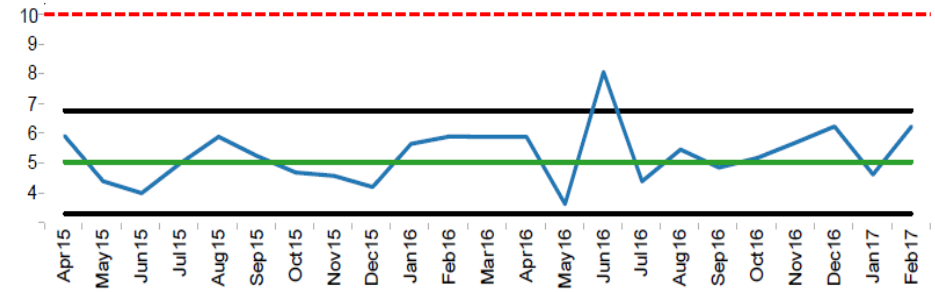
Safe Staffing Alerts

Target: 0 YTD: 99 Jan 17: 11 Feb 17: 7 Movement: ▼-4



Ward Staffing Unfilled Duty Hours

Target: 10% YTD: N/A Jan 17: 4.63% Feb 17: 6.25% Movement: ▲1.62%



WELL LED – Workforce Indicators

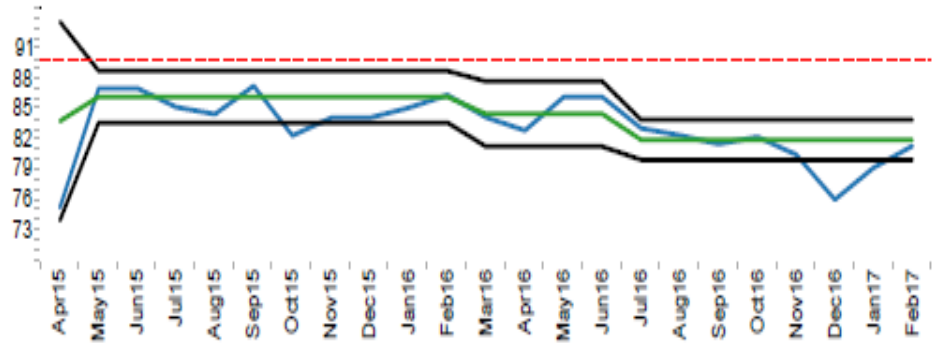
Briefing:

- Appraisal rates remain a concern for both medical and non-medical staff.
- This triangulates with the low scores we see in the staff recommendation rates.

Target --- Average (Mean) LCL Metric Measure UCL

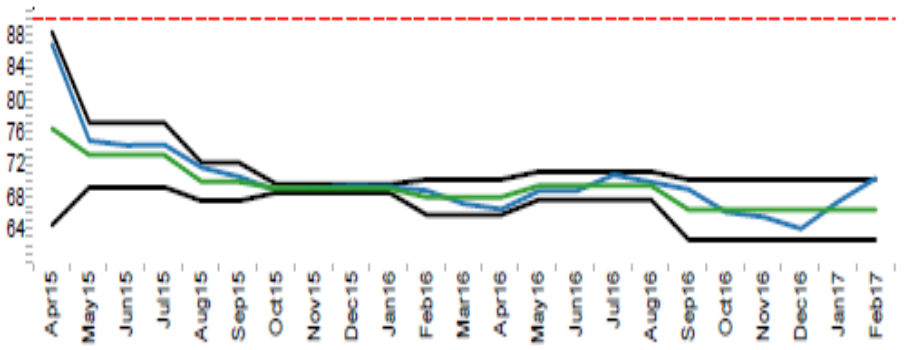
IPR Appraisal Medical

Target: 90% YTD: N/A Jan 17 79.22% Feb 17: 81.37% Movement: ▲2.15%



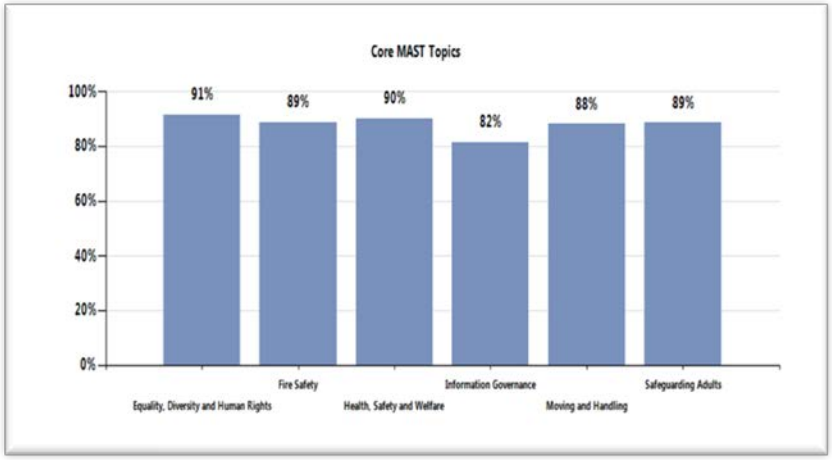
IPR Appraisal Non-Medical

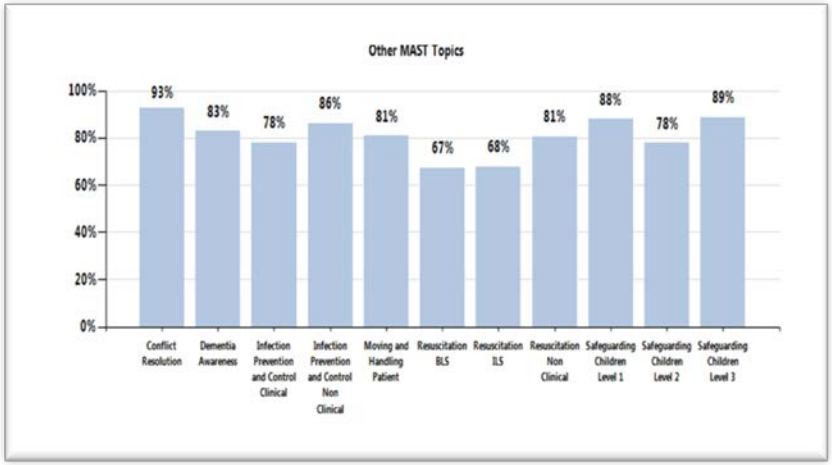
Target: 90% YTD: N/A Jan 17 67.53% Feb 17: 70.42% Movement: ▲2.89%



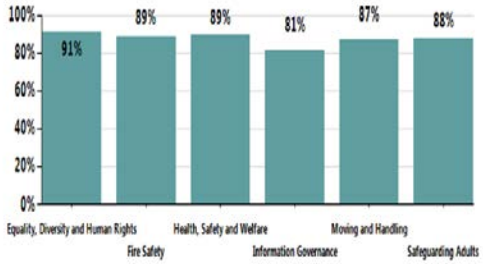
WELL LED – Workforce Indicators

Briefing:
The Trust achieved 85% compliance for MAST in March, meeting its target and achieving the highest level of compliance the Trust has seen. There are some areas where further progress is required, most notably with resuscitation and with doctors' compliance, and this is being addressed.

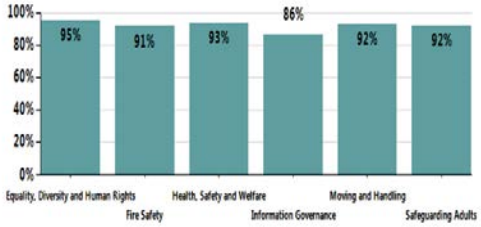




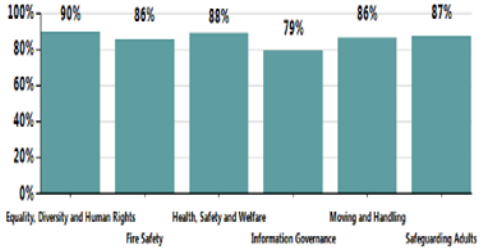
W&C



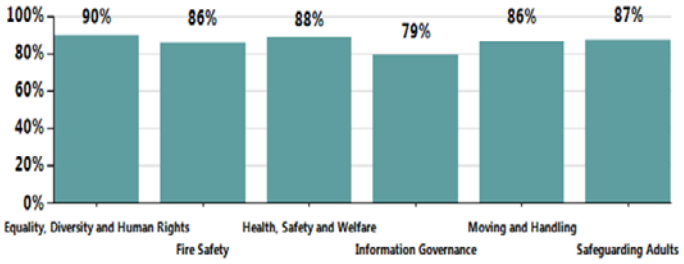
Community



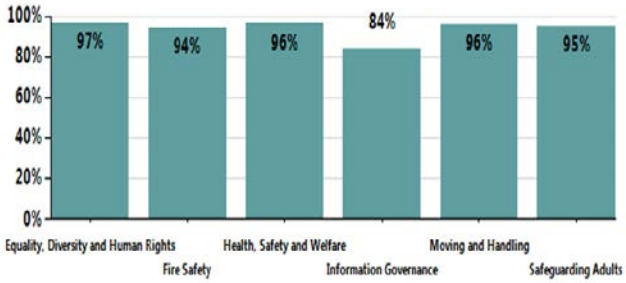
Medicine



Surgery



SWL Pathology



A look ahead

Daily Activity & Performance Report

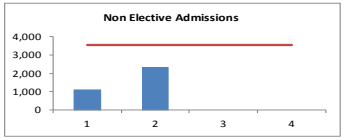
St George's University Hospitals NHS NHS Foundation Trust

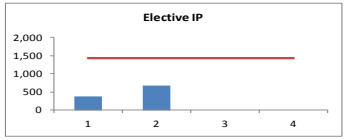
	Feb-17								Mar-17																			
	Activity Wk 1 (13th Feb - 19th Feb)								Activity Wk 2 (20th Feb - 26th Feb)								Activity Wk 3 (27th Feb - 5th March)								Activity Wk 4 (6th March - 12th March)							
Indicator	Mon	Tue	Wed	Thur	Fri	Sat	Sun	Total	Mon	Tue	Wed	Thur	Fri	Sat	Sun	Total	Mon	Tue	Wed	Thur	Fri	Sat	Sun	Total	Mon	Tue	Wed	Thur	Fri	Sat	Sun	Total
ED Attendances	476	407	440	425	437	392	431	3,008	568	470	465	434	469	399	414	3,219	501	466	523	429	509	431	446	3,305	513	485	442	468	423	440	472	3,243
ED 4 Hr Breaches	26	21	27	36	47	25	12	194	66	58	55	24	29	21	9	262	72	31	77	45	72	43	20	360	87	45	13	48	41	32	63	329
ED Performance	94.5%	94.8%	93.9%	91.5%	89.2%	93.6%	97.2%	93.55%	88.4%	87.7%	88.2%	94.5%	93.8%	94.7%	97.8%	91.86%	85.63%	93.35%	85.28%	89.51%	85.85%	90.02%	95.52%	89.11%	83.04%	90.72%	97.06%	89.74%	90.31%	92.73%	86.65%	89.86%
Ambulance Arrivals	106	99	106	103	110	95	106	725	103	96	101	99	104	100	106	709	104	100	121	103	122	112	132	794	103	103	88	118	108	103	106	729
Re-Pat Waiting	18	18	20	25	27	21	19	21	19	26	29	31	30	30	28	28	27	26	23	27	27	27	20	25	20	22	25	27	24	16	11	21
DTOC	25	25	21	24	24	25	25	24	25	22	21	20	20	23	23	22	23	24	25	27	29	29	29	27	30	29	25	29	34	33	33	30
Non DTOC	18	25	32	33	26	26	26	27	26	22	21	18	18	20	20	21	20	24	26	29	28	28	28	26	24	22	26	30	25	27	27	26
Non Elective admissions	183	193	168	169	235	147	115	1,210	172	205	163	213	215	150	107	1,225	150	156	202	183	182	135	125	1,133	167	210	197	181	216	122	125	1,218
Discharges	167	173	151	150	187	123	96	1,047	167	200	162	204	200	135	101	1,169	136	159	210	172	172	123	121	1,093	150	186	169	156	176	99	111	1,047
Discharge Lounge Use	23	12	25	29	18	0	0	107	18	24	21	29	23	0	0	115	16	23	24	0	21	0	0	84	30	28	22	22	17	Closed	Closed	119
Occupancy Rates	92.88%	93.93%	93.38%	91.72%	89.85%	84.99%	86.76%	90.50%	88.32%	91.0%	91.9%	95.0%	90.6%	86.5%	86.3%	89.96%	88.54%	91.4%	97.0%	92.4%	92.2%	90.8%	89.7%	91.71%	94.10%	94.4%	93.3%	93.6%	91.9%	86.3%	85.1%	91.23%
Electve IP	59	58	48	45	83	11	18	322	75	66	66	57	51	9	14	338	92	76	48	72	59	8	16	371	72	47	48	52	58	3	19	299
Elective Day Case	128	104	146	124	110	7	0	619	130	134	177	157	132	19	0	749	105	138	169	129	128	7	0	676	129	148	140	147	124	7	0	695
Cancelled Operations	9	5	3	8	3	2	1	31	12	11	13	11	8	5	1	61	15	7	10	10	8	0	0	50	10	4	6	9	5	0	1	35
OP New	659	877	683	686	520	65	47	3,537	834	972	770	725	624	79	44	4,048	836	952	787	754	522	76	50	3,977	831	927	707	691	582	75	42	3,855
OP Follow Up	1,426	1,679	1,536	1,342	1,282	16	5	7,286	1727	1803	1933	1568	1441	40	1	8,513	1668	1881	1630	1423	1300	23	9	7,934	1796	1838	1809	1526	1402	28	2	8,401

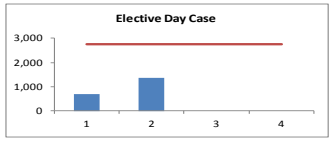
Activity Mar Month to date against Plan

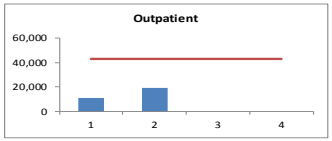
Indicator	Activity	Plan	Variance	% Diff
Non Elective Admissions	2020	1524	496	24.6%
Electve IP	474	573	-99	-20.9%
Elective Day Case	1174	1096	78	6.6%
Outpatient Activity	17326	17304	22	0.1%

Cumulative Weekly Activity against Monthly Plan - Mar 2017







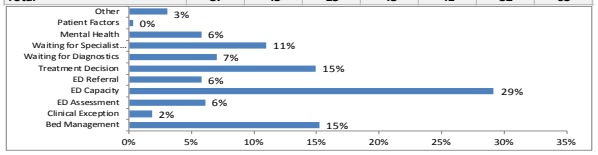


Performance

ED Performance

	Wk 1	Wk 2	Wk 3	Wk 4	MTD	Q4	YTD
ED Patients within 4 Hours	93.6%	91.9%	89.1%	89.9%	89.5%	88.7%	91.8%

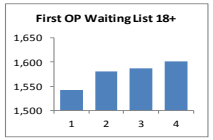
Daily ED Breach Reasons	06/03/2017	07/03/2017	08/03/2017	09/03/2017	10/03/2017	11/03/2017	12/03/2017
Bed Management	15	10	4	8	7	1	5
Clinical Exception	2	0	0	2	2	0	0
ED Assessment	3	2	0	2	2	3	8
ED Capacity	39	12	0	13	5	3	24
ED Referral	5	3	1	2	3	5	0
Treatment Decision	6	6	5	10	6	7	9
Waiting for Diagnostics	1	1	0	0	7	5	9
Waiting for Specialist Opinion	11	6	2	5	4	4	4
Mental Health	2	3	1	5	2	4	2
Patient Factors	0	0	0	1	0	0	0
Other	3	2	0	0	3	0	2
Total	87	45	13	48	41	32	63

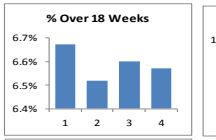


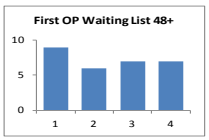
RTT Performance

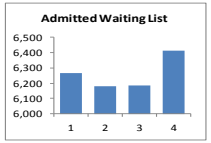
	Apr-16	######	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17
Incomplete Waiting List Size (All)	35,626	37,243	38,849	39,573	40,299	38,935	38,594	37,608	38,249	41,619	43,848
Incomplete 18+ (All)	3,753	3,575	4,540	4,938	5,801	5,148	5,140	5,158	6,988	9,350	10,946
Incomplete 18+ (All)	89.5%	90.4%	89.5%	87.5%	85.6%	86.8%	86.7%	86.3%	81.7%	77.5%	75.0%

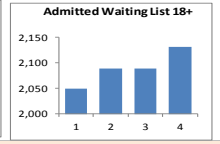
Weekly PTL Updates	17/02/2017	24/02/2017	03/03/2017	10/03/2017
First OP Waiting List	23,119	24,241	24,037	24,377
First OP Waiting List 18+	1,543	1,580	1,587	1,602
% Over 18 Weeks	6.7%	6.5%	6.6%	6.6%
First OP Waiting List 48+	9	6	7	7
Admitted Waiting List	6,264	6,182	6,186	6,412
Admitted Waiting List 18+	2,050	2,089	2,089	2,131
% Over 18 Weeks	32.7%	33.8%	33.8%	33.2%
Admitted Waiting List 48+	51	48	48	52

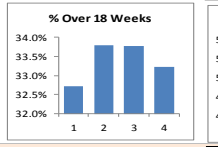


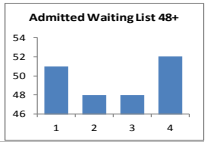












Summary 52 Wk Breaches First OP, Continuing OP & Admitted

Report Date	Last Wk	Tip Ins this Wk	Removed	Total
10/02/2017	41	9	4	46
17/02/2017	46	12	17	41
24/02/2017	41	8	9	40
03/03/2017	40	4	4	40

52+ Breaches	Admitted PTL	Outpatient PTL
Total 52 Wk Pts	19	21
Without TCI Date	0	0
With TCI Date	19	19
Treated	0	0
ROTT	0	2

Specialty	Total patients
Cardiac surgery	2
Ear, Nose & Throat	11
Gastroenterology	4
General Surgery	10
Neurology	1
Paediatrics Med & Surg	1
Plastic Surgery	3
Trauma & Orthopaedics	5
Urology	2
Vascular Surgery	1
Grand Total	40

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	6 April 2017	**Agenda No**	**2.5**
Report Title:	Elective Care Recovery Programme		
Lead Director/ Manager:	Diana Lacey, Director Elective Care Recovery Programme		
Report Author:	Diana Lacey, Director Elective Care Recovery Programme		
Freedom of Information Act (FOIA) Status:	Unrestricted Restricted (select using highlight)		
Presented for:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify) (select using highlight)		
Executive Summary:	This paper gives an update on the implementation of the plan to recover the integrity of elective care data used to administer patient tracking lists (PTL), and deliver the 18 week referral to treatment (RTT), diagnostic and cancer access standards. The early indications suggest that progress is on being made towards a return to national RTT reporting in 2018/19.		
Recommendation:	The Board is asked to note the progress made.		
Supports			
Trust Strategic Objective:	1. Deliver our Transformation Programme enabling the Trust to meet its operational and financial targets. 2. Ensure the Trust has an unwavering focus on all measures of quality and safety, and patient experience.		
CQC Theme:	Well-Led		
Single Oversight Framework Theme:	Operational Performance		
Implications			
Risk:	Patients may come to harm as a consequence of waiting in excess of 18 weeks for treatment. A high number of patients waiting will adversely affect Trust performance against the referral to treatment (RTT) standards, and Sustainability and Transformation trajectory with subsequent loss of income. There will be an additional loss of income as the Trust will be fined for non-reporting of the RTT standard. This may affect the reputation of the Trust.		
Legal/Regulatory:	Delivery of the programme will aid the Trust to return to reporting of the referral to treatment (RTT) standard which is a requirement of the NHS Constitution. Delivery of the programme will help to address issues raised in the recent CQC report.		
Resources:	There are no specific resource implications associated with this update.		
Previously Considered by:		**Date :**	
Equality Impact Assessment:	N/A		
Appendices:	Approach to recovery of RTT data quality and performance.		

Elective Care Recovery Programme Report
Trust Board
6 April 2017

1.0 PURPOSE

1.1 The purpose of this paper is to provide the Trust Board with an update on the delivery of the Elective Care Recovery Programme (ECRP).

2.0 BACKGROUND

2.1 Following identification of a number of performance and data quality issues by the national Referral to Treatment (RTT) Intensive Support Team (IST), St George's University Hospitals NHS Trust commissioned a comprehensive review of their systems and processes that manage patients on the elective care pathway. The review conducted by MBI identified multiple operational process and technology issues at every stage of the elective care pathway that posed significant risks to the quality of care and safety of patients.

2.2 Specifically, the Trust has a high number of 'open' patient records on its Patient Administration Systems (PAS) dating back to at 2014 and possibly earlier. The Trust cannot say with certainty that these patients have been treated or are at the correct stage of their care pathway and it is probable that patients may have been harmed due to their extended wait. The Trust Board took the decision to suspend national reporting of RTT performance in July 2016.

2.3 The scale and complexity of the resolution to the issues is great. The Elective Care Recovery Programme has been established to rectify the issues and return St George's to national reporting of the RTT standard.

2.4 The Recovery Programme has three areas of focus; validating and correcting historic patient records, assessing patients with excessive waits for clinical harm and expediting their treatment, and ensuring data capture is accurate, complete and timely in future.

3.0 UPDATE

3.1 The Recovery Programme is now established with a detailed programme of work, and executive leads identified for each work stream. The Terms of Reference and membership of the programme Board have been revised to reflect the growing maturity of the programme which will in future be chaired St George's Chief Executive Officer. Local commissioners, specialised commissioners and regulators are invited to Board meetings.

3.2 The review of patients who may have been harmed is overseen by the Clinical Harm Review Group chaired by Dr Nicola Payne (Deputy Medical Director, NHS England London Region). Patients included in the review are all patients who have waited more than 52 weeks for treatment, those who have not been seen by a clinician for more than six months, and others identified at risk through DATIX, GP and primary care alerts. In the 126 cases reviewed no harm had occurred in 110 of the cases, and in 14 cases low harm had occurred.

3.3 In 2 cases, serious harm had occurred. In each instance there was a delay in making a follow up appointment for the patient. Both patients have been informed.

3.4 'Cymbio' have been engaged for the first phase of validation and correction of historic electronic patient records. The contract is forecast to cost £1,016k with £297k due in this financial year, and take four -five months to complete.

3.5 At week 4 7,118 of 124,538 validations have been completed. The early outcomes are as follows:

- The majority of patients need to be discharged. 3,068 of the 7,118 are patients who have been treated but for whom there is no discharge letter. Discussions are underway with Clinical Commissioners to determine the optimal process to do this.
- Very low numbers of patients, 216 of 7,118 (2%) have been identified who need to be added back into RTT waiting lists and need to be booked
- However, the number of patients who are not on RTT pathways but do need follow-up appointments is challenging, 576 of 7,118 (7%)
- This means that overall 9% of patients checked so far need to come in for an appointment. If that trend continues it is possible that an additional 9,900 appointments may be required.
- To date the specialties most affected are Dermatology and ENT.
- For 1,435 of the 7,118 (20%) validations the results are inconclusive. For these patients either the latest appointment outcomes have not been recorded on the system, or could not be updated on the system for technical reasons. Work is underway to resolve the technical issues so this number should reduce dramatically. However, the issue of not 'outcoming' patient appointments is an ongoing issue which has both clinical and financial implications.

3.6 The Outline Business Case the second phase of validation was agreed by the Strategic Oversight Group (SOG). The tender process will begin in April.

3.7 An external review by the national RTT Intensive Support Team in February 2016 identified 21 groups of patients being inappropriately excluded from all patient tracking lists contravening national RTT guidance. From February these patients have no longer been excluded from the tracking lists. This is major step in improving the safety of the tracking process. The records of patients who have been historically excluded from the PTLs are included for validation in the Cymbio contract referenced above.

3.8 The key reason an electronic record is incomplete is the absence of standard operating procedures and a lack of understanding of the 18RTT rules and how to use them. The processes where the highest incidence of errors is made have been identified and work is underway to develop Standard Operating Procedures for these five processes which will complete in early June.

3.9 Work is also in progress to ensure accurate, complete and timely outcome recording for patient appointments and will entail the redeployment of the use of Clinic Outcome Forms. It is an essential component of the programme to ensure that patients are not 'lost', and that the Trust bills accurately for work undertaken.

3.10 Immediate training has those targeted staff who recorded the highest incident of errors. 189 users (87% of the target user base) have completed training and the number of errors reduced from a high in 4002 in April 2016 to 2382 in March 2017.

3.11 The validation team has been expanded and is focussed on validating and correcting the records of patients as the patient is referred into the Trust (specifically to ensure that the clock start is accurate), and when the patient is added to the admitted patient PTL. In addition each week the validation team will validate the records of the longest waiting patients enabling clinical and operational teams to ensure that all long wait patients have a date for treatment.

3.12 The current focus is on all patients waiting 36 weeks or longer but will continue to reduce as patients are treated. 42 patients are known to be waiting more than 52 weeks for treatment.

4.0 NEXT STEPS

4.1 Prioritise the development of standard operating procedures for those procedures where areas where there are the highest incidence of errors

4.2 Develop and deliver the project for the redeployment of Clinic Outcome Forms

4.3 Focus on treating long wait patients by clinical teams and Divisions.

4.4 Award contract to external supplier for Phase 2 of the technical validation

4.5 Complete the training needs assessment for the all staff with administrative responsibility for the elective patient pathway.

5.0 RETURN TO REPORTING

5.1 Until the approach to phase 2 of the validation process is agreed and commissioned it will not be possible to forecast when the Trust will be in a position to consider a return to national reporting of RTT performance data.

5.2 Other NHS Trusts who have had similar issues with data quality have found the recovery to be a lengthy process taking in excess of eighteen months. Given their experience and what we already know about the volume of records to be corrected St Georges will most likely return to reporting in 2018/19.

6.0 RECOMMENDATION

6.1 The Trust Board is asked to note progress being made.

Author: **Diana Lacey, Director Elective Care Recovery Programme**
Date: **31st March 2017**

Meeting Title:	Trust Board		
Date:	6 April 2017	**Agenda No**	**2.6**
Report Title:	Hospital Pharmacy Transformation Plan 2016 - 2020		
Lead Director/ Manager:	Professor Andrew Rhodes, Medical Director		
Report Author:	Chris Evans, Chief Pharmacist		
Freedom of Information Act (FOIA) Status:	Unrestricted		
Presented for:	Approval		
Executive Summary:	The Hospital Pharmacy Transformation Plan (HPTP) will underpin the Trust Pharmacy and Medicines Optimisation strategy and business planning for 2017/18 and subsequent years. HPTP will ensure that 80% of pharmacy staff resource is utilised for clinically focused patient facing medicines optimisation services by April 2020. This will include medicines reconciliation, medicines administration, prescribing of medicines, pharmacists working in out-patient and pre-admission clinics, medication safety and governance. The HPTP has identified the transformational work that has started and achieved, in progress and yet to be completed by April 2020. Work started and achieved includes; provision of a 7 day ward pharmacy service, including medicines reconciliation on the Acute Medical Unit and Surgical Assessment Unit, increasing the percentage of prescribing pharmacists to 33%, medicines administration pharmacists working in paediatrics, NNU and neuro-rehabilitation, roll out of electronic prescribing and medicines administration (EPMA) to 60% In-patient areas, delivery of annual medicines optimisation savings programme and the review of stores/procurement with achievement of 85% electronic ordering and 10 day stock holding. The pharmacy acts as a third party provider to other Trusts for a number of services, including radio-pharmacy, pre-packing/over-labelling, pharmaceutical “specials” manufacture and quality assurance. Transformational initiatives started, but need to be completed by April 2020 include; rollout of EPMA to all In-patient and Out-patient areas, increasing the percentage of prescribing pharmacists to 80%, reconfiguration of both pharmacy technician and pharmacy assistant workforce to deliver up to 80% patient facing clinical pharmacy technicians and pharmacy assistants. Workforce transformation will be delivered through support by Health Education England and apprenticeship models. Workforce transformation will be achieved through existing resources. Implementation of ePrescribing Chemotherapy for paediatrics and eInvoicing across Finance and Pharmacy will be delivered in 2017/18. This plan has been shared with SWL partners, as well as SEL and NWL partners in order to support collaboration and economies of scale. The work		

	will feed into the agreed SWL STP medicines optimisation agenda. The plan will be reviewed and developed as new NHS benchmarking data is made available forming part of a continuous cycle of service transformation and improvement. The plan will be overseen by the Medicines Optimisation Committee with reporting on progress and by exception to the Patient Safety Quality Board and Trust Finance and Performance Review.		
Recommendation:	Trust Board is asked to approve the Hospital Pharmacy Transformation Plan to be delivered by 2020		
Supports			
Trust Strategic Objective:	1. Ensure the Trust has an unwavering focus on all measures of quality and safety, and patient experience. 2. Deliver our Transformation Programme enabling the Trust to meet its operational and financial targets		
CQC Theme:	Safe, effective, caring, responsive, well lead		
Single Oversight Framework Theme:	Strategic Change		
Implications			
Risk:	• Insufficient IT infrastructure and funding to enable Trust roll out of EPMA to all wards and departments. • Workforce engagement with momentum of transformation. • Workforce recruitment such as pharmacy technicians mitigated by commissioning of correct training numbers via HEE. • Training places to increase, maintain critical staffing levels for succession planning of prescribing pharmacists • Maintain and ensure adequate gain shares are in place with commissioners and that support infrastructure costs and incentivisation • Lack of joined up partnership working with SWL partners, other London partners and SWL STP programme		
Legal/Regulatory:	Trusts are required to have signed off plans, submitted to NHSI		
Resources:	Infrastructure and funding to enable Trust roll out of EPMA Training places/funding to maintain staffing levels of prescribing pharmacists Access to critical assessment and diagnostic skills training Agreed business plan process to develop opportunities for collaborative working in order to release savings and benefits Scope for reinvesting medicines optimisation savings to improve patient care and safety (linked to medicines optimisation)		
Previously Considered by:	Draft plan submitted to NHSI October 2016 Approved Executive Management Team	**Date**	Oct 2016 13.03.17
Equality Impact Assessment:	N/A		
Appendices:	Appendix 1 - Hospital Pharmacy Transformation Plan 2016 – 2020		

Hospital Pharmacy Transformation Plan
Board Meeting, 6 April 2017

1.0 PURPOSE

1.1 The purpose of the paper is to update EMT and the Board on the Hospital Pharmacy Transformation Plan (HPTP), to be delivered by April 2020.

2.0 BACKGROUND

2.1 On 5 February 2016, Lord Carter published the final report to the Secretary of State for Health, identifying unwarranted variation across all of the main resource areas worth an estimated £5bn in terms of efficiency opportunity. The report stated that the NHS could save at least £800m through transforming hospital pharmacy services and medicines optimisation. It made eight recommendations at acute trust, regional and national levels. All of the recommendations were accepted.

3.0 RECOMMENDATIONS OF THE CARTER REPORT FOR HOSPTIAL PHARMACY TRANSFORMATION PLAN

3.1 Trusts through the HPTP, develop plans by April 2017 to ensure hospital pharmacies achieve their benchmarks such as increasing pharmacist prescribers, e-prescribing and administration, accurate cost coding of medicines and consolidating stock holding, in agreement with NHSI and NHSE by April 2020; so that their pharmacists and clinical pharmacy technicians spend more time on patient-facing medicines optimisation services.

3.2 Developing HPTP at local level with each Trust board nominating a Director to work with the Chief Pharmacist to implement the changes identified, overseen by NHSI and in collaboration with professional colleagues locally, regionally and nationally with the Chief Pharmaceutical officer for England, signing off each of the regions HPTP as submitted by NHSI

3.3 Ensuring that more than 80% of trust pharmacist resource is utilised for direct medicines optimisation activities, medicines governance and safety remits and reviewing the provision of all local infrastructure services, which could be delivered collaboratively with another Trust of through a third party provider

3.4 Each Trust's Chief Clinical Information Officer working with the Chief Pharmacist moving prescribing and administration from traditional drug cards to electronic prescribing and medicines administration systems (EPMA)

3.5 Each Trust's Finance Director working with the Chief Pharmacist, ensuring that coding of medicines, particularly high cost drugs is accurately recorded within NHS Reference Costs

3.6 NHSI publish a list of the top 10 medicines with savings opportunities monthly for Trusts to pursue.

3.7 The Commercial Medicines Unit (CMU) in DH undertake regular benchmarking with the rest of the UK and on a wider international scale to ensure NHS prices continue to be competitive, and updating its processes in line with the DH NHS Procurement Transformation Programme as well as giving consideration as to whether the capacity of the CMU is best located in the DH or in the NHS working alongside NHSE Specialist Pharmacy Services and Specialised Commissioning functions

3.8 Consolidation medicine stock holding and modernising the supply chain to aggregate and rationalise deliveries to reduce stock holding days from 20 to 15, deliveries to less than 5 per day and ensuring 90% of orders are sent and processed electronically

4.0 IMPLICATIONS

Risks

4.1 Insufficient IT infrastructure and funding to enable Trust roll out of EPMA to all wards and departments
4.2 Workforce engagement with momentum of transformation
4.3 Workforce recruitment such as pharmacy technicians mitigated by commissioning of correct training numbers by HEE
4.4 Training places to increase and maintain critical staffing levels of Prescribing Pharmacists
4.5 Risks to implementation of medicines savings initiatives mitigated by ensuring adequate gain shares are in place with commissioners and that support infrastructure costs and incentivisation
4.6 Lack of joined up partnership working with SWL partners, other London partners and SWL STP programme

Legal Regulatory

4.2 Trusts are required to have signed off plans, submitted to NHSI

Resources

4.3 Infrastructure and funding to enable Trust roll out of EPMA
4.4 Training places and funding to increase and maintain critical staffing levels of prescribing pharmacists
4.5 Agreed business plan process to develop opportunities for collaborative working in order to release savings and benefits
4.6 Scope for reinvesting medicines optimisation savings to improve patient care and safety (linked to medicines optimisation)

5.0 NEXT STEPS OR TIMELINE

5.1 Continue to maintain and roll out the transformational initiatives described in the Plan Summary

5.2 Deliver the remaining transformational initiatives as described in the Plan Summary against the agreed timelines

6.0 RECOMMENDATION

6.1 The Board is asked to approve the Hospital Pharmacy Transformation Plan to be delivered by 2020

Author: **Chris Evans, Chief Pharmacist**
Professor Andrew Rhodes, Medical Director
Date: **29 March 2017**

St George's University Hospitals NHS
NHS Foundation Trust

HOSPITAL PHARMACY TRANSFORMATION PLAN 2016-2020

EXECUTIVE SUMMARY

The Hospital Pharmacy Transformation Plan (HPTP) will underpin the Trust Pharmacy and Medicines Optimisation strategy and business planning for 2017/18 and subsequent years. HPTP will ensure that 80% of pharmacy staff resource is utilised for clinically focused patient facing medicines optimisation services by April 2020. This will include medicines reconciliation, medicines administration, prescribing of medicines, pharmacists working in out-patient and pre-admission clinics, medication safety and governance.

The HPTP has identified the transformational work that has started and achieved, in progress and yet to be completed by April 2020. Work started and achieved includes; provision of a 7 day ward pharmacy service, including medicines reconciliation on the Acute Medical Unit and Surgical Assessment Unit, increasing the percentage of prescribing pharmacists to 33%, medicines administration pharmacists working in paediatrics, NNU and neuro-rehabilitation, roll out of electronic prescribing and medicines administration (EPMA) to 60% of In-patient areas, delivery of annual medicines optimisation savings programme and the review of stores/procurement with achievement of 85% electronic ordering and 10 day stock holding. The pharmacy acts as a third party provider to other Trusts for a number of services, including radio-pharmacy, pre-packing/over-labelling, pharmaceutical “specials” manufacturing and quality assurance.

Transformational initiatives started, but need to be completed by April 2020 include; rollout of EPMA to all In-patent and Out-patient areas, increasing the percentage of prescribing pharmacists to 80%, reconfiguration of both pharmacy technician and pharmacy assistant workforce to deliver up to 80% patient facing clinical pharmacy technician and pharmacy assistants. Workforce transformation will be delivered through support by Health Education England and apprenticeship models. Workforce transformation will be achieved through existing resources. Implementation of ePrescribing Chemotherapy for paediatrics and eInvoicing across Finance and Pharmacy will be delivered in 2017/18.

This plan has been shared with SWL partners, as well as SEL and NWL partners in order to support collaboration and economies of scale. The plan will feed into the agreed SWL STP medicines optimisation agenda. The plan will be reviewed and developed as new NHS benchmarking data is made available forming part of a continuous cycle of service transformation and improvement. The plan will be overseen by the Medicines Optimisation Committee with reporting on progress and by exception to the Patient Safety Quality Board and Trust Finance and Performance Review.

1 METRICS AND PLAN

Domain	Metric	Transformation Plan	KPI target	Provider Current Value	Provider Target for 2020
Money & Resources	Pharmacy Staff & Medicines Costs per WAU	Maintain the 2014/15 metric, which is less than peers and national median	-	£340	Clarification required
Money & Resources	Medicines Costs per WAU	Maintain the 2014/15 metric which is less than peers and national median. Annual medicines optimisation programme to continue and to incorporate the Top 10 list of medicines savings.	-	£239	Claification required
Money & Resources	High Cost Medicines per WAU	2014/15 value is less than peers and national median. Work with NHSE and SWLMOG to ensure efficient and optimum use of HCD	-	£83	Clarification required
Money & Resources	Non High Cost Medicines per WAU	2014/15 value is less than peers and national median. Review of optimum usage of medicines on-going. Maintain high visibility of optimum usage and reducing medicine wastage at Board to ward level.	-	£156	Clarification required
Money & Resources	Pharmacist resource utilised for Direct patient care	Review of all non-core services that can be provided in-house more efficiently in order to release pharmacist staff time for patient facing activity. Responsible pharmacist time in the dispensary is being freed up by moving more services across to the outsourced outpatients	>80%	68%	>80%
Safe	% ePrescribing IP	EPMA has been rolled out to 60% of wards. Roll out to 100% of wards by April 2020	100%	60%	100%
Safe	% ePrescribing OP	Trust to roll our EPMA to all out-patient clinics by April 2020	100%	0%	100%
Safe	% ePrescribing Discharge	Roll out to 100% wards by April 2020	100%	60%	100%
Safe	% ePrescribing Chemotherapy - Adults	Target met for adults	100%	100%	100%
Safe	% ePrescribing Chemotherapy - Paediatrics	Develop action plan to roll out eChemotherpay for paediatric patients by April 2018	100%	0%	100%

Safe	Total Antibiotic Consumption in DDD*/1,000 Admissions	The Trust is undertaking the national antimicrobial CQUIN 2016/17 to reduce antibiotic consumption compared to 2013/14 data. The 2016/17 CQUIN has been met. The following actions have been undertaken: • Update of the Empirical Treatment Guidelines. • Re-launch of a weekly antibiotic ward round with a Consultant Microbiologist and Antimicrobial Pharmacist. • Implementation of a hard stop date for oral antibiotics on the electronic prescribing system planned for April 2019. This will reduce inappropriate continuation of oral antibiotics.	As peers	4574	As peers
Safe	% Use of Summary Care Record (or local system) per Month	Trust is a high user of summary care records. Increased access to medical staff would further improve usage	-	72%	Need clarification
Safe	% Diclofenac vs Ibuprofen & Naproxen	Continue to adhere to current prescribing protocol.	-	4.8%	<5.0%
Effective	Number of days Stockholding	Target met and continual monitoring	15	15	15
Effective	% Pharmacists Actively Prescribing	Rolling programme of Prescribing Pharmacists training for all pharmacists band 7 and above in clinical posts. Review of SWL sector strategy to be able to achive target (joint training to allow staff to be released	>80%	33.4%	>80%
Effective	% Medicines reconciliation with 24 hours of admission	Embedded in clinical practice and supported by 7 day working. Process to be reviewed to ensure optimum skill mix of ATO/Pharmacy Technician/Pharmacist in the process by April 2018.	80%	80%	80%
Effective	% Use Soluble Prednisolone of total prednisolone uptake	Lower than peers (3%) and national median (3.6%).	<2.5%	0%	<2.5%

Effective	% Biosimilar Infliximab uptake (February 2017)	Continue collaborative working with clinians and commissioners to ensure all relevant patients are switched and maximum savings optimised. Use gainshare to incentivise	Top quartile	91%	Top quartile
Effective	% Biosimilar Etanercept uptake (February 2017)	As above.	Top quartile	97%	Top quartile
Effective	Number of Daily Deliveries	Currently at 15. Suppliers are not yet in position to consolidate orders to reduce the number of daily deliveries. Trust willl adopt the national pharmacy procurement best practice recommendtions and LPP agenda	5	15	5
Effective	Orders sent electronically	Homecare companies do not currently have the ability to invoices electronically. Pharmacy checking with all our suppliers to implement electronic invoices where possible.	90%	85%	90%
Effective	Invoices processed electronicaly	Develop Trust business case to action Finance department to process invoices electronically	90%	0%	90%
Responsive	Sunday On Ward clinical pharmacy hours of service	Pharmacy provides 7 day ward pharmacy service. Pharmacists provide seven hours clinical pharmacy service on Acute Medical Unit on Saturday and Sunday and attend weekend PTWR		7.5 hours	
Well-led	% Sickness absence rate	This figure is lower than the Trusts target. Sickness monitored regularly.		1.92%	
Well-led	% Staff with appraisals (February 2017)	HR provide monthly figures on staff due appriasals	85%	92%	85%
Well-led	% staff with statutory and Mandatory Training (February 2017)	HR provide monthly figures	85%	89%	85%
Well-led	% Staff turnover rate	Develop action plan to support a turnover rate comparable to peers.	As peers	21.42%	As peers

2 PLAN SUMMARY

A number of key transformational intiatives have been implemented: These include

- Provision of 7 day ward pharmacy service, including medicines reconciliation in the Acute Medicial Unit and Surgical Assessment Unit.
- The percentage of prescribing pharmacists is at 33%.
- ePrescribing Chemotherapy for adult patients has been rolled out for 100% patients.
- EPMA has been rolled out to 60% of In-patient areas.
- Embedded annual Medicines Optimisation savings programmes. Delivered £2m in 16/17. Current plan for 17/18 at £2.2m.
- Acting as a third party provider for pharmacy services across SW London and beyond eg radiopharmacy, pre-pack/over-labelling, QC services.
- Medicines administration pharmacists working in Paediatrics, NNU and Neuro-rehabilitation
- Review of stores/procurement, rationalising to one site, 85% implementation of electronic ordering and achievement of 10 day stock holding.

A number of key transformational initiatives are required to achieve the recommendations. These include:

- Workforce transformation including increasing and extending pharmacist prescribing roles, skill mixing of existing pharmacy technician/assistant roles, enhancement of 7 day working medicines optinmisation (medicines reconciliation at weekends as a minimum across all wards).
- Enhanced and extended IT/Digitalisation, including roll out of EPMA to 100% Trust by April 2020.
- Implementation of ePrescribing Chemotherapy for paediatrics and eInvoicing for Finance and Pharmacy by April 2018.
- Infrastructure changes to maximise staff focus on direct patient facing care such as; outsourcing/review of ward box assembly, direct intravenous fluids delivery, outsouced parenteral nutrition compounding, chemotherapy dose banding and explore smarter methods of service delivery e.g. medicines topping up service, rationalise one stop dispensing where beneficial

- Identify opportunities for collaborative working via the South London and NW London Acute Trust networks/partners
- Link this workplan with the agreed SWL STP medicines optimisation agenda
- Buidling on current review of Pharmacy commercial service, to scope potential savings across SWL into the preferred option.
- Continuation and expansion of current Pharmacy role as a “third party provider” of infrastructure services eg radiopharmacy, pre-pack/over-labelling, pharmaceutical “specials” manufacturing and quality control.

3 RISKS AND CRITICAL DEPENDENCIES

Key issues include:

- Insufficient IT infrastructure and funding to enable Trust roll out of EPMA to all wards and departments
- Workforce engagement with momentum of transformation.
- Workforce recruitment such as pharmacy technicians mitigated by commissioning of correct training numbers via HEE.
- Training places and funding to increase and maintain critical staffing levels for succession planning of prescribing pharmacists
- Access to critical assessment and diagnostic skills training
- Risks to implementation of medicines saving initiatives mitigated by ensuring adequate gain shares are in place with commissioners and that support infrastructure costs and incentivisation
- Lack of joined up partnership working with SWL partners, other London partners and SWL STP programme

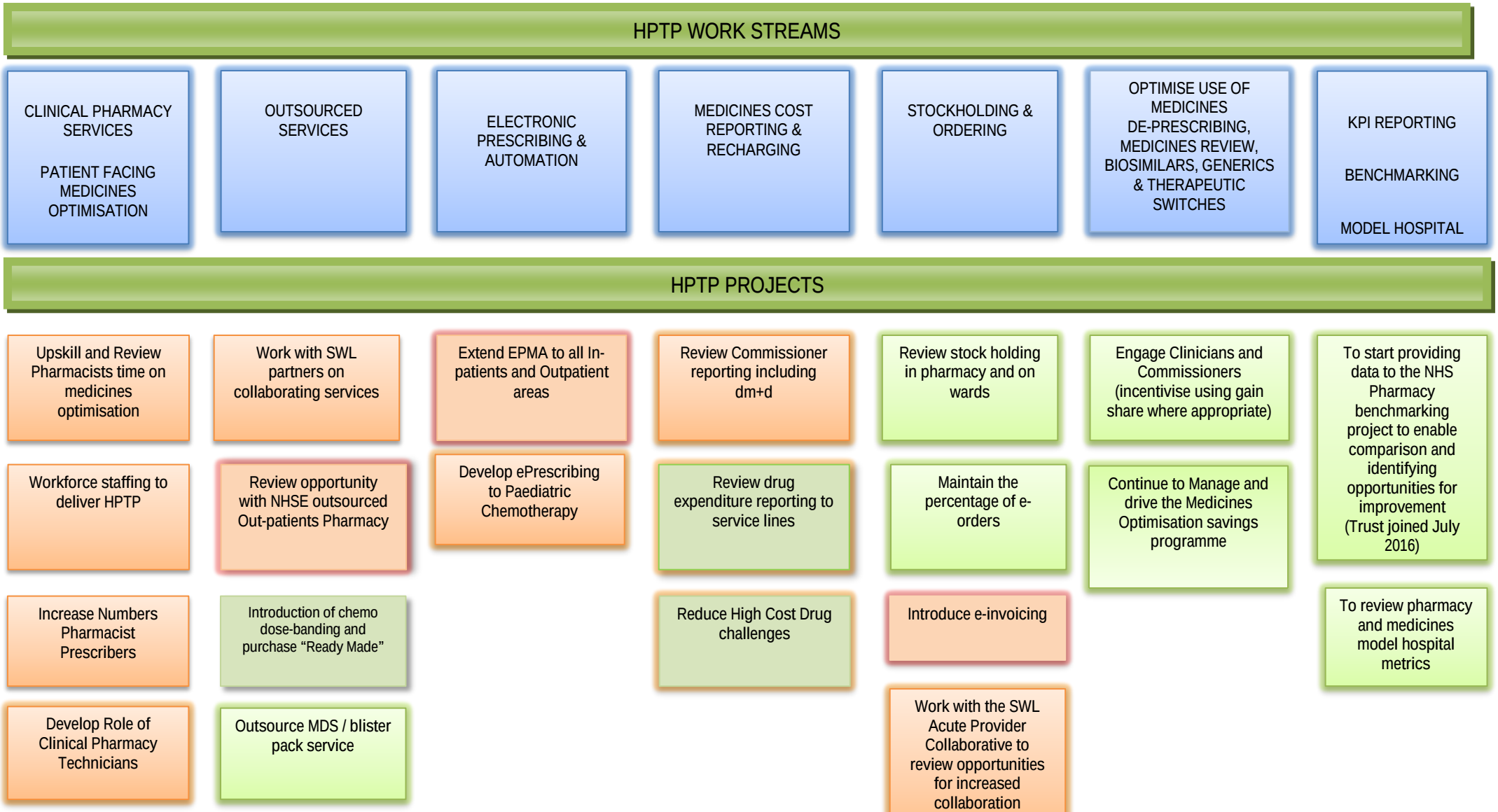
4 ISSUES AND MITIGATION

Known issues include

- Link IT and Infrastructure funding to Trustwide strategic business planning

- Identify alternative funding streams for Prescribing Pharmacists eg hard to recruit staff in patient facing healthcare
- Escalate workforce training and development needs are part of HEE strategy
- Use gainshare, from medicines optimisation savings, to both incentivise clinical engagement and invest in new services for patients
- Collaborative working and shared service delivery with SW London partners and beyond
- Celebrate and optismise the achievement and engagement todate and on-going

1 HPTP Workstream Map



St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**TRUST BOARD**		
Date:	**6 April 2017**	**Agenda No**	**3.1**
Report Title:	**Summary Finance Report- Month 11 2016/17**		
Lead Director/ Manager:	Iain Lynam, Chief Restructuring Officer and Acting Chief Finance Officer		
Report Author:	Michael Armour, Reporting Accountant		
Freedom of Information Act (FOIA) Status:	Unrestricted		
Presented for:	Assurance		
Executive Summary:	The Trust's YTD deficit is now £72.0m. February financial performance is an in-month deficit of £4.8m, which is £2.6m better than a £7.4m in-month deficit forecast. However included is £4.2m of accounting technical adjustments/benefits including; VAT on Commercial Pharmacy (£2.4m), bad debt benefit (£0.6m), release of increments accrual (£0.5m), Estates capitalisation of interim costs (£0.5m) and Linden Lodge upside (£0.2m). The restated February financial performance is an in-month deficit of £9.0m which is £1.6m adverse to forecast. The principal components of the shortfall are: activity and therefore income shortfalls in Adult and Paediatric Critical Care (£0.8m) caused by reduced elective activity in other Divisions, additional pay cost catch-up for Consultants (£0.2m), sickness and supernumerary cover in Agency Nursing (£0.2m) and unachieved reductions in interim costs (£0.2m). For 16/17 year-end, the Trust is projecting a forecast outturn of c£74M deficit against the £76M re-forecast deficit position at Month 9 (December 2016). This is a £2M improvement to the position as a result of non-recurring accounting/technical adjustments.		
Recommendation:	The Trust Board notes the current Trust financial position including the improved forecast outturn for 2016-17.		
Supports			
Trust Strategic Objective:	Deliver our Transformation Plan enabling the Trust to meet its operational and financial targets.		
CQC Theme:	Well-Led		
Single Oversight Framework Theme:	Finance and Use of Resources		
Implications			
Risk:	**BAF Risk 6**: Failing to Deliver the Financial Plan		
Legal/Regulatory:	The Trust manages its finances in line with standard accounting regulation and guidance set out by NHS Improvement.		
Resources:	N/A		
Previously Considered by:	Executive Management Team Finance & Performance Committee	**Date**	27.03.17 29.03.17
Equality Impact Assessment:	N/A		
Appendices:	N/A		

Summary Finance Report
Month 11 2016/17

Trust Board 6th April 2017

Contents

1. Financial Performance for Month 11 (February 2017)

Income & Expenditure	Annual Budget £'m	Current Month Budget £'m	Current Month Actual £'m	Current Month Variance £m	Year to Date (YTD) Budget £'m	Year to Date (YTD) Actual £'m	Year to Date (YTD) Variance £m	Current Month Reforecast @ M10 (£71m deficit control total) Forecast £'m	Current Month Reforecast @ M10 (£71m deficit control total) Variance £m
SLA Income	650.3	52.3	49.5	(2.8)	593.0	585.8	(7.2)	51.5	(2.0)
STF Income	17.6	1.5	0.0	(1.5)	16.1	0.0	(16.1)	0.0	0.0
Other Income	112.2	9.3	8.4	(0.8)	103.0	107.6	4.6	9.7	(1.3)
Overall Income	**780.1**	**63.0**	**57.9**	**(5.1)**	**712.1**	**693.3**	**(18.7)**	**61.3**	**(3.3)**
Pay	(486.3)	(40.7)	(40.5)	0.3	(445.6)	(453.7)	(8.2)	(40.5)	0.1
Non Pay	(275.9)	(21.2)	(19.2)	2.0	(254.7)	(278.6)	(24.0)	(24.9)	5.7
Overall Expenditure	(762.2)	(61.9)	(59.6)	2.3	(700.2)	(732.4)	(32.1)	(65.4)	5.8
EBITDA	**17.9**	**1.1**	**(1.7)**	**(2.8)**	**11.8**	**(39.0)**	**(50.8)**	**(4.1)**	**2.4**
Financing costs	(35.1)	(2.9)	(3.1)	(0.1)	(32.2)	(32.9)	(0.8)	(3.2)	0.2
Surplus/(deficit)	**(17.2)**	**(1.8)**	**(4.8)**	**(2.9)**	**(20.4)**	**(72.0)**	**(51.6)**	**(7.4)**	**2.6**
Memo: One-off accounting Items	0.0	0.0	4.2	4.2	0.0	4.2	4.2		
Restated surplus/(deficit)	**(17.2)**	**(1.8)**	**(9.0)**	**(7.1)**	**(20.4)**	**(76.2)**	**(55.8)**	**(7.4)**	**(1.6)**

Key Messages

The **actual Month 11 financial position is a deficit of £4.8m**. This is a £2.6m improvement against the £7.4m Month 11 forecast deficit. However, the largest contributor to this improvement is £4.2m of accounting technical adjustments/benefits including; VAT on Commercial Pharmacy (£2.4m), bad debt benefit (£0.6m), release of increments accrual (£0.5m), Estates capitalisation of interim costs (£0.5m) and Linden Lodge upside £0.2m.

The **restated Month 11 deficit is £9m** (after the removal of these one-off benefits), which is £1.6m adverse to forecast. This is broadly due to the following: activity and therefore income shortfalls in Adult and Paediatric Critical Care (£0.8m) caused by reduced elective activity in other Divisions, additional pay cost catch-up for Consultants (£0.2m), sickness and supernumerary cover in Agency Nursing (£0.2m) and unachieved reductions in interim costs (£0.2m).

The **YTD deficit is £72m**

- **SLA Income** *(slides 6-9)* - £2m shortfall against Month 11 forecast. This is as a result of: cancellation of elective activity (£0.9m) as a result of the reduction in pay rates for WLI sessions and £0.8m reduced income for bed days as Adult and Paediatric intensive care are lower as a result of reduced elective activity.
- **Pay** *(slides 10-13)* – The actual position for Month 11 is £0.1m underspend to forecast. The restated Month 11 position is £1m adverse to forecast owing primarily to Consultant catch up on WLI payments (£0.2m), unachieved reduction in interim costs (£0.2m), recoding of Non-Pay to Pay for MOD Consultants (£0.2m), and increased agency to cover sickness and supernumerary posts (£0.2m). However, £1m of one-off accounting benefits have been included to offset the position (£0.5M increment provision release and £0.5m capitalisation of Estates interims) and bring it back to broadly balance position.
- **Non Pay** *(slide 14)* - £5.7m favourable to forecast in Month 11due to: £2.6m of VAT reclaims, £1m underspend in Pharmacy drugs (which is offset in Commercial Pharmacy income), £0.8m in clinical consumables underspend, £0.6m bad debt release and £0.2m MOD recode to Pay in Surgery.

2. Analysis of cash movement M11

Source and application of funds - cash movement analysis:
M11 YTD and forecast vs Plan

	Actual vs Plan YTD			Based on forecast £71m deficit			
	Plan YTD £m	Actual YTD £m	*Actual YTD VAR £m*	*Plan Year £m*	*Forecast Outturn £m*	*Forecast VAR £m*	Notes based on forecast £71m deficit
Opening cash 01.04.16	7.4	7.4		*7.4*	*7.4*		
Income and expenditure deficit	-21.3	-72.0	***-50.7***	*-17.2*	*-76.1*	***-58.9***	
Depreciation	22.8	22.9	***0.1***	*25.0*	*25.0*	***0.0***	
Interest payable	4.7	4.9	***0.2***	*5.1*	*5.8*	***0.7***	
PDC dividend	5.7	4.8	***-0.9***	*6.3*	*5.3*	***-1.0***	
Other non-cash items	-0.2	0.1	***0.3***	*-0.2*	*4.9*	***5.0***	
Operating deficit	**11.8**	**-39.2**	***-51.0***	**19.0**	**-35.2**	***-54.2***	
Change in stock	0.4	-0.2	***-0.6***	*0.6*	*0.6*	***0.0***	
Change in debtors	-0.4	-26.6	***-26.3***	*1.8*	*-20.9*	***-22.7***	does not assume debt targets met
Change in creditors	-0.9	32.7	***33.6***	*-5.5*	*10.6*	***16.1***	
Net change in working capital	-0.9	5.8	***6.8***	-3.1	-9.6	**-6.5**	
Capital spend (excl leases)	-31.3	-24.1	***7.3***	*-33.4*	*-26.6*	***6.8***	The capital cash spend forecast is £26.6m - comprising an expenditure underspend of £2m and an increase in capital creditors of £4.75m against the baseline budget. As previously reported this means no additional borrowing would be required to finance capital expenditure in year.
Interest paid	-4.3	-4.1	***0.2***	*-5.1*	*-5.6*	***-0.5***	
PDC dividend paid	-3.1	-3.1	***0.0***	*-6.3*	*-5.3*	***1.0***	
Other	-7.5	-6.5	***1.1***	*-8.0*	*-7.8*	***0.2***	
Investing activities	-46.2	-37.7	***8.5***	*-52.7*	*-45.3*	***7.4***	
WCF/ISF borrowing	31.0	72.6	***41.6***	*32.5*	*87.6*	***55.2***	The borrowing forecast excludes emergency (unapproved) capital funding as the capital cash forecast is to under spend the baseline budget. Therefore all the additional borrowing is to finance the higher deficit. The borrowing forecast is £0.6m lower than last month due to a reductio in the forecast year end cash balance.
Closing cash 31.10.17 / 31.03.17	3.0	8.9	***5.9***	3.0	4.9	***1.9***	

M01- M11 YTD cash movement
The better performance on working capital (+£6.8m) and cash under spend (+£7.3m) on the capital programme offset some of the adverse cash impact of the higher operating deficit (-£51m) and helped the Trust to restrict the increase in borrowing necessary to finance the higher revenue deficit to £41.6m.

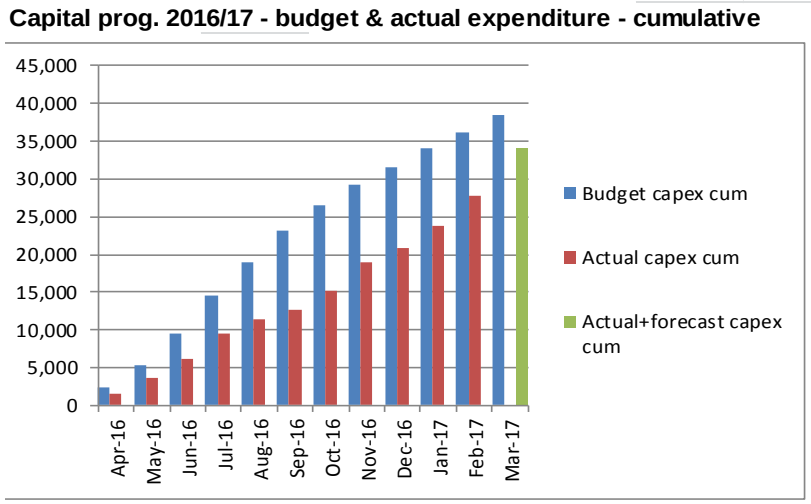
M11 YTD cash movement

- Within the I&E deficit of £72m YTD, depreciation (£22.9m) does not impact cash. The accruals for interest payable (£4.9m) and PDC dividend (£4.8m) are added back and the amounts actually paid for these expenses shown lower down for presentational purposes. This generates a YTD cash "operating deficit" of £39.2m.
- The operating variance from plan of £51m in cash is directly attributable to the I&E deficit. Members will recall that the NHSI plan and Internal trust plan are phased differently (see slide 15).
- The Trust has been able to partially offset the larger operating deficit with better performance on working capital (+£6.8m), the cash under spend on capital (+£7.3m), lower interest paid (+£0.2m),lower finance lease repayments (+£1m) (in 'Other') enabling the Trust to retain a £5.9m higher cash balance and restrict the increase in borrowing necessary to finance the higher I&E deficit to £41.6m.

Forecast outturn cash movement

- The total forecast borrowing requirement is £87.6m, £55.2m higher than plan. This extra borrowing is required to finance the higher operating deficit.

3. Capital programme M11



CAPITAL BUDGET & EXPENDITURE M11 - BY SPEND CATEGORY

Row Labels	**2016/17 Budget Total**	16/17 Budget YTD £000	16/17 Actual YTD	16/17 YTD variance	*M12 Forecast £000*	***Forecast outturn £000***	**Forecast variance £000**
Infra Renewal -EPC	**9,389**	9,389	6,228	3,161	*586*	***6,814***	**2,575**
Infra Renewal	**7,491**	6,824	2,059	4,765	*268*	***2,327***	**5,164**
IMT	**4,972**	4,670	6,799	-2,129	*1,135*	***7,934***	**-2,962**
Med Eqpt	**4,613**	4,094	2,472	1,622	*672*	***3,144***	**1,469**
Major Projs	**8,901**	8,380	9,388	-1,008	*3,541*	***12,929***	**-4,028**
Other	**349**	320	420	-100	*0*	***420***	**-71**
SWL PATH	**385**	368	401	-33	*0*	***401***	**-16**
Grand Total	**36,099**	34,045	27,767	6,278	*6,202*	***33,969***	2,130

- Capital expenditure in February was £3.9m and year to date expenditure is £27.7m, an underspend of £6.3m (M10: £8.2m). The table above shows the YTD under spend relates mainly to the energy performance contract (EPC) (£3.1m – down £1m on M10) for which the programme slipped earlier in the year, and infrastructure renewal (£4.7m), which includes the scheme to replace the stand-by generators. Expenditure on the EPC has accelerated over the last three months.
- The trust is forecasting approx £5m of expenditure this year on CQC related schemes including the Renal unit re-location and the demolition programme against the emergency capital bid. DH approved a capital loan of £16.2m for emergency investment on 28th February. This loan will be drawn down in the first two quarters of 2017/18.
- The Trust submitted a gross capital expenditure forecast of £34.1m for the year to NHSI in January and this must not be exceeded. The latest assessment is that the Trust will come within £0.2 of this target.
- The forecast cash underspend relating to capital expenditure is unchanged at £6.75m comprising the approx £2m expenditure underspend and £4.75m increase in capital creditors.

4. Divisional Actuals vs Forecast

Division	M11 Forecast £m	M11 Actual £m	Variance £m	Comments
C&W, Diagnostics, Therapies	(1.3)	(2.9)	(1.6)	**Adverse** to forecast owing to SLA Bed days shortfall (£0.8m), and Pay overspend (£0.6m) owing to catch up on WLI payments and sickness and supernumerary agency cover.
Medicine and Cardiovascular	4.4	4.5	0.1	On plan
Surgery and Neurosciences	1.8	1.7	(0.1)	On plan
Community Services	1.6	1.5	(0.1)	On plan
Central and Overheads (restated)	(13.9)	(13.8)	0.1	On plan
Restated Total	**(7.4)**	**(9.0)**	**(1.6)**	
Accounting benefits	0.0	4.2	4.2	**Favourable** owing to one-off technical accounting benefits of £4.2m; including VAT reclaims (£2.4m), Bad debt benefit (£0.6m) and Estates interim capitalisation (£0.5m).
Actual Total	**(7.4)**	**(4.8)**	**2.6**	

- At Month 11, the Trust's **actual** financial position is £2.6m favourable to forecast, as per the M10 deficit forecast plan.
- However, after removing one-off accounting benefits of £4.2m, the Trust's **restated** Month 11 financial position is adverse to forecast by £1.6m largely as a result of reduced activity and increase pay in CWDT (as shown in the above table)

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	6 April 2017	**Agenda No**	**3.3**
Report Title:	Investment, Divestment & Dis-investment Group - Demolition of Clare House		
Lead Director/ Manager:	Anna D'Alessandro – Director, Financial Performance		
Report Author:	Tom Ellis, Head of Business Planning		
Freedom of Information Act (FOIA) Status:	Unrestricted Restricted		
Presented for:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify)		
Executive Summary:	The Investment, Divestment & Dis-investment Group (IDDG) meets every two weeks to review investment proposals for the trust. IDDG can approve business cases up to £250k, with items above that amount requiring EMT, F&P and Trust Board approval, dependent on value. The Trust Board is asked to approve the following case, discussed at EMT and F&P: ▪ Demolition of Clare House and associated decant costs, including modular builds		
Recommendation:	The Trust Board is asked to formally ratify the decision taken at IDDG, approved at EMT and F&P, to incur expenditure associated with this business cases.		
Supports			
Trust Strategic Objective:	All four trust strategic objectives		
CQC Theme:	Addresses all five key themes: Safe, effective, caring, responsive and well-led		
Single Oversight Framework Theme:	Addresses all five key themes: Quality of Care, Finance and use of resources, Operational performance, Strategic change, leadership and improvement capability.		
Implications			
Risk:	Failure to adhere to Trust policies in relation to the approval and sign-off of business cases, including a lack of appropriate scrutiny of decisions taken by IDDG, EMT and F&P.		
Legal/Regulatory:	-		
Resources:	-		
Previously Considered by:	Investment, Divestment & Dis-investment Group EMT Finance & Performance Committee	**Date**	07.02.17 and 21.03.17 27.02.17 and 27.03.17 29.03.17
Equality Impact Assessment:	Included in business cases as and when appropriate.		
Appendices	None.		

Investment, Divestment & Dis-investment Group
Trust Board – 6 April 2017

1.0 Introduction

The Investment, Divestment & Dis-investment Group (IDDG) meets every two weeks to review investment proposals in the trust. IDDG can approve business cases up to £250k. Any investments over that amount requiring EMT approval, up to the value of £1m. For business cases between £1m and £3m, F&P approval and ratification of the decision is required, and for sums above this, the business case needs to go to the Trust Board for final approval.

It should be noted that the process around business case approval is currently being reviewed, with the aim of a new business case development and approval process being implemented during quarter one of 2017/18. This will include processes for approval outside of normal meeting timetables.

2.0 Business Cases requiring F&P approval

Due to the speed of decision making and action required the following business case, for the demolition of Clare House, is presented to the Trust Board for retrospective ratification and approval. It should be noted that:

- That the demolition of Clare House, and the associated relocation and modular building costs, are part of a well understood programme of estate demolition and upgrade that Trust Board members are well acquainted with. The assumption in this paper therefore is that the Trust Board are fully sighted on, and have approved in principle, the Clare House demolition as part of the wider redevelopment programme.
- Though the Trust Board has been apprised of the demolition of Clare House previously, this was as part of the wider agreement around the Estates Recovery Plan. No business case has been presented to the Trust Board for specific approval relating to Clare House previously.
- The demolition of Clare House had to be expedited to ensure that the write off costs were not counted against the trusts control total, requiring the building to be put beyond use by 31 March 2017.
- The need to ensure expenditure associated with the new modular buildings elements of the Clare House demolition business case is counted against the trusts 16/17 capital programme

Business Case	Description	Value, £000's
Clare House Demolition	IDDG approved the proposals to demolish Clare House, as part of the agreed trust programme of demolition and renewal. This figures includes increased usage and costs associate with 120 The Broadway, and the purchase of the new proposed modular build for the old Chest Clinic site	7,490

The originally approved sum for the Clare House demolition and associated developments was £7.597m. This number was subsequently reduced at the IDDG meeting on the 21 March, to the £7.49m shown above.

This Business Case was discussed at EMT on 27 March and F&P on the 29 March, with a recommendation that it be forwarded to Trust Board for final approval.

3.0 Recommendation

The Trust Board is asked to formally approve demolition of Clare House and associated developments as per the information above, and the documentation attached.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board Meeting		
Date:	6 April 2017	**Agenda No**	**4.1**
Report Title:	Workforce Information Report		
Lead Director/ Manager:	Mark Gammage, HR Advisor to the Board		
Report Author:	Sion Pennant-Williams, Workforce Intelligence Manager		
Freedom of Information Act (FOIA) Status:	Unrestricted		
Presented for:	Update		
Executive Summary:	This report provides workforce information for February 2017. Staff in post has decreased whilst bank & agency usage has remained consistent. The pay spend has stabilised and agency spend is down. Sickness levels have decreased following a seasonal spike in January, and stability has increased. Non-medical appraisal compliance has increased to74% (highest level since August 2015), and MAST compliance has reached the target of 85% for the first time this year. Benchmarking Q3 data against other Teaching Trusts show that St George's performs worse against the average but current data for St George's fair better for appraisal and MAST. The number of interims has reduced from 127 to 124. Next month we will report on the whole year and also see reductions in interims usage with contracts ending, some converting to substantive positions and IT support forming part of a new service contract. Results from the family and Friends Test show improvements since Q2 (the last time the survey was conducted) on all measures although there is a considerable amount of effort and focus required to improve staff engagement to the levels we would want		
Recommendation:	The Board is asked to note the workforce performance report and actions outlined within it.		
Supports			
Trust Strategic Objective:	All Trust objectives		
CQC Theme:	Well-led		
Single Oversight Framework Theme:	Financial efficiency and operational performance		
Implications			
Risk:	Failure to achieve financial and other targets and manage within agreed control totals		
Legal/Regulatory:	Failure to meet NHSI control total		
Resources:	n/a		
Previously Considered by:	Regular Board report	**Date**	05.01.17
Equality Impact Assessment:	n/a		
Appendices:	Workforce Information slides		

Workforce Information report
Trust Board, 6 April 2017

1.0 PURPOSE

1.1 To provide workforce information for the Trust Board outlining trends and explaining changes in staffing composition to support decision-making and Board assurance.

2.0 CONTEXT

2.1 Revised KPI targets were presented to the Workforce & Education Committee for discussion and the following amendments were agreed:

Sickness – decrease from 3.5% to 3%
Vacancy – decrease from 12% to 10%
Appraisal compliance – increase from 85% to 90%
MAST compliance – increase from 85% to 90%

Trajectories are being planned at the moment with the aim to start reducing these targets at the beginning of the 17/18 financial year. These trajectories will be underpinned by action plans supporting improvements.

3.0 ANALYSIS

3.1 The staff in post in February has reduced by 28.02 FTE, and funded establishment has decreased by 22.59 FTE. Bank & Agency usage has remained consistent, however agency spend as a percentage of total pay costs has decreased from 8% to 5.39%.

3.2 Sickness levels have decreased by 0.38% following an increase in January, however they are still 0.16% higher than February 2016. Stability has increased to 84.49%.

3.3 Non-medical appraisal compliance has increased to 74.13% (as of mid-March), which is the highest it's been since August 2015. Medical compliance decreased from 81.98% to 78.33 %, but due to increased focus on appraisals this is expected to increase.

3.4 MAST compliance has increased to 85%, which means that we are meeting our target compliance and have achieved the highest level of compliance to date.

3.5 A quarterly benchmarking exercise for Teaching Trusts across the country has provided data on 24 different Trusts, including 6 Trusts based in London. When comparing St George's figures for quarter 3 against the average of all 24 Trusts, and the average of just the 6 London Trusts, it shows that we perform worse against most KPIs.

3.6 In Q2, 74% of our staff said they would recommend our Trust as a place to be treated (in the family and friends test) and 36% said they would recommend the Trust as a place to work. These scores have improved in Q4[1] to 77% and 48% respectively. The trust also asked a further 10 questions including whether staff felt encouraged to be involved in making changes that affect their work area, whether they felt safe to challenge and speak up that the Board and executives were providing clear direction and in all areas scores improved from Q2. It is however recognised that over 50% of our staff do not recommend the Trust as a place to work

[1] There was no Q3 because the staff survey took place during this period

and the Trust needs to remain focussed on leadership and management training, staff engagement and embedding systems of appraisal and MAST.

4.0 IMPLICATIONS

Risks

4.1 The risks on staff engagement feature in the Trust's risk register alongside failure of leadership. Similarly, the risks to meeting the Trust's financial control total whilst also providing safe and effective care to patients form the primary focus for the Trust.

5.0 ACTIONS

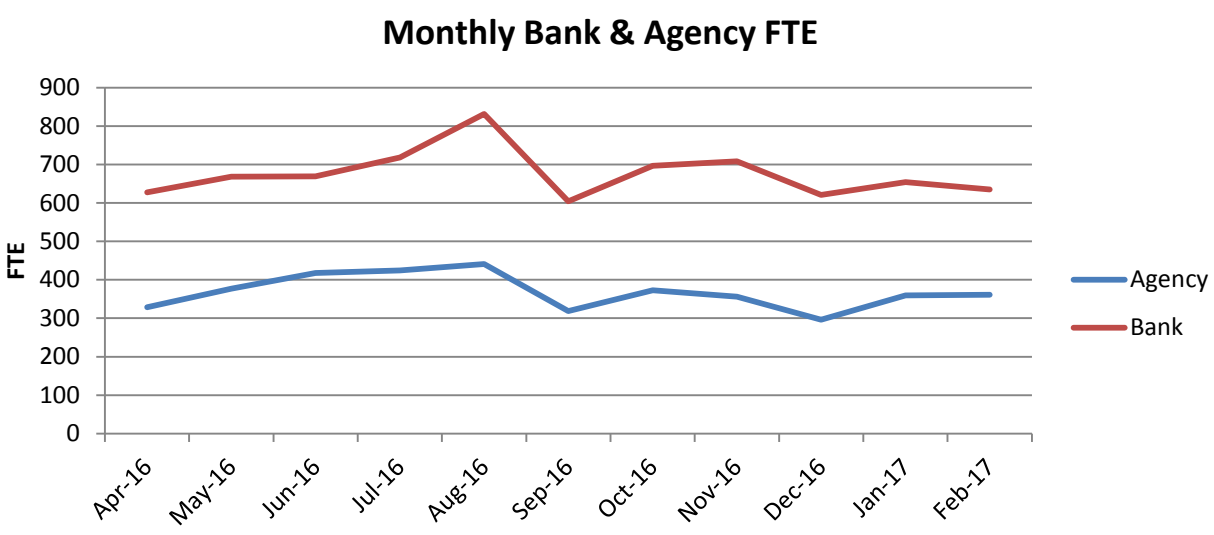
5.1 Proposed KPIs to be agreed for key metrics for 2017/18.

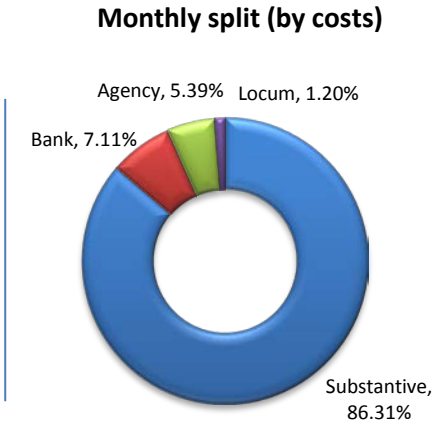
6.0 RECOMMENDATION

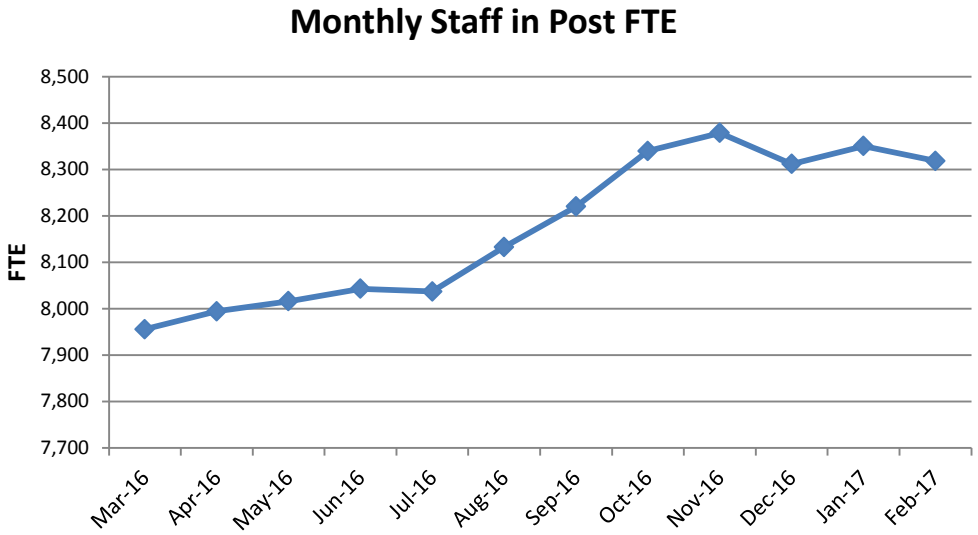
6.1 The Board is asked to note the workforce performance report and actions outlined within it.

Section 1: Current Staffing Profile and Bank & Agency

The data below displays the current staffing profile of the Trust and key bank & agency data







COMMENTARY

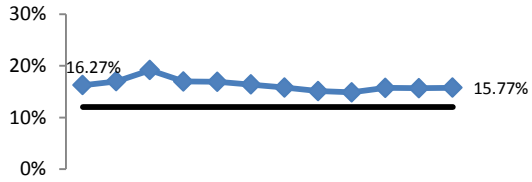
Staff in post has reduced by 28 FTE, funded establishment has also reduced by 23 FTE.

Bank & Agency usage has remained consistent since January.

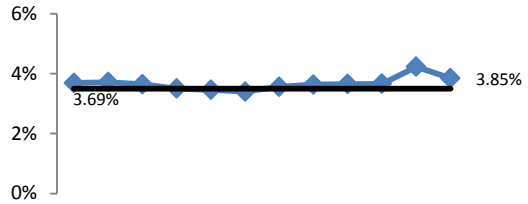
Agency spend as a percentage of the total pay bill has decreased from 8% in January to 5.39%.

Section 2: Workforce KPIs

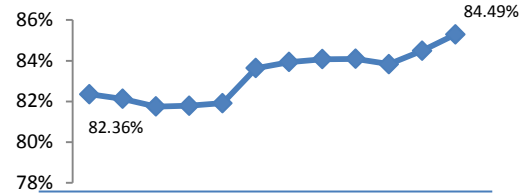
Vacancy Rate Year Trend



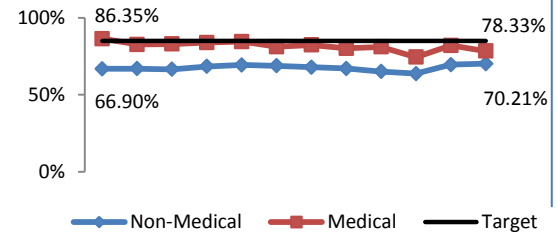
Sickness Rate Year Trend



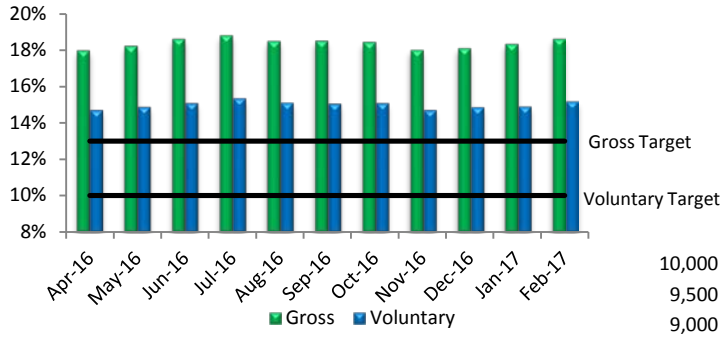
Stability Year Trend



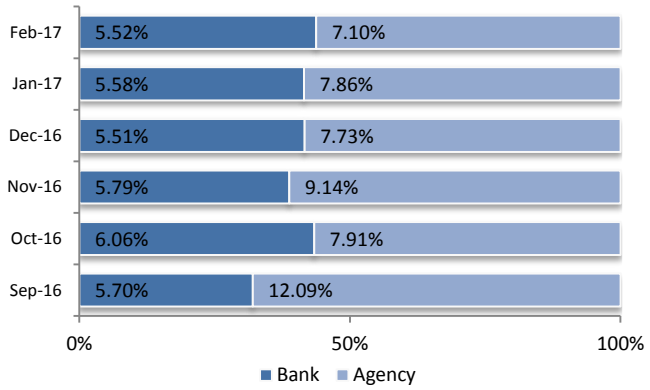
Appraisal Rate Year Trend



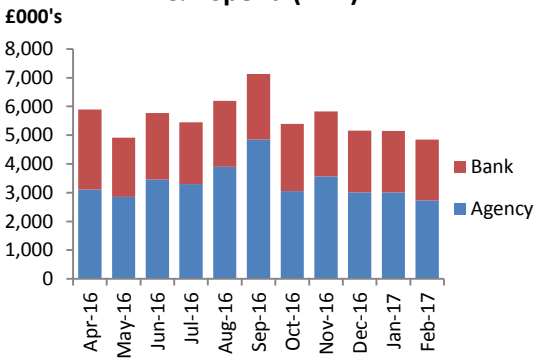
Turnover YTD



Bank/Agency Mix



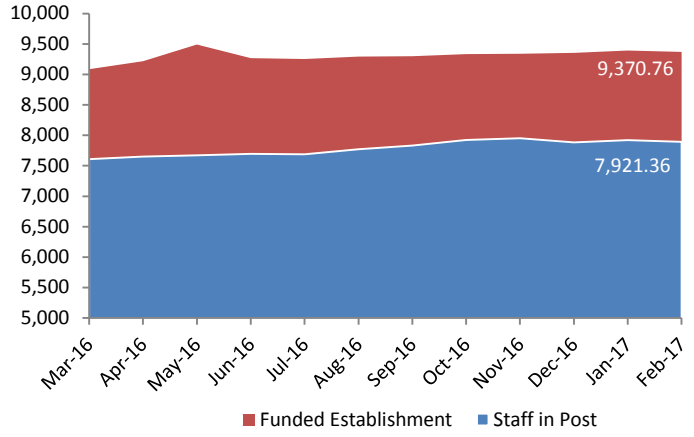
B&A Spend (YTD)



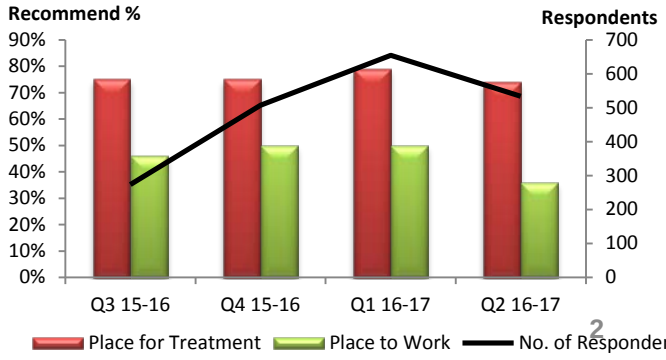
* Does not include SWLP or Central costs

KPI	Change over the year	Change since last month
Vacancy	-0.50%	0.10%
Sickness	0.16%	-0.38%
Stability	2.93%	0.80%
Gross Turnover	0.67%	0.27%
Voluntary Turnover	0.47%	0.06%

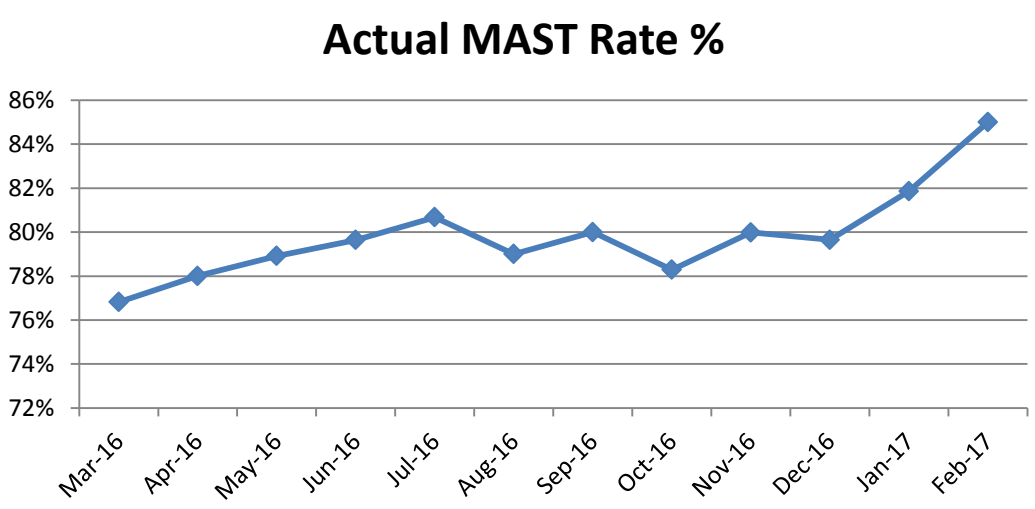
Trust Establishment & Fill Rate



Friends & Family Test



Section 3: MAST Compliance



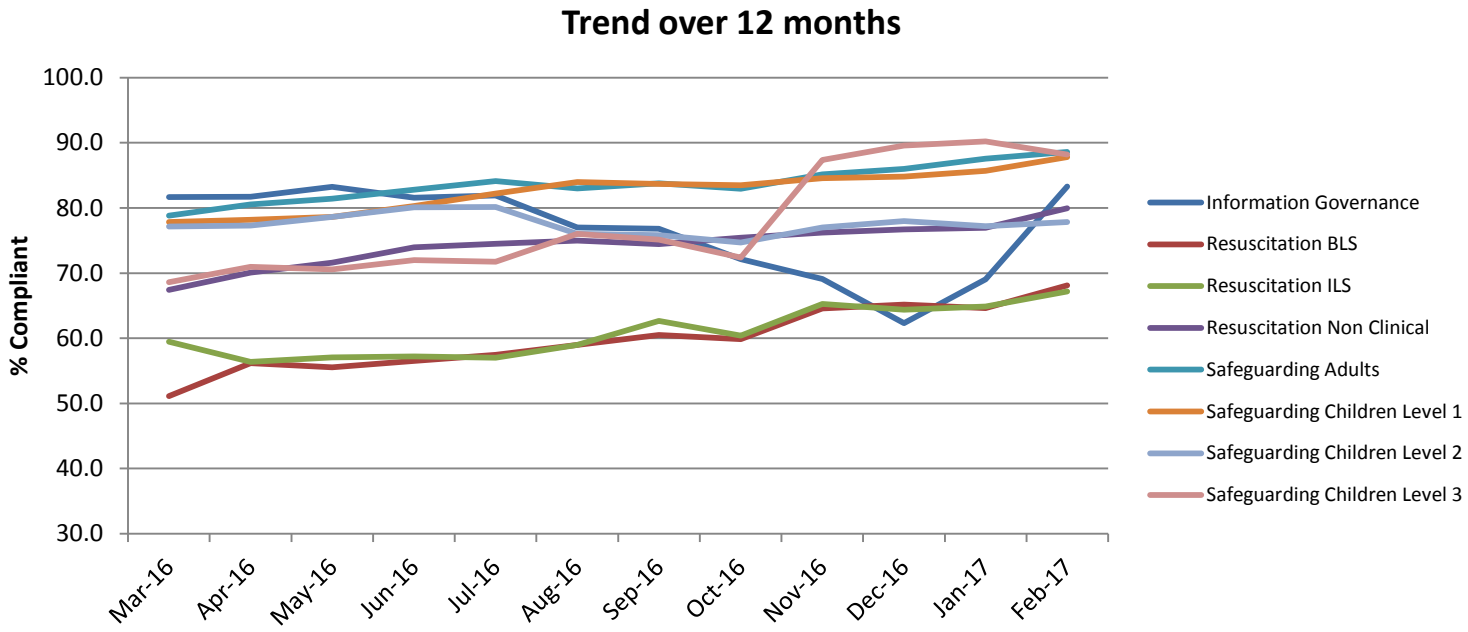
COMMENTARY

A programme of working is taking place including:

- Changing the method of delivery to on-line testing as far as possible and only training when required
- Reviewing who needs to access the training
- Reviewing the frequency of refresher periods
- Reporting compliance futures for departments so that they are proactive with compliance
- System changes so that accessibility issues are resolved.

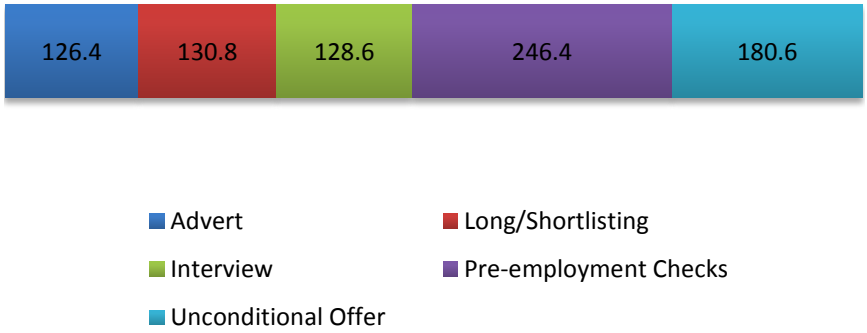
Current Issues:

- Fall in compliance rates – largely due to staffing pressures
- Staff unable to access training externally- Software and licencing and IG issue
- Process review between Recruitment/Payroll/Education Department for new starters
- Not enough capacity to provide the training for the needs identified, particularly in resuscitation and safeguarding.
- There is currently a disconnect between actual training completed and the training being reported – this is an issue which is being focussed on.



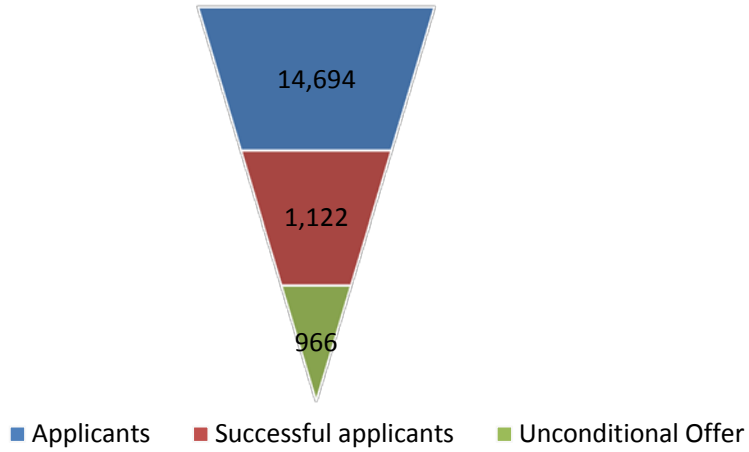
Section 4: Recruitment Pipeline

Non-Medical Current Pipeline (FTE)

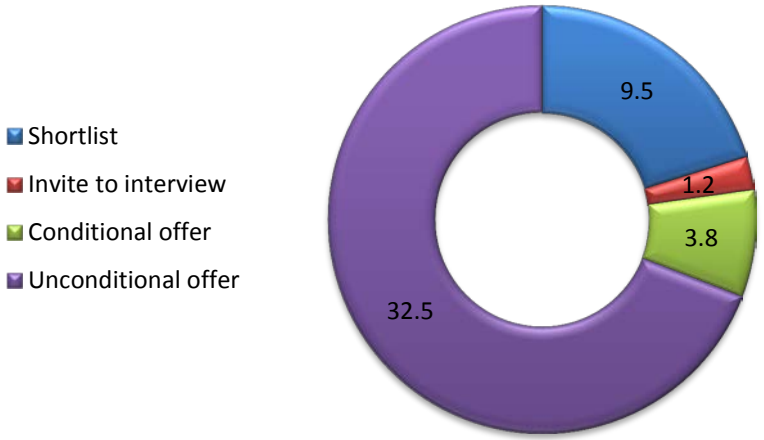


* Data is a snapshot from the end of February

Non-Medical Recruitment volumes (over 6 months)



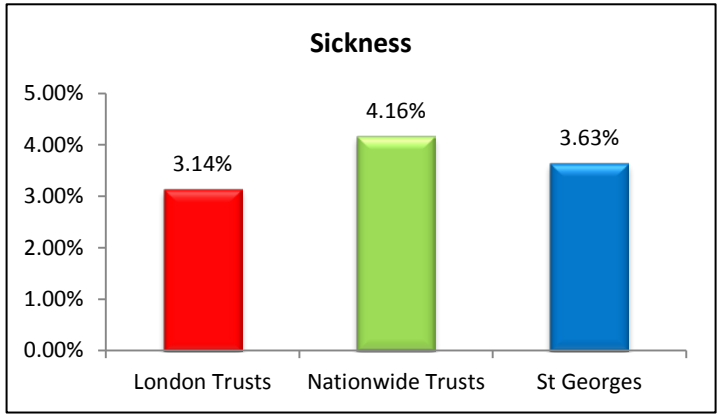
Average days taken for key stages in Non-Medical Recruitment Process (over 6 months)



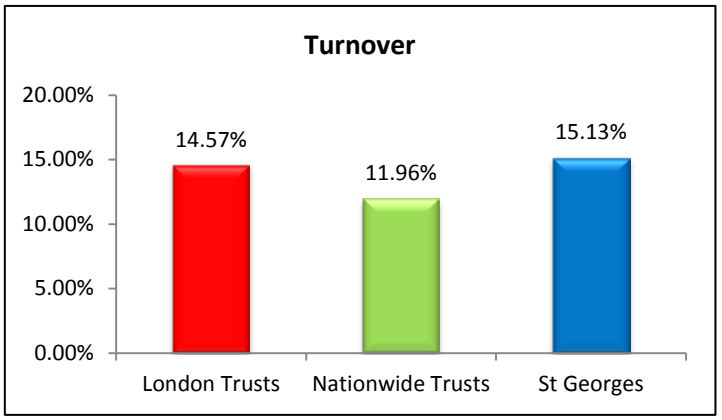
Shortlist – days that Recruiting Managers take to shortlist
Invite to interview – days between shortlisting being received from Recruiting Manager to interview invites being sent out
Conditional offer – days between interview outcome paperwork received to formal conditional offer
Unconditional offer – days between conditional offer and unconditional offer

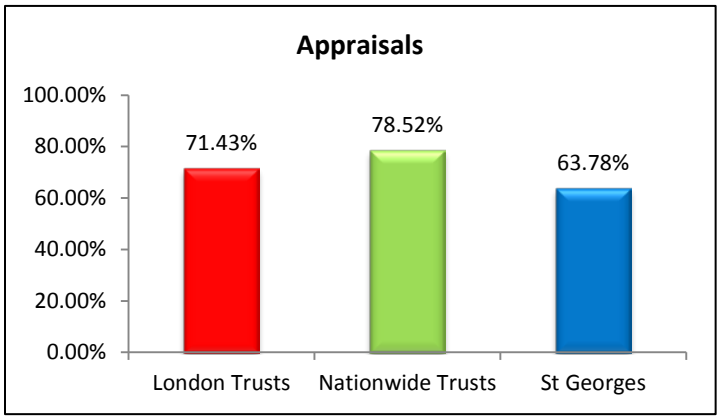
NB: Reporting from the Trac system is relatively new to the Trust and so the figures are intended as a guide only at this stage as they may not be wholly accurate. These reports are highlighting gaps in housekeeping within the Trac system which potentially affect these reports and so Medical recruitment is being removed for the time being

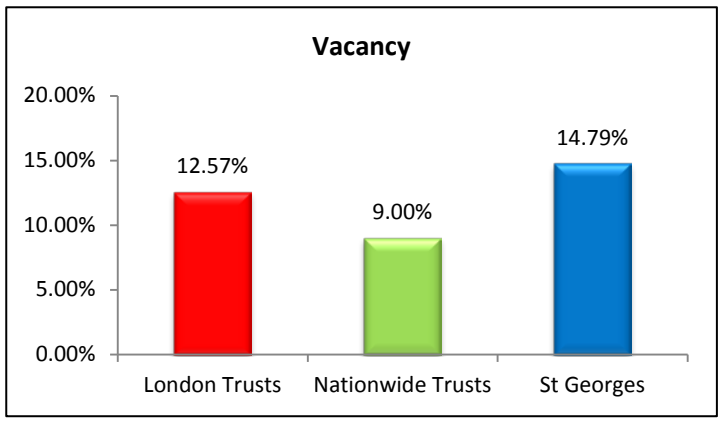
Section 5: Benchmarking from Quarter 3 data

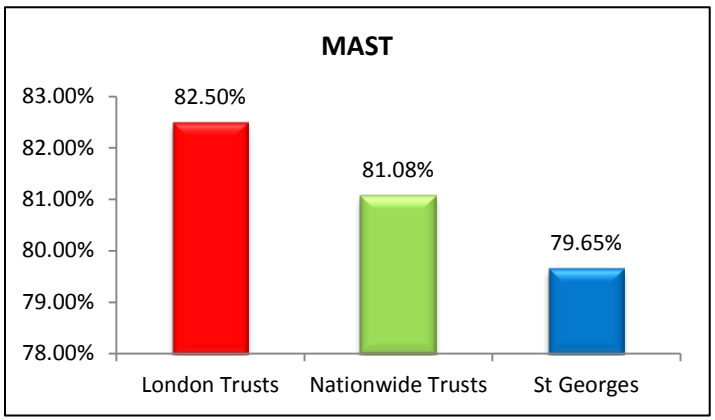


Figures taken from 24 Teaching Trusts nationwide, including 6 Trust in London, for quarter 3. St Georges data is shown next to the mean figures for all Trusts, and just London Trusts. This shows that St Georges perform worse at all levels against the London average, and at all levels except for sickness when looking at the nationwide average.









Section 6: Month 11 Interim Analysis

Function	Number	Notes	
CEO Office	5		Application of interims: • 35 BAU • 89 major programmes
Operations	10	Includes RTT	
IT	59	Includes stabilisation	
Estates	7	Includes backlog & CQC	
Finance	8	Increase to support coding vacancies	
HR	2		
Governance	3	Includes CQC	
Procurement	-		*Turnaround: • 5 PMO • 7 Outpatients • 2 Revenue/coding • 2 PP, Overseas • 6 major programmes
Turnaround*	22		
Sub-total	**116**		
SWLP	8		
Total	**124**		

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	06.04.2017	**Agenda No**	**5.1**
Report Title:	Corporate Risk Report		
Lead Director/ Manager:	Paul Linehan, Head of Governance		
Report Author:	Maria Prete, Risk Manager		
Freedom of Information Act (FOIA) Status:	Unrestricted Restricted		
Presented for:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify)		
Executive Summary:	1) Core operational risk exposure areas: • Timely Access to Clinical Services/Patient Harm • Insufficient Resilience/Unstable Critical IT/Estates Infrastructure • Unsustainable Financial Position • Inadequate Governance/Reputation Loss 2) Proposal for new format of report The Head of Governance and the Trust Secretary are currently in discussion on how to best present the information related to the Corporate Risk Register and the Board Assurance Framework. Proposal report will be presented and discussed at the April Risk Management Committee.		
Recommendation:	The Board are invited to consider the CRR and: • Work through each decision point highlighted in this report • Where the Board are not satisfied, to agree further actions required to bring the risks under prudent controls; and • Consider the extent to which the Board's appetite for taking risks is adopted or if changes are needed to achieve prudent control.		
Supports			
Trust Strategic Objective:	Ensure the Trust has an unwavering focus on all measures of quality and safety, and patient experience.		
CQC Theme:	Safe / Well-led.		
Single Oversight Framework Theme:	Quality of Care (safe, effective, caring, responsive). Leadership and Improvement Capability (well-led).		
Implications			
Risk:	These risks could have a direct bearing on requirements within NHSI's Single Oversight Framework, ongoing CQC Registration or the achievement of Trust policies, aims and objectives should the mitigation plans be ineffective.		
Legal/Regulatory:	Compliance with Heath and Social Care Act (2008), Care Quality Commission (Registration Regulations) 2014, the NHS Act 2006, NHSI Single Oversight Framework, Foundation Trust Licence		
Resources:	There are no specific resource implications		
Previously	Risk Management Committee	**Date**	08.03.2017

Considered by:			
Equality Impact Assessment:	N/A		
Appendices:	A. Risk Grading Matrix / Risk Escalation Arrangements (illustrated) B. Table 1: Core Operational Risk Drivers – March 2017 C. Figure 1: Emergent Risk Horizon Scan – March 2017 D. Figure 2: Interpreting the Risk Horizon **Appendix 1** - Full Corporate Risk Register		

Corporate Risk Report
Trust Board, 6 April 2017

1.0 PURPOSE

1.1 To highlight key risks and provide assurance regarding their management.

2.0 BACKGROUND OR CONTEXT

2.1 The Corporate Risk Register (CRR) has been kept under review with input from the Executive during March 2017

2.2 The CRR continues to be developed and reassessed accordingly. It is anticipated that review will be continuous in order to ensure the profile of risk presented to the Committee is relevant and always up to date.

2.3 Training continues to be rolled out to support and assist risk register gatekeepers at divisional and corporate levels. This will allow efficient analysis, better oversight and enhanced risk escalation arrangements.

2.4 It is anticipated that the CRR will evolve as further analysis, challenge and development of the risk profile progresses; and our understanding of uncertainty facing the Board's strategy emerges.

3.0 ISSUE

3.1 Core Operational Risk

The understanding of corporate risk is evolving rapidly as the Executive identify and address uncertainty ahead. A range of significant/extreme operational risks have been identified and are currently being mitigated. These risks could have a direct bearing on requirements within NHSI's Single Oversight Framework, ongoing CQC Registration or the achievement of Trust policies, aims and objectives should the mitigation plans be ineffective. Table 1 illustrates using a driver diagram the primary cause, effect and potential impact of core operational risks currently on the CRR. The Board remains exposed to extreme risk in the following areas:

- Timely Access to Clinical Services/Patient Harm
- Insufficient Resilience/Unstable Critical IT/Estates Infrastructure
- Unsustainable Financial Position
- Inadequate Governance/Reputation Loss

3.2 Core Strategic Risk

The Board's strategic risks have been assessed and incorporated into the Board Assurance Framework (BAF). The strategic risk vectors currently identified within the BAF are as follows (in no particular order):

- **Corporate strategy not aligned to commissioning intentions or anticipated regulatory changes** (i.e. the Trust, CCGs or regulators are moving in different directions - one of the causes might be that commissioning intentions are not known to the Trust, or a lack of clarity regarding corporate strategy, other potential causes might include conflict, competition or poor stakeholder relations)
- **Exposure to local and specialist commissioner affordability** (this is currently subject to further review)
- **Loss of influence within and across the local health economy** (one of the potential causes might be inadequate stakeholder relationships)

- **Addressing demand for care** (on the assumption that demand for services will continue to grow and supply-side resources continue to be stretched)
- **Future supply, recruitment and retention of the workforce** (thereby affecting staffing levels, quality, safety and operational compliance)
- **Failure to retain critical community contracts** (one of the causes might be poor quality/performance/outcomes, or inadequate stakeholder relationships)
- **Expanding deficit and non-delivery of the financial plan** (to incorporate the combined effects of income volatility, liquidity and CIP delivery)
- **Poor or insufficient quality governance** (i.e. poor standards of care, unintended consequences of CIP, poor risk management, non-compliance with CQC)
- **Insufficient performance against contracts and KPIs** (to incorporate applicable KPIs in the NHS Outcomes Framework)
- **Poor service user experience** (inadequate user satisfaction with services for example, this has subsequently been incorporated with the quality governance vector)
- **Failure to deliver the estate improvement or backlog maintenance**
- **Prolonged and unrecoverable critical IT system down time**.

The BAF remains subject to review by the Board's committees. The company Secretary leads on the BAF

3.3 Proceedings of the Risk Management Committee

The Risk Management Committee met on the 8th March 2017 to review the corporate risk register and to review in more detail reportable risk in: (i) Community Services Division, (ii) Finance and (iii) ICT

- Proposal for closure of 'CRR-0006 - Power failure – electrical fault in Knightsbridge Wing risk as the area has now been closed.

- Progress on CSD 796 - Potential loss of income due to bidding for newly tendered services being unsuccessful risk:
  - The Trust has taken the decision not to bid for Sexual Health Services due to value of activity substantially devalued.
  - Community Adult Health Services Wandsworth bid in progress
  - Health Visitor tender – bid delayed

- IT disaster recovery plan desk top exercise was undertaken in February. The findings were as follow: the current disaster recovery plan is not fit for purpose; proposal for changing the scope of the disaster recovery project to focus on IT business continuity; back-up of some of the data already in place; currently reviewing other possibility in order to give the trust full contingency.

4.0 IMPLICATIONS

Legal Regulatory

4.1 Compliance with Heath and Social Care Act (2008), Care Quality Commission (Registration Regulations) 2014, the NHS Act 2006, NHSI Single Oversight Framework, Foundation Trust Licence

Resources

4.2 There are no specific resource implications, except where indicated on a specific risk basis and are subject to decision elsewhere.

5.0 DECISION POINTS

The Board to consider:

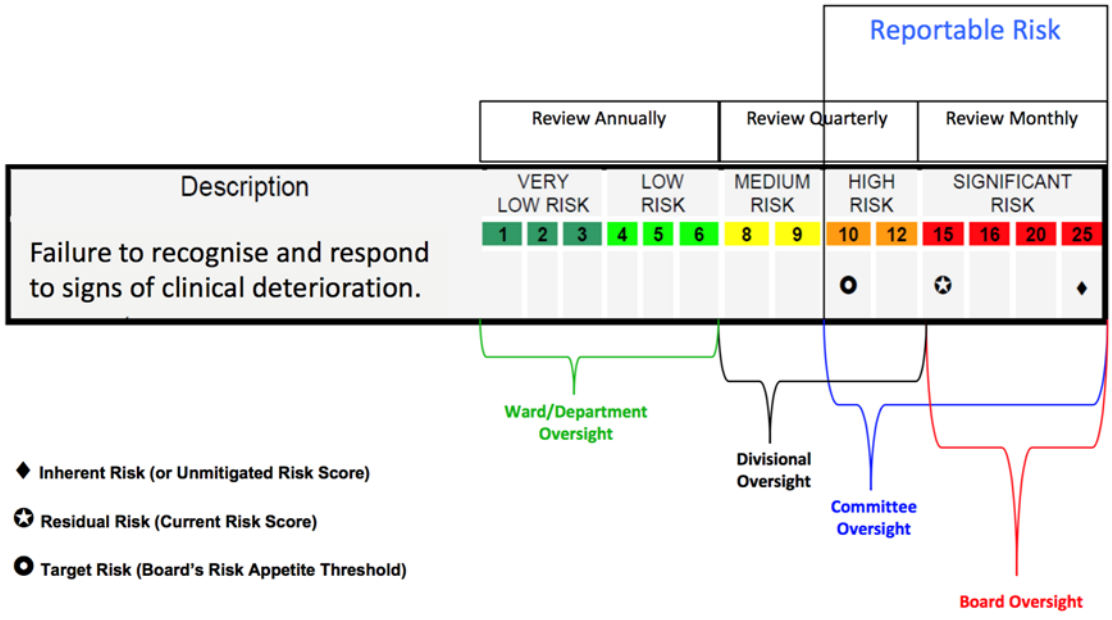
(i) Is the Board satisfied that it has sufficient visibility of material risk exposures?
(ii) Is the Board satisfied that the control frameworks for mitigating those material risks are sufficiently understood and complied with by management?

APPENDIX [A]

[Guidance: Risk Grading Matrix]

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

[Guidance: Risk Escalation Arrangement (illustrated)]



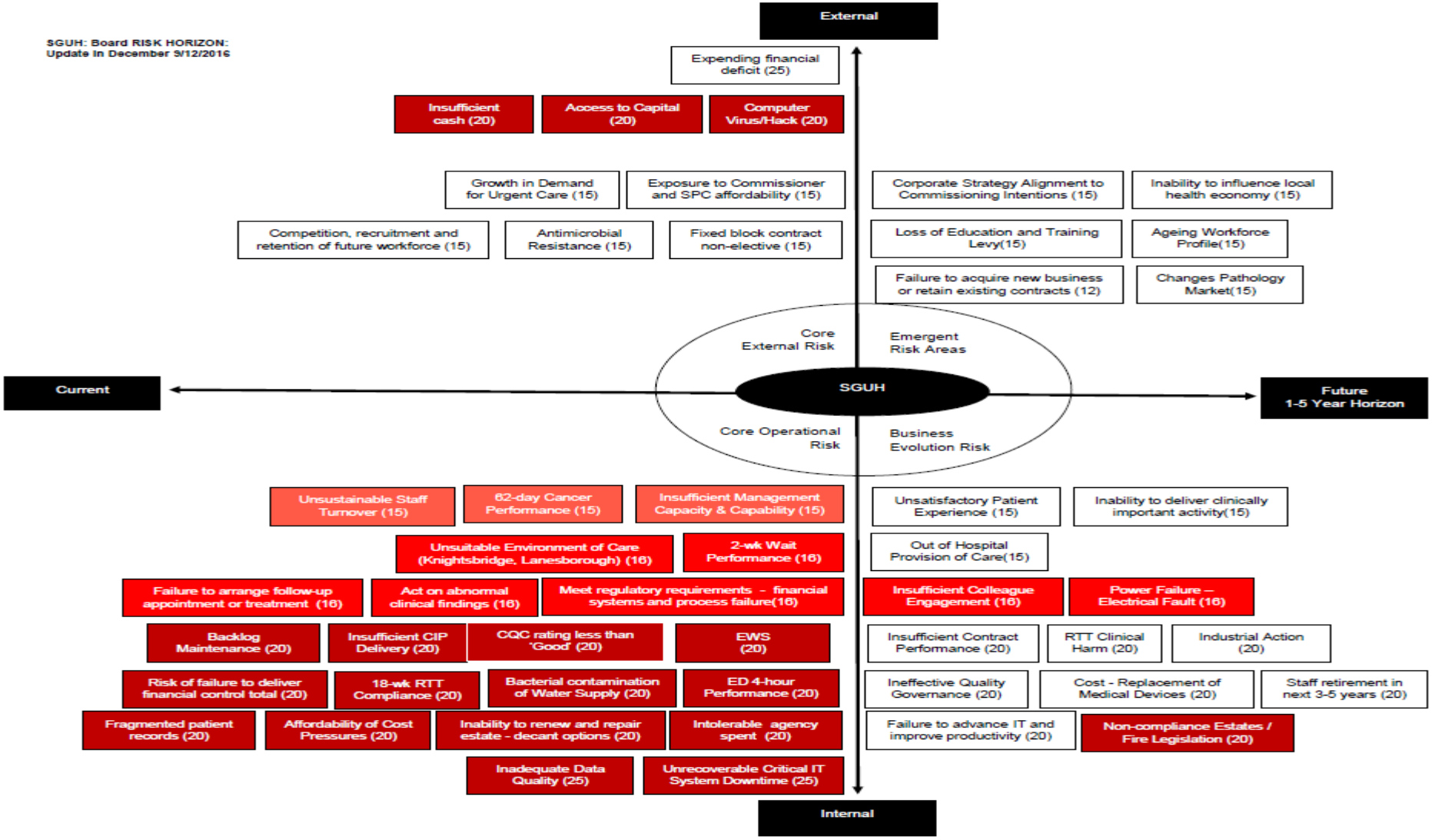
APPENDIX [B]

[Table 1: Core Operational Risk Drivers – March - 2017]

PRIMARY CAUSE	RATING	IN MONTH CHANGES	EFFECT	POTENTIAL IMPACT 16/17
Increasing 18-Week RTT backlog with potential for clinical harm	20	⇔	Timely Access to Clinical Services / Patient Harm	Continuity of Clinical Services Material Breach of Licence Conditions Integrity of CQC Certificate of Registration
Below target 2-week wait performance	16	⇔		
Below target 62-day cancer performance	15	⇔		
Failure to arrange follow-up appointments or treatments (where clinically required)	16	⇔		
Below target ED 4-hour performance	20	⇔		
Recognising, escalating and responding to the sign of deteriorating patient	20	⇔		
Unsuitable environment of care (Renal Unit, Lanesborough OPD) – risk of premises closure, prosecution, fire	16	⇔	Insufficient Resilience / Unstable critical IT and Estates Infrastructure	
Potential unplanned closure of premises / non-compliance with estates or Fire legislation	20	⇔		
Bacterial contamination of water supply (Legionella, Pseudomonas)	20	⇔		
Inability to address backlog maintenance requirements	20	⇔		
IT storage: unrecoverable IT system downtime (affecting critical clinical, web and email systems)	25	⇔		
Vulnerability to computer virus or attack	20	⇔		
Inability to renew and repair clinical areas due to high bed occupancy and no decant options	20	⇔		
Power failure – electrical fault	16	Close		
Insufficient CIP delivery in 2016/17	20	⇔	Unsustainable Financial Position in 2016/17 and beyond	
Insufficient cash to meet payment demand	20	⇔		
Lack of access to capital to address in-year IT, Estates and equipment replacement cost pressures	20	⇔		
Potential loss of income due to bidding for newly tendered services being unsuccessful	15	⇔		
Inability to control agency staffing and associated staffing costs	20	⇔		
Risk of failure to deliver the financial control total	20	⇔		
Inability to meet regulatory requirements due to financial system and process failure	16	⇔		
Failure to come out of special measures by the next CQC inspection	20	⇔	Inadequate Governance / Reputation Loss	
Failure to recognise, communicate and act on abnormal clinical findings	16	⇔		
Fragmented electronic and manual patient records	20	⇔		
Unsustainable levels of staff turnover	15	⇔		
Insufficient management capacity or capability to deliver turnaround programme	20	⇔		
Failure to secure colleague engagement	20	⇔		
Inadequate data quality, completeness or consistency	25	⇔		
↑ = Risk Increase; ↓ Risk reduced; ⇔ No change from previous report to Board.				

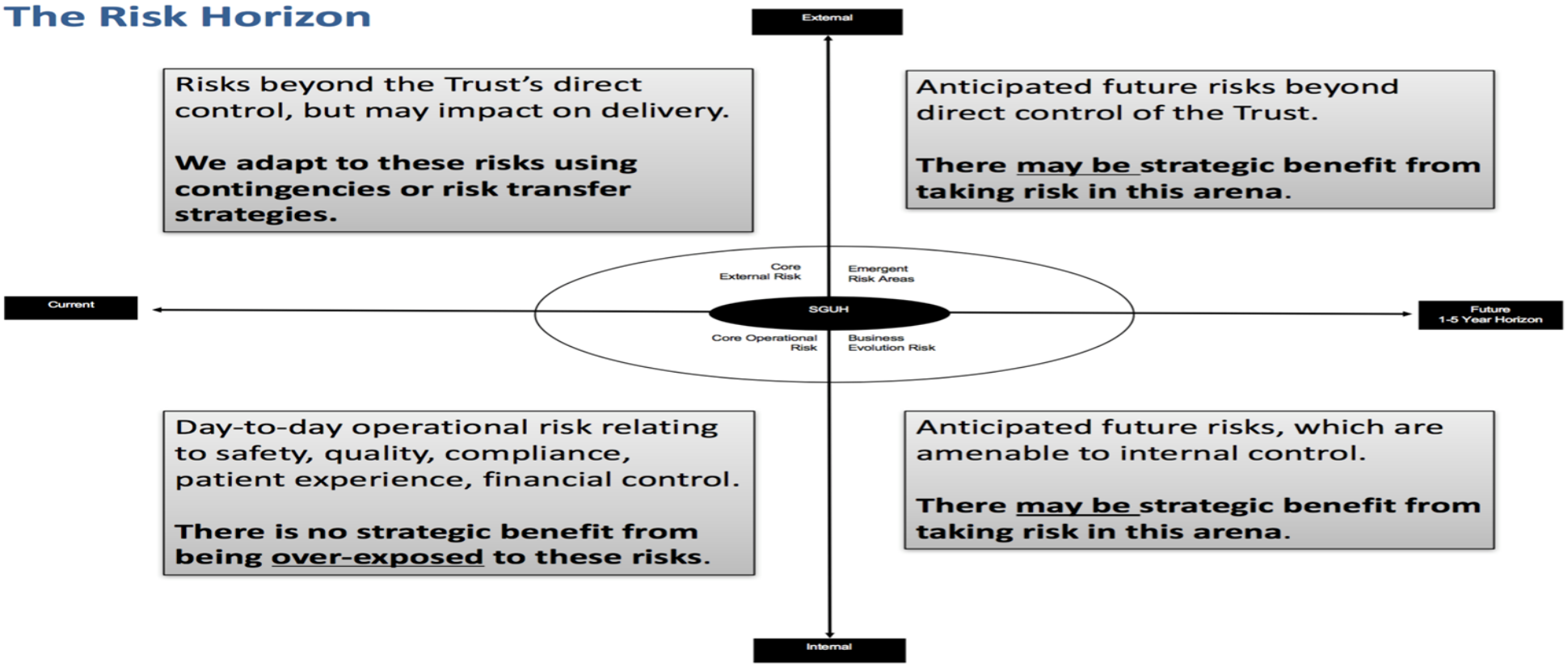
APPENDIX [C]

[Figure 1: Emergent Risk Horizon Scan – March- 2017]



APPENDIX [D]

[Figure 2: Guidance - Interpreting the Risk Horizon]



Corporate Risk Register 01.03.2017

RMC(17)MAR.26

Ref	Title	Opened	Manager	Description	Initial Risk Scoring	C	L	Current Risk Scoring	Current Risk Level	Controls	Gaps in controls	Assurance	Gaps in assurance	Actions Synopsis	Actions Due date	Actions Done date	Last updated
CRR-0008	Inability to address backlog maintenance requirements	25/07/2016	Hancock*, Richard	There is a risk to the quality and safety of patient care in the event the Estates and Facilities team are unable to complete required estates works in a timely way due to the impact of capital investment within run-rate schemes. Reduction of the scale of the Trust's capital programme means that not all of the Trust's high priority projects can be funded at the time they are needed. In order to achieve identified savings targets, the Estates and Facilities Department has to reduce labour and materials expenditure on its planned and reactive maintenance service.	20	4. Major	5. Almost Certain	20	Extreme	Risk assessments are undertaken for each project. Monitored through the Capital Programme Monitoring Group (CPMG) & Project Programme Boards and the Investment, Divestment and Disinvestment Group (IDDG). Engagement with the department early in the capital scheme and jointly agree how this can be managed Health and Safety management function closely involved in maintenance service Works procurement and prioritisation process implemented in September 2015 A PMO has been put in place as of September '16 to track activity in line with plans on teh project schedule and report any deviations from plans PPM workload controlled through organised work allocation from the Estates system. This is designed to cover all planned preventative maintenance. PPM jobs carried out monthly are reported via Estates Ass. Director.	A new PMO has been created but there will be a lead time for the identification of gaps, creation of required governance process & tools and implementation. This work continues as focus moves from outside capital projects to incorporate the whole division. Not all PPMs jobs are held within the Estates system presently Six Facet Survey draft report being produced at the end of February 2017 will provide an up to date detailed view of backlog maintenance that is required.	Monitoring of project and maintenance activity through project/programme boards and Divisional Governance Boards. New Divisional project board will ensure visibility of all works. IDDG has representation from all Divisions and quality and safety of patient care is the highest prioritisation for all capital projects.	Require the latest six facet survey report to determine which jobs need to be completed and their priority. Additional schemes/projects were not foreseen, such as demolitions. As buildings are demolished this will allow reallocation of resource to other work required.	The action remains to gain line of sight to this funding in the Trust budget and to have a plan which lays out how and when the initiatives will be delivered. A six-facet survey is being procured that will provide the Tooting campus with a thorough condition report, this will form the basis for prioritised repairs Require further reporting from Finance on year end cost recovery goals to enable better departmental planning and action. There is an interim Estates Strategy being currently compiled this requires input from the Clinical strategy to inform the direction of services for Estates to support. Upon completion of the Six Facet Survey, a prioritised list of repairs will be produced. Asset and PPM programme being developed for all estates assets. Staffing levels have increased to undertake additional works for CQC and other urgent works. Materials and services procurement issues with appropriate response times. Planet FM system (the estates helpdesk and job request system) is being upgraded to allow prioritisation and work backlog to be monitored. A draft report will be provided as a result of the six facet survey, this will be provided at the end of January at which point Estates and Facilities will evaluate the outputs and use it to schedule and prioritise works.	31/01/2017 14/11/2016 30/11/2016 24/10/2016 31/03/2017 28/02/2017 28/02/2017	 17/11/2016 05/12/2016 24/10/2016 	Vanessa Davies 13/02/2017 09:15:09
CRR-0007	Potential unplanned closure of premises / non-compliance with estates or Fire legislation			Risk of premises closure, prosecution and fines as a result of non-compliance with fire regulations in accordance with the Regulatory Reform (Fire Safety) Order 2005 (RRO). Ability of the Trust to demonstrate its compliance in accordance with the Regulatory Reform (Fire Safety) Order 2005 (RRO)						The Director of Estates and Facilities commissioned a fire assessment, initially of the LW during April 2016. This provided a prioritised repair list. These repairs are monitored through the Health, Safety & Fire Committee. Regular meetings/communication with Fire Brigade to check progress. Specialist fire safety resource in place to lead on the actions. Planned and reactive monitoring of fire safety. Fire risks assessments (FRAs) prepared	Comprehensive surveys and assessments of compartmentation.	Estates Fire Managers regularly review the list of trained Responsible Person & Senior Nurses to ensure that their training is up to date. The responsibility for rostering a fire trained ward RP rests with the nursing leadership. External -London Fire Brigade are pleased with the Trusts current progress and the LFB have signed a memorandum of partnership with the Trust. A letter from LFB can be provided highlighting the current	Further effort is required to ensure that all staff are appropriately trained to increase rate of compliance, specifically general staff and Fire Marshalls.	Implement action plan in period. (Fire risk assessments, training, infrastructure, governance). Monitor progress through Health, Safety & Fire Committee and via Risk Management Committee. A more practical, ward based training event will be delivered for future courses Further discussion on possible action to be taken to encourage attendance to Fire safety courses.	30/12/2016 31/03/2017 	26/01/2017 	Maria Prete* 09/02/2017 16:13:11

Ref	Title	Opened	Manager	Description	Initial Risk Scoring	C	L	Current Risk Scoring	Current Risk Level	Controls	Gaps in controls	Assurance	Gaps in assurance	Actions Synopsis	Actions Due date	Actions Done date	Last updated
										by Fire Safety Specialists (the last one via International Fire Consultants – IFC – in April 2016) and issued to the Director, Estates & Facilities, Head of Estates and Compliance Managers		assessment of the Trust for Fire Safety.			30/12/2016	26/01/2017	
										Two permanent Fire Officers are in post, reporting to Head of Estates Compliance	All remaining main blocks have been assessed for Fire Safety and there is a plan for the whole site to have an upgraded L1 alarm by 31/03/17.	A review of Fire Safety Management at St Georges Hospital by the Fire Protection Association has been undertaken. The "Review of Fire Safety Management" has been received and highlights the good work undertaken by the Fire Safety Team together with further recommendations which are included in the Estates Action Plan.		L1 fire alarm will be installed, replacing the L2 alarm for the remaining Tooting estate.	31/07/2017		
										Established "Responsible Fire Persons" email circulation list to send personal emails to ward/area managers							
										We have installed a new L1 Fire Alarm throughout LW.FRAs of LW undertaken in April 2016.				The Fire Compartmentation works are ready to go out to tender via procurement with a project completion date of March 2017. The tender process will have a duration of 4 weeks.	31/03/2017		
										Internal - Reporting on fire risk assessments to Health, Safety and Fire Committee and escalate any issues to the Risk Management Committee.		Required number of fire wardens trained (991) has been met.					
										Key performance indicators are reported to Health safety and Fire committee, RMC and QRC.				The replacement of Fire Doors throughout SGH is out to tender with a return date of 08-Nov. After awarding the contract, the works duration is estimated to be 3 months.	31/03/2017		
										The mechanism is in place to maintain the conversations and this is tracked at the Risk Management Committee.							
CRR-0018	Unsuitable environment of care (Renal Unit, Lanesborough OPD) - risk of premises closure, prosecution, fire	31/10/2012	Hancock*, Richard	Risk of premises closure, prosecution and fines as a result of failure to demonstrate full compliance with E&F guidance and legislation (HSE & HTM) Until the Premises Assurance Model (PAM) compliance is completed, there are gaps in the mandatory and statutory estates compliance documentation.	16	4. Major	4. Likely	16	Extreme	Revised estates management structure is in place this includes compliance managers. The plan is to add a dedicated compliance manager within the Facilities team	All recommendations from the estates action plan are not complete	Authorising Engineers appointed in all HTM areas	Full compliance reports not yet available. Only an external audit/cold-eye review would provide the total exposure risk. A super-set of compliance could then be developed and maintained via the Health, Safety and fire Committee.	An external audit would define the gaps and prioritise the fixes. To ensure that regular updates are provided to the committees monitoring this risk. Staff training undertaken IRO asbestos, Legionella, H&S Infection Control, Contractor Management (including Risk Assessments & Method Statements). Planned Maintenance activities being developed for assets. Premises Assurance Model being undertaken for Trust.	28/02/2017		Vanessa Davies 13/02/2017 09:40:26
										Management structure which includes delegated responsibility	Until PAM is mature, the Trust will continue to have gaps in the evidence that we have met and are current with compliance standards	April 2016 - External H&S audit undertaken which indicates a 75% compliance (Empathy EC)					
										An assessment into all the varied control and logging systems across all Trust suppliers and locations. Planet FM system (the estates helpdesk and job request system) is being upgraded to allow compliance to be monitored	There are up to eight different call centres, depending on what building and service a customer requires. This is planned to be rationalised	Internal - Estates compliance records being assembled, ahead of external audit. NHS Estates Profession are supportive of this approach	A Six-Facet Survey is being commissioned to provide a site-wide condition report of the Tooting estate. This will output a prioritised set of actions and complinace of each will need to be identified.				
										An audit on the gaps in compliance has been completed.	A plan to rationalise as many functions into one Staff Help Centre is being worked on. Aim for delivery during 3rd quarter 2016	Action plans will need to be collated into a cohesive programme and regular reports will need to be submitted to the EMT and reformed QRC.					
										The Trust will move to the Estates Profession agreed standard of Premises Assurance Model (PAM) to provide the compliance governance going forward. This has started and all compliance points have been	Further compliance points and actions for the PAM are being collated from interviews for external review. Initial interviews with Estates and Facilities staff for PAM are continuing, there are additional interviews in the coming	Internal audit review findings: whilst	External - H&S Executive – issue with electrical outlets on Richmond ward has resulted in a notice of contravention of the health and safety act (actions underway, activity funded and being installed)				

Ref	Title	Opened	Manager	Description	Initial Risk Scoring	C	L	Current Risk Scoring	Current Risk Level	Controls	Gaps in controls	Assurance	Gaps in assurance	Actions Synopsis	Actions Due date	Actions Done date	Last updated
										identified, collected and evidenced.	weeks.	some progress has been made with the remaining agreed actions, overall progress has been slower than desired in key areas.					
										The Estates action plan will be further revised as higher risk items are closed	A Six-Facet survey is being commissioned by week commencing 03/10/16, to provide a site wide condition report of the Tooting estate. This will take approx. 6 weeks. The output will be a prioritised set of actions and compliance of each will need to be identified.						
CRR-0017	Inability to renew and repair clinical areas due to high bed occupancy and no decant options	30/05/2014	Hancock*, Richard	Lack of decant space for capital schemes delays the ability to deliver some large capital schemes.	16	3. Moderate	5. Almost Certain	15	Extreme	Detailed decant plans will sit under the Trust's Estate Director working with the Turnaround Director.	No aggregated view of impacts of several decisions not to proceed or to delay works	Documented risk assessments received by Project boards and reviewed when business cases approved	Financial position may mean potential inability to finance mitigating actions	A review of space and potential decant options have taken place and a proposal will be discussed at the EMT. The Space committee needs to continue to develop the space strategy and assess space issues and location of decant space. The Space Policy will look to implement a Space Utilisation Group.	31/03/2017		Vanessa Davies 13/02/2017 09:38:39
										Risk assessments undertaken for each project.							
										Space surveys are undertaken on an annual basis to provide room usage data to enable the project manager to work out a plan.							
										Monitored through CPMG, programme monitoring Boards and IDDG.	Short term planning brings forward new priorities that unbalance existing plans.	Capital project delivery is reviewed through CPMG, Project Programme Boards and IDDG.		Review of space and potential decant areas well developed and being discussed at EMT. Tasks being undertaken by Estates and Facilities	31/08/2016	22/09/2016	
										Mitigating Action - The Trust received temporary Planning permission (temp up to 5 years) for the new Wandle annex – 4 storeys c 5000m2.				New modular building being acquired to provide space for decant of Clare House	31/03/2017		
										Potential for space realisation as a result of Fixed Close Transfer work.							
										Identified rental office space offsite for non-clinical staff relocation to free up space for priority requirements	Infrastructure issues for Knightsbridge Wing has resulted in the need to identify alternative space or decant space as a matter of urgency	Impact of turnaround 'collision of priorities' now mitigated by combined planning between Estates and Turnaround leads.		To address clinical decant from Clare house, moving Education from Education Centre to enable clinical staff from Clare House to move into Education Centre. The Education Centre will require conversion into clinical space before decant.	31/03/2017		
										Space Utilisation Group now in place to develop a Trust space policy and assess the space issues across the Trust							
										Project team in place to carry out Demolition programme for Knightsbridge Wing and Clare House running up to the 31.03.17							
CRR-0016	Bacterial contamination of water supply (Legionella, Pseudomonas)			There is a risk to patient safety from water-borne infection. This risk has been increased as a result of legionella being found in isolated areas in the St George's Hospital site. There are different water-borne infections in different buildings; Legionella and Pseudomonas.						Water testing regime in place as part of the planned preventative maintenance programme.	Unable to fit filters to every single tap, as non-compliant model of sinks or taps in some cases. Not all mitigating actions can be applied, as PALL filters do not fit some of the sinks.	Water testing and cross party committee DIPC/IC Committee have recognised improvements across last 18 months	The general condition of the hand wash stations within endoscopy increases the possibility of failed samples due to non HTM compliant clinical sinks installed, sensor taps installed that are proven to reduce water flow, along with providing multiple surface areas for proliferation and also fitted with flexible hoses.	Monitor the testing regime and results.	14/11/2016	17/11/2016	Maria Prete* 09/02/2017 16:12:33
										If high counts of legionella are found it is chemically treated in accordance with trust water management policy				Water report presented to EMT (26/09/16), presenting actions underway and further recommended actions.	28/10/2016	17/11/2016	
										Water testing being carried out in accordance with HTM04, L8 and HSG274		Water safety committee report goes to Infection Control committee and Health, Safety and Fire Committee		All outlets in Endoscopy sampled 15/09/2016 for legionella (10 day incubation). Results from samples taken 15/09/2016 will determine which sinks will be required to be isolated if PALL filters cannot be			
										Testing regime and results kept in			Authorising Engineer (Water Systems) appointment process incomplete and thus legally unable to start position at Trust.				

Ref	Title	Opened	Manager	Description	Initial Risk Scoring	C	L	Current Risk Scoring	Current Risk Level	Controls	Gaps in controls	Assurance	Gaps in assurance	Actions Synopsis	Actions Due date	Actions Done date	Last updated
		14/05/2014	Hancock*, Richard		16	5. Catastrophic	3. Possible	15	Extreme	electronic evidence log book.(Zetasafe)				installed and replaced with mobile wash station to minimise the risks. Estates currently have four emergency hand wash stations available and will look to hire additional units as required following results of tests taken on 15/09/2016.	13/02/2017		
										Water responsible persons trained and certified				Replacement of IPS Panels, Sinks, Taps and removal of dead legs, worked tendered with 6 weeks lead in time from order.	17/02/2017		
										An interim water safety manager is in post to oversee the flushing and water safety processes; also working alongside the Compliance Manager for compliance related activities.		Water flushing regime has now been taken over from the clinicians by the Estates team (apart from weekends), in order that 100% water return figures can be maintained. As at 15/09/2016, 100% flushing of little used outlets was achieved.		Estates require full access to all ceiling voids and water services within Richmond ward to enable a permanent solution to be identified for the poor circulation issues being experienced. Following risk assessment this work would not be possible or safe in an occupied ward space and expected down time of Ward would be 10 days, this will be subject to findings.	31/03/2017		
										St James calorifier is decommissioned and hot water is fed via plate heat exchangers			Discrepancies of temperatures exist between SGUL and Trust records, for Grosvenor Wing. University temperatures are significantly lower.	Design of scheme underway for the replacement of aged plant, we have emergency funding of 1.5m to replace the GW water plant; this and the removal of dead legs will reduce this risk	31/01/2018		
										There is a Water Safety Plan in place that provides the guidance, instruction, specification and infrastructure for the implementation of the Trust's Management & Control programme for: The control of Legionella, hygiene, 'safe' hot water, cold water and drinking water systems including Pseudomonas aeruginosa – advice for augmented care units.		100% flushing reported for Legionella on low-use outlets since October 2016 to date (16-Jan-17)		A suitable and sufficient Legionella risk assessment compliant with UKAS ISO/IEC 17020:2012, BS8580:2010 and ACoP (L8) shall be carried out by the Trust's externally appointed specialist independent advisor on all buildings currently owned or occupied by the Trust, In order to identify and assess the risk of Legionellosis and water quality issues from work activities and water sources on the premises and organise any necessary precautionary measures.	28/02/2017		
										Deadlegs are removed as discovered whilst other planned work continues across the estate			The Trust has not reached consecutive 3 months of 100% flushing returns.	A suitable and sufficient Pseudomonas aeruginosa risk assessment compliant HTM04-01 (HTM04-01 2016 supersedes the addendum)shall be carried out on all designated augmented care units, in order to identify and assess the risk of Pseudomonas aeruginosa infections from work activities and water sources within the designated areas and organise any necessary precautionary measures.	28/02/2017		
												The Health Safety Executive inspector		The Estates team are to take back in-			

Ref	Title	Opened	Manager	Description	Initial Risk Scoring	C	L	Current Risk Scoring	Current Risk Level	Controls	Gaps in controls	Assurance	Gaps in assurance	Actions Synopsis	Actions Due date	Actions Done date	Last updated
										Up to date policies in place across the Trust to work in conjunction with the Water Safety plan to ensure compliance.		was satisfied the Trust had undertaken adequate testing, monitoring and remedial action to mitigate risks in water temperature. Inspector satisfied that the Trust had dealt with prior failures correctly. Inspector agreed with the view to develop an in-house water management team. HSE are aware of discrepancy of temperatures between SGUL and Trust for Grosvenor Wing.		house the testing of water from the existing their-party supplier (ClearWater). Water flushing has now moved under the remit of Mitie as part of their contractual obligations with the Trust.	31/03/2017		
										There are alarms in place to alert the Trust if the chlorine levels drops below or exceeds the set specification.				Independent assessor with previous high level HSE experience will assure the discrepancies of temperatures exist between SGUL and Trust records, for Grosvenor Wing. University temperatures are significantly lower.	28/02/2017		
CRR-0006	Power failure - electrical fault	01/03/2016	Hancock*, Richard	Patient safety risk due to electrical infrastructure in Knightsbridge Wing in danger of major failure. A recent large failure of an electrical panel caused the wing to be evacuated. The aged electrical panel had a catastrophic failure, affecting the estate in the following two ways a) Knightsbridge Wing, which needed to be evacuated and temporary repairs were required. b) The affect on the wider Tooting estate needed to be understood. The electrical infrastructure has reached the end of its useful life.	20	4. Major	4. Likely	16	Extreme	Temporary repairs undertaken, and can be evidenced.	Remaining 10% of building to be decanted. Clinical services will be decanted by 03/02/2017. The whole building will be empty by 31/03/2017.	To provide adequate assurances the electrical services in Knightsbridge wing to be refurbished and tested to BS 7671 and where appropriate additional circuits and accessories fitted to HTM 06.	Building is due to be decanted and demolished by Q2 2017.	Wiring assessment completed, repairs underway as a precaution until a total relocation of all staff and services can be completed. Six facet survey undertaken, view is that building is beyond economic repair. Trust Board decision to vacate and demolish	31/03/2017	31/01/2017	Maria Prete* 01/02/2017 13:31:09
										Fixed wiring assessment complete, Knightsbridge wing found to be beyond economical repair. Trust Board approved decision to demolish the building.							
										To remove the risk of patient safety, the building has been decanted up to 90% of its residents.	Medical Physics equipment to be moved by 31.3.17	The demolition of Knightsbridge Wing is part of the wider Demolitions Programme which is monitored through CPMG, IDDG and Programme Boards.		A scheme is being worked up to look at site wide HV and LV works, in addition to this there will be new generators, switch gear and transmissions installed to increase the capacity across the site and replace aged equipment.	27/11/2017	31/01/2017	
										from January 2017 no patients in Knightsbridge							
CRR-1179	Failure to come out of special measures by the next CQC inspection	09/01/2017	Linehan, Paul	The risk the Trust fails to achieve a good or outstanding rating with CQC by 2019. This caused by insufficient QIP delivery, a further deterioration in standards of care. This may result in further regulatory intervention.	15	5. Catastrophic	4. Likely	20	Extreme	Quality improvement plan develped to programme manage all actions identified in CQC inspection prep programme and CQC report findings	Lack of robust compliance framework in order to ensure Quality Assurance of services across all services and divisions		CQC formal report received- significant issues with estates, IT infrastructure and risk management	Review of Quality Metrics	31/03/2017		Vanessa Davies 15/02/2017 14:13:10
										Director of Quality Governance to lead QIP work and QIP PMO in place							
										Quality Observatory (overaching care audit) looked at across the Trust to promote great visibility and reporting against 5 domains and associated Standards	Refinement of Quality metrics to monitor performance						
										Thematic Back to the florr weekly visits							
										reports to Patient Safety Quality Board / Quality Committee / Trust Board							
CRR-0004	Insufficient Cost Improvement/Transformation Programme in 2016/17 and subsequent years, 2017/18, 2018/19			Cost Improvement/Transformation Programme slippage - The Trust does not deliver transformation cost improvement programme objectives In 2016/17 the Trust needs to deliver an overall CIP target of £42.7m through its Turnaround Programme. This increases to c£80m in 2017/18-2018/19. At the start of 2016/17, the plan had an unallocated target of £6m. Slippage with some schemes has occurred either as it has been established benefit will not materialise or as schemes are more difficult/ take						Turnaround Board ("TAB") to oversee FY16/17 and FY17/18 Transformation programme, driving and delivering a robust programme for 2016/17 and subsequent years through regular review meetings	processes improved but documentation needs to be completed	Non Executive Director and NHSI observation of performance of TAB and holding workstreams to account in terms of both financial targets and milestone achievements	Constant challenge to stop changes being implemented	•Allocation of unallocated targets	30/12/2016	09/01/2017	Maria Prete* 17/01/2017 14:36:29
										Detailed implementation plans developed and continually updated to manage the quantitative and qualitative aspects of each programme							
										PMO managing Transformation							

Ref	Title	Opened	Manager	Description	Initial Risk Scoring	C	L	Current Risk Scoring	Current Risk Level	Controls	Gaps in controls	Assurance	Gaps in assurance	Actions Synopsis	Actions Due date	Actions Done date	Last updated
		20/07/2015	Paice, Jane	longer to implement. There is an on-going process of tracking and identifying additional opportunities. •Risk of double count across schemes •Capacity constraints may prevent delivery of those improvement plans dependent on increased activity •Some savings identified may only be non-recurrent	20	4. Major	5. Almost Certain	20	Extreme	programme, ensuring robust processes in place for tracking, resoucing, change control Divisional finance managers signoff financial scoping for each scheme and own benefit realisation Change control form to be submitted for each change in financial savings targets/ scope of programme QIA completed - sent to Medical Director and Chief Nurse for schemes with risk of 12 or greater and in excess of £100k Divisional steering groups, meet fortnightly and approve all schemes Executive SRO has oversight of each programme to ensure adherence to scope, timescales and realisation of benefits Divisional involvement in the development and challenge of detailed implementation plans and allocation of targets by division Ongoing detailed analysis to address any slippage and emerging gap and to prepare for future years Reforecast of transformation programme savings and alternative schemes within the programmes proposed to recover shortfalls Progress reviewed as part of monthly Divisional performance meetings Report to Finance & Peformance Committee monthly to present progress, challenges, resulting action/ next steps		FY16/17 £27m actual delivered		Identify and propose alternative schemes to recover shortfalls 2017/18 target to be defined and allocated	31/03/2017 31/03/2017		
CRR-1180	Potential loss of income due to bidding for newly tendered services being unsuccessful			Activity and associated income/contribution will potentially be lost due to:• Service Line Tenders in Q4 2015/16.e.g. Impact on contract from Q3 2017/18. The values are : HV						Deliver services in line with commissioner requirements in advance of any service lines being tendered. This will ensure CSD is well placed to win any tender. For eg, the	Time constraint means developing deliverable specifications with commisioners and clinical leads for services that will be tendered are difficult to develop.	CSD services being delivered to commisioner expectations and joint working with commissioners in place where appropriate - eg development of CAHS, outcomes frameworks for	Unknown Pre Qualification Questions (PQQ) and tender specification.	monthly meetings with Commissioners to develop tender model, which is afforable. Monthly review of tender stage	30/12/2016	23/02/2017	Maria Prete* 23/02/2017 12:35:18

Ref	Title	Opened	Manager	Description	Initial Risk Scoring	C	L	Current Risk Scoring	Current Risk Level	Controls	Gaps in controls	Assurance	Gaps in assurance	Actions Synopsis	Actions Due date	Actions Done date	Last updated
		12/06/2014	Benincasa*, Alison	£5.7m, ISHS £6.4m,& CAHS £14.7m potential overall profit loss £6m.potential overall loss of contribution (20%) £5m. Jan 2017 EMT decision not to respond to Invitation to Tender (ITT) for integrated sexual health services.	12	4. Major	4. Likely	16	Extreme	development and implementation of Communithy Adult Health Services (CAHS) with Wandsworth CCG.Divisional decision made not to bid for RSH services in Wandsworth due to undeliverables in specification		CAHS and LD, provision of data for ISHS services etc		progress for services at DMB.	31/03/2017	23/02/2017	
										Annual business plan for the division clearly programmes tender work and business developments associated with these	No trust lead in commercial function or business development identified to support - so process reliant on CSD leadership team.		Lack of benchmarking data	to progress the tender bid for Health visiting in readiness for sept 2017.	01/08/2017		
										Strong working relationships with all current commissioners and work together collaboratively.		KPI/ CQUINs / LDIP= currently Green and monitored at DMT monthly		continue series of staff engagement sessions post Trust Board decision not to proceed with response to ITT.	28/04/2017	23/02/2017	
											Limited expertise in tender writing.		Potential instability in the workforce due to decision not to progress with ITT				
										February 2017 staff briefing commenced. Staff informed of decision not to progess with Invitatiokn to Tender (ITT) for Integrated Sexual Health Services				Risk assessment to be understand the impact on service provision as a result of any decision relating to not to respond to the tender process/ loss of contract.	28/04/2017		
CRR-0023	Below target 2-week wait performance	01/08/2016	Gordon, Mark	The Trust are currently not achieving the 2WW performance standard for cancer. Whilst the 2WW performance was recovered in February 2016, process and capacity issues remain a risk to sustaining this, with only 25% of patients being contacted within 2 working days or receipt of referral. Identified risks are: 1.Risk of clinical or psychological harm to patients who are not seen within the access standard 2.Poor patient experience due to delays from GP referral to date 1st seen 3.Financial risk to the organisation from contract penalties where targets are not met 4.Reputational risk to the organisation	12	4. Major	4. Likely	16	Extreme	Cancer Performance Recovery Action Plan written and agreed with the Board and the Commissioners with a trajectory of improvement to recover 2WW performance from July 2016	Patient Choice – patients choosing to be seen outside of the 14 day access standard, even when a choice of dates are offered.	Cancer KPIs are monitored weekly through the cancer performance meeting, chaired by the COO. Performance continues to demonstrate a month-on-month improvement, with a 100% increase in patients now contacted within 48 hours (15% Feb 16, to 30.7% in July 2016) and a 13% increase (6.6% to 19.9%) in patients booked within 7 days.		Improved engagement with primary care to ensure that patients are referred informed that they are on a suspected cancer pathway and available to attend at short notice.	30/09/2016	07/09/2016	Vanessa Davies 13/02/2017 10:07:59
										Cancer Programme lead appointed to oversee delivery of key actions and cancer performance recovery	Major Risk to the 2WW Cancer pathway is the reduction of the management team that has recovered the position in the past 6 months.			Requests to fill the Cancer pathway posts to be reiterated at Directors' Group on 22/09/16	22/09/2016	17/11/2016	
										Demand and Capacity plan developed to deliver booking by day 7, to ensure that patients are offered choice.							
CRR-0011	Below target ED four hour performance			Risk to patient experience and safety as a result of potential Trust failure to meet Emergency Access performance trajectory agreed with NHSE and NHSI . This is caused by bed capacity Specialty response times to referrals, delays to assessment and referrals in the ED Mental health breaches. Should the Trust recurrently fail to meet agreed trajectory, Emergency						1.Emergency department actions – led by DDO and Clinical Director for ED	Lack of Interprofesional standards, to minimise delays in speciality response to the ED	Q1 Target - 90.2% Achieved- 92.49%	Continued failure to meet the 95% performance standard	Previous Days ED performance and action required to metigate performance to be incorporated into the 9.00 am meeting with GMs and COO			Maria Prete* 01/02/2017 09:24:20
										2.Whole hospital actions – led by Chief Nurse through 'Flow' programme							
										3.Wider system actions – led by SRG	Lack of visibility and accountability for speciality performance within divisions	Q2 Target - 93.37% Achieved- 93.13%					
										Progress in delivering action plan regularly reviewed: ED action plan via							

Ref	Title	Opened	Manager	Description	Initial Risk Scoring	C	L	Current Risk Scoring	Current Risk Level	Controls	Gaps in controls	Assurance	Gaps in assurance	Actions Synopsis	Actions Due date	Actions Done date	Last updated
		01/06/2014	Gordon, Mark	meet agreed trajectory Emergency Access Standards there would be a risk to: -Patient experience whereby patients would not be treated or transferred within four hours -Patient safety – delays in patients receiving ED or specialist senior clinical input -Risk of regulatory action including from commissioners and regulators - Trust reputational damage of failure to deliver the agreed trajectory	20	4. Major	5. Almost Certain	20	Extreme	ED Senior team meeting weekly/ Whole hospital actions via OMT fortnightly/Wider system actions via System Resilience Group performance meeting monthly/•Overall the plan is reviewed with the CEO and Director of Delivery and Improvement on a fortnightly basis					30/12/2016	01/02/2017	
										Continued close and pro-active working with ECIST. ED dashboard and operational standards agreed, finalised and in place							
										Investments in patient flow schemes (£4m) including ED hot lab	Vacancies within UCC ENP's impacting on performance	Q3 Target - 92.22% Achieved- 93.37%	Bed numbers are lower than in prvious years with no plans to increase bed capacity - the plan is to rely on increased throughput of remaining bed stock only	Epeciality performance data collected from ED performance to be incorporated into divisional performance reviews	30/12/2016	01/02/2017	
										Integration of the hospital services within the ED effort at the Front Door							
										Improvements in Bedflow generated by a variety of measures: establishment of integrated discharge team (IDT); reduction of medically fit for discharge (MFD)							
										work to reduce attendance from frequent fliers	Reduction in bed stock causing reduced flow of patients out of ED	Q4 Target - 92.34%					
										GM leads operational management of ED flow from floor of Majors.							
										Three times daily flow meetings between ED and medics patient							
CRR-0024	Failure to meet 62-day GP referral to treatment Cancer Performance standard	01/11/2015	Gordon, Mark	Failure to meet 62-day GP referral to treatment Cancer Performance standard. The Trust are currently not achieving the 62 day referral to treatment access standard for cancer. In addition, whilst the 2WW performance was recovered in February 2016, process and capacity issues remain a risk to sustaining this, with only 25% of patients being contacted within 2 working days or receipt of referral. Identified Risk are: 1. Risk of clinical or psychological harm to patients who ae not treated within the access standard, due to potential disease progression 2. Poor patient experience due to delays in diagnostic and treatment events in pathways 3. Financial risk to the organisation from contract penalties where targets are not met 4. Reputational risk to the organisation 62 day waits are on trajectory. Q2 has consitently been ahead of the 85% tartet and is at 90.2%	12	5. Catastrophic	3. Possible	15	Extreme	Cancer Performance Recovery Action Plan written and agreed with the board and the Commissoners with a trajectory of improvement to recover performance from July 2016	The Trust is a tertiary and diagnostic centre for a number of pathways, and therefore are dependent on patients being referred from other Trust by day 38 to ensure that treatment can commence by day 62.In some pathways, particularly H & N and lung, there is poor compliance from other Trust, which puts the trajectory at risk	2 day waits are on trajectory. Q2 has consistently been ahead of the 85% target, and is at 90.2 %		Breach reallocation guidance has been agreed from Oct 2016, that allows the reallocation of a full breach when a patient is referred after day 38 in a pathway. Sector- wide Joint working groups are to be established in H&N and lung to improve the pathway and overall experience for patients on an inter-trust transfer.	31/10/2016	17/11/2016	Vanessa Davies 13/02/2017 10:08:23
										Cancer Programme lead appointed to oversee delivery of key actions and cancer performance recovery							
										RCA completed for all patients who are not treated within the 62 day standard (or 31 days from decision to treatment commencing). Any patient on a cancer pathway 95 days+ (diagnosed and not disgnosed) is assessed by a lead cancer clinician for clinical or psychological harm. All RCAS are signed off by the CEO, director of nursing and medical Director	Effectiveness of RCAs due to unclear process and tracking of competeness and actions / lessons learnt	The number of patients on an open suspected cancer over 100 days has reduced month on month to an average of 4 patients		Improved governance process to be introduces. A formal monthly clinical harm review - Board to be established from July 2016	29/07/2016	24/08/2016	
										Weekly PTL Assurance meetings are in place, chaired by GM for Cancer Services, to expedite individual patient pathways, ensuring corrective action is taken when delays are identified							

Ref	Title	Opened	Manager	Description	Initial Risk Scoring	C	L	Current Risk Scoring	Current Risk Level	Controls	Gaps in controls	Assurance	Gaps in assurance	Actions Synopsis	Actions Due date	Actions Done date	Last updated
										Expansion of Bronchoscopy and Thoracic surgery capacity has increased improvement by 9.5%.							
CRR-0012	Increasing number of patients waiting more than 18 weeks for treatment with potential for clinical harm	31/05/2014	Gordon, Mark	Increasing number of patients waiting more than 18 weeks for treatment with potential for clinical harm Possible impact on patients safety as they may come to harm as a consequence of waiting in excess of 18 weeks for treatment. Impact on Trust performance against the referral to treatment (RTT) standard, and the sustainability and transformation fund (STF) trajectory with subsequent loss of income. Risk to Trust's reputation as a well managed organisation.	20	5. Catastrophic	4. Likely	20	Extreme	Trust in receipt report following review data quality and administartive processes that support management of patient tracking (waiting) lists	No contract with supplier to undertake technical historic validation of patient records	No moderate or severe harm incidents identified to date by the Clinical harm panel	Rising of PTL. Number of patients waiting more than 52 weeks for treatment recovery increasing	project board to review and discuss next steps, confirm gaps in workstreams, leads	05/12/2016	02/02/2017	Maria Prete* 22/02/2017 10:04:19
										Director appointed to develop and lead implementation of recovery programme including approach, key milestones and timelines							
										NHSI approved recovery plan with 6 overarching workstreams: Clinical Harm, Validation, Operational grip and capacity management, data quality, training and communication							
										6 work streams have been set up	No Backlog clearance plan for each specialty with waiting list size in excess of the IMAS recommendation						
										Weekly RTT performance meeting							
										Weekly elective care recovery performance meeting (patient by patient review of long waiters/ 40+ weeks)			RTT program in place for 6 weeks . Not able to measure progress				
										Performance monitoring report provides overview of current waiting list and progress with backlog reduction, activity run rate using IMAS with optimum waiting list size as target, plus action tracker	Insufficient management of RTT Programme						
										detailed backlog recovery plan with top 6 specialties with highest number of waiting list							
										Focus approach to validation				all gaps in controls are addressed within the RTT work plan. Work through work plan	31/03/2019		
										Weekly / monthly PTL production report circulated to GMs)	Training needs assessment and waiting plan						
										External reporting to Commissioners, regulators, NHSE and NHSI			no assurance that current patients will not wait more than 18 weeks				
										ECR Board (chair recovery Director). Programme performance report							
										DIP Board (chaired by CEO) review risks to delivery / mitigation	National reporting (NHSE) of mandatory data reporting of RTT suspended						
										SOG (chair NHSI)							
										Clinical Harm review panel (external chair), reporting to both ECR Board, and Patient Safety and Quality Board.							
CRR-0014	Failure to secure colleague engagement			Enhanced risk of disengagement of staff due to changes within senior management team & a potential lack of corporate memory with interim senior team Prolonged risk of inability to effectively enagate t he senior management team						Delivery of HR priorities plan with focus on: right staff, right time, right place, right skills	Limited ability to influence or mitigate external factors including; London wide issues of staff turnover, turnaround and financial position	Negative Staff survey results and medical engagement score. Break down to 10 reasons - highlighted in gaps in controls that are not addressing the issue	Difficult to ascertain level of management engagement	Re-written workforce priorities programme to be launched in September 2016 including Fit for the Future campaign.	30/09/2016	21/10/2016	Vanessa Davies 13/02/2017 09:19:36
										Support from staff side representatives and governors in engaging staff (SNAG)	Levels of disengagement amongst managers makes it difficult to effectively deliver the programme			Quarterly staff survey to commence quarter 2	31/08/2016	21/10/2016	
														Finalising team brief by Head of Comms. This will require local cascade and feedback	01/11/2016	17/11/2016	

Ref	Title	Opened	Manager	Description	Initial Risk Scoring	C	L	Current Risk Scoring	Current Risk Level	Controls	Gaps in controls	Assurance	Gaps in assurance	Actions Synopsis	Actions Due date	Actions Done date	Last updated
		01/04/2016	Gammage, Mark		20	5. Catastrophic	4. Likely	20	Extreme	Listening into Action		Progress against workforce action plan reports to Workforce and Education Committee					
										Chair and CEO Exec briefings and Team briefings (monthly)	Difficulties in Managers to hold consistent team meeting ensuring staff are kept informed			outline framework and identify responsabilities	31/01/2017	30/01/2017	
										Additional quarterly survey - 'temperature check'		Progress against workforce CIP		Implementation of actions as a result of staff survey	31/03/2017		
										Monthly team briefings	No clear understanding of management role (when and what)			Review bullying and harrassment training package.	28/02/2017		
														Raise awareness / publicise the new bullying and harassment policy	31/03/2017		
														A new plan to implement engagement programme with managers to bridge the gap between the executive and managers/staff	31/03/2017	25/01/2017	
CRR-0026	Inability to control agency staffing and associated staffing costs	30/09/2016	Gammage, Mark	Inability to control agency temporary staffing cost. Unable to demonstrate a control on agency temporatry staffins as shown by breach of annual cap value.	16	4. Major	5. Almost Certain	20	Extreme	Completion of NHSI self-sertification	Monthly Exec oversight meeting (to start in November 2016		No known level of non compliance	The Trust is full member of South West London Bank which agree max rates across London and offer banks rates to each other - to Start in April 2017	28/04/2017		Vanessa Davies 13/02/2017 09:32:59
										No agency invoice is paid without booking number							
										Monthly data analysis which shows reasons for reuest and rates of use by ward level - data will be used by the monthly Exec meeting							
										All requests for agency are required to be booked throught the Central Bank Office following approval from Chief Nurse for Nursing, DDOs for medical staff	No formal Exec Ojectives		Not known Central Bank office performance to ensure Max bank fill & Min agency fill & best price				
										Exec Management are briefed on which service lines are frigile and require higher agency input							
										Nursing rostering prepared 8 weeks in advance							
										Vacancy control panel (VCP) approving posts							
CRR-0022	Insufficient management capacity or capability to deliver turnaround programme	01/10/2015	Gammage, Mark	Risk of inadequate management capacity to ensure required support and engagement with turnaround programme whilst also delivering business as usual. There is a risk to both effective engagement and support of the turnaround programme delivery where management capacity is insufficient to support the programme whilst delivering business as usual. Similarly, a risk to service delivery may arise if core business is not prioritised appropriately	15	4. Major	5. Almost Certain	20	Extreme	Programme management approach to the requirements of turnaround.	No plan in place to ensure cascading of information to all staff	increase in partecipation		Explore mandate team brief with Comms and EDs to be presented to EMT	28/04/2017		Vanessa Davies 13/02/2017 09:52:36
										Regular staff and senior team leader briefings							
										Communication messages are designed to be honest in order to engage staff							
										Clarity to reassure staff around financial position of trust and believe they can contribute to recovery				Leadership paper to be presented to Trust Board in January 2017 outlining paln to develop capability of clinical and general managers	31/03/2017		
										Expanded Friends & Family test to assess staff quarterly							
										Management skills compulsory for all new starter with management posts		80% report SGH good place to be cared					
										Management induction programmes and leadership development. Programmes provided at a number of levels				Plam from January to June 2017 to focus on triumvirate and their roles	30/06/2017		
										Use of interim to support management actions							
										Turnaround Board to oversee effectiveness							
										Plan at Executive Level to replace							

Ref	Title	Opened	Manager	Description	Initial Risk Scoring	C	L	Current Risk Scoring	Current Risk Level	Controls	Gaps in controls	Assurance	Gaps in assurance	Actions Synopsis	Actions Due date	Actions Done date	Last updated
										executives							
CRR-0025	Unsustainable levels of staff turnover	01/10/2015	Gammage, Mark	Failure to recruit and retain sufficient workforce with the right skills to provide quality of care and service at the appropriate cost. NHS Trusts in London have traditionally had high turnover rates for some staff groups (mainly nursing) and most recently this has been increasing at St. George's. The impact is particularly significant in relation to band 5 nurses, where there is a very high volume of recruitment and in some specialist areas such as oncology, paediatrics and theatres. We are reporting staffing fill of 90%~+ in Safe Staffing reports but the difficulties in staffing create pressures in terms of being able to deliver their services Larger financial expenditure as agency therapists and Locume Agency Doctors.	12	5. Catastrophic	3. Possible	15	Extreme	There is a workforce priority plan which has an underpinning action plan. Aproved by the Board in Sept 2016		Workforce plan has been rewritten and focuses on current needs of SGH. To be reviewed in Sept 2017	Actions for Workforce priority plan beinng implemented. Need more time before assessing if working	Workforce plan to be rewritten and focused on current needs of St Georges so risk to be redrafted with new actions and deliverables for 1st September	01/09/2016	21/09/2016	Vanessa Davies 13/02/2017 10:20:25
										The workforce and education committee meets bi-monthly, supports the delivery of the plan and monitors its milestones.							
										There is a concise monthly workforce information report to the board that identifies key trends against the workforce key performance indicators including turnover, vacancy rate and bank and agency usage. The report includes detail of bank fill rates and it will also take a monthly focus on key issues on recruitment							
										The monthly quality report to the board includes detail regarding the nursing workforce including a tracker of SAFE nursing staffing compliance and of staffing alerts that have been reported				seek to identify gaps after first level of review			
										A medical workforce group meets every tuesday led by the Medical Director. This group will report to the workforce and education committee					29/09/2017		
										Executive team reviews SIP headcount number weekly							
CRR-0019	Failure to recognise, communicate and act on abnormal clinical findings	19/07/2016	Rhodes*, Andrew	Should the Trust fail to ensure robust mechanisms for the timely and appropriate follow up of all diagnostics tests undertaken and critical test results eg blood tests , cell path and radiology this may result in adverse impact upon patient care in terms of delays in treatment	16	4. Major	4. Likely	16	Extreme	All doctors have been reminded of their responsibility for ensuring that tests that they order are followed up	The effectiveness of the SOPs is not consistent	There is no ability to track compliance through Tableau of other results at the present	The feedback from consultants completing the audit indicates compliance issues. Whereas for some consultants the system seems to work satisfactorily, for many it does not.	SOPs to be reviewed by DCs for each Care Group to ensure fit for purpose	02/01/2017		Vanessa Davies 13/02/2017 09:42:48
										All Care Groups have developped Standard Operating Procedures to ensure that this happens	Radiology safety net not reliable as emails are not received by the appropriate staff		The main issue raised was in respect of correct attribution of patients to consultants. This results in consultants being a) required to endorse patients for whom they are not responsible, and b) results of their own patients not being received for endorsement	Re-audit SOPs to ensure fit for purpose	28/02/2017		
											A significant proportion of results are attributed to the wrong consultant making the electrical sign off inconsistent		Issues regarding the time required to comply with the new system, and the limitations of IT systems were common themes. Some of the specific issues raised could possibly be rectified by additional training, others would require system changes (either technical or in respect of workflows				
										All serious incidents resulting from failure to follow up tests have been reviewed and themes reported to Divisions.	Policy for Acting on Diagnostic test Results to be updated	There is limited ability of ensuring that once results are seen, the correct actions are followed.		Review /update policy for acting on results	01/12/2016		
													limited assurance as results attributed to wrong consultants				
										Radiology have strengthened their safety net system. This now includes e mail to MDT for unexpected cancer (cancer MDTs have instituted a red flag system to ensure oversight).	not all results are reported via iClip			implement RCA recommendations	03/04/2017		
CRR-0001	Inadequate Data Quality,			Poor Data Quality within the current						Governance accountability at board	Use of different IT systems	Initial clinical harm review of 1000	No assurance on which data can be	Risk meeting with commissioners,			Maria Prete*

Ref	Title	Opened	Manager	Description	Initial Risk Scoring	C	L	Current Risk Scoring	Current Risk Level	Controls	Gaps in controls	Assurance	Gaps in assurance	Actions Synopsis	Actions Due date	Actions Done date	Last updated
	completeness or consistency	22/07/2016	Rhodes*, Andrew	methods of generating, monitoring, tracking and reporting against waiting lists The current RTT PTLs pose a risk to patient safety as planned patients and Non-RTT follow up patient are not being managed appropriately & RTT and DM01 externally reported figures are inaccurate The failure to attribute consultant activity appropirately. this is an issue that affetcts all patients and has resulted i a failure to endorse results that may mean missed diagnosis of disease. This has an effect on clinical documentation, coding of activity and discharge processes The risk to patient is compounded by the fact that 3 different systems are used within the Trust (CErner, Rio, iSoft) Delays and inaccuracies in coding activity lead to uncertainties in the validity of risk adjusted mortality and other nationally-published outcome data	25	5. Catastrophic	5. Almost Certain	25	Extreme	level. MBI report presented to Board RTT specialist at board level Clinical harm board set up to review patient level records Clinical Coding - policy in place agreed with clinicians Clinical Coding - training in place - Income generator supporting clinicians with correct coding Clinical Coding - validation of data ECR Board chaired by Diana Lacey NHSI on board from 13 February 2017 to procure external provider for technical solutions recruitment to post for elective care pathway	Clinical Coding - Capacity of clinical teams to provide reviews Clinical Coding - Insufficient interaction between clinical and coding teams Clinical Coding vacancies (7.5 WTE) lead to delays in activity being coded No validation of data through Kite Marking Data Quality policy not up to date RTT - No SOPs on how to input data Trainings not developped / resources for trainings not identified Inconsistent verification of data prior to be externally submitted No IT strategy Clinical Coding - External audit - Payment by result audit no longer run Incomplete/ inaccurate information provided/inputted	patient notes found no severe harm	trusted Risk not able to be quantified until phase one of project complete recruitment to post for elective care pathway may not be enough, i.e. training	NHSI (week commencing 27/6/16) Action Plan to be present to EMT for approval Ensure DQ governance group is connected to DQ Board Data quality strategy paper to be presented to EMT (Mark Hamilton) Business case for NHSI care pathway (Diana Lacey) Finalise resource requirement for elective care pathway (Diana Lacey) Develop revenue coding recovery plan (Iain Lynam) ICT strategy to be presented to Board and agreed (Larry Murphy) Data Quality Policy to be updated	31/08/2016 31/03/2017 30/12/2016 30/12/2016 30/12/2016 30/03/2017 31/03/2017	26/10/2016 22/02/2017 22/02/2017	22/02/2017 10:02:17
CRR-0010	Fragmented Electronic and manual patient records	14/06/2016	Rhodes*, Andrew	A failure of staff to document clinical information in the correct system (paper or electronic) caused by the operation of dual systems may result in inappropriate treatment. A failure of staff to review clinical information caused by a fractured clinical record may result in inappropriate clinical decision making. A failure of staff to transcribe information caused by the need to transition from an electronic process to a paper process (or vice versa) caused by the operation of dual systems may result in transcribing errors resulting in medical errors.	20	5. Catastrophic	4. Likely	20	Extreme	Patients outlying in live areas will remain on paper. Monitoring of incidence reports (Datix, SIs, Compliants, Feedback from GPs) for frequency and severity of incidences and to follow up with relevant areas Development of BC to move to full roll out	Under reporting of incidences Patients outlying in non-live areas will have a paper record Lack of creation of Departmental Standard Operational Procedures (SoPs) when gaps are noticed BC not complete and agreed	Organisation paused after completion of roll out to Paediatrics, Cardiac, Nephrology and Neuro which are relatively ring fenced in terms of beds therefore transitions of care within one admission from paper to electronic and vice versa are relatively less likely.	In extenuating circumstances patients may be transferred to live areas from non-live areas. Multiple use of clinical systems in uncontrolled manner	Roll out eClinical Documentation and ePMA to the remaining IP areas on St Georges Hospital site.	01/04/2017		Vanessa Davies 13/02/2017 09:16:58
CRR-0029	Failure to arrange follow-up appointments or treatments (where clinically required)			Risk failure to follow up patients as clinically required . Caused by inconsistent processes and procedures for ensuring that patients receive timely and appropriate follow up appointments and/or treatment once						SOPs / cashing up systems Access Policy	not all services have robust SOPs or processes in place to ensure follow up of patients in Outpatient clinics or following DNA.	Cashing up of outpatients runs at >99%	No assurance data from RTT working group as yet	SOP audits need to be repeated and quality checked	01/02/2017		Vanessa Davies 13/02/2017 09:31:09

Ref	Title	Opened	Manager	Description	Initial Risk Scoring	C	L	Current Risk Scoring	Current Risk Level	Controls	Gaps in controls	Assurance	Gaps in assurance	Actions Synopsis	Actions Due date	Actions Done date	Last updated
		30/09/2016	Rhodes*, Andrew	seen in clinic May result in delayed diagnosis or treatment leading to severe personal harm	16	4. Major	4. Likely	16	Extreme	RTT project board and programme Data quality working group established within trust to address Attribution of consultant Communication to Patients & GPS	Variable processes for arranging follow up care upon discharge Clinical outcome forms @ OP not completed RTT programme has not yet made sufficient progress	RTT programme has new programme director Access policy signed off	SOP audits not complete	RTT programme needs to develop SOPs for processes	01/02/2017 01/02/2017		
CRR-0013	Vulnerability to computer virus or attack 'Ransom ware'	07/04/2016	Murphy, Larry	A large increase in the computer malware known as "Ransom ware" is affecting Trust computer data. There is a high risk that data that has been affected will be lost if the affected files are not identified and restored within a short time frame	20	4. Major	5. Almost Certain	20	Extreme	NHS N3 gateway anti malware software Local Websense anti malware software Local Anti-virus software Regular and repeated user education and communication Firewall updates have been applied Supplier informed and anti-malware suite security controls increased. Continuous monitoring of reported infections. Replacing more vulnerable XP machines (more prone to infection)	Ransom ware infections continue to be reported Project underway to replace xp machines Unproven / out of data ICT Business Continuity plan testing Full back-up solution - full coverage expected in Mar. 2017.	ICT systems team restoring identified corrupt files from back-ups. Minimal data loss reported Regular reports (XP Replacement project, security patching, anti-virus management, change control board) to be tabled at meetings (ICT Management tean, IG Committee)	New ransomware is created daily - the Trust is vulnerable until security patch has been created by vendor and successfully rolled out over estate Awaiting procurement of Snow (software management system) to govern ICT estate	Creation of Standard Operation Procedure for Escalation of ICT Incidents test back up solution	31/03/2017 28/04/2017		Vanessa Davies 28/02/2017 14:07:36
CRR-0009	IT storage: unrecoverable IT system downtime affecting critical clinical, web and email systems	25/07/2016	Murphy, Larry	A failure to maintain and invest in the IT infrastructure for a lengthy period (7+ years) caused by a lack of funding in IT has resulted in an 'end of life' infrastructure that is likely to fail and result in catastrophic implication for the Trust in terms of corporate and clinical systems failures. The specific areas of risk within the infrastructure are; •Data backup facility outdated and unreliable •IT data storage capacity at limit, high risk to operational viability of the Trust •Computer hardware in clinical areas slow, old and unreliable •High numbers of XP computers in IT estate. Core Trust systems will not be able to be accessed from XP PCs from December 2016	20	5. Catastrophic	5. Almost Certain	25	Extreme	On-going monitoring of infrastructure. Program of work in place to eliminate specific areas of risk Procured two new back up facilities. Email back-up solution now completed and working. Tactical data storage has been procured and deployed. XP Replacement Project underway with 362 machines replaced to date (07/12/2016) Quarterly Board updates on the ICT Stabilisation and Recovery Programme. Weekly Project progress meetings and Fortnightly Project Board meetings Reporting the progress and exposure, quarterly, to the Information Governance Committee Service desk statistic analysis reporting (Heat Portal) for individuals back-up storage files. On-going Capacity Management to monitor usage On-going maintenance of Network hardware and configuration and	All issues yet to be exposed. Full back-up solution procured and to be deployed; full coverage expected in March 2017. XP Replacement Project delivery slower than anticipated due to the uncovering of unknown systems and ownership. Lack of detection and asset management software (used to indentify hardware/software conponenets) Testing of the business continuity plan	Some improvement in resilient and storage. Fewer service desk calls relating to historical issues.	Not all issues have been uncovered Still not fully resilient and have many single points of failure	Complete and test the deployment of the full back up solution Complete the XP Replacement project Test Disaster Recovery Solution implement detection and asset management software Complete the deployment of long-	31/03/2017 30/06/2017 14/04/2017 31/03/2017		Vanessa Davies 27/02/2017 15:52:23

Ref	Title	Opened	Manager	Description	Initial Risk Scoring	C	L	Current Risk Scoring	Current Risk Level	Controls	Gaps in controls	Assurance	Gaps in assurance	Actions Synopsis	Actions Due date	Actions Done date	Last updated
										manage change undertaken by the IT Opertions Team	and full disaster recovery			term storage facilities			
										Deployment of long-term storage facilities has been completed					15/02/2017	27/02/2017	
										Table-top exercise has been completed							
CRR-0005	Insufficient cash to meet payment demands	01/06/2016	Pratt, Margaret	There is a significant risk that the Trust will have insufficient funds to meet payment demands. The risk has emerged because i) the trust is trading at a deficit ii) unplanned income volatility cannot be managed through timely reduction in related expenditure iii) shortages of key staff groups lead to higher agency premium spend worsening the financial position iv) the trust is struggling to deliver the cost efficiencies planned v) the Trust is struggling to collect debts due to data quality and systems/process issues vi) the trust has failed to secure STFF £17.6m due to adverse performance and I&E	20	5. Catastrophic	4. Likely	20	Extreme	Short term cash flow forecast (STCFF) prepared on a weekly basis - detailed forecast daily	Systems and process weaknesses impact the ability of the Trust to accurately capture and report relevant information	Variable assurance provided by NHSI that the loan will be forthcoming	Emergency infrastructure and costs/capital required to address the impact are still estimates	Director of Finance Operations to write proposition to improve financial systems for next F&P	28/02/2017		Vanessa Davies 01/03/2017 11:33:57
										Capex approved, monitored and challenged through Investment and Divestment Group (IDDG)							
										Recovery plans developed to minimise deficit	The trust continues to trade at a deficit with an increasing trend in actual pay costs and income under plan.			Monitor impact of recovery on September and October financials and consider impact on forecast position	15/11/2016	27/01/2017	
										Monthly divisional performance meetings to understand and challenge I&E, forecast and recovery plans							
										Targeted collection of aged debts	The cost improvement programme at M9 has a PMO risk assessed full year forecast of £24m of the £50m target.						
										demand and capacity model to understand capacity impacts on ability to deliver income as per plan / forecast, in first draft and tested			ITFF loan application for funds required to meet the cash requirements of the trust is underway	identify alternative schemes to close the shortfall on CIP	31/10/2016	28/11/2016	
										Close relationship with NHSi relationship partner to monitor performance and requirements for funding are being met	Revers of the increase payment terms from 60 days to 30 days - half still at 60 days						
										Board level committees challenging divisions on recovery plans, investments, divestments		Track record of requesting less work capital facilities from NHSI on a monthly basis than forecasted. Deviation from forecast not material					
										Board level committees monitoring cash position and forecast demands on cash.	M9 increased forecast deficit to 80.7m from 54.5m. Removed 20m headroom contingency			Improve departmental processes to ensure robust cash collection and capture of income	31/03/2017		
										Board level support to secure maintenance funding and loan facility			Trust is spending at risk against the £39m backlog maintenance funding request				
										sent letter to NHSI forecast for 34.1m which compare to a budget of 38.4m. Within 34.1m is 3m of emergency infrastructure expenditure	£39memergency infrastructure fund request submitted (spending at risk)						
										Monitor impact of recovery on September and October financials and consider impact on forecast position							
										Working through CQC report plan	PMO work not completed			Complete process of review decision to revoke the increase supplier payment terms to 60 days, back to 30 days	28/02/2017		
										PMO collates and facilitates production of CIPs							
										Committee at purchase order level to review every week by director of							

Ref	Title	Opened	Manager	Description	Initial Risk Scoring	C	L	Current Risk Scoring	Current Risk Level	Controls	Gaps in controls	Assurance	Gaps in assurance	Actions Synopsis	Actions Due date	Actions Done date	Last updated
										Finance Operation , Director of Estates and Director of Information. Outcome 34.1m capital spent by end March 2017 including 3m emergency infrastructure							
CRR-0015	Lack of access to capital to address in-year IT, Estates and equipment replacement cost pressure	20/07/2015	Pratt, Margaret	The Trust faces higher than expected costs due to:- unforeseen service pressures loss of SRG and Education funding, with related costs not being removed impairment of assets Underinvestment in prior years resulting in urgent work to address backlog maintenance, stabilise the IT infrastructure, implement improvements required by the CQC and address RTT data quality issues The trust needs to adapt to changes in service/funding arrangements, for example the loss of funding in specific areas such as SRG schemes and Education. There is a high risk that unfunded resource will be required to support capacity and delivery. Unforeseen impairment of assets may have a negative impact on I&E Premium costs related to the supply of scarce resources eg cost of agency nurses due to nursing staff shortages – risk that these costs will not be appropriately monitored and controlled	16	4. Major	5. Almost Certain	20	Extreme	Enhanced monthly divisional performance meetings Business Planning Process and Business planning steering group - the expected impact of cost pressures on financial performance is considered and robust provisions are made for future increases in cost in line with high level Guidance from NSHI. IDDG has assumed role of managing cost pressures Contingency Reserves are set aside in line with NHS Guidance at 1% of Turnover EMT and Business Planning Steering Group oversight of the business planning process. Monitoring of cost pressures in-year through the financial reporting regime. New pressures are identified as early as possible and the financial impact is reported to the Finance and Performance committee. Vacancy control panel Costs are based on data from robust historical costing systems including PLICS and Reference Costs which have been calculated in line with national guidance. Necessary additional I&E investments to be met by an increase in divisional CIP Impairment risk monitored by F&P and external accounting guidance sought Reduced use of external capacity by better capacity planning and management of internal resources. Transformation programmes have identified controls to mitigate premium agency spend Detailed Agency expenditure tracking and redevelopment of headcount tracker Weekly monitoring of headcount tracker by Executives Development of transformation savings schemes	Workforce and financial plans do not explicitly reflect the level and premium costs of agency staffing	Monthly financial reporting of performance to the Board Identification and review of cost pressures through the Business Planning cost pressure review process. Divisional monthly performance review meetings		Implementation of transformation savings schemes Weekly monitoring of headcount tracker by Executives Design and implementation of operational levels to reduce deficit	30/09/2016 31/08/2016 31/08/2016		Vanessa Davies 01/03/2017 11:34:13
CRR-0027	Risk of failure to deliver the financial control total	/10/2016	, Margaret	The Trust is unable to deliver activity within the tariff set by NHSE and NHSI. In consequence, the Trust cannot deliver its financial control total.	20	atastrophic	4. Likely	20	xtreme	Analysis and quantification of the drivers of deficit at care group level including premium workforce costs implementation of practical, realistic and deliverable plans to eliminate the drivers of deficit ensuring that contracted activity volumes can and are delivered within the tariff available	Identification of cost drivers does not enable reduction in costs Plans are impacted by issues with the Estates		Although activity can be agreed, costs to deliver the activity are subject to wider market pressures. In addition, further lack of assurance exists due to the trust not delivering its control total over the past two years.	produce draft business plans for 16/17	24/11/2016	30/12/2016	Vanessa Davies 17/01/2017 16:32:54

Ref	Title	Opened	Manager	Description	Initial Risk Scoring	C	L	Current Risk Scoring	Current Risk Level	Controls	Gaps in controls	Assurance	Gaps in assurance	Actions Synopsis	Actions Due date	Actions Done date	Last updated
		11	Pratt			5. Ca	4				CIP have not delivered			produce final business plans for 16/17			
										Monthly divisional performance meetings to understand and challenge I&E, forecast and recovery plans					23/12/2016		
											System weaknesses expose the Trust to challenges and payment is not received						
										Investment into Turnaround and development/delivery of Cost Improvement plans							
CRR-0028	Inability to meet regulatory requirements due to financial system and process failure	11/10/2016	Pratt, Margaret	There is a significant risk that the Trusts current financial systems and processes are not sufficient enough to meet statutory obligations, prevent fraud, mismanagement of funds or inappropriate decision making by Trust officers.	16	4. Major	4. Likely	16	Extreme	The finance function carries out a number of processes to ensure that the trust:	Systems and process weaknesses limit the effectiveness of the processes to accurately capture and report relevant information.	The trust has been audited both internally and externally. Significant regulatory breaches were not reported.	Although no material issues have emerged to date, failure to resolve significant issues leaves the trust exposed to future issues.	Procurement workplan to address process issues across trust and within procurement to be implemented	30/11/2016		Vanessa Davies 13/02/2017 09:32:40
											i) Receivables are significantly overdue						
										i) produces robust financial data to enable regulatory reporting (statutory and NHS)	ii) A significant level of debt is written off as irrecoverable from NHS, private patrients and overseas patients.	No significant contractual or legal challenges have been raised by the trust suppliers					
										ii) identifies fraud and misappropriation of trust resources through control accounts, segregation of duties and approval hierarchy	iii) Insufficient provisions on the balance sheet expose the I&E						
										iii) budgets for, reports and forecasts financial position on a regular basis	iv) Data quality is poor and not all activity is captured	No significant contractual or legal challenges have been raised by the trust employees		Data quality action plan to be implemented			
										iv) collects debts and makes appropriate payments	v) Cost improvement plans are not delivering as planned						
										v) trains, appraises, performance manages and supports staff as they carry out duties	vi) Demand and capacity modelling is not clearly linked to infrastructure maintenance and activity forecast	No material fraud has been identified			30/11/2016		
											vii) Trust staff do not comply with required Procurement processes						
										vi) Procures goods and services following required Procurement regulations	vii)Post Project Evaluations are not always carried out post investment in approved business cases						
CRR-1143	Recognising, escalating and responding to the signs of deterioration	2016	ndrew	Risk of failure of recognising, escalating and responding to the signs of deterioration patient. This is caused by the suboptimal use of EWS as observations not completed correctly, not clearly escalated or promptly responded in order to commence treatment. This may result in avoidable death, and/or breach of CQC registration requirements.		ophic	ely		me	Policy for Minimum Standard for Adult in-patient observation	Training is not mandatory, It is not part of MAST, Not recorded on TotaraShould be booked through Totora and recorded on ARIS	Critical care liaison project identifying gaps in recording, reporting, recignition, escalation and identifying solutions. Educational /support project showing quality imprvement of EWS.	Critical care liaison project. Educational support project will terminate in March 2017	Policy for the Minimum standard for adult in-patient observation to be updated	31/01/2017	26/01/2017	
										Critical care liaison project Educational /support project (six month project to improve EWS and Sepsis recognition currently in place) involving 3 nurses: each urse covers one area/ward showing how to identify sick patient and guide them on what needs to be done to prevent deterioration	Training package covers only qualified nurses and not HCA. HCAs are only trained on how to take obs but not reporting	EWS audit achieved base line target (80%). Target now has been increased to 100%	EWS data not adequate	embed SAFER care bundle	28/02/2017		
										Follow up of patient once discharged from ITU	No emergency response team		No data on who has been trained / competency done	Business case for outreach team	28/02/2017		
										EWS audit undertaken bi-annually	Locums / agency staff not knowledgeble on Trust policies despite agency contract stating requirement of knowledge of obs		QIP - actions behind scheduled time, some overdue actions	Observation machine software to be upgraded with new EWS escaltion criteria	31/03/2017		
										STARR project - to promote ward-based learning across the Trust by deploying a mobile education troupe to support local tailored needs analysis, action planning and evaluation	Poor local ownership of processes			Review of Locum/agency staff contract to ensure requirements (knowledge of taking obs) are clearly stated	31/03/2017		

Ref	Title	Opened	Manager	Description	Initial Risk Scoring	C	L	Current Risk Scoring	Current Risk Level	Controls	Gaps in controls	Assurance	Gaps in assurance	Actions Synopsis	Actions Due date	Actions Done date	Last updated
		07/12/2	Rhodes, A		20	5. Catastr	4. Like	20	Extren	Audit programme added to RATE to facilitate local monthly audits	Currently no use of white board to document obs			Review of current education package to provide a moire structured package of training leading to a Care Certificate in deteriorating Adult.	31/03/2017	16/02/2017	
										Policy includes the emergency response and clinical communicaton	No systematic record keeping of competency			Deteriorating patient training package to be added to MAST to facilitate training and competency record keeping	31/03/2017		
										Training package reviewed -delivered by Resus, Simulation and Practice Educators	STARR project - slow progress due to shortage of skills			Identify and train senior medical, nurses and HCA chanpions on each ward to lead implemntation of local EWS process	28/04/2017		
										Policy disseminated to Divisional Triumvirate for distribution within Division; and to all Sisters				Upload EWS chart on iClip	01/05/2017		
										Review /monitoring of serious incidents for learning				working with IT team on barrier to implement use of white board	31/05/2017		
										EWS chart updated							
										Reporting of adverse incidents				Develop business case for technological software	02/10/2017		
										Nurses encouraged to do Harm Free Care							
										EWS programm part of QIP							
										EWS monitored and reported to CQRM and PSQB							

St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO THE TRUST BOARD: 6 April 2017

Paper Title:	Report to the Board from Audit Committee: 15 March 2017
Sponsoring Director:	Sarah Wilton, Non-executive Director
Author:	Sarah Wilton, Non-executive Director
Purpose: *The purpose of bringing the report to the board*	To provide the Board with a summary of the proceedings from the last Audit Committee
Action required by the board: *What is required of the board – e.g. to note, to approve…?*	To note the update
Document previously considered by: *Name of the committee which has previously considered this paper / proposals*	N/A

Summary:

Enclosed are the key messages from the Audit Committee meeting held on 15 March 2017. The Board is asked to note the proceedings.

Key risks identified:
Risks are detailed within the report.

Related Corporate Objective: *Reference to corporate objective that this paper refers to.*	All Corporate Objectives.
Related CQC Standard: *Reference to CQC standard that this paper refers to.*	N/A

Equality Impact Assessment (EIA): Has an EIA been carried out? (Yes / No)
If yes, please provide a summary of the key findings

No specific groups of patients or community will be affected by the initiatives detailed in the report. Where there may be an impact on patients then consultation will be managed as part of that specific programme.

REPORT TO THE BOARD FROM THE AUDIT COMMITTEE MEETING ON 15 MARCH 2017

The key points which the Audit Committee wishes to bring to the Board's attention this month following its last meeting are listed below:

ACTION TRACKER

1. The Audit Committee was very disappointed to note 31 overdue actions from TIAA Internal Audits completed during 2016/17. We had been assured that the Executive would address the action tracker robustly with at least quarterly oversight from EMT, to be led by the Director of Quality Governance and the Director of Finance. Regrettably this seems to have slipped again, despite considerable efforts by TIAA and the Co Sec, and needs urgently to be re-instituted. It's not entirely clear whether this assurance shortfall results from a lack of clarity of executive accountability, or inadequate resource allocation, or a lack of effective prioritisation, or a combination of all three, but the Audit Committee expects and requires urgent action to be taken to provide the necessary assurance that all significant Internal Audit recommendations are completed within the agreed timeframe.

2. We ask the Board to endorse this approach which will require the Executive to co-operate with TIAA, to take responsibility individually and severally as an Executive team for progressing and implementing agreed actions arising from Internal Audits and to report back progress to the Audit Committee in a timely and regular manner. We will report on progress in our Annual Report to the Board.

INTERNAL AUDIT

3. The Audit Committee received Internal Audit Reports on Payroll and Governance Risk Management which received reasonable assurance.

4. The Audit Committee received a follow-up report of the Q1 audit of Overseas Pre-Admission which received only limited assurance, with one urgent recommendation and with the remaining seven recommendations from the Q1 audit still outstanding, with deadlines having been pushed back to September 2017, including that relating to Stage One training of the relevant staff. While we understand that a pilot has been underway, the Committee was very concerned that the main audit recommendations are still outstanding.

5. The Committee received an Internal Audit Report on Procurement: this too received only limited assurance. The three urgent recommendations are that a procurement strategy is required, that breaches of procurement processes are common and not fully reported and that the invoice backlog needs resolution.

6. Only limited assurance could be provided by the Internal Audit of ICT: Telecoms and Security, with the one urgent recommendation relating to communication with SGUL not yet addressed. The CIO assured the Committee that the issues identified were all being addressed and that there is no major risk associated with the proposed implementation timetable.

7. The Audit Committee was also briefed on an operational, rather than assurance, Internal Audit review: 'Finance Deep Dive' which had been completed at the request of the CFO. The Committee noted with concern that four urgent recommendations had been made, relating to the backlog in accounting for Accounts Payable, lack of adequate provision for Agresso user training, updating required for General Ledger codes and inadequate confirmation that PwC report recommendations in June relating to the accounting system have been completed and sustained.

EXTERNAL AUDIT

8. The External Auditors reported that they were encouraged by the their early work on both the financial accounts and the quality accounts, and confirmed that the Finance team is well briefed and engaged.

9. The detailed year end timetable for completion of the external audit and preparation and approval of the annual report and accounts was brought to the Audit Committee for approval. Particular and early attention will be paid to income recognition, asset write-offs as agreed with NHSI and disclosure of Director and Senior Management emoluments, amongst other key areas.

COUNTER FRAUD

10. The progress on several cases was discussed and noted. Counter Fraud staff confirmed that, where required, the relevant professional bodies had been notified of cases in progress. Progress on one long outstanding matter continues to be slow and Audit Committee asked for the necessary steps to be taken to expedite this enquiry. The Committee was not, however, adequately assured that the the learning from completed cases is being appropriately disseminated so that the risk of similar frauds occurring can be reduced; the Committee Chairman undertook to meet separately with the Counter Fraud lead to discuss how this should be improved.

WHISTLEBLOWING

11. An oral report of four cases was provided to the Committee. This will be presented in writing in future by the the responsible executive who is currently the HR Advisor to the Board.

AUDIT COMMITTEE: TERMS OF REFERENCE AND MEMBERSHIP

12. With reference to its revised Terms of Reference, the Committee noted that reports of losses and special compensation, the finalised Trust Scheme of Delegation and other matters would be reported to the next Committee meeting, together with the results of the Committee evaluation and the Committee's Annual Report to the Board.

13. The Committee thanked Gillian Norton for her contribution to the Audit Committee, noting that she had resigned from the Committee following her appointment as Chair of the Trust. Ann Beasley was welcomed as a new member of the Committee.

Sarah Wilton
Chair: Audit Committee
March 2017