Trust Board Meeting (Part 1) Agenda

Date and Time: **Thursday, 30 May 2019, 10:00-13:00**
Venue: **Barnes, Richmond & Sheen Rooms, Queen Mary Hospital, Roehampton Lane Roehampton, London SW15 5PN**

Time	Item	Subject	Lead	Action	Format
FEEDBACK FROM BOARD WALKABOUT					
10:00	**A**	**Visits to various parts of the site**	**Board Members**	Note	Oral
1.0 OPENING ADMINISTRATION					
10:30	**1.1**	**Welcome and apologies**	**Gillian Norton** Chairman	Note	Oral
	1.2	**Declarations of interest**	**All**	Assure	Report
	1.3	**Minutes of meetings on 25/04/2019 and 23/05/2019**	**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
2.0 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
11:20	**2.3**	**Safe Staffing Report: (Nursing and Midwifery Inpatient Establishment Review April 2019)**	**Avey Bhatia** Chief Nurse/ Director of Infection Prevention and Control	Assure	Report
11:30	**2.4**	**Cardiac Surgery Update**	**Richard Jennings** Chief Medical Officer	Assure	Report
11:40	**2.5**	**Mortality Monitoring Committee Report and Learning from Deaths**	**Richard Jennings** Chief Medical Officer	Assure	Report
3.0 FINANCE					
11:50	**3.1**	**Finance and Investment Committee Report**	**Ann Beasley** Committee Chair	Assure	Report
12:00	**3.2**	**FIC (Estates Assurance) Report**	**Tim Wright** NED Lead	Assure	Report
12:10	**3.3**	**Finance Report (Month 01)**	**Andrew Grimshaw** Chief Financial Officer	Update	Report

Time	Item	Subject	Lead	Action	Format
4.0 GOVERNANCE					
12:20	**4.1**	**Audit Committee Report**	**Sarah Wilton** Committee Chair	Assure	Report
12:30	**4.2**	**St George's Hospital Charity Report (Q4)**	**Suzanne Marsello** Director of Strategy	Review	Report
12:40	**4.3**	**Provider Licence Compliance Self-Certification**	**Stephen Jones** Director of Corporate Affairs	Approve	Report
5.0 CLOSING ADMINISTRATION					
12:50	**5.1**	**Questions from the public**	**Gillian Norton** Chairman	Note	Oral
	5.2	**Any new risks or issues identified**	**All**	Note	
	5.3	**Any Other Business**		Note	
	5.4	**Reflections on the meeting**		Note	
13:00	**6.0 PATIENT STORY**		**Bernadette Kennedy**	Note	Oral
13:10 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 27 June 2019, 10.00 – 13.00

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 2019-20 (Thursdays)									
28.03.19	25.04.19	30.05.19 (QMH)	27.06.19	25.07.19	29.08.19	26.09.19	31.10.19	28.11.19	19.12.19
30.01.20	27.02.20	26.03.20							

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		
Harbhajan Brar	Director of Human Resources & Organisational Development	DHROD
James Friend	Director of Delivery, Efficiency & Transformation	DDET
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
Presenters		
Bernadette Kennedy	Head of Therapies (QMH)	HoT
Secretariat		
Tamara Croud	Interim Assistant Trust Secretary	IATS
Apologies		
Ellis Pullinger	Chief Operating Officer	COO
Quorum:	*The quorum of this meeting is a third of the voting members of the Board which must include one non-executive director and one executive director.*	

Meeting Title:	**TRUST BOARD**		
Date:	**30 May 2019**	**Agenda No.**	**1.2**
Report Title:	**Board Member Declarations of Interest**		
Lead Director/ Manager:	**Stephen Jones, Director of Corporate Affairs**		
Report Author:	**Stephen Jones, Director of Corporate Affairs**		
Presented for:	**For Information**		
Executive Summary:	The updated Register of Board Members' interests is attached as Appendix A. It was agreed, in March, that a report on Board Members' Interests be presented at each Board meeting to ensure transparency, public record and afford members the opportunity to update their interests and to declare any conflicts.		
Recommendation:	For the Board to note, review and provide any relevant updates.		
Supports			
Trust Strategic Objective:	Balance the books, invest in our future		
CQC Theme:	Well Led		
Single Oversight Framework Theme:	Leadership and improvement capability (well-led) – Effective boards and governance.		
Implications			
Risk:	As set out in the paper		
Legal/Regulatory:	The public rightly expect the highest standards of behaviour in the NHS. Decisions involving the use of NHS funds should not be influenced by outside interests or expectations or private gain.		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A
Appendices:	Appendix A. Register of Board Members' interests		

Appendix A. Register of Board Members' interests

Name	Role	Description of Interest	Relevant Dates		Comments
			From	To	
Chairman and Non-Executive Board Members					
Gillian Norton	Chairman	Deputy Lieutenant (DL) Greater London Lieutenancy Representative DL for Richmond	October 2016	Present	
Ann Beasley	NED, Deputy Chairman, Chair of the Finance and Investment Committee	ACAS Independent Financial Adviser ACAS Audit Committee Member	December 2017	Present	Remunerated
Ann Beasley	NED, Deputy Chairman, Chair of the Finance and Investment Committee	Florence Nightingale Foundation, Mentor	April 2018	Present	Non remunerated
Ann Beasley	NED, Deputy Chairman, Chair of the Finance and Investment Committee	South West London and St George's mental Health NHS Trust, Chair	1 October 2018	Present	Remunerated
Stephen Collier	Non-Executive Director & Workforce and Education Committee Chair	Member, Advisory Board: Healthcare Market News (monthly publication)	2015	Present	

Name	Role	Description of Interest	Relevant Dates		Comments
			From	To	
Chairman and Non-Executive Board Members					
Stephen Collier	Non-Executive Director & Workforce and Education Committee Chair	Member, Advisory Board: Cielo Healthcare (Milwaukee, USA)	2015	Present	
Stephen Collier	Non-Executive Director & Workforce and Education Committee Chair	Member, Health Leaders Panel: Nuffield Trust	2014	Present	
Stephen Collier	Non-Executive Director & Workforce and Education Committee Chair	Trustee: ReSurge Africa (medical charity)	2015	Present	
Stephen Collier	Non-Executive Director & Workforce and Education Committee Chair	External Advisor: Schoen Klinik (German provider of mental health and surgical services)	2018	Present	

Name	Role	Description of Interest	Relevant Dates		Comments
			From	To	
Chairman and Non-Executive Board Members					
Stephen Collier	Non-Executive Director & Workforce and Education Committee Chair	External Advisor: Imperial College, in relation to potential academic/research-led medical & technology developments/collaborations on the new White City campus	2016	Present	
Stephen Collier	Non-Executive Director & Workforce and Education Committee Chair	Independent Advisor to the Inquiry into Issues raised by Patterson	2018	Present	
Stephen Collier	Non-Executive Director & Workforce and Education Committee Chair	Chairman of NHS professionals Limited (provider of managed staff services to the NHS	2018	Present	
Stephen Collier	Non-Executive Director & Workforce and Education Committee Chair	Chairman and shareholder: Eden Futures (supported living provider)	2016	Present	

Name	Role	Description of Interest	Relevant Dates		Comments
			From	To	
Chairman and Non-Executive Board Members					
Stephen Collier	Non-Executive Director & Workforce and Education Committee Chair	Chairman and shareholder: Cornerstone Healthcare group (dementia care provider)	2018	Present	
Jenny Higham	Non-Executive Director (St George's University of London University Representative)	Board Governor: Kingston University	November 2015	Present	
Jenny Higham	Non-Executive Director (St George's University of London University Representative)	Principal: St George's, University of London	November 2015	Present	
Jenny Higham	Non-Executive Director (St George's University of London University Representative)	Visiting Professor: Lee Kong Chian School of Medicine in Singapore	January 2010	Present	
Jenny Higham	Non-Executive Director (St George's University of London University Representative)	Honorary Consultant: Imperial College London	November 2011	Present	

Name	Role	Description of Interest	Relevant Dates		Comments
			From	To	
Chairman and Non-Executive Board Members					
Jenny Higham	Non-Executive Director (St George's University of London University Representative)	Chair: Medical Schools Council	August 2016	July 2019	
Jenny Higham	Non-Executive Director (St George's University of London University Representative)	Trustee: Medical Schools Council Assessment Alliance	2013	Present	
Jenny Higham	Non-Executive Director (St George's University of London University Representative)	Trustee: Medical Schools Council Assessment Alliance	2013	Present	
Jenny Higham	Non-Executive Director (St George's University of London University Representative)	Collaboration for Leadership in Applied Health Research and Care (CLAHRC) Non-remunerated Board Member	2017	Present	

Name	Role	Description of Interest	Relevant Dates		Comments
			From	To	
Chairman and Non-Executive Board Members					
Sir Norman Williams	Non-Executive Director, Chair Quality and Safety Committee, Senior independent Director	Chairman National Clinical Improvement Programme/Getting it Right First Time Board member: Overseeing the development of the National Clinical Improvement Programme within NHS Improvement (NHSI) and the Getting it Right First Time (GIRFT) programme.	May 2018	May 2020	One day per week- remunerated

Name	Role	Description of Interest	Relevant Dates		Comments
			From	To	
Chairman and Non-Executive Board Members					
Sir Norman Williams	Non-Executive Director, Chair Quality and Safety Committee, Senior independent Director	Consultant: TSALYS Medical Technology start-up company: Advisor to company and minimal shareholder.	2017	Present	Ad Hoc commitment. Remunerated
Sir Norman Williams	Non-Executive Director, Chair Quality and Safety Committee, Senior independent Director	Senior Clinical Advisor, Secretary of State for Health	September 2015	July 2018	Was regular advisor to Rt. Honourable Jeremy Hunt MP I-2 days per week. Remunerated
Sir Norman Williams	Non-Executive Director, Chair Quality and Safety Committee, Senior independent Director	Emeritus Professor, Queen Mary's University	August 2017	Present	Titular- Non remunerated
Sir Norman Williams	Non-Executive Director, Chair Quality and Safety Committee, Senior independent Director	Non-Executive Director Private Healthcare Information Network (PHIN)	2015	Present	Approx. 1 day per month.- remunerated

Name	Role	Description of Interest	Relevant Dates		Comments
			From	To	
Chairman and Non-Executive Board Members					
Sir Norman Williams	Non-Executive Director, Chair Quality and Safety Committee, Senior independent Director	President, Bowel & Cancer Research	2011	Present	Titular- non remunerated
Sir Norman Williams	Non-Executive Director, Chair Quality and Safety Committee, Senior independent Director	Chairman of Panel, Gross Negligence Manslaughter in Healthcare review. Chaired panel and was author of report.	6 February 2018	30 June 2018	Remunerated
Sir Norman Williams	Non-Executive Director, Chair Quality and Safety Committee, Senior independent Director	Chairman, Steering Committee National Institute for Health Research (INHR) Diagnostic Evidence Co-operative, Leeds: Chairs meetings of the committee	March 2018	Present	Non remunerated
Sir Norman Williams	Non-Executive Director, Chair Quality and Safety Committee, Senior independent Director	Trustee Patient Safety Watch	2019	Present	Non remunerated

Name	Role	Description of Interest	Relevant Dates		Comments
			From	To	
Chairman and Non-Executive Board Members					
Sir Norman Williams	Non-Executive Director, Chair Quality and Safety Committee, Senior independent Director	Chairman Royal College of Surgeons of England Honours Committee	2018	Present	Non remunerated
Sarah Wilton	Non-Executive Director and Audit Committee Chair	Non-Executive Director, and Audit and Risk Committee Chair - Capita Managing Agency Limited	2004	Present	
Sarah Wilton	Non-Executive Director and Audit Committee Chair	Non-Executive Director, and Audit and Risk Committee Chair - Hampden Members' Agencies Limited	2008	Present	
Sarah Wilton	Non-Executive Director and Audit Committee Chair	Trustee and Vice Chair - Paul's Cancer Support Centre	1995	Present	
Sarah Wilton	Non-Executive Director and Audit Committee Chair	Magistrate - South West London Magistrates Court and Central London Family Court	2005	Present	
Timothy Wright	Non-Executive Director	Owner/Director, Isotate Consulting Limited	January 2013	Present	IT advisory and consulting services to private and public sector clients (none of whom are in the healthcare sector)
Timothy Wright	Non-Executive Director	Trustee, St George's Hospital Charity	19 January 2018	Present	

Name	Role	Description of Interest	Relevant Dates		Comments
			From	To	
Executive Board Members					
Jacqueline Totterdell	Chief Executive	Partner, NHS Interim Management and Support	2005	Present	
Avinderjit (Avey) Bhatia	Chief Nurse and Director of Infection Prevention and Control	None			
Harbhajan Brar	Director of Human Relations and Organisational Development	Ethics Committee Member, Institute for Arts in Therapy and Education (IATE)	1 May 2018	Present	Ad-hoc role
Andrew Grimshaw	Chief Finance Officer	None			
Dr Richard Jennings	Medical Director from December 2018	None			

Name	Role	Description of Interest	Relevant Dates		Comments
			From	To	
Non-Voting Board Members					
James Friend	Executive Director of Delivery, Efficiency & Transformation	Special Advisor to Secretary of State, Department of Health	2016	2017	Remunerated Requirements of Civil Service code expires on April 2019
James Friend	Executive Director of Delivery, Efficiency & Transformation	Trustee, Carrie's Home Foundation	2018	Present	Non-remunerated
James Friend	Executive Director of Delivery, Efficiency & Transformation	Trustee, Westcott Sports Club	2018	Present	Non-remunerated
James Friend	Executive Director of Delivery, Efficiency & Transformation	Council Liaison Officer, Mole Valley Conservative Association	2017	Present	Non-remunerated
James Friend	Executive Director of Delivery, Efficiency & Transformation	Member Hut Management Committee, Westcott	2012	Present	Non-remunerated
James Friend	Executive Director of Delivery, Efficiency & Transformation	Trustee, Westcott Village Association	2010	Present	Non-remunerated

Name	Role	Description of Interest	Relevant Dates		Comments
			From	To	
Non-Voting Board Members					
James Friend	Executive Director of Delivery, Efficiency & Transformation	District Councillor Westcott, Mole Valley District Council	2008	Present	Member of Audit Committee, Chair of Development Control Committee Remunerated
James Friend	Executive Director of Delivery, Efficiency & Transformation	Church Warden, St John's The Evangelist, Wotton	2004	Present	Non-remunerated
James Friend	Executive Director of Delivery, Efficiency & Transformation	Volunteer, Radioway	1994	Present	Non-remunerated
James Friend	Executive Director of Delivery, Efficiency & Transformation	Associate Member, Association of Corporate Treasurers	1998	Present	Non-remunerated
James Friend	Executive Director of Delivery, Efficiency & Transformation	Member Westcott Cricket Club	1996	Present	Non-remunerated
James Friend	Executive Director of Delivery, Efficiency & Transformation	Member Chartered Institute of Bankers	1996	Present	Non-remunerated

Name	Role	Description of Interest	Relevant Dates		Comments
			From	To	
Non-Voting Board Members					
James Friend	Executive Director of Delivery, Efficiency & Transformation	Member, National Trust	1992	Present	Non-remunerated
Kevin Howell	Director of Estates and Facilities	None			
Stephen Jones	Director of Corporate Affairs	Wife is a senior manager at NHS England	5.3.18	Present	
Suzanne Marsello	Director of Strategy	None			
Ellis Pullinger	Chief Operating Officer	None			

Minutes of the St George's University Hospitals NHS Foundation Trust Board Meeting In Public (Part One)
Thursday 25 April 2019, 10:00 – 13:30
Hyde Park Room, 1st Floor, Lanesborough Wing, St George's Hospital

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

IN ATTENDANCE		
Bernadette Kennedy	Head of Therapies and Community (Staff Story)	BK
Ellis Pullinger	Chief Operating Officer	COO
James Friend	Director of Delivery, Efficiency & Transformation	DDET
Stephen Jones	Director of Corporate Affairs	DCA
Suzanne Marsello	Director of Strategy	DS

APOLOGIES		
Jenny Higham	Non-Executive Director	NED
Harbhajan Brar	Director of HR & OD	DHROD
Kevin Howell	Director of Estates & Facilities	DEF
Sally Herne	NHSI Improvement Director	NHSI-ID

SECRETARIAT		
Michael Weaver	Interim Head of Corporate Governance (Minutes)	IHoCG

Feedback from Board Visits

Members of the Board provided feedback on the departments visited which included Cavell Ward, Marnham Ward, Day Surgery Unit, Max Fax Unit, Richmond Ward, Ambulatory Care and Acute Dependency, Florence Ward, Keate Ward, Heart Failure Unit, Amyand Ward, Rodney Smith Ward, St James Radiology and Fracture Clinic.

The CEO reported Cavell Ward and Marnham Ward were organised, calm and caring wards with young, enthusiastic teams. On Cavell Ward, the Chairman and CEO noted a number of patients were waiting for social services. On Marnham Ward the Chairman and CEO sat in on a respiratory multidisciplinary team (MDT) meeting. The CEO agreed to speak to the neurophysiology unit and look into reported delays in patients receiving cardiac echo scans. The wards were small and cramped on St James' Wing and there was an old tiled floor on Marnham Ward that needed refurbishment. The Chairman and CEO were impressed with the innovative work undertaken by both teams and the calmness of the wards.

Feedback from Board Visits

Ann Beasley and the CN visited the Fracture Clinic and Interventional Radiology in St James' Wing. Areas of improvement in the Fracture Clinic included the Friends and Family Test (FFT) self-check in. The environment was brighter, cleaner, less cluttered and attention had been given to the storage of medical records. In Interventional Radiology, the layout of the waiting area was much improved and more welcoming. Staff spoke of patient outcomes and how they are monitored and plans for creating a Direct Intravenous Access Service (DIVA). Ann Beasley reported the pilot for the virtual fracture clinic had come to an end and was in the process of being evaluated. The COO said he would be happy to brief the Chairman and Non-Executive Directors on future plans for the virtual fracture clinic.

Sir Norman Williams reported on his visit to Ambulatory Care and Acute Dependency Unit (AAU). The main problem facing the unit was patient flow. Another key issue was drainage. Sir Norman understood that action was being taken to improve the situation but noted that it was unacceptable to hear of about such cases. The COO agreed and noted that this was being taken very seriously. The main problem facing Richmond Acute Medical Unit was patient flow although the average bed stay was only 1.4 days. Nursing staff vacancies had improved significantly, but junior doctor staffing and consultant vacancies remained an issue. There had been a number of vacancies in OT however the situation was improving with the support of the university. The DDET agreed to look into cases of workstations on wheels being transported between wards. The Chairman sought assurance the reported sewerage problems were being addressed. The CEO acknowledged the Trust had some significant infrastructure problems. The Trust had received £27m additional capital funding which would be invested into core infrastructure, including sewerage, fire safety, water, electricity and theatre ventilation. The Trust was acting to reduce the number of sewerage blockages caused by the inappropriate disposal of wipes. Action taken by the Trust had reduced the number of reported blockages and the introduction of biodegradable wipes would help to reduce blockages further. The Deputy Director of Estates and Facilities reported on plans for a dedicated planned preventative maintenance programme for clearance in the areas where blockages occurred and plans for a review of the structure and design of the present sewerage system.

The CMO and DCA visited Keate Ward and Florence Nightingale Ward. Keate Ward had a large number of medical and surgical outliers, which resulted in 15 different clinicians undertaking three different ward rounds at the same time which presented a challenge for the nurse in charge. Florence Nightingale Ward had few medical and surgical outliers. The ward had a stable core of 6 nurses who are experienced in airway management who trained other staff. An example of good practice was the use of portable magnetic signs that identified patients with swallowing difficulties, special dietary needs or at risks from falls.

The COO visited Belgrave Ward and the Heart Failure Unit. There was a large amount of senior nurse experience on Belgrave Ward and a well organised team with good retention rates. Staff were currently reviewing how they may utilised space more efficiently. The main challenge for the Heart Failure Unit was ensuring that all patients were able to access the unit. The Chairman commented on a key theme emerging from today's discussion in relation to nursing staff. The turnover of nursing staff was reported to be much lower, the level of recruitment of nursing staff had improved and vacancies were lower.

Stephen Collier and the DDET visited Rodney Smith Ward and Amyand Ward. Three themes emerged from the visit: IT, space and the recruitment market. Rodney Smith was a very busy ward which was tidy, well organised and had enthusiastic staff. Key observations included the very positive use of iClip in the multidisciplinary team board round and very good visual management. There were developing recruitment challenges and these were increasingly challenging. The DDET agreed he would follow up on a data protection issue identified during the visit. Amyand Ward was busy, well organised and well led. The ward was making good use of Health Care Assistants (HCAs) and it was good to see HCAs go onto take the Nurse Associates course.

Feedback from Board Visits
Tim Wright and the DS visited the Maxillofacial and Orthodontic Outpatients unit. The unit was a clean, modern and the check-in kiosk was used. Staff spoke of the work they are undertaking to encourage links with local colleges to develop orthodontic technicians in order to support succession planning. There were some minor but important estates issues. The orthodontic area was split into paediatrics and adults, an open plan area with four bays but there was no screening which compromised privacy. There were potential trip hazards that need to be reviewed. Of particular note was evidence of previous investment that provides the Trust with the means to produce highly accurate prosthetics for use in theatre. Such technology reduces theatre time and helps to streamline theatre procedures.

		Action
1.0	**OPENING ADMINISTRATION**	
1.1	**Welcome, Introductions and apologies** The Chairman welcomed everyone to the meeting. Apologies had been received from Jenny Higham, Harbhajan Brar, and Kevin Howell. Sarah Wilton had indicated she would join the meeting later.	
1.2	**Declarations of Interest** The Board noted the register of Board members' interest. There were no new declarations of interest to note.	
1.3	**Minutes of the meeting held on 25 April 2019** The minutes of the meeting held on 28 March 2019 were agreed as an accurate record.	
1.4	**Action Log and Matters Arising** The Board reviewed the action log and agreed to close those actions proposed for closure. Two actions remained open and were not yet due.	
1.5	**Chief Executive Officer's Update** The CEO explained that, following Board approval in March, the Trust had launched its new clinical strategy 2019-24 on 23 April, St George's day. This was the culmination of a lot of hard work by staff across the Trust. This was the first time in several years that the Trust had in place an agreed strategy and it was significant that this had been developed in partnership with staff at all levels. The CEO expressed her thanks to the DS for her and her team's work in developing the strategy and the communication team for their work on its launch. The CEO noted that the Trust had received £27m additional capital funding from NHS Improvement. This was welcome and would enable the Trust to make a number of necessary improvements to its estate. The bulk of the funding would be invested into core infrastructure, including sewerage, fire safety, water, electricity and theatre ventilation. The CEO explained that the Trust had made changes to visiting hours and relatives could now visit their loved ones any time between 8.00 am and 8.00 pm. Dr Gill Cluckie, Consultant Nurse for Stroke, had been appointed as the new joint London Clinical Director for Stroke and Dr Jeremy Isaacs, Consultant Neurologist, had been appointed as Dementia Clinical	

		Action
	Director for London. The CEO concluded her update noting that the Channel 4 documentary series 24 Hours in A&E, which was filmed at the Trust, had been shortlisted for a BAFTA nomination. This was testament to the many staff and patients who feature, plus the hard work of teams across the Trust who worked behind the scenes to make the series possible. Ann Beasley welcomed the introduction of open visiting hours that would provide a greater opportunity for family members to visit and support their loved ones and considered that this was an important change that would have a real impact. The Chairman asked for future CEO reports to include an update on matters reported on across South West London (SWL). The CEO agreed and noted that the DS would provide a contribution on this for future reports. The Board noted the report.	
2.0	**QUALITY AND PERFORMANCE**	
2.1	**Quality and Safety Committee Report** Sir Norman Williams, Chair of the Committee, provided an update on the meeting held on 18 April 2019. The Committee considered a report on the patient story reported to the Board in February 2019. The story reported on the experience of a patient who had experienced problems with pain control as an outlier on Champneys Ward. The Committee heard about the scope of the review that had been undertaken and was assured by the steps taken since the incident and the responses given, and noted that the use of e-prescribing had improved. The Committee endorsed the Quality Improvement Plan for 2019/20. It noted the infection control performance during 2018/19 during which period there had been 1 case of MRSA and 31 cases of C.difficle, against a threshold of 30 cases. There had been an increase in grade three pressure ulcers and the Committee agreed this would be kept under close scrutiny. The Committee had reviewed the action plan to address CQC 'Must' and 'Should' recommendations and was disappointed that there remained four outstanding actions. These would be reviewed monthly until their completion by September 2019. The Committee reviewed the results from the core services self-assessments against the CQC Fundamentals of Care Standards. Maternity Services had downgraded their own safe domain from a rating of good to requires improvement and Outpatients had revised its well-led and caring rating to requires improvement. The next stage would be to undertake an independent external review which would be triangulated with the internal self-assessments and form an overall view and judgement. The Committee considered the results of its annual effectiveness review and approved the proposed action plan to address the key issues arising from the review. The Chairman thanked Sir Norman Williams for his report and invited comments from the Board. Ann Beasley asked why the Committee agreed to close the CQC Action Plan when there were four actions yet to be completed. The CN explained that the four outstanding actions related to appraisal rates in ED, the safe storage of medical records in outpatient areas, and compliance with level one Mental Capacity Act (MCA) Deprivation of Liberty Safeguards DoLs training. Although the Plan had been closed, the Committee would continue to monitor these outstanding actions on a monthly basis, as would the Trust Executive	

		Action
	Committee. The CN said that the core services self-assessments against the CQC Fundamentals of Care Standards had been a very thorough process that involved many members of staff. The self-assessment had helped to identify areas where additional support was needed. An external review, running in parallel to the core services self-assessment would provide an overall assessment of each service. Reflecting on the Committee's consideration of the report of the Mortality Monitoring Committee, which would be presented to the Board in May 2019, the CMO reflected on how the Trust measures and reports avoidable mortality, and suggested that improved triangulation with the information received from Serious Incident (SI) reports would be beneficial. Feedback from the clinical governance review would help the Trust to identify how the different sources of data could be better triangulated. The COO asked the Board to note the Trust would report a thorough mitigation plan on risks identified in the Cardiac Catheter Laboratories to the Trust Executive Committee on 1 May 2019. The COO and CMO had met with the clinical lead for Cardiology to discuss plans for the replacement of the Cardiac Catheter Laboratories. The Trust shared the concerns of staff members about the length of time it has taken to replace the Labs and it would commit to proceed with a programme for replacement at the earliest possible time. The CFO confirmed there was an active business case process, the Trust has selected the equipment and it has been put out to tender. The material issue had been securing sufficient financial support given the scale of the project and the potential requirement for NHS Improvement approval. The Trust needed to strike a balance between proceeding at pace, remaining compliant with procurement legislation and undertaking the work within a Private Finance Initiative (PFI) building. Sir Norman asked for assurance that the issues with the reliability of equipment did not pose a risk to patient safety. The CMO reported that colleagues in Cardiology had created a Standard Operating Procedure (SOP) that detailed the action to be taken in each clinical scenario should there be any fault or failure with imaging equipment and there were a number of risk mitigations that had been put in place for a number specific clinical scenarios. The Board noted the report.	
2.2	**Integrated Quality and Performance Report (IQPR)** The DDET gave an overview of the report, which reflected a move towards a Statistical Process Control (SPC) control limits approach. The Trust had exceeded the target for Day Case and Elective Surgery and Outpatient first appointments in March 2019. Performance against the Four-Hour Operating Standard in March was 83.1%. The Trust had exceeded the threshold for C.difficile in 2018/19 by one case. The COO asked the Board to note the Trust was reporting a position of 27 against a trajectory of 31 for the number of patients waiting over 52 weeks for surgery. The overall Referral to Treatment (RTT) position for March was 86% at year-end which was 2% above the planned trajectory. The COO asked the Board to note a report on RTT by specialty. The Trust was disappointed to see that 62-day RTT performance had fallen to 77.8% in February 2019 but it was confirmed that the Trust was confident 62-day RTT performance would be back up to 85% for the month of March and the Trust would meet the standard by year end. The Chairman congratulated the COO and the team for the performance	

		Action
	in relation to RTT. Tim Wright asked whether the report to Board could include the most up to date data and information, as the latest position was often relayed orally at Board meetings. The CFO stated the need to strike a balance between the timeliness of the report and the amount of effort required to produce the most complete a report with the most up to date information. The DDET explained that there needed to a fixed set of data that is consistent with the previous period set of data reported to the Board. The Chairman expressed her disappointment with the continuing variability in ED performance and asked the COO to comment on measures being taken to improve in this area. The COO reported that the current variability continued to be a concern and the Trust was working to produce a plan that will detail the action to be taken to improve performance. Sir Norman Williams reminded the Board that ED performance was a major problem across the country, with most EDs not achieving the 95% target. Demand on ED at the Trust last month was 11% higher than the same time the previous year and the frailty of patients attending ED had also increased. The Chairman asked the Board to note that the ED performance was a key constitutional standard. Whilst acknowledging there was volatility there are days when the Trust does not achieve the ED standard even with relatively low numbers and good bed flow and therefore the Board needs to understand what action the Trust was taking to improve. The CN acknowledged that the target of 30 cases of C.difficile had been missed by one case in 2018/19. Despite this, the Trust was one of the best performing units in the country. A Root Cause Analysis (RCA) was undertaken on every case of C.difficile and there had been no recorded lapses in care. In order to understand where further improvements could be made the Trust would review all 62 reported cases of C.difficile over the last two years. Stephen Collier asked about the small increase in agency spend and whether this was just a blip or whether it was more significant. The CFO did not consider the year end position on agency spend to be a step change. There were some pressures and systemic issues that need to be addressed more robustly particularly around the management of annual leave at year end where agency expenditure was often required in order to maintain staffing levels to cover annual leave. Action was being taken in some areas where there were specific pressures. Action was also being taken though Cost Improvement Programme (CIP) to tackle overall agency spend. The Board noted the report.	
2.3	**Cardiac Surgery Update** The CMO presented an update on the steps being taken to improve the cardiac surgery service. He noted that a locum post in cardiac surgery would be converted into a substantive post and would shortly go out to advert. The Trust had appointed two Clinical Nurse Specialists (CNS) to assist with case management of cardiac surgery referrals. A Programme Lead and Administrator had been appointed to oversee the improvement programme. The NHSI-commissioned external mortality review was ongoing and the Trust understood that it was making good progress. The Trust had committed to notifying the relatives of all	

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	deceased patients who had been cared for in the unit. There were some challenges in finding the up to date contact details for some of those families, but progress was being made. The Trust had recently met the coroner to update her on the progress of the mortality review. At the beginning of April 2019, the CMO and DS attended a planning workshop of the South West London Steering Group which looked at opportunities to engage in further networking and collaboration between the provider trusts in South London in a number of key specialist areas. One of the four areas discussed was cardiac services in general and cardiac surgery. There were opportunities in specialist areas to make quality more sustainable if the different provider organisations networked more effectively in South London. The Board noted the report.	
2.4	**Transformation Update** The DDET introduced the report which set out the progress and impact of the transformation work completed at the end of 2018/19. During 2018/19, nearly 600,000 patients had benefitted from the transformation initiatives that reached implementation or live testing. Headline benefits analysis for 2018/19 showed that the £3.4m planned CQUIN and CIP dividends has been delivered. Transformation activity was being integrated into the operational areas for 2019/20 to ensure the risk of silo working would be mitigated. A significant amount of work had been completed on the medical e-roster rollout, which was now live in the ED and other specialties were coming on stream. The DDET expressed his thanks to the DHROD and his operational HR team for their support, working alongside the transformation team to implement a sustainable transformation programme. The Clinical Negligence Scheme incentive arrangements had been rolled forward for 2019/20 and the Maternity team were working to support this programme of work. Transformation on unplanned and admitted patient care was undergoing a full review, refresh and relaunch for 2019/20. The ED front door workstream had closed in March 2019 following the delivery of its planned improvements, as did the ED processes workstream which had delivered multiple efficiency savings. The DDET also set out the work to be undertaken in 2019/20, which included same day emergency care (ambulatory care) and discharge. The CEO asked to know if the rollout of the e-rostering software was for consultants and junior medical staff. The DDET confirmed that the rollout of e-rostering would start with junior medical staff first and then consultant staff. With reference to Appendix One, Key Performance Indicators, Stephen Collier asked to know whether the Trust was comparing like with like when reviewing progress against the baseline set in 2017/18. The DDET said this was the case. He also reported on discussion of downstream ward transfers before noon at the Finance and Investment Committee where it was noted the target was too ambitious. A key tool would be the roll out of the high performing team model to 26 wards within the Trust. The Chairman noted the amount of red reported in Appendix 1, in particular performance reported against metrics 3 and 4. The Admitted Pathway Four Hour Operating Standard was reported as 70.3% in October 2018 and as of March 2019 it was 54.7% against a baseline of 64.3%. The Chairman commented that this underlined the concerns expressed earlier regarding ED performance. The Board noted the report	

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3.0	**FINANCE**	
3.1	**Finance and Investment Committee Report** Ann Beasley, Chair of the Committee, provided an update on the meeting held on 18 April 2019. The Committee had discussed strategic risks within its remit, and had considered a report on water safety as well as undertaking a deep dive on financial risks. The Committee noted the position at year end was as expected in August 2018 which demonstrated a degree of maturity around the Trust's financial planning processes and gave assurance to the Committee. In this context, the Committee was encouraged that exiting financial special measures may be possible later in the year and there had been a good discussion on this. As usual, the Committee had discussed activity and performance. It had also received updates on the Costing Transformation Programme, the Trust's longer-term financial plan, and the Improving Healthcare Together project. The Chair of Southern Healthcare NHS Foundation Trust had shadowed the Committee Chair during the meeting and was impressed with the quality of data reported to the Committee and the trust between Executive and Non-Executive Directors which fostered a supportive but challenging relationship. The Chairman thanked Ann Beasley for her report and invited questions. Sir Norman Williams asked what more the Trust needed to do to exit financial special measures. Ann Beasley replied that what was crucial was not only having a robust financial plan but demonstrating delivery against this over the coming months. The CFO agreed that the Trust needed to deliver what it said it would do and meet its agreed control total. The CEO explained that while the triggers for placing Trusts in special measures were clear, the criteria and process for exiting special measures was far less clear and she had asked NHS Improvement for greater clarity on this. As a percentage of turnover, the Trust was no longer an outlier in terms of its financial performance and, without minimising the challenges which remained, was in a significantly better financial position than a number of Trusts in London and across the country. The CEO stated that if the Trust was on track to meet its agreed control total after quarter one 2019/20 the Board should ask NHSI for clarity on the path for exiting financial special measures. The Chairman agreed the Trust should review its position after quarter one but also suggested that in September 2019 it would have a more informed view of the likely year end position. The CFO agreed the Trust needed to be open and honest about what needed to be achieved but it also needed to know about the conditionality attached to non-recurrent funding as this could have a major impact on the Trust's ability to deliver its plan. The Chairman asked to know why the Committee had not reported the outcome of its annual effectiveness review. Ann Beasley explained the pressure of year end work had prevented the Committee from undertaking this and that it would be reported on at the next meeting. The Board noted the report.	

		Action
3.2	**Month 12 Finance Report** The CFO explained that the Trust was reporting a pre- Provider Sustainability Fund (PSF) deficit of £52m at the end of Month 12 (March), which was £23m adverse to plan. The CFO asked the Board to note one material variation. On 18 April 2019 the Trust received an additional sum of £6.9m in PSF funding from NHS Improvement that meant the Trust's year end position would be a deficit of £45.1m. The Trust had adjusted the reported draft accounts and these had been submitted on 24 April. Stephen Collier asked to know whether the Trust's position in Month 12 was as predicted. The CFO confirmed that this was the case and that the position was in line with the agreed forecast with NHS Improvement. Stephen Collier also asked about the reasons for the year end position on pay expenditure, which was overspent by £4.7m. The CFO explained there were two material reasons: the treatment of pay awards that came into the accounts at Month 12 and the treatment of GP Leo and other trading services. Medical staffing was overspent and actions were being taken to address this. The CEO asked for future finance reports to include the monthly run rate. The CFO explained that the Month 12 finance report was always somewhat cut down, but assured the Board that the monthly run rate figures would be included in the Month 2 finance report. The Board noted the report.	
4.0	**STRATEGY**	
4.1	**Corporate Objectives 2018/19: Q4 Review** The DS provided an update on the quarter 4 and year end position for the 2018/19 Corporate Objectives. The Q4 position represented an improvement from Q3 but was not sufficient to change the overall RAG rating for the year. The DS asked the Board to note the objectives which had not been delivered in Q4 as planned which continued to pose a risk into 2019/20. Sarah Wilton asked to know whether lessons learnt in 2018/19 would be applied in 2019/20 to ensure there was an improvement in delivery. In response, the CEO stated the Trust had taken a different approach in 2019/20 which reflected learning from the previous year. A smaller but more strategic set of objectives had been identified and agreed in order to provide greater focus on the key objectives. In addition to the performance management framework being devised by the CFO, the DS reported on work being undertaken with the Divisions to develop their own sub-set of objectives that would drive their work and ensure it was aligned with the Corporate Objectives. The Board approved the report and the proposed actions to address the outstanding priorities which had not been met in 2018/19.	
5.0	**WORKFORCE**	
5.1	**Workforce and Education Committee Report** Stephen Collier, Chair of the Committee, provided an update on the meeting held on 4 April 2019. The Committee had reviewed the results of the staff survey. There were some positive results, including an increased response rate from 51% to 54% compared with the previous year. However, there were a number of other, less positive results. Bullying and harassment was a concern, and there were generally negative comments not only on this but also around ethnicity, race and	

		Action
	gender, and engagement. Despite significant work to improve the culture of the Trust, the results of the survey suggested little overall movement, and this was reflected in the verbatim comments. There was recognition that addressing the issues raised in the staff survey would take considerable time and effort to successfully address. The DHROD and his team were monitoring the position on pensions and pensions taxation and how that influences and effects retention behaviour within the Trust. The HR team were also undertaking a review of the market for healthcare professionals' as part of the preparatory work for development of the workforce strategy. With regards to Guardian of Safe Working, no fines had been levied in the quarter four 2018/19 and the number of exceptions reports continue to be reduced. The CEO reported she had read all of the 5,000 comments submitted as part of the staff survey. The CEO had invited the triumvirates and representatives from HR and finance to discuss the comments and identify what action the Trust needed to take. Feedback would be used to inform the action plan. Sarah Wilton raised a number of actions that needed to be taken to ensure the Trust was compliant in relation to Freedom to Speak Up. Comments made in the annual staff survey suggested that staff did not have confidence in the arrangements and this was a concern. A recent internal audit report had also identified a number of areas that needed strengthening. Stephen Collier reported that a fundamental review of the raising concerns at work policy was underway which would help ensure the process was robust. The CEO agreed and noted that she had recently published a blog on raising concerns and had asked that the policy be developed with input from staff who had experience of the process. Sir Norman Williams supported the steps being taken to strengthen this. The CEO commented that the Board had committed to focusing on cultural change this year and the Trust would be working hard to ensure that staff felt psychologically safe to raise concerns. She noted that the Board would receive a formal report in May 2019 setting out the proposed action plan to address the issues arising from the survey and a further report on quarter one objectives. The Board noted the report.	
6.0	**GOVERNANCE**	
6.1	**Audit Committee Report** Sarah Wilton, Chair of the Committee, provided an update on the meeting held on 17 April 2019. Internal Audit had completed six reviews since the Committee met in January 2019, five of which had provided reasonable assurance (Board Assurance Framework, Patient Engagement, Car Parking (Tooting), and Data Security and Protection Toolkit). The Committee was pleased to note the reasonable assurance rating on patient engagement and noted plans to undertake a further audit in this area in 12 to 18 months and that patient representatives would be asked to help frame its scope. The Committee, however, was disappointed to learn of the limited assurance rating of the internal audit review into Consultants Job Planning. It heard that the Executive team understood the issues and were taking steps to address them and that oversight was being provided by the Trust Executive Committee. A report relating to a review on Bullying and Harassment was currently in draft awaiting a management response and this would be considered at the next meeting. The Committee looked forward to reviewing this given the importance of this issue and the responses to the recent staff	

		Action
	survey. The Committee approved the internal audit programme for 2019/20, but asked that consideration be given to how to include reviews of learning and embedding good practice. Members of the Committee met the external auditor partner for a confidential and private meeting before the start of the full audit committee. The Committee also agreed a process and timeline for the re-tendering of the Trust's internal audit services from April 2020 and would consider the outcome of the tender at its next meeting. The CMO asked the Board to note the Local Negotiating Committee (LNC) has come to an agreement with the Trust about the latest job planning toolkit that removes one of the barriers that was holding up the process of consultant job planning. The Board noted the report.	
6.2	**Fit and Proper Persons (FPP) Test Annual Report** In the absence of the DHROD, the CEO presented an update on the Trust's compliance with the Fit and Proper Persons Test, set out in Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The Board noted the Trust continued to be fully compliant with the Regulation and that all Executive and non-Executive Directors would be asked to sign FPP declarations forms on an annual basis.	
6.3	**Board Assurance Framework**	
6.3.1	**Quarter 4 Board Assurance Framework Report** The CN presented the Quarter 4 2018/19 review of the BAF, noting that this incorporated the latest assurance ratings and statements from the Board sub-Committees, and asked the Board to note the following changes: • SR16 (Strategy): The assurance rating had been moved from partial to significant assurance, and the risk score lowered from 6 to 3, following the agreement of the new clinical strategy in March 2019. This risk was recommended for closure and a new risk related to the delivery of the new strategy would be described for 2019-20. • SR2 (Pathways): The risk score had been reduced from 15 to 12 on the basis that there was now significant assurance on the quality of data for referral to treatment times and on the steps taken to stabilise the safety and governance of cardiac surgery. However, the Trust's performance in ED remained an area of concern. • SR8 (Culture): The risk score had been reduced from 12 to 10 following discussions at the Workforce and Education Committee. The Board noted the risk scores, assurance ratings and statements for the 14 risks assigned to its assuring Committees. It also noted the risk ratings, agreed the proposed assurance ratings, and approved the proposed assurance statements for the four strategic risks (SR9; SR16; SR14; SR17) that were reserved to the Board.	
6.3.2	**Proposed changes to the Board Assurance Framework 2019/20** The CN introduced a paper setting out changes to the process for the management of strategic risks through Board Assurance Framework in 2019/20. Adopting this process would allow consistency in reporting as well as the detail around individual risks, gaps in control, assurance and actions being taken to address the gaps. It would also ensure that the	

		Action
	assuring Committees would see the detail of the constituent risks that fed into the strategic risk. The revised BAF had been developed to align with the new clinical strategy and the major strategic challenges to the organisation. The Chairman asked members of the Board to comment on the proposed strategic risks. The CMO questioned the wording as set out in SR13 noting that it risked implying that the Board believed there was underlying culture of harassment and bullying, which was not the case despite the real challenges around this as shown in the staff survey. Ann Beasley questioned the wording of SR5 and suggested that it needed to be revised to make clear what would lead to the Trust failing to make progress in delivering the strategy. The CFO asked the Board to note SR7 stated there was a risk that the Trust would not develop plans to achieve unsupported financial balance within "x" years. This was because the Trust was still developing the plan to achieve a position of unsupported financial balance. The CN accepted the challenge on the wording of SR5 and SR6 and suggested that a more precise definition of the risk may emerge when there was discussion of the constituent parts that sat beneath each strategic risk. Tim Wright asked where the information governance risks would be reported. The Chairman suggested this was not a strategic risk. The Board agreed there should be further discussion as to the wording for the description of SR5 and SR6 and a revised form of words should be circulated to members of the Board for their approval. The DS asked the Board to note that in the previous version of the BAF the strategy items were placed under 'Build a better St George's' but in the revised version was placed elsewhere. The CN explained that she felt this was appropriate as the clinical strategy was about treating patients in the right place at the right time. The Chairman sought views from members of the Board and in their absence suggested that her slight preference was to agree with the CN. The CN set out the rationale for the proposed changes in how the Board received assurance on the management of strategic risks from its Committees. Ann Beasley supported the proposed approach. The Trust needed to improve the speed with which emerging risks were reported and a consistent way of rating risks was essential across the Committees. Sarah Wilton asked to know how the Audit Committee would discharge its responsibility to ensure the Trust's risk assurance process was working as it should at both Trust and divisional level. The CN agreed that the proposed process should set out how the Audit Committee would receive assurance on this. The Board noted and approved the 2019/20 risks and agreed the CN would revise the risk description for SR5 and SR6 and circulate a revised form of words to members of the Board for their approval. It also approved the proposal for the future management of strategic risks through the assuring Committees, and noted that this that would include detail of how the Audit Committee will receive assurance the Trusts risk assurance process is working as it should.	**CN** **TB25.04.19/01** **CN** **TB25.04.19/02**

		Action
6.4	**Board Forward Work Plan 2019/20** The DCA introduced the Board Forward Work Plan 2019/20 which set out a proposed cycle of business for the Board over the coming year. The plan had been developed with the input of Executives and was aligned to the work of the Board sub-Committees. It ensured the Board had a systematic framework for addressing all statutory and mandatory requirements as well as principles around good governance. The Board approved the proposed cycle of business for the Board's meetings in public.	
7.0	**CLOSING ADMINISTRATION**	
7.1	**Questions from the public** The Chairman invited questions from the public. Having heard the update on cardiac surgery earlier in the meeting, a member of the public commented that the sincerity, transparency and compassion with which the Board had addressed the issues around cardiac surgery had left him with a sense of assurance. He asked whether the Board considered the service to be safe. The CMO advised that cardiac surgery was safe, and the Trust had been taking a number of steps to further strengthen the service, including putting in place new leadership for the service and more robust governance. During this period, complex and high risk patients continued to be treated as neighbouring Trusts. The same member of the public went on to ask questions about the potential impact on the medical school in the event the Trust became insolvent. The CFO explained that the medical school was an entirely separate legal entity and was unaffected by the Trust's position in financial special measures and was not subject to regulatory oversight by NHS Improvement. Although the Trust had faced significant financial challenges, it was classified as a going concern and continued to meet its financial obligations and this had been independently verified by the external auditors. While the Trust was in financial special measures, it had received support from the Department of Health and Social care. The chances of it failing to continue to be a going concern were negligible. The Trust's financial performance had improved significantly and while there remained challenges, the Trust was performing significantly better than a large number of Trusts across the country. A public Governor asked about the position of the Trust's transformation programme given that a new clinical strategy had now been agreed. The DDET advised that the need for transformation remained, despite the launch of the strategy. A number of transformation projects had been delivered and had been moved back to the operational teams as business as usual activity. However, there were significant opportunities to improve the way in which services were delivered across the Trust and the transformation team continued to have a key role to play. This was particularly important given operational teams did not always have the capacity to undertake transformational work alone alongside the delivery of day-to-day activity.	
7.2	**Any other risks or issues identified** The Board agreed that the refurbishment of cardiology catheter laboratories risk rating would be increased on the risk register.	

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7.3	**Any Other Business** There were no matters of any other business raised for discussion.	
7.4	**Reflections on the meeting** The Chairman invited the DS to offer reflections on the meeting. She commented that a theme running across the agenda was patient safety and patient experience and discussion of this had been present on all items. There had been helpful and appropriate challenge during the discussions on ED performance. In terms of participation, it was notable that most of the comments and challenge had come from the Non-Executive Directors, until the discussion on the Board Assurance Framework where there had been significantly more input from Executives. This may reflect the fact that Executives had already had the opportunity to comment on most items, with the exception of the BAF, as these had been reviewed previously at the Trust Executive Committee. The discussions also demonstrated that the Board had started to discuss culture and the changes needed, and some areas had been highlighted for future consideration by the Board. Tim Wright reflected that at Board there was a necessary focus on the hard metrics around performance, finance and quality, but given the Trust's vision of providing outstanding care every time it was it is important that there remained an explicit focus on care as part of those discussions. The Chairman agreed, noting that this was at the heart of everything the Board considers.	
8.0 PATIENT STORY The patient story was deferred to the Public Board meeting in May 2019 due to technical difficulties with the video.		
Meeting closed at 13.30 hours **Date of next meeting: Thursday 30 June 2019 at Queen Mary Hospital**		

Trust Board Action Log Part 1 - May 2019

Action Ref	Section	Action	Due	Lead	Commentary	Status
TB28.02.19/9	**Reflections on the meeting**	The Chairman asked the CN to bring one of the leadership programme presentations to Board.	30.05.2019	**CN**	Verbal Update to be provided at the meeting	**OPEN**
TB28.02.19/10	**Reflections on the meeting**	The Board should give consideration to including Board Committee minutes in the Board pack	30.05.2019	**DCA**	Verbal Update to be provided at the meeting	**OPEN**
TB25.04.19/01	**Proposed changes to the Board Assurance Framework 2019/20**	The CN agreed that the proposed process would set out how the Audit Committee would receive assurance how the Committee would discharge its responsibility to ensure the Trust's risk assurance process was working as it should at both Trust and divisional level	27.06.2019	CN		**NOT YET DUE**
TB25.04.19/02	**Proposed changes to the Board Assurance Framework 2019/20**	The CN would revise the risk description for SR5 and SR6 and circulate a revised form of words to members of the Board for their approval	27.06.2020	CN		**NOT YET DUE**

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	24 May 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 report – Trust Board, Thursday 30 May

Developments in our external environment

Over the past few weeks, we have continued to engage with our local and national partners; and this will become increasingly important as we look towards closer collaboration, in line with our new strategy.

The Trust Board held its second meeting with Wandsworth and Merton Clinical Commissioning Groups on 21 May. The focus of the meeting was on how we can work more closely together to deliver better healthcare for the populations we serve – including local implementation of the priorities set out in the NHS 10 Year Plan.

Clearly, providers and commissioners in south west London face different challenges and issues. But, ultimately, we all share the same aim, which is to improve care for patients and local communities, and the discussions we had last week around some common areas – e.g. early diagnosis of cancer, transformation of out-patient services, and services for older people – were very positive.

Our work as part of the Acute Provider Collaborative is trying to turn aims of joint working into real, tangible benefits for the four providers involved – namely St George's, and our colleagues at Epsom and St Helier, Croydon and Kingston.

We are starting to see real progress in some areas – including reducing variation in use of drugs, and establishing a common approach to staff recruitment. Of course, the principles of the ACP mean changing ways of working, which can be challenging – so engagement, particularly from clinicians and senior decision makers, is crucial.

Members of the executive team continue to take an active role in the South West London Health and Care Partnership (SWLHCP). Indeed, both Dr Richard Jennings, Chief Medical Officer, and myself attended a conference last month organised by SWLHCP; which provided us with an excellent opportunity to engage with local stakeholders, both in and outside the health sector.

In terms of key updates, the SWLHCP will shortly be sharing the Merton and Wandsworth Local Health and Care Plans with the public; and we will be encouraging our staff here at St George's to share their views as well.

Delivering on our vision and strategy

As you know, we launched our new five year strategy last month – which sets us the ambition of providing outstanding care, every time for our patients, staff and the communities we serve.

We are working closely with key services – including priority areas such as cancer, neurosciences and paediatrics – to make our ambitions a reality; and the level of engagement has been very good, which bodes well for the future.

We are already seeing delivery on the ground. For example, one of our stated ambitions in our new strategy is to develop tomorrow's treatments, today, through innovation, research and training. With this in mind, it was great to hear last week that we recruited over 13,000 patients to clinical trials at the Trust during 2018/19 – more than double the number of patients during both of the previous two years.

Of course, one of our four strategic priorities is also to deliver strong foundations – and this includes making sure patients receive the care they need, in a timely fashion. Our performance in this area is more of a mixed picture.

On a positive note, the number of patients waiting more than a year for treatment has reduced significantly in recent months – down to 27 by the end of March. This is of course still too many, but evidence that progress is being made. Elsewhere, emergency care performance during April was 85.4% against a trajectory of 90% - so there is clearly still work to do.

We continue to take positive steps to manage the challenges with our hospital estate at St George's. However, we know there are risks to manage – including the potential for legionella – and this is why water outlets and pipework are regularly disinfected, and special filters are attached to taps in a number of areas. This year, we will be investing £3.5 million into water safety, which will enable us – among other things - to create additional water supplies to the site.

Celebrating our staff

We were delighted to celebrate the second annual St George's Hero awards on 16 May, which was once again supported by the St George's Hospital Charity. Nearly 300 people - mostly staff – attended the event, where 8 different awards were given out; including for Inspirational Leader; Team of the Year; plus the Lifetime Achievement awards.

The event was hosted by TV personality Lorraine Kelly, and attended by a number of our friends and supporters; including local MPs and Mayors, plus fundraisers and donors. It was a fantastic evening, and it is quickly becoming an annual event that everyone at the Trust looks forward to. Long may it continue, and I am grateful once again to the charity (and sponsors on the night) for their support.

Elsewhere, the documentary series 24 Hours in A&E, filmed at St George's since 2014, was unlucky not to scoop a BAFTA for best factual documentary, but to even be short-listed was a fantastic achievement; particularly as our main reason for taking part is to educate and inform the public about the workings of a modern emergency department.

The Trust has also been short-listed for a Nursing Times award for its work on recruiting band five nurses, which is a group of staff with a historically high turnover at the Trust. Our recruitment and communications teams have organised a number of recruitment days, and used social media and other innovative methods to encourage attendance – with as many as 147 nurses appointed on a single day. We saw a massive reduction in agency spending last year – down to £17.2 million from £43 million in 2017/18 – and a range of initiatives such as this are helping us keep agency spending low.

Administration/key appointments

There have been two significant appointments at a senior level within the organisation in recent weeks.

Steve Livesey, cardiac surgeon, joined us in early December last year to provide leadership for our cardiac surgery service. He initially joined us on secondment for a year (from Southampton), but I am pleased to say that, last month, he was appointed to the role on a permanent basis.

Since arriving, Steve has introduced major improvements within the service for the benefit of patients and staff - this includes embedding significant governance improvements within the service, and planning the forthcoming introduction of a new cardiac surgery case management team.

Elsewhere, Andrew Grimshaw, our Chief Financial Officer, was appointed to the role of Deputy Chief Executive in May. As Deputy Chief Executive, Andrew has taken on additional responsibility in addition to his Chief Financial Officer role - including having overall responsibility for estates and facilities, with Kevin Howell, our Director of Estates and Facilities, now reporting directly into Andrew.

As stated above, the Trust is making a significant multi-pound investment into our hospital estate this year, and the change in executive portfolios will enable us to make sure we fully maximise the opportunities provided by this investment.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	30 May 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, Mable Wu, Kaye Glover		
Presented for:	Information and assurance about Quality and Performance for Month 1		
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 elective length of stay, continued positive recommendation rate through Friends and Family survey from our inpatients, and sustained improvement in the number of on the day cancellations. However existing challenges continue in particular Four Hour Operating Standard and patient flow. The Trust has achieved six of the seven Cancer standards returning to compliance against the 62 day standard. The Trust did not achieve the six week diagnostic standard in April.		
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:	Safe Caring Responsive Effective Well Led		
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**	23/05/19
Equality Impact Assessment:			
Appendices:			

Integrated Quality & Performance Report for Trust Board

Meeting Date – 30 May 2019
Reporting period – April 2019

St George's University Hospitals NHS
NHS Foundation Trust

HOW ARE WE DOING?

April 2019

Daycase and Elective Surgery operations

Actual
4,481

Target 4,893

Discharges before 11am

Actual 17%

Target 30%

Four Hour Emergency Standard

Actual
85%

Target 95%

Whole Trust Inpatient Friends and Family Test

Actual
97%

Target 95%

Outpatient First Appointment

Actual 15,746

Target 16,570

March 2019

Referral to Treatment Standard – Incomplete pathways

Actual
86%

Target
92%

Balanced Scorecard Approach

St George's University Hospitals NHS Foundation Trust

Executive Summary – April 2019

St George's University Hospitals NHS Foundation Trust

Our Outcomes

- The Emergency Department saw nearly a 3% increase in the total number of patients attending the Emergency Department compared to the same month last year, treating an additional 14 patients per day, with the increases coming in patients self-presenting to the department.
- A step change seen in the number of stranded patients, with a decrease in both stranded and super stranded patients in April.
- Performance against the Four Hour Operating Standard increased in April reporting 85.4%, which was below the monthly improvement trajectory of 90%.

Our Finance and Productivity Perspective

- Elective and Daycase activity is currently showing below plan year to date however there will be a level of post month data catch up.
- The number of Elective procedures per working day has seen a positive increase compared to the same period last year, treating on average 15 more patients per working day.

Our Patient Perspective

- The C Diff reporting 2019-2020 will change to apportioning healthcare onset versus community onset is 48 hours rather than 72 hours. The trust target is no more than 48 incidents.
- A total of four MSSA bacteraemia incidents reported in April, compared to two last year. The trust internal threshold for 2019/20 is 25 cases.

Our Process Perspective

- Performance against the Four Hour Operating Standard in April was 85.4%, which was below the monthly improvement trajectory of 90%.
- The Trust achieved six of the seven Cancer standards in the March.
- In April, Trust performance fell below the national standard for the six week diagnostic waits with a total of 115 patients waiting greater than six weeks and a performance of 98.4% against a target of 99.0%
- In April 93.3% of patients with on the day cancellations were re-booked within 28 days and the number of cancellations have reduced by 30% compared to the same period last year.
- Performance against Incomplete Pathway Completeness currently stands at 86.1% which is above our locally agreed trajectory of 84%.

Our People Perspective

- The Trust Vacancy rate continues be within the expected process limits and shows little variation around a mean of 9.3% and a standard deviation of 0.2%.
- The Trust sickness level has remained above target of 3%, however a decrease is seen for a third consecutive month reporting 3.1% in April with two consecutive months below the lower process limit.
- Mandatory and Statutory Training figures for April were recorded at 89.8% with a mean of 89.3% and a tighter standard deviation of 0.3% for the past five months.
- For April, the monthly target set was £1.25m. The total agency cost is worse than the target by £0.31m.

Balance Scorecard

St George's University Hospitals NHS Foundation Trust

OUR **OUTCOMES**	How are we doing?				
OUR **FINANCE** & **PRODUCTIVITY** PERSPECTIVE	Activity Summary	Bed productivity (length of stay)	G Outpatient productivity (attendances per day)	Theatre productivity (cases per session)	
OUR **PATIENT** PERSPECTIVE	Patient safety	Infection Control R	Mortality	Readmissions	Maternity G	Patient Voice
OUR **PROCESS** PERSPECTIVE	Emergency Flow	Cancer A	Diagnostics G	On the day cancellations	18 Week Referral to Treatment
OUR **PEOPLE** PERSPECTIVE	Workforce	Agency use			

Our Finance and Productivity Perspective

The table below compares activity to previous months, year to date and against plan

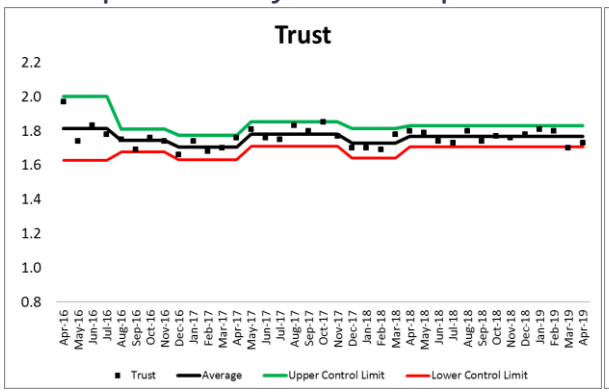
		Activity compared to previous year			Activity against plan for month		Activity compared to previous year			Activity against plan YTD	
		Apr-18	Apr-19	Variance	Plan Apr-19	Variance	YTD 18/19	YTD 19/20	Variance	Plan YTD	Variance
ED	ED Attendances	13,511	13,851	2.52%	13,912	-0.44%	13,511	13,851	2.52%	13,912	-0.44%
Inpatient	Elective & Daycase	4,357	4,481	2.85%	4,892	-8.40%	4,357	4,481	2.85%	4,892	-8.40%
	Non Elective	3,812	4,171	9.42%	3,896	7.06%	3,812	4,171	9.42%	3,896	7.06%
Outpatient	OP Attendances	51,233	52,807	3.07%	54,756	-3.56%	51,233	52,807	3.07%	54,756	-3.56%

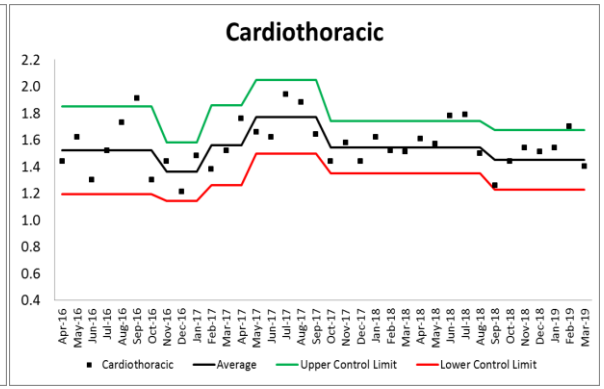
>= 2.5% and 5% (+ or -)
>= 5% (+ or -)

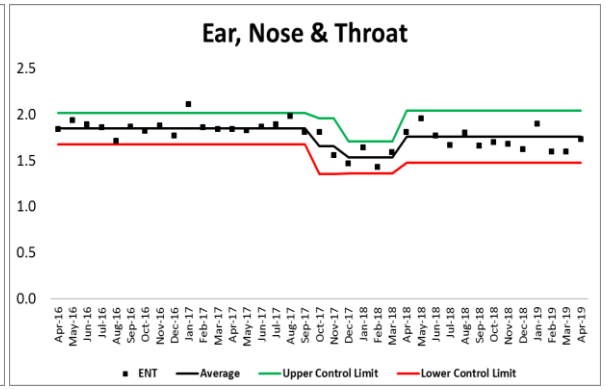
Source: SLAM

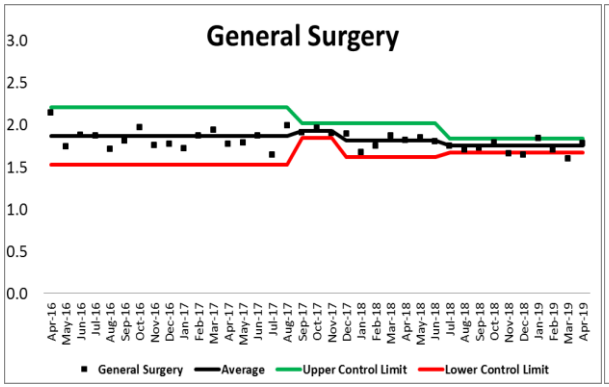
Our Finance and Productivity Perspective

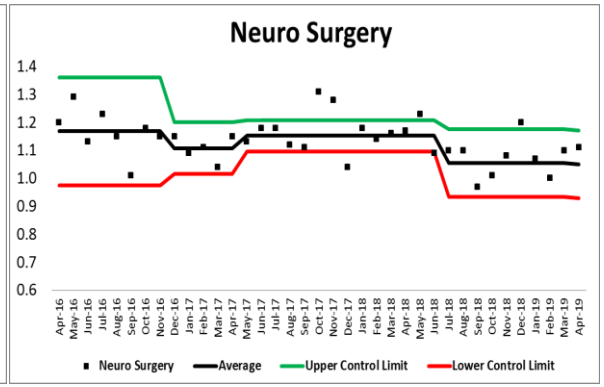
Theatre productivity – cases per session

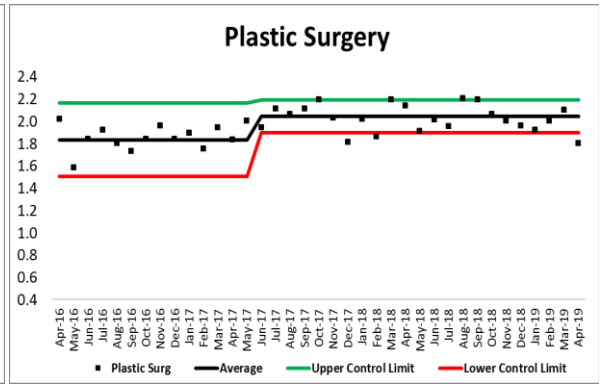


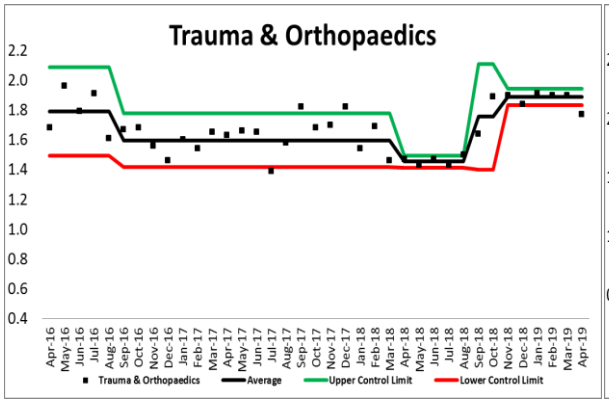


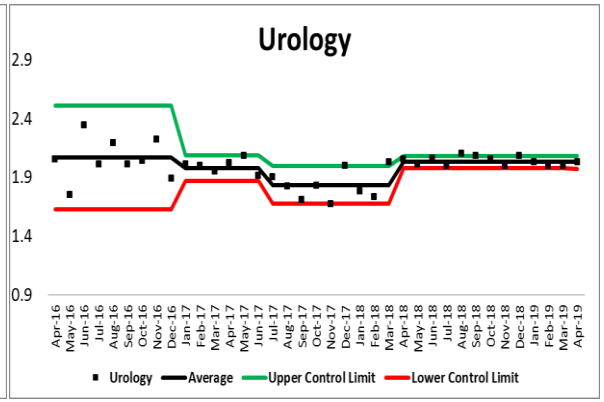


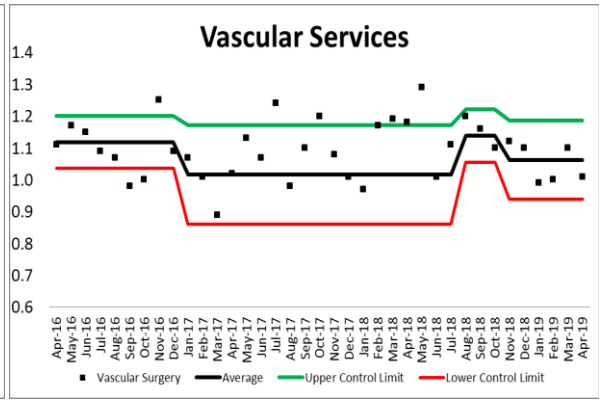












Our Finance and Productivity Perspective

Theatre – Touch time utilisation

Theatre Utilisation

Main List Specialty	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	Number of Patients in the last month
Cardiothoracic	79%	81%	75%	74%	69%	70%	70%	73%	72%	72%	80%	74%	70%	66
ENT	75%	81%	77%	80%	84%	76%	77%	82%	78%	80%	76%	74%	75%	147
General Surgery	79%	78%	80%	82%	79%	82%	80%	82%	84%	78%	78%	82%	81%	190
Gynaecology	77%	77%	77%	83%	81%	77%	83%	87%	81%	79%	88%	74%	81%	139
Neurosurgery	76%	87%	80%	74%	84%	78%	76%	81%	80%	82%	78%	75%	79%	168
Oral and Maxillo Facial Surgery	58%	71%	73%	89%	75%	82%	63%	84%	78%	84%	67%	91%	61%	17
Paediatric Dentistry	62%	53%	50%	53%	58%	55%	56%	60%	62%	65%	68%	65%	58%	32
Paediatric Surgery	78%	82%	80%	81%	78%	75%	74%	72%	75%	76%	82%	74%	77%	85
Plastic Surgery	73%	74%	73%	77%	75%	75%	77%	74%	78%	74%	75%	69%	76%	154
Renal Medicine & Surgery	67%	76%	71%	72%	78%	61%	67%	82%	60%	66%	67%	83%	66%	20
Trauma & Orthopaedics	87%	76%	85%	84%	79%	82%	90%	85%	90%	81%	83%	90%	83%	122
Urology	77%	84%	78%	88%	84%	84%	85%	86%	81%	86%	82%	80%	79%	203
Vascular Surgery	77%	77%	76%	72%	68%	74%	76%	70%	74%	76%	82%	75%	68%	43
Grand Total	**77%**	**80%**	**78%**	**79%**	**79%**	**78%**	**79%**	**80%**	**80%**	**79%**	**79%**	**77%**	**77%**	**1,386**

Theatre Average Cases per Session

Main List Specialty	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
Cardiothoracic	1.6	1.6	1.8	1.8	1.5	1.3	1.4	1.5	1.5	1.5	1.7	1.4	1.48
ENT	1.8	1.9	1.8	1.7	1.8	1.7	1.7	1.7	1.6	1.9	1.6	1.6	1.73
General Surgery	1.9	1.9	1.8	1.8	1.7	1.7	1.8	1.7	1.6	1.8	1.7	1.6	1.78
Gynaecology	2.4	2.3	2.3	2.7	2.6	2.5	2.6	2.5	2.9	2.7	2.6	2.3	2.54
Neurosurgery	1.2	1.2	1.1	1.1	1.1	1.0	1.0	1.1	1.2	1.1	1.0	1.1	1.11
Oral and Maxillo Facial Surgery	3.0	3.6	3.0	4.0	3.7	3.9	3.1	3.8	3.8	3.7	3.1	4.0	2.67
Paediatric Dentistry	4.3	3.7	4.2	4.0	3.8	4.1	3.9	4.5	4.7	4.4	4.3	4.1	3.91
Paediatric Surgery	2.4	2.6	2.4	2.6	2.6	2.7	2.6	2.7	2.7	2.6	2.5	2.6	2.42
Plastic Surgery	2.2	2.0	2.0	2.0	2.2	2.2	2.1	2.0	2.0	1.9	2.0	2.1	1.80
Renal Medicine & Surgery	1.8	1.5	1.7	1.4	1.4	1.3	1.6	1.5	1.4	1.2	1.8	1.5	1.89
Trauma & Orthopaedics	1.6	1.4	1.6	1.6	1.5	1.6	1.9	1.9	1.8	1.9	1.9	1.9	1.77
Urology	2.1	2.1	2.1	2.0	2.1	2.1	2.1	2.0	2.1	2.0	2.0	2.0	2.03
Vascular Surgery	1.2	1.3	1.0	1.1	1.2	1.2	1.1	1.1	1.1	1.0	1.0	1.1	1.01
Grand Total	1.8	1.8	1.8	1.8	1.8	1.7	1.8	1.8	1.8	1.8	1.8	1.7	1.73

What the information tells us

- For T&O and Plastics the number of cases per session fell below the lower process limits, however the total number of patients treated per day have remained the same, resulting in more sessions and less productivity.
- The Trust's overall average cases per session shows little variation around a mean of 1.77 cases per session - this is shown by how close the upper and lower process limits are on the SPC chart
- Touch time utilisation and the number of patients operated on in each theatre session have remained steady over the past 12 months with little improvement seen

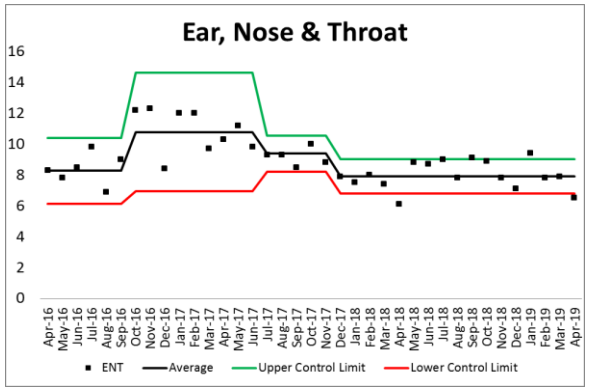
Actions and Quality Improvement Projects

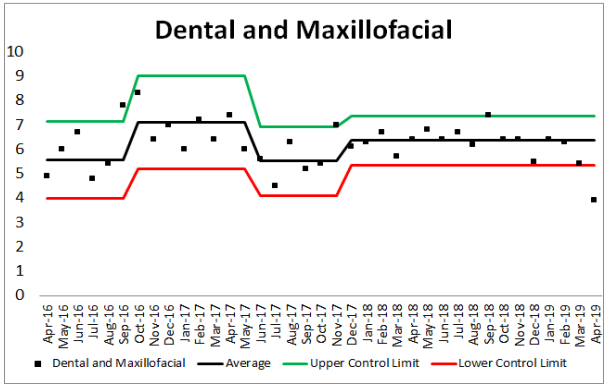
- Clinicians continue to reviewing their lists to verify patient order and appropriate case mix, this is linked to theatre team review identifying theatre equipment requirements, skill mix and specialist equipment to be ordered as required. A newly developed tool will be introduced to look at the list planning process.
- Actions from 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.
- 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%.
- Pathway Coordinators continue to review bookings targets and on the days issues in their Daily Huddles

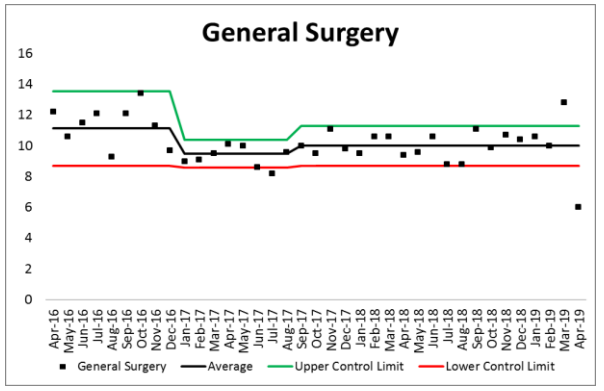
Our Finance and Productivity Perspective

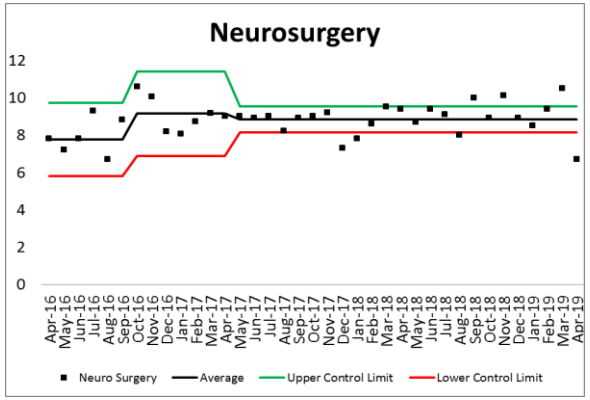
St George's University Hospitals NHS Foundation Trust

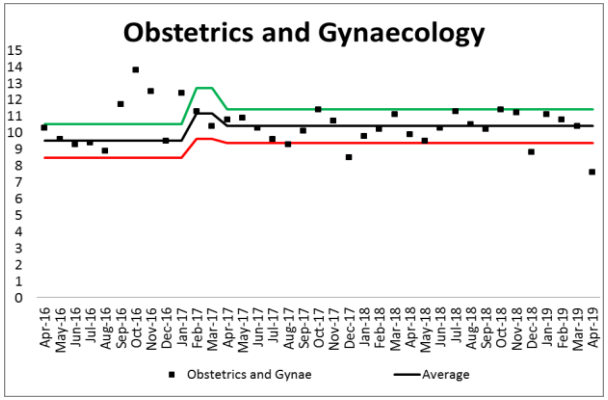
Number of Elective and Daycase Patients treated per Working Day

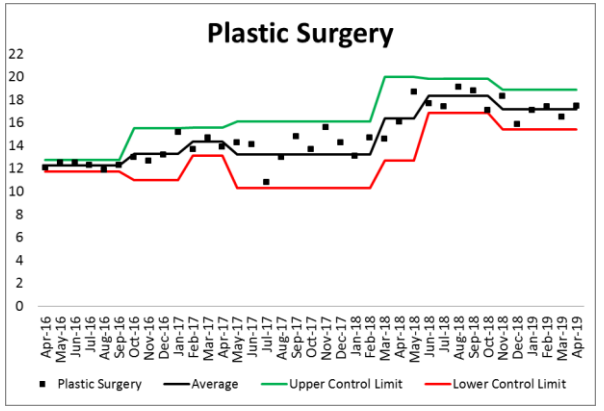


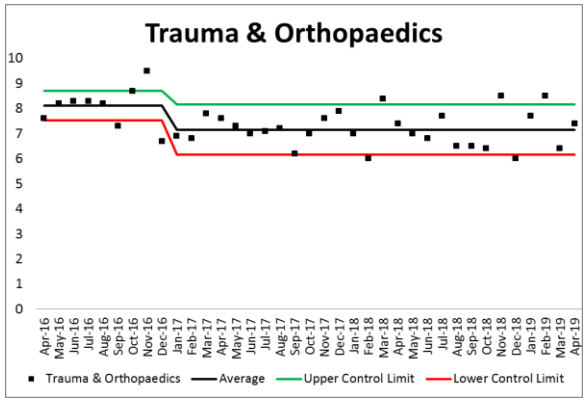


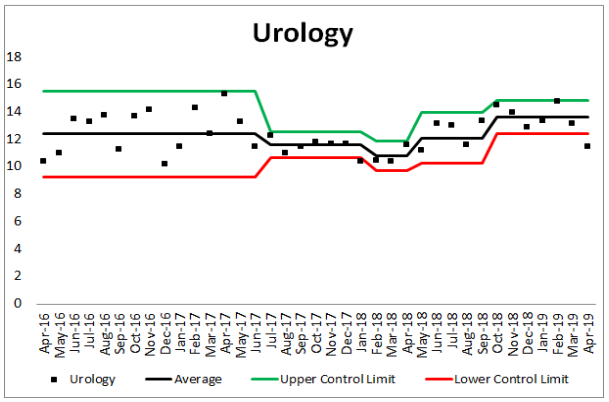


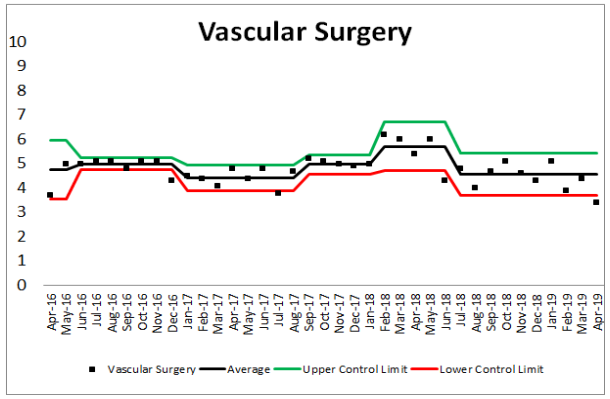












Our Finance and Productivity Perspective

St George's University Hospitals NHS Foundation Trust

Number of Elective and Daycase Patients treated per Working Day

Months	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	2018-19 YTD	2019-20 YTD	Variance	Discharges for month
Cardiology & Cardiac Surgery	14.8	16.3	17.0	15.5	15.4	15.7	14.0	16.8	13.8	14.7	17.2	16.2	9.2	14.8	9.2	-37.8%	240
Clinical Haematology	1.8	2.1	2.2	1.7	1.4	2.2	1.7	1.5	1.8	1.0	1.3	1.4	0.6	1.8	0.6	-65.7%	15
Diabetes & Endocrinology	2.0	2.3	1.5	1.7	1.9	2.0	2.0	1.8	1.2	2.0	1.6	1.8	1.3	2.0	1.3	-35.0%	33
Endoscopt & Gen Med	55.0	60.9	61.0	55.6	55.7	56.3	54.6	59.2	49.7	57.3	56.4	61.6	42.4	55.0	42.4	-22.8%	1,103
Ear, Nose & Throat	6.1	8.8	8.7	9.0	7.8	9.1	8.9	7.8	7.1	9.5	7.9	7.9	6.5	6.1	6.5	6.6%	168
General Surgery	9.4	9.6	10.6	8.8	8.8	11.1	9.9	10.7	10.4	10.7	10.5	12.8	6.0	9.4	6.0	-36.2%	155
Gynaecology and Obstetrics	9.9	9.5	10.3	11.3	10.5	10.2	11.4	11.2	8.8	11.0	10.8	10.4	7.6	9.9	7.6	-22.8%	197
Max Fax & Dental	6.4	6.8	6.4	6.7	6.2	7.4	6.4	6.4	5.5	6.7	7.2	5.4	3.9	6.4	3.9	-39.1%	101
Neurosurgery	9.4	8.7	9.4	9.1	8.0	10.0	8.9	10.1	8.9	8.2	9.3	10.5	6.7	9.4	6.7	-28.3%	173
Neurology	25.2	24.2	27.9	25.9	24.0	25.6	30.0	28.8	24.2	28.7	34.3	31.0	25.4	25.2	25.4	1.0%	661
Oncology	1.7	1.9	1.8	1.8	1.7	1.6	1.8	1.2	1.5	2.8	2.7	1.8	3.0	1.7	3.0	81.8%	77
Paediatric Medicine	10.1	10.1	8.5	10.0	9.5	9.6	12.0	10.3	10.9	10.5	12.5	11.9	9.6	10.1	9.6	-4.5%	249
Paediatric Surgery	8.5	8.0	8.5	8.3	8.6	9.9	9.2	10.7	8.4	9.6	10.0	10.0	6.7	8.5	6.7	-20.7%	173
Pain Clinic	5.7	6.0	5.5	4.5	4.4	5.3	5.3	6.2	5.2	5.1	5.3	5.3	3.5	5.7	3.5	-38.1%	90
Plastic Surgery	16.1	18.7	17.7	17.4	19.1	18.8	17.1	18.3	15.9	17.1	17.4	16.5	10.5	16.1	10.5	-34.8%	274
Renal Medicine	5.3	5.4	5.7	4.5	5.3	5.4	4.7	3.8	4.4	3.2	5.2	3.7	3.3	5.3	3.3	-37.7%	86
Trauma & Orthopaedics	7.4	7.0	6.8	7.7	6.5	6.5	6.4	8.5	6.0	7.7	8.5	6.4	5.3	7.4	5.3	-28.4%	137
Urology	11.6	11.2	13.2	13.0	11.6	13.4	14.5	14.0	12.9	13.4	14.8	13.2	11.5	11.6	11.5	-0.9%	300
Thoracic Surgery	2.6	3.0	3.3	3.5	2.5	2.4	2.5	2.9	2.7	2.3	3.2	3.1	1.7	2.6	1.7	-33.3%	44
Vascular Surgery	5.4	6.0	4.3	4.8	4.4	4.7	5.1	4.6	4.3	5.1	3.9	4.4	3.4	5.4	3.4	-37.0%	89
Other	4.0	6.5	6.2	6.4	6.4	4.8	5.3	5.6	5.5	6.5	6.6	4.2	4.5	4.0	4.5	13.9%	116
Grand Total	217.9	233.0	236.4	227.3	219.8	231.5	231.9	240.6	209.4	233.1	246.3	239.4	172.4	217.9	172.4	-20.9%	4,481

Daycase as a percentage of all Elective Activity	73.1%	75.1%	74.4%	80.1%	77.2%	75.3%	76.6%	77.0%	75.0%	77.7%	77.1%	74.8%	75.4%

What the information tells us

- April 2019 data appears below the lower process limit however this is likely due to a lag in coding
- General Surgery last two months are outside of process limits which will be monitored as April coding catches up
- Looking at previous months, all other specialties are within their process limits with no special cause variation of concern

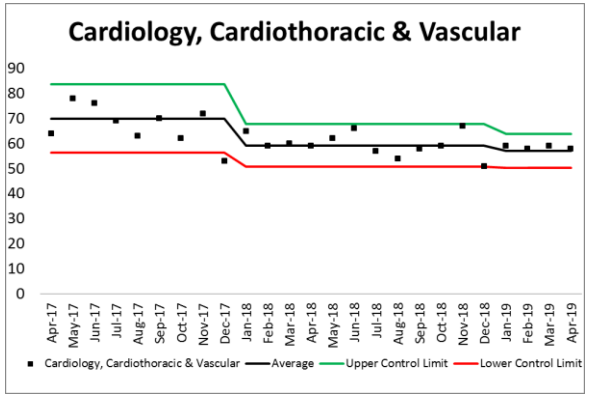
Actions and Quality Improvement Projects

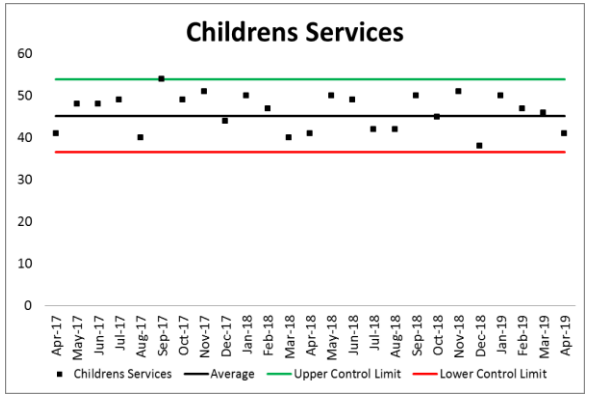
- Theatres are ensuring that there is focused work supporting a prompt start to all theatre sessions. This is linked to a weekly task and finish group,
- Agreement and plan to change Theatreman Diagnosis codes (currently SNOMED) to OPCS 4.8 codes which will support more accurate timings of theatre cases 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.

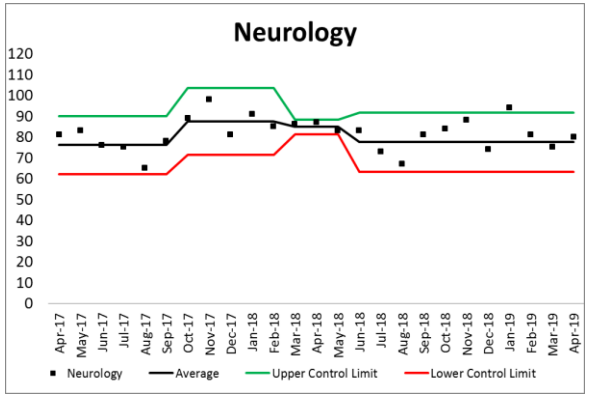
Our Finance and Productivity Perspective

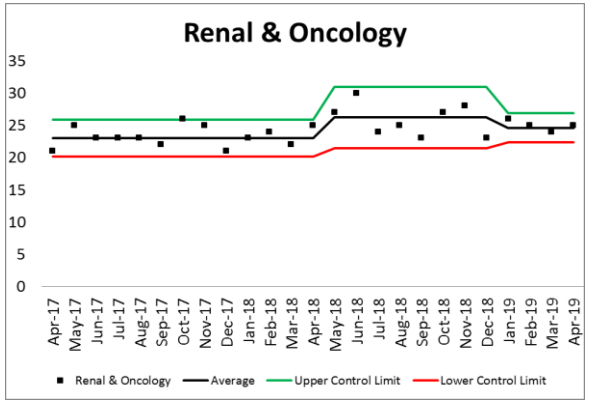
St George's University Hospitals NHS Foundation Trust

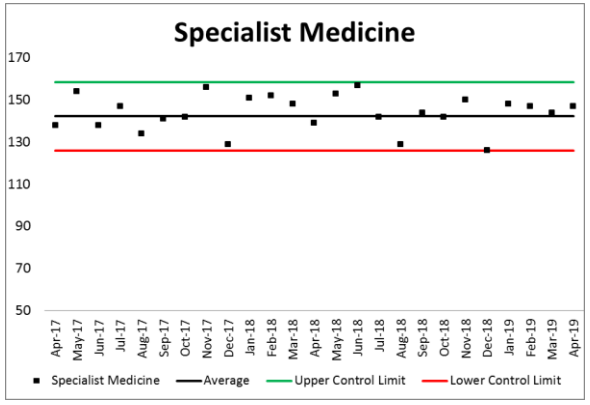
Number of First Outpatient attendances per Working Day

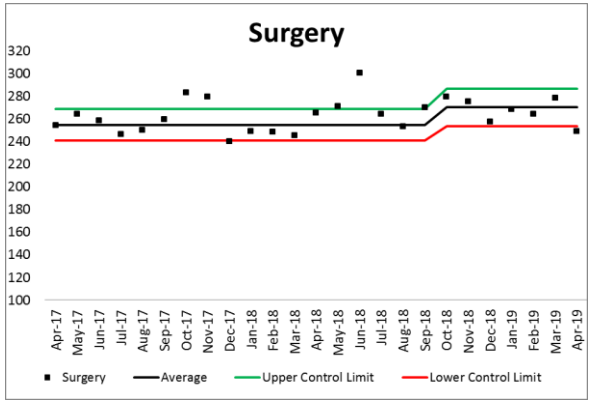


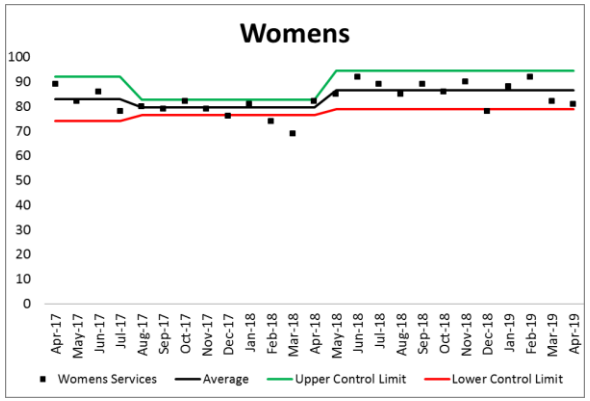


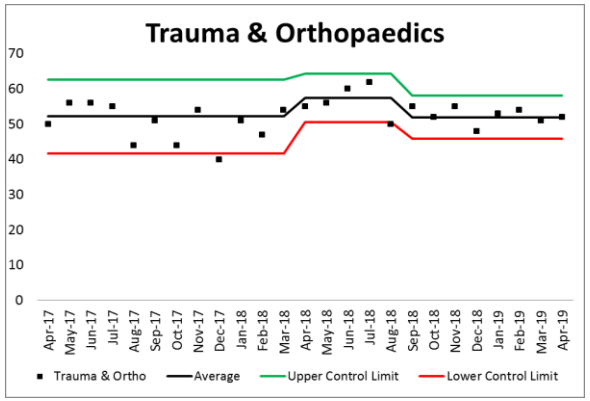


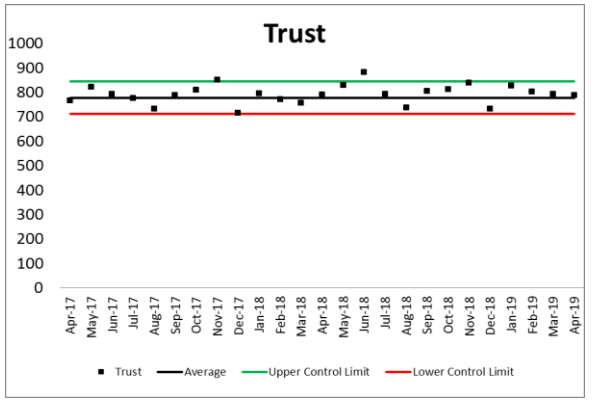








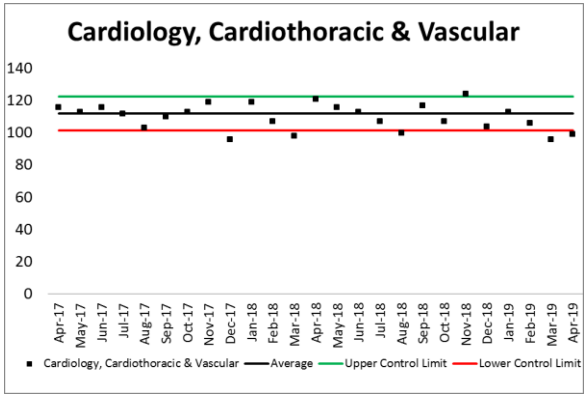


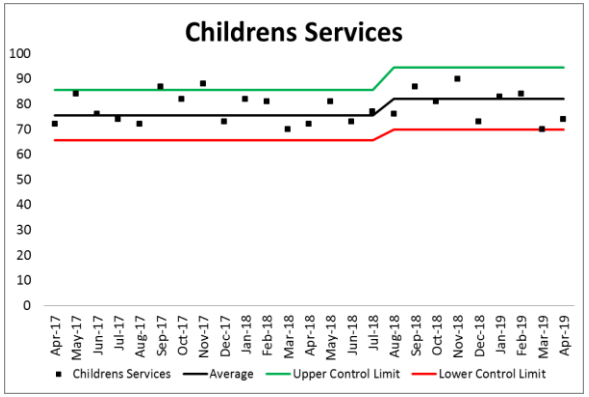


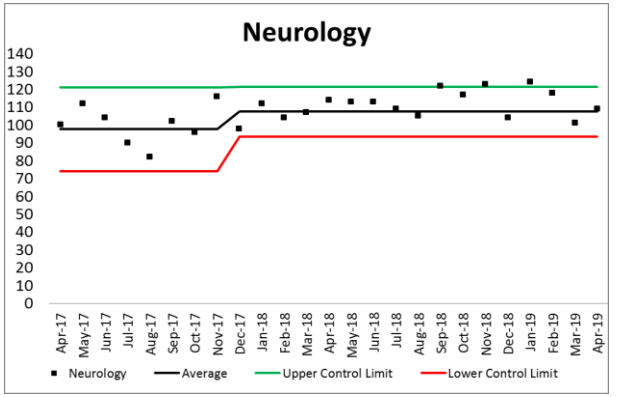
Our Finance and Productivity Perspective

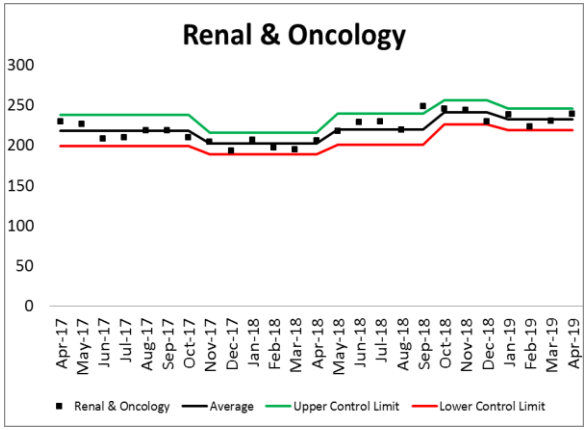
St George's University Hospitals NHS Foundation Trust

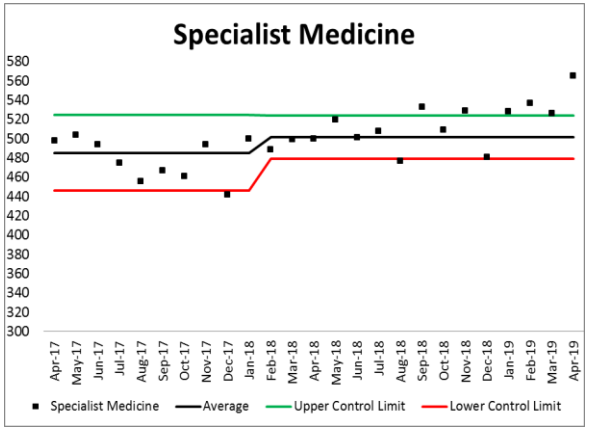
Number of Follow Up Outpatient attendances per Working Day

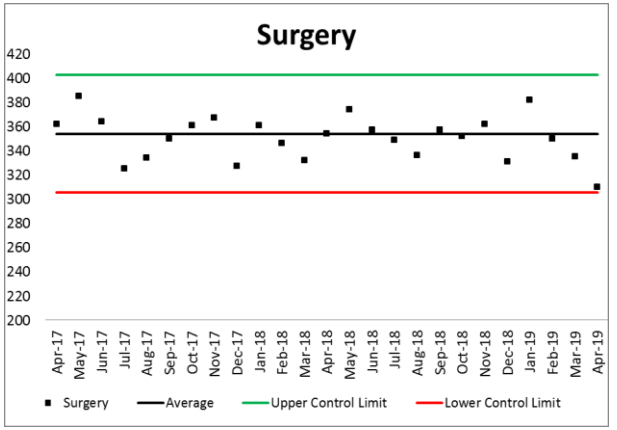


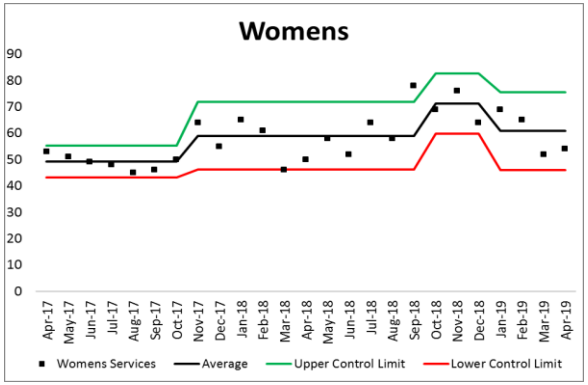


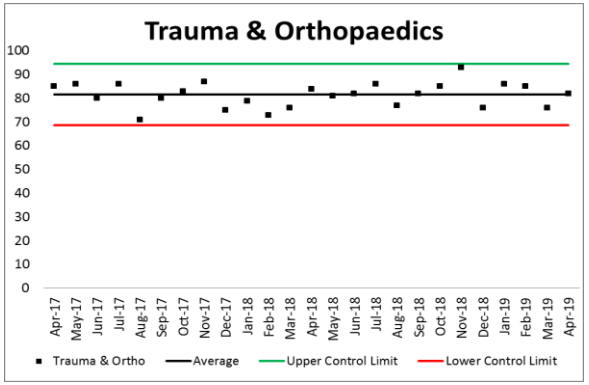


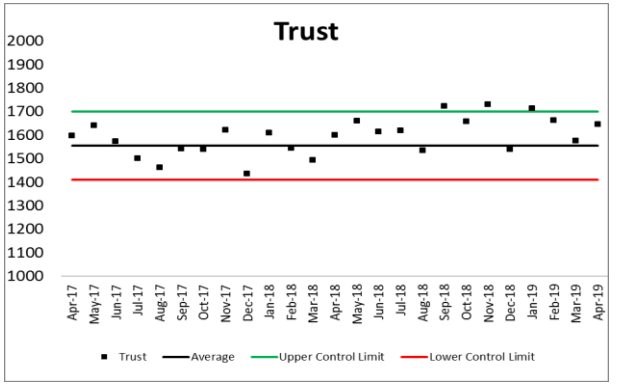












Outpatient productivity

First Outpatient Attendances (average per working day)

Directorate	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	First Outpatient Attendances per 2018-19 YTD	2019-20 YTD	Variance
Cardiology, Cardiothoracic & Vascular Services	59	62	66	57	54	58	59	67	51	59	58	59	58	59	58	-1.4%
Childrens Services	41	50	49	42	42	50	45	51	38	50	47	46	41	41	41	-0.2%
Neuro	87	83	83	73	67	81	84	88	74	94	81	75	80	87	80	-8.1%
Renal & Oncology	25	27	30	24	25	23	27	28	23	26	25	24	25	25	25	2.0%
Specialist Medicine	139	153	157	142	129	144	142	150	126	148	147	144	147	139	147	6.0%
Surgery	265	271	300	264	253	270	279	275	257	268	264	278	249	265	249	-6.0%
Womens Services	82	85	92	89	85	89	86	90	78	88	92	82	81	82	81	-1.1%
T&O	55	56	60	62	50	55	52	55	48	53	54	51	52	55	52	-5.9%
Other	37	38	43	38	34	36	37	34	36	39	33	32	55	37	55	46.9%
Total	**790**	**827**	**880**	**791**	**737**	**805**	**812**	**838**	**731**	**826**	**801**	**791**	**787**	**790**	**787**	-0.3%

Follow Up Outpatient Attendances (average per working day)

Directorate	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	FollowUp Outpatient Attendances 2018-19 YTD	2019-20 YTD	Variance
Cardiothoracic & Vascular Services	121	116	113	107	100	117	107	124	104	113	106	96	99	121	99	-18.3%
Childrens Services	72	81	73	77	76	87	81	90	73	83	84	70	74	72	74	3.1%
Neuro	114	113	113	109	105	122	117	123	104	124	118	101	109	114	109	-4.3%
Renal & Oncology	205	217	228	229	219	248	245	243	229	238	223	230	239	205	239	16.4%
Specialist Medicine	500	520	501	508	477	533	509	529	481	528	537	526	565	500	565	13.1%
Surgery	354	374	357	349	336	357	352	362	331	382	350	335	310	354	310	-12.5%
Womens Services	50	58	52	64	58	78	69	76	64	69	65	52	54	50	54	8.3%
T&O	84	81	82	86	77	82	85	93	76	86	85	76	82	84	82	-1.8%
Other	99	98	94	89	86	97	92	91	77	91	92	87	112	99	112	13.4%
Total	**1,598**	**1,659**	**1,613**	**1,618**	**1,534**	**1,721**	**1,656**	**1,730**	**1,539**	**1,713**	**1,661**	**1,574**	**1,644**	**1,598**	**1,644**	2.9%

What the information tells us

- Outpatient first attendance activity at Trust level has remained within its process limits since April 2017 and all specialties, except for Surgery, are within their expected process limits
- Across the Directorates, First Outpatient attendances averaged 787 per working day and is below the SLA target for the month, however this is expected to increase once coding has been completed. The RAG rating applied is based on the SLA plan per working day which saw an decrease in activity compared to the same period Outpatient follow-up activity at Trust level has remained within its process limits since April 2017
- Outpatient follow-ups for Specialist Medicine are above their upper process control limit for the previous four months whereas Cardiology's previous two months are below their lower process limit
- It is worth noting that February and March's data have not yet been fully updated with M12 freeze data and next months data capture along with SPC charts will provide a more accurate view of our outpatient productivity to date.

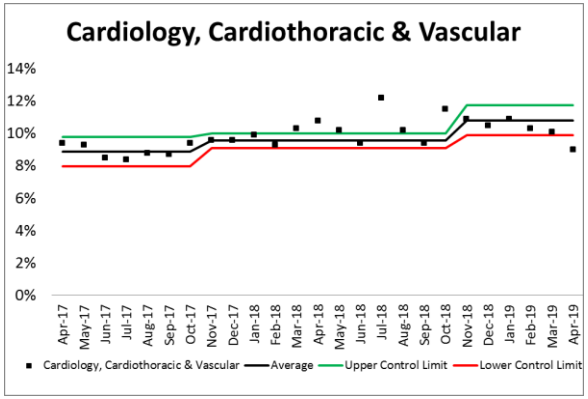
Actions and Quality Improvement Projects

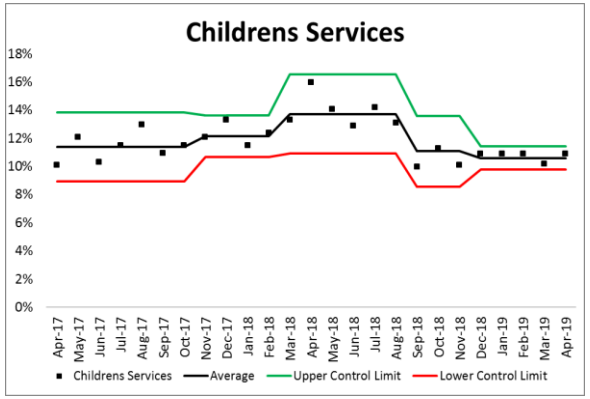
- Services are reviewing the recording of particular appointments as some will be classified as outpatient procedures.

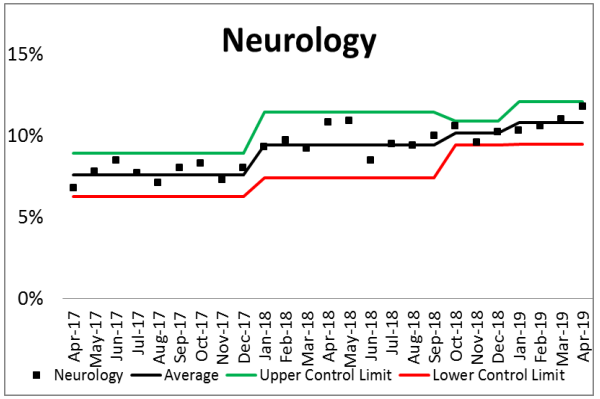
Our Finance and Productivity Perspective

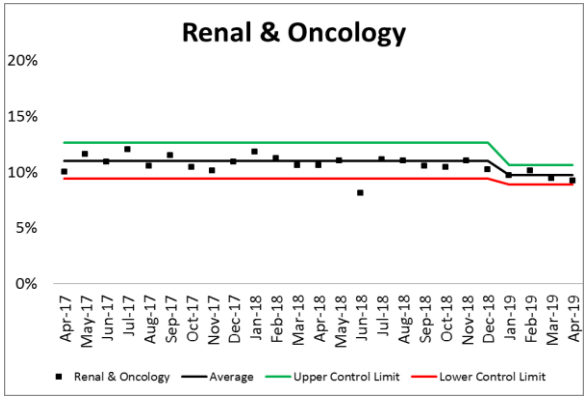
St George's University Hospitals NHS Foundation Trust

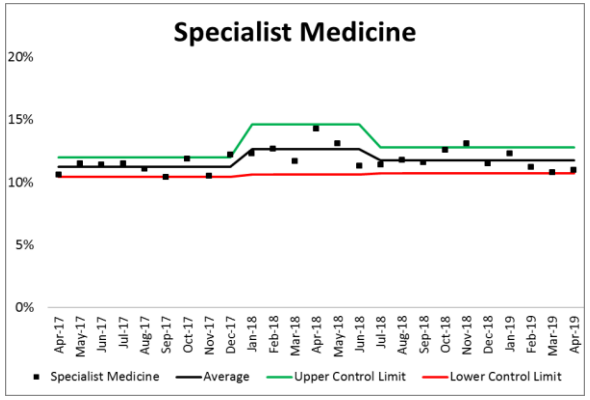
Percentage of patients that did not attend their appointment

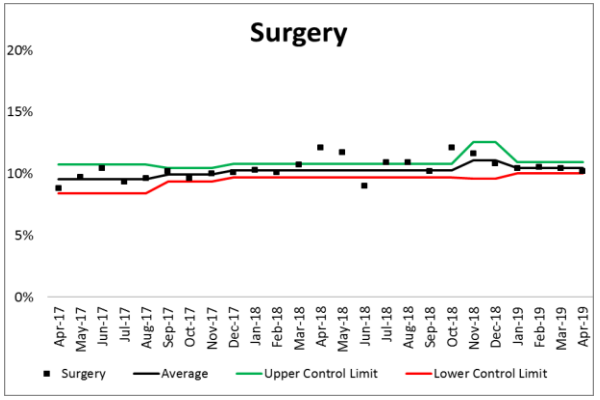


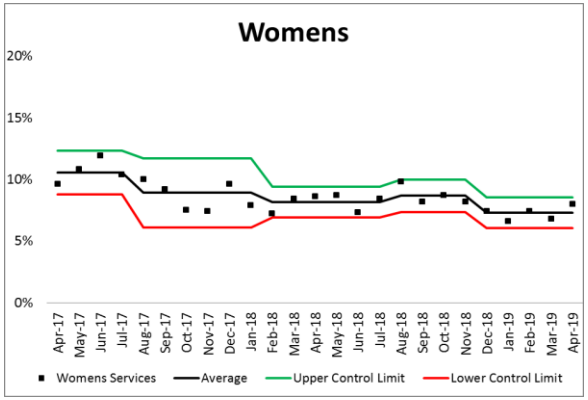


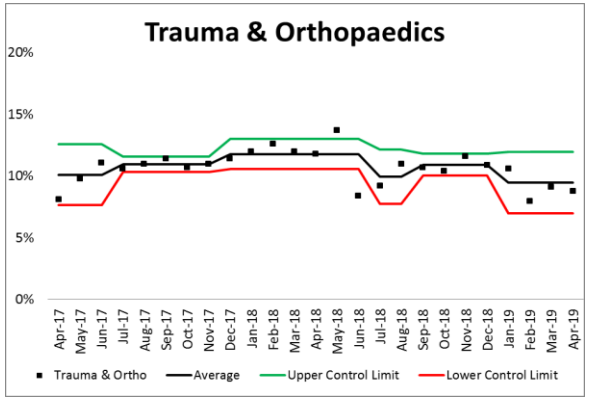


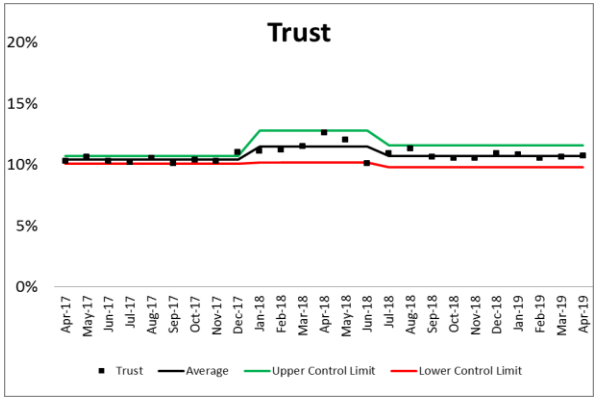








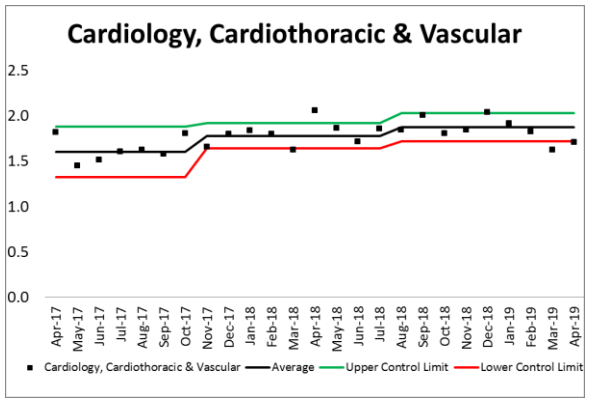


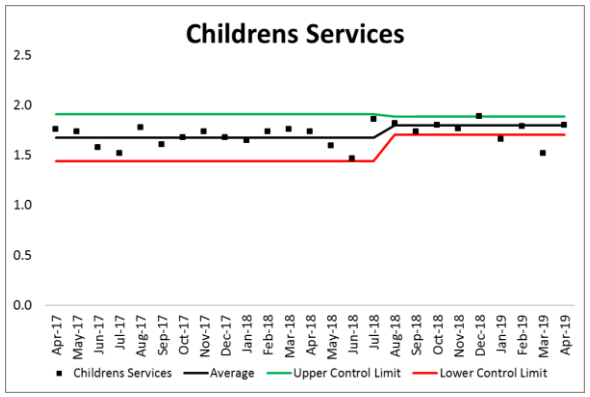


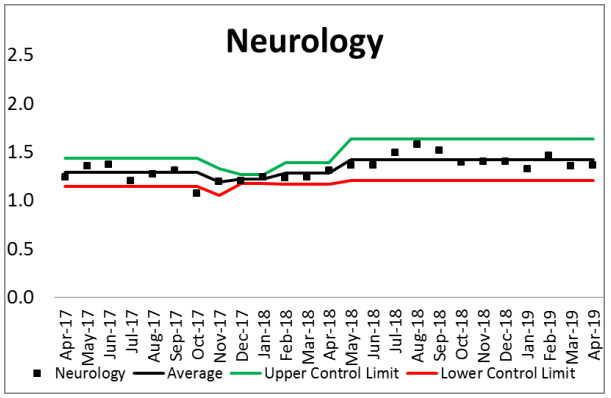
Our Finance and Productivity Perspective

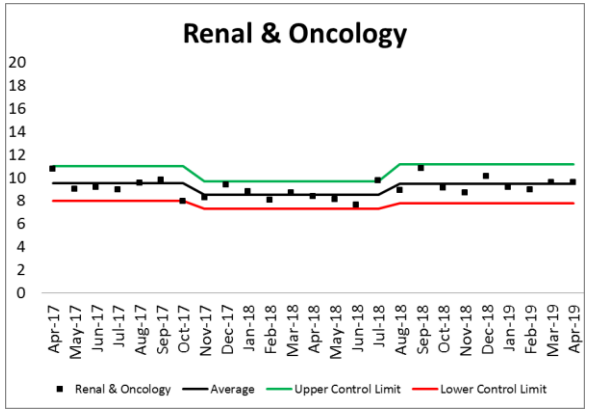
St George's University Hospitals NHS Foundation Trust

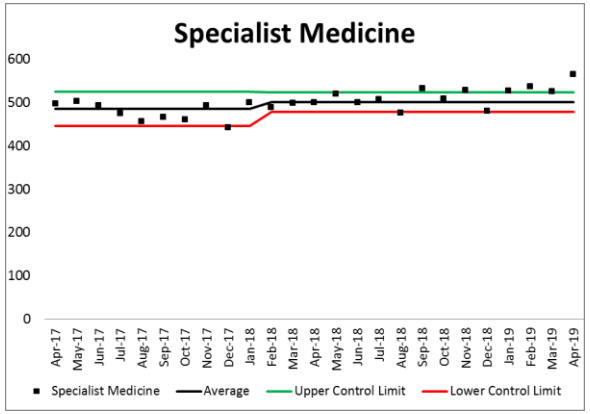
New to Follow Up Ratios

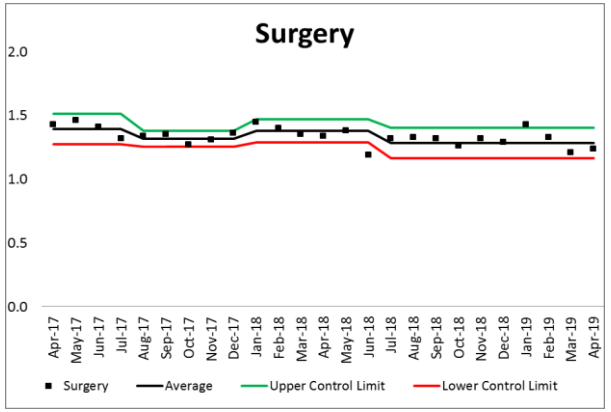


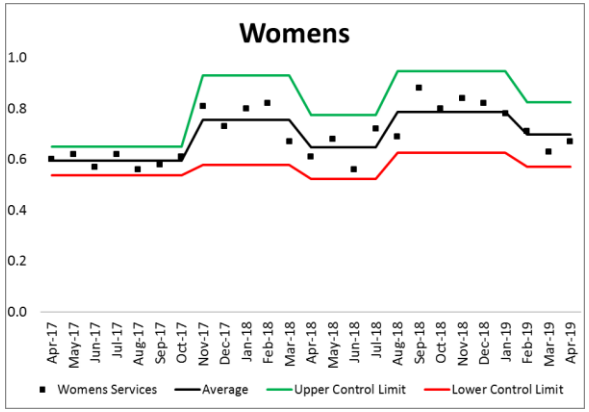


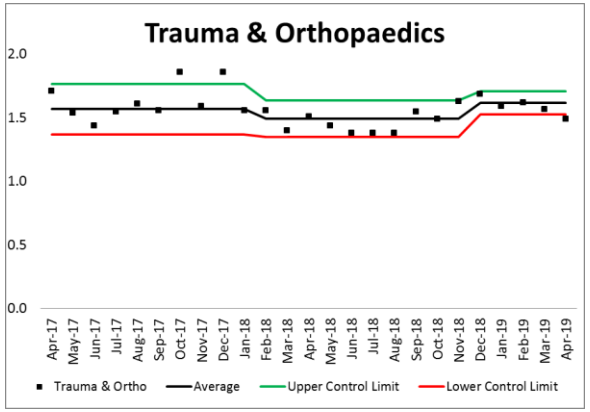


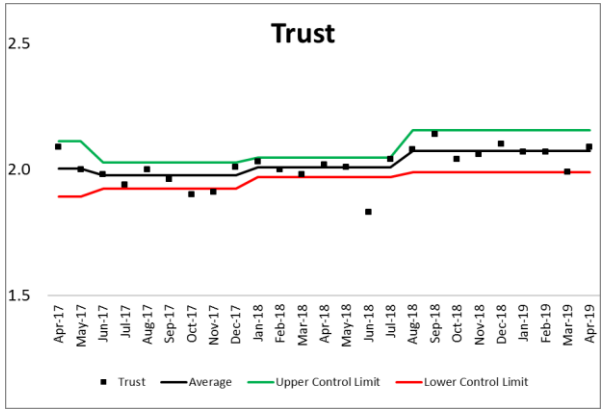












Outpatient productivity

First and Follow Up DNA Rates (by month)

Directorate	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	DNA patients in the last month	rate 2018-19 YTD	Variance
Cardiothoracic & Vascular Services	10.8%	10.2%	9.4%	12.2%	10.2%	9.4%	11.5%	10.9%	10.5%	10.9%	10.3%	10.1%	9.0%	254	10.8%	-1.8%
Childrens Services	16.0%	14.1%	12.9%	14.2%	13.1%	10.0%	11.3%	10.1%	10.9%	10.9%	10.9%	10.2%	10.9%	304	16.0%	-5.1%
Neuro	10.8%	10.9%	8.5%	9.5%	9.4%	10.0%	10.6%	9.6%	10.2%	10.3%	10.6%	11.0%	11.8%	501	10.8%	1.0%
Renal & Oncology	10.6%	11.0%	8.1%	11.1%	11.0%	10.5%	10.4%	11.0%	10.2%	9.7%	10.1%	9.4%	9.2%	321	10.6%	-1.4%
Specialist Medicine	14.3%	13.1%	11.3%	11.4%	11.8%	11.6%	12.6%	13.1%	11.5%	12.3%	11.2%	10.8%	11.0%	1,556	14.3%	-3.3%
Surgery	12.1%	11.7%	9.0%	10.9%	10.9%	10.2%	12.1%	11.6%	10.8%	10.4%	10.5%	10.4%	10.2%	1,343	12.1%	-1.9%
Womens Services	8.6%	8.7%	7.3%	8.4%	9.8%	8.2%	8.7%	8.2%	7.4%	6.6%	7.4%	6.8%	8.0%	611	8.6%	-0.6%
T&O	11.8%	13.7%	8.4%	9.2%	11.0%	10.7%	10.4%	11.6%	10.9%	10.6%	7.9%	9.1%	8.8%	286	11.8%	-3.0%
Other	10.0%	9.5%	11.6%	12.9%	13.8%	12.5%	14.4%	15.4%	14.2%	12.9%	12.9%	14.3%	14.2%	1,344	10.0%	4.2%
Total	**12.6%**	**12.0%**	**10.1%**	**10.9%**	**11.3%**	**10.6%**	**10.5%**	**10.5%**	**10.9%**	**10.8%**	**10.5%**	**10.6%**	**10.7%**	**6,520**	**12.6%**	**-1.9%**

First and Follow Up Ratio

Directorate	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	First to FollowUp Ratio 2018-19 YTD	2019-20 YTD	Variance
Cardiothoracic & Vascular Services	2.06	1.87	1.72	1.86	1.85	2.01	1.81	1.85	2.04	1.92	1.83	1.63	1.71	2.06	1.71	-17.1%
Childrens Services	1.74	1.60	1.47	1.86	1.82	1.74	1.80	1.77	1.89	1.66	1.79	1.52	1.80	1.74	1.80	3.4%
Neuro	1.31	1.36	1.36	1.49	1.57	1.51	1.39	1.40	1.40	1.32	1.46	1.35	1.36	1.31	1.36	4.2%
Renal & Oncology	8.38	8.08	7.64	9.75	8.89	10.77	9.08	8.68	10.13	9.15	8.92	9.58	9.56	8.38	9.56	14.0%
Specialist Medicine	3.60	3.40	3.19	3.59	3.71	3.70	3.58	3.53	3.81	3.57	3.65	3.65	3.84	3.60	3.84	6.6%
Surgery	1.34	1.38	1.19	1.32	1.33	1.32	1.26	1.32	1.29	1.43	1.33	1.21	1.24	1.34	1.24	-6.9%
Womens Services	0.61	0.68	0.56	0.72	0.69	0.88	0.80	0.84	0.82	0.78	0.71	0.63	0.67	0.61	0.67	9.5%
T&O	1.51	1.44	1.38	1.38	1.55	1.49	1.63	1.69	1.59	1.62	1.57	1.49	1.58	1.51	1.58	4.3%
Other	2.64	2.54	2.20	2.31	2.52	2.70	2.49	2.69	2.16	2.33	2.79	2.72	2.04	2.64	2.04	-22.8%
Total	**2.02**	**2.01**	**1.83**	**2.04**	**2.08**	**2.14**	**2.04**	**2.06**	**2.10**	**2.07**	**2.07**	**1.99**	**2.09**	**2.02**	**2.09**	**3.2%**

What the information tells us

- The Trust DNA rate has remained within its process limits for the previous ten months however this masks variability amongst the specialties.
- Neurology has had a steady upward trend for the previous six months whereas Cardiology has had a steady downward trend and, in April, the specialty was below its lower limit. All other specialties are within their process limits for DNA rates
- The Trust's First to Follow up ratio is within its process limits and all specialties are within expected limits except Specialist Medicine. Specialist medicine has seen an unusual increase in Follow-up attendances without a commensurate increase in First attendances.

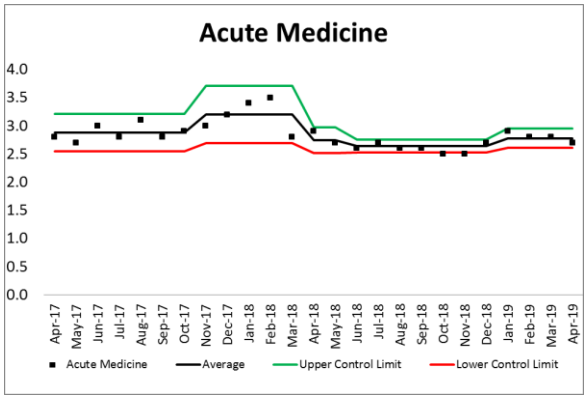
Actions and Quality Improvement Projects

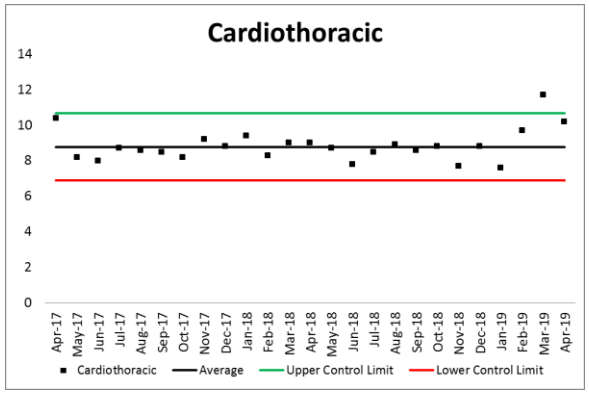
- Timelines for the Outpatient Projects which will be finalised by the end of May.
- The two way text reminders are currently live in Dermatology, Plastics, Trauma & Orthopaedics, Haematology, Audiology, Audiological Medicine and ENT

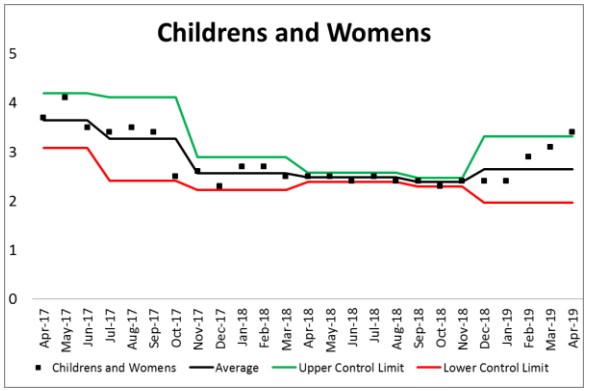
Our Finance and Productivity Perspective

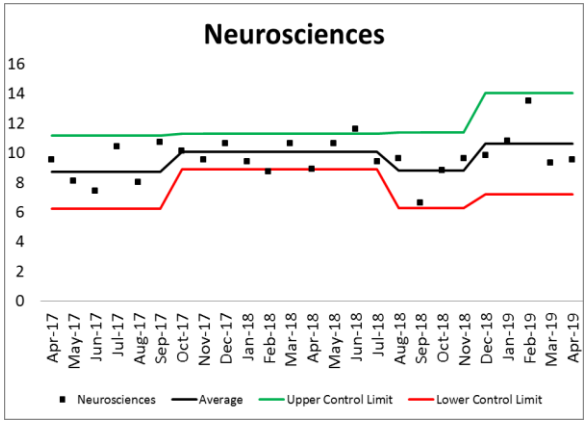
St George's University Hospitals NHS Foundation Trust

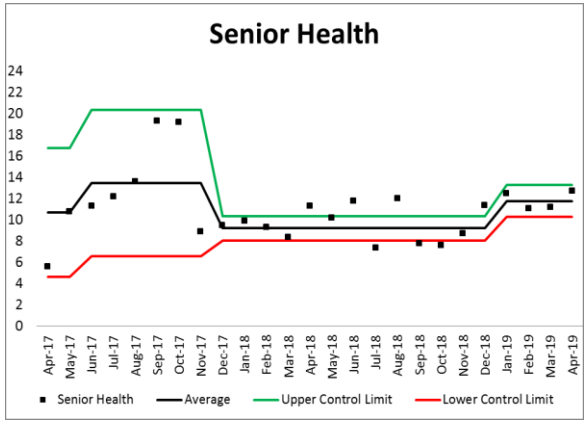
Non Elective Length of Stay

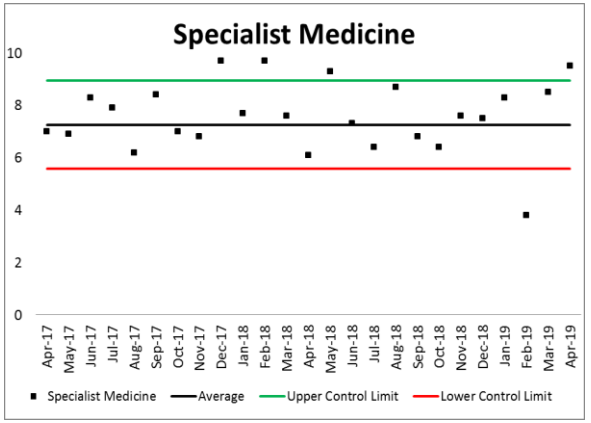


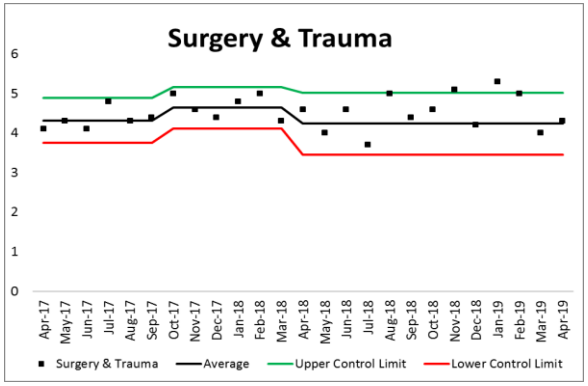


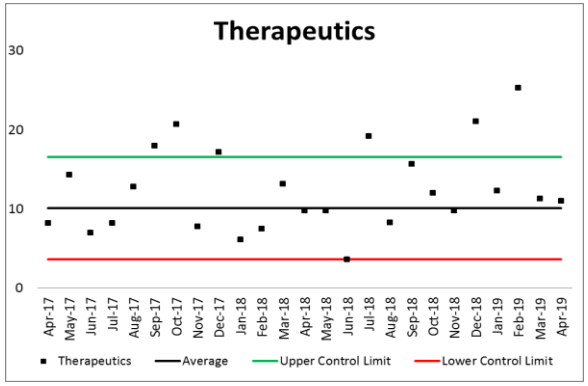


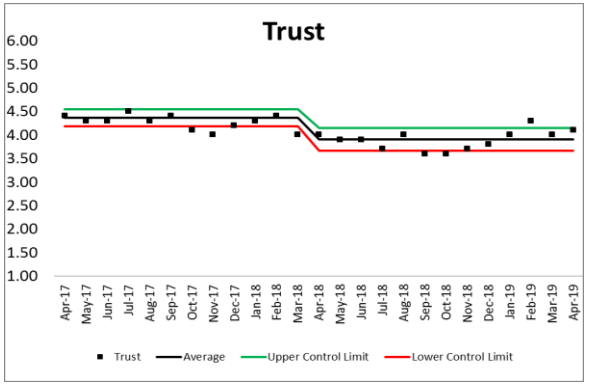












Length of Stay

Non Elective Length of Stay (General and Acute Beds)

															Average length of Stay		
Directorate	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	Discharges in the last month	2018-19 YTD	2019-20 YTD	Variance
Acute Medicine	2.9	2.7	2.6	2.7	2.6	2.6	2.5	2.5	2.7	2.9	2.8	2.8	2.7	2,600	2.9	2.7	-6%
Cardiothoracic	9.0	8.7	7.8	8.5	8.9	8.6	8.8	7.7	8.8	7.6	9.7	11.7	10.2	148	9.0	10.2	13%
Childrens & Women	2.5	2.5	2.4	2.5	2.4	2.4	2.3	2.4	2.4	2.4	2.9	3.1	3.4	851	2.5	3.4	34%
Neurosciences	8.9	10.6	11.6	9.4	9.6	6.6	8.8	9.6	9.8	10.8	13.5	9.3	9.5	223	8.9	9.5	6%
Senior Health	11.3	10.2	11.8	7.4	12.0	7.8	7.6	8.7	11.4	12.5	11.1	11.2	12.7	98	11.3	12.7	12%
Specialist Medicine	6.1	9.3	7.3	6.4	8.7	6.8	6.4	7.6	7.5	8.3	6.8	8.5	9.5	160	6.1	9.5	56%
Surgery & Trauma	4.6	4.0	4.6	3.7	5.0	4.4	4.6	5.1	4.2	5.3	5.0	4.0	4.3	820	4.6	4.3	-7.3%
Therapeutics	9.8	9.8	3.6	19.2	8.3	15.7	12.0	9.8	21.1	12.3	25.3	11.3	11.0	26	9.8	11.0	12%
Grand Total	**4.0**	**3.9**	**3.9**	**3.7**	**4.0**	**3.6**	**3.6**	**3.7**	**3.8**	**4.0**	**4.3**	**4.0**	**4.1**	**5,014**	**4.0**	**4.1**	3%

What the information tells us

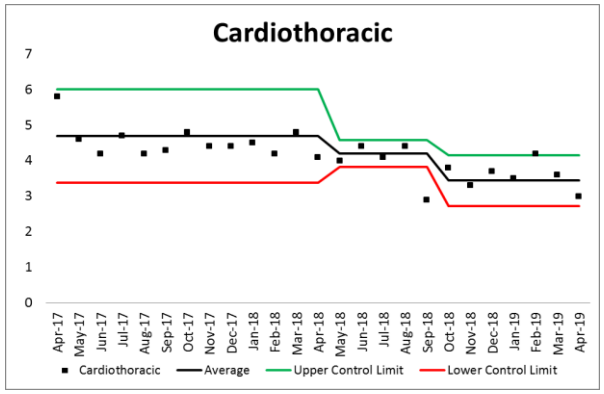
- The Trust's Non-Elective Length of stay is within the expected process limits however there has been a steady upward trend in the past eight months.
- Children's and Women's division has shown a steady increase in LOS and an increase in variability; Specialist Medicine is outside its process limits for two of the past three months.
- Senior Health has had an increase moving from a mean of 9 day LOS to a mean of 12 day LOS though the variability has remained small.
- Neurosciences has had an increase moving from a mean of 9 day LOS to a mean of 11day LOS and the variability has increased.
- Surgery and Trauma remains within its expected process limits

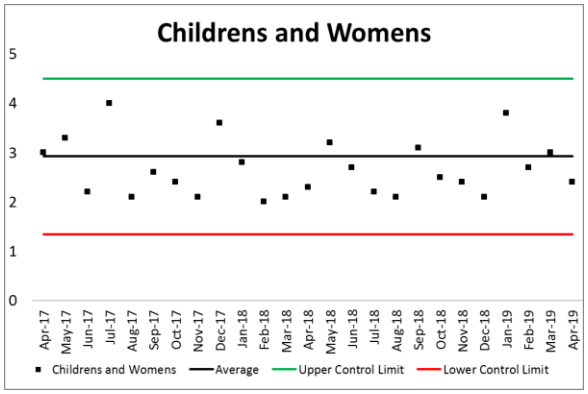
Actions and Quality Improvement Projects

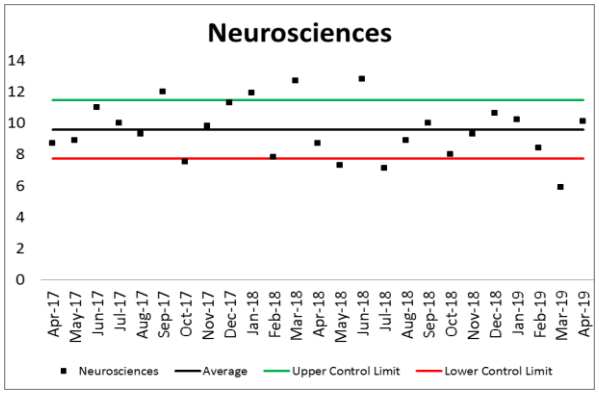
- The Emergency Department and Inpatient Clinical teams have identified a range of patient experience, quality and productivity opportunities to evolve the processes embedded within iClip and these need to be the immediate priority.
- Support Ward teams to deliver SAFER consistently.
- A return to a concerted focus on stranded patients is being implemented by the Medcard Division

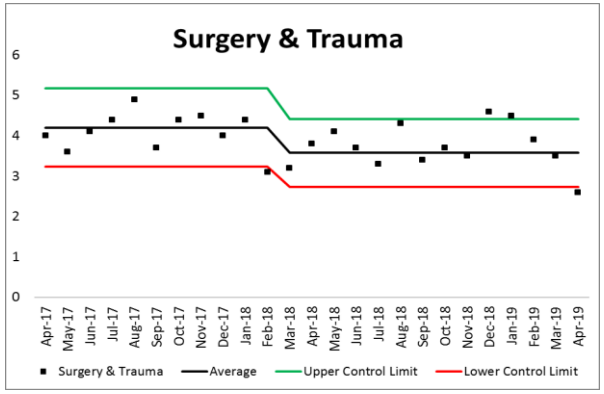
Our Finance and Productivity Perspective

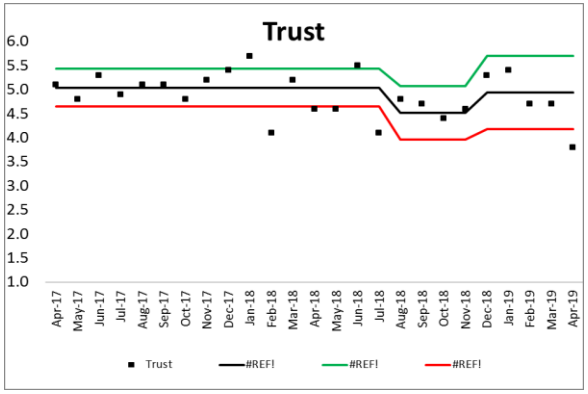
Elective Length of Stay











Length of Stay

Elective Length of Stay (Excluding Daycase)

														Average length of Stay		
Directorate	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	Discharges in the last month	2018-19 YTD	2019-20 YTD	Variance
Cardiothoracic	4.1	4.0	4.4	4.1	4.4	2.9	3.8	3.3	3.7	3.5	4.2	3.6	3.0	207	4.1	3.0	⇩ -27%
Childrens & Women	2.3	3.2	2.7	2.2	2.1	3.1	2.5	2.4	2.1	3.8	2.7	3.0	2.4	79	2.3	2.4	⇧ 4%
Neurosciences	8.7	7.3	12.8	7.1	8.9	10.0	8.0	9.3	10.6	10.2	8.4	5.9	10.1	169	8.7	10.1	⇧ 16%
Surgery & Trauma	3.8	4.1	3.7	3.3	4.3	3.4	3.7	3.5	4.6	4.5	3.9	3.5	2.6	452	3.8	2.6	⇩ -32%
Grand Total	**4.6**	**4.6**	**5.5**	**4.1**	**4.8**	**4.7**	**4.4**	**4.6**	**5.3**	**5.4**	**4.7**	**4.7**	**3.8**	**907**	**4.6**	**3.8**	⇩ -18%

What the information tells us

- The Trust's Elective overall elective length of stay was below the lower control limit.
- Surgery and Trauma Directorate was also below its lower control limit with all other directorates performing within expectation.
- 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

Balance Scorecard

St George's University Hospitals NHS Foundation Trust

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 R	Mortality	Readmissions	Maternity G	Patient Voice
OUR **PROCESS** PERSPECTIVE	Emergency Flow	Cancer A	Diagnostics G	On the day cancellations	18 Week Referral to Treatment	
OUR **PEOPLE** PERSPECTIVE	Workforce	Agency use				

Our Quality Improvement Programme (QIP) Safety Priorities

Indicator Description	Threshold /Target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
Number of 2222 calls / 1000 adult ordinary IP admissions		8.77	9.25	9.27	7.42	9.48	4.91	9.85	9.37	11.33	10.97	11.13	8.79	6.99
Number of Cardiac Arrests / 1000 adult ordinary IP admissions (to become avoidable cardiac arrests)		2.61	2.85	2.97	2.04	3.16	2.00	0.68	3.36	2.60	3.77	3.26	2.76	3.92
% of patients in ED with Red Flag sepsis receiving antibiotics within an hour (adults)	90%	97%	97%	99%	100%	96%	92%	91%	95%	94%	95%	93%	88%	90.60%
Increase in compliance with appropriate response to EWS (adults)	85%	88%	94%	93%	100%	94%	95%	92%	92%	93%	96%	87%	90%	93%
MCA & DoLs - Level 1	85%					72.6%	77.6%	79.5%	80.8%	83.4%	83.9%	86.3%	88.6%	89.8%
MCA & DoLs - Level 2	85%										21.7%	32.2%	42.0%	53.2%
Resuscitation BLS	85%	82.6%	83.4%	82.0%	80.5%	71.1%	70.5%	70.5%	70.3%	69.8%	70.5%	71.5%	74.1%	76.2%
Resuscitation ILS	85%	72.8%	72.9%	73.0%	72.2%	64.2%	64.2%	64.3%	66.3%	68.5%	70.2%	69.3%	71.3%	72.1%
Resuscitation ALS	85%	18.6%	18.7%	19.1%	18.4%	24.4%	24.2%	27.1%	40.4%	51.2%	64.2%	67.0%	70.4%	72.7%

What the information tells us

- The Trust has maintained its step change performance for patients receiving antibiotics within an hour in ED throughout FY 2018/19
- Resuscitation BLS (Basic Life Support) training performance deteriorated between May 2018 to December 2018. Additional training capacity has been commissioned to ensure delivery the performance target by 30 September 2019
- Resuscitation ALS (Advanced Life Support) training performance has improved from October 2018 onwards. Work was undertaken to ensure that training compliance was recorded correctly. This performance metric is also benefitting from additional training capacity as outlined above.
- Mental Capacity Act and Deprivation of Liberties – Level 1 training continues its steady upward improvement in performance
- Mental Capacity Act and Deprivation of Liberties – Level 2 training was recently launched and is showing consistent improved performance month on month

Actions and Quality Improvement Projects

Implementing Treatment Escalation Plan (TEP)

- Information Technology (IT) working towards TEP being on iCLIP. Audit measures have been agreed with IT in readiness for electronic audit facility anticipated by end of Q3
- Developing driver diagrams in line with Quality Improvement project methodology
- Palliative care audit data demonstrates increased use of TEP in this group of patients between January and March 2019

Deteriorating Patients

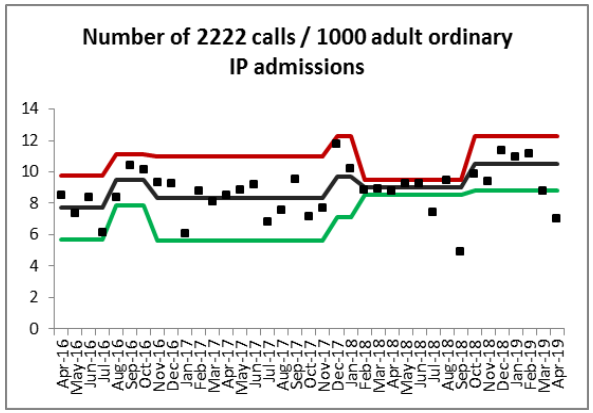
- Successful Trust wide rollout of National Early Warning Score 2 (NEWS2) in late March 2019
- Improved divisional engagement with Deteriorating Adults Group from nursing, with responsibility for driving improvements across the Trust
- Highlighted lack of visibility of observations at the bedside. Review underway to establish viability of siting PC screens in rooms/bays versus a move to hand held devices
- Developing management level and monthly audit data with IT for NEWS2 in iCLIP in readiness for electronic audit facility anticipated by end of Q3
- NHS/PSA/W/2018/009 Risk of harm from inappropriate placement of pulse oximeter probes completed

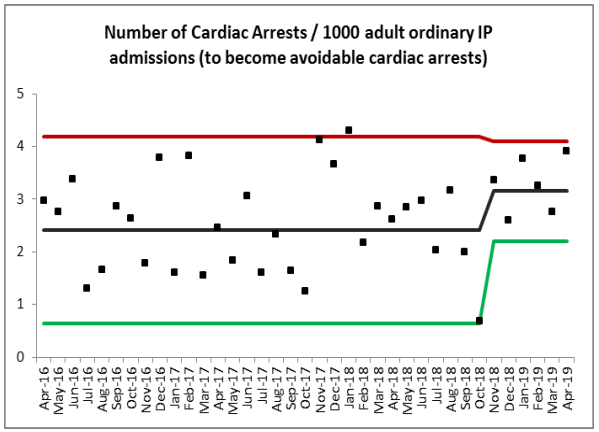
Progress and actions: MCA awareness and quality of assessments

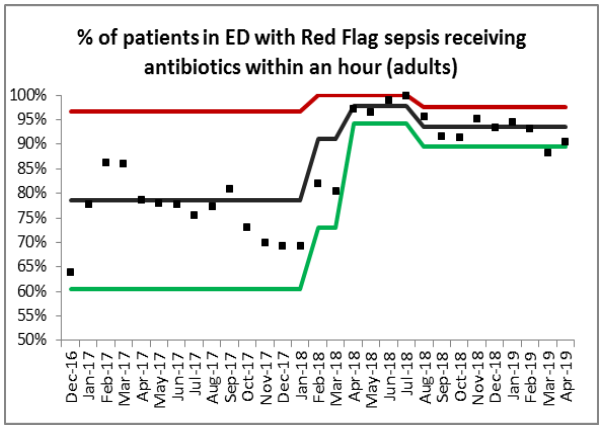
- Scoping exercise underway to commission small scale group work approach to support the application of MCA and DoLs training to practice
- Engaged with SW London sector to develop a standardised audit tool and work has commenced. Taking a sector approach will enable to Trust to benchmark practice with similar Trusts and create a community of practice.
- The level 1 training performance target of 90% in response to CQC MUST do from 2018 inspection is on trajectory for delivery by 31 May 2019

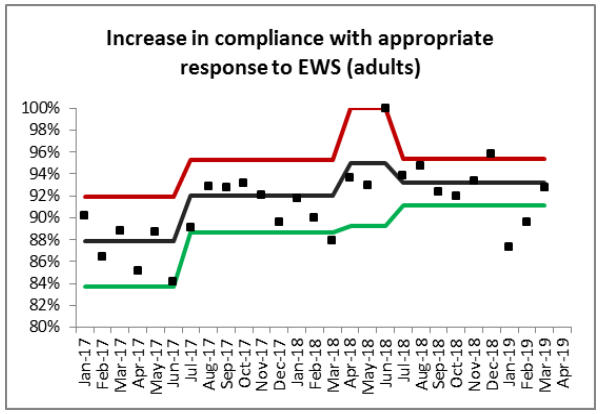
Our Patient Perspective

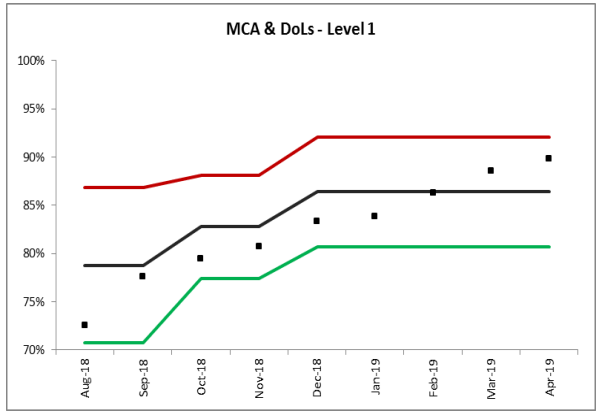
Quality Priorities

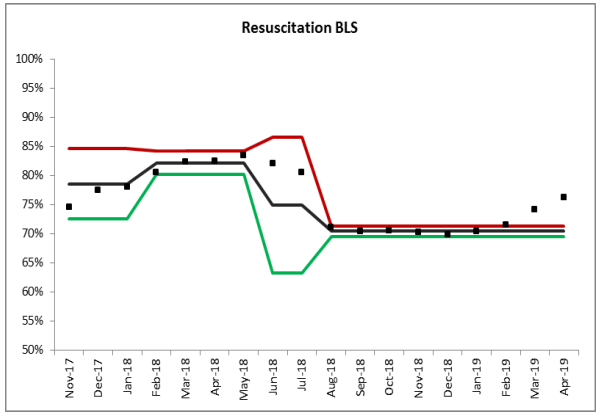


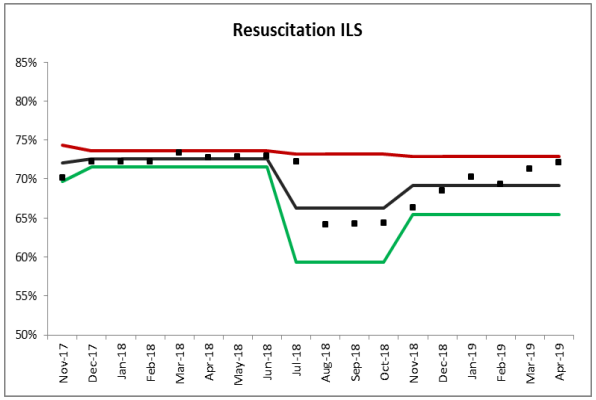


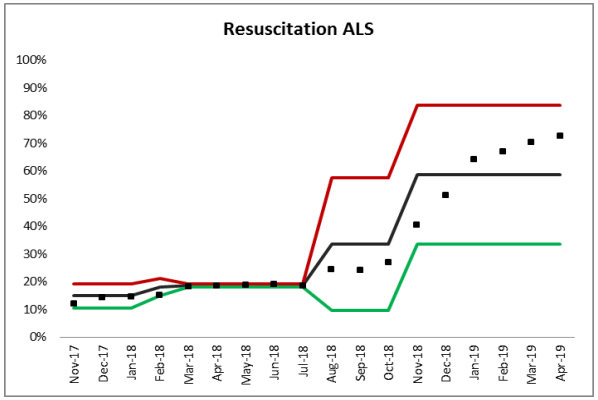












Our Patient Perspective

St George's University Hospitals NHS Foundation Trust

Patient Safety

Indicator Description	Target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
Number of Never Events in Month	0	1	0	0	0	0	0	2	0	0	1	0	0	1
Number of SIs where Medication is a significant factor	0	0	0	0	0	0	0	1	1	0	0	0	0	0
Number of Serious Incidents	8 / mth	4	5	2	4	1	3	5	6	6	6	6	4	3
Serious Incidents - per 1000 bed days	N/A	0.17	0.21	0.09	0.17	0.04	0.13	0.20	0.26	0.26	0.25	0.27	0.16	0.13
Safety Thermometer - % of patients with harm free care (all harm)	95%	93.1%	95.3%	96.5%	94.9%	95.7%	96.3%	95.1%	95.0%	95.6%	95.9%	96.5%	96.0%	96.1%
Safety Thermometer - % of patients with harm free care (new harm)	95%	97.8%	98.0%	98.7%	98.5%	98.2%	99.0%	98.3%	97.7%	97.6%	98.4%	98.6%	98.3%	98.3%
Percentage of patients who have a VTE risk assessment	95%	95.9%	95.8%	96.0%	96.9%	96.4%	96.2%	96.0%	96.2%	95.5%	95.9%	95.7%	95.5%	
Number of Patient Falls	N/A	138	117	155	143	136	141	181	173	148	128	147	135	143
Falls (Moderate and Above Severity)	N/A	3	1	1	1	1	0	1	3	1	3	1	2	2
Number of patient falls- per 1000 bed days	N/A	5.77	5.01	6.70	6.11	5.91	6.26	7.40	7.50	6.32	5.29	6.52	5.34	6.00
Acquired Category 2 Pressure Ulcers	N/A	2	6	10	20	15	9	12	25	13	10	16	6	4
Acquired Category 2 Pressure Ulcers per 1000 bed days	N/A	0.08	0.26	0.43	0.85	0.65	0.40	0.49	1.08	0.56	0.41	0.71	0.24	0.17
Avoidable Category 3 & 4 Pressure Ulcers	0	5	0	2	2	3	1	0	0	1	0	3	3	0
Avoidable Category 3 & 4 Pressure Ulcers per 1000 bed days	0	0.21	0	0.09	0.09	0.13	0.04	0	0	0.04	0	0.13	0.12	0.00
Acquired Category 3 Pressure Ulcers		11	4	6	5	3	2	1	3	7	7	4	11	8
Number of overdue CAS Alerts	0	0	0	0	0	0	0	0	0	0	0	0	0	0

What the information tells us

- One patient Never Event was reported in April 2019
- There has been a reduction in the number of Serious Incidents (SIs) reported in the month with the previous two months below the lower process limit.
- The number of falls reported in April was 143, this averages to over 4 falls per day. Of the falls reported two patient sustained moderate harm.
- A further decrease in acquired category two pressure ulcers has been seen in April with eight patients acquired a category 3 or unstageable pressure ulcer, none of these were found to be avoidable.

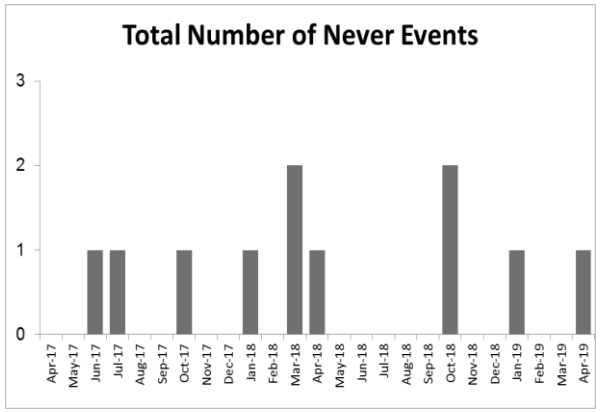
Actions and Quality Improvement Projects

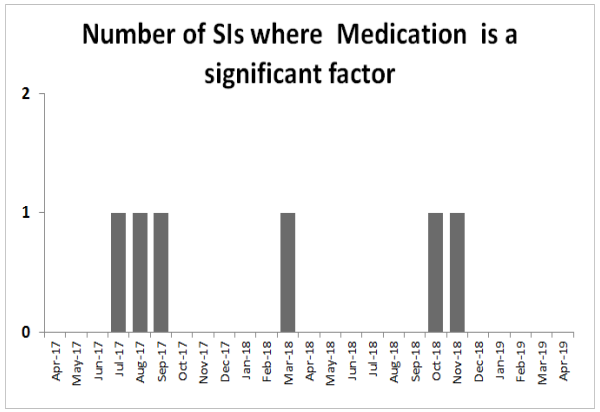
- The Falls co-ordinator is working with divisions, wards and falls champions to improve Falls practice, promote best practice for Falls Prevention and is continuing to carry out targeted Falls education and training..
- The Tissue Viability Nurses have provided daily teaching across these three areas and supported the ward teams in the reviewing of the practice on the ward. This has included making suggestions on how the staff undertake and document wound assessments.
- The Tissue Viability Team is currently reviewing the assessment documentation and care plan on iClip following completion of the RCAs to ensure that it is more user friendly and a care plan is automatically triggered on at risk patients.

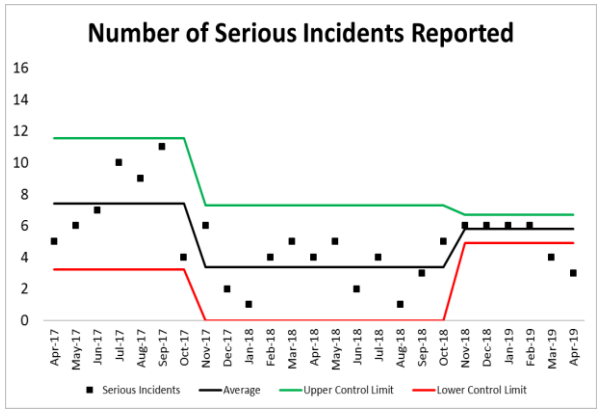
Our Patient Perspective

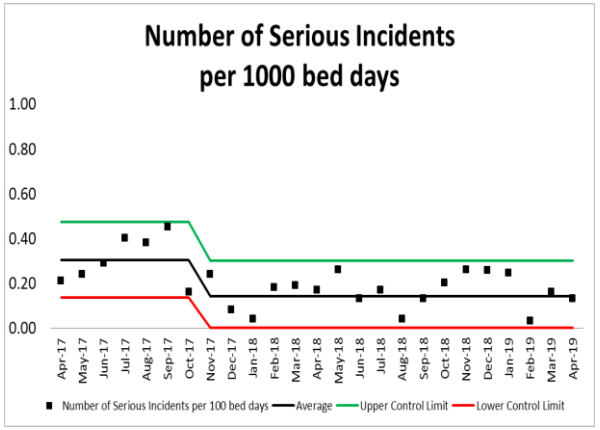
St George's University Hospitals NHS Foundation Trust

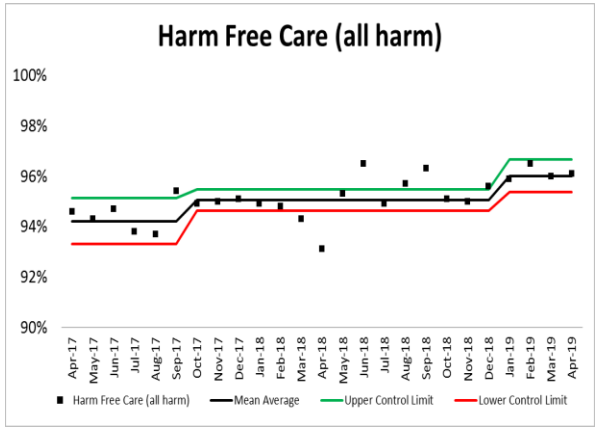
Patient Safety

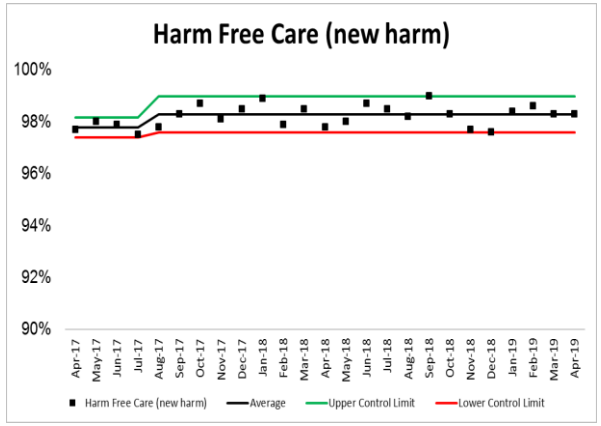


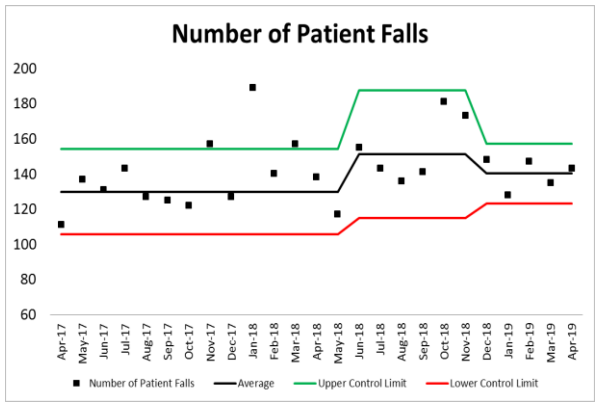


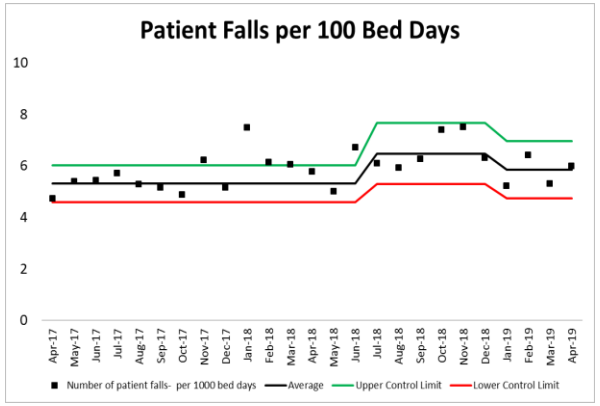


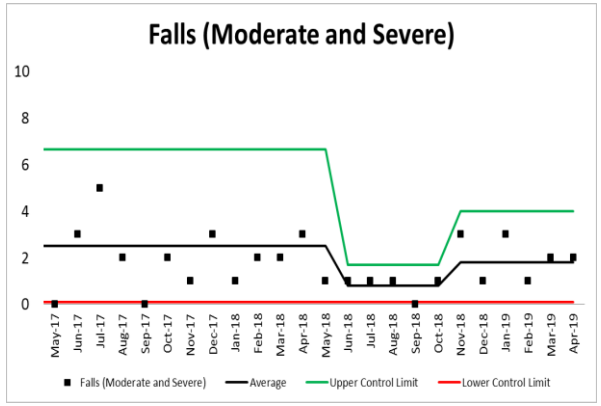








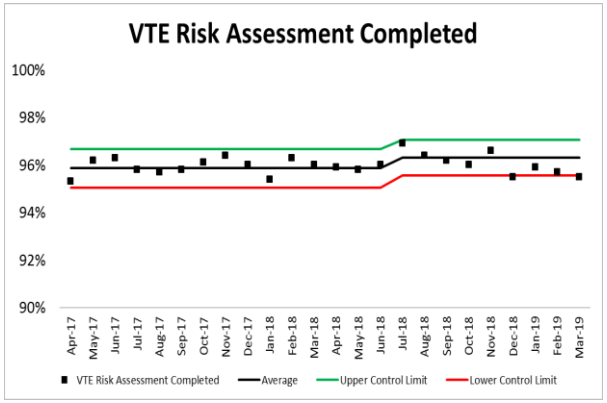


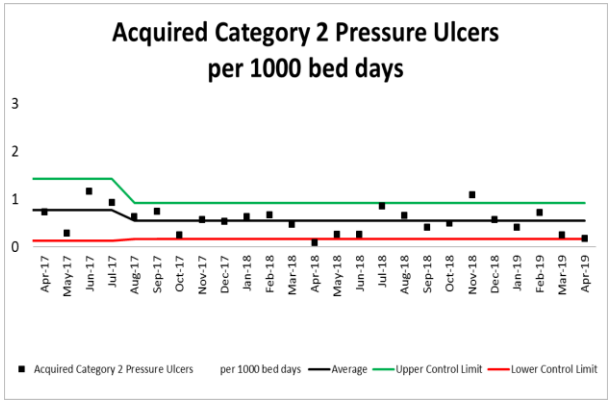


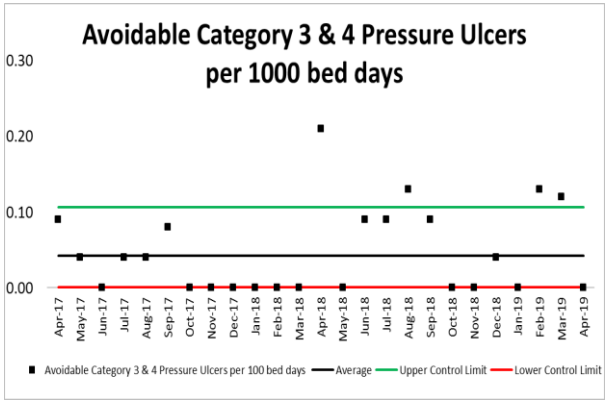
Our Patient Perspective

St George's University Hospitals NHS Foundation Trust

Patient Safety







Our Patient Perspective

Infection Control

Indicator Description	Threshold	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	Trend
MRSA Incidences (in month)	0	0	0	0	0	0	1	0	0	0	0	0	0	0	
Cdiff Hospital acquired infections	48													4	
Cdiff Community Associated infections														0	
MSSA	25	2	2	1	1	2	1	4	2	5	3	2	2	4	
E-Coli	60	1	9	6	4	3	4	2	4	3	1	4	6	4	

What the information tells us

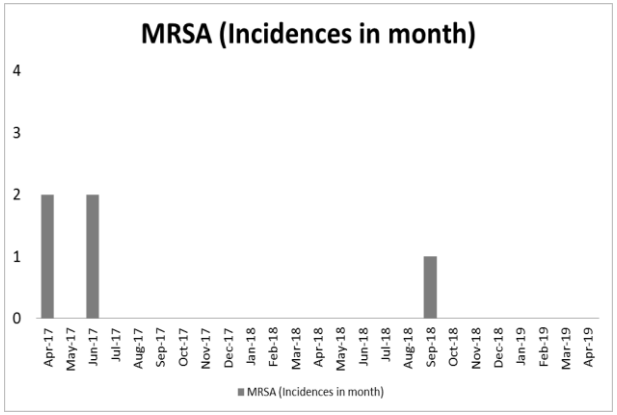
- The Cdiff reporting 2019-2020 will change to apportioning healthcare onset versus community onset is 48 hours rather than 72 hours. The data collected in 2018-19 for each Trust have been used to set the new targets for these categories. For the month of April 4 Cdiff Hospital acquired infections were reported.
- The Trust annual threshold for E coli is 60 for 2019-20 and year to date the Trust has reported 4 cases in April.
- 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 2019/20. The Trust reported a total of 4 incidents in the month of April and year to date.

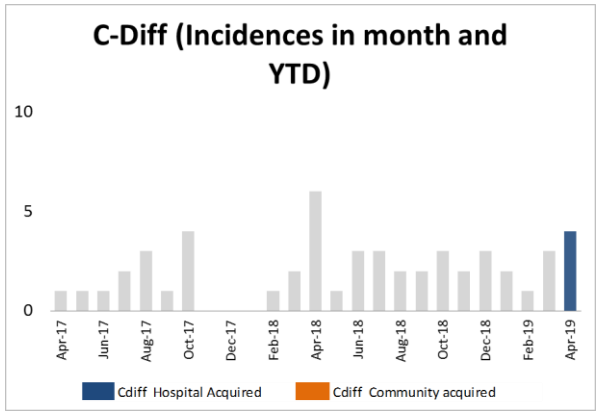
Actions and Quality Improvement Projects

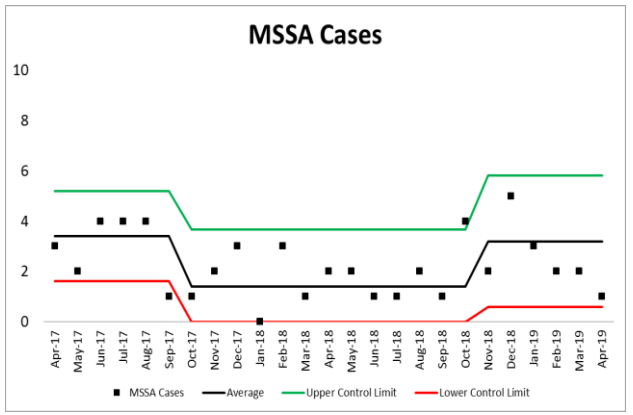
- All C Diff cases have undergone a Root Cause Analysis (RCA). No lapses in care have been identified to date, however a review of all C Diff cases in 2018/19 is being carried out to look for themes that may identify an opportunity to work with system partners to improve outcomes for patients.

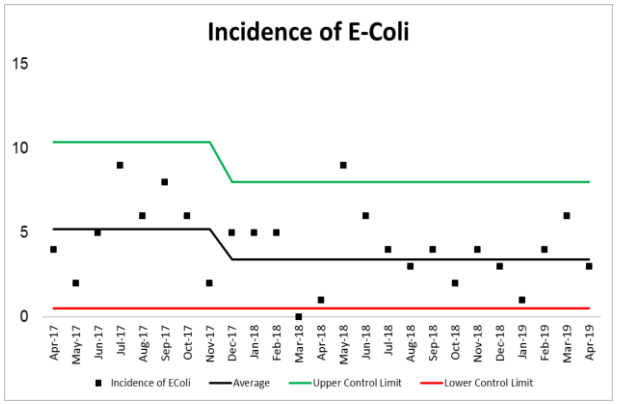
Our Patient Perspective

Infection Control









Our Patient Perspective

Mortality and Readmissions

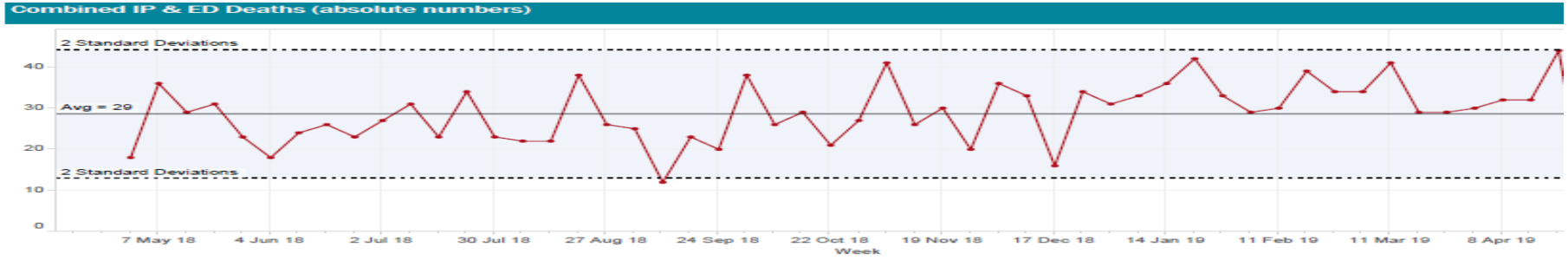
Indicator Description	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Feb-18 to Dec-18	Trend
Hospital Standardised Mortality Ratio (HSMR)	97.3	93.8	106.3	94.9	86.7	79.5	69.8	80.3	73.0	64.2	76.9	74.5	74.5	84.1	
Hospital Standardised Mortality Ratio Weekend Emergency	107.9	123.7	121.5	113.8	78.2	97.6	79.5	72.2	62.7	82.4	113.3	79.1	79.1	92.7	
Hospital Standardised Mortality Ratio Weekday Emergency	95.3	84.9	95.6	79.7	87.1	82.5	67.6	78.1	68.4	60.1	64.9	78.2	78.2	80.4	

Indicator Description	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Trend
Summary Hospital Mortality Indicator (SHMI)	0.83	0.83	0.83	0.83	0.82	0.82	0.82	0.82	0.82	0.84	0.84	0.84	0.84	
Emergency Readmissions within 30 days following non elective spell (reporting one month in arrears)	10.6%	8.8%	8.7%	8.7%	8.50%	8.20%	8.20%	7.00%	8.90%	8.30%	7.60%	8.20%	7.20%	

Please note SHMI data is reflective of the period January 2018 to December 2018 based on a rolling 12 month period (published April 2019).
HSMR data reflective of period February 2018 – December 2018 based on a monthly published position (published April 2019).
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.

What the information tells us

Both the Trust-level mortality indicators (SHMI and HSMR) remain lower than expected compared to national patterns and deaths as a percentage of discharges has increased above standard variation. 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

Definitions	Target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
Total number of women giving birth (per calendar day)	14 per day	14	14	13	13	13	15	13	14	13	14	13	13	14
% of all deliveries where caesarean section occurred	<28%	26.3%	28.1%	28.0%	25.1%	23.2%	23.8%	26.8%	27.5%	23.7%	29.2%	28.5%	31.4%	30.4%
% deliveries with Emergency C Section (including no Labour)	<8%	8.4%	7.8%	9.7%	6.6%	6.2%	6.5%	6.8%	8.3%	7.0%	9.3%	9.4%	10.8%	9.8%
% Time Carmen Suite closed	0%								0	0	0	0	0	5.0%
% of all births in which woman sustained a 3rd or 4th degree tear	<5%	3.8%	3.5%	3.5%	5.1%	4.5%	3.3%	2.0%	3.6%	1.5%	2.1%	1.4%	2.0%	1.5%
% of all births where women had a Life Threatening Post Partum Haemorrhage >1.5 L	<4%	1.9%	2.8%	1.7%	2.4%	3.6%	1.8%	2.0%	2.6%	2.7%	2.6%	1.9%	3.0%	2.7%
Number of term babies (> 34 weeks), with unplanned admission to NNU		7	12	12	2	17	11	8	9	10	12	6	10	12
Supernumerary Midwife in Labour Ward	>95%							95.2%	98.3%	100%	98%	96%	97%	95%
Number of babies still born at term (37 weeks+)	<3	0	1	1	1	0	0	0	1	0	1	0	3	1
Number of babies still born at term (24 to 36 weeks and 6 days)	<3	1	0	0	0	3	1	3	0	1	2	2	2	1
Number of babies born alive who die within (7 days of birth)	<3	1	0	1	1	3	1	2	0	3	0	0	0	1
% women booked by 12 weeks and 6 days	90%	57.7%	61.4%	67.9%	75.0%	77.8%	82.6%	78.0%	84.4%	86.2%	84.7%	86.6%	87.3%	83.3%

What the information tells us

- The Emergency C-section rate for the previous four months is above the upper process limit. This if also reflected in the percentage of C-sections which has been above the mean for the previous four months
- 3rd and 4th degree tears continue on a steady downward trajectory with the in month variability also reducing.
- The number of women booked by 12 weeks and 6 days of pregnancy is within expected process limits.

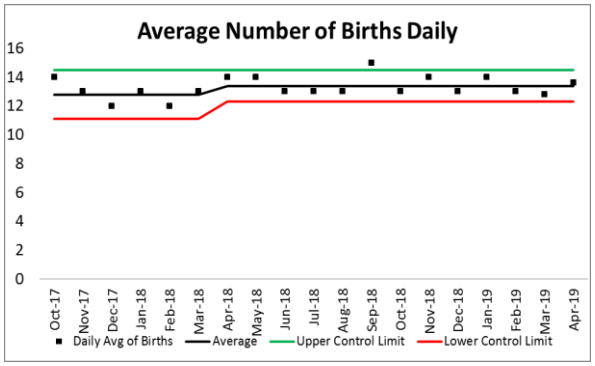
Actions and Quality Improvement Projects

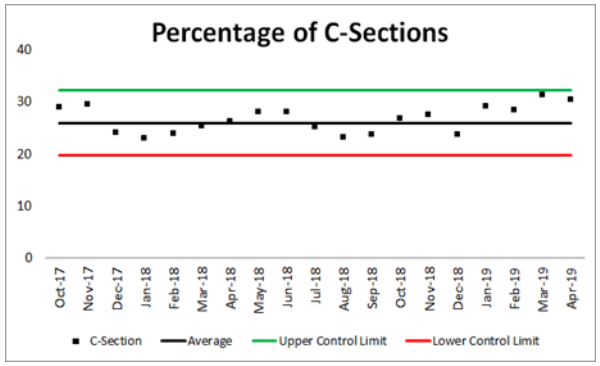
- The C-section rate continues to be monitored each month.
- The emergency C-section raise will be reviewed.
- In April the Carmen suite was closed on 3 occasions (which represents 5%) and was re-opened as soon as safe staffing was available. This will be examined further.

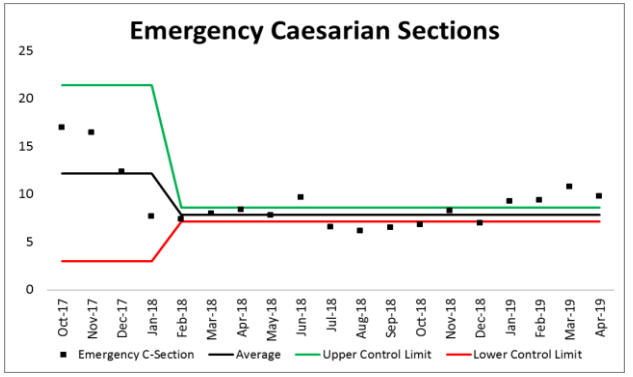
Our Patient Perspective

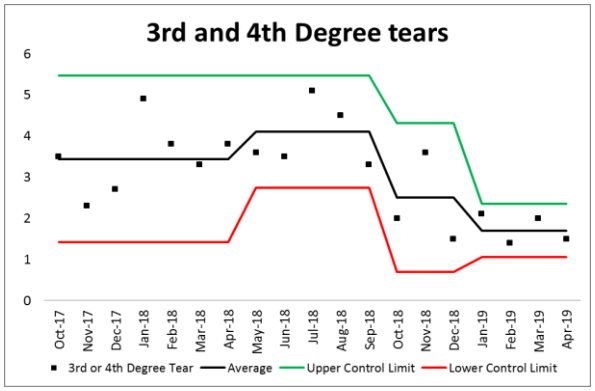
St George's University Hospitals NHS Foundation Trust

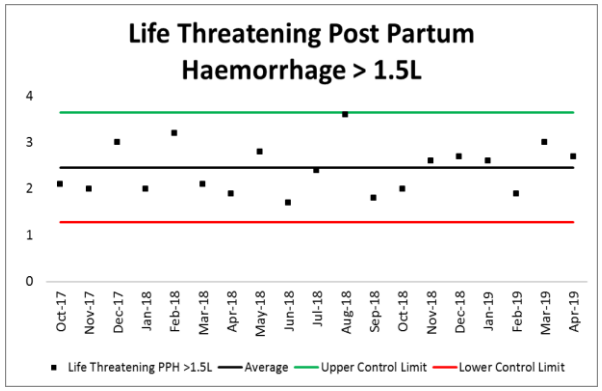
Maternity

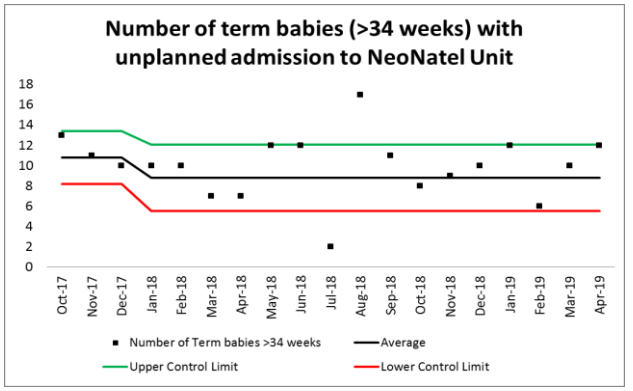


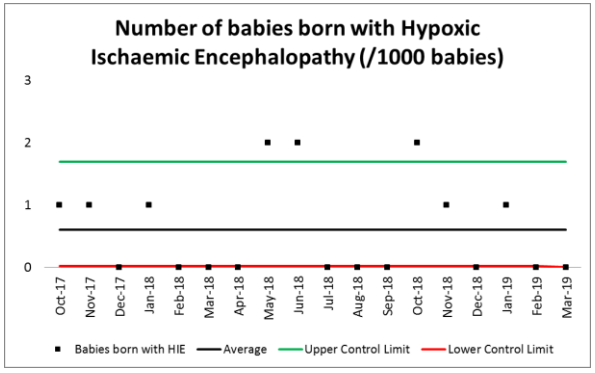


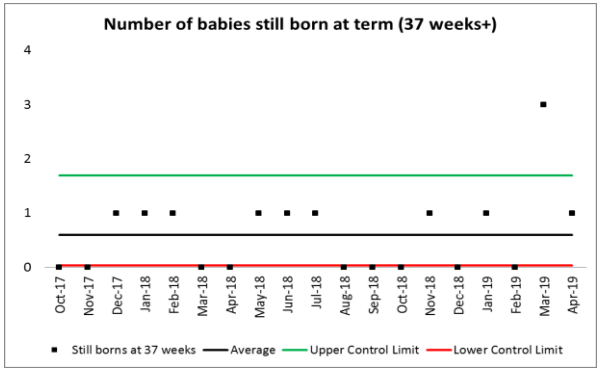


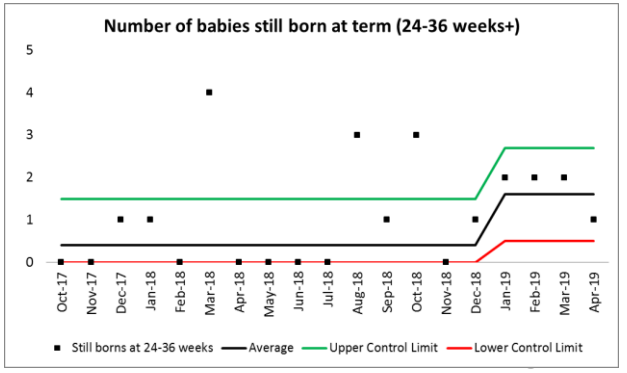






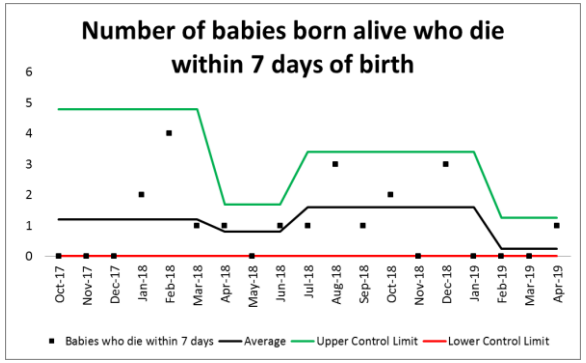


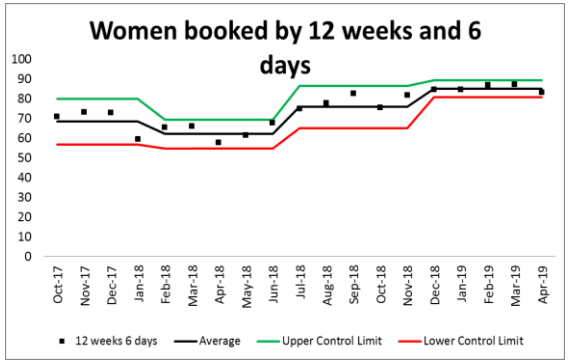




Our Patient Perspective

Maternity





Our Patient Perspective

St George's University Hospitals NHS Foundation Trust

Patient Voice

Indicator Description	Target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
Emergency Department FFT - % positive responses	90%	84.0%	85.0%	85.5%	83.7%	84.6%	83.5%	84.2%	79.2%	84.2%	82.8%	78.5%	81.6%	80.1%
Inpatient FFT - % positive responses	95%	97.2%	97.3%	97.1%	96.7%	96.6%	96.3%	97.0%	95.5%	96.4%	96.5%	96.0%	96.9%	96.5%
Maternity FFT - Antenatal - % positive responses	90%	100.0%	97.2%	100.0%	100.0%	100.0%	100.0%	100.0%						100.0%
Maternity FFT - Delivery - % positive responses	90%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	97.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Maternity FFT - Postnatal Ward - % positive responses	90%	100.0%	98.4%	100.0%	100.0%	100.0%	98.7%	100.0%	100.0%	90.9%	95.6%	95.7%	91.7%	96.4%
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%	97.1%	98.5%	98.3%	98.0%	98.4%	99.5%	95.6%	97.4%	96.1%	96.3%	94.9%	98.9%	98.3%
Outpatient FFT - % positive responses	90%	97.3%	97.3%	97.4%	97.4%	97.1%	96.3%	94.9%	97.3%	95.6%	96.1%	92.3%	90.7%	90.5%
Mixed Sex Breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Complaints Received		96	85	79	120	96	93	90	88	78	92	84	101	108
% of Complaints responses to within 25 working days	85%	69%	85%	67%	55%	71%	76%	76%	75%	78%	66%	55%	80%	72%
% of Complaints responses to within 40 working days	95%	55%	67%	77%	67%	71%	43%	60%	63%	48%	30%	64%	44%	56%
% of Complaints responses to within 60 working days	95%	100%	100%	67%	None Due	None Due	None Due	100%	None Due	None Due	100%	100%	100%	100%
Number of Complaints breaching 6 months Response Time	0							0	0	0	0	0	0	1
PALS Received		264	317	292	337	294	335	416	353	252	369	334	478	457

What the information tells us

- ED Friends and Family Test (FFT) – In the month of April 80.1% of patients attending the Emergency Department would recommend the service to family and friends. The response rate has increased to 15% in the month of April, although below our target of 20%.
- Inpatient Friends and Family Test (FFT) continues to be above threshold reporting 96% in April providing reasonable assurance on the quality of patient experience
- We continue to deliver above target against our outpatient recommend rate, however in the last 2 months this has fallen to 90%, coinciding with an increase in our response rate with the introduction of text messaging.
- Maternity and Community FFT remain above local threshold with work continuing to improve the number of patients responding which is currently below target.

Actions and Quality Improvement Projects

Patients can now access the FFT on our website. In addition to the monthly reports of performance to ward areas a weekly report to matrons/ward managers is now in place. This gives the number of discharges versus the number of FFT responses completed and clearly identifies areas that need to improve. Text messaging the FFT after appointment has started in a number of clinics.

Complaints and PALS: The indicator has changed slightly so that compliance can be seen for each category of complaint for the reporting month. We are monitoring the number of deadlines that are met in the month. For example: in April 72% of 25 day complaints, with a response deadline in April, achieved that deadline. PALS concerns are still high compared with earlier months, concerns raised in March and April are being analysed to see if a reason for this can be identified.

Our Patient Perspective

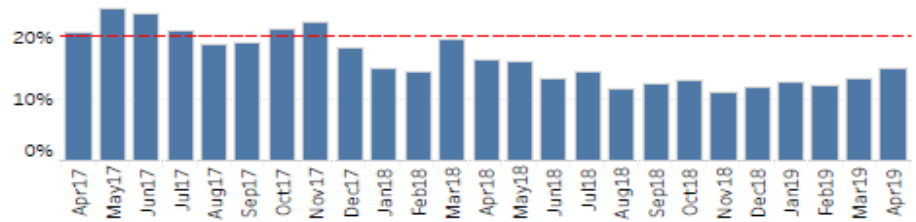
Patient Voice

CARING – Friends and Family Test

--- Target ¢ MetricMeasure Percentage Neutral

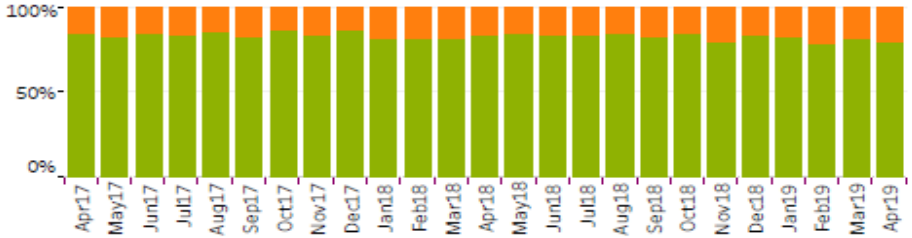
A&E Friends & Family Response Rate

Target: 20% Mar 19: 13.20% Apr 19: 14.90% Movement: ▲1.70%



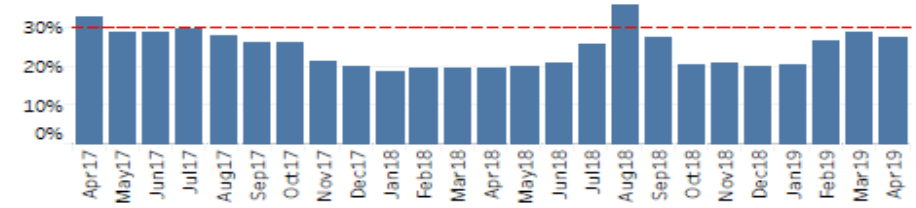
A&E Friends & Family Recommend Rate

The expected target is 90%



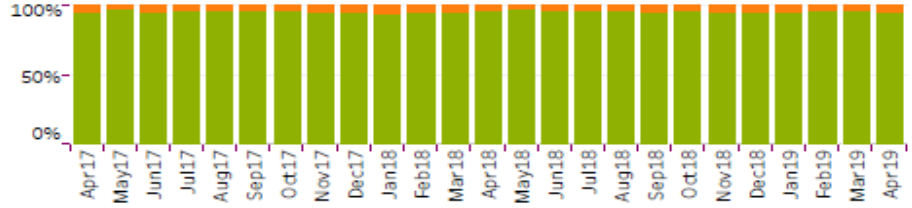
IP Friends & Family Response Rate

Target: 30% Mar 19: 28.90% Apr 19: 27.50% Movement: ▼-1.40%



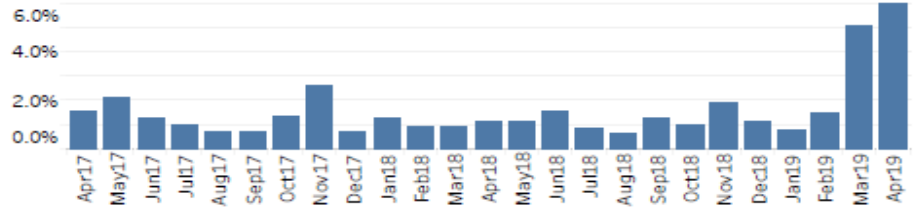
IP Friends & Family Recommend Rate

The expected target is 95%



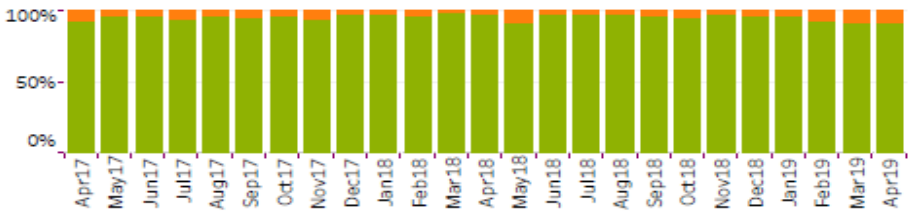
OP Friends & Family Response Rate

Target: 20% Mar 19: 5.00% Apr 19: 7.10% Movement: ▲2.10%



OP Friends & Family Recommend Rate

The expected target is 90%



Our Patient Perspective

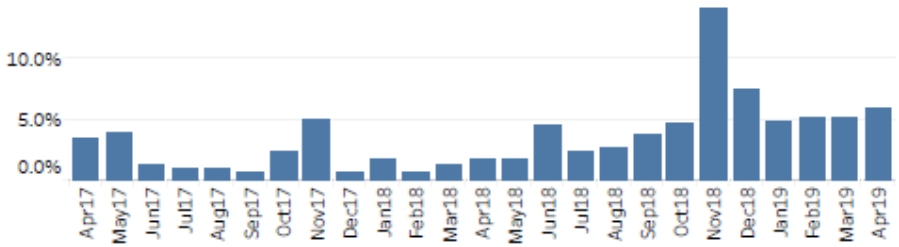
Patient Voice

CARING – Friends and Family 2

--- Target ¢ MetricMeasure Percentage Neutral

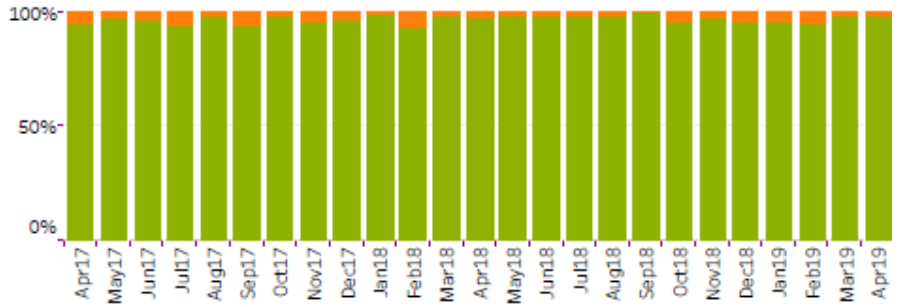
Community Friends & Family Response Rate

Target: 20% Mar 19: 5.10% Apr 19: 5.90% Movement: ▲0.80%



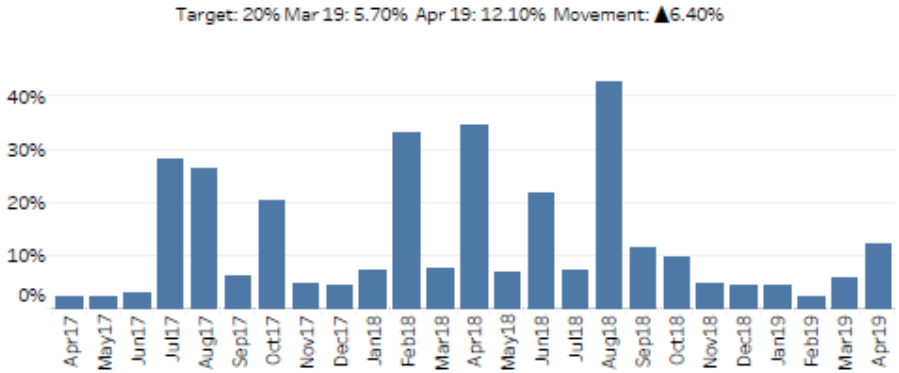
Community Friends & Family Recommend Rate

The expected target is 90%



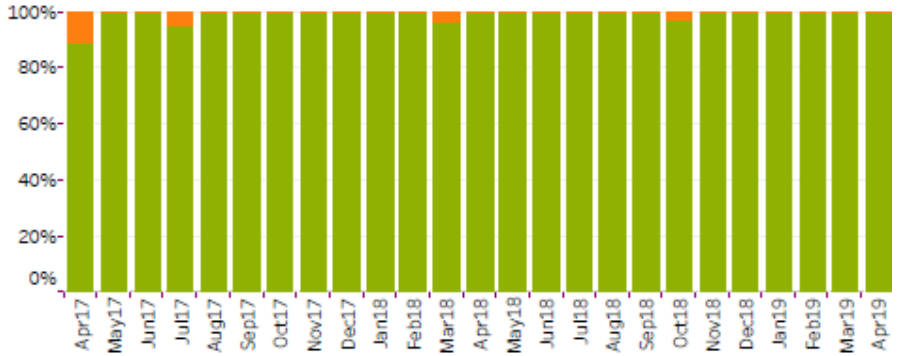
Maternity (Birth) Friends & Family Response Rate

Target: 20% Mar 19: 5.70% Apr 19: 12.10% Movement: ▲6.40%



Maternity (Birth) Friends & Family Recommend Rate

The expected target is 90%



Balance Scorecard

NHS
St George's University Hospitals
NHS Foundation Trust

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 R	Mortality	Readmissions	Maternity G	Patient Voice
OUR **PROCESS** PERSPECTIVE	Emergency Flow	Cancer A	Diagnostics G	On the day cancellations	18 Week Referral to Treatment	
OUR **PEOPLE** PERSPECTIVE	Workforce	Agency use				

Our Process Perspective

St George's University Hospitals NHS Foundation Trust

Emergency Flow

Indicator Description	Target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
4 Hour Operating Standard	95%	88.4%	93.3%	93.6%	93.3%	91.1%	90.3%	90.1%	85.5%	85.6%	84.2%	82.2%	83.1%	85.4%
Patients Waiting in ED for over 12 hours following DTA	0	1	1	0	1	0	1	0	1	2	0	0	1	1
Admitted patients with a length of stay 7 Days or Greater		303	265	278	271	272	266	287	294	291	315	321	315	298
Ambulance Turnaround - % under 15 minutes	100%	45.0%	45.7%	43.6%	42.0%	42.3%	46.4%	42.5%	37.4%	37.0%	33.9%	33.0%	33.0%	35.1%
Ambulance Turnaround - % under 15 minutes (London Average)	100%	45.2%	45.7%	47.4%	46.7%	48.1%	52.6%	47.4%	46.5%	44.7%	41.6%	43.1%	45.4%	43.5%
Ambulance Turnaround - number of patients not handed over within 30 minutes	0	92	65	72	67	85	109	111	138	135	145	87	94	76
Ambulance Turnaround - % under 30 minutes	100%	95.3%	96.8%	96.3%	96.2%	95.5%	94.1%	94.5%	93.0%	93.6%	92.3%	95.1%	93.6%	95.5%
Ambulance Turnaround - % under 30 minutes (London Average)	100%	88.8%	91.9%	93.7%	93.1%	92.2%	92.5%	92.2%	91.5%	90.5%	88.2%	90.3%	92.7%	91.7%
Ambulance Turnaround - number over 60 minutes	0	1	0	0	0	2	3	0	3	1	13	6	8	6

What the information tells us

- The Emergency Department saw nearly a 3% increase in the total number of patients attending the Emergency Department compared to the same month last year, treating an additional 14 patients per day, with the increases coming in patients self-presenting to the department.
- A step change seen in the number of stranded patients, with a decrease in both stranded and super stranded patients in April. Performance reported are at levels achieved before December 18.
- Performance against the Four Hour Operating Standard increased in April reporting 85.4%, which was below the monthly improvement trajectory of 90%. Admitted performance has remained within its process limits since January whereas non-admitted performance has varied.

Actions and Quality Improvement Projects

- In April, just under 1,000 patients were streamed back to Primary Care, with the percentage of all attending patients directed elsewhere for assessment and treatment increasing by 40% compared to the same period last year. Commissioner colleagues are looking to work more closely with individual GP practices to understand the root causes of this growth
- Divisions are reviewing stranded and super stranded patients in escalation review meetings and we continue to work with sector colleagues to further improve processes to enable and facilitate discharge.
- MADE Event (Multi-Agency-Discharge-Event) took place in April with Local Health and Social Care System Partners

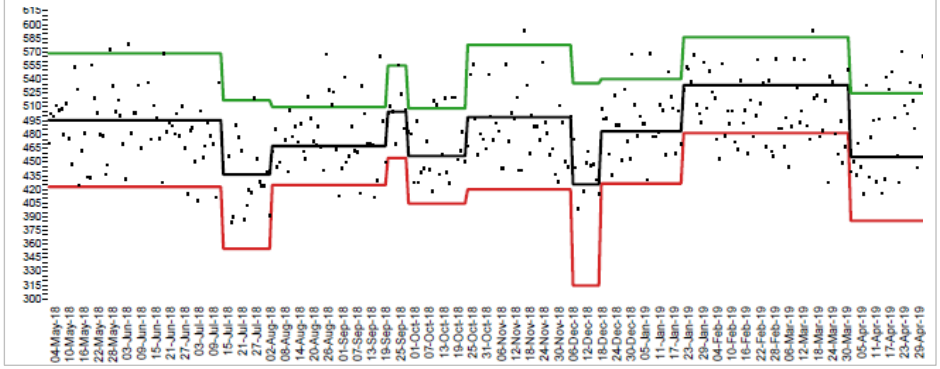
Our Process Perspective

St George's University Hospitals NHS Foundation Trust

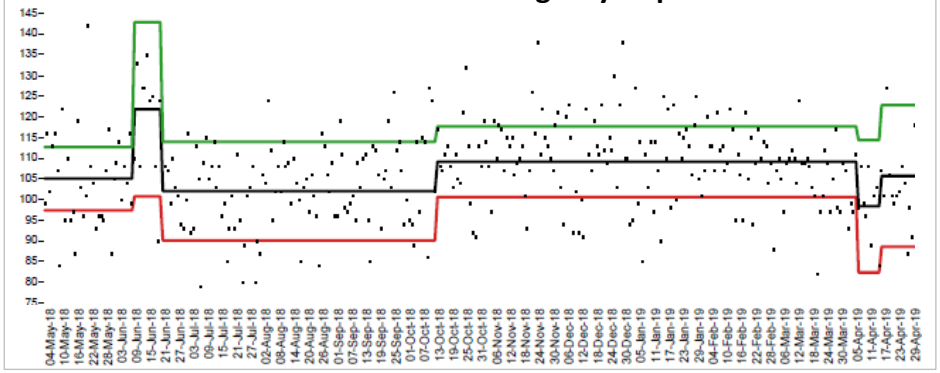
Emergency Flow

Total | Average | Upper Control Limit | Lower Control Limit

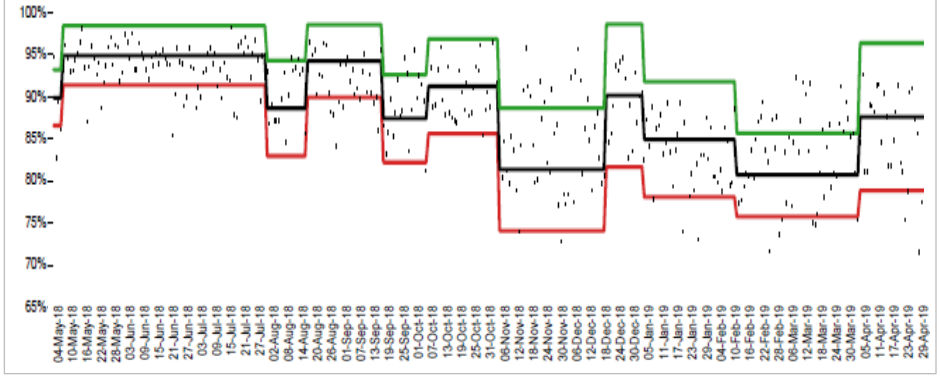
Number of Attendances to Emergency Department



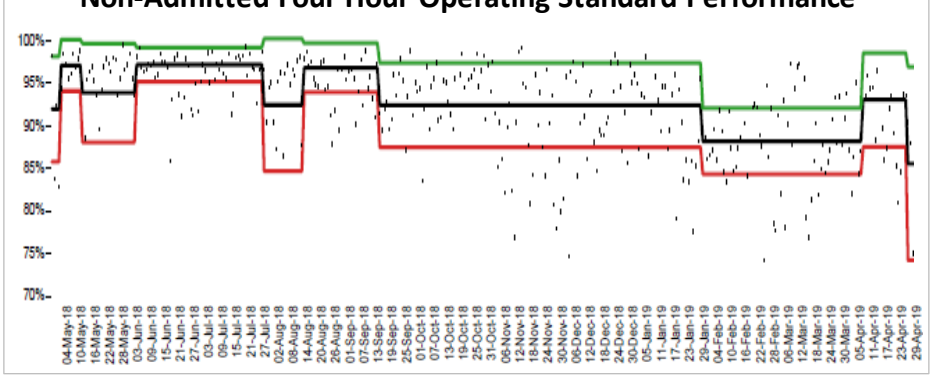
Ambulance Arrivals to the Emergency Department



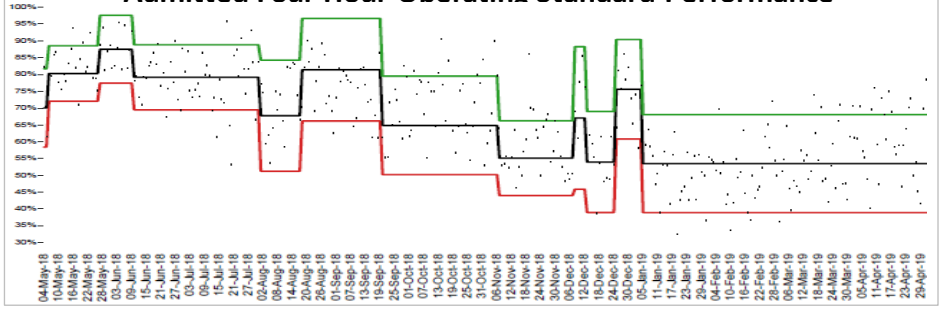
Four Hour Operating Standard Performance



Non-Admitted Four Hour Operating Standard Performance



Admitted Four Hour Operating Standard Performance



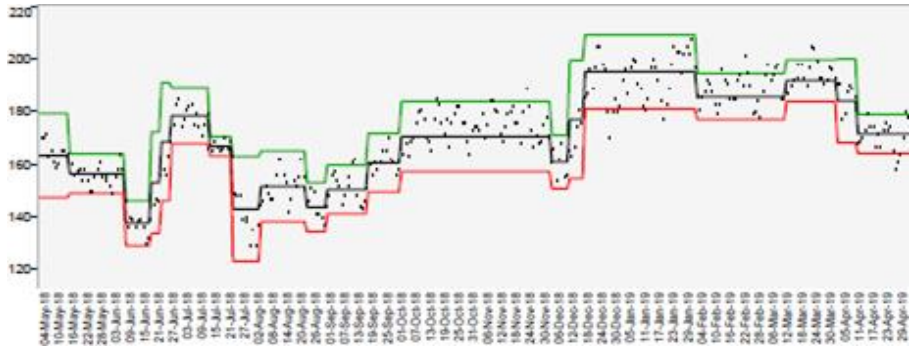
Our Process Perspective

St George's University Hospitals NHS Foundation Trust

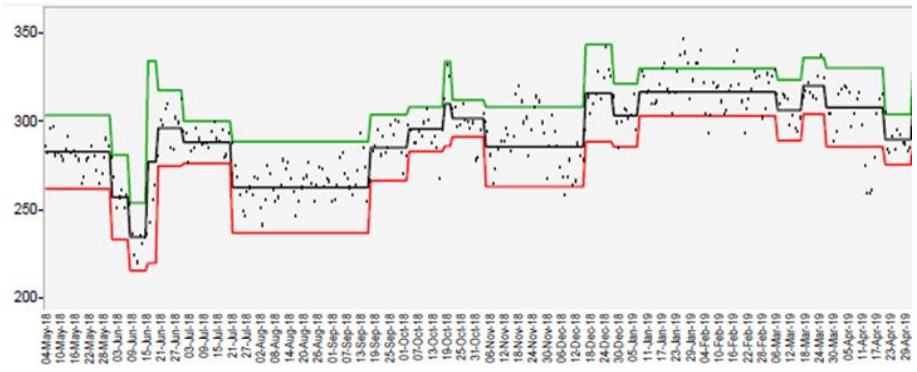
Emergency Flow

Total — Average — Upper Control Limit — Lower Control Limit

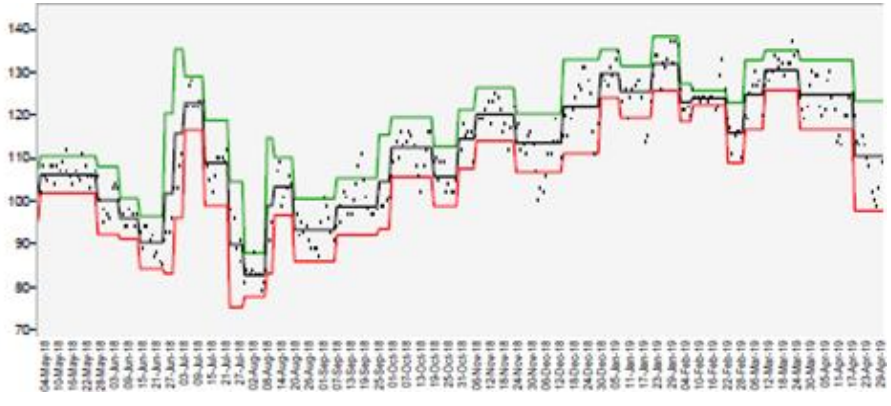
Admitted patients with a length of stay 7 Days or Greater



Admitted patients with a length of stay 14 Days or Greater



Admitted patients with a length of stay 21 Days or Greater



Our Process Perspective

St George's University Hospitals NHS Foundation Trust

Referral to Treatment

Indicator Description	Target	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
RTT Incomplete Performance	92%	84.5%	85.2%	86.1%												
RTT Incomplete Trajectory		83%	84%	84%	84.3%	84.6%	84.9%	85.3%	85.5%	85.8%	86.1%	86.5%	86.8%	87.2%	87.7%	88.1%
Total waits greater than 18 weeks (inc 52Wk waiters)		5,921	5,929	5,515												
Total waits greater than 18 weeks Trajectory				6,400	6,263	6,142	6,020	5,859	5,779	5,657	5,536	5,376	5,255	5,095	4,894	4,734
Total waits greater than 52 weeks	0	118	116	27												
Total waits greater than 52 weeks Trajectory				31	23	16	9	5	5	5	0	0	0	0	0	0
RTT Incomplete Performance - Admitted		65.50%	65.50%	66.61%												
Total waits greater than 18 weeks - Admitted		1,563	1,563	1,428												
Total waits greater than 52 weeks - Admitted	0	62	63	18												
RTT Incomplete Performance -Non Admitted		87.72%	87.70%	88.45%												
Total waits greater than 18 weeks - Non Admitted		4,358	4,366	4,087												
Total waits greater than 52 weeks - Non Admitted	0	56	53	9												

What the information tells us

- The Trust remains ahead of trajectory for RTT incomplete performance in March 2019 for a third consecutive month following a return to reporting in January 2019.
- A sizeable reduction in the number of patients waiting over 52 weeks for first definitive treatment from 116 in February 2019 down to 27 in March 2019.

Actions and Quality Improvement Projects

- Currently validating April month end performance ahead of submission 20th May 2019 – The Trust will submit a position ahead of trajectory for incomplete performance.
- Continue daily monitoring of all patients waiting over 52 weeks for first definitive treatment three month forward look.
- Continue to reduce the number of patients unbooked for first outpatient appointment – Monitoring all patients above 15 weeks from week commencing 13th May (shifting from 18 weeks).
- Revised RTT governance structure and meeting schedule to be fully implemented by Tuesday 21st May 2019.

Our Process Perspective

Referral To Treatment

Specialty	Admitted		Non Admitted	
	Total	% within 18 weeks	Total	% within 18 weeks
General Surgery	319	33.5%	578	79.4%
Urology	228	63.2%	1,044	88.4%
Trauma & Orthopaedics	253	54.2%	2,436	87.8%
Ear, Nose & Throat (ENT)	443	49.0%	1,959	87.8%
Ophthalmology	0		0	
Oral Surgery	6	83.3%	393	95.4%
Neurosurgery	181	70.7%	1,931	83.1%
Plastic Surgery	340	55.0%	1,069	84.3%
Cardiothoracic Surgery	0		2	50.0%
General Medicine	0		23	100.0%
Gastroenterology	448	95.3%	1,648	87.7%
Cardiology	735	76.3%	2,263	87.6%
Dermatology	2	100.0%	2,115	91.3%
Thoracic Medicine	0		1,495	91.6%
Neurology	39	87.2%	2,272	91.5%
Rheumatology	2	100.0%	856	82.5%
Geriatric Medicine	0		73	98.6%
Gynaecology	278	52.9%	2,064	95.5%
Other	1,003	74.9%	13,176	88.1%
Total	**4,277**	**66.6%**	**35,397**	**88.5%**

Within 18 weeks	Over 18 weeks	Total	% within 18 weeks	Over 42 weeks	Over 52 weeks
566	331	897	63.1%	65	21
1,067	205	1,272	83.9%	10	0
2,275	414	2,689	84.6%	10	0
1,937	465	2,402	80.6%	38	0
0	0	0		0	0
380	19	399	95.2%	0	0
1,733	379	2,112	82.1%	11	0
1,088	321	1,409	77.2%	15	0
1	1	2	50.0%	0	0
23	0	23	100.0%	0	0
1,872	224	2,096	89.3%	8	0
2,544	454	2,998	84.9%	2	0
1,934	183	2,117	91.4%	4	0
1,370	125	1,495	91.6%	0	0
2,114	197	2,311	91.5%	1	0
708	150	858	82.5%	3	0
72	1	73	98.6%	0	0
2,118	224	2,342	90.4%	8	0
12,357	1,822	14,179	87.2%	113	6
34,159	**5,515**	**39,674**	**86.1%**	**288**	**27**

Our Process Perspective

St George's University Hospitals NHS Foundation Trust

Diagnostics

Indicator Description	Threshold	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	Trend
6 Week Diagnostic Performance	1%	0.2%	0.2%	0.3%	0.3%	0.2%	0.4%	0.2%	0.5%	0.6%	0.5%	0.3%	0.5%	1.6%	
6 Week Diagnostic Breaches	N/A	15	14	25	24	15	30	18	39	37	41	24	40	115	
6 Week Diagnostic Waiting List Size	N/A	7,956	7,735	7,809	7,236	6,946	7,617	7,593	7,322	6,652	7,649	7,754	7,622	7,247	

Indicator Description	Threshold	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	Trend
MRI	1%	0.1%	0.0%	0.4%	0.0%	0.3%	0.1%	0.2%	0.3%	0.6%	0.4%	0.6%	0.1%	0.3%	
CT	1%	0.1%	0.0%	0.3%	0.0%	0.0%	0.0%	0.2%	0.1%	0.7%	0.6%	0.0%	0.0%	0.1%	
Non Obstetric Ultrasound	1%	0.0%	0.0%	0.3%	0.0%	0.1%	0.6%	0.0%	0.0%	0.0%	0.0%	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%	0.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.5%	
Audiology Assessments	1%	5.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
Echocardiography	1%	0.2%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.8%	0.4%	4.3%	12.1%	
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%	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%	0.0%	
Sleep Studies	1%	0.0%	0.0%	0.0%	1.1%	1.5%	0.0%	0.0%	7.7%	2.4%	1.1%	0.8%	2.7%	4.6%	
Urodynamics	1%	5.0%	23.9%	6.3%	26.5%	0.0%	13.9%	14.6%	10.2%	8.5%	16.3%	14.0%	0.0%	5.7%	
Colonoscopy	1%	0.6%	0.4%	0.0%	0.0%	0.0%	0.0%	0.7%	3.0%	0.0%	2.9%	1.0%	0.0%	1.0%	
Flexi Sigmoidoscopy	1%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.2%	
Cystoscopy	1%	1.0%	0.8%	3.0%	1.8%	4.4%	2.6%	3.0%	4.5%	5.4%	3.2%	0.0%	1.9%	3.2%	
Gastroscopy	1%	1.0%	0.0%	0.0%	1.8%	0.0%	0.3%	0.0%	0.0%	0.6%	1.4%	0.6%	1.8%	2.1%	

What the information tells us

- In April, trust performance fell below the national standard for the six week diagnostic waits, performance exceeded the upper process limits, with a total of 115 patients waiting greater than six weeks and a performance of 1.6%.
- Compliance has not been achieved within seven modalities, with the largest increase being within Echocardiography.

Actions and Quality Improvement Projects

- New post in place to provide operational leadership to diagnostics within Cardiology and the service expects to be compliant in May.
- Performance and recovery plans continue to be monitored through the weekly performance meetings.

Our Process Perspective

St George's University Hospitals NHS Foundation Trust

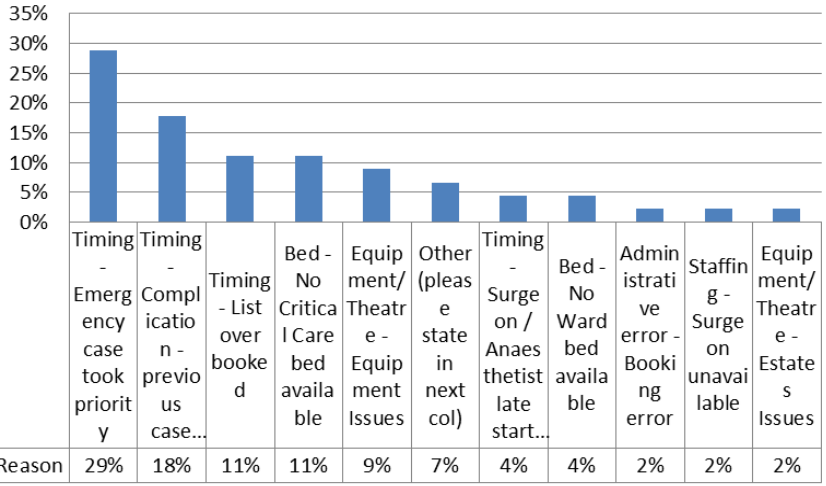
On the Day Cancellations for Non-Clinical Reasons

Indicator Description	Target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
Number of on the Day Cancellations		64	87	42	54	44	55	52	53	60	86	73	49	45
Number of on the Day cancellations re-booked within 28 Days		60	80	33	51	39	48	50	52	58	86	71	47	42
% of Patients re-booked within 28 Days	100%	93.8%	92.0%	78.6%	94.4%	88.6%	87.3%	96.2%	98.1%	96.7%	100.0%	97.3%	95.9%	93.3%

What the information tells us

- The variability in On the Day cancellations has reduced significantly coupled with an overall improvement with the mean number of cancelled operations per day at 1.4.
- Similarly, the rebooking process has significantly reduced its variability and has also improved with, on average, 97% rebooked within 28 days for the previous six months
- In April, 93.3% of patients were re-booked within 28 days and the number of cancellations have reduced by 30% compared to the same period last year.
- Reasons for on the day cancellations include Trauma cases taking priority, complications and ITU bed capacity.

Reason for Cancellation

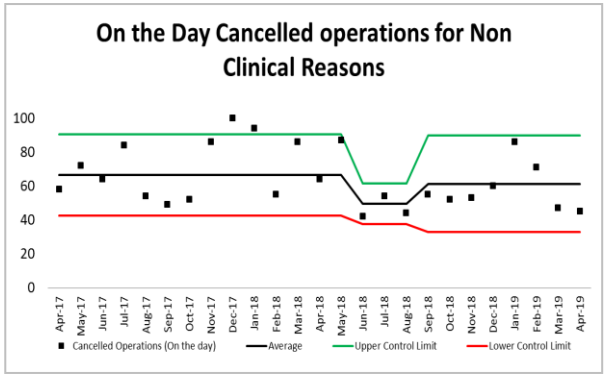


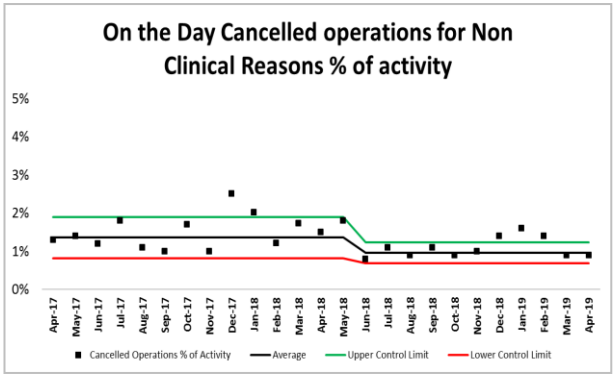
Actions and Quality Improvement Projects

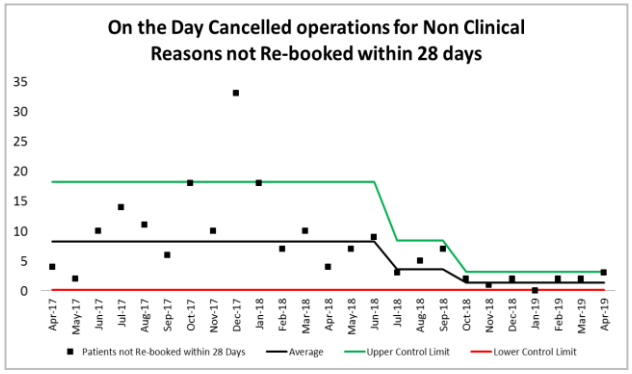
- Continue to roll out Patient Pathway Co-ordinators booking Pre-Operative Assessments for Day Surgery, as well as Inpatient cases improving patient experience and slot utilisation. This has already significantly improved the average utilisation rates from 50% in December to 73% in February and achieving 90% in the first week of March for Pre Op Assessment slots.
- Following successful implementation of the Text Reminder Service within Day Surgery Pre-Assessment, Inpatient Surgery Pre-Assessment expansion is being explored
- Call to every patients before surgery continues to work well, next steps are to create a list of patients that are fit (via improved POA process) and available at short notice (via improved triaging processes) to fill gaps of any short notice cancellations
- At times of high non-elective activity, ensure that elective patients are reviewed, including their bed requirements, in advance of the day of surgery

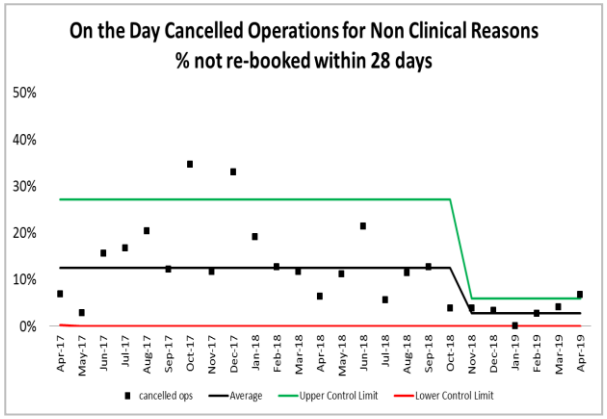
Our Process Perspective

On the Day Cancellations for Non-Clinical Reasons









Our Process Perspective

St George's University Hospitals NHS Foundation Trust

Cancer

Indicator Description	Target	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	No of Patients
Cancer 14 Day Standard	93%	96.8%	93.1%	93.3%	83.0%	93.1%	95.0%	95.5%	96.3%	95.9%	96.6%	94.4%	93.3%	94.4%	1,360
Cancer 14 Day Standard Breast Symptomatic	93%	96.8%	94.4%	79.4%	22.2%	55.2%	86.4%	97.9%	97.1%	95.4%	96.9%	97.4%	94.6%	94.7%	263
Cancer 31 Day Diagnosis to Treatment	96%	96.5%	98.4%	99.0%	97.0%	98.4%	98.5%	99.0%	99.1%	96.5%	98.2%	97.4%	98.4%	98.1%	216
Cancer 31 Day Second or subsequent Treatment (Surgery)	94%	95.5%	100.0%	95.7%	94.1%	95.0%	96.6%	100%	96.9%	96.6%	94.6%	97.9%	94.4%	96.2%	26
Cancer 31 Day Second or subsequent Treatment (Drug)	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	99
Cancer 62 Day Referral to Treatment Standard	85%	88.1%	92.3%	85.9%	89.6%	85.7%	85.7%	80.6%	87.8%	88.1%	94.8%	86.2%	77.8%	85.0%	60
Cancer 62 Day Referral to Treatment Standard Reallocated Position	85%												80.5%	85.0%	63.5
Cancer 62 Day Referral to Treatment Screening	90%	95.2%	80.8%	92.7%	84.6%	73.8%	91.6%	94.1%	91.8%	93.2%	82.0%	88.7%	70.5%	76.6%	32

What the information tells us

- The Trust met six of the seven Cancer standards in the month of March, continuing to achieve the 14 day standard, and returning to compliance against the 62 day standard.
- Trust compliance against the 14 day standard was 94.4% with Gynaecology, Urology and Upper GI continuing to report below the target of 93%. Monthly performance remains inside process limits.
- Trust compliance against the 62 day target was 85% with a total of four tumour groups non-complaint, Head and Neck, Lower GI, Lung and Upper GI. Performance continues to show variability over recent months but has remained within the Trusts confidence limits. Our internal 62 day performance was 89.1% in March.
- As shown by the wide upper and lower process limits, Cancer 62 day screening performance has been varied over the past thirteen months reporting the fourth consecutive month below the target of 90%.

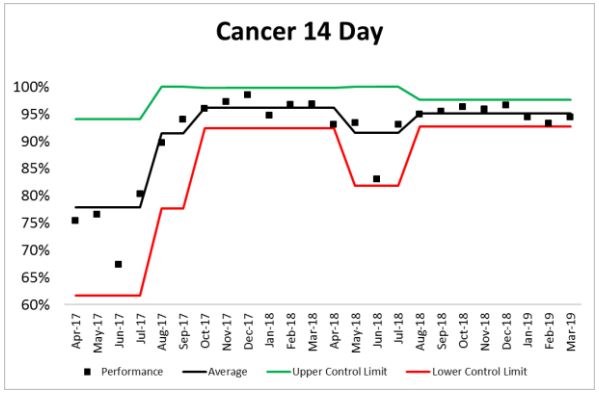
62 Day wait for First Treatment- GP referral to treatment (actual and internal performance)			
Month	Target	Actual Performance	Internal Performance
Oct-18	85%	87.8%	92.5%
Nov-18	85%	88.1%	100.0%
Dec-18	85%	94.8%	100.0%
Jan-19	85%	86.2%	96.0%
Feb-19	85%	77.8%	81.6%
Mar-19	85%	85.0%	89.1%

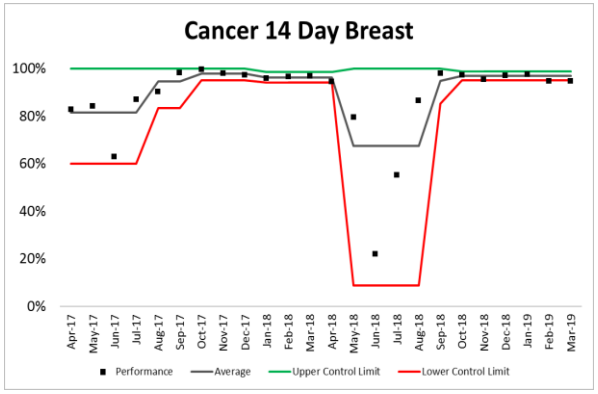
Actions and Quality Improvement Projects

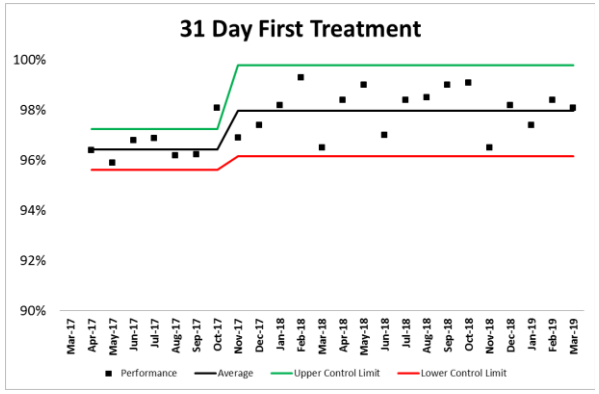
- There is a continued focus on improving internal processes as well as working with local providers to improve 38 day performance. Improvement trajectories have been agreed with other SWL providers to improve waiting times and quicker access to diagnostics and treatment for shared patients
- Capacity 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.
- Demand and Capacity plans currently being reviewed for all tumour groups currently non-compliant within 14 day and 62 day standards.

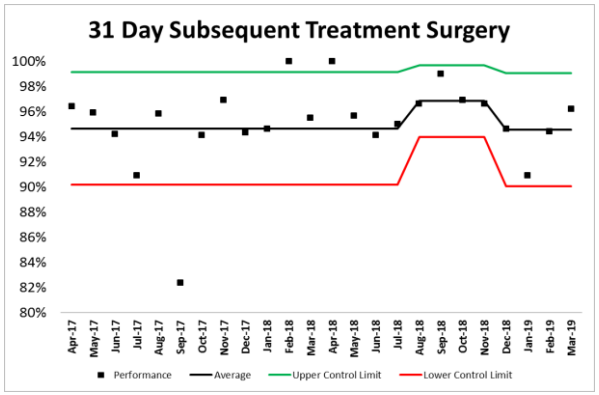
Our Process Perspective

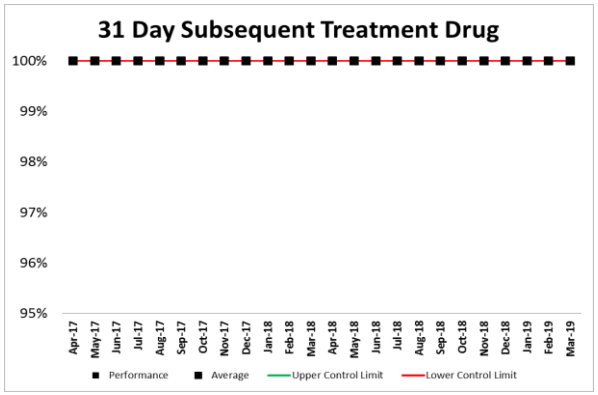
Cancer

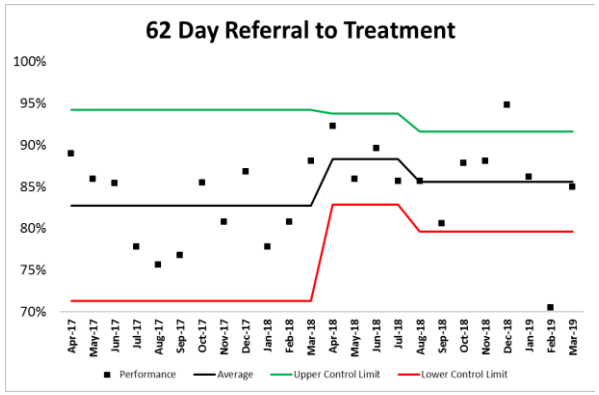


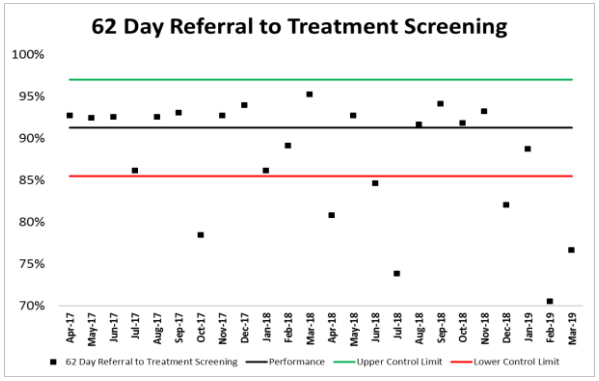












Our Process Perspective

St George's University Hospitals NHS Foundation Trust

Cancer

14 Day Standard Performance by Tumour Site - Target 93%

Tumour Site	Target	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	No of Patients
Brain	93%	100.0%	100.0%	100.0%	75.0%	100.0%	100.0%	-	100.0%	-	100.0%	100.0%	100.0%	-	0
Breast	93%	93.9%	94.8%	91.9%	61.2%	87.4%	97.5%	94.5%	99.4%	97.4%	98.8%	97.4%	98.6%	97.9%	239
Children's	93%	100.0%	80.0%	100.0%	100.0%	90.9%	-	100.0%	50.0%	100.0%	100.0%	100.0%	100.0%	100.0%	5
Gynaecology	93%	94.3%	94.9%	91.9%	86.1%	91.7%	90.8%	81.9%	87.8%	87.5%	95.9%	69.5%	65.3%	80.0%	115
Haematology	93%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.2%	100.0%	100.0%	100.0%	100.0%	100.0%	20
Head & Neck	93%	100.0%	100.0%	97.5%	92.3%	93.0%	95.6%	99.3%	99.8%	98.1%	96.0%	98.5%	100.0%	99.3%	150
Lower Gastrointestinal	93%	97.8%	94.1%	90.3%	67.5%	94.7%	98.9%	94.3%	98.1%	95.8%	94.5%	97.2%	92.1%	94.5%	256
Lung	93%	100.0%	100.0%	96.3%	90.9%	97.6%	94.7%	95.2%	100.0%	100.0%	100.0%	93.3%	100.0%	96.9%	32
Skin	93%	95.9%	94.1%	93.8%	92.7%	93.3%	92.9%	97.4%	96.6%	97.4%	97.6%	97.1%	95.9%	97.6%	330
Upper Gastrointestinal	93%	95.3%	85.2%	88.1%	89.9%	96.6%	93.9%	96.7%	98.8%	95.4%	94.1%	91.8%	90.9%	83.5%	85
Urology	93%	98.2%	81.3%	92.9%	96.5%	95.2%	93.1%	96.8%	92.4%	93.4%	96.6%	94.5%	94.2%	92.2%	128

62 Day Standard Performance by Tumour Site - Target 85%

Tumour Site	Target	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	No of Patients
Brain	85%	-	-	-	-	-	-	-	-	100.0%	100.0%	-	-	-	0
Breast	85%	88.9%	94.1%	84.6%	91.7%	90.9%	78.9%	100.0%	100.0%	100.0%	100.0%	100.0%	82.4%	90.9%	11
Children's	85%	-	-	-	-	-	-	-	-	-	-	-	-	-	0
Gynaecology	85%	0.0%	100.0%	80.0%	100.0%	75.0%	100.0%	80.0%	90.0%	100.0%	83.3%	88.9%	50.0%	100.0%	2
Haematology	85%	81.8%	100.0%	63.6%	100.0%	100.0%	88.9%	75.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	2.0
Head & Neck	85%	80.0%	100.0%	90.0%	75.0%	72.7%	81.8%	80.0%	100.0%	86.7%	87.5%	46.2%	85.7%	80.0%	2.5
Lower Gastrointestinal	85%	100.0%	100.0%	100.0%	100.0%	71.4%	83.3%	66.7%	88.9%	100.0%	100.0%	100.0%	81.8%	66.7%	6
Lung	85%	100.0%	100.0%	87.5%	83.3%	71.4%	66.7%	28.6%	50.0%	70.0%	72.7%	80.0%	75.0%	70.0%	5
Skin	85%	100.0%	100.0%	90.9%	100.0%	100.0%	100.0%	84.6%	92.3%	100.0%	100.0%	92.3%	100.0%	89.7%	14.5
Sarcoma	85%	-	-	-	-	-	-	-	-	-	-	-	-	-	0
Upper Gastrointestinal	85%	66.7%	87.5%	33.3%	80.0%	100.0%	78.9%	50.0%	54.5%	100.0%	100.0%	0.0%	50.0%	60.0%	2.5
Urology	85%	96.7%	80.5%	84.6%	84.9%	85.7%	88.2%	92.9%	88.9%	77.8%	95.0%	89.5%	71.1%	88.9%	13.5
Other	85%	-	-	-	-	-	100.0%	-	100.0%	100.0%	-	0.0%	-	100.0%	1

Balance Scorecard

St George's University Hospitals NHS Foundation Trust

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	18 Week Referral to Treatment	
OUR **PEOPLE** PERSPECTIVE	Workforce	Agency use				

Our People Perspective

Workforce

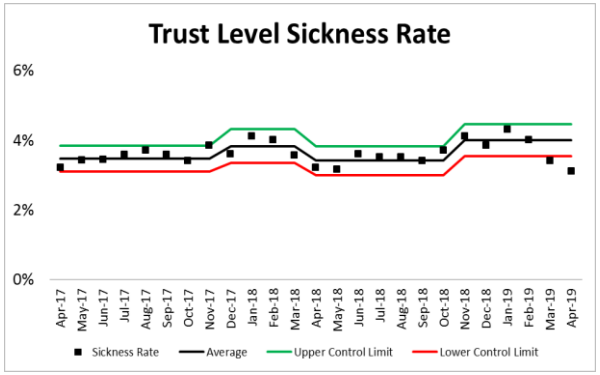
Indicator Description	Target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
Trust Level Sickness Rate	3.2%	3.2%	3.2%	3.6%	3.5%	3.5%	3.4%	3.7%	4.1%	3.8%	4.3%	4.0%	3.4%	3.1%
Trust Vacancy Rate	10%	12.6%	11.3%	11.0%	10.6%	10.2%	10.4%	9.3%	8.9%	9.4%	9.4%	9.3%	9.6%	9.1%
Trust Turnover Rate* Excludes Junior Doctors	13%	16.9%	17.0%	17.3%	17.4%	17.1%	16.6%	16.6%	16.9%	16.9%	17.1%	17.1%	17.5%	17.1%
Total Funded Establishment		9,469	9,318	9,242	9,239	9,160	9,180	9,165	9,171	9,196	9,229	9,238	9,248	9,112
IPR Appraisal Rate - Medical Staff	90%	81.1%	81.3%	79.9%	77.7%	Not currently provided								
IPR Appraisal Rate - Non Medical Staff	90%	61.2%	63.4%	64.6%	67.6%	69.7%	69.7%	69.7%	71.8%	71.5%	70.9%	71.3%	70.4%	71.6%
Overall MAST Compliance %		86.5%	87.4%	88.1%	89.2%	89.3%	88.2%	88.3%	88.3%	89.1%	89.3%	89.1%	89.4%	89.8%
Ward Staffing Unfilled Duty Hours	10%	6.5%	5.1%	4.9%	5.8%	5.5%	6.7%	6.6%	5.1%	6.1%	6.6%	6.7%	7.2%	5.6%

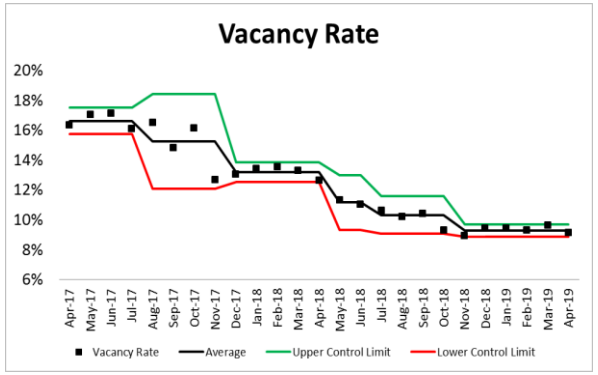
What the information tells us

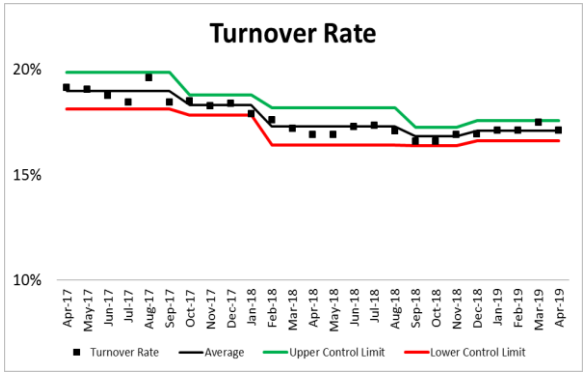
- The Trust Vacancy rate continues be within the expected process limits and shows little variation around a mean of 9.3% - this is shown by how close the upper and lower process limits are on the SPC chart with a standard deviation of 0.2%
- The Trust sickness level has remained above target of 3%, however a decrease is seen for a third consecutive month reporting 3.1% in April with two consecutive months below the lower process limit.
- Mandatory and Statutory Training figures for April were recorded at 89.8% with a mean of 89.3% and a tighter standard deviation of 0.3% for the past five months.
- Medical Appraisals rates are being reviewed and will not be reported this month.
- Non-medical appraisal have seen an improvement in the month of April however remains below target with a performance of 71.6% against a 90% target. However, as can be seen by the tight upper and lower process limits for the previous six months, the process is stable and will not likely reach 90% without external action.
- The total funded establishment has moved below our lower control limit reporting 9,112 which is a decrease of 3.8% compared to the same period last year

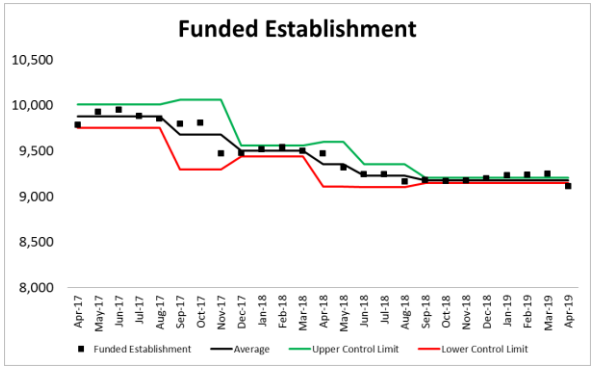
Our People Perspective

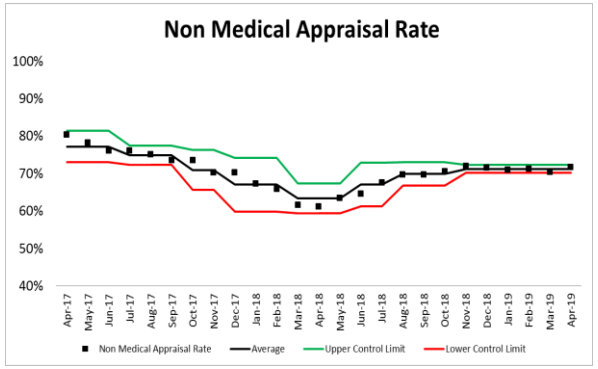
Workforce

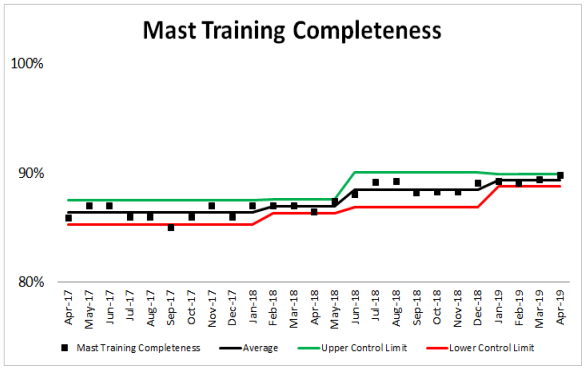


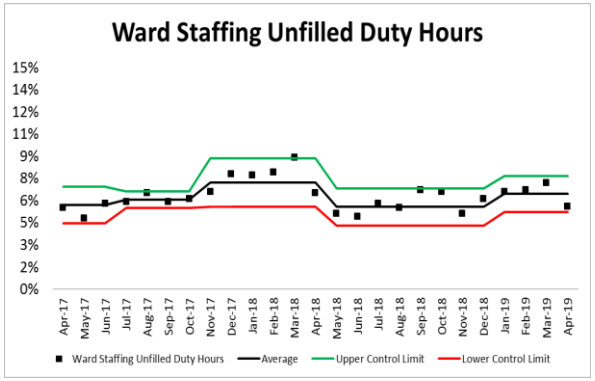






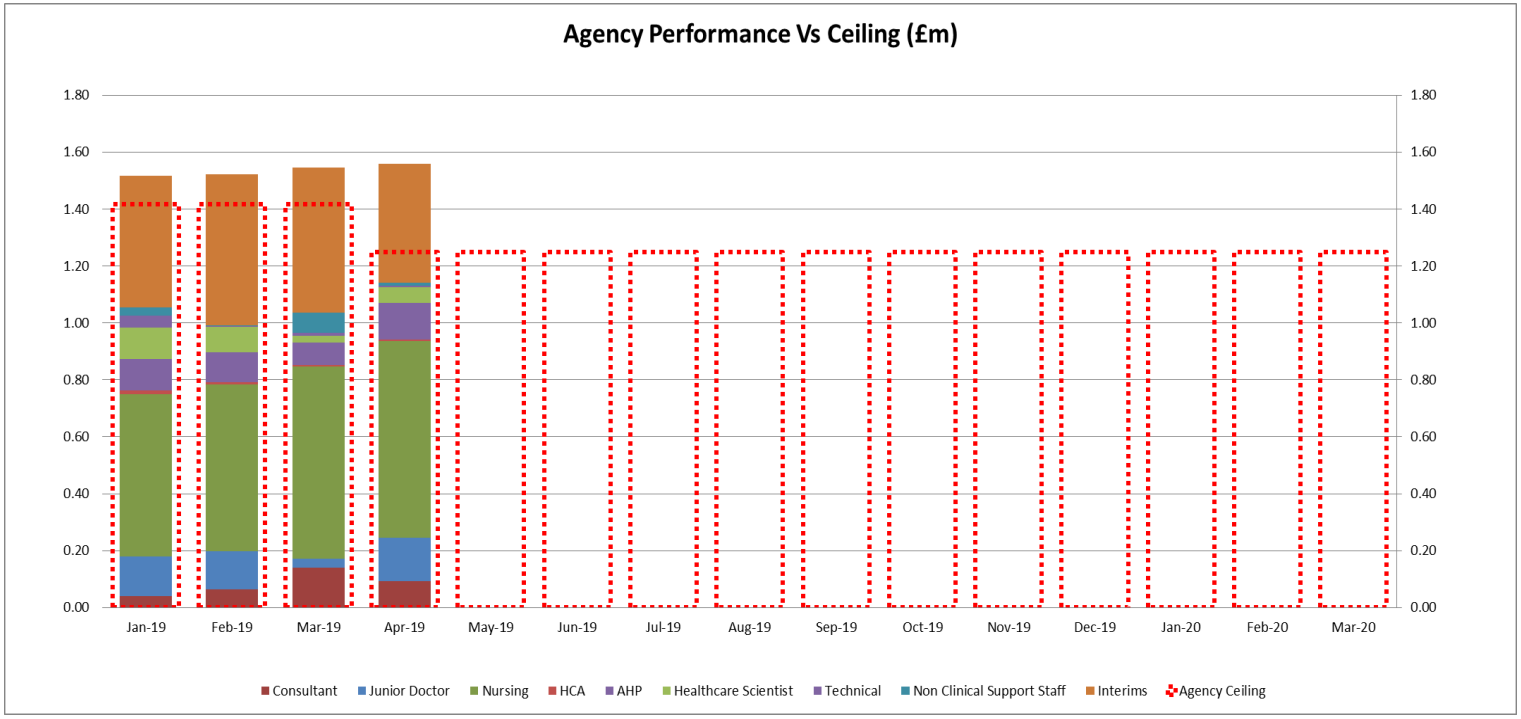






Our People Perspective

Agency Use



What the information tells us

- The Trust's total pay for April was £46.67m. This is £0.49m favourable to a plan of £47.16m.
- The Trust's 2019/20 annual agency spend target set by NHSI is £20.55m. There is an internal annual agency target of £15.00m.
- Agency cost in April was £1.56m or 3.3% of the total pay costs. For 2018/19, the average agency cost was 3.2% of total pay costs.
- For April, the monthly target set was £1.25m. The total agency cost is worse than the target by £0.31m.
- The biggest areas of overspend were Interims (£0.12m), Nursing (£0.11m) and Junior Doctor (£0.08m).

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	30th May 2019	**Agenda No**	**2.3**
Report Title:	Safe Staffing Report (Nursing and Midwifery Inpatient Establishment Review April 2019)		
Lead Director/ Manager:	Avey Bhatia- Chief Nurse & Director of Infection Prevention & Control		
Report Author:	Richard Lloyd-Booth- Deputy Chief Nurse		
Presented for:	Assurance		
Executive Summary:	Trusts have a duty to ensure safe staffing levels are in place and patients have a right to be cared for by appropriately qualified and experienced staff in a safe environment. This Nursing and Midwifery establishment review has followed methodology as set out by the Nursing Quality Board (2014). The methodology followed are: • The use of evidenced based tools such as Safer Nursing Care Tool kit • Reference to critical care guidelines • Paediatric guidelines such as the Royal College of Nursing and British Association of Perinatal Medicine • Professional Judgement Model • Comparison with national data and peers with the use of Care Hours Per Patient Day (CHPPD) on NHSI Model Hospital • Location, design and speciality of the ward/unit • Nursing and Midwifery quality outcome measures • Supernumery time for ward/unit managers • Reviewing headroom requirements and benchmarking against national standards • Nurse to patient ratios Following this methodology this review has assessed all inpatient areas and concluded the nursing and midwifery staffing numbers as safe and compliant with national recommendations.		
Recommendation:	• For the Trust Board to be assured that the triangulation of the Safer Nursing Care Tool, Professional Judgement and RN to patient ratios, demonstrates that the Trust has a reliable framework in place to ensure nurse staffing levels are commensurate with workload and quality & safety requirements for each ward. • The Trust Board to note the methodology followed and that all inpatient areas have been reviewed and have safe funded establishment levels for 2019/20. • The Trust Board is asked to support the approach to budget setting for Enhanced Care going forward into 2019/20 and the on-going work to sustain effective use of the staffing resource in terms of processes and controls into 2019/20.		
Supports			
Trust Strategic Objective:	Right care, right place, right time, Treat the patient, Treat the person, Build a better St George's, Balance the books invest in our future		
CQC Theme:	All		
Single Oversight Framework Theme:	Quality of Care Strategic Change		
Previously Considered by:	Nil	**Date**	
Appendices:	1. Copy of safe staffing numbers & ratios per ward		

Nursing Establishment Review April 2019

1.1 Introduction

In July 2014 the National Institute for Health and Care Excellence (NICE) issued safe staffing guidance for acute hospitals, to ensure that robust and evidence based methodologies are applied and thus patients receive safe and high quality care. The National Quality Board (NQB) in July 2016 detailed their expectations and framework within which decisions about safe and sustainable staffing should be made. In January 2018 the NQB published an improvement resource for all involved in clinical establishment setting, approval and deployment to support the delivery of safe, effective, caring, responsive and well-led ensure the right people, with the right skills at the right time and place to put patients first, are central to the delivery of high quality care.

In line with this guidance, St George's University Hospitals NHS Foundation Trust undertakes regular nurse establishment reviews reflecting the principles of best practice every 6 months.

The purpose of this report is to inform the Trust Board of the outcomes of the April 2018 assessment of nursing and midwifery staffing levels

This paper reports on the safe staffing levels at St George's for 2018/19 and revised into 2019/20 and comprises of the following main elements:

- The process for the nursing and midwifery establishment review and governance of the review
- The proposed changes to the nursing and midwifery establishment and the reflections into 2019/20 budget

1.2 Methodology

Providing high quality care to all patients means that St George's must use their available resources in the most efficient way possible for the benefit of our patients. Setting establishments is complex and having the right staff, with the right skills, in the right place is about more than the numbers and type of staff (registered and unregistered) but is also about leadership, culture, support and education.

The Trust uses the methodology as set out by the National Quality Board Guidance (NQB) when setting the right staffing levels on its wards. Establishment setting is completed twice a year. The Trust uses the evidenced based Acuity and Dependency Tool Safer Nursing Care Tool (SNCT)[1] and triangulates this with nursing sensitive quality indicators such as Pressure Ulcers, Incidents, Harms, safe staffing red flags (NICE), Patient Experience and uses Professional Judgement and comparison from other NHS peers via the Model Hospital Care Hours per Patient Day (CHPPD) data.

The table below is taken from the NQB staffing guidance and highlights our methodology.

[1] Safer Nursing Care Tool kit (2014) Shelford Group

Safe, Effective, Caring, Responsive and Well-Led Care		
Measure and Improve - patient outcomes, people productivity and financial sustainability - - report investigate and act on incidents (including red flags) - - patient, carer and staff feedback -		
- Implementation Care Hours per Patient Day (CHPPD) - - develop local quality dashboard for safe sustainable staffing -		
Expectation 1	**Expectation 2**	**Expectation 3**
Right Staff 1.1 evidence-based workforce planning 1.2 professional judgement 1.3 compare staffing with peers	**Right Skills** 2.1 mandatory training, development and education 2.2 working as a multi-professional team 2.3 recruitment and retention	**Right Place and Time** 3.1 productive working and eliminating waste 3.2 efficient deployment and flexibility 3.3 efficient employment and minimising agency

2.0 High level summary of outcome

The 2018/19 end of year establishment review has identified changes to skill mix and staffing levels. Money from underspent wards have funded overspent wards where any increases have been made we have worked with the finance department to ensure they have been reflected in the 2019/20 funded establishment budgets.

It should be noted that the establishment review considers safe staffing levels for existing ward capacity. Safe staffing levels for any planned capacity growth are considered as part of the business cases for those service developments.

2.1 Process for the establishment review

The process for the establishment review followed the same principles as previous years with the following changes:

- Following a review by NHSI on how we measure and recorded acuity and dependency we strengthened the oversight of the Safer Nursing Care Tool which is the tool used at St George's to measure acuity and dependency.
- Further training was provided to all ward managers and senior nursing staff at each site on the use of the SNCT to ensure consistent application of the tool.
- Deep dives of the SNCT scoring took place on all sites in February. This independent data validation is key in ensuring transparency and equity when using the data for staffing establishments. This deep dive data was used to inform the staffing review.

The purpose of the establishment review was to:

- Compare the average patient acuity for the deep dive period February 2019 to the previous years and consider seasonal variation.
- Review Care Hours per Patient Day (CHPPD) data compared to St George's and peer average.
- Review the local quality metrics for the period of February 2018- February 2019
- Assess that the demand templates are set right on health-roster following the most recent establishment reviews.
- Consider the impact of the % of supervisory time for ward managers.
- Review and seek assurance around measures in place for effective rostering.
- Seek assurance around recruitment and retention plans at ward/department level

2.2 Governance of the establishment review

As with previous years Safer Nursing Care Panels were held by the Divisional Directors of Nursing to complete their ward by ward reviews of the establishments. Ward Managers, Matrons and Heads of

Nursing attended these panels with involvement from the divisional finance managers supporting the panels early in the process.

3.0 Outcome of the establishment review

3.1 Headroom

No changes are proposed to the commitment of 22% headroom (with 1% parental leave headroom being held centrally) as agreed in 2018. (Critical care areas are currently set to 25% to reflect additional training and education and national guidelines)

3.2 Nursing Associates

The Nursing Associate (NA) is a new generic nursing role in England that bridges the gap between healthcare support workers and registered nurses. NAs are registered with the Nursing and Midwifery Council (NMC) and subject to regulatory requirements such as revalidation and fitness to practise.

This year's safe staffing review has incorporated the NA role into staffing establishments from April 2019. Seven registered WTE NAs have been introduced across a variety of different practice settings:
Richmond, Champneys, McKissock, Florence, Gunning & Holdsworth Wards

A Quality Impact Assessment has been completed for areas where the NA roles are being introduced to provide assurance there are no unintended consequences in relation to quality and safety

3.3 Ward Establishment Changes

The change to the ward establishments are shown at Appendix 1. A summary of the changes for each division follows.

3.4 Medicine & Cardiovascular Division

The overall picture on our medical and cardiology wards is consistent with last year's review and the safer nursing care tool supports the budgets proposed. Skill mix change of staff and professional judgment has been provided across the division. Some additional posts have been reintroduced to the Emergency Department (ED) in order to meet the Royal College of Emergency Medicine Best Practice Guideline[2] such as a dedicated Paediatric ED co-ordinator

3.5 Surgery Neuro Theatres & Cancer Division

Skill mix changes to support the Trauma wards within the Trust have been identified within this review.

3.6 Children's, Women's, Diagnostics Therapy and Community Division

3.6.1 Critical Care

Revaluation of cost improvement schemes from last year have required 5.0wte to be put back into the overall critical care budget and have been funded as part of their establishment

3.6.2 Maternity

As part of the safe staffing review approved by the Trust Board in April 2018 a 1:28 midwife to birth staffing ratio for maternity services was agreed for the maternity staffing establishment. During 2018/19 the maternity workforce transformation programme introduced the role of Maternity Support Worker (MSW) across the sites and we have been moving staffing from a 100% Registered Midwife (RM) skill mix to RM: MSW skill mix of 90:10.

[2] The Royal College of Emergency Medicine Best Practice Guideline 2017

The 2018/19 review of maternity safe staffing, which was supported by the Director of Midwifery, made the following recommendations based upon sustaining a 1:28 midwife to birth ratio:

- Maternity continues with the roll out of the Midwifery Support Worker role
- Some headroom changes were agreed mainly replacing staff at band who are off sick, study leave and annual leave with like for like and not at a lower band. Currently this generically set at band 5 in their budgets and has contributed for end of year overspend.

- A business case to support the addition of 5 midwives for the national programme of continuity of carer is under consideration.

- Analysis of the birth rate for 2018/19 to date shows the number of births appears to be consistent with previous years, and therefore the overall establishment for 2019/20 will remain unchanged.

3.6.3 Paediatrics and Neonatal Nursing

A National Safer Nursing Care Tool (SNCT) for children's was developed in 2017. Implementation of this tool across St George's children's wards began in late 2018.

Validated data from this SNCT has informed the 2019/20 data for staffing reviews. Skill mix review across our inpatient Paediatric has taken place and actions identified by the Birmingham Children's review 2018 have seen the overall establishment increase by 4.36 WTE these posts include the staffing for an admissions area within Nichols ward.

The 2018/19 staffing review used British Association of Perinatal Medicine guidance (BAPM)[3], quality indicators and professional judgement. The Neonatal Unit has a funded establishment that is based on activity. The safe nursing numbers reflect the BAPM guidelines for neonatal and are adjusted at times significantly based on activity.

3.7 Breakdown of increases or decreases in WTE per division

The below table is a summary by division of the comparison to overall nursing, midwifery and care staff funded establishments. All adjustments are reflected in the 2019/20 budget.

Division	18/19 WTE	19/20WTE	Movement WTE
Medcard	1,060.53	1,065.30	4.77
SNTC	620.01	620.18	0.17
CWDT	660.27	670	9.73
Total:	2,340.81	2,355.48	14.67

4.0 Key areas of work supporting safe staffing

There are a number of key components that are fundamental to ensuring sustainable delivery of safe and high quality nursing and midwifery care within available staffing and financial resources.
These components include the following:

4.1 Workforce controls

In June 2018 the Trust introduced a more robust performance management framework for rostering compliance, agreeing a KPI framework and weekly workforce monitoring meetings across sites.
A Trust wide nursing dashboard has been developed with RAG rating and weekly monitoring of roster KPIs. This ensures greater scrutiny of rostering compliance from the Divisional leadership team, leading to a reduction in temporary staffing use.

[3] British Association of Perinatal Medicine (BAPM) Optimal Arrangements for Neonatal Intensive Care Units in the UK A Framework for Practice (2014)

Work is underway in partnership with South West London St Georges Mental Health Trust to see how we can work collaboratively together to reduce the agency spend on Registered Mental Health Nurses and share resources to benefit our patients and support our staff.

In 2019/20 this work will continue to sustain and embed the improvements seen in 2018/19, with a continued focus on reducing unavailability and deep dive into roster compliance in ED and Maternity.

4.2 Safe Staffing

The Trust continues to publish the monthly planned versus actual staffing levels we are seeking to include these in the Integrated Performance Report and a detailed report was discussed at Quality and Safety Committee last month.

Safe Care Live (SCL) is a tool to record patient acuity and dependency in real time. SCL links with Health Roster and shows if staffing levels on the shift match patient acuity and dependency. SCL has been rolled out to all adult and children's wards in all hospital sites over the last year. All adult wards are recording SNCT categories for their patients twice daily on health roster alongside the ward staffing data.

5.0 Future plans

Proposed model for Enhanced Care in 2019/20
The Enhanced Care (EC) policy is to support the delivery of consistent, safe and effective care for the most vulnerable patients in hospital i.e. those who require close observation/intervention and patients who are at risk of harm or harming. These patients have particular support needs that cannot be met through the usual level of ward based care alone. The Safer Nursing Care tool does not include provision for EC in the WTE recommendations.

Although the Divisional Directors of Nursing (DDNGs) have reduced the number of additional duties for Enhanced Care the impact of EC cannot be eliminated. Continuing to operate without recognising the cost pressure stemming from the provision of enhanced care will result in a persistent overspend across the Trust which may mask other variation in spend that need to be carefully managed.

A review of headroom for the ED department needs to be considered in 20/21. Currently the headroom is set to 22% as with our ward areas. However the increasing demand for training and education and reflections from best practice suggests that headroom of 25% should be applied to ED.

Therefore future workforce plans for 20/21 will have a view to developing a model of enhanced care to meet the needs of St George's and reviewing headroom for ED

6.0 Recommendations

The Board is asked to:

- Note the governance process for setting establishments for 2019/20.
- Note the outcome of the review and support the Corporate Nursing recommendations outlined in this paper for changes to the ward establishments which have been included in the Trust budget for 2019/20.
- Support the approach to budget setting for Enhanced Care going forward into 2019/20.
- Note the on-going work to sustain effective use of the staffing resource in terms of processes and controls into 2019/20.

Author: **Richard Lloyd-Booth**
Deputy Chief Nurse
Date: **24/05/2018**

APPENDIX 1- Safe Staffing Numbers

(The number of RN on the long day includes the Nurse in charge of the Ward/Unit)

Ward	Speciality	No of Beds	Total WTE per Shift		SNTC Recommended		**Skill Mix** note the Ratio of patients does not include the Nurse in Charge on the Day shift					
			Long Day	Night	Long Day	Night	Long Day			Night		
			WTE	WTE	WTE	WTE	Registered	Unregistered	Ratio RN to Patient	Registered	Unregistered	Ratio RN to Patient
Allingham Ward	Respiratory	28	11	7	11	7	7*	4	1:4.6	4	3	
Amyand Ward	Senior Health	32	11	8	11	7	6	5	1:6.4	5	3	1:6.4
Belgrave Ward AMW	Cardiac	24	8	6	8	6	5	3	1:6	4	2	1:6
Benjamin Weir Ward AMW	Cardiac Surgery	32	10	8	11	7	7	3	1:5	6	2	1:5
Brodie Ward	Neuro Surgical	30	10	8	10	7	6	4	1:6	5	3	1:6
Cardiothoracic Intensive Care Unit (CTICU)	Critical Care	21	22	20	NA		22	0	NA	19	1	NA
Caroline Ward	Cardiothoracic	24	8	5	8	5	5	2	1:6	4	0	1:6
Cavell	Short Stay Medical	28	10	6	10	6	6	4	1:5	5	2	1:5
Champneys Ward	Renal	18	7	4	7	4	5	2	1:4.5	3	1	1:6
Cheselden Ward	Cardio Vascular	22	7	4	7	4	5	2	1:5	3	1	1:7
Coronary Care Unit	Critical Care	11	6	6	6	6	6	0	1:2	6	0	1:2
Dalby Ward	Senior Health	22	9	7	9	7	5	4	1:5.5	3	4	1:7.2
Florence Nightingale Ward	ENT Surgical	22	8	5	8	4	6	2*	1:4.4	4	1*	1:5.5
Fred Hewitt Ward	Childrens	17	7	5	7	5	5	2*	1:3.4	4	1	1:3.4
General Intensive Care Unit (Gen ICU/HDU)	Critical Care	22	21	21	NA		20	1		20	1	
Gordon Smith Ward	Haematology/Onco	19	5	3	6	3	4	1	1:4	3	0	1:6
Gray Ward	Gen Surgical	32	10	6	11	7	7	3	1:5	4	2	1:8
Gunning Ward	Trauma/Ortho	28	9	7	10	7	6	3*	1:5.6	4*	3*	1:7
Gwynne Holford Ward	Neuro Rehab	36	10	6	10	6	5	5	1:9	3	3	1:12
Heart Failure Unit	Cardiology	11	4	3	NA		3	1	1:3	3	0	1:3
Heberden	Senior Health	24	11	7	11	7	5	6	1:6	3	4	1:8
Holdsworth Ward	Trauma/Ortho	26	9	7	10	6	6	3	1:6.5	4*	3*	1:6.5
James Hope Ward	Cardiology	16	6	1	NA		5	1	1:3	2	0	1:8
Jungle Ward	Childrens	15	6	0	NA		5	1	cover 7:30-8 split shifts			
Keate Ward	Plastics/Gyane	21	6	5	7	4	4	2	1:7	3	2	1:7
Kent Ward	Neuro Surgical	31	13	10	13	9	6*	7*	1:6.2	5	5	1:6.2
Marnham Ward	Medicine	28	10	7	10	7	7	3	1:4	5	2	1:4
Mary Seacole Ward	Rehab	42	12	12	12	9	6*	6	1:7	6*	6	1:7
Mcentee Ward	Infectious Diseases	18	6	4	6	3	4	2	1:6	3	1	1:6
Mckissock Ward	Neuro Surgery	21	7	6	8	5	4	3	1:7	3	3	1:7
Neo Natal Unit (NNU)	Childrens		25	24	NA		25	0		24	0	
Neuro Intensive Care Unit (Neuro ICU)	Critical Care	18	17	17	NA		15	2		15	2	
Nicholls Ward	Childrens	19	8	7(6 T-S)	8	7	7*	1	1:3	5	2	1:3.8
Paediatric Intensive Care Unit (PICU)	Critical Care		13	12	NA		11	2		11	1	
Pinckney Ward	Childrens	15	8	6			6	2*	1:3	5	1	1:3
Richmond Ward	Acute Medical	43	14	14	14	14	8	6	1:5.3	8	6	1:5.3
Richmond Ward- ADU	Acute Medical	8	6	6	6	6	4	2	1:2	4	2	1:2
Rodney Smith Med Ward	Genn Med/Diabetes	28	9	8	10	6	5	4	1:7	4	4	1:7
Ruth Myles Ward	Oncology	13	6	3	6	3	5	1	1:3.2	3	0	1:4.3
Surgical Admissions Lounge	Surgical		6	6	6	6	3	3		3	3	
The Nye Bevan Unit	Surgical Assessment	8/8/15	7	5	7	5	5	2	1:7	4	1	1:7
Thomas Young	Neurology	26	10	8	10	7	5	5	1:6.5	4	4	1:6.5
Trevor Howell Ward	Oncology	19	7	5	7	4	5	2	1:4.7	3	2	1:6.3
Vernon Ward	Urology	31	9	6	9	6	6	3	1:6.2	4	2	1:7.5
William Drummond HASU	Stoke	20	11	11	11	11	9	2	1:2.8	9	2	1:2.8

Updated May 2019

*this indicates a change from 2017/18

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board (part 1: public)**		
Date:	**30 May 2019**	**Agenda No**	**2.4**
Report Title:	**Cardiac Surgery Update**		
Lead Director	**Dr Richard Jennings, Chief Medical Officer**		
Report Authors:	**Matt Jarratt, General Manager, Cardiac, Vascular and Thoracic Surgery** **Julia Mitchell, Interim General Manager, Cardiac Vascular and Thoracic Surgery**		
Presented for:	**Assurance and discussion**		
Executive Summary:	This paper provides an update to the Trust Board on the steps being taken to improve the cardiac surgery service following the NICOR safety alert (March 2018) and the findings of the independent review (Professor Bewick, July 2018). Since the last update to the Trust Board (April 2019) the following key developments have taken place: • The Independent Mortality Review Panel has continued to meet. • 'Being open' letters are continuing to be sent to all next of kin associated with the mortality review (the first stage of application of duty of candour). • Appointments have been made to the Case Management team, and the team will begin work on 3 June 2019. • An independent HR consultant commissioned to provide support to the service has completed the first phase of her work. • There has been a further meeting of the Quality Summit (20 May 2019). • There has been a meeting with Health Education England, which was positive. It was agreed that trainees will not yet return, but that the situation can be reconsidered with a view to deciding whether or not trainees should return in April 20. • The Trust has reached a settlement with Professor Marjan Jahangiri.		
Recommendation:	The Trust Board is asked to note 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.		
Previously Considered by:		**Date**	

St George's University Hospitals NHS
NHS Foundation Trust

CARDIAC SURGERY UPDATE
Trust Board, 30 May 2019

1.0 PURPOSE

To update Trust Board on progress being made with Cardiac Surgery since the last presentation to Trust Board (April 2019).

2.0 EXTERNAL ASSURANCES

2.1 Meetings of the independent Mortality Review Panel

2.1.1 The independent mortality review panel has continued to review patients.
2.1.2 It is reviewing the notes of 201 deaths following cardiac surgery, from 2013-2018.
2.1.3 As notified previously, a 'being open' letter is being sent to the named next of kin associated with the patient, signed by the Chief Medical Officer.
2.1.4 A dedicated phone line and e-mail address remains in place (staffed by senior nursing staff), to provide a single point of contact for next of kin (available Mon-Fri in working hours).
2.1.5 There is a continued challenge with securing the correct contact details for next of kin. Currently 150 of the 201 NoK details have been successfully validated, with letters sent.

2.2 There has been a further meeting of the **Quality Summit** (20 May 2019).

2.3 There has been a meeting with **Health Education England,** which was positive, with trainees possibly returning in April 20.

3.0 INTERNAL DEVELOPMENTS

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

3.1 **Pre-operative Assessment and case management**. The team has been appointed, and is due to begin work on 3 June 2019.

3.2 **Culture and behaviour.** The independent HR consultant commissioned to support the culture and behaviour within the service has completed the initial phase of her work.

3.3 **Professor Marjan Jahangiri**. Professor Jahangiri and the Trust have entered into a settlement in relation to the issues in 2018. Professor Jahangiri and the Trust have issued a joint public statement in relation to this.

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.

5.0 IMPLICATIONS

There continue to be three extreme risks on the risk register for this service, with another due to be added in the next week:

1 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 not been reduced within the last month.

2 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 not been reduced within the last month.

3 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 service continues to demonstrate safe working, and its morbidity and mortality outcomes are in line with those of peer trusts; as such in June 19 a review will be undertaken of this risk, with a view to potentially reduce the scoring.

In addition, there continues to be a risk in regard to junior medical staffing. This is being managed through active recruitment and the use of bank and, where necessary, agency staff. The rota is complete and we are not experiencing gaps at any point. As such, the risk continues to be controlled.

6.0 RECOMMENDATION

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

Meeting Title:	**Trust Board**		
Date:	30 May 2019	**Agenda No**	2.5
Report Title:	Mortality Monitoring Committee (MMC) Report & Learning from Deaths		
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		
FOIA Status:	Unrestricted		
Presented for:	Update		
Executive Summary:	The paper provides an overview of the work of the MMC and an overview of data for 2018/19 and where useful a comparison to 2017/18. 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. 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:	The Board is asked to note this report considered at Quality & Safety Committee in April 2019.		
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:	Patient Safety & Quality Group	**Date**	17/04/19
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 Quality & Safety Committee 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 2018/19. Comparison to the previous year and consideration of the complete dataset gained over the two years, since implementation of the Learning from Deaths framework, is also provided. An update on the delivery of requirements of the Learning from Deaths framework and progress against the objectives that were agreed for the year is also detailed.

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 (ME) system. This quarter we have participated in the third meeting of the Learning from Deaths London Network, which involved working with local trusts to discuss opportunities to work collaboratively in establishing the ME system. Upcoming events include the Royal College of Pathologists meeting 'Implementing the Medical Examiner System' and we will assist in the delivery of the forthcoming meeting of the Health Innovation Network's Community of Practice.

2.2 Progress against priorities for MMC in 2018/19

In our first quarterly report of 2018/19 we defined a number of priorities which are set out below, with an update on progress at year end.

- Refine fields added to RCP Structured Judgement Review (SJR) to strengthen the quality and impact of our data locally and to implement SJR tool for all mortality reviews requested by MMC. These will include better documentation of escalation routes where concerns are raised and identification of mental health diagnoses.
    - 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 quality of overall care, which was suggested by the CQC.
- Make training available to clinicians on use of SJR methodology.
    - We continue to roll-out the SJR methodology to specialty teams and are keen to continue this work over the coming year. Services such as Critical Care and Orthopaedics have received training and are implementing the methodology. The MMC hope that implementation of the SJR across all services will be incorporated within the recommendations of the CMO-procured current review of our Mortality and Morbidity and MDT processes. The implementation of the ME system will also support this work across the organisation.
- Strengthen systems for monitoring the outcome of escalations to Risk and clinical teams.
    - We have added fields to our review forms to better capture required actions. There is further improvement to be made, which will be supported by implementation of the ME system and by having a central role working across both the ME office and trust governance of mortality surveillance, review and investigation.
- Complete the restructure of the Clinical Effectiveness (CE) Department to allow the CE manager to specialise in mortality governance, which will ensure existing processes are developed and strengthened.

    - In May 2018 the Clinical Audit Manager post was reintroduced. Over the year the CE manager has provided training to the post-holder and continued to provide support and oversight. Having now been involved with all of the key objectives of the effectiveness and audit team the CA manager is now able to manage the functions of the team, releasing the CE Manager from non-mortality work.
- To review the Learning from Deaths Policy in line with publication of national guidance on engagement with families and carers.
    - We are confident that we are compliant with national guidance but have not formally reviewed the policy. The delay was agreed with the interim medical director and was caused by other priorities that have arisen. With the ongoing evolution of the national mortality and learning from deaths agenda the MMC felt it prudent to postpone formal review in order that we can incorporate changes that will be required for ME implementation. This will be prioritised early in 2019/20 ensuring that the Learning from Deaths policy is updated to describe how we comply with the latest national recommendations. It will be necessary to review other trust policies in order to reflect the impact of the ME system.
- Research and implement a Medical Examiner function that supports and enhances the work already underway by the MMC.
    - 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 better support and improve processes for the bereaved; 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 has been approved and we have now formed a project group to enable us to begin delivering this service. Early in 2019/20 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.
- Strengthen central understanding of local M&M processes and provide guidance and support to ensure that we maximise learning.
    - We continue to roll-out the SJR methodology to specialty teams and completing this roll out will be a key priority for 2019/20. We have also supported the design and launch of the Record of Death form in iClip. Information from the MMC and interviews with the Chair and CE Manager have been used to inform the current review of M&M and MDT processes.

2.3 Priorities for MMC in 2019/20

These will be discussed and agreed by the MMC in April and will be detailed in the first quarterly report of 2019/20, but it is anticipated that key priorities will include:

- Fully implement the Medical Examiner (ME) system in order to meet the requirement of the National ME that all deaths in secondary care will be subject to ME scrutiny by the end of March 2020.
- Recruit a new Chair of the Mortality Monitoring Committee, who will lead governance of mortality at an organisational level.
- To develop our use of SHMI (summary hospital-level mortality indicator) data as the national resource is improved.
- Support implementation of the recommendations arising from the current review of M&M and MDT processes.

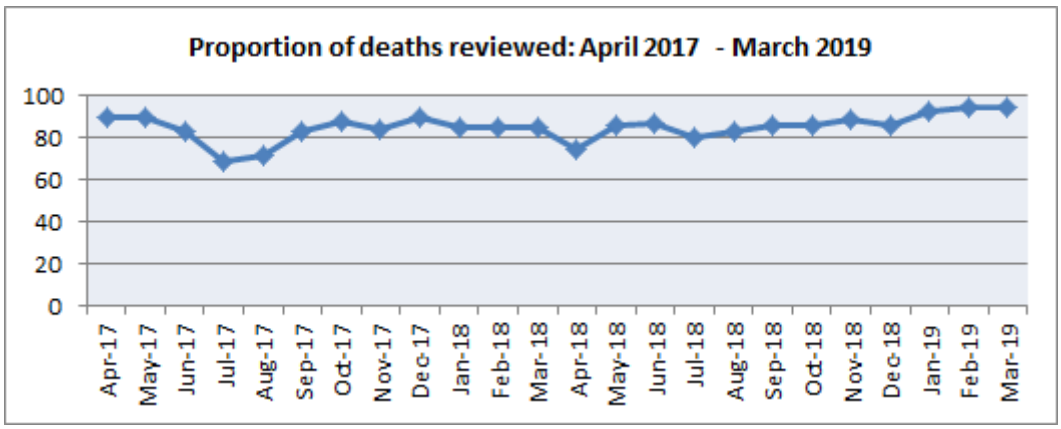
3.0 MONTHLY INDEPENDENT REVIEW OF MORTALITY

3.1 The following analyses include all deaths and do 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 (NQB) dashboard is shown in Appendix 1.

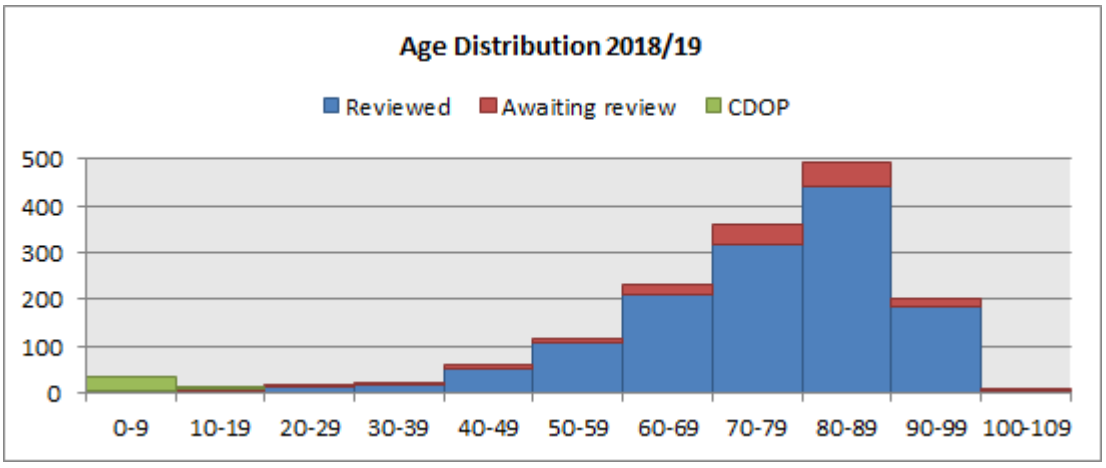
It should be noted that all deaths that occur in patients with learning disabilities have been submitted to the Learning Disabilities Mortality Review Programme (LeDeR). The LeDeR reviews are co-ordinated by the CCG and to date we have not been informed of the outcome of review for any of our patients. In addition to submitting patients to the national programme we carry out local review using our standard methodology. In 2018/19 there have been 9 LD deaths and no avoidability has been identified in any of these cases. We have amended the NQB dashboard to reflect this information.

3.2 Overview of 2018/19

Between April 2018 and March 2019 there were 1550 deaths. Members of the MMC have carried out independent review of 1346 of these, using our locally developed online screening tool and structured review tool, both based on the RCP tool. This represents 87% of deaths, significantly in excess of our target of reviewing 70% of deaths each quarter and above the 84% achieved in the first year of implementation. The chart below shows that we have maintained a review rate of over 80% since May 2018, with a peak of 94% in the latest quarter.



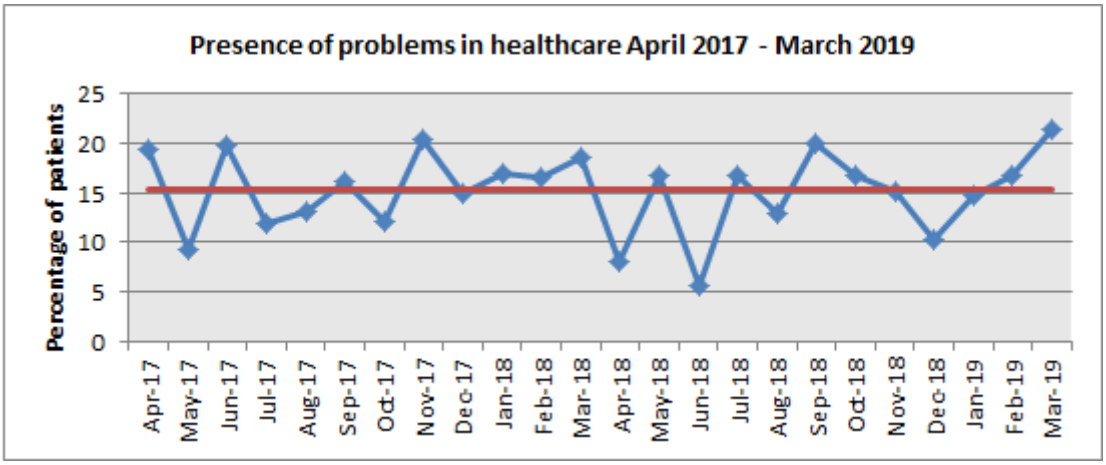
The age profile of deceased patients remains consistent, with the highest proportion of deaths in the 80-89 age group. As expected this profile is almost identical to that seen in 2017/18. All child deaths are reviewed locally by clinical teams and by the Wandsworth CDOP. Of note, a revised CDOP process which increases the emphasis on Trusts coordinating multi-professional reviews must be implemented by September 2019.



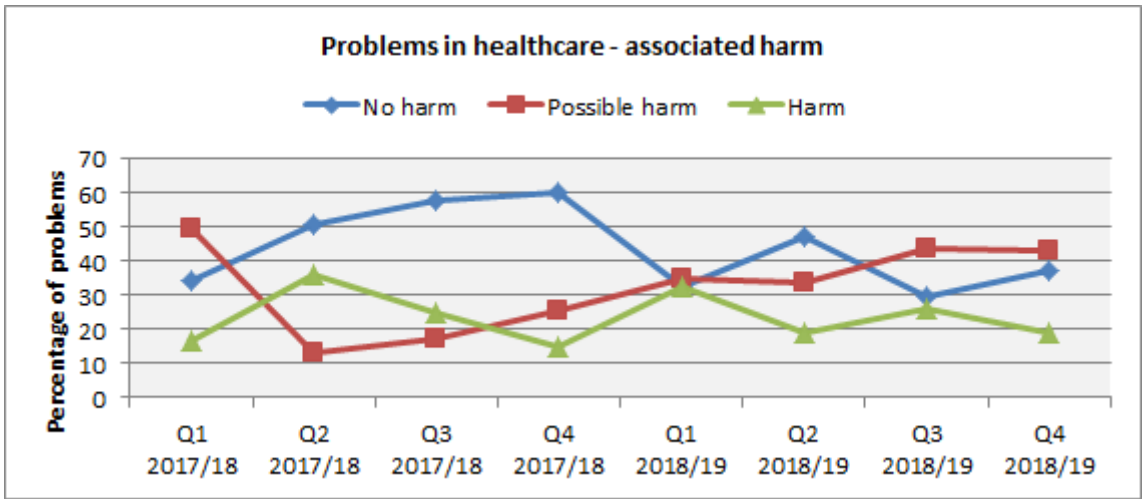
The structured judgement review requires reviewers to identify problems in healthcare and to assess whether or not these have caused harm. The RCP define a number of problems in healthcare, as detailed in the tables below. This year, one or more problems in healthcare were identified in 14.9% of the cases reviewed, which is slightly lower than the average for the previous year to date (15.7%). Looking at these data monthly across the 2 years shows fluctuation around the mean of 15.3%.

Problems in healthcare 2018/19

	Q1	Q2	Q3	Q4	Total
No	268	238	295	345	**1146**
Yes	32	46	48	74	**200**
% with problems	10.7	16.2	14.0	17.7	**14.9**



It is important to note that not all of these problems led to harm and include recognised complications of treatment. The chart below shows that the minority of problems are thought to have led to harm. Over the 2 years reviewers felt that observed problems did not lead to harm in 45.4% of cases, probably led to harm in 32.4% and did cause harm in 22.2%. In 2018/19, these figures are 37%, 40% and 23% respectively. This is a slight change from the previous year when a greater proportion of problems were thought not to have led to harm (51.5%) and a smaller proportion (26.9%) possibly led to harm. The proportion thought to have resulted in harm is similar over the two years.



In 2018/19 the most common problem in healthcare identified by reviewers was problems related to treatment and management plan with 28.2% of problems reported being in this category. Furthermore, for 9 of the 12 months it was the most frequently observed problem. This profile differs to that seen in 2017/18 when this accounted for only 12.4% of problems.

Problems in healthcare: 2018/19	**No harm**	**Probably harm**	**Harm**	**Total**
Assessment, investigation or diagnosis	6	7	6	**19**
Medication/IV fluids/electrolytes/oxygen (other than anaesthetic)	4	6	1	**11**
Related to treatment and management plan	17	31	19	**67**
Infection control	3	15	4	**22**
Operation/invasive procedure	10	9	12	**31**
Clinical monitoring	10	7	4	**21**
Resuscitation following a cardiac or respiratory arrest	4	5	0	**9**
Communication	14	2	0	**16**
Other	20	13	9	**42**
TOTAL	**88**	**95**	**55**	**238**

In 2017/18 the most frequently observed problem was with 'operation/invasive problems' with 15.4% of problems falling into this category. This year this accounted for 13% of the problems noted. 2018/19 has also seen a much lower incidence of problems related to resuscitation following a cardiac or respiratory arrest.

Problems in healthcare: April 2017 – March 2019	**Q1 17/18**	**Q2 17/18**	**Q3 17/18**	**Q4 17/18**	**Q1 18/19**	**Q2 18/19**	**Q3 18/19**	**Q4 18/19**
Assessment, investigation or diagnosis	3.8	9.4	4.1	3.2	12.5	13.2	1.8	0.0
Medication/IV fluids/electrolytes/oxygen (other than anaesthetic)	8.9	11.3	4.1	6.3	5.0	1.9	5.3	6.8
Related to treatment and	17.7	13.2	8.2	11.6	37.5	24.5	40.4	25.4

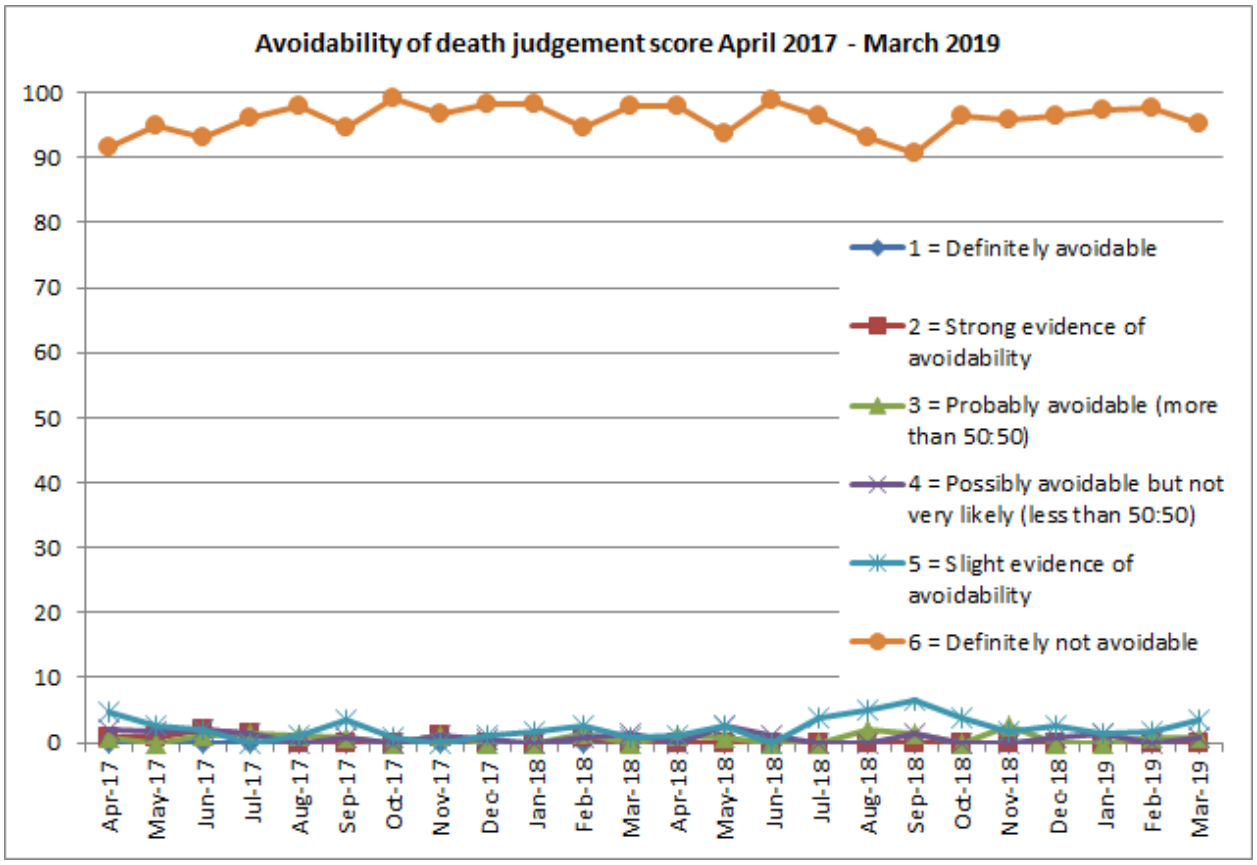
management plan								
Infection control	10.1	7.5	3.1	10.5	2.5	3.8	7.0	15.3
Operation/invasive procedure	20.3	15.1	13.4	13.7	10.0	18.9	17.5	16.9
Clinical monitoring	11.4	9.4	17.5	15.8	12.5	9.4	7.0	10.2
Resuscitation following a cardiac or respiratory arrest	5.1	9.4	20.6	14.7	5.0	5.7	1.8	3.4
Communication	-	-	-	-	-	-	7.0	6.8
Other	22.8	24.5	28.9	24.2	15.0	22.6	12.3	15.3

In October 2018 we amended the screening and structured judgement review tools in order to capture problems related to communication. To date 16 problems of this type have been identified; none were thought to have led to harm.

A judgement regarding avoidability of death is made for all reviews. Over the two year period, we have consistently seen that the vast majority of deaths are deemed to be definitely not avoidable. For the period as a whole this proportion is 96.1%, with 96.3% in 2017/18 and 95.9% in 2018/19. There have been no cases where independent review suggests that the death was definitely avoidable in this time period.

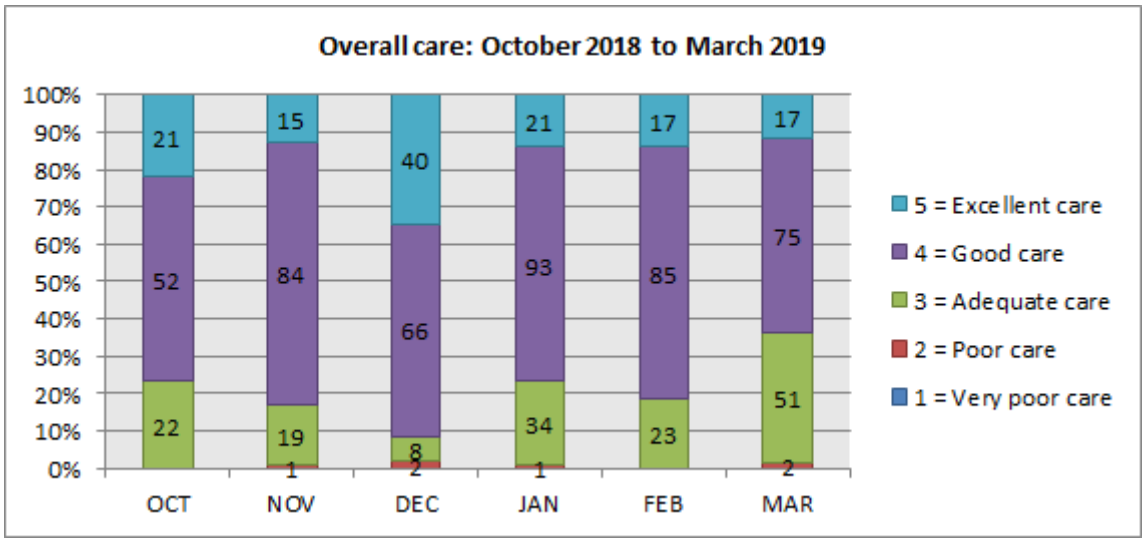
This year there were ten (0.7%) deaths judged to be more than likely avoidable for that point in time, but no deaths thought to be definitely avoidable. In the previous year there were 15 deaths (1.0%) thought to be more than likely avoidable, and again no deaths judged as definitely avoidable.

Avoidability of death judgement score 2018/19	**Q1**	**Q2**	**Q3**	**Q4**	**Total**
6 = Definitely not avoidable	290	266	330	405	**1291**
5 = Slight evidence of avoidability	4	14	9	9	**36**
4 = Possibly avoidable but not very likely (less than 50:50)	4	1	1	3	**9**
3 = Probably avoidable (more than 50:50)	2	3	3	2	**10**
2 = Strong evidence of avoidability	0	0	0	0	**0**
1 = Definitely avoidable	0	0	0	0	**0**
TOTAL	300	284	343	419	**1346**



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

In October we began recording a score reflecting the reviewers' judgement of the overall care provided. Each month the majority of patients were felt to have received care that was either good or excellent. Over the 6 month period that we have collected this data 17.5% of care was rated as excellent, 60.8% as good, 21.0% as adequate and under 1% as poor. There were no cases of very poor care found.



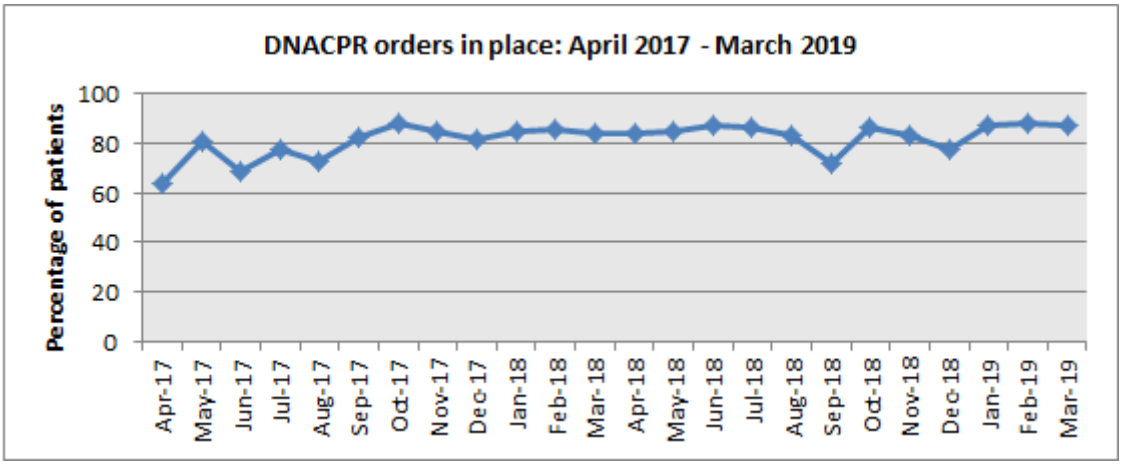
Any death that the MMC review suggests may be avoidable is escalated to the Risk Team to consider investigation. Any significant problem of care, whether or not it affected outcome, is highlighted to the clinical team for discussion and local learning.

4.0 THEMES AND LEARNING

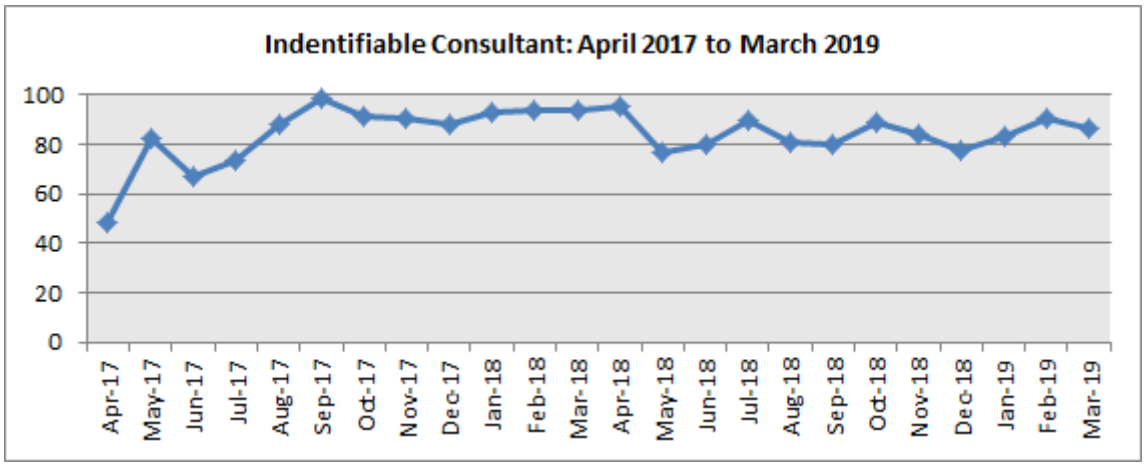
The following summary provides an update on a number of issues previously highlighted and learning from the independent review of cases and MMC activity this quarter.

4.1 DNACPR discussions and identifiable consultant

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



There also appears to have been improvement in the ability to identify the consultant responsible for the patients care, from a poor position at the beginning of the period to a rate of between approximately 80 and 90 per cent throughout 2018/19.



4.2 Identification of Learning

In the latest quarter there have been a number of cases escalated for further review. 19 cases have been referred to the service for M&M review and reflection and 3 cases have been referred to working groups, including the Deteriorating Adults Group and Hospital Thrombosis Group for consideration. In addition to seeking specialist opinion, issues that have been highlighted for discussion include documentation, management of deterioration and establishing ceilings of treatment and consideration of earlier palliative care. There have also been cases where the importance of handover and improved communication has been highlighted. These issues are largely consistent with those reported during the year.

The MMC review team have received positive feedback and reflection on individual and system learning from a number of clinicians as a consequence of being asked to review a case. Encouragingly a number of cases have been referred to the MMC reviewers by clinicians, including junior doctors, which demonstrates a positive reporting and learning culture.

The sharing of information between the mortality review team and risk team continues and has been strengthened over the year. Between January and March 2019 the two teams have collaborated on the review and investigation of 26 deaths, including five cases that have been scrutinised as part of the ongoing cardiac surgery work. It should be noted that only two of these patients underwent cardiac surgery.

There have been a number of process changes brought about over the year following work between the MMC and clinical services. These include implementation of a new inpatient protocol related to trial without catheter; a strengthened process for reviewing images in order to look for and report unexpected findings; and exploring potential options for the development of a safety net IT system for accessing neurology images remotely.

5.0 NATIONAL MORTALITY DATA AND SERVICES OPEN TO EXTERNAL SCRUTINY

5.1 National Adult Cardiac Surgery

Prospective Investigation and governance procedures previously described are ongoing. The Mortality Monitoring Committee is contributing to early independent reviews of all deaths in patients who have had cardiac surgery or been under the care of the team. These reviews are shared, generally within 24 hours of the death, with the Risk team who co-ordinate 72 hour reviews and consideration at the serious incident declaration meeting.

6.0 LATEST NATIONAL PUBLISHED RISK-ADJUSTED MORTALITY

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

The SHMI for October 2017 to September 2018 was published on 14th February 2019. For this period our mortality is categorised as lower than expected at 0.84. We are one of only 15 trusts nationwide in this category and one of 13 that also had a lower than expected number of deaths for the same period last year.

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. In the most recent publication there are a small number of new alerts, indicating a trend of fewer deaths than expected. These are for UTI (July 2018), Sepsis (August 2018), and Pneumonia (August 2018). There are no alerts resulting from a run of more deaths than expected.

It is anticipated that from May 2019 NHS Digital intend to publish the SHMI on a monthly basis. Coupled with this, there will be a number of improvements, including additional fields in the record level extract for Trusts, inclusion of a one-page summary aimed at a clinical audience and SHMI bandings for a subset of the larger SHMI diagnosis groups. This will enable us to make better use of our SHMI data to understand outcomes at a more granular level.

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

Analysis	Period	Score	Banding
HSMR	Jan 18 – Dec 18	84.7	Significantly better than expected
HSMR: Weekday emergency admissions	Jan 18 – Dec 18	80.0	Significantly better than expected
HSMR: Weekend emergency admissions	Jan 18 – Dec 18	96.8	Not significantly different to expected

Comparing our mortality to a peer group of 18 non-specialist acute trusts in our region shows that we are one of 14 trusts whose mortality following emergency weekday admission is better than expected. Of this same peer group we are one of 11 trusts where mortality following admission at the weekend is in line with expected. The number of trusts with better outcomes than expected for this cohort falls to 7.

Wandsworth CCG accounts for the highest proportion of our activity. Of interest, for this group of local patients our standardised mortality ratio is better than expected overall, and is also better than expected for emergency weekday admissions and weekend admissions.

Each month the MMC evaluate risk-adjusted mortality at both diagnosis and procedure group level and where data suggests our outcomes are significantly different to expected; these are 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 March 2019 the committee considered data covering the period January 2018 to December 2018 and reviewed all diagnosis and procedure groups where there was a signal suggesting our outcomes were different to expected. It was noted that there were fewer signals

than the previous month. For each, existing mortality reviews were considered, alongside the trend data.

Work that has been prioritised to understand these signals in more detail includes the review of all cases in the 'Short gestation, low birth weight, fetal growth retardation' and 'Other perinatal conditions' diagnosis groups. The Lead Midwife for Governance is preparing a report on stillbirths and early neonatal deaths on delivery suite, for discussion at the June MMC meeting. All neonatal deaths are reviewed by the independent CDOP panel and also reported to the national confidential enquiry / outcome review programme.

The coding team continue their work to consider how to optimise accuracy and timeliness of clinical coding and also working on developing an improved process for recording finished consultant episodes, in order to comply with coding rules whilst capturing a more specific diagnosis. This would impact positively on the number of cases within the 'Residual codes unclassified' grouping.

Appendix 1: National Quality Board Dashboard – data to 31st March 2019

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

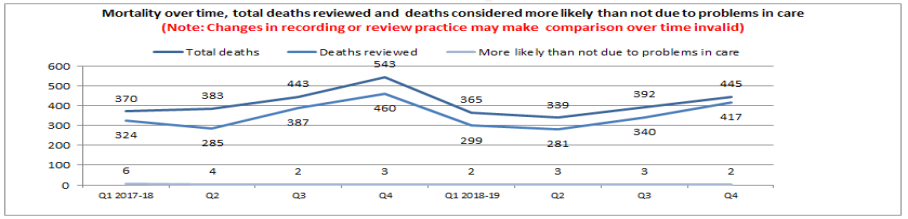
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

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
152	132	143	125	1	1
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
445	392	417	340	2	3
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
1541	1739	1337	1456	10	15

Time Series: Start date 2017-18 Q1 End date 2018-19 Q4



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	1	0.7%	This Month	1	0.7%	This Month	5	3.5%	This Month	136	95.1%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	2	0.5%	This Quarter (QTD)	3	0.7%	This Quarter (QTD)	9	2.2%	This Quarter (QTD	403	96.6%
This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	10	0.7%	This Year (YTD)	9	0.7%	This Year (YTD)	36	2.7%	This Year (YTD)	1282	95.9%

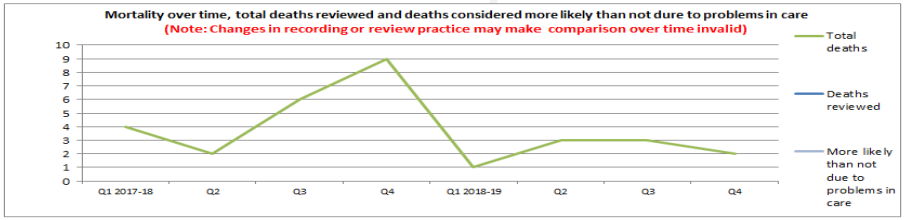
Summary of total number of learning disability deaths and total number reviewed under the LeDeR methodology. Please note that all LD deaths are reviewed using our standard approach, pending reviews as directed by the LeDeR process. The outcome of these local reviews is displayed in the second data grouping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

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

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered more likely than not due to problems in care	
This Month	Last Month	This Month	Last Month	This Month	Last Month
2	0	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
2	3	0	0	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
9	21	0	0	0	0

Total Number of Deaths in scope		Total Deaths Reviewed Through the Local Review Methodology		Total Number of deaths considered more likely than not due to problems in care	
This Month	Last Month	This Month	Last Month	This Month	Last Month
2	0	2	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
2	3	2	3	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
9	21	9	21	0	0

Time Series: Start date 2017-18 Q1 End date 2018-19 Q4



St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**TRUST BOARD**		
Date:	**30th May 2019**	**Agenda No.**	**3.3**
Report Title:	**M01 Finance Report 2019/20**		
Lead Director/ Manager:	Andrew Grimshaw		
Report Author:	Michael Armour & Tom Shearer		
Presented for:	Update		
Executive Summary:	The Trust has reported a deficit in month 1 of £8.8m which is equal to the Pre-PSF/FRF/MRET plan. Within the position, income is adverse to plan by £0.8m, and expenditure is underspent by £0.8m. CIP performance is £1.0m which is in line with plan. The Trust has recognised £2.0m of PSF/FRF/MRET funding in Month 1 in line with plan.		
Recommendation:	The Trust Board notes the trust's financial performance in M1 19/20.		
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:	Finance and Investment Committee	N/A	N/A
Appendices:	N/A		

St George's University Hospitals NHS
NHS Foundation Trust

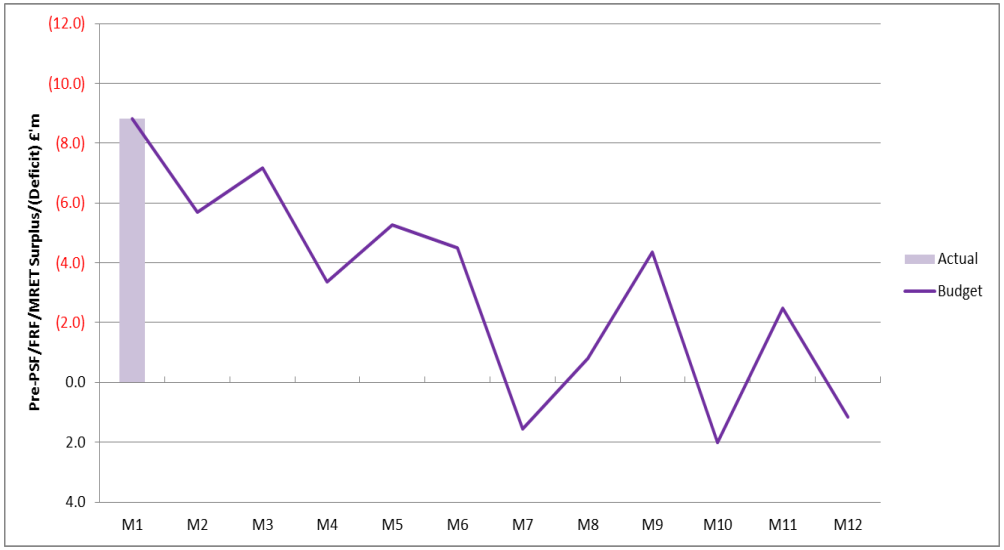
Finance Report M01

Chief Financial Officer

23rd May 2019

1. M1 Financial Performance

			Full Year Budget (£m)	M1 Budget (£m)	M1 Actual (£m)	M1 Variance (£m)
Pre-PSF/FRF/MRET	**Income**	SLA Income	681.0	54.7	54.7	(0.0)
		Other Income	156.3	13.1	12.4	(0.8)
	Income Total		**837.3**	**67.8**	**67.0**	**(0.8)**
	Expenditure	Pay	(532.6)	(47.2)	(46.7)	0.5
		Non Pay	(306.1)	(26.5)	(26.3)	0.2
	Expenditure Total		**(838.7)**	**(73.6)**	**(72.9)**	**0.7**
	Post Ebitda		(36.3)	(3.0)	(2.9)	0.1
Pre-PSF/FRF/MRET Total			**(37.7)**	**(8.8)**	**(8.8)**	**0.0**
PSF/FRF/MRET			34.7	2.0	2.0	0.0
Grand Total			**(3.0)**	**(6.9)**	**(6.9)**	**0.0**



Trust Overview

- Overall the Trust is reporting a Pre-PSF/FRF/MRET deficit of £8.8m at the end of Month 1, which is on plan.
- SLA income is reported on budget. The income information available at month 1 is not sufficiently complete to allow full reporting (as per 18/19)

- **SLA Income** is on plan as per the above.

- **Other income** is £0.8m adverse due to commercial pharmacy shortfall (£0.5m) which is offset in non-pay, as well as shortfalls in Overseas income (£0.1m), and other income shortfalls (£0.1m) within overheads.

- **Pay** is £0.5m favourable. This is due to vacancies within non-clinical posts (£0.2m), underspends in ward (£0.1m) and non-ward (£0.2m) nursing, as well as AHPs (£0.1m). These underspends are over and above vacancies targets which are held within divisions.

- **Non-pay** is £0.2m underspent, largely due to underspends in commercial pharmacy offset with other income as above (£0.5m), which is partially offset with a pressure resulting from NHS Supply Chain not identifying sufficient savings against planning targets (£0.2m) as well as corporate overspends (£0.1m) which are offset in pay.

- **CIP performance** is on plan, at £1.0m delivered.

- **PSF/FRF/MRET Income** is on plan in month 1, as the Trust expects to achieve the control total in Q1, and receive payment in full.

Note: all contingencies and unallocated cost pressure funding have been accrued to maintain consistency of reporting vs. the plan. Other phasing adjustments have also been made (as per 18/19) for the same reason)

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	The Trust Board		
Date:	30th May 2019	**Agenda No**	**4.2**
Report Title:	**St. George's Hospital Charity: Quarterly Update (Q4 2018/29)**		
Lead Director	Suzanne Marsello, Director of Strategy (Director Sponsor for St George's Charity)		
Report Author:	Amerjit Chohan, CEO, St George's Charity Vivien Gunn, Grants Manager, St George's Charity		
Presented for:	**Update**		
Executive Summary:	The Charity supported a number of schemes in Q4 2019/20 to the value of £109,087. The Charity Trust held an away day in February where they reviewed the Trust's priorities for schemes they would want to support in 2019/20. The Charity has recently established a research funding programme to fund Trust and University staff to conduct research to benefit patient care within the Trust, local communities and the wider NHS. The charity is also working in partnership with The Christian Blandford Charity, Momentum Charity and Samuels Charity and together aim to raise £500k to fund the refurbishment of Nicholls, Freddy Hewitt and Pinkney wards. At the Trustees meeting of May 17th, Trustees agreed to fundraise for the redevelopment of the renal dialysis facilities, and also confirmed approval of the Trust's formal application to develop the new intranet.		
Recommendation:	Trust Board is asked to: • Note the report, and the investment that has been awarded by the Charity in support of Trust projects.		
Supports			
Trust Strategic Objective:	1. Treat the patient, treat the person 2. Right care, right place, right time 3. Balance the books, invest in our future 4. Build a better St. George's 5. Champion Team St. George's 6. Develop tomorrow's treatments today		
CQC Theme:	1. **Safe**: you are protected from abuse and avoidable harm. 2. **Effective**: your care, treatment and support achieves good outcomes, helps you to maintain quality of life and is based on the best available evidence. 3. **Well-Led**		
Single Oversight Framework Theme:	▪ Strategic Change		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	Trust Executive Committee	**Date:**	22nd May 2019
Appendices:	none		

1.0 Purpose

1.1 The report is provided to give the Trust Board an update regarding the activities of the Charity in Q4 2018/19

1.2 A regular quarterly report will be provided going forward that details grants awarded and other key activity related to the Charity.

2.0 Update

2.1 A quarterly update from St George's Charity is included in the attached report including details schemes that have been supported by the Charity

3.0 Recommendation

3.1 Note the report, and the investment that has been awarded by the Charity in support of Trust projects.

St. George's Hospital Charity Q4 2018/29 Update

1.0 St George's Hospital Charity Grants Update: Q4 2018/2019

In the last quarter to end FY March 31st 2019, Trustees met on March 22nd 2019 and approved a total grant value of £109,087 as follows:

1)

Grant Ref.:	GR18-19/050
Amount:	£26,000
Grant:	The purchase of a cardiovascular monitoring device for the Cardiac Investigations Department
Funds:	Raised through the Cardiac Appeal - Fund Code 11141

2)

Grant Ref.:	SPF 18-19/019
Amount:	£41,587.20
Grant:	The Development of a Functional Walking Course to support Amputees with Prosthesis to negotiate a variety of Walking Surfaces within the safety of the Douglas Bade Rehabilitation Centre
Funds:	Special Purpose Fund: The Douglas Bader Rehabilitation Fund – Code 11132

3)

Grant Ref.:	Two connected grants: SPF 18-19/020 and SPF 18-19/021
Amount:	£26,500
Grant:	Salary of Clinical Trials Administrator (£11.5K) and Salary of Clinical Trials Co-Ordinator (£15K) regarding the Haematology Oncology Academic Clinical Trials.
Funds:	Special Purpose Fund: Oncology Research Fund Code 11113

4) On appeal following the board meeting

Grant Ref.:	GR18-19/048
Amount:	£15,000
Grant:	An app for a mobile for patients with Functional Neurological Disorder to improve their understanding of their illness, to improve control through specific techniques and offer signposting and support
Funds:	The Wolfson Neuro Rehab Legacy – Code 11266

In addition:

- Confirmed approval to contribute to the Trust for the development of a new intranet, in the Trustees' Meeting on May 17th 2019.

2.0 Supporting Research

The Charity has recently established a research funding programme to fund Trust and University staff to conduct research to benefit patient care within the Trust, local communities and the wider NHS. The charity works with the Medical Advisory Group which considers research applications and makes recommendations to Trustees.

A total of £426,286 was approved for research as follows:

- £134,790 – Antifungal Optimisation in High Risk Patients at St George's Hospitals NHS FT.
- £127,292 - The Clinical Application of Genomics in Sudden Cardiac Death and Inherited Cardiac Conditions
- £151,060 - Clinical and Molecular Evaluation of Overgrowth-Intellectual Disability Syndromes (previously known as the Childhood Overgrowth Study)
- Over the next two years the charity will hold two open rounds per year of research funding. There will be a total research fund of £1,380,000 to be allocated. This has been left as legacies to the charity and falls into the categories listed below:
- £343,000 Gynaecological Cancer research
- £220,000 Cancer Research
- £817,000 Intensive Care Unit Research (Atkinson Morley Wing)

3.0 Trustee Meeting 17th May

At the Trustees meeting of May 17th, Trustees agreed to fundraise for the redevelopment of the renal dialysis facilities, and also confirmed approval of the Trust's formal application to develop the new intranet.

4.0 Special Purpose Funds

The charity oversees in the region of 230 Special Purpose Funds, each with a declared intention to support a specific ward, department, area of research, service or group of patients. Each Special Purpose Fund has designated Fund Advisers who are staff members. Fund Advisers have delegated authority to review and authorise expenditure approvals and applications for funding from the Charity.

The total value in these funds overall is in the region of £6 million. Last year total SPF expenditure was just under £900,000. In order to put the money in them to good use we are in discussions with our Trustees to discuss how best:

- to make the SPF portfolio accurate and efficient
- to establish communications with the SPF community and the Trust broadly to put the funds to good use in a collaborative manner
- ensuring that we have feedback from the SPF community so we understand the impact of these funds
- support SPF funds to raise more money

5.0 The Charity 'Away Day'

On February 8th 2019 our Trustees held an 'Away Day'. The Trust's Director of Strategy presented the Trust's desired option areas for charity funding. These were:

- The Redevelopment of the Courtyard Clinic to improve Renal Services
- Wolfson Centre at QMH – restructure the ground floor space to facilitate clinical improvements for patients
- Critical Care/Coronary Care – facilities refurbishment to increase coronary care bed capacity and improved patient environment
- Surgical Assessment Lounge Improvements – to improve patient experience

The Charity recognised it would be difficult to support funding for all four projects. It was agreed that discussions would continue internally and between charity and the Trust to enable the Charity to report to Trustees on the conclusions arising from these discussions.

6.0 Children's Services

The charity is working in partnership with The Christian Blandford Charity, Momentum Charity and Samuels Charity. Together we aim to raise £500k to fund the refurbishment of Nicholls, Freddy Hewitt and Pinkney wards.

The charity is also being supported by a donor who has offered to provide air circulation and air cooling systems across all three wards.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	30 May 2018	**Agenda No**	**4.3**
Report Title:	Annual Self-Certification of Compliance with Foundation Trust Licence		
Lead:	Stephen Jones, Director of Corporate Affairs		
Report Author:	Stephen Jones, Director of Corporate Affairs		
Presented for:	Approval		
Executive Summary:	Each year each NHS Foundation Trust must undertake a self-certification of compliance with its licence conditions. The self-certification covers three licence conditions: • Systems for compliance with licence conditions and related obligations (Condition G6); • Availability of resources (Condition CoS7(3)); • NHS foundation trust governance arrangements (condition FT4(8)); • Training of Governors. NHS foundation trusts are no longer required to submit their self-certifications to NHS Improvement (NHSI). However, NHSI selects a number of Trusts to audit the self-certifications. St George's was selected for audit in 2018 and NHSI was content with its self-certification. As there have been no material; changes in the process, the self-certification set out in this paper adopts the same approach as used by the Trust in 2018. The self-certification must be published on the Trust's website by 30 June 2019.		
Recommendation:	The Board is asked to review and approve the self-certification against each of the licence conditions, including the proposed response in each area so that the Trust can complete the process within the established timetable.		
Supports			
Trust Strategic Objective:	All objectives		
CQC Theme:	Addresses all five key themes: Safe, Effective, Caring, Responsive and Well-led		
Single Oversight Framework Theme:	Well-led		
Implications			
Risk:	N/A		
Legal/Regulatory:	An assessment of compliance with licence conditions is required annually.		
Resources:	There are no resource implications.		
Previously Considered by:	N/A	**Date**	N/A
Equality Impact Assessment:	N/A		
Appendix:	Key Questions and Proposed Response		

Annual Self-Certification of Compliance with Foundation Trust Licence

Trust Board Meeting, 30 May 2019

1.0 PURPOSE

1.1 This paper sets out the Trust's proposed self-certification against its provider licence.

2.0 BACKGROUND

2.1 NHS Improvement (NHSI) requires all Foundation Trusts to undertake a self-certification on an annual basis against three licence conditions and one further activity, the training of governors. The purpose of the self-certification is to provide assurance that the Trust is compliant with the conditions of its licence. Compliance with the licence is routinely monitored through the Single Oversight Framework but the annual self-certification is intended to provide additional assurance.

2.2 Providers were previously required to submit their self-assessments to NHSI via a dedicated portal. However, since 2018 this is no longer the case and NHSI instead selects a number of Trusts to ask for evidence that they have self-certified, either by providing the completed or relevant Board minutes and papers recording sign-off. In 2018, St George's was selected as one of the Trusts whose self-certification was audited. The Trust provided its self-certification and related documentation and NHSI was satisfied that the process had been completed appropriately.

3.0 SELF-CERTIFICATION REQUIREMENTS

3.1 The Trust is required to self-certify the following conditions after the financial year end:

- That the Trust has taken all precautions to comply with the licence, NHS acts and NHS Constitution. This involves the Trust self-certifying that it has systems and processes that identify risks to compliance with the licence, NHS acts and NHS Constitution and that guard against those risks occurring (Condition G6).

- That the Trust has a reasonable expectation that required resources will be available to deliver designated services over the coming 12 months (Condition CoS7(3)). The Trust is required to self-certify against one of the following statements:

    - The required resource will be available for 12 months from the date of the statement;
    - The required resources will be available over the next 12 months, but specific factors may cast doubt on this; or
    - The required resources will not be available over the next 12 months.

  The required resources include: management resources, financial resources and facilities, personnel, physical and relevant asset guidance.

- That the Trust has appropriate governance structures and systems in place. There is no set approach for demonstrating this, but NHSI expects a compliant approach to involve a review of the effectiveness of the Board and Committee structures, reporting lines and performance and risk management systems (Condition FT4(8)).

- That the Trust has provided adequate and appropriate training to its governors to enable them to carry out their roles.

3.2 For each condition or activity the Trust must either:

- Confirm it has complied with the specific requirement; or
- Confirm it has not complied with the specific requirements, and explain why.

3.3 It is considered good practice to set out a brief statement explaining how the Trust considers it has complied, including any risks and mitigating actions. These will not be submitted to NHSI, though NHSI may review these should NHSI select the Trust for audit purposes.

3.4 The deadline for submission of all self-certifications, except for FT4(8), is 31 May 2019. For FT4(8), the deadline is 30 June 2019, but there is no reason not to provide all responses at the same time. The self-certifications must be published on the Trust's website by 30 June 2019.

4.0 SELF-ASSESSMENT

4.1 The self-assessment set out at Appendix 1 proposes to the Board that the Trust is compliant with all three conditions, as well as the additional declaration in relation to the training of governors.

4.2 In relation to licence condition CoS7(3) (sufficient resources to deliver services over the coming 12 months), we propose to confirm that we are compliant, notwithstanding the fact that the Trust has an agreed control total of £3m deficit for 2019/20. As the commentary explains, this confirmation of compliance is on the basis that the Trust has agreed its control total with NHSI and has submitted to NHSI a Board-approved Annual Plan for 2018/19. While the plan forecasts a 2019/20 deficit of £3m and the Trust remains in financial special measures, we consider that the plan provides the assurance that the Trust can reasonable meet this licence condition. This is consistent with the approach taken in 2018 where the Board agreed that the Trust should self-certify that it met this licence condition despite having a forecast deficit of £29m for 2018/19. In 2017, however, the Trust reported that it was non-compliant with CoS7 as at that point in time it did not have in place an agreed annual plan. Given the fact that the Trust remains in financial special measures, the Board is asked to consider whether it is content to approve a self-certification of compliance in relation to this condition.

5.0 RECOMMENDATION

5.1 The Board is asked to review and approve the self-certification against each of the licence conditions, including the proposed response in each area so that the Trust can complete the process within the established timetable.

Stephen Jones
Director of Corporate Affairs
24 May 2019

APPENDIX 1

SELF CERTIFICATION AGAINST LICENCE CONDITIONS 2018/19: CERTIFICATION DECLARATIONS AND STATEMENTS

Licence condition	Description of licence condition	Suggested declaration (Confirmed / Not confirmed)	Suggested statement
G6	Has the Trust taken appropriate steps to establish, review and maintain systems to identify and effectively manage risks?	*Confirmed*	*The Trust has taken appropriate steps to establish sound arrangements for risk management in the Trust. Following an external governance review in 2017/18, the Board developed and agreed a Board Assurance Framework and process for assessing the strategic risks set out in the BAF. The BAF is reviewed by the Board was a quarterly basis during 2018/19, and these arrangements will remain in place in 2019/20. Strategic risks on the BAF are allocated to the sub-Committees of the Board, with the exception of four strategic risks that are reserved to the Board. The Board sub-Committees review the risks allocated to them at each meeting and consider the risk scores, including any changes, and assurance statements to the Board. The BAF is supported by the Chief Nurse and DIPC and by the Director of Quality Governance. The Board held a workshop on 17 January 2019 to consider further refinements and improvements to the BAF for 2019/20. A revised BAF, aligned to the Trust's new clinical strategy 2019-24, was reviewed and approved by the Board at its meeting on 25 April 2019. Risks on the Corporate Risk Register are scrutinised monthly by the Risk Management Executive, which undertakes this on behalf of the Trust Executive Committee. As part of the development of the updated BAF, the Trust has made refinements to improve its risk management processes. In 2018/19, the internal audit programme included a review of the Trust's BAF and this received a 'reasonable assurance' rating.*
FT4(8)	Does the Trust have in place the governance systems necessary achieve the objectives set out in the licence condition?	*Confirmed*	*Following the external review of governance undertaken in 2017/18, the Trust made changes to strengthen its Committee structures, reporting lines and risk management systems. The Trust has in place established Board and Committee structures. Committees review their effectiveness on an annual basis and these and these are used to identify areas for improvement. Terms of reference for the sub-Committees of the Board are agreed by the Board, and in 2018/19 the Board agreed minor changes to the Terms of Reference of the Audit Committee and Finance and Investment Committee. There is an established risk management system (see statement above relating to condition G6). The Trust's performance*

			is reviewed by the Board at each meeting, supported by the work of its sub-Committees. In 2018/19, the Trust's internal audit programme included an audit of the Trust's governance and this received a 'reasonable assurance' rating.
CoS7(3)	Does the Trust have a reasonable expectation that it will have the required resources available to deliver designated services for the next 12 months?	*Confirmed*	*The Trust is subject to both quality and financial special measures. However, the Trust has agreed a control total of £3m deficit with NHS Improvement for 2019/20 and has submitted a Board-approved Annual Plan for 2019/20 to NHSI. The plan forecasts a deficit of £3m and achieving this is subject to the delivery of an identified cost improvement programme of £45.8m in 2019/20 and reported to the Finance Committee on 23 May 2019 that £35.5m of 'green' CIPs had been identified. The Trust recognises that aspects of its IT infrastructure and estate, in particular, need to be addressed but does not regard this as posing a risk to the resources available to deliver services in the next 12 months. An additional £27m of capital funding was secured from NHSI in April 2019 and this will enable the Trust to address some of the most pressing estates issues. Management resources were enhanced through substantive appointments to the Board and though other senior appointments in 2017/18 and there has been a high degree of stability on the Board in 2018/19, with a new Chief Medical Officer joining in December 2018. Continuity on the Board has been further strengthened for 2019/20 with the reappointment by the Council of Governors of two Non-Executive Directors to second terms of office, commencing in October 2019, and by the reappointment of the Chairman to a second term from April 2020.*
-	Has the Trust taken steps to ensure Governors are equipped with the skills and knowledge they require to fulfil their roles?	*Confirmed*	*The Trust has continued to provide a range of training and development opportunities for governors to support them in their roles throughout 2018/19. All new Governors receive a welcome letter from the Chairman and are invited to meet with the Corporate Affairs team to complete their Code of Conduct and discuss the sort of training and induction they require. In 2018/19, Governors had briefings on the major strategic issues facing the Trust, NHS finances, the annual plan, the development of the new clinical strategy, learning from incidents, staff education and development, and patient engagement. Governors also received a number of briefings on steps being taken by the Trust to improve its cardiac surgery service. The Council of Governors held an away day in January 2019 and received presentations from the outgoing London Regional Director of NHSI and the Chair of the South West London Health and Care Partnership. It also held a workshop on how Governors and Non-Executive Directors could add value to the effective governance of the Trust, including how best to hold NEDs to account. A number of visits across the Trust were organised for Governors, including to*

			Queen Mary's Hospital, Dalby Ward, Gunning Ward, and Neurosciences. Governors have been invited to take part in PLACE inspections at both the Tooting and Roehampton sites. All Governors are both notified of and encouraged to attend events for Governors to increase their skills and knowledge and are supported to attend the NHS Providers Annual Conference for Governors. Governors receive Parts 1 and 2 Board papers and are welcome to attend Part 2 of the Board as well as the sub-Board Committees. This ensures Governors have a range of information available to help them perform their roles effectively. The Council of Governors reviewed the training Governors had received in 2018/19 at its meeting on 22 May 2019 and agreed that the Trust should self-certify that this condition had been met. The Trust is committed to the training and development of its Governors and will continue to provide such support in 2019/20.