Trust Board Meeting (Part 1) Agenda

Date and Time: **Thursday, 27 June 2019, 10:00-13:00**
Venue: **Hyde Park Room, 1st Floor, Lanesborough Wing, St George's Hospital**

Time	Item	Subject	Lead	Action	Format
FEEDBACK FROM BOARD WALKABOUT					
10:00	**A**	**Visits to various parts of the site**	**Board Members**	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 30 May 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**	**Clinical Governance Review**	**Richard Jennings** Chief Medical Officer	Assure	Report
11:30	**2.4**	**Cardiac Surgery Update**	**Richard Jennings** Chief Medical Officer	Assure	Report
11:40	**2.5**	**Quality Improvement Academy (Quarterly)**	**James Friend** Director of Delivery, Efficiency and Transformation	Assure	Report
11:50	**2.6**	**Safeguarding Adults Annual Report**	**Avey Bhatia** Chief Nurse/ Director of Infection Prevention and Control	Assure	Report
3.0 WORKFORCE					
12:00	**3.1**	**Workforce and Education Committee Report**	**Stephen Collier** Committee Chair	Assure	Report
4.0 FINANCE					
12:10	**4.1**	**Finance and Investment Committee Report**	**Ann Beasley** Committee Chair	Assure	Report

Time	Item	Subject	Lead	Action	Format
12:20	**4.2**	**FIC (Estates Assurance) Report**	**Tim Wright** NED Lead	Assure	Report
12:30	**4.3**	**Finance Report (Month 02)**	**Andrew Grimshaw** Chief Financial Officer	Update	Report
5.0 GOVERNANCE					
12:40	**5.1**	**CQC Statement of Purpose**	**Avey Bhatia** Chief Nurse/ Director of Infection Prevention and Control	Approve	Report
6.0 CLOSING ADMINISTRATION					
12:50	**6.1**	**Questions from the public**	**Gillian Norton** Chairman	Note	Oral
	6.2	**Any new risks or issues identified**	**All**	Note	
	6.3	**Any Other Business**		Note	
	6.4	**Reflections on the meeting**		Note	
13:00 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 25 July 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
Secretariat		
Tamara Croud	Interim Assistant Trust Secretary	IATS
Apologies		
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:	**27 June 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 2019, 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, 30 May 2019, 10:00 – 13:30
Barnes, Richmond and Sheen Rooms, Queen Mary Hospital, Roehampton Lane, Roehampton
London SW15 5PN

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
Jenny Higham	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/Deputy Chief Executive Officer	CFO/DCEO
Dr Richard Jennings	Chief Medical Officer	CMO
IN ATTENDANCE		
Harbhajan Brar	Director of HR & OD	DHROD
James Friend	Director of Delivery, Efficiency & Transformation	DDET
Stephen Jones	Director of Corporate Affairs	DCA
Suzanne Marsello	Director of Strategy	DS
Fiona Ashworth	Deputy Director of Operations (deputising for COO)	DDO-MedCard
APOLOGIES		
Ellis Pullinger	Chief Operating Officer	COO
Sally Herne	NHSI Improvement Director	NHSI-ID
SECRETARIAT		
Tamara Croud	Interim Assistant Trust Secretary (Minutes)	IATS

Feedback from Board Visits

Members of the Board provided feedback on the departments visited.

Day Case, Endoscopy and Dermatology (Chairman and DDET): The DDET reported that the Day Case Unit had a great team who were eager to do the best for patients. The underutilisation of theatres was mentioned and the team flagged the opportunity to use the unit for other minor surgical work. The teams asked for support to install a Wi-Fi connection to enable downloading of friends and family test results and to improve the communication between the Roehampton and Tooting sites especially in relation to transferring patients. A key issue related to receiving histology results from the Kingston pathology system. This required results to be emailed securely via an NHS.NET email

Feedback from Board Visits

address rather than accessing them through South West London Pathology (SWLP). The Dermatology Unit had staffing challenges, with 40% of the leadership team on long term sickness. The team had, however, demonstrated a high level of flexibility and moved staff and patients around to ensure the best care was provided. Generally the teams reflected that equipment was kept updated by PFI partners, the site is easily accessible with good parking for patients.

Gwynne Holford Ward and Wolfson Rehabilitation Unit (Ann Beasley and CN): The CN reported that the service supported the whole patient pathway, was well equipped and had sufficient space. The service flagged that when patients were repatriated to the community there was variability and sometimes a significant reduction in the level of therapy intervention they received. There was a real gap and unmet need and there was an opportunity for the Trust to influence the creation of a different way of delivering the pathway which may result in the reduction of the number of days patients spend in inpatient beds. The team was collegiate and dynamic. Ann Beasley commented that the integration with mental health and the rehabilitation team was very good. She flagged that with different Clinical Commissioning Groups (CCGs) commissioning varying degrees of step down services could result in some patients staying longer in hospital than necessary and the Trust should raise this with commissioners. It was agreed that the DS and DDET would discuss step down service provision with local commissioners to ascertain if there is any way to improve the pathway.

Outpatients (Phlebotomy, Audiology, Dermatology, ENT, Minor Injuries) and MIU (Sir Norman Williams, DCA and CMO): The CMO reported that there was generally good morale in the teams and people were more positive about the impending rollout of iClip than previously. There was evidence of how staff challenges could impact on the team and certain services not being delivered when key staff were away. There was also a very long wait for phlebotomy services, on average around 2.5 hours. Teams reflected that the estate was very nice and clean but there were some challenges with space even though there were some empty or underused parts of the estate at QMH.

Gait Lab/Wheelchair Service and Special Seating (Sarah Wilton and DHROD): The DHROD reported that the service supported around 10,000 patients who use mobility devices and wheelchairs. A key issue for the service was recruiting permanent staff. Patients were waiting around seven months for the gait service and this largely related to staffing issues. Teams also raised concerns about the procurement process for the servicing of wheelchairs. This is currently out for tender and it was suggested the Trust should consider provision of an internal service to ensure quality is maintained. Generally, staff raised issues around lack of senior leadership visibility on the QMH site, lack of QMH representation at the recent staff awards and the possibility of having the Trust's pooled car service extended to the site to use for patients.

Outpatient Physiotherapy and Rehab and Bader Gym (Tim Wright and Andrew Grimshaw): The CFO/DCEO reported that the service had a positive group of staff who were happy with the estate and there was a strong sense of community. The management of the variability of services contracted by the various CCGs presented a level of complexity for the teams. The teams commented that ICT was working well but some support was needed to help people transition from older systems. Communication also needed to be improved along with increased visibility of senior leaders to mirror what was available on the Tooting site especially when there are big change programmes and developments. The Chairman referred to the fact that previously, it had been agreed that Executives would have a regular presence at QMH and questioned whether this had broken down. The CEO said this was still the intent and advised that there were discussions about having formal Comcell meetings on a weekly basis which included an executive director being present on the QMH site.

Bryson Whyte Rehab Unit and Mary Seacole Ward (Stephen Collier, CEO, and DDC-MedCard): The DDO-MedCard reported that staff were ambitious about doing the best for patients and working on initiatives through the quality improvement programme. There had been real progress, with teams feeling there is joint working and a sense of one team. Teams continued to look at how to build on MCA/DoLs training compliance. They were also working on opportunities to recruit more staff and looking at bed usage. Transfer of patients and the consequences of transferring patients in unsociable hours and peak busy times for the wards was also raised as an issue. Stephen Collier

Feedback from Board Visits
commented that he came away from the visit quietly encouraged by the thinking going on behind service delivery, that vacancies were being well managed and that there was good use of the Allocate system. Douglas Bader Rehabilitation Centre (Jenny Higham and DS): The DS reported that the visit was very positive, and a good flagship service for the Trust with some long standing staff members having served at the hospital for between 25 and 44 years. Staff were also aware of the implications of the move from tariff to vouchers and were already thinking through the implications of this. Having only one nurse specialist was an issue; when she was on leave a consultant did the dressings but the team had a plan and wanted the authority to progress this. The Chairman flagged that these were good visits but sensed there was a lack of understanding about the move to block contracts and work should be done in divisions to effectively communicate the implications of this change.

		Action
1.0	**OPENING ADMINISTRATION**	
1.1	**Welcome, Introductions and apologies** The Chairman welcomed everyone to the meeting and noted that apologies had been received from the COO, who was being represented by the DDO-MedCard.	
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 meetings held on 25 April 2019 and 23 May 2019** The minutes of the meeting held on 25 April 2019 were agreed as an accurate record subject to the following changes: • Page 1: Revise the name of the meeting room; and • Page 10, item 5.1, penultimate paragraph, update the number of comments received on the staff survey to *'1,000 comments'*. The minutes of the meeting held on the 23 May 2019 were approved subject to reflecting the minor amendments provided by Ann Beasley outside the meeting.	
1.4	**Action Log and Matters Arising** The Board reviewed the action log and agreed: • **Action TB28.02.19/9**: The CN would take forward the presentation on the leadership programme as a staff story at the July 2019 Board meeting. • **Action TB28.02.19/10**: The DCA had reviewed this action and discussed options with the Chairman. Given the cycle of Committee meetings, including agreed Committee minutes in Board papers would mean the Board receiving minutes from the previous month, rather than the most recent meeting. It was therefore proposed that, as a first step, minutes of Board Committees would be circulated to all Board members, once agreed by the relevant Committee. This would ensure the Board was sighted on the discussions at Committee. It was	

		Action
	noted that reports of the Committee Chairs to the Board were an important vehicle for the Committee conveying its sense of the extent to which it was assured. Ann Beasley commented that there are some matters which are considered by the Committee but which are not appropriate for the public domain and should Committee minutes be incorporated into Board papers, Committees would need to produce two sets of minutes. It was agreed that this action could be closed.	
1.5	**Chief Executive Officer's Update** The CEO reported that the Trust had held a successful Board-to-Board meeting with Merton and Wandsworth Clinical Commissioning Groups (CCGs) which had focused on how we could work together most effectively for the benefit of patients. The Acute Provider Collaborative continued its joint working across South West London on initiatives to drive savings from joint procurement, staff recruitment campaigns and back office efficiencies. There are now four to five key workstreams being progressed. In line with the new Trust Strategy, good progress was being made on the ambition to become a more research focused organisation, with the number of clinical trials taking place across the Trust having doubled from the previous year. The Trust was taking positive steps to manage the challenges with its estate at St George's, and was investing £3.5m in improving its water systems. The Trust had celebrated its staff at the St George's Hero Awards on 16 May 2019. The awards were well attended and demonstrated the commitment of staff across the organisation. The documentary series 24-hours in A& E had been shortlisted for a BAFTA and the Trust's Nurse Recruitment Campaign for Band 5 nurses had been shortlisted for a Nursing Times Award. The Trust was pleased with the recent appointment of Steve Livesey as Associate Medical Director for Cardiac Surgery on a permanent basis. Andrew Grimshaw had been appointed to the role of Deputy Chief Executive Officer alongside his role as Chief Finance Officer. As part of this, he had also taken on overall executive responsibility for estates and facilities. In response to a question from Sarah Wilton, the CEO also advised that the Trust continued to hold afternoon tea events for long service staff members and their guests, which were very well received. The Chief Executive's Officer report was noted.	
2.0	**QUALITY AND PERFORMANCE**	
2.1	**Quality and Safety Committee Report** Sir Norman Williams, Chair of the Committee, presented the report of the meeting held on 23 May 2019. The Committee had noted the recent infection control cases which included four clostridium difficile (C.difficle) cases, four cases of salmonella, and four cases of candida auris. In the case of C.difficle the Committee noted that there had been a change in the reporting requirements which may result in an increase in the number of cases reported over the year. The incidents of salmonella and candida auris (yeast infection) were not of the usual type of infection control issues seen at the Trust and the Committee would conduct a review of these cases at its next meeting in June 2019 with the Consultant Microbiologist. The CN reported that there was very clear guidance on how the Trust should manage infection control cases and the Trust was working with Public Health England. The CN advised that the Infection Prevention and Control Group was also scrutinising these incidents. The Committee was pleased to receive the quality improvement safety priorities dashboard as part of the Integrated Quality and Performance Report (IQPR) and welcomed the improvement in the Advance Life Saving Training. Whilst the	

		Action
	performance on responding to complaints had dropped, the Committee was reassured that the new Head of Patient Experience would take leadership of the issues and drive performance improvement. There were eight 12-hour trolley breaches in 2018-19 and one in April 2019 and the Committee would conduct a review of the key drivers once the root cause analysis has been completed. The Committee was also concerned about the pace for completing the remaining three outstanding Care Quality Commission actions and, as a result of the limited assurance, the Committee had asked the executive to look again at the timeline and robustness of the actions. Having been previously concerned about mortality at the weekend, the Committee was pleased to note that there was no trend of higher mortality at the weekend. The Trust was required to have implemented seven-day services by April 2020. Whilst good progress was being made against the four key standards there were some resourcing challenges related to the provision of MRI at the weekend and to every patient being seen by a consultant within 14 hours of admission. Sir Norman Williams flagged that consultant job planning would be a key factor in delivering effective efficient seven-day services. The CMO advised that MRI was available at the weekend but it happened on an ad hoc basis. This was being monitored closely and follow-up reports would be presented to the Quality and Safety Committee. The Committee heard that commissioners had closed the review into clinical harm caused by delays in referral to treatment and the final report is pending. The Trust would need to consider how it closed its internal review in addition to how it utilises the Critical Care Outreach Team effectively to improve pathway flows. The CMO advised that until the final report is published there is no way of assessing the degree of clinical harm caused to patients by referral to treatment delays but there were currently no reported cases of significant clinical harm caused. The Committee noted that there were gaps in the NICE compliance and Sir Norman Williams advised that it may be useful to have this as a regular agenda item at the multi-disciplinary team meetings which were currently being reviewed. Ann Beasley commented it would be useful to understand the nature of the gaps and how they were being addressed. Sir Norman Williams advised that the clinical effectiveness team does audit compliance with the NICE guidance but there were challenges in receiving reports back from services. The Committee had asked for a follow-up report. The CN reported that should any service want to deviate from NICE guidelines there was a strict process which involved applying to the Patient Safety and Quality Group The Committee had also flagged the need to keep the pace of delivery around patient engagement and in getting patients involved in transformation and service change work. The DDET advised that patient engagement was extremely valuable in the transformation programme and work continued on co-design with patients. The Chairman advised that Governors recognised that there was patient participation in some projects but that concerns had been raised that the establishment of the Patient Participation Engagement Group (PPEG) had not led to new areas of patient involvement. She commented that there should be a more formal process for getting patients and stakeholders effectively engaged in the transformation work and how this was facilitated and tracked by PPEG. The Committee also received the learning report following two never events and noted that in relation to the transfusion never event, the Trust was working with South West London Pathology (SWLP) to improve oversight of incidents and improve clinical governance. The Board noted the report.	

		Action
2.2	**Integrated Quality and Performance Report (IQPR)** The DDET provided an overview of the IQPR which had been considered at the recent Finance and Investment and Quality and Safety Committee meetings. The DDET noted that the IQPR now included 'plot the dots' style data in statistical process chart form. As a result of an administration error, when patients were transferred from the Tooting site to Queen Mary Hospital the six week diagnostic standard was not achieved in April 2019 which for the first time in over a year but the expectation was that this would improve by May 2019. Non-elective waits increased a little in month 1 which reflected the fact that the Trust was operating under winter pressure conditions for longer than usual. The length of stay for women and children for the last five month increased against trajectory and the elective length of stay for cardiothoracic was down. The CN advised that the Quality and Safety Committee would conduct a deep dive into maternity services at its June 2019 meeting and would explore the drivers for length of stay performance. The DDO-MedCard reported that the Trust was struggling to deliver the trajectory for the emergency 4-hour operating standard. Additional support was being given to the ED to drive systemic changes. The DHROD advised that, since the report was published, the mandatory and statutory training (MAST) overall rating had moved from 89.3% to 91% which was positive. Appraisals rates for doctors were 88% and non-medical appraisals continue to improve, and currently stood at 84.5%. NHS Improvement (NHSI) had set a cap of £20.55m for agency spend in the current year and the Trust was focusing its efforts on ensuring its expenditure on interims and junior doctors were maintained within this limit. Stephen Collier commented that the Trust was under increased pressure to deliver reduced agency spend targets. He noted that whilst the Trust was not achieving its agency target at present, on review of the past 12 months it was clear that great progress has been made overall. On a general point, he flagged that the Trust should map control limits as opposed to having the data drive the control limit. The DDET advised that the Trust was using the formula provided by NHSI but the Trust had flagged this issue with them. Ann Beasley advised that the Finance and Investment Committee would be conducting a reconciliation of the activity data to ensure that it was tracking performance effectively. It was also good to see that the Trust was ahead of its referral to treatment (RTT) trajectory. Sarah Wilton reflected that it was useful to have the breakdown of MAST data and queried whether the Trust would be able to attain the target of 85% and above on the other training targets. The CN advised that more capacity had been put in place to deliver training but more focus was needed on the 'did not attends' (DNAs). This was being monitored on a weekly basis and the focus was very much on achieving the 85% MCA/DoLs training target, which was expected to take 2-3 months to achieve. Sir Norman Williams expressed concern about performance against discharges before 11am which is reported to be 17% against a target of 30% and had not changed for some time. The DDO-MedCard advised that this was currently under review with divisions to drive improvements in the patient pathway and increased focus was being given to the back end of the ward and how to improve flow and encourage staff to discharge patients on time. The Board noted the report.	
2.3	**Safe Staffing Report (Nursing and Midwifery Inpatient Establishment Review April 2019)** The CN presented the report noting that a key change to the nursing establishment had been the introduction of nursing associate roles. These were new roles which were registered with the Nursing and Midwifery Council. The Trust currently had	

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	seven such posts working in different practice areas with more due to start. The Trust was required to review its nursing establishment twice yearly. Whilst no changes were proposed this year, the Trust would need to consider the nursing establishment in the Emergency Department in addition to supporting the implementation of the new model in maternity which called for continuity of carer and the potential impact over the next two years. Stephen Collier commented that the nursing establishment equated to circa £140m of the Trust's total people cost and it was good for the Board to see the report and how this was being managed. There was, however, a question of clarity pertaining to the coverage. The CN confirmed that the headroom assumptions did include provision for sickness, training and annual leave which could vary across different divisions especially in relation to training. When benchmarked against other organisations, there was a range between 19 and 26% headroom provisions. The DDET flagged that the Trust had received challenges from NHSI about flow and he queried the degree to which the Trust had factored in analysis of the number of patients ready for discharge and the number of staff available to manage this process and whether there were any flags. The CN advised that alerts that were currently available related to a ward's ability to maintain safety but there were no alerts about flow. There were discharge coordinators on wards but the absence of such persons did have an impact on flow. There were also flow coordinators on wards where there was a high throughput of patients. The CFO flagged that whilst the paper addressed plans for having safely staffed wards it did not adequately address the issue of consistent delivery of the planned establishment. Although the nursing establishment budget was currently in balance some wards were underspent and thought needed to be given not only to whether or not there are any safety concerns where wards were operating with fewer staff than the establishment but also to the financial implications of having a full establishment of staff in place. The CN reported that the Quality and Safety Committee reviewed the planned versus actual nurse staffing levels to ensure that wards were able to deliver safe effective services and care to patients. The Trust was operating in a dynamic environment and requirements could change so even with the tools for planning safe staffing levels there were other actions taken in real time to support effective operation of wards on a shift-by-shift basis. However, it was recognised that more needed to be done on flow and efficiency. The CFO also flagged that the proposed increases to headroom alluded to in the report would need to form part of the 2020/21 planning round. The Board noted the report, the governance processes for setting the nursing establishment, the approach to budget setting for Enhanced Care for 2019/20, the 2019/20 ward establishment, and ongoing work to sustain effective use of the staffing resources.	
2.4	**Cardiac Surgery Update** The CMO reported that since the last meeting, the Trust had been pleased to have recruited the case management team which would start in June 2019 to help with patient flow and the patient journey through cardiac surgery. A Quality Summit had been held with system partners on 20 May 2019 and this had gone well. Whilst there was no complacency on the safety of the service there was confidence that the Trust had a safe cardiac surgery unit and, as such, discussions had focussed on developing plans for networked cardiac services and improving coordination in order to provide patients with better services. The Trust had met Health Education England (HEE) representatives and there had been discussions with HEE about when the Trust would be in a position to receive trainee doctors in the unit. HEE would keep this under review, but it was unlikely to take place before April 2020.	

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	The Independent External Mortality Review continued under the leadership of Dr Mike Lewis. As part of this, the Trust was writing to relatives of those who had died following cardiac surgery between April 2013 and September 2018, and had so far been able to identify and write to over 150 of the 200 families. The CMO noted that the General Manager of Cardiac Surgery would be leaving the Trust at the beginning of June 2019 on promotion to another Trust. He had been instrumental in a lot of the quality improvement that had been implemented. The Trust was sorry to see him go but wishes him well. The Chairman reflected that the General Manager would be missed and the Board extended their thanks for his support.	
2.5	**Mortality Monitoring Committee Report and Learning from Deaths** The CMO presented the report, noting that the Quality and Safety Committee had also reviewed the report in some detail at its meeting in April 2019. The report presented an overview of mortality in 2018/19. There had been 1,550 inpatient deaths within that period, of which 1346 had been reviewed by the Mortality Monitoring Committee (MMC) using the structured judgement review tool. 15% of those cases identified problems in healthcare and of that 15%, healthcare problems caused harm in 22% of cases. The number of problems related to resuscitation following a cardiac or respiratory arrest had decreased. A large proportion of the deaths reviewed were judged to be *'definitely not avoidable'* with 10 deaths judged to be '*probably avoidable'* and none that have been scored '*strongly probably'*. The reviews of deaths noted that there were well documented discussions about 'do not attempt resuscitation' (DNAR) for cardiac patients but the Trust was working on ensuring that all patients had treatment escalation plans. Sir Norman Williams flagged that the Trust's low *'probably avoidable'* score of 0.7% was subject to challenge given that the national average was 3.6% avoidable mortality. Ann Beasley welcomed the introduction of the new version of the tool which better identified mental health patients and she queried when the Trust would be able to conduct more analysis on deaths and avoidable deaths of mental health patients and work with Mental Health trusts to review individual cases. The CMO advised that the Trust was working with Mental Health partners but there was a real challenge in doing high quality joint investigations into deaths and there was a recognition that more could be done on this. A report would come to the Quality and Safety Committee in two months. In relation to the *avoidable* death scoring, the CMO advised that the issue was less about objectivity and more about the Trust's over reliance on the structured judgement review process which was meant to be one of several pillars that gave an organisation assurance that it understood its mortality performance. Whilst there was nothing wrong with the scoring there was more work to do and in the last Serious Incident Panel it was agreed that the *avoidability* of death score would be assessed and triangulated in discussions with the MMC. It was also noted that Dr Nigel Kennea would be stepping down from his role as Chair of the MMC. During his time chairing the Committee, the MMC had made good progress on a complex issue and the Trust was making headway on appointing his successor. The Board thanked Dr Kennea for his dedication and work in taking this agenda forward to the benefit of the Trust. The Board noted the annual report from the Mortality Monitoring Committee and Learning from Deaths.	
3.0	**FINANCE**	
3.1	**Finance and Investment Committee Report** Ann Beasley, Chair of the Committee, provided an update on the meeting held on	

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	23 May 2019. This was the first of the new structure for FIC meetings which were now being held in two parts to allow dedicated time for the consideration of both finance issues and estates and facilities issues. The Committee had held a good deep dive into Information and Communications Technology (ICT) risks. There was a mature understanding of what was driving the overall risks and it was likely that the underlying risks would be reduced with the new investment in ICT. However, this, in itself, may give rise to new risks. The Committee agreed to produce a monthly reconciliation of activity and finance. The Committee had been encouraged by the latest position on the Cost Improvement Plans (CIPs) and was assured that that 100% of CIP schemes would be Green by the end of June 2019 (end of Q1 2019/20). Currently 78% of those schemes were green which equate to £35.5m of the £45.8m. In reviewing its effectiveness, the Committee had agreed that it would receive more information about the underlying run rate. The Committee also reviewed the submission on Improving Healthcare Together and the outline business case to refurbish the Cardiac Catheter laboratories and could recommend these to the Board. Tim Wright noted that the Trust now needed to outline its future ICT strategy to ensure that investments were aligned with the Trust's long-term plan. The Chairman commented that the Board was not well sighted on ICT, while noting that the draft ICT strategy was due to the Board later in the year, and commented that the Council of Governors had raised some issues at its recent meeting about ongoing problems staff had encountered with ICT. The Chairman noted that the Council of Governors had expressed a desire to hear directly from the Chief Information Officer at its next meeting. The Board noted the report.	
3.2	**Finance (Estates Assurance) Report** Tim Wright, NED lead for estates, provided an update on the first monthly meeting of the estates element of the Finance and Investment Committee. The Finance and Investment Committee (Estates) – FIC(E) – was being held to provide more comprehensive assurance on estates risks. It had focused on the establishment of new governance structures for monitoring estates issues, which included the establishment of a new Executive-led Estates Management Group. The FIC(E) had reviewed the estates risks noting the scale of work ahead. The Committee heard about the progress being made on the actions outlined in the Authorised Engineer's report on water safety and had discussed in detail the short-term mitigations being put in place. The intention was to discuss the mid-to-long-term plans at the meeting in June 2019. The Committee considered the procurement proposal for identifying suppliers to support the Trust in addressing these issues and had been assured that there was funding available for this. The Board noted the report and the establishment of new governance processes for managing estates risks and issues.	
3.3	**Finance Report (Month 01)** The CFO advised that the Trust is broadly on plan at Month 1. The Board noted the Month 1 finance report.	
4.0	**GOVERNANCE**	
4.1	**Audit Committee Report** Sarah Wilton, Chair of the Committee, provided an update on the Committee meeting held on 20 May 2019. The meeting had focused on approving the year-end reports namely, the Annual Report, Annual Accounts and Quality Report for 2018/19. All the reports and supplementary documents were endorsed and recommended by the Committee for approval by the Board. The Board had subsequently approved and adopted the reports at its extraordinary meeting held	

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	on 23 May 2019 in advance of the deadline for submission to NHS Improvement. The Committee also considered three internal audit reports. The Committee welcomed the reasonable assurance rating from the Assurance Review of Governance and noted the limited assurance rating in relation to the Review of Estates and Facilities Car Parking (Queen Mary's). Of particular note was the output of the operational review into bullying and harassment. The review had included holding workshops in which 18 members of staff had shared their experience of long standing bullying and harassment concerns in a confidential environment. Its findings triangulated with recent staff survey results and work to clarify and update the relevant policies and processes to get a clear path for staff to raise concerns was an area the Committee felt was a high priority on which it expected to see a full report at is August meeting. It was noted that the reference to this being a '*no assurance'* report reflected the fact that it was an operational review rather than an assurance review, and as such no rating would be applied. The CEO advised that her biggest concern was how staff felt and the importance of making progress on delivering the changes in organisational culture which were required. The Board would consider a report at its next meeting setting out the action plan for addressing the issues highlighted by the most recent NHS staff survey. Work was ongoing with the Freedom to Speak Up Guardian and the DHROD to build in robust processes and systems to engage and track responses where staff had raised concerns. The gaps had been identified and it was recognised that better ways of capturing staff concerns were needed. The DHROD advised that the raising concerns policy had been reviewed and the Trust was looking at introducing software for managing and tracking concerns which would improve the overall management of the process. It was also recognised that more work was needed on publicising and communicating the policy and the work of the FTSU guardians. Sir Norman Williams noted that it was important that there was clarity in the processes to ensure that staff could raise concerns. The Chairman flagged that NEDs were concerned about the length of time it had taken to bring an action plan in response to the staff survey to Board and stated that this needed to come to the June meeting. Reflecting on the wider challenges about cultural change, the CEO noted that it typically took organisations between 3 and 5 years to change the culture of an organisation. The past 18 months had been focused on getting the organisation where it needed to be on key quality, performance, and financial issues and the focus was now shifting to driving cultural change. The Board noted the Audit Committee report.	
4.2	**St George's Hospital Charity Report (Q4)** The DS presented the quarter four report from the St George's Hospital Charity. The Charity's general purpose fund had been fully utilised in 2018/19 which was a positive sign and there has been significant improvement in the relationship between the Trust and the Charity. The Medical Advisory Group which was established a year ago to drive investment of charitable funding into research was moving forward. The Charity was now focusing on Special Purpose Funds (SPFs). The Charity was focussed, this year, on working with the Trust to ascertain how best to spend these monies and rationalise the circa 200 SPFs to get greater benefit for patient and staff. In light of the publication of the Trust's new clinical strategy 2019-24, the Charity was working with the Trust to align priorities to the Trust's forward plans. Jenny Higham noted that it was exciting that the Charity was making larger allocations which are more likely to generate bigger grant submissions and drive enthusiasm among clinical staff. It was also good that investment had been aligned to clinical and research areas where the Trust was a	

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	leader, in lymphedema and cardiac risk in the young. Tim Wright commented on the improved relationship between the Trust and the Charity and commended the DS, as executive lead, for her role in this. Over the last 18 months fundraising and spending of funds had improved. The Charity was taking steps to strengthen the grant making process. It was in a much better position than previously but recognised that more work was needed on process. The DDET commented it would be useful to receive progress updates on all the projects in which the Charity had invested. The DS also advised that the Charity recognised that in relation to capital schemes it is willing to make provision for project management support so there was not a delay in starting these projects once the allocation has been made. The Board noted the report and the investment awarded by the Charity in support of Trust projects.	
4.3	**Provider Licence Compliance Self-Certification** The DCA reported that each year the Trust was required to undertake a self-certification of compliance with its licence conditions around systems for compliance with licence conditions and related obligations (condition G6), availability of resources (condition CoS7 (3)), and governance arrangements including training of governors (condition FT4 (8)). The Trust was also required to self-certify that it had provided training to its Governors. At its meeting on 22 May 2019, the Council of Governors reviewed the training provided to Governors in 2018/19 and agreed that the Trust could state compliance with regards to the level of training provided to governors. The Board approved and endorsed the self-certification of compliance with licence conditions.	
5.0	**CLOSING ADMINISTRATION**	
5.1	**Questions from the public** The Chairman invited questions from the public. She also formally noted that at the start of the meeting a group of members of the public had presented a petition raising concerns about ID checks and the charging of overseas patients but the group had not wished to stay until the section of the meeting in which questions from the public would be addressed. Nevertheless, a written response to the points made would be provided to the group. Jonathon Broad, a paediatric doctor and representative of Patients not Passports, asked to present a letter signed by almost 200 healthcare staff and students at the Trust highlighting the group's serious concerns about what it regarded as the inequality of ID checks and the impact on providing safe care and staff wellbeing. The signatories to the letter believed the policy was discriminatory and contradictory to the Trust's values. He also expressed thanks to the CMO for agreeing to meet him in the near future to discuss these issues. The letter set out four key demands of the Trust: suspending upfront charges; suspending ID checks; conducting a full impact assessment; and calling on the government to suspend this policy in line with the position taken by a number of the medical Royal Colleges and the British Medical Association (BMA). Dr Broad asked the Board three specific questions: i. Will the Trust respond to the call from the staff and students suspend the ID checks and upfront charging?	

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	The CFO advised that the NHS provided free access to care on a residency basis and not everyone in the UK was eligible; individuals needed to meet the residency criteria to qualify for free care. The Trust and other NHS organisations had a legal duty to recover costs from people who were not eligible for free healthcare and this was a statutory requirement on all NHS organisations. This was not a new requirement. There were certain circumstances where free care was available to everyone, for example emergency care and life saving services. However, once people move from such services ongoing care may become chargeable and this was a standard, longstanding government policy. The Trust was ultimately accountable to the government as a public body and as such was required to comply with that policy. As a result its ability to suspend that policy was limited. It is also very challenging for the Trust to challenge government policy in the same way as the BMA and the Royal Colleges. Those organisations were membership bodies which were entirely separate from government so could challenge the government on its position. As a public sector organisation, the Trust was required to discharge its obligations under the statutory and policy framework governing the NHS. It would not be appropriate for the Trust to comment on policies such as these, which were ultimately political matters for government and Parliament. ii. What measures are in place to guarantee that these policies do not compromise patient safety? The CMO advised that from a clinical perspective he was not aware of any cases in which the Trust's implementation of this policy had negatively impacted on safety. Patients who required emergency care were always treated and were not charged. The Trust and the Board recognises this could sometimes be difficult for staff. The concerns were, however, recognised in addition to the complexities and nuances when reviewing on a case by case basis. There was, potentially, a lot of value in having a face-to-face discussion about the specifics of staff concerns in the context of patient safety, and the CMO was happy to discuss whether the Trust was getting the balance right, whether there was clarity on the difference between non-emergency care and emergency care, and whether there were nuances and variations and other elements to clarify which would enable staff to deliver the type of care they wanted to provide. iii. Does the Trust have plans to conduct a full impact assessment of the policy and make this public? The CFO/DCEO advised that the government had undertaken a full risk assessment of this policy which was available on the overseas visitors' website for the Department of Health and Social Care (DHSC). The Trust had reviewed this risk assessment and believed it was suitable to support the processes the Trust goes through. The Trust had robust processes in place which detailed how the Trust seeks to identify people who would be subject to the policy. The Trust adhered to government recommendations in terms of how it should identify people who were not eligible for free healthcare. The Trust had employed specialist people to give effect to this policy across the Trust and endeavoured to ensure this was done in a fair and even way. The Trust reviewed this to ensure these were clear and there was no reason to believe the Trust was not applying the government rules in a fair and equitable way. The Trust Executive Committee had also reviewed the DHSC recommendations some time ago when the Department requested that the Trust enhanced its requirements for overseas visitors' cost recovery. The Trust had reviewed this and was assured that its practice was satisfactory. To put this in context the Trust had a turnover of £850m, £650m of which came from patient care. Around £2m in income came from overseas visitors, of which	

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	less than half was actually paid. There was very active support from the DHSC to encourage NHS trusts to ensure recovery of all eligible income from overseas visitors and there were active processes to support organisations to comply in a way that is fair and equitable as well as national documentation setting out guidelines for doing so which the Trust as adopted. Jonathon Broad thanked the Board and commented that whilst it was recognised that the Trust could not do much to suspend charges the Trust potentially could do more with regards to the impact assessment, including looking at whether the policies were being applied equally and consistently across all Trust services. He suggested a more comprehensive impact assessment was required and that he would be happy to support such a review. He also flagged that he did not believe that ID checks were mandated by the government and this was one of the processes which meant there was unequal and unfair charging which could be distressing for staff. Given that the BMA and Royal Colleges were stating that the policy was unequal and unfair, Dr Broad commented that it was time for the Trust and clinicians to look at what could be done otherwise there was a risk that there could be hostility towards people of different colour and migration backgrounds. The Trust therefore needed to think about what it could do and how it could ensure its policies were more inclusive. The Chairman thanked Jonathon Broad for his contribution and agreed that the CMO would pick-up on behalf of the Board the outstanding points. She also noted that the Board was willing to consider this matter further but noted the Trust's legal obligations. A written response from the CFO/DCEO would be provided responding to Dr Broad's questions. <u>Cardiac Surgery</u> Polly McCowen, member of the public, asked the Board to explain steps taken to learn from issues outlined in the joint public statement regarding Professor Marjan Jahangiri, Consultant Cardiac Surgeon posted on 20 May 2019. The CMO advised that the Trust had a policy as to how it should investigate issues involving doctors which mirrored the national Maintaining High Professional Standards (MHPS) guidance. In light of the events of August 2018, the Trust had committed to reviewing and, where appropriate, revising its policy to make sure it was clear and robust. This work was already underway and would be completed in the coming months. In addition, the broader and more important issue was that the Trust wanted to ensure that it did not get to a position where it faced the kind of issues that had emerged in the cardiac surgery department, where there had been issues around sub-optimal internal governance and ineffective team working. The Trust was therefore undertaking a piece of work to review how it structured clinical governance across the Trust and this would be considered by the Board in the coming months. This would be an important piece of work in making sure that there was clarity about the governance arrangements across all services and in relation to the process for escalating concerns so that they could be dealt with in a timely manner. The member of public reported that the Mr Justice Nicklin's judgement of 28 August 2018 had flagged that the MHPS policy had not been followed in that case and that it was important the Board understood the issues set out in the judgement. The Chairman commented that the Board was aware of the High Court ruling and accepted its findings. In response to a comment from the member of the public on who had taken the decision to exclude the surgeon, the Chairman clarified that the DCA had not been involved in taking the decision on the exclusion and it was important that this was corrected.	
5.2	**Any new risks of issues identified**	

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	It was noted that there we no new risks identified from the discussions.	
5.3	**Any other business** There were no matters of any other business raised.	
5.4	**Reflections of the meeting** The Chairman invited Stephen Collier to lead reflections on the meeting. He commented that it was important that the Board continued to hold meetings at the Queen Mary Hospital site. It was important for the Board to have the opportunity to meet QMH staff and it also gave the Board a very different insight into the work conducted at QMH particularly in relation to rehabilitation. In relation to feedback from the visits as there was a lot to say it would be useful to either have a high level theme set for the visits or to give guidance on the level of feedback required which would give some consistency to the reporting back to the Board. It was also evident that there was the right balance in the level of challenge during discussions. Other observations were that the front sheets of Board reports were not as well used as they had been previously and it may be time to rethink how they are used and to simplify them; those writing papers needed to use them appropriately. The depth of analysis by Board Committees on a number items was useful and had fostered more strategic, constructive discussions which triangulated trends and across clinical, operational and financial areas. The Board gave thoughtful and respectful responses to questions from the public and time was given to individuals and its proceedings are enhanced by having the public in attendance. The CMO reflected that it was good to receive challenge and when parties were mutually respectful it could lead to good quality discussions. Sarah Wilton reflected that it was good to come to Queen Mary Hospital and the Board should come back in the next six months. However, she noted that in the subsequent discussions on the papers there was no mention of QMH outside the feedback from the site visits and this should be more explicit in future reports. Jenny Higham commented that it may be useful, in future, to provide some bullet points on each service being visited ahead of the visits taking place to ensure that reports back focus on key issues, performance and governance as opposed to descriptions of the services. The Chairman pointed out that guidance had been provided in the past but this could be looked at again.	
6.0	**PATIENT/STAFF STORY**	
	Patient Story – Transfers between Trust sites The Board watched a video recording of a patient who relayed her experience of being transferred from the St George's Hospital in Tooting (SGH) back to Queen Mary Hospital (QMH). The patient had been sent to the SGH for an X-ray and transferred back to QMH at 2:10 am having been told that she would not be transferred following her X-ray. She found this very disruptive and distressing and would have preferred to have stayed at SGH until the next day. The HoTC advised that the video had been shared with staff as part of the Trust's quality improvement work, who are asked to share their thoughts and reflections on the patient's experience in order to drive change and improve quality for future patients. The story was also shared with the referring team and would be shared with the transformation team to drive Trust--wide change. Two members of staff from QMH, a junior doctor and a discharge coordinator, also shared their reflections on the impact of late transfers. They flagged issues around the ability to effectively assess patients late at night or early in the morning when there was limited staffing, the fact that sometimes patients were not medically fit to be on a rehabilitation ward with co-	

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	morbidities which required treatment on acute wards, the lack of records such as drugs charts, the stress on patients, and the impact on staff who feel that they were not providing the best care. The HoTC noted that capturing the real story involved getting the spectrum of experience from staff, patients and teams from both sites. There had been two early morning transfers since December 2018. Looking at the data for May 2019, it was evident that most patients were referred in the afternoon, between 12:30 and 16:30, hence patients were arriving at the time a large proportion of staff were ending their shifts. Only one patient arrived at circa 22:00 but most arrived by 19:00 just before a number of doctors finished their shifts. When iClip is installed at QMH there would be better tracking of these patients which would help ensure that inappropriate transfers were avoided. Consideration had to be given to how the Trust could work differently to change the system to ensure the issues highlighted in the patient story did not reoccur. All the intelligence about referrals, transfer times, arrival times and transport information would be used to drive improvements. Sarah Wilton asked that an update on the quality improvement work be presented to the Quality and Safety Committee in the next 3-6 months. The DHROD advised that patient communication was evidently an issue and communication should be a key element of the quality improvement programme. The CMO advised that it was important that the Trust considered how staff felt when they are pressed to receive patients in the way described in the patient story. Something needed to be done about improving communication between teams to ensure there was greater mutual understanding. The HoTC advised that communication with patients, staff and between teams would be part of the ongoing improvement work. The Chairman on behalf of the Board thanked the HoTC and colleagues for sharing the story and asked that the Board's thanks be passed on to the patient.	

Date of next meeting: 27 June 2019, Hyde Park Room, St George's Hospital

Trust Board Action Log Part 1 - June 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~~ 25/07/2019	**CN**	The Board agreed at its meeting on 30 May 2019 that this item would be taken as a staff story on 25 July 2019	**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~~ 25/07/2019	CN	The process will be reflected to demonstrate how the Audit Committee will receive assurance. A paper will be presented to the August Audit Committee outlining this.	**OPEN**
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	~~27.06.2019~~ 25/07/2019	CN	This work is ongoing and will be reflected in the Board Assurance Framework document presented to the Board in July.	**OPEN**

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	27 June 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 to the Trust Board – June 2019

Developments in our external environment

One of the four priorities set out in our recently agreed five year strategy – *delivering outstanding care, every time* – is closer collaboration with our partners, as well as the communities we serve. So I am pleased that we are increasingly active in this area.

Since the last Trust Board in May, I have met Rosena Allin-Khan, MP for Tooting. I have also met Justine Greening MP, to discuss, among other things, future provision of services at Queen Mary's Hospital, which is located in her constituency. The Queen Mary's site is crucial to our future, and we are already making better use of the excellent facilities it provides, with some of our urology clinics at St George's moving to Roehampton over the coming weeks and months.

The transfer of some urology clinics to Queen Mary's was a topic for discussion at the recent Wandsworth Health Overview and Scrutiny Committee, where I also talked about the steps we are taking to deliver wider improvements at the Trust. I have attended every meeting of the Wandsworth scrutiny meeting since taking up the post of Chief Executive, and it is right that I do so as part of our engagement with local communities.

Both myself and executive colleagues also continue to engage with local healthcare leaders – I recently attended the South West London Health and Care Partnership programme board, and Suzanne Marsello, our Director of Strategy, will be attending the Merton Health and Wellbeing Board on 25 June to discuss the emerging Merton Local Health and Care Plan, which we continue to be involved in.

I am also very pleased to see the work we are doing with South West London and St George's Mental Health Trust to improve the experience of patients with mental health needs. We have established a joint mental health reference group, which is already helping us to develop practical improvements here at St George's – in areas including emergency care, diabetes management, plus other long-term conditions. We are also doing important work to support women with mental illness during pregnancy and after childbirth – with 90 women seen in special clinics over the past 6 months.

In terms of the national picture, the NHS interim people plan has naturally generated lots of discussion. This has partly focussed on service delivery, but also – I am pleased to say - the long-term health and well-being of staff in the health service, which is something we are focussed on here at St George's. The interim NHS people plan majors on the premise of the people who work in the NHS being our greatest asset - but making this a reality for people on the ground is key.

Of course, some of the specific workforce challenges – i.e. staff training – are a national issue and require a national response. At St George's, we have a good story to tell in terms of staffing – with vacancy rates now consistently below 9%, and fantastic turnout at our recruitment days - but we mustn't be complacent. We know many staff enjoy working here, but far too many still don't – and whilst this is slowly changing, it isn't happening quickly enough.

Finally, I was delighted to hear that Amanda Pritchard has been appointed to the position of Chief Operating Officer for NHS England/NHS Improvement. Amanda has done a fantastic job at our neighbours Guy's and St Thomas', and whilst her appointment to such a key national role is a loss to south London, it is great both for her, and the health service.

Delivering on our vision and strategy

I have said from the outset that, now our new five year strategy has been agreed, the focus must turn to implementation and delivery; I don't want our strategy to simply be viewed as a document that sits on a shelf!

I am confident that we are making real progress in this area. Our teams have been busy developing implementation plans, and this will be crucial if we are to turn our ambitions into real, tangible benefits for patients and staff. The same is true of the supporting strategies we need to put in place – and we expect our separate workforce, research, digital, estates, quality and education strategies to come to Trust Board at intervals between now and the end of the year.

I attended a fantastic event last month as part of the process of building our research strategy. Our links with St George's, University of London, are so important in this regard; and I am pleased to say there was good attendance at the event from healthcare professionals with links to both the Trust and the university.

There was also a listening event run by Voice, our cancer patient user group, to discuss plans for the future of cancer services here at the Trust. Suzanne Marsello and some of our clinicians spoke at the event; as did Mairead Griffin, Director of Nursing for Cancer and End of Life Care at Guy's and St Thomas'. Over 100 people took part in table discussions at the event about how we can deliver the cancer ambitions set out in our strategy; as well as improve the service we provide in the here and now.

Major trauma is also a key part of our strategy, and it was positive to see us celebrate the 5th anniversary of the helipad at St George's last month, with over 780 patients airlifted to us for treatment during this period. The helipad is a key part of the service we offer for some of the most seriously injured patients from across Surrey and the south west – and wouldn't be possible without excellent team working between clinical and non-clinical teams.

Celebrating our staff

We always work hard to celebrate success, and the achievements of our staff.
Most notably, Professor Mike Sharland, who has links with both the university and the Trust, was made a Commander of the British Empire (CBE) in the Queen's Birthday Honours.

Professor Sharland was recognised for his work on antimicrobial resistance, in which he is a world leading expert. But we are also delighted that he is a paediatric consultant here at the Trust, and highly regarded by staff and patients alike.

Elsewhere, the work of our bone marrow transplant team was recognised in the London Evening Standard. Dr Mickey Koh, Consultant Haematologist and stem cell transplant lead, led the care we provided to patient Lauren West, who had a bone marrow transplant with us seven years ago, and was able to conceive naturally against the odds this year, thanks to the fantastic care our multi-disciplinary team provided.

I was also delighted to hear about the achievements of our renal team in a new report published last month. The report, published by the UK Renal Registry (UKRR), revealed that our renal transplant team have the highest patient survival rates in the country.

The team delivers consistently above average patient survival rates at both one year and five years after a kidney transplant. This includes patients receiving either deceased or living donor transplant kidneys. The fact they do this despite less than optimal facilities – which we are working to address – is all the more impressive.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	27 June 2019	**Agenda No**	**2.2**
Report Title:	**Integrated Quality and Performance Report (M02)**		
Lead Director/ Manager:	James Friend, Director of Delivery, Efficiency & Transformation		
Report Author:	Emma Hedges, Divisional Performance Manager Mable Wu, Business Intelligence Functional Lead Kaye Glover, Performance Development Manager		
Presented for:	Information/Assurance		
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 increase elective activity with 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 and the Trust return to compliance against the six week diagnostic standard. However existing challenges continue in particular Four Hour Operating Standard and patient flow. The Trust has achieved four of the seven Cancer standards in April reporting non-compliance in both 14 and 62 day standard. Please note that the report is under development working to incorporate NHSI recommendations.		
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 and 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 & Investment Committee Quality & Safety Committee	**Date**	20/6/2019 20/6/2019
Equality Impact Assessment:			
Appendices:			

Integrated Quality & Performance Report for Trust Board

Meeting Date – 27 June 2019
Reporting period – May 2019

St George's University Hospitals NHS
NHS Foundation Trust

HOW ARE WE DOING?

May 2019

Daycase and Elective Surgery operations

Actual
5,166

Target 5,134

Discharges before 11am

Downstream Wards

Actual 11%

Target 15%

Four Hour Emergency Standard

Actual
86%

Target 95%

Whole Trust Inpatient Friends and Family Test

Actual
96.7%

Target 95%

Outpatient First Appointment

Actual 16,836

Target 17,401

April 2019

Referral to Treatment Standard – Incomplete pathways

Actual
86%

Target
92%

Balanced Scorecard Approach

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 G	Diagnostics R	On the day cancellations	18 Week Referral to Treatment	
OUR **PEOPLE** PERSPECTIVE	Workforce	Agency use				

Key

Current Month

A Previous Month

Executive Summary – May 2019

Our Outcomes

- The number of patients that have been treated in our Daycase and Elective theatres on a daily working day basis has increased significantly.
- Eight Serious Incidents (SIs) were reported in the month which is above the upper process limit
- Inpatient FFT Response rate reached 40% exceeding the target of 30% for the first time since August 2018.

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 20 more patients per working day.

Our Patient Perspective

- Quality Improvement Key Programmes show steady progress
- A total of six MSSA bacteraemia incidents reported in May, compared to two last year and four in April 2019. The trust internal threshold for 2019/20 is 25 cases.
- Responding to 25 day complaints and 40 day complaints remains challenging with performance at 79% and 46% respectively
- There were eight Serious Incidents reported in May which is above the upper process control limit.

Our Process Perspective

- Performance against the Four Hour Operating Standard in May was 86.5%, which was below the monthly improvement trajectory of 90%.
- Performance against Incomplete Pathway Completeness currently stands at 85.8 % which is above our locally agreed trajectory of 84.3%.
- In May, the Trust performance returned to meet the national standard for the six week diagnostic waits with a total of 53 patients waiting greater than six weeks. This is a performance of 99.4% against a target of 99.0%
- The Trust achieved four of the seven Cancer standards in the March.
- In May, 98.6% of patients with on the day cancellations were re-booked within 28 days and the number of cancellations have reduced by 21% compared to the same period last year.

Our People Perspective

- As a result of the new financial year budgets being entered on the systems the funded establishment has increased by over 100 FTE, which has resulted in the vacancy rate increasing to 10.3%
- Non-medical appraisal have seen a further improvement in the month of May however remains below target with a performance of 72.5% 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.
- Medical appraisal rates are now being reported by the new appraisal system and currently stands at 85.4%.
- For May, the monthly target set was £1.25m. The total agency cost is worse than the target by £0.54 m.

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 G	Diagnostics R	On the day cancellations	18 Week Referral to Treatment
OUR **PEOPLE** PERSPECTIVE	Workforce	Agency use			

Our Finance and Productivity Perspective

St George's University Hospitals NHS Foundation Trust

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	
		May-18	May-19	Variance	Plan May-19	Variance	YTD 18/19	YTD 19/20	Variance	Plan YTD	Variance
ED	ED Attendances	14,517	14,760	1.67%	14,375	2.68%	28,028	28,610	2.08%	28,287	1.14%
Inpatient	Elective & Daycase	4,894	5,166	5.56%	5,134	0.62%	9,251	9,811	6.05%	10,027	-2.15%
	Non Elective	4,179	4,265	2.06%	4,044	5.46%	7,991	8,336	4.32%	7,940	4.99%
Outpatient	OP Attendances	56,201	54,890	-2.33%	57,644	-4.78%	107,433	109,064	1.52%	112,400	-2.97%

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

>= 5% (+ or -)

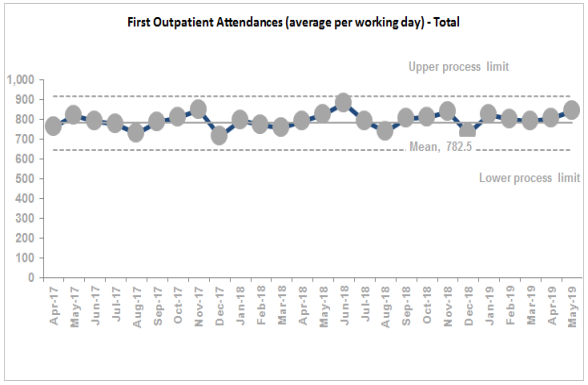
Source: SLAM

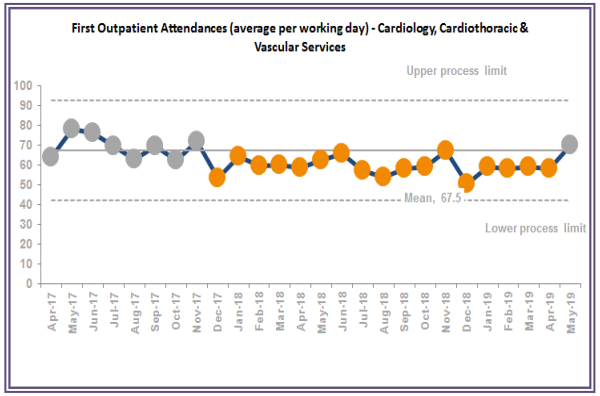
Our Finance and Productivity Perspective

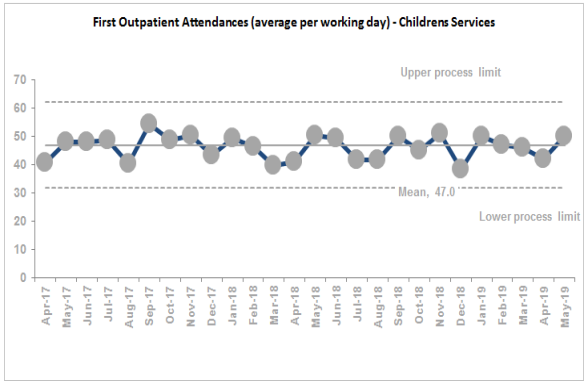
St George's University Hospitals NHS Foundation Trust

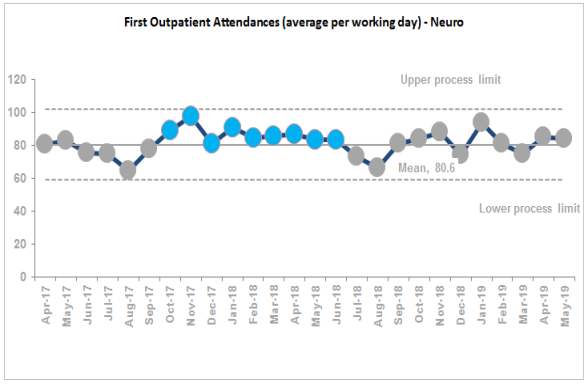
Number of First Outpatient attendances per Working Day

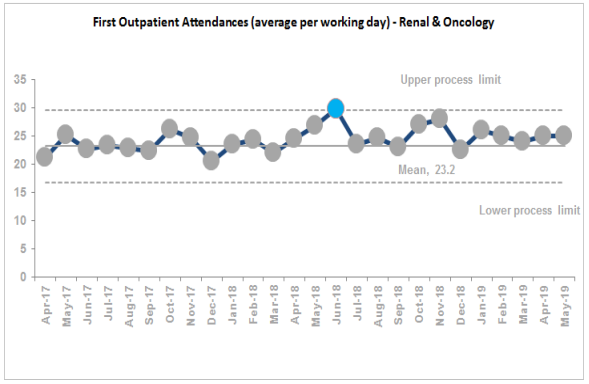
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

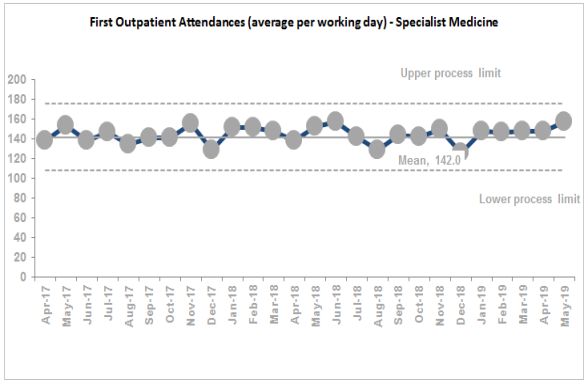


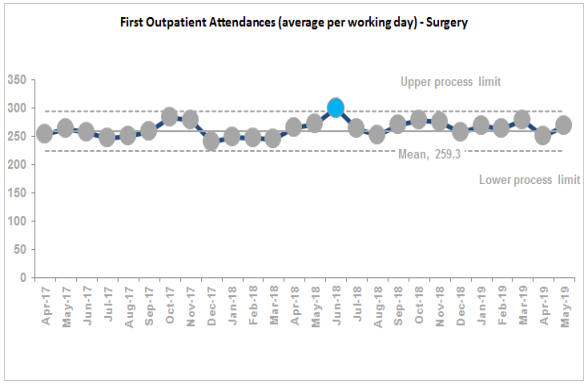


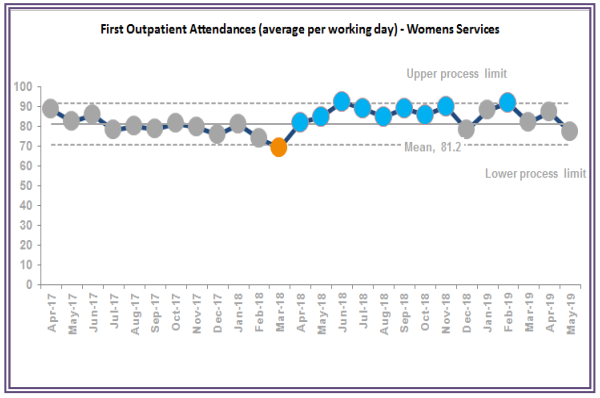


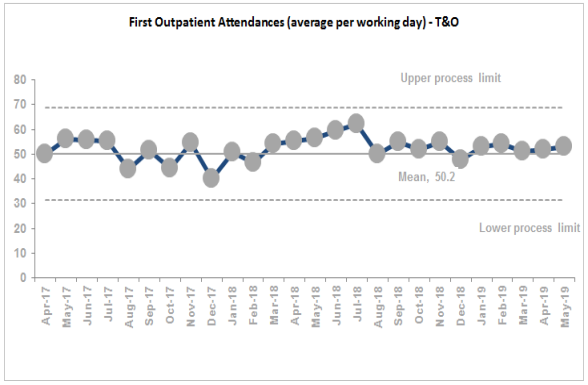








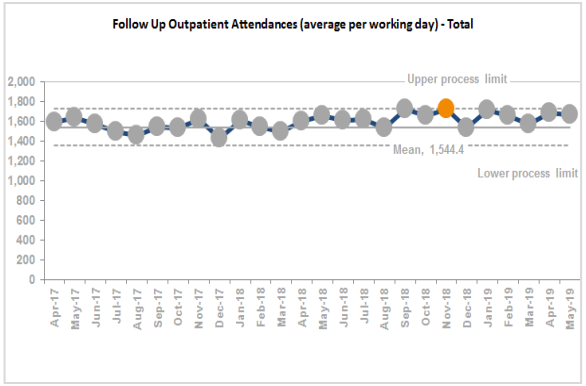


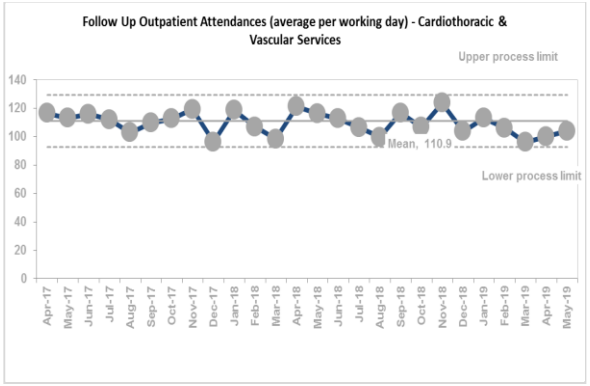


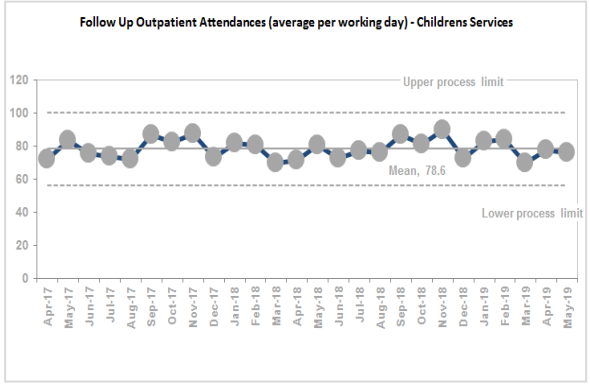
Our Finance and Productivity Perspective

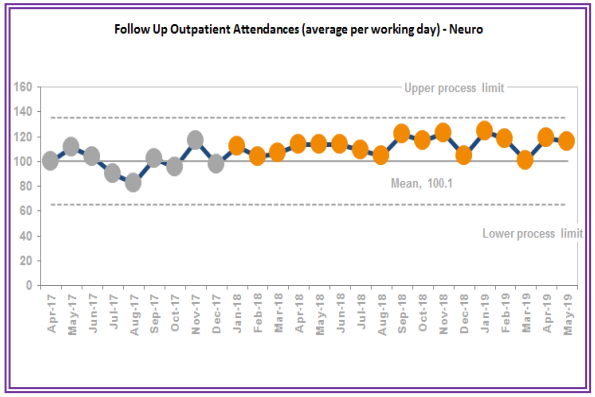
Number of Follow Up Outpatient attendances per Working Day

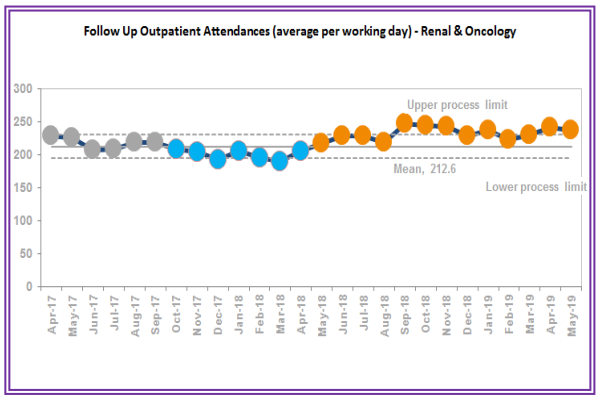
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

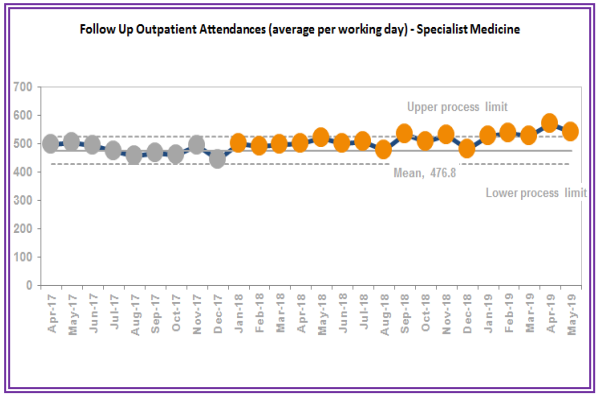


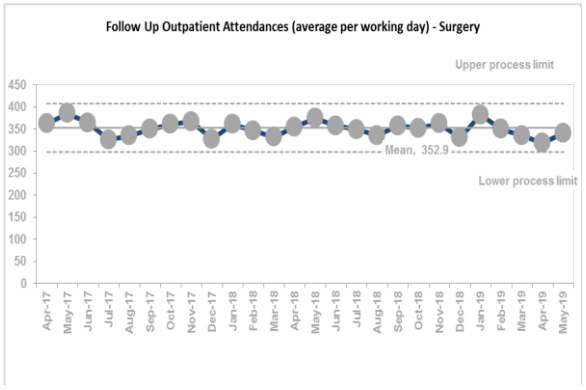


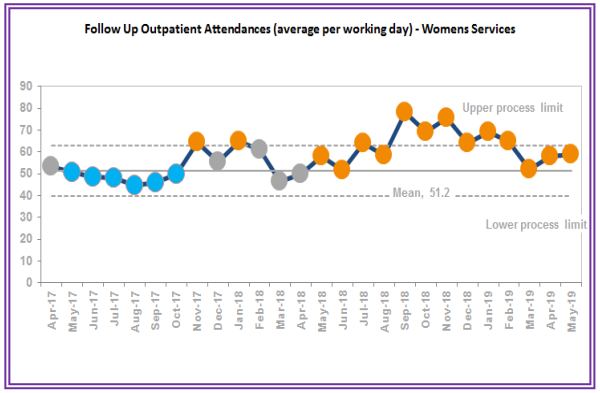


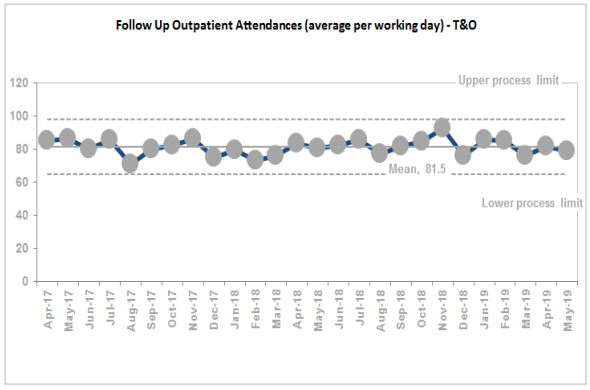












Our Finance and Productivity Perspective

St George's University Hospitals NHS Foundation Trust

Outpatient productivity

First Outpatient Attendances (average per working day)

Directorate	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	First Outpatient Attendances per working day 2018-19 YTD	2019-20 YTD	Variance
Cardiology, Cardiothoracic & Vascular Services	62	66	57	54	58	59	67	51	59	58	59	58	70	61	64	5.7%
Childrens Services	50	49	42	42	50	45	51	38	50	47	46	42	50	46	46	0.4%
Neurosciences	83	83	73	67	81	84	88	74	94	81	75	85	84	85	85	-0.9%
Renal & Oncology	27	30	24	25	23	27	28	23	26	25	24	25	25	26	25	-2.7%
Specialist Medicine	153	157	142	129	144	142	150	126	148	147	148	148	157	146	153	4.6%
Surgery	271	300	264	253	270	279	275	257	268	264	278	251	269	268	260	-3.0%
Womens Services	85	92	89	85	89	86	90	78	88	92	82	87	77	83	82	-1.7%
T&O	56	60	62	50	55	52	55	48	53	54	51	52	53	56	53	-5.9%
Other	38	43	38	34	36	37	34	36	39	33	32	59	57	38	58	53.0%
Total	**827**	**880**	**791**	**737**	**805**	**812**	**838**	**731**	**826**	**801**	**791**	**807**	**842**	**808**	**825**	**2.0%**

Follow Up Outpatient Attendances (average per working day)

Directorate	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	FollowUp Outpatient Attendances per working day 2018-19 YTD	2019-20 YTD	Variance
Cardiothoracic & Vascular Services	116	113	107	100	117	107	124	104	113	106	96	100	104	119	102	-14.1%
Childrens Services	81	73	77	76	87	81	90	73	83	84	70	78	76	76	77	0.9%
Neurosciences	113	113	109	105	122	117	123	104	124	118	101	119	116	114	118	3.4%
Renal & Oncology	217	228	229	219	248	245	243	229	238	223	230	242	238	211	240	13.5%
Specialist Medicine	520	501	508	477	533	509	529	481	528	537	526	572	541	510	557	9.1%
Surgery	374	357	349	336	357	352	362	331	382	350	335	318	341	364	330	-9.6%
Womens Services	58	52	64	58	78	69	76	64	69	65	52	58	59	54	59	8.6%
T&O	81	82	86	77	82	85	93	76	86	85	76	82	79	82	81	-2.1%
Other	98	94	89	86	97	92	91	77	91	92	87	118	119	98	119	20.7%
Total	**1,659**	**1,613**	**1,618**	**1,534**	**1,721**	**1,656**	**1,730**	**1,539**	**1,713**	**1,661**	**1,574**	**1,685**	**1,673**	**1,629**	**1,679**	**3.1%**

What the information tells us

- Outpatient first attendance activity has remained within its process limits since April 2017.
- Across the Directorates, the number of first outpatient attendances averaged 842 per working day, however, compared to the same period last year has seen a growth in activity of 2%. Although activity is below the SLA target for the month, this is expected to increase once coding has been completed.
- Follow-up activity is showing an increase of 3% compared to the same period last year with an average of 1,673 attendances per day in the reporting period.
- At Trust level follow-up activity has remained within its process limits. At specialty level Specialist Medicine, Renal & Oncology, Women's and Neurosciences are above the mean. Increases within Specialist medicine were predominantly Diabetes / Endocrine and Dermatology however, these services were generally busy and the follow-up ratio did not deteriorate significantly. Cardiothoracic and Vascular services remain below the mean however, a rise in activity is noted since March 2019.
- The RAG rating applied is based on the SLA plan per working day.

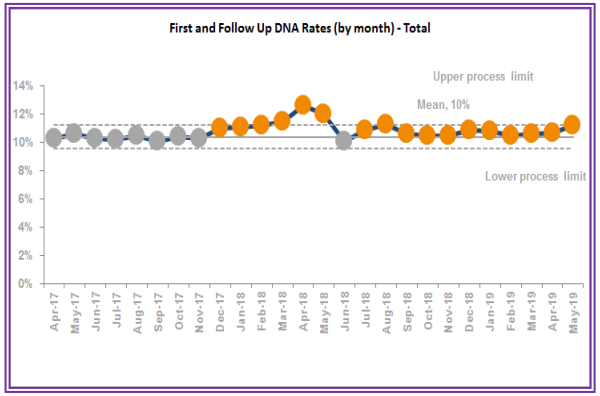
Actions and Quality Improvement Projects

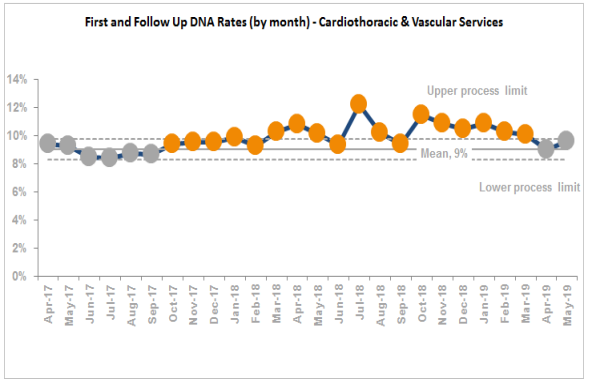
- Services are reviewing the recording of particular appointments as some will be classified as outpatient procedures.
- Specialist Medicine are working with the Outpatient Transformation Team to reduce follow-up appointments and are currently piloting Clinical Assessment Service (CAS) in Gastroenterology.

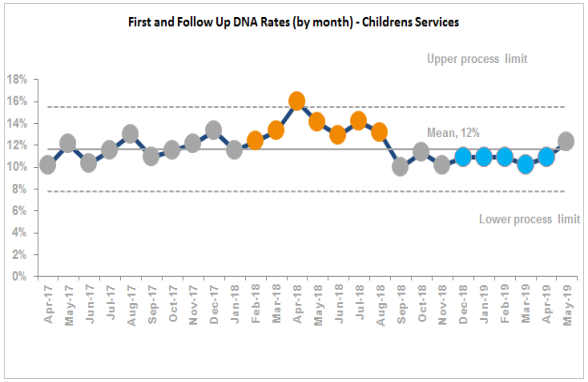
Our Finance and Productivity Perspective

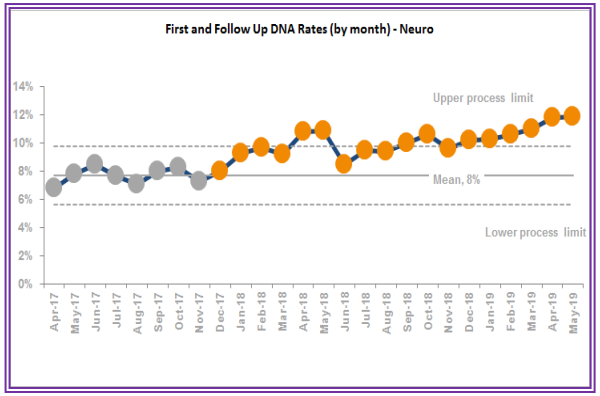
Percentage of patients that did not attend their appointment

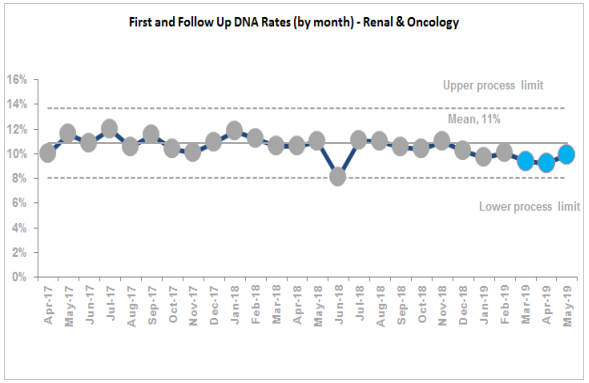
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

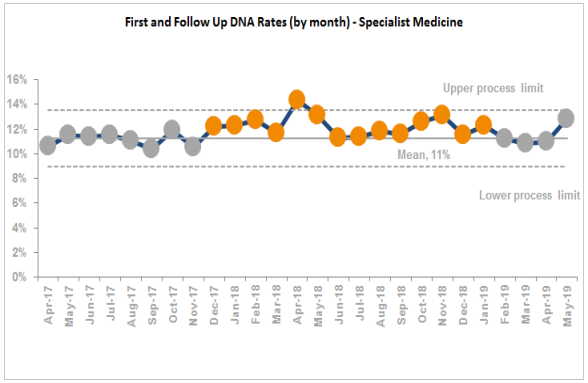


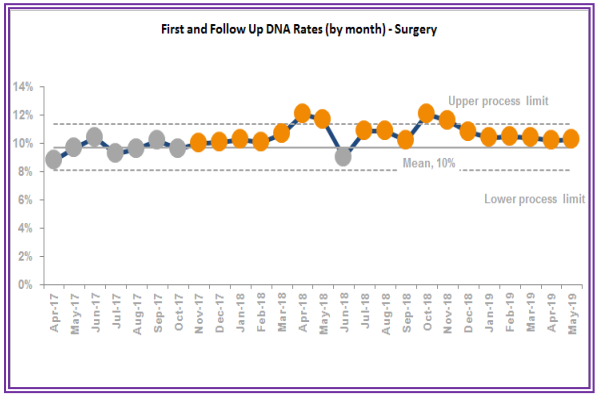


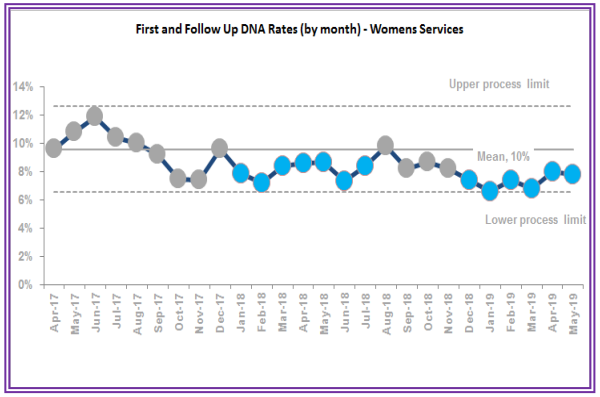


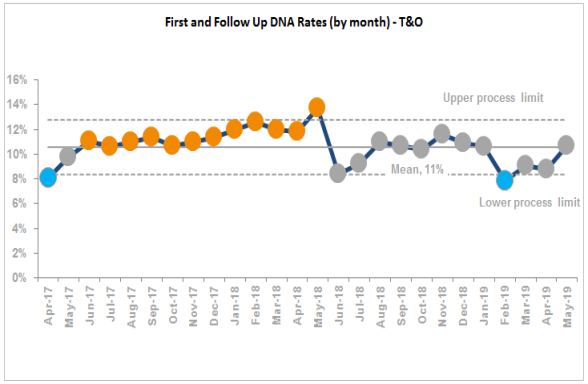








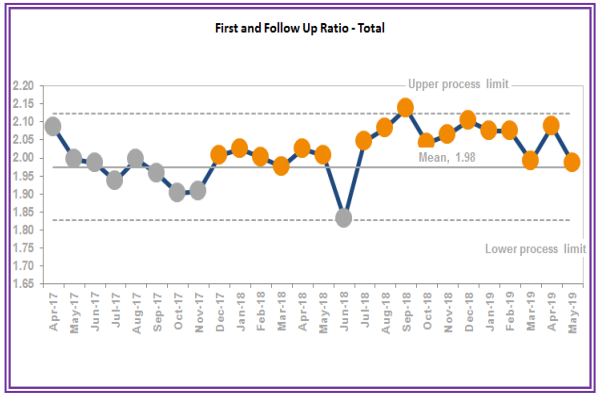


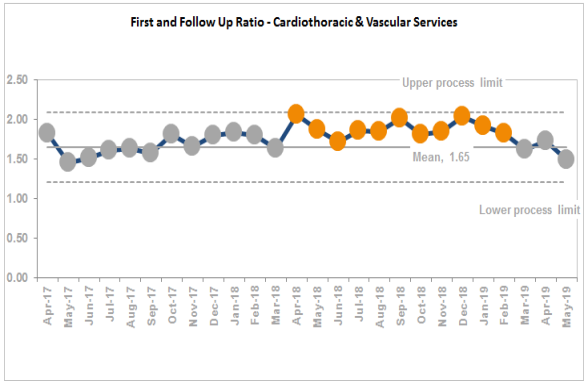


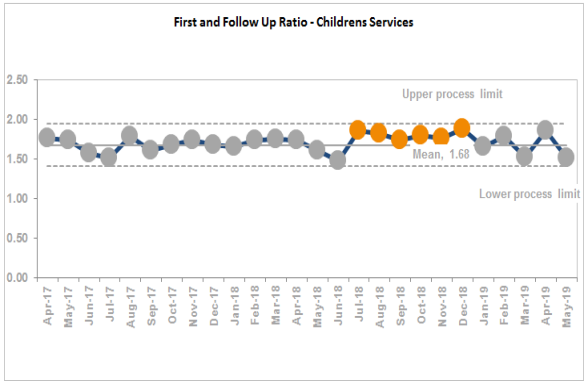
Our Finance and Productivity Perspective

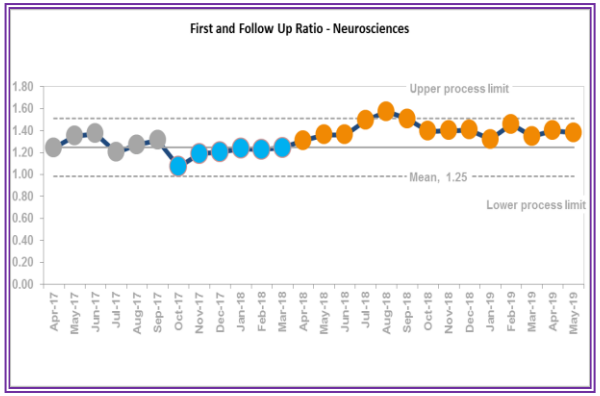
New to Follow Up Ratios

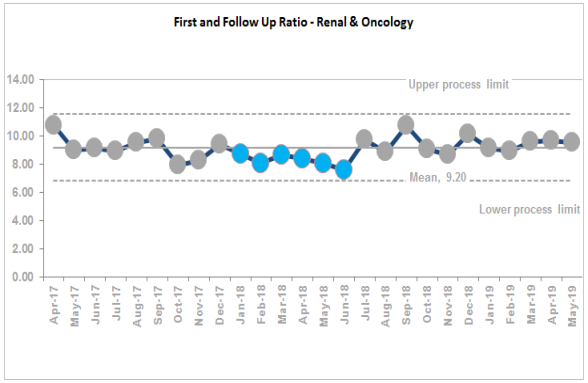
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

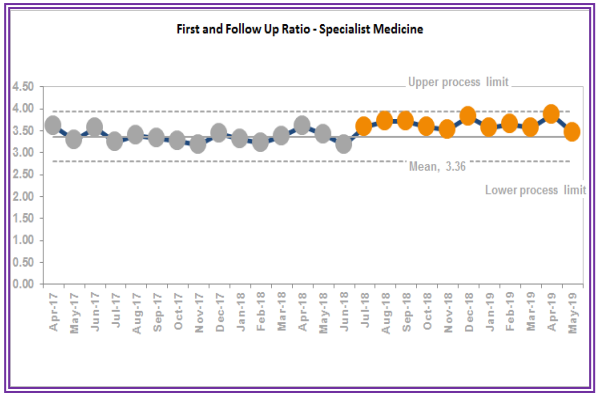


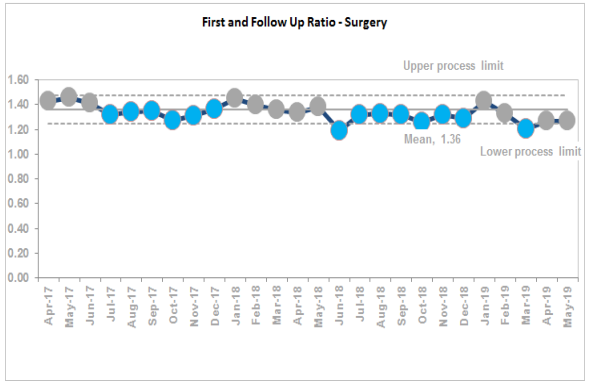


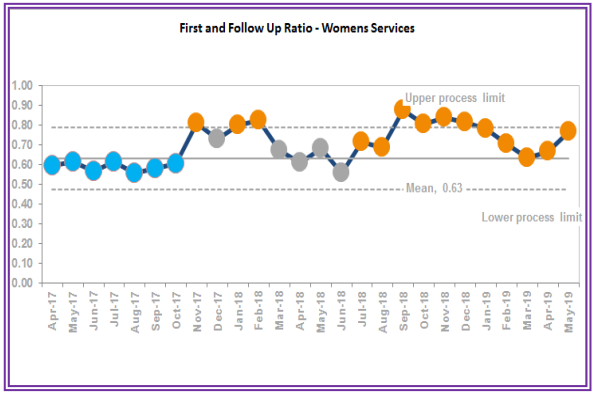


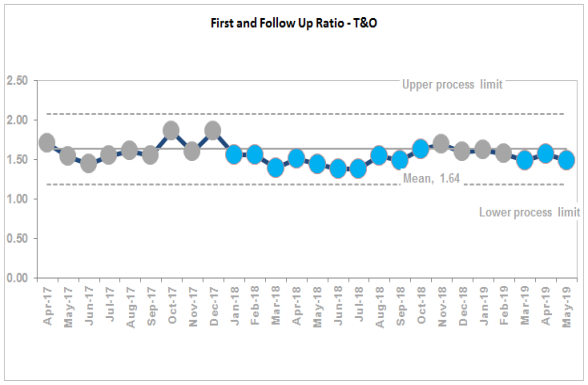












Outpatient productivity

First and Follow Up DNA Rates (by month)

Directorate	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	DNA patients in the last month	Patients not attending rate 2018-19 YTD	Patients not attending rate 2019-20 YTD	Variance
Cardiothoracic & Vascular Services	10.2%	9.4%	12.2%	10.2%	9.4%	11.5%	10.9%	10.5%	10.9%	10.3%	10.1%	9.0%	9.6%	290	10.5%	9.3%	-1.2%
Childrens Services	14.1%	12.9%	14.2%	13.1%	10.0%	11.3%	10.1%	10.9%	10.9%	10.9%	10.2%	10.9%	12.3%	396	15.1%	11.6%	-3.5%
Neurosciences	10.9%	8.5%	9.5%	9.4%	10.0%	10.6%	9.6%	10.2%	10.3%	10.6%	11.0%	11.8%	11.9%	522	10.9%	11.9%	1.0%
Renal & Oncology	11.0%	8.1%	11.1%	11.0%	10.5%	10.4%	11.0%	10.2%	9.7%	10.1%	9.4%	9.2%	9.9%	357	10.8%	9.6%	-1.3%
Specialist Medicine	13.1%	11.3%	11.4%	11.8%	11.6%	12.6%	13.1%	11.5%	12.3%	11.2%	10.8%	11.0%	12.8%	1,799	13.7%	11.9%	-1.8%
Surgery	11.7%	9.0%	10.9%	10.9%	10.2%	12.1%	11.6%	10.8%	10.4%	10.5%	10.4%	10.2%	10.3%	1,488	11.9%	10.3%	-1.7%
Womens Services	8.7%	7.3%	8.4%	9.8%	8.2%	8.7%	8.2%	7.4%	6.6%	7.4%	6.8%	8.0%	7.8%	578	8.7%	7.9%	-0.7%
T&O	13.7%	8.4%	9.2%	11.0%	10.7%	10.4%	11.6%	10.9%	10.6%	7.9%	9.1%	8.8%	10.7%	320	12.8%	9.8%	-3.0%
Other	9.5%	11.6%	12.9%	13.8%	12.5%	14.4%	15.4%	14.2%	12.9%	12.9%	14.3%	14.2%	13.4%	1,341	9.8%	13.8%	4.1%
Total	**12.0%**	**10.1%**	**10.9%**	**11.3%**	**10.6%**	**10.5%**	**10.5%**	**10.9%**	**10.8%**	**10.5%**	**10.6%**	**10.7%**	**11.2%**	**7,091**	**12.3%**	**11.0%**	-1.4%

First and Follow Up Ratio

Directorate	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	First to FollowUp Ratio 2018-19 YTD	First to FollowUp Ratio 2019-20 YTD	Variance
Cardiothoracic & Vascular Services	1.87	1.72	1.86	1.85	2.01	1.81	1.85	2.04	1.92	1.83	1.63	1.72	1.49	1.96	1.60	-18.2%
Childrens Services	1.60	1.47	1.86	1.82	1.74	1.80	1.77	1.89	1.66	1.79	1.52	1.86	1.52	1.67	1.69	0.9%
Neurosciences	1.36	1.36	1.49	1.57	1.51	1.39	1.40	1.40	1.32	1.46	1.35	1.40	1.38	1.33	1.39	4.3%
Renal & Oncology	8.08	7.64	9.75	8.89	10.77	9.08	8.68	10.13	9.15	8.92	9.58	9.68	9.52	8.23	9.60	16.6%
Specialist Medicine	3.40	3.19	3.59	3.71	3.70	3.58	3.53	3.81	3.57	3.65	3.55	3.86	3.45	3.50	3.66	4.3%
Surgery	1.38	1.19	1.32	1.33	1.32	1.26	1.32	1.29	1.43	1.33	1.21	1.27	1.27	1.36	1.27	-6.7%
Womens Services	0.68	0.56	0.72	0.69	0.88	0.80	0.84	0.82	0.78	0.71	0.63	0.67	0.77	0.65	0.72	11.1%
T&O	1.44	1.38	1.38	1.55	1.49	1.63	1.69	1.59	1.62	1.57	1.49	1.58	1.49	1.47	1.53	4.0%
Other	2.54	2.20	2.31	2.52	2.70	2.49	2.69	2.16	2.33	2.79	2.72	2.00	2.09	2.59	2.04	-21.1%
Total	**2.01**	**1.83**	**2.04**	**2.08**	**2.14**	**2.04**	**2.06**	**2.10**	**2.07**	**2.07**	**1.99**	**2.09**	**1.99**	**2.02**	**2.04**	1.1%

What the information tells us

- The Trust DNA rate has remained within its process limits for the previous 11 months however within the reporting period has moved nearer to the upper control limit. There is variability amongst the specialties.
- Neurosciences have had a steady upward trend for the previous seven months. Children services, although remain within the control limits has seen an increase within the reporting period and is above the mean as well as Cardiothoracic, Specialist Medicine and Trauma & Orthopaedics.
- The Trusts First to Follow-up ratio is above the mean however, remains within its process limits and all specialties are within expected levels,

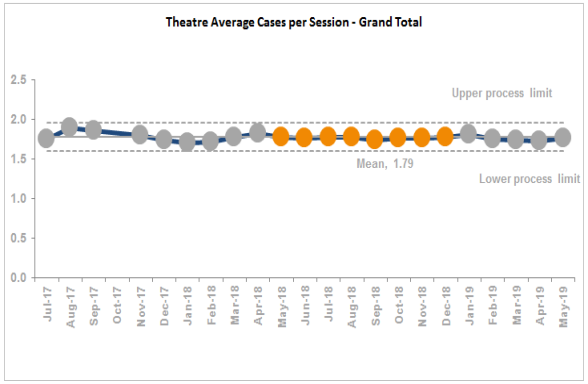
Actions and Quality Improvement Projects

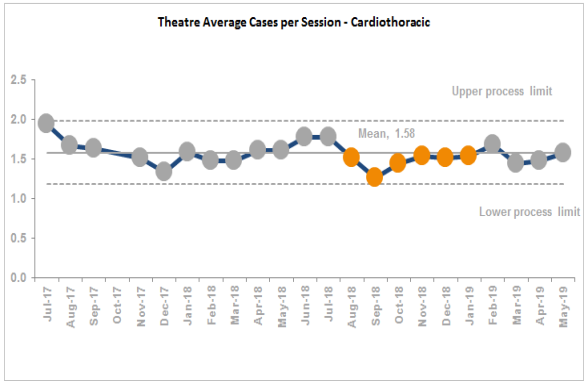
- Divisions are currently scoping opportunities to implement virtual follow-up appointments and open access to support reducing follow-up attendances and improve new to follow-up ratios across the services.
- Two way text reminder service are currently live in Dermatology, Plastics, Trauma & Orthopaedics, Haematology, Audiology, Audiology Medicine and Ear Nose & Throat

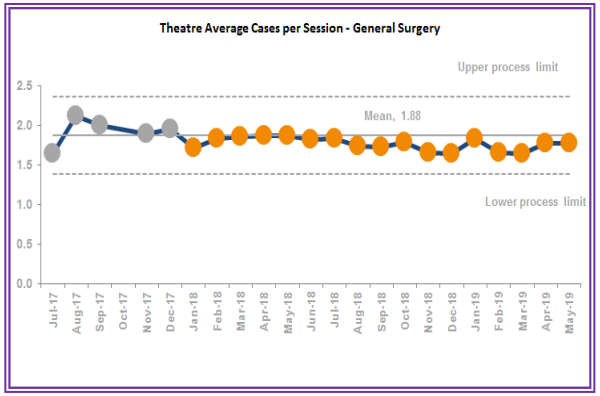
Our Finance and Productivity Perspective

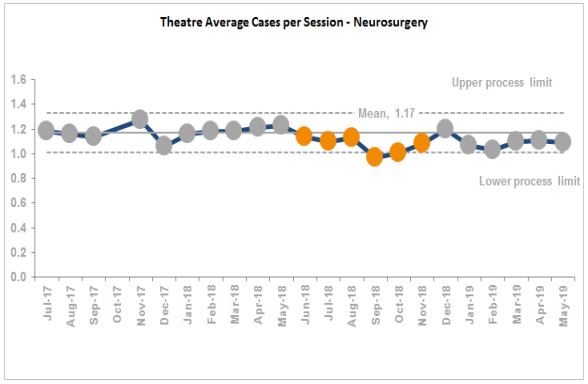
Theatre productivity – cases per session

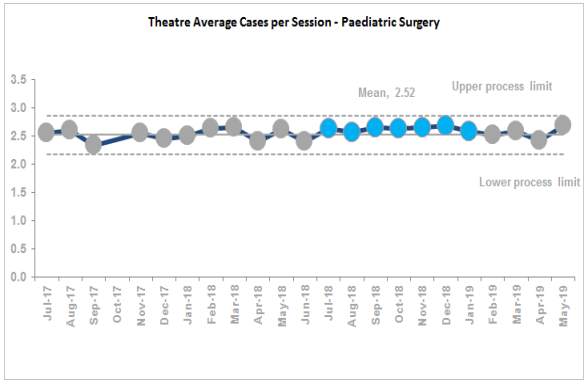
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

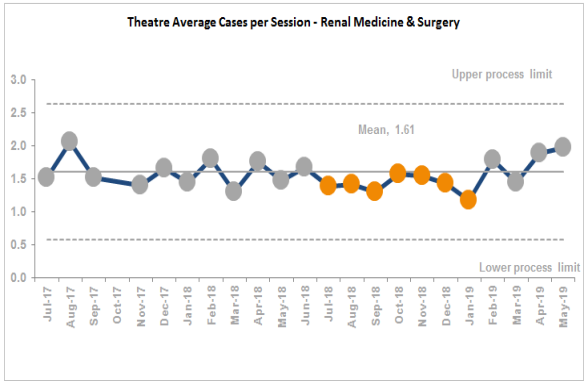


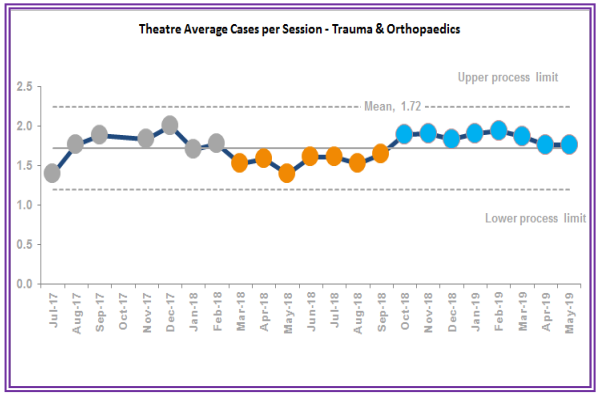


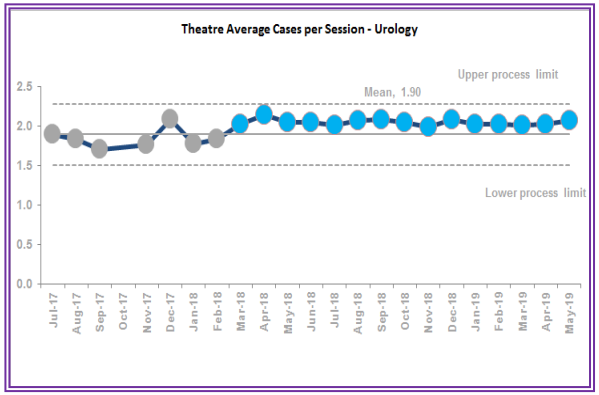


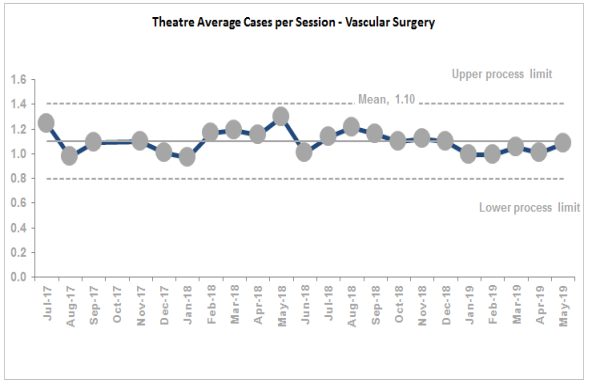












Theatre – Touch time utilisation

Theatre Utilisation

Main List Specialty	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Number of Patients in the last month
Cardiothoracic	81%	75%	74%	69%	70%	70%	73%	72%	72%	80%	74%	70%	68%	73
ENT	81%	77%	80%	84%	76%	77%	82%	78%	80%	76%	74%	75%	78%	150
General Surgery	78%	80%	82%	79%	82%	80%	82%	84%	78%	78%	82%	81%	80%	158
Gynaecology	77%	77%	83%	81%	77%	83%	87%	81%	79%	88%	74%	81%	71%	140
Neurosurgery	87%	80%	74%	84%	78%	76%	81%	80%	82%	78%	75%	79%	78%	177
Oral and Maxillo Facial Surgery	71%	73%	89%	75%	82%	63%	84%	78%	84%	67%	91%	61%	72%	35
Paediatric Dentistry	53%	50%	53%	58%	55%	56%	60%	62%	65%	68%	65%	58%	80%	38
Paediatric Surgery	82%	80%	81%	78%	75%	74%	72%	75%	76%	82%	74%	77%	79%	111
Plastic Surgery	74%	73%	77%	75%	75%	77%	74%	78%	74%	75%	69%	76%	78%	181
Renal Medicine & Surgery	76%	71%	72%	78%	61%	67%	82%	60%	66%	67%	83%	66%	88%	16
Trauma & Orthopaedics	76%	85%	84%	79%	82%	90%	85%	90%	81%	83%	90%	83%	81%	123
Urology	84%	78%	88%	84%	84%	85%	86%	81%	86%	82%	80%	79%	78%	190
Vascular Surgery	77%	76%	72%	68%	74%	76%	70%	74%	76%	82%	75%	68%	73%	60
Grand Total	**80%**	**78%**	**79%**	**79%**	**78%**	**79%**	**80%**	**80%**	**79%**	**79%**	**77%**	**77%**	**77%**	**1,452**

Theatre Average Cases per Session

Main List Specialty	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
Cardiothoracic	1.6	1.8	1.8	1.5	1.3	1.4	1.5	1.5	1.5	1.7	1.4	1.5	1.6
ENT	1.9	1.8	1.7	1.8	1.7	1.7	1.7	1.6	1.9	1.6	1.6	1.7	1.9
General Surgery	1.9	1.8	1.8	1.7	1.7	1.8	1.7	1.6	1.8	1.7	1.6	1.8	1.8
Gynaecology	2.3	2.3	2.7	2.6	2.5	2.6	2.5	2.9	2.7	2.6	2.3	2.5	2.2
Neurosurgery	1.2	1.1	1.1	1.1	1.0	1.0	1.1	1.2	1.1	1.0	1.1	1.1	1.1
Oral and Maxillo Facial Surgery	3.6	3.0	4.0	3.7	3.9	3.1	3.8	3.8	3.7	3.1	4.0	2.7	3.1
Paediatric Dentistry	3.7	4.2	4.0	3.8	4.1	3.9	4.5	4.7	4.4	4.3	4.1	3.9	4.9
Paediatric Surgery	2.6	2.4	2.6	2.6	2.7	2.6	2.7	2.7	2.6	2.5	2.6	2.4	2.7
Plastic Surgery	2.0	2.0	2.0	2.2	2.2	2.1	2.0	2.0	1.9	2.0	2.1	1.8	1.8
Renal Medicine & Surgery	1.5	1.7	1.4	1.4	1.3	1.6	1.5	1.4	1.2	1.8	1.5	1.9	2.0
Trauma & Orthopaedics	1.4	1.6	1.6	1.5	1.6	1.9	1.9	1.8	1.9	1.9	1.9	1.8	1.8
Urology	2.1	2.1	2.0	2.1	2.1	2.1	2.0	2.1	2.0	2.0	2.0	2.0	2.1
Vascular Surgery	1.3	1.0	1.1	1.2	1.2	1.1	1.1	1.1	1.0	1.0	1.1	1.0	1.1
Grand Total	1.8	1.8	1.8	1.8	1.7	1.8	1.8	1.8	1.8	1.8	1.7	1.7	1.8

What the information tells us

- There has been little variation in the number of theatre cases per session with 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. All services remain within the control limits within the reporting period with Urology and Trauma and Orthopaedics staying consistently above their mean.
- 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

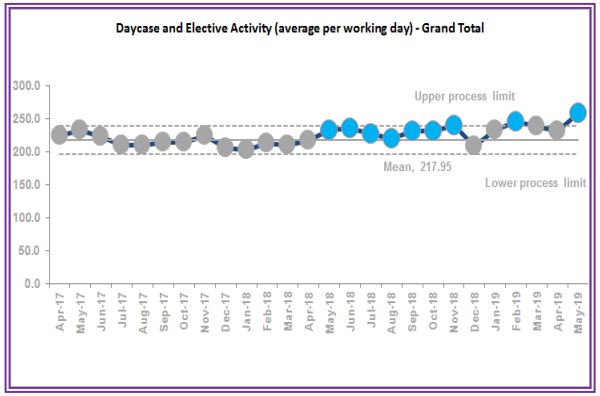
Actions and Quality Improvement Projects

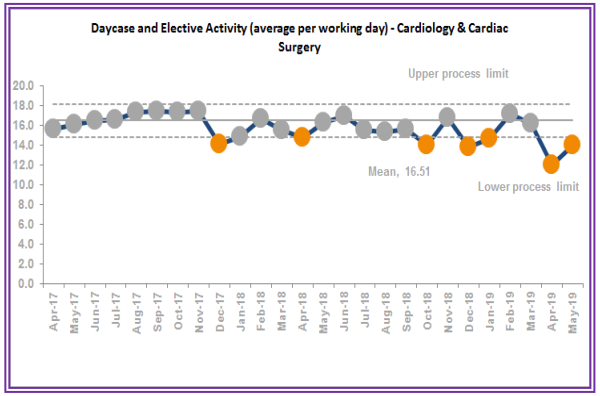
- Clinicians continue to reviewing their lists to verify patient order and appropriate case mix, this is linked to theatre team review identifying theatre equipment requirements, skill mix and specialist equipment to be ordered as required. A newly developed tool will be introduced to look at the list 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

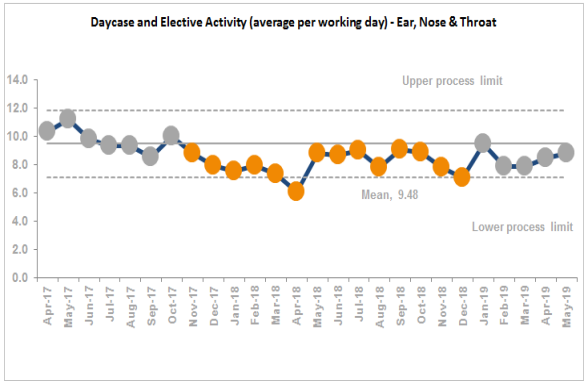
Our Finance and Productivity Perspective

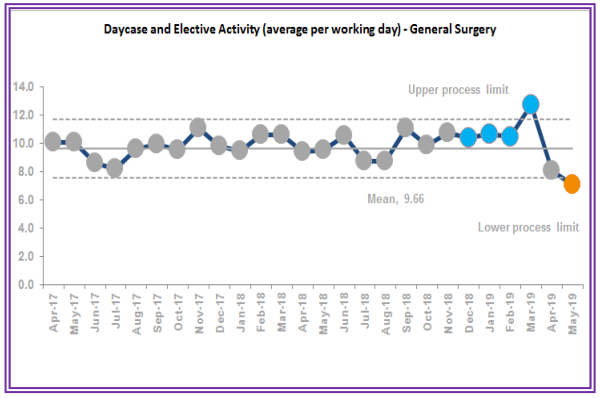
Number of Elective and Daycase Patients treated per Working Day

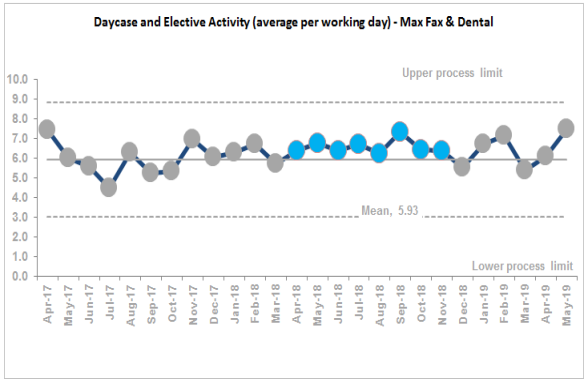
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

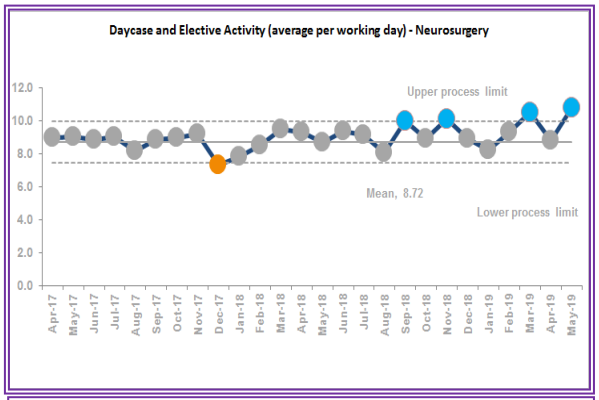


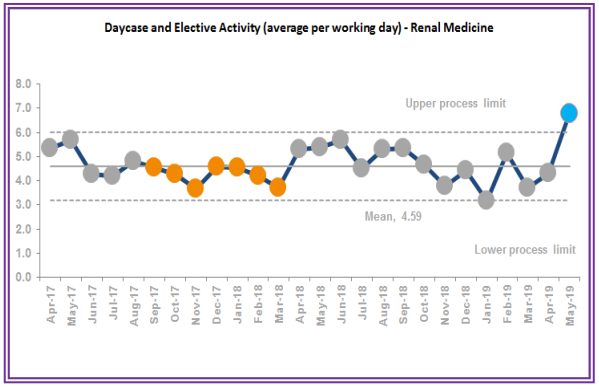


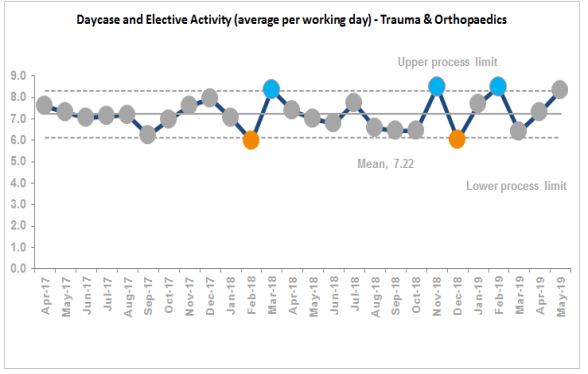


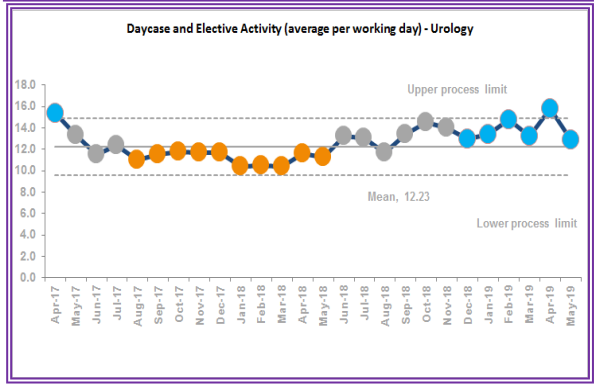












Our Finance and Productivity Perspective

St George's University Hospitals NHS Foundation Trust

Number of Elective and Daycase Patients treated per Working Day

Months	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	2018-19 YTD	2019-20 YTD	Variance	Discharges for month
Cardiology & Cardiac Surgery	16.3	17.0	15.5	15.4	15.7	14.0	16.8	13.8	14.7	17.2	16.2	12.0	14.0	15.5	13.0	-16.4%	279
Clinical Haematology	2.1	2.2	1.7	1.4	2.2	1.7	1.5	1.8	1.0	1.3	1.4	0.8	0.9	1.9	0.9	-56.3%	17
Diabetes & Endocrinology	2.3	1.5	1.7	1.9	2.0	2.0	1.8	1.2	2.0	1.6	1.8	1.8	2.4	2.2	2.1	-3.1%	47
Endoscopy & Gen Med	60.9	61.0	55.6	55.7	56.3	54.6	59.2	49.7	57.3	56.4	61.6	57.4	71.1	57.9	64.3	11.0%	1,422
Ear, Nose & Throat	8.8	8.7	9.0	7.8	9.1	8.9	7.8	7.1	9.5	7.9	7.9	8.5	8.8	7.5	8.7	16.0%	176
General Surgery	9.6	10.6	8.8	8.8	11.1	9.9	10.7	10.4	10.7	10.5	12.8	8.1	7.1	9.5	7.6	-19.9%	142
Gynaecology and Obstetrics	9.5	10.3	11.3	10.5	10.2	11.4	11.2	8.8	11.0	10.8	10.4	9.9	11.4	9.7	10.7	9.9%	228
Max Fax & Dental	6.8	6.4	6.7	6.2	7.4	6.4	6.4	5.5	6.7	7.2	5.4	6.1	7.5	6.6	6.8	3.3%	150
Neurosurgery	8.7	9.4	9.1	8.0	10.0	8.9	10.1	8.9	8.2	9.3	10.5	8.8	10.8	9.0	9.8	8.5%	216
Neurology	24.2	27.9	25.9	24.0	25.6	30.0	28.8	24.2	28.7	34.3	31.0	32.4	35.4	24.7	33.9	37.3%	708
Oncology	1.9	1.8	1.8	1.7	1.6	1.8	1.2	1.5	2.8	2.7	1.8	4.0	3.5	1.8	3.8	111.0%	69
Paediatric Medicine	10.1	8.5	10.0	9.5	9.6	12.0	10.3	10.9	10.5	12.5	11.9	12.9	12.2	10.1	12.6	24.3%	243
Paediatric Surgery	8.0	8.5	8.3	8.6	9.9	9.2	10.7	8.4	9.6	10.0	10.0	8.9	11.0	8.2	10.0	21.0%	219
Pain Clinic	6.0	5.5	4.5	4.4	5.3	5.3	6.2	5.2	5.1	5.3	5.3	4.5	3.0	5.8	3.8	-35.4%	60
Plastic Surgery	18.7	17.7	17.4	19.1	18.8	17.1	18.3	15.9	17.1	17.4	16.5	15.0	16.9	17.4	16.0	-8.4%	337
Renal Medicine	5.4	5.7	4.5	5.3	5.4	4.7	3.8	4.4	3.2	5.2	3.7	4.3	6.8	5.3	5.6	3.9%	136
Trauma & Orthopaedics	7.0	6.8	7.7	6.5	6.5	6.4	8.5	6.0	7.7	8.5	6.4	7.3	8.3	7.2	7.8	8.3%	165
Urology	11.2	13.2	13.0	11.6	13.4	14.5	14.0	12.9	13.4	14.8	13.2	15.8	12.9	11.4	14.4	25.7%	257
Thoracic Surgery	3.0	3.3	3.5	2.5	2.4	2.5	2.9	2.7	2.3	3.2	3.1	2.2	3.2	2.8	2.7	-2.7%	63
Vascular Surgery	6.0	4.3	4.8	4.4	4.7	5.1	4.6	4.3	5.1	3.9	4.4	4.4	5.1	5.7	4.8	-16.7%	101
Other	6.5	6.2	6.4	6.4	4.8	5.3	5.6	5.5	6.5	6.6	4.2	7.5	6.6	5.2	7.1	35.2%	131
Grand Total	233.0	236.4	227.3	219.8	231.5	231.9	240.6	209.4	233.1	246.3	239.4	232.3	258.3	225.4	245.3	8.8%	5,166

Daycase as a percentage of all Elective Activity	75.1%	74.4%	80.1%	77.2%	75.3%	76.6%	77.0%	75.0%	77.7%	77.1%	74.8%	76.4%	76.4%

What the information tells us

- May 2019 data is above the upper process limit and above SLA plan with an average of 258 cases per day. There will also be an element of data catch up and activity numbers are likely to increase once coding is complete.
- Neurosurgery and Renal Medicine are above the upper control limit in the reporting period. General Surgery and Cardiology / Cardiac Surgery are below the lower process limit which will be monitored as May coding catches up. Urology has been above its mean for the past six months.

Actions and Quality Improvement Projects

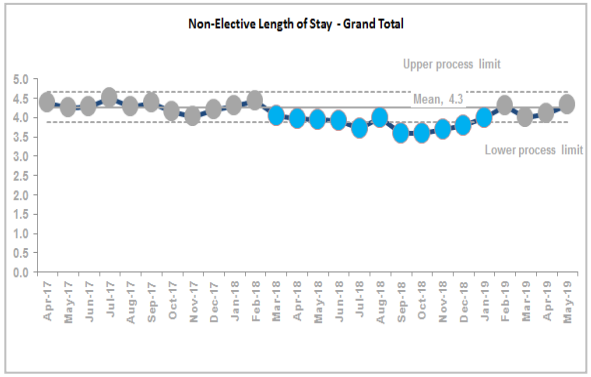
- Theatres are ensuring that there is focused work supporting a prompt start to all theatre sessions. This is linked to a weekly task and finish group,
- Agreement and plan to change Theatreman Diagnosis codes (currently SNOMED) to OPCS 4.8 codes which will support more accurate timings of theatre cases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

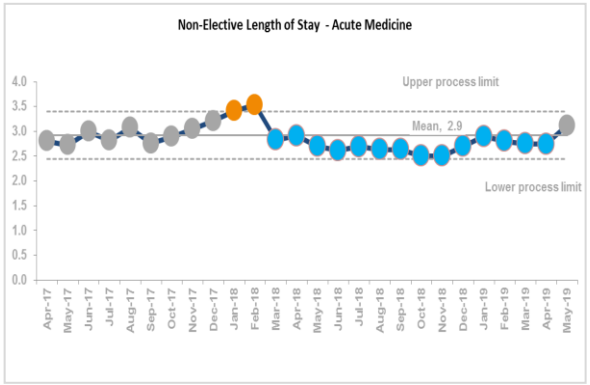
Our Finance and Productivity Perspective

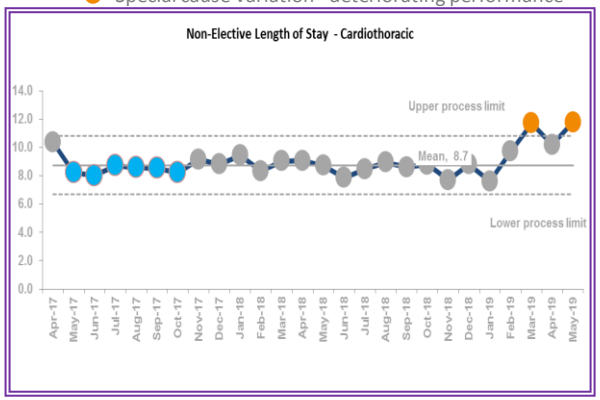
St George's University Hospitals NHS Foundation Trust

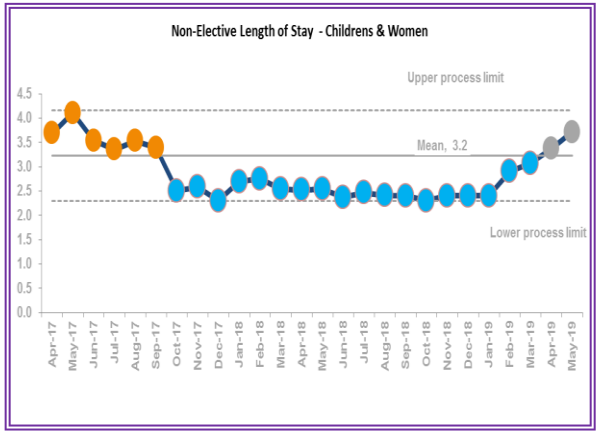
Non Elective Length of Stay

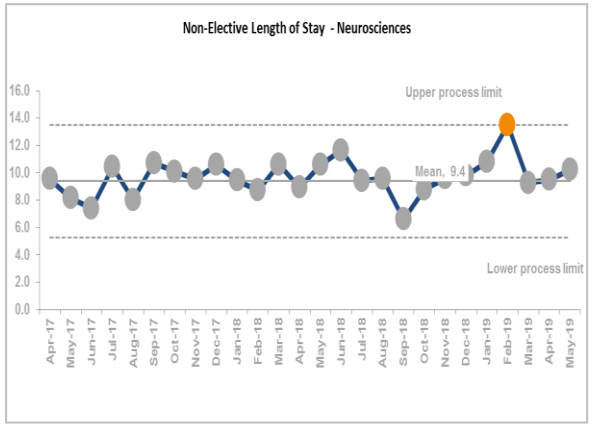
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

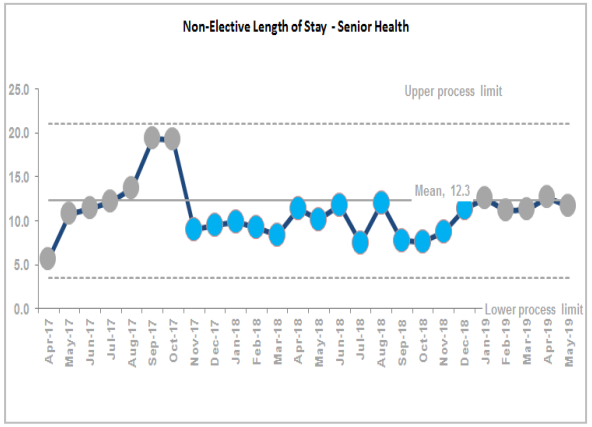


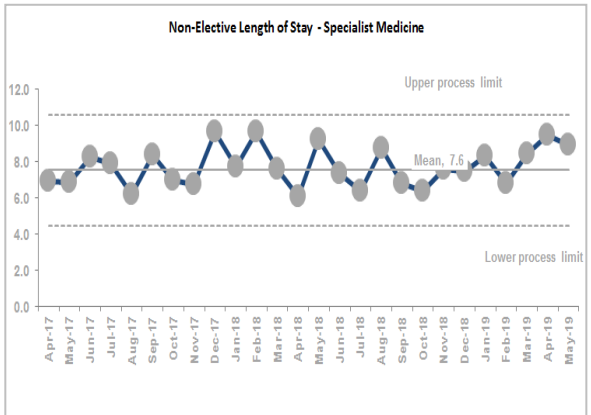


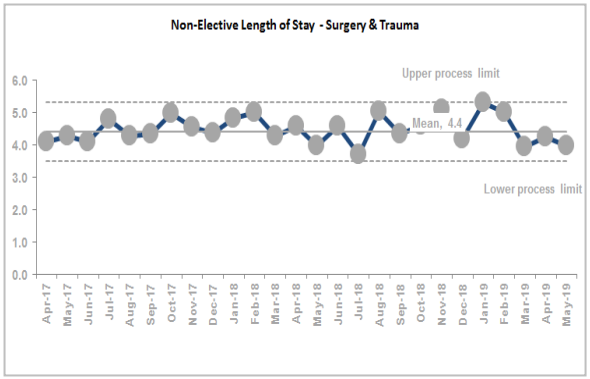


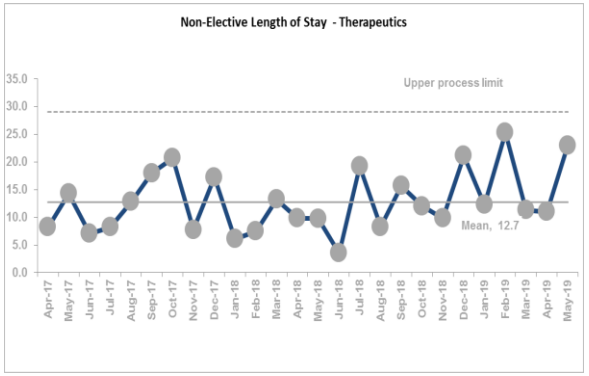












Length of Stay

Non Elective Length of Stay (General and Acute Beds)

														Average length of Stay		
Directorate	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**Apr-19**	**May-19**	**Discharges in the last month**	**2018-19 YTD**	**2019-20 YTD**	**Variance**
Acute Medicine	2.7	2.6	2.7	2.6	2.6	2.5	2.5	2.7	2.9	2.8	2.8	2.7	3.1	2,665	2.8	2.9	⇧ 4%
Cardiothoracic	8.7	7.8	8.5	8.9	8.6	8.8	7.7	8.8	7.6	9.7	11.7	10.2	11.8	133	8.9	11.0	⇧ 24%
Childrens & Women	2.5	2.4	2.5	2.4	2.4	2.3	2.4	2.4	2.4	2.9	3.1	3.4	3.7	823	2.5	3.5	⇧ 40%
Neurosciences	10.6	11.6	9.4	9.6	6.6	8.8	9.6	9.8	10.8	13.5	9.3	9.5	10.2	221	9.7	9.9	⇧ 1%
Senior Health	10.2	11.8	7.4	12.0	7.8	7.6	8.7	11.4	12.5	11.1	11.2	12.7	11.7	95	10.8	12.2	⇧ 13%
Specialist Medicine	9.3	7.3	6.4	8.7	6.8	6.4	7.6	7.5	8.3	6.8	8.5	9.5	8.9	132	7.7	9.2	⇧ 20%
Surgery & Trauma	4.0	4.6	3.7	5.0	4.4	4.6	5.1	4.2	5.3	5.0	4.0	4.3	4.0	865	4.3	4.1	⇩ -3.9%
Therapeutics	9.8	3.6	19.2	8.3	15.7	12.0	9.8	21.1	12.3	25.3	11.3	11.0	23.0	22	9.8	17.0	⇧ 74%
Grand Total	**3.9**	**3.9**	**3.7**	**4.0**	**3.6**	**3.6**	**3.7**	**3.8**	**4.0**	**4.3**	**4.0**	**4.1**	**4.3**	**4,956**	**4.0**	**4.2**	⇧ 6%

What the information tells us

- The Trusts Non-Elective length of stay is within the expected process limits.
- Cardiothoracic Non-Elective length of stay has been above the mean for the past four months with May being above the upper control limit with an average of 11.8 days.
- Children and Women's Services has shown a steady increase in Non-Elective length of stay and remains above the mean in the SPC chart presented.

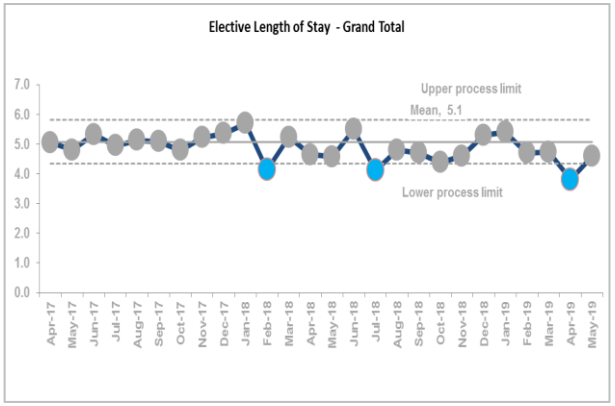
Actions and Quality Improvement Projects

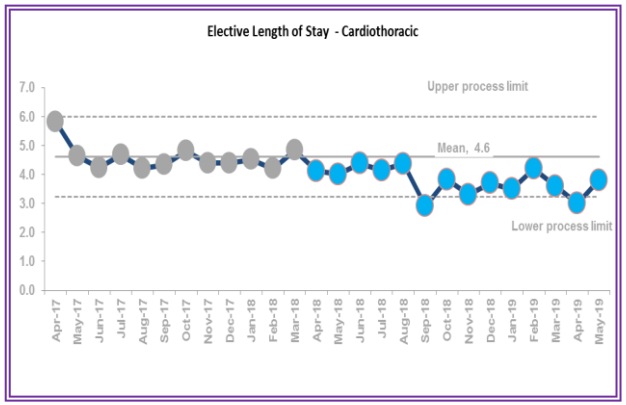
- The Emergency Department and Inpatient Clinical teams have identified a range of patient experience, quality and productivity opportunities to evolve the processes embedded within iClip and these need to be the immediate priority.
- Support Ward teams to deliver SAFER consistently.
- A return to a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

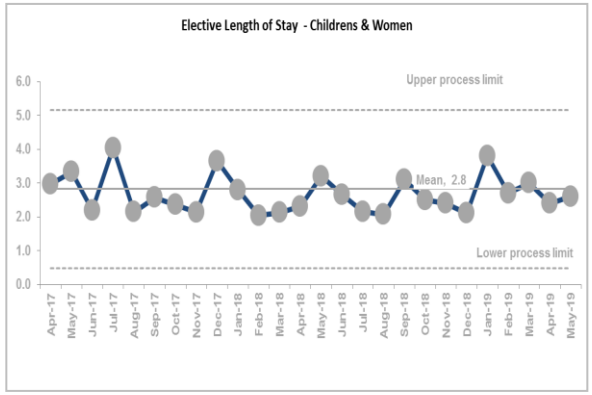
Our Finance and Productivity Perspective

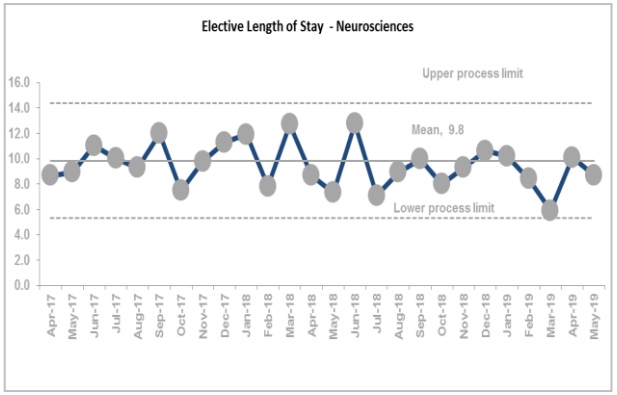
Elective Length of Stay

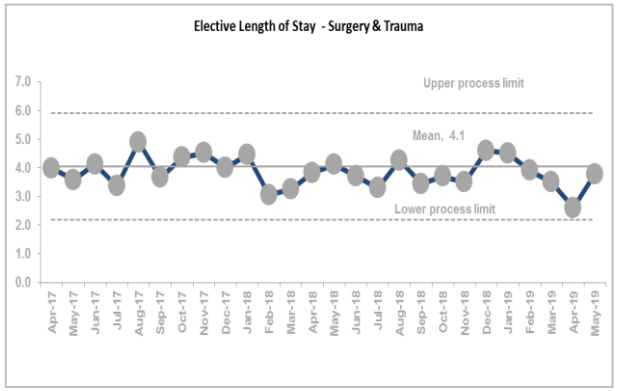
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance











Length of Stay

Elective Length of Stay (Excluding Daycase)

															Average length of Stay		
Directorate	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Discharges in the last month	2018-19 YTD	2019-20 YTD	Variance
Cardiothoracic	4.0	4.4	4.1	4.4	2.9	3.8	3.3	3.7	3.5	4.2	3.6	3.0	3.8	194	4.1	3.4	⇩ -16%
Childrens & Women	3.2	2.7	2.2	2.1	3.1	2.5	2.4	2.1	3.8	2.7	3.0	2.4	2.6	80	2.8	2.5	⇩ -9%
Neurosciences	7.3	12.8	7.1	8.9	10.0	8.0	9.3	10.6	10.2	8.4	5.9	10.1	8.7	147	8.0	9.4	⇧ 18%
Surgery & Trauma	4.1	3.7	3.3	4.3	3.4	3.7	3.5	4.6	4.5	3.9	3.5	2.6	3.8	377	4.0	3.2	⇩ -20%
Grand Total	**4.6**	**5.5**	**4.1**	**4.8**	**4.7**	**4.4**	**4.6**	**5.3**	**5.4**	**4.7**	**4.7**	**3.8**	**4.6**	**798**	**4.6**	**4.2**	⇩ -9%

What the information tells us

- The Trust's Elective overall elective length of stay is within the process control limits with all Directorates within the expected range.
- Cardiothoracic Length of Stay has been consistently below its mean.
- 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

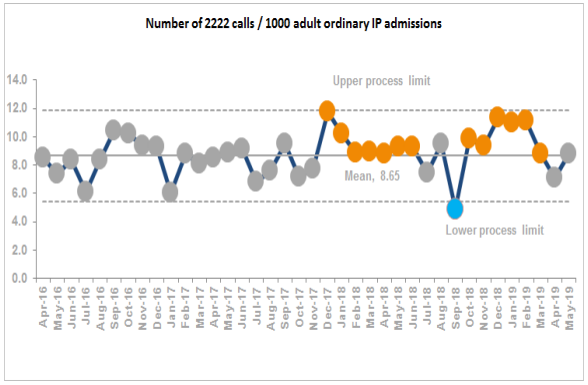
St George's University Hospitals NHS Foundation Trust

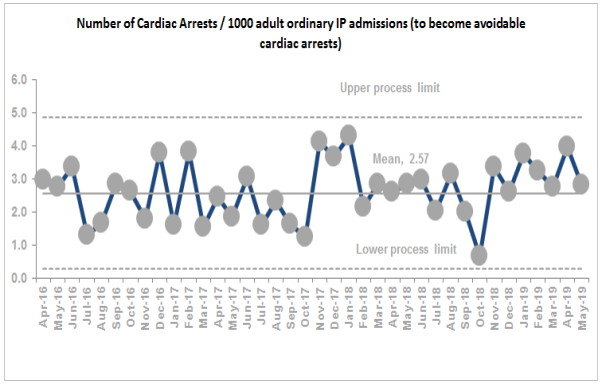
OUR **OUTCOMES**	How are we doing?					
OUR **FINANCE** & **PRODUCTIVITY** PERSPECTIVE	Activity Summary	Bed productivity (length of stay)	G Outpatient productivity (attendances per day)	Theatre productivity (cases per session)		
OUR **PATIENT** PERSPECTIVE	Patient safety	Infection Control	Mortality	Readmissions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

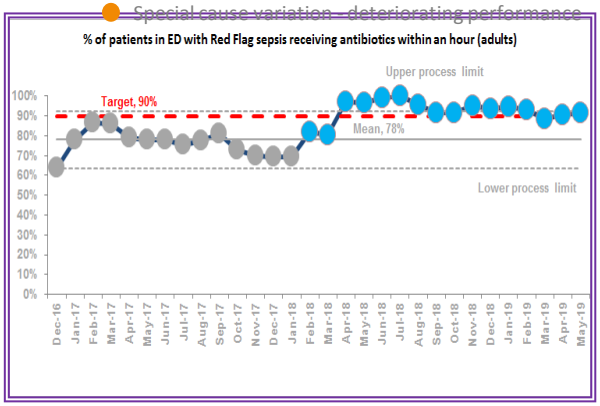
Our Patient Perspective

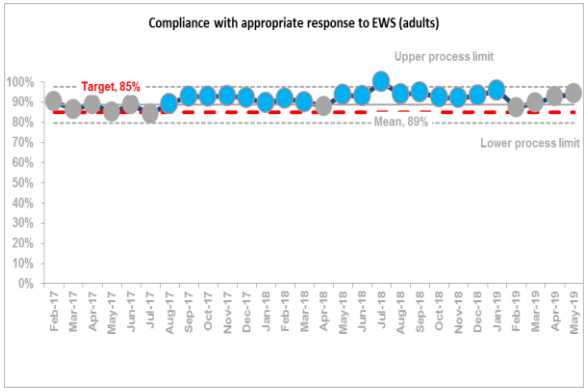
Quality Priorities

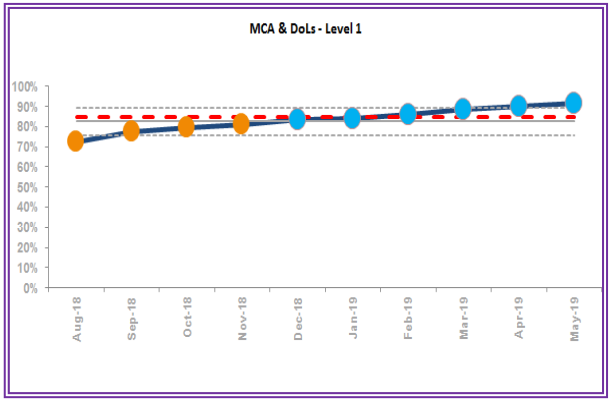
Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance

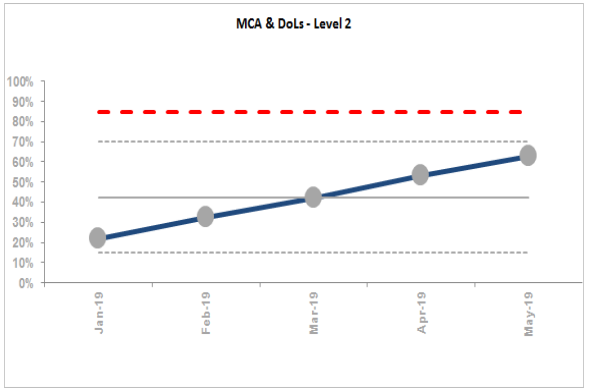


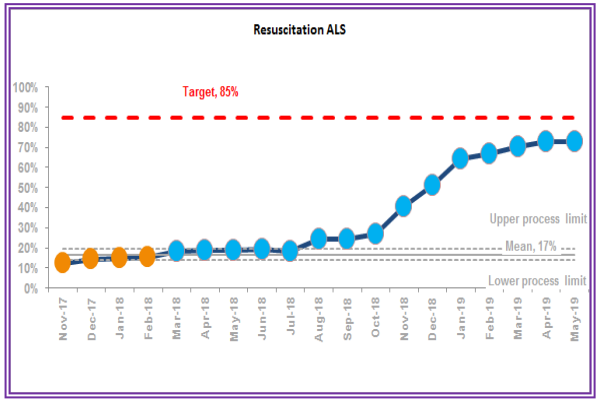


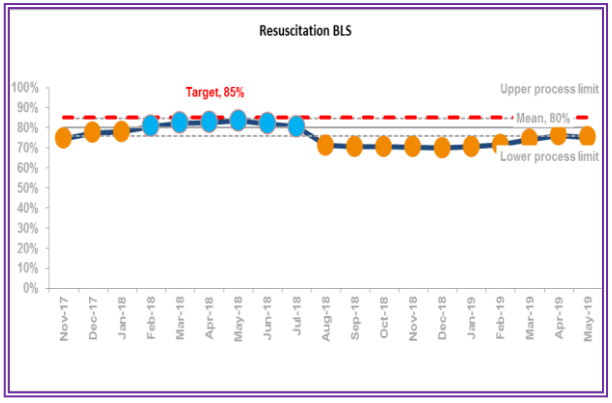


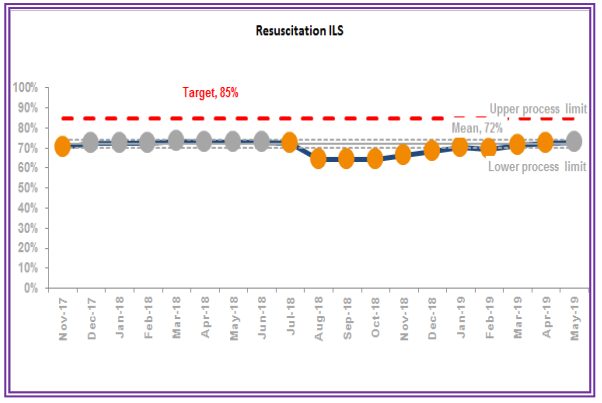






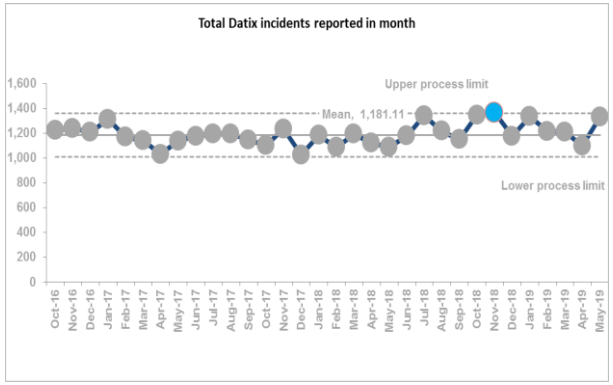






Our Patient Perspective

Quality Priorities



- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

Our Patient Perspective

Our Quality Improvement Programme (QIP) – TEP & Deteriorating Patients

Indicator Description	Threshold /Target	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
Number of 2222 calls / 1000 adult ordinary IP admissions		9.2	9.3	7.4	9.5	4.9	9.8	9.4	11.3	11.0	11.1	8.8	7.1	8.8
Number of Cardiac Arrests / 1000 adult ordinary IP admissions (to become avoidable cardiac arrests)		2.8	3.0	2.0	3.2	2.0	0.7	3.4	2.6	3.8	3.3	2.8	4.0	2.8
% of patients in ED with Red Flag sepsis receiving antibiotics within an hour (adults)	90%	96.6%	99.1%	100.0%	95.7%	91.6%	91.4%	95.3%	93.5%	94.5%	93.2%	88.3%	90.6%	91.4%
Compliance with appropriate response to EWS (adults)	85%	93.6%	92.9%	100.0%	93.8%	94.7%	92.4%	92.0%	93.3%	95.8%	87.3%	89.6%	92.7%	94.2%
Resuscitation BLS	85%	83.4%	82.0%	80.5%	71.1%	70.5%	70.5%	70.3%	69.8%	70.5%	71.5%	74.1%	76.2%	75.2%
Resuscitation ILS	85%	72.9%	73.0%	72.2%	64.2%	64.2%	64.3%	66.3%	68.5%	70.2%	69.3%	71.3%	72.1%	72.7%
Resuscitation ALS	85%	18.7%	19.1%	18.4%	24.4%	24.2%	27.1%	40.4%	51.2%	64.2%	67.0%	70.4%	72.7%	73.0%

What the information tells us

- The Trust has continued to maintain its step change performance for patients receiving antibiotics within an hour in ED
- Resuscitation BLS (Basic Life Support) training. Additional training capacity has been commissioned to ensure delivery of this performance target by 30 September 2019. Compared with last month there has been a slight deterioration in performance. Focus on attendance levels at booked training is required.
- Resuscitation ILS and ALS (Intermediate and Advanced Life Support) training performance. This performance metric is also benefitting from additional training capacity as outlined above. Focus on attendance levels at booked training is required.
- In Quarter 3, the National Cardiac Arrest Audit result shows a national survival to discharge rate post cardiac arrest as approximately 20% - St Georges Hospital were twice the national average at 41.5%

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

Cardiac Arrests

- The good news is that despite a difficult year with compliance in training, our survival to discharge post cardiac arrest remains twice the national average. Compliance is increasing across all disciplines. We are actively recruiting into vacancies and have identified Resus champions who will be trained to deliver in-house Basic Life Support Sessions. eILS courses have been introduced for all staff who have previously attended a full day ILS. We are working hard on reducing DNA rates and have implemented a 'wait-list' system to fill unused places.

Our Patient Perspective

Our Quality Improvement Programme (QIP) – MCA & Clinical Governance

Indicator Description	Threshold /Target	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
MCA & DoLs - Level 1	85%				72.6%	77.6%	79.5%	80.8%	83.4%	83.9%	86.3%	88.6%	89.8%	91.8%
MCA & DoLs - Level 2	85%									21.7%	32.2%	42.0%	53.2%	62.9%
Total Datix incidents reported in month		1,086	1,177	1,340	1,217	1,147	1,345	1,366	1,174	1,333	1,215	1,208	1,096	1,329
Open SI investigations >60 days	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Duty of Candour completed within 20 working days, for all incidents at moderate harm and above (one month in arrears)	100%												100.0%	Data avaliable in July
Duty of Candour completed within 10 working days, for all incidents at moderate harm and above	100%	84%	82%	86%	39%	47%	64%	66%	78%	67%	62%	Compliance timeframe changed from 10 working days to 20 working days		

What the information tells us

- Mental Capacity Act and Deprivation of Liberties – Level 1 training has exceeded the performance trajectory. Level 2 training is showing consistent improved performance month on month
- Duty of Candour – A total of 29 qualifying incidents (moderate and above severity) were reported in April 2019. Duty of candour was fulfilled in all cases within 20 working days.

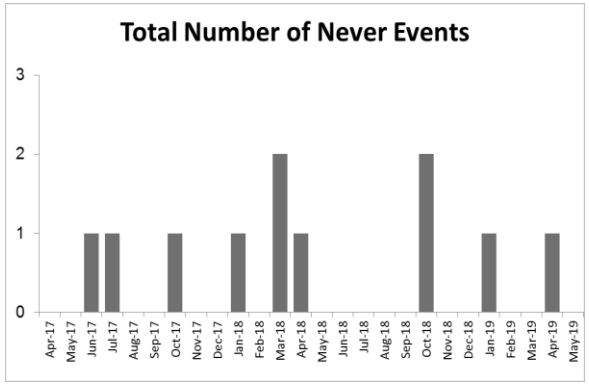
Actions and Quality Improvement Projects

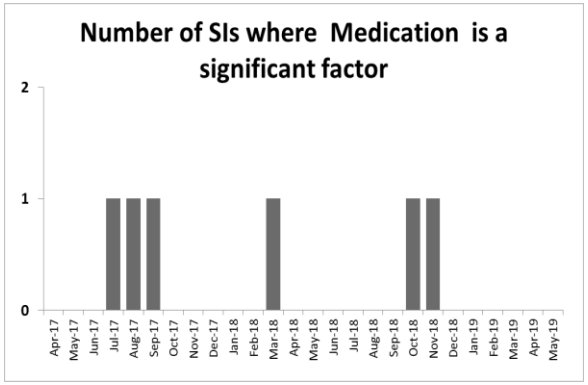
Progress and actions: MCA awareness and quality of assessments

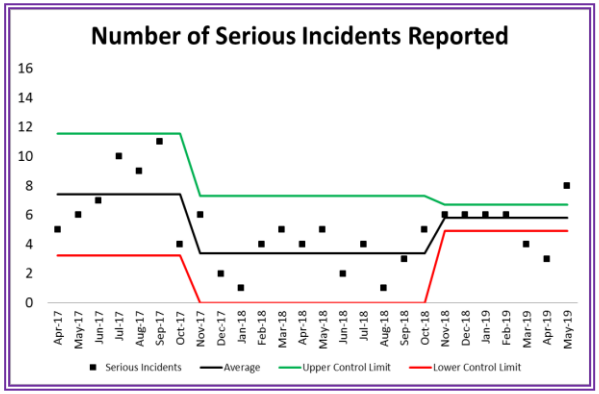
- Scoping exercise underway to commission small scale group work approach to support the application of MCA and DoLs training to practice
- Engaged with SW London sector to develop a standardised audit tool and work has commenced. Taking a sector approach will enable to Trust to benchmark practice with 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 delivered by 31 May 2019 (91.8%)
- Audit question framework developed to provide small scale pulse check of staff awareness. To commence reporting from July 2019

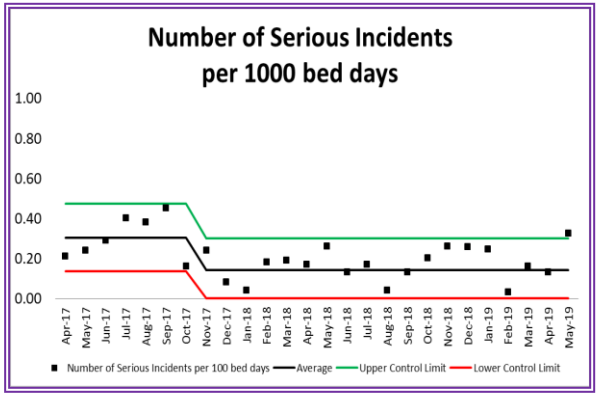
Our Patient Perspective

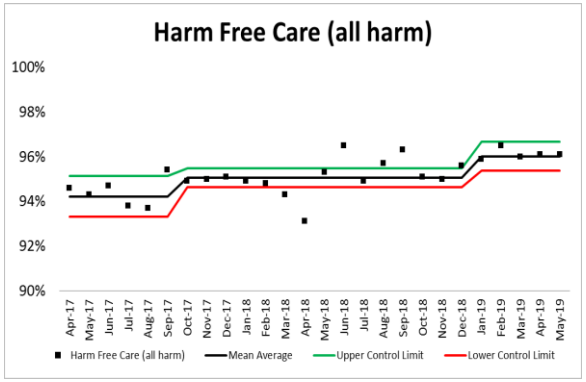
Patient Safety

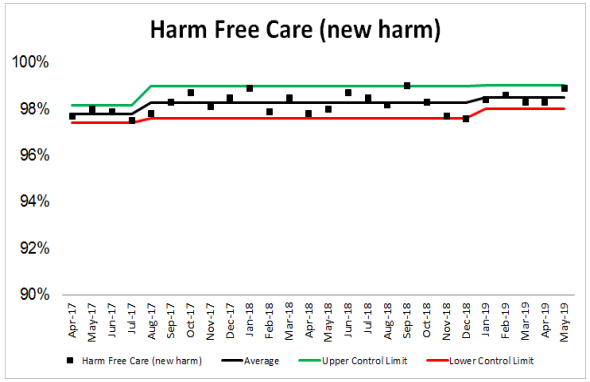


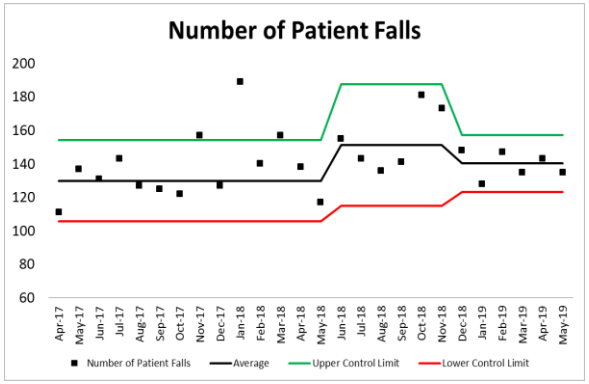


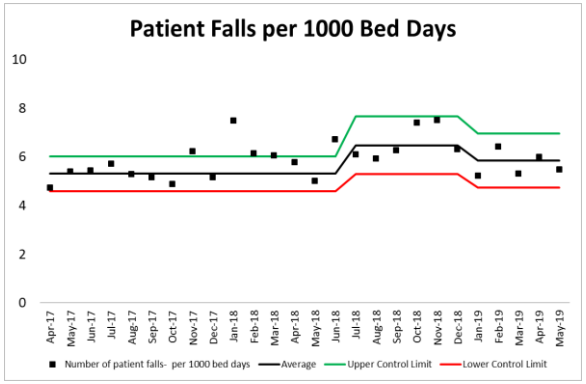


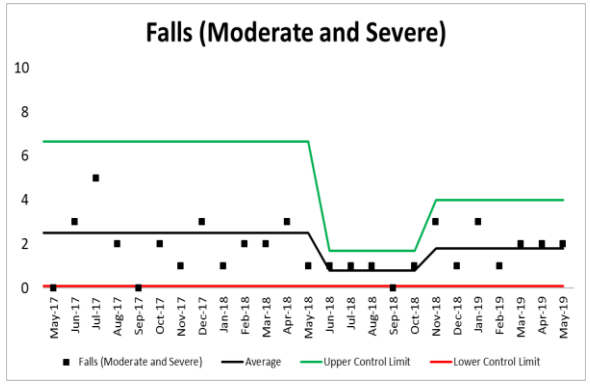








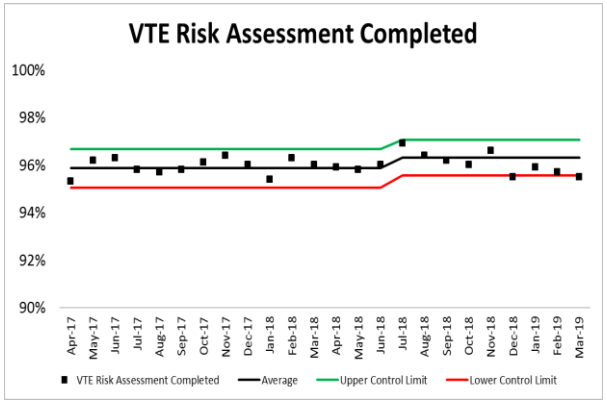


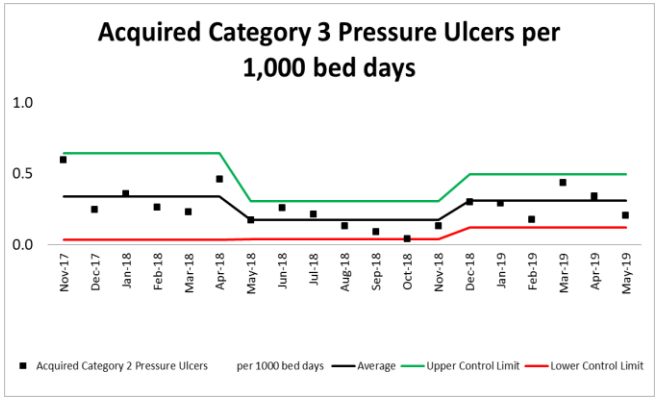


Our Patient Perspective

St George's University Hospitals NHS Foundation Trust

Patient Safety





Our Patient Perspective

Patient Safety

Indicator Description	Target	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
Number of Never Events in Month	0	0	0	0	0	0	2	0	0	1	0	0	1	0
Number of SIs where Medication is a significant factor	0	0	0	0	0	0	1	1	0	0	0	0	0	0
Number of Serious Incidents	8 / mth	5	2	4	1	3	5	6	6	6	6	4	3	8
Serious Incidents - per 1000 bed days	N/A	0.21	0.09	0.17	0.04	0.13	0.20	0.26	0.26	0.25	0.27	0.16	0.13	0.32
Safety Thermometer - % of patients with harm free care (all harm)	95%	95.3%	96.5%	94.9%	95.7%	96.3%	95.1%	95.0%	95.6%	95.9%	96.5%	96.0%	96.1%	96.1%
Safety Thermometer - % of patients with harm free care (new harm)	95%	98.0%	98.7%	98.5%	98.2%	99.0%	98.3%	97.7%	97.6%	98.4%	98.6%	98.3%	98.3%	98.9%
Percentage of patients who have a VTE risk assessment	95%	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	117	155	143	136	141	181	173	148	128	147	135	143	135
Falls (Moderate and Above Severity)	N/A	1	1	1	1	0	1	3	1	3	1	2	2	2
Number of patient falls- per 1000 bed days	N/A	5.01	6.70	6.11	5.91	6.26	7.40	7.50	6.32	5.29	6.52	5.34	6.05	5.48
Acquired Category 2 Pressure Ulcers	N/A	6	10	20	15	9	12	25	13	10	16	6	4	17
Acquired Category 2 Pressure Ulcers per 1000 bed days	N/A	0.26	0.43	0.85	0.65	0.40	0.49	1.08	0.56	0.41	0.71	0.24	0.17	0.69
Acquired Category 3 Pressure Ulcers		4	6	5	3	2	1	3	7	7	4	11	8	5
Acquired Grade 3 Pressure Ulcers per 1000 bed days		0.17	0.26	0.21	0.13	0.09	0.04	0.13	0.30	0.29	0.18	0.44	0.34	0.20
Number of overdue CAS Alerts	0	0	0	0	0	0	0	0	0	0	0	0	0	0

What the information tells us

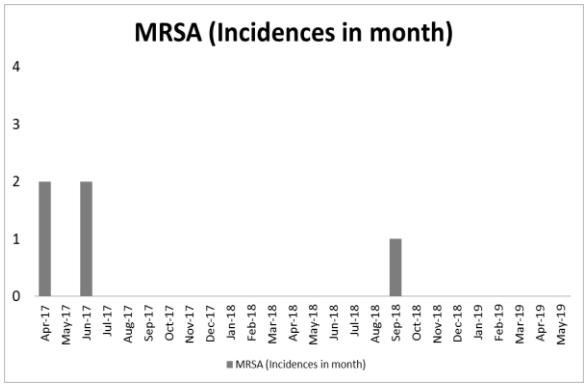
- There has been an increase in the number of Serious Incidents (SIs) reported in the month reporting outside of the upper process limit.
- The number of falls reported in May was 135, there is no significant change and the number of falls remain within the lower and upper control limits. Of the falls reported two patient sustained moderate harm.

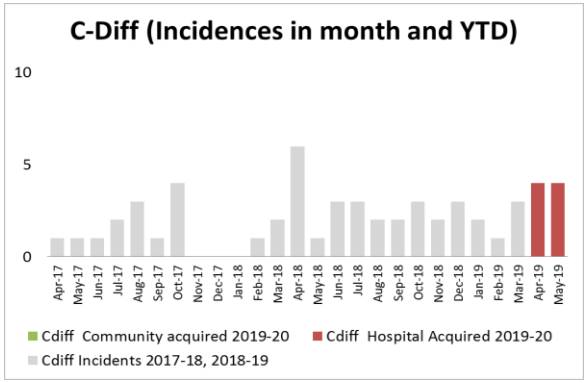
Actions and Quality Improvement Projects

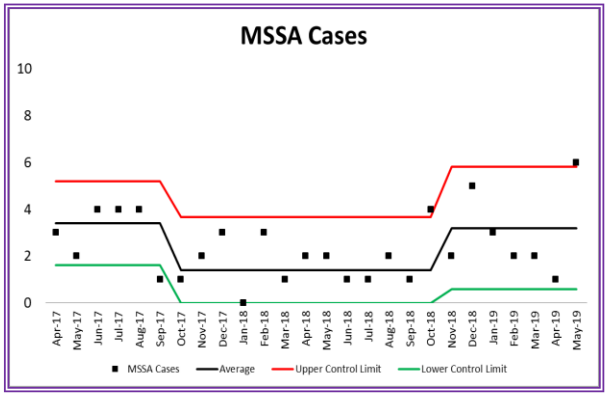
- Falls – Recruited to falls coordinator position, focused work will continue on identified wards and a project group will be established to deliver the elements of the Falls CQUIN this year.
- Tissue Viability – From April 2019 all pressure area damage within the Trust that is not documented at the point of admission is attributed to St Georges and the avoidability category has been removed. This is in line with the national guidance and to standardise reporting across NHS Trusts. The team are now capturing all types of pressure damage and moisture lesions, including the location on the body. A review of historical data is being completed to allow adaption of teaching to focus on common areas of damage and learning.

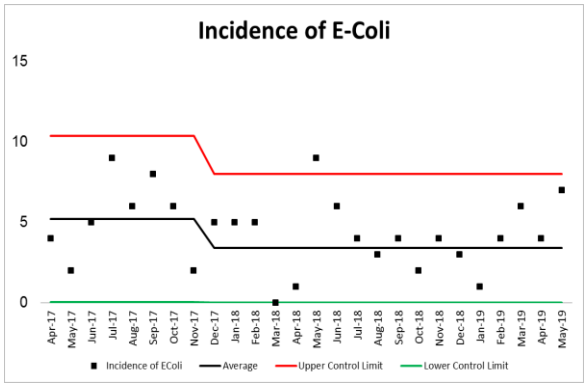
Our Patient Perspective

Infection Control









Our Patient Perspective

Infection Control

Indicator Description	Threshold	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	YTD Actual
MRSA Incidences (in month)	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0
Cdiff Hospital acquired infections	48	1	3	3	2	2	3	2	3	2	1	3	4	4	8
Cdiff Community Associated infections													0	0	0
MSSA	25	2	1	1	2	1	4	2	5	3	2	2	4	6	10
E-Coli	60	9	6	4	3	4	2	4	3	1	4	6	4	7	11

What the information tells us

- The Cdiff reporting 2019-2020 has now changed 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 May, four Cdiff Hospital acquired infections were reported.
- The number of Ecoli cases reported remains within the control limits
- There are no National thresholds for MSSA bacteraemia at present however the Trust has set itself an internal target of a 10% reduction based on last year's position setting the threshold at 25 incidents for 2019/20. The increase of cases in May has moved the trend outside of the upper control limit.

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.
- All MSSA cases are now to undertake a RCA

Our Patient Perspective

Mortality and Readmissions

Indicator Description	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-18 to Jan-19	Trend
Hospital Standardised Mortality Ratio (HSMR)	93.8	106.3	94.9	86.7	79.5	69.8	80.3	73.0	64.2	76.9	74.5	77.6	78.1	81.5	
Hospital Standardised Mortality Ratio Weekend Emergency	123.7	121.5	113.8	78.2	97.6	79.5	72.2	62.7	82.4	113.3	79.1	74.6	85.2	89.5	
Hospital Standardised Mortality Ratio Weekday Emergency	84.9	95.6	79.7	87.1	82.5	67.6	78.1	68.4	60.1	64.9	78.2	79.4	74.1	78.5	

Indicator Description	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Trend
Summary Hospital Mortality Indicator (SHMI)	0.83	0.83	0.82	0.82	0.82	0.82	0.82	0.84	0.84	0.84	0.84	0.84	0.84	
Emergency Readmissions within 30 days following non elective spell (reporting one month in arrears)	8.7%	8.7%	8.5%	8.20%	8.20%	7.00%	8.90%	8.30%	7.60%	8.20%	7.20%	8.20%	8.20%	

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.

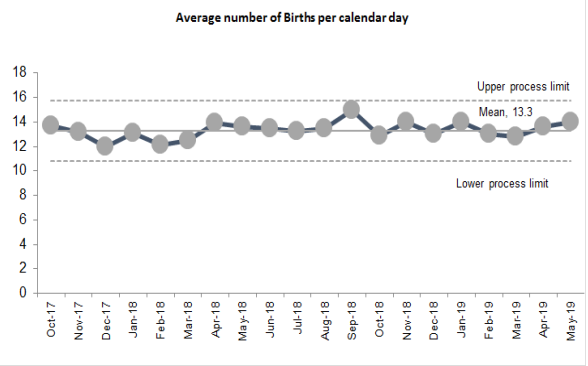
What the information tells us

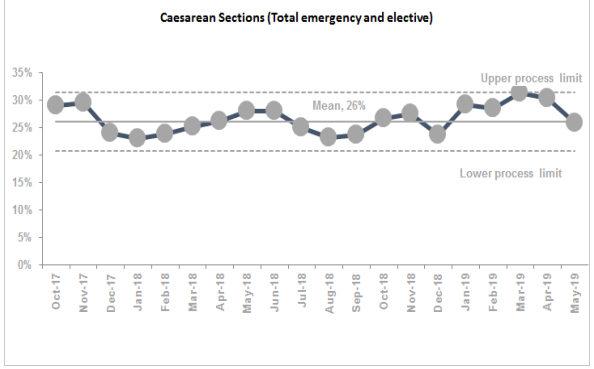
Both the Trust-level mortality indicators (SHMI and HSMR) remain lower than expected compared to national patterns and deaths as a percentage of discharges has increased above standard variation. Caution should be taken in over-interpreting these signals, however as they mask a number of areas of over 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.

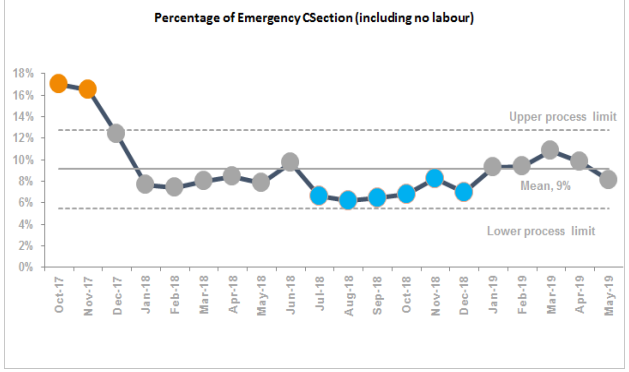
Our Patient Perspective

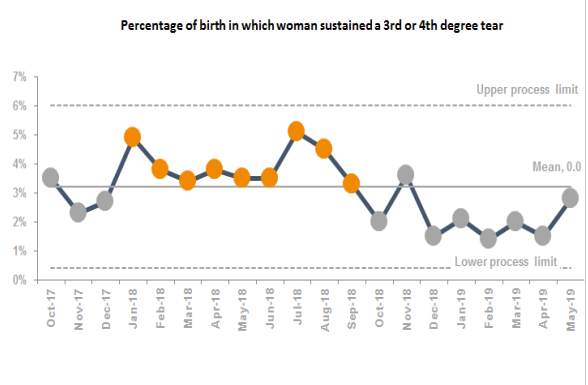
Maternity

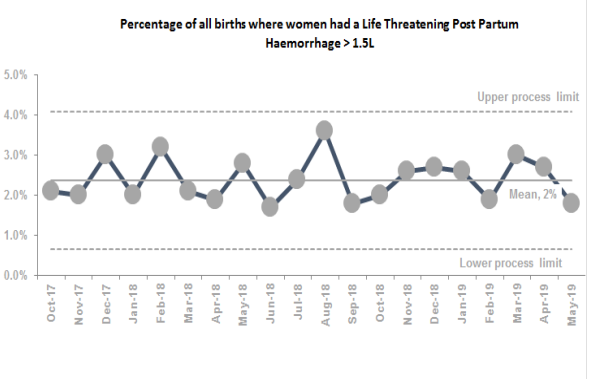
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

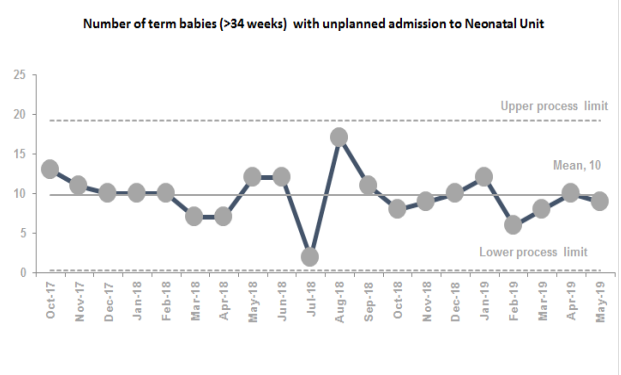


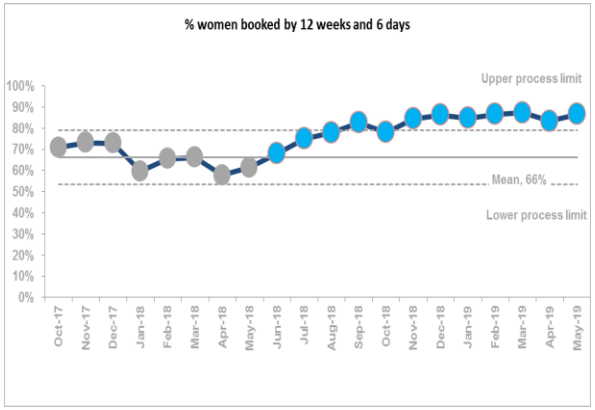












Our Patient Perspective

Maternity

Definitions	Target	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
Total number of women giving birth (per calendar day)	14 per day	14	13	13	13	15	13	14	13	14	13	13	14	14
% of all deliveries where caesarean section occurred	<28%	28.1%	28.0%	25.1%	23.2%	23.8%	26.8%	27.5%	23.7%	29.2%	28.5%	31.4%	30.4%	25.9%
% deliveries with Emergency C Section (including no Labour)	<8%	7.8%	9.7%	6.6%	6.2%	6.5%	6.8%	8.3%	7.0%	9.3%	9.4%	10.8%	9.8%	8.1%
% Time Carmen Suite closed	0%							0	0	0	0	0	5.0%	0
% of all births in which woman sustained a 3rd or 4th degree tear	<5%	3.5%	3.5%	5.1%	4.5%	3.3%	2.0%	3.6%	1.5%	2.1%	1.4%	2.0%	1.5%	2.8%
% of all births where women had a Life Threatening Post Partum Haemorrhage >1.5 L	<4%	2.8%	1.7%	2.4%	3.6%	1.8%	2.0%	2.6%	2.7%	2.6%	1.9%	3.0%	2.7%	1.8%
Number of term babies (> 34 weeks), with unplanned admission to Neonatal Unit		12	12	2	17	11	8	9	10	12	6	8	10	9
Supernumerary Midwife in Labour Ward	>95%						95.2%	98.3%	100%	98%	96%	95%	97%	98%
% women booked by 12 weeks and 6 days	90%	61.4%	67.9%	75.0%	77.8%	82.6%	78.0%	84.4%	86.2%	84.7%	86.6%	87.3%	83.3%	86.6%

What the information tells us

- The emergency and overall C-section rates for the previous four months are both above the mean, although have decreased slightly in May.
- 3rd and 4th degree tears continue on a steady downward trajectory.
- The number of women booked by 12 weeks and 6 days of pregnancy is within expected process limits, but remains red as it is below the target.

Actions and Quality Improvement Projects

- The C-section rate continues to be monitored each month.
- Each KPI on the Dashboard can now be broken down by the woman's ethnicity, which will help us to identify any variation in outcomes relating to ethnicity
- After the three closures of Carmen Suite in April, the unit remained open throughout every shift in May.

Our Patient Perspective

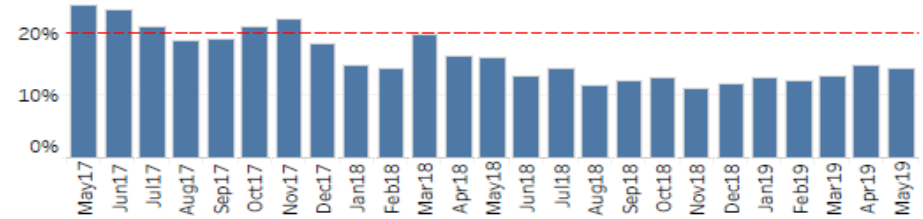
Patient Voice

CARING – Friends and Family Test

--- Target ¢ MetricMeasure Percentage Neutral

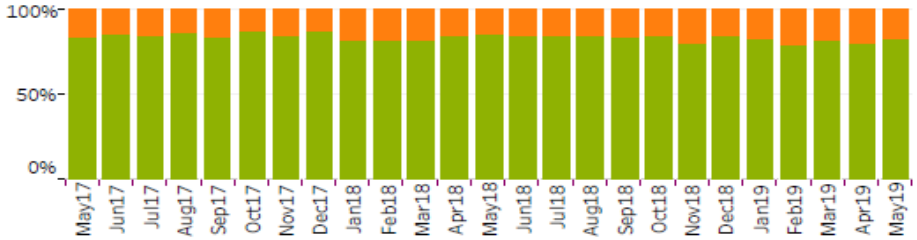
A&E Friends & Family Response Rate

Target: 20% Apr 19: 14.90% May 19: 14.30% Movement: ▼-0.60%



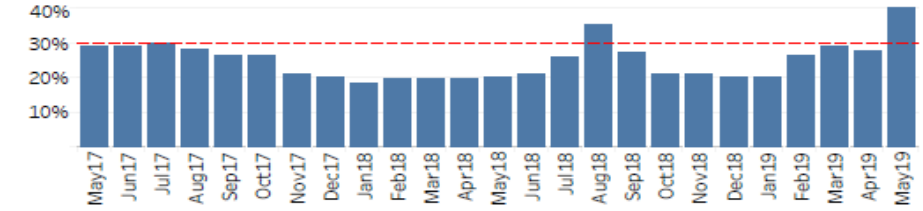
A&E Friends & Family Recommend Rate

The expected target is 90%



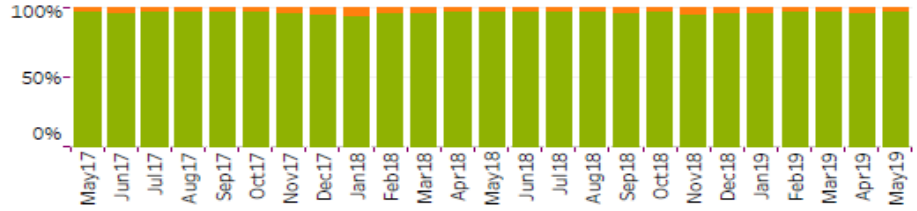
IP Friends & Family Response Rate

Target: 30% Apr 19: 27.50% May 19: 40.30% Movement: ▲12.80%



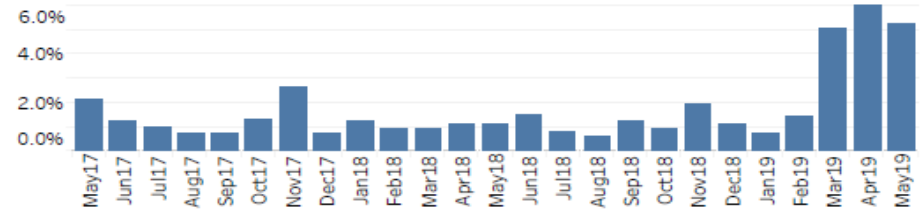
IP Friends & Family Recommend Rate

The expected target is 95%



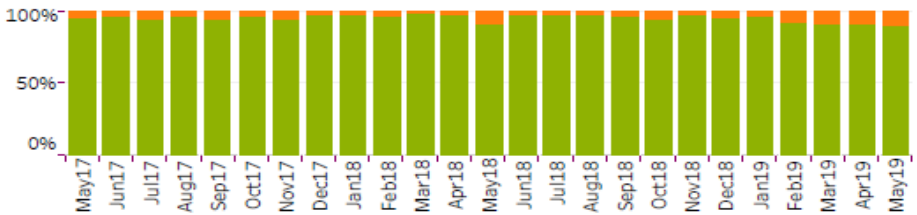
OP Friends & Family Response Rate

Target: 20% Apr 19: 7.10% May 19: 5.20% Movement: ▼-1.90%



OP Friends & Family Recommend Rate

The expected target is 90%



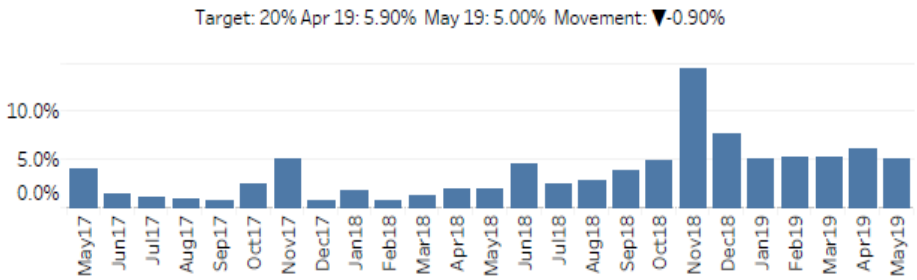
Our Patient Perspective

Patient Voice

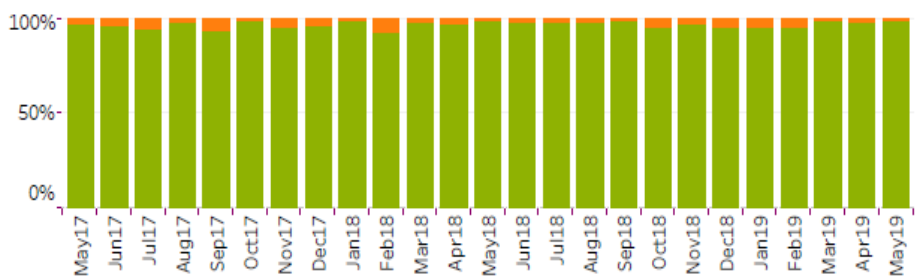
CARING – Friends and Family 2

--- Target ¢ MetricMeasure Percentage Neutral

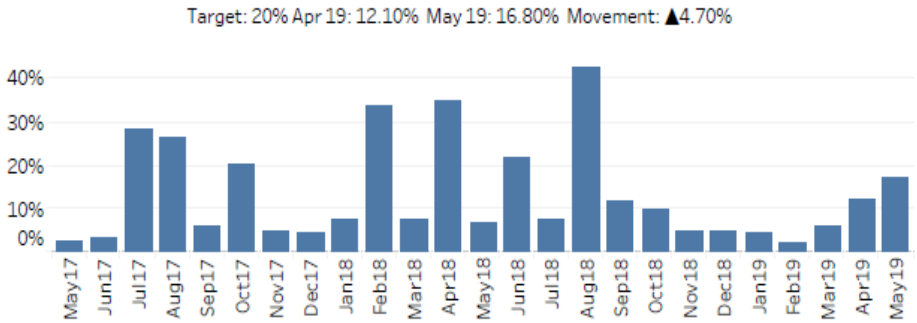
Community Friends & Family Response Rate



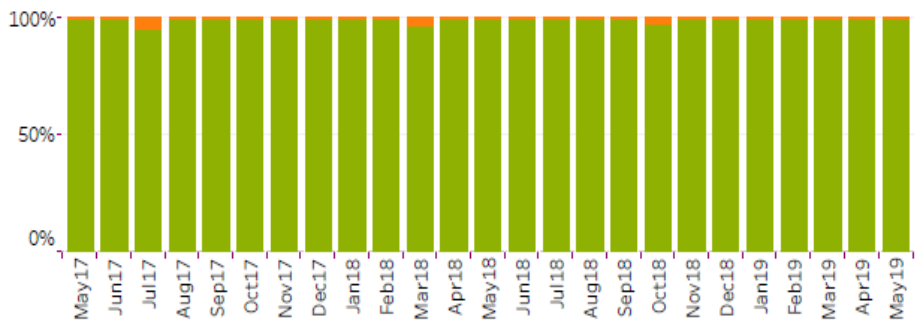
Community Friends & Family Recommend Rate
The expected target is 90%



Maternity (Birth) Friends & Family Response Rate



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



Our Patient Perspective

Patient Voice

Indicator Description	Target	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
Emergency Department FFT - % positive responses	90%	85.0%	85.5%	83.7%	84.6%	83.5%	84.2%	79.2%	84.2%	82.8%	78.5%	81.6%	80.1%	82.5%
Inpatient FFT - % positive responses	95%	97.3%	97.1%	96.7%	96.6%	96.3%	97.0%	95.5%	96.4%	96.5%	96.0%	96.9%	96.5%	96.7%
Maternity FFT - Antenatal - % positive responses	90%	97.2%	100.0%	100.0%	100.0%	100.0%	100.0%						100.0%	90.0%
Maternity FFT - Delivery - % positive responses	90%	100.0%	100.0%	100.0%	100.0%	100.0%	97.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Maternity FFT - Postnatal Ward - % positive responses	90%	98.4%	100.0%	100.0%	100.0%	98.7%	100.0%	100.0%	90.9%	95.6%	95.7%	91.7%	96.4%	94.6%
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%	98.4%
Community FFT - % positive responses	90%	98.5%	98.3%	98.0%	98.4%	99.5%	95.6%	97.4%	96.1%	96.3%	94.9%	98.9%	98.3%	98.8%
Outpatient FFT - % positive responses	90%	97.3%	97.4%	97.4%	97.1%	96.3%	94.9%	97.3%	95.6%	96.1%	92.3%	90.7%	90.5%	90.2%
Mixed Sex Breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Complaints Received		85	79	120	96	93	90	88	78	92	84	101	108	102
% of Complaints responses to within 25 working days	85%	85%	67%	55%	71%	76%	76%	75%	78%	66%	55%	80%	72%	79%
% of Complaints responses to within 40 working days	95%	67%	77%	67%	71%	43%	60%	63%	48%	30%	64%	44%	56%	46%
% of Complaints responses to within 60 working days	95%	100%	67%	None Due	None Due	None Due	100%	None Due	None Due	100%	100%	100%	100%	100%
Number of Complaints breaching 6 months Response Time	0						0	0	0	0	0	0	1	0
PALS Received		317	292	337	294	335	416	353	252	369	334	280	249	247

What the information tells us

- ED Friends and Family Test (FFT) – In the month of May 82.5% of patients attending the Emergency Department would recommend the service to family and friends. The response rate has remained at 15% in the month of May, and is below our target of 20%.
- Inpatient Friends and Family Test (FFT) continues to be above threshold reporting 96.7% in May providing reasonable assurance on the quality of patient experience. Inpatient response rate has increase to 40% and is now above the target set.
- We continue to deliver above target against our outpatient recommend rate, however in the last three months this has fallen to 90%, coinciding with an increase in our response rate with the introduction of text messaging.

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 May 79% of 25 day complaints, with a response deadline in May, achieved that deadline.

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 G	Diagnostics R	On the day cancellations	18 Week Referral to Treatment	
OUR **PEOPLE** PERSPECTIVE	Workforce	Agency use				

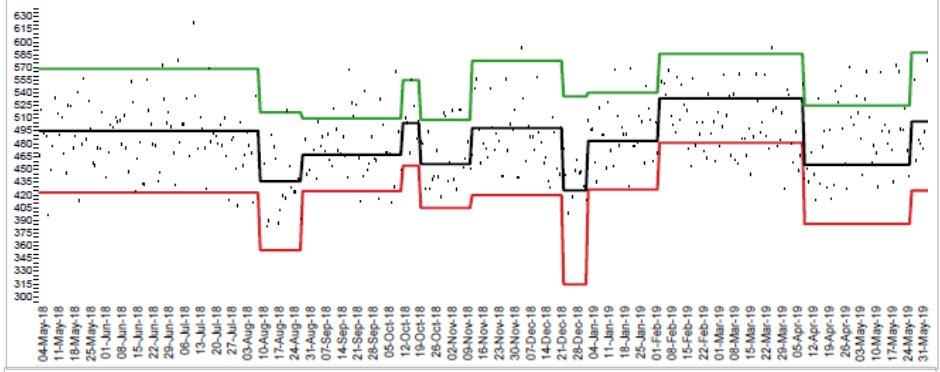
Our Process Perspective

St George's University Hospitals NHS Foundation Trust

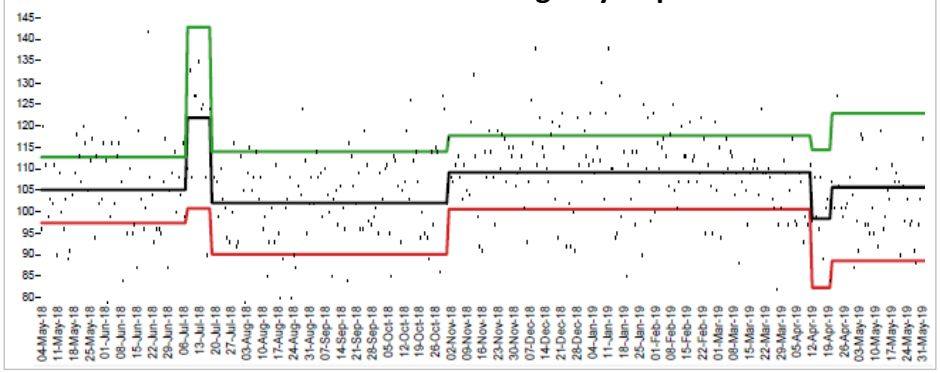
Emergency Flow

Total — Average — Upper Control Limit — Lower Control Limit

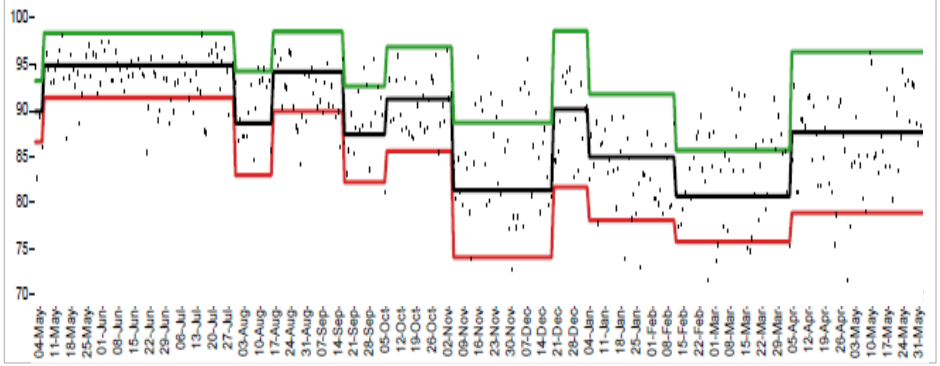
Attendances to the Emergency Department



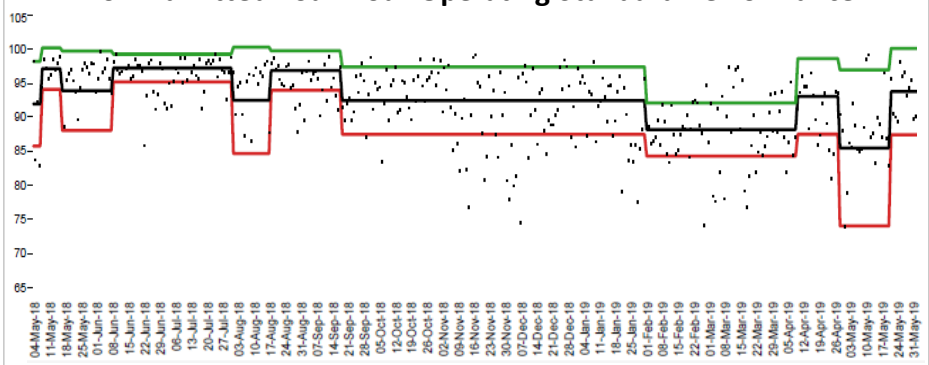
Ambulance Arrivals to the Emergency Department



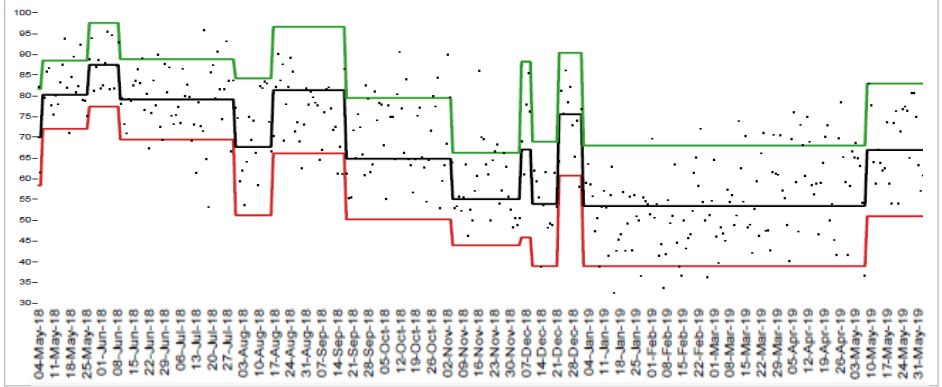
Four Hour Operating Standard Performance



Non-Admitted Four Hour Operating Standard Performance



Admitted Four Hour Operating Standard Performance



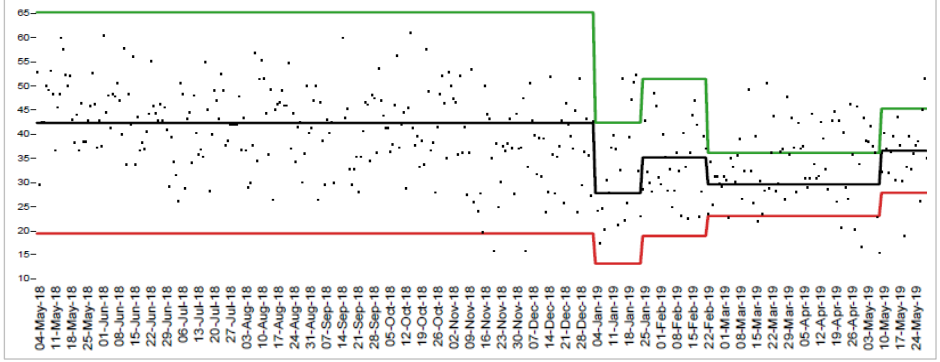
Our Process Perspective

St George's University Hospitals NHS Foundation Trust

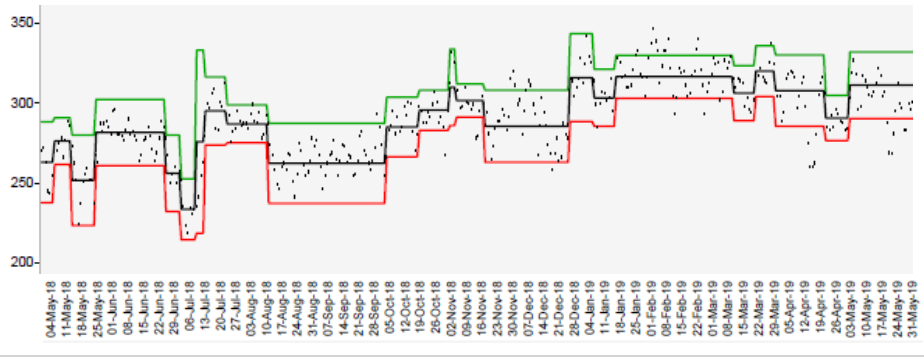
Emergency Flow

Total | Average | Upper Control Limit | Lower Control Limit

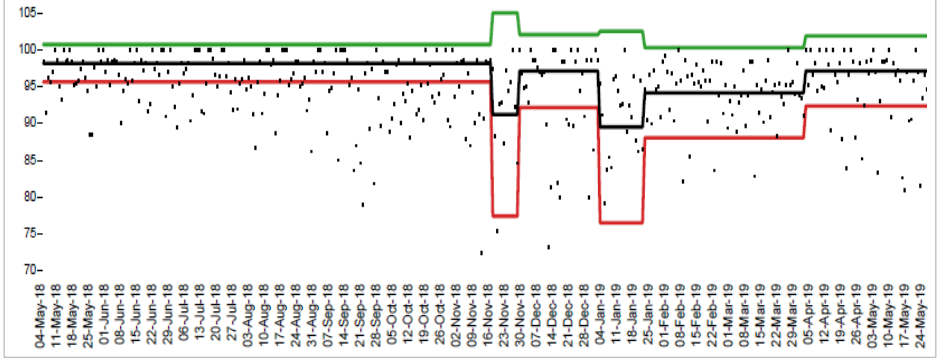
LAS Handover Times 15 Minutes



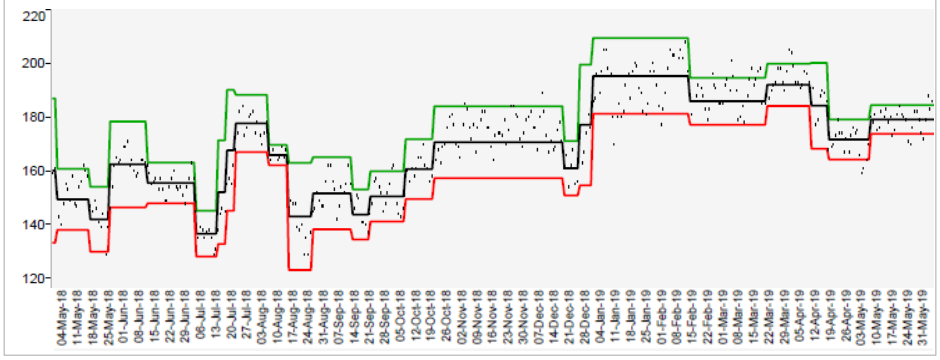
Admitted patients with a length of stay 7 Days or Greater



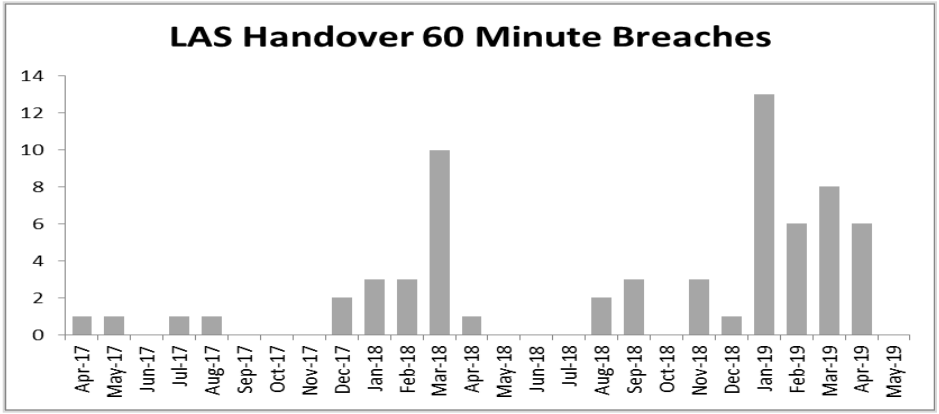
LAS Handover Times 30 Minutes



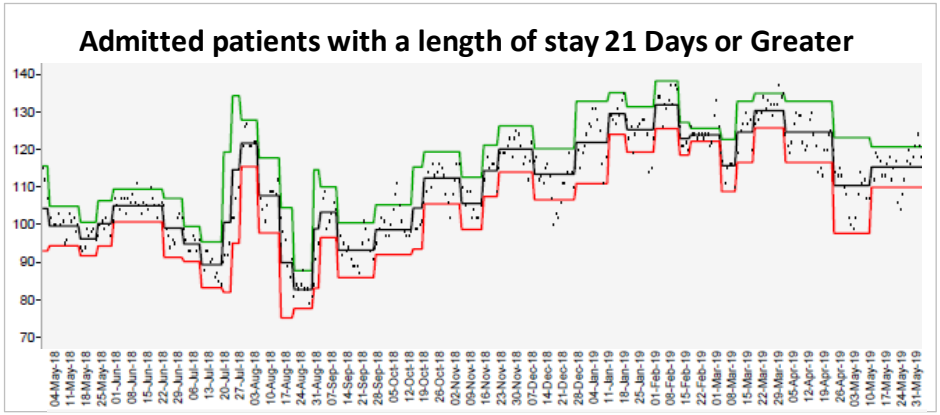
Admitted patients with a length of stay 14 Days or Greater



LAS Handover 60 Minute Breaches



Admitted patients with a length of stay 21 Days or Greater



Our Process Perspective

Emergency Flow

Indicator Description	Target	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
4 Hour Operating Standard	95%	93.3%	93.6%	93.3%	91.1%	90.3%	90.1%	85.5%	85.6%	84.2%	82.2%	83.1%	85.4%	86.5%
Patients Waiting in ED for over 12 hours following DTA	0	1	0	1	0	1	0	1	2	0	0	1	1	0
Admitted patients with a length of stay 7 Days or Greater		265	278	271	272	266	287	294	291	315	321	315	298	301
Ambulance Turnaround - % under 15 minutes	100%	45.7%	43.6%	42.0%	42.3%	46.4%	42.5%	37.4%	37.0%	33.9%	33.0%	33.0%	35.1%	35.2%
Ambulance Turnaround - % under 15 minutes (London Average)	100%	45.7%	47.4%	46.7%	48.1%	52.6%	47.4%	46.5%	44.7%	41.6%	43.1%	45.4%	43.5%	44.4%
Ambulance Turnaround - number of patients not handed over within 30 minutes	0	65	72	67	85	109	111	138	135	145	87	94	76	112
Ambulance Turnaround - % under 30 minutes	100%	96.8%	96.3%	96.2%	95.5%	94.1%	94.5%	93.0%	93.6%	92.3%	95.1%	93.6%	95.5%	94.3%
Ambulance Turnaround - % under 30 minutes (London Average)	100%	91.9%	93.7%	93.1%	92.2%	92.5%	92.2%	91.5%	90.5%	88.2%	90.3%	92.7%	91.7%	92.2%
Ambulance Turnaround - number over 60 minutes	0	0	0	0	2	3	0	3	1	13	6	8	6	0

What the information tells us

- The Emergency Department saw a 2% increase in the total number of patients attending the unit compared to the same month last year, this is predominantly within the number of self presenters / walk in patients, treating an additional ten patients per day.
- Although attendances remain within the upper and lower control limits, attendances within the last three months are above the mean and shows variability on a daily basis. The number of patients either discharged, admitted or transferred within four hours of arrival has seen a steady increase since February 2019, increasing performance to 86.5% in May, however below where we want to be and below the monthly improvement trajectory. Admitted performance has remained within its process limits since January whereas non-admitted performance shows more variability.
- A step change is seen in the number of patients staying in a hospital bed greater than 14 days. Performance reported are at levels achieved before December 2018.

Actions and Quality Improvement Projects

The Medicine and Cardiovascular Division have commenced the development and immediate delivery of an Internal Improvement Programme. A governance structure for the Programme has been agreed. The Programme includes specific actions to deliver increases in the performance achieved in an Urgent Care Centre (UCC) setting, improved Ambulance Handover performance and reductions in Long Length of Stay and Bed Occupancy.

Specifically, in the last month the Medicine and Cardiovascular Division have:

1. Appointed a designated Improvement Director to oversee the development and delivery of the Internal Improvement Programme.
2. Developed new rota for juniors in ED and UCC to take effect from August. This is more aligned to demand and will be replicated for all clinical staff in ED/UCC. In addition a tactical plan has been implemented with immediate effect.
3. Developed an inter-professional standard and dashboard to ensure patients flow out of ED into speciality wards without delay. This will go live in July.
4. Closed ten beds on Rodney Smith.
5. Commenced a Plan Do Study Act (PDSA) on an ambulatory gastro service utilising four Allingham beds.
6. Developed an Internal Improvement Programme Action Plan.
7. Developed a detailed Ambulance Handover Improvement Plan.

Our Process Perspective

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%	85.8%											
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%
RTT Total Incomplete Waiting Lize Size		40,016	40,037	39,674	41,013											
RTT Total Incomplete Waiting Lize Size Trajectory					39,890	39,880	39,870	39,860	39,850	39,840	39,830	39,820	39,810	39,800	39,790	39,780
Total waits greater than 18 weeks (inc 52Wk waiters)		5,921	5,929	5,515	5,812											
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	22											
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%	65.30%											
Total waits greater than 18 weeks - Admitted		1,563	1,563	1,428	1,511											
Total waits greater than 52 weeks - Admitted	0	62	63	18	7											
RTT Incomplete Performance -Non Admitted		87.72%	87.70%	88.45%	88.30%											
Total waits greater than 18 weeks - Non Admitted		4,358	4,366	4,087	4,301											
Total waits greater than 52 weeks - Non Admitted	0	56	53	9	15											

What the information tells us

- The Trust remained ahead of trajectory for RTT incomplete performance in Apr-19 for the eighth consecutive month. The Trust is also ahead of trajectory for number of patients breaching 52 weeks and total waits greater than 18 weeks.
- The Trust performance dropped from 86.1% in Mar-19 to 85.8% in Apr-19. This is the first reduction in performance since Sept-18.
- The Trust has seen an increase in PTL size from Mar-19 to Apr-19. This is as a result of fewer admitted and non admitted clock stops being applied and an increase in referrals throughout Apr-19.

Actions and Quality Improvement Projects

- Currently validating May-19 month end performance ahead of submission 19th June 2019. The Trust will submit a position ahead of trajectory for incomplete performance for May-19. The PTL is likely to remain above trajectory.
- Continued daily monitoring of all patients waiting over 52 weeks for first definitive treatment three month forward look to ensure the Trust remains ahead of trajectory. This includes a forward look of all patient waiting over 32 weeks.
- Sign off amendments to the Trust Access Policy in June and circulate to all operational teams. This will support closure of current Contract Performance Notice (CPN).
- Undertake a review of all un-outcomed historic activity (admitted and non admitted) to ensure monthly submission is an accurate reflection of activity undertaken

Our Process Perspective

Referral To Treatment

Specialty	Admitted		Non Admitted		Within 18 weeks	Over 18 weeks	Total	% within 18 weeks	Over 42 weeks	Over 52 weeks
	Total	% within 18 weeks	Total	% within 18 weeks						
General Surgery	290	34.1%	614	79.2%	585	319	904	64.7%	46	10
Urology	201	64.7%	1,089	87.1%	1,078	212	1,290	83.6%	7	0
Trauma & Orthopaedics	216	47.7%	2,577	87.7%	2,364	429	2,793	84.6%	9	0
Ear, Nose & Throat (ENT)	402	45.0%	2,023	87.9%	1,959	466	2,425	80.8%	35	0
Ophthalmology	0	0.0%	0	0.0%	0	0	0		0	0
Oral Surgery	19	100.0%	391	35.0%	375	35	410	91.5%	0	0
Neurosurgery	156	69.9%	1,920	81.1%	1,666	410	2,076	80.3%	2	0
Plastic Surgery	337	46.9%	1,226	81.7%	1,160	403	1,563	74.2%	42	2
Cardiothoracic Surgery	0	0.0%	0	0.0%	0	0	0		0	0
General Medicine	0	0.0%	14	100.0%	14	0	14	100.0%	0	0
Gastroenterology	507	92.5%	1,854	91.9%	2,172	189	2,361	92.0%	9	0
Cardiology	851	72.0%	2,580	86.3%	2,840	591	3,431	82.8%	6	0
Dermatology	2	100.0%	2,315	91.8%	2,128	189	2,317	91.8%	3	0
Thoracic Medicine	0	0.0%	1,607	91.3%	1,467	140	1,607	91.3%	1	0
Neurology	68	97.1%	2,384	89.1%	2,189	263	2,452	89.3%	1	0
Rheumatology	0	0.0%	949	80.9%	768	181	949	80.9%	3	0
Geriatric Medicine	0	0.0%	40	95.0%	38	2	40	95.0%	0	0
Gynaecology	272	52.6%	2,146	93.5%	2,150	268	2,418	88.9%	7	0
Other	1,034	72.7%	12,929	88.9%	12,248	1,715	13,963	87.7%	79	10
Total	**4,355**	**65.3%**	**36,658**	**88.3%**	**35,201**	**5,812**	41,013	**85.8%**	**250**	**22**

- There are a number of specialties reported under speciality 'Other'. This follows guidance set out in the documentation, "Recording and reporting referral to treatment (RTT) waiting times for consultant-led elective care" – produced by NHS England.
- The full breakdown of 52 week breaches reported in Apr-19 was 19 General Surgery (this includes patients recorded under 'Other' where bariatric surgery is reported) and 3 Plastic Surgery (this includes one paediatric plastic surgery patient, again reported under 'Other').

Our Process Perspective

St George's University Hospitals NHS Foundation Trust

Diagnostics

Indicator Description	Threshold	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Trend
6 Week Diagnostic Performance	1%	0.2%	0.3%	0.3%	0.2%	0.4%	0.2%	0.5%	0.6%	0.5%	0.3%	0.5%	1.6%	0.6%	
6 Week Diagnostic Breaches	N/A	14	25	24	15	30	18	39	37	41	24	40	115	53	
6 Week Diagnostic Waiting List Size	N/A	7,735	7,809	7,236	6,946	7,617	7,593	7,322	6,652	7,649	7,754	7,622	7,247	8,215	

Indicator Description	Threshold	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Trend
MRI	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%	0.3%	
CT	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%	0.0%	
Non Obstetric Ultrasound	1%	0.0%	0.3%	0.0%	0.1%	0.6%	0.0%	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%	0.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.5%	0.0%	
Audiology Assessments	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%	
Echocardiography	1%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.8%	0.4%	4.3%	12.1%	4.2%	
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%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%	0.0%	0.0%	
Sleep Studies	1%	0.0%	0.0%	1.1%	1.5%	0.0%	0.0%	7.7%	2.4%	1.1%	0.8%	2.7%	4.6%	1.9%	
Urodynamics	1%	23.9%	6.3%	26.5%	0.0%	13.9%	14.6%	10.2%	8.5%	16.3%	14.0%	0.0%	5.7%	0.0%	
Colonoscopy	1%	0.4%	0.0%	0.0%	0.0%	0.0%	0.7%	3.0%	0.0%	2.9%	1.0%	0.0%	1.0%	0.6%	
Flexi Sigmoidoscopy	1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.2%	0.0%	
Cystoscopy	1%	0.8%	3.0%	1.8%	4.4%	2.6%	3.0%	4.5%	5.4%	3.2%	0.0%	1.9%	3.2%	6.4%	
Gastroscopy	1%	0.0%	0.0%	1.8%	0.0%	0.3%	0.0%	0.0%	0.6%	1.4%	0.6%	1.8%	2.1%	2.3%	

What the information tells us

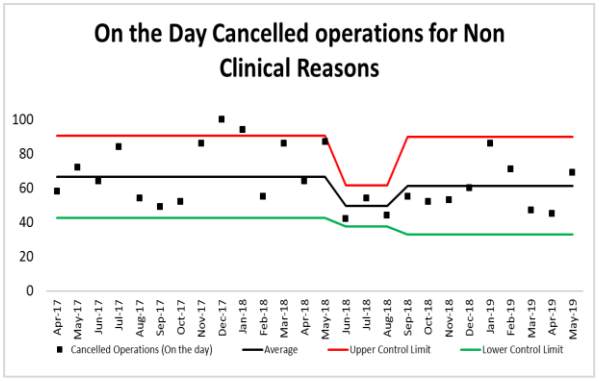
- In May, trust performance returned to compliance for the six week diagnostic standard, and performance returned to within the process limits, with a total of 56 patients waiting greater than six weeks and a performance of 0.6%.
- Compliance has not been achieved within four modalities, Echocardiography and Sleep Studies where the number of six week waiters has reduced, Cystoscopy and Paediatric Gastroscopy have seen increases in the number of patients waiting greater than six weeks

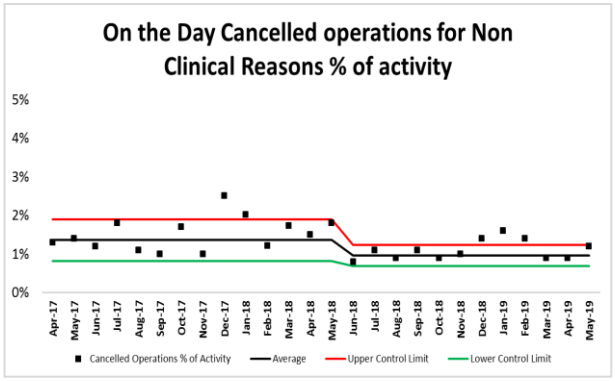
Actions and Quality Improvement Projects

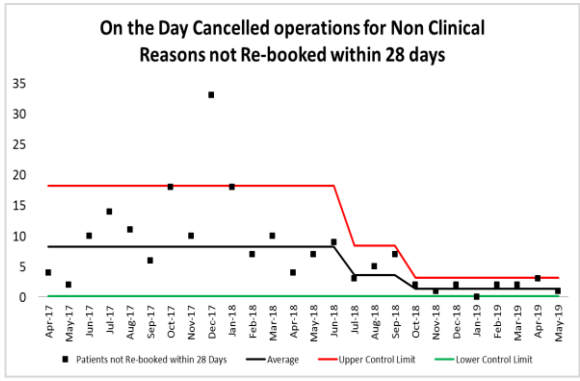
- New post in place to provide operational leadership to diagnostics within Cardiology and the service expects to remain compliant.
- Performance and recovery plans continue to be monitored through the weekly performance meetings.

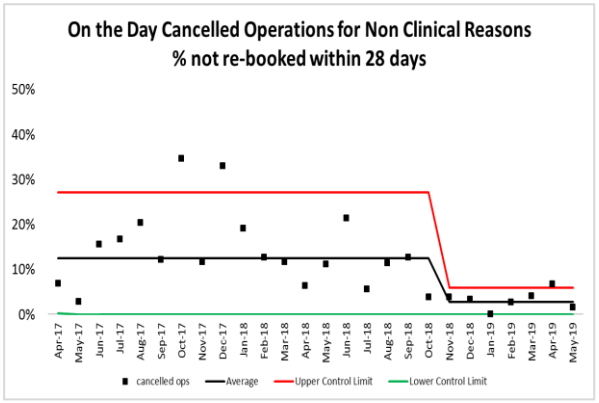
Our Process Perspective

On the Day Cancellations for Non-Clinical Reasons









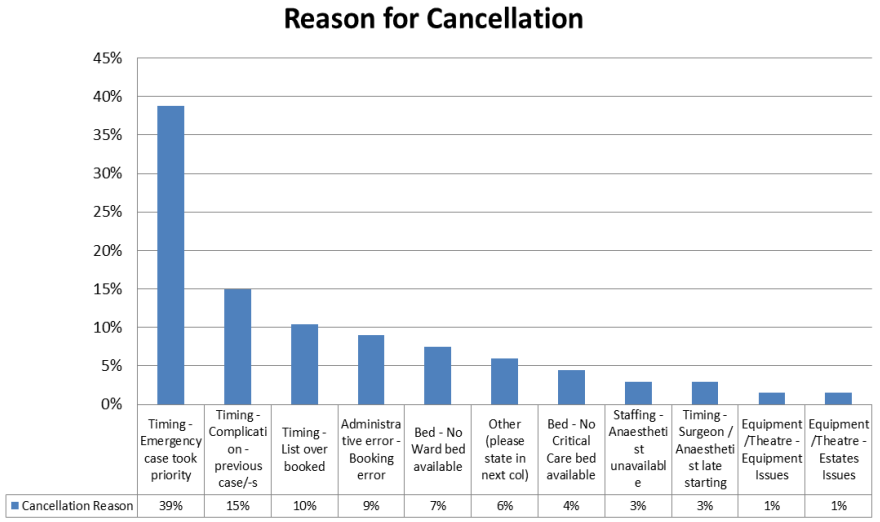
Our Process Perspective

On the Day Cancellations for Non-Clinical Reasons

Indicator Description	Target	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
Number of on the Day Cancellations		87	42	54	44	55	52	53	60	86	73	49	45	69
Number of on the Day cancellations re-booked within 28 Days		80	33	51	39	48	50	52	58	86	71	47	42	68
% of Patients re-booked within 28 Days	100%	92.0%	78.6%	94.4%	88.6%	87.3%	96.2%	98.1%	96.7%	100.0%	97.3%	95.9%	93.3%	98.6%

What the information tells us

- There has been some variability in On the Day cancellations however performance remains within expected levels and a reduction of 21% is seen compared to the same month last year.
- 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 May, 98.6% of patients were re-booked within 28 days.
- Reasons for on the day cancellations include Trauma cases taking priority, complications and ITU bed capacity.



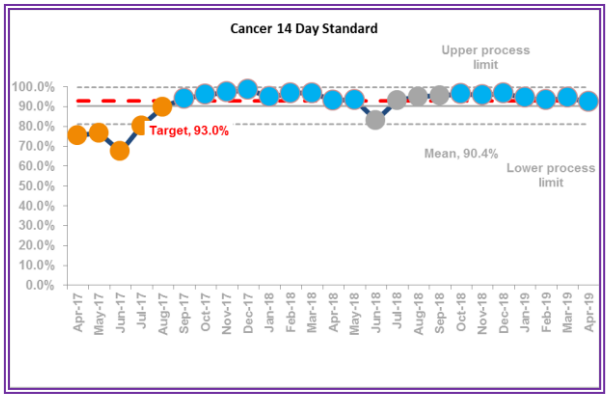
Actions and Quality Improvement Projects

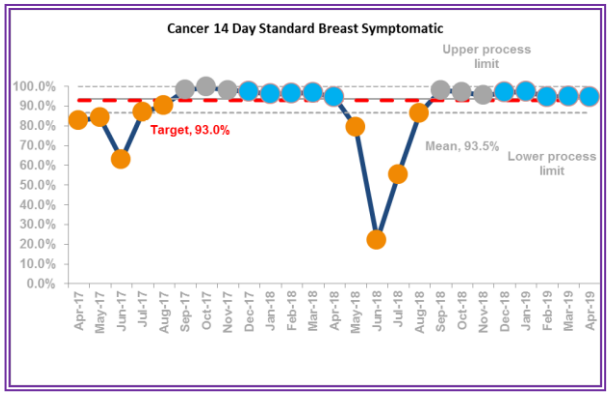
- Continue to roll out Patient Pathway Co-ordinators booking Pre-Operative Assessments for Day Surgery, as well as Inpatient cases improving patient experience and slot utilisation. This has already significantly improved the average utilisation rates.
- Following successful implementation of the Text 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

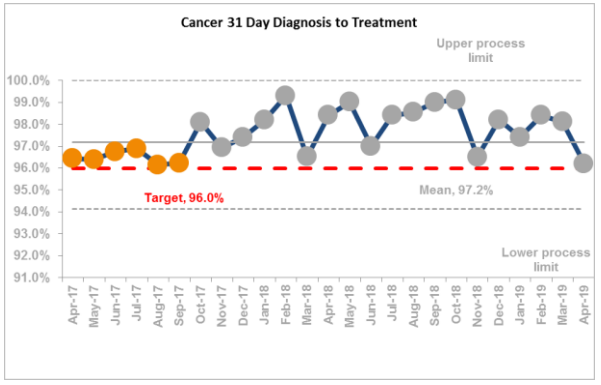
Our Process Perspective

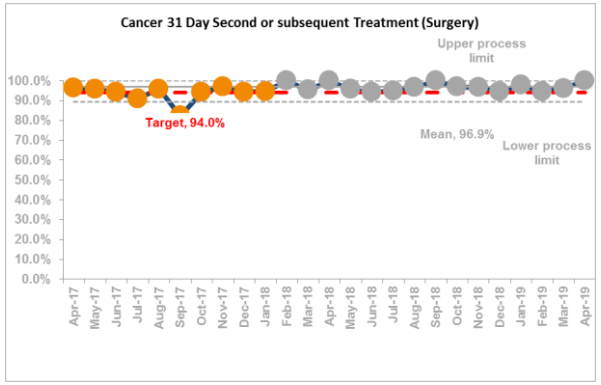
Cancer

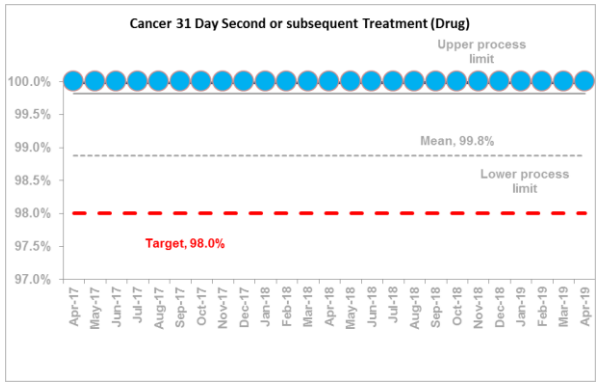
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

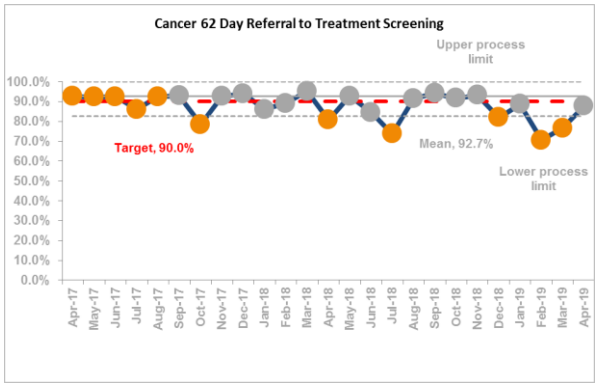


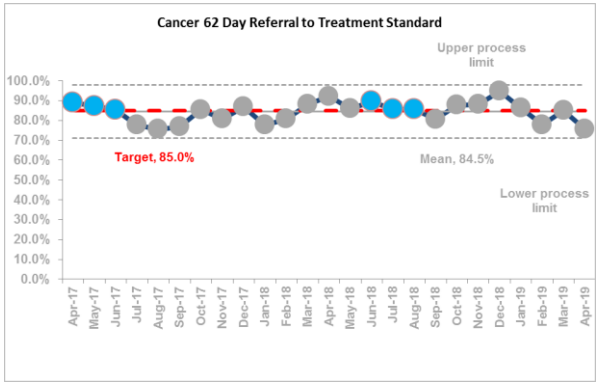


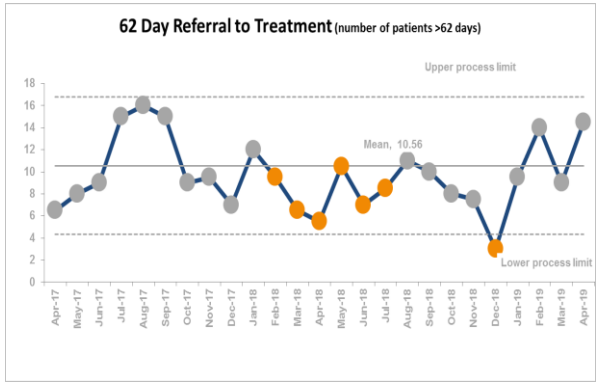












Our Process Perspective

Cancer

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	No of Patients
Cancer 14 Day Standard	93%	93.1%	93.3%	83.0%	93.1%	95.0%	95.5%	96.3%	95.9%	96.6%	94.4%	93.3%	94.4%	92.4%	1,359
Cancer 14 Day Standard Breast Symptomatic	93%	94.4%	79.4%	22.2%	55.2%	86.4%	97.9%	97.1%	95.4%	96.9%	97.4%	94.6%	94.7%	94.4%	251
Cancer 31 Day Diagnosis to Treatment	96%	98.4%	99.0%	97.0%	98.4%	98.5%	99.0%	99.1%	96.5%	98.2%	97.4%	98.4%	98.1%	96.2%	209
Cancer 31 Day Second or subsequent Treatment (Surgery)	94%	100.0%	95.7%	94.1%	95.0%	96.6%	100%	96.9%	96.6%	94.6%	97.9%	94.4%	96.2%	100.0%	26
Cancer 31 Day Second or subsequent Treatment (Drug)	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	94
Cancer 62 Day Referral to Treatment Standard (Re-allocated from April-19)	85%	92.3%	85.9%	89.6%	85.7%	85.7%	80.6%	87.8%	88.1%	94.8%	86.2%	77.8%	85.0%	75.6%	61.5
Cancer 62 Day Referral to Treatment Screening	90%	80.8%	92.7%	84.6%	73.8%	91.6%	94.1%	91.8%	93.2%	82.0%	88.7%	70.5%	76.6%	87.7%	28.5

What the information tells us

- The Trust has reported a non-compliant position for both Two Week Rule (TWR) and 62 day referral to treatment for the month of April 2019 and is expected to be non-compliant against both standards in May 2019. As a result, a recovery action plan is now in place to deliver improvements in access for patients from June onwards.
- Within the 14 Day Standard, the tumour groups of Gynaecology, Lower Gastrointestinal, Upper Gastrointestinal and Urology were below the target of 93%. At Trust level performance remains within the upper and lower control limits with variability shown within Urology and Lower Gastrointestinal in recent months.
- The number of patients awaiting treatment greater than 62 days from referral is above the mean with a performance of 75.6% against the target of 85%. Challenges exists within all tumour groups. Gynaecology continue to show variability in performance but remain within the control process control limits, Haematology fell below the lower control limit reporting 30%, showing a similar position to May 2018. Lower Gastrointestinal have seen a steady decline since January 2019 with performance beneath the lower control limit.
- 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 fifth consecutive month below the target of 90%.

Actions and Quality Improvement Projects

The recovery action plan has three key parts in it:

1. TWR referrals. Main action is to ensure that all TWR clinics are aiming to provide capacity to see patients at seven days or less. The booking profile for the month of April showed that less than one third of all patients were booked within the first seven days of their referral date.
2. TWR 'cashing up' of the outcomes of each outpatient appointment in clinic. The number of patients not cashed up immediately post clinic has risen through April but is now reducing through a targeted action by the Corporate Outpatients management team. Any delay in a time limited cancer pathway is significant especially when managing against the 62 day standard.
3. Targeted support to three specific services (Gynaecology, Upper and Lower GI). For Upper and Lower GI, access to endoscopy is the focus with changes to the administrative function plus lower GI to increase straight to test slots for this diagnostic test. For Gynaecology, short term capacity planning six weeks in advance (both clinic and diagnostic capacity) is the focus.

Our Process Perspective

St George's University Hospitals NHS Foundation Trust

Cancer

14 Day Standard Performance by Tumour Site - Target 93%

Tumour Site	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	No of Patients
Brain	93%	100.0%	100.0%	75.0%	100.0%	100.0%	-	100.0%	-	100.0%	100.0%	100.0%	-	100.0%	1
Breast	93%	94.8%	91.9%	61.2%	87.4%	97.5%	94.5%	99.4%	97.4%	98.8%	97.4%	98.6%	97.9%	99.5%	208
Children's	93%	80.0%	100.0%	100.0%	90.9%	-	100.0%	50.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	1
Gynaecology	93%	94.9%	91.9%	86.1%	91.7%	90.8%	81.9%	87.8%	87.5%	95.9%	69.5%	65.3%	80.0%	75.0%	96
Haematology	93%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.2%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	20
Head & Neck	93%	100.0%	97.5%	92.3%	93.0%	95.6%	99.3%	99.8%	98.1%	96.0%	98.5%	100.0%	99.3%	98.0%	153
Lower Gastrointestinal	93%	94.1%	90.3%	67.5%	94.7%	98.9%	94.3%	98.1%	95.8%	94.5%	97.2%	92.1%	94.5%	85.6%	298
Lung	93%	100.0%	96.3%	90.9%	97.6%	94.7%	95.2%	100.0%	100.0%	100.0%	93.3%	100.0%	96.9%	100.0%	33
Skin	93%	94.1%	93.8%	92.7%	93.3%	92.9%	97.4%	96.6%	97.4%	97.6%	97.1%	95.9%	97.6%	96.9%	350
Upper Gastrointestinal	93%	85.2%	88.1%	89.9%	96.6%	93.9%	96.7%	98.8%	95.4%	94.1%	91.8%	90.9%	83.5%	87.9%	58
Urology	93%	81.3%	92.9%	96.5%	95.2%	93.1%	96.8%	92.4%	93.4%	96.6%	94.5%	94.2%	92.2%	90.1%	141

62 Day Standard Performance by Tumour Site - Target 85%

Tumour Site	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	No of Patients
Brain	85%	-	-	-	-	-	-	-	100.0%	100.0%	-	-	-	-	0
Breast	85%	94.1%	84.6%	91.7%	90.9%	78.9%	100.0%	100.0%	100.0%	100.0%	100.0%	82.4%	90.9%	83.3%	6
Children's	85%	-	-	-	-	-	-	-	-	-	-	-	-	-	0
Gynaecology	85%	100.0%	80.0%	100.0%	75.0%	100.0%	80.0%	90.0%	100.0%	83.3%	88.9%	50.0%	100.0%	66.7%	3
Haematology	85%	100.0%	63.6%	100.0%	100.0%	88.9%	75.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	30.0%	5
Head & Neck	85%	100.0%	90.0%	75.0%	72.7%	81.8%	80.0%	100.0%	86.7%	87.5%	46.2%	85.7%	80.0%	77.8%	4.5
Lower Gastrointestinal	85%	100.0%	100.0%	100.0%	71.4%	83.3%	66.7%	88.9%	100.0%	100.0%	100.0%	81.8%	66.7%	41.7%	6
Lung	85%	100.0%	87.5%	83.3%	71.4%	66.7%	28.6%	50.0%	70.0%	72.7%	80.0%	75.0%	70.0%	71.4%	3.5
Skin	85%	100.0%	90.9%	100.0%	100.0%	100.0%	84.6%	92.3%	100.0%	100.0%	92.3%	100.0%	89.7%	100.0%	7
Sarcoma	85%	-	-	-	-	-	-	-	-	-	-	-	-	-	0
Upper Gastrointestinal	85%	87.5%	33.3%	80.0%	100.0%	78.9%	50.0%	54.5%	100.0%	100.0%	0.0%	50.0%	60.0%	100.0%	3
Urology	85%	80.5%	84.6%	84.9%	85.7%	88.2%	92.9%	88.9%	77.8%	95.0%	89.5%	71.1%	88.9%	83.0%	23.5
Other	85%	-	-	-	-	100.0%	-	100.0%	100.0%	-	0.0%	-	100.0%	-	0

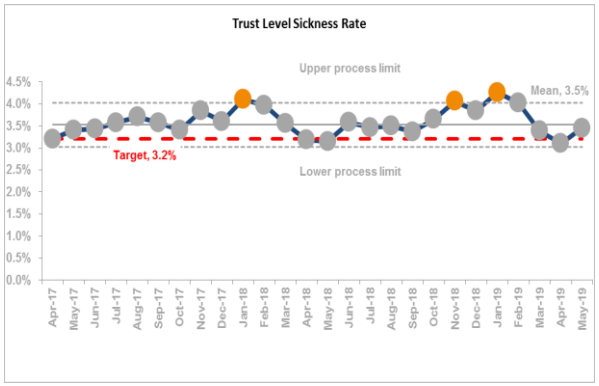
Balance Scorecard

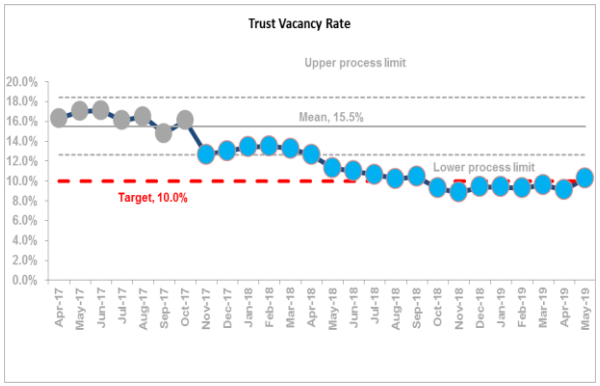
St George's University Hospitals NHS Foundation Trust

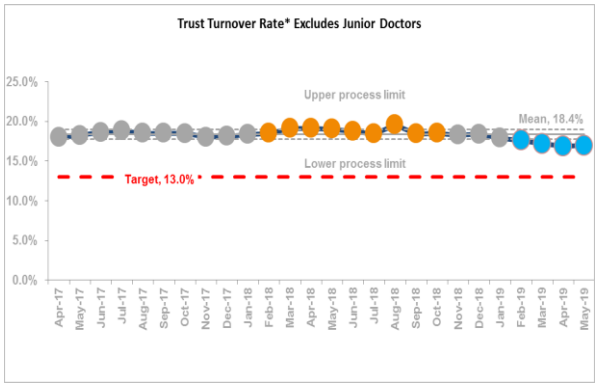
OUR **OUTCOMES**	How are we doing?					
OUR **FINANCE** & **PRODUCTIVITY** PERSPECTIVE	Activity Summary	Bed productivity (length of stay)	Outpatient productivity (attendances per day)	Theatre productivity (cases per session)		
OUR **PATIENT** PERSPECTIVE	Patient safety	Infection Control	Mortality	Readmissions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

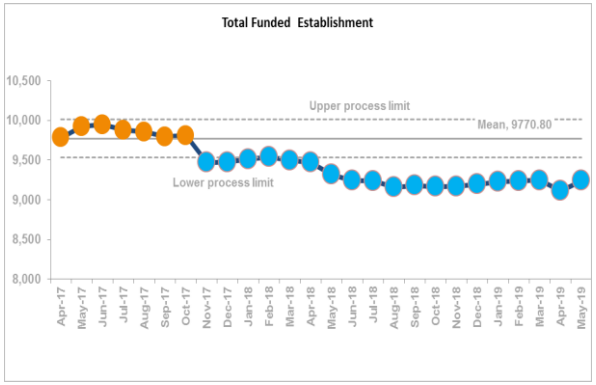
Our People Perspective

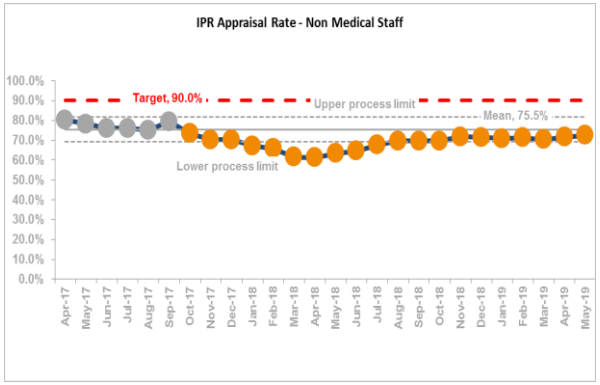
Workforce

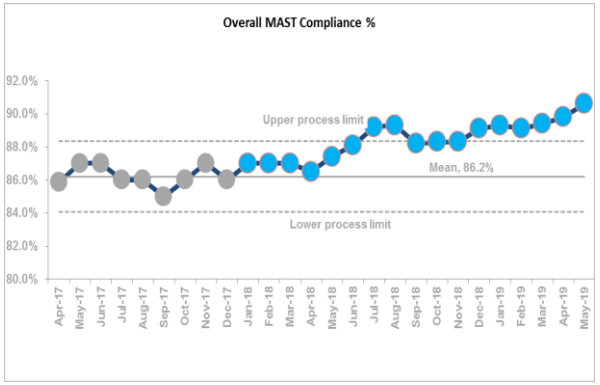


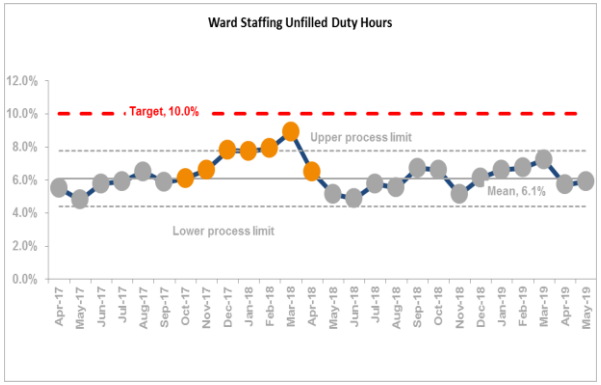












Our People Perspective

St George's University Hospitals NHS Foundation Trust

Workforce

Indicator Description	Target	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
Trust Level Sickness Rate	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%	3.5%
Trust Vacancy Rate	10%	11.3%	11.0%	10.6%	10.2%	10.4%	9.3%	8.9%	9.4%	9.4%	9.3%	9.6%	9.1%	10.3%
Trust Turnover Rate* Excludes Junior Doctors	13%	17.0%	17.3%	17.4%	17.1%	16.6%	16.6%	16.9%	16.9%	17.1%	17.1%	17.5%	17.1%	17.4%
Total Funded Establishment		9,318	9,242	9,239	9,160	9,180	9,165	9,171	9,196	9,229	9,238	9,248	9,112	9,241
IPR Appraisal Rate - Medical Staff	90%	81.3%	79.9%	77.7%	Data Unavailable									85.4%
IPR Appraisal Rate - Non Medical Staff	90%	63.4%	64.6%	67.6%	69.7%	69.7%	69.7%	71.8%	71.5%	70.9%	71.3%	70.4%	71.6%	72.5%
Overall MAST Compliance %		87.4%	88.1%	89.2%	89.3%	88.2%	88.3%	88.3%	89.1%	89.3%	89.1%	89.4%	89.8%	90.6%
Ward Staffing Unfilled Duty Hours	10%	5.1%	4.9%	5.8%	5.5%	6.7%	6.6%	5.1%	6.1%	6.6%	6.7%	7.2%	5.7%	5.9%

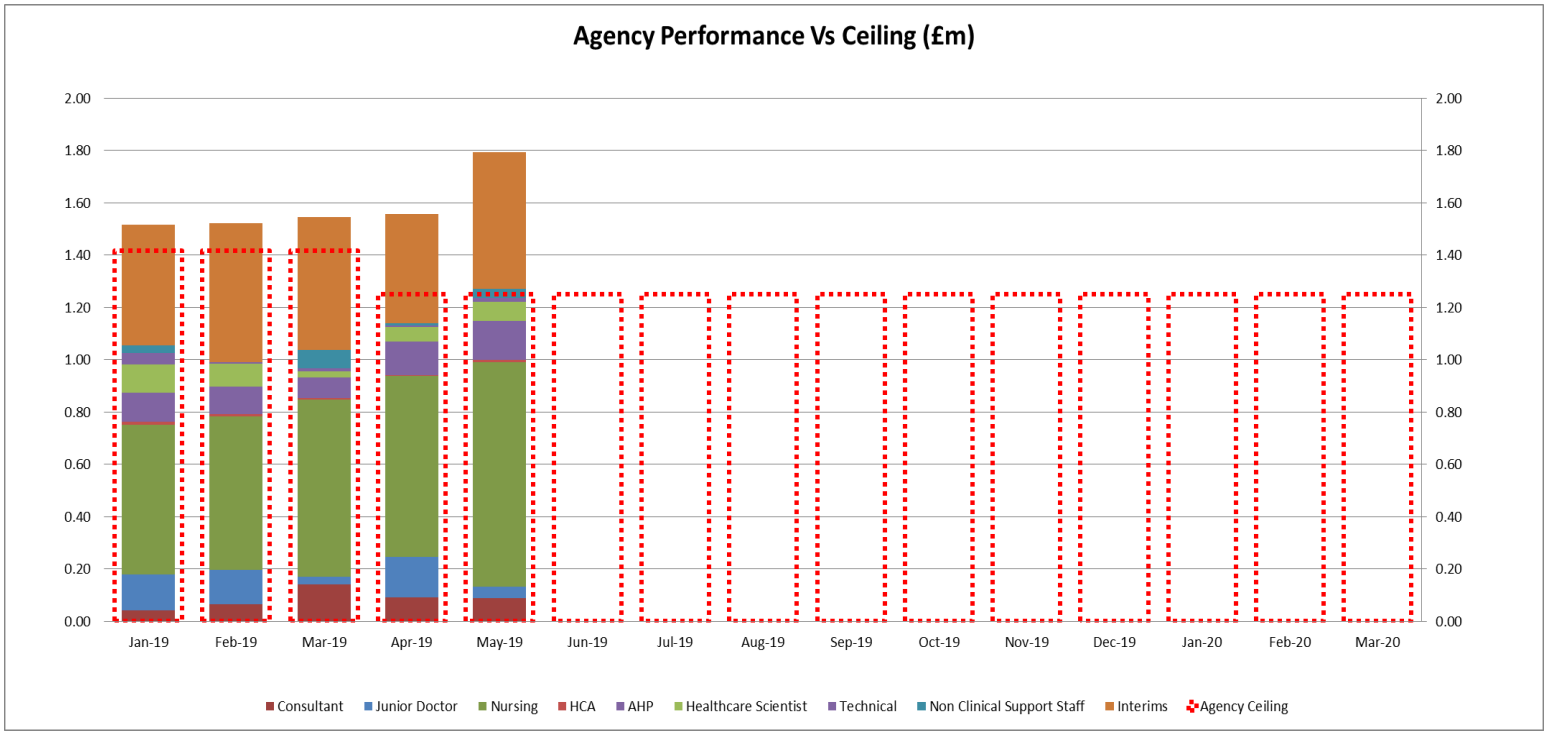
What the information tells us

- The Trust sickness level is above the target of 3% however remains is within the upper and lower process limit.
- As a result of the new financial year budgets being entered on the systems the funded establishment has increased by over 100 FTE, which has resulted in the vacancy rate increasing to 10.3%
- Mandatory and Statutory Training figures for May were recorded at 90.6% with a mean of 89.3% and a tighter standard deviation of 0.3% for the past six months.
- Medical appraisal rates are now being reported by the new appraisal system and currently stands at 85.4%.
- Non-medical appraisal have seen a further improvement in the month of May however remains below target with a performance of 72.5% 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.

Our People Perspective

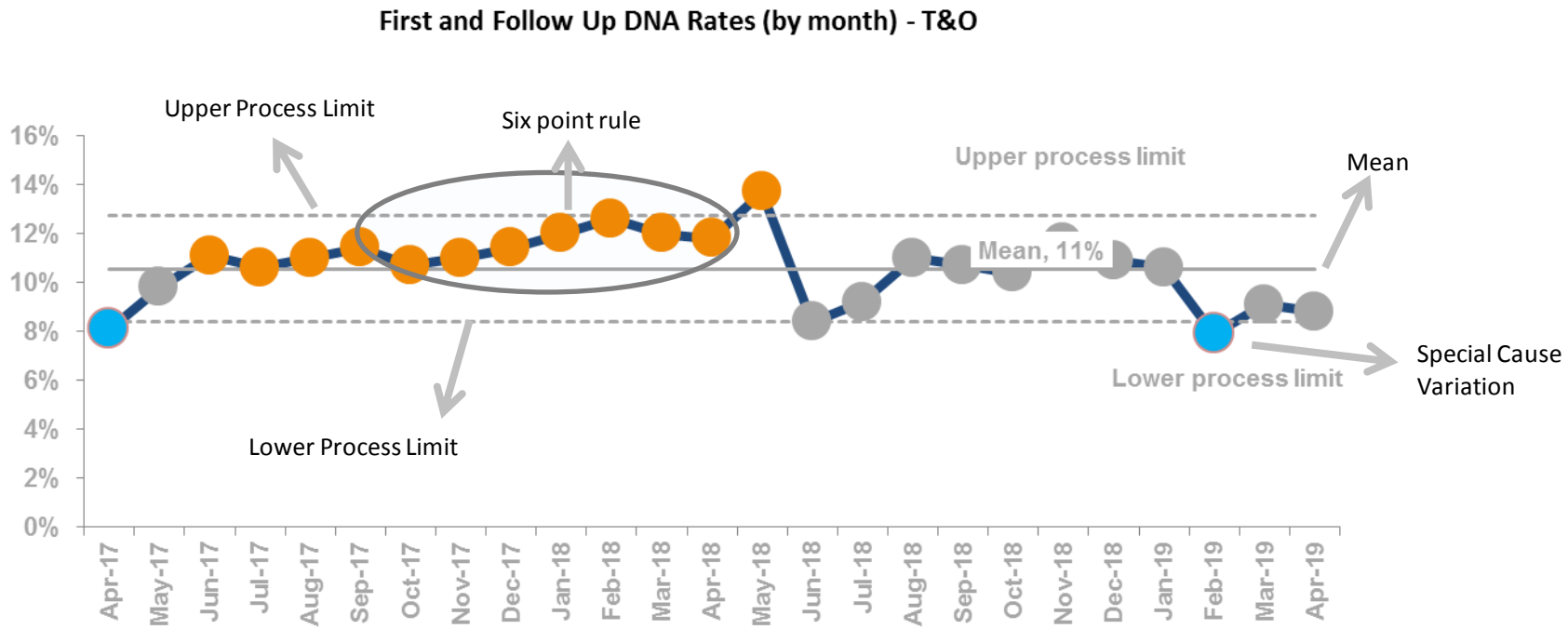
St George's University Hospitals NHS Foundation Trust

Agency use



- The Trust's total pay for May was £46.37m. This is £0.29m adverse to a plan of £46.08m.
- 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 May was £1.79m or 3.9% of the total pay costs. For 2018/19, the average agency cost was 3.2% of total pay costs.
- For May, the monthly target set was £1.25m. The total agency cost is worse than the target by £0.54m.
- Agency cost is £0.23m higher compared to April. There have been increases mainly in Nursing (£0.17m), Interims (£0.10m) and Non Clinical (£0.03m) .
- The biggest areas of overspend were Nursing (£0.27m) and Interim (£0.22m).

Interpreting SPC (Statistical Process Control) Charts



SPC Chart – A time series graph to effectively monitor performance over time with three reference lines; Mean, Upper Process Limit and Lower Process Limit. The variance in the data determines the process limits. The charts can be used to identify unusual patterns in the data and special cause variation is the term used when a rule is triggered and advises the user how to react to different types of variation.

Special Cause Variation – A special cause variation in the chart will happen if

- The performance falls above the upper control limit or below the lower control limit
- 6 or more consecutive points above or below the mean
- Any unusual trends within the control limits

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	**27 June 2019**	**Agenda No**	**2.3**
Report Title:	**Clinical Governance Review**		
Lead Director/ Manager:	Dr Richard Jennings, Chief Medical Officer		
Report Author:	Dr Richard Jennings, Chief Medical Officer		
Freedom of Information Act (FOIA) Status:	**Unrestricted**		
Presented for:	**Discussion/Assurance**		
Executive Summary:	In January 2019, an independent review into the governance arrangements around the Trust's mortality and morbidity meetings and multi-disciplinary team meetings was commissioned by the Chief Medical Officer. The purpose of the review was to examine the safety governance and culture of these meetings at a care group/departmental level, identifying areas of good practice and highlighting any areas for improvement.		
Recommendation:	The Board is asked to consider and discuss the review and note the Governance Review Action Plan which was also considered by the Quality and Safety Committee on 20 June 2019.		
Supports			
Trust Strategic Objective:	• Treat the patient, treat the person • Right care, right place, right time • Build a better St George's		
CQC Theme:	Safety, Effectiveness, Responsive, Caring and Well led		
Single Oversight Framework Theme:	1. Quality of Care (safe, effective, caring, responsive) 2. Leadership and Improvement Capability (well-led)		
Implications			
Risk:	Failure to deliver quality improvements in line with the expectations of the CQC will result in reputational damage, loss of confidence in the organisation, and perceived failure of leadership		
Legal/Regulatory:	Level of compliance with CQC key lines of enquiry		
Resources:	N/A		
Previously Considered by:	Quality and Safety Committee Trust Executive Committee	**Date**	20/06/2019 19/06/2019
Equality Impact Assessment:	N/A		

St George's University Hospital NHS Foundation Trust

Governance review: mortality and morbidity and multidisciplinary team meetings

April 2019

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Executive summary:
Governance review: mortality and morbidity and multidisciplinary team meetings

Purpose of the review

In January 2019 Richard Jennings, the chief medical officer at St George's University Hospital NHS Foundation Trust, commissioned an independent review of the governance arrangements around the trust's mortality and morbidity meetings and multi-disciplinary team meetings. The purpose of the review was to examine the safety governance and culture of these meetings at a care group/departmental level, identifying areas of good practice and highlighting any areas for improvement.

Summary: main findings from the review

The review team focussed on the following three areas:

1. Learning from deaths

St George's University Hospitals NHS Foundation Trust response to the various inquiries/investigations and national reports and guidance documents relating to how NHS trusts can improve their clinical governance, data collection, reporting and learning from deaths.

Key findings

Although the trust has made steady progress in implementing the National Quality Board's *National Guidance on Learning from Deaths, a framework for NHS Trusts and NHS Foundation Trusts for identifying, reporting, investigating and learning from deaths in care (2017)*, there is still more work to do particularly around areas such as:

- A refresh of the trust's current 2018 policy on *learning from deaths* to ensure that it is current, and has taken account of any new national guidance on learning from deaths, and how compliance with the policy is monitored to ensure that key outputs are achieved
- Engagement and support to bereaved families
- Strengthening the role, purpose and responsibilities of the mortality monitoring committee so that it has a higher profile within the trust, stronger links to the clinical divisions, and has a key role in the trust's governance infrastructure
- The implementation of the medical examiner system and how this will interface with the learning from deaths framework.

2. Mortality and morbidity meetings

Mortality and morbidity meetings have a central function in supporting service to achieve and maintain high standards of care. Through observation and discussions the review team examined the current performance of a selection of mortality and morbidity meetings at care group level and assessed these against national standards and best practice guidance.

Key findings:

- Meetings were generally held in an atmosphere of openness and transparency
- Although meeting attendance was variable those who were there obviously really valued the opportunity to discuss cases of morbidity and mortality
- Junior doctor and nurse/allied health professional attendance was variable, often due to other commitments – this limits learning opportunities and gaining additional perspectives
- Chairing skills were variable with some good examples of meetings that were inclusive with members actively engaged and learning opportunities explored. This was in contrast to others where discussion/debate was not encouraged
- The use of a consistent systems approach to case reviews was not found
- Resource issues in time, administration support, IT technology, room allocation in some areas. Other areas appeared to be well resourced, which can lead to a feeling of inequality
- Lack of clarity on how lessons learnt and practice change are embedded and shared
- Trust wide policy on morbidity and mortality meetings that would provide a model framework for divisions and care groups to consider best practice when holding their meetings

3. Multidisciplinary team meetings

The purpose of a multidisciplinary meeting is to ensure a specialist team reviews all patients' care so that high quality diagnosis, treatment and care is provided and that the all patients have the benefit of a range of expert advice needed for high quality care. Through observation and discussions the review team examined the current performance of a selection of multidisciplinary meetings across care group specialisms and assessed these against national standards and best practice guidance.

Key findings:

- Variation in the quality and structure of the meeting was observed; some meetings worked to well-established frameworks and were well resourced in terms of administration support, availability of IT, and room allocations.
- Others tended towards the chaotic – with lack of clarity around who was chairing/running the meeting, poor room allocation, discussions dominated by individuals
- Most meetings were well prepared for with relevant information available to support the discussions
- Good practice was observed where the patient record was updated in real time, but this was not consistent across all meetings and retrospective recording can increase the risk of transcription errors
- Team working and behaviours were generally inclusive and individuals encouraged to contribute to discussions, with differing opinions valued
- Examples of patient focussed holistic approach to discussion were observed that led to patient centred clinical decision making
- The role of the multidisciplinary coordinator was well established and valued in some areas, and added to the effectiveness of the meeting. This role is not available to all multidisciplinary meetings
- Resource issues for preparation and attendance at meetings was a theme for some disciplines, where they are required to attend a large number of meetings
- Peer review was not embedded as a quality assurance process across all services
- Development of a trust wide approach to the way multidisciplinary meetings should operate would improve consistency and behaviours and expectation of the outputs from them

Other areas

The review team have also mapped out the key meetings for morbidity and mortality and multidisciplinary team meetings that occur in each of the divisions. They identified gaps, and highlighted areas where such meetings should take place, but there is no record of such a meeting. This is a tool for divisional chairs to have oversight of these important meetings and for them to consider how they use this information to support their clinical governance systems and gain assurance that meetings are taking place, and that learning is being shared and effecting change in practice.

The review team have not undertaken a clinical governance review, but through their work have observed some areas of governance that the trust may want to consider. These relate to areas such as:

- How to strengthen the ward to board governance systems
- Capacity challenges within the corporate governance team
- A model to improve the understanding of terminology of assurance and reassurance
- Improving the interfaces between the serious incident, mortality review process and quality improvement techniques could support a more consistent approach to learning and improving when things wrong

Recommendations

These recommendations are the result of a high level of distillation from various observations made in the full report. There are a number of other observations and comments in the report that underpin these recommendations and these should be taken into account when developing a response to this review.

Mortality and morbidity/MDT meetings

1. It is recommended that a mortality strategy should be developed that incorporates all the various strands of the learning from deaths framework, with a clear focus on improving the quality of clinical care and preventing avoidable patient death.

2. The chief medical officer should consider how the interface between the new medical examiner system (when implemented) and the learning from deaths framework will operate at St George's to ensure independence of the medical examiner's role is maintained as intended within the latest guidance.

3. The forthcoming review of the learning from deaths policy should ensure that it encompasses all relevant new national guidance with particular focus on:
    - how bereaved families are engaged and supported and consideration of the involvement of a patient reference group in the development of this policy
    - strengthening the role of the mortality monitoring committee in delivering its aim to support clinical teams in their local mortality and morbidity governance processes.

- the mechanism for monitoring and providing periodic assurance to the board that the intentions of the policy are being met

4. It is recommended that the role of the mortality monitoring committee is revised so that it has a higher profile within the trust corporate quality governance structure. This should include consideration of how this committee can best deliver the trust's mortality strategy when developed.

5. Develop an overarching trust wide policy for conducting care group level mortality review meetings based on the latest best practice guidance. This will provide a model framework for divisions and care groups to consider best practice in holding such meetings, and how learning opportunities are shared that influence changes in practice.

6. Develop an overarching trust wide policy for conducting care group level multidisciplinary meetings from which local standard operating procedures can be developed based on the latest best practice guidance. The policy should incorporate how each MDT will assess (at least annually) its own effectiveness/performance and benchmark itself against similar MDTs, making use of peer review and other national tools as they become available. The policy should include how the board receives assurance – positive and negative – on the effectiveness of its MDTs.

7. Design and implement a training needs analysis for those chairing and participating in local morbidity and mortality and multidisciplinary meetings. This should include giving consideration to establishing a community of practice approach with those who chair mortality and morbidity and MDT meetings, involving executive leadership to build relationships and share learning through discussion and activities.

8. It is recommended that as part of the protocol for developing and approving new clinical services consideration is given to the impact a new service will have on clinical support services, particularly in the resource requirement required to attend multidisciplinary team meetings

Quality governance

9. Consider what changes are required to provide support and resource to the chief medical officer in concert with the chief nursing officer, reflecting their need for an integrated approach to quality governance.

10. Reflect on the organisation's ward to board reporting framework of meetings to ensure that the board continues to receive reliable assurance on the quality (safety, effectiveness and experience) of the services it offers, and that it meets its statutory responsibilities in this regard.

11. Review the corporate quality governance leadership and capacity so that the divisions are supported to provide a consistent and uniform approach in their delivery of the trust's quality governance arrangements.

12. Consider a development programme for the divisional senior leadership team to provide greater understanding and good practice in governance systems and process particularly seeking and receiving assurance as part of the trust's risk management arrangements.

13. Consider reviewing the roles of divisional chair, clinical director, care group lead, and clinical governance, to ensure that these role expectations and responsibilities are consistent, clear, well understood, and properly resourced in terms of protected time, support, and development to enable staff to deliver them in line with trust expectations.

14. Consider conducting a medical engagement programme across the trust's consultant body. This will establish a baseline to inform the chief medical officer to consider what other mechanisms might be necessary to ensure the most senior leaders keep in touch with their medical workforce.

15. The trust may want to reflect on the perception that the culture is medically dominated, and consider how it can achieve parity of esteem across all professions delivering clinical services to patients.

1.0 Introduction

In January 2019 Richard Jennings, the chief medical officer at St George's University Hospital NHS Foundation Trust, commissioned an independent review of the governance arrangements around the trust's mortality and morbidity (M&M) and multi-disciplinary team meetings (MDTs). The purpose of the review was to examine the safety governance and culture of these meetings at a care group/departmental level, identifying areas of good practice and highlighting any areas for improvement.

The scope of the review was agreed at the outset with the chief medical officer and a review team commissioned to undertake the review.

2.0 Review approach

Terms of reference for the review were established and agreed with the chief medical officer (appendix 1). These were shared with the leadership teams in the trust's three divisions:

- Surgery, neurosciences, cancer and theatre division (SNCT)
- Medicine and cardiovascular division (Medcard)
- Children's, women's, diagnostic, therapies, outpatients, critical care and community services division (CWDTOCC)

A review team of governance professionals, with wide ranging healthcare experience, were engaged in January to undertake the project (see team profiles at appendix 2):

- Elizabeth Seale
- Wendy Cookson

In March the team were joined by:

- Geraldine Lavery

A shortlist of specialties from the three divisions was identified through early meetings with divisional chairs for the focus of the review:

- Head and neck surgery
- Urology (cancer)
- General surgery
- Gynaecology
- Breast services
- General critical care and diagnostics
- Haematology
- Peripheral vascular surgery

- Non-surgical cardiology
- Renal transplant
- Emergency department

Some additional areas were observed during the review.

3.0 Methodology

The review team used a range of quantitative and qualitative techniques to undertake this review

- ***Assessment tools and evidence grids***

Bespoke tools for capturing meeting observations and analysis of documents were developed. These were based on the most recent published best practice guidance and to ensure the findings from the review are as objective and evidenced based as possible.

- ***Document review***

The review team had access to and examined a number of documents, which ranged from and included trust policies and protocols, agendas, reports and minutes from various trust meetings at both a strategic, divisional, and operational level. Some documents were provided for reference, whilst others have been considered in more detail. A variety of national policy, guidance and frameworks have also been considered; these are listed in appendix 2.

- ***Meetings and discussions with key individuals***

The review team members had twenty-three meetings/discussions with a wide range of individuals at an executive, corporate, divisional and operational level. The purpose of these was to understand the effectiveness of the trust's quality governance arrangements, current practices and how links between the local divisional meetings (mortality and morbidity, and multidisciplinary team meetings in particular) and how corporate meetings are arranged and how related assurance is obtained.

- ***Observations***

A total of 29 multidisciplinary and mortality and morbidity meetings were observed. A board committee, and corporate and divisional governance meetings were also observed – a list of these various meetings is included in appendix 3.

4.0 Acknowledgement

The review team would like to express their appreciation to all of those who engaged in the review process and gave their time to meet with or speak to them.

5.0 Background

The trust was authorised by Monitor as a Foundation Trust in February 2015. It is one of the country's principal teaching hospitals, partnered with St George's, University of London, which trains medical students and carries out advanced medical research. The trust also hosts the Faculty of Health and Social Care Sciences for St George's, University of London and Kingston University, which is responsible for training a wide range of healthcare professionals.

There are two hospital sites. The main acute healthcare site is St George's Hospital, Tooting with 995 beds, and Queen Mary's hospital at Roehampton providing rehabilitation services with 88 beds. As well as acute services, the trust provides a wide range of specialist services, and a range of community services. The trust employs over 9,000 staff and is the largest provider of healthcare in southwest London, serving a population of 1.3 million.

The trust has been through a challenging period over the last few years. It has been subject to both financial and clinical 'special measures' and has been working closely with healthcare regulators to improve its performance.

In June 2018, following concerns that the cardiac surgery unit was a mortality outlier, the trust's chief executive, Jacqueline Totterdell, commissioned an independent review of cardiac surgery services. The findings from that report and other concerns triggered a focused inspection on the cardiac unit from the Care Quality Commission (CQC), the healthcare regulator. This inspection took place in August and September 2018, with the CQC publishing its report in December 2018. The key findings from the CQC report raised various issues about governance systems and process, culture and behaviour within the cardiac services. This service is part of an on-going recovery programme and is outside the scope of this review.

6.0 Context – learning from deaths

Over the past few years a number of national inquiries/investigations such as the Francis Inquiry into Mid Staffordshire NHS Foundation Trust, the Keogh Review, and the Berwick report, have quite rightly put patient safety into the public limelight. All of these reports highlight a number of key areas, including leadership and culture, patient safety, and the systems of assurance that enable organisations to be confident that they are safe and effective. In December 2016 CQC's report *Learning, candour and accountability: A review of the way NHS Trusts review and investigate the deaths of patients in England* found that learning from deaths was not given sufficient priority in some

organisations and consequently valuable opportunities were being missed. This led to the National Quality Board development of the March 2017 *National Guidance on Learning from Deaths, a framework for NHS Trusts and NHS Foundation Trusts for identifying, reporting, investigating and learning from deaths in care*. This guidance set out standards and requirements on how NHS trusts can improve their clinical governance, data collection, reporting and learning from deaths. In July 2018 the National Quality Board issued further guidance, *Learning from deaths: guidance for NHS trusts on working with bereaved families and carers*. The purpose of this guidance is to assist trusts to improve engagement with families, and learning when things go wrong.

An independent medical examiner system is part of the Government's response to public inquiries into the serial killer Dr Harold Shipman and key recommendations of the Francis report, and the Morecambe Bay maternity inquiry. This non-statutory system will introduce a new level of scrutiny whereby all deaths will be subject to an independent medical examiner review. It is anticipated that this process will become a statutory system in the coming years.

The implementation of the medical examiner system to review all hospital deaths was due to commence in April 2019. Recent joint communications from the NHS England, NHS Improvement, and the London Learning from Deaths network have extended this period of implementation until April 2020 for all deaths in secondary care and all deaths by the end of March 2021. Communication from the recently appointed National Medical Examiner has set out further clarity and support to NHS trust medical directors on the requirement of the phased implementation.

The role of the medical examiners will be to promote robust, transparent and independent scrutiny of the death certification process. When undertaking medical examiner work they will be independent of the trust that employs them. They will, however, be expected to share full information with their trusts to inform mortality reviews and clinical governance systems, which will help support the Learning from Deaths process. They should not however be the trust's mortality lead, learning from deaths lead, or chair the trust's mortality surveillance group or equivalent.

One of the expectations of the new medical examiner system will be to increase engagement with bereaved families and the recent CQC report on *Learning from deaths: a review of the first year of NHS trusts implementing the national guidance* reinforces the importance of this.

The report states that although their findings demonstrate the beginning of progress in NHS trusts in implementing the guidance from the National Quality Board (March 2017 and July 2018) there is still considerably more work to do. The CQC found examples of the same issues and concerns identified in previous reports and NHS trusts must act now to build on the key drivers for change, including:

- Encouraging values and behaviours that enable engagement with families and carers as well as support for staff
- Providing clear and consistent leadership at a senior level with challenge and oversight from non-executives
- Creating a positive, open and learning culture where people who use services, and staff, feel confident to speak out
- Providing staff with the time, support and training to carry out robust reviews and investigations of deaths
- Developing positive working relationships with partner organisations to share information and learning following the deaths of people for whom they have provided care

7.0 Key findings: St George's response to learning from deaths

Following the publication of the national guidance on Learning from Deaths (LfD) framework, the trust has proactively been implementing the requirements from this guidance and has made good progress in a number of areas. At board level the chief medical officer is the executive lead on LfD, and the non-executive director who chairs the Quality and Safety Committee (QSC) (a board sub-committee) has oversight of progress, with specific responsibilities to:

- Ensure the processes in place are robust and can withstand external scrutiny, by providing challenge and support
- Champion and support learning and quality improvement
- Assure published information and ensure that information published is a fair and accurate reflection of the provider's achievements and challenges

The trust board receive quarterly reports on the learning from deaths from the Mortality Monitoring Committee. These reports summarise progress against the trust's priorities for 2018/19 in relation to implementation of the 'Learning from Deaths' framework and implementation of the medical examiner system. They also provide a summary of reviews completed of the trust's inpatient deaths using a dashboard, and externally viewed mortality data, at trust and service level, with an update on the trust's current position and actions it is progressing. The reports also include

analysis of Dr Foster data at diagnosis and procedure group level. The review team was told that this report is now shared with all consultants to raise awareness and share learning.

An associate medical director is in post with specific responsibility to lead on learning from deaths. A clinical effectiveness manager supports this role, along with two clinicians who are trained in undertaking case reviews of medical records using the structured judgement review (SJR) method. This is a national recognised clinical governance tool to guide mortality case record reviews. The trust has agreed a target to screen 70% of all inpatient deaths, which is consistently achieved and exceeded. Reviews are conducted within two days of the death, using bereavement office records, and a screening form is completed. Individual clinicians and/or care group leads are contacted if further clarification is required, and any feedback on the initial review is provided in real time. Any deaths with particular concerns are escalated for a SJR. The clinical effectiveness manager holds all completed screening and SJR records in a central database.

Reviewers were told that having senior doctors in the bereavement office each day helps support bereaved families. Families are given a booklet describing what happens next together with a dedicated email address to make contact with any further queries. The bereavement office conduct a user survey with bereaved families and feedback from this was described to the reviewers as 'fantastic'. An example was described where through the support of the LfD team working closely with a family and the coroner, they were able to provide greater insight into the circumstances surrounding the death of a patient. This resulted in the coroner's and family's concerns being satisfied without the need for an inquest.

7.1 Mortality monitoring committee

The trust's Mortality Monitoring Committee (MMC) is an operational group that meets monthly, chaired by the associate medical director for LfD. The committee reports to the Patient Safety and Quality group (PSQG), then through that group to the board sub-committee – the Quality and Safety Committee.

An example of a mortality flag was identified to the reviewers, who then followed the process of the MMC in considering this. The example identified was an ICNARC (intensive care national audit and research centre) dashboard issued in August 2018, showing the standardised mortality ratio for general intensive care unit (GICU) for January to December 2017 as a negative alert, with increasing mortality in quarters three and four 2017/18. The clinical leaders within the unit had been asked to provide an explanation of the data and any resultant learning. The MMC received the findings from this work in October. This investigation was undertaken by the audit lead, adult

critical care and the consultant care group lead for GICU, both of whom are members of the MMC. The committee also considered that previous scrutiny of local mortality reviews and case record reviews conducted by the MMC had not identified any themes or areas of concern.

Although the GICU internal review found that the current local mortality and morbidity processes lacked robust systematic capture of themes/issues, it concluded that nothing from the weekly reviews had revealed any systemic concerns. In response to this review the GICU reported that they have developed enhanced local M&M review and reporting processes. Their aim is to complete SJRs for 80% of deaths within 12 months, including for patients who have died post discharge from the unit. They also plan to pilot peer review of complex cases and compare findings with the associate medical director for LfD. Members of the MMC concluded from this body of evidence together with 2018/19 data for quarter one that there are no systemic issues of concern.

This may be a useful example of improvement work that the MMC may want to monitor to evaluate the impact of these actions by GICU, specifically regarding the introduction of an SJR approach to a local mortality and morbidity process, together with the findings from comparison of peer review of complex cases with those from the corporate review over time.

7.1.1 Terms of reference for the mortality monitoring committee

Terms of reference for the MMC were reviewed and updated in February 2019. The review team considered both versions and make the following observations:

1. The aims of the committee have been updated. They now include reference to the committee supporting the establishment and development of the medical examiner system. Attendance of the medical examiner at the meeting would seem appropriate when this role is developed, although recent communication from NHSI and NHSE reinforces the need for the independence of this role and their involvement in the MCC.
2. The terms of reference may benefit from an introductory section that sets out the context and expectations from the national LfD guidance rather than refer to LfD as one of the five aims.
3. Although the membership has been expanded in the most recent version, it may require further review to consider wider senior nurse representation, the addition of an acute physician/ED representative, and representation from clinical support services such as pharmacy.
4. Both versions of the terms of reference identify the person with the title associate medical director for governance as the committee chair. In practice, the committee is chaired by the associate medical director for LfD. The terms of reference need to reflect an accurate description of who is expected to undertake the chair's role.

A further review of the membership of the committee should be considered to ensure the appropriate disciplines are represented at both operational and corporate levels, and that there are clear links to the divisions and to their governance systems through to care group level.

Consideration should also be given to whether it should be the chief medical officer's responsibility to chair this key committee and whether this committee is placed appropriately in the trust governance meetings structure. By doing so it would enable the committee to have a more strategic role than it does currently in terms of overseeing implementation of the learning from deaths framework.

7.1.2 Mortality monitoring committee meetings observation and review of papers

The review team observed the meeting of the February MMC, met on three occasions with the associate medical director for LfD, and reviewed the meeting notes from three previous meetings of the MMC (October and November 2018, and January 2019).

From observation of the February 2019 MMC meeting and review of meeting notes the review team would highlight:

- whether there is a conflict between the chairing of the committee and the presentation of the centrally reviewed cases by the same function, which can result in a lack of challenge and scrutiny of the cases and information presented
- there is significant focus on sharing information with the group around the ongoing development of the medical examiner and how the trust is responding to this agenda
- a lack of clarity regarding the trust's approach to continuous learning from mortality reviews undertaken locally as well as those termed as 'internal MMC independent' which are undertaken by the associate medical director for LfD and his two associates, together with any link with the strands of the trust's quality improvement plan such as the deteriorating patient. For example, the clinical lead for this improvement workstream does not attend the MMC
- there was limited evidence of escalation of cases from local mortality reviews to the MMC for wider consideration or learning. The main focus appeared to be on the presentation of the internal independent review of cases and the seeking of confirmation of the findings from members of the group. The reviewers were only able to find one instance of

delegation of actions from the MMC to a local mortality and morbidity meeting (October 2018 MMC meeting notes)

Further to the above, when comparing the outputs from the MMC to the trust policy on LfD, the review team would suggest the committee considers whether it is confidently able to demonstrate compliance with the policy in the areas highlighted below, and whether it is consistently effective in supporting the local M&M process, and that this is well understood within each care group. The policy states:

- *The MMC support clinical teams in their local mortality governance processes to strengthen learning, and support directly the bereavement office in ensuring timely and accurate death certification. (section 5.4)*
- *The MMC receives service level mortality reviews and summaries of mortality meetings and use this data to develop greater understanding of quality and outcomes across the organisation. (section 6.2)*
- *Issues identified by casenote review are fed directly to the service governance lead for inclusion in their mortality reviews and discussion. (section 6.2)*

In discussions with individuals and following observations at some of the local mortality and morbidity meetings there was not always a good knowledge and awareness of the MMC.

One example of how the MMC links with the local mortality and morbidity process is a case that was discussed at one of the observed local M&M meeting. The death occurred in February 2019 and is an example of a case that the review team believed might benefit from consideration at the MMC.

It was a complex case concerning a patient death following surgical post-operative complication. The case was screened by the associate medical director for LfD on the day following the patient's death. No concerns were raised from this review in terms of avoidability and the care was judged to be adequate. The associate medical director for LfD wrote to the surgeon that day to ask that he feed back whether there was any learning from such a complex case and drew attention to the late presentation. As this was a death following elective admission, he then asked one of the operating surgeons to complete a review using a specific template. Further enquiries by the review team have now indicated that the case is due for discussion at the April meeting of the MMC.

This was an interesting case as it involved a complex procedure that is not frequently carried out. At the local mortality and morbidity meeting there was discussion of whether this particular procedure should be attempted given that it is so uncommon that surgeons undertake it very infrequently. The chief medical officer may wish to consider with his divisional chairs what the appropriate route is for escalation to provide a more independent and wider assessment of the clinical risks associated with cases such as this.

This is the only example seen during the review of a case being escalated from the local M&M review to the MMC although there may of course have been others.

The review team also saw an example of close working between the associate medical director for LfD, the MMC and the stroke service. He told the review team that in addition to the daily screening of hospital deaths, any resulting SJRs, and management of the MMC, his focus had been on improving outcomes in specific areas such as:

- stroke: e.g. use of naso-gastric tubes in stroke unit
- fractured neck of femur: patient mortality halved since 2016 following a mortality alert
- GICU: 'ICNARC data is now good', reporting to the end of life group
- out of hospital cardiac arrests

Although these areas are critical to the overall reduction in mortality, there may be other areas where deaths are less prevalent that would benefit from this level of support.

7.1.3 Attendance at mortality monitoring committee meetings

During the period under review it was noted that although meetings were quorate, they are poorly attended, with usually less than 50% attendance from a core membership of seventeen. Attendance tended to be from a small core group. Divisions/clinical specialties across the breadth of the trust were not well represented. This raises a further question as to how strong the links are between the MCC and clinical care groups.

7.1.4 Mortality monitoring committee links to local mortality and morbidity

From scrutiny of the MMC notes, it was not possible for the review team to link cases discussed with those observed at local M&M meetings due to timing differences. The way in which cases are captured in minutes however would not enable a reviewer to make this link without more detailed information on the case. It was not possible to identify if the case discussion was as a result of the corporate mortality review process or due to escalation from a local M&M. There is not a clear

formal governance pathway from local M&Ms to the MMC. The MMC should consider how this could be strengthened. The completed mapping tool produced as part of this review should assist with this.

From conversations with care group staff around local M&M meetings, there was variable understanding of the trust's corporate mortality arrangements including the case record review process and the availability of an associate medical director for support/advice and awareness of the MMC. Those that were aware of the role of the associate medical director in LfD spoke very highly of his commitment and the support he provides to his clinical peers. The chief medical officer may need to consider how it improves the profile, attendance, and wider understanding of the MMC and the valuable work it is capable of. The introduction of the medical examiner role and the changes to current arrangements this will involve may present an ideal opportunity to communicate more widely with staff.

7.1.5 Deaths of those with a learning disability

From reviewing reports and discussions with staff, the review team noted that inpatient deaths of those with learning disabilities were being referred to the local Learning Disabilities Mortality Review Programme (LeDeR) for detailed review. The reviewers were told that the trust is not receiving feedback for learning, however, because the LeDeR programme has a significant backlog of deaths awaiting review. This is a potential area for concern as the trust may be overlooking valuable learning opportunities applicable to this cohort of vulnerable patients. All deaths of people with learning disabilities should be subject to an SJR in addition to notification to the LeDeR programme *[ref: p.23 National Quality Board: Learning from Deaths; Guidance for NHS trusts on working with bereaved families and carers]*. The dashboard included in reports to the trust board lacks clarity on how learning disability deaths are being reviewed within the trust. Reference is made to using a 'standard approach' rather than providing assurance that all deaths of those with a learning disability receive an SJR in accordance with the national guidance. If the trust is not conducting a full SJR of these cases then consideration should be given to making these deaths a priority for internal SJR aside from awaiting the findings from the LeDeR programme reviews. Involving the trust's learning disability team in these reviews might prove helpful if this approach is not already in place.

7.2 Trust policy on learning from deaths

A trust-wide policy on learning from deaths is in place, with a review date of March 2018. This policy explains the reporting structure and states that:

- *The Mortality Monitoring Committee (MMC) reports directly to PSQB (sic) and is responsible for coordinating reviews of deaths and mortality signals, and escalating concerns about potentially*

avoidable deaths directly to the risk team for urgent clinical review and possibly serious incident (SI) investigation.

- *The MMC supports clinical teams in their local mortality governance processes to strengthen learning, and supports directly the bereavement office in ensuring timely and accurate death certification.*

The policy requires review and updating to ensure it has taken account of any new national guidance around learning from deaths, including but not limited to National Quality Board July 2018 *Learning from deaths; Guidance for NHS trusts on working with bereaved families and carers* and the recent CQC update. The review team understands that this policy is to be updated in the near future. When making changes to this document it will be useful to take account of the NHSI *Template Learning from Deaths policy, September 2017*, and the *Implementing the Learning from Deaths framework: key requirements for trust boards, July 2017*. Detailed consideration should also be given to how the corporate policy and practice aligns with local policy and procedures around mortality and morbidity meetings at care group level.

8.0 Key findings: mortality and morbidity meetings

8.1 Expectations of a good mortality and morbidity meeting

Mortality and morbidity review is a well-established process within surgical and medical specialties. These meetings provide an opportunity to educate trainees, learn lessons from clinical outcomes and drive improvements in service delivery. There is an expectation that all relevant staff groups will regularly attend mortality and morbidity meetings as a key activity for reviewing their performance and that of their team, and ensuring quality. Mortality and morbidity meetings have a central function in supporting services to achieve and maintain high standards of care.

With the introduction of the learning from deaths guidance in 2017, all trusts are expected to conduct reviews of a proportion of their deaths using case record review methodology, followed by a structured judgment review (SJR) if indicated, with possible escalation to serious incident status for a full investigation where concerns indicate that poor practice or poor care contributed to the patient's death. Trusts are required to produce a quarterly dashboard of all deaths reviewed, including those categories of death where a review is mandated, such as people with mental health problems or a learning disability.

The Royal College of Physicians has published a toolkit that aims to support the implementation of the SJR process to effectively review the care received by patients who have died: *Mortality Toolkit: Implementing SJRs for improvement, v1.3 June 2018*. The objective of the toolkit is to allow learning

and support the development of quality improvement initiatives when problems in care are identified.

The toolkit covers a number of areas where change can be required, including culture, leadership and training. Effective trust and divisional leadership is seen as integral to the implementation of SJRs, with a specific focus on clinical leadership. The toolkit refers to such leadership as being the 'driving force' for implementing and spreading the use of SJR as well as developing the open and learning focused culture needed to significantly influence improvement initiatives within organisations.

The toolkit also provides an example of the operational processes a trust may follow when undertaking an SJR. Within this process, the feedback to specialties/divisions with a clear link to M&M meetings is seen as key, together with strong links to quality improvement/patient safety teams. It should be noted that the content of this toolkit is intended to be advisory rather than prescriptive.

St George's has only trained twelve or thirteen clinicians in SJR methodology. Consequently, it has not been widely rolled out and used routinely when conducting mortality reviews at care group level where concerns around a death have been identified following initial case note review. The report to the Patient Safety & Quality Board, January 2019, however states that SJR methodology continues to be rolled out to specialty teams and that the MMC is keen to continue with this work during 2019.

8.2 Observations

The review team have observed sixteen M&M meetings across the care group specialisms. A list of the meetings can be found in appendix 3 to this report. The team have made an assessment of the practice observed across the following categories: *[ref: Royal College of Surgeons: Morbidity and Mortality Meetings: a guide to good practice, November 2015]*

- The quality of preparation and organisation of meetings
- How well supported and attended meetings were
- The types of behaviours that participants displayed and if they ensured discussions were held in an open and inclusive atmosphere
- How cases for review were selected
- The quality of the presentation and discussion of cases

- The use of recognised classification systems in reaching decisions on the assessment of quality of care
- Agreement and recording of actions arising from meetings
- Clear identification of lessons learned and how they were to be implemented

8.3 Summary of findings

Within the cohort of meetings observed, the review team found fairly wide variation in how the meetings were organised and attended. There was an absence of a consistent approach to both the case reviews and the way in which meetings were conducted. A number of meetings did not have a coordinator who supported the preparation and organisation of the meeting, such as helping prepare slides, book rooms, create attendance lists and take notes for dissemination to members and others. This was a recurring theme and a number of clinicians shared with the reviewers their frustration that they needed to use junior doctor time or their own time in order to make these meetings happen. Using junior doctors to prepare cases is seen as good practice for their individual development; however, it should be recognised that time to enable this should be protected. In one instance, it was identified to the review team that there is a lack of consistency and parity in the amount of support and resource available to those undertaking a clinical governance lead role at care group level. The team observed that this was putting considerable pressure on some individuals.

Individuals shared concerns that there was insufficient time allowed to deliver and expand their clinical governance lead role, which meant that they are often using their own time to prepare for meetings, 72-hour reports, attend the serious incident review group and prepare for coroners' cases. This was felt to restrict the opportunities to benefit from pro-active learning rather than limiting their activity to reflecting when things go wrong. Despite the resource challenges, the quality of preparation and presentation was generally good.

In general, the review team concluded that meetings are happening regularly and on schedule, although a small number were deferred to a later date when attendees could reconvene. The meetings tended to be held early in the morning (at 0800) or in the middle of the day. Meetings appeared to be popular with staff and well attended, and in most cases all staff were given an equal voice in the discussion, although this was not always the case. There was one meeting where the style of presentation was somewhat pedestrian, with little audience engagement encouraged; any discussions were dominated by a small sub-set of attendees. Nurses and junior doctors were not present at some M&M meetings and were in the minority at others. In some cases it was explained

that they could not be released from their ward commitments. The absence of protected time was consistently raised with the review team. Attendance at mortality and morbidity meetings by healthcare professionals is an expectation and should be recorded and used for appraisal, medical revalidation, and doctors in training and other healthcare staff.

Case presentations did not generally use a formal presentation methodology such as SBAR (Situation, Background, Assessment, Recommendation) or a systems approach to setting out the human, system and patient factors taken into account as part of the review. Some meetings used a formal grading classification system for grading adverse events and quality of care, such as the Clavien-Dindo system. This system is widely used throughout surgery for grading adverse events, e.g. complications which occur as a result of surgical procedures, and has become the standard for many surgical specialties. None of the meetings observed referred to the use of the Royal College of Physicians national mortality case record review process and structured judgement review (SJR) methodology. St George's was a pilot site for during the introduction of this process in 2017. The SJR case note methodology is an evidence-based methodology for reviewing the quality of care provided to those patients who die. The Royal College of Physicians publication *Using the structured judgement method: A clinical governance guide to mortality case record reviews, 2016,* describes the key criteria for this methodology with scoring 1 to 5. The SJR methodology is one such approach that has been rolled out through training delivered by the Royal College of Physicians over the past two years or so. Other approaches exist, such as those based on the PRISM methodology (preventable incidents, survival and mortality) and the NCEPOD grading system (national confidential enquiry into patient outcome and death). One meeting was seen to use only 'expected' versus 'unexpected' and in others no formal classification system seemed to be applied.

The review team was told that, due to lack of engagement and resource pressures, Dr Foster metrics (day case, length of stay, readmissions, mortality) are no longer routinely sent out to divisions. Although access to Dr Foster data is available to all clinical teams and is captured in reports to the MMC and upwards to the board, consideration may need to be given as to how this is used at a local, directorate and divisional governance level.

In many cases, all deaths within the service were reviewed, which is good practice as opposed to applying a selection methodology. Triangulating Dr Foster data with local M&M review findings would however be further good practice.

Whilst there were some positive examples of morbidity cases being discussed at meetings to gather alternative views and share learning, this was not universal, with a predominance of cases presenting relating to patient deaths.

Attendance at meetings was variable depending on the size of the care group, but there was a sense that clinicians in attendance really valued the opportunity to discuss cases of mortality and morbidity with their colleagues.

An area for particular attention is the recording of agreement within the group on the learning points and actions arising from meetings. This was captured in a few instances and was dependent on the level of administrative support available. Where lessons learned were identified it was not always clear how this was to be shared or changes implemented. Notes were provided following some meetings but not all.

Meetings were generally held in an atmosphere of openness and inclusivity. There were some particularly notable examples of good practice from the stroke quarterly meeting and the combined emergency department and cardiothoracic ICU monthly meeting. In another example, however, the chair of a meeting did not encourage discussion and was seen to shut down any potential conversation and talked over colleagues. This prevented decisions being taken and some important points that individuals raised were not captured.

There was very little evidence that M&M meetings were being organised or conducted using a trust-wide agreed approach or methodology. The majority of meetings were run by extremely motivated and capable clinicians who had designed their own bespoke approach to running an M&M meeting. No evidence of a corporate trust-wide policy or procedure was found during the review, and some clinicians were not aware of the associate medical director for LfD role or the presence of a mortality monitoring committee, as mentioned earlier in the report.

8.4 Areas of good practice

Below are some areas of good practice from the review team's observations. These should only be considered as examples; there were areas of good practice in all of the meetings observed.

- **SNCT neurosciences/stroke**

The review team attended the SNCT quarterly neurosciences M&M meeting that included stroke and neurology. The meeting was well attended. The consultant stroke physician gave a presentation

she had given to the UK stroke forum in December 2018. This is an example that may be useful for sharing as part of the implementation of any improvements. The reviewers heard that the associate medical director for LfD worked closely with this group and had been involved in the resulting improvements in the stroke service.

- **Combined emergency department (ED) and general intensive care unit (GICU)**

The review team observed a joint mortality review meeting between ED and GICU teams. These teams regularly review patients who have died where both teams have been involved in the care of and decision-making process and where there are the greatest opportunities for learning. Reviewers were told that this is held monthly and 'we've been doing this for years'. There were sixteen members of staff with a mixture of seniors, juniors, intensivists and ED doctors at the meeting. The presentation of cases was of a high quality and took very much a teaching approach, engaging with and involving all of those present. There were some excellent conversations around the social and personal impact regarding one of the cases discussed that involved a patient who had survived. Family and patient interaction was consistently well described. The involvement of an independent mental capacity advocate was referred to and a candid discussion took place around the challenges of having 'difficult conversations'. The recording of a treatment escalation plan (TEP) and do not attempt to resuscitate (DNAR) was included in discussions and there was good reflection on the decisions made for each patient at the time. The only area for improvement would be the involvement of a wider staff group that included nursing staff.

- **Vascular service**

The vascular care group lead and recently appointed governance lead are in the process of implementing a new approach with their clinical governance meetings, moving towards a more integrated model. They have allowed more time for this meeting (three hours), which includes a section for consideration of mortality and morbidity reviews. These meetings take place on a rolling programme on Tuesday mornings with protected time from clinical work. The review team observed the first of these meetings and although there was some difficulty with the room booking, the meeting was well attended, well planned and chaired, with individuals engaged and contributing. The review team recognised this change is at an embryonic stage but is likely to demonstrate an approach that could work well as it develops and embeds under the current leadership.

8.5 Areas for development

Other meetings that were observed showed a mixture in quality of practice from which the following themes were observed:

- some evidence of chairing skills that would benefit from development in order to keep discussions on time and encourage open and honest debate, give an equal voice to all participants, and capture the shared purpose of learning
- absence of junior doctors – 'busy on wards'
- absence of nurses – 'busy on wards' or when in attendance, appeared reluctant to contribute to discussions
- no discussion of local Dr Foster data
- patient information non anonymised, e.g. initials and date of birth used to identify patient
- no administrative support
- no notes distributed to attendees or evidence of attendance lists being taken
- some inconsistencies in the use of formal grading classification systems when drawing conclusions
- in one adverse incident presented the focus was on the possibility for litigation rather than learning from the event

The review team were unable to observe the renal transplant three-monthly mortality review meeting. The clinical lead explained that the meeting that was planned for observations was cancelled because there had been no deaths to review. The review team subsequently met with the clinical lead to better understand this response. They were told that the only deaths that would be reviewed in this meeting were deaths that occurred during the transplant process. Deaths of patients awaiting transplant, or those patients post-transplant who subsequently died, would be reviewed as part of the renal M&M. Unfortunately the review team was unable to observe the M&M meeting for the renal care group to explore this further and establish how the renal service and renal transplant mortality review processes consider the entirety of the patients' journey. Another example of this relates to gynaecology, where clinical staff who refer cancer patients to a specialist cancer service elsewhere are not invited to join their MDT or M&M meetings. This is an area that may require further exploration.

9.0 Key findings: multidisciplinary team meetings

Multidisciplinary team (MDT) meetings provide a forum for clinicians working within a homogeneous treatment group, such as a cancer tumour group, to refer their patients for

discussion and treatment planning. The primary intent of the MDT meeting is prospectively to review individual patients, considering the diagnostic and treatment aspects of the patient's care and make recommendations on best management based on evidence. Factors which have been identified as enhancing the effectiveness of MDT meetings include, but are not limited to, a positive team environment, clear meeting goals and strong leadership.

Having regular MDT meetings helps to improve discussion between members and enhances communication flow across treating teams and facilities. Team members are better able to monitor treatment variations and advise others regarding evidence based guidelines. MDT meetings should provide education opportunities, and the collegiate workings of the MDT can add to the wellbeing of individual team members.

9.1 Expectations of a good multidisciplinary meeting

The development of the MDT process across cancer services is well advanced both nationally and internationally. The work done in recent years on this process was designed to address the following:

- diagnostic assessments made by generalists rather than specialists
- staff often working in isolation without direct discussion between professionals
- absence of collated information making audit virtually impossible
- communication with patients often poor, as was communication between primary, secondary and tertiary care

Cancer services have therefore led the way in terms of setting out the characteristics of an effective MDT and the expected outcomes for patients. The document by the National Cancer Action Team: *The Characteristics of an Effective Multidisciplinary Team (MDT), February 2010*, together with other published sources, have been used to set the scene for the review and provide a framework for the evaluation of the quality of practice observed at St George's.

Multidisciplinary team meetings aim to ensure that a specialist team that incorporates the necessary knowledge should review the care of all patients; skills and experience to ensure high quality diagnosis, treatment and care to ensure that all patients have the benefit of the range of expert advice needed for high quality care.

The MDT meeting therefore is about considering the patient in a holistic way, and not just about the treatment of their presenting complaint or condition. To support this, an MDT should take into account the patient's views, preferences and circumstances wherever possible.

An MDT makes recommendations and can only be as good as the information available to the MDT present at the meeting. For this reason, the availability of investigation results, pathology slides, and radiology images and patients records at the meeting is essential. The final decision on the way forward needs to be made by the patient in discussion with their clinician. Any significant differences between the recommended plan for the patient and the ultimate decision agreed should be fed back to the MDT so that all members have the opportunity to review and learn from these cases.

According to the same document by the National Cancer Action Team, effective MDT working should result in:

- treatment and care being considered by professionals with specialist knowledge and skills in the relevant aspects of the conditions being discussed
- patients being assessed and offered the level of information and support they need to cope with their condition
- continuity of care, even when different aspects of care are delivered by different individuals, teams or providers
- good communication between primary, secondary and tertiary care where applicable
- adherence to national and local clinical guidelines
- good data collection for the benefit of the patient and for the purposes of audit and research
- improved equality of outcomes as a result of better understanding and awareness of patients' characteristics and through reflective practice
- promotion of good working relationships between staff, thereby enhancing their job satisfaction and quality of life
- opportunities for education/professional development of team members (implicitly through the inclusion of junior team members and explicitly when meetings are used to devise and agree new protocols and ways of working)
- optimisation of resources – effective MDT working should result in more efficient use of time which should contribute to more efficient use of NHS resources more generally

The purpose of the MDT and its expected outputs should be clearly defined locally and there should be agreed policies, guidelines or protocols in place to guide staff towards how the MDT is expected to operate. Policies should include how the MDT assesses its own effectiveness including benchmarking itself against similar MDTs. This approach is well developed in cancer services and is embedded at St George's for this cohort of meetings. The review team were told that a mixture of internal and external peer reviews of cancer MDTs are to be conducted in 2019. External reviews for lung and skull based cancers had been completed; head and neck had been delayed with document submission planned for June.

The reporting process for peer review of cancer was explained; these reports go to both directorate and divisional governance board meetings. Escalation to the PSQG is on an exceptions basis. The review team also saw evidence of the national peer review for the breast screening service as part of national peer review. The national guidance was co-written by the lead for breast screening at St George's and was highlighted as a best practice example in this regard *[ref:* Public Health England: *NHS Breast Screening Programme clinical guidance for breast cancer screening assessment. NHSBSP publication number 49 Fourth edition November 2016]*

9.2 Observations

The review team observed fourteen MDT meetings across various care group specialisms. A list of the meetings can be found in appendix 3 to this report. The team have made an assessment of the practice observed across the following categories: *[ref:* The National Cancer Action Team: *The characteristics of an effective multidisciplinary team, February 2010]*

- the constitution of the multidisciplinary team
- meetings attendance
- teamwork and culture
- patient-centred clinical decision-making
- infrastructure for meetings
- clinical governance: mechanisms and monitoring
- organisational support

9.3 Summary of findings

One meeting was cancelled and there was another where the team were not informed of a change of venue. The reason for cancellation of a meeting related to the availability of a key member of staff. The reviewers were unable to ascertain if this weekly meeting was to be rescheduled to

happen later that week, or what happened to the patients whose care was not discussed. Good practice would be that there is a contingency arrangement in place should a key member of the MDT be absent for whatever reason rather than the meeting being postponed or cancelled.

There were variations in the quality and structure of the meetings observed. Those meetings that are working to a well-established framework, such as cancer tumour-site MDT meetings, were found to be meeting most of the key criteria expected, with some examples of best practice seen. For example, the review team saw evidence of effective leadership, team working and culture with opportunities for good teaching practice for junior staff. The team also saw evidence of a patient-focused holistic approach to the patient under discussion and this was not limited to cancer MDTs. For example, at the perinatal MDT, a case involving an expectant mother with learning disabilities was discussed, and there was consideration given to the impact on the whole family of any decisions or recommendations being made, and the support they would require. This was enabled by various disciplines being present who had been in contact with the patient or brought their experience from similar cases, and who therefore made a valuable contribution to the patient-centred discussion. There was good knowledge of not only the clinical circumstances but also of wider social challenges for this person and their family which resulted in a clear pro-active way forward for this woman and her family.

Generally, the referring doctor presented their case(s) for discussion and other members of the MDT where their input was required. Mature team working was evident in many of the meetings observed, resulting in patient-centred clinical decision-making. This contrasted with other meetings that appeared somewhat chaotic, with individuals joining and leaving the meeting at various points, and side conversations taking place, causing a potential distraction. It is not necessarily inappropriate for staff to attend for a short period of time where their input is limited to a small number of cases. It is helpful to structure and plan meetings, wherever possible, to minimise this. The quality of the chairing of the meetings often dictated the effectiveness of the discussions and the recommendations achieved.

For cancer tumour-site MDTs, it was clear that the MDT co-ordinator was recognised as a core member of the team; they were seated within the room where they could hear and see everything that they needed to capture decisions and recommendations for each patient. Some non-cancer MDTs had a co-ordinator presence, but this was not consistent across all MDTs. Similarly, in some cases, the patient electronic record was updated in real time, which would be considered as best practice; however, this was not comprehensive across all MDTs.

There was one specific example observed where the wider team supported the coordinator to complete their records accurately. Discussions were halted between cases until the coordinator had rung a bell, indicating they had completed their notes and could give their full attention to the next case.

Given the value that a dedicated MDT coordinator adds to the effectiveness of MDT meetings this is an area that the trust may wish to review and address. The resource impact of providing an MDT coordinator for each care group MDT will not be inconsiderable.

Registers of attendance were observed as being in place at most meetings with members signing in and out, but timings were not routinely captured. The best example of use of attendance lists was where the sheet was pre-populated with the names and designations of those expected to attend; this was then countersigned by attendees as they arrived. Generally, the review team member(s) observing were introduced to team members and their details included on the attendance list. There was a small number of occasions when the observer's attendance was not anticipated and their presence was not questioned by the group. More than once the member of the review team observing was handed the list of patients being discussed, which contained detailed and confidential information. They were not always asked to hand this in at the conclusion of the meeting.

Team working and culture of the MDTs was for the most part inclusive, with encouragement of individuals to contribute to the discussion and different opinions valued. There were instances where requests for clarification were sought and responded to. For example, the team observed an MDT where the team maintained a quiet and calm demeanour throughout and where agreement on the decisions being reached was pro-actively sought.

There were other meetings where this did not take place, and where discussions were dominated by senior clinicians. It was not always clear who was chairing the meeting, or responsible for the overall running of the meeting and providing a verbal summary/overview at the end of each case discussion to confirm consensus and provide an opportunity for further questions to be raised. As expected, there was a mixture of people presenting the cases, and the chairing responsibilities seemed to shift to the individual presenting at any given time, contributing to a lack of clarity as to the structure of the meeting.

An important aspect of achieving an effective MDT is to have suitable infrastructure and resources available to support the team. Although there were no dedicated MDT rooms within specialties, the trust has seminar rooms that appear to be set aside for MDT use. They are in a quiet location (often in the basement) and suitably soundproofed to ensure confidentiality. Not all rooms were of a suitable size to accommodate the wider MDT membership. For example, juniors were not invited to one MDT observed due to a combination of lack of space and the pace of the meeting not being supportive of learning for them. Another MDT was held in an outpatient clinic treatment room where staff had to stand and huddle around a desktop computer screen to view images.

Most rooms used had access to equipment for projecting and viewing radiology images, specimen biopsies, and also to retrospective pathology reports. Access to live electronic patient records was observed to be limited. In most cases, a coordinator or clinician recorded the decisions/recommendations in longhand or on screen to be uploaded retrospectively to the patient record. This increases the risk of transcription error and does not allow the team to check in real time how decisions are being captured. The delay in uploading information to the electronic patient note system was highlighted to the review team as an area of potential patient safety risk.

There was one occasion where the venue regularly changed mid-meeting to access different communication systems, causing some disruption to attendees, and another where the meeting was curtailed due to over-booking of the room. The review team observed examples of meetings where facilities for video-conferencing and sharing of images failed to operate for all or part of the meeting. Clinicians raised this with the review team as a regular problem, although the issue was not always with the St George's system but rather the other trust being communicated with. Where this happened, there was not always IT expertise available to resolve the issue within the duration of the meeting.

A very high proportion of the MDT meetings observed began at 0800 and finished by 0900, to enable staff to attend their other duties, be they theatres, outpatient clinics or ward rounds. In other cases the MDT lasted all morning and attendees appeared to have protected time for these meetings. Another variation was MDT members attending between 1230 and 1430 rather than having protected time within their core hours. It is appreciated that core hours will be locally agreed and therefore these timings may be considered acceptable within the trust.

The reviewers were told by one care group lead how they ensure all MDTs requiring their input are attended and prepped fully. This requires a significant amount of staff time – currently 28 PAs

per week (112 hours) and it continues to grow as specialist consultants are employed without business cases for support from others, for example radiology, histopathology and pharmacy. An example of radiology input to one significant MDT is in urology, where regularly there are 70 patients reviewed weekly, each needing their results ready for the MDT the day before, as well as a radiologist attending to report and offer their opinion, as required. Not all of this time is possible to job plan due to the total number of radiologists employed, so is done in their own time. We observed pathologists attending at the same meetings, side by side with the radiologists, and assume this issue is similar for them.

The impact on clinical support services such as pathology, radiology and pharmacy of introducing additional MDT meetings, needs to be considered, particularly when developing new clinical services.

It was clear during the MDT meetings observed which patient was under discussion and the reasons why. Test results/images/samples and appointment dates were seen to be available, along with access to radiology and pathology information for the patients discussed.

The team did not see any specific evidence that when there were significant changes to their decisions/recommendations within the MDT, for example once the clinician had met with the patient, that this was fed back to the team for review and learning if appropriate.

There was no evidence of a trust-wide approach to the way in which MDTs are expected to operate, for example, a policy, guideline or standard operating procedure, which sets out the purpose of the MDT and defining the trust's expectation regarding outputs. The review team were provided with a draft *operational policy for cancer quality surveillance process (formerly peer review)* document. The draft policy describes both the internal and external peer review process and expected outcomes. It also includes how serious concerns/risks identified during the process will be escalated to the trust executive and others, as appropriate.

There is also a draft standard operating procedure (SOP) for Cardiac Surgery MDTs; this appears to be a stand-alone and bespoke guidance document designed to address a specific specialism and treatment pathway. The SOP as it stands is not transferable to other areas, but, in conjunction with the policy for cancer quality surveillance, it could be used as a basis for the development of a trust-wide MDT policy supported by local, specialty-specific standard operating procedures.

The review team did not find any prior evidence of any internal or external audits having been undertaken of processes, outcomes and review of data to confirm that treatment recommendations match current published best practice that may lead to improvement actions.

10.0 Mapping of the trust's mortality and morbidity and multidisciplinary meetings

As part of the terms of reference, the review team was tasked with providing a map of divisional MDTs and mortality and morbidity meetings, and to identify any gaps. Information on when, where and frequency of these meetings was not universally held in any corporate function or within the divisional structures. Those who were expected to attend as well as others working in the specialist area knew about meetings. In one case there was a list on the door inviting students to attend the MDTs (although the information on the list was inaccurate). There were some notable exceptions, one of which was radiology services, where a detailed record of all meetings attended and by which team members was maintained. Another example was the pharmacy service.

Various individuals, particularly the divisional governance managers who helped to gather their divisional and care groups' information, assisted the review team in this task. The outputs from this element of the review can be found in appendix 5 of this report. This should provide the chief medical officer and each of the divisional chairs a reasonably comprehensive list of the key meetings. It is important to understand that it may not represent a full profile of meetings or guarantee that they did or do take place. For example, members of the review team were scheduled to attend meetings themselves, and a small number were either cancelled at short notice or did not take place.

The table should be a useful resource for the chief medical officer when undertaking job planning, by providing evidence of the time taken by doctors in preparing for and attending these meetings.

From the information in the mapping tables it is evident that a great deal of activity takes place. It was apparent that these meetings are largely well attended by key personnel, students and juniors. The chief medical officer and divisional chairs should take some reassurance from this. However, there are some gaps in the tables; this does not necessarily mean the meetings do not take place – just that the review team have not been able to obtain that information or have been unable to fully interpret the information provided. The yellow highlights on the tables refer to gaps in the detail of meetings that are in place, such as time and venue. The green highlights identify gaps where the review team believe there should be a record of a meeting. This is an area that the divisional chairs

may wish to explore in more detail with their care group leads. They may also want to consider how they use this information as part of their governance systems to gain assurance that meetings are taking place and that learning from these meetings is shared and effecting change in practice.

11.0 Other observations

The purpose of this review was not to evaluate the governance arrangements at the trust beyond those relating to mortality and morbidity, and the MDT process. Through this work, however, the review team observed meetings other than those focused exclusively on mortality and morbidity, and MDTs. From those meeting observations, individual discussions, and wider document review, the team has gained some insight into the wider trust governance arrangements. This section of the report takes account of this, which may be helpful for the organisation to consider.

11.1 An effective ward to board governance structure

Most NHS trusts find the development of an effective assurance flow of information from ward level to the board a demanding task. The multiple clinical and/or quality related forums that exist in NHS trusts between an individual ward and the board, together with potential for inconsistency in the way that they report and provide assurance, presents a continuous challenge to executives and non-executives alike when considering the reliability of the information provided to them. Although each organisation is unique, there are commonalities that cut across providers in terms of creating an effective governance and assurance structure, from ward to board. A useful document for trusts to help them address some of these challenges is NHS Providers*: TDA ward to board assurance, 2015*

11.2 Ward to board governance at St George's

11.2.1 Meetings infrastructure

The review team were only able to consider some limited information of the trust's representation of its corporate groups and committees that make up its ward to board governance and assurance structure. The information was provided in a diagram that attempted to describe this structure but did not include sufficient detail to provide a complete picture.

It appears from this information that a resuscitation committee does not form part of the ward to board assurance/reporting structure. Furthermore, the team was told that the trust does not have a corporate clinical effectiveness/audit forum and has not had this function for some time. Currently, the PSQG agrees the annual clinical audit programme and will receive a six-monthly update on progress. National audits are reported to PSQG and some local audits are received as part of other work, such as NEWS, LocSSIPs and falls. Given the extremely wide remit of this one

group and lack of medical representation, it may be worth considering if it has the capacity to give clinical audit and effectiveness the attention it requires. The trust may wish to consider altering its structure to reduce pressure on this group by instigating sub-groups aligned to the Darzi headings of patient safety, patient experience, and clinical effectiveness, to do the 'heavy lifting' for what needs to be a more strategically-focused forum.

On the ward to board clinical governance structure the MMC is reporting to the board on the LfD framework through a number of layers. Consideration may need to be given to whether this is at the appropriate level to provide adequate board assurance or whether there should be a shorter line of reporting.

11.2.2 Assurance reporting

A large number of documents and reports were reviewed that support the wider clinical governance arrangements at St George's. These included divisional reports to the PSQG and TEC, two serious incident reports, retrospective review and analysis from serious incidents (quarterly), complaints and PALs reports. For each of these, the review team observed positive examples of connection between the information coming from divisions and that from the corporate process. Reports and documents were well-presented and made good use of diagrams and photographs rather than relying solely on narrative. Introducing a heat map approach when triangulating intelligence from the various strands of clinical governance may help further highlight areas of particular concern. Mortality review was not explicitly used when correlating patient safety or experience themes and learning.

The team observed that committee and board reports were generally well constructed with front sheets setting out the purpose of the report, and an executive report to guide the reader. The amount of effort put into this area of governance at St George's is clearly considerable. It should be noted that this was outside the scope of this piece of work and the team have therefore not undertaken an in-depth review of these reports for quality of content.

The trust may wish to examine whether it is placing too much reliance on individuals rather than robust systems and processes. And conversely, ensuring that systems and processes enable individuals to perform well within their designated role.

11.3 Assurance versus reassurance

From the totality of the information and evidence gathering as part of this piece of work, the

review team reflected on how the trust might strengthen its assurance arrangements. For example, understanding the difference between assurance and reassurance is vital in supporting the trust board, committees and groups, including the divisional boards, to provide the right information and data so that it is clear what action may be required and enable these to be monitored. Reassurance is founded on high levels of trust in an individual (or sometimes a process), often based on personal experience or knowledge. It is characterised by 'trust me, it's all ok' whereas assurance is characterized by having confidence that it is 'all ok' because there are several different sources of information that suggest it is. Assurance is a report on what is happening (data) providing evidence sourced from multiple places (interpreting the data, identifying the facts and what needs to be done) thus enabling an informed judgment to be made.

In considering its own board and divisional assurance arrangements, St George's may give some thought to the three lines of defence approach.

The Chartered Institute of Internal Auditors papers on Governance of Risk*: Three lines of Defence [Dec. 2015]* suggests that the effectiveness of an organisation's risk management framework depends upon the board and senior management being able to rely on adequate line functions – including monitoring and assurance functions within the organisation. The 'three lines of defence' is a model as a way of explaining the relationship between these functions and is a guide as to how responsibilities should be divided:

1. **First line of defence** – functions that own and manage risk (operational management, divisions, corporate functions); responsible for assessing, controlling and mitigating risk)
2. **Second line of defence** – functions that oversee or specialise in risk management (compliance, risk management, quality, IT, financial controls); responsible for monitoring risk and reporting adequate risk related information up and down the organisation)
3. **Third line of defence** – functions that provide independent assurance (internal audit, external audit, regulator); provides assurance to the trust board and its committees on the effectiveness of the first and second lines of defence.

This is a useful model for the trust to consider in strengthening risk management and assurance processes.

11.4 Links between the serious incident and mortality review processes

The review team met with the associate medical director for serious incidents and observed a meeting of the serious incident decision meeting (SIDM) that is held each week. The team also reviewed two serious incident reports. The chief nursing officer and associate medical director for

serious incidents jointly chair the meeting. The meeting observed was chaired by the chief medical officer in the associate medical director's absence. The style of meeting may therefore have differed as a result of this, and the group may want to consider the learning from a fresh approach.

The review team observed that the process worked well in terms of escalation of incidents for review; review of 72-hour reports; decision making on status of the investigation required; and the quality of presentations and investigation reports. The terms of reference for the SIDM include receiving assurance on the discharge of duty of candour and family engagement. The review team saw examples of good engagement with families as part of the mortality review and serious incident process. They also heard from one division that families seldom wish to receive a copy of the final report. This is considered uncommon and the trust may want to ensure it is appropriately engaging patients and families from the outset when an adverse event occurs. The duty of candour as set out in regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) 2014 is only effectively discharged when the findings from the investigation have been shared, unless the trust captures evidence that the patient or their family has declined. The team noted that compliance with this regulation was proving a challenge at the time of the review.

A monthly governance newsletter is published that goes to all care group and clinical governance leads that includes 'key learnings' and 'incident of the month'. The current readership is between 400 and 600 staff.

In terms of the interface with the mortality review process, the review team were told it was not always perfect but overall the serious incident panel agree with the SJR outcomes and this is seen as a great asset within the trust. The quality improvement work around reducing the incidence of fractured neck of femur incidents was cited as an example of effective joint working. Reviewers were told that the associate medical director for serious incidents and the associate medical director for LfD work closely and collegiately.

From these discussions and observations throughout the review, the team concluded that the trust has yet to embrace formal quality improvement (QI) techniques to support a consistent approach to learning and improving when things go wrong, or when the need for improvement is highlighted. The review team believe there is work underway to set up a QI academy with appropriately trained staff. Including human factors training in this improvement workstream could be beneficial. The review team heard that quality improvement projects, such as that for sepsis, were being

compromised because the improvement work was not sustained over a sufficient period to fully embed changes in practice.

The review team received copies of serious incident reports following the deaths of patients who were lost from the patient tracking list (PTL), resulting in delays in their treatment that the harm review process concluded contributed to their deaths. The associate medical director for LfD was not aware of these two cases. Reviewers did not pursue whether this was because the deaths had not been screened or if they had been screened but not escalated for an SJR. The trust has developed a harm review process following the identification of a significant patient waiting list issue. Involving the associate medical director for LfD in the harm review panels may add important expertise to this process. There were other areas where reviewers expected to see closer working, such as the deteriorating patient QI Programme (QIP) lead and her attendance the mortality monitoring and resuscitation committees. The team were told that the QIP lead has a good relationship with the resuscitation team lead but does not get involved in the resuscitation committee. The review team believe the deteriorating patient QIP lead is a key stakeholder in this group and potentially the mortality review committee. The trust may want to review its resuscitation committee arrangements against resuscitations council guidelines and consider where this forum fits within its ward to board clinical governance reporting and assurance structure. The guidelines can be found at: https://www.resus.org.uk/quality-standards/acute-care-quality-standards-for-cpr/#resuscommittee

11.5 Management of the deteriorating patient

There is no critical care outreach team at St George's to provide support to staff managing patients who deteriorate on the wards and in other areas. The team have been told that this is being addressed through the trust's quality improvement plan: deteriorating patient workstream, which is one of the trust's priorities for 2018/19.

11.6 Governance capacity

The trust has a devolved governance structure with each division, free to devise their own support arrangements, resources, systems and processes. The team observed that divisions had different approaches to their divisional governance. This seemed to work better in some divisions than others. There appeared to be little interface between the divisional directors of nursing and governance, and their governance managers, with the central (corporate) quality governance team. This could lead to duplication of effort and opportunities for sharing good practice may be missed. Reviewers also noted that the central quality governance team is small for the size and scale of St

George's. For example, the risk team was applauded for their work in supporting the serious incident decision meeting (SIDM) and chasing outstanding actions, but a question was raised as to whether they had the capacity to support 'deep learning'.

The reviewers also heard that there has been insufficient capacity within the central risk team to keep up to date with version developments in the Datix risk management system. This may be inhibiting its functionality and the quality of information that users can extract, as well as preventing the introduction of additional modules as they are developed, which includes one for mortality review. St George's is currently in the bottom quartile for the numbers of incidents reported according to the NRLS (national reporting and learning service) database when benchmarked with similar trusts. Staff told the review team that the limited resource in the team means that NRLS uploads are not undertaken within the advised timeframe and this can impact on reports if other trusts are uploading in a more timely way. This is an area that may warrant a separate piece of work.

The team observed that the chief nursing office and the chief medical officer work closely together on quality (clinical) governance. The corporate quality governance resource, however, sits within the nursing directorate, including the clinical effectiveness team who support the mortality process. The chief medical officer is not similarly supported and this should be recognised in a trust the size of St George's and with such a large consultant body. A more integrated model of clinical governance between the chief medical officer and the chief nursing officer's teams would help address this. The specific needs of the chief medical officer are perhaps an area for consideration within any proposed changes.

12.0 Conclusions

From the recent CQC Learning from deaths report it is clear that their well-led inspections have had a focus on the implementation of the learning from deaths guidance and how trusts engage with families and gain learning when people die in their services. CQC inspections are likely to continue with this focus, as well as how trusts make the links between the strategic well led element and findings from its core service reviews. This will be particularly relevant for showing how learning is acquired from local mortality review and other clinical governance threads such as incident investigation and application of the duty of candour. The findings from this review should provide St George's with some level of assurance and insight into where it is on its journey towards fully implementing the learning from deaths guidance. It should also provide some assurance that M&M and MDT meetings are functioning in the way expected to a greater or lesser degree. It is

important to note that this review is a snapshot in time and based on a sample of the many meetings that take place.

The greatest learning from this review is the need for the trust to focus on establishing strong frameworks, systems and processes to support these strands of work, and the ongoing implementation of the learning from deaths framework. This will shift the focus of assurance (or reassurance) from high performing, motivated individuals to a robust ward to board clinical governance process. This should in turn provide such enthusiasts with the support and recognition to conduct their roles effectively and appropriately within a wider structure. Placing overreliance on individual members of staff can lead to a lack of resilience in the governance infrastructure, introducing a level of risk within the organisation. This model can also unintentionally create a culture of dependency and may even disempower others from taking responsibility for their own areas of governance or practice.

Overwhelmingly, the review team found the divisional leadership team to be well engaged with the review and recognised the value it could offer them in strengthening their internal governance arrangements. The review team met a wide range of staff who were enthusiastic, highly motivated, with an energy to do things well. There was, however, an observation that the trust has a medical hierarchy and questioned whether there was parity between nursing, allied healthcare professionals, and the medical body.

As part of this review the team were not tasked with undertaking a cultural assessment of the organisation. In observations and discussions, however, there were frustrations expressed, particularly around the availablity of resources. There is an appreciation that the trust, like many other trusts, is experiencing financial and capacity challenges. There was a real pride in the services being provided, although there was a perception that some of these challenges were barriers to St George's being the best that it can be.

13.0 Recommendations

These recommendations are the result of a high level of distillation from various observations made in the full report. There are a number of other observations and comments in the report that underpin these recommendations and should be taken into account when developing a response to this review.

Mortality and morbidity/MDT meetings

1. It is recommended that a mortality strategy should be developed that incorporates all the various strands of the learning from deaths framework, with a clear focus on improving the quality of clinical care and preventing avoidable patient death.

2. The chief medical officer should consider how the interface between the new medical examiner system (when implemented) and the learning from deaths framework will operate at St George's to ensure independence of the medical examiner's role is maintained as intended within the latest guidance.

3. The forthcoming review of the learning from deaths policy should ensure that it encompasses all relevant new national guidance with particular focus on:
    - how bereaved families are engaged and supported and consideration of the involvement of a patient reference group in the development of this policy
    - strengthening the role of the mortality monitoring committee in delivering its aim to support clinical teams in their local mortality and morbidity governance processes.
    - the mechanism for monitoring and providing periodic assurance to the board that the intentions of the policy are being met

4. It is recommended that the role of the mortality monitoring committee is revised so that it has a higher profile within the trust corporate quality governance structure. This should include consideration of how this committee can best deliver the trust's mortality strategy when developed.

5. Develop an overarching trust wide policy for conducting care group level mortality review meetings based on the latest best practice guidance. This will provide a model framework for divisions and care groups to consider best practice in holding such meetings, and how learning opportunities are shared that influence changes in practice.

6. Develop an overarching trust wide policy for conducting care group level multidisciplinary meetings from which local standard operating procedures can be developed based on the latest best practice guidance. The policy should incorporate how each MDT will assess (at least annually) its own effectiveness/performance and benchmark itself against similar MDTs, making use of peer review and other national tools as they become available. The policy

should include how the board receives assurance – positive and negative – on the effectiveness of its MDTs.

7. Design and implement a training needs analysis for those chairing and participating in local morbidity and mortality and multidisciplinary meetings. This should include giving consideration to establishing a community of practice approach with those who chair mortality and morbidity and MDT meetings, involving executive leadership to build relationships and share learning through discussion and activities.

8. It is recommended that as part of the protocol for developing and approving new clinical services consideration is given to the impact a new service will have on clinical support services, particularly in the resource requirement required to attend multidisciplinary team meetings.

Quality governance

9. Consider what changes are required to provide support and resource to the chief medical officer in concert with the chief nursing officer, reflecting their need for an integrated approach to quality governance.

10. Reflect on the organisation's ward to board reporting framework of meetings to ensure that the board continues to receive reliable assurance on the quality (safety, effectiveness and experience) of the services it offers, and that it meets its statutory responsibilities in this regard.

11. Review the corporate quality governance leadership and capacity so that the divisions are supported to provide a consistent and uniform approach in their delivery of the trust's quality governance arrangements.

12. Consider a development programme for the divisional senior leadership team to provide greater understanding and good practice in governance systems and process particularly seeking and receiving assurance as part of the trust's risk management arrangements.

13. Consider reviewing the roles of: divisional chair, clinical director; care group lead; and clinical governance, to ensure that these role expectations and responsibilities are

consistent, clear, well understood, and properly resourced in terms of protected time, support, and development to enable staff to deliver them in line with trust expectations.

14. Consider conducting a medical engagement programme across the trust's consultant body. This will establish a baseline to inform the chief medical officer to consider what other mechanisms might be necessary to ensure the most senior leaders keep in touch with their medical workforce.

15. The trust may want to reflect on the perception that the culture is medically dominated, and consider how it can achieve parity of esteem across all professions delivering clinical services to patients.

Appendix 1

Terms of *ref*erence

Purpose of the review

To examine the safety governance and culture at care group/department level, identifying areas of good practice and highlighting any areas for improvement.

Findings to be reported to the Chief Medical Officer.

Scope of the review

1. Map key meetings, identifying gaps – mortality and morbidity and MDTs
2. Establish trust, local and national quality standards for these meetings
3. Map current assurance processes that ensure basic quality measures are met.
4. Examine current performance by care group/department against expected standards.
5. Examine team behaviours, culture and morale through observation of meetings, selected on a sample basis, and structured interviews.

Appendix 2

Review team profiles and areas of responsibility

Elizabeth Seale, review team member and report author

Elizabeth is an independent consultant with wide-ranging experience in quality and corporate governance, patient safety and risk management. Elizabeth has a successful track record in regulation and inspection, and has held board and operational governance posts in provider organisations. She leads on turnaround programmes in NHS trusts and private providers in breach of licence undertakings, in quality special measures, or facing CQC enforcement action. Elizabeth reviews and supports organisations to strengthen their board governance and assurance structures, systems and processes, and risk management arrangements to strengthen compliance with the CQC well-led domain. Her experience includes leading on independent investigations following serious incidents or complaints. Elizabeth is vice-chair of an academy trust school.

Geraldine Lavery, review team member and report author

Geraldine is an independent consultant providing governance advice and support to organisations. She is a Non-Executive Director for a company providing residential, nursing and home care. She also works as a Specialist Advisor with the Care Quality Commission, providing advice and input for the Commission's well-led regulatory inspections. She has a held an Executive Director of Quality Governance and other senior management roles in both the NHS and in healthcare regulation. Geraldine is experienced in undertaking independent serious incident investigations and governance reviews, supporting organisations to improve in these areas through leadership and management development, implementation of effective governance systems and regulatory compliance. She has worked at both a strategic and operational level.

Wendy Cookson, review team member and meetings map author

Wendy is an MBA, degree nurse who has worked in healthcare for 29 years. For the past 8 years as an independent advisor, she has successfully directed acute and mental health Trusts out of CQC Quality Special Measures. She is an expert in clinical and corporate governance, and a National 'Well-Led' reviewer. As well as her UK work, Wendy has advised on major trauma for an Irish hospital group, healthcare specific training for staff of a global facilities management company, and a global law firm on a clinical risk assessment tool to avoid patient harm. Wendy is a Non-Executive Director on the boards of the 7th largest Trust in the UK, a CIC and a Trustee of small charity in London.

Appendix 3

Reference documents

- Chartered Institute of Internal Auditors: *Governance of Risk: Three lines of defence* (Dec. 2015)
- CQC: *Learning from deaths: a review of the first year of NHS trusts implementing the national guidance* (18 March 2019)
- Healthcare Improvement Scotland: *Mortality and Morbidity Reviews Practice Guide* (Working Version - July 2018)
- Juliet Higginson et al.: *Mortality and morbidity meetings: an untapped resource for improving the governance of patient safety?*
- National Cancer Action Team: *The Characteristics of an Effective Multidisciplinary Team* (February 2010)
- NHS Improvement: *Implementing the Learning from Deaths framework: key requirements for trust boards* (July 2017)
- NHS Improvement: *Template Learning from Deaths policy* (September 2017)
- NHS Providers: *TDA/ward to board assurance* (2015)
- National Quality Board: *Learning from deaths; Guidance for NHS trusts on working with bereaved families and carers* (First edition, July 2018)
- National Quality Board: *National Guidance on Learning from Deaths. A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care* (First edition March 2017)
- Public Health England: *NHS Breast Screening Programme clinical guidance for breast cancer screening assessment.* (NHSBSP publication number 49 Fourth edition November 2016)
- Royal College of Physicians: *Mortality Toolkit. Implementing Structured Judgement Reviews for Improvement* (7 June 2018)
- Royal College of Physicians: *Using the Structured Judgement Review method. A clinical governance guide to mortality case record reviews* (2016)
- Royal College of Surgeons: *Morbidity and Mortality Meetings: a guide to good practice.* (November 2015)

Appendix 4

Meetings observed

Mortality and morbidity

Meeting title	Date
Gynae risk meeting	01.04.19
General ICU	12.03.19
Neuro ICU	12.03.19
Cardiothoracic ICU	29.03.19
Emergency department clinical governance	06.03.19
Emergency department and general ICU combined M&M	27.03.19
Chest medicine	19.03.19
Medical oncology	28.02.19
Percutaneous coronary intervention (PCI)	02.04.19
General surgery	12.04.19
Vascular	29.03.19
Head and neck surgery – joint with Royal Marsden	14.03.19
Maxillofacial surgery	27.03.19
Stroke and neurology – quarterly	22.03.19
Vascular clinical governance	19.03.19
CNST anaesthetic ICU	05.03.19

MDT

Meeting title	Date
Urology cancer	22.02.19 & 27.02.19 (part)
Lung cancer	08.04.19
Gynaecology oncology	25.03.19
Upper gastrointestinal	22.03.19
Adult neurology	29.03.19
Symptomatic breast	13.03.19
Lower gastrointestinal	22.03.19
Breast screening quality assurance	29.03.19
Early pregnancy – acute gynaescan	27.03.19
Complex spine	29.03.19
Haematology oncology	10.04.19
Interventional cardiology	02.04.19
Vascular access	02.03.19
Urology – three-site	22.03.19

Appendix 5

Meetings map

CWDTOCC M&M

Speciality	CD	Care group lead	Governance Lead	Sub Speciality	MMM Y/N	Day and Time	Frequency	Location	Named Lead
DIRECTORATE: DIAGNOSTICS, CRITICAL CARE AND BREAST SERVICES									
Breast	Robert Morgan	Mamatha Ready		Screening 2nd Screening Symptomatic Benign	Y (Included in Clinical Governance Meeting every 2 months)	[Day and time]	[Frequency]	[Venue]	
ICU	Rafik Bedair	Jonathan Ball	Ursula Miskolci (mortality)	General ICU	Y	Tuesdays 8.30-9.00	Weekly	GICU Seminar room, SJW	
				Long-term patients (7 days +)					
				Rehab patients					
		Dominic Spray		Cardio Thoracic ICU	Y	Fridays 14.30-16.00	Weekly	CTICU Seminar room, AMW	
		Ashliegh Sherrington		Neuro ICU	Y	Wednesdays 13.00 (variable)	Weekly	NICU Consultant office or NICU Seminar room	
Radiology		Lakshmi Ratnam			Y (In departmental discrepancy meetings)	[Day and time]	[Frequency]	[Venue]	
Interventional Radiology		Raj Das							
Pharmacy		Vin Kumar (Chief Pharmacist)			n/a				
DIRECTORATE: WOMEN'S HEALTH									
Maternity	Austin Ugwumadu			Perinatal	Y	Monday 13 - 14.30	Weekly		
				CTG	N	[DAY] 12.30-14.00	Weekly		
				Fetal	Y	Wednesday 13.00	Weekly		
				Maternity					
				Obstetrics					
				Obstetric HDU					
Gynaecology	Robert Morgan	Hugh Burns	Suruchi Pandey	Gynaecology					
			Prof. Manyoundea	AGU					
			Kevin Hayes	EPU	n/a				
				Colposcopy	n/a				
			?Mr Ojha	Scan review	n/a				
				Fibroid	N				
Gynae-Oncology	? Should this be in oncology			Gynae-oncology	N				
Neonatal	Sijo Francis	Charlotte Huddy	Donovan Duffy	Paediatrics	Y	Monday 13.30	Monthly	NNU/SCU where there is space	
DIRECTORATE: CHILDREN'S SERVICES									
Paediatric orthopaedics	Sijo Francis								
Acute Paediatrics (acute team)					Y	Various (with ED)	Monthly	[venue]	
Acute Paediatrics (integrated care team)									
Speciality Paediatrics (Respiratory)									
Speciality Paediatrics (Gastroenterology)									
Acute Paediatrics with surgical (renal)									
Acute Paediatrics with surgical					Y	Tuesday 4th of June 2019 (next)	Annually		
Acute Paediatrics (ED)					Y	Various (with med)	Monthly	[venue]	
Acute Paediatrics (Oncology)									
Acute Paediatrics (Haematology)									
Speciality Paediatrics (allergy)									
Speciality Paediatrics (allergy)									
Neurorehab									
Paediatric neurodisability									
Speciality Paediatrics (endocrinology)									
NICU					Y	Wednesday 13.00	Weekly	[venue]	
PICU					Y	Various (with ED and Med)	Quarterly	Clinical Governance days	
DIRECTORATE: OUTPATIENTS									
OUT OF SCOPE									

SNCT M&M

Speciality	CD	Care group lead	Governance Lead	Sub Spec	MMM Y/N	Day and Time	Frequency	Location	Named Lead
DIRECTORATE: SURGERY, MAX FAX, ENT, UROLOGY, PLASTICS									
General Surgery	Tim Bishop	Andrew War	George Vasilik	Lower GI (colorectal)	Y	Friday 8-9	Monthly	Education Centre opposite to Courtyard	
				Upper GI					
ENT		Sarah Little	Rob Harris						
Ophthalmology				LUTS					
Audiology		Elwina Timehan			n/a				
Max Fax		Helen Witherow			Y	4th Wednesday 9.00	Monthly	Max Fax Seminar Room	Helen Witherow
Dental		Ricahrd Porter	Jamie Gwilliam		Y				
Plastics			Catherine Milroy		n/a				
Urology		Marco Bolge	Dav Sharma	Renal					
				Prostate					
				Bladder					
				Penile	n/a				
				Urology (joint)					
Bariatric					?				
T&O		Sham Omar	Magnus Arnander						
DIRECTORATE: CANCER									
Cancer	Nicholas Hyde	Enji Ofo		H&N					
		Matt Lundy		Skin					
				Lung					
		Daniel Jones		Lymphoma					
				Haematology					
				Oncology					
				Liver					
DIRECTORATE: NEUROSCIENCES									
Neurology		Niranjanan Nirmalanan than	Usman Khan	Epilepsy	Y		Quarterly		Usman Khan
				Surgery/Complex					
				Neuro-inflammatory					
				Neuro-genetics					
				Neuro-muscular					
				Movement disorders					
				Neuro-oncology					
				Headache					
Stroke			Gillian Clucky	Vascular	Y		Monthly		Lillian Choy
				Nero-vascular					
Neurosurgery		Simon Stapl	Sam Hettige	Spinal	Y		Quarterly		Sam Hettige
				Neuro-Paediatrics					
Pain Management				Acute	n/a				
				Chronic	n/a				
Neuro-rehab			Sancho Wong		n/a				
Neuroradiology			Andrew McKin	Cochleal Implant	n/a				
				Pituatory	n/a				
				Fetal medicine	n/a				
Neurophysiology					n/a				
DIRECTORATE: MAJOR TRAUMA									
Major trauma	Anthony Hudson		Richard Hartop		Y	Wednesday 10.00	Bi-weekly	5th Floor, SJW offices	Richard Hartopp
DIRECTORATE: THEATRES AND ANAESTHETICS									
Theatres	Sarah-Jane Hammond	Anthony Addei		Theatres and anaesthetics	Y	Tuesday 8am	Monthly (1st Tuesday)	John Parker Lecture Theatre AMW	
Anaesthetics		Elizabeth Wi	Oliver Seyfried						

MedCard M&M

Speciality	CD	Care group lead	Governance Lead	Sub Spec	MMM Y/N	Day and Time	Frequency	Location	Named Lead
DIRECTORATE: CARDIOLOGY CAG AND CARDIOVASULAR									
Cardiology	Stephen Brecker Peter Holt	Raj Sharma	Manav Sohal	EP	Y	Monday (last of the month) 0800	Monthly	Cardiac Rehab Gym	
				Coronary/Valve					
				Intervention	Y	Tuesday (except last of the month) 08.00	Weekly	CCAG seminar room	
				Aortic					
				Heart failure/CMR					
				Echo/Valves					
				Inherited Conditions					
				Heart Failure	Y		3 monthly		
				TAVI					
Cardiac Surgery		Steve Livesey		Cardiac Cardiac aortic Valve	Y	Rotating Monthly Meeting	Monthly	John Parker Lecture Theatre, AMW	Steve Livesey
Peripheral Vascular Surgery		Gary Maytham	Damian Kellehe	Aortic Periphral vasular Carotid surgery	Y	M&M Tuesday 8.00 3rd Tuesday of every month. Part of integerated governance meeting	Monthly	Neuroseminar Room	Prof Holt / Prof Loftus Mr Mo Abdelhamid / Mr Paul Moxey Gary Maytham
Thoracic Surgery		Paul Vaughan	Doug Treanor	Cardiothoracic Pulmonary Hypertension	Y	Tuesday/Thursday [Time]	Half day 3 per year	Hunter Wing me	Dr Paul Vaughan
Vascular Access									
Aortic									
Vascular Malformations (radiology meeting					n/a				
DIRECTORATE: ED AND ACUTE MEDICINE									
ED	Sunil Dasan	Paul Holmes	Will Glazebrook		Y	First Wednesday [Time]	Monthly	ED Seminar roo	WG/BC
Acute Medicine	Jane Evans	Stephen Brincat							
Senior Health		Bryony Elliot							
DIRECTORATE: RENAL, HAEMATOLOGY, ONCOLOGY AND PALLIATIVE CARE									
Renal Transplant (1)	Daniel Jones	Ian MacPhee			Y	Tuesday 8-9	Quarterly	Room 4.019-20.	Dr Steve Nelson
Renal Transplant (2)		Ian MacPhee		Donor offer declined' patients	n/a				
Nephrology		Ian MacPhee			Y				Ian McPhee
Renal surgery		Abbas Ghazanfar			Y	Tuesday 8-9		Various	Abbas Ghazanfar
Clinical Haematology		Elizabeth Rhodes		Clinical Haematology Non-Malignant ITP Thrombosis Haemophilia Haemato-oncology Lymphoma	Y Y Y Y Y Y Y	Tuesday lunchtime 12:30	Every 2 months	Various	
Medical Oncology and Palliative Medicine		Muireann Kellehar	Catherine McGow	Oncology	Y	Thursday 1:45pm	Twcie monthly	Various	Dr Jason Chow
				Palliative care	Y	Morning handover 9-9.30 am Lunchtime 1300 Discussions happen Mon-Fri depending on when the service is notified of the death		Morning GW2.050 Lunchtime GW2.050	Dr Catherine McGowan
Fistula	Matt Laundy	Ian MacPhee			n/a				
DIRECTORATE: SPECIALIST MEDICINE									
Rheumatology	Matt Laundy	Arvind Kaul							
Chest Medicine		Yee-Ean Ong							
Dermatology and Lymphoedema		Victoria Akhras							
Diabetes and Endocrinology		Arshia Panahloo		Endocrine Diabetic foot					
Gastro and endoscopy (including hepatobillary)		Penny Neild			n/a				

CWDTOCC MDT

Speciality	CD	Care group lead	Governance Lead	Sub Spec	MDT Y/N	Day and Time	Frequency	Location	Named Lead
DIRECTORATE: DIAGNOSTICS, CRITICAL CARE AND BREAST SERVICES									
Breast	Robert Morgan	Mamatha Ready		Screening	Y	Wednesday 10.30	Weekly	Seminar room, Rose Centre	
				2nd Screening	Y	Friday 1.30	Weekly	Seminar room, Rose Centre	
				Symptomatic	Y	Wednesday 8.00	Weekly	Seminar room, Rose Centre	
				Benign	Y	Friday 12.30	Weekly	Seminar room, Rose Centre	Mr Anup Sharma
ICU	Rafik Bedair	Jonathan Ball	Ursula Miskolci (mortality)	General ICU	Y	10.00	Daily	In the clinical area	
				Long-term patients (7 days +)	Y	14.00	Daily	In the clinical area	
				Rehab	Y	10.00	Daily	In GICU	
		Dominic Spray		Cardio Thoracic ICU	Y	Friday 2-4	Monday and Thursday	In CT ICU	
		Ashliegh Sherrington		Neuro ICU	Y	Wednesday 12:30	Weekly	NICU Seminar room	
Radiology		Lakshmi Ratnam		n/a	59 specialty MDT meetings				
IR		Raj Das							
Pharmacy		Vin Kumar (Chief Pharmacist)			21 specialty MDT meetings + 84 other care group/governance meetings				
DIRECTORATE: WOMEN'S HEALTH									
Maternity	Austin Ugwumadu			Perinatal	Y	Monday 13 - 14.30	Weekly		
				CTG	Y	[Day] 12.30-14.00	Weekly		
				Fetal	Y	Wednesday 13.00	Weekly		
				Maternity	Y	Thursday 13 – 14.00	Monthly		
				Obstetrics	Y	Thursday [Time]	Weekly	FMU	
				Obstetric HDU	Y	[Day] 13.00	6 weekly		
Gynaecology	Robert Morgan	Hugh Byrne	Suruchi Pandey	Gynaecology	Y	Tuesday 8.00	Weekly	Seminar Room Cellular Pathology	Thomas Ind; Dr S Heenan
			Prof. Manyoundea	AGU	Y	?	Weekly		
			Kevin Hayes	EPU	Y	Wednesday 12.30	Weekly	Room 4, Clinic A, Ground Floor Lanesborough	
				Colposcopy	Y				
			?Mr Ojha	Scan review	Y	Monday 8.30	Weekly	Genetics Seminar Room, LGF, JW	
				Fibroid	Y	Wednesday 2nd or 3rd week [Confirm]	Monthly	Tutorial Room, x ray, SJW	Prof. Issac Manyonda, Prof Bell, Drs Ratnam, Maill and Dax
Gynae-Oncology				Gynae-oncology	Y	Monday 8.30	Weekly	Genetics Seminar Room, LGF, JW	None
Neonatal	Sijo Francis	Charlotte Huddy	Donovan Duffy	Paediatrics	Y	Monday 13.30	Weekly	Neontal unit seminar room	Charlotte Huddy
DIRECTORATE: CHILDREN'S SERVICES									
Paediatric orthopaedics	Sijo Francis				Y	Monday 8.00	Bi-weekly	Seminar room, x ray, SJW	
Acute Paediatrics (acute team)					Y	Wednesday [Time]	weekly	Seminar Room	
Acute Paediatrics (integrated care team)					Y	Tues/Wed/Thurs depending on clinic 13.00-14.00 or 13.30 - 14.30	Bi-weekly	GP clinics putneymead, battersea rise, brocklebank	
Speciality Paediatrics (Respiratory)					Y	Tuesday [Time]	Weekly	Seminar Room	
Speciality Paediatrics (Gastroenterology)					Y	Thursday [Time]	Weekly	Seminar Room	
Acute Paediatrics with surgical (renal)					Y	Wednesday [Time]	Monthly	Radiology Dept	
Acute Paediatrics with surgical									
Acute Paediatrics (ED)					Y	Wednesday [Time]	Monthly	various	
Acute Paediatrics (Oncology)					Y	Tuesday [Time]	Monthly	Seminar Room	
Acute Paediatrics (Haematology)					Y	Tuesday [Time]	Weekly	Haematology Offices, Jenner Wing	
Speciality Paediatrics (allergy)					Y	Thursday [Time]	Monthly	Jenner Wing Meeting Room	
Speciality Paediatrics (allergy)					Y	Friday [Time]	Weekly	Dragons Children's OPD	
Neurorehab					Y	Thursday [Time]	Weekly	Nicholls Ward parents room	
Paediatric neurodisability					Y	Tuesday [Time]	Bi-weekly	CDC	
Speciality Paediatrics (endocrinology)					Y	Thursday [Time]	Weekly	Consultants office	
NNICU									
PICU									
DIRECTORATE: OUTPATIENTS									
OUT OF SCOPE									

SNCT MDT

Speciality	CD	Care group lead	Governance Lead	Sub Spec	MDT Y/N	Day and Time	Frequency	Location	Named Lead
DIRECTORATE: SURGERY, MAX FAX, ENT, UROLOGY, PLASTICS									
General Surgery	Tim Bishop	Andrew Wan	George Vasilikostas	Lower GI (colorectal)	Y	Friday 13.00	Weekly	Genetics Seminar Room. LGF, SJW	Andy Ramwell (Drs Beharry, Barber)
				Upper GI	Y	Friday 12.30	Weekly	Seminar Room 1, LGF, SJW	Sofie Barker (Drs Barber and Fowkes)
ENT		Sarah Little	Rob Harris						
Ophthalmology				LUTS	Y	Wednesday 10.00	Monthly	Seminar Room 1, LGF, SJW	Mr S Sabbagh (Dr R Das)
Audiology		Elwina Timehan			n/a				
Max Fax		Helen Witherow			N (input into other speciality MDTs)				
Dental		Ricahrd Porter	Jamie Gwilliam		N (input into other speciality MDTs)				
Plastics			Catherine Milroy						
Urology		Marco Bolgeri	Dav Sharma	Renal	Y	Wednesday 10.30	Weekly	Seminar Room, Cellular Path, LGF, JW	Mr Chris Anderson, Rami Issa (Drs Das, Gonsalves,
				Prostate					
				Bladder					
				Penile	Y	Tuesday 9.30	Weekly	Seminar Room, Cellular Path, LGF, JW	Mr Nick Watkin, Rami Issa
				Urology (joint)	Y	Friday 7.45	Weekly	Seminar Room, Cellular Path, LGF, JW	Mr Chris Anderson, Rami Issa (Drs J Pilcher, Renani)
Bariatric					Y	Wednesday 8-9	Weekly	Thomas Addison Unit	
T&O		Sham Omargy	Magnus Arnander						
DIRECTORATE: CANCER									
Cancer	Nicholas Hyde	Enji Ofo		H&N	Y	Thursday 8.00	Weekly	Seminar Room 1 Cellular Path, LGF, JW	Graham Smith
		Matt Lundy		Skin	Y	Thursday 8.00	Weekly	Genetics Seminar Room. LGF, SJW	Barry Powell
				Lung	Y	Monday 8.00	Weekly	Cellular Pathology Seminar Room	Adrian Draper
		Daniel Jones		Lymphoma	Y	Wednesday 13.45	Weekly	Cellular Pathology Seminar Room	Ruth Pettengell (Dr
				Haematology					
				Oncology					
				Liver	Y	Friday (3rd)	Monthly	Seminar 1 LGF SJW	Dr D Fortn (Drs Gonsalvas, Re nini)
DIRECTORATE: NEUROSCIENCES									
Neurology		Niranjanan Nirmalananthan	Usman Khan	Epilepsy	Y	2nd Friday 13.30	Monthly	John Ambrose Seminar Room 2nd Floor, AMW	
				Surgery/Complex					
				Neuro-inflammatory	Y	Friday 9.30	Weekly	Neuro-radiology reporting room	
				Neuro-genetics	Y	Thursday 9.00	Weekly	John Ambrose Seminar Room 2nd Floor, AMW	
				Neuro-muscular					
				Movement disorders					
				Neuro-oncology	Y	Friday 8.00	Weekly	John Ambrose Seminar Room 2nd Floor, AMW	
				Headache					
Stroke			Gillian Clucky	Vascular	Y	Tuesday12.00	Weekly	St James Wing	
				Nero-vascular	Y	Tuesday12.30	Weekly	John Ambrose Seminar Room 2nd Floor, AMW	
Neurosurgery		Simon Stapleton	Sam Hettige	Spinal	Y	Friday 8.00	Weekly	Seminar Room, x ray, SJW	Mr M Crocker (Dr N Papdakos)
				Neuro-Paediatrics	Y	Friday 12.00	Weekly	Genetics Seminar Room, Cellular Pathology	
Pain Management				Acute	Y (clinical)	Thursday (3rd)	Monthly	Neuroradiology	
				Chronic	Y (MDT)	Thursday (4th)	Monthly	Pheonix	
Neuro-rehab			Sancho Wong		n/a				
Neuroradiology			Andrew McKinon	Cochleal implnt	Y	Tuesday 9.00	Bi-monthly		
				Pituatory	Y	3rd Wed 10.00	Monthly		
				Fetal medicien	Y	Wednesday 13.00	Weekly		
Neurophysiology									
DIRECTORATE: MAJOR TRAUMA									
Major trauma	Anthony Hudson			Richard Hartop	Y	Monday 12.30	Bi-weekly	John Parker Leacture Theatre, AMW	
DIRECTORATE: THEATRES AND ANAESTHETICS									
Theatres	Sarah-Jane Hammond	Anthony Addei		Theatres and anaesth	n/a				
Anaesthetics		Elizabeth Willaims	Oliver Seyfried		n/a				

MedCard MDT

Specialty	CD	Care group lead	Governance Lead	Sub Spec	MDT Y/N	Day and Time	Frequency	Location	Named Lead
DIRECTORATE: CARDIOLOGY AND CARDIOVASULAR									
Cardiology	Stephen Brecker Peter Holt	Raj Sharma	Manav Sohal	EP	Y	Monday (except last	Weekly	Cardiac Rehab Gym	
				Coronary/Valve	Y	Monday-Friday 08.00	Daily	John Parker LT, AMW	
				Intervention	N				
				Aortic	Y	Tuesday 08.00 (after coronary/valve meeting)	Weekly	John Parker LT, AMW	
				Heart failure/CMR	Y	Thursday 08.00 (after coronary/valve meeting)	Weekly	John Parker LT AMW	
				Echo/Valves	Y	Friday 08.00 (after coronary/valve meeting)	Weekly	John Parker LT AMW	
				Inherited Conditions	Y	Wednesday 1730	Monthly	John Parker LT AMW	
				Heart Failure	Y	Thursday 0915	Weekly		
				TAVI	Y	Monday 08.00	Weekly	John Parker Seminar, AMW Room	
Cardiac Surgery		Steve Livesey		Cardiac	Y	Daily 0800	Daily	John Parker Lecture Theatre, AMW	Steve Livesey
				Cardiac aortic		Tuesday 0900	Monthly		Proj Jahingiri
				Valve		Friday 0900	Weekly		Raj Sharma
Peripheral Vascular Surgery		Gary Maytham	Damian Kelleher	Aortic	Y	Tuesday 9.30	Weekly	Seminar Room, X-ray	Prof Holt / Prof Loftus
				Periphral vasular	Y	Tuesday 11.00			Mr Mo Abdelhamid / Mr Paul Moxey
				Carotid surgery	Y	Tuesday 12.00			Gary Maytham
Thoracic Surgery		Paul Vaughan	Doug Treanor	Cardiothoracic	Y	Tuesday 8.00	Weekly	John Parker Seminar Room AMW	Prof M Jahangiri
				Pulmonary Hypertension	Y	Wednesday 17.00	Monthly	Cardiology Confereence Room	Prof Madden
Vascular Access					Y	Tuesday 12.30	Weekly	Seminar Room, X-ray	Prof Olivier
Aortic					Y	Tuesday 9.30	Weekly	Seminar Room, X-ray	Ian Loftus
Vascular Malformations (radiology meeting					Y	3rd Tuesday 12.30	Monthly	Small Tutorial, x ray	Latskmi Ratnam / Ms C Milroy
DIRECTORATE: ED AND ACUTE MEDICINE									
ED	Sunil Dasan	Paul Holmes	Will Glazebrook		Y	Wednesday 8.00			
Acute Medicine	Jane Evans	Stephen Brincat							
Senior Health		Bryony Elliot							
DIRECTORATE: RENAL, HAEMATOLOGY, ONCOLOGY AND PALLIATIVE CARE									
Renal Transplant (1)	Daniel Jones	Ian MacPhee			Y	Friday 8.00 - 09.00 Network attendees from St Georges, St Heller and Brighton Hospitals	Weekly	Room 2.11.3 Renal Offices, 2nd floor Grosvenor Wing.	
Renal Transplant (2)		Ian MacPhee		'Donor offer declined' patients	Y		Quarterly		
Nephrology		Ian MacPhee			Y				Ian McPhee
Renal surgery		Abbas Ghazanfar							
Clinical Haematology		Elizabeth Rhodes		Clinical Haematology					
				Non-Malignant	Y	3 on a weekly basis [Day and Time]	Weekly		
				ITP	Y	Tuesday 11.45	Weekly		
				Thrombosis	Y	[Day] 11:45,	Weekly		
				Haemophilia	Y	[Day] 12:30,	Weekly		
				Haemato-oncology	Y	Wednesday 1pm-3pm	Weekly	Starts in Genetics Seminar room for a 3-way teleconferencing then shift to Pathology sem room 1	
				Lymphoma					
Medical Oncology and Palliative Medicine		Mulreann Kellehar	Catherine McGowan	Oncology	N (attend tumour group MDTs)				
				Palliative care	N	all patients reviewed at least weekly by a consultant and a CNS as an MDT They also have a twice monthly clinical case discussion to support the team around particularly challenging or emotive cases			
Fistula	Matt Laundy	Ian MacPhee			Y	Tuesday 12.30	Weekly	Seminar Room, X ray	Prof Olivera
DIRECTORATE: SPECIALIST MEDICINE									
Rheumatology	Matt Laundy	Arvind Kaul							
Chest Medicine		Yee-Ean Ong							
Dermatology and Lymphoedema		Victoria Akhras			Y				
Diabetes and Endocrinology		Arshia Panahloo		Endocrine	Y	Tuesday (2nd and 4th) 12.30	Bi Monthly	Seminar Rose Centre	Dr Anup Sharam (Drs Wojclechowski, Beharry)
				Diabetic foot	Y	Thursday 8.00	weekly	Seminar room, x ray	Sr S Saha (Dr Morgan)
Gastro and endoscopy (include hepatobiliary)		Penny Nelid							

Governance Improvement Plan:

M&M, MDT and clinical governance 2019

Action plan title/subject:	Governance review: Mortality and morbidity, MDT and Clinical Governance CQC Well-Led domain
Ward/Department name:	N/A
Date of draft:	May 2019
Approved by and date:	TBA
Monitoring forum:	PSQG
Board assurance committee:	Quality and Safety Committee
Executive leads:	Richard Jennings, Chief Medical Officer Avey Bhatia, Chief Nursing Officer
Action plan lead:	
Date last amended:	First draft – 09.05.19 Second draft – 28.05.19 Third draft – 21.06.19

RAG rating key
Deadline missed/will be missed. No evidence of mitigation
Deadline missed/will be missed. Evidence of mitigation
On target – evidence of progress
Executive owner confirmed evidence action complete. Return to BAU

Action plan guidance:

Each action owner will be required to develop a delivery plan which will set out the key steps in their approach to managing the project. This should include identifying additional resources they may require to support effective delivery and sustainability of the action(s). For example this could include areas such as:

- Consultant job planning
- Administration support
- Environmental requirements
- Audio/visual equipment
- IT support

It is recommended that each action lead use the 'project on a page' template to set out there approach. Once this has been developed this will need to be agreed and signed off by the executive lead.

Recommendation		Action	Action SRO	Action owner	Completion date	Evidence of completion and sustainability	BRAG Rating
M&M							
1	A mortality strategy should be developed that incorporates all the various strands of the learning from deaths framework, with a clear focus on improving the quality of clinical care and preventing avoidable patient death.	Produce mortality strategy. Assurance process for implementation. Approval by Quality Committee - July 2019.	CMO on behalf of board	AMD for LfD	30.09.19	Link to assurance reporting (quarterly) on implementation of LfD.	
2	The CMO should consider how the interface between the new medical examiner system (when implemented) and the learning from deaths framework will operate at St George's to ensure independence of the medical examiner's role is maintained as intended within the latest guidance.	As part of the review of clinical governance structure i.e. integrated governance with full independence for ME role. Recruitment process. Design legacy AMD for LfD role once ME role established.	CMO	CMO/ Review team	01.09.19		

Recommendation	Action	Action SRO	Action owner	Completion date	Evidence of completion and sustainability	BRAG Rating
3	The forthcoming review of the learning from deaths policy should ensure that it encompasses all relevant new national guidance with particular focus on:	Review and revise policy in line with section 7.2 of the governance review report, taking specific account of the NHSI *Template Learning from Deaths policy, September 2017* and the *Implementing the Learning from Deaths framework: key requirements for trust boards, July 2017*	CMO	AMD for LfD in consultation with divisional chairs/ Deputy CNO (Patient Experience)	30.09.19	Monitoring against 70% standard, with explicit reporting on completed SJRs for LD. Include in integrated thematic reviews to Q&S Committee: quarterly	
3.1	• the mechanism for monitoring and providing periodic assurance to the board that the intentions of the policy are being met	Set up a patient reference group for learning from deaths to engage with on the expectations and content of the LfD policy					
3.2	• how bereaved families are engaged and supported and consideration of the involvement of a patient reference group in the development of this policy	Set up a patient reference group for learning from deaths to engage with on the expectations and content of the LfD policy				Bereavement services survey results reported to PEG. Healthwatch commissioned feedback	

Recommendation	Action	Action SRO	Action owner	Completion date	Evidence of completion and sustainability	BRAG Rating
3.3	• strengthening the role of the mortality monitoring committee in delivering its aim to support clinical teams in their local mortality and morbidity governance processes	Review and revise terms of reference in line with section 7.1.1 to 7.1.4 of the governance review report, to include membership, strengthening links to local M&Ms, and chair responsibility.	CMO	AMD for LfD in consultation with divisional chairs/ Deputy CNO (Patient Experience)	30.09.19	Corporate governance team to design tool to test effectiveness of the MMC annually	
3.4	Ensure the policy includes the need for every death of a person with a learning disability is reviewed using the SJR process.	Include in the policy review and revision.				Expanded MMC report to Q&S committee to include all LD SJRs	
3.5		Conduct a retrospective SJR review of learning disability deaths from 2017/18 to date, with findings reported to Quality & Safety Committee before calendar year end.		AMD for LfD/ LD team	30.11.19	Expanded MMC report to Q&S committee to include all LD SJRs	

Recommendation	Action	Action SRO	Action owner	Completion date	Evidence of completion and sustainability	BRAG Rating
4	It is recommended that the role of the mortality monitoring committee is revised so that it has a higher profile within the trust corporate quality governance structure. This should include consideration of how this committee can best deliver the trust's mortality strategy when developed.	(Links to recommendation/action 1. - development of mortality strategy.) Included in Phase 2: ToR for ward to board (W2B) structure.	CMO/ CNO	Director of Corporate Affairs in conjunction with the review team	31.08.19	Corporate governance team to design tool to test effectiveness of the MMC annually. Include in annual effectiveness review of the Q&S committee	

Recommendation	Action	Action SRO	Action owner	Completion date	Evidence of completion and sustainability	BRAG Rating
5	Develop an overarching trust wide policy for conducting care group level mortality review meetings based on the latest best practice guidance. This will provide a model framework for divisions and care groups to consider best practice in holding such meetings, and how learning opportunities are shared that influence changes in practice.	Develop a policy in line with and that addresses the findings in section 8.0 of the governance review report, specifically using the *Mortality Toolkit: Implementing SJRs for improvement, v1.3 June 2018.* As a minimum, this should include: • how to chair an M&M meeting • involvement of junior doctors, nurses, AHPs and other relevant staff groups • review of Dr Foster data • standardised method of presentation and grading classification • focus on learning and quality improvement opportunities • peer review • audit process • clinical governance reporting arrangements	CMO/ CNO	Divisional Chairs/ Deputy CNO (Patient Safety)/ AMD for LfD	30.09.19	RSM to conduct follow-up independent review: 2019/20, reporting to Audit Committee. Peer review arrangements, quarterly reporting to PQSG	

	Recommendation	Action	Action SRO	Action owner	Completion date	Evidence of completion and sustainability	BRAG Rating
MDT							
6	Develop an overarching trust wide policy for conducting care group level multidisciplinary meetings from which local standard operating procedures can be developed based on the latest best practice guidance. The policy should incorporate how each MDT will assess (at least annually) its own effectiveness/performance and benchmark itself against similar MDTs, making use of peer review and other national tools as they become available. The policy should include how the board receives assurance – positive and negative – on the effectiveness of its MDTs.	Develop a policy in line with the expectations in section 9.1 of the governance review report and that responds to the findings in section 9.3. This should include as a minimum: • the constitution of the multidisciplinary team • meetings attendance • teamwork and culture • patient-centred clinical decision-making • infrastructure for meetings • clinical governance mechanisms and monitoring • peer review • audit process • organisational support	CMO/ CNO	Divisional Chairs	30.09.19	RSM to conduct follow- up independent review: 2019/20, reporting to Audit Committee. Peer review arrangements reported quarterly to PQSG	

Recommendation	Action	Action SRO	Action owner	Completion date	Evidence of completion and sustainability	BRAG Rating
7	Design and implement a training needs analysis for those chairing and participating in local morbidity and mortality and multidisciplinary meetings..	Take into account: constitution of the MDT; meetings attendance - expectations and recording; teamwork and culture; patient-centred decision-making; clinical governance (eg. Peer review arrangements); and ensuring effective shared learning. Phase 2: TNA. Terms of reference for the review team's support for this action to be agreed with CMO	CMO/ CNO	Review team	31.08.19	Training reports to Workforce Development Committee	

Recommendation	Action	Action SRO	Action owner	Completion date	Evidence of completion and sustainability	BRAG Rating
7a	This should include giving consideration to establishing a community of practice approach with those who chair mortality and morbidity and MDT meetings, involving executive leadership to build relationships and share learning through discussion and activities	Establish two communities of practice for MDT and M&M chairs. This should include: • a virtual community for sharing information and learning • quarterly joint meeting which include opportunities to meet with executive leaders • define and establishing KPI's to monitor performance against policy • establish a central repository and system for reporting quality assurance to CMO/CNO • consider introducing an accreditation system • establish a peer review and audit process	CMO/ CNO	CMO	31.8.19	Annual assurance report to the Quality & Safety Committee	

	Recommendation	Action	Action SRO	Action owner	Completion date	Evidence of completion and sustainability	BRAG Rating
8	Part of the protocol for developing and approving new clinical services should give consideration to the impact a new service will have on clinical support services, particularly in the resource requirement required to attend multidisciplinary team meetings.	All business cases linked to the development of new clinical services presented to the Business Case Development Group to have given explicit consideration to the impact on clinical support services before being recommended to the Trust Investment/Disinvestment Group (IDG). Consider the need to modify existing bid paperwork to ensure it supports this change.	Trust executive	Chair of BCDG	31.08.19	RSM to conduct review: 2019/20	

	Recommendation	Action	Action SRO	Action owner	Completion date	Evidence of completion and sustainability	BRAG Rating
CLINICAL GOVERNANCE							
9	Consider what changes are required to provide support and resource to the chief medical officer in concern with the chief nursing officer, reflecting their need for an integrated approach to quality governance.	Phase 1: ToR for governance resilience review.	CMO/ CNO	Review team	31.07.19	Overarching TEC approved report on completion of phases 1 and 2 to Q&S Committee October (by 17.10.19)	
10	Reflect on the organisation's ward to board reporting framework of meetings to ensure that the board continues to receive reliable assurance on the quality (safety, effectiveness and experience) of the services it offers, and that it meets its statutory responsibilities in this regard.	Phase 2: Ward to Board (W2B) quality governance meetings structure review.	CMO/ CNO on behalf of the Board	Director of Corporate Affairs in conjunction with the Review team	31.08.19	Overarching TEC approved report on completion of phases 1 and 2 to Q&S Committee	

	Recommendation	Action	Action SRO	Action owner	Completion date	Evidence of completion and sustainability	BRAG Rating
11	Review the corporate quality governance leadership and capacity so that the divisions are supported to provide a consistent and uniform approach in their delivery of the trust's quality governance arrangements.	Phase 1: included in the agreed terms of reference for governance resilience review.	CMO/ CNO	Review team	31.07.19	October (by 17.10.19)	
12	Consider a development programme for the divisional senior leadership team to provide greater understanding and good practice in governance systems and process particularly seeking and receiving assurance as part of the trust's risk management arrangements.	Phase 2: TNA Terms of reference for the review team's support for this action to be agreed with CMO	CMO/ CNO	Review team	31.08.19	Overarching TEC approved report on completion of phases 1 and 2 to Q&S Committee October (by 17.10.19)	

Recommendation	Action	Action SRO	Action owner	Completion date	Evidence of completion and sustainability	BRAG Rating
13	Consider reviewing the roles of divisional chair, clinical director, care group lead, and clinical governance, to ensure that these role expectations and responsibilities are consistent, clear, well understood, and properly resourced in terms of protected time, support, and development to enable staff to deliver them in line with trust expectations.	Links to Phase 1: ToR for governance resilience review. This should align with the expectations as set out in a trust accountability framework	Trust executive	Review team	31.07.19		
14	Consider conducting a medical engagement programme across the trust's consultant body. This will establish a baseline to inform the chief medical officer to consider what other mechanisms might be necessary to ensure the most senior leaders keep in touch with their medical workforce.	CMO action to be completed by RJ	CMO	TBC	Results by 31.03.20	Trust board approved action plan by 30.04.20	

Recommendation	Action	Action SRO	Action owner	Completion date	Evidence of completion and sustainability	BRAG Rating
15	The trust may want to reflect on the perception that the culture is medically dominated, and consider how it can achieve parity of esteem across all professions delivering clinical services to patients.	Include in the rollout of high performing teams programme as part of the QI Academy, and include in the human factors training programme.	CMO/ CNO	AMD for QI	Incorporate into rollout and human factors training by 31.07.19	Trust board quarterly report by 31.03.20	
16	Although not included as a specific recommendation in the report, establishing a mechanism for maintaining an up to date record of all MDT and M&M meetings is required	Divisions to establish and maintain a process for ensuring up to date records of all MDT and M&M meetings is in place. This should include a system for ensuring quarterly reporting to the CMO/CNO as part of the quality reporting as set out in action 7a above.	CMO/ CNO	Divisional Chairs Divisional Directors of Nursing and Governance	First quarter report 31.8.19	Central repository Quarterly reporting to CMO/CNO	

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	27 June 2019	**Agenda No**	**2.4**
Report Title:	**Cardiac Surgery Services Update**		
Lead Director	Richard Jennings, Chief Medical Officer		
Report Authors:	Julia Mitchell, General Manager, Cardiac, Vascular and Thoracic Surgery Fiona Ashworth, Divisional Director of Operations		
Presented for:	Assurance		
Executive Summary:	This report provides an update to Trust Board on the steps being taken to improve the cardiac surgery service following the NICOR safety alerts and the findings of the independent report by Professor Bewick (July 2018). Since the last update to the Trust Board in May 2019, the following key developments have taken place: • The Independent Mortality Review Panel has continued to meet, increasing its frequency from once a fortnight to twice a week. • 'Being open' letters are being sent to all next of kin associated with the mortality review (the first stage of application of duty of candour). To date 167 letters have been sent. • Two Clinical Nurse Specialists have started beginning of June 19 they will be part of the Case Management Team, and will benefit patients from more resilience in list and pathway management. • The Consultant in Cardiac Surgeon post has been advertised as a permanent post closing 14th July 2019. • Cardiac surgery has an interim General Manager in the service, and has appointed to the Programme Manager, who will support the on-going implementation of the cardiac surgery action plan. The new appointee starts on 01 July 2019. • Quality and Safety committee received an update on safety and outcomes on 20th June 2019. • Trust board are also advised that an external quality summit was held on the 19th June.		
Recommendation:	The Board is asked to discuss and take assurance from the update on progress being made in Cardiac Surgery.		
Supports			
Trust Strategic Objective:	• Treat the patient, treat the person • Right care, right place, right time • Champion Team St George's		
CQC Theme:	• Safe, Well Led		
Single Oversight Framework Theme:	• Quality of Care, Leadership and Improvement Capability		
Implications			

Risk:	As set out in the paper		
Legal/Regulatory:	The paper details the Trust's engagement with regulators on this issue.		
Previously Considered by:		**Date**	

Quality and Safety Committee- CARDIAC SURGERY UPDATE

1.0 PURPOSE

1.1 To update the Trust Board on the progress being made with Cardiac Surgery since the presentation to the Board in May 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 and has increased it frequency from once a fortnight to twice a week.

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 Currently 167 of the 201 Next of Kin have been successfully contacted and being open letter have been sent. There is a continuing challenge with securing the correct contact details for next of kin for all 201 patients.

2.1.6 The most recent meeting of the external Quality Summit took place on 19th June 2019.

3 INTERNAL DEVELOPMENTS

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

3.1.1 Pre-operative Assessment and case management. The additional nursing appointments (B7 and B8a) to enable the Case Management Team are now in place June 2019. The Team will be the single be point of contact for patients offering continuity and support to navigate a complex pathway.

3.1.2 Additional substantive consultant recruitment. The existing locum consultant position (currently filled) is being advertised on a permanent basis, closing on the 14th July 2019.

3.1.3 Programme Manager – we are have recruited to the Programme Manager post following the departure of the last post holder. The programme manager will support the on-going implementation of the cardiac surgery plan in addition to the mortality review and future planning.

3.1.4 Quality and Safety committee received an update on safety and outcomes on 20th June 2019.

4.0 INTERNAL ASSESSMENT

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

5.0 RISK REGISTER

5.1 The three extreme risks remain on the risk register, these are:

1) Losses incurred through reduced income as a result of decreased activity, and direct costs incurred through the 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).

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. As such, the risk is controlled.

6.0 RECOMMENDATION

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

Date: 27 June 2019

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	27 June 2019	**Agenda No.**	**2.5**
Report Title:	Quality Improvement Academy (Quarterly)		
Lead Director	James Friend. Director of Delivery, Efficiency and Transformation		
Report Authors:	Martin Haynes, Improvement Methodology Director Dr. Mark Hamilton, Associate Medical Director		
Presented for:	Noting		
Executive Summary:	The last quarter has been a period of growth and consolidation for the Quality Improvement Academy (QIA). Firstly, this included the acquisition of four new staff to lead GIRFT, support the impending Flow Coaching Academy programme, work as part of the SWL Acute Provider Collaborative and extend coaching support for quality improvement project teams across the trust. Secondly this covered preparations for the expected CQC inspection. This paper highlights some of the larger elements of the QIA's activities over the past quarter.		
Recommendations:	For the Board to note the intentions and progress of the Academy to date.		
Supports			
Trust Strategic Objectives:	Right Care, Right place, Right Time Balance the Books, Invest in the Future Build a Better St George's Champion Team St George's Develop Tomorrow's Treatments Today		
CQC Themes:	Safe and Effective - Well Led		
Single Oversight Framework Theme:	▪ Quality of Care (safe, effective, caring, responsive) ▪ Finance and Use of Resources		
Implications			
Risk:	None in this paper.		
Legal / Regulatory:	N/A		
Resources:	None requested in this paper.		
Previously considered	Quality & Safety Committee	Date:	20/06/2019
Appendices:			

Quality Improvement Academy

1. Purpose

The purpose of this paper is to update Trust Board on the key activities and progress of the Quality Improvement Academy (QIA) during Q1 2019/20.

2. Q1 in summary

This has been a period of significant growth for the Quality Improvement Academy and the arrival of four new staff has greatly improved capacity to support an increasing portfolio of work. This now includes 17 active GIRFT specialties, development of the South West London Acute Provider Collaborative improvement pathways and preparation for launch of the Flow Coaching Big Room workshops.

At the same time understanding and engagement around the St George's Way framework is driving much broader range of improvement conversations that cover both the technical and cultural elements of quality improvement. This is an important development that is helping create the conditions for sustainable improvement across the Trust.

At the same time the rising demand has challenged the team to remain responsive to the organisation and simultaneously adopt a more structured and critical review of what it is possible to deliver without compromising quality of delivery.

The paper highlights the bigger pieces of work currently in progress, but also signals some major new activities in the months ahead and we are happy to receive feedback, or provide more information at any time.

3. Q1 Activity Overview

The following is summary of the QIAs larger work activities over the past quarter.

3.1 CQC Preparedness

Led by Alison Benincasa and with support from a small team with SGUH and Sally Herne & Nasmin Lappage, from NHSI, a large part of this quarter's activity was coordination of the CQC Provider Information Request covering data requests, quality reviews and final, on time submission on 16th May. They recently completed a detailed after-action review of the process which will inform plans for ongoing reviews in the months ahead.

3.2 Organisation Development Approach

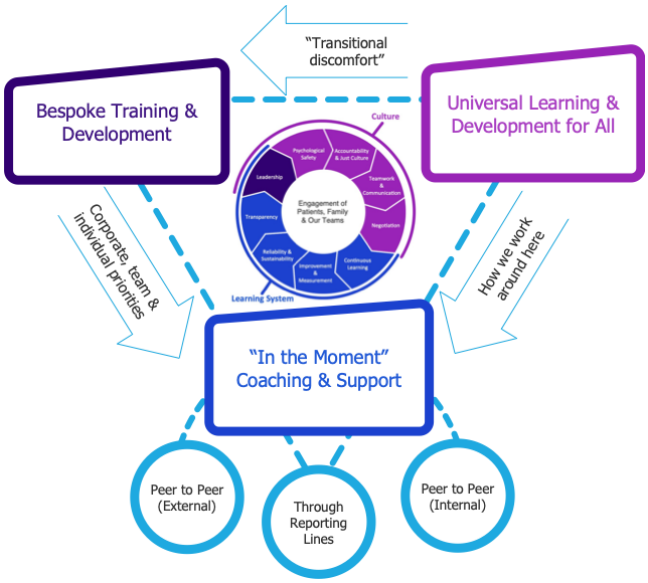
As part of developing a broader Quality, Organisation Development & Improvement Strategy, the team has consolidated its key organisation development approach, which is built around the St George's Way framework and comprises three core themes:

- **Universal training & development required for all staff** – what it means to work at SGUH, what matters to us and the non-negotiable elements and expectations of leadership in our organisation.

- **Bespoke training & development** – a process of co-developing training and development support based upon specific local needs and aligned to the Trust strategy and team business plans.

- **In-the-moment coaching and support** – the key differentiator that will help individuals and teams bring their development work to life, with support/challenge/coaching from internal subject matter experts and peer-to-peer learning.

Proposed Organisation Development Approach



The team is currently working on plans to launch a bi-monthly **Leadership Forum** to actively engage and develop our top 200 leaders. This will build on the work started with the King's Fund in 2018 and establish regular meeting point where leaders from across the organisation can get together in a safe space to reflect, learn and grow. Themes include:

- Exploration of the St George's Way framework and build interest in topic areas, encouraging curiosity from our leadership team.

- Provide a platform for the CEO and executives to engage with a large number of leaders on systems and organisational issues, such as the implementation of the 2019-24 strategy outstanding care every time.

- Provide our leaders with time out to reflect and work on their local leadership challenges.

- Network across different divisions, sharing experiences and learning.

3.3 Getting It Right First Time (GIRFT)

Two new members of staff transferred into the QIA this quarter to provided trust-wide leadership and support for this programme. They have already concluded a number of meetings with the London GIRFT team and are now working with trust colleagues to determine local training, coaching and support needs across the active pathways. This also included a presentation to the Council of Governors' Meeting.

Work is currently prioritised around Vascular, Trauma & Orthopaedics, Renal and Gynaecology who have GIRFT progress reports due for submission at the end June.

3.4 Flow Coaching Academy

Our team of 8 coaches continued their monthly flow coaching training in Sheffield and are currently planning launch of their weekly 'Big Room' improvement sessions which are expected to start at the end of June / early July. The St George's "Big Room" pathways are pre-operative assessment, gastroenterology, hand therapy and paediatric trauma.

A new member of staff transferred into the team in April to support a range of improvement projects and take the operational lead for the Flow Coaching programme.

3.5 SWL Acute Provider Collaborative (APC)

The QIA has taken a key role as part of the APC team helping shape the improvement methodology and supporting the diagnostic activities for the first APC pathway workshop (ENT earwax micro-suction). The team completed key stakeholder meetings and data analyses in preparation for pathway engagement workshop involving 30 staff from across SWL.

The workshop helped establish an 'ideal future state' ambition and a series of improvement actions to be undertaken over the next 30, 60 and 90 days. It is expected this model will be deployed for all future pathway projects.

Finally, in recognition of the increasing workload, a new member of staff transferred into the QIA at the beginning of June to help lead our ongoing engagement with the APC improvement pathways

3.6 Quality Improvement Coaching & Support Activities

The Academy continues to support a wide range of improvement projects across the Trust, including:

- Improving recognition and escalation of deteriorating patient on the neurosurgical wards.
- New Early Warning Score (NEWS2).
- Treatment Escalation Plans (corporate priority project).
- Critical care – 6 concurrent projects.
- Pre-Operative Assessment including clinical pathways, high risk anaesthetic clinic and outpatient triage.
- End of life care, including launch of awareness video.
- High performing teams, including working styles/team development on Mary Seacole ward at QMH.

3.7 Other examples of QIA work this quarter:

- Leadership development workshops with SNCT divisional leadership team.
- Second 'Creating Conditions for Improvement workshop with Trust Executive Committee (including working session with Care Group Leads).
- Problem solving and improvement workshops with frontline members of outpatient teams.
- Launch of half-day introduction to QIA training workshop as part of Enhanced Leadership Programme.
- Continued development of QIA website.
- Preparation of communications materials to support CQC readiness for staff.
- Completion of 10 post implementation review posters capturing learning from improvement/transformation projects.
- Delivered two standalone QI workshops to c60 clinical staff on 17th & 18th June in partnership with Institute for Health Improvement.

4. Forward View

Plans for Q2 2019/20

- Launch of Leadership Forum (early Sept) as part of organisation development approach
- Support for CQC inspections
- Ongoing project coaching / support
- Continue development of Quality, Organisation Development & Improvement strategy
- Deliver leadership development workshops with MedCard & CWDT divisional leadership teams

- Launch Flow Coaching Big Room improvement sessions
- Continued support of APC pathway projects and facilitation of key stakeholder engagement workshops
- Welcome three new member of staff (funded by Quality Special Measure monies) to support extension of High Performing Teams project
- Deliver QI development workshops for Trust Board team

5. Conclusion

The reach of the Quality Improvement Academy continues to grow significantly and the addition of new staff will enable the team to support a wider scope of work across the Trust and local system. Demand for our QI training workshops also remains high and we continue to evolve both the range and detail of content in response to organisation demands.

Similarly, as understanding of the St George's Way increases, so does demand for QI support and facilitation around the cultural elements of the framework. This is a positive development over the quarter as teams recognise the importance of psychological safety, accountability & teamwork as key enablers of sustainable change.

Part of the team's challenge in the next two quarters is developing a wider group of improvers who can 'take the lead' for local improvement projects. Therefore, we will need to maintain a careful balance between training/development and real time coaching for project teams.

We are excited for the launch of the Leadership Forum and believe it will be a powerful way to actively engage senior leaders to shape and lead cultural change across the Trust.

Meeting Title:	**Trust Board**		
Date:	27 June 2019	**Agenda No**	**2.6**
Report Title:	Annual Adult Safeguarding Report		
Lead Director/ Manager:	Avey Bhatia – Chief Nurse and Director of Infection Prevention and Control		
Report Author:	David Flood, Named Nurse for Safeguarding Adults, Bill Turner – Head of Safeguarding for Children and Adults		
Presented for:	Assurance		
Executive Summary:	The report highlights some of the key achievements of, and areas of challenge for, the Safeguarding Adults team over the previous financial year, as well as seeking to set out key future pressures, challenges and opportunities for the Adult Safeguarding Service at the Trust. The work of the Adult Safeguarding Team covers four aspects (Safeguarding Adults, Learning Disabilities, Mental Capacity/ Deprivation of Liberty Safeguards and Prevent). Given the importance and diversity of these portfolios separate annual reports for Learning Disabilities, MCA and DoLs and Safeguarding Children will be provided. The Trust Safeguarding Adults team received 882 contacts regarding safeguarding in 2018/19 of which 320 resulted in formal referrals to the local authority safeguarding adults services. Both these figures represent slight increase on the previous year (full details available in report) During the reporting year, the internal governance of Safeguarding has been considerably strengthened by the launch of a combined Safeguarding Children and Adults Committee, chaired by the Chief Nurse, which meets bimonthly. The Designed Leads for Safeguarding Children and Adults at Wandsworth and Merton CCGs (combined roles) are invited to this meeting and receive papers, which provides an additional level of external oversight to the Trust's Safeguarding work. The Trust Safeguarding Adults team has continued to participate as fully as possible in local Safeguarding Partnership work, and in the Regional Safeguarding Adult Provider Forum network. . Safeguarding training compliance has remained above the trust target of 85% and the team are reviewing the content to ensure this matches current practice. The Trust is now exceeding the 85% compliance rate for Prevent training and this is no longer an area for concern. A future area of pressure relates to the implementation of the new Intercollegiate Safeguarding Adults guidance. The Trust is compliant with its duties for Safeguarding Adults and have had no missed cases relating to Safeguarding Adults identified by local authorities.		
Recommendation:	The Board is asked to receive this report noting that it was also discussed at the Quality and Safety Committee on 20 June 2019.		

Supports			
Trust Strategic Objective:	- Treat the patient – treat the person - Right care, right place, right time -		
CQC Theme:	Safe / Caring / Well Led		
Single Oversight Framework Theme:	N/A		
Implications			
Risk:	The Annual Report identifies potential areas of risk.		
Legal/Regulatory:	The Annual Report references the Trust's legal and regulatory duties in this area.		
Resources:	The Annual Report references the currently available resources.		
Previously Considered by:	Quality & Safety Committee Safeguarding Adults and Children's Committee	**Date:**	20/06/2019 10/06/2019
Appendices:	Nil		

Safeguarding Adults – Annual Report 2018/19

1. Introduction

St George's University Hospitals NHS Foundation Trust has a commitment and responsibility to ensure that all patients receive safe, effective and dignified care. In particular we have a duty under Care Quality Commission's '*Fundamental Standards'* to ensure that those adults most at risk should "not suffer any form of abuse or improper treatment while receiving care. This includes: neglect, degrading treatment, unnecessary or disproportionate restraint and inappropriate limits on their freedom."

This report provides a summary of activity with regard to safeguarding adults' activity at the Trust and highlights how St George's responds to and reports on concerns and allegations of abuse and neglect and how we ensure that safeguarding is integral to everyday practice.

It is important to note that the Care Act 2014 sets out in primary legislation to which adult safeguarding duties apply; a key difference to safeguarding children is that there is *not* a universal definition. It is set out in full below.

In the context of the legislation, specific adult safeguarding duties apply to any adult who:

- ***Has care and support needs**, and*
- *Is experiencing, or is at risk of, abuse or neglect, and*
- *Is unable to protect themselves from either the risk of, or the experience of abuse or neglect, because of those needs.*

***Within** the scope of this definition are:*

- *All adults who meet the above criteria regardless of their mental capacity to make decisions about their own safety or other decisions relating to safeguarding processes and activities;*
- *Adults who manage their own care and support through personal or health budgets;*
- *Adults whose needs for care and support have not been assessed as eligible or which have been assessed as below the level of eligibility for support;*
- *Adults who fund their own care and support;*

This Annual Report specifically covers Safeguarding Adults activity at the Trust. This report does not cover Mental Capacity Act, Deprivation of Liberty Safeguards (which following the passage of the Mental Capacity (Amendment) Act in May 2019, will be replaced by the new Liberty Protection Safeguards regime).

The reporting year was a busy and pressured one for the Safeguarding Adults team at the Trust. Although there has been a levelling of the previous rise in the number of referrals to the team, the quantitative data does not reflect the significant complexity of the issues experienced by many of the patients referred to the team, and the continuing impact of public sector austerity can and does impact on the ability of partner agencies (especially local authorities) to support the most vulnerable members of the community.

2. Safeguarding Structure and Policy

St George's utilises the Pan-London Adult Safeguarding Procedures which were published in January 2016 in an attempt to provide a consistent response from all agencies involved in adult safeguarding across London. An updated version of these procedures, following a consultation in which the Trust took part, was published in May 2019. These procedures were developed following the introduction of the Care Act 2014 which stands as the key piece of legislation in relation to Safeguarding Adults. These procedures have been adopted by our local partner agencies and by St Georges Adult Safeguarding Committee. The Safeguarding Team will review key challenges to the Procedures and complete any impact assessment regarding any changes in policy and practice which we might need to consider as a result. At the time of writing this report, a synopsis of the areas which have changed is awaited from the London ADASS (Association of Directors of Adult Social Services) who lead on the production and review of the procedures on behalf of the London Adult Safeguarding Board. Updates to these procedures, following a consultation in which the Trust took part, have been published in May 2019. These procedures were developed following the introduction of the Care Act 2014- the key piece of legislation in relation to Safeguarding Adults. These procedures have been adopted by our local partner agencies and by St Georges Adult Safeguarding Committee. St George's local safeguarding guidance, revised in light of the Care Act, sits alongside

the Pan London procedures to ensure staff respond appropriately and proportionately to safeguarding concerns.

An important overall observation is that as the key legislation and Multiagency guidance relating to Safeguarding Adults is considerably more recent than that which relates to Safeguarding Children, there is very considerable variation both between and sometimes within local authorities as to how the procedures are applied. This is also reflected in the way that our local authority partners record data and information. This situation highlights the particular importance of effective partnership working in the Safeguarding Adults sector.

The current staff resources in the Adult Safeguarding team are:

Job Title	Band	WTE	Role comments
Head of Safeguarding – Adults & Children	8B	1 wte	The post holder is responsible for leading the Safeguarding Children and Safeguarding Adults function at the Trust, therefore approximately 0.5 of the post holder's time specifically relates to Safeguarding Children. The postholder works closely with Named and Designated professionals within the Trust, CCG and local authority to ensure the Trust fully discharges its Safeguarding responsibilities. The postholder is extensively involved in partnership work, including but not confined to Safeguarding Children and Safeguarding Adult Boards.
Lead Nurse – Safeguarding Adults	8A	1 wte	The postholder is the operational lead, and first point of contact for Safeguarding Adult issues at the Trust. On any given day this can involve responding to a number of contacts from Trust staff or elsewhere, and often involves much more extensive in involvement in a specific case. The postholder also supports partnership safeguarding activity locally (for example attending the Community Multiagency Risk Assessment Panel) and provides Adult Safeguarding training to staff groups when face to face training is specifically requested or needed. The postholder will also review Trust records in relation to specific patients when there is a requirement to do so.
Safeguarding Administrator	3	1 wte	This is a business support post, providing administrative support also both the Adult and Children's Safeguarding team.
Lead Nurse: Learning Disabilities	7	1 wte	The postholder leads the Learning Disability Nursing service at St George's. This primarily involves providing a service to patients who have been admitted to the Hospital or who are attending the Trust as outpatients. The team provide direct support to patients, many of whom they know well, and provide support and advice to staff. The Band 7 postholder also leads the Trust's strategic work and partnership engagement regarding Learning Disability, although given the operational demands of the post, mean that involves in key initiatives such as the LeDeR programme (Learning Disabilities Mortality Review Programme) can be constrained by the need to ensure that the service is covered operationally.
Learning Disabilities Nurse	6	1 wte	This postholder is an experienced Learning Disability nurse who provides support to patients, and other learning disability related work, and is line manager by the Band 7 postholder.
Mental Capacity Act and DoLs Practitioner	7	1 wte	This practitioner is responsible for operational and strategic leads of the Trust's considerable workstream regarding Mental Capacity and Deprivation of Liberty

Job Title	Band	WTE	Role comments
			Safeguards. The postholder is also leading on the considerable workstream re preparing for the transition. In the reporting year a major focus of the postholder was the design of bespoke Mental Capacity Training materials

3. Safeguarding Alerts April 2018-March 2019

The Safeguarding Team collate data on all 'incoming' contacts to the team. In general these contacts are raised (on the phone, via email or in person) by a member of Trust staff to the Lead Nurse for Safeguarding Adults, although contacts/referrals are also made to the team by other agencies i.e. a Local Authority, or another NHS Trust (i.e. when a patient is admitted to the Trust and the Local Authority is already involved in a safeguarding matter, or whereby a patient is transferred between hospitals). The second row in the table indicates the number of Safeguarding Adult referrals made by the Trust to a Local Authority. In Safeguarding Adults, all such referrals have been completed by the Safeguarding Adults team. The involvement of the Safeguarding Adult Team following a contact varies considerably; in some cases brief advice only might be provided, to advise that Safeguarding procedures are not applicable in the circumstances of the case (although in such cases colleagues are always advised to make contact again if the situation changes or they need further advice) or it might involve a considerable volume of activity such as direct and extensive patient and family contact, referral and liaison with partner agencies and extensive attendance representing the Trust at internal and external partnership meetings. Although there is no typical or average case the level activity normally sits somewhere between these two poles.

Please note that this information does not capture the considerable volume of referrals from the Trust to Local Authorities to adult social care when hospital discharge is required (although the Safeguarding team may become involved in some of the more complex cases in this category). The data in tables 2 and 3 relates to the first row of table 1 (contacts into the Safeguarding team) and the data in tables 4 and 5 relate to the second row of table 1 (external referrals from the Safeguarding team to a Local Authority).

The second row records the number of external referrals i.e. the number of referrals made to a Local Authority Safeguarding Adult Team by the Trust Safeguarding Adult Team. Both Merton and Wandsworth have adult social work teams based at the hospital, although the team have links with the Safeguarding Teams in local authorities across South West London. As will be seen from the data, the number of referrals 'out' is considerably smaller than the number of referrals 'in'. This reflects the considerable role the Trust Adult Safeguarding team play in providing advice, support, and working with colleagues to consider thresholds for intervention.

Table 1:

Number of contacts and referral by year:

Year	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Contacts made to the Trust Safeguarding Adult Team (number)	502	602	825	855	971	841	813	882
Referral made by the Trust Safeguarding Adults Team to a Local Authority Adult Safeguarding team. (number)	133	240	294	290	322	307	316	320

N.B the figures up to and including 2015/16 *included* referrals in relation to MCA/DoLS. As of 2016/17 we are now recording MCA/DoLS figures separately.

Table 2:

Number of Safeguarding Adult contacts (i.e. into the Trust Safeguarding Adult team) by primary presenting concern 2018/19.

Neglect	220
Physical	85
Emotional	43
Sexual	19
Financial	48
Domestic Violence	37 *
Self-neglect	93
Discharge issues and concerns	50
Pressure Ulcer screening	78
Advice/Information exchange	194
Other	15

*- Please note that the Trust employs a Clinical Nurse Specialist for Domestic Violence (who also leads on Female Genital Mutilation response outside of maternity). The figure of 37 for domestic violence only refers to domestic violence cases in which a *Safeguarding Adult threshold (as defined by the Care Act 2014) was also met* (i.e. the patient concerned had an identified need under the Care Act). In such cases there is either close working between the relevant Trust Staff, or it is agreed who is the best placed colleague to lead on the case. The majority of the cases in which the CNS for Domestic Violence provides support, advice and intervention do **not** also involve the Safeguarding Adults team and it is important not to read the above data as suggesting that the Trust only became involving in 37 domestic violence cases in the reporting year.

Breakdown of incoming referrals by Local Authority.

As seen below the largest proportion of Safeguarding referrals at the Trust relate to Wandsworth. Both Merton and Wandsworth have a team of social workers located at the Hospital, who are able to undertake Safeguarding work alongside social care assessment and care management work. For any Safeguarding matter potentially related to the provision of patient care at the Trust, the London Borough of Wandsworth is the lead authority. Please note this data does **not** include referrals to Local Authorities under the Mental Capacity Act asking for the Deprivation of Liberty Safeguards to be applied.

Table 3:

Number of Safeguarding Adult contacts during the financial year 2018/19 sorted by local authority.

Wandsworth	415
Merton	204
Lambeth	57
Croydon	28
Kingston	18
Sutton	34
Richmond	15
Surrey	24
Other	87

Table 4: Number of local authority referrals sorted by presenting concern:

Primary presenting concern	Number of referrals
Neglect	100
Physical	48
Emotional	20
Sexual	11
Financial	26
Domestic Violence	6
Self-neglect	45
Discharge issues and concerns	6
Pressure Ulcer screening	25
Advice/Information exchange	30
Other	3

Table 5:

Local authority referrals sorted by Local Authority:

Local authority Safeguarding Adult team referred to	Number of referrals
Wandsworth	194
Merton	79
Lambeth	14
Croydon	8
Kingston	6
Sutton	12
Richmond	3
Surrey	2
Other	2

4. Patient Story (a vignette illustrated different aspects of Adult Safeguarding at the Trust)

All of the patients with who the Trust Safeguarding team work, have their own story to tell, and they often involve a number of significant adverse life experiences, as well as stories involving great courage, individuality and humour. As well as helping staff identify and address Safeguarding issues, the team have a key role in working directly with patients and staff to ensuring that care and support are provide in a personalised, and person-centred way. The team also support patients in the sometimes complex issue of forming trusting relationships with out of hospital services. The vignette below illustrates just one patient's story. The patients name and sex has been removed for confidentiality.

The patient is 73 years old and was admitted to hospital after Police forced entry to their home after concerns were raised around on-going welfare. The Lead Nurse for Safeguarding Adults was contacted as there were reports from London Ambulance Service of significant self-neglect and severe hoarding which warranted further enquiry. The Lead Nurse discussed the case with the Local Authority Hospital Social Work team. Whilst the patient was very clear in their view that the Police action was unwarranted, and an infringement of their rights, the Local Authority had requested that the Police take this action as they had received many reports about the patient's wellbeing and had been unable to contact them. The Ambulance Service was very concerned about the cluttered state of the home environment.

The patient was very angry at all agencies for inferring their private life, in particular they did not want to see or speak with a social worker. The patient did agree to speak with the Trust Safeguarding Lead Nurse who explored with them their views and wishes about the concerns professionals had. The patient made it very clear that they

did not want any services or support upon discharge from hospital, although it was obvious there were a number of ways in which they would struggle to care for themself.

The patient did eventually agree to see a social worker after much discussion and persuasion. The Lead Nurse and the Social Worker managed to spend some time with them but the patient remained clear that they didn't want support. There was no reason to doubt the mental capacity to make this decision, and the patient went home soon afterwards

The case was considered at the CMARAP (Community Multiagency Risk Assessment Panel), which by keeping offers of support consistent and open, was, after some time, able to oversee a plan which led to some limited engagement with the patient.

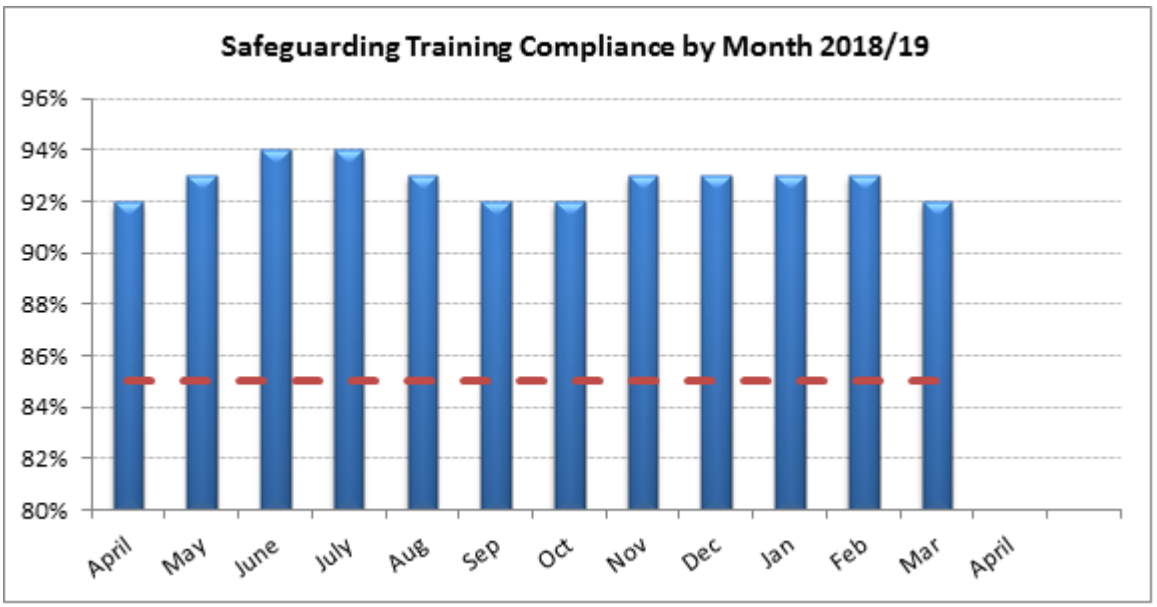
Some months after the difficult admission to hospital there was evidence of reduced risk, including a fire risk assessment having taken place and installation of fire alarms and sprinklers, reduced hoarding and she was engaging with her GP around psychological support

5. Training Compliance 2018/19

All staff working at St Georges University Hospital NHS FT are required to undertake level 1 Safeguarding Adults training. This training is delivered via the e-learning platform and requires users to complete the module and pass a short test after.

The training target for this mandatory training is 85% compliance. As is illustrated by the above below, the Trust-wide levels of Training compliance in Safeguarding Adults are good and have been consistently above the Trust target of 85% for the year.

The Safeguarding team are currently working to deliver the training framework against the new Intercollegiate Guidance, which requires a variety of levels of training mirroring that of Safeguarding Children.



6. Partnership Working and Priority Areas:

The Trust is actively involved in partnership safeguarding activity in relation to Safeguarding Adults, including Local Safeguarding Adult Boards, as well as Health Safeguarding Leads Partnership meetings. The Trust has recently offered to host a meeting of the SW London Safeguarding Adults Health Leads meeting, and will be exploring hosting this meeting on a permanent basis.

The lead nurse for adult safeguarding attends the monthly 'CMARAP' – Community Multiagency Risk Assessment Panel for adults at risk across Wandsworth. These are an opportunity for teams across Wandsworth to present complex cases to senior operational leads across social services, mental health, police, housing, acute health and fire with a view to mitigating risk. Themes include self-neglect, hoarding, disengagement from services, drug and alcohol use and housing issues. There have been a number of successful outcomes for clients through this process.

The Safeguarding Adult team is actively engaged in partnership working at a local level. Safeguarding is a continuum and our responsibility to ensure vulnerable adult patients are appropriately safeguarded does not begin and end with their attendance/admittance and discharged from hospital.

Furthermore the Safeguarding team seek to make long term contributions towards safeguarding outcomes wherever possible i.e. attending planning meetings with partners to plan long term care for specific patients, or with the Lead Nurse for Adult Safeguarding attending Wandsworth Community Multiagency Risk Assessment Panel which meets on a monthly basis to seek to mitigate risk on high risk vulnerable adults living in Wandsworth.

The Named Nurse for Safeguarding Children, the Lead Nurse for Adult Safeguarding and the Head of Safeguarding all contribute more widely to Safeguarding activity via local Children's and Adults' Safeguarding Boards.

The Trust is a Member of Merton Safeguarding Adults' Board, whilst at the Richmond and Wandsworth Safeguarding Adult Boards; Health is represented by the CCG. The Trust reports through the Director of Quality and CCG Safeguarding Leads to this meeting. In the year ahead the Safeguarding team is undertaking work to ensure that our contribution to partnership safeguarding activity (i.e. Safeguarding Boards) is proportionate to the size of the team, is focused on improving safeguarding practice and outcomes across agencies, including our own, and makes a demonstrable difference to activity, whilst avoiding both duplication and ensuring that data collection is purposeful and strategic.

In general, and as would be expected, the Trust has strongly developed partnership working arrangements, and regular contact at a range of levels with both Wandsworth and Merton Councils and Safeguarding Boards

It is notable however that both the Children and Adults Safeguarding Teams are increasingly asked to provide input in relation to a number of patients from a wider range of boroughs, specifically (but not exclusively) Lambeth, Croydon and Surrey. Developing closer links with these Boroughs remains a priority.

There are a number of specific areas of work undertaken by the Safeguarding Team which extend across both the Children's and Adults Safeguarding strands. The report will provide a brief commentary on each of these.

Domestic Violence:

- The Trust employs a Clinical Nurse Specialist for Domestic Violence and Female Genital Mutilation, who works in close partnership with a Senior Independent Domestic Violence Advisor who is an employee of Victim Support based on site at St George's. Both these staff members can be contacted by staff across the Trust, and work either directly with patients who may be experiencing domestic abuse, either during their time in hospital, or after they have been discharged, or provide advice and guidance to staff to support them in patient care in relation to domestic violence.

- The Independent Domestic Abuse Advisor (who is not a Trust employee) is also able support to

provide advice and support to staff experiencing domestic violence in their personal life.

- There is also a Clinical Midwife Specialist for Domestic Abuse works closely with the team when required.

- The Clinical Nurse Specialist has both an operational and strategic role, and the team are working to ensure that staff across the Trust are aware of the support and expertise the postholder can provide. The postholder is also involved in delivering the Trust's training offer but the team is considering ways of extending this.

- The Clinical Nurse Specialist is also the Trust's MARAC lead (Multiagency Risk Assessment Conference) and takes part in three local MARACs (each London Borough has its own MARAC). As an Acute Trust having contact with a very large number of patients this is a key part of the role, and a significant demand on the Clinical Nurse Specialist's time. [please see below for an explanation of MARAC]

- Each borough MARAC is essentially a multiagency body with set up with the purpose of increasing the safety, health and well-being of victims/survivors, adults and their children
- Determine whether the alleged perpetrator poses a significant risk to any particular individual or to the general community
- Construct jointly and implement a risk management plan that provides professional support to all those at risk and that reduces the risk of harm
- Reduce repeat victimisation
- Improve agency accountability, and
- Improve support for staff involved in high-risk domestic abuse cases *(taken from Richmond upon Thames MARAC website, June 2018)*

Female Genital Mutilation FGM:

The Trust's work in the area of FGM prevention has developed during the course of the year, and the Trust now employs a full time Clinical Specialist Midwife for FGM and Perineal Health, who works in close partnership with the Clinical Nurse Specialist for Domestic Violence and FGM (who leads on FGM issues outside of the maternity department). The NHS and other public bodies have been on a public 'learning journey' in relation to female genital mutilation in recent years and there have been a number of important changes for Acute Trusts to respond to.

The Trust has now implemented the FGM-IS system, led by NHS Digital, which is a Smartcard based system designed to add an indicator to the Health records of a female infant or child with a family history of FGM. The Trust also uses our Enhanced RATE system to record contact with patients with FGM, and, along with all Trusts nationally, share anonymised data with NHS England about the number of patents seen at the Trust who have undergone FGM. Over and above the foregoing the Safeguarding team also ensures that FGM is treated as a Safeguarding issue where required.

From June 2019 the Trust will begin hosting a part-time FGM Advocate. This post is funded by the Home Office, and the advocate is employed by the Barnardos National FGM Centre. The postholder will be supervised on a day to day basis by the Clinical Midwife Specialist.

Prevent:

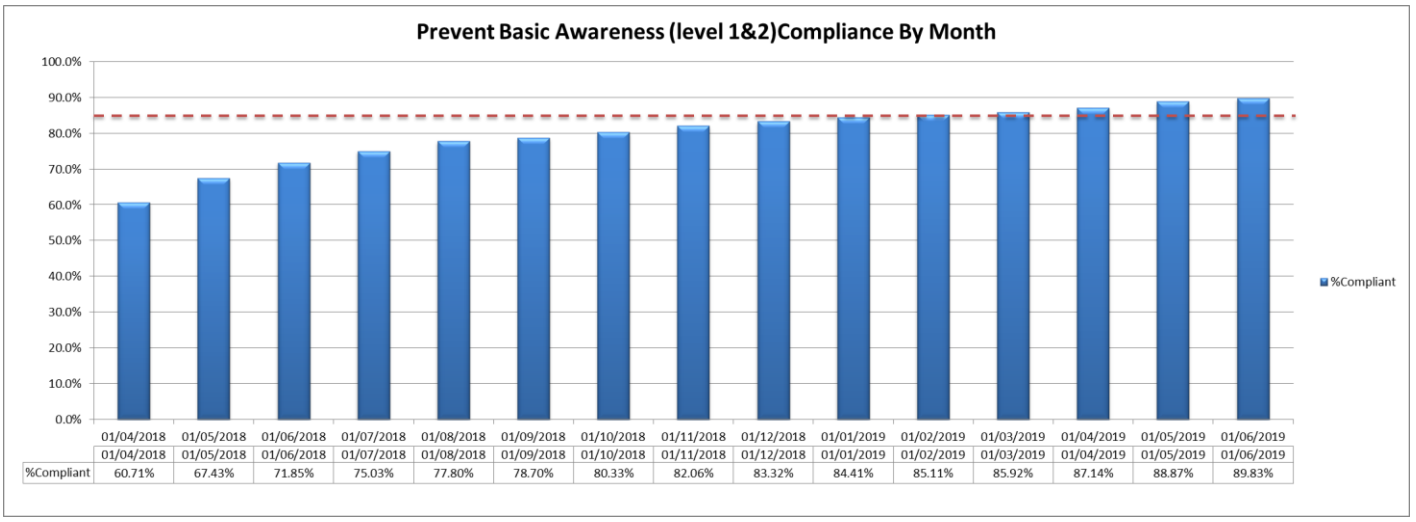
Prevent (short for 'Preventing Radicalisation' work conducted under the auspices of the Government's counter-terrorism strategy) work at the Trust encompasses both the Children's and Adults team and engagement with the NHS England Regional Prevent coordinator as well as local partnerships.

A key theme of Prevent work in the Trust is seeking to improve uptake of Prevent training, which

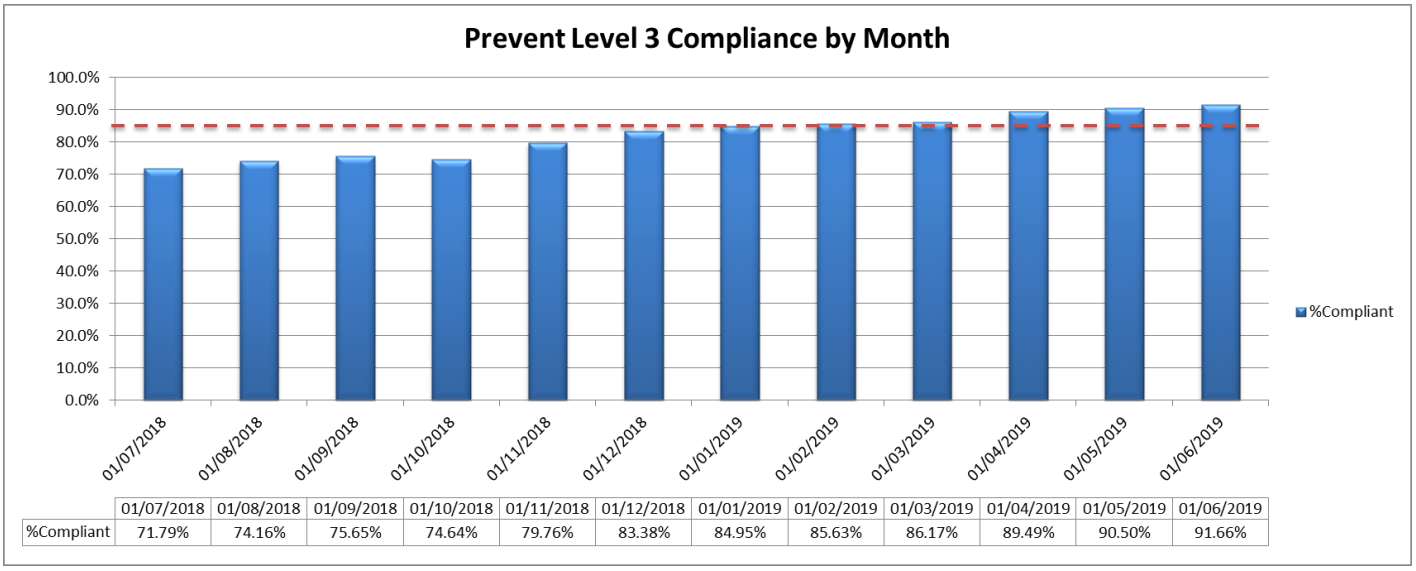
is a statutory requirement. In May 2018 the Trust launched the Level 3 Prevent Elearning module – this has radically improved our compliance and we now comfortable exceed the 85% target.

The Head of Safeguarding is the Trust Prevent lead and the contact person for referrals. As there is a general lack of published information regarding the role of Acute Trusts in the Prevent strategy it is important for the Trust Lead to develop and maintain the existing working relationship with NHS England Regional Prevent Lead to ensure that we are up to date with any developments, as well as horizon scanning more generally.

The new online training seeks to ensure that staff are aware that Prevent activity is not exclusive to adherents of any specific religion or ideology, and also highlights the growing importance of the far-right terrorist threat. The principal reference to the NHS in the Government's updated Counter Terrorism Strategy (Contest: Home Office (June 2018) refers in the main to Mental Health services but Prevent nonetheless remains an important area of the Trust's work.



	01/04/2018	01/05/2018	01/06/2018	01/07/2018	01/08/2018	01/09/2018	01/10/2018	01/11/2018	01/12/2018	01/01/2019	01/02/2019	01/03/2019	01/04/2019	01/05/2019	01/06/2019
%Compliant	60.71%	67.43%	71.85%	75.03%	77.80%	78.70%	80.33%	82.06%	83.32%	84.41%	85.11%	85.92%	87.14%	88.87%	89.83%



	01/07/2018	01/08/2018	01/09/2018	01/10/2018	01/11/2018	01/12/2018	01/01/2019	01/02/2019	01/03/2019	01/04/2019	01/05/2019	01/06/2019
%Compliant	71.79%	74.16%	75.65%	74.64%	79.76%	83.38%	84.95%	85.63%	86.17%	89.49%	90.50%	91.66%

7. Safeguarding Adult Reviews:

The Trust is an active participant in Safeguarding Adult Reviews (SAR). Whilst numbers are too small to establish a definitive hypothesis, there is a tendency for cases which are the subject of a SAR to come from a wider geographical area than solely from the Boards of which we are members, or the Local Authorities with whom we work closely with on a regular basis. It is likely this is linked to the Trust's status as a trauma and tertiary referral centre insofar as the Trust

admits patients from a wider arena in respect of complex, challenging and serious medical presentations.

At the current time the Trust has recently participated in one Safeguarding Adult Review, however this is only a 'snapshot' as we from time to time received notifications requesting information about a case, as the first part of a Safeguarding Board determining if a Review is required. This is not a predictable workflow and represented a significant potential pressure on the Trust's small Safeguarding team.

As with Serious Case Reviews in respect of children the team is seeking to develop a strategy to more effectively harness learning from reviews on a national level – this is more challenging as there is no central collation of SARs nationally. A project led by SCIE (Social Care Institute for Excellent) is apparently underway to address this deficit and we will follow developments closely. The Head of Safeguarding has recently completed training via the Wandsworth Safeguarding Adults Board in the 'Learning Together' model of Safeguarding Adult Review, which was pioneering by SCIE and seeking to deploy a systemic learning model to review processes.

An area of work for future development relates to SARs published nationally which contain important learning for Acute Hospitals- there are often reviews published in other areas which may contain potentially important learning for Acute Trusts on a national basis.

8. The wider picture

There is a large cohort of adult patients at the Trust who fall outside the fairly closely defined remit in the Care Act 2014 of adult safeguarding (see above). This is not to say that there are not a large number of patients at the Trust who would benefit from additional support or intervention of one kind or another. One group in such a category are young people who present at the Hospital following injury incurred as a result of peer or peer violence. Another group 'missing' from Safeguarding Adults legislation are young people who, as children, were in the care of the local authority – i.e. 'care leavers' (whether or not they are formally receiving a leaving care service).

When considering the care and support needs of young people at the Trust, we work closely with the Redthread Youth Violence Intervention Programme. They have a co-located team of youth workers based in the Emergency Department who provide a high quality and responsive service to young people aged 11 to 24 who have experienced or are at risk of serious violence, domestic violence, sexual assault, or exploitation.

There are also significant areas of work and pressure within the Trust which impact patients who are defined as vulnerable adults within the Care Act, but which are indirectly, as opposed to directly linked to Safeguarding, such as issues around safe discharge and adult social care packages.

9. Key risks and challenges in relation to Adult Safeguarding at the Trust.

The key risk for the service which are being managed as follows:
Ensure that the small staff team is able to response to increasing demand due to the scope of adult safeguarding work being although well-defined inconsistently applied and thus generating very high numbers of referrals.

Ensuring that we respond and engage efficiently with all local agencies / authorities across wide geographical area the Trust serves.

In December 2018 updated Intercollegiate Safeguarding Adults guidance was published which clarifies the expectations around Safeguarding Adult training and in particularly sets out expectations regarding face to face as well as e-learning. In common with many or all provider Trusts, we have identified that this represents a potentially significant pressure, as currently the Trust does not employ external trainers, and compliance with face to face learning is harder to achieve than with e learning. The Trust is actively engaged with the Regional Adult Safeguarding Provider leads following, and with a Health Education England initiative in order to work collectively to meet some of these challenges and updates will be provided to relevant

bodies in the Trust as this work progresses.

The Mental Capacity (Amendment) Act 2019 has now been passed, with replaces the current system of Deprivation of Liberty Safeguards (a system overseen and managed by Local Authorities) with the Liberty Protection Safeguards (which gives a greater role to the Trust in decision making around the Deprivation of Liberty). Important (national) Codes of Practice in this area are being written, and implementation by June 2020 will be a challenge from a clinical care, practice and resourcing perspective.

The provisions of the Homelessness Reduction Act 2017 requiring that the Trust offer a referral to any patient who is homeless, or threatened with homelessness within 56 days, to a local authority (of their choice) are now in force. Whilst this is not a Safeguarding Duty under the Care Act 2014, it is important to highlight that awareness of this duty across the Trust is not high, and there remains work to do to ensure that staff offer to refer patients falling into this category the local authority referral to which they are entitled, although it important to note that the Trust's role involves making a referral to a local authority housing department, and this does not guarantee a particular outcome in terms of housing.

10. Conclusion:

The Trust is compliant with its statutory and regulatory obligations regarding Safeguarding Adults, and has participated in the annual Safeguarding Adults self-assessment and assurance with the local authority.

The work of the Safeguarding Adults' team encompasses four strands, and all areas will need to be considered and addressed in the Service Development Plans for the team.

i) Operational safeguarding work; i.e. the provision of advice, active involvement in identified safeguarding cases (ranging for limited to extensive involvement) and the provision of Safeguarding Adults training.

ii) 'Strategic' safeguarding work: developing practice across the Trust to ensure that systems, processes and workplace culture create an environment in which Safeguarding matters can be identified, and when they are identified, effectively addressed. This involves developing internal and external working relationships, the review of available resources and ensuring that quality assurance mechanisms are agile and fit for purpose.

iii) Quality assurance and reporting: There are a considerable volume of reporting requirements in respect of the Safeguarding Adults team, including CCG and local Safeguarding Adult Boards as well as to NHS England (who are sent quarterly figures on priority areas such as FGM and Prevent) and where required the CQC and through internal governance processes within the Trust.

iv) Partnership safeguarding activity: This involves 'formal' Safeguarding Partnerships at Local Safeguarding Adult Boards but also the development and maintenance of effective working relationships between organisations. As identified earlier in the report, the Trust would benefit from developing partnerships or closer working relationships with a wider range of local authorities specifically Lambeth, Surrey and Croydon.

It is hoped that this report gives an indication of the depth and complexity of the work undertaken by the Safeguarding Adults team, and provides assurance that there are appropriate structures and training in place to support safeguarding principles as defined in the Care Act, and as required to meet regulatory standards.

Inevitably an Annual Report involves looking back and reviewing the previous year, however the future year will involve the production and implementation of a Service Development plan, a review of training of the Trust's Adult Safeguarding Training needs and capacity, and the closer integration of Domestic Violence into both Children and Adults safeguarding work at the Trust.

We are also keen to focus partnership working activity, within the available capacity of the team, into activity which has a clear focus on improving outcomes, and which is successful in doing so.

The Team take part in a variety of London wide discussions with Safeguarding Adults colleagues in provider Trusts and seeking to capture best practice regionally will be a theme of the year ahead.

In summary, this was a busy and successful year for the Safeguarding Adults team at the Trust. It is clear both from patient impact and from feedback from partners that the team played an essential role in supporting some of the most vulnerable patients the Trust provides care for, and in combating abuse and neglect, and our contribution to local partnerships has been valued. Given the size of the team, there is an inevitably more that the team would do if it had a larger staff base; i.e. extending quality assurance work and follow up on cases, or providing advice/support and signposting to the considerable group of patients who have additional vulnerabilities but do not meet a 'Care Act threshold' in terms of Safeguarding Adult legislation. A larger team would also impact the visibility of the Trust Safeguarding Adults function, and enhance the team's capacity to provide face to face training. The workload and capacity of the team will be subject to ongoing review in the year ahead.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	27 June 2019	**Agenda No.**	**3.1**
Report Title:	Workforce and Education Committee Report		
Lead Director/ Manager:	Stephen Collier, Chair of Workforce and Education Committee		
Report Author:	Stephen Collier, Chair of Workforce and Education Committee		
Presented for:	Information		
Executive Summary:	This paper sets out the key issues reviewed and agreed by the Committee at its meeting on 13 June 2019, including commenting on assurance to the Board on key risks allocated to the Committee. There are no increased risks to be drawn to the attention of the Board. However, the Committee was concerned at two areas reviewed at the meeting and concluded that these should be specifically identified in this Report. First, the continuing trends of increasing spend on agency staff and a decreasing spend on bank staff. The inference is that the Trust's Bank fill rate is in decline, and we have asked for a detailed analysis to be undertaken. Second, the Committee noted that whilst the Trust is able to re-set its operational policies reasonably quickly, the target timescale for implementation of these is at times over-optimistic. This is linked to a requirement for clearer prioritisation between competing activities, and the targeting of resources to the higher priority areas. We have therefore encouraged more realistic and achievable timeframes for the introduction of new or updated policies, clear direction of appropriate resources, and checks on the progress of implementation.		
Recommendation:	Receive this report		
Supports			
Trust Strategic Objective:	Valuing our staff		
CQC Theme:	Are services at this Trust well-led		
Single Oversight Framework Theme:	Board Assurance, Risk management		

1. Committee Chair's Overview

We continue to have good attendance at the Committee and I would again thank all who made the time to attend, particularly given the experience they bring and their insight and willingness to contribute.

The areas of focus at this month's meeting were: continuing increase in agency spend; progress on the Trust's HR KPIs; forward planning and workforce strategy; the Staff Engagement Plan 2019-21; compliance; policy development; and the operation of the Trust's disciplinary processes. The Committee also reviewed the feedback from its Effectiveness Review, and agreed new draft Terms of Reference reflecting its focus on assurance. These Terms of Reference are now brought to the Board for its review and hopefully its approval.

2. Key points:-

Board Assurance

The Committee has certain risks[1] allocated to it by the Board as part of the Board Assurance Framework, and the Committee's assessment of these risks has not changed. **At the end of its meeting the Committee concluded that there had been no changes to any material risks facing the Trust**.

However, the Committee was concerned at two areas reviewed at the meeting, and asked that these be drawn to the attention of the Board as they may be indicators of change. First, the continuing upward trend over now five months of spend on agency staff and in parallel a decreasing spend on bank staff - and the prospective financial impact of this (see chart below). The inference is that the Trust's Bank fill rate is static or in decline, and we have asked for a more detailed analysis to be undertaken to assess whether this is the case, and if so why, and how this trend can be reversed. We were advised – and accept – that this issue is already getting significant management focus and attention within the Trust. A number of themes were identified that were understood to be driving agency spend, but no data was available to support these suggestions. A deeper analysis will therefore be prepared.

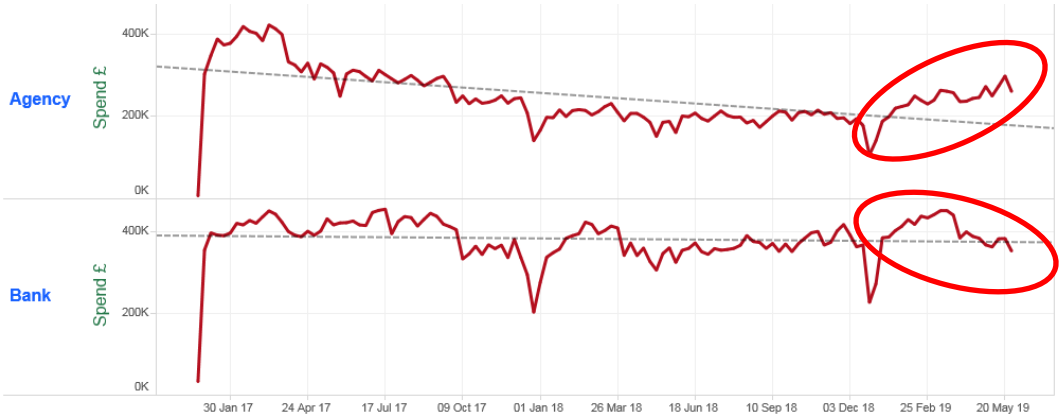


Chart – showing trends in agency and bank spend across the Trust (Dec 16 to May 19)

[1] SR 11 – cultural shift (staff feel engaged, safe and empowered);SR12 deliver diversity and inclusion; SR13 failure to address culture of bullying and harassment; SR14 recruit and retain the right workforce and SR15 unable to deliver new ways of working to deliver our clinical strategy.

Second, the Committee noted that whilst the Trust is able to re-set its operational policies reasonably quickly, the target timescale for implementation of these is at times over-optimistic. This is linked to a requirement for clearer prioritisation between competing activities, and the targeting of resources to the higher priority areas. We have therefore encouraged more realistic and achievable timeframes for the introduction of new or updated policies, clear direction of appropriate resources, and checks on the progress of implementation. This discussion within the Committee was focussed on one new policy in particular but raised a more general point. For the specific policy, the implementation timescale will be re-assessed before it is presented to the Audit Committee for review, and its implementation progress will be reviewed by the Committee in October.

Strategic Themes

Theme 1 - Engagement

The Committee reviewed and endorsed the proposed draft **Staff Engagement Plan 2019-21**, noting the success measures were in a number of areas linked to results of the national staff survey, or the Trust's own quarterly staff FFT results.

As a result of continuing sickness of the Trust lead, there was no **WRES** update available.
The Committee did however review an informative analysis of **Trust disciplinary cases by ethnic group**. This analysed 120 disciplinary cases initiated in the Trust in the twelve months to March 2019 and had been prepared following a request from the Committee at an earlier meeting. The report identified that, on average, the relative likelihood of employees from the Black/Black British ethnic group entering the disciplinary process in 2018/19 was 2.98 times greater than white staff. The analysis also looked at individual staff bands to assess whether the 2.98 figure was a function of a bias to engage at any one or more specific staff bands, but concluded that this was not the case. The Committee was encouraged to hear that a number of actions are being progressed by management to address this and to improve the position. These actions centre on ensuring sufficiently senior and experienced managers are involved in disciplinary process issues; the delivery of unconscious bias training; and the consistent application of processes and progress decisions. The Committee will continue to monitor progress. It was pointed out that focussed action can lead to positive change, in that two years ago the figure stood at 3.88.

The Trust had received a letter dated 24 May 2019 from the Chair of NHSI (Baroness Harding) outlining the **learning from a disciplinary process at another London Trust** that had resulted in a tragic suicide for the individual member of staff concerned some three years ago. A number of recommendations had been made to ensure that this would not occur again, and the Trust was asked to review its own processes and procedures against these. The Committee reviewed the Trust's self-assessment of its current disciplinary policies and processes. Overall, the Trust's policies referenced in the self-assessment were compliant with the recommendations. However, in the time available there had not been time to evaluate the processes actually followed, and the Committee agreed (in this discussion and in a discussion earlier in the meeting) that it would be helpful to receive more information and in a time-series form on the management of disciplinary processes. Management will therefore be bringing this timeliness data to future meetings of the Committee, with an appropriate commentary.

We reviewed a **pan-London review of individual Trusts' gender pay gap** (GPG). The Trust's mean GPG is 13.6%, and below the London average (16.3%), but there is still much to do – particularly in the area of encouraging female consultants to put themselves forward for Clinical Excellence Awards (which within the GPG legislation fall within the definition of a 'bonus').

Theme 2 – Leadership and Progression

There were no specific papers referencing this theme, although we will be receiving an update on the Trust approach to leadership and organisational development to deliver a sustained cultural shift at the next meeting.

Theme 3 - Workforce Planning and Strategy

We reviewed a number of **workforce statistics**, noting that most metrics were moving in the right direction: the vacancy rate had further decreased to 9.12% (down over 4% on a year ago); Trust sickness had fallen back to 3.1% (now below target) although the Committee noted that this varied from 1.02% in one department to 5.98% in another; and staff turnover had fallen (albeit marginally) to 17.12%. Appraisal rates continue to be improved: Non-medical appraisal compliance has increased marginally to 71.6%, whilst medical appraisal has been moved up to 86% overall with consultants at over 90%%.

MAST compliance has now moved through the 90% threshold, and stands at 90.7%, reflecting the continuing increase seen over the last 12 months. However, a concerted effort is needed on mandatory resuscitation training as the current levels of compliance are having an adverse impact on the overall MAST compliance level being achieved by the Trust.

Now that the Trust has announced its Clinical Strategy and NHSI has issued its Interim People Plan (which we reviewed in some detail at the meeting), management has started on the preparation work for the Trust's own **Workforce Strategy.** An initial structure for the Strategy was reviewed and the key feedback from the Committee was that the Strategy should be short and focus on those elements that the Trust could control or influence. Management will be bringing a first draft Strategy to the August meeting of the Committee for review with a view to sign off in December.

Following its success with **Nurse Associates**, the trust has recently established a Steering Group scoping the role, development and governance around the role of the **Advanced Clinical Practitioner** (ACP). 31 such roles are being progressed, with various levels of external funding support.

Theme 4 – Compliance

We reviewed the latest report from the Trust's **Guardian of Safe Working**. To summarise a comprehensive discussion, the reduction in the number of exception reports continued (albeit that this was to some extent an anticipated seasonal shift) and the level and timing of reporting suggested that junior doctors were more comfortable with the system overall. However, one of the exception reports involved an immediate safety concern (the second this calendar year) and this was therefore elevated to the Trusts' CMO who has since been actively involved and attempted to address the issue reported. Part of the background is that there has been a further increase in the number of rota gaps in medicine and cardiology, and recruitment to these is becoming more difficult as the labour market continued to tighten. There are now 78 rota gaps across the Trust, as against 45 last quarter.

Attendees at the Committee noted an apparent increase in the risk to staff of **violence and aggression** from patients and visitors in certain areas, and executive management are going to review the position and if appropriate implement mitigants.

Other – we sought and received assurance from Harbhajan Brar that he was not aware of any areas where there had been or was any **non-compliances by the Trust**.

Stephen J Collier
16 June 2019

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**TRUST BOARD**		
Date:	**27 June 2019**	**Agenda No.**	**4.3**
Report Title:	**M02 Finance Report 2019/20**		
Lead Director/ Manager:	Andrew Grimshaw, Chief Operating Officer		
Report Author:	Michael Armour, Reporting Accountant Tom Shearer, Director of Financial Performance		
Presented for:	Update		
Executive Summary:	The Trust has reported a deficit to date in M2 of £14.5m which is equal to the Pre-PSF/FRF/MRET plan. Within the position, income is adverse to plan by £1.4m and expenditure is underspent by £1.4m. CIP performance is £2.2m which is in line with plan. The Trust has recognised £3.9m of PSF/FRF/MRET funding in Month 1 in line with plan.		
Recommendation:	The Board is asked to note the Trust's financial performance in M2 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

Financial Report Month 02 (May 2019)

Chief Finance Officer

27th June 2019

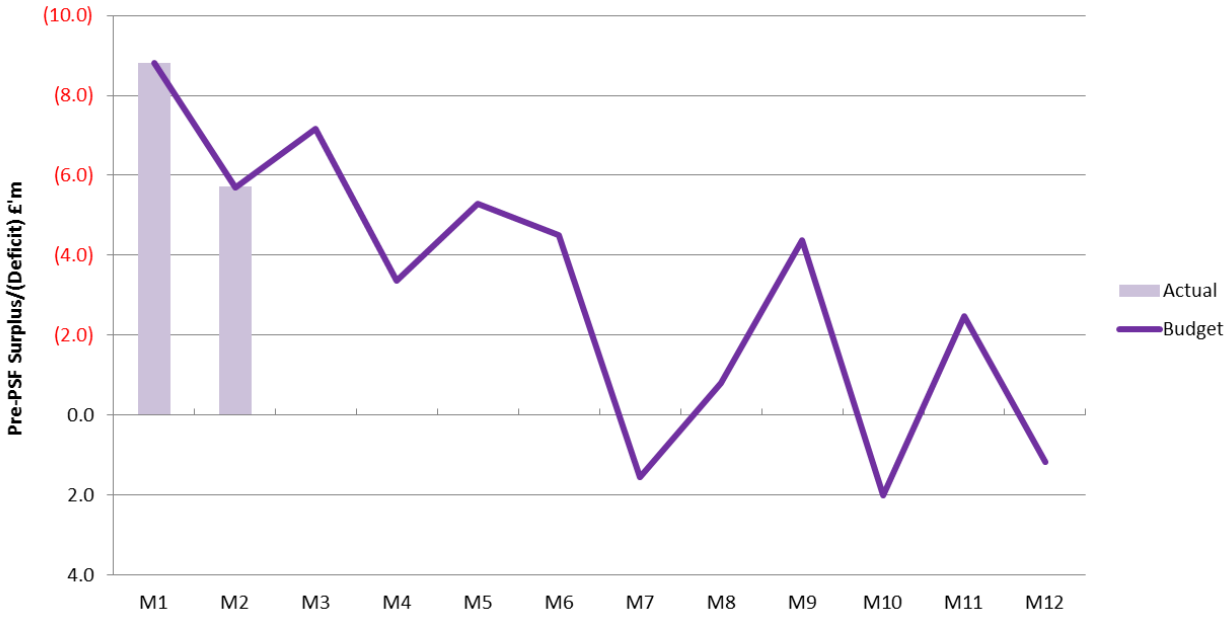
Executive Summary – Month 02 (May)

Area	Key issues	Current month (YTD)	Previous month (YTD)
Target deficit	**The trust is reporting a Pre-PSF/MRET/FRF deficit of £14.5m** at the end of May, which is **on plan**. Within the position, income is adverse to plan by £1.4m, and expenditure is underspent by £1.4m. Within income there remains a high level of estimation consistent with this point in previous years. **M2 YTD PSF/MRET/FRF income of £3.9m** in the plan has **been achieved** in the Year-to-date position, as the Trust is equal to the Pre-PSF/MRET/FRF plan.	On plan	On plan
Income	Income is reported at £1.4m adverse to plan year to date. SLA income is on plan with minor variances between PoDs offsetting at present. Non-SLA income is adverse to plan, which is mainly owing to shortfalls in Pharmacy and Pathology income, both of which are offset by less costs.	£1.4m Adv to plan	£0.8m Adv to plan
Expenditure	Expenditure is £1.4m favourable to plan year to date in May. This is caused by Non Pay favourable variance of £1.2m which is offset in other income. Pay is favourable to plan by £0.2m to date, where non-clinical pay is underspent owing to vacancies.	£1.4m Fav to plan	£0.8m Fav to plan
CIP	The Trust planned to deliver £2.2m of CIPs by the end of May. To date, £2.2m of CIPs have been delivered; which is on plan. Expenditure reductions of £2.2m have impacted on the position. A £3.9m gap remains in Green schemes identified against the £45.8m target.	On plan	On plan
Capital	Capital expenditure of £5.2m has been incurred year to date. This is to plan. The current month YTD position is £5.2m and the previous month YTD position is £2.7m	£5.2m To plan	£2.7m To plan
Cash	At the end of Month 2, the Trust's cash balance was £3.1m, which is better than plan by £0.1m.	£0.1m Fav to plan	£0.2m Fav to plan
Use of Resources (UOR)	At the end of May, the Trust's UOR score was 4 as per plan.	UOR score 4	UOR score 4

Contents

1. Month 02 Financial Performance

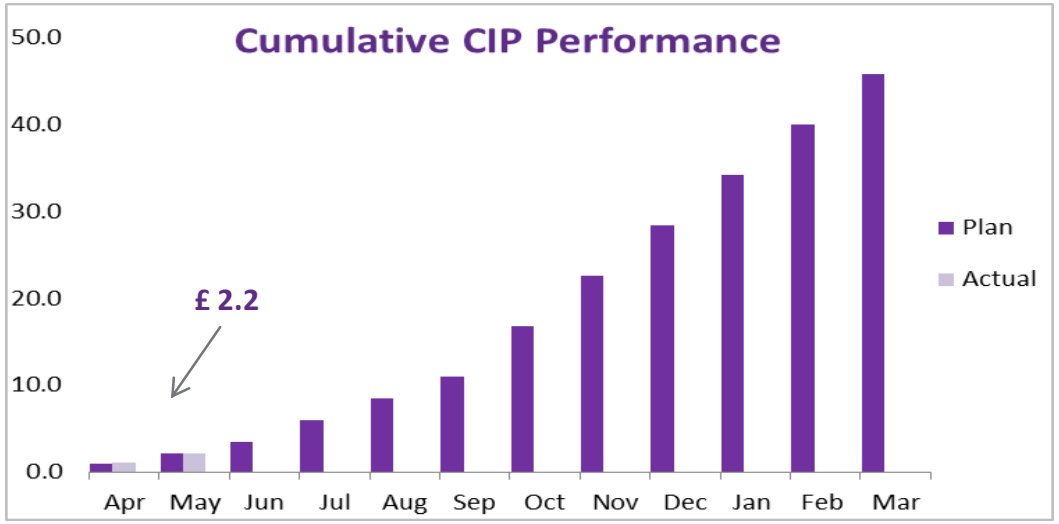
			Full Year Budget (£m)	M2 Budget (£m)	M2 Actual (£m)	M2 Variance (£m)	M2 Variance %	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)	YTD Variance %
Pre-PSF/FRF/MRET	Income	SLA Income	679.7	56.6	56.7	0.0	0.1%	111.3	111.4	0.0	0.0%
		Other Income	157.6	13.2	12.6	(0.6)	(4.7%)	26.3	24.9	(1.4)	(5.3%)
	Income Total		**837.3**	**69.8**	**69.3**	**(0.6)**	**(0.8%)**	**137.7**	**136.3**	**(1.4)**	**(1.0%)**
	Expenditure	Pay	(532.6)	(46.1)	(46.4)	(0.3)	(0.6%)	(93.2)	(93.0)	0.2	0.2%
		Non Pay	(306.1)	(26.4)	(25.7)	0.8	2.9%	(52.9)	(51.9)	1.0	1.8%
	Expenditure Total		**(838.7)**	**(72.5)**	**(72.0)**	**0.5**	**0.7%**	**(146.1)**	**(145.0)**	**1.2**	**0.8%**
	Post Ebitda		(36.3)	(3.0)	(2.9)	0.1	2.5%	(6.1)	(5.9)	0.2	3.1%
Pre-PSF/FRF/MRET Total			**(37.7)**	**(5.7)**	**(5.7)**	**(0.0)**	**(0.3%)**	**(14.5)**	**(14.5)**	**(0.0)**	**(0.1%)**
PSF/FRF/MRET			34.7	2.0	2.0	0.0	0.0 %	3.9	3.9	0.0	0.0 %
Grand Total			**(3.0)**	**(3.7)**	**(3.8)**	**(0.0)**	**(0.5%)**	**(10.6)**	**(10.6)**	**(0.0)**	**(0.1%)**



Trust Overview

- Overall the Trust is reporting a Pre-PSF deficit of £14.5m at the end of Month 02, which is on plan.
- **SLA Income** is on plan, after adjustment for block contract values. There remains a large level of estimation within the M2 income position due to the high level of un-coded activity in the position.
- **Other income** is £1.4m under plan, which is owing to Pharmacy services income, and Pathology income, both of which are offset by reduced cost.
- **Pay** is £0.2m underspent. Non-Clinical pay underspend caused by vacancies is the main driver.
- **Non-pay** is £1.2m underspent, mainly offset by reduced pharmacy services pathology income.
- **PSF Income** is on plan at M02 YTD, at £3.9m. The Trust has met the pre-PSF control total target of a £14.5m deficit.
- **CIP delivery** of £2.2m is on plan. Delivery to plan is:
  - Pay £0.5m favourable
  - Non-pay £0.1m adverse
  - Income £0.4m adverse

2. CIP Performance M02



Delivery

YTD (£ m)			
Category	**Plan**	**Act**	**Variance**
Income	0.5	0.0	(0.4)
Pay	1.1	1.6	0.5
Non Pay	0.6	0.5	(0.1)
Total	**2.2**	**2.2**	**(0.0)**

Plan

2019/20 (£ m)			
Category	**Plan**	**Green Schemes**	**Variance**
Income	9.4	7.1	(2.3)
Pay	23.4	18.5	(4.9)
Non Pay	13.0	16.3	3.3
Total	**45.8**	**41.8**	**(3.9)**

CIP Delivery and Variance

- CIP delivery at the end of M2 is on track compared to plan
- CIP plan Green rating has improved by £4m to £41.8m from the position reported at May FIC, which is 91% of the target

CIP Plan

- The CIP delivery profile steps up at M7, by when the £3.9m gap to 100% Green will need to be closed, to assure full delivery of the target in full

CIP Pipeline / Mitigations

- TEC has taken the decision to hold £3m of budgeted cost pressures as a CIP, until this can be replaced by pipeline schemes. This is included in the current Green plan total of £41.8m
- In addition, all divisions have been asked to identify further CIP schemes that relate to discretionary spend, e.g. use of interims
- Divisions continue the work to translate existing amber, red and pipeline CIP schemes to Green

3. Balance Sheet as at Month 02

	Mar-19 Audited Account (£m)	YTD Plan (£m)	YTD Actual (£m)	YTD Variance to Plan (£m)	YTD Variance to Audited Account (£m)
Fixed assets	**390.5**	**390.1**	**391.7**	**1.6**	**1.2**
Stock	**7.8**	6.5	7.3	0.8	-0.5
Debtors	**101.9**	69.7	109.7	40.0	7.8
Cash	**3.2**	3.0	3.2	0.2	0.0
Creditors	**-122.4**	-102.4	-126.8	-24.4	-4.4
Capital creditors	**-4.3**	-3.6	-7.1	-3.5	-2.8
PDC div creditor	**0.0**	0.0	0.0	0.0	0.0
Int payable creditor	**-1.2**	-1.2	-1.7	-0.5	-0.5
Provisions< 1 year	**-0.5**	-0.5	-0.5	0.0	0.0
Borrowings< 1 year	**-57.6**	-59.5	-57.4	2.1	0.2
Net current assets/-liabilities	**-73.1**	**-88.0**	**-73.3**	**14.7**	**-0.2**
					0.0
Provisions> 1 year	**-1.0**	-1.0	-1.0	0.0	0.0
Borrowings> 1 year	**-284.3**	-283.0	-296.0	-13.0	-11.7
Long-term liabilities	**-285.3**	**-284.0**	**-297.0**	**-13.0**	**-11.7**
					0.0
Net assets	**32.1**	**18.1**	**21.4**	**3.3**	**-10.7**
Taxpayer's equity					
Public Dividend Capital	**133.4**	133.4	133.4	0.0	0.0
Retained Earnings	**-213.4**	-214.4	-224.1	-9.7	-10.7
Revaluation Reserve	**110.9**	97.9	110.9	13.0	0.0
Other reserves	**1.2**	1.2	1.2	0.0	0.0
Total taxpayer's equity	**32.1**	**18.1**	**21.4**	**3.3**	**-10.7**

M02 YTD Balance Sheet

- **The position has been considered at month 2 compared to the actual audited balance sheet in March 19. The commentary below relates to variances to year end. The plan balance sheet will be revised at the next opportunity based on the audited accounts.**
- Fixed assets are £1.2m higher than year end. This includes depreciation charges and capital spend to month 2.
- Stock is £0.5m lower than at year end, mainly due to a decrease in central store area.
- Debtors is £7.8m higher in May as a result of a timing difference with hard to collect invoices. These are being resolved in June.
- Creditors are £4.4m higher from year end. This includes NHSPS invoices and these invoices will be paid monthly from June.
- Capital creditors are £2.8m higher than plan, due to timing issues.
- £5.3m of capital loan was received in May subject to an interest rate of 1.55%. The Trust has requested a drawdown of capital loan in June of £4m with the same interest rate as in May. This is in line with the plan.
- The cash position is as planned. Cash resources are tightly managed at the end of the month to ensure the £3.0m minimum cash balance is not exceeded.
- The Trust requested working capital loan of £6.4m in April and £5.2m in May, a total of £11.6m to fund the current year deficit as per the submitted plan. The Trust will not request a draw down in June.
- The deficit financing borrowings are subject to an interest rate 3.5%.

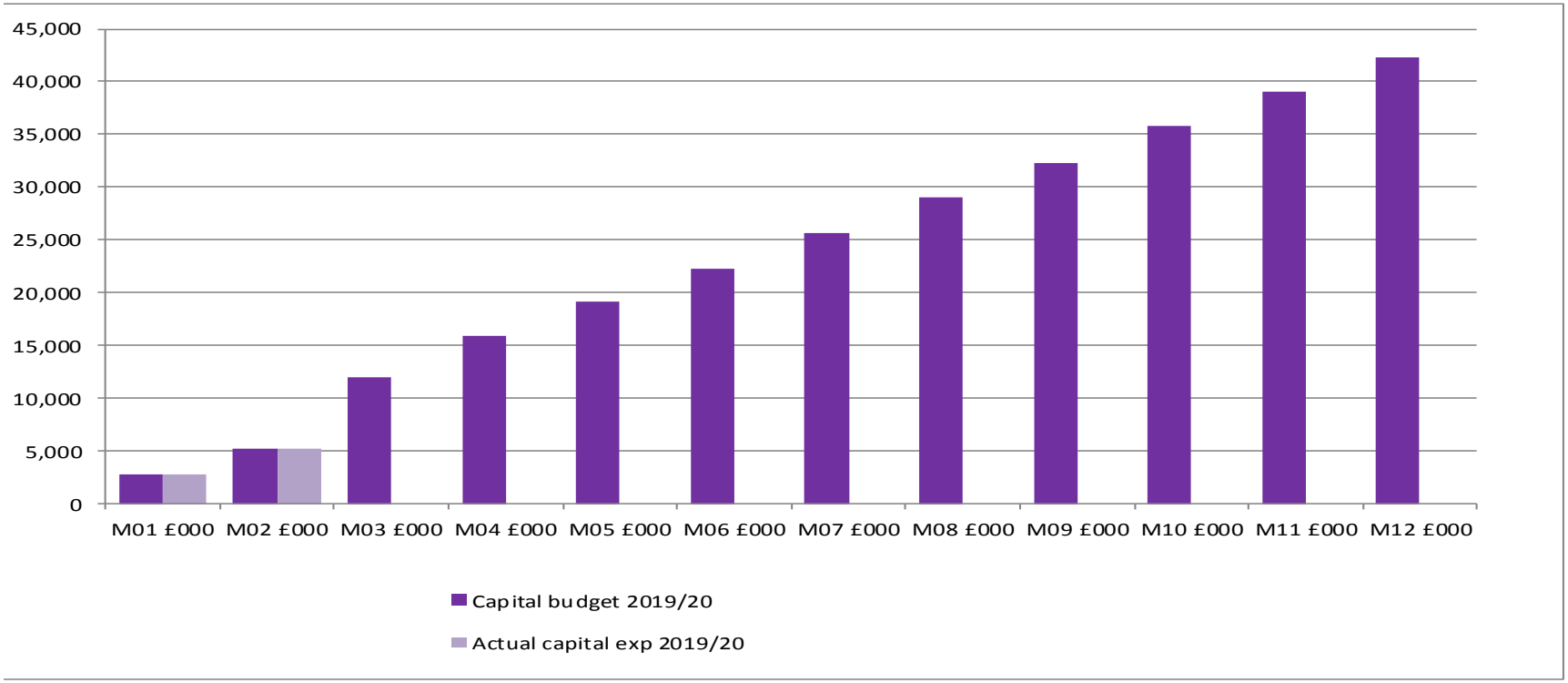
4. Cash flow – Performance vs Plan YTD M2 2019

- The actual M2 cash balance was £3.1m is to plan. The drawdown request for April and May is £11.6m with a variance of £1.8m. The relates wholly to deficit and timing of receipt of MRET funding for Qtr 4.The Trust has not requested funding for June and is managing its working capital effectively. The Trust proposes to repay in August £6.4m borrowed in April, to benefit from savings from interest payments.

Ref	Area	PLAN YTD £000	Actual YTD £000	Variance	Risk	Comment	Lead
1	**Receipts**	**141,580**	**140,572**	**-1,008**		Slightly lower than plan. Actions underway to secure more cash in June.	**LB**
2	**Payments**	**-160,547**	**-152,609**	**7,938**		Includes NHSPS outstanding invoice of £3.4m however these payments will be monthly from June. Also includes a shortfall in capital payment to date due to timing issues	**LB**
3	**Borrowings - deficit financing**	**13,478**	**11,616**	**-1,862**		Lower drawdown than plan. The combined actual drawdown for April and May of £11.6m and the requested drawdown for June of £4.0m is a total of £15.6m and is in line with the submited plan.	**LB**
4	**Capital loan**	**5,257**	**5,257**	**0**		The trust has been granted capital loan of £27.2 million for the year. Actual loan received is in line with the plan. £4.0m has been requested for June and has been approved	**LB**
	Opening cash position	**3,232**	**3,521**	**289**			
	Net cash change	**-232**	**-421**	**-189**			
5	**Closing Cash Position**	**3,000**	**3,100**	**100**			

5. Capital budget and expenditure at M02

Capital budget 2019/20 and YTD expenditure



- The Trust's funded capital expenditure budget for 2019/20 is £42.3m.
- The Trust has incurred capital expenditure of £5.2m in the first two months of the year. This spend is on plan.

6. Finance and Use of Resources Risk Rating

Use of resource risk rating summary	Plan (M02 YTD)	Actual (M02 YTD)
Capital service cover rating	4	4
Liquidity rating	4	4
I&E margin rating	4	4
Distance from financial plan	n/a	2
Agency rating	1	1
SCORE BEFORE OVERRIDES		3
SCORE AFTER OVERRIDES		4

Basis of the scoring mechanism

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

Commentary

- 1 represents the best score, with 4 being the worst.
- At the end of May, the Trust had planned to deliver a score of 4 in "capital service cover rating", "liquidity rating" and "I&E margin rating", and 1 in "agency rating".
- The Trust has scored as expected in these 4 categories, with the first 3 owing to adverse cash and I&E performance.
- The "agency rating" score of 1 is due to improved control and recruitment plans to reduce agency spend within the cap. The internal Trust cap of £15.0m is lower than the external cap of £20.5m.
- The distance from plan score is worked out as the actual % YTD I&E deficit (7.60%) minus planned % YTD I&E deficit (7.50%). This value is -0.10% which generates a score of 2.

Overrides

- The Trust's score is based on the average of the 5 metrics which generates a score of 3.
- However a number of overrides exist which may change this score.
- As the Trust is currently in financial special measures, the Trust score deteriorates to a 4 automatically.

Meeting Title:	**Trust Board**		
Date:	27/06/2019	**Agenda No**	**5.1**
Report Title:	CQC Statement of Purpose		
Lead Director/ Manager:	Avey Bhatia, Chief Nurse and Director of Infection Prevention and Control		
Report Author:	Elizabeth Palmer, Director of Quality Governance		
Freedom of Information Act (FOIA) Status:	Unrestricted		
Presented for:	Approval		
Executive Summary:	All organisations registered with the CQC are required by law to have a statement of purpose; the document includes a standard set of information about our services. The document is required to be accurate and up to date. The statement must be approved by the Board. The statement has been created using the CQC template. It has three parts: • Part 1 gives the legal status of the Trust and the contact details for service of documents • Part 2 describes our aims in providing our services – the high level strategic aims for 2019-24 have been used as they describe our purpose in the longer term. • Part 3 gives details of each of our registered locations. For each location the regulated activities we have registered and the services provided are listed. The service user groups as defined by the CQC are also given. We have five registered locations; we also provide some services from other premises. These premises and the services provided from them have been reviewed to confirm that we are not required to register these premises as a location. The outcome of the assessment, having applied the CQC rules, is that the services are included within the registered location, St George's Hospital.		
Recommendation:	The Board is asked to approve the statement of purpose.		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	Well-led.		
Single Oversight Framework Theme:	Leadership and Improvement Capability (well-led).		
Implications			
Risk:			
Legal/Regulatory:	Compliance with Heath and Social Care Act (2008), Care Quality Commission (Registration Regulations) 2014, the NHS Act 2006, NHSI Single Oversight Framework, Foundation Trust Licence		
Resources:	N/A		
Previously Considered by:	Trust Executive Committee	**Date**	12 & 19 June 2019 June
Equality Impact Assessment:	N/A		
Appendices:	Statement of purpose June 2019		

St George's University Hospitals NHS Foundation Trust

Statement of purpose

Health and Social Care Act 2008

Statement of purpose

Part 1

Name and legal status

Health and Social Care Act 2008, Regulation 12, schedule 3

The provider's business contact details, including address for service of notices and other documents, in accordance with Sections 93 and 94 of the Health and Social Care Act 2008

1. Provider's name and legal status							
Full name[1]	St George's University Hospitals NHS Foundation Trust						
CQC provider ID	RJ7						
Legal status[1]	Individual	☐	Partnership	☐	Organisation	☒	

2. Provider's address, including for service of notices and other documents	
Business address[2]	St George's Hospital Blackshaw Road Tooting
Town/city	London
County	
Post code	SW17 0QT
Business telephone	020 8725 1635
Electronic mail (email)	Jacqueline.totterdell@stgeorges.nhs.uk

Part 2

Aims and objectives

The Trust's aim is to provide Outstanding Care, Every Time for patients, staff and the communities we serve. To support this vision, the Trust agreed a set of strategic objectives. These are:

- Treat the patient, treat the person
- Right care, right place, right time
- Balance the books, invest in our future
- Build a better St. George's
- Champion Team St. George's
- Develop tomorrow's treatment today

Our Strategy for 2019-2024 will help us realise this vision. Our priorities for the next five years describe what we aim to achieve by providing the regulated activities at the locations described in part 3 of this statement of purpose

Strong foundations
We will be an organisation with strong foundations, providing outstanding care, every time. We will ensure we have the fundamentals in place, including a culture of quality improvement. We will provide the right care in the right place at the right time; invest in our staff; balance our books financially; upgrade our buildings and hospital estate; and improve our digital infrastructure.

Excellent local services
We will be a provider of excellent local hospital services for the people of Wandsworth and Merton. We will seize the opportunities identified by our patients, staff and partners to offer planned care (such as outpatient appointments) that is designed around the lives of our patients and delivered using the latest technology; and offer more same day emergency care, so that more patients can be seen, treated and discharged without needing to be admitted to a hospital bed.

Closer collaboration
We will be a leading partner in delivering joined up, sustainable health services for people across south west London. We will work more closely with our local GPs, community services and other hospitals in the area to ensure that patients get the right care in the right place at the right time. We will also work in partnership to respond to the changing needs of our ageing population and help support the financial sustainability of the wider NHS.

Leading specialist healthcare
We will be a provider of leading specialist healthcare for the people of south west London, Surrey, Sussex and beyond. We will strengthen and develop our specialist services, working in partnership with other trusts across south west London and beyond. Crucially, this will involve continuing to be the major trauma centre for the region, and acting as a major centre for cancer, children's and neuroscience services. We will continue to develop our growing strength in research . We will also continue to play a key role in training the next generation of clinicians, in partnership with St George's University of London.

Part 3

Registered locations

St George's Hospital

Blackshaw Road
Tooting
London
SW17 0QT

020 8672 0007

At this location we provide services used by the whole population.

We provide the following regulated activities at this location:

Treatment of disease, disorder or injury
Assessment or medical treatment for persons detained under the Mental Health Act 1983
Diagnostic and screening procedures
Family planning
Maternity and midwifery services
Surgical procedures
Termination of pregnancies

Queen Mary's Hospital

Roehampton Lane
Roehampton
London
SW15 5PN

At this location we provide services used by children from 0 -18 and adults from 18 - 65+.

We provide the following regulated activities at this location:

Diagnostic and screening procedures
Surgical procedures
Treatment of disease, disorder or injury

The table below shows which of our services are provided at our two main hospital sites.

Service	**St George's Hospital**		**Queen Mary's Hospital**	
	Inpatient	Outpatient	Inpatient	Outpatient
Amputee rehabilitation			Y	Y
Audiology		Y		Y
Breast Screening		Y		
Cancer Services	Y	Y		
Cardiac Surgery	Y	Y		

Service	St George's Hospital		Queen Mary's Hospital	
	Inpatient	Outpatient	Inpatient	Outpatient
Cardiology	Y	Y		Y
Chest Medicine	Y	Y		
Clinical Genetics		Y		
Clinical Haematology	Y	Y		
Clinical Infection Unit	Y	Y		
Critical Care – Cardiothoracic ICU	Y			
Critical Care – General ICU	Y			
Critical Care – Neuro-sciences ICU	Y			
Dental • Paediatric • Restorative • Orthodontics	Y	Y		
Dermatology	Y	Y		Y
Diabetes/Endocrinology	Y	Y		
Dietetics	Y	Y		
Elderly Rehabilitation	Y	Y	Y	Y
Emergency Department		Y		
Endoscopy	Y	Y	Day case	
ENT	Y	Y		
Gastroenterology	Y	Y		
General Medicine	Y	Y		
General Surgery	Y	Y		
Gynaecology	Y	Y		
Hepatology	Y	Y		
HIV		Y		Y
Integrated Falls Service	Y	Y		
Interventional Radiology	Y			
Lymphodema	Y	Y		
Maxillofacial	Y	Y		
Minor injuries unit				Y
Neonatal ICU	Y			
Neuroradiology	Y	Y		
Neuro rehabilitation			Y	Y
Neurosurgery	Y	Y		
Neurology	Y	Y		
Obstetrics	Y	Y		
Oncology	Y	Y		
Ophthalmology	Y	Y		
Orthotics				Y
Paediatric Intensive Care Unit	Y			
Paediatric Medicine	Y	Y		
Paediatric Oncology	Y	Y		
Paediatric Physiotherapy	Y	Y		
Paediatric Surgery	Y	Y		

Service	St George's Hospital		Queen Mary's Hospital	
	Inpatient	Outpatient	Inpatient	Outpatient
Pathology Services	Y	Y		
Chronic Pain Service		Y		
Palliative Care	Y	Y		
Pharmacy	Y	Y		
Physiotherapy	Y	Y		Y
Plastic Surgery	Y	Y		
Podiatry		Y		Y
Radiology	Y	Y	Y	Y
Renal Medicine	Y	Y		
Rheumatology	Y	Y		
Senior Health	Y	Y		
Speech and Language Therapy	Y	Y		
Stroke	Y	Y		
Thoracic Surgery	Y	Y		
Trauma & Orthopaedics	Y	Y		
Urology	Y	Y		
Vascular Surgery	Y	Y		
Wheelchair Services				Y

St John's Therapy Centre

162 St John's Hill
Battersea
London
SW11 1SW

At this location we provide services used by adults from 18 – 65+ and children from 0 -18 as outpatients.

We also provide a day hospital service for residents of Wandsworth who are over 65 years of age. The Day Hospital provides an interim facility between acute and primary care settings for this group of patients. They are able to access multidisciplinary assessment and support together with treatment and rehabilitation by therapists on individual and group basis.

We provide the following regulated activities at this location:

Diagnostic and screening procedures

We provide this through the following services:

- X-ray
- Phlebotomy

Treatment of disease, disorder or injury

We provide this regulated activity through outpatient services for the following specialties:

- Integrated falls service and bone health
- Colorectal surgery

- Dermatology
- Dietetics
- Ear, nose and throat
- Audiology
- Gynaecology
- General medicine
- Nephrology
- Plastic surgery
- Rheumatology
- Paediatrics
- Physiotherapy
- Podiatry
- Senior health
- Speech and language therapy

Nelson Health Centre

Kingston Road
Wimbledon Chase
London
SW20 8DB

The Nelson Health Centre is funded through a NHS Local Improvement Finance Trust (LIFT), the overall responsibility for the development lies with Community Health Partnerships (CHP), a limited company wholly owned by the Department of Health. Merton CCG commissions the clinical services provided within The Nelson Health Centre. We share this location with a number of other healthcare providers, the Nelson GP Practice; Nelson Pharmacy; Central London Community Healthcare; and South West London and St George's Mental Health NHS Trust.

At this location we provide outpatient services to the whole population.

We provide the following regulated activities:

Diagnostic and screening procedures
We provide this regulated activity through the following services:

- X-ray
- Ultrasound
- Endoscopy
- Cardiac tests such as Echo and ECG
- Phlebotomy

Treatment of disease, disorder or injury
We provide this regulated activity through outpatient services for the following specialties:

- Gynaecology
- General medicine
- General surgery
- Respiratory medicine
- Rheumatology

- Dermatology
- Trauma and orthopaedics
- Diabetes
- Cardiology
- Urology
- Renal
- Rheumatology
- Plastics
- Colorectal surgery
- Gastroenterology

Her Majesty's Prison Wandsworth

Heathfield Road
Wandsworth
London
SW18 3HS

At this location we provide services to the adult prison population.

We provide the following regulated activities at this location:

Treatment of disease, disorder or injury
Diagnostic and screening procedures

Note: From 31 August 2019 the healthcare services at HMP Wandsworth will no longer be provided by St George's University Hospitals NHS Foundation Trust and we will remove this location from our registration.