St George's University Hospitals NHS
NHS Foundation Trust

Public Board Papers

31 January 2019

Trust Board Meeting
Part 1 - Public

Date and Time: **Thursday 31 January 2019: 10:00 – 13:15**

Venue: **Hyde Park Room, St George's Hospital**

Time	Item	Subject	Lead	Action	Format
FEEDBACK FROM BOARD WALKABOUT					
10:00	**A**	**Visits to various parts of the site**	**Board Members**	-	Oral
OPENING ADMINISTRATION					
10:30	**1.1**	**Welcome and apologies**	**Gillian Norton** Chairman	-	Oral
	1.2	**Declarations of interest**	All	-	Oral
	1.3	**Minutes of meeting on 20 December 2018**	**Gillian Norton** Chairman	Approve	Report
	1.4	**Action log and matters arising**	**All**	Review	Report
10:35	**1.5**	**CEO's update**	**Jacqueline Totterdell** Chief Executive	Inform	Report
QUALITY & PERFORMANCE					
10:45	**2.1**	**Quality and Safety Committee report**	**Sir Norman Williams** Committee Chair	Assure	Report
11:00	**2.2**	**Integrated Quality & Performance report**	**James Friend** Director of Delivery, Efficiency and Transformation	Review	Report
11:15	**2.3**	**Cardiac Surgery Update**	**Richard Jennings** Chief Medical Officer	Assure	Report
11:25	**2.4**	**Learning from deaths Q3 Report**	**Richard Jennings** Chief Medical Officer	Assure	Report
11:35	**2.5**	**Transformation update Q3 Report**	**James Friend** Director of Delivery, Efficiency and Transformation	Inform	Report

Time	Item	Subject	Lead	Action	Format
FINANCE					
11:45	**3.1**	**Finance and Investment Committee report**	**Ann Beasley** Committee Chair	Assure	Report
12:00	**3.2**	**Month 9 Finance Report**	**Andrew Grimshaw** Chief Financial Officer	Update	Report
STRATEGY					
12:05	**4.1**	**Clinical Strategy Highlight Report**	**Suzanne Marsello** Director of Strategy	Update	Report
12:10	**4.2**	**Corporate Objectives 2018 / 2019 Q3 Report**	**Suzanne Marsello** Director of Strategy	Review	Report
GOVERNANCE					
12:20	**5.1**	**Audit Committee Report**	**Sarah Wilton** Committee Chair	Assure	Report
12:30	**5.2**	**Board Assurance Framework (BAF) Q3 Report**	**Avey Bhatia** Chief Nurse and Director of Infection, Prevention and Control	Review	Report
12:40	**5.3**	**Emergency Preparedness Resilience and Response - Annual EPRR Assurance submission to NHS England (London)**	**Ellis Pullinger** Chief Operating Officer	Assure	Report
CLOSING ADMINISTRATION					
12:50	**6.1**	**Questions from the public**			Oral
	6.2	**Any new risks or issues identified**	All		
	6.3	**Any Other Business**			
	6.4	**Reflections on the meeting**			
13.00	**PATIENT / STAFF STORY**				
13.15	**CLOSE**				

Resolution to move to closed session
In accordance with Section 1 (2) Public Bodies (Admissions to Meeting) Act 1960, the Board is invited to approve the following resolution: “That representatives of the press and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest”.

Date of next meeting: Thursday 28 February 2019, 10.00 – 13.00

Hunter Room, St George’s University

Trust Board
Purpose, Meetings and Membership

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

Meetings in 2018-19 (Thursdays)									
25.01.18	22.02.18	29.03.18	26.04.18	31.05.18	28.06.18	26.07.18	30.08.18	27.09.18	25.10.18
29.11.18	20.12.18	31.01.19	28.02.19	28.03.19	25.04.19	30.05.19	27.06.19	25.07.19	29.08.19

Membership and In Attendance Attendees		
Members	**Designation**	**Abbreviation**
Gillian Norton	Chairman	Chairman
Jacqueline Totterdell	Chief Executive Officer	CEO
Ann Beasley	Non-Executive Director/Deputy Chairman	NED
Stephen Collier	Non-Executive Director	NED
Jenny Higham	Non-Executive Director (St George's University Representative)	NED
Sir Norman Williams	Non-Executive Director/Senior Independent Director	NED
Sarah Wilton	Non-Executive Director	NED
Tim Wright	Non-Executive Director	NED
Avey Bhatia	Chief Nurse & Director of Infection, Prevention & Control	CN
Andrew Grimshaw	Chief Finance Officer	CFO
Richard Jennings	Chief Medical Officer	CMO
In Attendance	**Designation**	**Abbreviation**
Harbhajan Brar	Director of Human Resources & Organisational Development	DHROD
James Friend	Director of Delivery, Efficiency & Transformation	DDET
Kevin Howell	Director of Estates & Facilities	DEF
Stephen Jones	Director of Corporate Affairs	DCA
Suzanne Marsello	Director of Strategy	DS
Ellis Pullinger	Chief Operating Officer	COO
Sally Herne	Quality Improvement Director, NHS Improvement	QID
Secretariat	**Designation**	**Abbreviation**
Michael Weaver	Interim Head of Corporate Governance	IHCG
Jill Jaratina	Interim Assistant Trust Secretary	IATS

Minutes of the St George's University Hospitals NHS Foundation Trust Board Meeting
Part 1 (Public)
Thursday 20 December 2018, 10:00 – 13:30
Boardroom, 2nd Floor Hunter Wing, St Georges University

Name	Title	Initials
PRESENT		
Gillian Norton	Chairman	Chairman
Jacqueline Totterdell	Chief Executive Officer	CEO
Ann Beasley	Non-Executive Director	NED
Sir Norman Williams	Non-Executive Director	NED
Sarah Wilton	Non-Executive Director	NED
Tim Wright	Non-Executive Director	NED
Avey Bhatia	Chief Nurse and Director of Infection, Prevention & Control	CN
Andrew Grimshaw	Chief Finance Officer	CFO
Richard Jennings	Chief Medical Officer	CMO

IN ATTENDANCE		
Harbhajan Brar	Director of Human Resources & Organisational Development	DHROD
James Friend	Director of Delivery, Efficiency &Transformation	DDET
Kevin Howell	Director of Estates & Facilities	DEF
Stephen Jones	Director of Corporate Affairs	DCA
Suzanne Marsello	Director of Strategy	DS
Ellis Pullinger	Chief Operating Officer	COO

APOLIGIES		
Stephen Collier	Non-Executive Director	NED

SECRETARIAT		
Shelia M Murphy	Interim Trust Secretary (Minutes)	IDTS

Feedback from Board Visits	
Members of the Board gave feedback on the departments visited, which included Sterile Services, Emergency Department, Clinical Research Facility, Surgical Day Unit, Estates Workshop, Central Stores Receipt and Delivery, Neurology Intensive Care, Holdsworth, Florence, Keate, Caroline, Belgrave and Kent Wards. The COO commented on the enthusiasm of staff on Florence Ward which dealt mainly with cancer patients and patients with difficult social and clinical histories. There was an issue with the amount of time it took for patients to be transferred to the Royal Marsden for radiology treatment for which both trusts had shared responsibility. The Chairman spoke with a patient who had difficulty communicating but was full of praise for the staff and the care he had received.	

Feedback from Board Visits	Action
Ann Beasley reported that the Emergency Department (ED) had been calm and quiet with very enthusiastic and committed staff. The new patient streaming process was working well, with patients waiting no more than 15 minutes to be seen. There was concern about the increase in the volume of patients attending which made it hard to keep pace with demand. In Paediatric ED, the patient flow did not work as well and children often became delayed in assessment. The CN commented that feedback from staff on iClip rollout that it caused some delays in discharge. Tim Wright reported on the Clinical Research Facility which used to be part of the University before transferring to the Trust. It was a patient-facing activity funded by the Clinical Research Network with 400 trials covering a wide range of areas and 11,000 patients involved. He also reported on his visit to the Day Surgery Unit which was spacious, clean and calm, and saw 30 patients a day using five theatres. The text message appointment reminders to patients were working well, achieving 86% response, but had dropped to 76% last month with increased DNAs. Staffing was an issue as was insufficient storage space, with the corridors full of bulky equipment. The DDET reported on his visit to Florence and Keate Wards. He commented that a request to the estates team to fix lights in certain patient areas had taken a week to resolve. He highlighted that additional hardware was required to make better use of iClip. **The DDET highlighted a serious information governance breach, having confiscated an unattended iClip card. He noted that this would be raised formally with the Chief Information Officer via the CFO.** Sir Norman Williams commented that he had spoken to a number of junior doctors from EU member states who expressed concern about the effect of Brexit on their ability to continue working in the NHS. The CFO commented that the Estates Workshop was efficient and reflected on the huge effort by staff. A particular issue for the Workshop was short notice requests. Central Stores had received a Values Award for going above and beyond in rolling out the new stock system. The CMO observed that staff on both Caroline and Belgrave Wards were disappointed by falling from gold to bronze in a recent Ward Accreditation, which was due principally to issues with the assessment of patients. Overall, the wards were well run, friendly and very welcoming. The DS visited Kent Ward, which held silver accreditation and was only two points off gold. In the PFI part of the site, there were problems with a leaking shower leak and as a result 12 patients were having to depend on one shower unit. The DS highlighted that she had found an unlocked drugs cupboard during the visit which was a concern. The NICU was very busy, and relied very heavily on agency staff. In Neuro Intensive Care, there were good links between consultants which had a positive impact on patient care. The Chairman reflected that, overall, there were a lot of things that were positive and that the feedback had moved on a good deal recent months, particularly in relation to estates. Undoubtedly, there continued to be problems with the estate, but what had come through clearly was the generally good morale among staff.	**CFO**

OPENING ADMINISTRATION		Action
1.1	**Welcome, Introductions and apologies**	
	The Chairman opened the meeting and noted that Stephen Collier had given his apologies. She noted that Board was taking place earlier in the month due to the festive period and that, as a result, some of the performance data would be less comprehensive than usual but this was unavoidable.	
1.2	**Declarations of Interest**	
	It was noted that there were no declarations of interest.	
1.3	**Minutes of the meeting held on 29 November 2018**	
	The minutes of the meeting held on 29 November 2018 were agreed as an accurate record subject to two amendments: • Item 1.5: Amend second sentence to read "those who did not provide reports". • Item 2.3: Amend final sentence of second paragraph to add "older people's" after "planned".	
1.4	**Action Log and Matters Arising**	
	The Board reviewed the action log and agreed to close those actions proposed for closure, subject to the substantive discussion on item 2.3 of the agenda on the Elective Care Recovery Programme which would address whether this action had been completed.	
1.5	**Chief Executive Officer's Update**	
	The CEO provided an update on the following issues: • NHS Improvement and NHS England had now appointed the majority of the executive roles in the new joint structure, with Sir David Sloman, Chief Executive of the Royal Free London NHS Foundation Trust, becoming Regional Director for London, replacing Steve Russell. • Steve Livesey had started with the Trust earlier that month and was already having a positive impact on the cardiac surgery unit and would be undertaking improvements to the governance of the unit as well as taking forward measures to improve team behaviours and ways of working. It was noted that the CQC report on cardiac surgery, which had been published on 6 December 2018, confirmed the cardiac surgery service was safe but also noted that improvements were needed in a number of areas, including the culture of the unit. • Performance in cancer and diagnostics was strong but there remained challenges in delivering the emergency care performance standard. • Average response rates to the 2018/19 NHS staff survey in England were 46.4%, with the Trust having achieved a response rate of 54%, which was an improvement compared with the previous year. Flu immunisation was currently at 75% of all Trust staff, and this was above the national average.	

OPENING ADMINISTRATION		Action
1.5	**Chief Executive Officer's Update**	
	• The Diversity and Inclusion Strategy had been launched. All executives would be champions across a variety of groups and this should ensure the work received focused attention. In addition, staff objectives would be set with a specific focus on seeking to ensure a reduction in bullying and harassment at the Trust. • Financially, the Trust remained in a challenged position and further progress was required. A range of factors had contributed to this, including loss of income from certain sources including cardiac surgery and overspends in medical staffing. It was noted that nursing had done well but other areas still needed to reduce cost. **The Board noted the report.**	
QUALITY AND PERFORMANCE		
2.1	**Quality and Safety Committee Report**	
	Sir Norman Williams updated the Board noting specifically: • **QIP Dashboard** - it was noted progress had plateaued, with no deterioration but also no improvement, which was disappointing. Challenges remained such as achieving the one hour standard for giving antibiotics to patients with suspected sepsis and complaints. • **CQC Action Plan** – This was on track apart from eight amber actions which would be on-going such as those for Estates. These would need to be carefully monitored. • **SWL Pathology** – SWLP had performed very well overall, although it was noted that there had been two similar Never Events 11 months apart involving the cross matching of plasma. The recent incident report was being investigated and would report shortly. Immediate action had been taken as the controls put in place since the first incident had not been sufficient. Learning was said to have taken place but the Committee was concerned that a similar incident could have taken place. The Committee had been assured that the necessary actions had now been taken, in particular the standardisation of the blood typing process across all sites where SWLP provided services. • **IQPR** - There had been an increase in falls which was a concern to the Committee, but the outcomes were better. There had also been an increase in type 2 pressure ulcers. The Trust had exceeded its internal threshold for C.Difficile infection rates but still within the national target	

2.1	Quality and Safety Committee Report	Action
	• **PSQG** - The Committee heard that the Trust should be reasonably confident that no serious harm had arisen due to delays in treatment. There were 17 outstanding actions in Children's, Women's, Diagnostic, Theatres, Critical Care and Community Services but the Committee had been assured that appropriate actions were in place. Ann Beasley commented that the SWLP never events were a concern given that there had been two similar events in a relatively short period of time. She queried why the Committee was now assured that remedial action had been taken and that a similar events would not occur. She also queried whether there should be a longer period for following up on never events to ensure there were no similar occurrences. Sir Norman Williams commented that training had not been implemented and reiterated the difficulty with recruitment to the team which had now been rectified. Both events had been on the Croydon site. The CN commented that processes were being standardised across the four different centres which would help prevent future such incidents but this had been challenging. Performance against the antibiotic one hour standard in the emergency department had been reviewed and this suggested an electronic issue relating to IClip rather than a fall in the number of patients receiving treatment within the timescale. With reference to falls and pressure ulcers, the CN drew attention to the timing of the report and availability of data. In response to the Chairman's comment that the Committee was eager to ensure learning is implemented promptly, the CMO observed that learning could be seen in other areas such as C.Difficile and hand hygiene, particularly with the involvement of senior role models and the empowerment of junior staff. The CEO commented that the CMO was undertaking a wider piece of work on clinical governance across the organisation to ensure there was appropriate training and clinical governance across all areas. This would provide the Board with the necessary assurance that the Trust had in place robust structures, systems and processes of clinical governance Trust-wide. The Chairman commented that there was no doubt the accreditation scheme had transformed wards but the Board would like to see evidence that the improvement was embedded and that learning around never events had taken place. She also observed that the work on governance should include SWLP. **The Board noted the report.**	
2.2	**Integrated Quality and Performance Report**	
	It was noted that, due to the timing of the Board meeting, the report was not as comprehensive as usual. The DDET summarised the monthly performance noting there remained a challenge around the 4 hour operating standard and discharge before 11:00 am. Cancer performance continued to be strong and the diagnostic access six week target had been achieved for 12 months.	

2.1	Quality and Safety Committee Report	Action
	However, more work needed to be undertaken with neurosciences and in relation to theatre cancellations. There remained a focus on addressing on the day cancellations for non-clinical reasons; among patients cancelled for this reason, in November 2018 98.1% of these patients had been rebooked within 28 days. The non-elective length of stay had increased in November with a knock on effect on bed availability. It was noted the maternity dashboard had been useful in tracking performance with the continuity of care a key action. The COO reported there would be root cause analysis undertaken on the 2 mental health cases exceeding the 12 hour wait which would be taken to the Trust Executive Committee and Quality and Safety Committee for review.	
2.2	**Integrated Quality and Performance Report**	**Action**
	The CEO commented that informing patients of cancellations on the day should not happen. If junior doctors were listing patients who were then cancelled on the day by consultants this needed to be reviewed. The CN commented that it was the first time that cancelled operations had reached amber with the new General Manger in theatres having a significant positive impact. Tim Wright queried whether staff were conscious of the value of data input such as the importance of discharge times showing the holistic picture of the hospital. The DDET commented that this was not consistent at present. Sarah Wilton commented that staff on the Board visits earlier in the day had referred to encountering some difficulties with IClip. The CFO responded that there would always been difficulty at first but agreed with Tim Wright that there was a need for staff to be on board with the process. The Chairman commented on the high performance on diagnostics and cancer and stated that there needed to be a continuing focus on the emergency department and noted that oversight of juniors should not be overlooked. The DHROD explained that the Trust continued to improve its vacancy rate which had reduced to 8.9% in November 2018. He also noted that the latest data in relation to the Workforce Race Equality Standard would become available in January 2019 and this would be an area of focus. **The Board noted the report.**	
2.3	**Elective Care Recovery Programme Update**	
	The COO presented the report, which explained that the Trust continued to shadow report internally on its referral to treatment waiting time performance and was continuing to see a reduction in the size of the waiting list. The COO also set out the training that staff had received in relation to RTT, with 1,103 staff scheduled to have been trained by the end of December 2018. In addition, since October 2018, all new staff joining the Trust were being trained on RTT. **The Board noted the report, and agreed that the outstanding action relating to RTT training on the Action Log could be closed.**	

2.4	Quality Improvement Academy Update	Action
	The DDET introduced Martin Haynes, Improvement Methodology Director, who gave an overview of the paper, and highlighted the positive participation of staff during the recent Quality Improvement week. He drew attention to the areas in which progress had been made against various initiatives. In response to a question from Sir Norman Williams, the DDET commented that whether the momentum and enthusiasm of staff could be maintained was, to some degree, a cultural issue which was in the process of being addressed. The CEO added that the whole organisation needed to be involved, starting with the Board, with clear objectives for the year ahead. Trust-wide, teams were already responding positively by identifying issues and finding ways to remedy them, such as the steps ICU had taken in reducing ventilation-acquired pneumonia. **The Board noted the report, and agreed that there was significant scope to learn from other organisations, such as Orlando Health which the CEO and colleagues had recently visited, and that the challenge would be around maintaining momentum.**	
2.5	**Cardiac Surgery Update**	
	The CMO presented the report noting that the cardiac surgery service had moved on significantly since the CQC inspection in August 2018 and with the appointment of Steve Livesey, who had taken up post in early December and whose positive impact was already apparent. Mr Livesey was undertaking a review to consider taking back some of the more intermediate complexity cases, through a move from a Euroscore ll of less than two to a Euroscore II of up to five. A range of external assurances continued to be in place with NHS England and NHS Improvement. An independent review of mortality within the period of the NICOR alerts (2013-18) was now in place and had started its work earlier that month. The CMO commented it would be important to identify improvement opportunities in cardiac surgery, but also look beyond this and consider lessons that could be learned in the other areas of the Trust, particularly in relation to clinical governance and learning from Serious Incidents. Sir Norman Williams asked how long the independent mortality review panel was expected to last. The CMO explained that the work had only recently started and initial progress had been slower than anticipated; in part the duration of the review would depend on how quickly the Trust could provide the panel with the information it needed. Sir Norman Williams also commented that the Board needed assurance that there were no other departments in a similar situation. The CEO commented that the CMO would be undertaking a review of clinical governance across the Trust and this would help provide assurance to the Board. In relation to cardiac surgery, the CEO emphasised that the issues with the service had been known within the Trust for some time, but that this was the first time the Trust had sought to tackle the issues.	

2.5	**Cardiac Surgery Update**	**Action**
	An entirely new Executive team had been appointed over the past 18 months and was committed to addressing the problems with the service. The CEO stated that, the CMO's review of Trust-wide clinical governance was likely to identify areas of exemplary practice and others that needed improvement, but the process would identify these areas and provide the assurance required. The DHROD commented that there were areas known to have historical problems and HR was working to ensure staff understood the importance of raising concerns early and how to do so. The Chairman queried whether Mr Livesey had direct access to the Independent Scrutiny Panel, and the CMO confirmed this was the case. **The Board noted the report.**	
2.6	**Water Safety**	
	The DEF presented the report and confirmed that work was being carried out in line with statutory requirements and regulations and reiterated the measures in place to address the risk. The Board was informed of actions underway with completion dates of March and April 2019 to address some of the areas of risk, but there remained gaps in compliance which would require significant capital investment to address. The DEF informed the Board that a recent presentation to the Water Safety Group had been well received and would be presented to Board. The DEF noted that all staff were working together to train staff. Ann Beasley commented that the report provided limited assurance and expressed concern at the gaps in assurance. The Chairman agreed, but also noted that it was a positive step to have the report at Public Board to ensure there was transparency and accountability on such an important issue. The CEO added that the Trust had been engaging with NHS Improvement about water quality and emphasising the need for urgent capital investment. **The Board noted the report.**	
FINANCE		
3.1	**Finance and Investment Committee Report**	
	Ann Beasley presented the report highlighting that the Committee had held useful discussions about financial risk, with Estates and IT remaining high, and had a better understanding of what was being delivered and what needed further mitigation. It was noted that a lot of the mitigation relied on capital funding approval which was still awaited and had been escalated to the Provider Oversight Meeting (POM) with NHS Improvement on 19 December 2018. The Committee also agreed that without this confirmation of funding, patient safety issues were of such a nature that a letter should be written to the Chair of NHS Improvement explaining the severity of the Trust's current capital situation. Emergency flow had been discussed including the potential financial impact.	

3.1	Finance and Investment Committee Report	Action
	It was commented that it was very disappointing that the deficit year-to-date exceeded the control total for the year. It was observed that the forecast for the Trust is between a median case of £55.6m deficit and best case of £51.6m, and there was a commitment from the Executive to deliver the best case scenario. The Committee had emphasised the need to get ahead particularly on the cost improvement programmes. It was reported that there was very good control on cash but once the control total was exceeded cash would become tighter. The CFO noted the deteriorating financial position but commented that whilst the Trust was getting some things wrong there was much it was getting right. Certain issues, such as medical pay, needed to be resolved in order that the impact was not repeated next year. The full CIP value had been delivered and should be again next year. **The Board noted the report.**	**CFO**
3.2	**Month 8 Finance Report**	
	The CFO noted the position was in line with the revised forecast with some variance but consistent with the prediction and pressures previously highlighted. The key issues were cash and capital. The problems with capital had been discussed at the Provider Oversight Meeting with NHS Improvement on 19 December 2018, which had advised that the Trust write to the Chief Executive of NHSI to set out the risks associated with the delay in capital funding. The Chairman added that, at the POM, NHS Improvement had explained that it now recorded such risks on its own corporate risk register. The Chairman commented that there remained no comfort in the current financial position, and there was a significant risk that the Trust would finish the year with the same level of deficit as the previous financial year, and in the best circumstances only just better. **The Board noted the report, and agreed that the CFO should prepare a letter to the Chief Executive of NHS Improvement early in the new year setting out the patient safety risks around further delay in approving the Trust's capital bid.**	**CFO**

WORKFORCE		Action
4.1	**Workforce and Education Committee Report**	
	The DHROD introduced the report in the absence of the Committee Chair. He commented that detailed conversations had taken place on how to change the Trust's culture but this would, by definition, be a long term project. Further to the Board's request that Strategic Risk 8 on the Board Assurance Framework be reviewed, the Committee had agreed to increase the score from 10 to 12 to better reflect the risk around organisational culture. It was also noted that the Diversity and Inclusion Strategy, which had been considered by the Board earlier in the year, had now been launched. The DHROD informed the Board that Mark Hamilton, Associate Medical Director, was looking at seven day services specifically NHSI standards 2, 5, 6 and 8 and had identified a challenge with delivery of standard 2 (requiring all patients to be seen by a consultant within 14 hours of admission) as the cost of compliance was expected to be extremely high. In addition, the DHROD informed the Board that Dr Serena Haywood had been appointed as Guardian of Safe Working subsequent to Mr Sunil Dasan stepping down from the role. In relation to the national VSM pay award, he also noted that whilst there had been an update from NHS Improvement the details of the award required further clarification. **The DHROD would bring a paper on the VSM pay award to the Nomination and Remuneration Committee in January 2019.** Sir Norman Williams expressed disappointment on the 14 hour standard, commenting that it was unacceptable for patients not to be seen within this time frame and suggested the DHROD and CMO look further into this. The CN commented that the Committee's report was clear that currently the Trust was at 78% and needed to be at 90% compliance. The CMO commented that change was needed and that patients should not have to wait until the next consultant ward round to be seen. If the best has been done to optimise the system and the standard cannot be reached it would be necessary to consider what else needed to be done. In response to Ann Beasley asking for the risk score to be reassessed, the DHROD commented that three components fed into the overall score with areas scored at 12 being considered a higher priority. The Chairman commented that the constituent parts did not always have the same weighting but that there was concern that there was inconsistent practice between Committees. **The Board noted the report with the Chairman commenting that seven day working needed further work by the Quality and Safety Committee and Workforce and Education Committee. It was noted that the Board workshop on the BAF on 17 January 2019 would consider the Trust's approach to scoring of risks.**	**DHROD** **CN**

STRATEGY		**Action**
5.1	**Clinical Strategy Highlight Report**	
	The DS commented that there had been a three hour Board strategy seminar that week with dates booked for future seminars. Stakeholder events emerging themes were set out in the Appendix to the report. It was noted that executive director colleagues were aware of the need to ensure all staff groups attended events, not just clinical staff. The DS commented that the report summarised emerging themes, the need for alignment with strategy and that staff are being involved with the strategy development. **The Board noted the report, the progress, issues and risks identified.**	
GOVERNANCE		
6.1	**GDPR Implementation Update**	
	The CFO presented the report. Jenny Hingham asked how the Trust compared with Trusts in becoming compliant with GDPR. The CFO responded commenting that while some Trusts were compliant already, others were in a similar position to St George's. The Chairman asked whether it was yet clear when the Trust would be compliant. The CFO explained that the Trust had made considerable progress in becoming GDPR compliant but there was more to do and a plan was in place to ensure full compliance by mid-2019. The DCA suggested that given the pressure on the Board agenda, it may be appropriate for updates on GDPR to be taken through the Finance and Investment Committee to allow for more detailed scrutiny and assurance than was possible at Board. **Ann Beasley, Chair of the Committee, and the CFO agreed that, from January 2019, FIC would consider GDPR and DPA implementation and provide assurance to the Board on progress with compliance.** **The Board noted the report.**	**CFO**
ESTATES		
7.1	**Patient Led Assessment of the Care Environment (PLACE) 2018**	
	The DEF presented the paper commenting that further to a workshop in September 2018 all low cost issues arising from the assessment had been addressed and preparation was underway for the 2019 PLACE assessment. Overall, St George's had improved but there remained disappointment at the scores for disability and dementia, recognising however that these were issues nationally. The DEF commented that whilst a comparison was not available with other trusts or a national level, he understood the Trust was in the top 50% for the country and top 25% in London. **Sarah Wilton expressed gratitude to the patients who had given their time to the PLACE inspections, which had provided the Board with a very different perspective. It was also noted that the charity had funded a disability study and this would be brought to the Board.**	**DS**

7.1	**Patient Led Assessment of the Care Environment (PLACE) 2018**	**Action**
	The CEO commented that it was necessary to differentiate between sites to ensure that the report was not misleading. The CN commented that there remained a lot of work to do to improve the conditions for patients in some areas and this needed to be costed. Tim Wright asked whether there were likely to be unforeseen capital requests for reviews, to which the DEF responded by commenting that large capital bids were not anticipated. **The Board noted the recommendations set out in the report and requested that the DEF thanked the volunteers for a critical piece of work**.	**DEF**
CLOSING ADMINISTRATION		
8.1	**Questions from the Public**	
	A member of the public referred to the CQC report on cardiac surgery, which had been published on 6 December 2018, and asked the Chairman to explain what steps had been taken at Trust level to rectify what had been described in the report as a lack of credible and effective leadership and managerial oversight. The Chairman responded that the issues affecting the cardiac surgery service were longstanding and that the NICOR alert, which warned of potential excess mortality in the unit, covered the period from April 2013 during which time a completely new Board had been appointed, including a new Executive team. The Trust had undertaken a major restructure of its clinical divisions earlier in the year and the CMO would be leading a comprehensive review of clinical governance across the Trust to ensure that systems and processes functioned effectively, issues were identified early and that lessons were learnt. **A question was raised concerning the attitude of some of the diagnostic staff which was considered unpleasant and upsetting for patients. The Chairman asked the COO to investigate and report back to Board on matters raised concerning the attitude of some of the diagnostic staff which was considered unpleasant and upsetting for patients**	**COO**
8.2	**Any new risks or issues identified**	
	The information governance breach identified during the Board visits was flagged as a risk and that this would be addressed.	
8.3	**Any Other Business**	
	No other business was identified.	
CLOSING ADMINISTRATION		
8.4	**Reflection on meeting**	
	The Chairman introduced the item noting that she had agreed with the CEO and DCA a more structured approach to reflections, with Executive Directors and Non-Executives taking it in turns to lead the discussion following Board meetings. On this occasion, she asked the DCA to offer his reflections on the meeting. The DCA offered reflections on the quality of the agenda, the supporting paperwork, the discussion at the meeting and participation across the Board.	

8.4	Reflection on meeting	Action
	The Board agenda had been quite heavy, albeit that there had been a good balance between seeking assurance, setting strategy, and discussing culture and that the agenda items corresponded to the major areas of risk on the Board Assurance Framework. The papers supported productive discussions at the meeting, but as had been identified at the Board development day in October, there were opportunities to improve the quality of Board papers and this was being taken forward. In terms of the discussions, the DCA noted that these generally complemented and built on the discussions at the sub-Committees of the Board, rather than duplicated them, and that the discussion of the Quality and Safety Committee report had been a good example of this, which tested and probed where the Committee felt assured. The discussion on cardiac surgery had been the most reflective to date in Part 1 of the Board. The DCA also highlighted the number of occurrences during the meeting where a contribution referred back to the earlier Board visits across the Trust, which demonstrated the value of holding the visits prior to Board meetings. The CEO commented that the Executives should seek to distill the key points of their papers when presenting rather than summarise their reports as well as focus more clearly on assurance. She also noted that the Board should not only be about Non-Executive Directors questioning Executives but that the Executives should challenge each other more than at present. Jenny Higham and the Chairman commented that where an item was to be discussed in both public and private, it was not always clear which issues should be discussed in which part of the meeting. The Chairman emphasised the importance of public accountability given the Trust's current position.	
PATIENT STORY		
As the patient (Patient M) was unable to attend, Victoria Morrison, Head of Nursing (Surgery and Major Trauma), and Martin Haynes, Improvement Methodology Director, set out the details of the story and the lessons learnt by the Trust. The patient's experience had resulted in a complex complaint. The patient had received successful surgery as a result of which she was temporarily incapacitated. She was cared for on a ward in which a fellow patient had undergone emergency amputation and a patient known to staff to have challenging behaviour was also admitted. The behaviour of these patients was intimidating, particularly towards Patient M, resulting in Patient M having to be provided with a security escort on discharge from the ward. It was acknowledged how Patient M must have felt given that she was incapacitated and could not walk away from the situation. Discussion took place on the need to ensure staff and users of the Trust were fully aware of the zero tolerance policy but also the need for staff to be properly informed of issues so that they could appropriately prioritise against competing demands. Also identified was the risk of accepting as "norms" issues that should and could be addressed such as proximity of single sex toilet facilities for patients and communicating such issues with patients. The staff involved had been extremely upset about the failure to transfer Patient M to another ward.		

PATIENT STORY	Action
As a result of the experience, the Trust's violence and aggression policy was now followed more rigorously and the zero tolerance aspects of this had been implemented. The CEO commented that there appeared to be a culture of not applying the policy due to a lack of knowledge among staff. **The DHROD commented that he would look into staff awareness of the violence and aggression policy further as it linked in with bullying and harassment on which the Trust was committed to addressing. The DEF commented that staff could be afraid that violence or aggressive patients knew where they worked and that the policy would only go so far to protect them.** The CMO queried if an issue was that staff did not know what should be tolerated and how much support they would receive from management. The CN commented on the fact that this was an immobile patient who was unable to walk away from a situation. Victoria Morrison and Martin Haynes responded that the Violence and Aggression Group had noted a lack of support from clinical leads in securing exclusion and that there were ethical considerations. However, an awareness of policy would mean that the warning process could start as soon as possible. The Chairman thanked Victoria and Martin for presenting the patient's experience. The CEO commented that the complaint had prompted staff to think in a different way, to learn and apply policy, but there remained a need to empower staff and make it clear what would not be tolerated.	**DHROD**

Date of next meeting: Thursday 31 January 2018 at St George's Hospital

Trust Board Action Log Part 1 - December 2018

Action Ref	Section	Action	Due	Lead	Commentary	Status
TB 20.12.2018/01	**Board visits**	Information Governance breach involving Iclip cards to be raised with Chief Information Officer	31/01/2019	**CFO**	Information Governance Breach has been raised with the Chief Information Officer (CIO) and discussed at Information Governance group. Actions to addressthe issue are being identified.	**PROPOSED FOR CLOSURE**
TB 20.12.2018/02	**Finance and Investment Committee report**	CFO should prepare a letter to be sent to the Chair of NHS Improvement early in the new year setting out the patient safety risks around further delay in approving the Trust's capital bid.	31/01/2019	**CFO**	Letter drafted for Chair and CEO and sent to NHS Improvement.	**PROPOSED FOR CLOSURE**
TB 20.12.2018/03	**Workforce and Education Committee report**	The DHROD to bring a paper on the VSM pay award to the Nomination and Remuneration Committee in January 2019.	31/01/2019	**DHROD**	On agenda for Nomination & Remuneration Committee meeting on 31 January 2019	**PROPOSED FOR CLOSURE**
TB 20.12.2018/04	**Workforce and Education Committee report**	Board workshop on the BAF on 17 January 2019 would consider the Trust's approach to scoring of risks.	17/01/2019	**CN**	Addressed as part of Board workshop, held on 17 January 2019.	**PROPOSED FOR CLOSURE**
TB 20.12.2019/05	**GDPR implementation update**	FIC would consider GDPR and DPA implementation and provide assurance to the Board on progress with compliance.	24/01/2019	**CFO**	Considered at Finance and Investment Committee on 24 January 2019.	**PROPOSED FOR CLOSURE**
TB 20/12/18 Ref	**Questions from the Public**	The Chairman asked the COO to investigate and report back to Board on matters raised concerning the attitude of some of the diagnostic staff which was considered unpleasant and upsetting for patients	31/01/2019	**COO**	The member of staff concerned acknowledges that their behaviour was inappropriate and has received an informal written warning a as per Trust Policy	**PROPOSED FOR CLOSURE**

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	31 January 2019	**Agenda No.**	**1.5**
Report Title:	**Chief Executive Officer's Update**		
Lead Director/ Manager:	**Jacqueline Totterdell, Chief Executive**		
Report Author:	Jacqueline Totterdell, Chief Executive		
Presented for:	Assurance		
Executive Summary:	Overview of the Trust activity since the last Trust Board Meeting.		
Recommendation:	The Board is requested to receive the report for information.		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	All		
Single Oversight Framework Theme:	All		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A

Chief Executive's Update
Trust Board, 31 January 2019

The NHS Long Term Plan and the Trust's strategy

I want to begin my report to the Trust Board this month by talking briefly about the NHS Long Term Plan, and how it links to our emerging five year strategy here at the Trust.

The NHS Long Term Plan – published earlier this month – represents a significant milestone for the health service, and the potential for radical change is clear; including for major secondary care providers like St George's. The greater focus of the Government's plan is on prevention, and primary care – and this has been rightly welcomed. Other services – such as mental health – are also set to see greater investment than has come before, which is long overdue.

Like all acute care providers, we are looking at the NHS Long Term Plan and digesting what it means for us – and, as importantly for St George's, how it links with our own strategy for 2019-24, which will be published in the coming months.

Staff and stakeholders have been heavily involved in the development stages of our strategy – with nearly 500 people taking part in 23 engagement events over the past 6 months. Central to our strategy will be an ambition to become a provider of outstanding services; a great partner; and the centre of choice for tertiary and specialist services.

What this means in practice – and how it links with service delivery – will become more apparent in the coming weeks, and be informed by what staff and members of the public have told us, as well as the direction of travel set out in the NHS Long Term Plan.

UK withdrawal from the European Union

The UK's withdrawal from the European Union has been the subject of intense national debate this month, and preparations are underway across the NHS, including contingency planning for a 'no deal Brexit' on 29 March 2019.

In December 2018, the Department of Health and Social Care issued guidance to all NHS organisations regarding the steps that needed to be taken to ensure 'operational readiness' for a 'no deal Brexit'. Prior to this, Trusts had been instructed not to take any action in relation to Brexit planning, and building increased levels of stock was explicitly prohibited. A national review of supplier readiness was completed in November 2018. Earlier this month, Dr Keith Ridge, Chief Pharmaceutical Officer at NHS England, wrote to all Trust pharmacy teams setting out the steps that had been taken at national level to maintain medicines supply in the event of a 'no deal' Brexit, which reiterated previous advice to Trusts not to stockpile medicines.

At regional level, NHS England and NHS Improvement have established regional groups involving key stakeholders to share intelligence, considering emerging issues, and discuss mitigating actions required in relation to any adverse impacts on the health and social care. The Trust is participating in the NHS London Brexit Oversight Group and has nominated the Chief Nurse to be a member of the group.

Internally, the Trust has appointed the Chief Finance Officer as the Senior Responsible Officer and 'Brexit Lead' and a small working group has been established to support him in this role, with the

Chief Medical Officer acting as clinical link to the group. The group held its first meeting earlier this month and, to date, has not identified any material risks across the scope of its work.

The Trust announced in November 2018 that it would fully reimburse the costs of the application by any member of staff from an EU member state who wished to remain in the UK after Brexit. St George's has more than 1,200 EU staff who are highly valued and make an enormous contribution to the services we provide every day. This month, the Prime Minister announced that from 30 March 2019, EU nationals who wish to remain in the UK will no longer need to pay to apply for settled status and all applications made prior to this will be reimbursed.

Cardiac surgery at St George's

In last month's update, I talked about the positive difference Steve Livesey was making as the new clinical lead for the cardiac surgery service at St George's. Steve joined us on 3 December from Southampton, and is working at pace to deliver the improvements we all know are needed, and as confirmed by the CQC's inspection report before Christmas – and this has been welcomed by staff in the unit.

Last week, we announced that NHS Improvement had commissioned a mortality review of patients who underwent cardiac surgery at the Trust between April 2013 and September 2018. The purpose of the review is to examine the safety and quality of care that patients who died during this period received. In the announcement, we were clear that the review is welcome, because it will give everyone – including current patients - complete confidence that everything is being done to ensure we have a safe and sustainable cardiac surgery service.

News of the review will naturally concern the relatives of some former patients, and we have put in place a dedicated phone number people can call if they would like to talk to somebody. Detailed information about the review has also been posted on the Trust website. It is important to stress that the review is part of good governance, and there are no concerns about the current safety of the service. The review will have no negative impact on the day to day running of the service, and this is important, given the pressures our teams have faced in recent months.

As an organisation, we remain committed to cardiac surgery, and we are – step by step – making progress with the improvement plan we have in place for the service. However, as I've said before, some of the issues are long-standing, and will not be fixed overnight.

Referral to treatment (RTT), and our operational performance

It is well known that the Trust stopped reporting its referral to treatment (RTT) data in 2016 due to data quality concerns.

We have made significant progress since then, and hope to be in a position to return to reporting on the Tooting site before the end of March this year, subject to the approval of the Trust Board. An external assessment of our data quality and operational processes has been undertaken, which has not identified any obstacles that would prevent us from reporting our RTT position again. We now have robust systems and processes in place at St George's for tracking and prioritising our patients – on the one hand, this is the very least we should have, but the fact we have put this in place, given the significant problems of the past, is a big step forward. Of course, reducing our waiting lists and making sure patients get the treatment they need remains a challenge– and an organisational priority for us on a daily basis.

Our emergency care performance has been very challenged in January, as expected. Our teams coped exceptionally well over the Christmas and New Year period, particularly compared to other London Trusts, but it has been more difficult in recent days and weeks.

Last year our performance for cancer and diagnostics was consistently good, and I am determined we maintain this during 2019 – it is good for our patients, and also gives us a strong platform to build from in terms of operational performance more generally.

Diversity and inclusion

Another major priority for the coming year is diversity and inclusion, an issue that has been raised by our staff as an organisational problem for a number of years.

In a bid to tackle this, we have established four separate groups to look at specific areas; namely Black, Asian and Minority Ethnic (BAME); Disability and Wellbeing; Lesbian, Gay, Bisexual and Trans (LGBT); and Women. Few people probably realise that, for example, 42% of our staff are from a Black, Asian or Minority Ethnic background. And yet, this degree of representation is not reflected across all of our staffing grades. We need to properly understand this. We know our BAME staff are less likely to be shortlisted and appointed to a role when compared to staff who are white. We also that we are twice as likely to start a disciplinary process with our BAME members of staff than we are with a white member of staff. This is not right, and we have to do something about it.

I attended the first meeting of the BAME group last week – and, whilst attendance wasn't as good as I would have hoped, I learned a huge amount. This included hearing from staff about their experiences of inequity, or frustration at the lack of progress the organisation has made in ensuring that everyone is valued equally; everyone has the same opportunities; and all are treated fairly.

It is clear that commitments have been made in the past, but insufficient progress has been made – we need to rectify this, and in a way that will make a meaningful difference to our staff, and their working lives here at the Trust.

High quality care and reasons to celebrate

As always, there are many examples of our staff providing high quality care, and going above and beyond.

Many of will have read about the case of former BBC journalist Martin Bell, who had reconstructive facial surgery under the care of surgeon Helen Witherow and our maxillofacial team. I've visited the maxillofacial team myself, and the work they do really is something to behold; so it's great to see them in the public eye.

Elsewhere, our new e-learning course for staff on the Mental Capacity Act is proving very popular, and to date, 500 staff have taken it, which is positive, given we know that this is an area we need to improve on, and at pace.

Finally, I am delighted that the St George's Hero Awards will be taking place in May this year, courtesy of the St George's Hospital Charity.

The inaugural awards last year were fantastic, and I am hoping hundreds of staff are once again put forward for the eight categories that will open for nominations on 4 February.

Other business

I can confirm that there have been no uses of the Trust seal since the last Trust Board meeting.

Jacqueline Totterdell,
Chief Executive

Meeting Title:	**Trust Board**		
Date:	31 January 2019	**Agenda No**	**2.1**
Report Title:	**Quality and Safety Committee report**		
Lead Director/ Manager:	**Sir Norman Williams, Chairman of the Quality and Safety Committee**		
Report Author:	Sir Norman Williams, Chairman of the Quality and Safety Committee		
Presented for:	Assurance		
Executive Summary:	The report sets out the key issues discussed and agreed by the Committee at its meeting on the 24 January 2019.		
Recommendation:	The Board is requested to note the update.		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	All CQC domains		
Single Oversight Framework Theme:	Quality of care, Operational Performance, Leadership and Improvement Capability		
Implications			
Risk:	Relevant risks considered		
Legal/Regulatory:	CQC Regulatory Standards		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A
Appendices:	N/A		

Quality and Safety Committee Report – January 2019

Matters for the Board's attention

The Quality and Safety Committee met on Thursday 24 January 2019 and agreed to bring the following matters to the Board's attention:

1. Learning from clinical audits to prevent recurrence of Serious Incidents and Never Events

Members of the Committee noted an action for the Director of Quality Governance to provide a report demonstrating that actions taken as a result of serious incidents and never events have been delivered, and are sustained, for the meeting in February 2019. As Chair, I emphasised the need to ensure the Committee was assured that learning from such incidents has been embedded. The report should contain quantifiable data that provides evidence that lessons have been learnt. Members of the Committee noted there had been a recurrence of Never Events where there had been an identifiable need for training.

2. Quality Improvement (QIP) Dashboard

The Committee discussed the QIP dashboard and noted that a number of Key Performance Indicators (KPIs) appeared stable. The Committee noted the Trust was changing its focus around key drivers and introducing a revised and refreshed quality improvement plan (QIP) from April 2019. The Trust is planning a significant number of staff events with Executive leads to review the proposed QIP and the Trust is confident the refreshed plan will lead to an improvement against the KPIs.

3. Duty of Candour

The Committee noted a slippage in performance in KPI QR05, Duty of Candour completed for all incidents (as graded on the Trust Risk Management System) at moderate harm and above. The deterioration in performance was considered to be a local issue that related to capacity in a division. The Committee noted remedial action being taken by the Trust to recover performance.

4. Trust Action Plan in Response to the Care Quality Commission (CQC) Inspection Update

As at 24 December 2018, 30 of the 80 actions were completed. The Trust had missed the deadline for one red action, with no mitigation in place. There were 8 amber actions, two of which are regulatory requirements, where the deadline had been missed / will be missed with mitigation for delivery in place and with evidence of progress supplied. To ensure the Trust meets all the regulatory requirements identified in the CQC Inspection in March 2018 the Trust had set up a weekly Executive Challenge meeting to review all areas of concern, identify what additional support is required to complete the action and hold to account those directly responsible for delivery of the action. The Chair expressed concern in relation to performance associated with Basic Life Support training, reported as 64% as of 11 January 2019. The Trust was commissioning additional training resources and expected to achieve 85% performance across all mandatory training areas.

5. Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS)

The Trust was required to ensure staff receive training so they are aware of their responsibility and apply the Principles of Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The Trust had set a training target of achieving 90% of staff trained to level 1 MCA and DoLs by 31 December 2018. As of 24 December 2018 overall performance was 82%. The Trust was confident it would meet its target for Level 1 training by 31 March 2019.

6. Integrated Quality and Performance Report (IQRP)

The Committee were informed of a Never Event reported in January 2019 and two Serious Incidents that were subject to an on-going Root Cause Analysis (RCA) investigation. The Committee noted only one case of Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia had been reported to date for 2018/2019.

7. Elective Care Recovery Programme

The Committee supported the recommendation that the Trust is ready to return to Referral to Treatment (RTT) National Reporting for the Tooting site from February 2019. The Trust Board meeting in Public on 31 January 2019 would take the final decision.

8. **Patient Safety and Quality Group**

Clinical Harm
The Committee noted that the South West London (SWL) General Practitioners (GP) have sought assurance that all patients they have identified as having potential for harm have been independently reviewed. A group of 40 patients where this is unclear are being reviewed by a GP on the Clinical Harm review panel. The Committee noted that at the time of the PSQG report no patients have been found to have suffered harm.

Legal Services
The Committee received an update on clinical negligence claims, including a claim related to a 2011 serious incident that led to serious harm to the patient and which resulted in a damages of £4.4 million. The serious incident investigation carried out at the time identified failings. Learning and the actions taken have been shared across the organisation.

9. Water Safety Report

The Committee asked the Trust Executive to decide the process for providing assurance to the Board through the Finance and Investment Committee.

10. Mortality Monitoring Committee (MMC) Report including Mortality and Learning from Deaths Quarter 3 Report

The Committee received a report of the work of the MMC for Q3 2018/19 that included information and learning identified through independent case record review and an update on the delivery of requirements of the Learning from Deaths framework. The Committee noted and supported the introduction of the Medical Examiner System from April 2019.

11. Board Assurance Framework (BAF)

The Committee noted the quality of data for RTT has been stable for several months and asked for the significant assurance to be reflected in the assurance statement. Assurance on sustainability remains 'partial' and the overall view of assurance for this risk. . The Committee noted the need to review the current risk score for SR4 and its link to SR17 as the level of reported risk did not reflect emerging risks in the external environment related to the STP.

Sir Norman Williams
Committee Chair

24 January 2019

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	31 January 2019	**Agenda No**	**2.2**
Report Title:	**Integrated Quality and Performance Report**		
Lead Director/ Manager:	**James Friend, Director of Delivery, Efficiency & Transformation**		
Report Author:	Emma Hedges & Kaye Glover		
Presented for:	Information and assurance about Quality and Performance for the year to Month 9.		
Executive Summary:	This report consolidates the latest management information and improvement actions across our quality, patient access, performance and workforce objectives. The Trust is performing positively against a number of indicators, including a reduction in patient's length of stay, continued positive recommendation rate through Friends and Family survey from our inpatients, and increasing the number of cancelled operations re-booked within 28 days. However existing challenges continue in particular Four Hour Operating Standard and patient flow. The Trust has maintained compliance against the Diagnostic access target, all Cancer standards and continues to manage the use of agency workforce.		
Recommendation:	The Board is requested to note the report		
Supports			
Trust Strategic Objective:	Treat the Patient, Treat the Person Right Care, Right Place, Right Time		
CQC Theme:	All		
Single Oversight Framework Theme:	Quality of Care Operational Performance		
Implications			
Risk:	NHS Constitutional Access Standards are not being consistently delivered and risk remains that planned improvement actions fail to have sustained impact		
Legal/Regulatory:	The trust remains in Quality Special Measures based on the assessment of the Regulator NHS Improvement		
Resources:	Clinical and operational resources are actively prioritised to maximise quality and performance		
Previously Considered by:	Finance and Investment Committee	**Date**	24/01/2019
Equality Impact Assessment:	None		
Appendices:	None		

excellent
kind
responsible
respectful

St George's University Hospitals NHS
NHS Foundation Trust

Integrated Quality & Performance Report for Trust Board

Meeting Date – 31 January 2019
Reporting period – December 2018

Outstanding care, every time

St George's University Hospitals NHS
NHS Foundation Trust

OUTSTANDING CARE, EVERY TIME

OUR **OUTCOMES**	How are we doing?					
OUR **FINANCE & PRODUCTIVITY** PERSPECTIVE	Activity Summary	Bed productivity (length of stay)	Outpatient productivity (Attendances per day)	Theatre productivity (cases per session)		
OUR **PATIENT** PERSPECTIVE	Patient safety	Infection Control	Mortality	Readmissions	Maternity	Patient Voice
OUR **PROCESS** PERSPECTIVE	Emergency Flow	Cancer	Diagnostics	On the day cancellations		
OUR **PEOPLE** PERSPECTIVE	Workforce	Agency use				

St George's University Hospitals NHS
NHS Foundation Trust

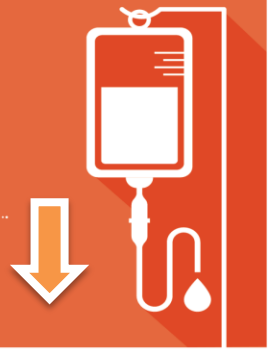
HOW ARE WE DOING?

December 2018

Daycase and Elective Surgery operations

Actual
4,124

Target 4,289



Discharges before 11am

Actual 17.53%

Target 30%

Four Hour Emergency Standard

Actual
85.64%

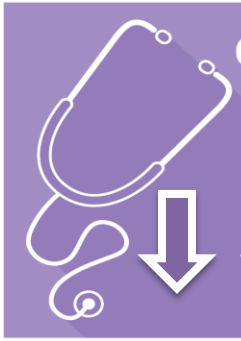
Target 95%

Whole Trust Inpatient Friends and Family Test

Actual
96%

Target 95%

Outpatient First Appointment



Actual 14,407

Target 13,756

Better data, safer patients

Outpatients appointments with RTT outcome recorded

Actual
91%

Target
88%

Activity Summary

St George's University Hospitals NHS
NHS Foundation Trust

The table below compares activity to previous months and year to date and against plan for the reporting period

		Activity compared to previous year			Activity against plan for month		Activity compared to previous year			Activity against plan YTD	
		Dec-17	Dec-18	Variance	Plan Dec-18	Variance	YTD 17/18	YTD 18/19	Variance	Plan YTD	Variance
ED	ED Attendances	13,539	13,869	2.44%	14,398	-3.67%	124,795	125,932	0.91%	127,721	-1.40%
Inpatient	Elective & Daycase	3,924	3,818	-2.70%	4,289	-10.98%	40,974	43,138	5.28%	45,154	-4.46%
	Non Elective	3,852	4,027	4.54%	4,278	-5.86%	35,008	36,019	2.89%	37,683	-4.42%
Outpatient	OP Attendances	43,588	44,718	2.59%	46,426	-3.68%	468,849	496,920	5.99%	493,535	0.69%

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

Source: SLAM

Executive Summary – December 2018

St George's University Hospitals NHS
NHS Foundation Trust

Our Outcomes

- The area of greatest delivery challenge to the Trust is around Emergency Flow where are seeing increased attendances through the Emergency Department and non elective admissions compared to the same period last year. Four hour operating standard performance has been varied throughout the month. Bed Occupancy has been above 92.5% impacting the time at which patients requiring admission can leave the Emergency Department and when the next patients can be treated.
- Whilst our Elective activity volumes are close to plan and there is more assurance around data capture there is still capacity to increase utilisation across our theatres. An activity recovery plan is in place to provide assurance over the aspects of the delivery control framework and sets out eleven key improvements underway.

Finance and Productivity

- Elective and Daycase activity is currently showing below plan however there will be a level of post month data catch up. Cases per session are below previous highs in Cardiothoracic, Oral & Maxillofacial Surgery and as a Trust below the same period last year. Theatre touchtime utilisation is tracked weekly and is currently performing at 80% against the 85% threshold targeted. The number of daycase procedures per working day has seen a positive increase compared to the same period last year, treating on average fourteen more patients per working day. Overall planned care operations per day are up by 11 year to date compared to 2017.

Our Patients

- The Trust reported three patients with attributable Clostridium Difficile infection in December, against an annual target set at 30 cases in 2018/19. The Trust is reporting twenty-five cases year to date and is above the threshold trajectory for the period between April and December.
- Both the Trust-level mortality indicators (SHMI and HSMR) remain lower than expected compared to national patterns.

Process

- Performance against the Four Hour Operating Standard in December was 85.6%, which was below the monthly improvement trajectory of 90%. The improvement trajectory requires the delivery of 90% performance in January 2019 and relies upon continued improvement in the experience for patients not requiring admission.
- The Trust achieved all of the seven national mandated cancer standards in the month of November, continuing to achieve 14 day standard and the 62 day standard.
- Focus remains on reducing on the day non clinical cancellations and ensuring that all patients are rebooked within 28 days, in December 96.7% of our cancelled patients were re-booked within 28 days.

Our People

- The Trust Vacancy rate has been achieved in the month of December reporting 9.4% against a target of 10%
- Staff sickness remains above the trust target of 3% for the month of December.
- Non-medical appraisal rates remain below target in December with a performance of 71.5% against a 90% target.
- For December, the Trust's total pay was £42.14m. This is £0.22m adverse to a plan of £41.93m

Length of Stay

Non Elective Length of Stay (General and Acute Beds)

Directorate	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Discharges in the last month	Average length of Stay 2017-18	Average length of Stay 2018-19	Variance	Trend
Acute Medicine	3.2	3.4	3.5	2.8	2.9	2.7	2.6	2.7	2.6	2.6	2.5	2.7	3.0	2,560	3.0	2.7	-0.30	
Cardiothoracic	8.8	9.4	8.3	9.0	9.0	8.7	7.8	8.5	8.9	8.6	8.8	7.8	9.0	330	8.8	8.6	-0.21	
Childrens & Women	2.3	2.7	2.7	2.5	2.5	2.5	2.4	2.5	2.4	2.4	2.4	2.4	2.4	1,725	3.5	2.4	-1.09	
Neurosciences	10.6	9.4	8.7	10.6	8.9	10.6	11.6	9.4	9.6	6.6	7.7	8.4	8.4	237	9.4	9.0	-0.41	
Senior Health	9.5	9.9	9.3	8.4	11.3	10.2	11.8	7.4	12.0	7.8	7.6	8.8	10.8	86	11.5	9.7	-1.76	
Specialist Medicine	9.7	7.7	9.7	7.6	6.1	9.3	7.3	6.4	8.7	6.8	6.4	7.9	7.1	236	7.7	7.3	-0.41	
Surgery & Trauma	4.4	4.8	5.0	4.3	4.6	4.0	4.6	3.7	5.0	4.4	4.6	5.2	3.8	885	4.5	4.4	-0.07	
Therapeutics	17.2	6.1	7.5	13.2	9.8	9.8	3.6	19.2	8.3	15.7	24.7	9.8	22.5	18	11.8	13.7	1.94	
Grand Total	**4.2**	**4.3**	**4.4**	**4.0**	**4.0**	**3.9**	**3.9**	**3.7**	**4.0**	**3.6**	**3.6**	**3.8**	**3.9**	**6,077**	**4.5**	**3.8**	-0.63	

Briefing

- The non elective length of stay data is based on the patient's discharge date from the hospital.
- Over the last twelve months patients admitted to the hospital via an emergency pathway spend on average 3.8 days in a hospital bed, this includes patients with a zero length of stay. At Trust level this remains in line with National Model Hospital data.
- In the month of December Acute Medicine and Senior Health have seen a 10% increase in patient length of stay, however, compared to the previous year the Trust has seen an overall reduction across all directorates improving bed workflow and reducing the umber of patients waiting for a hospital bed to become available from the Emergency Department.
- The implementation of a fully embedded ambulatory care unit within Acute medicine continues to enable rapid access to same day assessment, diagnostics and treatment and increased usage of the discharge lounge which has seen a 5% increase in throughput compared to December 2017 as well as a positive reduction in the number of Delayed Transfers of Care declared.

Actions

- The Emergency Department and Inpatient Clinical teams have identified a range of patient experience, quality and productivity opportunities to evolve the process embedded within iClip and these need to be the immediate priority
- One off clinical capacity is required to return the stranded patient volumes to levels where there is confidence that patients are being enabled to leave hospital in a timely manner and others admitted likewise.

Length of Stay

Elective Length of Stay (Excluding Daycase)

Directorate	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Discharges in the last month	Average length of Stay 2017-18	2018-19	Variance	Trend
Cardiothoracic	4.4	4.5	4.2	4.8	4.1	4.0	4.4	4.1	4.4	2.9	3.8	3.3	3.7	182	4.6	3.9	-0.69	
Childrens & Women	3.6	2.8	2.0	2.1	2.3	3.2	2.7	2.2	2.1	3.1	2.5	2.4	2.4	52	2.7	2.5	-0.15	
Neurosciences	11.3	11.9	7.8	12.7	8.7	7.3	12.8	7.1	8.9	10.0	8.0	9.1	10.3	134	10.1	9.0	-1.10	
Surgery & Trauma	4.0	4.4	3.1	3.2	3.8	4.1	3.7	3.3	4.3	3.4	3.6	3.6	4.6	323	3.9	3.7	-0.23	
Grand Total	**5.4**	**5.7**	**4.1**	**5.2**	**4.6**	**4.6**	**5.5**	**4.1**	**4.8**	**4.7**	**4.4**	**4.6**	**5.6**	**691**	**5.1**	**4.7**	-0.39	

Briefing

- Over the last twelve months patients admitted to the hospital via an elective pathway spend on average 4.7 days in a hospital bed, a reduction in length of stay has been observed compared to the previous years meaning patients can be discharged home earlier following their procedure.
- The Trust has observed significant improvement within Neurosciences compared to last year reducing the length of stay of our planned patients by one day.
- Latest Model Hospital data indicates that around four beds of capacity could be released at any one time were the Trust to match peer group Daycase rates, with 1,200 fewer patients needing to stay in hospital overnight each year.
- The Theatres Teams are also working to ensure that patients with increased likelihood of being able to go home on the day of their operation are placed at the start of the Theatre list to maximise the probability that they do not need to be admitted

St George's University Hospitals NHS
NHS Foundation Trust

Outpatient Productivity

First Outpatient Attendances (average per working day)

Directorate	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	First Outpatient Attendances per working day 2017-18	2018-19	Variance	Trend
Cardiology, Cardiothoracic & Vascular Services	53	65	59	60	59	62	66	57	54	58	59	67	48	66	59	-10.8%	
Childrens Services	44	50	47	40	41	50	49	42	42	50	45	51	39	47	45	-2.3%	
Neuro	81	91	85	86	87	83	83	73	67	81	84	88	73	82	80	-2.8%	
Renal & Oncology	21	23	24	22	25	27	30	24	25	23	27	28	22	23	25	9.7%	
Specialist Medicine	129	151	152	148	139	153	157	142	129	144	142	150	125	144	142	-1.3%	
Surgery	240	249	248	245	265	271	300	264	253	270	279	275	255	256	270	5.4%	
Womens Services	76	81	74	69	82	85	92	89	85	89	86	90	69	80	85	7.1%	
T&O	40	51	47	54	55	56	60	62	50	55	52	55	49	50	55	9.2%	
Other	31	33	35	32	37	38	43	38	34	36	37	34	34	54	37	-32.2%	
Total	**715**	**794**	**771**	**756**	**790**	**827**	**880**	**791**	**737**	**805**	**812**	**838**	**714**	**803**	**799**	-0.4%	

Follow Up Outpatient Attendances (average per working day)

Directorate	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	FollowUp Outpatient Attendances per working day 2017-18	2018-19	Variance	Trend
Cardiothoracic & Vascular Services	96	119	107	98	121	116	113	107	100	117	107	124	95	111	111	0.2%	
Childrens Services	73	82	81	70	72	81	73	77	76	87	81	90	75	78	79	1.0%	
Neuro	98	112	104	107	114	113	113	109	105	122	117	123	97	102	113	10.4%	
Renal & Oncology	193	206	197	191	205	217	228	229	219	248	245	243	225	209	229	9.5%	
Specialist Medicine	442	500	489	499	500	520	501	508	477	533	509	529	478	482	506	5.1%	
Surgery	327	361	346	332	354	374	357	349	336	357	352	362	324	351	352	0.1%	
Womens Services	55	65	61	46	50	58	52	64	58	78	69	76	52	53	62	17.3%	
T&O	75	79	73	76	84	81	82	86	77	82	85	93	75	80	83	3.3%	
Other	41	47	48	42	99	98	94	89	86	97	92	90	76	50	91	82.2%	
Total	**1,437**	**1,612**	**1,545**	**1,496**	**1,598**	**1,659**	**1,613**	**1,618**	**1,534**	**1,721**	**1,656**	**1,730**	**1,496**	**1,554**	**1,625**	4.6%	

Briefing

- Outpatient activity year to date is above plan by 0.7%, over performing in both First and Follow up appointments driven by Children's and Women's Division and Surgical Specialties
- Across the Directorates, First Outpatient attendances averaged 714 per working day and is below the SLA target for the month, although this is likely to be a factor of data capture and will catch up. A number of services are slightly below monthly SLA plan for the month, which we will expect to increase once coding has been completed. The RAG rating applied compares to the SLA plan per working day which saw a reduction in December due to the bank holidays. Activity remained comparable to last years activity.
- Follow-up attendances on average remain consistent however remains above plan, meaning that the new to follow up ratios are above where we need them to be against target. This is particularly seen within Diabetes, Respiratory, Rheumatology and General Surgery where the ration is above national average. Services are reviewing the recording of particular appointments as some will be classified as outpatient procedures.

Actions

- Two way text reminder service being extended to 400 patients per day

Outpatient Productivity

First and Follow Up DNA Rates (by month)

Directorate	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	DNA's in the last month	Patients not attending rate 2017-18	Patients not attending rate 2018-19	Variance	Trend
Cardiothoracic & Vascular Services	9.6%	9.9%	9.3%	10.3%	10.8%	10.2%	9.4%	12.2%	10.2%	9.4%	11.5%	10.9%	9.8%	251	8.8%	10.5%	⇧ 1.7%	
Childrens Services	13.3%	11.5%	12.4%	13.3%	16.0%	14.1%	12.9%	14.2%	13.1%	10.0%	11.3%	10.1%	10.6%	268	10.4%	12.5%	⇧ 2.1%	
Neuro	8.0%	9.3%	9.7%	9.2%	10.8%	10.9%	8.5%	9.5%	9.4%	10.0%	10.6%	9.6%	10.3%	366	8.4%	10.0%	⇧ 1.6%	
Renal & Oncology	10.9%	11.8%	11.2%	10.6%	10.6%	11.0%	8.1%	11.1%	11.0%	10.5%	10.4%	11.0%	10.1%	313	10.8%	10.4%	⇩ -0.4%	
Specialist Medicine	12.2%	12.3%	12.7%	11.7%	14.3%	13.1%	11.3%	11.4%	11.8%	11.6%	12.6%	13.1%	11.5%	1,298	13.0%	12.3%	⇩ -0.7%	
Surgery	10.1%	10.3%	10.1%	10.7%	12.1%	11.7%	9.0%	10.9%	10.9%	10.2%	12.1%	11.6%	10.7%	1,261	10.9%	11.0%	⇧ 0.1%	
Womens Services	9.6%	7.9%	7.2%	8.4%	8.6%	8.7%	7.3%	8.4%	9.8%	8.2%	8.7%	8.2%	7.2%	506	9.9%	8.3%	⇩ -1.6%	
T&O	11.4%	12.0%	12.6%	12.0%	11.8%	13.7%	8.4%	9.2%	11.0%	10.7%	10.4%	11.6%	10.9%	323	9.3%	10.9%	⇧ 1.6%	
Other	12.0%	10.6%	11.5%	14.0%	10.0%	9.5%	11.6%	12.9%	13.8%	12.5%	14.4%	15.4%	14.4%	1,184	10.0%	12.7%	⇧ 2.7%	
Total	**11.0%**	**11.1%**	**11.2%**	**11.5%**	**12.6%**	**12.0%**	**10.1%**	**10.9%**	**11.3%**	**10.6%**	**10.5%**	**10.5%**	**10.9%**	**5,770**	**10.2%**	**11.0%**	⇧ 0.8%	

First and Follow Up Ratio

Directorate	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	First to FollowUp Ratio 2017-18	First to FollowUp Ratio 2018-19	Variance	Variance	Trend
Cardiothoracic & Vascular Services	1.80	1.84	1.80	1.63	2.06	1.87	1.72	1.86	1.85	2.01	1.81	1.85	1.98	1.68	1.89	0.21	⇧ 12.5%	
Childrens Services	1.68	1.65	1.74	1.76	1.75	1.60	1.47	1.86	1.82	1.74	1.80	1.77	1.92	1.69	1.75	0.06	⇧ 3.6%	
Neuro	1.20	1.24	1.23	1.24	1.31	1.36	1.36	1.49	1.57	1.51	1.39	1.40	1.33	1.24	1.41	0.17	⇧ 13.7%	
Renal & Oncology	9.39	8.77	8.07	8.67	8.38	8.08	7.64	9.75	8.89	10.77	9.08	8.68	10.22	9.02	9.06	0.03	⇧ 0.4%	
Specialist Medicine	3.44	3.30	3.22	3.38	3.60	3.40	3.19	3.59	3.71	3.70	3.58	3.53	3.82	3.35	3.57	0.22	⇧ 6.7%	
Surgery	1.36	1.45	1.40	1.35	1.34	1.38	1.19	1.32	1.33	1.32	1.26	1.32	1.27	1.37	1.30	-0.07	⇩ -5.0%	
Womens Services	0.73	0.80	0.82	0.67	0.61	0.68	0.56	0.72	0.69	0.88	0.80	0.84	0.76	0.67	0.73	0.06	⇧ 9.1%	
T&O	1.86	1.56	1.56	1.40	1.51	1.44	1.38	1.38	1.55	1.49	1.63	1.69	1.53	1.60	1.51	-0.09	⇩ -5.9%	
Other	1.34	1.43	1.35	1.31	2.64	2.54	2.20	2.31	2.52	2.70	2.49	2.64	2.22	1.05	2.47	1.42	⇧ 134.6%	
Total	**2.01**	**2.03**	**2.01**	**1.98**	**2.02**	**2.01**	**1.83**	**2.04**	**2.08**	**2.14**	**2.04**	**2.06**	**2.10**	**1.94**	**2.04**	**0.10**	⇧ 5.1%	

Briefing

- The Netcall text reminder service was implemented during June and the Trust have now started two way text reminder pilots for a number of clinic types within Plastics and Dermatology.
- Compared to the previous year the Trust is seeing an increase in patients not attending their outpatient appointments with a number of services above threshold. For the month of December 11% of patients did not attend, this on average is 300 patients per working day.

Actions

- One way text reminders are fully live and two way is now being piloted

Theatre – Touch Time Utilisation

Theatre Utilisation

Main List Specialty	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Number of Patients in the last month
Cardiothoracic	76%	69%	74%	64%	79%	81%	75%	74%	69%	70%	70%	73%	72%	70
ENT	71%	70%	75%	77%	75%	81%	77%	80%	84%	76%	77%	82%	78%	106
General Surgery	78%	79%	78%	77%	79%	78%	80%	82%	79%	82%	80%	82%	84%	184
Gynaecology	80%	88%	80%	82%	77%	77%	77%	83%	81%	77%	83%	87%	81%	100
Neurosurgery	76%	81%	77%	83%	76%	87%	80%	74%	84%	78%	76%	81%	81%	153
Oral and Maxillo Facial Surgery	50%	82%	76%	62%	58%	71%	73%	89%	75%	82%	63%	84%	78%	17
Paediatric Dentistry	61%	51%	46%	57%	62%	53%	50%	53%	58%	55%	56%	60%	62%	31
Paediatric Surgery	83%	79%	78%	74%	78%	82%	80%	81%	78%	75%	74%	72%	75%	100
Plastic Surgery	71%	68%	68%	69%	73%	74%	73%	77%	75%	75%	77%	74%	78%	154
Renal Medicine & Surgery	74%	77%	74%	79%	67%	76%	71%	72%	78%	61%	67%	82%	60%	19
Trauma & Orthopaedics	80%	82%	86%	80%	87%	76%	85%	84%	79%	82%	90%	85%	92%	101
Urology	74%	75%	79%	79%	77%	84%	78%	88%	84%	84%	85%	86%	81%	175
Vascular Surgery	66%	65%	75%	77%	77%	77%	76%	72%	68%	74%	76%	70%	74%	44
Grand Total	**75%**	**76%**	**77%**	**77%**	**77%**	**80%**	**78%**	**79%**	**79%**	**78%**	**79%**	**80%**	**80%**	**1,254**

Theatre Average Cases per Session

Main List Specialty	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Trend
Cardiothoracic	1.3	1.6	1.5	1.5	1.6	1.6	1.8	1.8	1.5	1.3	1.4	1.5	1.5	
ENT	1.5	1.7	1.4	1.6	1.8	1.9	1.8	1.7	1.8	1.7	1.7	1.7	1.6	
General Surgery	2.0	1.7	1.8	1.9	1.9	1.9	1.8	1.8	1.7	1.7	1.8	1.7	1.6	
Gynaecology	2.2	2.3	1.9	2.5	2.4	2.3	2.3	2.7	2.6	2.5	2.6	2.5	2.9	
Neurosurgery	1.1	1.2	1.2	1.2	1.2	1.2	1.1	1.1	1.1	1.0	1.0	1.1	1.2	
Oral and Maxillo Facial Surgery	1.9	3.9	3.6	3.3	3.0	3.6	3.0	4.0	3.7	3.9	3.1	3.8	3.8	
Paediatric Dentistry	3.8	3.6	4.0	4.3	4.3	3.7	4.2	4.0	3.8	4.1	3.9	4.5	4.7	
Paediatric Surgery	2.5	2.5	2.6	2.7	2.4	2.6	2.4	2.6	2.6	2.7	2.6	2.7	2.7	
Plastic Surgery	1.9	2.0	1.9	2.2	2.2	2.0	2.0	2.0	2.2	2.2	2.1	2.0	2.0	
Renal Medicine & Surgery	1.7	1.5	1.8	1.3	1.8	1.5	1.7	1.4	1.4	1.3	1.6	1.5	1.4	
Trauma & Orthopaedics	2.0	1.7	1.8	1.5	1.6	1.4	1.6	1.6	1.5	1.6	1.9	1.9	1.8	
Urology	2.1	1.8	1.8	2.0	2.1	2.1	2.1	2.0	2.1	2.1	2.1	2.0	2.1	
Vascular Surgery	1.0	1.0	1.2	1.2	1.2	1.3	1.0	1.1	1.2	1.2	1.1	1.1	1.1	
Grand Total	**1.7**	**1.7**	**1.7**	**1.8**	**1.8**	**1.8**	**1.8**	**1.8**	**1.8**	**1.7**	**1.8**	**1.8**	**1.8**	

Briefing

Touchtime Utilisation on average for the past 12 months is at 78% against a targeted threshold of 85% seeing an improved performance in November and December. Work is on-going across all specialties to support an increase in utilisation and increase in theatre case bookings. Daily huddles are now in place to review booking targets with the patient pathway coordinators, this is having a positive impact reaching our target booking numbers and increasing Day Surgery Utilisation reporting 80% in December 2018 vs 75% in December 2017

Actions

- Clinicians are reviewing their lists to verify patient order and appropriate case mix, this is linked to theatre team review identifying theatre equipment requirements, skill mix and specialist equipment to be ordered as required. A newly developed tool will be introduced to robustly look at the list planning process.
- Actions form the weekly list planning are reviewed and discussed which is further reviewed and supported by General Managers and services. All actions are reviewed in list planning the following week.
- Increase to baseline Patient Pathway Coordinator (PPC) numbers has been agreed for financial year 18/19 to provide additional bank support to the teams to streamline processes particularly around the pre-assessment pathway and build a pool of pre assessed patients.
- The booking teams (PPC) will commence using the Four Eyes Insight scheduling tool this will provide accurate activity planning information along with the ability to schedule lists at 95-105 %.
- Daily Huddles with Pathway Coordinators have commenced reviewing daily booking targets and identifying on the day issues with services

Number of Elective Patients treated per Working Day

														Average No. of Patients per month			
Months	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**2017-18**	**2018-19**	**Variance**	**Discharges for month**
Cardiology & Cardiac Surgery	7.3	6.9	7.8	8.7	7.4	7.9	8.7	6.3	7.6	7.3	6.5	7.4	7.2	7.8	7.4	-6%	167
Clinical Haematology	0.7	0.5	0.3	0.8	0.7	0.5	0.7	0.6	0.7	0.7	0.4	0.7	0.9	0.6	0.6	13%	11
Endoscopy & General Medicine	1.0	0.7	0.6	0.4	0.9	0.5	1.2	0.4	0.5	1.0	0.5	0.6	0.7	0.6	0.7	15%	11
ENT	5.2	5.2	5.4	5.6	3.7	5.0	5.3	3.7	3.3	5.6	5.9	4.7	4.4	5.9	4.6	-22%	114
General Surgery	6.0	5.2	6.2	6.9	5.0	4.9	5.5	3.8	4.4	6.3	6.6	7.0	7.4	5.7	5.6	-1%	109
Gynae & Obstetrics	2.6	2.4	3.1	3.9	3.2	2.5	2.9	2.4	2.8	2.6	2.9	2.7	2.1	3.2	2.7	-16%	61
Max Fax & Dental	3.1	3.6	3.4	3.0	3.2	3.2	3.0	1.6	2.8	3.4	3.3	2.8	2.6	2.8	2.9	4%	50
Neuro Surgery	4.7	5.1	5.7	6.5	6.0	6.2	6.1	5.7	5.0	6.7	5.9	7.4	6.3	5.7	6.1	8%	108
Neurology	1.6	1.2	1.8	1.4	1.5	1.2	1.5	1.5	1.5	1.9	1.6	1.2	1.1	1.5	1.5	-4%	28
Oncology	0.7	0.2	0.6	0.6	1.0	0.8	0.7	0.8	0.8	0.6	0.7	0.5	0.5	1.0	0.7	-31%	26
Paediatric Medicine	0.7	0.6	0.6	0.5	1.6	0.8	1.2	0.4	1.9	0.4	0.7	0.6	0.2	0.8	0.9	4%	15
Paediatric Surgery	2.1	1.9	1.9	1.6	1.6	2.0	1.8	1.8	1.5	1.9	1.4	1.5	1.3	1.9	1.6	-14%	36
Plastic Surgery	6.8	5.1	5.9	6.4	5.0	5.6	4.8	2.3	2.0	4.1	3.4	4.1	3.0	6.1	3.8	-38%	114
Renal Medicine	0.9	0.8	1.1	1.0	1.1	1.1	1.6	1.0	1.1	1.1	1.0	1.0	0.6	1.2	1.1	-14%	28
Trauma & Orthopaedics	3.3	2.9	2.2	4.0	3.0	2.1	2.0	2.0	2.5	2.7	2.2	3.2	2.3	3.1	2.4	-21%	61
Urology	4.8	4.7	6.0	6.8	7.6	6.1	6.1	4.6	5.5	7.1	6.9	6.5	5.7	7.0	6.2	-10%	156
Vascular Surgery	2.8	2.7	3.9	3.7	3.2	3.4	2.8	2.5	2.8	2.7	2.6	2.3	1.7	2.8	2.7	-5%	47
Other	3.8	3.7	4.0	4.2	3.4	4.1	4.5	3.8	3.4	3.3	3.0	3.9	3.8	3.9	3.7	-5%	73
Grand Total	**58.1**	**53.6**	**60.1**	**66.0**	**58.5**	**58.0**	**60.5**	**45.2**	**50.2**	**58.9**	**55.5**	**57.7**	**51.8**	**61.5**	**55.1**	-10%	**1,215**

Briefing

- There has been a switch of activity from Elective Ordinary to Elective Daycase during 2018/19 of approximately twelve patients per day year on year.
- Theatres are ensuring that there is focused work supporting a prompt start to all theatre sessions this is linked to a weekly task and finish group, highlighting and unblocking issues for long term sustainability and change; the work from the task and finish group will be shared across all theatre services.

Actions

- Agreement and plan to change Theatreman Diagnosis codes (currently SNOMED) to OPCS 4.8 codes which will support more accurate timings of theatre cases and utilisation.
- Identified data quality issues with informatics team which will identify increased theatre utilisation
- SNTC Division finance has completed service specific one pagers in conjunction to identify actions required to support SLA achievement

Number of Patient Daycases per Working Day

														Average No. of Patients per month			
Months	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**2017-18**	**2018-19**	**Variance**	**Discharges for month**
Cardiology & Cardiac Surgery	6.8	8.0	8.9	6.9	7.5	8.4	8.3	9.2	7.7	8.4	7.6	9.5	6.9	8.5	8.2	-4%	132
Clinical Haematology	1.1	1.5	2.4	2.1	1.1	1.6	1.5	1.1	0.7	1.5	1.3	0.7	0.9	1.6	1.2	-27%	17
Endoscopy	53.3	46.2	51.2	50.4	54.1	60.3	59.8	55.3	55.2	55.3	54.2	58.6	46.5	52.8	55.5	5%	884
ENT	2.8	2.3	2.6	1.8	2.5	3.9	3.3	5.3	4.5	3.4	3.6	3.8	2.4	3.1	3.6	15%	45
General Surgery	3.8	4.2	4.5	3.7	4.5	4.7	5.1	5.0	4.4	4.9	4.0	4.4	3.1	4.1	4.4	8%	59
Gynae & Obstetrics	5.9	7.4	7.1	7.2	6.7	7.0	7.4	9.0	7.8	7.7	8.6	8.5	6.2	7.1	7.6	8%	118
Max Fax & Dental	3.0	2.7	3.4	2.7	3.2	3.5	3.3	5.1	3.4	4.0	3.2	3.7	2.9	3.2	3.6	11%	56
Neuro Surgery	2.6	2.7	2.9	3.0	3.4	2.5	3.2	3.5	3.1	3.3	3.1	3.5	2.9	3.0	3.2	5%	56
Neurology	21.4	23.8	21.0	20.8	23.7	23.0	26.4	24.4	22.5	23.9	29.0	28.2	23.5	22.4	24.9	11%	447
Oncology	1.4	1.5	1.2	1.1	0.7	1.1	1.1	1.0	0.9	1.1	1.0	0.8	1.0	1.6	1.0	-38%	19
Paediatric Medicine	7.9	9.0	8.3	6.8	8.5	9.4	7.2	9.6	7.6	9.2	11.3	9.6	10.6	8.3	9.2	12%	202
Paediatric Surgery	5.1	6.3	6.9	7.1	6.9	6.0	6.8	6.5	7.1	8.0	7.9	9.4	7.1	6.8	7.3	7%	134
Plastic Surgery	7.5	8.0	8.8	8.2	11.2	13.1	12.9	15.1	17.2	14.7	13.4	14.4	11.1	7.8	13.7	75%	210
Renal Medicine	3.6	3.8	3.1	2.7	4.3	4.3	4.1	3.5	4.2	4.2	3.8	2.8	2.9	3.3	3.8	16%	56
Trauma & Orthopaedics	4.6	4.2	3.8	4.4	4.4	4.9	4.7	5.8	4.0	3.5	4.0	5.3	3.5	4.1	4.5	8%	67
Urology	6.8	5.7	4.5	3.7	4.1	5.1	7.1	8.4	6.1	6.3	7.9	7.8	6.2	4.8	6.6	36%	117
Vascular Surgery	2.1	2.3	2.4	2.3	2.2	2.6	1.5	2.3	1.6	2.0	2.6	2.3	2.7	2.2	2.2	0%	51
Other	7.4	8.2	9.3	9.0	8.8	11.3	10.5	10.5	9.8	9.2	9.5	12.1	8.6	7.9	10.0	27%	163
Grand Total	**148.5**	**149.1**	**153.5**	**144.8**	**159.4**	**175.1**	**175.9**	**182.1**	**169.6**	**172.3**	**177.8**	**185.5**	**149.1**	**154.2**	**171.9**	**11%**	**2,833**

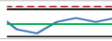
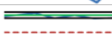
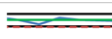
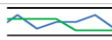
Briefing

- The number of daycase procedures per working day has seen a positive increase compared to the same period last year, treating on average eighteen more patients per working.
- December data is showing that activity was below plan however this is expected to increase once coding has been completed

Actions

- Bespoke scheduling manuals for Day Surgery Unit services to support activity will be rolled out to inpatient services as phase 2

Patient Safety

Indicator Description	Target	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Trend (12 months)
Number of Never Events in Month	0	0	1	0	2	1	0	0	0	0	0	2	0	0	
Number of SIs where Medication is a significant factor	0	0	0	0	1	0	0	0	0	0	0	1	1	0	
Number of Serious Incidents	8 / mth	2	1	4	5	4	5	2	4	1	3	5	6	6	
Serious Incidents - per 1000 bed days	N/A	0.08	0.04	0.18	0.19	0.17	0.21	0.09	0.17	0.04	0.13	0.20	0.26	0.26	
Safety Thermometer - % of patients with harm free care (all harm)	95%	95.1%	94.9%	94.8%	94.3%	93.1%	95.3%	96.5%	94.9%	95.7%	96.3%	95.1%	95.0%	95.6%	
Safety Thermometer - % of patients with harm free care (new harm)	95%	98.5%	98.9%	97.9%	98.5%	97.8%	98.0%	98.7%	98.5%	98.2%	99.0%	98.3%	97.7%	97.6%	
Percentage of patients who have a VTE risk assessment	95%	96.0%	95.4%	96.3%	96.0%	95.9%	95.8%	96.0%	96.9%	96.4%	96.2%	96.0%	96.2%		
Number of Patient Falls	N/A	127	189	140	157	138	117	155	143	136	141	181	173	148	
Falls (Moderate and Above Severity)	N/A	3	1	2	2	3	1	1	1	1	0	1	3	1	
Number of patient falls- per 1000 bed days	N/A	5.17	7.49	6.15	6.05	5.77	5.01	6.70	6.11	5.91	6.26	7.40	7.50	6.32	
Acquired Category 2 Pressure Ulcers	N/A	13	16	13	12	2	6	10	20	15	9	12	25	13	
Acquired Category 2 Pressure Ulcers per 1000 bed days	N/A	0.53	0.63	0.57	0.46	0.08	0.26	0.43	0.85	0.65	0.40	0.49	1.08	0.56	
Avoidable Category 3 & 4 Pressure Ulcers	0	0	0	0	0	5	0	2	2	3	1	0	0	1	
Avoidable Category 3 & 4 Pressure Ulcers per 1000 bed days	0	0.00	0.00	0.00	0.00	0.21	0.00	0.09	0.09	0.13	0.04	0.00	0.00	0.04	
Acquired Category 3 Pressure Ulcers		6	9	6	6	11	4	6	5	3	2	1	3	7	
Number of overdue CAS Alerts	0	0	0	0	0	0	0	0	0	0	0	0	0	0	

Briefing

- Six Serious Incidents (SIs) were reported in December, with a total of 36 SIs year to date.
- The number of falls reported in December was 148, of the falls reported one patients sustained moderate harm.
- All grade 3 and 4 pressure ulcers that are acquired at the Trust have had a rapid response review completed. These are reviewed by a panel chaired by the Chief Nurse to establish their avoidability. In December 7 patients acquired a grade 3 or grade 4 pressure ulcer of which one was avoidable.

Actions

- The Falls co-ordinator is working with divisions, wards and falls champions to improve falls practice, promote best practice for falls prevention and is continuing to carry out bespoke falls education and training.
- The Trust is participating in the NHSI Pressure Ulcer Collaborative and has focused on two wards. The programme will be rolling out to other wards.

Infection Control

Indicator Description	Threshold	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	YTD Actual	YTD Theshold	Trend (12 months)
MRSA Incidences (in month)	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	
Cdiff Incidences (in month)	30	0	0	1	2	6	1	3	3	2	2	3	2	3	25	22.5	
MSSA	25	3	0	3	1	2	2	1	1	2	1	4	2	5	20	19	
E-Coli	60	5	5	5	5	1	9	6	4	3	4	2	4	3	36	45	

Briefing

- The C Diff annual threshold for 2018/19 is 30 cases. For 2019-2020 the time limit for apportioning healthcare onset versus community onset is 48 hours rather than 72 hours. The data collected in 2018-19 for each Trust will be used to set the new targets for these categories. In the month of December the Trust reported three cases, totalling 25 cases year to date.
- The Trust annual threshold for E coli is 60 for 2018-19 and year to date the Trust has reported 36 cases, 3 of which occurred in December.
- There are no National thresholds for MSSA bacteraemia at present however the Trust has set itself an internal target of a 10% reduction on last years position setting the threshold at 25 incidents for 2018/19. The Trust is reporting a total of 5 incidents in the month of December and remain below threshold.

Actions

- All Cdiff cases have undergone a Root Cause Analysis (RCA) the ward has been placed on a period of increased surveillance and audit. No immediate learning has been identified
- The Trust is anticipating an NHSI collaborative to reduce E Coli infections, representation from this group includes colleagues from partner organisations and is multi professional

Mortality and Readmissions

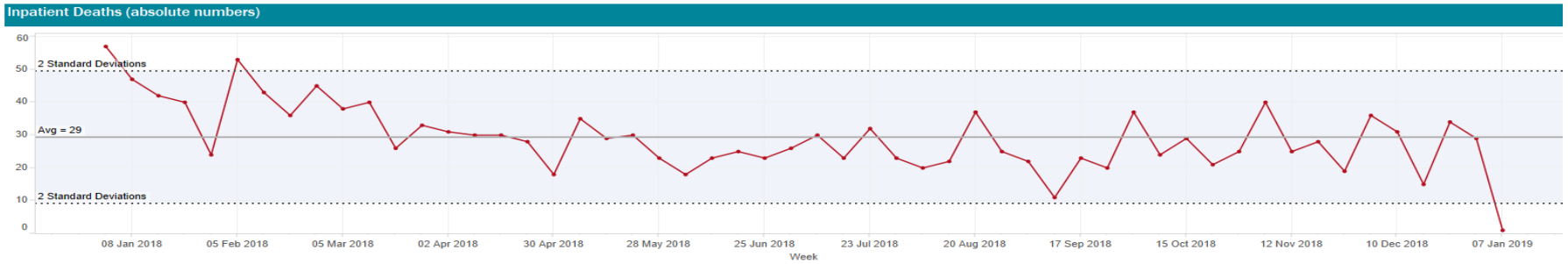
Indicator Description	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-17 to Aug-18	Trend
Hospital Standardised Mortality Ratio (HSMR)	78.9	86.1	90.1	72.6	97.3	93.8	106.3	94.9	86.7	79.5	69.8	80.3	73.0	86.0	
Hospital Standardised Mortality Ratio Weekend Emergency	89.5	93.7	101.2	78.8	107.9	123.7	121.5	113.8	78.2	97.6	79.5	72.2	62.7	96.3	
Hospital Standardised Mortality Ratio Weekday Emergency	68.8	75.5	88.3	76.2	95.3	84.9	95.6	79.7	87.1	82.5	67.6	78.1	68.4	82.3	

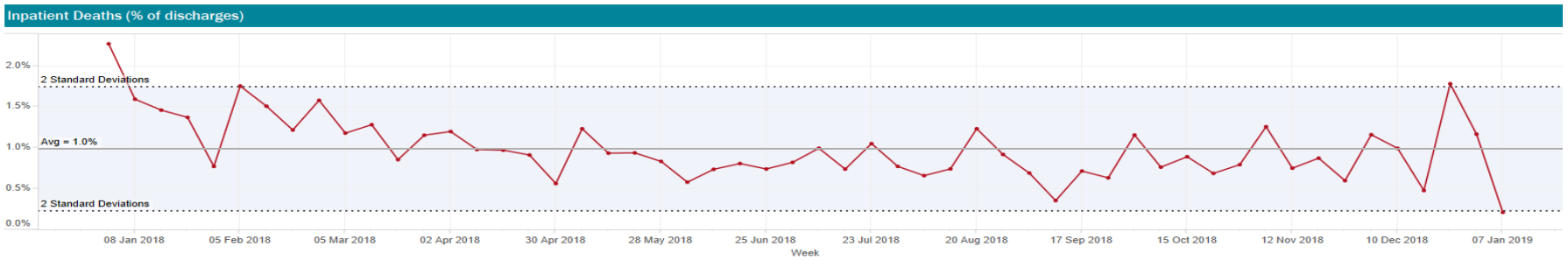
Indicator Description	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Trend
Summary Hospital Mortality Indicator (SHMI)	0.84	0.84	0.84	0.84	0.83	0.83	0.83	0.83	0.82	0.82	0.82	0.82	0.82	0.82	
Emergency Readmissions within 30 days following non elective spell (reporting one month in arrears)	9.2%	9.4%	8.9%	9.0%	9.2%	8.7%	8.8%	8.3%	8.90%	8.33%	8.24%	8.08%	7.50%		

Please note SHMI data is reflective of the period April 2017 to March 2018 based on a rolling 12 month period (published 20th September).
HSMR data reflective of period September 2017 – August 2018 based on a monthly published position (published 22nd December).
Mortality Green Rag Rating is reflective of periods where the Trust are better than expected, non-Rag Rating is where the Trist are in line with expected rates.

Briefing

Both the Trust-level mortality indicators (SHMI and HSMR) remain lower than expected compared to national patterns. Caution should be taken in over-interpreting these signals, however as they mask a number of areas of over performance and also under performance. In particular we are aware of mortality signals in cardiac surgery, general intensive care and total hip replacement surgery that are under investigation as well as a number of more discrete diagnostic and procedure codes from Dr Foster that are reviewed monthly by the Mortality Monitoring Committee.





Maternity

Indicator Description	Target	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Trend
Total number of women giving birth- (per calendar day)	14 per day	12	13	12	13	14	14	13	13	13	15	13	14	13	
% of all deliveries where caesarean section occurred	<31%	24.1%	23.0%	23.9%	25.3%	26.3%	28.1%	28.0%	25.1%	23.2%	23.8%	26.8%	27.5%	23.7%	
% deliveries with emergency C-section (including no Labour)	<21%	8.4%	7.7%	7.4%	8.0%	8.4%	7.8%	9.7%	6.6%	6.2%	6.5%	6.8%	8.3%	5.8%	
Number of hours in the month that Carmen Suite closed	0												No closures		
% of all births in which woman sustained a 3rd or 4th degree tear	<5%	2.7%	4.9%	3.8%	3.4%	3.8%	3.5%	3.5%	5.1%	4.5%	3.3%	2.0%	3.6%	1.5%	
% of all births where women had a Life Threatening Post Partum Haemorrhage >1.5 L	<4%	3.0%	2.0%	3.2%	2.1%	1.9%	2.8%	1.7%	2.4%	3.6%	1.8%	2.0%	2.6%	2.7%	
Number of term babies (> 34 weeks), with unplanned admission to NNU		10	10	10	7	7	12	12	2	17	11	8	9	10	
Supernumerary Midwife in Labour Ward	>95%											95.2%	98.3%	100%	
Number of babies born with Hypoxic Ischaemic Encephalopathy (/1000 babies)	<2/1000	0	1	0	0	0	2	2	0	0	0	2	1	0	
Number of babies still born at term (37 weeks+)	<3	1	1	1	0	0	1	1	1	0	0	0	1	0	
Number of babies still born at term (28 to 36 weeks and 6 days)	<3	1	1	1	0	2	2	0	1	0	1	0	2	0	
Number of babies still born at term (24 to 27 weeks and 6 days)	<3	1	1	0	4	1	0	0	0	3	1	3	0	1	
Number of babies born alive who die within (7 days of birth)	<3	0	2	4	1	1	0	1	1	3	1	2	0	3	
% women booked by 12 weeks and 6 days	90%	72.9%	59.6%	65.6%	66.1%	57.7%	61.4%	67.9%	75.0%	77.8%	82.6%	75.6%	81.9%	84.7%	

Briefing

- In December 413 women gave birth . The overall caesarean rate was lower than in the previous month, but still within expected parameters.
- The percentage of women who sustained a 3rd or 4th degree tear was lower this month than across the year.
- The number of women booked by 12 weeks and 6 days of pregnancy was at its highest level for the year. The Birth Centre was again open at all times during the month.

Actions

- Based on above review, instigate a review of cases if numbers fall outside of expected norms
- Continue to monitor staffing across the service with a plan for responsive recruitment : Business case for responsive recruitment being prepared for Divisional Management Board this month.
- To verify numbers for 3rd and 4th degree tears and identify any learning to share if number is significantly lower than previous months.

Patient Experience

St George's University Hospitals NHS
NHS Foundation Trust

Patient Voice

Indicator Description	Target	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Trend
Emergency Department FFT - % positive responses	90%	86.5%	82.2%	81.0%	81.4%	84.0%	85.0%	85.5%	83.7%	84.6%	83.5%	84.2%	79.2%	84.2%	
Inpatient FFT - % positive responses	95%	95.6%	94.7%	96.0%	96.3%	97.2%	97.3%	97.1%	96.7%	96.6%	96.3%	97.0%	95.5%	96.4%	
Maternity FFT - Antenatal - % positive responses	90%	100.0%	100.0%	100.0%	95.8%	100.0%	97.2%	100.0%	100.0%	100.0%	100.0%	100.0%			
Maternity FFT - Delivery - % positive responses	90%	100.0%	100.0%	100.0%	96.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	97.4%	100.0%	100.0%	
Maternity FFT - Postnatal Ward - % positive responses	90%	100.0%	99.0%	90.4%	100.0%	100.0%	98.4%	100.0%	100.0%	100.0%	98.7%	100.0%	100.0%	90.9%	
Maternity FFT - Postnatal Community Care - % positive responses	90%		100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%			100.0%	
Community FFT - % positive responses	90%	96.5%	99.2%	93.3%	98.3%	97.1%	98.5%	98.3%	98.0%	98.4%	99.5%	95.6%	97.4%	96.1%	
Outpatient FFT - % positive responses	90%	98.2%	97.6%	96.1%	98.4%	97.3%	97.3%	97.4%	97.4%	97.1%	96.3%	94.9%	97.3%	95.6%	
Mixed Sex Breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Complaints Received		68	90	80	94	96	85	79	120	96	93	90	88	78	
PALS Received		262	290	236	259	264	317	292	337	294	335	416	353	252	

Briefing

- ED Friends and Family Test (FFT) – In the month of December 84.2% of patients attending the Emergency Department would recommend the service to family and friends, however the response rate remains below our target of 20% .
- Inpatient Friends and Family Test (FFT) continues to be above threshold reporting 96.4% in December providing reasonable assurance on the quality of patient experience
- We continue to deliver above target against our outpatient recommend rate and although this has slightly decreased in the month of December the response rate has doubled due to the implementation of two way texting.
- Maternity and Community FFT remain above local threshold with work continuing to improve the number of patients responding,
- All complaints are assessed for complexity when they arrive and given a response time of 25, 40 or 60 working days. Complaints with a 25 day response time remain below the set trajectory of 85%, reporting in November a performance of 69%. For 40 day complaints received in October 41% were responded to within the timescale. There was one 60 day complaint received in September 2018, which met the response deadline achieving a performance of 100%. The complaints team continues to work with Divisions to improve our response times to patients and this is being monitored closely.

Actions

FFT action being taken to improve response rates includes: weekly feedback to all areas on their response rate, this is published on the Quality Posters at the entrance to the area; improving the accessibility of the FFT by increasing the number of tablets and using volunteers to assist patients with the survey; scoping other opportunities to improve accessibility for example putting FFT and other patient surveys on our public website.

Complaints and PALS: The weekly CommCell is being used to maintain organisational focus on meeting both timeliness and quality standards for complaint responses.

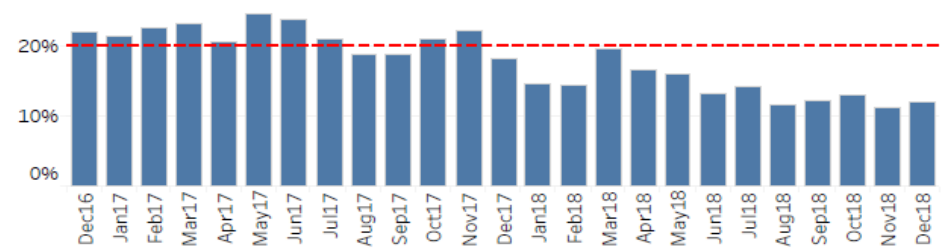
Patient Voice

CARING – Friends and Family Test

--- Target ¢ MetricMeasure Percentage Neutral

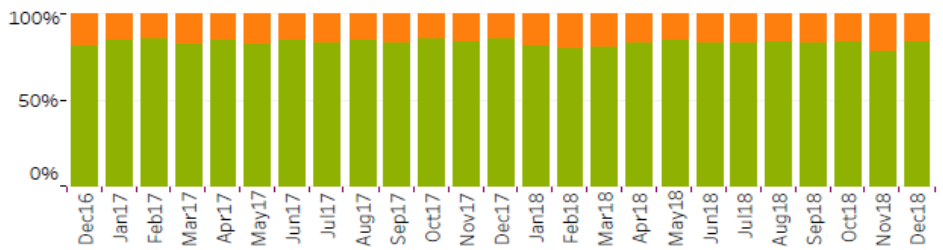
A&E Friends & Family Response Rate

Target: 20% Nov 18: 11.20% Dec 18: 11.90% Movement: ▲0.70%



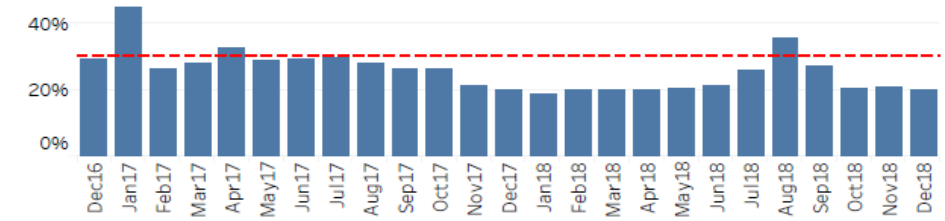
A&E Friends & Family Recommend Rate

The expected target is 90%



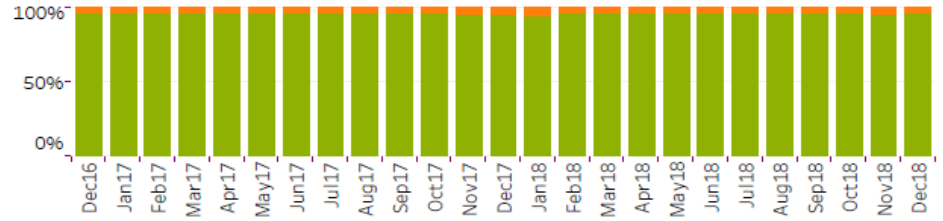
IP Friends & Family Response Rate

Target: 30% Nov 18: 21.00% Dec 18: 20.00% Movement: ▼-1.00%



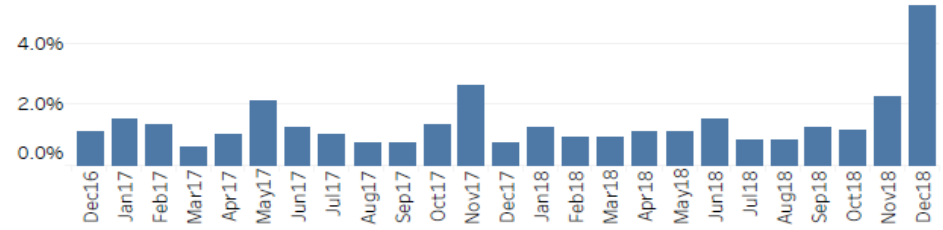
IP Friends & Family Recommend Rate

The expected target is 95%



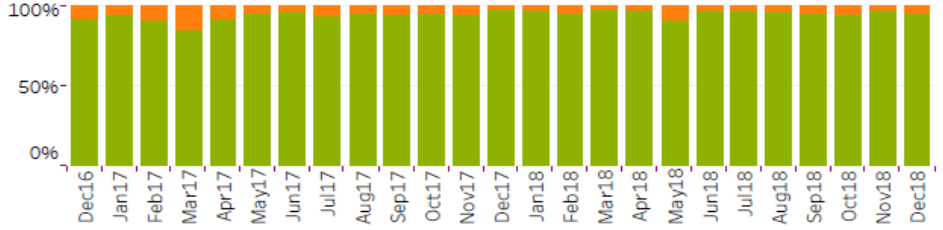
OP Friends & Family Response Rate

Target: 20% Nov 18: 2.20% Dec 18: 5.20% Movement: ▲3.00%



OP Friends & Family Recommend Rate

The expected target is 90%

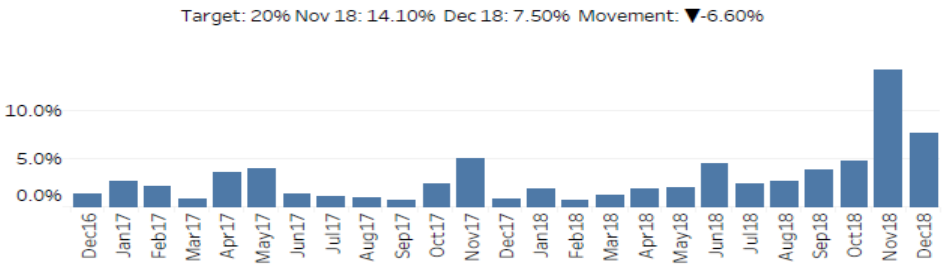


Patient Voice

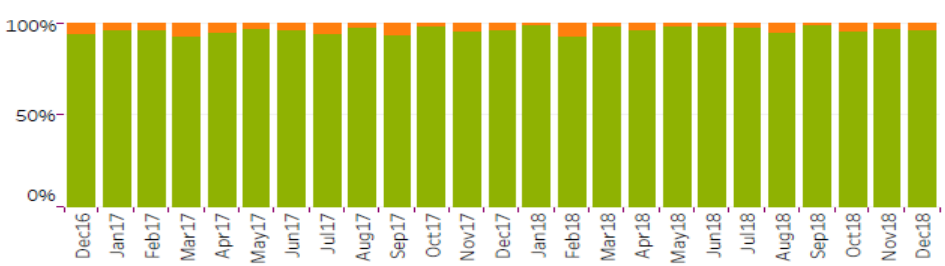
CARING – Friends and Family Test

--- Target ¢ MetricMeasure Percentage Neutral

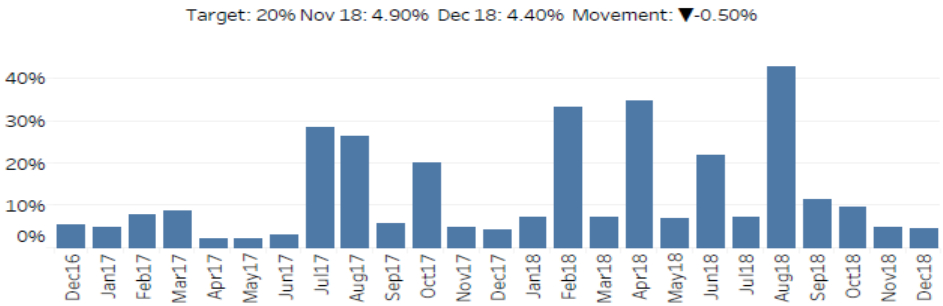
Community Friends & Family Response Rate



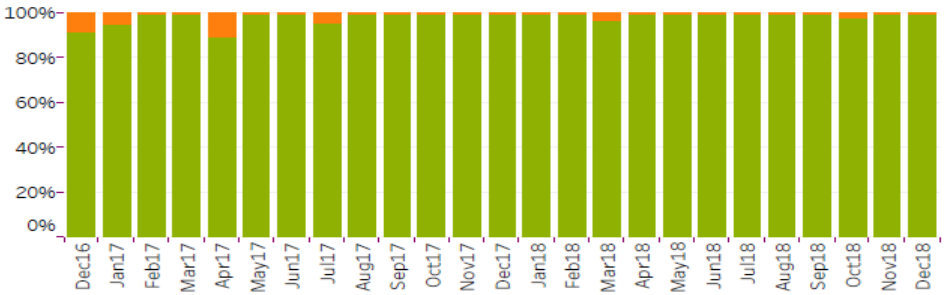
Community Friends & Family Recommend Rate
The expected target is 90%



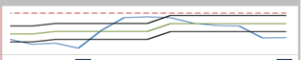
Maternity (Birth) Friends & Family Response Rate



Maternity (Birth) Friends & Family Recommend Rate
The expected target is 90%



Emergency Flow

Indicator Description	Target	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Trend
4 Hour Operating Standard	95%	85.0%	83.0%	83.5%	81.6%	88.4%	93.3%	93.6%	93.3%	91.1%	90.3%	90.1%	85.5%	85.6%	
Patients Waiting in ED for over 12 hours following DTA	0	0	0	0	2	1	1	0	1	0	1	0	1	2	
Time to Treatment (number of patients seen within 60 minutes)	60%	54.1%	51.7%	52.2%	52.6%	61.5%	63.5%	65.5%	63.7%	70.3%	64.1%	69.5%	68.2%	74.2%	
Admitted patients with a length of stay 7 Days or Greater		376	373	337	343	355	308	324	315	316	301	325	326	323	
Ambulance Turnaround - % under 15 minutes	100%	44.3%	41.0%	42.2%	41.0%	45.0%	45.7%	43.6%	42.0%	42.3%	46.4%	42.5%	37.4%		
Ambulance Turnaround - % under 15 minutes (London Average)	100%	42.1%	41.4%	42.2%	41.1%	45.2%	45.7%	47.4%	46.7%	48.1%	52.6%	47.4%	46.5%		
Ambulance Turnaround - number of patients not handed over within 30 minutes	0	112	180	135	105	92	65	72	67	85	109	111	138		
Ambulance Turnaround - % under 30 minutes	100%	94.8%	91.3%	93.2%	94.5%	95.3%	96.8%	96.3%	96.2%	95.5%	94.1%	94.5%	93.0%		
Ambulance Turnaround - % under 30 minutes (London Average)	100%	91.6%	86.7%	87.4%	87.5%	88.8%	91.9%	93.7%	93.1%	92.2%	92.5%	92.2%	91.5%		
Ambulance Turnaround - number over 60 minutes	0	2	3	3	10	1	0	0	0	2	3	0	3		

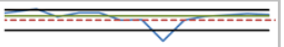
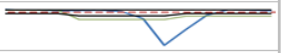
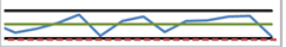
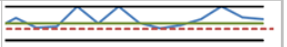
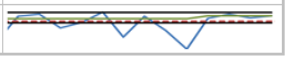
Briefing

- Performance against the Four Hour Operating Standard in December was 85.6%, which was below the monthly improvement trajectory of 90%. The improvement trajectory requires the delivery of 90% performance in January 2019 and relies upon continued improvement in the experience for patients not requiring admission.
- Improvement against the Four Hour standard shows improvement compared to last December, despite more than a 2% increase in Emergency Attendances with the increases coming in the more complex patients that require access to the full Majors Emergency facility. The number of patients admitted via the Emergency Department has increased by 7% compared to December 2017 (11 patients per day) and with bed occupancy increasing the focus remains on reducing long length of stay patients.
- New front door processes which focus on the streaming of patients has helped improve time to treatment times for patients as well as patient safety.
- Four Hour Operating Standard performance for patients requiring admission in December has seen an improvement compared to the previous month reporting 62.49%, improvements have also been observed within Paediatric 4 hour performance in admitted and non admitted care.

Actions

- Allocation of a Senior Clinician to each area within the ED to provide senior leadership and decision making in line with ED winter plan
- Review and re-allocation of nurses within existing establishment during daytime hours to support triage in Children's ED
- Dedicated ED porter to work with diagnostic imaging to be delivered within existing establishment
- Advanced Nurse Practitioner for Children's respiratory medicine to attend at ED daily
- Senior Clinical and Nursing time to be released to provide clinical challenge as part of daily Board Rounds
- Flu Point of Care Testing now re-launched for the Winter period, with the aim of reducing delays in the management of Flu, reducing the turnaround times from a minimum of 90 minutes to 18 minutes
- Continuous improvement review techniques are being applied to Non-Admitted Four Hour Operating Standard in the Emergency Department

Cancer

Indicator Description	Target	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	No of Patients	Trend (12 months)
Cancer 14 Day Standard	93%	97.3%	98.5%	94.8%	96.7%	96.8%	93.1%	93.3%	83.0%	93.1%	95.0%	95.5%	96.3%	95.9%	1,339	
Cancer 14 Day Standard Breast Symptomatic	93%	98.0%	97.3%	95.9%	96.5%	96.8%	94.4%	79.4%	22.2%	55.2%	86.4%	97.9%	97.1%	95.5%	242	
Cancer 31 Day Diagnosis to Treatment	96%	96.9%	97.4%	98.2%	99.3%	96.5%	98.4%	99.0%	97.0%	98.4%	98.5%	99.0%	99.1%	96.4%	196	
Cancer 31 Day Second or subsequent Treatment (Surgery)	94%	96.9%	94.3%	94.6%	100.0%	95.5%	100.0%	95.7%	94.1%	95.0%	96.6%	100%	96.9%	96.6%	29	
Cancer 31 Day Second or subsequent Treatment (Drug)	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	107	
Cancer 62 Day Referral to Treatment Standard	85%	80.8%	86.8%	77.8%	80.8%	88.1%	92.3%	85.9%	89.6%	85.7%	85.7%	80.6%	87.8%	87.8%	61.5	
Cancer 62 Day Referral to Treatment Screening	90%	92.7%	93.9%	86.1%	89.1%	95.2%	80.8%	92.7%	84.6%	73.8%	91.6%	94.1%	91.8%	93.1%	29.0	

Briefing

- The Trust continued to met all of the seven Cancer standards in the month of November, achieving both the 14 day standard and 62 day standard.
- Performance against 62 day standard was reported at 87.8% overall, reporting a total of 7.5 patients treated passed the 62 day target, this was due to complex pathways and late hospital referrals from other providers.
- 14 Day Standard achieved in all tumour groups with the exception of Gynaecology.

62 Day wait for First Treatment- GP referral to treatment (actual and internal performance)

Month	Target	Actual Performance	Internal Performance
Apr-18	85%	92.3%	96.7%
May-18	85%	85.9%	87.1%
Jul-18	85%	85.7%	89.4%
Aug-18	85%	85.7%	89.1%
Sep-18	85%	80.6%	85.0%
Oct-18	85%	87.8%	92.5%
Nov-18	85%	87.8%	93.6%

Actions

- There is a continued focus on improving internal processes as well as working with local providers to improve 38 day performance. Improvement trajectories have been agreed with other SWL providers to improve waiting times and quicker access to diagnostics and treatment for shared patients
- Capacity within the Breast pathway has been created within diagnostics through the addition of a new ultrasound machine at St George's Rose Centre site increasing the minimum weekly capacity by 60 slots weekly. On-going recruitment of vacant consultant posts, the creation of a new consultant post, and the introduction of a trainee position will further increase capacity by 60 slots and provide a more flexible and responsive service in the current year and a further 50 slots in year 2 once training is completed.

Cancer

14 Day Standard Performance by Tumour Site - Target 93%

Tumour Site	Target	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	No of Patients
Brain	93%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	75.0%	100.0%	100.0%	-	100.0%	-	0
Breast	93%	98.4%	98.2%	96.0%	96.5%	93.9%	94.8%	91.9%	61.2%	87.4%	97.5%	94.5%	99.4%	97.4%	190
Children's	93%	71.4%	100.0%	87.5%	100.0%	100.0%	80.0%	100.0%	100.0%	90.9%	-	100.0%	50.0%	100.0%	4
Gynaecology	93%	95.0%	97.6%	98.0%	96.8%	94.3%	94.9%	91.9%	86.1%	91.7%	90.8%	81.9%	87.8%	87.5%	120
Haematology	93%	100.0%	94.7%	91.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.2%	100.0%	34
Head & Neck	93%	99.4%	98.4%	100.0%	97.6%	100.0%	100.0%	97.5%	92.3%	93.0%	95.6%	99.3%	99.8%	98.1%	161
Lower Gastrointestinal	93%	97.7%	99.3%	95.2%	100.0%	97.8%	94.1%	90.3%	67.5%	94.7%	98.9%	94.3%	98.1%	95.8%	261
Lung	93%	100.0%	100.0%	92.3%	100.0%	100.0%	100.0%	96.3%	90.9%	97.6%	94.7%	95.2%	100.0%	100.0%	35
Skin	93%	95.5%	97.9%	92.7%	94.8%	95.9%	94.1%	93.8%	92.7%	93.3%	92.9%	97.4%	96.6%	97.4%	303
Upper Gastrointestinal	93%	99.0%	100.0%	89.0%	97.3%	95.3%	85.2%	88.1%	89.9%	96.6%	93.9%	96.7%	98.8%	95.4%	87
Urology	93%	97.1%	98.9%	95.0%	95.1%	98.2%	81.3%	92.9%	96.5%	95.2%	93.1%	96.8%	92.4%	93.4%	136

62 Day Standard Performance by Tumour Site - Target 85%

Tumour Site	Target	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	No of Patients
Brain	85%	100.0%	-	-	-	-	-	-	-	-	-	-	-	100.0%	0.5
Breast	85%	95.2%	100.0%	71.4%	100.0%	88.9%	94.1%	84.6%	91.7%	90.9%	78.9%	100.0%	100.0%	100.0%	9
Children's	85%	-	-	-	-	-	-	-	-	-	-	-	-	-	0
Gynaecology	85%	75.0%	67.0%	80.0%	77.8%	0.0%	100.0%	80.0%	100.0%	75.0%	100.0%	80.0%	90.0%	100.0%	6.5
Haematology	85%	-	100.0%	88.9%	83.3%	81.8%	100.0%	63.6%	100.0%	100.0%	88.9%	75.0%	100.0%	100.0%	0.5
Head & Neck	85%	81.8%	71.0%	100.0%	83.3%	80.0%	100.0%	90.0%	75.0%	72.7%	81.8%	80.0%	100.0%	86.7%	7.5
Lower Gastrointestinal	85%	80.0%	100.0%	100.0%	75.0%	100.0%	100.0%	100.0%	100.0%	71.4%	83.3%	66.7%	88.9%	100.0%	3
Lung	85%	41.2%	33.0%	90.9%	57.1%	100.0%	100.0%	87.5%	83.3%	71.4%	66.7%	28.6%	50.0%	70.0%	5
Skin	85%	91.7%	93.0%	86.7%	100.0%	100.0%	100.0%	90.9%	100.0%	100.0%	100.0%	84.6%	92.3%	100.0%	12
Sarcoma	85%	-	-	-	100.0%	-	-	-	-	-	-	-	-	-	
Upper Gastrointestinal	85%	84.0%	100.0%	33.3%	57.1%	66.7%	87.5%	33.3%	80.0%	100.0%	78.9%	50.0%	54.5%	100.0%	3
Urology	85%	72.7%	91.0%	60.7%	70.0%	96.7%	80.5%	84.6%	84.9%	85.7%	88.2%	92.9%	88.9%	77.8%	13.5
Other	85%	-	-	-	-	-	-	-	-	-	100.0%	-	100.0%	100.0%	1

Diagnostics

Indicator Description	Threshold	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Trend
6 Week Diagnostic Performance	1%	0.1%	0.1%	0.0%	0.2%	0.2%	0.2%	0.3%	0.3%	0.2%	0.4%	0.2%	0.5%	0.6%	
6 Week Diagnostic Breaches	N/A	6	10	3	17	15	14	25	24	15	30	18	39	37	
6 Week Diagnostic Waiting List Size	N/A	6,440	6,884	7,232	7,075	7,956	7,735	7,809	7,236	6,946	7,617	7,593	7,322	6,652	

Indicator Description	Threshold	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Trend
MRI	1%	0.0%	0.0%	0.0%	0.1%	0.1%	0.0%	0.4%	0.0%	0.3%	0.1%	0.2%	0.3%	0.6%	
CT	1%	0.0%	0.1%	0.0%	0.3%	0.1%	0.0%	0.3%	0.0%	0.0%	0.0%	0.2%	0.1%	0.7%	
Non Obstetric Ultrasound	1%	0.1%	0.1%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.1%	0.6%	0.0%	0.0%	0.0%	
Barium Enema	1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
Dexa Scan	1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.7%	0.0%	0.0%	0.0%	0.0%	
Audiology Assessments	1%	0.0%	0.0%	0.0%	0.0%	5.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
Echocardiography	1%	0.0%	0.0%	0.0%	0.0%	0.2%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
Electrophysiology	1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
Peripheral Neurophysiology	1%	0.3%	0.9%	0.0%	0.4%	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	
Sleep Studies	1%	0.0%	0.0%	0.4%	0.6%	0.0%	0.0%	0.0%	1.1%	1.5%	0.0%	0.0%	7.7%	2.4%	
Urodynamics	1%	0.0%	0.0%	0.0%	9.1%	5.0%	23.9%	6.3%	26.5%	0.0%	13.9%	14.6%	10.2%	8.5%	
Colonoscopy	1%	0.0%	0.0%	0.6%	0.7%	0.6%	0.4%	0.0%	0.0%	0.0%	0.0%	0.7%	3.0%	0.0%	
Flexi Sigmoidoscopy	1%	0.0%	0.0%	0.0%	0.0%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
Cystoscopy	1%	1.5%	2.8%	0.7%	0.0%	1.0%	0.8%	3.0%	1.8%	4.4%	2.6%	3.0%	4.5%	5.4%	
Gastroscopy	1%	0.4%	0.0%	0.0%	1.8%	1.0%	0.0%	0.0%	1.8%	0.0%	0.3%	0.0%	0.0%	0.6%	

Briefing

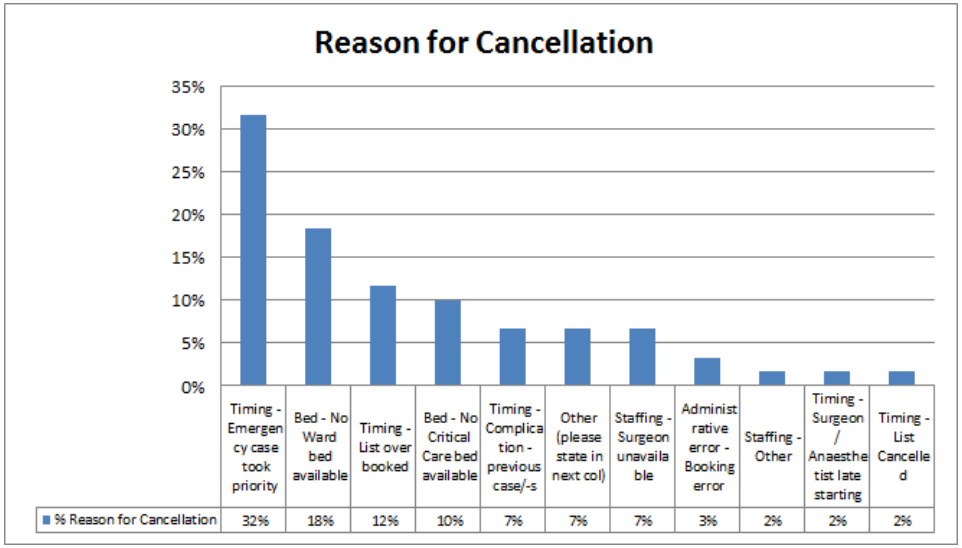
- The Trust has continued to achieve performance in December reporting a total of thirty-seven patients waiting longer than 6 weeks, 0.6% of the total waiting list.
- Compliance has not been achieved within Urodynamics, Cystoscopy or Sleep studies
- Performance and action plans continue to be monitored through the weekly performance meetings.

On the Day Cancellations for Non-Clinical Reasons

Indicator Description	Target	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Trend
Number of on the Day Cancellations		100	94	55	86	64	87	42	54	44	55	52	53	60	
Number of on the Day cancellations re-booked within 28 Days		67	76	48	76	60	80	33	51	39	48	50	52	58	
% of Patients re-booked within 28 Days	100%	67.0%	80.9%	87.3%	88.4%	93.8%	92.0%	78.6%	94.4%	88.6%	87.3%	96.2%	98.1%	96.7%	

Briefing

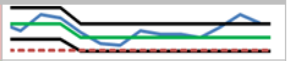
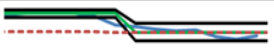
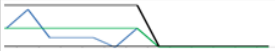
- In December 96.7% of our on the day cancelled patients were-rebooked within 28 days. Two patients were unable to be booked within the 28 day period due to ITU bed capacity.
- Reducing cancellations has been a key focus within the improvement work streams supporting the theatre productivity programme, and we have seen a significant improvement compared to the same period last year, reducing on the day cancellations by 40% and improving our performance against the 28 day standard and therefore improving patient experience.



Actions

- Continue to improve the Pre Operative Assessment (POA) Process and the availability of more high risk capacity for POA
- Text reminder service to be implemented within pre-assessment.
- Introduce a call to every patient before surgery to check that they are Ready, Fit and Able to attend 72 hours prior.
- At times of high non-elective activity, ensure that elective patients are reviewed, including their bed requirements, in advance of the day of surgery
- Standard operating procedures have been signed off and implemented.

Workforce

Indicator Description	Target	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Trend
Trust Level Sickness Rate	3%	3.6%	4.1%	4.0%	3.6%	3.2%	3.2%	3.6%	3.5%	3.5%	3.4%	3.7%	4.1%	3.8%	
Trust Vacancy Rate	10%	13.0%	13.4%	13.5%	13.3%	12.6%	11.3%	11.0%	10.6%	10.2%	10.4%	9.3%	8.9%	9.4%	
Trust Turnover Rate* Excludes Junior Doctors	13%	18.4%	17.9%	17.6%	17.2%	16.9%	17.0%	17.3%	17.4%	17.1%	16.6%	16.6%	16.9%	16.9%	
Total Funded Establishment		9,474	9,515	9,540	9,497	9,469	9,318	9,242	9,239	9,160	9,180	9,165	9,171	9,196	
IPR Appraisal Rate - Medical Staff	90%	78.9%	79.6%	76.9%	72.2%	81.1%	81.3%	79.9%	77.7%	Not currently provided					
IPR Appraisal Rate - Non Medical Staff	90%	70.2%	67.2%	65.9%	61.6%	61.2%	63.4%	64.6%	67.6%	69.7%	69.7%	69.7%	71.8%	71.5%	
% of Staff who have completed MAST training (in the last 12 months)		86%	87%	87%	87%	87%	87%	87%	89%	88%	88%	88%	89%	89%	
Ward Staffing Unfilled Duty Hours	10%	7.8%	7.7%	7.9%	8.9%	6.5%	5.1%	4.9%	5.8%	5.5%	6.7%	6.6%	5.1%	6.1%	
Safe Staffing Alerts	0	2	4	1	1	1	0	2	0	0	0	0	0	0	

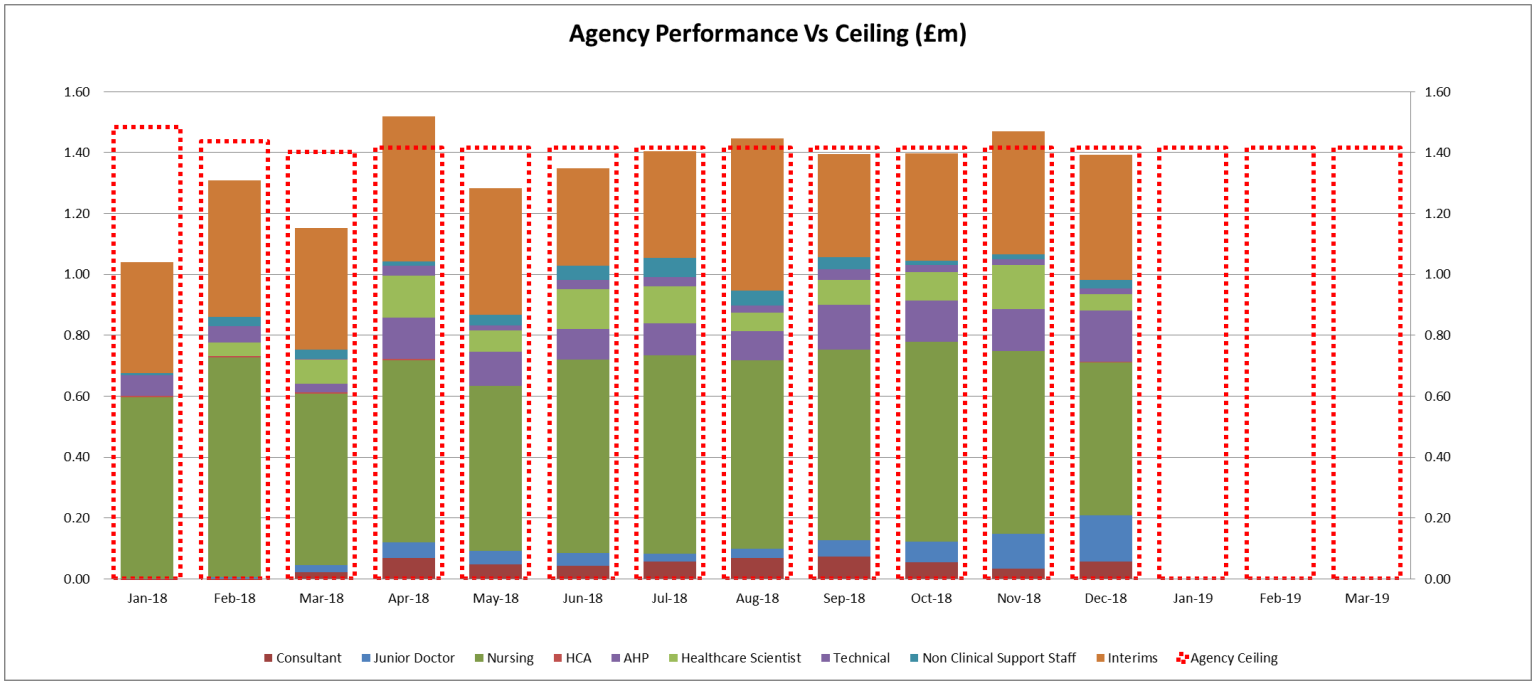
* Excludes Junior doctors

Briefing

- The Trust Vacancy rate continues to be below the target in the month of December reporting 9.4% against a Trust target of 10%
- The Trust sickness level has remained above target of 3% reporting 3.8% in the month of December.
- Mandatory and Statutory Training figures for December were recorded at 89%.
- Medical Appraisals rates are being reviewed and will not be reported this month.
- Non-medical appraisal rates remain below target with a performance of 71.5% against a 90% target.
- Percentage of Staff vaccinated against seasonal Influenza is 78% as at the 8th January 2019.

St George's University Hospitals NHS
NHS Foundation Trust

Agency Use



- The Trust's total pay for December was £42.14m. This is £0.22m adverse to a plan of £41.93m.
- The Trust's 2018/19 annual agency spend target set by NHSI is £21.30m. There is an internal annual agency target of £17.00m.
- Total agency cost in December was £1.39m or 3.3% of the total pay costs. For 2017/18, the average agency cost was 4.2% of total pay costs.
- For December, the monthly target set was £1.42m. The total agency cost is better than the target by £0.02m.
- Agency cost decreased by £0.08m compared to November. There has been decreases mainly in Nursing (£0.10m) and Healthcare Scientists (£0.09m), which is offset by increases in Junior Doctor (£0.04m) and AHP (£0.03m).
- The biggest area of overspend was in Interim, which breached the target by £0.11m.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	31 January 2019	**Agenda No**	**2.3**
Report Title:	**Cardiac Surgery Update**		
Lead Director	**Richard Jennings, Chief Medical Officer**		
Report Authors:	Matt Jarratt, General Manager, Cardiac, Vascular and Thoracic Surgery		
Presented for:	Assurance and discussion		
Executive Summary:	This report provides an update to Trust Board on the steps being taken to improve the cardiac surgery service following the NICOR safety alerts and the findings of the independent report by Professor Bewick (July 2018). Since the last update to Trust Board (December 2018), the following key developments have taken place: • SGH has responded in writing to the report of the Care Quality Commission into Cardiac Surgery at St. George's. • There has been a further meeting of the Independent Scrutiny Panel. • The Independent Mortality Review Panel has met on three occasions. • The unit has agreed and is putting in place a new model of Case Management, led by a strengthened clinical nurse specialist team – ensuring better coordinated care for all patients admitted to the cardiac surgery service. • An analysis has been undertaken on mortality outcomes for 2018, which show that the cardiac surgery unit's mortality position for 2018 was in line with that of peer trusts.		
Recommendation:	The Trust Board is asked to discuss and take assurance from the update on progress being made in Cardiac Surgery.		
Supports			
Trust Strategic Objective:	Treat the patient, treat the person; Right care, right place, right time; Champion Team St George's		
CQC Theme:	Safe, Well Led		
Single Oversight Framework Theme:	Quality of Care, Leadership and Improvement Capability		
Implications			
Risk:	As set out in the paper		
Legal/Regulatory:	The paper details the Trust's engagement with regulators on this issue.		
Resources:			
Previously Considered by:	Quality and Safety Committee	**Date**	24 January 2019

CARDIAC SURGERY UPDATE
Trust Board, 31 January 2019

1.0 PURPOSE

1.1 To update the Trust Board on progress being made with Cardiac Surgery since the last meeting of the Trust Board in December 2018.

1.2 The Board has received background context, detailing the causes leading to the current challenges facing cardiac surgery in previous submissions. This paper does not re-address either that information or any improvements and changes made prior to December 2018; rather it provides a summary of the key developments that have taken place since Christmas.

2.0 EXTERNAL ASSURANCES

2.1 Meeting of the Independent Scrutiny Panel for Cardiac Surgical Services at St. George's.

2.1.1 The panel met on Thursday 10 January 2019. It received a presentation from Jacqueline Totterdell, Dr Richard Jennings and Mr Steve Livesey, which provided a detailed review of all instances of mortality since September 2018; detailed the overall mortality position within cardiac surgery in the calendar year 2018, and summarised the key operational and governance improvements made within the service within the last month.

2.1.2 The ensuing panel discussion was constructive and positive. The panel noted that while there are clearly still significant improvements to be made within the service, that demonstrable improvements are evident over the last few months. In particular a discussion was held on the optimal ways to recover the service to full operational capacity, including the timing and tone of engagements with key referring trusts.

2.2 Meetings of the independent Mortality Review Panel

2.2.1 The independent mortality review panel began work in December 2018. Commissioned by NHSI it comprises subject matter experts (including a cardiac surgeon, cardiac anaesthetist and cardiologist). Its brief is to review past instances of mortality within cardiac surgery, to assess the quality of care and subsequent governance associated with each case. The panel reviews a given number of cases at each sitting (typically 5/6 cases), including a detailed review of all clinical records associated with the case. Following this process, the trust is sent a summary of the panel's findings, and asked to provide comment and response to any case of concern.

2.2.2 The Trust is ensuring that any findings of the Mortality Review Panel that may include useful learning to strengthen current quality and safety in the service are acted upon promptly. While the work of the panel is retrospective in nature (reviewing past instances of mortality), there is an encouragement for the trust to see this as a live process, and to identify areas of learning and improvement that can be made in immediate response to findings. In response to the work of the panel, the Trust is introducing some additional quality assurance measures, including a rolling audit of the completeness, quality and clarity of key components of clinical record documentation. The

Trust has liaised closely with NHSI with regard to its responses to any learning from the mortality review panel that may have implications for current quality and safety.

2.2.3 As part of this response this, the Chief Executive has initiated an internal senior group quality summit meeting comprising the clinical lead for cardiac surgery, CMO, Divisional Chair for Medicine and Cardiovascular, GM for Cardiac, Vascular and Thoracic Surgery, senior anaesthetists and senior cardiologists, where continued key themes for improvement are identified and considered, and progress of improvement is monitored. This is supplementary to the existing, established governance structure which supports the service.

2.3 **Quality Summit**

2.3.1 A meeting of the Quality Summit was due to take place on Wednesday 16 January 2019, but this was postponed by NHSI for administrative reasons, and was held instead on 28 January 2019.

2.3.2 The Quality Summit recognised the very significant improvements that have been made within the cardiac surgery service in terms of new leadership and greatly strengthened governance, and there was a positive discussion around the on-going support being provided by Guy's and St Thomas' NHS Foundation Trust and King's College Hospital NHS Foundation Trust. It was agreed that a further Quality Summit would take place in March 2019.

3 INTERNAL DEVELOPMENTS

Within the last four weeks, the following key service developments have taken place:

3.1 **Pre-operative Assessment and case management**. Agreed to implement an improved model for case management of all elective patients; including a clinical nurse specialist (CNS) led case management team supported by patient pathway coordinators – consultant overseen. In line with existing GSTT and Southampton models. This will enable a more streamlined patient experience, with fewer attendances pre-operatively.

3.2 **Operative working**. Mr Livesey overseeing all aspects of surgical activity, including pre-operative workup, intraoperative support for all surgeons and working with theatre staff and CITU to ensure the safety and quality of all surgical activity.

3.3 **ITU/ Anaesthetic/ cardiology engagement**. Strengthening Cardiothoracic Intensive Care Unit (CITU) engagement and improving existing pathways between cardiac surgery and CITU. Supported through establishment of a monthly review group (chaired by CEO), including CITU and anaesthetic representation to promote joint working and shared pathway development. ITU have been actively engaged in the full recovery programme for cardiac surgery, including creating and approving Standard Operating Procedures (SOPs). All patients continue to be admitted under cardiology and presented at daily MDTs. No elective patient is operated without MDT discussion and agreement.

3.4 **Data capture and reporting** Daily data capture of all key quality indicators as per the weekly morbidity dashboard. Weekly Serious Incident Decision Making Group review of any flagged cases (chaired by Associate Medical Director for patient safety, attended by CMO and Chief Nurse, and attended as required by the Associate Medical Director for Cardiac Surgery); weekly review of all complications at

surgeons meeting – which is a key forum for surgical management; strengthened monthly clinical governance meeting (format in accordance with Royal College guidance, chaired by Mr Livesey), including morbidity and mortality and key GIRFT quality indicators.

3.5 **Culture and behaviour.** There continues to be a dedicated work stream focused on improving the culture and behaviour of workforce, led by the Director of Human Resources and Organisational Development. Surgeons continue to be supported by the trust with Mr Livesey overseeing improvements within the unit on a day to day basis, including with each surgeon on an individual basis – ensuring that needs are being met and development prioritised.

4.0 INTERNAL ASSESSMENT

4.1 The safety of the service continues to be closely monitored by the Trust and a daily safety dashboard is considered by the Chief Medical Officer and Chief Nurse. The Trust is confident in the safety of the service is currently being maintained, but this continues to require a high level of oversight by a significant number of senior individuals within the Trust.

5.0 IMPLICATIONS

Risks

5.1 There continue to be three extreme risks on the risk register for this service:

- Losses incurred through reduced income as a result of decreased activity, and direct costs incurred through turnaround programme. (Original risk score 25, current score 20).The risk score has been reduced because we developed a clear financial forecast for the next year, which has proved accurate for the past four months. The risk is also reduced because the threshold for carrying out surgery at St George's was raised from EuroSCORE II of up to 2 to EuroSCORE II of up to 5.

- Adverse impact on patient safety within the service, and poor adherence to Trust values on poor behaviours from within cardiac surgery team, anaesthetics, theatre staff and other key groups (Original risk score 20, current score 15). The risk score has been reduced because of the steps we have taken to improve safety within the service including the introduction of daily multi-disciplinary team meetings to discuss all planned cases, a reduction in the level of risk of cases we undertake, the introduction of new leadership, stronger governance and a more stable workforce.

- Drop off in referrals and significant loss of patient and referrer confidence in the service caused by high media profile of current challenges. This impacts on the longer-term viability of the service (Original risk score 20, current score 15). The risk score has been reduced because we are commencing a programme of work meeting with, and listening to the feedback of, our referring Trusts in order to make further improvements to our referral pathways as necessary, and to build referrer confidence.

6.0 RECOMMENDATION

6.1 The Trust Board is asked to discuss and take assurance from the update on progress being made in Cardiac Surgery.

Date: 25 January 2019

Meeting Title:	**Trust Board**		
Date:	31 January 2019	**Agenda No**	**2.4**
Report Title:	**Learning from deaths Q3: Mortality Monitoring Committee (MMC) Report**		
Lead Director/ Manager:	**Dr Richard Jennings, Chief Medical Officer**		
Report Author:	Dr Nigel Kennea, Chair Mortality Monitoring Committee, Associate Medical Director Kate Hutt, Clinical Effectiveness Manager		
Presented for:	Assurance		
Executive Summary:	The paper provides an overview of the work of the MMC for Q3 2018/19. It includes a summary of the independent reviews completed. Externally viewed mortality data, at trust and service level is also detailed, with an update on our current position and actions underway. Also included is analysis of Dr Foster data at diagnosis and procedure group level. The report summarises progress against our priorities for 2018/19 in relation to implementation of the 'Learning from Deaths' framework and implementation of the Medical Examiner system.		
Recommendation:	• For the Trust Board to be updated on implementation of the 'Learning from Deaths' national framework and to support next steps in this process. • To support the introduction of the Medical Examiner system from April 2019. • To take assurance that SGUH has robust processes for assessing deaths and from learning any lessons that arise from them. • For divisional teams to use this report to take learning back to their services. • To note the specialty areas where mortality signals are present.		
Supports			
Trust Strategic Objective:	Data to help strengthen quality and safety work, as well as improve experience of bereaved families.		
CQC Theme:	Safe and Effective (Well Led in implementation of new framework)		
Single Oversight Framework Theme:	Safe		
Implications			
Risk:	This work will identify issues impacting on care quality day to day, and will identify risks that are escalated to trust and divisional governance teams. The 'Learning from Deaths' framework and national mortality agenda continues to evolve and requires ongoing change in process that requires resource, even with a mature mortality monitoring process. There is a risk that published mortality data and learning will not only be used for quality improvement, and that identifying problems in care could lead to adverse publicity.		
Legal/Regulatory:	'Learning from Deaths' framework is regulated by CQC and NHSI, and		

	demands trust actions including publication and discussion of data at Board level.		
Resources:	There are resource implications associated with this work, particularly introduction of the ME system that are being worked through and can be discussed with this paper.		
Previously Considered by:	Quality and Safety Committee	**Date**	24/01/19
Equality Impact Assessment:	N/A This is in line with the principles of the Accessible Information Standard		

MORTALITY MONITORING COMMITTEE UPDATE

1.0 PURPOSE

1.1 The purpose of this paper is to provide the Trust Board with an update on the work of the Mortality Monitoring Committee (MMC), focussing on information and learning identified through independent case record review of deaths for the third quarter of 2018/19. Also provided is an update on the delivery of requirements of the Learning from Deaths framework.

2.0 IMPLEMENTATION OF THE LEARNING FROM DEATHS FRAMEWORK AND NATIONAL STRATEGY

2.1 Guidance Development and Implementation

We have continued to be actively involved in the national agenda around Learning from Deaths and wider national work around mortality, namely the implementation of the Medical Examiner system. This quarter we have participated in the second meeting of the Learning from Deaths London Network and the inaugural meeting of the Health Innovation Network's Community of Practice.

2.2 Progress against priorities for MMC in 2018/19

- In October we implemented the second version of our independent screening and structured judgement review tools. They have been updated to more robustly flag patients with a serious mental health diagnosis; to capture problems in healthcare related to communication; and to better identify actions required following independent review. Also included is a score assessing overall care.
- We continue to roll-out the SJR methodology to specialty teams and are keen to continue this work over the coming year.
- The Record of Death form has been designed and launched in iClip.
- Work is progressing locally to design and implement the Medical Examiner system, which will strengthen the work already underway by the MMC. The ME office will be set up to review all non-coronial deaths and escalate any quality concerns; to support and liaise with the certifying doctor when writing the medical certification of cause of death; to support the bereaved in understanding the cause of death and identify any concerns that they have; and to liaise with the coroner and registrar. The business case for establishment of this function at St George's is in its final stages. Once approved we will need to move forward with the requirement to recruit a Lead ME, additional MEs equating to one whole-time equivalent, and an ME Officer. Trusts are required to have this system in place from April 2019.
- In quarter 4 we will review Terms of Reference for the MMC and ensure that the Learning from Deaths policy is updated to describe how we comply with the latest national recommendations.

We intend for our next quarterly report to be a full analysis of the data and experience gathered since we implemented prospective independent mortality review as part of the Learning from Deaths agenda. We will present 2 complete years of data which will help the MMC and others to set priorities for 2019/20.

3.0 MONTHLY INDEPENDENT REVIEW OF MORTALITY

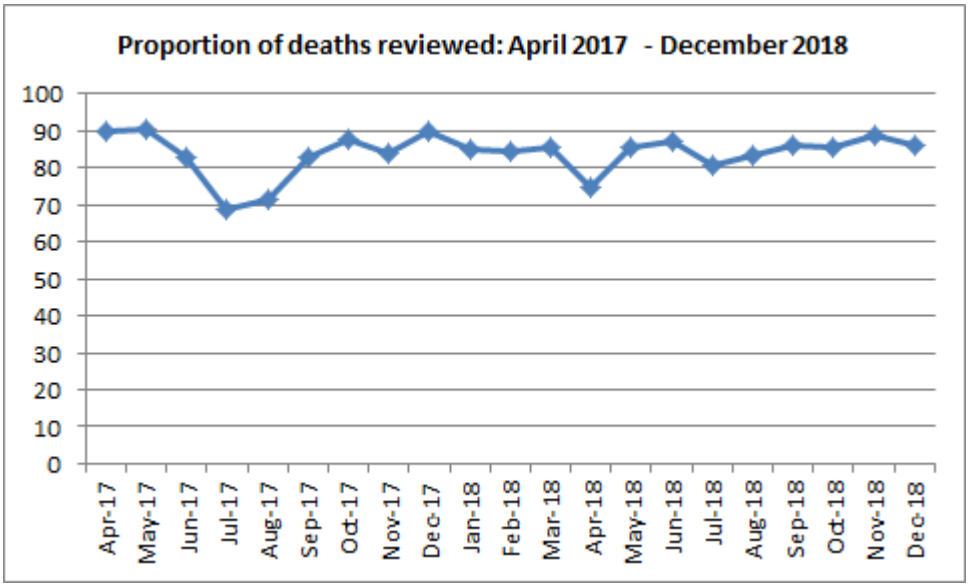
3.1 The following analyses include all deaths and does not consider deaths of patients with learning disabilities separately; however, this is required for the national dashboard. Our data reported in the format of the National Quality Board dashboard is shown in Appendix 1.

3.2 Overview of October to December 2018

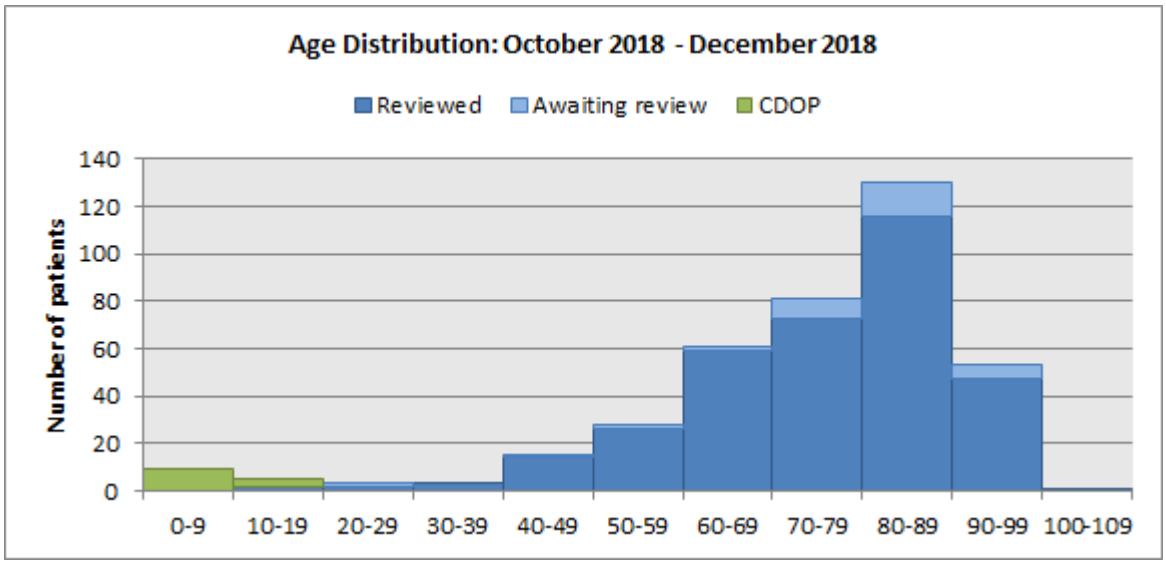
Between October and December 2018 there were 395 deaths. Members of the MMC have carried out independent review of 343 deaths, using our locally developed online screening tool and structured review tool, both based on the RCP tool. This represents 87% of deaths,

which is significantly above our target of reviewing 70% of deaths each quarter. Looking at the year to date, 927 of 1103 deaths have been independently reviewed in this way (84%). At the time of writing the MMC have logged reviews for 8 of the 40 adult deaths reported as not independently reviewed this quarter. Reviews from Trauma, Stroke and CTICU are visible and logged centrally.

All child deaths are reviewed by local teams and by the Wandsworth CDOP. Of note, the CDOP process has recently been reviewed nationally and is going to change with increased emphasis on Trusts coordinating multi-professional reviews. The paediatric services are reviewing new guidance and its impact on the Trust. The new process needs to be in place by September 2019.



The age profile of deceased patients remains consistent, with the highest proportion of deaths in the 80-89 age group.



This quarter, one or more problems in healthcare were identified in 14.0% of the cases reviewed, which is similar to the average for the year to date (13.6%). Not all of these problems led to harm and include recognised complications of treatment. Where there was a problem identified reviewers felt it did not lead to harm in 32.7% of cases, probably led to harm in 43.6% and did cause harm in 23.6%.

Problems in healthcare	**Oct**	**Nov**	**Dec**	**Total**
No	90	101	104	**295**
Yes	18	18	12	**48**
% with problems	16.7	15.1	10.3	**14.0**

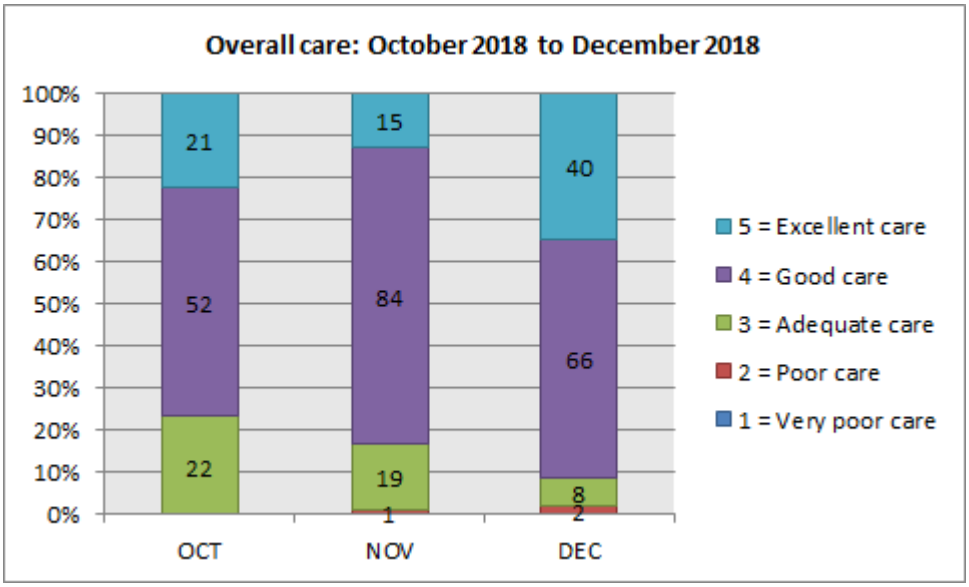
This quarter, the most commonly occurring problem as defined by the structured judgement review, is related to the treatment and management plan (n=23). This is consistent with the profile observed in the previous two quarters. In October we amended the screening and structured judgement review tools in order to capture problems related to communication. 330 of the 343 reviews were conducted using the new form and a communication problem was identified in 4 cases; none were thought to have led to harm.

Problems in healthcare: Quarter 3	**No harm**	**Probably harm**	**Harm**	**Total**
Assessment, investigation or diagnosis	0	1	0	**1**
Medication/IV fluids/electrolytes/oxygen (other than anaesthetic)	1	2	0	**3**
Related to treatment and management plan	6	11	6	**23**
Infection control	1	2	1	**4**
Operation/invasive procedure	4	1	5	**10**
Clinical monitoring	2	2	0	**4**
Resuscitation following a cardiac or respiratory arrest	0	1	0	**1**
Communication	2	2	0	**4**
Other	2	2	1	**5**
TOTAL	**18**	**24**	**13**	**55**

A judgement regarding avoidability of death is made for all reviews. The majority (96.2%) reviewed were assessed as definitely not avoidable, and no deaths were thought to be definitely avoidable. Three deaths (0.9%) were judged to be more than likely avoidable, for that moment in time.

Avoidability of death judgement score	**Oct**	**Nov**	**Dec**	**Total**
6 = Definitely not avoidable	104	114	112	**330**
5 = Slight evidence of avoidability	4	2	3	**9**
4 = Possibly avoidable but not very likely (less than 50:50)	0	0	1	**1**
3 = Probably avoidable (more than 50:50)	0	3	0	**3**
2 = Strong evidence of avoidability	0	0	0	**0**
1 = Definitely avoidable	0	0	0	**0**
TOTAL	108	119	116	**343**

In October we began recording a score reflecting the reviewers' judgement of the overall care provided. As this change was introduced a few days into October this evaluation was recorded for 330/343 reviews. Each month the majority of patients were felt to have received care that was either good or excellent. Over the 3 month period 23% of care was rated as excellent, 61% as good, 15% as adequate and under 1% as poor. There were no cases of very poor care found.



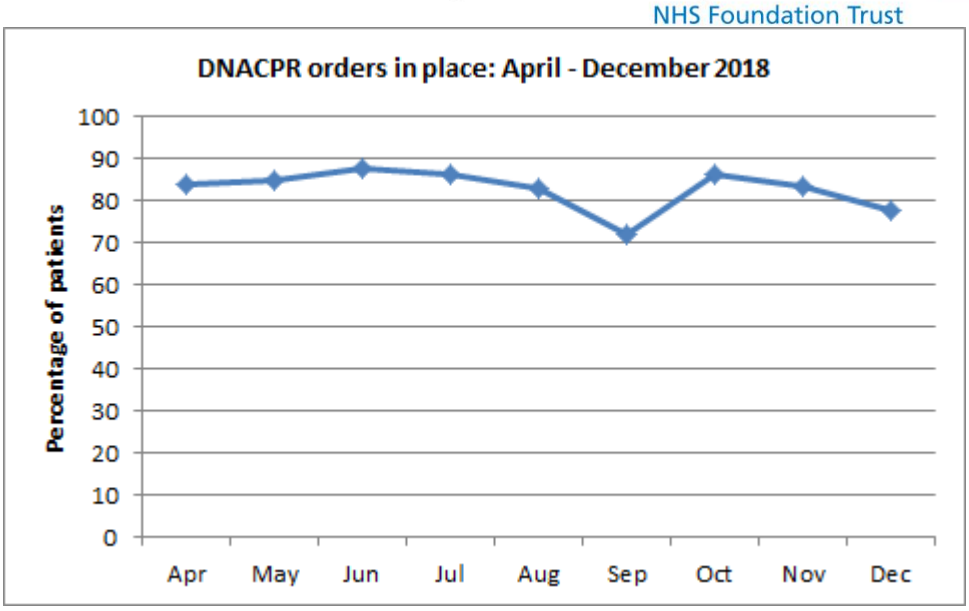
Any death that the MMC review suggests may be avoidable is escalated to the Risk Team to consider investigation. Any significant problem of care, whether or not it affected outcome, is highlighted to the clinical team for discussion and local learning.

4.0 THEMES AND LEARNING

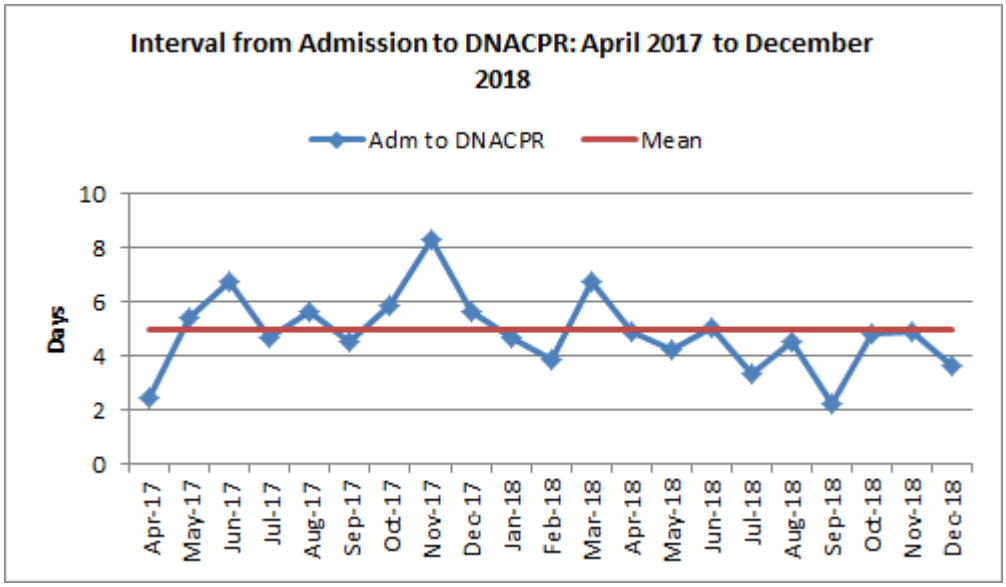
The following summary provides an update on a number of issues previously highlighted and learning from the independent review of cases and MMC activity this quarter.

4.1 DNACPR discussions

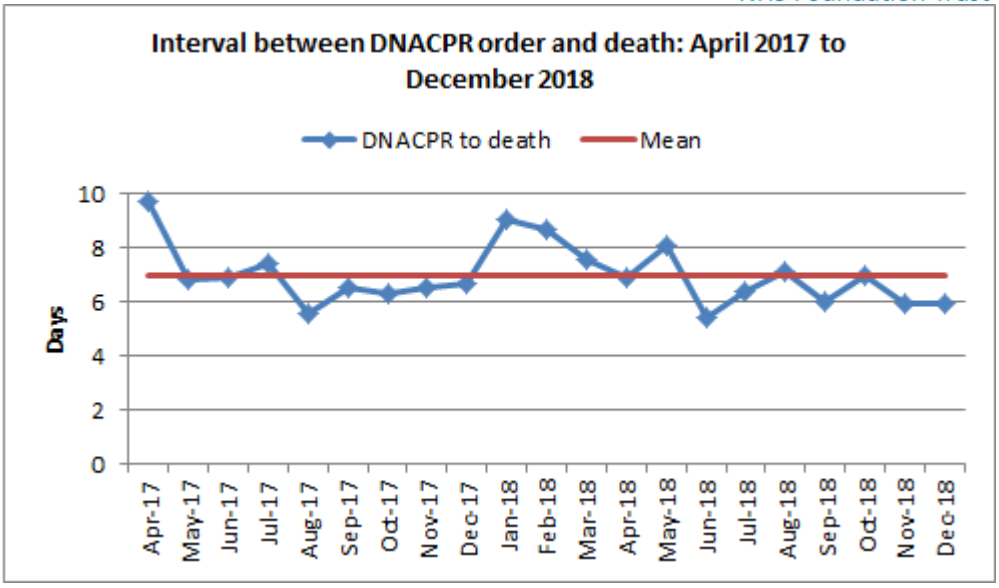
Data suggests that DNACPR discussions are held and documented at a fairly consistent level across the Trust.



The timeliness of assessment and documentation of DNACPR orders appears to have improved in the latest financial year. The chart below shows the interval between admission and documentation of DNACPR. Since April 2018 the monthly average has been at or below the mean for the period (5 days).



Over this period, the average interval between DNACPR order and death was 7 days. Since June 2018 the monthly average has been at or below the mean for the period.



4.3 Specific learning identified in the latest quarter

Changes to the review tools were introduced in October as part of work to strengthen the monitoring of actions resulting from queries raised with clinical services or referrals to the Risk Team. Over time this should help us to better identify and spread learning from mortality reviews and to demonstrate the effectiveness of this approach.

This quarter there have been a number of cases escalated for further review. 12 cases have been referred to the service for M&M review and reflection. In addition to seeking specialist opinion, issues that have been highlighted for discussion include documentation, the role of multidisciplinary decision making, management of deterioration and establishing ceilings of treatment and consideration of earlier palliative care. A number of operational issues have also been raised including the adjustments and facilities that may be required in the care of those patients with an exceptionally high body-mass index and also the impact of major trauma services on the delivery of other T&O services. Two patients with weight in excess of 150kg could not have imaging necessary for optimal care.

The sharing of information between the mortality review team and risk team continues. Over the quarter the two teams have collaborated on the review and investigation of 12 deaths, plus five of the deaths that have occurred in cardiac surgery over the period.

In December Dr Lillian Choy, Stroke Consultant , presented St George's stroke mortality meetings and the resultant learning and changes in practice at the UK Stroke Forum. The session explained how the service set up a monthly meeting, including the challenges and benefits and how this links with the Trust MMC. Dr Choy emphasised that the focus of discussion is on systems and processes and identifying potential improvements and learning, and not on individual competence or blame. Specific learning points and teaching topics were also shared, noting that many of these were around non-stroke specific topics such as sepsis, DNACPR decision making and discussions, treatment escalation plans, Coroner's referrals, duty of candour, documentation, clinical frailty and palliative care. In some instances, such as DNACPR documentation and NG tube insertion this resulted in audit work and change. Feedback from colleagues was shared, and showed that the majority of people are very positive about the impact of the meeting, both on their own learning and on patient care. It is seen as a chance to review practice and improve knowledge of policies and guidance and to discuss challenging cases. The meeting were felt to highlight areas that need focus and change within the service.

5.0 NATIONAL MORTALITY DATA AND SERVICES OPEN TO EXTERNAL SCRUTINY

5.1 National Adult Cardiac Surgery

Investigation and governance procedures previously described have continued this quarter. In December the NHS Improvement external panel carried out the first retrospective mortality review session. This was largely a pilot exercise to explore and finalise processes going forwards. It has been agreed that the deaths from the original NICOR alert (April 2013 to March 2016) will be prioritised for review and a schedule of meetings has been arranged for quarter 4. Members of the MMC continue to support this review.

The Mortality Monitoring Committee are contributing to early independent reviews of all deaths in patients who have had cardiac surgery and feeding these reviews to the Risk team who co-ordinate 72 hour reviews and consideration at the serious incident declaration meeting.

5.2 ICNARC (Intensive Care National Audit and Research Centre) - General Critical Care Mortality Alert

NHS England's Specialised Services Quality Dashboard, issued in August 2018, showed the standardised mortality ratio for GICU of 1.15 (January - December 2017) as a negative alert, with increasing mortality in Q3 and Q4 2017/18. The Medical Director asked clinical leaders within the unit to provide an explanation of the data and any resultant learning.

The outcome of the investigation was reported to MMC in October by the GICU Care Group Lead. It had not been possible to replicate the ICNARC model to identify precisely the cases contributing to the signal, nor to see the risk prediction for individual cases using the current ICNARC methodology. Scrutiny of local mortality reviews and independent reviews conducted by MMC did not identify any themes or areas of concern. Of the 301 eligible deaths MMC had reviewed 242 (80%); 96% of these found no evidence of avoidability. Of the 59 deaths not reviewed 16 occurred after transfer to another ICU.

Q1 2018/19 data has been released and shows an SMR of 1.0. This coupled with the investigation and ICNARC 90 day survival data (which shows that our mortality over time is in line with expected), provides assurance that there are no systemic issues of concern. However, GICU have developed enhanced local M&M review and reporting processes. The aim is to complete SJRs for 80% of deaths within 12 months, including patients that have died post discharge from the unit. Peer review of complex cases is also to be piloted and reviews will also be compared to the independent MMC reviews.

6.0 LATEST NATIONAL PUBLISHED RISK-ADJUSTED MORTALITY

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

The SHMI for July 2017 to June 2018 was published on 22nd November. For this period our mortality is categorised as lower than expected at 0.84. We are one of only 16 trusts nationwide in this category.

In addition to considering the overall mortality position reported by SHMI the MMC looks at the raw data by diagnosis group and also VLAD (variable life adjusted display) charts for a number of diagnosis groups, which show the difference between the expected number of deaths and observed deaths over time. Neither source of data reveals any diagnosis groups that the MMC consider require further investigation at this point. Where differences between observed and expected deaths are seen this has already been explored through our routine analysis of data via the Dr Foster platform.

6.2 Hospital Standardised Mortality Ratio (HSMR) [source: Dr Foster]

Analysis	Period	Score	Banding
HSMR	Oct17-Sep18	86.0	Significantly better than expected
HSMR: Weekday emergency admissions	Oct17-Sep18	82.3	Significantly better than expected
HSMR: Weekend emergency admissions	Oct17-Sep18	96.3	Not significantly different to expected

Each month the MMC look at risk-adjusted mortality at both diagnosis and procedure group level and where data suggests our outcomes are significantly different to expected this is investigated. Our system of prospective review and the central recording of mortality reviews from a number of specialties support us to establish a clearer picture of care and identify in a timely way where they may be areas that require further investigation.

At the most recent MMC meeting in November 2018 the committee considered data covering the period September 2017 to August 2018 and reviewed all diagnosis and procedure groups where there was a signal suggesting our outcomes were different to expected. For each of these existing mortality reviews were considered, alongside the trend data; these are summarised briefly below. In each group the majority of deaths have already been reviewed and no concerns or avoidability highlighted. Where there have been issues, these have been investigated and escalated as appropriate.

The committee felt that there was a good understanding of each of the signals and taking into account the work already done did not identify any signals requiring additional scrutiny at this time. However, it was agreed that particular vigilance of the 'Plastic repair of aortic valve (adult without CABG)' grouping is required.

The importance of accurate coding was also discussed as over time there has been an increase in the number of alerts in non-specific groupings. The committee agreed that clinicians need to provide coders with better information in order to support precise coding. Members suggested that where the information provided is insufficient consultants should be notified, and if there is no response this should be escalated, initially to Care Group leads.

Diagnosis/procedure group	Analysis summary
Coma, stupor and brain damage	Reviewed data for March to August 2018. 15 deaths observed against 11.1 expected. All have at least one review. No concerns or avoidability noted. Out of hospital cardiac arrest tends to be a key feature of this diagnosis group. Un-survivable sever neurological injury is seen in the Trust as a consequence of being a major trauma and neurosurgical centre.
Crushing injury or internal injury	17 deaths observed between September 2017 and August 2018 (7 expected). 13 deaths have at least one review recorded on the MMC database, including independent MMC review, Trauma review and CTICU review. 11/13 found no avoidability or concerns. 1 case was categorised as 5 (slight evidence of avoidability) and concerns from CTICU. 1 case was categorised as 4 (possibly avoidable but not very likely). Major trauma

	related deaths feature in this diagnosis group.
Non-specific chest pain	This was a new signal in September 2018. 5 deaths were observed between July 2017 and June 2018. 4 had been independently reviewed, with no avoidability found in 3. In 1 case there was slight evidence of avoidability and this was referred to the Deteriorating Adults Group. In November there had been no change to this position. Work with Clinical Coding is necessary to ensure such patients are more specifically coded with a more accurate diagnosis.
Occlusion of stenosis of precerebral arteries	3 deaths, against an expected 0.5. Each of these cases was independently reviewed by the MMC immediately following death and no avoidability was found. All 3 cases were transfers; 2 for possible thrombectomy.
Other fractures	5 deaths in the most recent 6 months of data, against an expected 7.7. Of these 3 have been independently reviewed and no avoidability found. Trauma related deaths impact on this grouping; patients with multiple injuries feature in this group.
Other perinatal conditions	The presence of this signal is well understood and mortality review processes are in place locally, in addition to periodic review by MMC Chair. The risk modelling used is not really suitable for these cases and does not manage well those cases where death is very likely. Such signals are commonplace in Trusts with fetal medicine units and tertiary neonatal units. All such deaths are reviewed by the clinical teams and by the CDOP process.
Residual codes unclassified	This signal is related to our coding and data submission processes. The committee are vigilant to any increases in the number of spells and deaths in this grouping as it impacts on cases included within the HSMR and other diagnosis groups. The committee have welcomed a new coder to the group who leads on the accurate and timely coding of deceased patients.
Plastic repair of aortic valve (adult without CABG)	9 deaths observed over the most recent 12 months, compared to 2.6 expected. All have at least one review (either independent review/review following elective admission/CTICU review). 3 have concerns noted -1 was an SI, 1 was an inquest and is being taken forward through existing governance processes. Cardiac surgery deaths are currently being monitored very closely with both internal and external review and scrutiny.
Reduction of fracture of bone (upper/lower limb)	This was a new signal in November 2018. 13 deaths (6.5 expected) between September 2017 and August 2018. 12 reviewed and no avoidability found in 11. 1 case assessed to be possibly avoidable but not very likely (less than 50:50). A rapid response report was completed and SIDM discussion.
Abdominal excision of uterus	There is 1 death in this grouping, related to uterine sarcoma. The case has been independently reviewed and found to be not avoidable. Death was related to cancer, rather than the procedure.
Contrast radiology or catheterisation of heart	This was a new signal November 18. The most recent quarter was investigated as periodic review of this grouping already occurs. There were 6 deaths between against 2.7 expected. All

	have 1 or more reviews with no concerns or avoidability noted.
Rest of joint	There are 5 deaths in the period. 4 have at least one review (either independent review, Trauma review or Orthogeriatric review). 3/4 found no avoidability or concerns. In one case there was slight evidence of avoidability found on independent review – this case was subject to an inquest, with a narrative verdict returned (accidental fall with osteoporosis and frailty).
Therapeutic transluminal operations on vein	6 deaths have occurred between March and August 2018. All have been independently reviewed and no avoidability identified. This grouping tends to represent very sick people who require PICC lines for administration of medicines such as antibiotics, chemotherapy and TPN.

Appendix 1: National Quality Board Dashboard – data to December 2018

St George's University Hospitals NHS Foundation Trust: Learning from Deaths Dashboard - December 2018-19

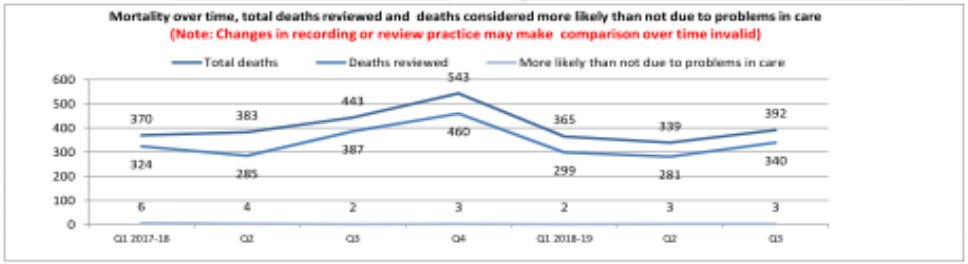
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

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

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

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered more likely than not due to problems in care PRISM Score<=3 or equivalent measure	
This Month	Last Month	This Month	Last Month	This Month	Last Month
135	133	116	118	0	3
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
392	339	340	281	3	3
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
1096	1739	920	1456	8	15

Time Series: Start date 2017-18 Q1 End date 2018-19 Q3



Total Deaths Reviewed, categorised by PRISM Score

Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	1	0.9%	This Month	3	2.6%	This Month	112	96.6%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	3	0.9%	This Quarter (QTD)	1	0.3%	This Quarter (QTD)	9	2.6%	This Quarter (QTD)	327	96.2%
This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	8	0.9%	This Year (YTD)	6	0.7%	This Year (YTD)	27	2.9%	This Year (YTD)	879	95.5%

Summary of total number of learning disability deaths and total number reviewed under the LeDeR methodology (Please note that all LD deaths are reviewed using our standard approach, pending reviews as directed by the LeDeR process)

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

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered more likely than not due to problems in care	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	1	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
3	3	0	0	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
7	21	0	0	0	0

Time Series: Start date 2017-18 Q1 End date 2018-19 Q3

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	31 January 2019	**Agenda No.**	**2.5**
Report Title:	**Transformation Quarter Three Report**		
Lead Director/ Manager:	**James Friend. Director of Delivery, Efficiency & Transformation**		
Report Author:	James Friend. Director of Delivery, Efficiency & Transformation, with the programme team		
Presented for:	Information		
Executive Summary:	This is the third quarterly report setting out to the Trust Board the approach, progress and impact of the Transformation work underway. It is largely taken from monthly reports provided to internal stakeholders throughout the Trust. Overall, progress remains on track with most key change objectives. Interdependencies on IT change capacity and operational management capacity remain the most significant factors setting the pace of deliverable change and improvement.		
Recommendation:	The Trust Board is asked to note the report.		
Supports			
Trust Strategic Objectives:	Treat the patient, treat the person Right care, right place, right time Balance the books, invest in our future Build a better St. George's Champion Team St. George's Develop tomorrow's treatments today		
CQC Themes:	Effective, Responsive and Well-led		
Single Oversight Framework Theme:	Strategic Change		
Implications			
Risk:	No additional risks are identified in this report		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	Trust Executive Committee monthly	**Date:**	Monthly throughout Q3.
Appendices:	Appendix One – Key Performance Indicators Appendix Two - Key Upcoming Deliverables		

1. Transformation Programme 2018-19

1.1. The Trust's programmes of transformation for 2018-19 are embedded alongside operational improvement both for quality and performance and for use of resources. Transformation opportunities have been prioritised for resourcing based on their quality and financial impact and their alignment to the three Principles of Transformation:

- Getting our patients to the most appropriate environment for their Assessment, for their Treatment and for their Care
- Aligning our Clinical Capacity to Pathway Demand
- Making the right thing to do for our patients be the easiest thing to be done by our clinicians

1.2. Operational programmes of work are sponsored by lead clinicians and functional programmes are sponsored by Executive Directors. Each workstream within the programme is governed by an agreed Terms of Reference document that the Steering Group uses to set out their objectives and implementation plan.

1.3. As with the first half of the year, members of the Transformation Team have continued to support operational colleagues by being formally and informally seconded into business as usual roles to create the environments ready for Transformation. This has been particularly the case in supporting the non-elective flow in recent weeks.

1.4. The team focuses on being exemplars of the Trust's improvement methodology and dedicates time each week to learning and reviewing specific parts of the curriculum, with more detailed sessions monthly. This quarter the focus has been on benefits tracking and balanced scorecard approaches.

1.5. Each week, the workstreams are held to account for delivery through the review of Weekly Workstream Monitoring Forms that set out the key operational, financial and workforce impacts of initiatives implemented to date and the plans for the delivery of immediately upcoming milestones.

2. Unplanned & Admitted Patient Care ("UAPC")

ED Front Door and Processes

2.1. All streaming CQUIN targets for Quarter 3 were achieved.

2.2. The Streaming Working Group continued to focus on improving efficiency of our front door processes and environment. Thanks to St George's Charity funding, contractors have been engaged to refurbish the Front Door area in January, providing a better experience for staff and patients. Following this, revised and clearer signs will be installed to help direct our patients and reduce wasted time and dissatisfaction due to confusion.

2.3. A series of PDSAs are being run to test time-saving ideas, including trialling a plug-in doorbell to support the new Streaming Escalation process and request immediate 'queue-busting' support when more than 5 patients are waiting for triage. This trial ended prematurely when the doorbell mysteriously disappeared after a few days! Lessons have been learned and our next

cycle in the PDSA will use a (more securely attached) tannoy to communicate streaming escalation alerts instead.

2.4. Work to improve data quality at the front door continued and in December five 'impossible' options were removed from an iClip field. This was a small change with a big impact – selecting these 'impossible' options led to undercharging and ED income loss of up to £20,000 per month. Work is also underway with Informatics and IT to streamline reporting processes. A request is in progress for the addition of a field in iCLIP that will save the Care Navigator up to 10 hours a week in manual reporting. Automating processes like this releases admin time which will instead be spent navigating our patients to the right place for their assessment, treatment and care.

2.5. The ED Processes workstream supported the ED Winter Plan and launched an interactive dashboard in December. This allows operational teams to monitor activity through the department, assess impact of the new model, and identify potential constraints or opportunities for improvement.

2.6. The two flu Point-of-Care Test machines were made ready to launch for when the local flu prevalence reached the agreed trigger point. Eighty ED nurses have now been trained to use them and IT have enabled the machines to send test results immediately into iCLIP allowing instant communication of results across the hospital. Flu Point-of-Care testing reduces result turnaround time from around 90 minutes to just 18 minutes, supporting patient flow through ED and allowing us to isolate infectious patients immediately, protecting our staff and other patients.

2.7. Two 'lean-principle' based projects are also being supported by the workstream: the ED arm of the IT Consolidation project and an ophthalmoscope replenishment project. A recent ED efficiency survey (completed by more than 70 ED staff members) highlighted IT issues and missing or broken clinical equipment as key causes of operational delay and opportunity for improvement in patient experience by reducing congestion in the department. Missing or broken ophthalmoscopes are estimated to absorb up to 400 minutes of clinical time per day across ED. Working with Medical Physics an additional 14 ophthalmoscopes will be delivered into the department in early 2019.

Inpatient Processes

2.8. The rollout of minimum standards and high performing team approach in the Wave one wards are well underway. A series of meetings have been held with the ward team to drive the improvement for their patients and team. Key improvement priorities established by the ward teams include improving board rounds efficiency, sharing success, defining roles and responsibilities to ensure tasks identified at the board rounds are completed and improving pre-11am discharge processes.

2.9. This workstream has supported and completed six week pilot of quicker and earlier turnaround of bloods for AMU and Cavell. The purpose of this pilot was to enable clinical team to confirm discharges much earlier via the morning board-rounds. During the pilot period, Cavell ward moved from receiving 20% of patients before Noon to 24%.

2.10. Surgery, Cancer, Neurosciences and Theatre (SCNT) division have been supported to implement a structured review of all stranded patients on a weekly basis, following the NHSI ECIP processes. The aim of these sessions is to understand what the plan is and what is the next thing that these patients are waiting for on the day of review and escalate accordingly.

Discharge Processes

2.11. The Merton Integrated Reablement & Rehabilitation pathway has launched in a limited area at St George's over the Christmas period involving the STAR & OPAL teams, enabling referral of patients who require a mix of health and social care support to one new single point of referral.

2.12. A Post Implementation Review for the initial pilot period of the Transfer of Care Bureau has been completed, reviewing the impact and current implementation issues highlights opportunity for improvement. Following this a further improvement plan is being actioned to optimise the current Bureau process and deliver the future structure and roles and responsibilities for on-going sustainability and performance.

Urgent Treatment Centre at Queen Mary's Roehampton

2.13. The project for the set-up of the conversion of the Queen Mary's Minor Injuries Unit into an Urgent Treatment Centre has met its key milestones this quarter.

2.14. Following the QMH site visit the launch of the Urgent Treatment Centre could now be scheduled for December 2019, subject to commissioner funding. The CCG, Emergency Department clinical team and SGH Estates jointly visited the Minor Injuries Unit to review the MIU footprint and the surrounding ground floor area to assess the potential works required to complete the upgrade to an Urgent Treatment Centre and to enable an impact appraisal (achievement of UTC principles and standards) to be carried out which would consider a number of estates and staffing options including do nothing and phased implementation.

2.15. It had been agreed that Cerner would be used as the clinical system for the service rather than an EMIS option.

2.16. Further consideration has been given to the management of patients with mental health issues who may develop a crisis whilst attending the centre and a review of the existing pathway will be undertaken by the Mental Health Trust.

3. Maternity

3.1. Work continues to ensure that all women booking with the Continuity of Carer teams are accurately recorded ahead of the first data collection in March 2019.

3.2. The maternity dashboard continues to be updated and reviewed, with over 20 indicators now live and being used for operational validation.

3.3. A position paper on a potential upgrade to the maternity IT system has been submitted for review by IT and the General Manager.

3.4. A questionnaire to capture women's experience of the Induction of Labour has been designed and will be trialled on the Postnatal Ward over the next few weeks.

4. Planned Care

Intermediate Tier - Dermatology Implementation

4.1. The Dermatology Intermediate Tier service has gone live and over the next few months will gradually increase the capacity as demand for the service grows.

Teledermatology

4.2. Teledermatology is now in testing phase with eighteen GP practices across Merton and Wandsworth. Patients and GPs will receive a diagnosis from the Consultant within five working days and any lesions the Dermatologist suspect to be cancerous will be upgraded to a Two Week Rule pathway. Based on successful implementation of Teledermatology in other Trusts this should significantly reduce the capacity pressures in skin cancer clinics.

Pre- Operative Assessment

4.3. Following the trust-wide master class held in November 18, a project charter has been developed together with a plan of objectives for the next 12 months.

4.4. The introduction of one way text reminders for all Pre-Operative Assessment ("POA") appointments is having an impact on the DNA rate which has reduced from over 7% to 5% for both the Day Surgery Unit and the centralised Inpatient POA services. The demand and capacity analysis has been completed resulting in the removal of two clinics per week in the Day Surgery Unit releasing one nurse for two days per week from early January.

4.5. On the day cancellations due to failure of POA have reduced to zero for both Day Surgery and the centralised inpatient service. All reports are now fully validated on a daily basis and data quality is improving.

Digital Outpatients - Check-in-kiosks

4.6. Check-in kiosks are now in eight Outpatient areas with a plan to redeploy existing kiosks (where there is a pair) to Rheumatology, Max-Fax and Clinic A. The installation in Clinic A will be part of a larger piece of work to improve patient flow in this busy area. Overall in December 3,500 patients checked themselves in via a kiosk.

Digital Patients – Patient Reminders

4.7. Two way text reminders have been introduced on a pilot basis of around 30-40 messages per day, allowing patients to confirm their attendance at their outpatient appointment or to request that their appointment be cancelled or rebooked. Early signs are that we are seeing around 4%

of our patients requesting that their appointment be cancelled or rebooked which is in line with our expectations.

4.8. Friends and Family Test requests have also started to be sent via text message, with around 200 requests per day being sent and an improvement seen on the click rate of our Friends and Family Test portal as a result.

5. Quality Improvement Academy

5.1. Building our capabilities to make quality improvement part of our everyday activities will take time and in Quarter 3 Jacqueline Totterdell, Richard Jennings and Mark Hamilton had the opportunity to make a site visit to Orlando Health in the US. The team started its QI transformation nearly ten years ago and have a many insights to share with other organisations embarking on a similar journey. In particular they identified how sustained commitment transforms patient care, staff engagement and use of resources.

5.2. Three team-based improvement projects have been supported in December:

- Brodie Ward - a GAPS (simulation team) led education-based project designed to address issues raised as part of the Ward Accreditation review process
- Amyand, Gray & Cavell Wards – roll out of the Trust's High Performing Teams framework designed to address flow related issues.
- Cardiac surgery (appreciative enquiry) and CTICU – building team capability to support self-determine and lead local improvement projects

5.3. The Academy is working with colleagues from Training & Education to create a fully integrated portfolio of leadership and quality improvement services for all levels of staff that have a key role, or interest in leading quality improvement projects.

5.4. An 'After Action Review' was facilitated following the recent electrical shutdown and highlighted a number of key learning points and specific improvement opportunities which will be shared across the project teams and Trust Executive Committee. A similar review was run for the Major Incident declared during that same weekend.

5.5. In collaboration with colleagues from IT and Corporate Nursing, the Quality Improvement Director facilitated a review to understand and address the unintended quality consequences of the recent iClip roll-out.

6. Transformation Programme 2019-20

6.1. Planning for next year has included a lively Planned Care event where specialty teams were able to hear the successes that colleagues elsewhere have delivered through transformed pathways this year and to select which areas they wanted to focus on for their own service business plans going forward. In parallel with the roll out of iClip to the Outpatient environment, Planned Care Transformation team members are likely to take more of an internal consultancy approach, moving into next year, helping each prioritised service to become an exemplar for up to date ways of working, including through linking with Health Innovation Network.

6.2. Alongside this, the Model Hospital information suite from NHS Improvement has been refreshed and identifies areas for improvement opportunity. It is worth noting that our Emergency Department has moved from being in the most expensive quartile nationally for

cost of service delivery in 2016-17 to being in the best quartile in 2017-18 – a huge well done to everyone who has delivered that change. Seven specialties have now identified Model Hospital Champions and are working on agreeing areas and productivity metrics that they want to specifically track. These metrics are being collated into an augmentation of the Tableau GIRFT Dashboard, which is also being shared across South West London, and the national team are providing support where required.

6.3. The Unplanned and Admitted Patient Care team have identified a refocus for next year on moving further clinical pathways into Ambulatory Care settings as creating value for patients as well as improving use of resources, in line with the transformation principle to get our patients to the most appropriate environment for their assessment, for their treatment and for their care. Should capital be identified their goal remains the creation of a best practice Emergency Floor to accelerate flow.

6.4. Details have now been published for the second round of the Maternity CNST Incentive scheme and, alongside expanding the Continuity of Carer offer; this will be a focus for the beginning of next year for the Maternity Transformation team.

6.5. Other emerging themes for next year are around how the patient demand at Queen Mary's Hospital is aligned to the physical and clinical capacity at that site and how, in partnership with South West London St George's NHS Foundation Trust, the experience for patients with Mental Health needs can be transformed in Emergency Care, in ward based care and in outpatient settings.

7. Recommendation

7.1. The Trust Board is asked to note the report.

Author: James Friend, Director of Delivery, Efficiency and Transformation

Date: 25 January 2019

Appendix One – Key Performance Indicators

	Metric	Baseline (2017/18)	Target	Actual								
				April	May	June	July	Aug	Sept	Oct	Nov	Dec
1	Proportion of Outpatient Attendances that are Non-Face to Face	0.6%	By year end: 1st Attendances = 20%	0.4%	0.6%	0.4%	0.5%	0.5%	0.5%	0.5%	0.6%	Not yet published
		3.2%	By year end: Follow-up Attendances = 50%	4.1%	4.9%	4.9%	5.8%	5.2%	6.5%	5.7%	5.2%	Not yet published
		2.3%	Overall, based on Follow-up to First Attendance Ratio of 2:1 = 40%	2.8%	3.4%	3.2%	4.0%	3.6%	4.4%	3.9%	3.6%	Not yet published
2	Outpatient Did Not Attend Rate	10.6%	8.0%	12.7%	12.0%	10.1%	10.8%	11.3%	10.5%	10.5%	10.5%	10.9%
3	Admitted Pathway Four Hour Operating Standard	64.3%	April – 69.0% May – 76.7% June & July – 87.1% August – 81.9% September – 87.1% October – 79.3% November – 81.9% December – 74.1%	67.9%	82.2%	81.5%	76.6%	74.7%	70.9%	70.3%	61.5%	62.8%
4	SAFER – Downstream Ward Transfers before Noon – St James's Wing Wards and Heberden	29.3%	33% (23.9% of Patients Admitted through ED Attend between 6am and 11am; 31.2% between 6am and Noon)	25.6%	26.1%	26.3%	25.8%	28.4%	24.9%	20.4%	25.3%	22.7%
5	Number of Women booked on to a Midwifery Continuity of Care Pathway	0	20% of bookings by March 2019					2	17	18	36	42

Key:
Red – worse than Baseline
Amber – better than Baseline but not better than Target
Green – better than Target
(NB – Where the Target is less stretching than the Baseline, due to other changes, then the Amber coding is reversed - Amber – better than Target but not better than Baseline)

Appendix Two - Key Upcoming Deliverables

Programme	Deliverable
Unplanned & Admitted Patient Care	QMH UTC - Demand & Capacity meeting to reassess the activity for the service
	QMH UTC - Gap analysis meeting to assess level of achievement of Urgent Treatment Centre principles and standards against various scenarios including a do nothing option
	Further training and education to ward staff re: DTOCs within pilot ward
	Support the Board round pilot on Gray Ward
	QMH UTC - Estates meetings with CCG and external contractor who carried out the original options appraisal work to understand the commissioner's initial forecast that no capital investment would be required to ensure the specification has been understood
	Schedule ED Front Door improvement estates work
	Develop an Intranet page for day to day escalations - Who, when and what - contacts and SLA to be collected
	Approve, develop and launch primary care streaming field in iClip
Planned Care	Complete the testing of voice reminders
	Increase the number of two way text reminders to around 400 per day
	Increase the number of Friends and Family test messages sent to around 500 per day
	Awareness session for all teams in Clinic A Lanesborough wing
Maternity	IT System position paper to go to Informatics Governing Group
	New Beginnings team to present to Trust Board
	Willow Team Continuity of Carer Team Leader transfers in ahead of official launch
	Establish the Out of Area Birth Centre Continuity of Carer team ahead of operational launch
	Induction of Labour project team initial meeting
	Pilot use of Induction of Labour patient experience questionnaire on the Postnatal Ward

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	31 January 2019	**Agenda No**	**3.1**
Report Title:	**Finance and Investment Committee report**		
Lead Director/ Manager:	**Ann Beasley, Chairman of the Finance and Investment Committee**		
Report Author:	Ann Beasley, Chairman of the Finance and Investment Committee		
Presented for:	Assurance		
Executive Summary:	The report sets out the key issues discussed and agreed by the Committee at its meeting on the 24 January 2019.		
Recommendation:	The Board is requested to note the update.		
Supports			
Trust Strategic Objective:	Balance the books, invest in our future.		
CQC Theme:	Well Led.		
Single Oversight Framework Theme:	N/A		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A
Appendices:	N/A		

Finance and Investment Committee – 24 January 2019

1.1 Finance Risks- the Deputy Chief Financial Officer (DCFO) updated the Committee on the latest position on the finance risks. He noted the increase and decrease in two functional risks that are under strategic risk 14 (relating to securing investment to address IT/Estates challenges). The Committee agreed to escalate the lack of progress with NHS Improvement on the capital loan to the next Provider Oversight Meeting (POM).

1.2 ICT Risks- the Chief Information Officer updated on ICT risks, showing latest progress on timelines for mitigating all ICT risks. In particular she noted the potential improvement on the data quality risk and the work done on GDPR. The Data Protection Officer has reviewed progress to date on GDPR.

1.3 Estates Risks- the Director of Estates & Facilities (DE&F) updated on Estates risks. He included the latest information on Corporate risks including the water supply and informed the Committee of some emerging risks and actions being taken to address them.

1.4. The Committee asked if more work could be done to keep the risk list in 'real time' as some of the risks emerging could be added to the schedule. The Committee also asked for some consistency of presentation with the different risk schedules.

1.5 Dalby Ward- the DE&F presented a paper updating on Dalby Ward. The Committee welcomed the improved environment and agreed with the recommendation to undertake a post project evaluation in 6 months, as the ward has only recently opened.

1.6 Performance- the Director of Delivery, Efficiency & Transformation (DDET) noted his expectation that Elective and Daycase activity in December has significantly increased between the time of the report and the committee meeting. He noted the infographic of the report has the value at 4,124 which is much higher than the 3,818 in the main report, and that he is expecting further improvement to match the plan of 4,289. The Chief Operating Officer (COO) observed the excellent performance in November (and expected in December) in all Cancer targets.

1.7 Emergency Flow - the COO noted latest performance and action plans in delivery of the 4 hour A&E target. December performance was 85.64%. The Committee noted the changes required in the approach of the site management team whilst observing the improved consistency of performance in January so far. The DDET observed the opportunity in patients staying over 7 days where pathways are not confirmed early enough, and in patients that breach, where an extra day's length of stay is experienced. He did note the extra 1,600 patients that have been admitted within four hours of arrival comparing 15th March 2018 to 13th January 2019 with the same period the previous year.

1.8 Financial Performance & Forecast- the Deputy CFO noted performance in December was in line with the agreed financial forecast, although this required £0.8m of non-recurrent measures, following the shortfall of Elective and Bedday income in Surgery and CWDT respectively. The Pre-PSF year to date deficit is £44.1m, which is adverse to plan by £17.7m. It was observed that the forecast for the Trust is between a median case of £55.2m deficit and best case of £51.4m.

1.9 The Committee explored some of the ways to improve financial performance as the Trust moves into 2019/20, including the support to operational management in setting challenging and achievable forecasts.

1.10 Capital Expenditure - The Interim Director of Financial Operations noted progress on the emergency capital bid and the capital and cash scenarios that existed should funding be made available from the Department of Health or otherwise. The Committee welcomed the approach taken while uncertainty still exists over funding.

1.11 Cash & Associated Issues- The Interim Director of Financial Operations noted the increased cash from payments (including capital payments), receipts and working capital borrowing, which was offsetting the lack of capital loan receipt of £19.8m. The Committee noted the working capital loan request agreed with NHS Improvement for £5.6m in January, £7.1m requested for February 2019, and expected request of a further £2.5m to cover March. This was on the basis of a £52m deficit. The committee noted the continued strong management of this position.

1.12 PLICS/SLR update – the Director of Financial Planning noted that all issues found following the review of Vascular Surgery had been or were being addressed. The Committee noted the challenge of engaging with clinical colleagues when the tariff changes in April.

1.13 Annual Planning Update – the Chief Financial Officer noted the work that has taken place so far to understand the recent planning guidance and control total information. He noted the £3.0m deficit that has been offered by NHS Improvement, which includes additional Provider Sustainability and Financial Recovery Funding. The implications for next year's CIP were also discussed. The Committee noted that while some aspects were subject to confirmation, the control total appeared to be more deliverable than in recent years.

1.14 Procurement Update– the Head of Procurement noted the further work done in the department since the last update. Fewer breaches and waivers have been processed and the team only has 2 vacancies at present. The department has also achieved level 1 status, one of 4 in London and the first in South West London. The Committee welcomed the progress made.

2.0 Recommendation

2.1 The Board is recommended to receive the report from the Finance and Investment Committee on 24 January 2019 for information and assurance.

Ann Beasley
Finance and Investment Committee Chair,
January 2019

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	31st January 2019	**Agenda No.**	**3.2**
Report Title:	**M09 Finance Report**		
Lead Director/ Manager:	**Andrew Grimshaw**		
Report Author:	Michael Armour & Tom Shearer		
Presented for:	Update		
Executive Summary:	Overall the Trust is reporting a Pre-PSF deficit to date of £44.1m at the end of Month 09 (December), which is £17.7m adverse to plan. Within the position, income is adverse to plan by £10.0m, and expenditure is overspent by £7.7m.		
Recommendation:	The Trust Board notes the trust's financial performance to date in December.		
Supports			
Trust Strategic Objective:	Balance the books, invest in our future.		
CQC Theme:	Well-Led		
Single Oversight Framework Theme:	Finance and use of resources		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	The Finance & Investment Committee	Date	24/01/19
Appendices:	N/A		

St George's University Hospitals NHS
NHS Foundation Trust

Financial Report Month 9 (December 2018)

Chief Finance Officer

31st January 2019

Executive Summary – Month 9 (December)

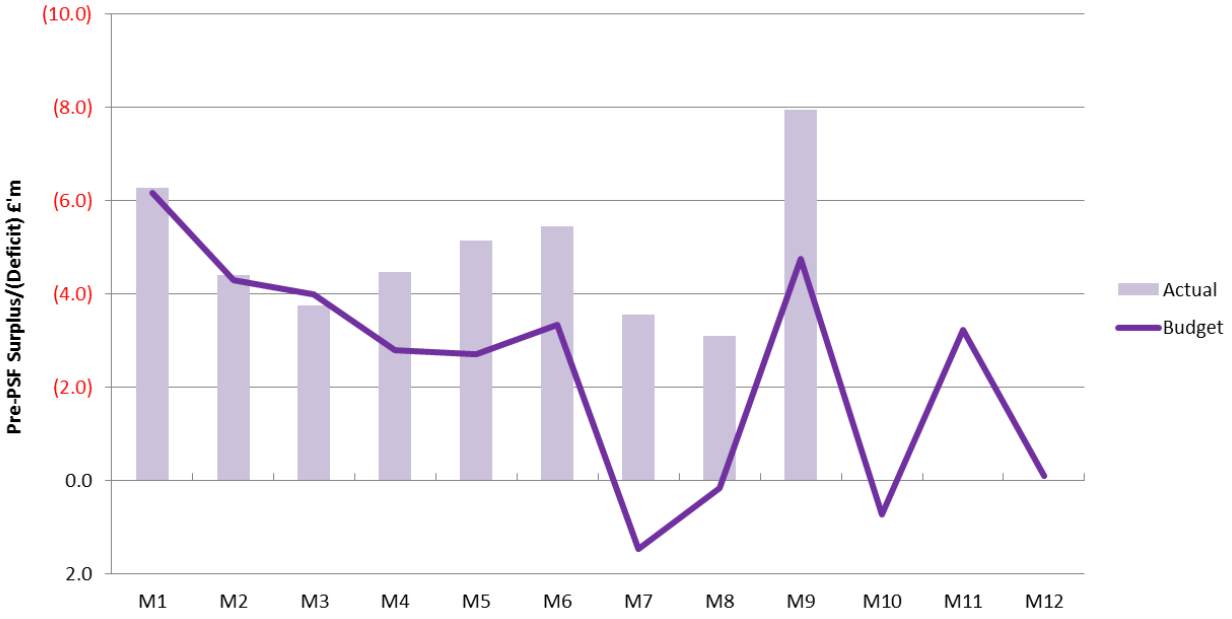
Note: All figures and commentary in this report refer to the revised Trust plan submitted to NHS Improvement on 20th June.

Area	Key issues	Current month (YTD)	Previous month (YTD)
Target deficit	**The trust is reporting a Pre-PSF deficit of £44.1m** at the end of December, which is **£17.7m adverse to plan**. Within the position, income is adverse to plan by £10.0m, and expenditure is overspent by £7.7m. There also remains an element of income estimation in the position which will need to be validated ahead of freeze dates. **M4-9 PSF income of £6.3m** in the plan has **not been achieved** in the Year-to-date position, as the Trust continues to be adverse to the Pre-PSF plan.	£17.7m Adv to plan	£14.5m Adv to plan
Income	Income is reported at £10.0m adverse to plan year to date. Elective is the main area of lower than planned performance; with shortfalls in volume (£12.2m) being offset by pricing gains (£5.1m) in other areas. Non-SLA income is also adverse to plan, with shortfalls private patient income the major cause.	£10.0m Adv to plan	£6.6m Adv to plan
Expenditure	Expenditure is £7.7m adverse to plan year to date in December. This is caused by Non Pay adverse variance of £6.9m (although a large proportion of this is offset in Income as pass-through is over-performing). Pay is adverse to plan by £1.1m in month, where medical pay is not being fully offset by other categories as it had been in previous months.	£7.7m Adv to plan	£7.9m Adv to plan
CIP	The Trust planned to deliver £34.2m of CIPs by the end of December. To date, £31.1m of CIPs have been delivered; which is £3.0m behind plan. Income actions of £7.5m and Expenditure reductions of £23.7m have impacted on the position.	£3.0m Adv to plan	£2.7m Adv to plan
Capital	Capital expenditure of £19.7m has been incurred year to date. This is £1.5m above plan YTD. The position is reported against the internally financed plan of £18.9m. This does not include DH capital loans (to be secured) of £27.873m. The loan has been reduced to £18m as per the request from NHSI due to timing of receipt and expected capital spend till March 2019	£1.5m Adv to plan	£0.1m Adv to plan
Cash	At the end of Month 9, the Trust's cash balance was £3.1m, which is better than plan by £0.1m. The Trust has borrowed £36.7m YTD which is in more than plan due to the I&E Deficit incurred. The Trust secured a loan of £5.6m for January and has requested £7.1m for February.	£0.1m Fav to plan	£0.2m Fav to plan
Use of Resources (UOR)	The Regulators Financial Risk Rating. At the end of December, the Trust's UOR score was 4 as per plan.	Overall score 4	Overall score 4

Contents

1. Month 9 Financial Performance

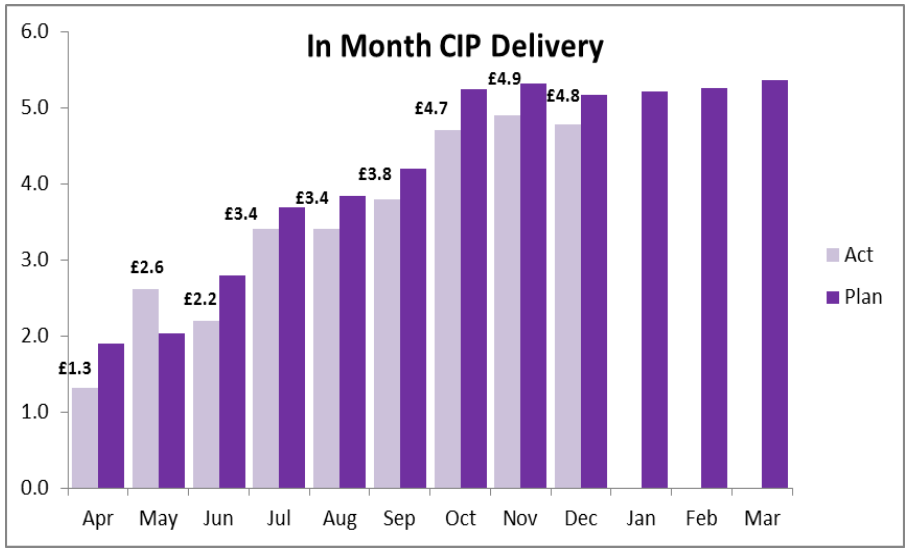
			Full Year Budget (£m)	M9 Budget (£m)	M9 Actual (£m)	M9 Variance (£m)	M9 Variance %	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)	YTD Variance %
Pre-PSF	**Income**	SLA Income	663.5	52.0	49.1	(3.0)	(5.7%)	494.2	485.0	(9.1)	(1.9%)
		Other Income	158.8	13.4	13.0	(0.4)	(3.2%)	120.4	119.6	(0.8)	(0.7%)
	Income Total		**822.3**	**65.5**	**62.1**	**(3.4)**	**(5.2%)**	**614.6**	**604.6**	**(10.0)**	**(1.6%)**
	Expenditure	Pay	(509.7)	(41.9)	(42.1)	(0.2)	(0.5%)	(384.0)	(385.1)	(1.1)	(0.3%)
		Non Pay	(307.6)	(25.4)	(25.0)	0.4	1.7%	(231.7)	(238.6)	(6.9)	(3.0%)
	Expenditure Total		**(817.3)**	**(67.3)**	**(67.1)**	**0.2**	**0.3%**	**(615.7)**	**(623.7)**	**(8.0)**	**(1.3%)**
	Post Ebitda		(34.0)	(2.9)	(2.9)	0.0	1.0%	(25.3)	(25.0)	0.3	1.3%
Pre-PSF Total			**(29.0)**	**(4.7)**	**(7.9)**	**(3.2)**	**(67.1%)**	**(26.4)**	**(44.1)**	**(17.7)**	**(66.8%)**
PSF			12.6	1.3	0.0	(1.3)	(100.0%)	8.2	1.9	(6.3)	(76.9%)
Grand Total			**(16.4)**	**(3.5)**	**(7.9)**	**(4.4)**	**(127.7%)**	**(18.2)**	**(42.2)**	**(24.0)**	**(131.7%)**

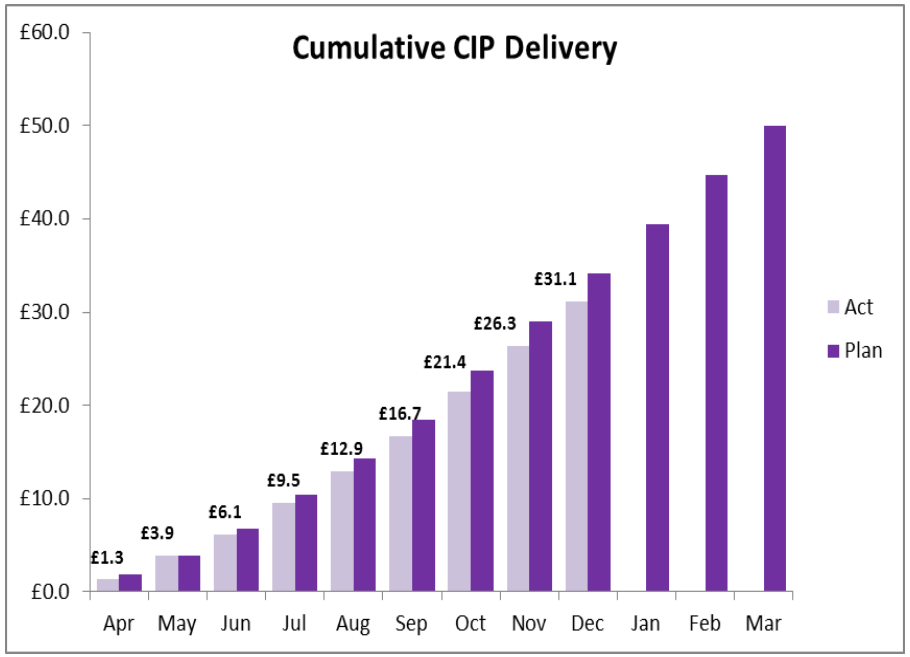


Trust Overview

- Overall the Trust is reporting a Pre-PSF deficit of £44.1m at the end of Month 9, which is £17.7m behind plan.
- **SLA Income** is £9.1m under plan. The main area of note is Elective with a material adverse variance (£7.1m), which is driven by lower than planned volumes of activity (12.2m) partially offset with increased income per case (£5.1m).
- **Other income** is £0.8m under plan, which is primarily Private patient income shortfall in Cardiology CAG.
- **Pay** is £1.1m overspent. Medical staffing overspends of £5.1m are partially offset by non-medical staffing underspends of £4.0m due to vacancies. It should be noted that within staff groups there are areas of over as well as under spending.
- **Non-pay** is £6.9m overspent, mainly owing to increased pass-through costs and delay in Procurement CIP delivery.
- **PSF Income** is adverse to plan in M9 by £6.3m, as the Trust has not met the pre-PSF control total target of a £26.4m deficit.
- **CIP delivery** of £31.1m is £3.0m behind plan. The Clinical Divisions' shortfalls have been partially offset by Overheads and Central schemes. Delivery to plan is:
  - Pay £0.5m favourable
  - Non-pay £0.8m adverse
  - Income £2.6m adverse

2. Month 9 CIP Performance





CIP Delivery Overview

- At the end of Month 9, the Trust is reporting delivery of £31.1m of savings or additional income through its Cost Improvement Programme.
- This compares to an external plan to have delivered £34.2m of savings or additional income by Month 9. Overall delivery is adverse of plan by £3.0m.
- The adverse variance to plan is due to under delivery of CIPs across all divisions as follows:
  - CWDTC - £618k
  - MedCard - £1,127k
  - SCNT - £1,464k

  primarily due to the under achievement of income and non-pay schemes.

Year End Forecast & Actions

- Based on the forecasting exercise, the Trust identifies £50m CIP forecast delivery which matches the 2018/19 plan, albeit with risks and opportunities.
- £46.2m is assessed as 'firm' delivery
- £3.8m is assessed as 'subject to some delivery risk' and key mitigation includes:
  - Delivery of divisional improvement actions £0.8m
  - Delivery of corporate improvement actions, primarily procurement and non-recurrent, £3.0m

3. Balance Sheet as at Month 9

	Mar-18 Audited (£m)	YTD Plan (£m)	YTD Actual (£m)	YTD Variance (£m)
Fixed assets	**377.2**	**395.6**	**379.6**	**-16.0**
Stock	**6.4**	6.4	8.1	1.7
Debtors	**112.3**	104.0	96.2	-7.8
Cash	**3.5**	3.0	3.1	0.1
Creditors				
	-118.4	-115.7	-126.1	-10.4
Capital creditors	**-15.4**	-8.6	-6.3	2.3
PDC div creditor	**0.0**	-0.1	-0.2	-0.1
Int payable creditor	**-0.7**	-2.4	-2.1	0.3
Provisions< 1 year	**-0.2**	-0.2	-0.2	0.0
Borrowings< 1 year	**-57.7**	-58.3	-57.6	0.7
Net current assets/-liabilities	**-70.2**	**-71.9**	**-85.1**	**-13.2**
Provisions> 1 year	**-1.0**	-0.7	-0.9	-0.2
Borrowings> 1 year	**-241.6**	-277.5	-272.1	5.4
Long-term liabilities	**-242.6**	**-278.2**	**-273.0**	**5.2**
Net assets	**64.4**	**45.5**	**21.5**	**-24.0**
Taxpayer's equity				
Public Dividend Capital	**133.2**	133.2	133.4	0.2
Retained Earnings	**-167.9**	-186.8	-211.0	-24.2
Revaluation Reserve	**97.9**	97.9	97.9	0.0
Other reserves	**1.2**	1.2	1.2	0.0
Total taxpayer's equity	**64.4**	**45.5**	**21.5**	**-24.0**

M01-M9 YTD Balance Sheet movement

- Fixed assets are £16.0m lower than plan due to lower capital spend than plan as capital bids are still being considered by the NHSI.
- Stock increased in month by £0.3m and remains £1.7m higher than plan due mainly to increase in Pharmacy and Cardiac stock. Pharmacy stock should reduce significantly over the remainder of the year.
- Overall debtors are £7.8m lower than plan.
- Creditors are £10.2m higher than plan relating mainly to the rescheduling of the payment of NHSPS rental charges and other NHS suppliers.
- Capital creditors are lower £2.3m than plan due to lower capital expenditure (no DH capital loans received yet)
- The cash position is £0.1m better than plan. Cash resources are tightly managed at the end of the month to ensure the £3.0m minimum cash balance is not exceeded.
- The Trust has borrowed £36.7m YTD for deficit financing which is more than plan. The Trust will drawdown £5.6m for January and has requested £7.1m for February to finance the deficit..
- The Trust had not drawn down any capital loans to date. A capital bid for approx £27.9m was submitted to NHSI at the end of August and is currently being reviewed by NHSI. This has now been revised down to £18.0m as per request from to submit based on ability to spend by March.
- The deficit financing borrowings are subject to an interest rate 3.5%. Also borrowings for new finance leases are lower than plan due to delay in receipt of capital loan

4. Month 9 YTD Analysis of Cash Movement

	YTD Plan £m	YTD Actual £m	YTD Variance £m
Cash balance 01.04.18	**3.5**	**3.5**	**0.0**
Income and expenditure deficit	-18.9	-43.0	-24.1
Depreciation	17.6	17.6	0.0
Interest payable	8.0	7.9	-0.1
PDC dividend	0.6	0.6	0.0
Other non-cash items	-0.1	-0.1	0.0
Operating deficit	**7.2**	**-17.0**	**-24.2**
Change in stock	0.0	-1.6	-1.6
Change in debtors	10.2	14.1	3.9
Change in creditors	-4.4	7.7	12.1
Net change in working capital	**5.8**	**20.2**	**14.4**
Capital spend (excl leases)	-41.3	-28.8	12.5
Interest paid	-6.5	-6.6	-0.1
PDC dividend paid	-0.5	1.5	2.0
Other	-0.3	-0.1	0.2
Investing activities	**-48.6**	**-34.0**	**14.6**
Revolving facility - repayment	0.0	0.0	0.0
Revolving facility - renewal	0.0	0.0	0.0
WCF borrowing - new	21.8	36.7	14.9
Capital loans	19.8	0.0	-19.8
Loan/finance lease repayments	-6.5	-6.3	0.2
Cash balance 31.12.18	**3.0**	**3.1**	**0.1**

M01-M9 YTD cash movement

- The cumulative M9 I&E deficit is £43.0m, £24.1m adverse to plan. (*NB this includes the impact of donated grants and depreciation which is excluded from the NHSI performance total).
- Within the I&E deficit of £43m, depreciation (£17.6m) does not impact cash. The charges for interest payable (£7.9m) and PDC dividend (£0.6m) 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 £17.0m.
- The operating deficit variance from plan of £24.2m.
- Working capital is better than plan by £14.4m. The favourable variance on debt comprises £3.6m adverse variance on invoiced debt and a £7.5m favourable variance on accrued debt. The £12.1m favourable variance on creditors relates mainly to the timing of payments for the CNST premiums and other NHS bodies.
- The Trust has borrowed £36.7m YTD which is higher than the YTD plan. The Trust had a draw down of £12.2m loan in December, has secured £5.6m in January and requested £7.1m for February. If the February draw down is approved, cumulative working capital borrowings would be £27.6m more than the plan as a result of the higher deficit. The borrowings are subject to an interest rate of 3.5% for the amounts drawn since November 17.

December cash position

- The Trust achieved a cash balance of £3.1m on 31 December 2018, £0.1m higher than the £3m minimum cash balance required by NHSI and in line with the forecast 17 week cash flow submitted last month.
- **The Trust will remain dependent on monthly borrowing from DH given the higher I&E deficit.**

5a. Capital Programme – total, internal and at risk

TOTAL - CAPITAL EXPENDITURE POSITION

Spend category	Internal Budget £000	M09 YTD budget £000	M09 YTD exp £000	*M09 YTD var £000*
Infrastructure renewal	**5,732**	**5,567**	5,119	*448*
IT	**3,220**	**3,220**	6,220	*-3,000*
Medical equipment	**1,890**	**1,889**	862	*1,027*
Major projects	**5,756**	**5,533**	5,249	*284*
Other	**1,108**	**928**	1,223	*-295*
SWLP	**545**	**544**	176	*368*
Urgent £11.8m March 2018 projects	**711**	**711**	1,058	*-347*
Total	**18,963**	**18,392**	19,907	*-1,515*

INTERNAL CAPITAL BUDGET only

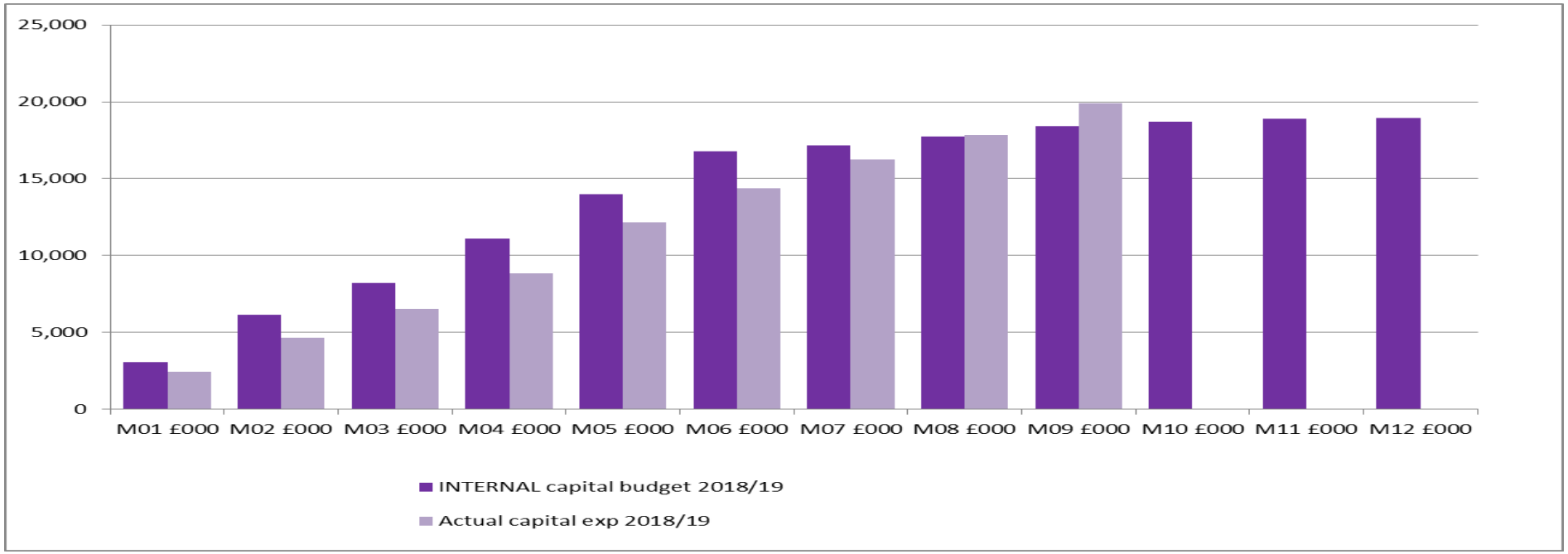
Spend category	Internal Budget £000	M09 YTD budget £000	M09 YTD exp £000	*M09 YTD var £000*
Infrastructure renewal	**5,732**	**5,567**	4,879	*688*
IT	**3,220**	**3,220**	3,870	*-650*
Medical equipment	**1,890**	**1,889**	862	*1,027*
Major projects	**5,756**	**5,533**	5,246	*287*
Other	**1,108**	**928**	1,223	*-295*
SWLP	**545**	**544**	176	*368*
Urgent £11.8m March 2018 projects	**711**	**711**	1,058	*-347*
Total	**18,963**	**18,392**	17,314	*1,078*

CAPITAL AT RISK EXPENDITURE only

Spend category			M09 YTD exp £000	*M09 YTD var £000*
Infrastructure renewal			240	*-240*
IT			2,350	*-2,350*
Medical equipment			0	*0*
Major projects			3	*-3*
Other			0	*0*
SWLP			0	*0*
Urgent £11.8m March 2018 projects			0	*0*
Total			2,593	*-2,593*

5b. Internal capital budget and expenditure M9

INTERNAL capital budget 2018/19 (excl bid - not approved) and YTD exp



- The Trust's internally funded capital expenditure budget for 2018/19 is £18.9m.
- The Trust has incurred capital expenditure of £19.9m in the first nine months of the year. This comprises £17.3m against the YTD internal capital budget of £18.4m and £2.6m expenditure incurred 'at risk' on the projects for which the Trust has submitted a bid for capital funding to NHSI. Therefore the capital programme is over spent by approx £1.5m at M09 overall. In addition to the spend at risk expenditure of £2.6m a further £2.6m has been approved.
- The main component of the year to date under spend on internal capital relates to the biggest project – the Lanesborough wing stand-by generators project (Infra Renewal category) which is under spent by approx £900k as at M09. This project and Medical equipment are behind schedule but is forecast to come within budget and so the M09 YTD underspend represents a temporary timing difference.

6. Finance and Use of Resources Risk Rating

Use of resource risk rating summary	Plan (M9 YTD)	Actual (M9 YTD)
Capital service cover rating	4	4
Liquidity rating	4	4
I&E margin rating	4	4
Distance from financial plan	n/a	4
Agency rating	1	1

Basis of the scoring mechanism

Area	Weighting	Metric	Definition	Score			
				1	2	3	4[1]
Financial sustainability	0.2	Capital service capacity	Degree to which the provider's generated income covers its financial obligations	>2.5x	1.75-2.5x	1.25-1.75x	< 1.25x
	0.2	Liquidity (days)	Days of operating costs held in cash or cash-equivalent forms, including wholly committed lines of credit available for drawdown	>0	(7)-0	(14)-(7)	<(14)
Financial efficiency	0.2	I&E margin	I&E surplus or deficit / total revenue	>1%	1-0%	0-(1)%	≤(1)%
Financial controls	0.2	Distance from financial plan	Year-to-date actual I&E surplus/deficit in comparison to Year-to-date plan I&E surplus/ deficit	≥0%	(1)-0%	(2)-(1)%	≤(2)%
	0.2	Agency spend	Distance from provider's cap	≤0%	0%-25%	25-50%	>50%

Commentary

- 1 represents the best score, with 4 being the worst.
- At the end of December, the Trust had planned to deliver a score of 4 in "capital service cover rating", "liquidity rating" and "I&E margin rating", and 1 in "agency rating".
- The Trust has scored as expected in these 4 categories, with the first 3 owing to adverse cash and I&E performance.
- The "agency rating" score of 1 is due to improved control and recruitment plans to reduce agency spend within the cap. The internal Trust cap is lower than the external cap of £21.3m.
- The distance from plan score is worked out as the actual % YTD I&E deficit (6.95%) minus planned % YTD I&E deficit (2.90%). This value is -4.05% which generates a score of 4.
- Distance from plan score in this report refers to the Trust plan submitted to NHS Improvement on 20th June.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	31 January 2019	**Agenda No**	**4.1**
Report Title:	**Clinical Strategy Highlight Report**		
Lead Director/ Manager:	**Suzanne Marsello, Director of Strategy**		
Report Author:	Ralph Michell, Head of Strategy Laura Carberry, Strategy and Partnership Manager		
Presented for:	Update		
Executive Summary:	In March 2018, the Board agreed to commence the development of a 5-year Clinical Service Strategy. This paper advises the Trust Board on the development of the 5-year Clinical Service Strategy to date (due end March 2019) and the deliverables in January, outlining progress so far, next steps and the identified issues and risks, in line with the agreed process and timescales.		
Recommendation:	The Board is asked to note the progress reported and the identified issues and risks.		
Supports			
Trust Strategic Objective:	Treat the patient, treat the person Right care, right place, right time Balance the books, invest in our future Build a better St. George's Champion Team St. George's Develop tomorrow's treatments today		
CQC Theme:	Safe, Effective and Well-Led		
Single Oversight Framework Theme:	Strategic Change		
Implications			
Risk:	As outlined in paper		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	Trust Executive Committee	**Date:**	23rd January 2019
Appendices:	Appendix 1: Clinical Strategy Development Timeline and Workstreams Appendix 2: Issues to be addressed as Clinical Strategy Development progresses		

Trust Strategy: Highlight Report

1.0 Purpose

1.1 This paper advises the Trust Board on the development of the 5-year Clinical Service Strategy to date (due end March 2019) and on the deliverables in January 2019, outlining progress so far, next steps and the identified issues and risks, in line with the agreed process and timescales.

2.0 Progress in January 2019:

2.1 All actions committed to are on plan for January 2019.

Deliverables/ Milestones for January 2019	Progress	Actions for February 2019	Completion Date/ RAG*
Overall Programme Plan (Workstream 1)	Programme Plan 'live' and ongoing progress on workstreams Project Risk Register reviewed	Delivery ongoing	**On plan**
Development of Options (Workstream 2)	Board Seminars on Strategy for Medical Specialties (17 January) and Surgical Specialties (22 January)	Completion of deliverables to enable Board Seminar to consider Support Services (12 February 2019)	**On plan**
Alignment, Deliverability and Prioritisation (Workstream 3)	Alignment of the different propositions and assessment of cohesion/ common themes, conflicts and likely reactions of stakeholders	Completion of deliverables to enable final Strategy Review in March 2019	**On plan**
Communication and Stakeholder Engagement (Workstream 4)	Confirmation of dates for Engagement Events in February 2019 and completion of deliverables in preparation	Engagement Events planned in early February 2019: • Public x 3 • Staff x 4 (incl. 1 at QMH-R) Communications Plan completed to detail engagement with our formal Stakeholders	**On plan**
'Into Delivery' Planning (Workstream 5)	Alignment to 2019/20 Business Planning i.e. Y1 of a 5yr Strategy Assessment of 2019/20 Business Plan submissions (30 November 2018) from Directorates/ Divisions for: • alignment and assurance of 2019/20- 2023/24 deliverables as explicitly linked to Service Strategies Completion of draft 2019/20 Corporate Objectives Divisional prioritisation of Service Developments	Board Seminar and Star Chambers in early February 2019 1st draft Operating Plan submission to NHSI (12 February 2019)	**On plan**
Enablers and Interdependencies (Workstream 6)	Initial discussions with Estates, IT and Workforce to agree approach and plan	None for February	**On plan**

Production and Publication of Strategy (Workstream 7)	Draft framework for 5-year Clinical Services Strategy produced	Communications Department to confirm Plain English Kite Mark process and timescales	**On plan**

** RAG rating refers to current in-month progress of the workstreams, rather than an assessment of the content covered in its entirety with its related risks.*

A Clinical Strategy Development Timeline is attached (Appendix 1) along with a description of the 7 workstreams.

3.0 Key Milestones for January 2019 onwards

- Board Seminars to cover Medical Specialities (17 January 2019) and Surgical Specialties (22 January 2019);
- Board Seminar covering Support Services (12 February 2019) plus an overall Strategy Review (6 March 2019);
- Engagement Events for Staff (5, 6, 18 and 21 February 2019) and the Public (7, 15 and 19 February 2019).

4.0 Issues and Risks

Capacity in the Clinical Divisions is the foremost significant risk to the strategy timescales.

No	Area	Description of Issue/ Risk	Mitigation	RAG
1.	Capacity (Clinical Divisions)	Bandwidth and breadth of challenges for Clinical and Managerial colleagues in the divisions and competing day-to-day priorities- finance, operational performance, quality standards- could lead to a lower prioritisation of strategy work leading to a delay in delivering a strategy	Strategy Team to engage and provide support, as far as possible, but clinical expertise and input will continue to be a key input and necessary requirement and resource restraint	
2.	Engagement (Clinical Divisions)	Clinical Strategy Development by end March 2019 is accelerating and Clinical Divisions communication and engagement could lack expediency and impetus leading to a delay in delivering a strategy and/ or difficulties with buy-in and ownership of the strategy	Divisional Engagement Plan agreed with Triumvirates Strategy Team attending Care Groups, Directorate Meetings and DMBs, as far as possible Further Engagement Events planned for Staff in early February 2019.	
3.	Reputational (Engagement Events)	Engagement Events- brief, concise sessions with lead-in limited. This could lead to criticisms of engagement being lip-service only and not authentic as it is rapidly rolled out and rushed.	Dates for February 2019, invitations to stakeholders and venues to be landed and locked down. Communications, Divisions, Strategy and Transformation teams working together on content/ format and delivery of events.	

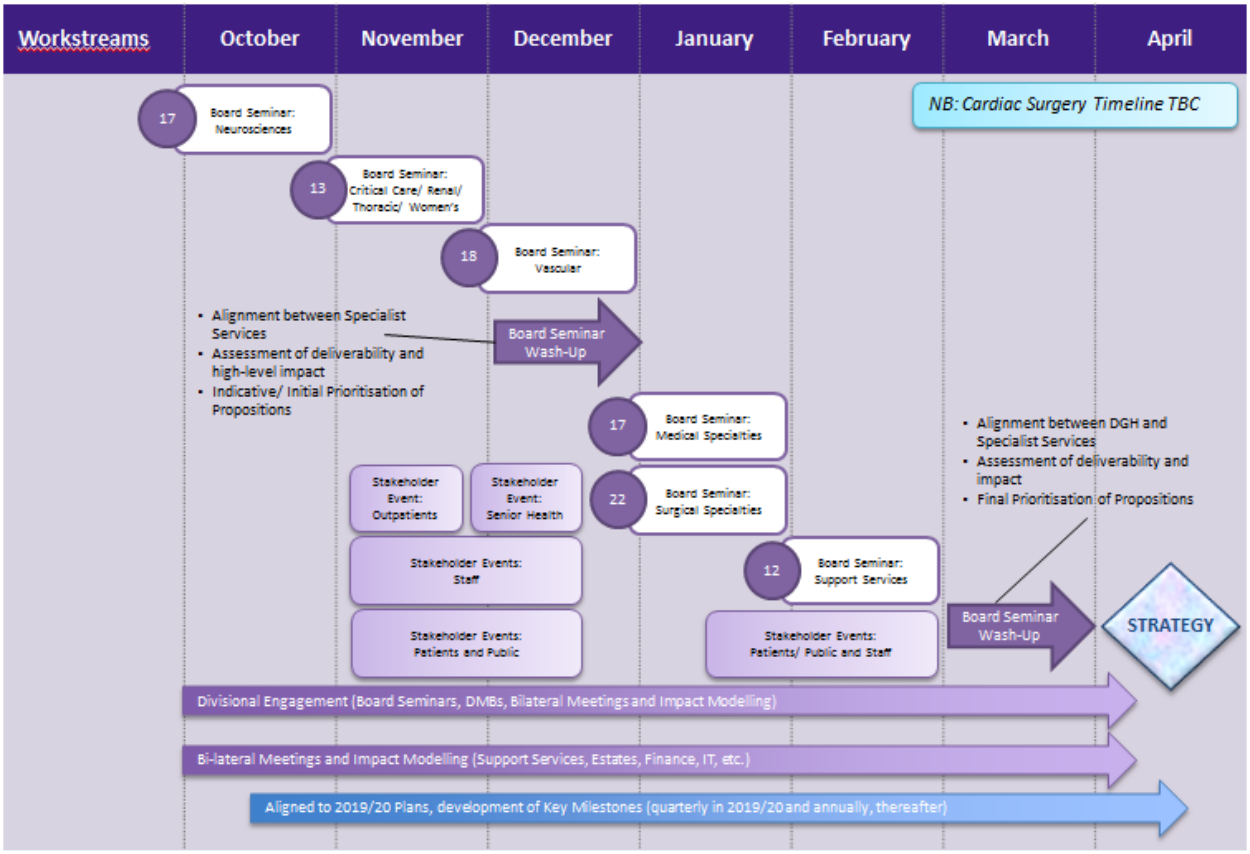
4.0 Recommendation

The Board is asked to note the progress reported and the identified issues and risks.

Author: **Laura Carberry, Strategy and Partnership Manager**
Date: **22 January 2019**

Appendix 1: Clinical Strategy Development Timeline and Workstreams

Clinical Strategy Development Timeline



Clinical Strategy Workstreams

Workstream	Description
1. Programme Management	Programme plan, risk register, etc.
2. Development of Options	Development of options for board to consider, (e.g. as per work to date for board seminars)
3. Alignment, Deliverability and Prioritisation	Making sure that the board's preferred options align and that any conflicts/issues are visible & managed, enabling the board to prioritise where necessary, and ensuring that what goes into the strategy is realistic & deliverable (with reference to money, estates, workforce, reactions of competitors/commissioners etc.)
4. Communications and Stakeholder Engagement	In developing the strategy and then disseminating once published. Covering a) strategically important stakeholders such as commissioners, regulators and b) staff & public.
5. 'Into delivery' Planning	Development of high-level milestones over the next 5 years for implementing the strategy
6. Enablers and Interdependencies	Alignment with business planning round for 19/20, and strategies for estates, finance (medium term financial plan), IT, workforce, research.
7. Production and Publication of Strategy	Agreeing what it should look like / who it should speak to; drafting/writing it; graphic design; publishing etc.

Appendix 2: Issues to be addressed as Clinical Strategy Development progresses

These are issues that have been identified from early strategy discussions and are points that will considered as the strategy is written. They are recorded here to ensure that they are not lost during the development process.

- The clinical strategy needs to be developed taking account of research and education priorities: meeting held with Principal of SGUL; Medical Director is a member of Strategy Project Steering Group. Medical Director to convene meeting re development of Research Strategy.
- Clinical innovation is a core part of the strategy: to be considered with each service as plans developed.
- The external environment analysis should include systems outside of SWL e.g. South London (links to specialised commissioning reviews), Surrey and Sussex: presentation to Board Strategy Seminar in July.
- Working within the SWL system at borough level with primary care, mental health and community provider colleagues within the wider health system is important: this will be picked up as the strategy work for the secondary health/ local hospital services is developed.
- Maximising the relationship with St. George's, University of London is an important partnership: meeting held with Principal of SGUL. Input to Board Seminars and links to Research Strategy.
- Include Kingston University as a key partner regarding training of nurses and other professional groups.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	31 January 2019	**Agenda No**	**4.2**
Report Title:	**2018/19 Corporate Objectives – Quarter 3 report**		
Lead Director	**Suzanne Marsello, Director of Strategy**		
Report Author:	Ralph Michell, Head of Strategy		
Presented for:	Assurance		
Executive Summary:	In June 2018 the Trust Board approved the Corporate Objectives for 2018/19, based on the strategic objectives linked to "Outstanding Care, Every Time." It was agreed that progress against the objectives and their associated quarterly milestones would be reported to the Trust Board on a quarterly basis. The attached paper is an update on progress in Quarter 3 (Q3).		
Recommendation:	Trust Board is asked to: Review the update, and in particular the assessment of where slippage presents a material risk to the year-end position Approve the report		
Supports			
Trust Strategic Objective:	Treat the patient, treat the person Right care, right place, right time Balance the books, invest in our future Build a better St. George's Champion Team St. George's Develop tomorrow's treatments today		
CQC Theme:	All		
Single Oversight Framework Theme:	Quality of Care (safe, effective, caring, responsive) Finance and Use of Resources Operational Performance Strategic Change Leadership and Improvement Capability (well-led)		
Implications			
Risk:	Any risks associated with the corporate objectives are covered within the BAF, Trust Risk Register or local risk registers		
Legal/Regulatory:	As legal/regulatory issues associated with the Corporate Objectives are covered by the governance underpinning that particular area of delivery of the trusts work programme		
Resources:	Delivery core business as usual of the trust, and supported by trust leadership cohort		
Previously Considered by:	Trust Executive Committee	**Date:**	23 January 2019
Appendices:	-		

2018/19 Corporate Objectives: Quarter Three Report

January 2019

1.0 Purpose

1.1 In June 2018 the Trust Board approved the Corporate Objectives for 2018/19, based on the strategic objectives linked to "Outstanding Care, Every Time."

1.2 It was agreed that progress against the objectives and their associated quarterly milestones would be reported to the Trust Board on a quarterly basis.

2.0 Progress Against Objectives in Q3

2.1 Corporate objectives for Q3 have been RAG rated on progress, as has each of the domains into which they are divided. Annex B sets out the methodology for arriving at RAG-ratings, previously agreed by the Trust Board.

2.2 12 objectives have been rated green, 11 amber, and 15 red. 11 had no applicable milestones for Q3.

2.3 In two cases, updates on progress in Q3 will be provided verbally to Trust Board (objectives 9.3 and 18.1). In one case (17.1), an update on whether slippage in previous quarters has now been resolved will also be provided verbally to Trust Board – the scoring below currently assumes no change from the Q2 position in this instance.

Organisational Objective	Green	Amber	Red	N/a (for quarter)	Update outstanding	Consolidated Quarterly Position	YTD position (and change on previous Q)
Treat the patient, treat the person	3	1	5				↓
Right care, right place, right time	4	4	3		1		↔
Balance the books, invest in our future		1	2	1			↓
Build a better St. George's	3	4	4	4			↓
Champion Team St. George's	1	1	1	3			↔
Develop tomorrow's treatments today	1			3	1		↔
OVERALL	**12**	**11**	**15**	**11**	**2**		↓

3.0 Risks and Mitigating Actions

3.1 The Q3 position represents a deterioration from Q2, when 19 objectives were rated green, 17 amber and 9 red.

3.2 However, for objectives rated amber/red in Q3, either work is sufficiently advanced at this stage, or sufficient remedial plans of action are in place, that in most cases the discussions with the objective owners suggests slippage does not currently pose a material risk.

3.3 The exceptions to this are those objectives relating to the following areas:

a) Training on the Mental Capacity Act
b) Identification of patients at risk of deterioration
c) Delivery of NHSI-agreed ED performance
d) Theatre productivity
e) Referral To Treatment (return to reporting, and elimination of 52-week waits)
f) Reduction of the deficit
g) Review of estates and securing external capital

3.4 All deliverables not met year to date as at Q3 are set out in Annex A, along with a progress update, mitigation and assessment of the extent to which slippage poses a material risk, as linked to the strategic risks on the Board Assurance Framework.

4.0 Recommendations

4.1 Trust Board is asked to:

- Review the update, and in particular the assessment of where slippage presents a material risk to the year-end position
- Approve the report

Annex A – Deliverables Not Met YTD

Objective	Deliverables not delivered & causing amber or red RAG rating	Progress update	Mitigation	Material risk? (Link to BAF)
Treat the patient, treat the person				
1.2 Ensure that the environment is safe and appropriate for the treatment of our patients, with plans to achieve relevant standards as our baseline	▪ Quarterly review to be undertaken of all PAM matters in December Board.	Not delivered	Presentation to be taken to Board Development Day. May now run into 19/20.	Not a material risk given that work to deliver is underway
2.1 Improve End of Life Care (EoLC) for patients and their families across the Trust	▪ Development and implementation of EoLC training programme	Training plan in place, but e-learning package not yet developed.	e-learning package being developed and forecast to be delivered in Q4	Not a material risk to the trust at this stage, as the work to deliver is underway.
3.1 Improve our compliance with Mental Capacity Act Assessment (MCAA)	▪ Develop L3 training	Not delivered due to lack of capacity and need to reconsider training needs analysis	Trust has stipulated that anyone we had previously planned to ask to undertake L3 training must complete L2 training. Note that L3 not yet mandated nationally, and not in our contract.L3 training forecast to be developed Q1 19/20.	**Potentially a material risk** to the trust, given CQC focus in this area.
3.2 Improve the safe, effective and appropriate use of restraints (e.g. bed rails) throughout the Trust	▪ Ensure staff are trained in relation to the MCA, as per objective above (other deliverables relating to this objective have been delivered).	Not delivered due to lack of capacity and need to reconsider training needs analysis	Trust has stipulated that anyone we had previously planned to ask to undertake L3 training must complete L2 training. Note that L3 not yet mandated	**Potentially a material risk** to the trust, given CQC focus in this area.

			nationally, and not in our contract.L3 training forecast to be developed Q1 19/20.	
4.1 Put in robust process to effectively identify patients who are at risk of deteriorating	▪ Review and make decision on requirements for Critical Care Outreach Team and our compliance against the relevant standards.	Business case drafted but decision not yet taken to Investment Committee	Final business case expected to go to Investment Committee in Q4.	**Potentially a material risk**
5.1 Ensure safe and secure handling of medicines focusing on room and fridge temperature monitoring solution for medicines	▪ Seek IDG approval for required investments, contingent on funding allocation from prioritised capital programme.	Delayed. Plan to go to IDG in Q4.	Continuing with current system – which from CQC perspective is fit for purpose.	Not a material risk to the Trust, but delivery of annual objective (installation of new solution) now unlikely to be met this year.
5.2 Continue to improve discharge medication turnaround times for patients to improve the patient experience and patient flow through the Trust	▪ Tender to external partners for monitored dosage systems	Tender drafted but not yet published.	Tender expected to be published in Q4	Not a material risk to the trust at this stage, as the work to deliver is underway and other activity relating to this objective is on track
Right care, right place, right time				
6.1 Enhance processes within ED to improve emergency care performance and patient care and experience	▪ Meet NHSI agreed ED performance of 92%.	▪ 87.1% performance in Q3.	▪ Papers to board in Q3 set out action to address ED performance.	**A material risk** to annual objective of meeting target performance agreed with NHSI
7.1 Admit patients to the right ward, discharge them efficiently and ensure a positive patient experience	▪ AMU bed occupancy at Midday =<90%.	▪ Narrowly not delivered – occupancy rate of 90.39%	▪ a number of initiatives implemented/ being implemented (e.g. exemplar patient, pre-11am early discharge, minimum standards, transfer	Not a material risk to the trust at this stage – remedial plan in place and end of year target of <90% occupancy still deliverable. [Awaiting confirmation this is still the judgment]

			of care bureau, weekend discharges pilot)	
7.2 Develop boundary-less flow to minimise LOS for patient requiring on-going treatment or care, and create the flexibility with hospital to maintain a steady state during periods of increased demand	▪ Launch of Smartboard in AMU ▪ Launch of auto-populated Repatriation Communications with partner hospitals	▪ Smartboard not delivered, awaiting new version of from supplier ▪ Launch of auto-populated repatriation communications not delivered	▪ *Awaiting feedback*	*Awaiting feedback*
7.4 Estates will draw up and assist with physical plans/options to support emerging operations plans/strategy	▪ Undertake Space Utilisation Review to be completed by end September. This review to inform first draft St. George's Estate Strategy (timing contingent on emergence of clinical strategy for South West London).	▪ Not delivered	▪ Space Utilisation Review expected to be complete in Q4. Estates strategy to follow agreement of clinical service strategy.	Not a material risk to the trust at this stage, as the work to deliver is underway.
8.1 Increase theatre productivity	▪ One theatre to be mothballed, following introduction of new service template delivering improved productivity. ▪ Theatre refurbishment programme starts	▪ Decision taken in Q1 to change plan and keep theatre open, with revised theatre template.	▪ Plan to absorb CIP impact of decision via increased activity. New theatre template introduced in Sept with revised activity plan by specialty.	**Potentially a material risk**, despite remedial action in place, objective may need to be carried over into 19/10.
9.1 Ensure patients have access to high quality outpatient care, including by standardising outpatient pathways, supported by ICT, ensuring all activity is captured and reported.	▪ Hybrid Mail implemented. ▪ Complete roll out of two way text reminders.	▪ Hybrid Mail delayed to allow for implementation & testing of a clinical system change in Cerner to enable users to select hybrid mail. ▪ Two-way texts live but only for small number of appointments	▪ Hybrid Mail expected to go live in Q4 ▪ Further expansion of two-way texts planned for coming weeks.	Not a material risk to the trust at this stage, as the work to deliver is underway.

9.3 Ensure that patients have easy access to the hospital to check appointment enquiries through phone and email system	▪ Fully scoped project plan	Verbal update to be provided by Andrew Grimshaw	Verbal update to be provided by Andrew Grimshaw	Not a material risk to the trust at this stage
10.1 Return Tooting campus to national reporting of the 18 week RTT standard and work to reduce waiting times against all national standards	▪ No patients waiting >52 weeks for all specialties apart from ENT & General Surgery. ▪ Reduction of outpatient caps at SGH to ensure booking does not extend out beyond max 14 weeks	▪ average of 5-6 patients now waiting >52 weeks in relevant specialties. ▪ Outpatient caps removed but 14 week target not met	▪ Mitigating actions set out in separate papers to Board	**Potentially a material risk**, as in-quarter delays could affect an already challenging target
Balance the books, invest in our future				
11.1 We will continue to reduce our deficit and aim to break even in 2019	▪ Meet target monthly deficit. ▪ Deliver CIP targets. ▪ Manage to budget.	▪ Not delivered, for reasons set out in detail in papers to FIC.	▪ Mitigating actions set out in papers to FIC.	**A material risk**, end of year targets unlikely to be met
11.2 We will deliver organisational efficiencies – from the way we buy drugs to how we use our clinical IT systems	▪ Develop a clinical IT strategy.	▪ Not delivered	▪ Proposal to develop clinical IT strategy once clinical service strategy is complete	Not a material risk at this stage, as the target deliverable for the year (£7m procurement CIP) can be delivered on basis of CIP programme that has already been agreed and without development of new clinical IT strategy.
11.3 We will develop a financial model to help us identify and prioritise future investment requirements	▪ Completion of draft long term financial model.	▪ Partially delivered – draft in place, but national tariff/rules changing and not yet published.	▪ Engagement with FIC/board on long-term financial model planned for Q4 with caveats/ assumptions for where national changes still awaited	Not a material risk at this stage, but original objective for the year (long-term plan signed of by Board by end of Q4) now likely to be delayed

11.4 Estates will produce a timely and accurate delivery of CIPs including service contract negotiations and agreement of possible land sales	▪ Prepare business case for sale of land and submit initial proposals to Executive Team and then onto Board in September ▪ Appoint legal teams to challenge outstanding historical PFI Issues and appoint to new Business Management Team which is being set up and should be functional by September ▪ Identify the Estates negotiations on the sale and agree the magnitude of the sale to the Executive Team, through to Board in December.	▪ Business case for sale of land not delivered – DV appointed to review land values in light of development properties from CCG's. ▪ Legal team appointed and business management team partially in place but not fully recruited. ▪ Awaiting offer letter from developer	▪ Expect to deliver business case for sale of land by March 2019 ▪ Recruitment to business management team expected to be fully in place by February. ▪ Offer letter from developer expected in Q4, with papers then going to FIC and Board also in Q4.	Not a material risk at this stage, Estates continue to deal with reactive maintenance.
Build a better St George's				
12.3 We will work with St. George's Hospital Charity to ensure money raised by fundraisers and donors is invested to improve care for patients and improve the working lives of our staff	▪ Work with the CEO of the Charity to identify where processes could be streamlined within the organisation to ensure that bids received by the Charity are ready to be considered by the Trustees when submitted.	▪ Not delivered due to CEO not being in post until December	▪ Discussions underway between Director of Strategy and new CEO, expected to be delivered in Q4.	Not a material risk to the trust at this stage, as the work to deliver is underway.
13.1 Undertaken an independent review of our corporate governance function	▪ Complete review of corporate governance structures below Board Committees and agree future structural design and reporting lines. ▪ Develop clear Board forward work programme for 2018/19. ▪ Agree new Terms of Reference for Trust Executive Committee.	▪ Review of corporate governance structures not delivered due unexpected demands on capacity due to cardiac surgery issues. ▪ Board forward work programme drafted but not yet agreed by board ▪ New ToR for TEC drafted	▪ Corporate governance structure review expected to be completed Q4 ▪ Board forward look coming to board for agreement in February.	Not a material risk to the trust at this stage, as the work to deliver is underway.

		but not yet agreed by TEC	▪ TEC draft ToR to be considered by TEC in January.	
13.2 More engagement and involvement of patients, front line staff and partner organisations	▪ Launch of new Trust corporate branding for use across all communications and reporting channels	▪ Rebranding exercise underway, but not yet complete	▪ Launch of new brand expected April 2019	Not a material risk
13.4 Ensure the appropriate governance measures are in place to learn from incidents and complaints	▪ Quarterly audit of actions agreed within SI reports / complaints responses.	▪ **Partially delivered.** Audit takes place for never events and SIs agreed with commissioners, but not all.	▪ Audit process to audit greater proportion of SIs to be agreed in Q4.	Not a material risk at this stage
13.5 Continue to monitor compliance with the risk management policy and improve risk registers at every level	▪ Ensure Divisional Governance Boards are reviewing and challenging their risks prior to presentation at RMC	▪ Ongoing, not complete	▪ Further work to be undertaken in Q4	Not a material risk to the trust at this stage, as the work to deliver is underway.
14.2 Renew local area network on Tooting site	▪ Wiring installed	▪ Core wiring in process and nearly completed, but not entirely delivered.	▪ Completion expected shortly	Not a material risk to the trust at this stage, as the work to deliver is underway.
14.4 Roll out iClip to Queen Mary's Hospital Roehampton	▪ Training commenced ▪ Equipment installed	▪ Both milestones have been delayed due to extension of timetable for deployment (data migration timescales extended). Therefore training inappropriate at this stage. Some equipment installed, but further work in Q4. for some areas	▪ Further work to be undertaken in Q4	Not a material risk to the trust at this stage, as the work to deliver is underway.
15.1 We will undertake substantial reviews and surveys of the overall Estate and Environment. This will clearly identify the back-log maintenance	▪ In line with the PAM documentation and the outcome of the surveys, publish the revised back-log maintenance list and identify high risk projects. ▪ Those projects such as Theatres and Ward Refurbishment will include within any bids	▪ Not delivered - due to lack of capital, the Theatres and ward refurbishments strategy has been reviewed to develop a programme of essential	▪ Mitigating actions currently being considered by TEC ▪ Authorised Engineer being asked to evaluate the	**Potentially a material risk** for trust to consider

position and allow for investment in such areas as Ward Refurbishment, Theatre Refurbishment and replacement of large Diagnostics dependent on Trust's priorities	made for upgrade of general infrastructure as part of the bidding process for emergency funding. Surveys will be underway with the majority reported by end of September. ▪ Reviews will be undertaken of progress and action plan/project plan and 5/10 year BM investment plan will be created with revised backlog maintenance number. ▪ Create a review of any emerging risk appetite issues to share with Risk management Executive.	works only in the highest priority areas ▪ Backlog maintenance capital bid for emergency monies has been made to eliminate operational failure. ▪ Await capital funding to finalise the survey and review of backlog maintenance costs, ▪ Risk workshop undertaken but milestone not fully complete	potential risk of failure. Revenue money will be redirected if necessary and routine maintenance curtailed. ▪ Capital funding to finalise the survey and review of backlog maintenance costs expected by April 2019. ▪ report to RME due February 2019; risk review to FIC in Feb/March 2019; BAF review Feb/March 2019.	
15.2 We will ensure a safe environment with plans to achieve relevant statutory standards as our baseline	▪ Monitor and report via PAM quarterly report to Board performance against all domains.	▪ Not delivered	▪ Board development day and training awaited. Performance will be identified in report to Board in March summarising progress.	**Potentially a material risk** for trust to consider
15.3 Undertake a market review of substantive contracts including the FM contract. Instigate the implementation of a potential measured equipment service governing in the first	▪ Undertake substantial review of Contracts and equipment within the hospital to find existing baseline. Update contact information in the first instance to negate any historical non-productive contracts and remove for savings plan linked to CIP ▪ Present to the Board findings of the overall Risk Strategy, the need for Risk appetite and	▪ Not delivered – await confirmation from NHSI for consultants fee approval – progress delayed. Expect resolution by end of financial year. ▪ Not delivered – risk workshop undertaken,	▪ Expect resolution by end of financial year. ▪ Report to RME expected in February 2019.	Not a material risk at this stage

instance Medical Equipment and large Diagnostic equipment	identify investment portfolio from the emerging issues.	report to RME expected in February 2019.		
Champion team St George's				
16.1 Improve staff engagement	▪ Pulse Survey ▪ Friends and Family scores	▪ Pulse Survey: Trust has received funding to use a product call go-engage, work has commenced but not yet complete. ▪ Friends and Family test not undertaken in Q3, full Staff Survey undertaken instead	▪ Roll out of go-engage expected Q4	Not a material risk to the trust at this stage, as the work to deliver is underway.
16.6 We will enhance communication for Estates and Facilities. We will be represented at relevant meetings and Divisional Joint meetings where we will publish a newsletters and action points linked to the PAM production. We will also performance dashboard for small works and reactive maintenance.	▪ Produce the initial draft for the newsletter for the Estates and Facilities Team and submit to Communications. ▪ Publish newsletter ▪ Quarterly divisional meeting held in December	▪ Milestones delayed due to capacity constraints	▪ Draft newsletter expected Q4	Not a material risk to the trust at this stage
Develop tomorrow's treatments today				
17.1 We will work closely with St. George's University of London to train the healthcare professionals of tomorrow	▪ Implement and iterate Corporate Objectives	▪ As at Q2, not delivered – objectives still being clarified. Richard Jennings to provide verbal update on Q3.	▪ As at Q2, objectives expected to be agreed shortly. Richard Jennings to provide verbal update on Q3.	Not a material risk to the trust at this stage, as the work to deliver is underway.
18.1 We will embed	▪ Agree the funding from the Trustees for Trust	Verbal update to be provided	Verbal update to be	Verbal update to be provided

research into clinical practice, to further foster a 'bench to bedside' culture within our organisation	research	by Richard Jennings	provided by Richard Jennings	by Richard Jennings
18.3 We will use the latest technology to improve outcomes for patients and make it easier for staff to provide care safely and effectively	▪ Approval of QMH Cerner business case ▪ Approval for additional MRI at St. George's.	▪ QMH Cerner FBC approved by TEC and coming to F&I in October. ▪ Additional MRI - bid for as 19/20 capital via STP bid for transformation capital, awaiting decision.	▪ If STP capital unavailable, trust will need to look to lease or find an alternative finance solution in 19/20	**Potentially a material risk** to successful delivery of March 2019 deliverable of QMH Cerner and MRI installation.
18.4 We will plan to work with our existing Stakeholders to ensure that the Trust achieves better value for money and sustainability out of any investment available from central funds	▪ Dependent on the outcome from the bidding process and the potential production of a clinical strategy from South West London in September (the initial timetable stated) we will undertake capital work in line with the projected timetables submitted	▪ Not delivered – wave 5 bids to be reviewed and developed in Q3 and Q4.	▪ Wave 5 bids to be reviewed and developed in Q3 and Q4	**Potentially a material risk** that any further slippage in Q3 and Q4 could mean the trust being unable to spend any funds awarded in a way that maximises VFM.

Annex B: Approach to RAG-rating

1. The RAG ratings for Q3 derived as follows. Each objective is shown as:

   - green for Q3 if all its Q3 milestones have been delivered, or if the position is overwhelmingly close to that (e.g. 5 milestones delivered, 1 partially delivered but due for completion in first week January).
   - amber for Q3 if some of the associated Q3 milestones have been delivered, and some not, or if the milestones are partially delivered.
   - red if the milestones for Q3 have not been delivered.

2. Each domain is RAG-rated on the basis of the average RAG-rating of each of its component objectives (all weighted equally).

3. The RAG rating for the year-to-date position shows whether there is any slippage against what we set out to do year-to-date. In most cases this will mean the RAG-rating is the same as for the Q3 position, but if the Q3 position is 'green' and we have still not delivered on a milestone from an earlier quarter, this is taken into account in the YTD position.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	31 January 2019	**Agenda No**	**5.1**
Report Title:	**Audit Committee report**		
Lead Director/ Manager:	**Sarah Wilton, Chair of the Audit Committee**		
Report Author:	Sarah Wilton, Chair of the Audit Committee		
Presented for:	Assurance and Approval		
Executive Summary:	The report sets out the key issues discussed and agreed by the Committee at its meeting on 10 January 2019.		
Recommendation:	The Board is requested to: • note the update on the key issues considered by the Committee at its meeting on 10 January 2019; and • agree the annual audit plan by the Trust's external auditor, and associated fees, on the recommendation of the Committee.		
Supports			
Trust Strategic Objective:	Balance the books, invest in our future.		
CQC Theme:	Well Led		
Single Oversight Framework Theme:	Finance and use of resources, Leadership and Improvement capability		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A
Appendices:	N/A		

Audit Committee Report – January 2019

Matters for the Board's attention

1. **Audit recommendations:** The Committee heard that the new process by which the Internal Auditors took a summary of audit recommendations to the Trust Executive Committee on a monthly basis was working well and this had helped reduce significantly the number of overdue internal audit actions, which was welcomed by the Audit Committee. Currently, there were six actions overdue and 54 not yet due. Four of the six overdue internal audit actions related to theatre productivity and the Committee heard that work was now underway after a late start. New theatre management was in place and a number of operational improvements had been made. The two further overdue actions related to consultants' appraisal and revalidation, and the Committee was assured that the Responsible Officer, who had retired from practice at the end of 2018, would remain in post as RO until a permanent replacement had been recruited.

2. **2018/19 internal audit progress report:** Eight internal audits had been completed since the Committee last met on 11 October 2018. Of these, two had received substantial assurance (core financial systems, and update on cancer pathway), three received reasonable assurance (delivery of CIP, Elective Care Recovery Programme, and complaints), and three limited assurance (Friends and Family Test, Cyber Security, and clinical systems not supported by central IT). There had been some minor amendments to the internal audit programme, principally around timings and ordering of audits. For the balance of the year, two internal audits were in the fieldwork stage, four were in the planning stages, and one was under review. The Committee noted the update. It also had a useful discussion about the client briefing notes provided by the internal auditors, noting that areas identified as "for action" or "for possible action" should, going forward, be considered by the Trust Executive Committee and a management response provided identifying either the actions proposed or an explanation of why action was not required. It was considered that this would provide the Committee with greater assurance on areas of possible risk.

3. **Final internal audit reports:** Nine final internal audits were considered by the Committee. The Committee welcomed the substantial assurance rating for the audit of core financial systems, noting that a significant amount of work had been undertaken to improve these systems, which had been reflected in the outcome of the audit. Substantial assurance had also been received on the audit of cancer management pathways. A new management team was in place, escalation pathways were documented, and compliance had been demonstrated by all relevant staff. The Committee felt that good progress had been made on CIP delivery, which received "reasonable assurance", but there was more to do, noting that the programme was £1.8m behind plan. Cyber Security had received "limited assurance" and the Committee heard that the Trust had received £1.8m to improve its IT network against cyber-attacks and to promote resilience. A number of issues, however, still needed to be addressed, including in relation to organisational culture. The Committee noted the information governance breach identified during the Board visits in December where an IClip card had been left unattended on a ward. The Committee heard that the "limited assurance" rating for the audit of clinical systems not supported by central IT was principally the result of unclear progress and lack of governance around these systems, but that this should be addressed through the ongoing work to develop a comprehensive asset register as part of the Trust's GDPR compliance work. The Committee agreed that further work was needed to drive this forward at pace. The audit of complaints had resulted in a score of "reasonable assurance", which reflected changes to the Trust's complaints policy and improvements in the complaints process which had increased in quality and reduced the number of

follow-up responses. Further work was identified in terms of recording the outcome of complaints on Datix and recording and monitoring lessons learnt. The audit on the high level update report on the Elective Care Recovery Programme had received "reasonable assurance", noting that shadow reporting was underway and a decision on returning to reporting on RTT would be considered by the Board in January 2019. "Limited assurance" had been received on the audit into Freedom to Speak Up. It was noted that a comprehensive review of the policy would be undertaken by the end of March 2019 to bring together the processes around FTSU and whistleblowing, which the audit had identified requiring clarification. This would include clarifying ownership of the policy, and the responsibilities of Executive and Non-Executive leads. It was also noted that awareness training for the Board on FTSU was planned in the coming months.

4. **Internal Audit Plan 2019-20:** The Committee reviewed the draft internal audit plan for 2019-20 which had previously been considered by the Trust Executive Committee on 19 December 2018. This included the fundamental review areas, including governance, risk, financial systems, data security and ICT. It also included a range of other areas which had been proposed by Executive Directors, linked to areas of strategic risk on the Board Assurance Framework. The Committee endorsed the draft plan, noting that the Trust Executive Committee planned to further refine this in the coming weeks, and a final version would be brought back to the Committee in April 2019.

5. **Internal audit arrangements beyond March 2020:** The Committee considered the arrangements for the provision of the Trust's internal audit function beyond the conclusion of its current contract with TIAA, which would expire in March 2020. It agreed that after four years with the current provider it would be appropriate to tender for a new provider of the service from 1 April 2020, and it agreed the process a timeline for doing so. This would involve use of the London Procurement Partnership framework, with a new provider selected by the end of July 2019 so that work could commence on the planning of the internal audit programme for 2020-21 in good time. The Committee will consider a final tender specification at its next meeting in April 2019.

6. **Annual audit plan and fees:** The Committee received a paper from the Trust's external auditors, Grant Thornton, which set out the planned scope and timing of the statutory audit of the Trust. The scope of the audit was set in accordance with the Code and International Standards on Auditing and would, as usual, form and express an opinion on the Trust's financial statements and value for money arrangements. The significant risks identified as requiring special audit consideration and procedures to address the likelihood of a material financial statement error were identified as: fraudulent reporting in revenue recognition; management over-ride of controls; and going concern. .Planning materiality had been identified as £12.95m to the Trust. The significant risks to value for money were identified as: financial outturn and financial sustainability; and addressing the actions identified by the CQC inspection. The audit would take place during April and May, with the fees calculated at £68,500. The Committee agreed that it should recommend the plan to the Board for approval.

7. **Accounting policies:** The Committee reviewed and agreed the draft accounting policies notes which were proposed for inclusion in the 2018-19 statutory annual accounts, and which were based on the standard template for NHS Foundation Trusts.

8. **Annual report and accounts 2018-19:** The Committee considered the plan and timetable for the production and submission of the Trust's Annual Report and Accounts (ARA) for 2018-19. NHS Improvement required all Trust's to submit their ARAs by 29 May 2019. The external audit would begin on 9 April and conclude by 10 May. The draft

accounts would be submitted to NHSI on 24 April. The Committee would review an initial draft of the Annual Report at its meeting in mid-April, followed in mid-May by an in depth review and recommendation to the Board for approval. In terms of structure, the Committee agreed to maintain the approach used successfully the previous year, including building in any feedback from the benchmarking exercise conducted by the Trust's external auditors.

9. **Losses and special payments:** The Committee heard that the Trust had made losses and compensation payments totalling £63,000 in the nine month period from 1 April 2018 to 31 December 2018. This compared with a total of £237,697 in the previous financial year.

10. **Aged debt:** The Committee heard that the Finance department had undertaken a review of its aged debt position and identified a number of aged debts below £10,000 that were not recoverable and were being written off by the CFO in line with the Trust's Scheme of Delegation. The overall effect of the write offs and associated transactions was to remove approximately £1.152m of non-recoverable debt from the Trust's balance sheet without adversely affecting the 2018-19 income and expenditure account.

11. **Counter fraud:** The Committee received an update on fraud cases and on preventative actions being undertaken by the Trust. The Committee considered the trends and in the types of fraud identified and where in the organisation these occurred. It also heard that a new policy on anti-fraud and anti-bribery was being developed and was currently with Unison for final agreement, and would be brought to the Finance and Investment Committee for approval.

12. **Signing of construction contracts:** The Committee was alerted to historic control issues concerning the signing of construction contracts at the Trust, with a total of 15 such contracts identified as being signed by the contractor but unsigned by the Trust. The Director of Estates and Facilities would be reviewing the contracts and the Committee considered a proposal that the DEF be given delegated authority to sign such documents in future up to the level defined for Executive Directors as set out in the Trust's Standing Orders, Scheme of Delegation and Standing Financial Instructions.

13. **Clinical audit programme:** The Committee considered an update on the clinical audit programme, and heard that this comprised 116 projects consisting of 40 national projects deemed mandatory by the National Clinical Audit and Patient Outcome Programme, 27 national projects recommended by NHS England, 3 projects required to comply with national requirements, and 46 internal priority audits covering key areas of quality. The Committee welcomed the update, but enquired as to how learning from clinical audit was embedded through the organisation and how this could be evidenced so as to provide assurance to the Board. It was noted that the issue of demonstrating impact was also a concern to the Quality and Safety Committee. It was agreed that the Quality and Safety Committee needed to understand and be assured on the content of the learning, with the Audit Committee being assured that there were sufficiently robust processes in place to ensure learning from clinical audits was embedded.

14. **Annual review of risk management policy:** A review of the Trust's risk management policy was presented to the Committee, which evaluated compliance with the Key Performance Indicators. Of five KPIs, the Committee heard that the Trust could evidence full compliance with three, with two considered to be partially compliant. The Committee was told that the policy was currently being updated to reflect changes in organisational structures but that there were no substantial changes to the underlying policy.

15. **Standing Orders, Scheme of Delegation and Standing Financial Instructions:** The Committee is required to consider annually the Trust's Standing Orders, Scheme of Delegation and Standing Financial Instructions. A review of these had previously been undertaken in April 2018 and the Committee was assured by the Chief Finance Officer and Director of Corporate Affairs that these remained sufficiently robust, albeit that a more comprehensive review would be undertaken and reported to the Committee in July 2019.

16. **Review of Audit Committee effectiveness:** The annual review of Audit Committee effectiveness was undertaken in late 2018 and the Committee considered the results. Overall, the review found that the Committee was working effectively. There was broad agreement that the role and responsibilities of the Committee were clear, that there was an appropriate mix of the skills required to provide assurance to the Board, and that its terms of reference were clear. The review found that there was broad agreement that the Committee's work programme covered the right areas needed to provide assurance, that the Committee provided strong and constructive challenge to the organisation, and that had both a good understanding of the control environment and reviewed the comprehensiveness and reliability of the assurances it received. Two issues were highlighted as potential areas for further development; first, that the Committee should consider greater use of assurance mapping to target areas of greatest risk; and second, to ensure the arrangements for induction and training of new members were fully in place. The Committee noted that plans for each of these would be brought back for further consideration.

Recommendation

17. The Board is asked to:
    - Note the update on the key issues considered by the Audit Committee at its meeting on 10 January 2019; and
    - Agree the annual audit plan by the Trust's external auditor, and associated fees, on the recommendation of the Committee.

Sarah Wilton
Audit Committee Chair, NED
January 2019

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	31 January 2019	**Agenda No**	**5.2**
Report Title:	**Board Assurance Framework (BAF)**		
Lead Director/ Manager:	**Avey Bhatia, Chief Nurse and Director of Infection Prevention and Control**		
Report Author:	Elizabeth Palmer, Director of Quality Governance		
Presented for:	Decision/Assurance/Discussion		

Executive Summary:

This paper brings to the Board the summary page of the Board Assurance Framework. The summary sheet of the BAF (appendix 1) gives an overview of the risk profile of the Trust and enables the Board to ensure its agenda is directed to improving control of these strategic risks. The BAF has been updated with the quarter 3 assurance rating and statements from the committees of the Board. [Note: The Workforce and Education Committee meets on 7 February, due to the timing of the Committee the assurance ratings for Q3 are not available at the time of this report.]

Assurance rating

There have been no changes to the assurance ratings for the strategic risks; however specific areas in SR2 and SR12 have positive assurances.

- The Quality and Safety Committee noted that it has significant assurance on controls managing risks to data quality specifically related to referral to treatment times.
- The Finance and Investment Committee noted improving assurance on the control of risks associated with the multiple healthcare record systems and production of discharge summaries following the roll out of iClip.

Ten risks have a 'partial' assurance rating; seven risks have a 'limited' assurance rating (see appendix 2 for definitions).

Risk scores

The risk score for SR8 has been increased to 12 (from 10) following the Board's request for the Workforce and Education Committee to review the score. The decision was made following discussion in Committee on the weight given to each contributing risk and recognises the greater impact of some on the development of a positive and supportive culture.

No change to the risk scores for other strategic risks.

Strategic Risks for the Board – SR9;SR16;SR17

The Board is asked to agree the assurance level for these risks based on the assurances from highlight reports and the Board strategy seminars.

When considering the risk score for these risks the Board's attention is drawn to the discussion of the external partnership element of SR4 at the Quality and Risk Committee (this risk is cross referenced to SR17). The QSC discussed emerging risks from developments in the external environment and the STP and how these might impact on the risk score for partnership risks.

Board Seminar – annual review of the BAF

	The Board reviewed the BAF in detail on 17 January and considered its effectiveness. The strategic risks are to be refreshed for 2019/20 and the Board will be incorporating emerging risks into its assurance framework (BAF).
	The Board is asked: 1. For strategic risks reserved to itself (SR 9,16,17) to: • Note the risk rating • Agree the proposed assurance rating • Agree the proposed assurance statement (shown in italics) 2. For the 14 risks assigned to its assuring committees to: • Note the risk score, assurance rating and statement from the relevant assuring committee.
Supports	
Trust Strategic Objective:	All
CQC Theme:	Well led
Single Oversight Framework Theme:	Quality of Care Leadership and Improvement Capability
Implications	
Risk:	The strategic risk profile
Legal/Regulatory:	Compliance with Heath and Social Care Act (2008), Care Quality Commission (Registration Regulations) 2014, the NHS Act 2006, NHSI Single Oversight Framework, Foundation Trust Licence
Resources:	N/A
Previously Considered by:	Quality and Safety Committee Finance and Investment Committee
Date	24 January 24 January
Equality Impact Assessment:	N/A
Appendices:	1. Summary Board Assurance Framework (BAF) 2. Assurance ratings - definitions

Appendix 2 **Assurance ratings - definitions**

Significant assurance	There are robust controls operating effectively to ensure that risks are managed and objectives achieved.
Partial assurance	The controls are generally adequate and operating effectively but some improvements are required to ensure that risks are managed and objectives achieved.
Limited Assurance	The controls are generally inadequate or not operating effectively and significant improvements are required to ensure that risks are managed and objectives achieved.
No Assurance	There is a fundamental breakdown or absence of controls requiring immediate action.

Appendix 1

Board Assurance Framework
Quarter 3 2018/19

BOARD ASSURANCE FRAMEWORK OVERVIEW										QUARTER 3
Strategic Objective	Risk appetite	Strategic Risk		Quarterly Assurance Rating Q1	Q2	Q3	Q4	Reason for Current Assurance Rating	Executive Lead	Assuring Committee	Current Risk Score
Treat the patient, treat the person	*Moderate*	*SR1*	We are unable to develop new roles, changes in skill mix and innovative ways of working that address the long term staffing (supply) requirements of the Trust as well as address the immediate recruitment and retention issues, which could result in care which is below the minimum standard.					**The Workforce and Education Committee meets on 7 February, the assurance rating will be updated at the meeting and reported at the February Board meeting.** The risk score is unchanged. Workforce remains a significant area of risk for the Trust and the Committee continues to consider that it has insufficent evidence that controls for this risk are effective.	Director of HR and OD	Workforce and Education Committee	16
	Low	*SR2*	Our processes for admitting, reviewing, treating, discharging and following up both elective and non-elective patients on their pathway are not timely or robust, resulting in poor, delayed or missed treatment.					**The risk score is unchanged. The Committee has received a significant level of assurance on the quality of data for referral to treatment times. However for the risk as a whole it wants to see sustained performance for timely treatment and continues to have partial assurance on the overall control of this risk.**	Chief Operating Officer	Quality Committee	15
	Low	*SR3*	We do not have effective, accessible and widely utilised learning and improvement methodologies, resulting in care which is below local and national standards and best practice.					**The risk score is unchanged. The Committee has noted where targets for 'should do' items in the Trust's response to the CQC inspection 2018 have not been met and the adjusted delivery dates. Quality improvement methodology is being used to drive improvement projects.**	Chief Nurse	Quality Committee	10
Right care, right place, right time	*Low*	*SR4*	Our pathways are not well integrated with, or supported by the key external organisations that make up the local health economy to enable us to manage demand or patient flow effectively, resulting in poor or delayed care for our patients.					**The risk score is unchanged. The Committee noted the cross reference to SR17 which will be discussed by the full Board. The Committee asked for the element of the risk score related to development of the STP to be reviewed in light of emerging risks in the external environment.**	Medical Director	Quality Committee	8
Balance the books, invest in our future	*Low*	*SR5*	Financial efficiency, forecasting and accountability is not seen as a priority for service managers or our wider workforce, resulting in overspending, poor budgetary management which could lead to poor service delivery and regulatory action.					**The risk score is unchanged. While good progress has been made in improving the working of the Finance function and how it supports the trusts operations, weaknesses remain in the organisations ability to manage to budget. While training is in place progress needs to improve. The full value of the CIP plan is in place although focus needs to be maintained on delivery. Good progress continues to be made in improving the working of Procurement. Improving the Trusts financial performance will improve the current risk rating.**	Director of Finance	Finance and Investment Committee	16
	Low	*SR6*	We do not understand our business sufficiently to identify and implement efficiency and improvement opportunities					**The risk score is unchanged. The new organisational structure has stabilised the Control Environment in most areas although some portfolios and spans of control are being revisited. Information and Communication aspects around the Model Hospital and benchmarked opportunities, particularly in planned care data quality, to drive demand and capacity planning for infrastructure and workforce prioritisation require further development.**	Director of Efficiency and Transformation	Finance and Investment Committee	20
	Low	*SR7*	We do not have a clear and effective business planning cycle to enable clear, timely and realistic plans and trajectories. This results in the Trust having incomplete plans and management action becoming reactive.					**The risk score is unchanged. The Finance function has developed an initial long term financial look forward. The risk score has been maintained due to the challenges emerging in the financial environment of the NHS and the uncertainty this creates until there is clarity on all the changes proposed. To address this risk the Trust needs to define robust actions to mitigate these risks.**	Director of Finance	Finance and Investment Committee	12
Champion team St George's	*Low*	*SR8*	Establishing a positive, supportive culture which is allied to accountability for delivery is not seen as a priority, with the result that our organisational culture is either negative/punitive or does not foster accountability amongst our workforce.					**The Workforce and Education Committee meets on 7 February, the assurance rating will be updated at the meeting and reported at the February Board meeting.** The risk score has increased to 12 to reflect the greater weight given to the risks with a direct impact on developing a positive and supportive culture. The Committee received assurance through reports on the developing Organisational Development Strategy and the staff friends and family test. The staff FFT indicates that this continues to be an area where improvement is needed.	Director of HR and OD	Workforce and Education Committee	12
	Moderate	*SR9*	Due to a failure to develop and implement an effective communications strategy our staff feel disengaged, uninformed and unvalued.					*The risk score is unchanged. Assurance rating unchanged, assurance from the staff survey on impact of communication strategy not yet available, publication in February 2019.*	(CEO) Director of Corporate Affairs	Board	12
	Low	*SR10*	We do not provide accessible training in the right place at the right time for our staff, in order to ensure that they are able to do their jobs effectively, resulting in staff dissatisfaction and poor care for patients.					**The Workforce and Education Committee meets on 7 February, the assurance rating will be updated at the meeting and reported at the February Board meeting.** The risk score is unchanged. The Committee received assurances through the mandatory training group report and the workforce KPIs. Mandatory training compliance has improved.	Director of HR and OD	Workforce and Education Committee (WEC)	9
	Moderate	*SR11*	We fail to develop our future leaders and we fail to provide clarity to them about their roles and accountabilities, which leads to low job satisfaction, high turn-over and on-going instability amongst our senior leaders.					**The Workforce and Education Committee meets on 7 February, the assurance rating will be updated at the meeting and reported at the February Board meeting.** The risk score is unchanged. The Committee continues to be assured that the controls are generally adequate through the delivery of the leadership development programme and workforce KPIs.	Director of HR and OD	Workforce and Education Committee	9
Build a better St George's	*Low*	*SR12*	Our IT systems are unreliable, unstable and do not support us to provide excellent care or provide us with the information and analysis required to manage the Trust effectively.					**The risk score is unchanged. The roll out of iClip at St George's provides and improved level of assurance on the control of risks associated with the multiple healthcare record systms and providsion of discharge summaries, however assurance remains limited on the overall control of this risk.**	Chief Information Officer (CIO)	Finance and Investment Committee	20
	Low	*SR13*	Our estate is poorly maintained and underdeveloped, resulting in buildings which are not fit for purpose and may be closed by the regulator, impacting delivery and risking patient safety.					**The risk score is unchanged. Assurance remains limited on the overall control of this risk. Assurances demonstrate that the risks are understood and mitigated in part, but complete mitigation of this risk is dependent on the availability of capital. Emergency bid made for infrastructure funding.**	Director of Estates and Facilities	Finance and Investment Committee	20
	Low	*SR14*	We are unable to secure the investment required to address our IT and estates challenges and as a result are unable to transform our services and achieve future sustainability.					**The risk score is unchanged. The Trust has not yet been able to confirm additional capital funding to support all known investment requirements. A range of bids have been submitted and the Trust awaits the responses on these. Working capital borrowing to fund the higher than planned forecast deficit in 18/19 has been agreed with NHSI.**	Director of Finance	Finance and Investment Committee	16
	Moderate	*SR16*	We do not have a clearly articulated and deliverable strategy underpinned by widely communicated and owned supporting delivery plans, resulting in an inability to take strategic decisions as an organisation, leading to difficulty in identifying clincial service priorities and consequently a lack of engagement in the future success of the Trust amongst our workforce.					*The risk score is unchanged. Assurance that controls are generally adequate and effective is taken from the monthly highlight reports to the Board meeting (part B). The strategy development project is being delivered as planned.*	(CEO) Director of Strategy	Board	12
	Moderate	*SR17*	A lack of strong, productive relationships with our key external stakeholders may result in a lack of alignment of the plans across the local health economy with our priorities and an inability to provide a source of collaborative leadership for the STP.					*The risk score is unchanged. Quarterly highlight reports to the Board meeting (part B) provide assurance on delivery of actions to improve partnership working.*	Chief Executive	Board	10
Develop tomorrow's treatments today	*High*	*SR15*	We fail to see an improvement in our research activity and profile with consequence impacting on the reputation of the Trust.					**The risk score is unchanged. Assurance reports are scheduled for Q4, no change in assurance level this quarter.**	Medical Director	Quality Committee	8

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	31 January 2019	**Agenda No.**	**5.3**
Report Title:	**Emergency Preparedness Resilience and Response - Annual EPRR Assurance submission to NHS England (London)**		
Lead Director/ Manager:	Ellis Pullinger		
Report Author:	Emergency Preparedness Manager (Lachlan Attwooll)		
Presented for:	Assurance		
Executive Summary:	This report provides an update on the outcomes of the 2018-19 NHS England EPRR Assurance process. The main points: • Trust achieved **PARTIAL COMPLIANCE** with the EPRR Core Standards. • Trust has agreed an action plan to achieve full compliance.		
Recommendation:	To note the NHS England EPRR assurance findings and the 'Partial' rating.		
Supports			
Trust Strategic Objective:	Treat the patient, Treat the person Right Care, Right Place, Right Time		
CQC Theme:	Well-led, Safe, Caring and Responsive		
Single Oversight Framework Theme:	Quality of Care Operational Performance		
Implications			
Risk:	If the work is not maintained, there is a risk that the trust will not be prepared in the event of a Major Incident or a significant Business Continuity disruption.		
Legal/Regulatory:	Emergency Preparedness, Resilience and Response standards are a requirement under the NHS England EPRR Framework 2015 which are aligned to the statutory duties under the Civil Contingencies Act 2004, and the Health and Social Care Act 2012.		
Resources:	n/a		
Previously Considered by:	n/a	**Date:**	n/a
Appendices:	Appendix 1 - Action plan for areas of 'partial compliance' Appendix 2 - 2018 EPRR Assurance Report from NHS England		

Emergency Preparedness Resilience and Response - Annual EPRR Assurance submission to NHS England

1 Purpose

This paper confirms our acceptance of, and response to NHS England's EPRR Assurance process for 2018-19.

2 Background

NHS England conduct an annual EPRR assurance process to be assured that NHS organisations are prepared to respond to an emergency, and have the resilience in place to continue to provide safe patient care during a major incident or business continuity event.

Following an initial self-assessment by the Trust back in October, NHS England met with key staff from St George's on 5 December to review our compliance with the EPRR core standards and to develop an action plan for areas of non-compliance. This meeting was attended by the Chair of the Major Incident Steering Group, the outgoing Clinical Director for Trauma, the Head of Operations and the Emergency Preparedness Manager.

- Details of our action plan are outlined in Appendix 1.
- The full EPRR Assurance Report from NHS England is attached as Appendix 2.

3 Findings of EPRR Assurance process

I am pleased to note that NHS England felt that 'overall, the Trust demonstrated its commitment to EPRR' and did not find any aspects of our arrangements to be non-compliant.

NHS England assessed St George's against 64 different core standards for EPRR and found us to be partially compliant with 11 of them. We were fully compliant with the remainder.

As the Accountable Emergency Officer for St George's I have been asked to assign an overall level of compliance for the Trust. In consultation with the Emergency Preparedness Manager, I can confirm that St George's agreed with the rating of **PARTIALLY COMPLIANT**.

4 Recommendations

To remedy the eleven areas of partial compliance, the following areas need to be prioritised in the year ahead.

- Review our CBRNe/HAZMAT plan.
- Ensure our business continuity plans detail how and when an incident should be escalated to a 'Critical incident'.
- Undertake annual reviews of all our key plans, including:
    - Mass prophylaxis centre plan
    - Pandemic influenza plan
    - Evacuation plan
- Roll out the full-day Major Incident and CBRNe/HAZMAT training programme for the Emergency Department.
- Check plans and procedures to ensure that they align to any new or updated guidance - this is likely to include:
    - Mass countermeasures

- Lockdown
- Evacuation and shelter
- Clinical guidance for major incidents

5 Next steps

To move the Trust towards full compliance with the EPRR core standards I have agreed an action plan with the Emergency Preparedness Manager focusing on the priorities outlined above. **Full details of our action plan can be found in Appendix 1**.

I am satisfied that the action plan agreed with the Emergency Preparedness Manager will drive improvement across these areas and will help to move the Trust towards full compliance with the EPRR core standards.

Ellis Pullinger

Chief Operating Officer,
AEO for St George's University Hospitals NHS Foundation Trust

Appendix 1 - Action plan for areas of 'partial compliance'

EPRR core standard	Description of core standard	Actions to be taken	Lead officer(s)	Timescale
1	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director, and have the appropriate authority, resources and budget to direct the EPRR portfolio. A non-executive board member, or suitable alternative, should be identified to support them in this role.	Identify an appropriate Non-Executive Director to support AEO role.	Ellis Pullinger	End of financial year.
5	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	Give consideration to increasing EPRR resource in line with comparable London Trusts.	Ellis Pullinger	-
11	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as per the EPRR Framework).	1. Amend the draft Trust Business Continuity Plan to clearly outline the triggers for escalation to a 'critical incident'. 2. Sign-off and adopt the revised Trust Business Continuity Plan.	1. Lachlan Attwooll 2. BC Steering Group	January 2019
15	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to pandemic influenza as described in the National Risk Register.	Review Pandemic Influenza Plan.	Major Incident Steering Group	February 2019
17	In line with current guidance and legislation, the organisation has effective arrangements in place to distribute Mass Countermeasures - including the arrangement for administration, reception and distribution, e.g. mass prophylaxis or mass vaccination.	Review Mass Countermeasures Plan.	Major Incident Steering Group	September 2019

EPRR core standard	Description of core standard	Actions to be taken	Lead officer(s)	Timescale
20	In line with current guidance and legislation, the organisation has effective arrangements in place to place to shelter and / or evacuate patients, staff and visitors. This should include arrangements to perform a whole site shelter and / or evacuation.	Review Evacuation Plan.	Major Incident Steering Group	June 2019
26	The organisation carries out training in line with a training needs analysis to ensure staff are competent in their role; training records are kept to demonstrate this.	Start delivering a full-day Major Incident and CBRNe training programme to staff.	Paul Clove / Emergency Department	January 2019
49	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(s).	1. Adopt the new BIA template at January meeting. 2. Complete service-level BIAs using the new template.	1. BC Steering Group 2. All services	1. January 2019 2. May 2019
51	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: people • information and data • premises • suppliers and contractors • IT and infrastructure These plans will be updated regularly (at a minimum annually), or following organisational change.	1. Formally sign-off and adopt the new Trust BCP with more details of arrangements for escalating to a 'Critical incident' and reference scenario-specific supporting plans. 2. Adopt the new BCP template for services. 3. Complete service-level BCPs using the new template.	1. BC Steering Group 2. BC Steering Group 3. All services	1. January 2019 2. April 2019 3. August 2019
57	There are organisation specific HAZMAT/ CBRN planning arrangements (or dedicated annex).	Significantly re-write the Trust CBRNe/HazMat Response Plan.	Emergency Preparedness Manager	April 2019
66	Internal training is based upon current good practice and uses material that has been supplied as appropriate. Training programme should include training for PPE and decontamination.	Start delivering a full-day Major Incident and CBRNe training programme to staff.	Paul Clove / Emergency Department	January 2019

2018 Emergency Preparedness, Resilience & Response (EPRR) Assurance Report

St. George's University Hospital NHS Foundation Trust

Version number: 1

First published: 21st December 2018

Prepared by: Caroline Fiore, EPRR Engagement Officer, NHS England (London)

Classification: OFFICIAL

Contents

1 2018-19 Assurance review summary

Overall, the Trust demonstrated its commitment to EPRR. Plans and processes exist to respond to incidents however a number of these have lapsed the required review timescales. A number of suggestions for improvement or further work have been given, focusing on business continuity planning, CBRNe/HAZMAT arrangements and maintaining on-going regular review of emergency plans.

The trust will focus on these areas, along with ensuring the maintenance of current arrangements and reviewing them where required in-light of new guidance that has or will be issued by NHS England and other agencies.

2 Assurance review process

The assurance process for St. George's Hospital was conducted as follows on 5th December 2018,

Assurance Meeting	Assurance Review attendance
CBRNe/HAZMAT assurance and site visit	• Emergency Preparedness Manager: Lachlan Attwooll • Trust CBRNe lead: Heather Jarman, Clinical Director for Trauma • MI / CBRNe training lead for ED: Paul Clove • NHS England (London) EPRR Team: Graham Leedham & Caroline Fiore • LAS CBRNe training officer: Andy Godfrey
Main Assurance Meeting	• Emergency Preparedness Manager: Lachlan Attwooll • Chair of Major Incident Steering Group (ED Clinical Director): Phil Moss • Head of Operations: Brendan McDermott • Wandsworth CCG: Iain Rickard • Peer reviewer: Jon Davis, Kings College Hospital • NHS England (London) EPRR Team: Graham Leedham & Caroline Fiore

3 Overall level of compliance

In accordance with the requirements laid out in the EPRR 2018-19 Assurance Process Letter (1st August 2018), the overall level of compliance is based on the total number of amber and red ratings.

In respect of St. George's Hospital for Core Standards 1 – 69, the following RAG ratings were agreed at the review meeting:

Red ratings	Amber ratings
0	11

St. George's Hospital was 83% compliant with the core standards and therefore has an assessed level of compliance of **PARTIALLY COMPLIANT**.

4 Assurance review outcomes

4.1 Main Assurance Visit Outcomes

Amber ratings were received for the following core standards:

- CS1: Appointed AEO (and NED)
- CS5: EPRR resource
- CS11: Critical incidents
- CS15: Pandemic Influenza
- CS17: Mass countermeasures
- CS20: Shelter and evacuation
- CS26: EPRR Training
- CS49: Business Impact Analysis
- CS51: Business Continuity Plans

The Trust has not been maintaining the required review timescales of a number of emergency plans, including pandemic influenza, business continuity, mass prophylaxis centre and evacuation plans (CS15, CS17, CS20, CS51), with some plans being a number of years out of date. Annual review ensures that plans are aligned to the latest guidance, reflects any organisational changes and includes lessons learned from incidents and exercises and should therefore be included on the EPRR workplan going forward.

An amber rating was given to reflect the two hour Major Incident and CBRNe/HAZMAT training that is delivered (CS26). Although it is recognised that a comprehensive training programme is in place across the trust, they key area for response, ED, is not receiving the required level of training. The Trust has already identified this as an issue and have moved to four hours sessions, with the plan to increase this to a full day in 2019.

The Trust is undergoing a review of their Business Continuity Management System, with plans to roll out new BIA and BCP templates in early 2019 (CS49 & CS51), amber ratings were given to reflect that there is work to be done to ensure that all departments have up to date BIAs and BCPs in place. Business Continuity plans were highlighted as out of date during the 2017 assurance and received an amber rating last year, therefore NHS England (London) would have expected an updated business continuity plan to have been in place prior to the 2018 assurance. However, a workplan is in place to address the amber ratings received for the business continuity core standards in early 2019.

The Trust's Corporate Business Continuity Plan should be reviewed to ensure that the triggers for escalation to 'critical incident' are clearly outlined and the requirements for annual review are met. The plan may benefit from action cards detailing the top-level management of the key risk business continuity scenarios.

The Trust and NHS England agreed together an amber rating for core standard 5 to reflect comparable resourcing of trusts of similar size and complexity, with the additional responsibilities that are linked to the South West London Trauma Network.

Full details of the assurance review meeting and the agreed RAG ratings can be found in appendix A.

4.1.2 Deep dive outcomes – Command & Control

Amber ratings were received for the following deep dive standards:

- DD8: Recovery planning

The Trust was fully compliant with the ICC requirements of the deep dive, a designated, equipped and tested ICC is in place, along with an identified back-up. One amber rating was given for the 'recovery planning' requirement and the organisation is recommended to provide additional detail within the Major Incident and Business Continuity plans with regards to recovery and stand down actions.

4.2 CBRNe/ HAZMAT Assurance Visit Outcomes

Amber ratings were received for the following CBRNe/HAZMAT core standards:

- 57: CBRNe/HAZMAT planning arrangements
- 66: Training programme

The Trust's CBRNe/HAZMAT plan had passed the annual review date and was therefore rated amber. A number of suggested changes have been given to ensure that decontamination and IOR processes are clearly outlined and new guidance is incorporated, including remove, remove, remove and the PHE CBRN handbook 2018.

The CBRNe/HAZMAT (and major incident) training day had only been delivered as a 2 hour session over 2017/18, which was agreed as being insufficient to deliver the key training requirements for CBRNe/HAZMAT response. The Trust has already identified this as an issue and have moved to 4 hours sessions, with the plan to increase this to a full day in 2019.

All of the required CBRNe/HAZMAT equipment was in place and has undergone the required maintenance. A recommendation was given to ensure equipment checks are recorded.

Staff who were questioned by LAS during the CBRNe/HAZMAT walk around were overall aware of the required processes for management of contaminated casualties and the requirement to remove the patient from the area. A 2007 foreign document was referred to and should be replaced with trust procedures. Full details of the LAS walkaround can be found in appendix C.

Full details of the CBRNe/HAZMAT assurance review meeting and agreed RAG ratings and discussion points can be found in appendix A.

4.3 Assurance review meeting agreed actions

The actions agreed at the assurance review meeting were as follows:

- Lachlan to detail the EPRR risk management process within EPRR policy
- Lachlan to liaise with Niall Smith SWLSTG who has delivered a number of BIA workshops recently

- Lachlan to ensure the CBRNe plan includes the up to date 24/7 contact number for CRCE
- Andy Godfrey to send new IOR flowchart to Lachlan
- Jon Davis to send Kings JESIP model to Lachlan
- Lachlan to liaise with Kingston Hospital about storage temperatures for PRPS suits.

4.4 Identified areas of good practice

The following areas have been identified as good practice:

- Allocation of the decontamination team and tent teams at the start of each ED shift

5 Next Steps: Action Plans and Governance

St. George's Hospital is required to submit the following documentation to england.london-assurance@nhs.net within two weeks of receipt of this report:

- The organisation's final EPRR RAG scores, as agreed at the review meeting using the self-assessment tool
- A resulting action/work plan providing clear actions, timescales and leads on areas where any further work is required against any of the green rated core standards
- A declaration of the overall level of compliance achieved from the AEO

5.1 Identified key priorities

The key priorities as identified at the assurance review meeting for the next twelve months include:

- Review of the Trust's CBRNe/HAZMAT plan to ensure it aligns to current guidance and clearly details IOR processes.
- Ensuring the business continuity plans detail how and when incidents should be escalated to Critical incidents.
- Ensuring annual plan reviews are maintained on-going, to focus on the priority revision of expired plans (in addition to those above), including;
    - Mass Prophylaxis Centre plan
    - Pandemic influenza pl
    - Evacuation plan
- Rolling out full day major incident and CBRNe/HAZMAT full training days (as per the current workplan)
- Reviewing plans and procedures to align to any new or updated guidance released by the NHS England National Team, which is likely to include:
    - Mass countermeasures
    - Lockdown
    - Evacuation and shelter
    - Clinical guidance for major incidents

6 Conclusion

In the 2018 assurance process, St. George's received an overall compliance rating of 'partial'. Whilst the panel recognised the work undertaken during 2018 in respect of EPRR, the review had identified several areas which did not achieve the criteria of the EPRR Core Standards.

The overarching reason for several of the amber ratings given was the failure to review emergency plans annually, resulting in some plans being a number of years out of date. This results in a concern that plans are not aligned to current guidance and still embedded within the Trust.

The Trust's business continuity management system also received 3 amber ratings to reflect the on-going work that is required to review the Corporate Business Continuity Plan and embed new BIA and BCP templates throughout the organisation.

A number of those core standards highlighted given amber ratings had already been identified as areas outstanding by the trust and workplans are in already place for to ensure they are addressed during 2019.

A number of additional minor edits and additions to documents have been passed onto the Trust by the NHS England (London) EPRR team for the trust to consider in the on-going review of plans, along with the incorporation of any guidance issued by NHS England or other London Resilience partners.

Lachlan and Kristel are thanked for their on-going hard work and commitment to deliver EPRR within the Trust.

Appendix A - assurance review meeting agreed RAG ratings and discussion points.

CS Ref	Standard	Self-assessment RAG rating	Agreed 2018 RAG rating	RAG rating rationale and review meeting comments
Governance				
1	**Appointed AEO**	**Green**	**Amber**	• No NED identified • AEO Ellis Pullinger • Currently discussions are taking place with board member to fulfil this role
2	**EPRR Policy Statement**	**Green**	**Green**	• In EPRR policy • Updated EPRR policy currently being developed
3	**EPRR board reports**	**Green**	**Green**	• Went to the board in Jan 18. Board report Feb 18
4	**EPRR work programme**	**Green**	**Green**	• Work programme linked to Core standards
5	**EPRR Resource**	**Green**	**Amber**	• Role is well supported by Brendon • A lot of good work is carried out in the trust but this would be enhanced with additional resources, particularly around the responsibilities that are linked to the South West London Trauma Network and comparison with trusts of similar size and complexity.
6	**Continuous improvement process**	**Green**	**Green**	• Debriefing detailed within MIP, along with report writing requirements. Action plans are reviewed by major incident steering group Will implement electronic tracking of patients following Ex Buzzard learning
Duty to risk assess				
7	**Risk assessment**	**Green**	**Green**	• Process links in with the corporate risk management system. Risks are escalated onto the corporate risk register as required. • Twice yearly risk management group forward planning e.g out of date `CBRNe suits. • Links to Local Risk Register • Action: Detail risk management process within EPRR policy
8	**Risk Management**	**Green**	**Green**	• Datex is used
Duty to maintain plans				
9	**Collaborative planning**	**Green**	**Green**	Examples of working with partners includes: • Helipad planning – exercise on 18th November • Excess deaths plans • Trauma network • BRF • Mass fatality and excess deaths planning • Event plan • Pan London Major Trauma Network plan in development.
11	**Critical incident**	**Green**	**Amber**	• Critical incident definition and reporting in draft BCP, but no detail as to how incidents escalate to critical • Not reflected in current plan
12	**Major incident**	**Green**	**Green**	• Last version June 2018 - check sign off procedure as version control indicates last sign off 2016 • Overall a good plan • Some updates from last year not included. • Some updates have been made to reflect new mass casualty guidance, but still some very out of date guidance referenced, e.g. 2009 London guidance. Need to ensure the plan aligns to the new guidance. • No major incident rapid discharge arrangements in plan • Some action cards incomplete (when putting them into a new layout) and require additional stand down actions to restore services, media messaging and ensure appropriate people are informed • Other stand down actions need to be included, not just debrief, as many departments will have ongoing actions. • A recovery, stand down checklist is planned.
13	**Heatwave**	**Green**	**Green**	• Last version 2018 June • Lainsborough Wing is one of the identified hotspots • The trust identifies areas in advance of heatwave declarations

14	**Cold weather**	**Green**	**Green**	• Winter management plan 2017 linked to Opal framework • Severe weather plan in place • Trust Winter Plan is signed off
15	**Pandemic influenza**	**Green**	**Amber**	• Pandemic flu plan 2015. This should be reviewed annually • No recent exercises taken place. • Peer reviewer - Kings exercise to take place in 2019
16	**Infectious disease**	**Green**	**Green**	• VHF plan & communicable infections plan also Ebola maintained by infection control.
17	**Mass Countermeasures**	**Green**	**Amber**	• Plan has not been updated since 2012. Plan should be reviewed annually to ensure it is up to date and aligns with any infrastructure changes within the organisation. • There has been a delay on the national Mass Countermeasure guidance being released.
18	**Mass Casualty - surge**	**Green**	**Green**	• MIP has been updated to include 2017 guidance expectations and draft 2018 London framework, but doesn't detail how this will be achieved. E.g. says that level 3 ITU to be doubled, but doesn't say how. • Kit list and supplies remains to be evidenced.
19	**Mass Casualty - patient identification**	**Green**	**Green**	• Detailed in MIP • A new electronic process is being implemented for up to 150 casualties
20	**Shelter and evacuation**	**Green**	**Amber**	• Last version 2016 covers full and partial evacuation and includes facilities at Putney hospital as a resource. • Last exercised 3 years ago. • New central guidance is being developed by the national EPRR team.
21	**Lockdown**	**Green**	**Green**	• Last version July 2017 • Maintained by facilities, no notice full site exercise in 2018
22	**Protected individuals**	**Green**	**Green**	• Media & social media policy in place, which includes details around the management of a VIP as a patient.
23	**Excess death planning**	**Green**	**Green**	• Excess deaths and mass fatalities plan in place • Mortuary escalation plan in place • Local Authority facility
Command & Control				
24	**On call mechanism**	**Green**	**Green**	• On Call rotas in place • Monthly Commex • Strategic equals executive directors, Tactical is senior managers
25	**Trained on call staff**	**Green**	**Green**	• Trust delivers own SLC courses held June 2018 external provider. • New NHS course is being developed for 2019
Training & exercising				
26	**EPRR Training**	**Green**	**Amber**	• A 2 hour session is currently delivered combined, MI and CBRN (amber). The trust has identified this is insufficient and has moved to 4hrs and will be a full day next year. • Trust wide induction training on EPRR. • ED drills no notice • Line manager and strategic and on call training, together with refreshers
27	**EPRR exercising and testing programme**	**Green**	**Green**	• Live ex – Tram Crash 2016. WannaCry 2017 Woking inflatable slide incident 2018 • Lockdown exercise 2018 • Table top – exercise Buzzard • Commex – 27th Sept 18 now October 18, monthly MI cascade
28	**Strategic and tactical responder training**	**Green**	**Green**	• Trust delivers own SLC courses held June 2018 external provider.
Response				
30	**Incident Co-ordination Centre (ICC)**	**Green**	**Green**	• Weekly testing • Back up identified • ICC SOP in place • Suggested monthly inventory
31	**Access to planning arrangements**	**Green**	**Green**	• Accessed via share drive, folders in ICC. Directors have laptops. • Potential use of Resilience Direct

32	**Management of business continuity incidents**	**Green**	**Green**	• Command and Control arrangements in place
33	**Loggist**	**Green**	**Green**	• 30 loggists across the trust, core from site management team • Looking for loggists to be used clinically • Check 3 year rotation
34	**Situation Reports**	**Green**	**Green**	• Submission of situation reports tested in Exercise Buzzard • Detailed in the MIP
35	**Access to 'Clinical Guidance for Major Incidents'**	**Green**	**Green**	• N/A- guidance not yet available • To be updated next year
36	**Access to 'CBRN incident: Clinical Management and health protection'**	**Green**	**Green**	• Seen in major incident cupboard
Warning & Informing				
37	**Communication with partners and stakeholders**	**Green**	**Green**	• MI plan covers Comms team 24/7 callout
38	**Warning and informing**	**Green**	**Green**	• Media training for on call staff
39	**Media strategy**	**Green**	**Green**	• Media & social media policy
Cooperation				
40	**LRHP attendance**	**Green**	**Green**	• N/A. But future accountability - Organisation type to be represented
41	**LRF / BRF attendance**	**Green**	**Green**	• Wandsworth and Merton BRFs attended
42	**Mutual aid arrangements**	**Green**	**Green**	• Detailed in MIP
46	**Information sharing**	**Green**	**Green**	• Data protection policy • Ensure this includes GDPR
Business Continuity				
47	**BC policy statement**	**Green**	**Green**	• BC policy to be added as appendix to EPRR policy • Approved by BC steering group in September, but updated EPRR policy not yet ratified
48	**BCMS scope and objectives**	**Green**	**Green**	• As above
49	**Business Impact Assessment**	**Green**	**Amber**	• Draft BIA template to be produced • All services to complete their BIAs by February • Workshops and online training will be delivered to support in the completion of these • Action - Liaise with Niall Smith SWLSTG who has delivered a number of BIA workshops recently
50	**Data Protection and Security Toolkit**	**Green**	**Green**	• Compliant with IG toolkit and working towards 2019 compliance
51	**Business Continuity Plans**	**Green**	**Amber**	• New template produced Oct 2018 • All BCPs will be reviewed <u>Corporate BCP;</u> • No MTPD detailed currently • Doesn't indicate how to escalate to critical, although it is defined • Would benefit from action cards as to how to manage different BC scenarios and action cards for commanders
52	**BCMS monitoring and evaluation**	**Green**	**Green**	• BC steering group monitors business continuity and will monitor the implementation of the new BIA and BCP templates • Performance management process in place
53	**BC audit**	**Green**	**Green**	• Linked as above • Meeting monthly currently strategic input • Process detailed in BC policy, this may be difficult to implement at this stage due to review

54	**BCMS continuous improvement process**	**Green**	**Green**	• Debriefing following lessons learned. Actions monitored by BCSG
55	**Assurance of commissioned providers / suppliers BCPs**	**Green**	**Green**	• Unaware whether part of procurement process, but is referenced in the new BC Policy • Consortium procurement is utilised • But not specifically in internal procurement process • Recommend to be included in the procurement policy
CBRN				
56	**Telephony advice for CBRN exposure**	**Green**	**Green**	• Detailed in plans • Update numbers for requesting countermeasures • Action – ensure up to date as out of date plan.
57	**HAZMAT / CBRN planning arrangement**	**Green**	**Amber**	• Version control confusing. Last approved version 2016. Evidence submitted is draft (amber) • Decontamination procedures seem to be unclear and muddled. The plan indicates that everyone will go through the tent and that the tent will always be set up. Some action cards only indicate wet decontamination as an option • Some of the action cards are for different roles but pretty much say the same thing, e.g. consultant and NIC. So confusion as to who would do what and may cause duplication • No remove remove remove, reflection of acid attacks etc. • Doesn't reflect new PHE guidance, e.g. old step 1 2 3 • Update countermeasures requests procedure • Dry decontamination for radiation – unsafe. Says dry decontamination but should be wet • Reporting back to entry control prior to taking off PRPS, not after. Ensures correct timings recorded • Emergency disrobe procedures to be detailed, along with ensuring suit isn't compromised, e.g. kneeling • Reflect requirement for ongoing teams • Andy from LAS offered to support in review of the trust's plan • Action: Andy to send new IOR flowchart
58	**HAZMAT / CBRN risk assessments**	**Green**	**Green**	• Last year amber • Seen risk assessment, now green • Reflect unmitigated risks and what risk is with mitigation's in place. Likely that this will go onto Datix and will require this layout. This can then also ensure that any risks get escalated as required
59	**Decontamination capability availability 24/7**	**Green**	**Green**	• 2 teams allocated for each shift- decon team and tent team (good practice) • Roster identifies who is trained and shows on rota each day • Morning handover, everyone confirms they are happy to take on this role
60	**Equipment and supplies**	**Green**	**Green**	• All equipment in place. • Ensure checks recorded
61	**PRPS availability**	**Green**	**Green**	• Stored within CBRN container. • Ensure training suits clearly labelled
62	**Equipment checks**	**Green**	**Green**	• 3 x RAMGENEs working and records kept. • Ensure records kept for checks of all CBRN equipment. • Checks carried out during training sessions CBRN equipment checks not carried out, only MI clinical quipment.
63	**Equipment PPM**	**Green**	**Green**	• Respirex service took place recently • Tent maintenance took place July 18 • RAM GENE – Oct service (Internal)
64	**PPE disposal arrangements**	**Green**	**Green**	• CBRNe waste management policy
65	**HAZMAT / CBRN training lead**	**Green**	**Green**	• Paul Clove is the CBRN training lead in ED
66	**Training programme**	**Green**	**Amber**	<u>CBRN training Observed in 2018</u> • Only 2 hour session delivered – insufficient. Feedback was provided to the EPLO following this. • Now have 4 hours and look to increase for next year to a whole day. Will include table top exercise, major incident. Day will include major incident training, IOR video and other videos and will have medical physics to test use of Ram Gene • NHS E to observe again over next year. • Amber but reflect that progress will be made over next year.

67	**HAZMAT / CBRN trained trainers**	**Green**	**Green**	• 7 trainers. Trained in July and all participate in delivering training throughout year
68	**Staff training - decontamination**	**Green**	**Green**	• Good response by staff overall. • But not to isolate. • Default to wet decon. (Dry decon scenario given) • Trust explained that they are likely to Isolate 1 patient as if they are sent outside would disproportionately whole ambulance entrance, so may be lower impact • Reception good response. • In IOR box, Victoria hospital procedures. 2007 - remove
69	**FFP3 access**	**Green**	**Green**	• Held in department • Training being rolled out now in winter period

Deep Dive				
CS Ref	**Standard**	**Self-assessment RAG**	**Agreed 2018 RAG rating**	**Assurance review meeting comments**
Incident coordination centres				
1	**Communication and IT equipment**	**Green**	**Green**	• ICC designated • Back up UPS and power available
2	**Resilience**	**Green**	**Green**	• Used daily by site team and so equipment tested on-going
3	**Equipment testing**	**Green**	**Green**	• Weekly testing by EPLO • To be evidenced
4	**Functions**	**Green**	**Green**	• ICC SOP in place
Command structures				
5	**Resilience**	**Green**	**Green**	• As discussed
6	**Stakeholder interaction**	**Green**	**Green**	• Self rated amber because further detail required in MIP, but NHS E felt that the trust interacts with stakeholders on-going.
7	**Decision making processes**	**Green**	**Green**	• Self rated amber - No JESIP in MIP but evidence of decision making within plans. • This to be added to ICC • Action: Jon to send Kings JESIP model to Lachlan
8	**Recovery planning**	**Green**	**Amber**	• Recovery section in MIP doesn't have much detail around the actions that are required for recovery • Not on Gold action card to consider • Recovery should run alongside response and this is not currently detailed in the plan • Good examples available from ESTH and Kingston

Appendix B– CBRNe/HAZMAT equipment checklist

CBRNe/HAZMAT equipment list			
Ref	**Equipment**	**Available?**	**Comments**
EITHER: Inflatable mobile structure			
E1	Inflatable frame	**N/A**	
E1.1	Liner	**N/A**	
E1.2	Air inflator pump	**N/A**	
E1.3	Repair kit	**N/A**	
E1.2	Tethering equipment	**N/A**	
OR: Rigid / cantilever structure			
E2	Tent shell	**Green**	Yes
OR: Built structure			
E3	Decontamination unit or room	**N/A**	Not available, but do have a tent
AND:			
E4	Lights (or way of illuminating decontamination area if dark)	**Green**	Yes. Inside and outside
E5	Shower heads	**Green**	Yes
E6	Hose connectors	**Green**	Yes
E7	Flooring appropriate to tent in use	**Green**	Yes
E8	Waste water pump and pipe	**Green**	Yes
E9	Waste water bladder	**Green**	Yes. Don't need to pre prime. Yes
PPE for chemical, and biological incidents			
E10	The organisation has the expected number of PRPS suits (sealed and in date) available for immediate deployment should they be required.	**Green**	21. All in container. First maintenance check
E11	Providers to ensure that they hold enough (appropriately labelled) training suits to facilitate their local training programme	**Green**	12 downstairs plus more upstairs
Ancillary			
E12	A facility to provide privacy and dignity to patients	**Green**	In dept if needed
E13	Buckets, sponges, cloths and blue roll	**Green**	Yes.

E14	Decontamination liquid (COSHH compliant)	**Green**	Yes
E15	Entry control board (including clock)	**Green**	Yes
E16	A means to prevent contamination of the water supply	**Green**	Bladder
E17	Poly boom (if required by local Fire and Rescue Service)	**N/A**	
E18	Minimum of 20 x Disrobe packs or suitable equivalent	**Green**	Yes
E19	Minimum of 20 x re-robe packs or suitable alternative	**Green**	Yes plus blankets
E20	Waste bins	**Green**	Bags
	Disposable gloves	**Green**	Yes. At back
E21	Scissors - for removing patient clothes but of sufficient calibre to execute an emergency PRPS suit disrobe	**Green**	Yes
E22	FFP3 masks	**Green**	In MI cupboard
E23	Cordon tape	**Green**	Radiation rope and tape
E24	Loud Hailer	**Green**	Cupboard
E25	Signage	**Green**	Cupboard
E26	Tabards identifying members of the decontamination team	**Green**	Cupboard
Radiation			
E27	RAM GENE monitors (x 2 per Emergency Department)	**Green**	Records for checking 3 all OK
E28	Hooded paper suits	**Green**	Yes
E29	Goggles	**Green**	Yes
E30	Overshoes & Gloves	**Green**	Yes

Other comments:
Patient conveyor 2 part
Suggestion: Photos of tent set up.
Equipment checks done through training sessions. But no records kept.
RAMGENE checklist in cupboard
Action: Liaise with Kingston about storage temps for PRPS suits
.
Consider: dirty zone if self presenting patients attend via ED entrance. Diagram in plan shows this is the clean zone, but would have been made dirty in the situation.
Consider: accessibility of equipment stored at the back of the container and accessing this in the event of an incident

Appendix C – LAS 'first contact' assessment

Core standard 68. Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.

Participant 1		
Location: Streaming	**Staff Type:** Streaming Nurse	**RRR Posters in situ?** Out of date IOR poster in cubicle but Remove poster seen elsewhere.
Scenario Posed: They are approached by a patient with a white powdered substance splashed over them. They state that they were on a bus and a fight had broken out and some youths had thrown white powder over them and now they felt unwell. What are your immediate actions?		
Answer: Would isolate patient outside or inside in cubicle. Referred to IOR / Remove kit in streaming cubicle. Contents seen, shown what was referred to as the manual – this was the Australian Victoria Hospitals Decontamination Manual (2007). No PHE guidance seen.		
RRR Poster / Procedure Referenced? No	**Previous Training?** Yes	
Participant Employed by Trust? Yes		
If NO, Employed by who? N/A		

Participant 2		
Location: ED Reception	**Staff Type:** Reception	**RRR Posters in situ?** None seen
Scenario Posed: They are approached by a patient with a white powdered substance splashed over them. They state that they were on a bus and a fight had broken out and some youths had thrown white powder over them and now they felt unwell. What are your immediate actions?		
Answer: Would isolate patient outside the department. Inform Nurse in Charge and assist staff as required.		
RRR Poster / Procedure Referenced? No	**Previous Training?** Yes	
Participant Employed by Trust? Yes		
If NO, Employed by who?		

Appendix D – NHS England (London) comments on submitted evidence

DOCUMENT NAME:	Major Incident Plan
VERSION NUMBER:	V2.10 June 2018
Page or point number	**Comments**
8,14	Refers to internal disaster recovery BCP.
8,14	Says community service would declare MI and it would be managed using the BCP
12 & 14	Do you still provide mobile teams? MERIT teams no longer requested
12	Refers to commissioning board – update
14	First line – reword. Decide on the required actions to take?
14	4.6 wouldn't declare a major incident. If community site near scene of incident, inform emergency services and NHS E. Would be informed if mass casualty
15	5.3 HCC should be HICC
17	Maybe group these to say what support they may be able to provide and detail mutual aid request procedure through NHS E
18	Lots of people are attending the HICC. May disrupt coordination of the incident. Send to staff pool?
18 7.3	Why 'clean' triage point? Clean is for CBRNe
18	7.4 update to align to London mass casualties plan
21	8.2 children triaged using paeds triage tape
24	Remove COMAH section as not required
26	Sunlight is now Berensden (since 2013)
26	Police unlikely to support lockdown
28	Casualty bureau not at New Scotland Yard
44	No longer use 'catastrophic'. Update table to current guidance
44	LRT guidance 2009. 2015 version available. Update
45	Update section to new London framework. NHSE may also declare a mass casualty incident
47	Has been updated to include 2017 guidance expectations and draft 2018 London framework, but doesn't detail how this will be achieved. E.g. says that level 3 ITU to be doubled, but doesn't say how.
48	Mentions primary care trusts

54	Maybe have a corporate leaflet, with logo etc
58	Croydon callsign now CROYDON2. List does not include Kingston
59	Thames Water – may now be Castle Water. check
	Burns section in previous plan taken out
	Bomb and blast injuries section has been removed.
	No major incident details about rapid discharge process
	Gold and silver teams not fully outlined, e.g. site team or supporting staff such as loggist or their location.
67	Gold action card: If self-declare MI, ensure relevant agencies notified. Start log. 'select location for ICC' – should be pre identified. Does consider activating recovery team.
74	Senior nurse action card incomplete, also medical coordinator, CSM/..and all on-going. Would these roles want to take any actions at standby, e.g. staffing considerations
77	Would site manager's role to identify bed capacity as the first action?
87	NHS E comms team is via LON01, not NHS01. Comms stand down would require additional messages to go out
	Action cards should also consider other stand down actions, such as who else needs to be stood down /alerted, any actions to restore the service, shut down extra activities, e.g. relatives reception centre etc

DOCUMENT NAME:	Corporate Business Continuity Plan
VERSION NUMBER:	V6. May 2015
Page or point number	**Comments**
	Plan is out of date, no update for last 3 years. Updates required from last year's assurance not completed, does not discuss , types of BC disruption, people, premises etc. There has been no progress (technically **red rating** as trust is still operating with this plan)
	Front links to other plans which are 5 years old
	Flow chart needs discussion, who is the disaster management team, this normally refers to a IT process
1.3	Significant internal incident – terminology
	Level 4 – should indicate that this is a reportable incident to NHSE
	Level 4 – states an 'internal major incident should be declared' -incorrect terminology
	Mixed terminology, internal major incident, internal serious incident etc
13.3	SITREP info is out of date
15	Refer to GDPR

19	Refers to information that would be required in a major incident , not bC
Appendix 4a	Staffing levels 4 years old, this needs updating
· Appendix 4	This was discussed at length at last assurance and needs complete review
Appendix 5	Seems to indicate that you would always cancel elective activity in a BC incident
	Sitrep out of date info and takes up many pages of the BCP, needs to be removed
	Action cards not fit for purpose of a BC incident, minimal information
Draft Trust BCP – Amber as in draft	
	Divert information is incorrect
	In flow chart where do they escalate to NHSE?
	Section 1.6 explain
	In principle the structure of this is an improvement

Includes comments from both LAS and NHS England (London)	
DOCUMENT NAME:	Chemical, Biological, Radiological and Nuclear Explosives (CBRNe) & Hazardous Materials (HAZMAT) Plan
VERSION NUMBER:	3.2
Page or point number	**Comments**
	Overall the plan needs updating to reflect new guidance, it does not refer to remove, remove, remove, access to countermeasures section is out of date, suggest that the plan needs annual review and amendment when new guidance is released
	Action cards – no remove, remove, remove, step 1,2,3 plus has not been updated
	Acton cards, lots of people doing the same actions, eg phoning estates
7 action card 1	Diagram is out of date. There is a newer version. External radiological contamination is wet decontamination. The roles add up to 14 -16 persons. Consider revising team roles / numbers. Can the department find 16 staff and still maintain business as usual? Just a point to consider.
11 action card 2 and subsequent cards	Diagram is out of date. There is a newer version.
13 Action Card 3	PHE 2018 Guidance has changed. Consider revision
24 – Action Card 8	Is this role necessary? Suggest as a loggist role or extra should staff numbers allow but not as a primary role.

25, 26 – Action Card 9, 10	The working time is up to 60 minutes. Suggest rewording as current text may suggest 1 hour wear regardless. At Salisbury earlier this year working times were reduced to 15 mins due to hot weather and tasks required. Sufficient resilience should be planned for such events / weather.
25, 26, 27, 29 – Action Card 9, 10, 11, 13	This should come before undressing. Entry control tracks whether an operative is in or out of the dirty zone. So to enter the dirty zone, operatives should arrive at entry control in standby dress state(hood off / AFU off). The AFU is started and the operative zipped in. This is the time in. At the end of the duty they exit the tent and report to entry control. This is the time out and we now know the operative is safely clean side. They can then undress and rehydrate. If they go to undress first the entry control clock is still running and in a busy scenario, a change of operatives in a protracted incident for example, there may be confusion as to how many operatives are in the dirty zone.
27, 29 – Action Card 11, 13	The working time is 60 minutes. See above.
33 – Action Card 17	Is this on the correct card? There isn't much advice on radiation and no specialist advice for decontamination of radiologically contaminated patients. . RPA card discusses them giving advice on biological agents
37, 39, 42	IOR / Remove flowchart and step 1,2,3 diagrams are out of date.
43 Flow chart column 1	Radiologically contaminated P1 patients will be transported in dirty condition if they can be safely managed. *LAS establish is decontamination area is set-up at SGH. If it is, ambulance to entrance via "clean" route in*. This is a confusing statement. Does this mean ' If the LAS have been advised that the decontamination structure has been set up then business as normal ambulances to be directed via a 'clean' route to ED' or are you asking for a representative of the LAS to be present? Please advise.
	Community card also needs remove guidance and update to step 1,2, 3 plus
45	guidance to be updated, some is 2002
49 – Section 7.6	Although trust policy probably will not change there has been a change in regulations around radiation and pregnancy. (6) Without prejudice to paragraph (1), an employer who undertakes work with ionising radiation must ensure that— (a) in relation to an employee who is pregnant, the conditions of exposure are such that, after the employee's employer has been notified of the pregnancy, the equivalent dose to the foetus is as low as is reasonably practicable and is unlikely to exceed 1 mSv during the remainder of the pregnancy; and (b) in relation to an employee who is breastfeeding, that employee must not be engaged in any work involving a significant risk of intake of radionuclides or of bodily contamination. (7) Nothing in paragraph (6) requires the employer who undertakes work with ionising radiation to take any action in relation to an employee until that employee's employer has been notified in writing by the employee of the pregnancy or that the employee is breastfeeding and the employer who is undertaking the work with ionising radiation has been made aware, or should reasonably have been expected to be aware, of that notification.
50	The IOR 2015 guidance has now changed to Remove, Remove, Remove 2017. This expands on dealing with corrosives as part of an initial response. Suggest revising this section to incorporate 2017 guidance.

51	JESIP is separate to IOR and is intended as a tool between blue light services. IOR can is a standalone procedure. However a separate section on JESIP and how it relates to acute trusts can be added if wanted
51	Steps 1,2,3 diagram as previously stated
53	Current teaching on Train the Trainer course that the patient is considered contaminated if they are reading twice background radiation by Ram-Gene.
60	*Unless casualties are demonstrating signs or symptoms of exposure to caustic or irritant substances:* Suggest revising to include biological / radiological substances.
60	Contamination monitoring must be done before treatment to ensure the principles of time, distance, shielding can be effective. If the patient is contaminated to such an extent that they pose a significant danger to staff, even with precautions, they may severely harm staff and extensively contaminate the ED. Contamination monitoring for gross contamination can be done quickly if required.
61	Suggest addition of guidance for persistent corrosive agents which may take up to 20 minutes to dilute until the burning stops. One-Stop and similar are thick and sticky and will need extensive irrigation.
64	Suggest addition of timings for walking and non-walking patients
68	Consider adding text for being upwind of contaminated casualty.
69	Also add other items within the department which may be used if blue roll is not available or used up. (Dressings, hand towels, toilet roll, strips of sheet or blanket)
69	Consider additional text stating treatment of a contaminated suit which the wearer has been cut out of in the dirty zone. The suit cannot be cleaned to be boxed up and returned so it may be beneficial to clarify the procedure for dealing with a damaged suit in the dirty zone
69	A red flashing light MAY show an AFU failure. Before carrying out an emergency cut-out the user should stand upright to increase airflow as bending may compress the internal air hose causing a low flow and resultant alarm. When straightened by standing up the flow may increase and the warning cease. Also check that the hose into the hood is not being obstructed by hair, helmet or the fabric of the hood itself. All of these are easily correctable and may stop exposing a wearer to contamination and the cost of replacing a PRPS suit. If warnings continue withdraw to dirty side and carry out the emergency cut-out for a distress to wearer.
71	This guidance has changed around countermeasure and equipment requests .
74	There is no guidance for non-ambulatory patients or timings for clinically decontaminating patients.
82	? % of bleach for washing solid keys and wedding band
96	no bleach on skin
	Disposal of PRPS – need to discuss recording of the suit number and informing NARU