St George's University Hospitals NHS

Trust Board Meeting (Part 1) Agenda

Date and Time: **Thursday, 25 July 2019, 10:00-13:40**
Venue: **Room 2.6 Hunter Wing, St George's University of London**

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 meeting on 27 June 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					
10:40	**2.1**	**Quality and Safety Committee Report**	**Sir Norman Williams** Committee Chair	Assure	Report
10:55	**2.2**	**Integrated Quality & Performance Report**	**James Friend** Chief Transformation Officer	Review	Report
11.10	**2.3**	**Cardiac Surgery Update**	**Richard Jennings** Chief Medical Officer	Assure	Report
11.20	**2.4**	**Transformation (Q1) Report**	**James Friend** Chief Transformation Officer	Assure	Report
11.30	**2.5**	**Learning from Deaths (Q1) Report**	**Richard Jennings** Chief Medical Officer	Assure	Report
11.40	**2.6**	**Safeguarding Children Annual Report**	**Avey Bhatia** Chief Nurse & Director of Infection Prevention and Control	Assure	Report
3.0 FINANCE					
11.45	**3.1**	**Finance and Investment Committee Report**	**Ann Beasley** Committee Chair	Assure	Report
11.55	**3.2**	**FIC (Estates) Report**	**Tim Wright** NED Lead	Assure	Report
12.05	**3.3**	**Finance Report (Month 03)**	**Andrew Grimshaw** Chief Financial Officer	Update	Report
4.0 STRATEGY					
12.15	**4.1**	**Corporate Objectives (Q1) Report**	**Suzanne Marsello** Chief Strategy Officer	Assure	Report

Time	Item	Subject	Lead	Action	Format
12.25	**4.2**	**Corporate Support Strategies**	**Suzanne Marsello** Chief Strategy Officer	Inform	Report
12.30	**4.3**	**Outpatients Strategy**	**Suzanne Marsello** Chief Strategy Officer **Emilie Perry** DDO - CW	Approve	Report
5.0 GOVERNANCE					
12.40	**5.1**	**Clinical Negligence Scheme for Trusts (CNST) – Maternity Services**	**Avey Bhatia** Chief Nurse & Director of Infection Prevention	Approve	Report
12.45	**5.2**	**Board Assurance Framework**	**Avey Bhatia** Chief Nurse & Director of Infection Prevention and Control	Approve	Report
12.55	**5.3**	**St George's Hospital Charity Report**	**Suzanne Marsello** Chief Strategy Officer	Assure	Report
13:00	**5.4**	**Horizon Scanning Report: Emerging Policy, Regulatory, Statutory and Governance Issues (Q1)**	**Stephen Jones** Chief Corporate Affairs Officer	Note	Report
13.05	**5.5**	**Workforce & Education Committee Terms of Reference Review**	**Stephen Jones** Chief Corporate Affairs Officer	Approve	Report
6.0 CLOSING ADMINISTRATION					
13.10	**6.1**	**Questions from the public**	**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	
7.0 VALUES AWARD AND PATIENT, STAFF STORY					
13.20	**7.1**	**Staff Values Award Presentation**	**Chairman**	-	Oral
13.25	**7.2**	**Leadership Programme Presentation**	**Avey Bhatia** Chief Nurse & Director of Infection Prevention	-	Oral
13:40 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".**					

St George's University Hospitals NHS

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 (QMH)	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	Chief People Officer	CPO
James Friend	Chief Transformation Officer	CTO
Stephen Jones	Chief Corporate Affairs Officer	CCAO
Suzanne Marsello	Chief Strategy Officer	CSO
Sally Herne	Quality Improvement Director – NHS Improvement	QID
Emilie Perry	Divisional Director of Operations – Children & Women *(deputising for COO)*	DDOCW
Secretariat		
Tamara Croud	Interim Assistant Trust Secretary	IATS
Apologies		
Ellis Pullinger	Chief Operating Officer	COO
Quorum:	*The quorum of this meeting is a third of the voting members of the Board which must include one non-executive director and one executive director.*	

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Meeting Title:	**TRUST BOARD**		
Date:	**25 July 2019**	**Agenda No.**	**1.2**
Report Title:	**Board Member Declarations of Interest**		
Lead Director/ Manager:	**Stephen Jones, Chief Corporate Affairs Officer**		
Report Author:	**Stephen Jones, Chief Corporate Affairs Officer**		
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		

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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	
Stephen Collier	Non-Executive Director & Workforce and Education Committee Chair	Member, Advisory Board: Cielo Healthcare (Milwaukee, USA)	2015	Present	

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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, 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	
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	

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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: Eden Futures (supported living provider)	2016	Present	
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)	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	

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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)	Honorary Consultant: Imperial College London	November 2011	Present	
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)	Collaboration for Leadership in Applied Health Research and Care (CLAHRC) Non-remunerated Board Member	2017	Present	

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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
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

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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	Non-Executive Director Private Healthcare Information Network (PHIN)	2015	Present	Approx. 1 day per month.- remunerated
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

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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	Remunerated
Sarah Wilton	Non-Executive Director and Audit Committee Chair	Non-Executive Director, and Audit and Risk Committee Chair - Hampden Members' Agencies Limited	2008	Present	Remunerated
Sarah Wilton	Non-Executive Director and Audit Committee Chair	Trustee and Vice Chair - Paul's Cancer Support Centre	1995	Present	Non remunerated
Sarah Wilton	Non-Executive Director and Audit Committee Chair	Magistrate – South West London Magistrates Court and Central London Family Court	2005	Present	Non remunerated
Sarah Wilton	Non-Executive Director and Audit Committee Chair	Co-opted Member – Wimbledon and Putney Commons Conservators Audit and Risk Committee	2019 (January)	Present	Non remunerated

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Name	Role	Description of Interest	Relevant Dates		Comments
			From	To	
Chairman and Non-Executive Board Members					
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	

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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	Chief of People	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	Chief Medical Officer	None			

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Name	Role	Description of Interest	Relevant Dates		Comments
			From	To	
Non-Voting Board Members					
James Friend	Chief Transformation Officer	Special Advisor to Secretary of State, Department of Health	2016	2017	Remunerated Requirements of Civil Service code expired on April 2019
James Friend	Chief Transformation Officer	Trustee, Carrie's Home Foundation	2018	Present	Non-remunerated
James Friend	Chief Transformation Officer	Trustee, Westcott Sports Club	2018	Present	Non-remunerated
James Friend	Chief Transformation Officer	Council Liaison Officer, Mole Valley Conservative Association	2017	Present	Non-remunerated
James Friend	Chief Transformation Officer	Member Hut Management Committee, Westcott	2012	Present	Non-remunerated
James Friend	Chief Transformation Officer	Trustee, Westcott Village Association	2010	Present	Non-remunerated
James Friend	Chief Transformation Officer	District Councillor Westcott, Mole Valley District Council	2008	Present	Member of Audit Committee, Chair of Development Control Committee Remunerated

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Name	Role	Description of Interest	Relevant Dates		Comments
			From	To	
Non-Voting Board Members					
James Friend	Chief Transformation Officer	Church Warden, St John's The Evangelist, Wotton	2004	Present	Non-remunerated
James Friend	Chief Transformation Officer	Volunteer, Radioway	1994	Present	Non-remunerated
James Friend	Chief Transformation Officer	Associate Member, Association of Corporate Treasurers	1998	Present	Non-remunerated
James Friend	Chief Transformation Officer	Member Westcott Cricket Club	1996	Present	Non-remunerated
James Friend	Chief Transformation Officer	Member Chartered Institute of Bankers	1996	Present	Non-remunerated
James Friend	Chief Transformation Officer	Member, National Trust	1992	Present	Non-remunerated
Stephen Jones	Chief Corporate Affairs Officer	Wife is a senior manager at NHS England	5 March 2018	Present	
Suzanne Marsello	Chief Strategy Officer	None			
Ellis Pullinger	Chief Operating Officer	None			

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Minutes of the St George's University Hospitals NHS Foundation Trust Board Meeting
In Public (Part One)
Thursday, 27 June 2019, 10:00 – 13:30
Hyde Park Room, 1st Floor, Laneborough Wing St George's Hospital

Name	Title	Initials
PRESENT		
Gillian Norton	Chairman	Chairman
Jacqueline Totterdell	Chief Executive Officer	CEO
Ann Beasley	Non-Executive Director	NED
Stephen Collier	Non-Executive Director	NED
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 Human Resources & Organisational Development	DHROD
Ellis Pullinger	Chief Operating Officer	COO
James Friend	Director of Delivery, Efficiency & Transformation	DDET
Stephen Jones	Director of Corporate Affairs	DCA
APOLOGIES		
Suzanne Marsello	Director of Strategy	DS
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.

Neuro Outpatients and Kent Ward: Chairman and DHROD
The DHROD reported that the two services were very clean and calm. Neuro Outpatients had a bronze level ward accreditation and were keen to learn from Kent Ward which had a gold rating, which was very evident from the visit. The good level of team engagement and joint working was also evident and this was reflected in the team morale.

Phlebotomy Outpatients and Gynaecology Outpatients: Ann Beasley
Ann Beasley reported that having previously visited these areas it was good to see the progress made. The teams were prepared for the Care Quality Commission (CQC) inspection and could

Feedback from Board Visits

clearly articulate key challenges in relation to fire, water and other safety checks. The Phlebotomy service was very busy and whilst the team was professional the environment was less friendly and facilities made the service feel undervalued. With more blood test taken for people outside St George's it was important to contact GPs to ensure they were not sending people to the Trust for blood tests. The teams commented that there had been real improvements in recruitment processes, though there were still some delays in relation to the processing of selected candidates and undertaking employment checks in a timely way. The printer in Phlebotomy had not been working for a year and it was agreed that the COO would follow this up.

Gunning and Holdsworth Wards: Sir Norman Williams and DDET

The DDET reported that the nursing lead had spoken highly about the closer team working between doctors and nurses. A key challenge for the service was space availability, with large pieces of equipment taking up valuable treatment space. However, the team had adopted a flexible approach. The team was actively using the quality board and they were very impressed by the prescribing pharmacists. Sir Norman Williams also reported that a discharge co-ordinator had commented that whilst processes were working well it would be useful to have better liaison with the community teams and asked the Trust to facilitate closer contact and engagement.

Sterile Services and Paul Calvert Theatre: Sarah Wilton and CWO

The CEO reported that there was a lot of good team working and staff engagement in Paul Calvert Theatre. Because of the size of orthopaedic instruments and space restrictions, Paul Calvert Theatre had moved to St James's wing and the team was currently progressing plans to convert recovery space into storage. Sterile Services was very impressive with the teams working well. With young enthusiastic staff they focused their recruitment on values predominately. Sarah Wilton also reported that there were some estates issues such as a leak which should be addressed immediately and there were also some issues with the kit. Orthopaedics was also working well with SWLEOC as part of the partnership. The COO advised that engineering and capital planning was looking at the how to fund and address the estates issues and refresh the equipment. In response to a question from the Chairman, the CEO reported that at each SWL Acute Provider Collaborative meeting the list of referrals to SWLEOC was reviewed and recently the Trust was referring more patients more quickly.

Surgical Admission Lounge and Nye Bevan Unit: Prof Jenny Higham and CMO

The CMO reported that the surgical admissions lounge was a very positive place to work but it was noted that the unit could be very hot with patients waiting up to nine hours for their surgical intervention. However, as a testimony to the very good staff engagement and management of patients, patients tended not to complain. The team was looking for charitable funding to renovate the space to be more patient focused. The Nye Bevan Unit, which received patients from the emergency department, conducted surgical ambulatory care. The service was currently quite modest and if the Trust were to upscale this service it could potentially prevent around two thirds of surgical admissions. The service was proactive and engaged with the emergency department pathway.

Emergency Department: Stephen Collier and CN

Stephen Collier reported that the department was focused on its performance in relation to the CQC's key lines of enquiry (KLOE). The service was looking at how it could move from a performance-driven service to a quality framework, for example time to treat, how they care and trauma, resuscitation emergency, leadership innovation and sepsis (TRELIS). In response to the staff survey, the team had established a staff council to address the key issues and ensure staff felt valued. The team were responding flexibly to the key changes in demand and capacity and the new head of nursing was already settling into the team. The Chairman queried the variability of performance against the 4 hour standard and commented that it was important that the Board noted the continued volatility around this performance metric. Whilst it was recognised that there may be a 'London-wide' element to performance, the Trust still had some way to go to demonstrate consistency. Stephen Collier reflected that the team saw this as a key performance metric but also felt the time to treat indicator was equally as valuable.

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Feedback from Board Visits
Dragon Centre and Child Development Centre: Tim Wright and COO Tim Wight reported that the environment was calm and nice. Space, however, was very limited in clinical rooms. Something needed to be done in relation to the two reception areas which could lead to patients being redirected. The Child Development Centre also had challenges with tensions with the community links. Two areas for further consideration in relation to the Dragon Centre related to flow and whether or not this would be improved by using chairs instead of beds.

		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 DS who was attending a South West London Heath and Care Partnership meeting on behalf of the CEO.	
1.2	**Declarations of Interest** The Board noted the register of Board members' interest. Sarah Wilton reported that since January 2019 she had been a co-opted member of the Wimbledon and Putney Commons Conservators Audit and Risk Committee. She also clarified that her roles with Hampden and Capita were remunerated. The DCA confirmed that the Board register of interests would be updated to reflect these changes. Sarah Wilton clarified that none of these new interests were relevant to the decisions and discussions at the meeting.	
1.3	**Minutes of the meetings held on 30 May 2019** The minutes of the meeting held on 30 May 2019 were agreed as an accurate record.	
1.4	**Action Log and Matters Arising** The Board reviewed the action log and noted that all three actions on the log were not yet due. However, it received an update on the following action: • **Action TB25.04.19/01**: The CN reported that she would be taking a paper on the BAF and risk management to the Audit Committee on 1 August which would address the action. On that basis, the Board agreed that this action could be closed and that an update on the Committee's consideration of the paper should be included in its report to the Board. It was agreed that prior to the Audit Committee, the CN would meet Sarah Wilton, in her role as Audit Committee Chair, to discuss the paper.	**CN**
1.5	**Chief Executive Officer's Update** The CEO highlighted the key elements of her report, noting the Trust's engagement with the South West London Health and Care Partnership, its joint working with South West London and St George's Mental Health Trust to improve the experience of patients with mental health needs, and the publication by NHS England and NHS Improvement of the NHS Interim People Plan. The Board received and noted the CEOs report.	

		Action
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 20 June 2019. The deep dive into the maternity service highlighted an increase in activity and the number of patients presenting with co-morbidities. The Committee recognised and commended some areas of very good performance and practice, but also noted that there were areas in which improvements could be made, for example around succession planning in the service. The Committee also challenged the service on the increase in the number of emergency caesarean sections and was told that the 8% target was a local target set based on previous year's performance where there were very few. The national target was 14% and the service would look at revising the local benchmark. The Committee noted that there had been eight clostridium difficile cases since April 2019 but no lapses in care had been found. The Committee would continue to monitor performance on infection control closely. There had also been eight serious incidents in May 2019, which was more than usual, and the Committee would consider the lessons learnt reports and continue to monitor this area closely as to any trends. The Committee was also pleased to note that there had been an improvement in the friends and family tests scores but noted more needed to be done to improve response rates. The Trust also completed two of the four outstanding actions related to nursing appraisals and the completion of the level 1 Mental Capacity Act/Deprivation of Liberty (MCA/DoLs) training target. More work was required on the resuscitation training and implementing the medical records storage units. The Committee was assured by the comprehensive review into the recent infection control incidents related to salmonella and candida auris. It had welcomed and reviewed the clinical governance review, which the Board would discuss later in the meeting. The Board noted the report.	
2.2	**Integrated Quality and Performance Report (IQPR)** The DDET gave an overview of the IQPR at Month 02 (May 2019). The IQPR now included the 'plot the dots' SPC data which was the output of the NHS Improvement (NHSI) benchmarking work. Elective activity had increased and the elective length of stay had reduced. The number of cancellations on the day demonstrated sustained improvement. The COO reported that in terms of emergency care flow the Trust received 9% more admissions in the past week compared to the same time last year. Compared with other Trusts across London, the Trust performance on delayed transfer of care was in a better place. It was however recognised that more needed to be done to manage the pathway and improve the discharge process. Work to improve cancer performance was underway and the focus was on the 62-day and 2-week targets. June performance was looking better than May's position. The CN flagged that the actions to deliver the resuscitation training targets in relation to the CQC action plan were set out in the IQPR. The Board was also asked to note that there had been 10 cases of Methicillin-sensitive Staphylococcus aureus (MSSA) since April 2019 and a root cause analysis was being undertaken for each case. Whilst this was not a mandated target for reporting the Trust was keeping this under close scrutiny.	

		Action
	The DHROD reported that the workforce data is now available in the 'plot the dot' format which was supporting effective performance management. Staff performance was improving with non-medical appraisal rates at 84.5% and consultant appraisal rates above 90%. Sir Norman Williams flagged that whilst it was good to see the improvement in the number of appraisals being undertaken it was equally important to focus on the quality of the appraisals and it would be therefore useful to conduct an audit of quality of the appraisals. Jenny Higham reported that the new consultants appraisals also had an element about feedback on the quality and noted that once the Trust had circa six months of data it could include this in the way Sir Norman had suggested. **It was agreed that the CMO and DHROD would look into reviewing quality of appraisals and report to the Workforce and Engagement Committee.** The CMO noted that whilst it was possible to complete an audit on appraisal quality the Board should be cognisant of the difficulties of meaningfully assessing this and noted that some of the information in medical appraisals may be subject to restrictions. In response to a query from Sir Norman Williams, the DDET advised that the internal target for discharges before 11 am had been reduced. This was to reflect that the important issues were making sure that flow and capacity was being managed effectively and that patients were placed in the right place to receive the right care. Having reviewed performance it was evident that a majority of patients were capable of being placed in downstream wards earlier than the arbitrary 11:00 am deadline. Sarah Wilton commented that when reviewing the content of the IQPR thought should be given to including benchmarking data. It would also be useful to understand when the Trust would achieve the complaints target. The COO advised that each committee needed to consider what benchmarking data would be useful and agreed to facilitate these discussions. In response to Sarah Wilton's comment on complaints, the CN reported that the Trust was forecasting achieving the complaints target by September 2019 and this work would be supported by the new head of patient experience and a new team was being established. The Chairman reflected that attaining the complaints target would not solely rest with the experience and complaints team and that the whole organisation needed to be mobilised to engage and respond to complaints effectively. In response to a query from Stephen Collier, the DDET advised that performance on the cardiothoracic waiting list was tracked weekly through the 'magic numbers' performance report and considered at the Trust Executive Committee. The COO reported that the movement in the waiting list related to a step-up of activity in May but this seemed to have stabilised in June. The Finance and Investment Committee would conduct a further review of this performance target by reviewing the patient tracking lists. The Board noted the report.	**CMO & CoP TB27.06.19/01**
2.3	**Clinical Governance Review** The CMO provided an overview of the comprehensive clinical governance review which had been externally facilitated and which had also been discussed at the Quality and Safety Committee the previous week. Whilst the Trust had a good reputation in relation to reviewing mortality and structured judgment reviews and was recognised as having a good clinical incident	

		Action
	review process, the issues with cardiac surgery had still arisen. The review process included 23 interviews with individuals, a review of 29 multi-disciplinary team (MDTs) and mortality meetings. The review outlined three key areas for development: i. Corporate Safety Processes: learning from deaths and ensuring there were more robust ways to feed into the departmental reviews; ii. MDTs: Whilst there was good practice in some areas there were variations. Therefore, there needed to be a robust system and proper capability to do the work. There was also a perception that the systems were too medically led. iii. Community of Clinicians: The Trust needed to build a community of clinicians responsible for safety governance reviews. This would include chairs of MDTs and mortality review meetings. This would also include a single governance process. The CEO noted the importance of this work and commented that it would require a change in culture, but there were green shoots in the organisation exemplified by the quality improvement work undertaken by the urologists. Sir Norman Williams commented that the Quality and Safety Committee had welcomed the review and noted that if implemented effectively this would result in significant quality improvement in the process. In addition, it was important that variation in practice was addressed and support was given to teams to implement the recommendations which included provision of co-ordinators to organise meetings; a business case should be developed to ensure there were sufficient resources. People also needed to feel that this work was of value and the clinical excellence awards framework could be used to encourage people to take this on. The CMO agreed that there were implicit resourcing issues and these would require upfront investment. When the recommendations were implemented the leaders of this work would have a new profile and this community would have direct access to the CMO and the Quality and Safety Committee which changed the profile of these roles which are sometimes currently taken on by the newest, most inexperienced members of staff. The CMO advised that consideration would be given as to how impact was best measured but as the variations reduce and the Trust moved to a single governance framework and more information being uploaded to national databases, outcomes would be a key indicator. Other indicators could include KLOE and get it right first time (GIRFT) metrics. **The CMO agreed to present a formal report to the Board on the metrics which will be used to measure impact of implementing the recommendations in the review.** The Chairman and Tim Wright commented on the ambitious timetable for implementing the actions in the implementation plan. **It was important to maintain the balance between pace and realism and CMO should include an update on implementation of the action plan in the next report to the Board.** The Board welcomed and noted the report.	**CMO TB27.06.19/02** **CMO TB27.06.19/03**
2.4	**Cardiac Surgery Update** The CMO presented an update on the steps being taken to improve the cardiac surgery service and outlined the key points of the report. The CN noted that there seemed to be lots of positive improvements and, given this,	

		Action
	queried the rationale for maintaining the current risk scoring. The CMO advised that the Trust had already adjusted the income forecast and the risk scoring related to the adjusted assumptions. The patient numbers had not changed but there remained some underlying volatility and as a result the CMO felt it was not appropriate to change risk scoring at this time. In addition, he commented that whilst other indicators remained on track, this did not give rise to changing the risk scoring at this stage but recognised that this may need to be done in the latter part of the year. Jenny Higham commented that the Trust had done a lot around patient referrals and it was important to ensure this and other cardiac surgery successes were effectively communicated in order to increase activity and income. This should include robust relationship development and building confidence in the Trust's service. The CMO agreed that more could be done to communicate the successful outcomes in the service but also noted that Steve Livesey, Associate Medical Director (Cardiac Surgery), was actively engaging with referring hospitals to rebuild patient referrals to the service. The Board noted the report.	
2.5	**Quality Improvement Academy Quarter 1 Update** The DDET introduced the report which set out the progress and impact of the Quality Improvement Academy (QIA) work completed. There was lots of good quality improvement work going on across the Trust with good examples including the Digestive Flow project. Work was now underway to look at how the Trust could effectively measure the impact of the QIA work and a Board seminar would be organised to engage the full Board in discussions. Sir Norman Williams suggested that it may be useful to use some of the GIRFT indicators to measure the outcomes and impact of the QIA work. The Chairman stated that it was important to hear staff talking about quality improvement (QI) and to ensure that QI was built in systematically into everything the Trust did and commented that the Board needed to be more involved and engaged with QI. The CN reported that the staff story in July would focus on QI and leadership. QI took a long time to implement and embed but the Trust was beginning to get traction throughout the organisation and more staff were engaged. The CEO noted that it was important that the Trust used 'the St George's Way' QI methodology in everything it did and this needed to be unpacked at the Board seminar. There were some fantastic initiatives across the Trust and the Trust needed to highlight this work. Sarah Wilton noted that the Board would benefit from seeing a heat map of activity and projects which would enable easy visibility of any gaps and how it triangulated with performance. She also queried the extent to which the maternity service was involved in QI and the DDET reported that the maternity team were part of three QI programmes including Diabetes and Outpatients. **It was noted that a Board Seminar on QI would be organised and consideration would be given to how best to measure impact.** The Board noted the report	**CCAO & CTO TB27.06.19/04**
2.6	**Safeguarding Adults Annual Report** The Board received and noted the Annual Safeguarding Adults Report which	

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	had been discussed at the Quality and Safety Committee on 20 June 2019. The CN outlined the key elements within the report. The Chairman noted that the Quality and Safety Committee had been substantially assured by this report. The Board noted the report.	
3.0	**WORKFORCE**	
3.1	**Workforce and Education Committee Report** Stephen Collier, Chair of the Committee, provided an update on the meeting held on 13 June 2019. The underlining workforce metrics were going in the right direction but it had been slow. There had been a divergence in the trend between agency spend and bank staff usage, with agency increasing and bank usage decreasing and the Committee were considering the key drivers and bank fill rates. The Committee was also cognisant of the need to balance pace and traction in addressing some of the key workforce issues and the ability of the Trust to prioritise key workforce actions. The Committee raised concerns about the progress being made in relation to the Workforce Race and Equality Standard especially in light of the national staff survey feedback and a report was due to the Committee soon. The Committee also considered the engagement plan being discussed in Part 2 of the Board, and were concerned that while it was a good start it did not go far enough to address the root cause issues and drive the change in culture required. Ann Beasley queried the overlap between the work of the Committee and that of the Finance & Investment Committee in reviewing agency spend noting that it was important that both committees were not focusing on the same things. She also queried the degree to which the Committee was considering key strategic risks. For example, the new clinical strategy called for new ways of working and it would be good to understand how the Committee was scrutinising and managing this risk. Stephen Collier reported that this was covered under theme three of the Committee's report and the Committee would consider a further report at its August meeting. In relation to wider workforce risks, the Committee critically examined workforce data and the impact on other key metrics . The DHROD also reported that in relation to Board Assurance Framework SR4 the Committee focused on different metrics to assess impact on culture and bullying and harassment. In addition, a report on new ways of working would be presented to the Board in December 2019. On diversity and inclusion, the Trust would have to start to think differently about how it delivered this agenda. Sarah Wilton queried how new ways of working fitted into the QI programme and noted that this work should not be done in isolation. The DHROD commented that the clinical strategy work was within the programme of work and would consider QI as part of this process. The DCA and CN flagged that with the new BAF risks, approved at the April Board, being presented in the new framework it was time to consider how each Committee looked and embedded this to ensure consistency. The CFO added that this would also be reflected in the way in which the Trust Executive Committee reviewed risks. The Chairman also noted the good performance in relation to sickness and absence rates and the CEO reported that focus would be given to how the Trust supported people to feel well-led. The Board noted the report.	
4.0	**FINANCE**	

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4.1	**Finance and Investment Committee Report** Ann Beasley, Chair of the Committee, provided an update on the meeting held on 20 June 2019. The Committee had discussed plans around the development of a five-year financial strategy and a further report would be presented to the Committee in September 2019. The Committee was pleased to see the inclusion in the IQPR of SPC charts and felt this was an important step in understanding changes in performance data. The Committee noted the good process made on the roll out of Cerner which was expected to go live at Queen Mary Hospital in September 2019. The Committee also considered the impact of the capital allocation across the SWL Health and Care Partnership. The Board noted the report.	
4.2	**Finance and Investment Committee (Estates) Report (FIC(E))** Tim Wright, Non-Executive Director lead for estates, provided an update on the meeting held on 20 June 2019. FIC(E) had noted the good progress made on the immediate actions related to water safety and noted the updates on work around fire and ventilation. The Committee was tracking progress in each area. In addition, the Committee considered the work that had started on developing the medium and long term plans for estates. The Committee continued to be concerned about capacity to undertake the work required and would receive the report from the external governance review in July 2019. The Chairman noted the significance of this work and commented that good progress was being made. The Board noted the report.	
4.3	**Month 02 Finance Report** The CFO reported that at Month 02 income and expenditure was in line with plan which was good news, but he noted that there was a long way to go until year-end. Key challenges included managing contract income and the tensions created with the block contract. On capital, the CFO noted that the Trust's capital budget for 2019/20 was £42.3m and that spend against this was on plan, with the Trust having spent £5.2m of capital expenditure year-to-date. Estates remained the key focus of capital expenditure. The Trust Executive Committee was maintaining weekly scrutiny of the financial position. The Board noted the report.	
5.0	**Governance**	
5.1	**Care Quality Commission (CQC) Statement of Purpose** The Board received and approved the CQC Statement of Purpose.	
6.0	**CLOSING ADMINISTRATION**	
6.1	**Questions from the public** The Chairman invited questions from the public. Mr Nicolas Low, a member of the public, raised concerns about recent media publications around MITIE and the reports that MITIE cleaning staff were also undertaking catering duties and he queried the extent to which	

		Action
	the Trust conducted due diligence on the business modelling and accounting practices of firms to which it awarded contracts and how this could impact on the Trust's reputation. The CFO reported that the Trust conducted all required due diligence processes, including looking at MITIE's ability to deliver the contract, as part of the robust procurement and tender award processes. For the avoidance of doubt, the CFO stated that catering and cleaning were conducted by different staff members.	
6.2	**Any other risks or issues identified** There were no other risks or issues identified that were not already considered by the Board or on the risk register.	
6.3	**Any Other Business** There were no matters of any other business raised for discussion.	
6.4	**Reflections on the meeting** The Chairman invited the CN to offer reflections on the meeting. The CN commented that the agenda items were managed flexibly within time giving more times to key discussion points as required to ensure Board members were able to raise the necessary points. The discussion on the clinical governance review was very good and it was good to see NED-on-NED challenge in addition to NED-on-Executive challenge, which was reflective of the progress the Board had made and the fact that it was working well as a unitary Board. The IQPR had developed and enhancements, such as the introduction of SPC charts, had further aided discussions. Thought was now needed about how relevant benchmarking data was included in the IQPR, but it was already evident that the discussions were more strategically focused. In particular, the triangulation made by the COO as part of the IQPR discussion was good. The CEO's report was now more strategically focused. Finally, it was now time to review the Board visits format to ensure it was addressing the needs of Board members. The Chairman and a number of Board members supported the review of the Board visits and noted that it was important to take the visits to another level, improve co-ordination of programme to ensure that all areas, including corporate functions, were covered, ensuring that Board members were not repeatedly going to the same areas and that learning from visits was embedded across the Trust. It was also suggested that visits take place at a different point of day although the Chairman noted that having the visits at the start of the day helps to focus discussions at the Board meeting. The Chairman noted that unfortunately the patient involved in the patient story was unavailable to attend the meeting. it was important to have a programme of patient and staff story lined up in advance so that one story would replace another if required at short notice. Where there was no patient available to attend Board staff were available to deliver the patient story, with their consent.	

Date of next meeting: Thursday 25 July 2019 at Room H2.6, Hunter Wing, St George's, University of London

Trust Board Action Log Part 1 - July 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	**See Agenda Item 7.2.** The Board agreed at its meeting on 30 May 2019 that this item would be taken as a staff story on 25 July 2019	**PROPOSED CLOSURE**
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	**See Agenda Item 5.2.** This work is ongoing and will be reflected in the Board Assurance Framework document presented to the Board in July.	**PROPOSED CLOSURE**
TB27.06.19/01	**Integrated Quality and Performance Report (IQPR) (Month 02)**	It was agreed that the CMO and DHROD would look into reviewing quality of appraisals and report to the Workforce and Engagement Committee.	19/12/2019	CMO & CoP		**NOT DUE**
TB27.06.19/02	**Clinical Governance Review**	The CMO agreed to present a formal report to the Board on the metrics which will be used to measure impact of implementing the recommendations in the clinical review.	31/10/2019	CMO		**NOT DUE**
TB27.06.19/03	**Clinical Governance Review**	It was important to maintain the balance between pace and realism and CMO should include an update on implementation of the action plan in the next report to the Board.	31/10/2019	CMO		**NOT DUE**
TB27.06.19/04	**Quality Improvement Academy Quarter 1 Update**	It was noted that a Board Seminar on Quality Improvement (QI) would be organised and consideration would be given to how best to measure impact.	29/08/2019	CCAO & CTO	This Board Seminar has been arranged for the 29 August 2019	**PROPOSED CLOSURE**

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Meeting Title:	**Trust Board**		
Date:	25 July 2019	**Agenda No.**	**1.5**
Report Title:	**Chief Executive Officer's Update**		
Lead Director/ Manager:	Jacqueline Totterdell, Chief Executive		
Report Author:	Andrew Grimshaw, Deputy Chief Executive/Chief Financial Officer (on behalf of Jacqueline Totterdell, Chief Executive, who was on annual leave at the time of writing)		
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

St George's University Hospitals NHS
NHS Foundation Trust

Chief Executive's report to the Trust Board – July 2019

Developments in our external environment

Developments in healthcare delivery at a regional and national level continue to have an impact on the services we provide.

At a national level, there has been a renewed focus on the performance of the provider sector of late. Throughout the country, all hospitals are seeing more patients, be it emergency, cancer, or planned/elective care – and demand for services shows no signs of slowing down.

We naturally aspire to deliver strong performance in all areas – and rightly so, because it is the least our patients expect. At St George's, our performance in some areas (such as diagnostics) remains strong, whereas elsewhere (such as emergency care) we are below the target we have set ourselves. It is important we continue to aim higher and, whilst the challenges in delivering emergency care are nationwide, we know there is more we can do.

Elsewhere, NHS England is carrying out a consultation in regards to proposed changes to children's cancer services, which is relevant to St George's, as provider of intensive care support services for paediatric cancer patients at the Royal Marsden.

At a very local level, I am pleased that Suzanne Marsello, our Chief Strategy Officer, has been asked to join an expert panel convened by South West London and St George's Mental Health NHS Trust and an academic partner.

The panel has been set up to help identify why people from a BAME background are over-represented in mental health services and, more importantly, how we can work collectively to tackle the issue. This is a great example of St George's working more as part of a wider system, whilst also enabling us to strengthen our partnership work with our local mental healthcare provider.

Delivering on our vision and strategy

As I said last month, I am keen that our new organisational strategy continues to drive everything we do, and work continues apace on the supporting strategies required to make our new strategy a reality.

I am particularly pleased that our outpatient strategy is being considered at Trust Board this month. Over 650,000 patients come into contact with the service every year, and for many people, it will be there only experience of receiving care at the Trust. We know that the service is not currently delivering everything our patients and staff need – and it is important we address this at pace.

Separately, one of our strategic priorities is **closer collaboration**, so I was pleased to see our Governors launching the Trust's new membership strategy earlier this month. Our membership community already includes more than 22,000 patients, staff, and members of the public.

St George's University Hospitals NHS
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However, we want to create more opportunities for members – both new and old – to get involved with their local hospital; and that is what our new membership strategy is designed to achieve. The strategy has been developed by our Governors, who represent the communities we serve – so I am excited about the potential for improvement in this area.

Another of our strategic priorities is providing **strong foundations**, so I was pleased to here this week that the roll-out of iClip to maternity services at St George's has been a success.

We are now live with electronic documentation across 96% of all inpatient areas at St George's, with plans to extend iClip to Queen Mary's later this year. The significance of this cannot be underestimated and, whilst staff are still adjusting to a new way of working, I am confident the change has been a very positive one overall.

Our work with St George's Hospital Charity is also helping us deliver organisational change, particularly for one of our most important organisational objectives, which is **Champion Team St George's**.

In recent weeks, the charity has confirmed funding for a new Trust intranet, which will make the working lives of our staff easier; as well as a new pinpoint system in the Emergency Department, to help keep our staff safe. I am grateful to the charity both for their generosity, but also the much stronger relationship we have developed with them in recent months.

Our people

Supporting and developing our staff is rightly something we take very seriously. We know there is more we need to do to make St George's an employer of choice, despite examples of best practice in some areas.

I am pleased we are doing some excellent work in relation to retaining and recruiting staff. Indeed, I was delighted to receive a letter this week from Ruth May, Chief Nursing Officer, praising the work we have done towards reducing our nursing turnover rate as one of the first Trusts to take part in the national Retention Programme.

This combines well with a year on year reduction in spending on agency staff, as well as our concerted effort to keep our vacancy rate down. Our vacancy rate has stayed below 10% for over six months now, so it is easy to forget that this used to be as high as 17%. We mustn't be complacent, but this is evidence of real, measurable progress.

Despite all this good work, our latest NHS staff survey results tell us that St George's needs to do more to engage, support and develop our existing staff. This is something we recognise, and continue to prioritise.

Celebrating our staff

As always, there is much to celebrate here at the Trust, and acknowledging the efforts of staff is something we work hard to do on a regular basis.

Last month, our Chairman Gillian Norton held a special tea party for Armed Forces Day at St George's. A number of our staff serve or have previously served in the armed forces, so it

was a fantastic opportunity for the Trust to say a small thank you to those who help the country in this way.

Separately, four members of St George's staff have been recognised in the latest round of academic promotions awarded by the university. Alex Trompeter was made an Honorary Reader in Orthopaedic Surgery; Kristiana Gordon was made an Honorary Reader in Dermatology & Lympho-vascular Medicine; Maite Tome an Honorary Reader in Cardiology and Paul Johns an Honorary Reader in Clinical Neuroanatomy. A huge well done to all four !

Administration/key appointments

There have been two significant appointments in recent weeks.

We have appointed Terence Joe as our new Head of Patient Experience and Partnership, reporting into our Chief Nursing Officer. This is an important role for the organisation as we look to improve the way we manage complaints, as well as how we listen to and act on feedback. Terence will also look at how we can enhance opportunities for volunteers here at the Trust.

Separately, our Chairman Gillian Norton announced the appointment last week of Richard Mycroft as our Lead Governor, following a vote by the Council of Governors. I am delighted for Richard, who lives locally and knows St George's very well. I am also grateful to Kathryn Harrison, who has done such an excellent job in the role for a number of years; she will be sorely missed.

St George's University Hospitals NHS
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2.1

Meeting Title:	**Trust Board**		
Date:	**25 July 2019**	**Agenda No**	**2.1**
Report Title:	**Quality and Safety Committee Report**		
Lead Director/ Manager:	**Sir Norman Williams, Chairman of the Quality and Safety Committee**		
Report Author:	**Sir Norman Williams, Chairman of the Quality and Safety Committee**		
Presented for:	Assurance		
Executive Summary:	The report sets out the key issues discussed and agreed by the Committee at its meeting on the 18 July 2019.		
Recommendation:	The Board is requested to note the update.		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	All CQC domains		
Single Oversight Framework Theme:	Quality of care, Operational Performance, Leadership and Improvement Capability		
Implications			
Risk:	Relevant risks considered.		
Legal/Regulatory:	CQC Regulatory Standards		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A
Appendices:	N/A		

St George's University Hospitals NHS
NHS Foundation Trust

Quality and Safety Committee Report – July 2019

Matters for the Board's attention

The Quality and Safety Committee met on Thursday, 18 July 2019 and agreed to bring the following matters to the Board's attention:

1. Deep Dive: Learning from Claims

The Committee received a comprehensive and interesting presentation on learning from claims, which provided the Committee with a detailed breakdown of the pattern of claims over the past ten years, the ways in which the Trust currently seeks to learn from them, and the plans for strengthening learning in future. It is important that the Trust and the Board has an understanding of the level of claims and ensures that learning is embedded not only to reduce the financial impact of such claims but to ensure that the issues that give rise to such claims do not recur and that harm is avoided. The Committee noted that a large volume of benchmarking data had been provided to the Trust through the Get It Right First Time (GIRFT) litigation workstream in recent weeks and this was currently being analysed. The Committee noted that this would be helpful in further strengthening benchmarking the Trust's claims. .

The Committee heard and were assured by the level of training being carried out and the joined up approach with the serious incidents processes and speciality level learning. It was also assured that the learning from each claim was passed on to the clinicians involved in each case. The Committee heard that NHS Patient Safety Strategy (July 2019) placed significant emphasis on learning from claims which had implications for the Trust going forward. It agreed that more could be done to further strengthen learning in this area, including triangulating this with learning from complaints, PALS and other areas.

2. Integrated Quality and Performance Report (IQPR)

The Committee considered the key areas of quality performance in month noting the improvement in the Mental Capacity Act and Deprivation of Liberty level 2 training.
The Committee also welcomed the news that the friends and family test (FFT) response rates for the inpatient areas had improved to 40% for 2 consecutive months however noted that the positive scores had decreased to 94% from a previously stable position of above 95%. Some initial exploration had been undertaken to understand why this change had occurred but there were no key underlying trends that can be directly attributed to this dip in performance.

The outpatients' response rates remain low at 6% and whilst this is an improvement on the previously reported response rates of 2% more needed to be done. The Committee heard that a number of technological solutions had been trialled in some outpatient areas and the appropriate system for obtaining FFT responses needed to be rolled out across all outpatient areas when it is expected that response rates would improve.

The Committee were disappointed to learn about the recent 'never event' relating to a retained swab. The Committee were pleased to note that the patient had made a good recovery and has been discharged home. This event should not have occurred and the Committee heard about the immediate actions taken and a debrief that took place with the theatre staff who discussed further improvements that could be made to reduce the chances of this incident happening again.

3. Exception Report: Care Quality Commission Outstanding Actions

The Committee noted that only one of the Care Quality Commission (CQC) actions remained outstanding related to achieving mandatory training targets. The particular area of concern is the ability to achieve 85% on resuscitation training which despite additional resources and training being put in place is not where it should be. The Committee were informed of all the actions underway, the focus that the divisions were giving this and that the focus would most definitely continue. The Committee were also reassured by the decision to keep under review the solutions and processes related to the action to review/improve medical records storage provisions in outpatient areas.

4. Clinical Negligence Scheme for Trust (CNST) – Maternity Services

The Committee considered the report which outlined the Trust's compliance against the 10 safety standards for maternity service in order that the Trust can apply for a rebate from NHS Resolutions. This report is presented later on the Board agenda but the Committee would like to recommend that the Board approves the submission based on the strong evidence that the Trust has indeed met the maternity safety standards.

5. Nurse Staffing Report (Planned vs Actual)

The Committee considered the nurse staffing report and noted that the overall fill rate remained at 95% for June 2019 and the fill rates were in the normal limits with the exception of two wards which related to high-levels of short-term sickness but these were effectively managed ensuring there were no safety issues.

6. Safeguarding Children Annual Report

The Committee also considered the Safeguarding Children Annual Report which is discussed later on the Board agenda. The Committee heard about the robustness of the Trust's children safeguarding systems and explored the steps that would be taken in the event that a child presents with knife wounds and was assured about the automatic safeguarding process that would be put in place and the degree of linkages with the Local Authorities, Social Services and external charitable organisations which work closely with the Trust such as Rethread.

7. Mental Capacity Act and Deprivation of Liberty Annual Report (2018/19)

The Committee also considered the Mental Capacity Act and Deprivation of Liberty Annual Report (2018/19) which will also be presented at the September Board meeting for information. The Committee was very assured by the report and in particular, welcomed the significant improvement in training which was at 80%.

8. Cardiac Surgery Update

The Committee also considered the Cardiac Surgery Update which is discussed later on the Board agenda.

9. Report from Patient Safety & Quality Group (PQSG)

The Committee received the summary from the PQSG which flagged three areas. The recent National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Acute Heart Failure Audit highlighted some disparity in the mortality of patients that are treated in the Trust Heart Failure Unit versus those treated as medical outliers The Trust is interrogating the results from the audit which was completed in April 2019 on admissions between March 2018-April 2019 and was considering any service model changes that may be required. The Committee also heard that whilst the Trust processes/practice for decontamination of the nasoendoscopes is in line with regulatory requirements best practice

is for the Trust to have a central decontamination system or use disposable scopes. A definitive decision will be made following the trail of disposable scopes.

The Committee also noted that it would receive the closing report on the clinical harm programme in October or November 2019.

10. Learning from Deaths (Quarter 01) Report

The Committee considered the quarter one report from the Monitoring Mortality Committee on Learning from Deaths which is also presented later on the Board agenda. The Committee heard that during the quarter a number of issues of care which potentially related to lack of senior scrutiny at the weekends and these have been escalated to ensure these are addressed as part of the actions to implement 7-day working. The Committee was assured by the report that this was being picked up as part of consultant job planning process which is an area of focus. The Committee did receive a report in May about weekend mortality and did receive assurance there were no increases in mortality at the weekend but will keep this under review. The Committee noted the delay in the appointment of the Lead Medical Examiner (ME) and whilst recognising that actions are underway to address this, the Chair asked to be provided with the definitive timeline for appointment of the ME in order to attain assurance.

11. South West London Pathology Quarterly Report

The Committee considered the quarter one report on the services provided by South West London Pathology. The report also included an update on the cervical screening service following an issue raised in April with the backlog on the number of cases. The Committee welcomed the news that whilst the national contracting issue and the delays in commissioning of the central hubs remained the Trust had identified and engaged two providers to conduct cervical screening tests. The Committee also explored the robustness around blood transfusion cross matching and were assured by the change in methodology and increase in resources to ensure that there are no further incidents similar to those flagged in April.

12. Elective Care and Referral to Treatment Quarterly Report

The Committee received the first quarterly report on elective care and the referral to treatment performance for May 2019.The Committee heard that the Trust was on track at its Tooting site and was assured about the performance. The Board received an update on the plans for the Queen Mary's Hospital site and will be asked to make a decision on going live in August.

13. Board Assurance Framework & Corporate Risk Registers

The Committee received the Board Assurance Framework and Corporate Risk Registers which focused on the four strategic risks which fall within its remit. The Board Assurance Framework will be discussed later in the Board agenda but the Committee would like to flag that it asked the Risk Management Executive to look, again, at the risk description and score for the Emergency Department four-hour standard. The Committee endorsed the assurance rating for the strategic risks and minded that further work was required to map out all the contributing risks.

Sir Norman Williams
Committee Chair
18 July 2019

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	25 July 2019	**Agenda No**	**2.2**
Report Title:	**Integrated Quality and Performance Report**		
Lead Director/ Manager:	James Friend, Chief Transformation Officer		
Report Author:	Emma Hedges, Mable Wu		
Presented for:	Information and assurance about Quality and Performance for Month 3		
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 significant increased elective activity with a reduction in patient's elective length of stay, with sustained improvement in the number of on the day cancellations re-booked within 28 days. The Trust remained ahead of trajectory for RTT incomplete performance in May-19 for the ninth consecutive month. Our Patient Safety metrics were all within expected process limits for the reporting period and the Quality Improvement Key Programmes show steady progress. However existing challenges continue in particular Four Hour Operating Standard and patient flow. The Trust has achieved five of the seven Cancer standards in May reporting non-compliance in both 14 and 62 day standard. Please note that the report is under development working to incorporate NHSI recommendations. London wide benchmarking data has been added for Four Hour Operating Standard and Diagnostics. Cancer benchmarking information will be added in month 4.		
Recommendation:	The Board is asked to note the report.		
Supports			
Trust Strategic Objective:	Treat the Patient, Treat the Person Right Care, Right Place, Right Time		
CQC Theme:	Safe Caring Responsive Effective Well Led		
Single Oversight Framework Theme:	Quality of Care Operational Performance		
Implications			
Risk:	NHS Constitutional Access Standards are not being consistently delivered and risk remains that planned improvement actions fail to have sustained impact		

St George's University Hospitals NHS
NHS Foundation Trust

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**	18/07/2019 18/07/2019
Equality Impact Assessment:			
Appendices:			

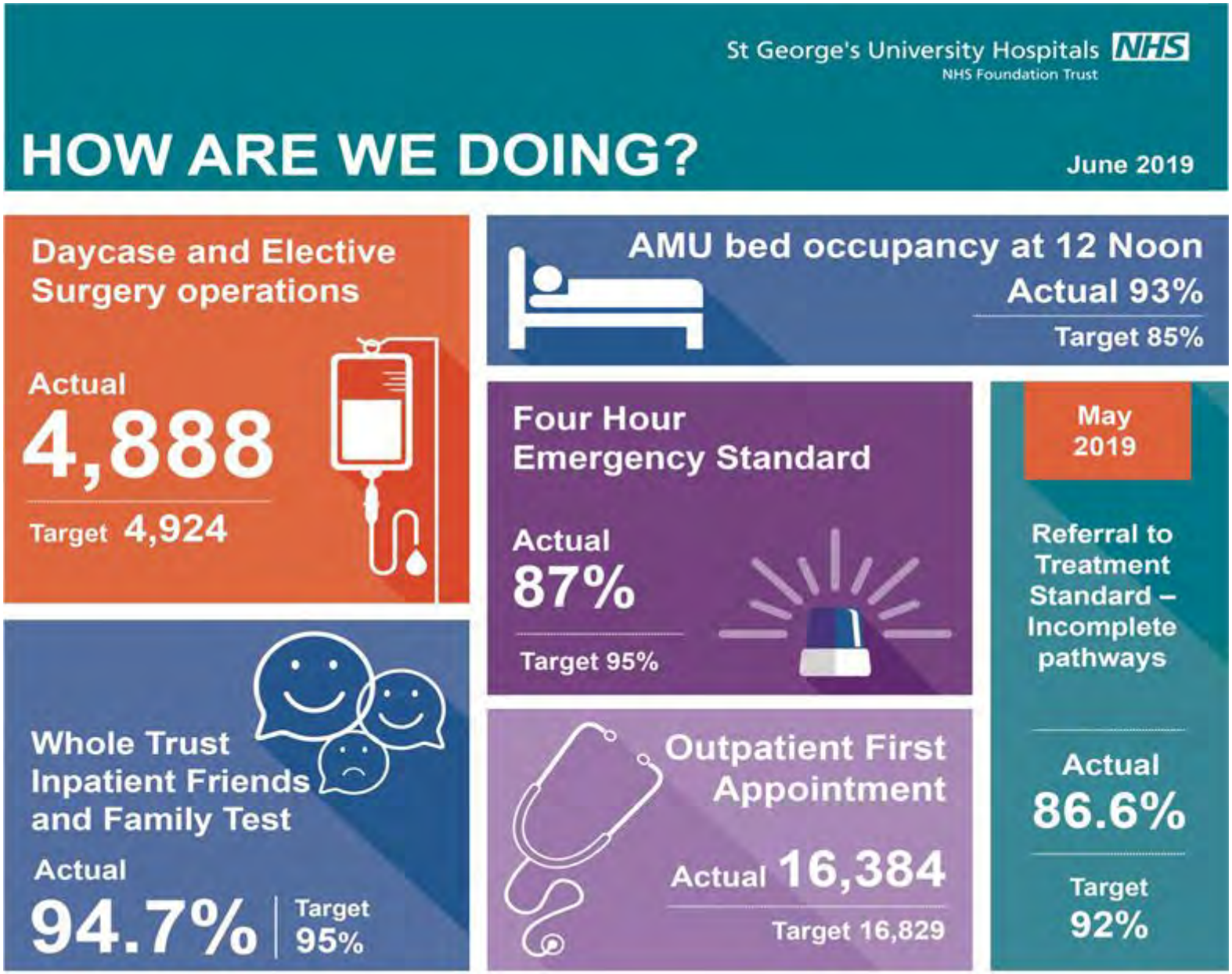
St George's University Hospitals NHS Foundation Trust

2.2

Integrated Quality & Performance Report for Trust Board

Meeting Date – 25 July 2019
Reporting period – June 2019

Our Outcomes



Balanced Scorecard Approach

St George's University Hospitals NHS Foundation Trust

2.2

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

Key

Current Month

(A) Previous Month

3

Executive Summary – June 2019

Our Finance and Productivity Perspective

- The number of patients that have been treated in our Daycase and Elective theatres on an average working day basis has increased significantly.
- 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 Trust continues to deliver more Elective procedures per working day whilst reducing the length of stay for these patients.
- Outpatient attendances remains a challenge with 8.1% less activity in Q1 2019/20 as compared to Q1 2018/19

Our Patient Perspective

- Quality Improvement Key Programmes show steady progress
- Patient Safety metrics were all within expected process limits.
- Responding to 25 day complaints and 40 day complaints remains challenging with performance at 78% and 57% respectively
- In Maternity services, the percentage of women booked by 12 weeks + 6 days reached its highest level to date
- The percentage of women in which women sustained a 3rd or 4th degree tear has continued to be below the previous mean following the implementation of a quality improvement project
- Our Inpatient Friends and Family Test dipped below 95% for the first time in three years

Our Process Perspective

- Performance against the Four Hour Operating Standard in June was 87.0%, which was below the monthly improvement trajectory of 94.3%.
- The Trust achieved five of the seven Cancer standards in the May.
- In June, the Trust performance met the national standard for the six week diagnostic waits with a performance of 99.6% against a target of 99.0%.
- In May, the Trust reported 86.6% for 18 week wait incomplete RTT performance which is above the monthly recovery trajectory of 84.6%. The National target is 92%
- London wide benchmarking data has been added for Four Hour Operating Standard and Diagnostics.
- In June, 100% of patients with on the day theatre cancellations cancellations were re-booked within 28 days.

Our People Perspective

- Overall Mandatory and Statutory Training rate has reached its highest level in three years at 91.2%
- Medical appraisal rates are now being reported by the new appraisal system and currently stands at 84.5%.
- The Trust's total pay for June was £45.95m against a plan of £46.03m.
- For June, Agency spend in June was £1.77m against a plan of £1.25m. The biggest areas of overspend were Nursing (£0.19m), Interims (£0.11m), Junior Doctor (£0.08m) and AHP (£0.08m).

Balance Scorecard

St George's University Hospitals NHS Foundation Trust

2.2

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

Our Finance & Productivity Perspective

5

Activity against our Plan

St George's University Hospitals NHS Foundation Trust

2.2

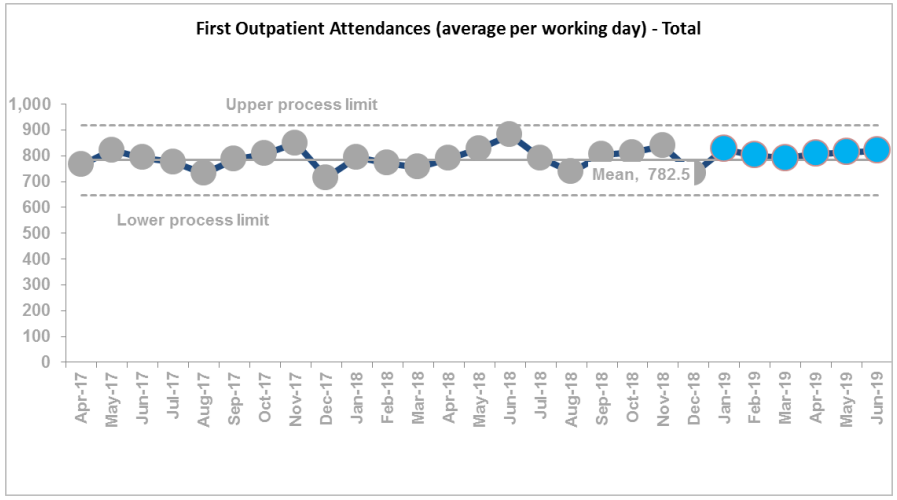
		Activity compared to previous year			Activity against plan for month		Activity compared to previous year			Activity against plan YTD	
		Jun-18	Jun-19	Variance	Plan Jun-19	Variance	YTD 18/19	YTD 19/20	Variance	Plan YTD	Variance
ED	ED Attendances	14,145	14,284	0.98%	13,912	2.67%	42,173	42,893	1.71%	42,198	1.65%
Inpatient	Non Elective	3,885	3,957	1.85%	3,908	1.25%	11,876	12,181	2.57%	11,847	2.82%
	Elective & Daycase	4,964	4,888	-1.53%	4,924	-0.73%	14,215	14,895	4.78%	14,991	-0.64%
Outpatient	OP Attendances	57,027	52,392	-8.13%	55,747	-6.02%	164,460	163,110	-0.82%	168,298	-3.08%

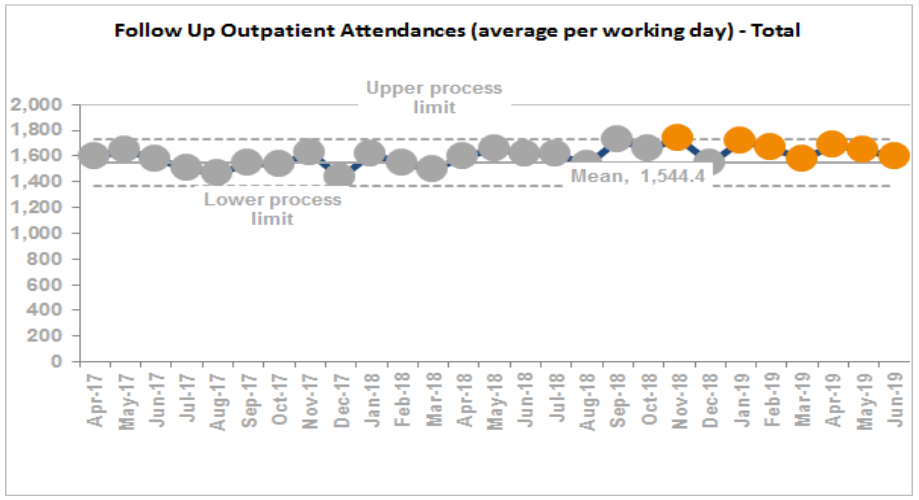
>= 2.5% and 5% (+ or -)
>= 5% (+ or -)

Note: Figures quoted are as at 01/07/2019, and do not include an estimation for activity not yet recorded (eg. un-cashed clinics). The expected performance vs. plan by POD post catch up is:

ED – No change
Elective and Daycase – Slight over-performance against plan (~1%)
Non-elective – Over-performance against plan (~3%)
Outpatients – Underperformance against plan (~2%)

Outpatient Productivity





What the information tells us

- Outpatient first attendance activity has remained within its process limits since April 2017 however activity has been above the mean for the past six months.
- Specialist Medicine, Renal & Oncology and Trauma & Orthopaedics have all had Outpatient first activity consistently above their mean for the past six months. Other directorates are within their expected process limits
- At Trust level follow-up activity has remained within its process limits and, similar to first attendances, has been above the mean for the past five months
- Four care groups, Specialty Medicine, Renal & Oncology, Women's Services and Neurosciences have had follow-up activity constantly above their mean.

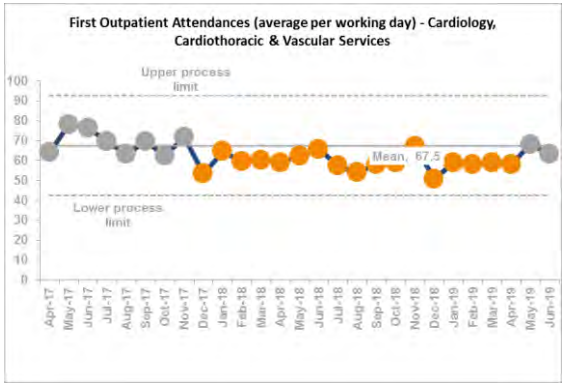
Actions and Quality Improvement Projects

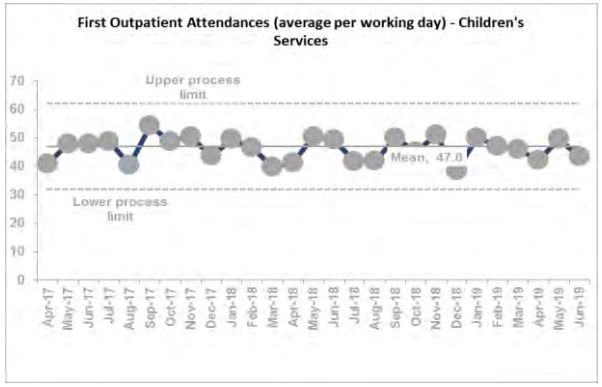
- Services are reviewing the recording of particular appointments as some will be classified as outpatient procedures.
- Care groups with higher levels of follow-up activity are reviewing demand forecasts as waiting list positions improve.
- The Trust is working in partnership with other hospitals across South West London to redesign six specific outpatient pathways.

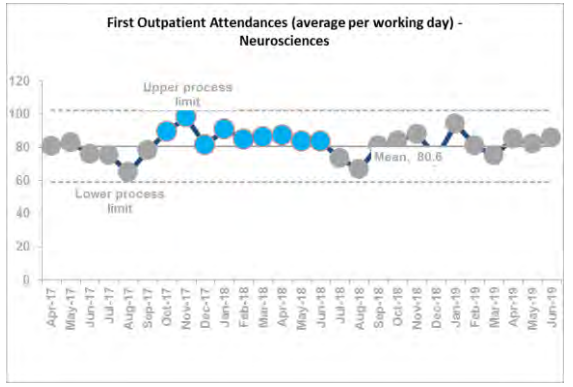
Number of First Outpatient attendances per Working Day

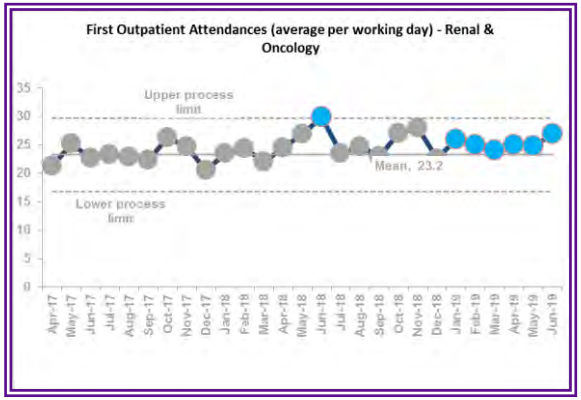
St George's University Hospitals NHS Foundation Trust

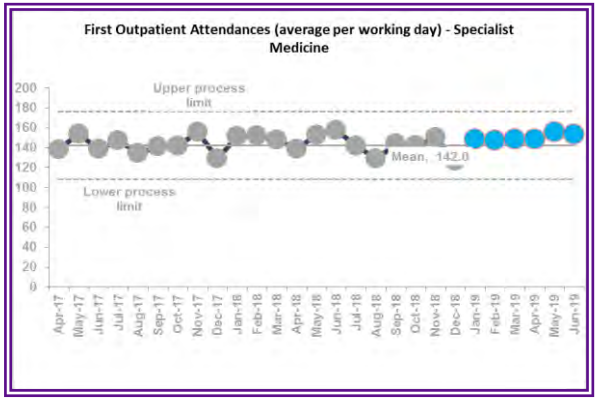
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

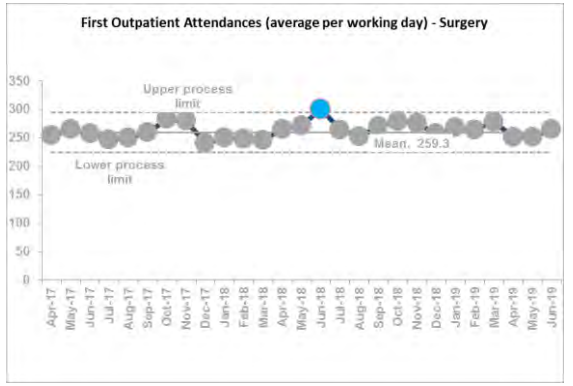


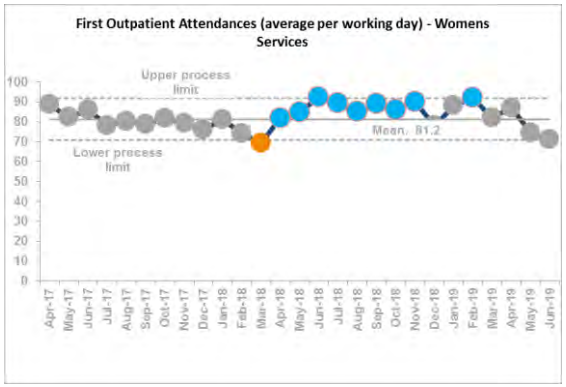


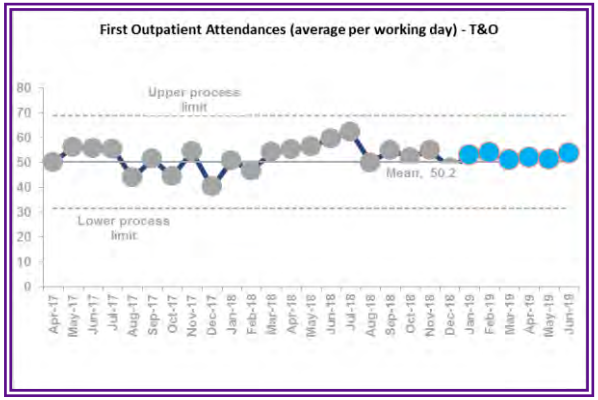








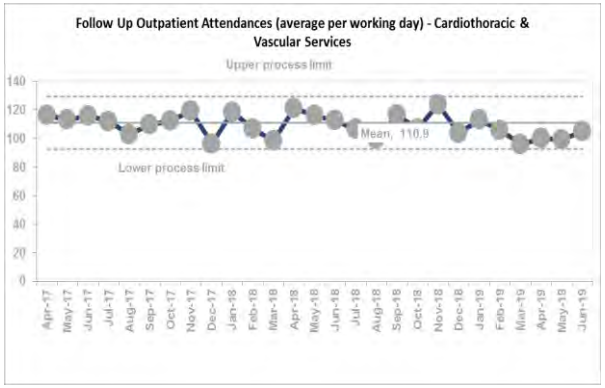


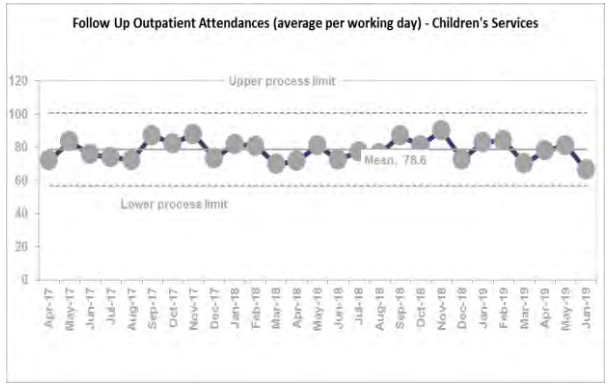


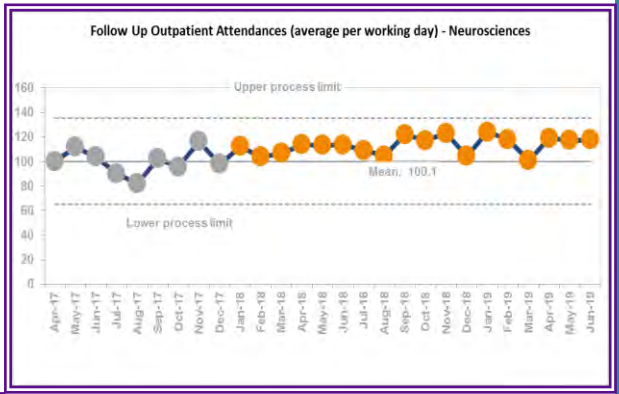
Number of Follow Up Outpatient attendances per Working Day

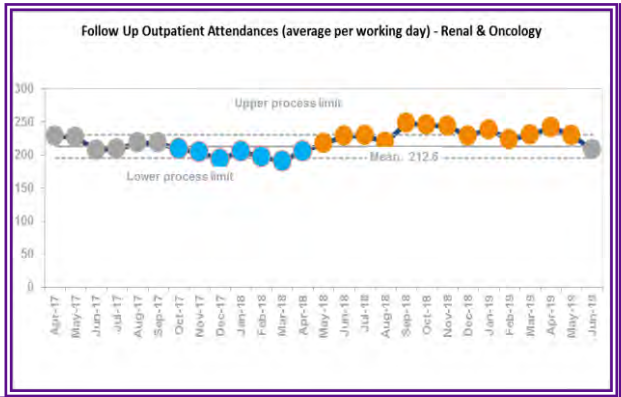
St George's University Hospitals NHS Foundation Trust

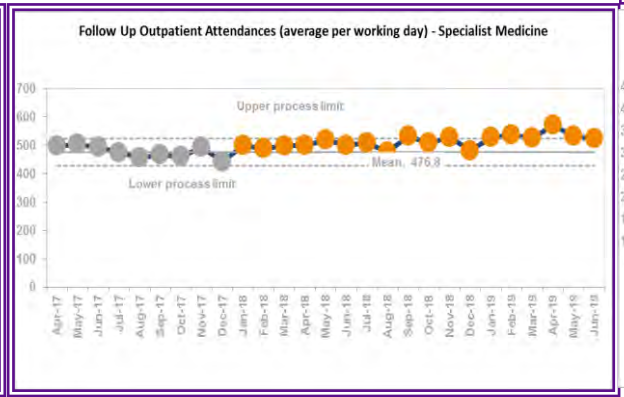
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

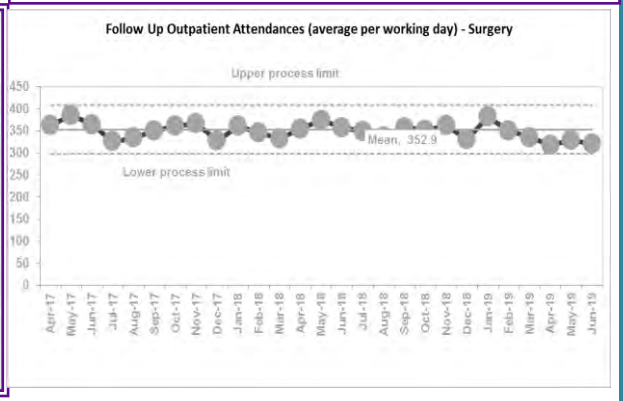


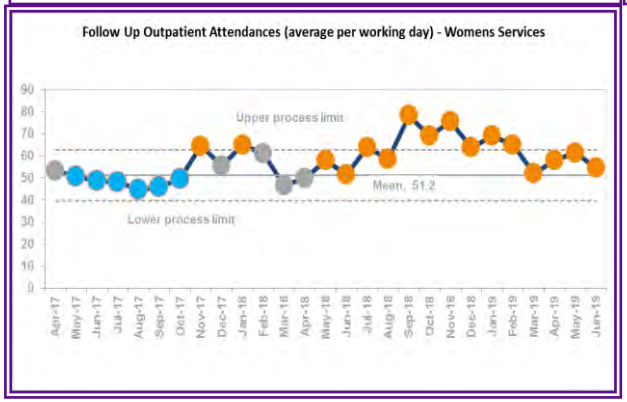


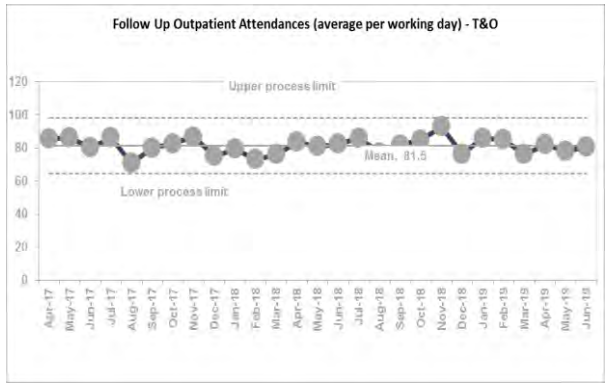




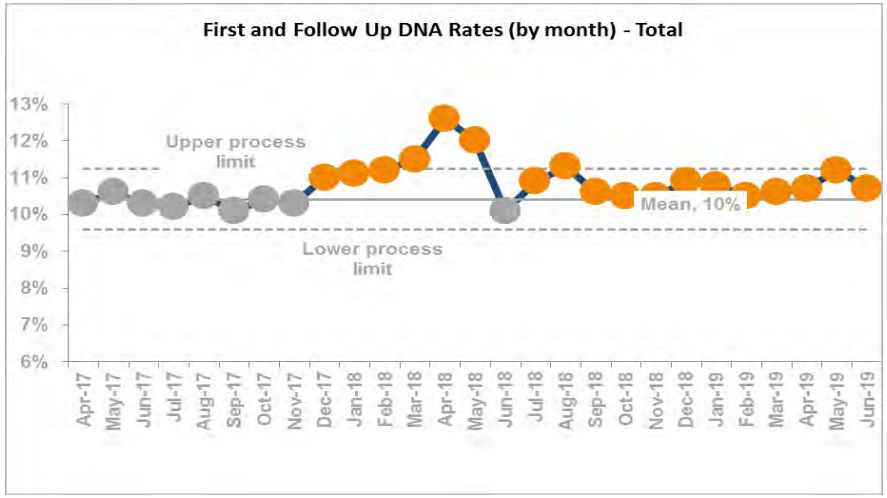








Outpatient Productivity



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 has fallen and is now within its expected process limits
- Both Women's services and Neurosciences have Follow up ratios that are consistently above their mean as both directorates have had increasing Follow up activity but have had consistent First activity
- Though Specialist Medicine has had an increase in First and Follow up activity, its ratio is still consistently above its mean
- Surgery and Trauma & Orthopaedics have both seen a reduction of First and follow up ratios with Surgery below its lower process limit
- The Trust DNA rate has been consistently above its mean however this masks variance among the directorates
- Women's services and Renal & Oncology have consistently been below its means whereas Neurosciences, Surgery and Other (Acute Medicine, Therapies and Diagnostics) have all been consistently above their means for over a year

Actions and Quality Improvement Projects

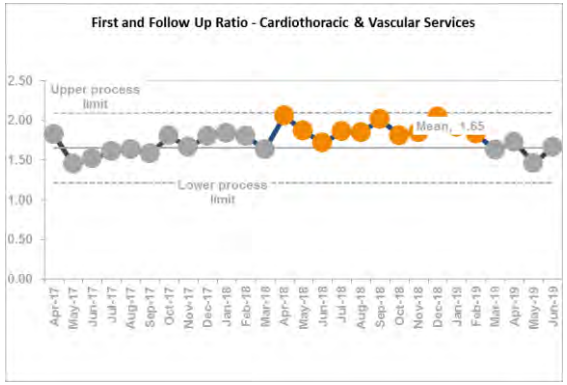
- Divisions are currently scoping opportunities to implement virtual follow-up appointments and open access to support reducing follow-up attendances and improve new to follow-up ratios across the services.
- Additional appointment types have been added to the two way text reminder service in Dermatology,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

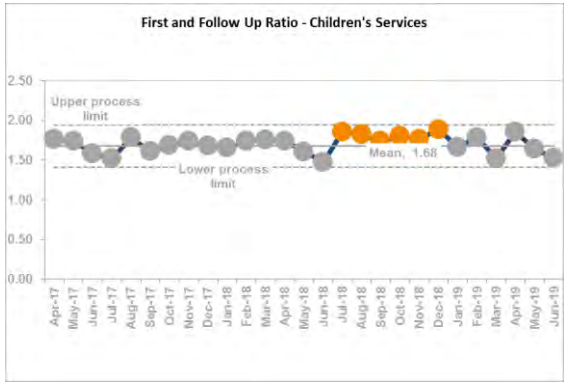
New to Follow Up Ratios

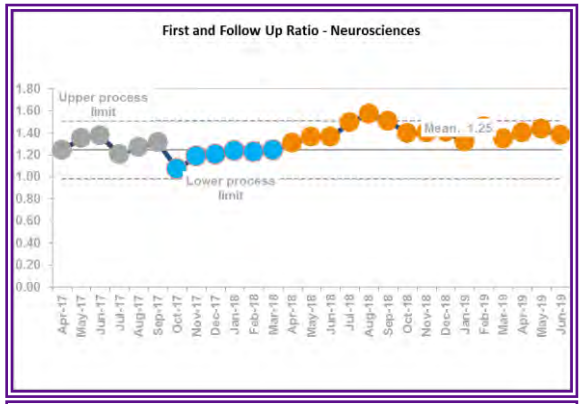
St George's University Hospitals NHS Foundation Trust

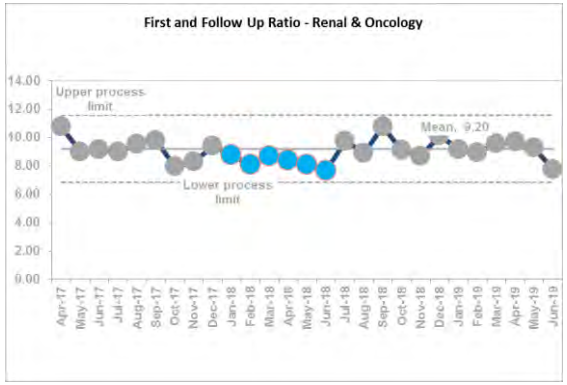
2.2

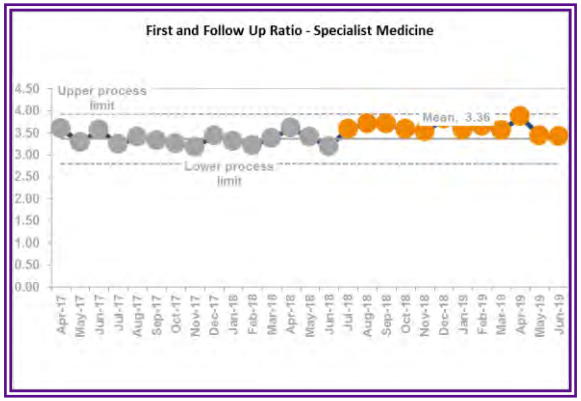
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

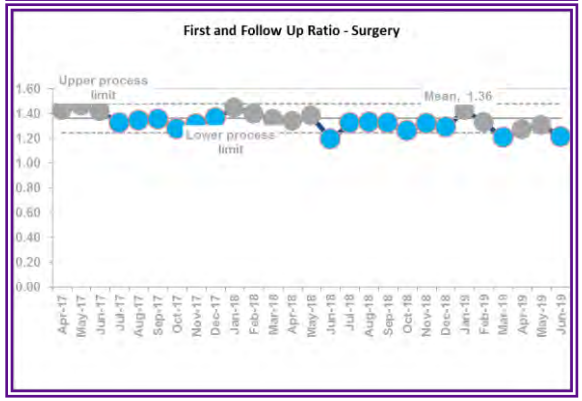


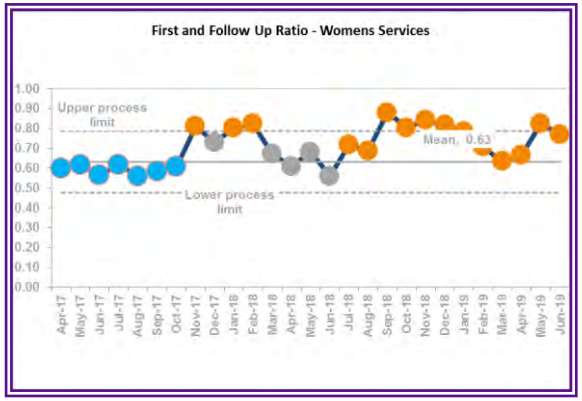


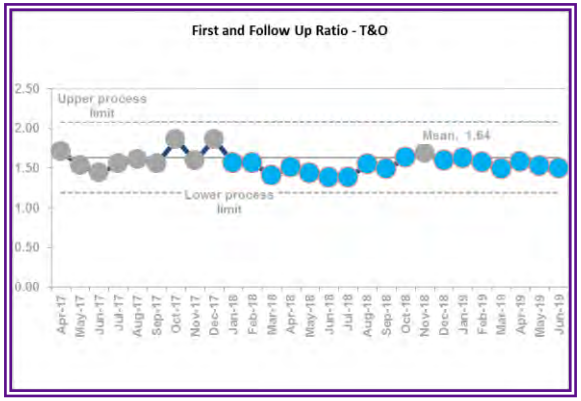








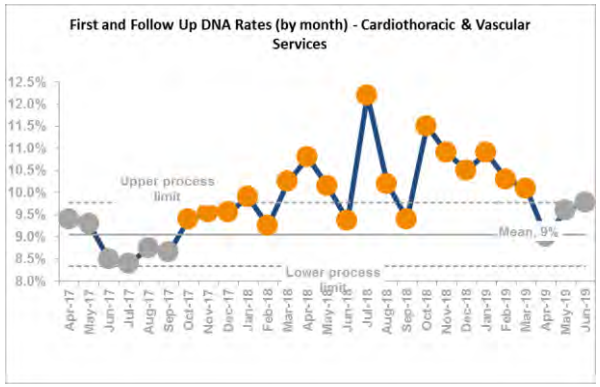


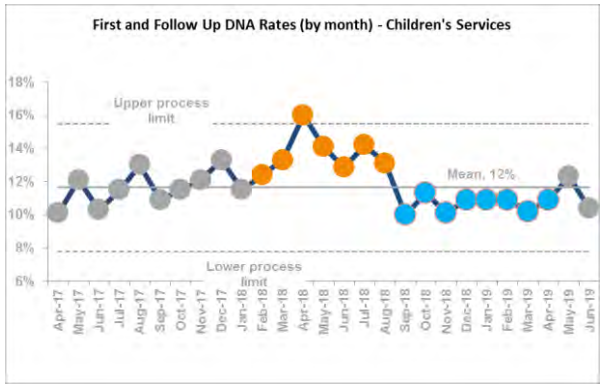


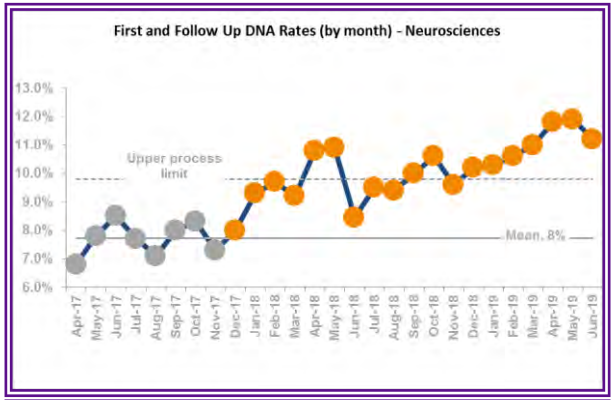
Percentage of patients that did not attend their appointment

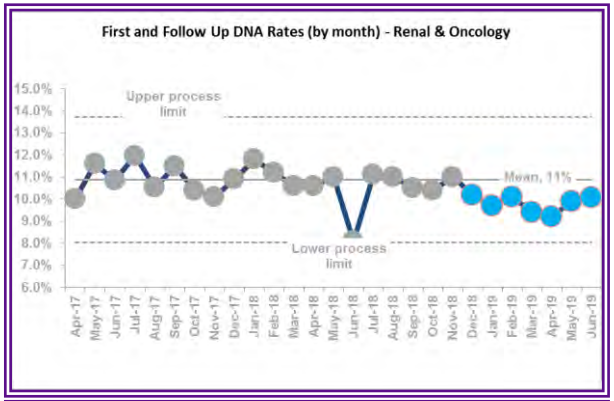
St George's University Hospitals NHS Foundation Trust

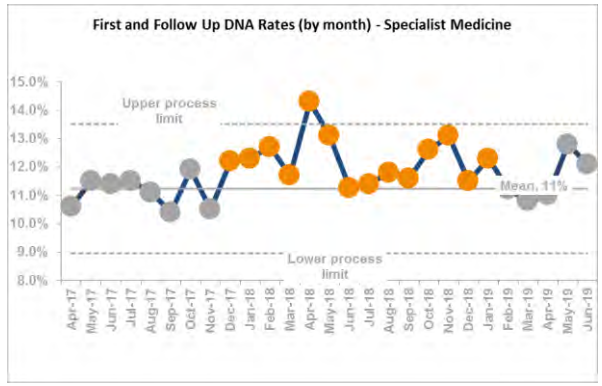
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

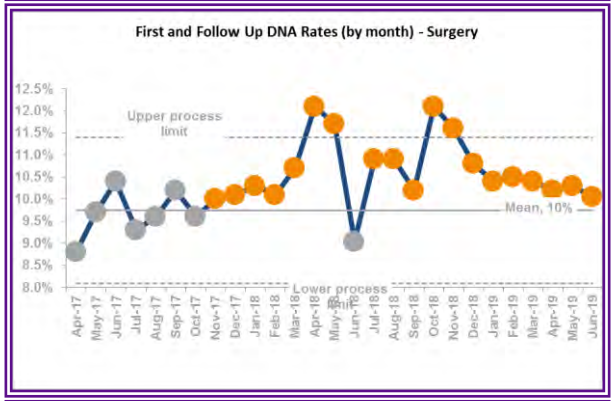


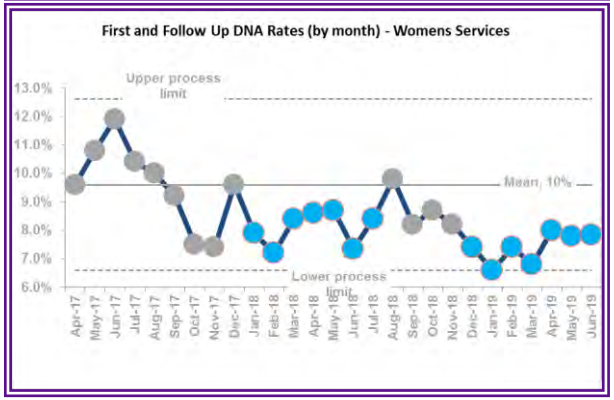


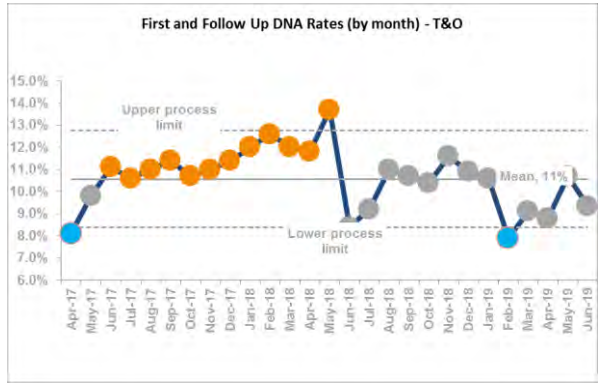


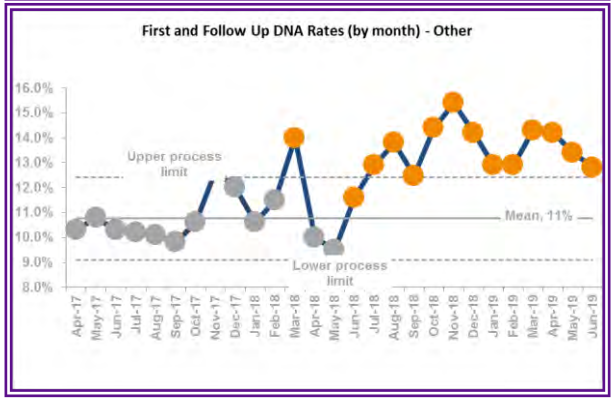








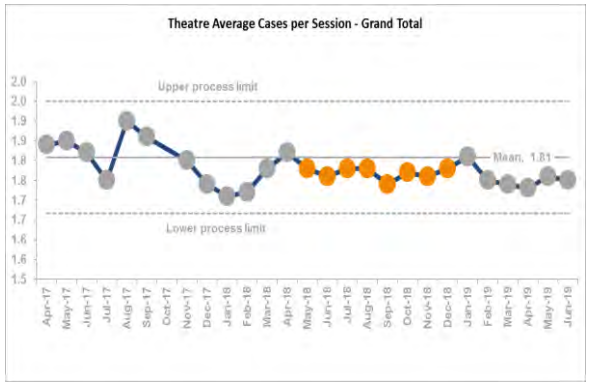


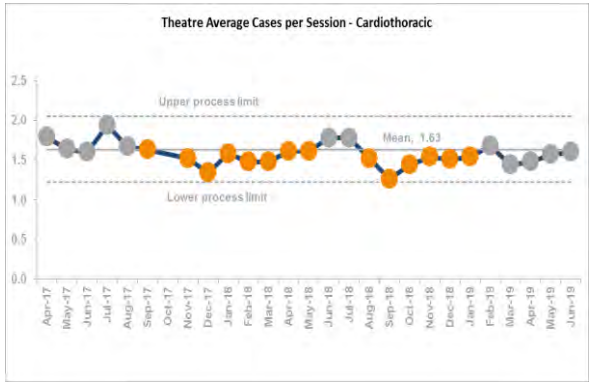


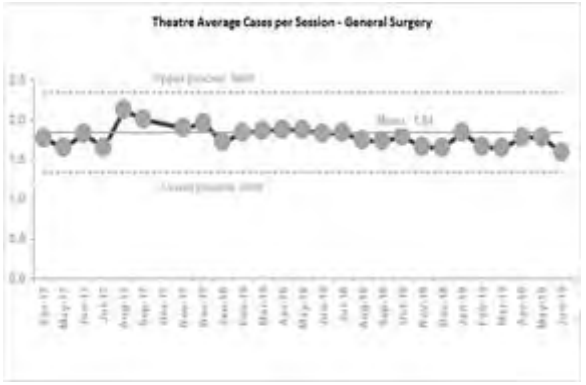
Theatre productivity – cases per session

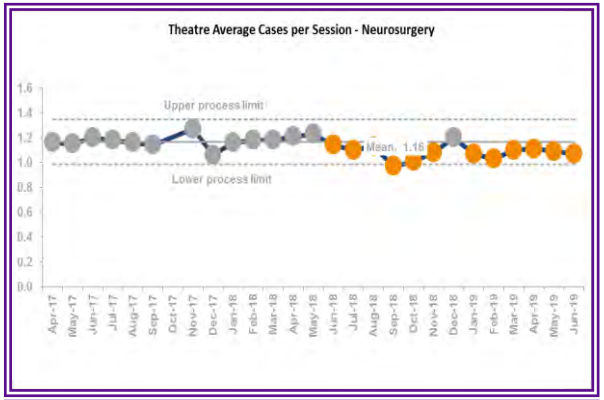
St George's University Hospitals NHS Foundation Trust

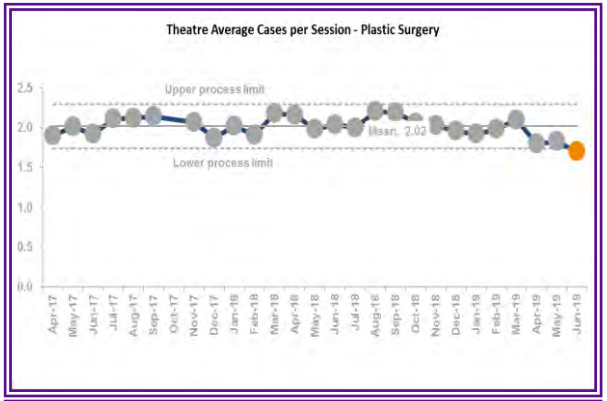
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

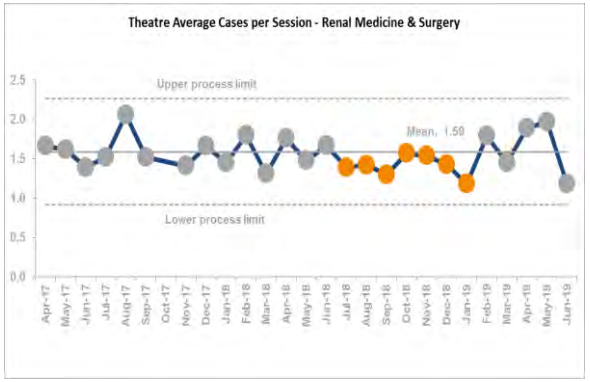


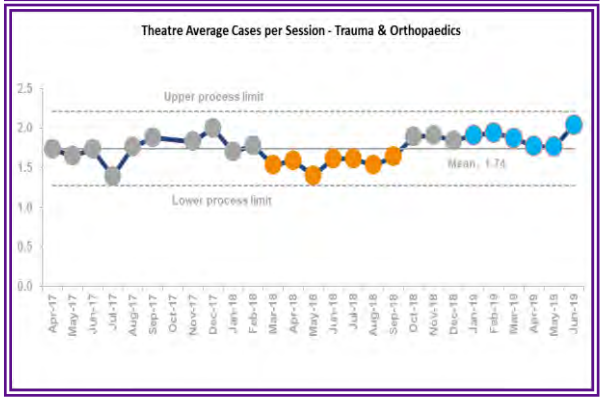


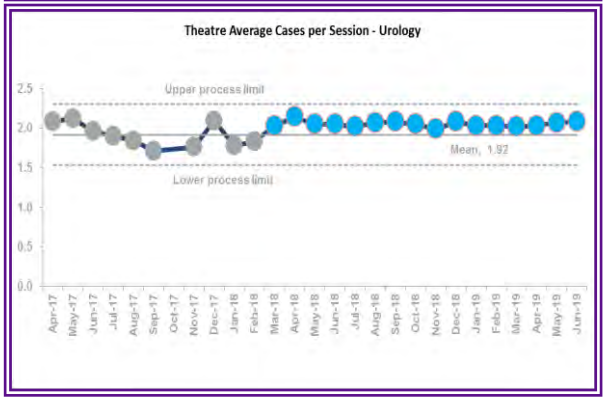


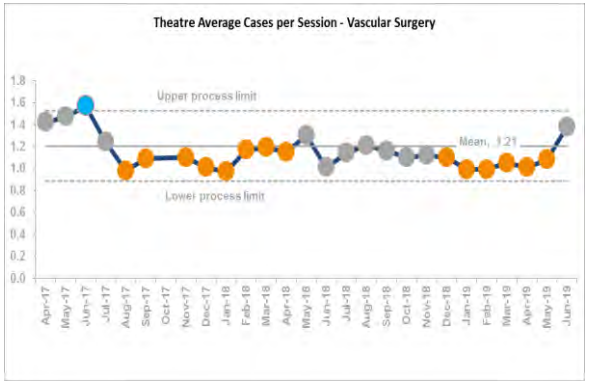








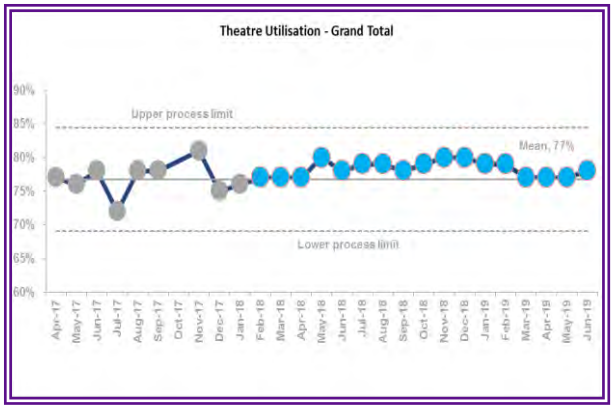


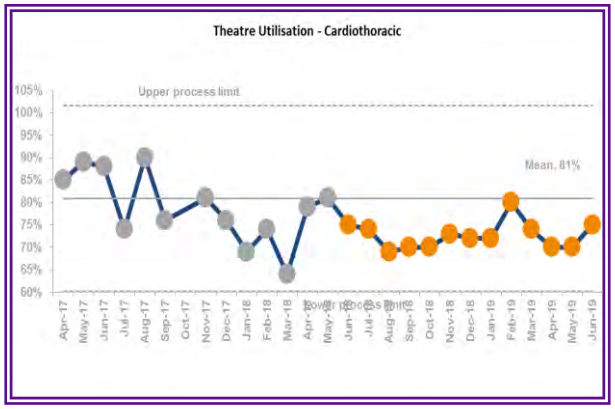


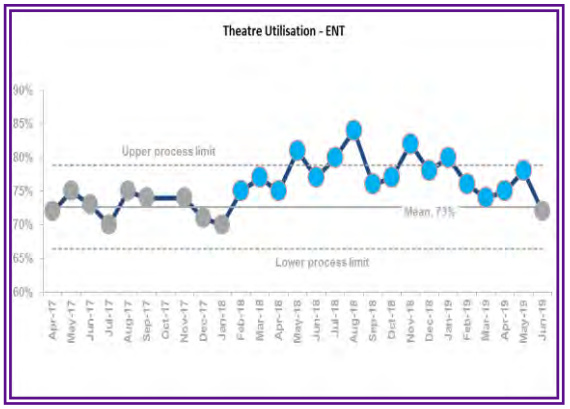
Theatre productivity – Utilisation

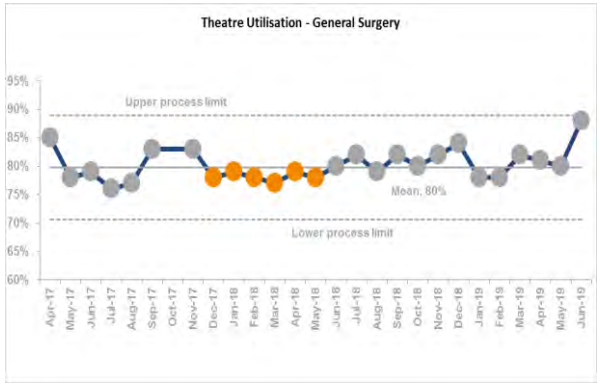
St George's University Hospitals NHS Foundation Trust

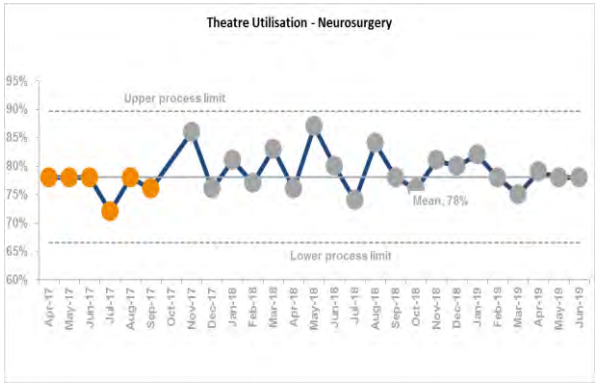
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

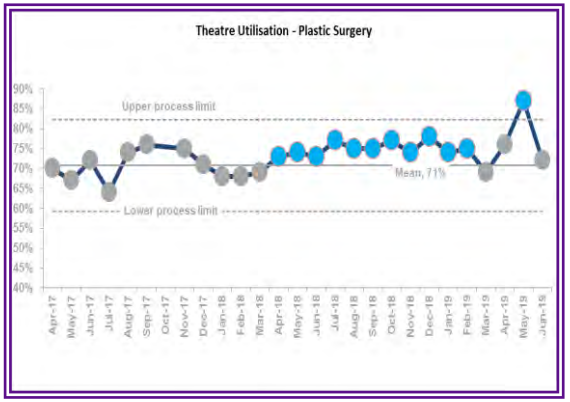


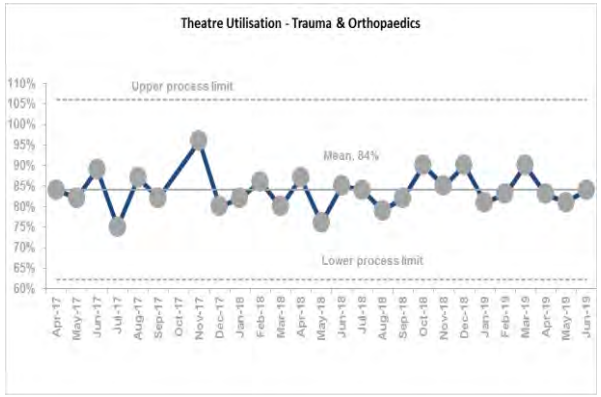


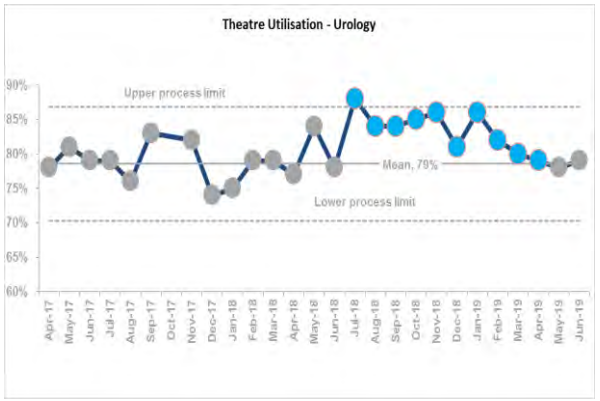


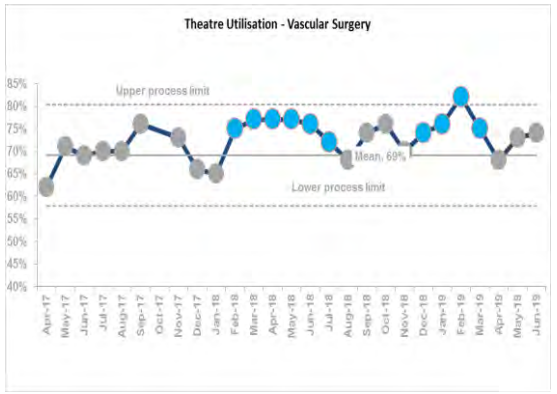












Theatre – Touch time utilisation

St George's University Hospitals NHS Foundation Trust

Theatre Utilisation

Main List Specialty	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Number of Patients in the last month
Cardiothoracic	75%	74%	69%	70%	70%	73%	72%	72%	80%	74%	70%	70%	75%	74
ENT	77%	80%	84%	76%	77%	82%	78%	80%	76%	74%	75%	78%	72%	155
General Surgery	80%	82%	79%	82%	80%	82%	84%	78%	78%	82%	81%	80%	88%	143
Gynaecology	77%	83%	81%	77%	83%	87%	81%	79%	88%	74%	81%	71%	78%	135
Neurosurgery	80%	74%	84%	78%	76%	81%	80%	82%	78%	75%	79%	78%	78%	150
Oral and Maxillo Facial Surgery	73%	89%	75%	82%	63%	84%	78%	84%	67%	91%	61%	72%	84%	27
Paediatric Dentistry	50%	53%	58%	55%	56%	60%	62%	65%	68%	65%	58%	80%	64%	38
Paediatric Surgery	80%	81%	78%	75%	74%	72%	75%	76%	82%	74%	77%	79%	79%	92
Plastic Surgery	73%	77%	75%	75%	77%	74%	78%	74%	75%	69%	76%	87%	72%	150
Renal Medicine & Surgery	71%	72%	78%	61%	67%	82%	60%	66%	67%	83%	66%	88%	69%	9
Trauma & Orthopaedics	85%	84%	79%	82%	90%	85%	90%	81%	83%	90%	83%	81%	84%	148
Urology	78%	88%	84%	84%	85%	86%	81%	86%	82%	80%	79%	78%	79%	196
Vascular Surgery	76%	72%	68%	74%	76%	70%	74%	76%	82%	75%	68%	73%	74%	80
Grand Total	**78%**	**79%**	**79%**	**78%**	**79%**	**80%**	**80%**	**79%**	**79%**	**77%**	**77%**	**77%**	**78%**	**1,397**

Theatre Average Cases per Session

Main List Specialty	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Cardiothoracic	1.8	1.8	1.5	1.3	1.4	1.5	1.5	1.5	1.7	1.4	1.5	1.6	1.6
ENT	1.8	1.7	1.8	1.7	1.7	1.7	1.6	1.9	1.6	1.6	1.7	1.9	1.9
General Surgery	1.8	1.8	1.7	1.7	1.8	1.7	1.6	1.8	1.7	1.6	1.8	1.8	1.6
Gynaecology	2.3	2.7	2.6	2.5	2.6	2.5	2.9	2.7	2.6	2.3	2.5	2.2	2.4
Neurosurgery	1.1	1.1	1.1	1.0	1.0	1.1	1.2	1.1	1.0	1.1	1.1	1.1	1.1
Oral and Maxillo Facial Surgery	3.0	4.0	3.7	3.9	3.1	3.8	3.8	3.7	3.1	4.0	2.7	3.1	3.4
Paediatric Dentistry	4.2	4.0	3.8	4.1	3.9	4.5	4.7	4.4	4.3	4.1	3.9	4.9	4.2
Paediatric Surgery	2.4	2.6	2.6	2.7	2.6	2.7	2.7	2.6	2.5	2.6	2.4	2.7	2.2
Plastic Surgery	2.0	2.0	2.2	2.2	2.1	2.0	2.0	1.9	2.0	2.1	1.8	1.8	1.7
Renal Medicine & Surgery	1.7	1.4	1.4	1.3	1.6	1.5	1.4	1.2	1.8	1.5	1.9	2.0	1.2
Trauma & Orthopaedics	1.6	1.6	1.5	1.6	1.9	1.9	1.8	1.9	1.9	1.9	1.8	1.8	2.0
Urology	2.1	2.0	2.1	2.1	2.1	2.0	2.1	2.0	2.0	2.0	2.0	2.1	2.1
Vascular Surgery	1.0	1.1	1.2	1.2	1.1	1.1	1.1	1.0	1.0	1.1	1.0	1.1	1.4
Grand Total	**1.8**	**1.8**	**1.8**	**1.7**	**1.8**	**1.8**	**1.8**	**1.8**	**1.8**	**1.7**	**1.7**	**1.8**	**1.8**

What the information tells us

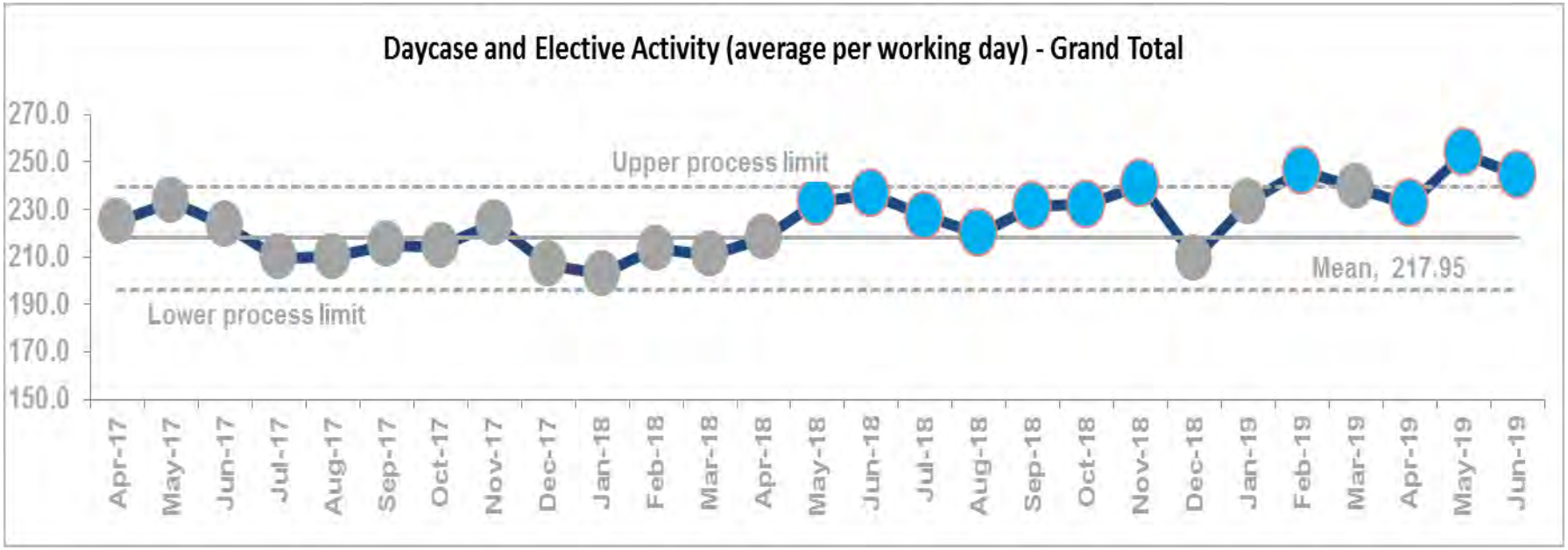
- The Trust's Cases per Session remains within its normal process limits.
- Trauma & Orthopaedics and Urology both are sustaining more cases per session above their mean whereas Neurosurgery has fallen below its mean for the past six months. All other specialties are within expected range
- The Trust's Theatre utilisation remains above its mean at 77% however it remains consistently below 85%
- Cardiothoracic's utilisation is consistently below its mean.
- ENT had a consistent run of theatre utilisation above its mean however in the past month, it has fallen back to within its 17/18 performance.

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

Number of Elective and Daycase Patients treated per Working Day

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



What the information tells us

- June 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.
- Neurology, Plastic Surgery, Trauma & Orthopaedics and Urology are all performing above their means with T&O above its upper limit.
- All of the other specialties are within their expected process limits.

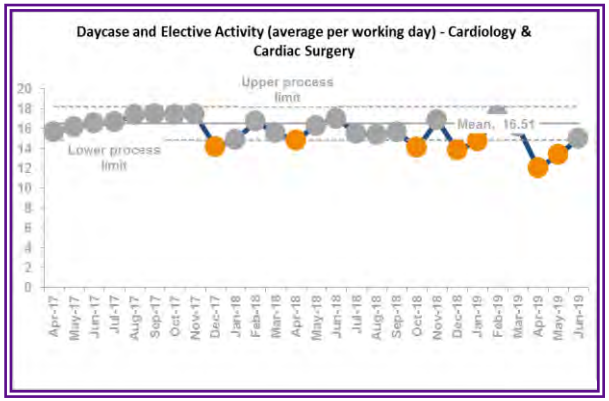
Actions and Quality Improvement Projects

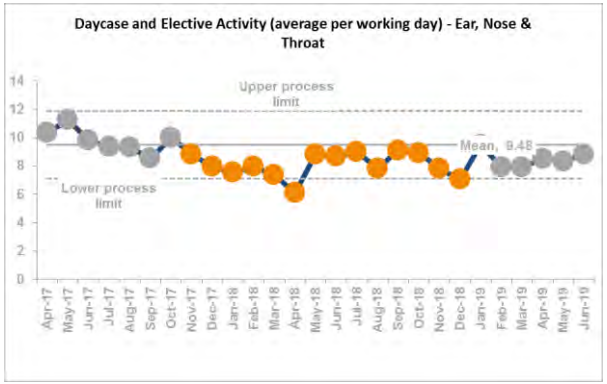
- Theatres are ensuring that there is focused work supporting a prompt start to all theatre sessions. This is linked to a weekly task and finish group.
- Agreement and plan to change Theatreman Diagnosis codes (currently SNOMED) to OPCS 4.8 codes which will support more accurate timings of theatre cases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

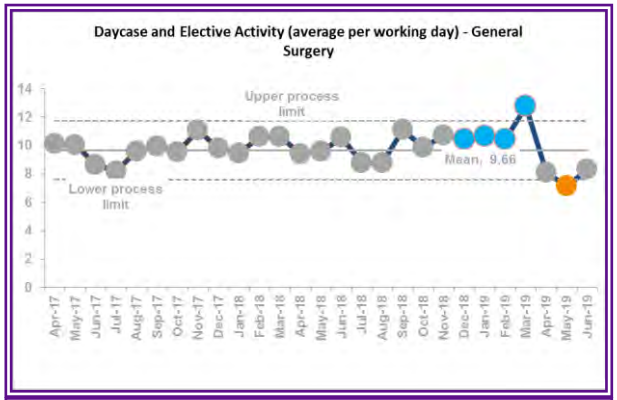
Number of Elective and Daycase Patients treated per Working Day

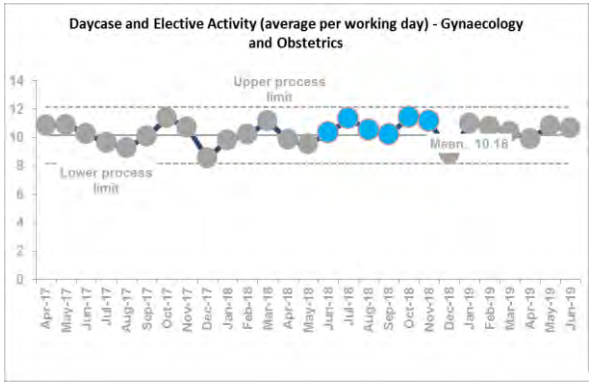
St George's University Hospitals NHS Foundation Trust

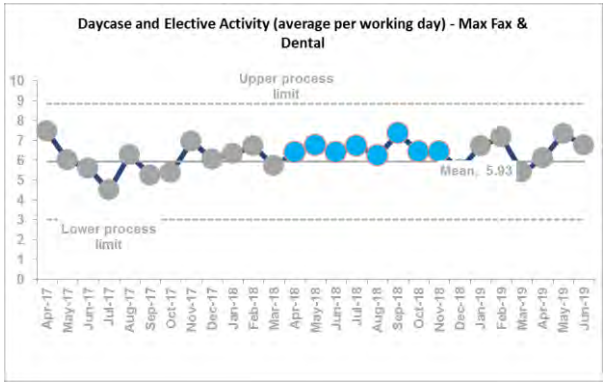
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

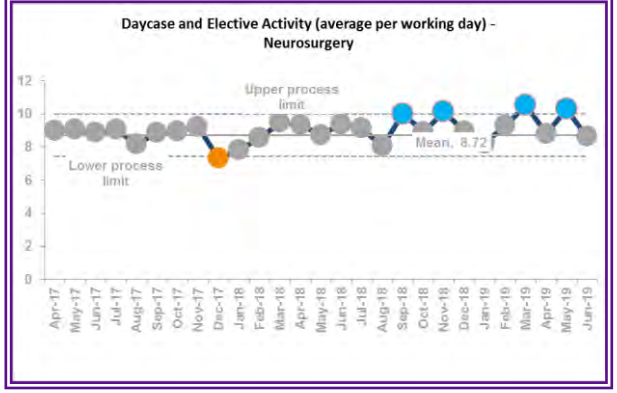


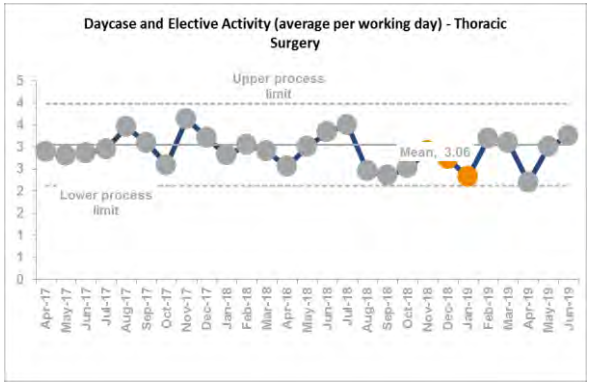


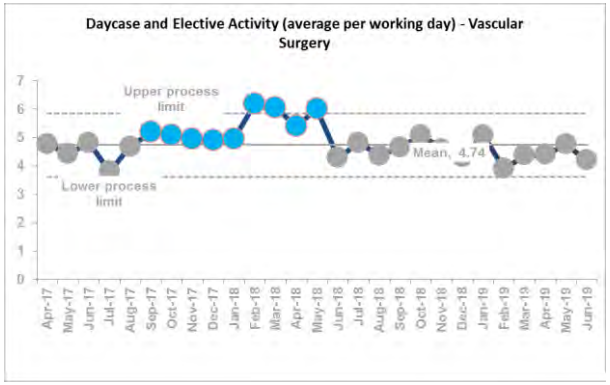


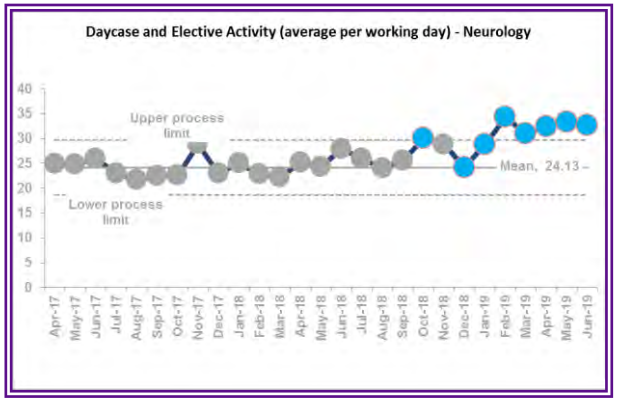








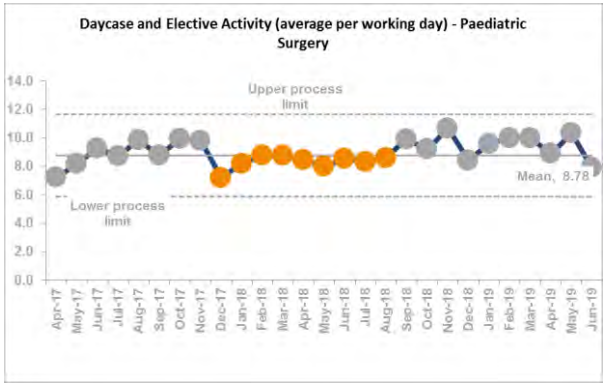


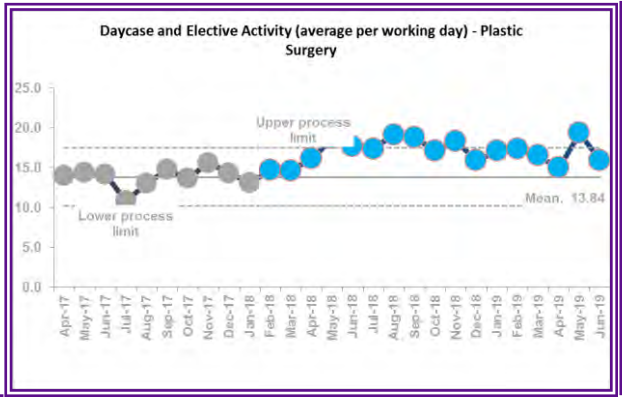


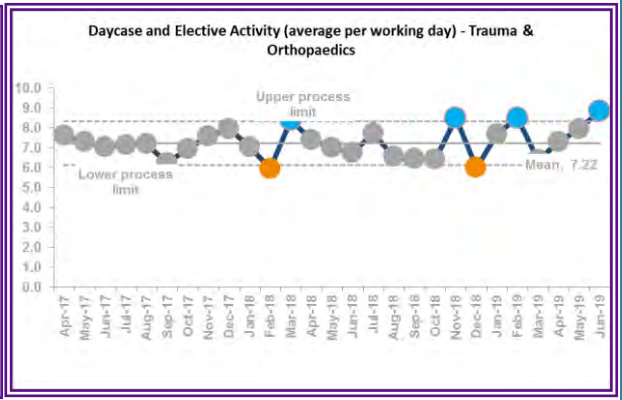
Number of Elective and Daycase Patients treated per Working Day

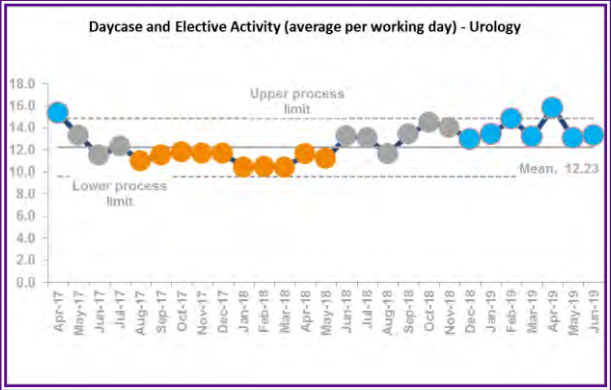
St George's University Hospitals NHS Foundation Trust

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



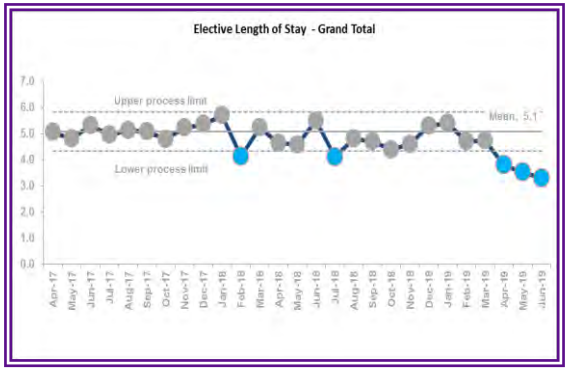


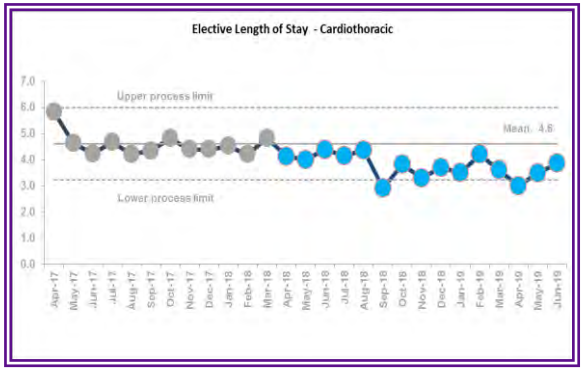


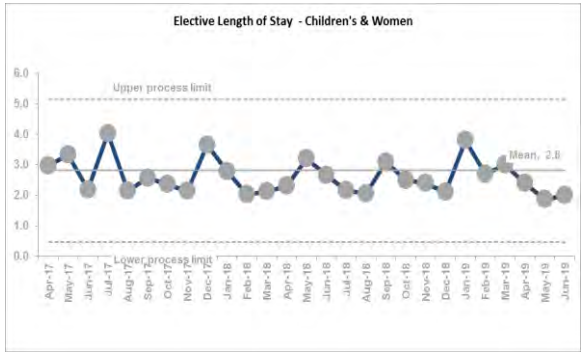


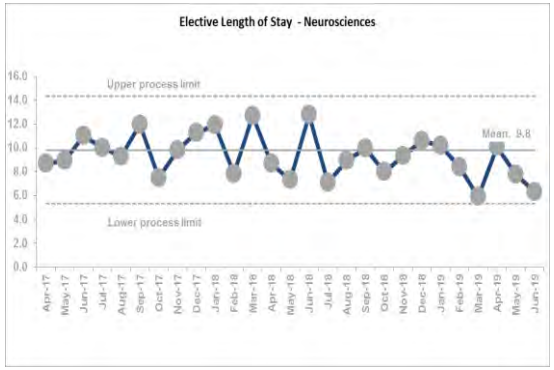
Elective Length of Stay (excluding daycase)

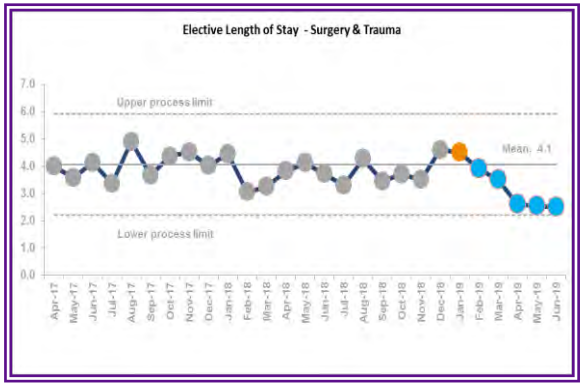
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance











Elective Length of Stay (excluding daycase)

St George's University Hospitals NHS Foundation Trust

															Average length of Stay		
Directorate	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**Apr-19**	**May-19**	**Jun-19**	**Discharges in the last month**	**2018-19 YTD**	**2019-20 YTD**	**Variance**
Cardiothoracic	4.4	4.1	4.4	2.9	3.8	3.3	3.7	3.5	4.2	3.6	3.0	3.5	3.9	222	4.2	3.5	-17%
Children's & Women	2.7	2.2	2.1	3.1	2.5	2.4	2.1	3.8	2.7	3.0	2.4	1.9	2.0	114	2.7	2.1	-23%
Neurosciences	12.8	7.1	8.9	10.0	8.0	9.3	10.6	10.2	8.4	5.9	10.1	7.8	6.3	166	9.6	8.1	-16%
Surgery & Trauma	3.7	3.3	4.3	3.4	3.7	3.5	4.6	4.5	3.9	3.5	2.6	2.5	2.5	607	3.9	2.5	-34%
Grand Total	**5.5**	**4.1**	**4.8**	**4.7**	**4.4**	**4.6**	**5.3**	**5.4**	**4.7**	**4.7**	**3.8**	**3.5**	**3.3**	**1,109**	**4.9**	**3.5**	-28%

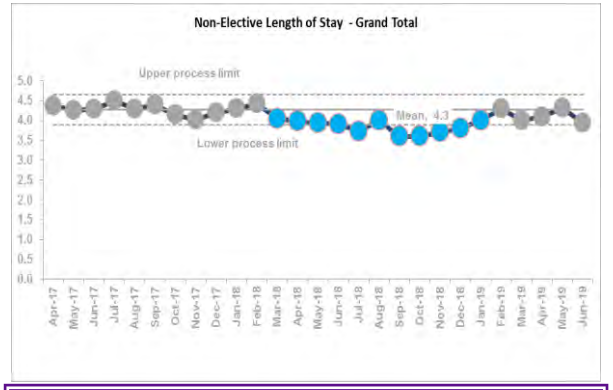
What the information tells us

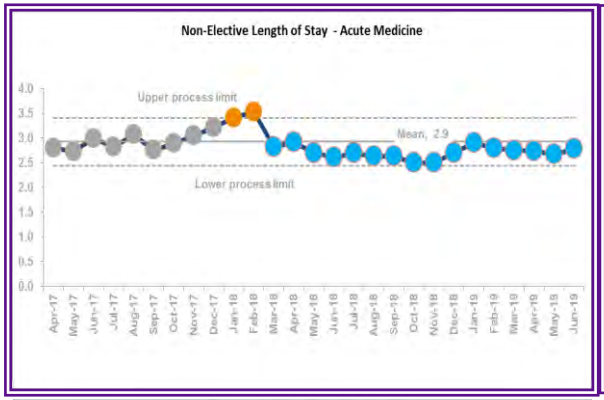
- The Trust's Elective overall elective length of stay is below its lower limit for the previous three months
- Cardiothoracic Length of Stay has been consistently reducing its
- Surgery and Trauma have reduced their length of stay month on month consistently for the previous six months

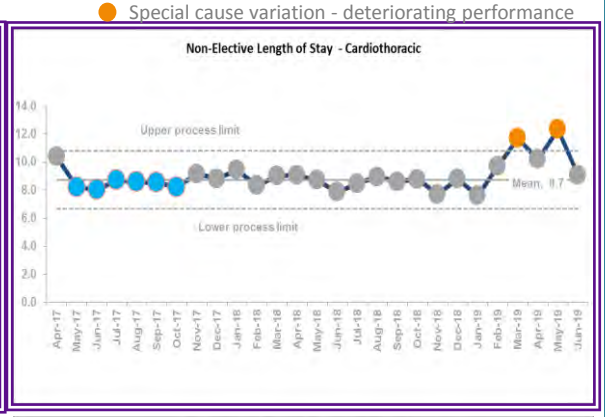
Non Elective Length of Stay

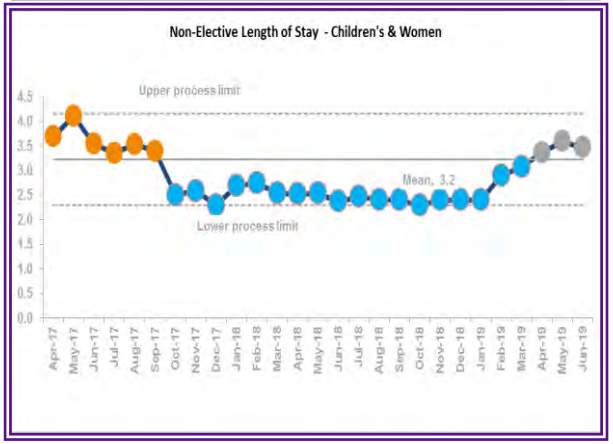
St George's University Hospitals NHS Foundation Trust

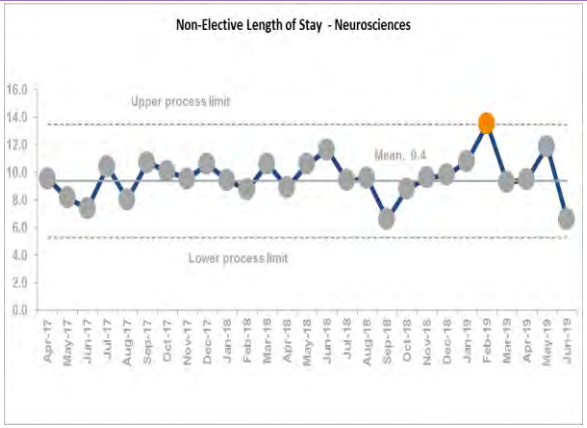
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

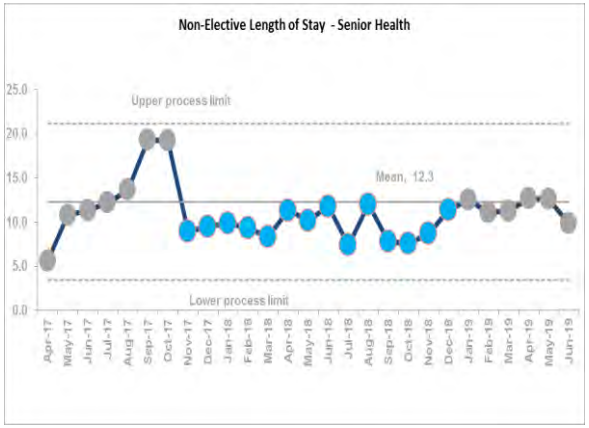


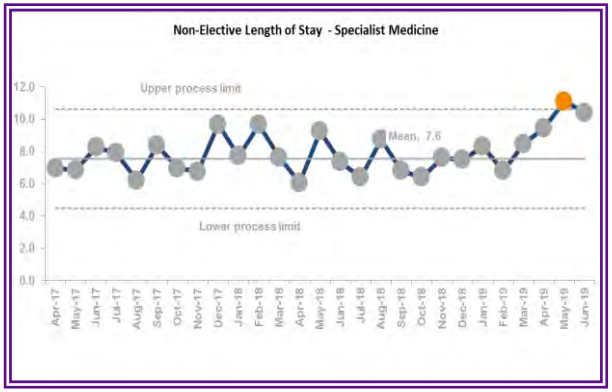


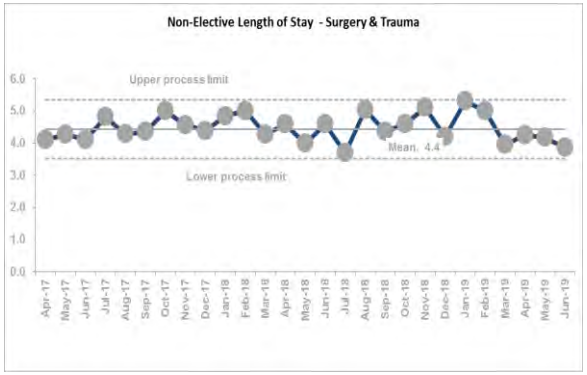


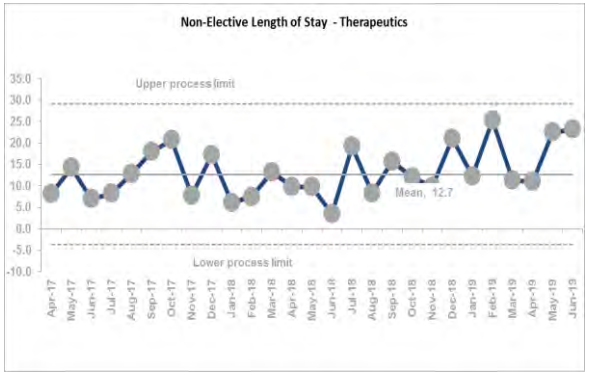












Non Elective Length of Stay

St George's University Hospitals NHS Foundation Trust

Directorate	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Discharges in the last month	Average length of Stay 2018-19 YTD	Average length of Stay 2019-20 YTD	Variance
Acute Medicine	2.6	2.7	2.6	2.6	2.5	2.5	2.7	2.9	2.8	2.8	2.7	2.7	2.8	2,418	2.7	2.7	-0.4%
Cardiothoracic	7.8	8.5	8.9	8.6	8.8	7.7	8.8	7.6	9.7	11.7	10.2	12.3	9.1	135	8.5	10.5	23%
Children's & Women	2.4	2.5	2.4	2.4	2.3	2.4	2.4	2.4	2.9	3.1	3.4	3.6	3.5	783	2.5	3.5	40%
Neurosciences	11.6	9.4	9.6	6.6	8.8	9.6	9.8	10.8	13.5	9.3	9.5	11.9	6.6	183	10.4	9.3	-10%
Senior Health	11.8	7.4	12.0	7.8	7.6	8.7	11.4	12.5	11.1	11.2	12.7	12.6	9.8	96	11.1	11.7	5%
Specialist Medicine	7.3	6.4	8.7	6.8	6.4	7.6	7.5	8.3	6.8	8.5	9.5	11.1	10.4	143	7.6	10.3	37%
Surgery & Trauma	4.6	3.7	5.0	4.4	4.6	5.1	4.2	5.3	5.0	4.0	4.3	4.2	3.9	792	4.4	4.1	-6.8%
Therapeutics	3.6	19.2	8.3	15.7	12.0	9.8	21.1	12.3	25.3	11.3	11.0	22.5	23.2	28	7.7	18.9	145%
Grand Total	**3.9**	**3.7**	**4.0**	**3.6**	**3.6**	**3.7**	**3.8**	**4.0**	**4.3**	**4.0**	**4.1**	**4.3**	**3.9**	**4,578**	**3.9**	**4.1**	4%

What the information tells us

- The Trust's Non-Elective length of stay is within the expected process limits.
- Acute Medicine continues to stay below its mean.
- Cardiothoracic and Specialist Medicine have dropped back to within normal process control limits after exceeding the upper limit in May 2019
- Children's and Women's directorate was consistently below its mean but are not within their process control limit and variation is due to common cause.
- All other directorates' variation are due to common cause

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 long and extended length of stay patients is being implemented by the Medcard Division.

Balance Scorecard

St George's University Hospitals NHS Foundation Trust

2.2

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

Our Patient Perspective

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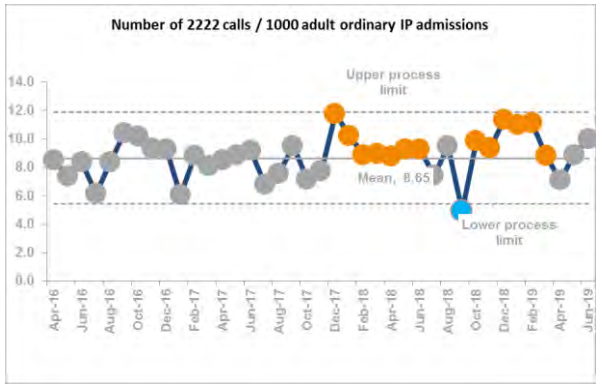
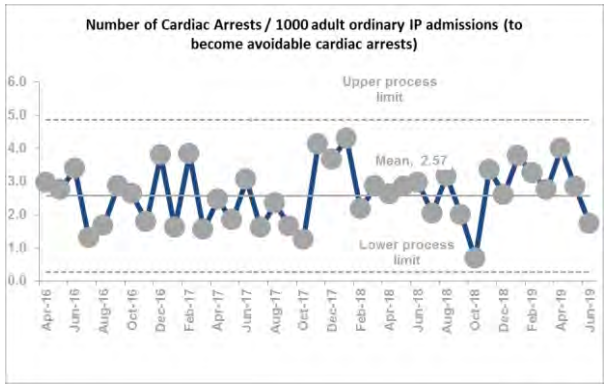
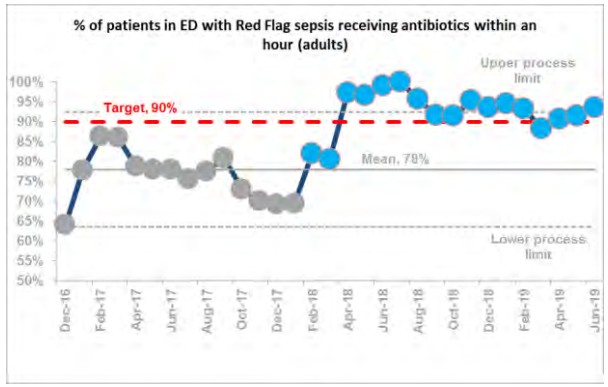
Quality Priorities – Treatment Escalation Plan and Deteriorating Patients

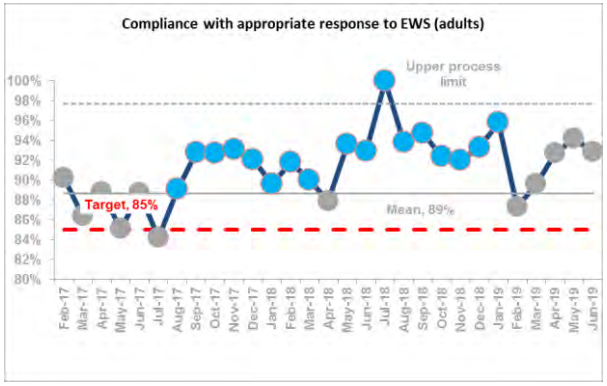
St George's University Hospitals NHS Foundation Trust

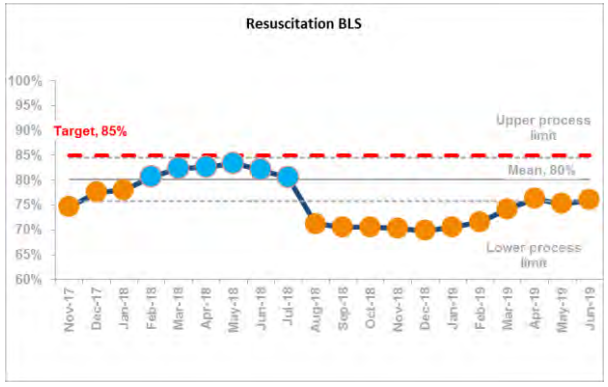
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

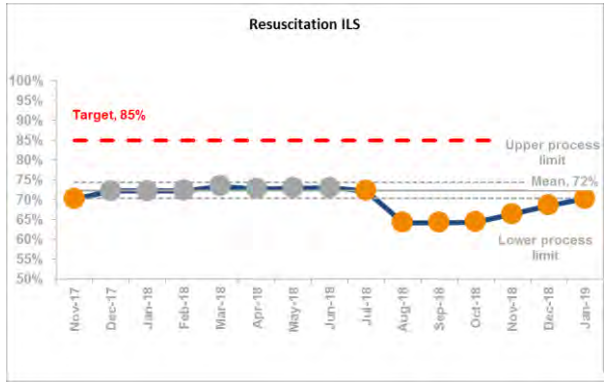


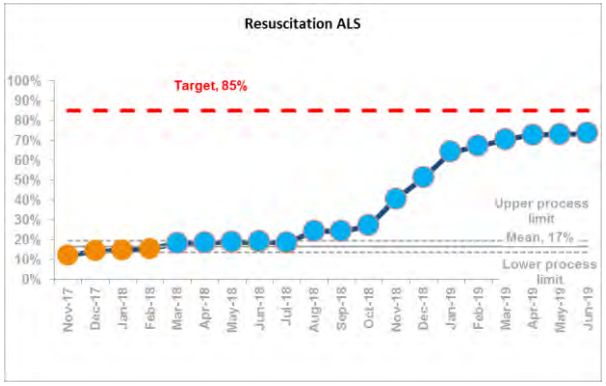












Quality Priorities – Treatment Escalation Plan and Deteriorating Patients

Indicator Description	Threshold /Target	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Number of 2222 calls / 1000 adult ordinary IP admissions		9.3	7.4	9.5	4.9	9.8	9.4	11.3	11.0	11.1	8.8	7.1	8.9	10.0
Number of Cardiac Arrests / 1000 adult ordinary IP admissions (to become avoidable cardiac arrests)		3.0	2.0	3.2	2.0	0.7	3.4	2.6	3.8	3.3	2.8	4.0	2.8	1.7
% of patients in ED with Red Flag sepsis receiving antibiotics within an hour (adults)	90%	99.1%	100.0%	95.7%	91.6%	91.4%	95.3%	93.5%	94.5%	93.2%	88.3%	90.6%	91.4%	93.5%
Compliance with appropriate response to EWS (adults)	85%	92.9%	100.0%	93.8%	94.7%	92.4%	92.0%	93.3%	95.8%	87.3%	89.6%	92.7%	94.2%	92.9%
Resuscitation BLS	85%	82.0%	80.5%	71.1%	70.5%	70.5%	70.3%	69.8%	70.5%	71.5%	74.1%	76.2%	75.2%	76.0%
Resuscitation ILS	85%	73.0%	72.2%	64.2%	64.2%	64.3%	66.3%	68.5%	70.2%	69.3%	71.3%	72.1%	72.7%	72.0%
Resuscitation ALS	85%	19.1%	18.4%	24.4%	24.2%	27.1%	40.4%	51.2%	64.2%	67.0%	70.4%	72.7%	73.0%	73.5%

What the information tells us

- The Trust has continued to maintain its step change performance for patients receiving antibiotics within an hour in ED
- Additional resuscitation BLS (Basic Life Support) training has been commissioned to ensure delivery of this performance target by 30 September 2019. The training team will be overbooking these courses due to an historic DNA rate.
- Resuscitation ILS and ALS (Intermediate and Advanced Life Support) training performance is also benefitting from additional training capacity as outlined above.

Actions and Quality Improvement Projects

Implementing Treatment Escalation Plan (TEP)

- Information Technology (IT) is working towards TEP being on iCLIP; this is currently in the test domain. Audit measures have been agreed with IT in readiness for electronic audit facility anticipated by end of Q3.
- The team are developing driver diagrams in line with Quality Improvement project methodology

Deteriorating Patients

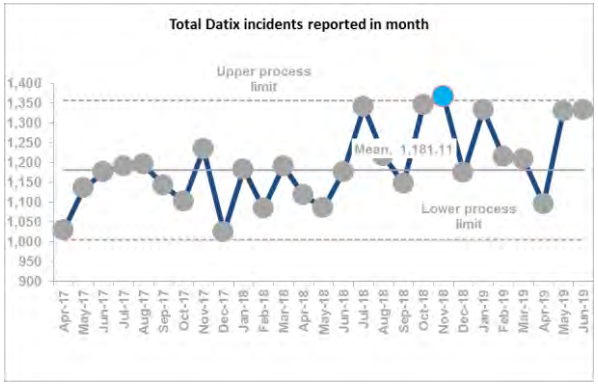
- Successful Trust wide rollout of National Early Warning Score 2 (NEWS2) in late March 2019
- Improved divisional engagement with Deteriorating Adults Group from nursing, with responsibility for driving improvements across the Trust
- Developing management level and monthly audit data with IT for NEWS2 in iCLIP in readiness for electronic audit facility anticipated by end of Q3
- Critical Care Outreach project group established and interim Matron appointed . Phased implementation due from Q3

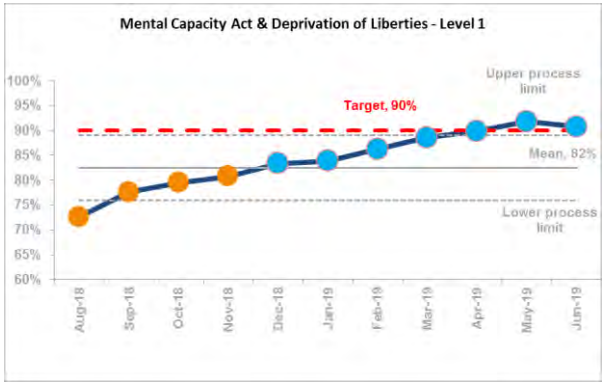
Resuscitation

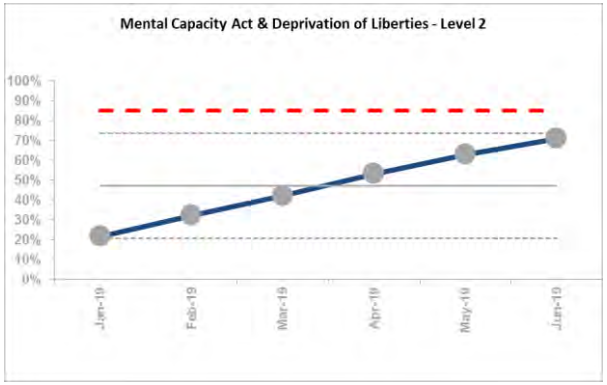
- Additional champions recruited to deliver training.
- Review of training model completed for BLS to increase capacity
- Training monitored weekly at Trust Communication Cell
- DNA list sent to divisional management teams to review and action.

Quality Priorities – Mental Capacity Act & Clinical Governance

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







Quality Priorities – Mental Capacity Act & Clinical Governance

Indicator Description	Threshold /Target	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Mental Capacity Act & Deprivation of Liberties - Level 1	90%			72.6%	77.6%	79.5%	80.8%	83.4%	83.9%	86.3%	88.6%	89.8%	91.8%	90.8%
Mental Capacity Act & Deprivation of Liberties - Level 2	85%								21.7%	32.2%	42.0%	53.2%	62.9%	70.9%
Total Datix incidents reported in month		1,177	1,340	1,217	1,147	1,345	1,366	1,174	1,333	1,215	1,208	1,096	1,329	1,332
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	100%											100.0%	data two months in arrears	
Duty of Candour completed within 10 working days, for all incidents at moderate harm and above	100%	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.

Actions and Quality Improvement Projects

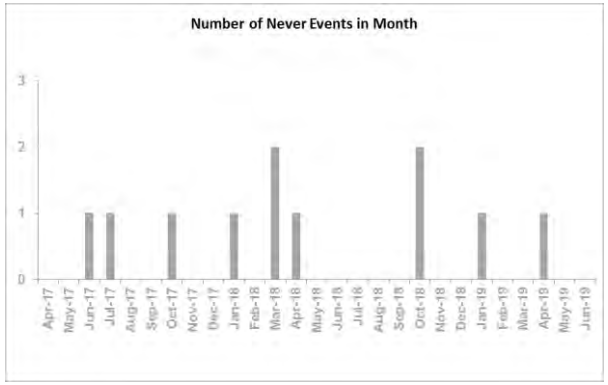
Progress and actions: MCA awareness and quality of assessments

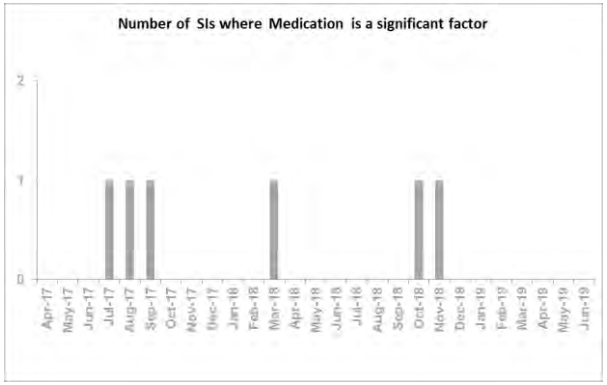
- Scoping exercise underway to commission small scale group work approach to support the application of MCA and DoLs training to practice
- Engaged with SW London sector to develop a standardised audit tool. Taking a sector approach will enable to Trust to benchmark practice with similar Trusts and create 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
- Trust wide staff knowledge survey to be developed and completed quarterly.
- Group established to develop electronic templates in iClip for documentation of MCA and Best Interests decisions for testing Q2

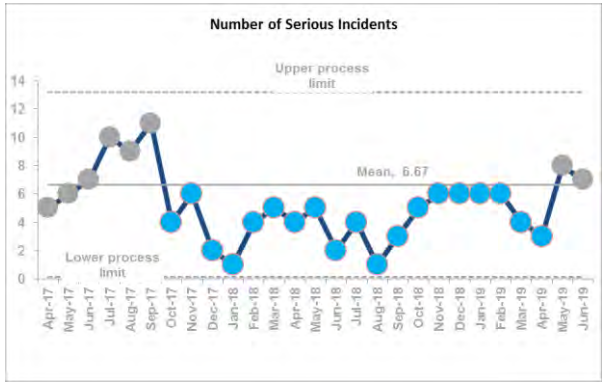
Patient Safety

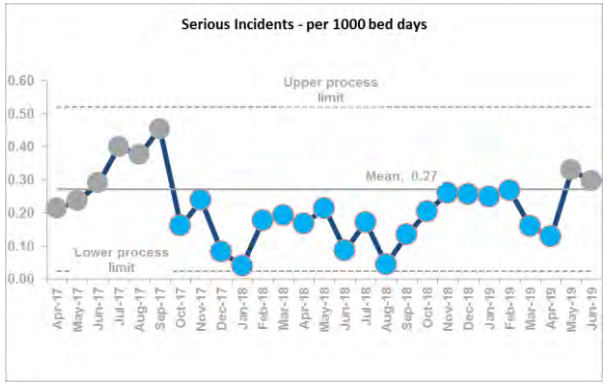
St George's University Hospitals NHS Foundation Trust

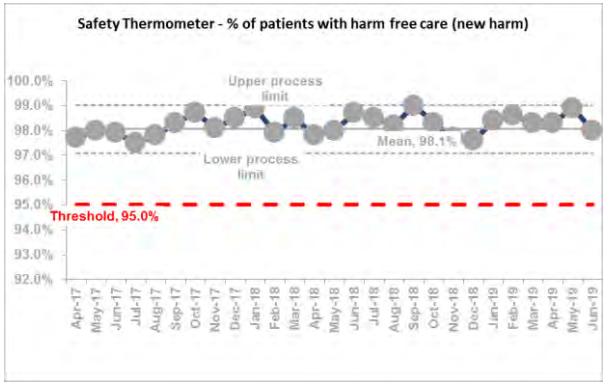
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

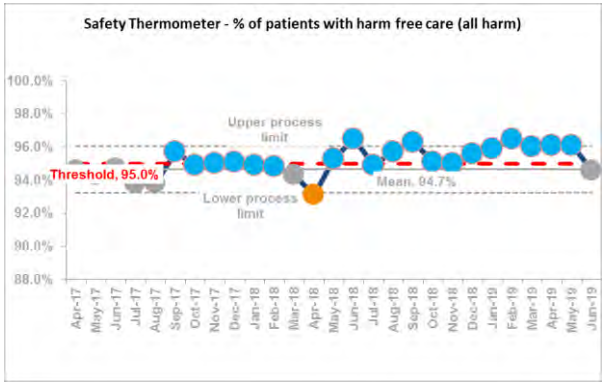


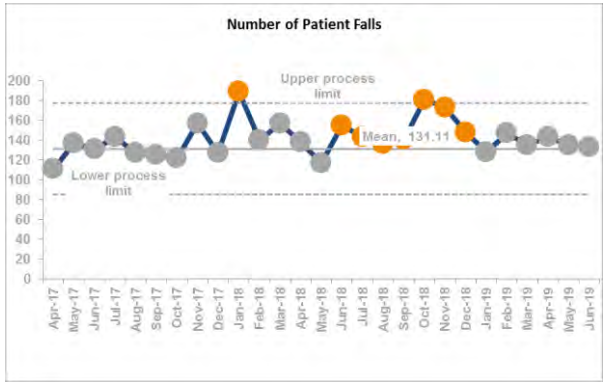


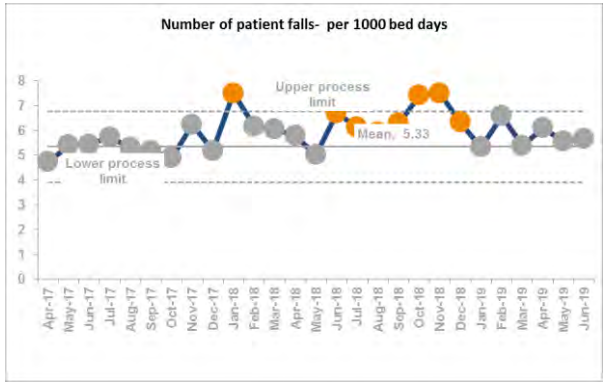


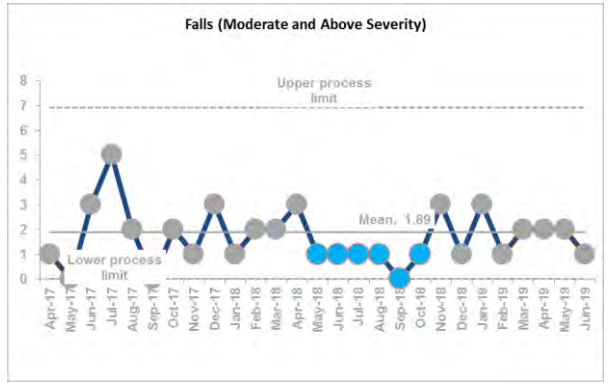






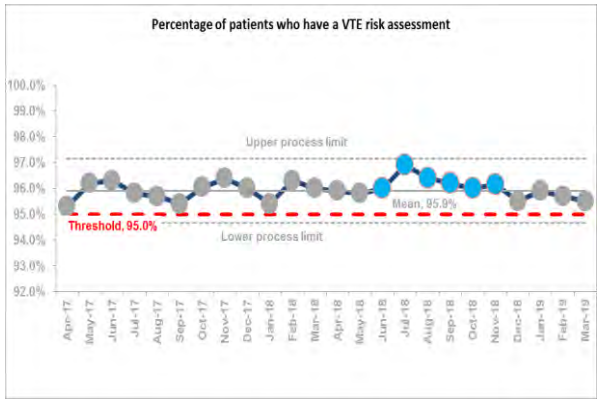


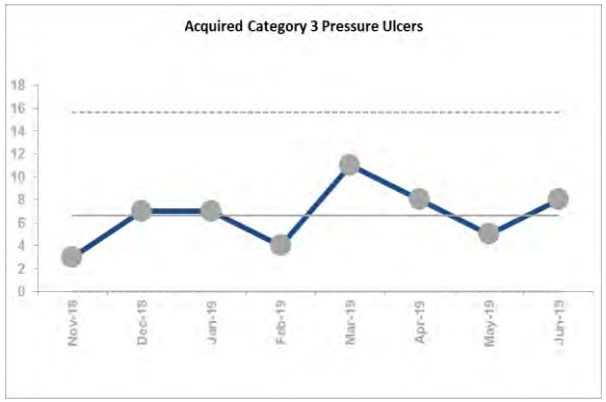


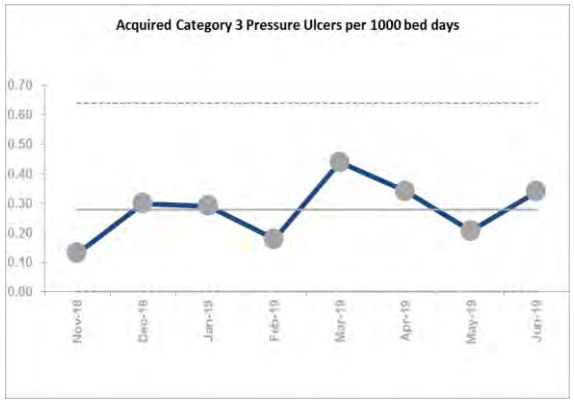


Patient Safety

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







Patient Safety

St George's University Hospitals NHS Foundation Trust

Indicator Description	Target	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Number of Never Events in Month	0	0	0	0	0	2	0	0	1	0	0	1	0	0
Number of SIs where Medication is a significant factor	0	0	0	0	0	1	1	0	0	0	0	0	0	0
Number of Serious Incidents	=<8 month	2	4	1	3	5	6	6	6	6	4	3	8	7
Serious Incidents - per 1000 bed days	N/A	0.09	0.17	0.04	0.13	0.20	0.26	0.26	0.25	0.27	0.16	0.13	0.33	0.30
Safety Thermometer - % of patients with harm free care (all harm)	95%	96.5%	94.9%	95.7%	96.3%	95.1%	95.0%	95.6%	95.9%	96.5%	96.0%	96.1%	96.1%	94.6%
Safety Thermometer - % of patients with harm free care (new harm)	95%	98.7%	98.5%	98.2%	99.0%	98.3%	97.7%	97.6%	98.4%	98.6%	98.3%	98.3%	98.9%	98.0%
Percentage of patients who have a VTE risk assessment	95%	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	155	143	136	141	181	173	148	128	147	135	143	135	133
Falls (Moderate and Above Severity)	N/A	1	1	1	0	1	3	1	3	1	2	2	2	1
Number of patient falls- per 1000 bed days	N/A	6.70	6.11	5.91	6.26	7.40	7.50	6.32	5.31	6.57	5.38	6.08	5.55	5.64
Acquired Category 2 Pressure Ulcers	N/A	10	20	15	9	12	25	13	10	16	6	4	17	20
Acquired Category 2 Pressure Ulcers per 1000 bed days	N/A	0.43	0.85	0.65	0.40	0.49	1.08	0.56	0.42	0.72	0.24	0.17	0.70	0.85
Acquired Category 3 Pressure Ulcers		6	5	3	2	1	3	7	7	4	11	8	5	8
Acquired Category 3 Pressure Ulcers per 1000 bed days		0.26	0.21	0.13	0.09	0.04	0.13	0.30	0.29	0.18	0.44	0.34	0.21	0.34
Number of overdue CAS Alerts	0	0	0	0	0	0	0	0	0	0	0	0	0	0

What the information tells us

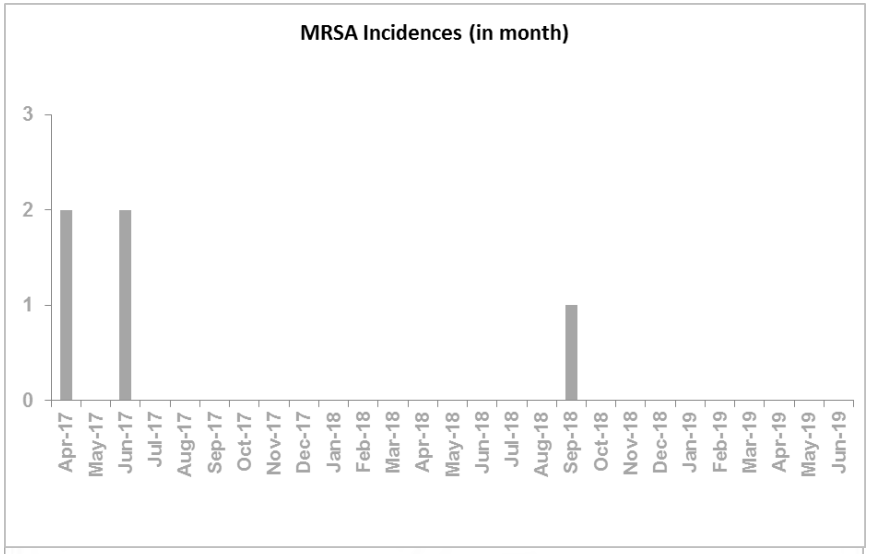
- The number of falls reported in June was 133, there is no significant change and the number of falls remain within the lower and upper control limits. Of the falls reported one patient sustained moderate harm

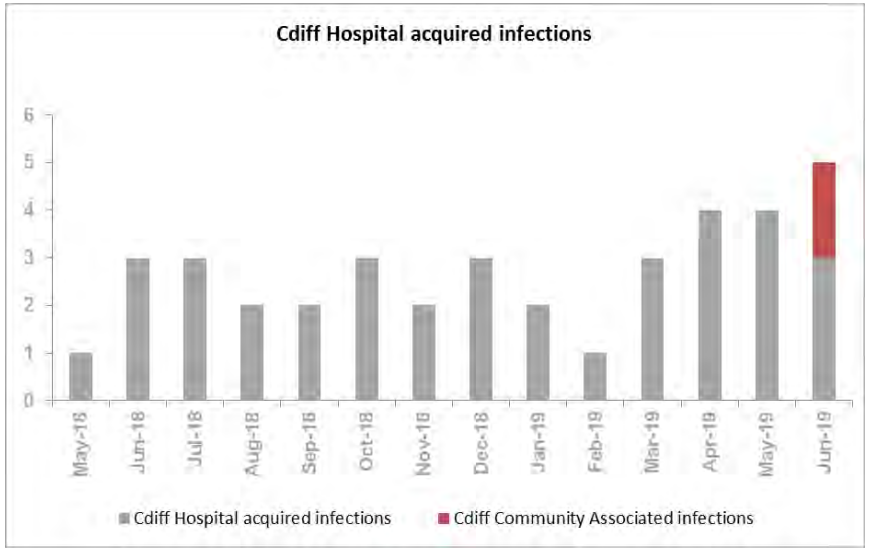
Actions and Quality Improvement Projects

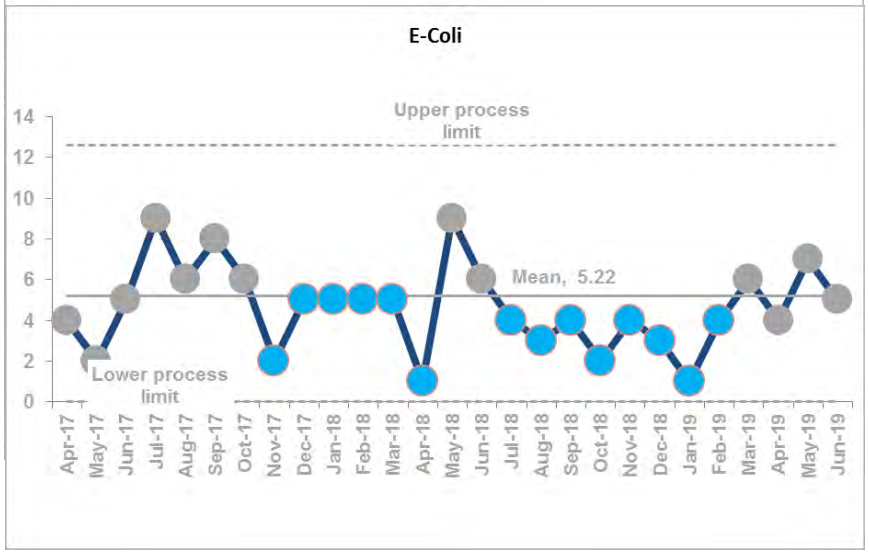
- Falls – Recruited to falls coordinator position, focused work will continue on identified wards and a project group will be established to deliver the elements of the Falls CQUIN this year.
- Tissue Viability – From April 2019 all pressure area damage within the Trust that is not documented at the 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.

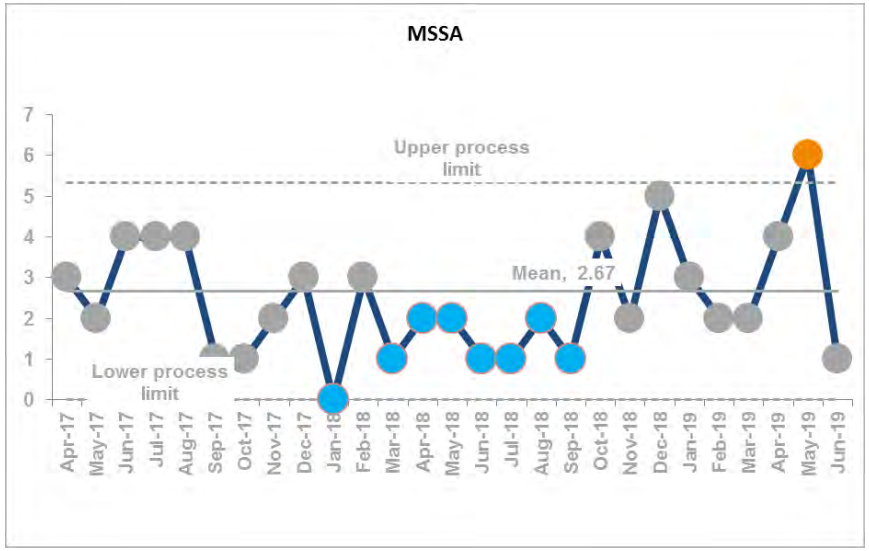
Infection Control

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









Infection Control

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

What the information tells us

- The Trust MRSA position remains at zero year to date.
- 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 June, five Cdiff Hospital acquired infections were reported. These have been recorded as three being hospital onset and two community onset.
- 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. There was one case of MSSA reported for June.

Actions and Quality Improvement Projects

- All Cdiff cases have undergone a Root Cause Analysis (RCA). No lapses in care have been identified to date, however a review of all Cdiff 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 to establish any causes and opportunities for learning and change in practice.
- A project group has been established across SWL STP to reduce the number of E-Coli infections.

Mortality and Readmissions

St George's University Hospitals NHS Foundation Trust

Indicator Description	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-19	April 2018 to March 2019	Trend
Hospital Standardised Mortality Ratio (HSMR)	106.3	94.9	86.7	79.5	69.8	80.3	73.0	64.2	76.9	74.5	77.6	78.1	79.4	81.5	
Hospital Standardised Mortality Ratio Weekend Emergency	121.5	113.8	78.2	97.6	79.5	72.2	62.7	82.4	113.3	79.1	74.6	85.2	83.1	89.5	
Hospital Standardised Mortality Ratio Weekday Emergency	95.6	79.7	87.1	82.5	67.6	78.1	68.4	60.1	64.9	78.2	79.4	74.1	76.3	78.5	

Indicator Description	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Trend
Summary Hospital Mortality Indicator (SHMI)	0.83	0.82	0.82	0.82	0.82	0.82	0.84	0.84	0.84	0.84	0.84	0.84	0.83	
Emergency Readmissions within 30 days following non elective spell (reporting one month in arrears)	8.7%	8.5%	8.20%	8.20%	7.00%	8.90%	8.30%	7.60%	8.20%	7.20%	8.20%	8.20%	7.90%	

Please note SHMI data is reflective of the period January 2018 to December 2018 based on a rolling 12 month period (published April 2019).
HSMR data reflective of period February 2018 – December 2018 based on a monthly published position (published April 2019).
Mortality Green Rag Rating is reflective of periods where the Trust are better than expected, non-Rag Rating is where the Trist are in line with expected rates.

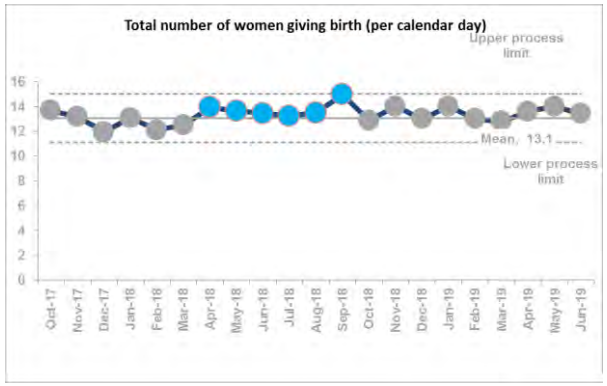
What the information tells us

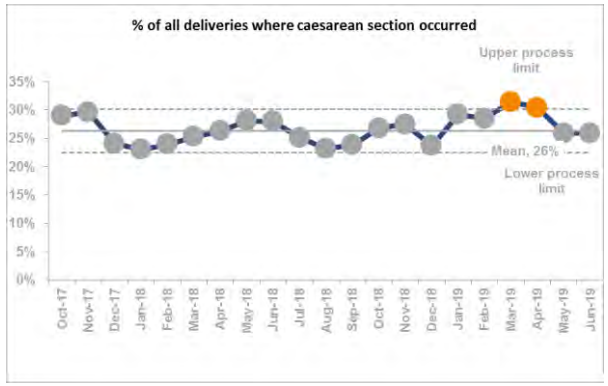
Both the Trust-level mortality indicators (SHMI and HSMR) remain lower than expected compared to national patterns and deaths as a percentage of discharges has increased above standard variation. Caution should be taken in over-interpreting these signals, however as they mask a number of areas of over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

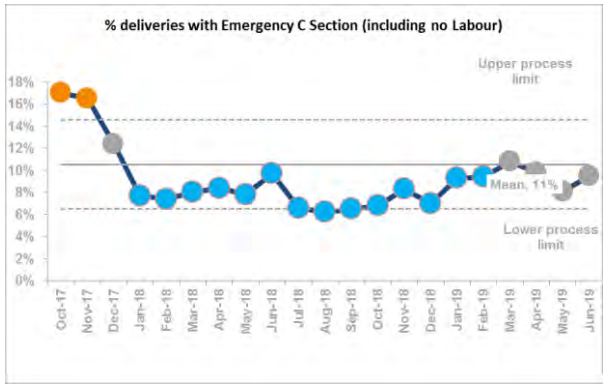
Maternity

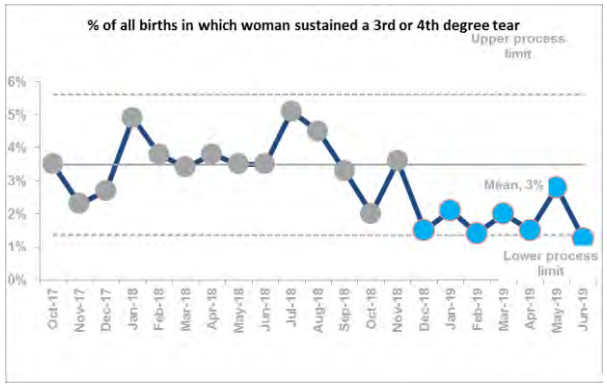
St George's University Hospitals NHS Foundation Trust

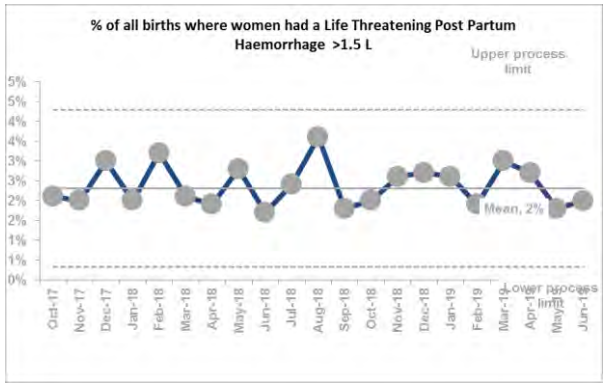
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

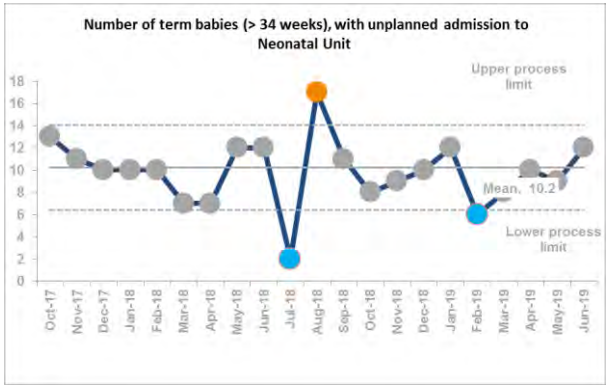


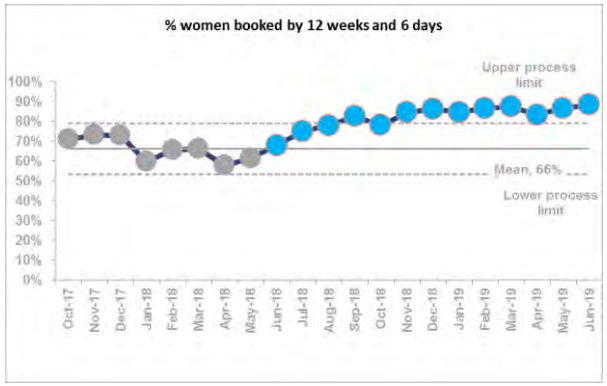












Maternity

St George's University Hospitals NHS Foundation Trust

Definitions	Target	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Total number of women giving birth (per calendar day)	14 per day	13	13	13	15	13	14	13	14	13	13	14	14	13
% of all deliveries where caesarean section occurred	<28%	28.0%	25.1%	23.2%	23.8%	26.8%	27.5%	23.7%	29.2%	28.5%	31.4%	30.4%	25.9%	25.9%
% deliveries with Emergency C Section (including no Labour)	<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%	9.5%
% Time Carmen Suite closed	0%						0%	0%	0%	0%	0%	5%	0%	7%
% of all births in which woman sustained a 3rd or 4th degree tear	<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%	1.2%
% of all births where women had a Life Threatening Post Partum Haemorrhage >1.5 L	<4%	1.7%	2.4%	3.6%	1.8%	2.0%	2.6%	2.7%	2.6%	1.9%	3.0%	2.7%	1.8%	2.0%
Number of term babies (> 34 weeks), with unplanned admission to Neonatal Unit		12	2	17	11	8	9	10	12	6	8	10	9	12
Supernumerary Midwife in Labour Ward	>95%					95.2%	98.3%	100.0%	98.4%	96.4%	95.2%	96.7%	98.4%	98.3%
% women booked by 12 weeks and 6 days	90%	67.9%	75.0%	77.8%	82.6%	78.0%	84.4%	86.2%	84.7%	86.6%	87.3%	83.3%	86.6%	88.4%

What the information tells us

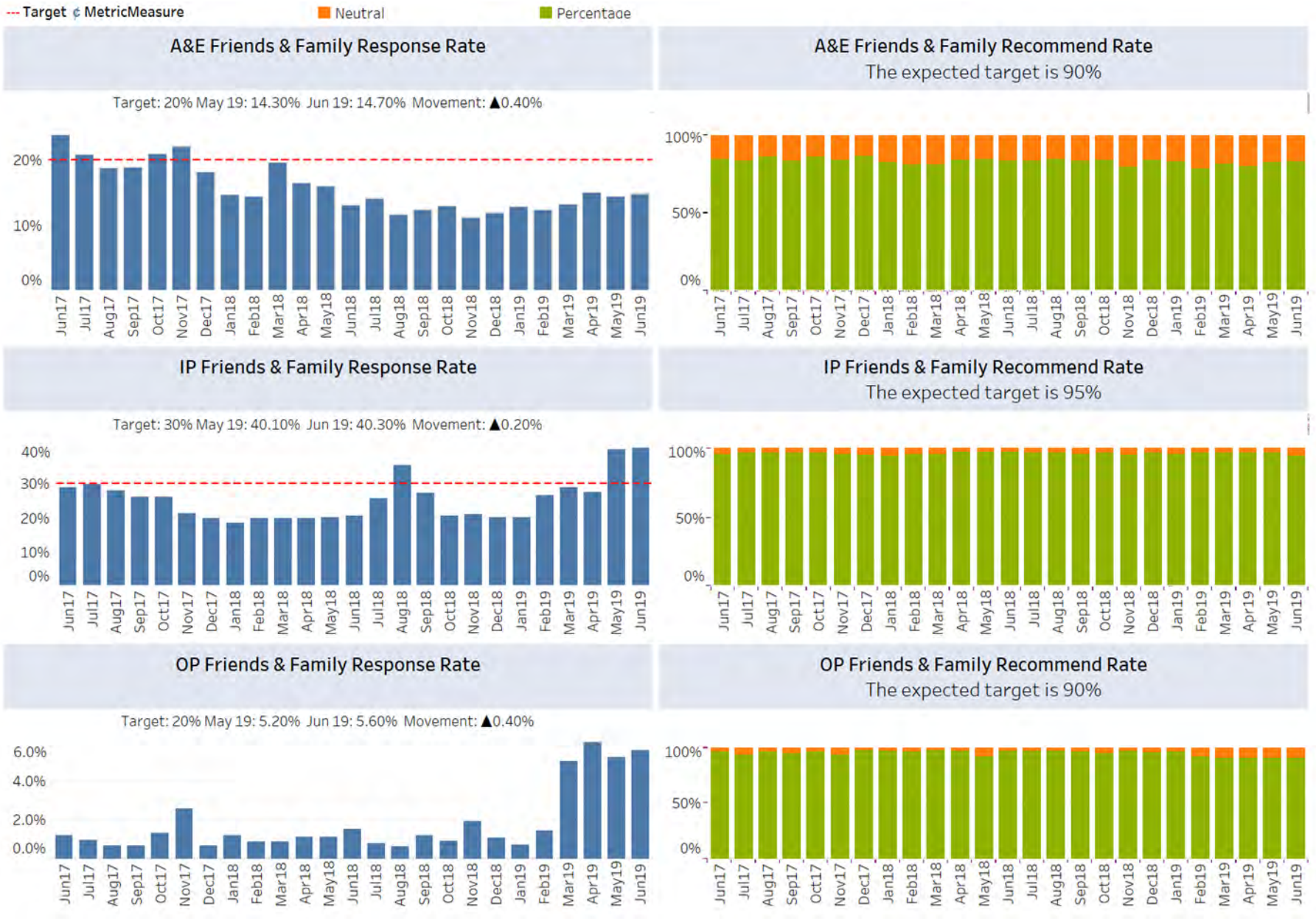
- The overall C-section rate has remained steady in June, and the emergency rate has also remained stable and within process control limits
- Carmen Suite was closed on four occasions in June, which is much higher than normal. This was due to a sewage flood (twice) and staffing issues (twice)
- The percentage of women booked by 12 weeks + 6 days reached its highest level to date
- The percentage of women in which women sustained a 3rd or 4th degree tear has continued to be below the previous mean following the implementation of a quality improvement project

Actions and Quality Improvement Projects

- Every effort continues to be made to keep Carmen Suite open across all shifts
- Wave 3 MatNeo Safety project will focus on trying to reduce the number of term infants admitted to the Neonatal Unit – work gets underway this month.

Patient Voice

St George's University Hospitals NHS Foundation Trust

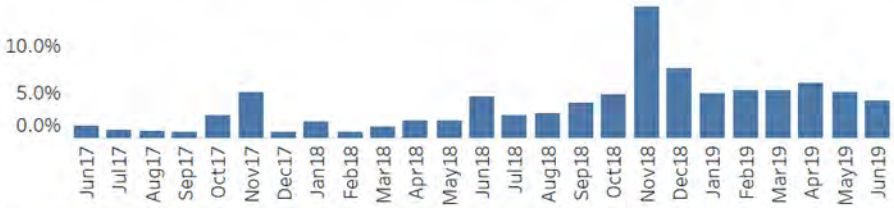


Patient Voice

Target ¢ MetricMeasure Percentage Neutral

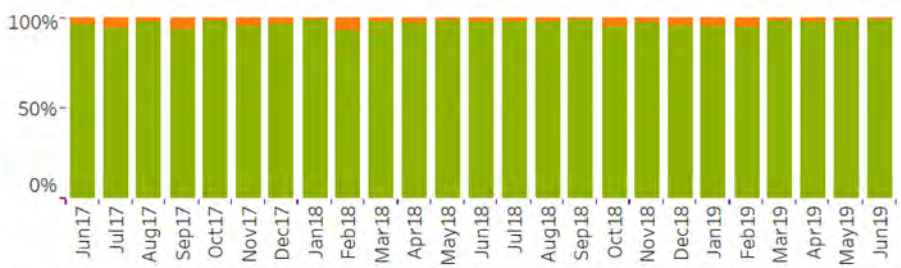
Community Friends & Family Response Rate

Target: 20% May 19: 5.00% Jun 19: 4.10% Movement: ▼-0.90%



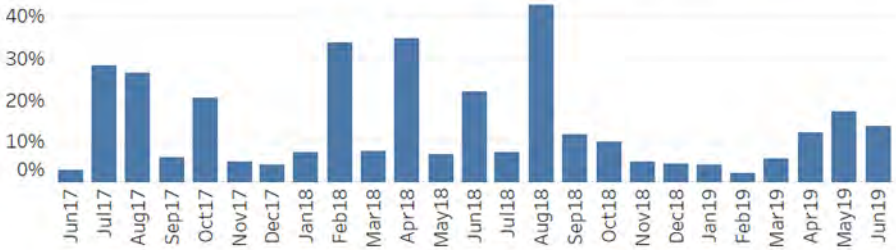
Community Friends & Family Recommend Rate

The expected target is 90%



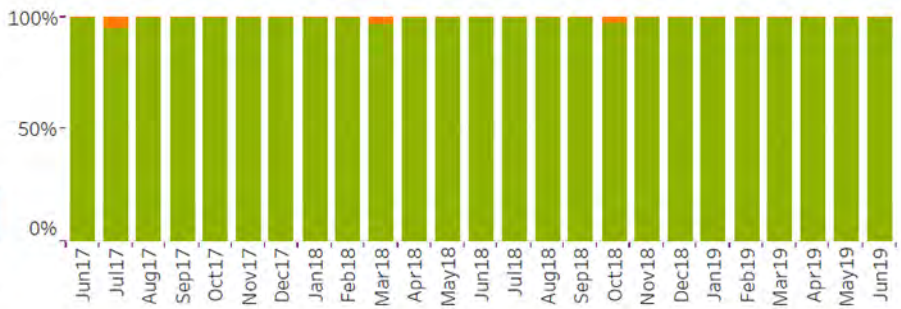
Maternity (Birth) Friends & Family Response Rate

Target: 20% May 19: 16.80% Jun 19: 13.50% Movement: ▼-3.30%



Maternity (Birth) Friends & Family Recommend Rate

The expected target is 90%



Patient Voice

St George's University Hospitals NHS Foundation Trust

Indicator Description	Target	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Emergency Department FFT - % positive responses	90%	85.5%	83.7%	84.6%	83.5%	84.2%	79.2%	84.2%	82.8%	78.5%	81.6%	80.1%	82.5%	83.3%
Inpatient FFT - % positive responses	95%	97.1%	96.7%	96.6%	96.3%	97.0%	95.5%	96.4%	96.5%	96.0%	96.9%	96.5%	96.7%	94.7%
Maternity FFT - Antenatal - % positive responses	90%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	0.0%				100.0%	90.0%	85.7%
Maternity FFT - Delivery - % positive responses	90%	100.0%	100.0%	100.0%	100.0%	97.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Maternity FFT - Postnatal Ward - % positive responses	90%	100.0%	100.0%	100.0%	98.7%	100.0%	100.0%	90.9%	95.6%	95.7%	91.7%	96.4%	94.6%	98.0%
Maternity FFT - Postnatal Community Care - % positive responses	90%	100.0%	100.0%	100.0%	100.0%	0.0%	0.0%	100.0%	0.0%	100.0%	100.0%	100.0%	98.4%	100.0%
Community FFT - % positive responses	90%	98.3%	98.0%	98.4%	99.5%	95.6%	97.4%	96.1%	96.3%	94.9%	98.9%	98.3%	98.8%	99.5%
Outpatient FFT - % positive responses	90%	97.4%	97.4%	97.1%	96.3%	94.9%	97.3%	95.6%	96.1%	92.3%	90.7%	90.5%	90.2%	90.6%
Mixed Sex Breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Complaints Received		79	120	96	93	90	88	78	92	84	101	108	102	96
% of Complaints responses to within 25 working days	85%	67%	55%	71%	76%	76%	75%	78%	66%	55%	80%	72%	79%	78%
% of Complaints responses to within 40 working days	95%	77%	67%	71%	43%	60%	63%	48%	30%	64%	44%	56%	46%	57%
% of Complaints responses to within 60 working days	95%	67%	None Due	None Due	None Due	100%	None Due	None Due	100%	100%	100%	100%	100%	100%
Number of Complaints breaching 6 months Response Time	0					0	0	0	0	0	0	1	0	0
PALS Received		292	337	294	335	416	353	252	369	334	280	249	247	218

What the information tells us

- ED Friends and Family Test (FFT) – In the month of June 83.3% 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 June, and is below our target of 20%.
- Inpatient Friends and Family Test (FFT) fell below 95% for the first time in three years. 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 with June performance of 90.6%.
- Maternity and Community FFT remain above local threshold with the exception of Antenatal Friends and Family score which was below the 90% threshold. Work is continuing to improve the number of patients responding which is currently below target.

Actions and Quality Improvement Projects

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

Complaints and PALS: The indicator has changed slightly so that compliance can be seen for each category of complaint for the reporting month. We are monitoring the number of deadlines that are met in the month. For example: in 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

2.2

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

Our Process Perspective

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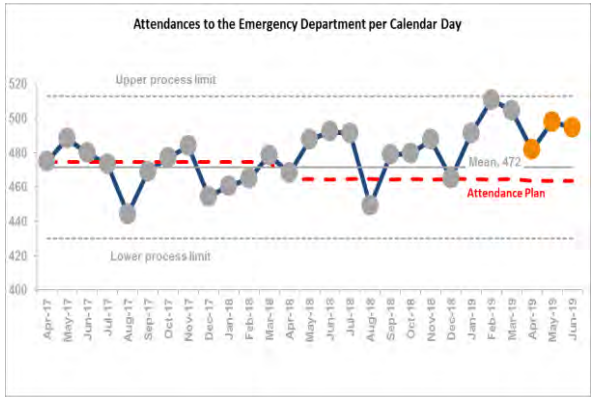
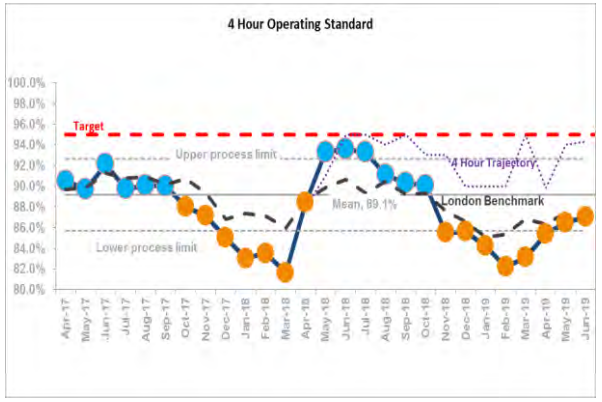
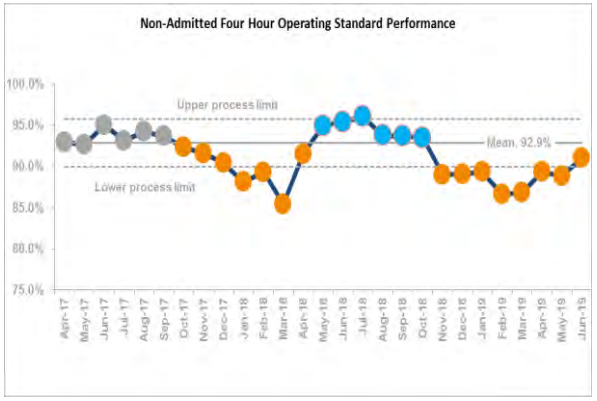
Emergency Flow

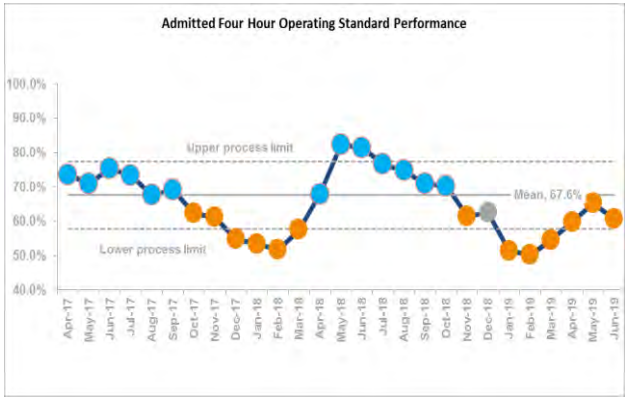
St George's University Hospitals NHS Foundation Trust

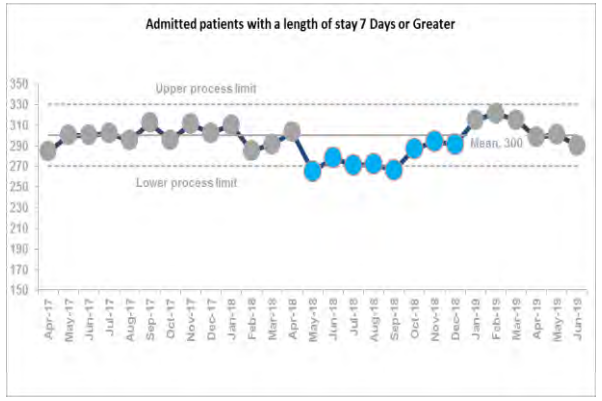
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

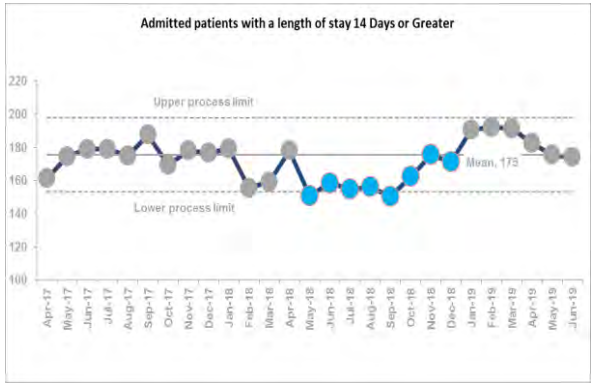


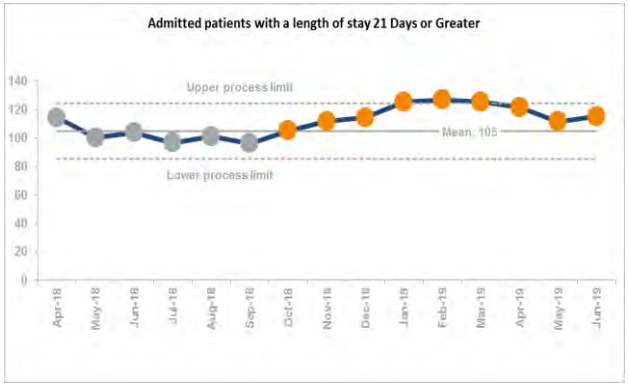








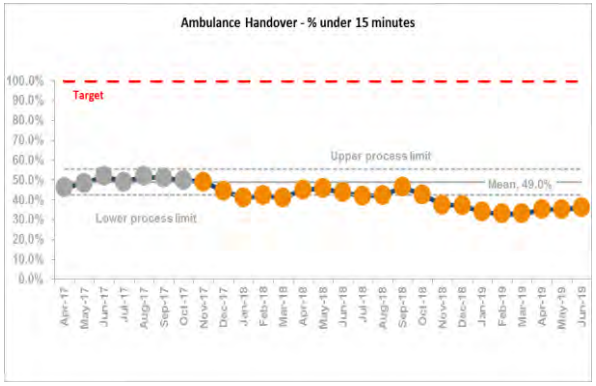


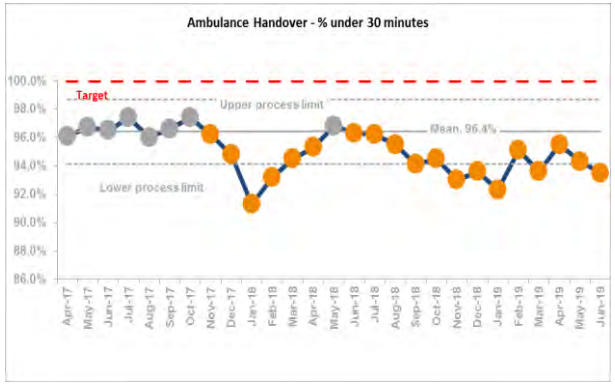


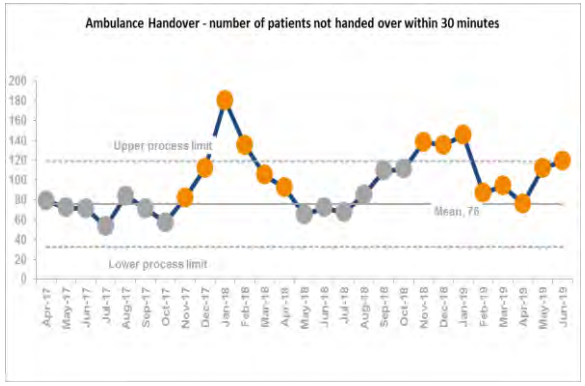
Emergency Flow

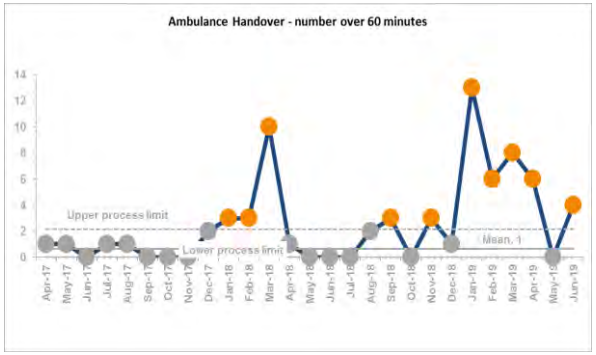
St George's University Hospitals NHS Foundation Trust

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









Emergency Flow

St George's University Hospitals NHS Foundation Trust

Indicator Description	Target	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
4 Hour Operating Standard	95%	93.6%	93.3%	91.1%	90.3%	90.1%	85.5%	85.6%	84.2%	82.2%	83.1%	85.4%	86.5%	87.0%
Patients Waiting in ED for over 12 hours following DTA	0	0	1	0	1	0	1	2	0	0	1	1	0	1
Admitted patients with a length of stay 7 Days or Greater		278	271	272	266	287	294	291	315	321	315	298	301	290
Ambulance Handover - % under 15 minutes	100%	43.6%	42.0%	42.3%	46.4%	42.5%	37.4%	37.0%	33.9%	33.0%	33.0%	35.1%	35.2%	36.0%
Ambulance Handover - % under 15 minutes (London Average)	100%	47.4%	46.7%	48.1%	52.6%	47.4%	46.5%	44.7%	41.6%	43.1%	45.4%	43.5%	44.4%	42.3%
Ambulance Handover - number of patients not handed over within 30 minutes	0	72	67	85	109	111	138	135	145	87	94	76	112	119
Ambulance Handover - % under 30 minutes	100%	96.3%	96.2%	95.5%	94.1%	94.5%	93.0%	93.6%	92.3%	95.1%	93.6%	95.5%	94.3%	93.5%
Ambulance Handover - % under 30 minutes (London Average)	100%	93.7%	93.1%	92.2%	92.5%	92.2%	91.5%	90.5%	88.2%	90.3%	92.7%	91.7%	92.2%	90.6%
Ambulance Handover - number over 60 minutes	0	0	0	2	3	0	3	1	13	6	8	6	0	4

What the information tells us

- Although attendances remain within the upper and lower control limits, attendances within the last four 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 87% in June, however below where we want to be and below the monthly improvement trajectory of 94.3% in order to achieve a year end position of 90%. Admitted performance has remained within its process limits since January whereas non-admitted performance shows more variability.
- The number of patients staying in a hospital bed greater than seven days has seen a downward trend and although remains within the upper and lower control process limits is below the mean in the month of June.

Actions and Quality Improvement Projects

Specifically, in the last month we have undertaken the following and a Trust to improve ED Flow:

1. Commenced the delivery of the new Ward Processes work on Marnham Ward and Cavell Ward. Designated resources for this work are still being identified.
2. Continued the development of an inter-professional dashboard to support the inter-professional standards to ensure patients flow out of ED into speciality wards without delay. This will go live in July.
3. Organised the first Internal Improvement Programme Board to occur in July.
4. Held a second AAA/AEC workshop to develop Trust-wide approaches and pathways for AEC.
5. Commenced delivery of the Ambulance Handover Improvement Plan with Trust and LAS colleagues planning a pathway and data capture review on week commencing 15.07.2019.
6. 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.
7. Closed ten general medical beds on Rodney Smith which have since been reallocated given bed pressures.

Referral to Treatment

St George's University Hospitals NHS Foundation Trust

2.2

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%	86.6%										
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	42,671										
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	5812	5717										
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	16										
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%	68.80%										
Total waits greater than 18 weeks - Admitted		1,563	1,563	1,428	1511	1459										
Total waits greater than 52 weeks - Admitted	0	62	63	18	7	8										
RTT Incomplete Performance -Non Admitted		87.72%	87.70%	88.45%	88.30%	88.80%										
Total waits greater than 18 weeks - Non Admitted		4,358	4,366	4,087	4,301	4,258										
Total waits greater than 52 weeks - Non Admitted	0	56	53	9	15	8										

What the information tells us

- The Trust remained ahead of trajectory for RTT incomplete performance in May-19 for the ninth consecutive month.
- The Trust has seen a reduction in, and is on trajectory for, the number of patients breaching 52 weeks and the total number of pathways greater than 18 weeks
- The Trust recorded its highest performance in May-19 of 86.6%.
- The Trust has seen an increase in waiting list size from Mar-19 to May-19. This is in part due to an increased deficit between the clock starts and clock stops; there has been an increased number of clock starts (referrals) and a decrease in completed pathways compared to March data. There is also an increased volume of duplicate referrals recorded on Cerner – this is currently under review.

Actions and Quality Improvement Projects

- The Trust will submit a June month end position ahead of trajectory for incomplete performance and a waiting list size above trajectory but below May volume.
- Continued daily monitoring of all patients waiting over 52 weeks for first definitive treatment – a four month forward look
- To manage PTL size:
    - Working closely with outpatient team to remove all the duplicate pathways and reviewing the potential future use of the ASI work lists
    - Increased validation resource within validation team, to focus on specific cohort with previous known errors (Code 11)
    - New crib sheet developed and disseminated to support correct selection of codes on clinic outcome forms.
    - Finalise review of historic activity without an outcome following last attendance, ensuring all activity undertaken is recorded
- Trust Access Policy was signed off with Trust Executive Committee and Merton and Wandsworth CCG. This has been circulated to all operational teams.

Referral to Treatment

St George's University Hospitals NHS Foundation Trust

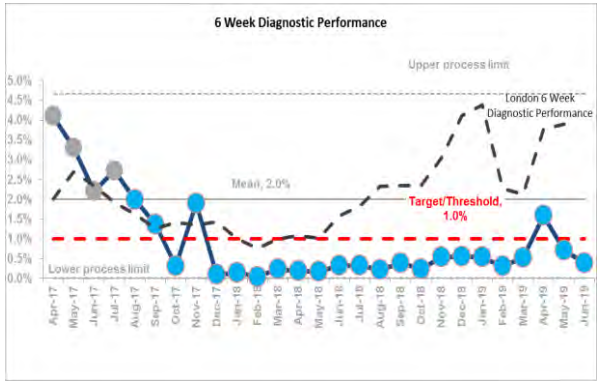
Specialty	Admitted		Non Admitted		Incomplete Pathway					
	Total	% within 18 weeks	Total	% within 18 weeks	Within 18 weeks	Over 18 weeks	Total	% within 18 weeks	Over 42 weeks	Over 52 weeks
General Surgery	276	35.9%	620	82.4%	610	286	896	68.1%	44	6
Urology	240	71.3%	1,180	85.7%	1,182	238	1,420	83.2%	13	3
Trauma & Orthopaedics	194	56.7%	2,673	88.0%	2,461	406	2,867	85.8%	9	0
Ear, Nose & Throat (ENT)	395	41.5%	2,139	87.0%	2,024	510	2,534	79.9%	23	1
Ophthalmology	0	-	0	-	0	0	0		0	0
Oral Surgery	12	83.3%	383	94.0%	370	25	395	93.7%	0	0
Neurosurgery	160	73.8%	2,082	82.9%	1,844	398	2,242	82.2%	0	0
Plastic Surgery	354	56.5%	1,261	86.0%	1,284	331	1,615	79.5%	36	1
Cardiothoracic Surgery	2	100.0%	0	-	2	0	2	100.0%	0	0
General Medicine	0	-	18	94.4%	17	1	18	94.4%	0	0
Gastroenterology	699	93.1%	1,859	89.7%	2,319	239	2,558	90.7%	9	0
Cardiology	950	72.6%	2,616	86.6%	2,955	611	3,566	82.9%	2	0
Dermatology	4	50.0%	2,469	93.8%	2,319	154	2,473	93.8%	5	0
Thoracic Medicine	0	-	1,727	88.7%	1,532	195	1,727	88.7%	2	0
Neurology	55	98.2%	2,637	91.9%	2,478	214	2,692	92.1%	5	0
Rheumatology	0	-	941	78.9%	742	199	941	78.9%	2	0
Geriatric Medicine	0	-	57	94.7%	54	3	57	94.7%	0	0
Gynaecology	278	52.5%	2,038	94.5%	2,071	245	2,316	89.4%	10	0
Other	1,061	75.8%	13,291	89.4%	12,690	1,662	14,352	88.4%	64	5
Total	**4,680**	**68.8%**	**37,991**	**88.8%**	**36,954**	**5,717**	**42,671**	**86.6%**	**224**	**16**

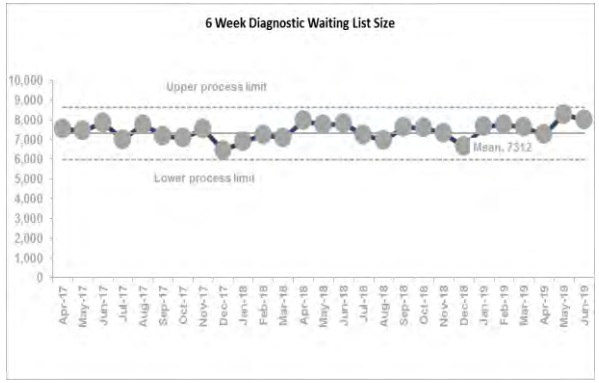
- There are a number of specialties reported under speciality 'Other'. This follows guidance set out in the documentation, "Recording and reporting referral to treatment (RTT) waiting times for consultant-led elective care" – produced by NHS England. The following slide outlines 'Other' specialties by treatment function group (TFG) and associated performance.

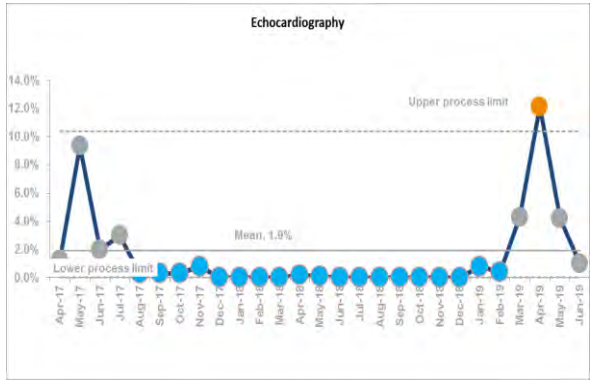
Diagnostics

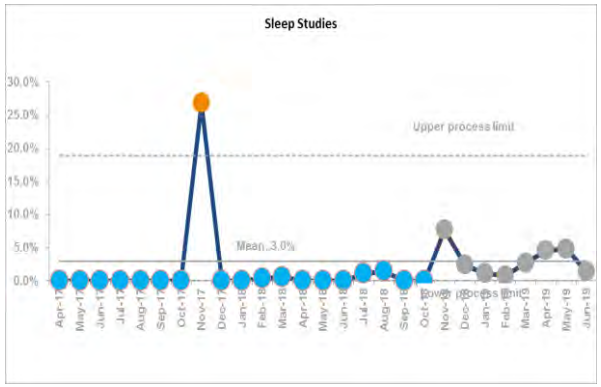
St George's University Hospitals NHS Foundation Trust

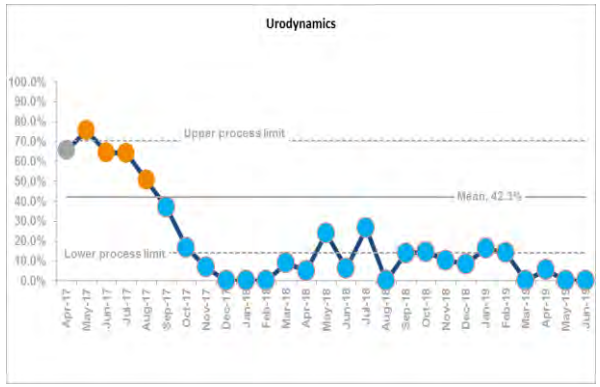
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

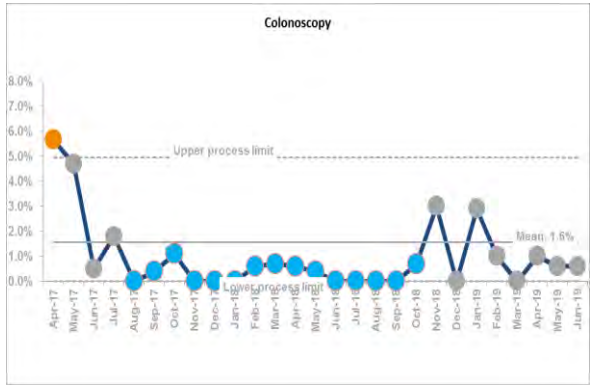


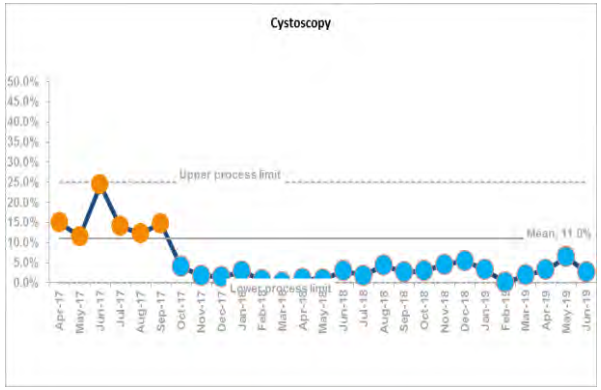


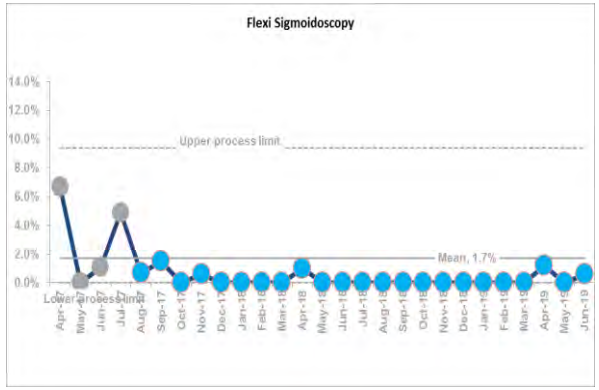


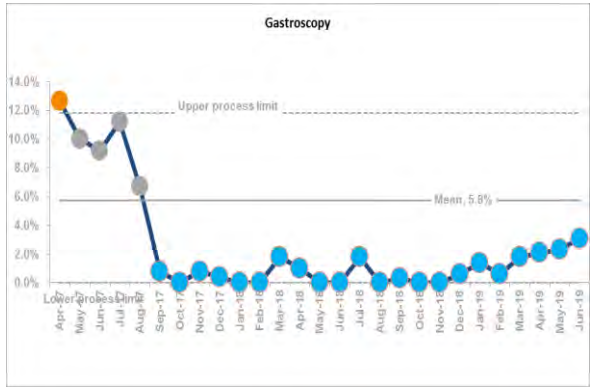












Diagnostics

St George's University Hospitals NHS Foundation Trust

Indicator Description	Threshold	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
6 Week Diagnostic Performance	1%	0.3%	0.3%	0.2%	0.4%	0.2%	0.5%	0.6%	0.5%	0.3%	0.5%	1.6%	0.7%	0.4%
6 Week Diagnostic Breaches	N/A	25	24	15	30	18	39	37	41	24	40	115	59	31
6 Week Diagnostic Waiting List Size	N/A	7,809	7,236	6,946	7,617	7,593	7,322	6,652	7,649	7,754	7,622	7,247	8,274	7,992

Indicator Description	Threshold	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
MRI	1%	0.4%	0.0%	0.3%	0.1%	0.2%	0.3%	0.6%	0.4%	0.6%	0.1%	0.3%	0.3%	0.0%
CT	1%	0.3%	0.0%	0.0%	0.0%	0.2%	0.1%	0.7%	0.6%	0.0%	0.0%	0.1%	0.0%	0.0%
Non Obstetric Ultrasound	1%	0.3%	0.0%	0.1%	0.6%	0.0%	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%	0.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.5%	0.0%	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%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.8%	0.4%	4.3%	12.1%	4.2%	1.0%
Electrophysiology	1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Peripheral Neurophysiology	1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Sleep Studies	1%	0.0%	1.1%	1.5%	0.0%	0.0%	7.7%	2.4%	1.1%	0.8%	2.7%	4.6%	4.8%	1.4%
Urodynamics	1%	6.3%	26.5%	0.0%	13.9%	14.6%	10.2%	8.5%	16.3%	14.0%	0.0%	5.7%	0.0%	0.0%
Colonoscopy	1%	0.0%	0.0%	0.0%	0.0%	0.7%	3.0%	0.0%	2.9%	1.0%	0.0%	1.0%	0.6%	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%	1.2%	0.0%	0.6%
Cystoscopy	1%	3.0%	1.8%	4.4%	2.6%	3.0%	4.5%	5.4%	3.2%	0.0%	1.9%	3.2%	6.4%	2.6%
Gastroscopy	1%	0.0%	1.8%	0.0%	0.3%	0.0%	0.0%	0.6%	1.4%	0.6%	1.8%	2.1%	2.3%	3.1%

What the information tells us

- In June, trust performance remained compliant against the six week diagnostic standard, and performance returned to within the process limits, with a total of 31 patients waiting greater than six weeks and a performance of 0.4%.
- The number of patients on the Trusts diagnostic waiting list remains within the upper and lower control limits.
- Compliance has not been achieved within three modalities, Sleep Studies although above the national standard has returned to within normal and expected range below the mean, Cystoscopy remains stable below the mean whereas Paediatric Gastroscopy although still within expected range has seen a steady increase in the number of patients waiting greater than six weeks over the past four months.

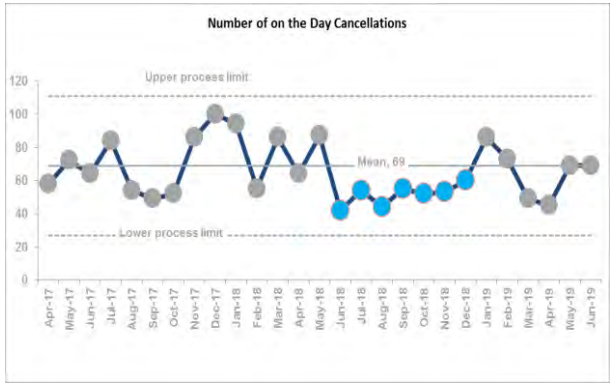
Actions and Quality Improvement Projects

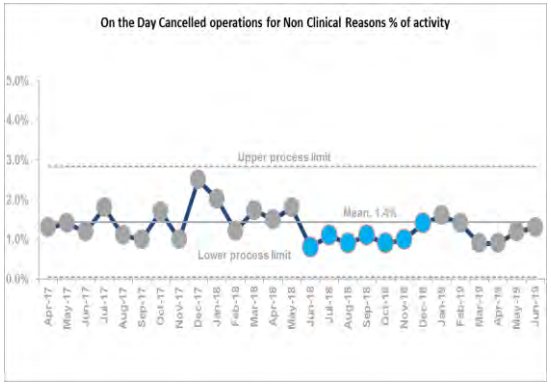
- The referral and booking process for patients requiring a sleep study diagnostic test have been reviewed with the Respiratory Team and the Central Booking Office. Standard Operating Procedures remain in place and any staff training needs will be addressed to ensure that all of our patients are offered and booked an appointment within six weeks with the appropriate escalation plans in place.

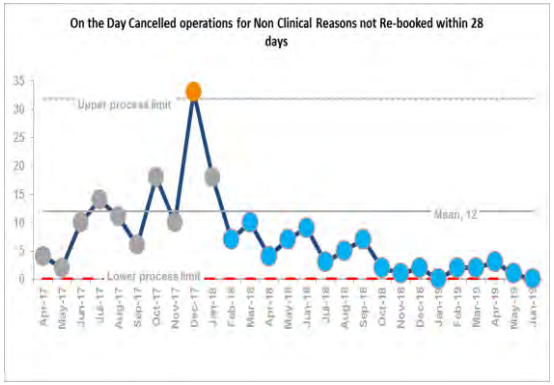
On the Day Cancellations for Non Clinical Reasons

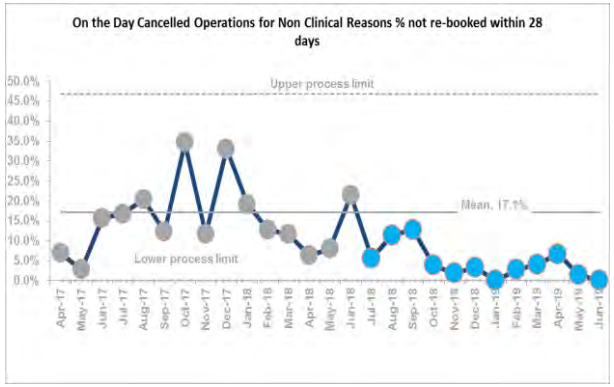
St George's University Hospitals NHS Foundation Trust

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









2.2

Our Process Perspective

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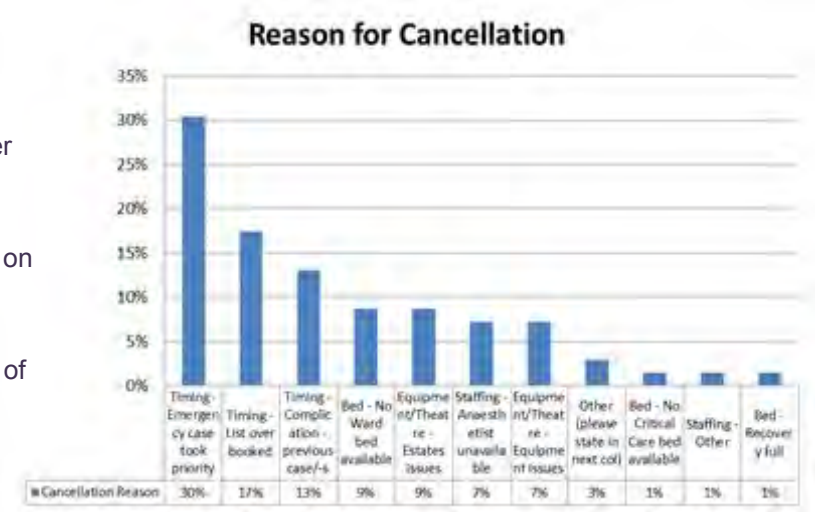
On the Day Cancellations for Non Clinical Reasons

St George's University Hospitals NHS Foundation Trust

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

What the information tells us

- There has been some variability in On the Day cancellations however performance remains within expected levels staying within the upper and lower control limits.
- The rebooking process has maintained recent improvement and reduced the variability in the number of patients re-booked within the 28 day standard with on average, 98% rebooked within 28 days for the previous six months. In June, 100% of patients were re-booked within 28 days.
- The main reason for on the day cancellations in June were due to the number of Trauma cases taking priority (21 cases cancelled), mainly affecting Trauma & Orthopaedics and General Surgery. Timing issues with a number of lists over booked were a reason for twelve cases being cancelled on the day with the highest proportion within Vascular Surgery and Paediatric Surgery



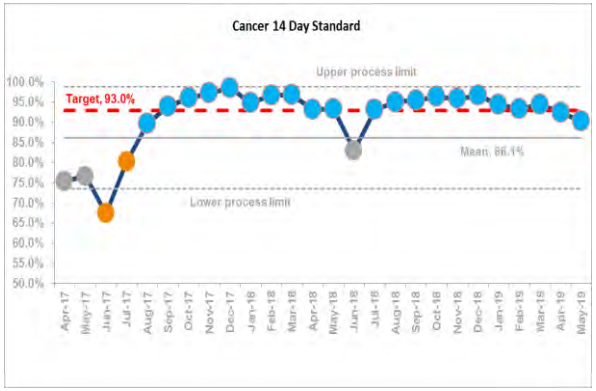
Actions and Quality Improvement Projects

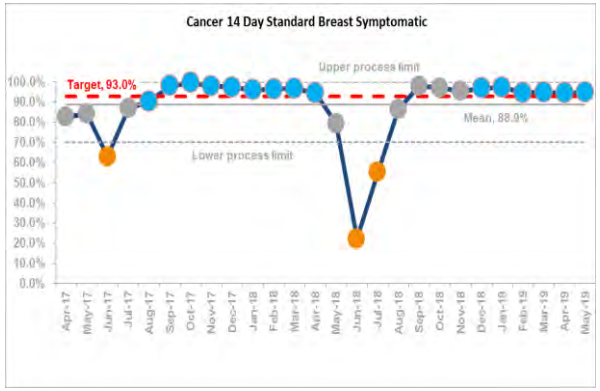
- Continue to roll out Patient Pathway Co-ordinators booking Pre-Operative Assessments for Day Surgery, as well as Inpatient cases improving patient experience and slot utilisation. This has already significantly improved the average utilisation rates.
- Following successful implementation of the Text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

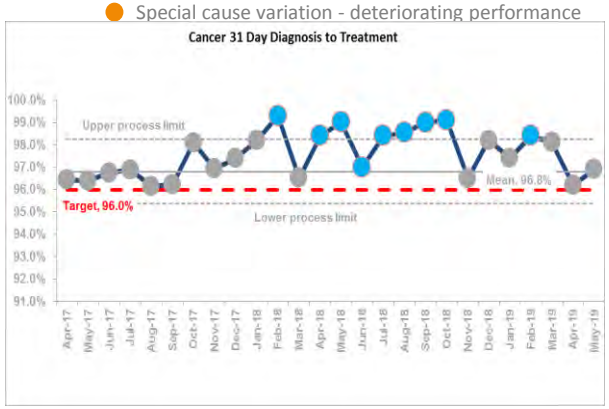
Cancer

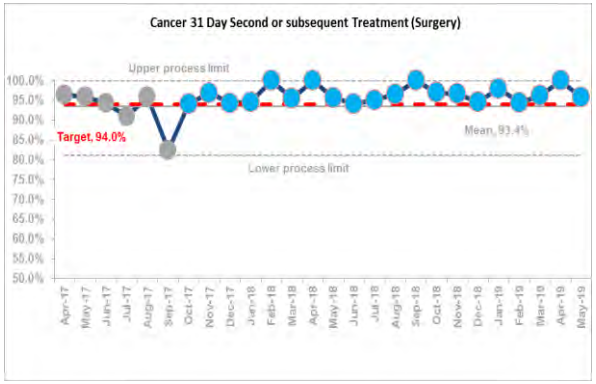
St George's University Hospitals NHS Foundation Trust

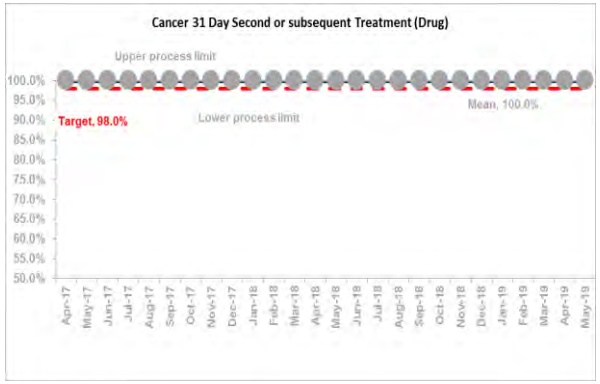
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

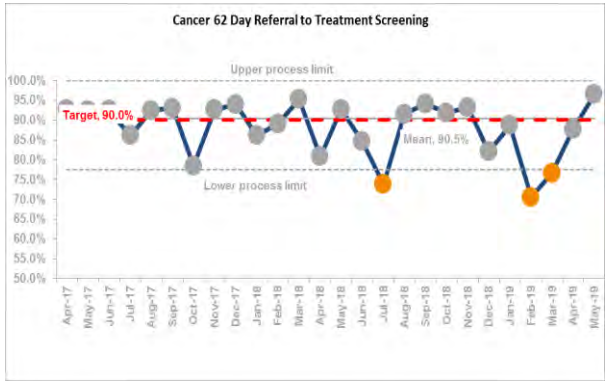


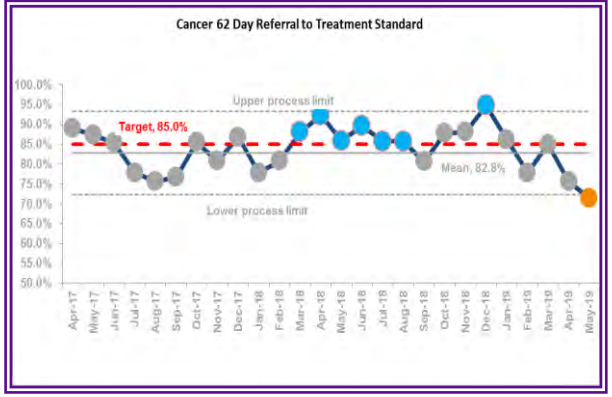


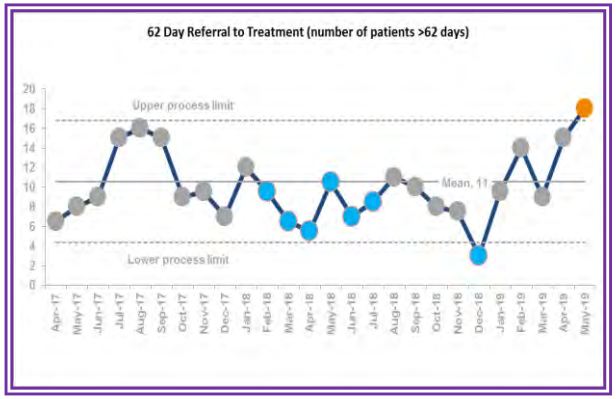












Cancer

St George's University Hospitals NHS Foundation Trust

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	No of Patients
Cancer 14 Day Standard	93%	93.3%	83.0%	93.1%	95.0%	95.5%	96.3%	95.9%	96.6%	94.4%	93.3%	94.4%	92.4%	90.2%	1,409
Cancer 14 Day Standard Breast Symptomatic	93%	79.4%	22.2%	55.2%	86.4%	97.9%	97.1%	95.4%	96.9%	97.4%	94.6%	94.7%	94.4%	94.9%	276
Cancer 31 Day Diagnosis to Treatment	96%	99.0%	97.0%	98.4%	98.5%	99.0%	99.1%	96.5%	98.2%	97.4%	98.4%	98.1%	96.2%	96.9%	194
Cancer 31 Day Second or subsequent Treatment (Surgery)	94%	95.7%	94.1%	95.0%	96.6%	100.0%	96.9%	96.6%	94.6%	97.9%	94.4%	96.2%	100.0%	95.7%	46
Cancer 31 Day Second or subsequent Treatment (Drug)	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	103
Cancer 62 Day Referral to Treatment Standard (Re-allocated from April-19)	85%	85.9%	89.6%	85.7%	85.7%	80.6%	87.8%	88.1%	94.8%	86.2%	77.8%	85.0%	75.6%	71.4%	63
Cancer 62 Day Referral to Treatment Screening	90%	92.7%	84.6%	73.8%	91.6%	94.1%	91.8%	93.2%	82.0%	88.7%	70.5%	76.6%	87.7%	96.5%	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 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 and Upper Gastrointestinal 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 71.4% against the target of 85%. Challenges exists within all tumour groups. Gynaecology continue to show variability in performance and performance continues to be below the mean but remain within the control process control limits, Head and Neck fell below the mean reporting 40%, showing a similar position to January 2019. Urology performance have seen a steady decline since for the previous three months with performance below the mean.
- As shown by the wide upper and lower process limits, Cancer 62 day screening performance has been varied over the past thirteen months reporting however has returned to compliance reporting 96.5% in the month of May

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.

Cancer

St George's University Hospitals NHS Foundation Trust

14 Day Standard Performance by Tumour Site - Target 93%

Tumour Site	Target	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	No of Patients
Brain	93%	75.0%	100.0%	100.0%	-	100.0%	-	100.0%	100.0%	100.0%	-	100.0%	-	0
Breast	93%	61.2%	87.4%	97.5%	94.5%	99.4%	97.4%	98.8%	97.4%	98.6%	97.9%	99.5%	96.3%	160
Children's	93%	100.0%	90.9%	-	100.0%	50.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	2
Gynaecology	93%	86.1%	91.7%	90.8%	81.9%	87.8%	87.5%	95.9%	69.5%	65.3%	80.0%	75.0%	59.3%	113
Haematology	93%	100.0%	100.0%	100.0%	100.0%	96.2%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	24
Head & Neck	93%	92.3%	93.0%	95.6%	99.3%	99.8%	98.1%	96.0%	98.5%	100.0%	99.3%	98.0%	97.8%	186
Lower Gastrointestinal	93%	67.5%	94.7%	98.9%	94.3%	98.1%	95.8%	94.5%	97.2%	92.1%	94.5%	85.6%	91.1%	258
Lung	93%	90.9%	97.6%	94.7%	95.2%	100.0%	100.0%	100.0%	93.3%	100.0%	96.9%	100.0%	95.6%	45
Skin	93%	92.7%	93.3%	92.9%	97.4%	96.6%	97.4%	97.6%	97.1%	95.9%	97.6%	96.9%	95.5%	374
Upper Gastrointestinal	93%	89.9%	96.6%	93.9%	96.7%	98.8%	95.4%	94.1%	91.8%	90.9%	83.5%	87.9%	70.2%	114
Urology	93%	96.5%	95.2%	93.1%	96.8%	92.4%	93.4%	96.6%	94.5%	94.2%	92.2%	90.1%	95.4%	133

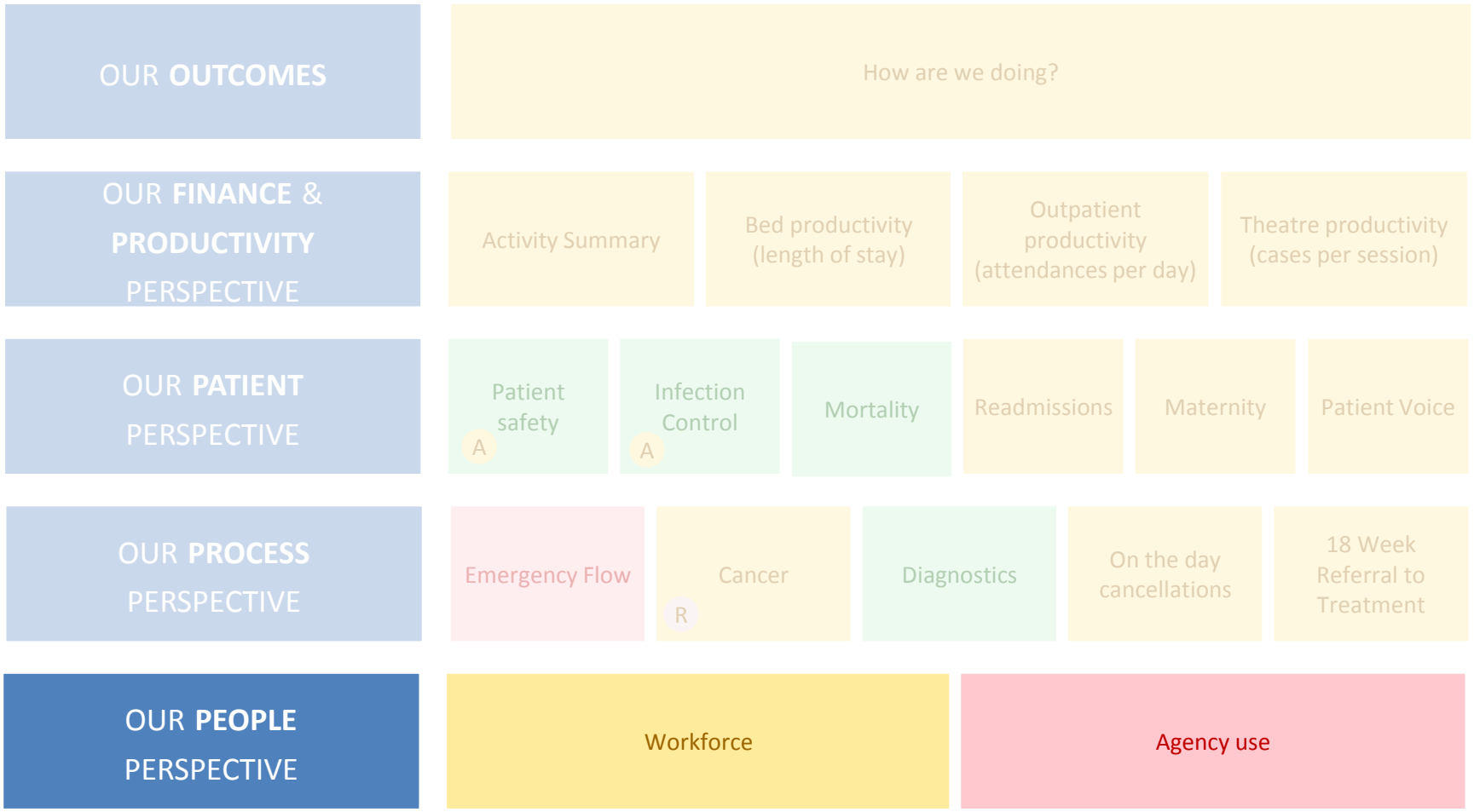
62 Day Standard Performance by Tumour Site - Target 85%

Tumour Site	Target	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	No of Patients
Brain	85%	-	-	-	-	-	100.0%	100.0%	-	-	-	-	-	0
Breast	85%	91.7%	90.9%	78.9%	100.0%	100.0%	100.0%	100.0%	100.0%	82.4%	90.9%	83.3%	80.0%	10
Children's	85%	-	-	-	-	-	-	-	-	-	-	-	-	0
Gynaecology	85%	100.0%	75.0%	100.0%	80.0%	90.0%	100.0%	83.3%	88.9%	50.0%	100.0%	66.7%	66.7%	3
Haematology	85%	100.0%	100.0%	88.9%	75.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	30.0%	33.3%	3
Head & Neck	85%	75.0%	72.7%	81.8%	80.0%	100.0%	86.7%	87.5%	46.2%	85.7%	80.0%	77.8%	40.0%	5
Lower Gastrointestinal	85%	100.0%	71.4%	83.3%	66.7%	88.9%	100.0%	100.0%	100.0%	81.8%	66.7%	41.7%	100.0%	4
Lung	85%	83.3%	71.4%	66.7%	28.6%	50.0%	70.0%	72.7%	80.0%	75.0%	70.0%	71.4%	100.0%	2.5
Skin	85%	100.0%	100.0%	100.0%	84.6%	92.3%	100.0%	100.0%	92.3%	100.0%	89.7%	100.0%	75.8%	16.5
Sarcoma	85%	-	-	-	-	-	-	-	-	-	-	-	-	0
Upper Gastrointestinal	85%	80.0%	100.0%	78.9%	50.0%	54.5%	100.0%	100.0%	0.0%	50.0%	60.0%	100.0%	20.0%	2.5
Urology	85%	84.9%	85.7%	88.2%	92.9%	88.9%	77.8%	95.0%	89.5%	71.1%	88.9%	83.0%	75.8%	16.5
Other	85%	-	-	100.0%	-	100.0%	100.0%	-	0.0%	-	100.0%	-	-	0

Balance Scorecard

St George's University Hospitals NHS Foundation Trust

2.2



Our People Perspective

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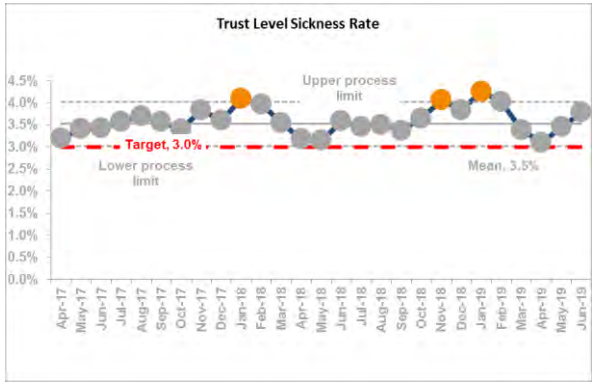
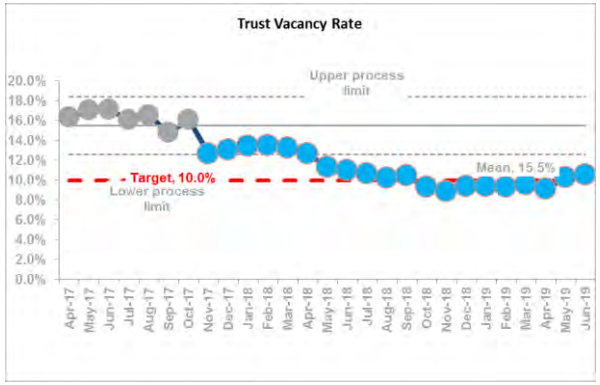
Workforce

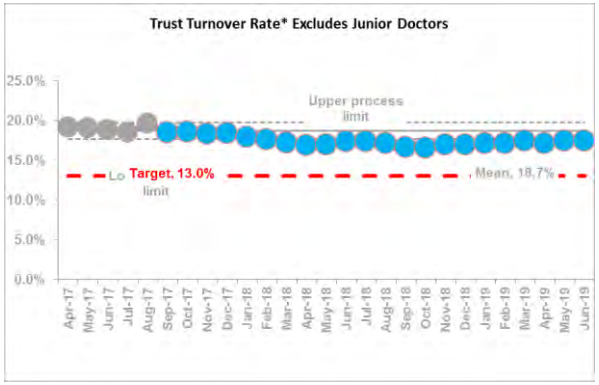
St George's University Hospitals NHS Foundation Trust

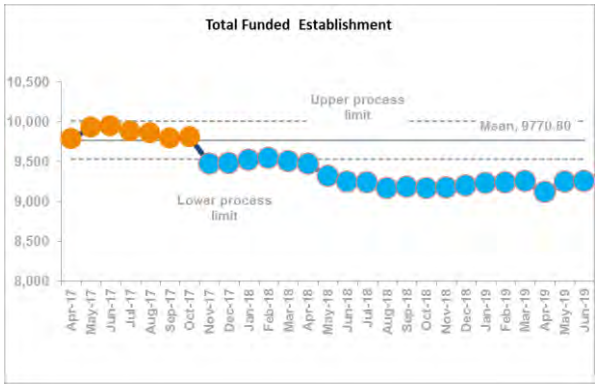
2.2

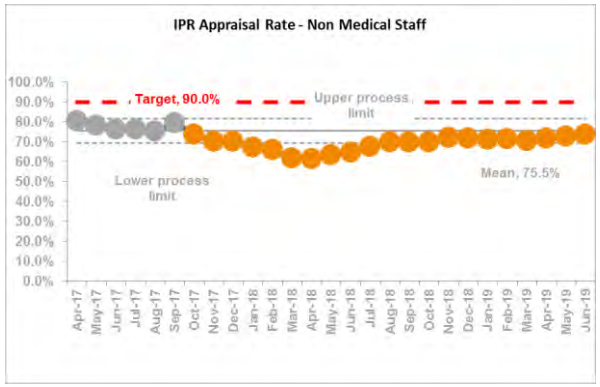
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

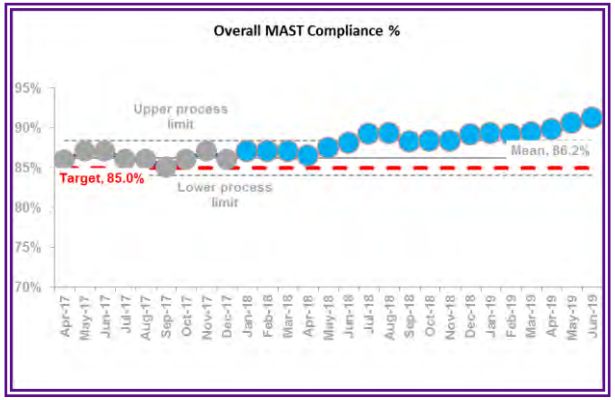


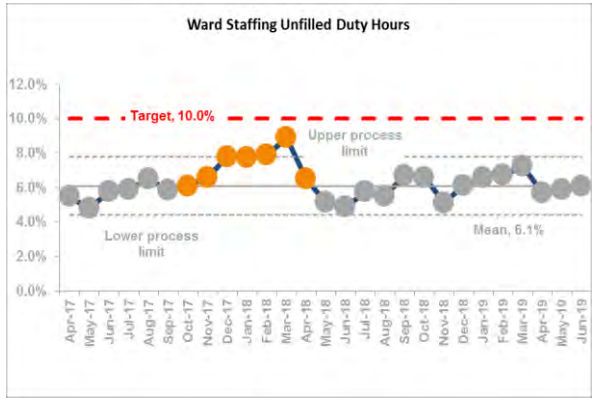












Our People Perspective

Workforce

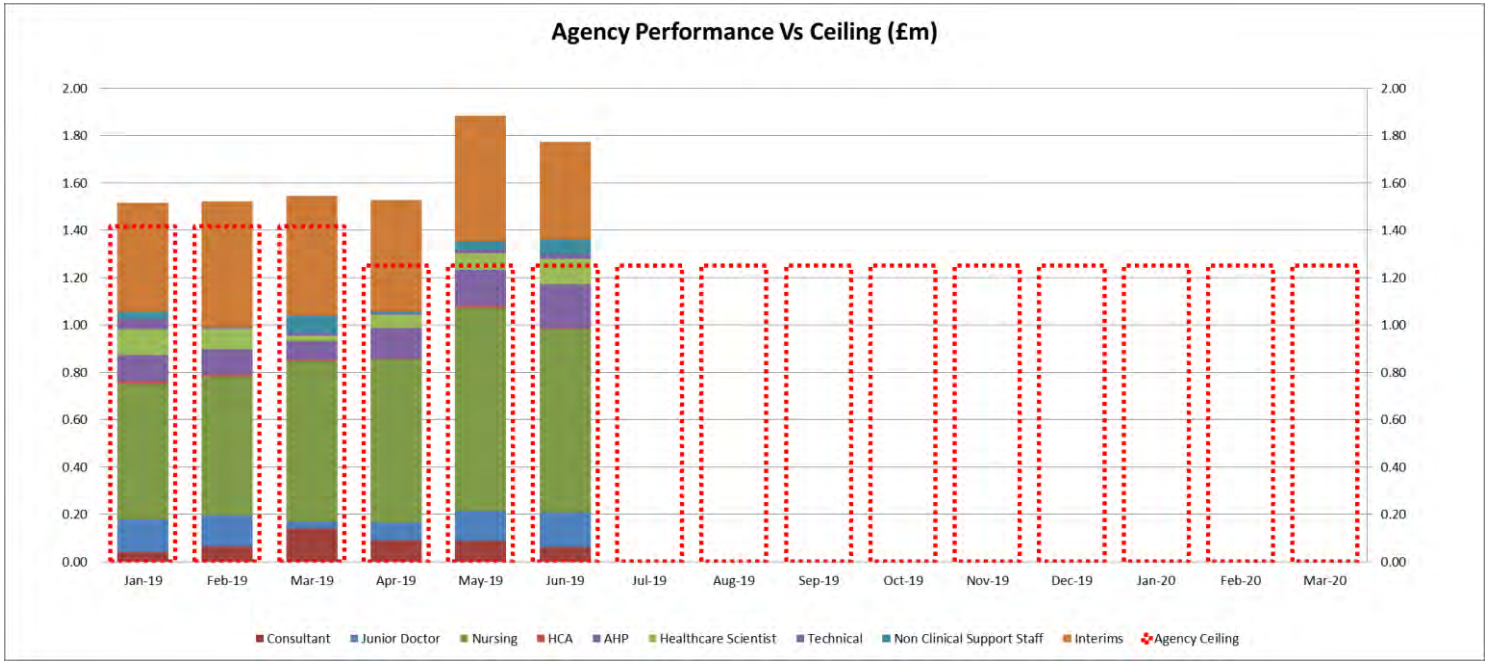
Indicator Description	Target	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Trust Level Sickness Rate	3.2%	3.6%	3.5%	3.5%	3.4%	3.7%	4.1%	3.8%	4.3%	4.0%	3.4%	3.1%	3.5%	3.8%
Trust Vacancy Rate	10%	11.0%	10.6%	10.2%	10.4%	9.3%	8.9%	9.4%	9.4%	9.3%	9.6%	9.1%	10.3%	10.5%
Trust Turnover Rate* Excludes Junior Doctors	13%	17.3%	17.4%	17.1%	16.6%	16.6%	16.9%	16.9%	17.1%	17.1%	17.5%	17.1%	17.4%	17.4%
Total Funded Establishment		9,242	9,239	9,160	9,180	9,165	9,171	9,196	9,229	9,238	9,248	9,112	9,241	9,251
IPR Appraisal Rate - Medical Staff	90%	79.9%	77.7%	Data Unavailable									85.4%	84.5%
IPR Appraisal Rate - Non Medical Staff	90%	64.6%	67.6%	69.7%	69.7%	69.7%	71.8%	71.5%	70.9%	71.3%	70.4%	71.6%	72.5%	73.6%
Overall MAST Compliance %	85%	88.1%	89.2%	89.3%	88.2%	88.3%	88.3%	89.1%	89.3%	89.1%	89.4%	89.8%	90.6%	91.2%
Ward Staffing Unfilled Duty Hours	10%	4.9%	5.8%	5.5%	6.7%	6.6%	5.1%	6.1%	6.6%	6.7%	7.2%	5.7%	5.9%	6.1%

* Excludes Junior doctors

What the information tells us

- Mandatory and Statutory Training figures for May were recorded at 91.2% with a mean of 89.3% and a tighter standard deviation of 0.3% for the past six months. There has been consistent improvement month on month of this figure.
- Medical appraisal rates are now being reported by the new appraisal system and currently stands at 84.5%.
- Non-medical appraisal have seen a further improvement in the month of June however remains below target with a performance of 73.6% against a 90% target. However, as can be seen by the tight upper and lower process limits for the previous six months, the process is stable and will not likely reach 90% without external action.

Agency use



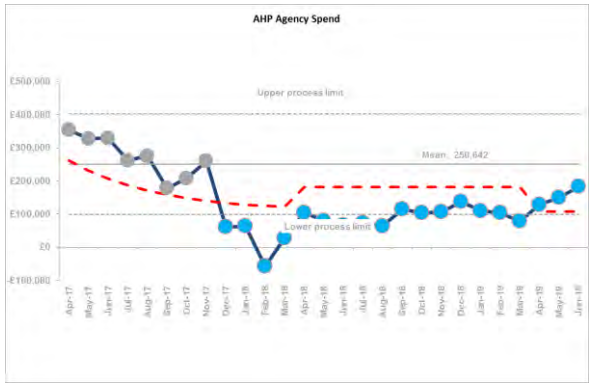
- The Trust's total pay for June was £45.95m. This is £0.08m favourable to a plan of £46.03m.
- The Trust's 2019/20 annual agency spend target set by NHSI is £20.55m. There is an internal annual agency target of £15.00m.
- Agency cost in June was £1.77m or 3.9% of the total pay costs. For 2018/19, the average agency cost was 3.2% of total pay costs.
- For June, the monthly target set was £1.25m. The total agency cost is worse than the target by £0.52m.
- Agency cost is £0.11m lower compared to May. There have been decreases mainly in Nursing (£0.19m), Interims (£0.11m) and Consultant (£0.03m) .
- The biggest areas of overspend were Nursing (£0.19m), Interims (£0.11m), Junior Doctor (£0.08m) and AHP (£0.08m).

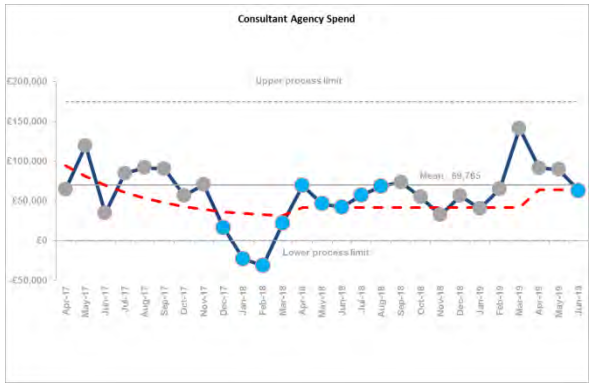
***restated to reflect the underlying agency spend**

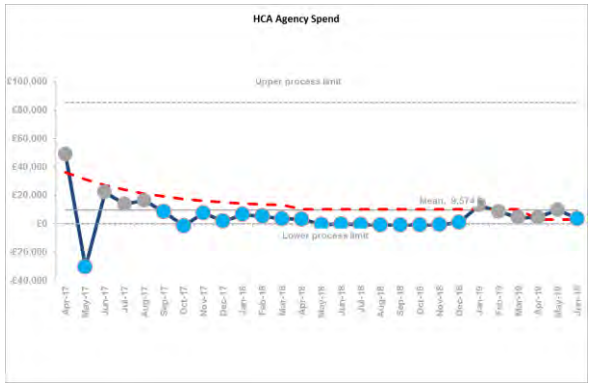
Agency use by staff group

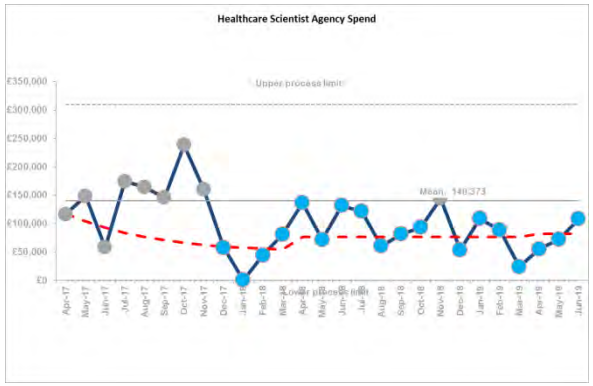
St George's University Hospitals NHS Foundation Trust

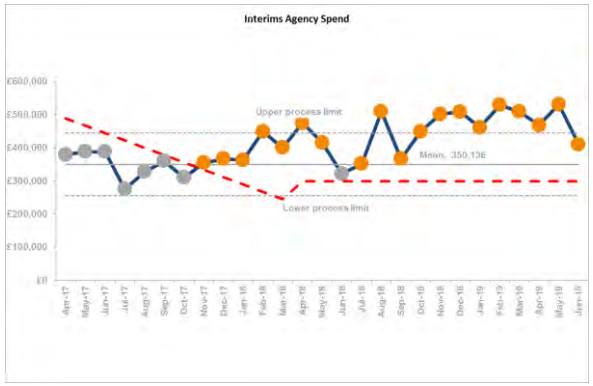
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

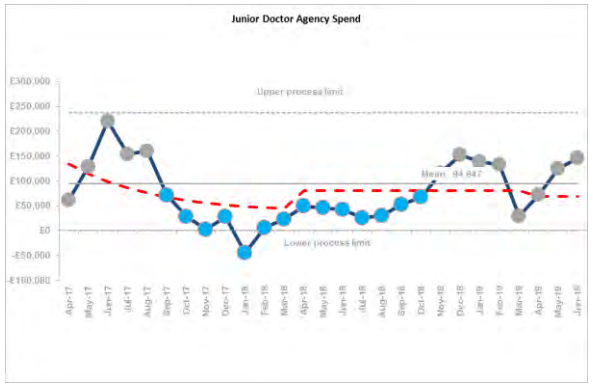


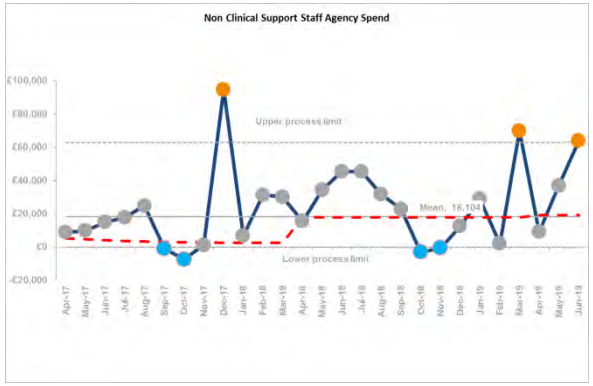


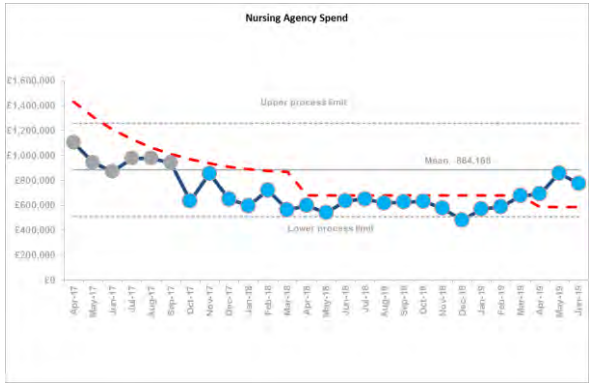


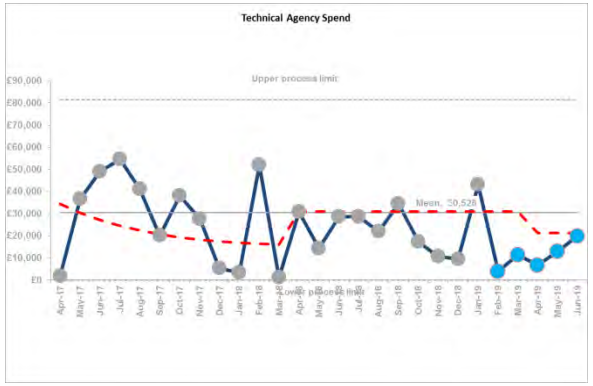












Appendix

1. First Outpatient Attendances (average per working day) data table
2. Follow-up Attendances (average per working day) data table
3. First to Follow-up Ratio data table
4. First and Follow-ups Did Not Attend rate data table
5. Elective and Daycase activity (average per working day) data table
6. Interpreting SPC (Statistical Process Control) Charts

Data tables

St George's University Hospitals NHS Foundation Trust

First Outpatient Attendances (average per working day)

Directorate	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Attendances in the last month	First Outpatient Attendances per working day 2018-19 YTD	2019-20 YTD	Variance	Variance
Cardiology, Cardiothoracic & Vascular Services	66	57	54	58	59	67	51	59	58	59	58	68	63	1,261	62	63	1	1.3%
Childrens Services	49	42	42	50	45	51	38	50	47	46	42	50	43	868	47	45	-2	-4.2%
Neurosciences	83	73	67	81	84	88	74	94	81	75	85	82	86	1,711	85	84	-1	-0.6%
Renal & Oncology	30	24	25	23	27	28	23	26	25	24	25	25	27	538	27	26	-2	-5.7%
Specialist Medicine	157	142	129	144	142	150	126	148	147	148	148	155	153	3,065	150	152	3	1.8%
Surgery	300	264	253	270	279	275	257	268	264	278	251	251	265	5,304	279	256	-23	-8.2%
Womens Services	92	89	85	89	86	90	78	88	92	82	87	75	71	1,419	86	78	-9	-10.3%
T&O	60	62	50	55	52	55	48	53	54	51	52	51	54	1,076	57	52	-5	-8.2%
Other	43	38	34	36	37	34	36	39	33	32	59	57	**57**	1,142	39	58	18	46.6%
Total	**880**	**791**	**737**	**805**	**812**	**838**	**731**	**826**	**801**	**791**	**807**	**814**	**819**	**16,384**	**832**	**814**	**-19**	-2.2%

Follow Up Outpatient Attendances (average per working day)

Directorate	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Attendances in the last month	FollowUp Outpatient Attendances per working day 2018-19 YTD	2019-20 YTD	Variance	Variance
Cardiothoracic & Vascular Services	113	107	100	117	107	124	104	113	106	96	100	99	105	2,095	117	101	-15	-13.2%
Childrens Services	73	77	76	87	81	90	73	83	84	70	78	81	66	1,325	75	75	0	0.1%
Neurosciences	113	109	105	122	117	123	104	124	118	101	119	117	118	2,357	114	119	5	4.4%
Renal & Oncology	228	229	219	248	245	243	229	238	223	230	242	229	208	4,167	217	227	10	4.4%
Specialist Medicine	501	508	477	533	509	529	481	528	537	526	572	533	524	10,475	507	543	36	7.1%
Surgery	357	349	336	357	352	362	331	382	350	335	318	328	321	6,422	362	322	-40	-11.0%
Womens Services	52	64	58	78	69	76	64	69	65	52	58	61	54	1,089	53	58	5	9.2%
T&O	82	86	77	82	85	93	76	86	85	76	82	78	81	1,612	82	80	-2	-2.4%
Other	94	89	86	97	92	91	77	91	92	87	118	118	117	2,345	97	118	22	22.2%
Total	**1,613**	**1,618**	**1,534**	**1,721**	**1,656**	**1,730**	**1,539**	**1,713**	**1,661**	**1,574**	**1,685**	**1,646**	**1,594**	**31,887**	**1623**	**1643**	**20**	**1.2%**

First and Follow Up Ratio

Directorate	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	First to FollowUp Ratio 2018-19 YTD	2019-20 YTD	Variance	Variance
Cardiothoracic & Vascular Services	1.72	1.86	1.85	2.01	1.81	1.85	2.04	1.92	1.83	1.63	1.72	1.46	1.66	1.88	1.62	-0.26	-14.1%
Childrens Services	1.47	1.86	1.82	1.74	1.80	1.77	1.89	1.66	1.79	1.52	1.86	1.64	1.53	1.61	1.67	0.07	4.2%
Neurosciences	1.36	1.49	1.57	1.51	1.39	1.40	1.40	1.32	1.46	1.35	1.40	1.43	1.38	1.34	1.40	0.06	4.6%
Renal & Oncology	7.64	9.75	8.89	10.77	9.08	8.68	10.13	9.15	8.92	9.58	9.68	9.26	7.75	8.04	8.89	0.86	10.7%
Specialist Medicine	3.19	3.59	3.71	3.70	3.58	3.53	3.81	3.57	3.65	3.55	3.86	3.43	3.42	3.40	3.57	0.17	5.1%
Surgery	1.19	1.32	1.33	1.32	1.26	1.32	1.29	1.43	1.33	1.21	1.27	1.31	1.21	1.30	1.26	-0.04	-3.2%
Womens Services	0.56	0.72	0.69	0.88	0.80	0.84	0.82	0.78	0.71	0.63	0.67	0.82	0.77	0.62	0.75	0.14	22.1%
T&O	1.38	1.38	1.55	1.49	1.63	1.69	1.59	1.62	1.57	1.49	1.58	1.52	1.50	1.44	1.53	0.09	6.2%
Other	2.20	2.31	2.52	2.70	2.49	2.69	2.16	2.33	2.79	2.72	2.00	2.06	2.05	2.46	2.04	-0.42	-17.2%
Total	**1.83**	**2.04**	**2.08**	**2.14**	**2.04**	**2.06**	**2.10**	**2.07**	**2.07**	**1.99**	**2.09**	**2.02**	**1.95**	**1.95**	**2.02**	**0.06**	3.3%

Data tables

First and Follow Up DNA Rates (by month)

Directorate	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-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	9.4%	12.2%	10.2%	9.4%	11.5%	10.9%	10.5%	10.9%	10.3%	10.1%	9.0%	9.6%	9.8%	283	10.1%	9.5%	-0.6%
Childrens Services	12.9%	14.2%	13.1%	10.0%	11.3%	10.1%	10.9%	10.9%	10.9%	10.2%	10.9%	12.3%	10.4%	283	14.3%	11.3%	-3.0%
Neurosciences	8.5%	9.5%	9.4%	10.0%	10.6%	9.6%	10.2%	10.3%	10.6%	11.0%	11.8%	11.9%	11.2%	496	10.1%	11.5%	1.4%
Renal & Oncology	8.1%	11.1%	11.0%	10.5%	10.4%	11.0%	10.2%	9.7%	10.1%	9.4%	9.2%	9.9%	10.1%	351	9.9%	9.9%	0.0%
Specialist Medicine	11.3%	11.4%	11.8%	11.6%	12.6%	13.1%	11.5%	12.3%	11.2%	10.8%	11.0%	12.8%	12.1%	1,644	12.9%	11.9%	-1.0%
Surgery	9.0%	10.9%	10.9%	10.2%	12.1%	11.6%	10.8%	10.4%	10.5%	10.4%	10.2%	10.3%	10.0%	1,438	10.9%	10.3%	-0.6%
Womens Services	7.3%	8.4%	9.8%	8.2%	8.7%	8.2%	7.4%	6.6%	7.4%	6.8%	8.0%	7.8%	7.8%	572	8.2%	8.1%	-0.1%
T&O	8.4%	9.2%	11.0%	10.7%	10.4%	11.6%	10.9%	10.6%	7.9%	9.1%	8.8%	10.7%	9.4%	286	11.3%	10.1%	-1.2%
Other	11.6%	12.9%	13.8%	12.5%	14.4%	15.4%	14.2%	12.9%	12.9%	14.3%	14.2%	13.4%	12.8%	1,156	10.4%	13.6%	3.3%
Total	**10.1%**	**10.9%**	**11.3%**	**10.6%**	**10.5%**	**10.5%**	**10.9%**	**10.8%**	**10.5%**	**10.6%**	**10.7%**	**11.2%**	**10.7%**	**6,509**	**11.6%**	**11.0%**	-0.6%

Elective and Daycase per working day

Months	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	2018-19 YTD	2019-20 YTD	Variance	Discharges for month
Cardiology & Cardiac Surgery	17.0	15.5	15.4	15.7	14.0	16.8	13.8	14.7	17.2	16.2	12.0	13.3	14.9	16.0	13.4	-16.3%	279
Clinical Haematology	2.2	1.7	1.4	2.2	1.7	1.5	1.8	1.0	1.3	1.4	0.8	0.8	0.7	2.0	0.8	-62.0%	17
Diabetes & Endocrinology	1.5	1.7	1.9	2.0	2.0	1.8	1.2	2.0	1.6	1.8	1.8	2.7	1.3	1.9	2.0	0.7%	47
Endoscopy & Gen Med	61.0	55.6	55.7	56.3	54.6	59.2	49.7	57.3	56.4	61.6	57.4	68.5	67.6	58.9	64.6	9.6%	1,422
Ear, Nose & Throat	8.7	9.0	7.8	9.1	8.9	7.8	7.1	9.5	7.9	7.9	8.5	8.3	8.8	7.9	8.5	8.3%	176
General Surgery	10.6	8.8	8.8	11.1	9.9	10.7	10.4	10.7	10.5	12.8	8.1	7.1	8.3	9.8	7.8	-20.8%	142
Gynaecology and Obstetrics	10.3	11.3	10.5	10.2	11.4	11.2	8.8	11.0	10.8	10.4	9.9	10.8	10.6	9.9	10.4	5.3%	228
Max Fax & Dental	6.4	6.7	6.2	7.4	6.4	6.4	5.5	6.7	7.2	5.4	6.1	7.3	6.7	6.5	6.7	3.4%	150
Neurosurgery	9.4	9.1	8.0	10.0	8.9	10.1	8.9	8.2	9.3	10.5	8.8	10.3	8.6	9.1	9.2	0.6%	216
Neurology	27.9	25.9	24.0	25.6	30.0	28.8	24.2	28.7	34.3	31.0	32.4	33.3	32.6	25.8	32.8	27.3%	708
Oncology	1.8	1.8	1.7	1.6	1.8	1.2	1.5	2.8	2.7	1.8	4.0	3.4	3.2	1.8	3.5	95.9%	69
Paediatric Medicine	8.5	10.0	9.5	9.6	12.0	10.3	10.9	10.5	12.5	11.9	12.9	12.3	11.4	9.6	12.2	27.7%	243
Paediatric Surgery	8.5	8.3	8.6	9.9	9.2	10.7	8.4	9.6	10.0	10.0	8.9	10.3	7.9	8.3	9.1	8.9%	219
Pain Clinic	5.5	4.5	4.4	5.3	5.3	6.2	5.2	5.1	5.3	5.3	4.5	3.1	4.9	5.7	4.2	-27.1%	60
Plastic Surgery	17.7	17.4	19.1	18.8	17.1	18.3	15.9	17.1	17.4	16.5	15.0	19.3	15.9	17.5	17.5	-0.1%	337
Renal Medicine	5.7	4.5	5.3	5.4	4.7	3.8	4.4	3.2	5.2	3.7	4.3	6.5	4.5	5.4	5.1	-6.2%	136
Trauma & Orthopaedics	6.8	7.7	6.5	6.5	6.4	8.5	6.0	7.7	8.5	6.4	7.3	8.0	8.8	7.1	8.0	13.4%	165
Urology	13.2	13.0	11.6	13.4	14.5	14.0	12.9	13.4	14.8	13.2	15.8	13.0	13.3	12.0	14.0	16.6%	257
Thoracic Surgery	3.3	3.5	2.5	2.4	2.5	2.9	2.7	2.3	3.2	3.1	2.2	3.0	3.2	3.0	2.8	-4.8%	63
Vascular Surgery	4.3	4.8	4.4	4.7	5.1	4.6	4.3	5.1	3.9	4.4	4.4	4.8	4.2	5.2	4.5	-14.7%	101
Other	6.2	6.4	6.4	4.8	5.3	5.6	5.5	6.5	6.6	4.2	7.5	7.4	6.7	5.6	7.2	29.9%	131
Grand Total	236.4	227.3	219.8	231.5	231.9	240.6	209.4	233.1	246.3	239.4	232.3	253.7	244.4	229.1	244.2	6.6%	5,166

Daycase as a percentage of all Elective Activity	74.4%	80.1%	77.2%	75.3%	76.6%	77.0%	75.0%	77.7%	77.1%	74.8%	77.0%	77.4%	75.4%

Interpreting SPC (Statistical Process Control) Charts

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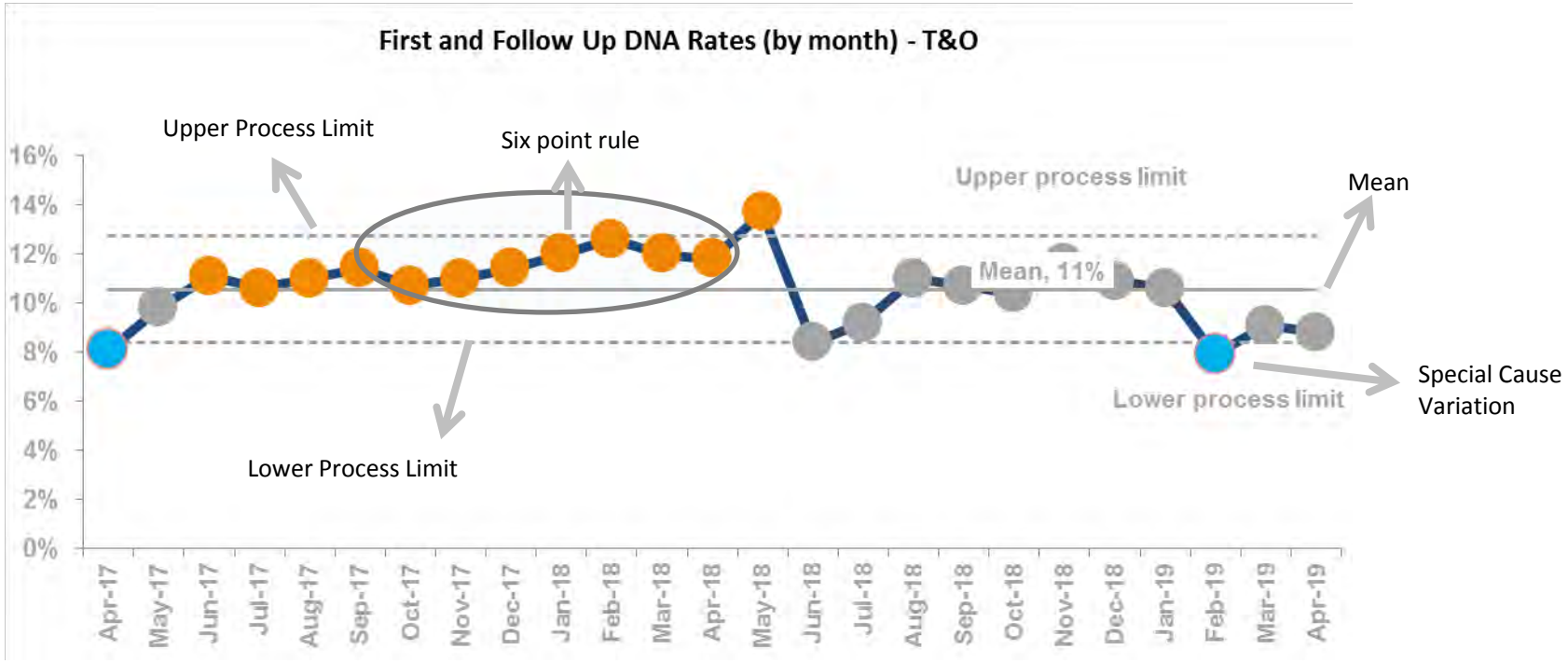

SPC Chart – A time series graph to effectively monitor performance over time with three reference lines; Mean, Upper Process Limit and Lower Process Limit. The variance in the data determines the process limits. The charts can be used to identify unusual patterns in the data and special cause variation 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

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2.3

Meeting Title:	**Trust Board**		
Date:	25 July 2019	**Agenda No**	**2.3**
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 June 2019, the following key developments have taken place: • The Independent Mortality Review Panel continues to meet twice a week and has now expanded the cohort of patients, for review, to 210. • '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, 176 letters have been sent. The process for defining when all efforts to contact the Next of Kin (NoK) has been exhausted, has been drafted, and will be submitted to the next Cardiac Surgery Steering Group meeting for approval. • Case Management in cardiac surgery held a successful Process Mapping meeting on the 2 July 2019 led by Alison Woolley, CNS. • Cheryl Ramsay, Interim Programme Manager started at the Trust on 1 July 2019 and will support the outcome of the Independent Review and Turnaround work. • Trust Board is also advised that an external Quality Summit is scheduled for the 24 July 2019.		
Recommendation:	The Trust Board is asked to discuss and take assurance from the update on progress being made in Cardiac Surgery.		
Supports			
Trust Strategic Objective:	• Treat the patient, treat the person • Right care, right place, right time • Champion Team St George's		
CQC Theme:	• Safe, Well Led		
Single Oversight Framework Theme:	• Quality of Care, Leadership and Improvement Capability		
Implications			
Risk:	As set out in the paper		
Legal/Regulatory:	The paper details the Trust's engagement with regulators on this issue.		
Previously Considered by:		**Date**	

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Trust Board Meeting - 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 Trust Board in June 2019.

2.0 EXTERNAL ASSURANCES

2.1 Meetings of the Independent Mortality Review Panel

2.1.1 The Independent Mortality Review Panel continues to review patients and holds meetings twice a week.

2.1.2 It is reviewing the notes of now 210 deaths following cardiac surgery, from 2013-2018 (this new figure includes patients from a "secondary scope" as defined by the Independent Mortality Review Panel's Terms of Reference).

3.0 INTERNAL DEVELOPMENTS

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

3.1 Case Management in Cardiac Surgery - A multi - disciplinary team reviewed the 3 main pathways – Elective, Urgent via St George's and Inter Hospital Transfers as to how they are currently working and how they should work in the future. Two key streams of work that came out of the discussion are:-

- Standardised "electronic" Elective Referral
- New ways of working for CNS's and the Medical Secretarial Team.

3.2 Interim Programme Manager - The Trust has successfully recruited to this post. Cheryl Ramsay started with the Trust on 1 July 2019 and will support the ongoing implementation of the cardiac surgery plan in addition to the mortality review and future planning.

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 that 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 Cardiac Surgery Risk Register was reviewed by the Cardiac Surgery Steering Group held on the 17 June 2019. Amendments to the nature of the Risks and mitigations were updated and will now be updated on DATIX (Risk Management system) for submission and approval as appropriate by Risk Management Executive.

The three extreme risks that remain on the risk register are (updates on the risks below will be provided in the next Cardiac Surgery Update Report):

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

- 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.

- 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.

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. The specialty has also been successful in actively recruiting into Registrar and SHO slots. 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: **11 July 2019**

St George's University Hospitals NHS Foundation Trust

2.4

Meeting Title:	**Trust Board**		
Date:	25 July 2019	Agenda No.	**2.4**
Report Title:	**Transformation Quarter 4 Report**		
Lead Director	James Friend, Chief Transformation Officer		
Report Author:	James Friend, Chief Transformation Officer		
Presented for:	Information		
Executive Summary:	This is the first quarterly report for 2019/20 setting out to the Trust Board the approach, progress and impact of the Transformation work completed at the start of 2019/20. The first quarter of the year has seen a series of new patient experience and efficiency initiatives launched across the Trust that resulted in nearly 150,000 patients benefitted from having a transformed experience and 400 staff participated in quality improvement training or initiatives. Partnership working with clinical and operational colleagues is moving the Trust towards making a reality of many of our strategic operational goals for how we serve our patients.		
Recommendations:	The Trust Board is asked to note the report.		
Supports			
Trust Strategic Objectives:	**Right Care, Right Place, Right Time** 9. Patient choice • *Aim: Ensure patients have access to high quality outpatient care, including by standardising outpatient pathways, supported by ICT, ensuring all activity is captured and reported* • *Aim: Offer patients greater choice in how they access acute specialties with alternative to face-to-face appointments* **Build a Better St. George's** 12. Strategy and engagement • *Aim: We will develop an organisational and clinical strategy that asserts St. George's position as a provider of local and world –reading specialist services* • *Aim: We will work with our partners and stakeholders to seek their views, so we address the challenges we face together* 13. Governance • *Aim: More engagement and involvement of patients, front line staff and partner organisations*		
CQC Themes:	• ***Effective*:** your care, treatment and support achieve good outcomes, help you to maintain quality of life and are based on the best available evidence. • ***Responsive*:** services are organised so that they meet your needs. • ***Well-led*:** the leadership, management and governance of the organisation make sure it's providing high-quality care that's based around your individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.		
Single Oversight Framework Theme:	• Strategic Change		
Implications			
Risk:	None directly in this paper.		
Legal/Regulatory:	N/A		
Resources:	None requested in this paper.		
Previously considered	Trust Executive Committee (as Monthly Reports)	Date:	May, June & July 2019.
Appendices:	Appendix One – Quarterly Transformation Report to Trust July 25, 2019		

2.4

Quarterly Transformation Report to Trust
July 25, 2019

James Friend, Chief Transformation Officer

St George's University Hospitals NHS
NHS Foundation Trust

2.4

Summary

The first quarter of the year has seen a series of new patient experience and efficiency initiatives launched across the Trust.

Partnership working with clinical and operational colleagues is moving the Trust towards making a reality of many of our strategic operational goals for how we serve our patients.

Highlights from the first three months of the year include:

- Each week 7,000 more patient letters are being sent centrally through automated transmission to the mailing provider
- New ambulatory care pathways have been tested in Digestive Health, helping more patients to be at home overnight
- More outpatients receiving text appointment reminders with the ability to reschedule and more checking in through the kiosks
- Ten completed Plan-Do-Study-Act cycles with Post Implementation Review posters
- A refreshed programme of Getting It Right First Time workshops and improvement opportunities has been identified through the Quality Improvement Academy
- Further patient involvement in Transformation projects scoped through the Patient Participation and Engagement Group
- Eight clinical services went live with eRosters for junior doctors

- Alongside an update on the Quality Improvement Academy, there are progress summaries on two main areas of Transformation included in this report - Digital Outpatients and Patient Flow, together with the Key Metrics being used to assess the impact of these Transformational Initiatives. Regular updates have also been provided to Trust Executive Committee on Maternity Transformation and Medical Staffing eRostering.

During the summer, the intention is to refresh the approach and ambition of Transformation across the Trust and alongside our system partners.

Success will see further disruption and improvement to how we work, challenging existing processes, all in the course of:

- Making the right thing to do for patients be the easiest thing to be done by clinicians,
- Getting our patients to the most appropriate environment for their assessment, for their treatment and for their care, and
- Aligning our clinical capacity to our pathway demand.

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Digital Outpatients

The objective of the Digital Outpatients work is to transform patient experience when booking and attending an outpatient appointment, building on the rollout of the electronic Referral Service (eRS) by centrally and consistently providing patients with appointment letters and reminders and by enabling them to check-in electronically when they arrive.

Most Planned Care Transformation activity, this year, is being delivered directly by the Operational teams and this Digital work will dovetail into the rollout of iClip across the planned care pathway later in the year.

In Quarter One 147,336 patients had a digitally transformed communication experience as a result of these initiatives

Check-in-kiosks

- Clinic managers and front line reception staff are proactively guiding patients toward the kiosks
- A volunteer has been recruited to perform “way-finding” and assist patients to self-check-in
- 17,394 self check-ins have been performed in the quarter and 125,529 text reminders sent

Two-Way Text Messaging

- This is now live in Urology, General Surgery, Colorectal, Bariatrics and Upper GI, where patients
- Patients can now confirm their attendance for their outpatient appointment and text message the booking service to cancel or rearrange the appointment.

Hybrid Mail

- Four additional letters types went live via Hybrid mail
- Reduced local service level printing and posting of 1,500 letters per day

No Wasted Appointments

- Pilot project in Urology Stones
- More than 100 patients are now being routinely reviewed each week (using less than 1 hour of consultant admin time)
- 34 potentially non-value adding appointments were avoided, providing certainty to patients without them needing to come to the hospital

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2.4

Patient Flow

The objective of the Patient Flow work is to transform patient experience when attending our Urgent Care Centre or experiencing an inpatient stay.

This sits alongside the Four Hour Operating Standard improvement activity being delivered directly by the Operational teams and the IT led identified opportunities to streamline operational processes through optimising the iClip related processes rollout in the Emergency Department and across the inpatient wards in 2018.

There are four areas of Transformation supported work:

A) **Base Wards Ambulatory Care** – extending the opportunities for inpatient care without a bed based setting through Ambulatory Care, helping patients to go home and then return for treatment processes to be delivered on a "day" basis. For example, the Digestive Health Ambulatory Care Bay two week pilot launched in June and during the initial test phase there was a faster transfer of patients from AMU to Allingham with a reduction in Allingham Ward bed occupancy of 5.6%. General Surgery, Neurosciences, Mary Seacole Ward and Acute Ambulatory Assessment (AAA) are all exploring opportunities to ambulate more patients.

B) **Therapies** – aligning the clinical capacity of the Therapies teams with demand to support shorter lengths of stay. This has started with a clinically led review of how to measure demand for Physiotherapy and Occupational Therapy services.

C) **Place** – For patients who currently arrive at the Emergency Department following GP referral, the objective is to get them to the most appropriate place for their treatment without passing through a repeated assessment process. Initially this work has started by leveraging the Make A Difference feedback system in place to support colleagues in Primary Care to make the right referral with the right information. The next step will be to ensure GPs are consistently aware of the available direct access pathways and to support our teams in being ready to appropriate receive such patients in our ambulatory areas including Acute Ambulatory Assessment, Blue Sky (Paediatrics), Acute Gynaecology Unit and Nye Bevan Unit (Surgery).

D) Urgency – Ahead of wider system level development to consider the evolution of the Urgent Care Centre (UCC) into a primary care led Urgent Treatment Centre, the clinical team is being supported to increase patient flow and provide better patient and staff experience through improving efficiency and reducing delays. Four key changes are being trialled: Reconfiguration of the UCC Assess area, a new cubicle allocation system, a new assessment procedure and a new system for nursing jobs prioritisation.

In Quarter One 2,234 patients had a transformed experience as a result of these initiatives

4

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Quality Improvement Academy (QIA)

- During the last thirteen weeks, the Quality Improvement Academy (QIA) team have delivered and participated in
- Staff development and system engagement including with the Acute Provider Collaborative ("APC") - through facilitating workshops on the Kidney stones pathway and Earwax / micro-suction
- A second Trust Executive Committee workshop with themes covering the Executive / Divisional accountability framework, and local improvement projects for clinical teams
- The national Flow Coaching programme where team members attended their fourth round of training in Sheffield
- The Get it Right First Time ("GIRFT") programme, supporting the national teams completing reviews with Geriatric Medicine, Vascular Surgery, Obstetrics & Gynaecology and Orthopaedics
- A second workshop with Outpatients on improvement ideas to address areas of concern from their staff survey results
- Supporting the Institute for Health Improvement (IHI) on site to review of our QIA activities and to co-deliver two highly interactive workshops. The IHI noted our growing progress and recommended additional actions to accelerate understanding and adoption of QI ways of working. The QIA team is now following up with the broad cross section of staff who attended.
- Other workshops facilitated included Paediatric clinical governance and GIRFT Neurology

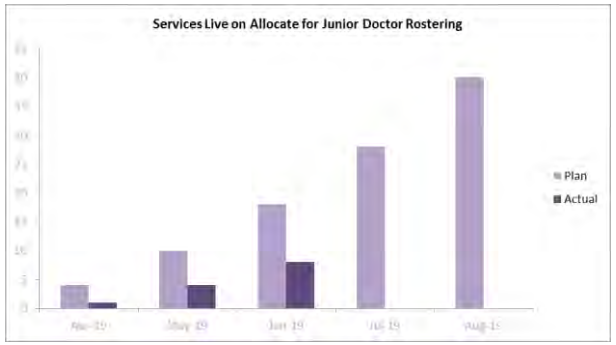
In Quarter One 400 staff participated in quality improvement training or initiatives

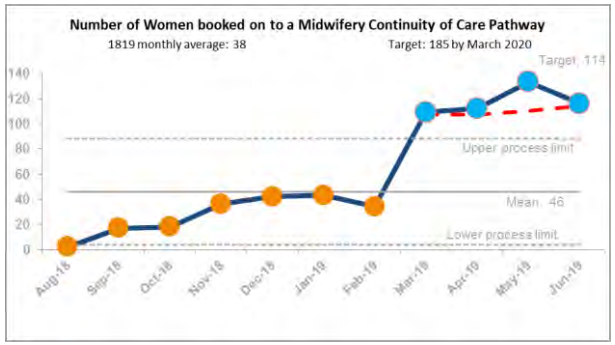
Patient Partners Engagement Group (PPEG)

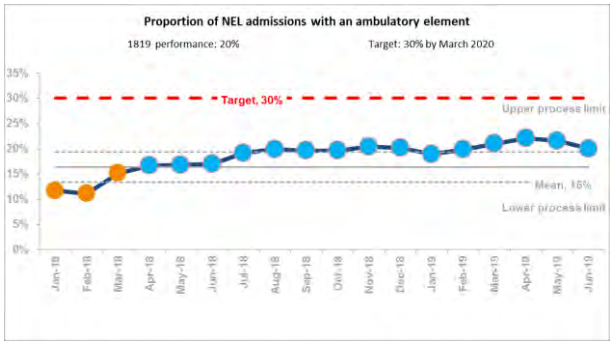
Forward planning for PPEG engagement from Transformation includes:

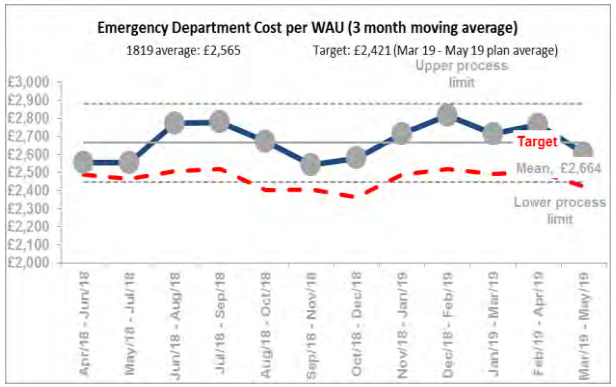
- Active engagement from Transformation representatives at all the PPEG meetings during the quarter
- Planned engagement and presentations on Transformation workstreams for:
  - Urology patient panel, including reviewing how the Friends and Family Test feedback can be improved for this service
  - Dermatology patient representatives
  - Wider patient engagement on the development of the outline business case for an Emergency Floor
  - Maternity Transformation through the next round of co-design workshops for the New Beginnings project

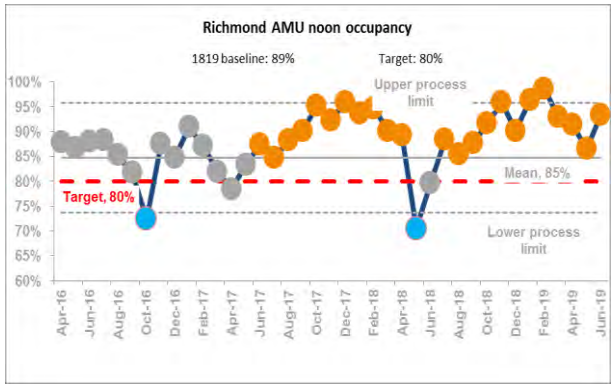
Key Transformation Indicators

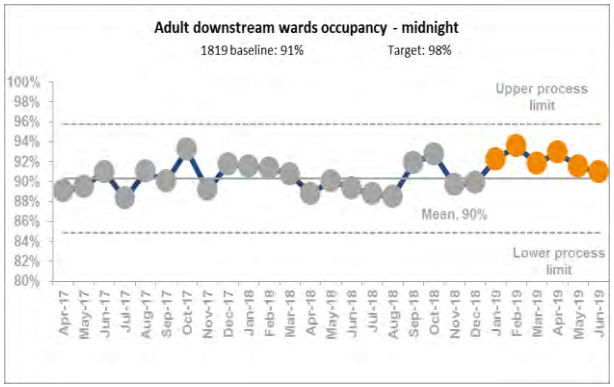


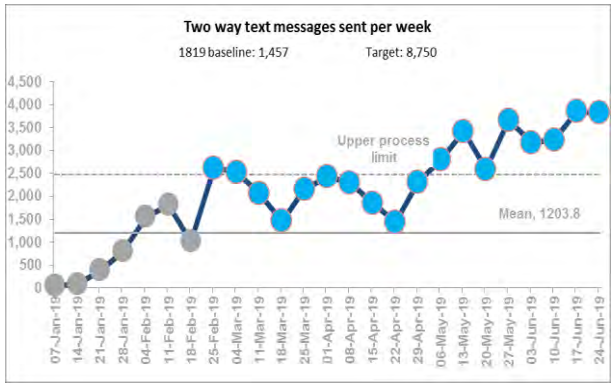


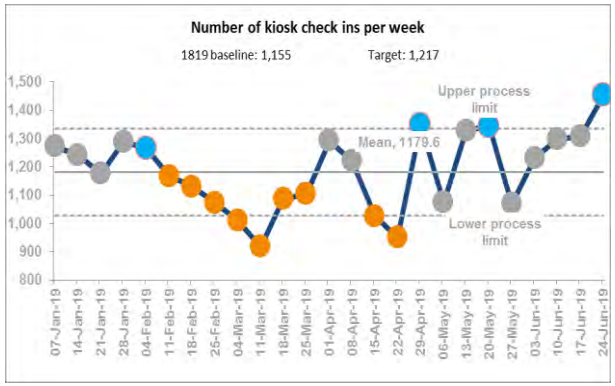












- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

Ten Completed Plan Do Study Act Cycles

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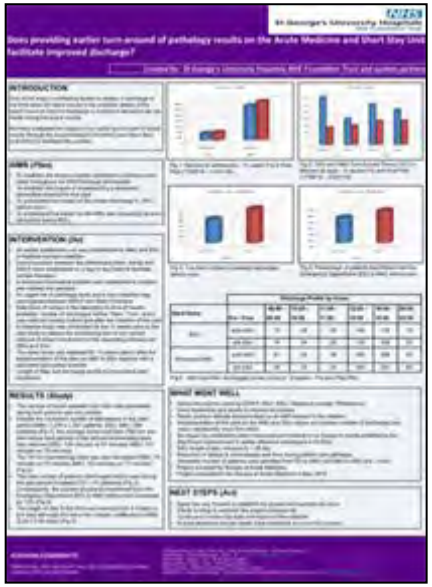

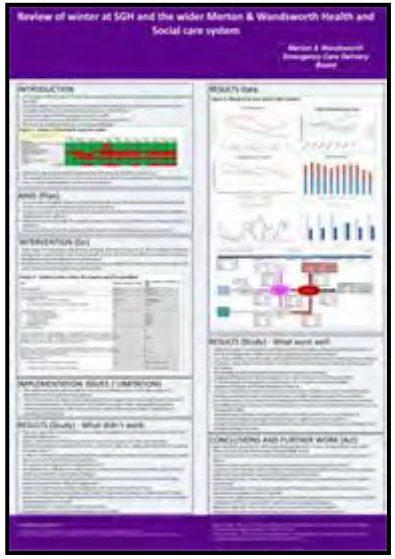

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2.5

Meeting Title:	**Trust Board**		
Date:	25 July 2019	**Agenda No**	2.5
Report Title:	**Learning from Deaths (Quarterly) Report**		
Lead Director/ Manager:	Dr Richard Jennings, Chief Medical Officer		
Report Author:	Kate Hutt, Clinical Effectiveness Manager Dr Nigel Kennea, Consultant Neonatologist (Acting Chair MMC)		
FOIA Status:	Unrestricted		
Presented for:	Assurance		
Executive Summary:	The paper provides an overview of the work of the MMC and data for Q1 2019/20. It includes a summary of the independent reviews completed and associated learning. The report summarises successes and areas for action in relation to implementation of the Learning from Deaths framework and the Medical Examiner system.		
Recommendation:	The Board is asked to: • Note the update on implementation of the Learning from Deaths national framework and with most urgent next steps in this process being the recruitment to the vacant position of Trust Lead for Learning from Deaths. • Note and support the introduction of the Medical Examiner system from April 2019. Immediate priorities include timely recruitment to the Lead Medical Examiner post and the allocation of space from which to launch the service. • Be assured that the Trust has robust processes for reviewing deaths and from learning any lessons that arise from them.		
Supports			
Trust Strategic Objective:	Data to help strengthen quality and safety work, as well as improve experience of bereaved families.		
CQC Theme:	Safe and Effective (Well Led in implementation of new framework)		
Single Oversight Framework Theme:	Safe		
Implications			
Risk:	This work will identify issues impacting on care quality day to day, and will identify risks that are escalated to trust and divisional governance teams. The 'Learning from Deaths' framework and national mortality agenda continues to evolve and requires ongoing change in process that requires resource, even with a mature mortality monitoring process. There is a risk that published mortality data and learning will not only be used for quality improvement, and that identifying problems in care could lead to adverse publicity.		
Legal/Regulatory:	'Learning from Deaths' framework is regulated by CQC and NHS Improvement, and demands trust actions including publication and discussion of data at Board level.		
Resources:	There are resource implications associated with this work, particularly introduction of the ME system that are being worked through and can be discussed with this paper.		
Previously Considered by:	Patient Safety & Quality Group Quality & Safety Committee	**Date**	17/07/19 18/07/19
Equality Impact Assessment:	N/A This is in line with the principles of the Accessible Information Standard		

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2.5

MORTALITY MONITORING COMMITTEE UPDATE

1.0 PURPOSE

1.1 The purpose of this paper is to provide the Patient Safety and Quality Group with an update on the work of the Mortality Monitoring Committee (MMC), focussing on information and learning identified through independent case record review of deaths for Q1 2019/20. An update on the delivery of requirements of the Learning from Deaths framework and the introduction of the Medical Examiner service is also detailed.

2.0 IMPLEMENTATION OF THE LEARNING FROM DEATHS FRAMEWORK AND NATIONAL STRATEGY

2.1 Learning from Deaths – Ongoing Development

Currently the position of Trust Lead for Learning from Deaths is vacant. This quarter, as an interim measure, the previous lead has continued to support mortality review processes. The Chair of the Mortality Monitoring Committee is fundamental to the delivery of mortality governance across the organisation. Furthermore, they will have a vital contribution to make in achieving the recommendations arising from the recent external review of mortality governance. The Chief Medical Officer has agreed to share the governance report and associated action plan with the Mortality Monitoring Committee on 24th July. This will allow the MMC to finalise objectives for the year.

Our engagement in the national agenda is well established. We are founding members of the Health Innovation Network's Learning from Deaths Community of Practice. This quarter we have participated in two meetings and shared with colleagues a practical example of using our hip fracture mortality data to drive improvements.

2.2 Medical Examiner Service – Implementation

The ME office will be set up to improve processes for the bereaved, including helping them to understand the cause of death and identify any concerns; to review all non-Coronial deaths and escalate quality concerns to Trust governance processes; to support and liaise with the certifying doctor when writing the medical certification of cause of death; and to liaise with the Coroner and Registrar, ensuring appropriate cases are subject to Coronial investigation.

The National Medical Examiner has made clear his expectation that by 31st March 2020 all in-hospital deaths should be subject to the scrutiny of the ME. Locally, the Medical Examiner (ME) project group is working through a plan to implement the service at St George's.

This quarter we have been consulting with a number of key stakeholders, including the Coroner, colleagues from the Mortuary Service and the Department of Health and Social Care. In particular, the meeting with the Chief Coroner for Inner West London was very positive and has established clear lines of communication and assisted in mutual understanding of roles and responsibilities.

The ME project is being led nationally by the Department of Health and Social Care and we have had discussions with the project lead to gain greater insight and to share our experiences, challenges and successes to date. Although we are not in a position to be accepted as a beta test site for the national IT system we have been given a prototype of the database, which will help us to design our processes and data collection in line with current best practice. We have advised the Department that we would be keen to be involved in the next phase of testing.

The project group has been working through a number of key priorities, including recruiting to the initial roles required to begin operating the ME service. The Lead Medical Examiner post has been advertised and the recruitment process is ongoing; however, it will not be possible to begin the ME service until appointment has been made. The Head of the ME and Mortality

Review Services is in post from 15th July and a new Bereavement Services Manager will shortly join the Trust.

An additional challenge is the identification of a suitable and necessary space from which to run the service. We are seeking a solution that will comply with the national recommendation that the ME office should be located close to Bereavement Services. The service cannot be established without this provision.

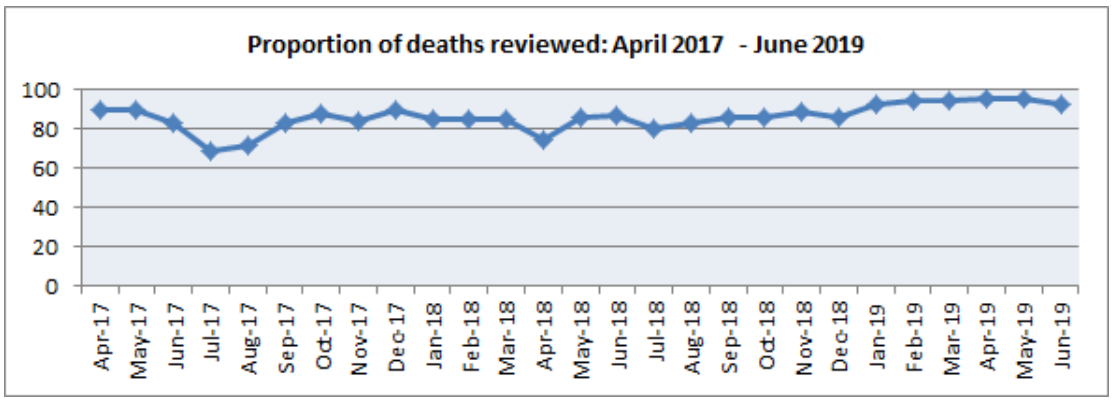
Delays in appointment of the Lead ME, additional MEs and the allocation of space may jeopardise our ability to have a full service in place by the national deadline.

3.0 MONTHLY INDEPENDENT REVIEW OF MORTALITY

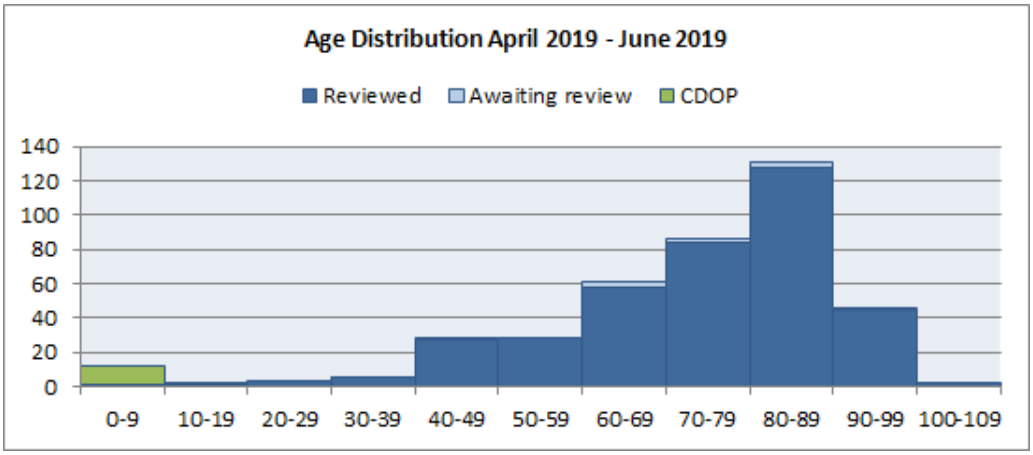
3.1 The following analyses include all deaths and do not consider deaths of patients with learning disabilities separately; however, this is required for the national dashboard. Our data reported in the format of the National Quality Board (NQB) dashboard is shown in Appendix 1. We have amended the NQB dashboard to reflect the local reviews of learning disability deaths.

3.2 Overview of April to June 2019

Between April and June 2019 there were 406 deaths, of which members of the MMC have reviewed 384. This represents an impressive 94.6% of deaths, significantly in excess of our target of 70%. These non-specialist, independent reviews are completed using our locally developed online screening tool and structured review tool, both based on the RCP tool. It should be noted that all child deaths are reviewed locally by clinical teams and by the Child Death Overview Panel.

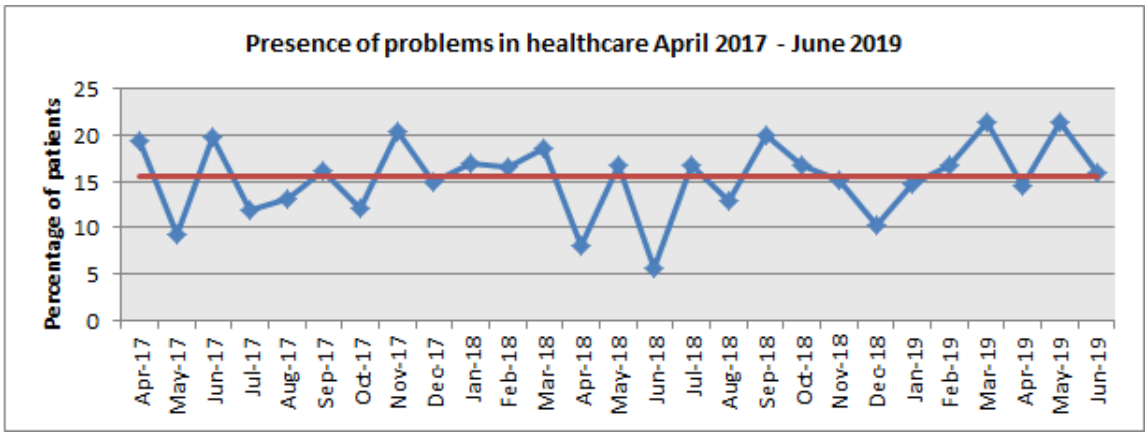


The age profile of deceased patients remains consistent, with the highest proportion of deaths in the 80-89 age group.

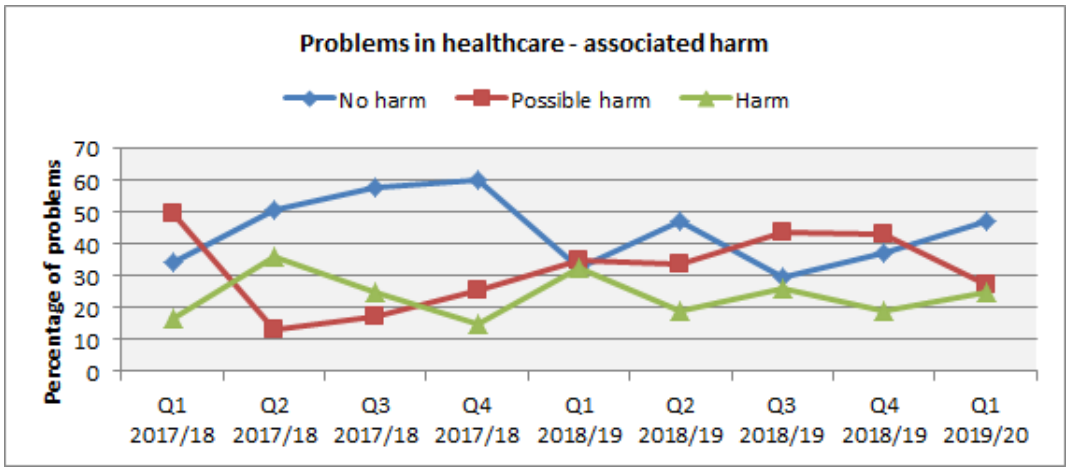


The structured judgement review requires reviewers to identify problems in healthcare and to assess whether or not these have caused harm. The RCP define a number of problems in healthcare, as detailed in the tables below. This quarter, one or more problems in healthcare were identified in 17.2% of the cases reviewed, which is similar to the rate observed in the previous quarter. Looking at the monthly data shows fluctuation around the mean of 15.6%.

Problems in healthcare Q1 2019/20				
	April	**May**	**June**	**Total**
No	123	95	100	**318**
Yes	21	26	19	**66**
% with problems	14.6	21.5	16.0	**17.2**



The problems identified include recognised complications of treatment and not all are judged to have led to harm. The chart below shows that a minority of problems led to harm. This quarter the observed problems did not lead to harm in 47.5% of cases, probably led to harm in 27.5% and did cause harm in 25.0%.



This quarter the most common problem in healthcare identified by reviewers was problems related to treatment and management plan with 22.5% of problems reported being in this category. This is consistent with the profile seen in 2018/19.

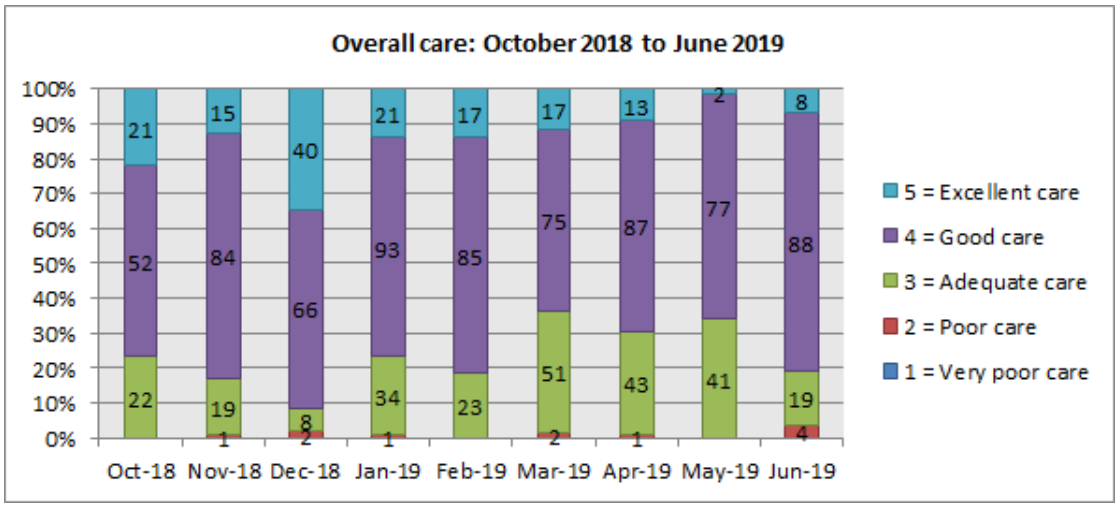
Problems in healthcare: Q1 2019/20	**No harm**	**Probably harm**	**Harm**	**Total**
Assessment, investigation or diagnosis	1	0	1	**2**
Medication/IV fluids/electrolytes/oxygen (other than anaesthetic)	4	2	2	**8**
Related to treatment and management plan	7	7	4	**18**
Infection control	4	3	2	**9**
Operation/invasive procedure	3	4	9	**16**
Clinical monitoring	0	2	0	**2**
Resuscitation following a cardiac or respiratory arrest	0	0	0	**0**
Communication	11	2	0	**13**
Other	8	2	2	**13**
TOTAL	**38**	**22**	**20**	**80**

A judgement regarding avoidability of death is made for all reviews. As in previous periods, the large majority (96.1%) of deaths this quarter were assessed as definitely not avoidable. Three deaths (0.8%) were judged to be more than likely avoidable, for that moment in time; however there were no cases where independent review suggested that the death was definitely avoidable.

Avoidability of death judgement score: Q1 2019/20	**April**	**May**	**June**	**Total**
6 = Definitely not avoidable	140	114	115	**369**
5 = Slight evidence of avoidability	2	5	3	**10**
4 = Possibly avoidable but not very likely (less than 50:50)	1	1	0	**2**
3 = Probably avoidable (more than 50:50)	0	1	1	**2**
2 = Strong evidence of avoidability	1	0	0	**1**
1 = Definitely avoidable	0	0	0	**0**
TOTAL	144	121	119	**384**

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

An assessment of overall care is provided for each death. This quarter the majority of patients were felt to have received care that was either good or excellent, with 6.0% of care rated as excellent, 65.8% as good, 26.9% as adequate and 1.3% as poor. There were no cases of very poor care found.



4.0 THEMES AND LEARNING

The following summary provides an update on a number of issues previously highlighted and learning from the independent review of cases and MMC activity this quarter. Also included is a focus on the deaths of patients with learning disabilities.

4.1 Learning disabilities

All deaths that occur in patients with learning disabilities are submitted to the national Learning Disabilities Mortality Review Programme (LeDeR). The LeDeR reviews are co-ordinated by the CCG. To date we have been asked to share our local reviews with the CCG for three patients and received feedback on one case, which commended the caring and considerate treatment of a patient in their last moments.

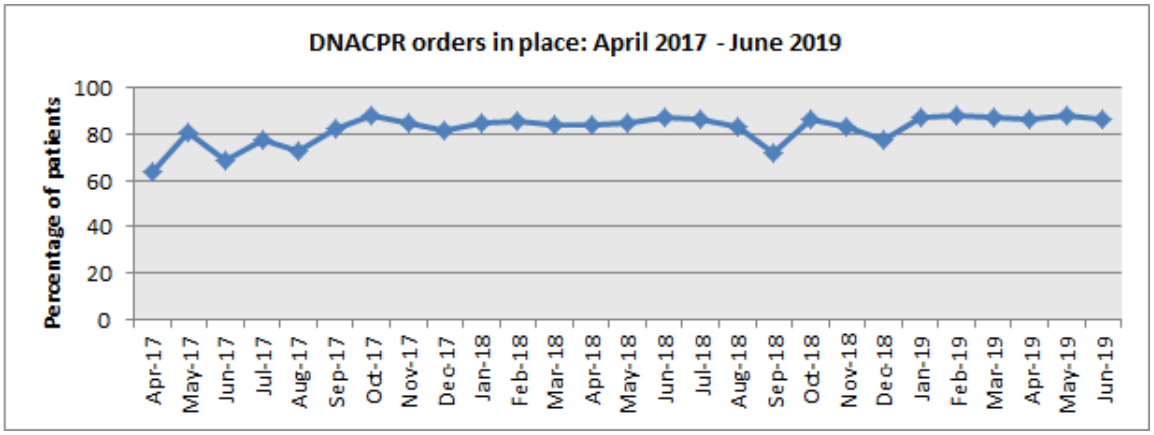
In addition to submitting patients to the national programme we carry out local review using our standard methodology. The table below summarises the deaths of patients with learning disabilities (LD) from the beginning of last year. Over the 5 quarters there were 12 deaths and reviews completed for 11, with no avoidability identified. This quarter two of the 3 LD deaths have been reviewed. No problems in healthcare were identified and both deaths were judged to be definitely not avoidable. Overall care was judged to be adequate in one case and good in the other.

LD DEATHS **Avoidability of death judgement score**	**Q1 18/19**	**Q2 18/19**	**Q3 18/19**	**Q4 18/19**	**Q1 19/20**
TOTAL DEATHS	1	3	3	2	3
LOCAL REVIEWS COMPLETED	1	3	3	2	2
6 = Definitely not avoidable	1	3	3	2	0
5 = Slight evidence of avoidability	0	0	0	0	0
4 = Possibly avoidable but not very likely (< 50:50)	0	0	0	0	0
3 = Probably avoidable (> 50:50)	0	0	0	0	0
2 = Strong evidence of avoidability	0	0	0	0	0
1 = Definitely avoidable	0	0	0	0	0

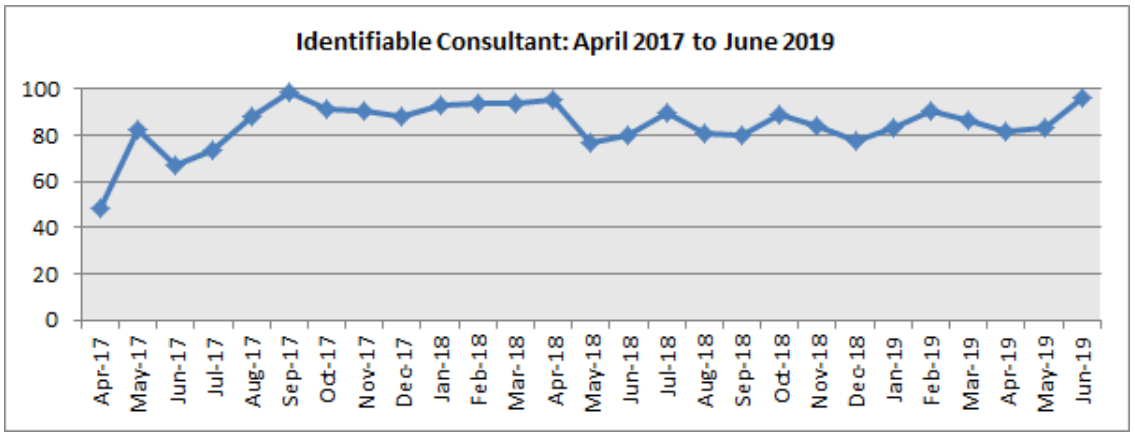
The Learning Disability Mortality Review Programme 2018 Annual Report was published in May 2019. The Clinical Nurse Specialist for Learning Disabilities has prepared a brief summary of the key findings and recommendations and will present this to the MMC in August.

4.2 DNACPR discussions and identifiable consultant

Data suggests that for those patients that die DNACPR discussions are held and documented for the large majority of patients.



Identification of responsible consultant is also maintained at over 80 per cent.



4.3 Identification of Learning

In the latest quarter there have been a number of cases escalated for further review, including 11 cases referred to the service for M&M review and reflection. In addition to seeking specialist opinion, issues that have been highlighted for discussion include documentation, management of end of life care, responsiveness of medical teams and frequency of senior review. Two cases have been referred to the Palliative Care Team for their assessment and in one instance this resulted in the palliative care team being invited to a specialty meeting to provide training.

This quarter a number of reviews have identified potential issues of care related to a lack of senior review at weekends. This issue has been raised directly with the Chief Medical Officer for his consideration and to inform the evolving picture of care out of hours.

The sharing of information between the mortality review team and other governance teams continues. This quarter the mortality review team have flagged 11 cases to the risk team for consideration of investigation. In two cases the risk team has facilitated the sharing of information with other hospitals that were involved in the final episode of care. Information from independent reviews has been shared with risk to inform incident investigations in another 10 cases. Review forms have also been used to directly inform two complaint investigations and one inquest. In addition, this quarter there have been four cases that have been scrutinised as part of the ongoing cardiac surgery work.

5.0 NATIONAL MORTALITY DATA AND SERVICES OPEN TO EXTERNAL SCRUTINY

5.1 National Adult Cardiac Surgery

Prospective investigation and governance procedures previously described are ongoing. The Mortality Monitoring Committee contributes to early independent review of all deaths in patients who have had cardiac surgery or been under the care of the team. This quarter four such reviews have been completed.

The NHS Improvement external panel has continued to hold retrospective mortality review sessions and has completed 163 reviews to date. Deaths following surgery from 2018 were reviewed first and the panel has also considered those from 2013 to 2016. It is now working through cases from 2017. The Panel has six sessions scheduled for July and is hopeful that it will complete the case reviews in this time. The Coroner is kept informed of the progress of reviews; however, prospective feedback is no longer received from the Panel.

6.0 LATEST NATIONAL PUBLISHED RISK-ADJUSTED MORTALITY

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

Since May 2019 NHS Digital has published the SHMI on a monthly basis, for a rolling 12 month period. In addition to Trust level data, site level values are also available.

The SHMI for February 2018 to January 2019 was published on 20th June 2019. For the Trust overall our mortality is categorised as lower than expected at 0.83. We are one of only 15 trusts nationwide in this category. The SHMI for St George' site is 0.84 (lower than expected) and for Queen Mary's is 0.68 (as expected).

In addition to producing VLAD (variable life adjusted display) charts for a number of diagnosis groups, which show the difference between the expected number of deaths and observed deaths over time, NHS Digital now provides a SHMI value for these diagnosis groups. The latest information is summarised in the table below and shows that our mortality is either better than, or in line with what would be expected for all the diagnosis groups analysed.

Diagnosis Group	SHMI value	SHMI banding
Cancer of bronchus; lung	0.70	Lower than expected
Secondary malignancies	0.70	Lower than expected
Pneumonia (excluding TB/STD)	0.80	Lower than expected
Urinary tract infections	0.58	Lower than expected
Septicaemia (except in labour), shock	1.00	As expected
Fluid and electrolyte disorders	0.68	As expected
Acute myocardial infarction	1.22	As expected
Acute bronchitis	0.84	As expected
Gastrointestinal haemorrhage	0.75	As expected
Fracture of neck of femur (hip)	0.76	As expected

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

HSMR analysis: April 2018 – March 2019	Score	Banding
HSMR	80.6	Better than expected
HSMR: Weekday emergency admissions	78.6	Better than expected
HSMR: Weekend emergency admissions	87.2	Better than expected

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

Most recently the MMC considered data from the period February 2018 to January 2019. At this time there were no new signals to consider; however, patient level data was examined for each of the groups. Information from care group reviews and independent reviews showed that the majority of cases had been reviewed, with few issues of care identified. In cases where concerns had been raised these had been managed through appropriate governance processes.

The procedure group 'Contrast radiology and catheterisations of heart' was considered in detail. 17 of the 20 deaths observed had been independently reviewed, with out of hospital cardiac arrest identified in 10 cases and no avoidability found. The cardiology governance lead had also reviewed the cases and noted that many of the patients had suffered non-ST elevation myocardial infarction and that the deaths related to remote complications and multi-organ failure. No concerns were identified and the committee were satisfied that further investigation was not required at that time.

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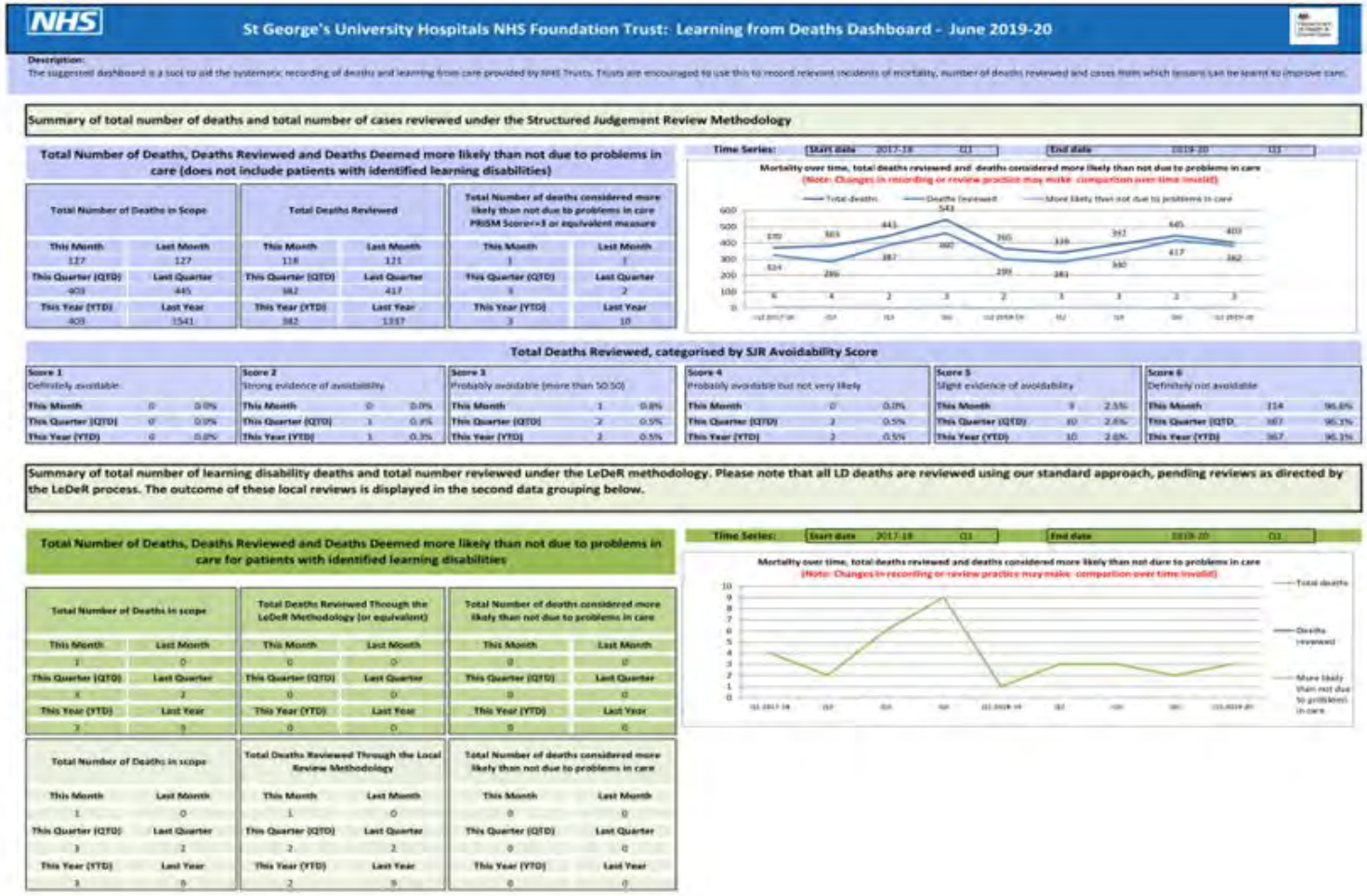
2.5

Appendix 1: National Quality Board Dashboard – data to 30th June 2019



NHS

St George's University Hospitals NHS Foundation Trust: Learning from Deaths Dashboard - June 2019-20

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

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

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

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered more likely than not due to problems in care PRISM Score<=3 or equivalent measure	
This Month	Last Month	This Month	Last Month	This Month	Last Month
127	127	118	121	1	1
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
403	445	382	417	3	2
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
403	1541	382	1317	3	10

Time Series: Start date 2017-18 Q1 End date 2019-20 Q1

Mortality over time, total deaths reviewed and deaths considered more likely than not due to problems in care
(Note: Changes in recording or review practice may make comparison over time invalid)

Total deaths; Deaths reviewed; More likely than not due to problems in care

Total Deaths Reviewed, categorised by SJR Avoidability Score

Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	0	0.0%	This Month	1	0.8%	This Month	0	0.0%	This Month	3	2.5%	This Month	114	96.6%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	1	0.3%	This Quarter (QTD)	2	0.5%	This Quarter (QTD)	2	0.5%	This Quarter (QTD)	10	2.6%	This Quarter (QTD)	367	96.1%
This Year (YTD)	0	0.0%	This Year (YTD)	1	0.3%	This Year (YTD)	2	0.5%	This Year (YTD)	2	0.5%	This Year (YTD)	10	2.6%	This Year (YTD)	367	96.1%

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

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

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered more likely than not due to problems in care	
This Month	Last Month	This Month	Last Month	This Month	Last Month
1	0	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
1	2	0	0	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
3	9	0	0	0	0

Total Number of Deaths in scope		Total Deaths Reviewed Through the Local Review Methodology		Total Number of deaths considered more likely than not due to problems in care	
This Month	Last Month	This Month	Last Month	This Month	Last Month
1	0	1	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
3	2	2	2	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
3	9	2	9	0	0

Time Series: Start date 2017-18 Q1 End date 2019-20 Q1

Mortality over time, total deaths reviewed and deaths considered more likely than not due to problems in care
(Note: Changes in recording or review practice may make comparison over time invalid)

Total deaths; Deaths reviewed; More likely than not due to problems in care

St George's University Hospitals NHS
NHS Foundation Trust

2.6

Meeting Title:	Trust Board		
Date:	25 July 2019	**Agenda No**	2.6
Report Title:	**Safeguarding Children – Annual Report**		
Lead Director/ Manager:	Avey Bhatia, Chief Nurse and Director of Infection Prevention and Control		
Report Author:	Bill Turner, Head of Safeguarding		
Presented for:	Assurance		
Executive Summary:	The annual safeguarding report details the systems and processes in place to safeguard children in acute and community services. The report demonstrates the Trust is committed to the safeguarding of children and promoting their welfare in line with the statutory requirements of the Children's Act. The report highlights some of the key areas of work and areas of challenge for the Safeguarding Children's team over the previous financial year, as well as seeking to set out key future pressures, challenges and opportunities for the Safeguarding Children Service at the Trust. This report is focused on activity over the past financial year, but also references changes and developments to the Service which are either planned, or already underway. The key issues to note in the report are: • The Trust is discharging the required statutory responsibilities as outlined in the Children's Act 2004 • There are clear lines of accountability, responsibility and governance which have been strengthened by the full integration of acute and community safeguarding teams. • Training at all levels is good but requires on going focus to maintain compliance in all areas. • Training at all levels including the bespoke training are comprehensive and in line with the requirements of the recommendations in the safeguarding children and young people Intercollegiate document. • Provision of supervision for staff needs to be increased and a central mechanism for recording this to be implemented, this is under review. • The Trust is fully committed to partnership working and is an integral part of the wider Multi Agency Safeguarding Hub (MASH) and a key member of the Local Safeguarding Children's Boards. • The Trust has safeguarding policies, procedures and guidance documents which reflect best practice and Pan London Standards. • The Trust is compliant with its duty to report cases to the Local Authority Designated Officer (LADO) . • The Trust has implemented alert systems for Child Protection and FGM • The Trust has joined the Adult and Children's Safeguarding meeting for better collaborative working and 'Think Family approach'		
Recommendation:	The Board is asked to receive and discuss this report and raise any concerns in terms of further assurance required.		

St George's University Hospitals NHS
NHS Foundation Trust

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:	If proper systems and processes and governance not in place failure to meet statutory requirements and potentially put children at risk.		
Legal/Regulatory:	Compliance with: (i) Heath and Social Care Act 2008 (ii) Section 11 Children's Act 2004 (iii) Working Together 2015 (iv) Regulation 13: Safeguarding service users from abuse and improper treatment		
Resources:	No additional resources required or requested.		
Previously Considered by:	Patient Safety and Quality Group Quality & Safety Committee	**Date:**	17 July 2019 18 July 2019
Appendices:	Nil		

St George's University Hospitals NHS
NHS Foundation Trust

Safeguarding Children – Trust Annual Report 2018/19

1. Introduction

St George's University Hospitals NHS Foundation Trust, and all staff and volunteers working for the Trust have important and distinct ethical, legal and where applicable, regulatory duties to ensure that all children and young people receiving services from the Trust receive safe and dignified care, and that they are safeguarded from harm, abuse and neglect, including ensuring that appropriate action is taken when the Trust becomes aware of potential issues of concern which come to our attention, taking place outside of the Trust.

This safeguarding duty may be enacted in the context of the administration of patient care directly, or by the Trust participating in multiagency safeguarding practice, such as sharing information with a local authority or attending a strategy meeting relating to a specific child. However, it is extremely important to note that the Trust's safeguarding duties also extend to children and young people who are **not** patients at the Trust (and who will not be physically seen by the staff member or clinical team providing treatment to the adult). These duties typically occur when the Trust receives information which might indicate that a child or children are potentially at risk of 'significant harm'.

Most commonly, this will occur when an Adult patient is receiving treatment at the Trust, and the consultation or treatment indicates that a referral to children's social care/support or advice from the Trust Safeguarding team might be needed (for example if an adult is presented at the Trust for issues related to domestic abuse, substance misuse or poor mental health). We refer to this as a 'Think Family' approach. These duties will apply whether or not the names and details of the children are known or not. It is important to reference this duty as it applies to all Trust staff including colleagues who seldom or never work with children as part of their day to day duties.

In essence, our Safeguarding duties as a Trust relate to all children, regardless of where or with whom they reside, and whether or not they have used any Trust services, and whoever at the Trust comes into contact with information which is relevant to Safeguarding a child.

In such cases, the Trust's duties principally relate to sharing information with relevant agencies, and participating in multiagency safeguarding processes, whereas in the cases of children who are inpatients or who receive direct and ongoing care from the Trust, we are likely to play a more active and substantial role in service provision.

The 'bedrock' of legislation relating to Safeguarding Children in the United Kingdom is the Children Act 1989, although there have been a number of important legislative and policy milestones since this time. In particular, the Act introduces the concept of 'significant harm' on which most statutory interventions and information sharing processes in relation to children, are based.

The key piece of Statutory Guidance relating to Safeguarding Children is *Working Together to Safeguard Children* (updated July 2018) and there is important regional guidance in the Pan London Child Protection Procedures (http://www.londoncp.co.uk/index.html).

The Children and Social Work Act 2017, along with the updated Working Together guidance, have significant implications for the Trust in the context of our involvement in Local Safeguarding Partnerships, the Trust's involvement in Serious Case Reviews, and

will also significantly affect the Trust's involvement in the review of Child Deaths (this being out of the scope of the present report).

The Pan London Procedures, which all NHS Trusts are obliged to follow, are updated on a six monthly basis, and contain detailed information to guide operational responses to specific situations and concerns. During the year updated Intercollegiate Guidance on Safeguarding Training (applicable to both Child and Adult Safeguarding) was published, and in February 2019 NICE (National Institute for Clinical Excellent) published guidance (Quality Standard 179) relating to Child Abuse and Neglect which the team are currently reviewing.

This report provides a summary of activity with regard to safeguarding children's 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 day to day clinical care and practice at George's.

2. Safeguarding Team Structure

The financial year 2018/19 has continued to see significant change in the children's team at the Trust, as during the course of the year both the Named Nurse for Safeguarding Children (Acute) and the Named Doctor for Safeguarding Children left the Trust; for another role and to retire respectively. Both roles have now been filed, although at the time of writing the Deputy Named Doctor post remains vacant. There were also staffing changes in the Clinical Nurse Specialist group.

In the Maternity Department, plans are underway to recruit to new, clearly defined role of Named Midwife for Safeguarding Children. The introduction of this post, which is a standard role across most Trusts of a similar size will enhance quality and breath of safeguarding practice in the Maternity Department, and add an additional layer of safeguarding oversight and assurance across all Maternity activity at the Trust.

The table below details the resources in place for dedicated duties relating to safeguarding children:

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.
Named Doctor – Safeguarding Children	Cons	0.3 wte	Responsible for clinical/medical advice on complex safeguarding cases across the Trust, working closely with the Head of Safeguarding and the Named Nurses in this respect, as well as acting as point of contact for Doctors with Safeguarding related query. At St George's the Named Doctor also leads a detailed programme of Safeguarding education/seminars (complementary to the Level 3 Safeguarding course) which is accessible to all doctors and nurses across the Trust. Like colleagues, the postholder is also extensively involved in partnership working.

Job Title	Band	WTE	Role comments
Deputy Named Doctor – Safeguarding Children	SpR	0.1 wte	Deputises for the Named Doctor, and also participates in Safeguarding activity alongside colleagues from the Safeguarding team.
Named Nurse for Safeguarding Children (Acute Services)	8A	1 wte	Responsible for clinical advice and guidance to all Trust staff on Safeguarding matters, both on specific cases and operationally. Responsible for the Trust's Level 3 training offer in respect of Children's Safeguarding, and oversees the development in the Trust's safeguarding children's work and for overseeing the provision of Safeguarding supervision to Nursing and Therapy staff across the Trust. The postholder is extensively involved in partnership working.
Clinical Nurse Specialist for Safeguarding Children	7	2 wte	The Clinical Nurse specialists provide advice and support to staff on all children's safeguarding issues and are a visible presence on wards (in the Emergency Department and Paediatric Wards). The Clinical Nurse Specialists are often involved in referrals to Local Authorities regarding safeguarding matters as well as taking part in case specific partnership meetings such as Strategy meetings and Child Protection conferences.
Clinical Nurse Specialist – Domestic Violence and FGM	7	1 wte	This post works across the Trust on Safeguarding activity which may relate to children or adults, but is managed within the Safeguarding Children's team to which most of the operational activity relates.
Safeguarding Administrator	3	1 wte	This post holder covers both the Children and Adults functions supporting the team with the considerable volume of administrative tasks associated with Safeguarding.
Named Nurse for Safeguarding Children (Community)	8A	0.6wte	The main focus of this role is acting as the Safeguarding Lead in respect of Community based services, although given the Trust's disinvestment from a number of community based services (specifically school nursing in September 2018) the postholder also provides much needed support to the Acute Team.
Paediatric Liaison Health Visitor/CNS Emergency Department Liaison, Safeguarding Children and Young people	7	1 wte	Liaison of information/notifications/referrals from the Emergency Department to School Nurses, Health Visitors and Local Authorities. Chairing the weekly safeguarding ED meeting, overseeing safeguarding practice within ED. Quality assurance of Safeguarding Practice within the ED department.
Administration (Paediatric Liaison and community services)	4	1.8 wte	These roles provide administrative support to the Liaison service and is responsible for data collection, and sending out the significant volume of information
Clinical Midwife Specialist * A recruitment process for a Band 8a Named Midwife is due to begin shortly (June 2018)	7	1.0 wte	Provide specialist safeguarding support to maternity services.

The Safeguarding Children's team are organised and managed separately from the Trust Looked After Children's team however the teams work closely together when required. The activities of the Looked After Children's Team are provided in a separate annual report.

It is also important to note that two voluntary sector teams work within the Trust, and work

closely with the Safeguarding Team, these being Redthread and the Independent Domestic Violence Advisor. A Barnardo's employee is also due to start work at the Trust from June 2019 meaning we will have a third co-located partner organisation.

Independent Domestic Violence Advisor (Victim Support employee):
This member of staff works closely with the Clinical Midwife Specialist and provides bespoke support to patients who are affected by domestic violence, including after discharge. This staff member can also provide independent and confidential support to Trust staff who have themselves experienced domestic violence.

***Redthread*:**
Redthread is a youth work charity providing support to young people with a range of vulnerabilities. Redthread have five youth work staff (including a Team Leader) and a Programme Coordinator based in the Emergency Department. Redthread have a presence in London, Nottingham and Birmingham's Major Trauma Centres, Homerton University Hospital and Heartlands Hospital. Whilst Redthread has developed a significant public profile in respect of their work in relation to knife crime, and this forms and important part of their work at the Trust, they work with young people aged 11-25 attending the Trust for any reason associated with youth violence including domestic violence, sexual violence, exploitation and non-weapon related assaults.

The team work proactively and flexibly with young people who have been admitted to Hospital, and seek to make use of the 'teachable moment' when a young person is hospitalised, to co-produce a longer term intervention with them.

Redthread's Youth Violence Intervention Programme is funded by The Mayor's Office of Policing and Crime, Lloyds Bank Foundation, Charles Hayward Foundation, Sir Walter St John's Educational Charity. They also partner with SOLACE to provide a youth IDVA who works with young women affected by domestic violence, and a Comic Relief funded young women's worker who supports young women affected by gang activity. Over the previous year, closer operational and strategic relationships have been developed between Redthread and the Trust Safeguarding team. Redthread actively contribute towards the Trust's multiagency Level III Safeguarding Training and the Trust Safeguarding team have helped support Redthread in their staff recruitment.

It is noted that Redthread, beyond core clinical services, are the main agency providing services to young people over the age of 18 who with additional vulnerabilities who use Trust services as these young adults are over the age at which the Safeguarding Children's team work. The vast majority of these young adults, despite their vulnerabilities are not generally seen as meeting the threshold for a Local Authority Adult Safeguarding intervention.

Whilst many young people using Trust services have additional vulnerabilities and needs, the vast majority of this cohort of young people will not meet the threshold for adult social care services. The contribution which Redthread is able to provide to this group of young adults is therefore particularly important, as they provide a service which is unlikely to be offered by any statutory services at this time.

Barnardos:

Barnardo's, the children's charity, host the National FGM Centre, on behalf of the Department for Education and the Local Government Association. The Home Office has provided funding for some specialist FGM related posts in the London Region, which will enable the Trust to host an FGM Advocate on a part time basis at the Trust, to support the work, and extend the capacity of the Trust's FGM Clinical Midwife specialist (particularly in terms of providing non-clinical, social and community support). The post is funded, in the first instance, for 12 months. The postholder will work under the day to day supervision of

the Clinical Midwife Specialist for FGM and Perineal Health. A postholder has been appointed, by Barnardosand is due to commence work at the Trust in June 2019. This is positive development and it is hoped that review of how the post has impacted and improved the care of women affected by FGM receiving care at Trust will form part of next year's Annual Report.

3. Policies and Governance:

The Chief Executive has overall responsibility for the safeguarding of children and there is a clear line of accountability in place. The Chief Nurse and Director of Infection Prevention and Control, on behalf of the Chief Executive has the responsibility to ensure that our contribution towards safeguarding children and promoting their welfare is discharged effectively throughout the whole organisation and that St George's University Hospitals NHS Foundation Trust is represented in local safeguarding partnerships.

The Chief Nurse is responsible for;

- Safeguarding children practice and assumes a strategic lead on all aspects of the Trust's contribution to safeguarding children
- Ensuring the Trust is represented on Local Safeguarding Children's Partnerships
- Ensuring that appropriate safeguarding processes are in place, including compliance with all legal, statutory and good practice requirements

The Trust has appropriate policies and procedures in place for safeguarding children which are available to all staff via the intranet on the Policy Hub. These policies and guidance are regularly reviewed to ensure that they are in date and updated as required in response to any national changes in requirements and legislation.

Ensuring that policies are not only compliant, and up to date, and most effectively support staff when dealing with practical safeguarding concerns, issues and challenges will be a key strategic priority for the new Named Nurse (Acute) in the coming six months (from the date of this report).

A key overall aim in reviewing the policies is to ensure that they effectively meet the needs of busy staff in pressured operational settings seeking guidance and support on what they need to do in potentially challenging or complex situations.

In January 2019 the Trust introduced an internal Joint Children's and Adults Safeguarding Committee (replacing the previous two, separate committees). Having a joint Committee is more congruent with the policy of 'think family' that the Safeguarding Team are keen to promote, but also means that a joint focus can be applied to relevant areas. Combining the Committees has also reduced the number of meetings which staff (particular those with broad remits or who cover large operational areas) are expected to attend, which has had a positive overall impact on attendance. However, the Committee will consider safeguarding matters separately or on a combined basis, as appropriate. Both the Designated Safeguarding Leads (Children and Adults) at the CCG have a standing invite to the Committee (and are sent papers if they cannot attend) which ensures that they are able to maintain an overview of the Trust's Safeguarding work, and are able to pose any queries required, and this is an important part of our relationship with CCG colleagues.

Staff in the Safeguarding Team hold regular operational meetings with the Emergency Department, the Neonatal Department and with Midwifery, and are able to attend specific

staff meetings upon request. The Trust also has an Female Genital Mutilation (FGM) Working Group (which is currently under review), and staff from the Team will attend ad hoc or time limited groups as required (i.e. re Child Protection Information Standard implementation (CP-IS) which allows the national flagging of children on protection plans). This Annual Report is updated on a biannual basis for the Safeguarding Children's Committee.

A weekly list is compiled by the Clinical Nurse Specialists for Safeguarding Children of all children who are inpatients at the Trust with whom the Safeguarding Team is currently substantially involved and is circulated to the Chief Nurse and relevant nursing managers, as well as to the Head of Safeguarding and Named Doctor for Safeguarding Children. This list plays an important role in the operational assurance of safeguarding practice.

4. Referrals and activity:

The Trust referred a total of 432 cases to Children's Specialist services in the year April 2017- March 2018. This is broken down by month in the table below.

SAFEGUARDING REFERRALS ARPIL 2018 TO MARCH 2019

Core Service	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Totals
Urgent & Emergency Services	203	162	159	158	682
Children & Young People	28	57	42	36	163
Maternity	12	10	7	11	40

Totals	243	229	208	205	885

Some presenting concerns behind referrals are – this is a non exclusive list.

- Children attending A&E following self-harm
- Children admitted to hospital due to safeguarding concerns
- Alcohol / substance misuse
- Children attending following attempted suicide
- Physical injuries resultant from violence inflicted by other young people
- Attendances related to mental health

The Trust now systematically records and securely stores all referrals made to a local authority children's services department. Beyond this, we are able to sort referrals by presenting concern and local authority area, providing a more nuanced and detailed picture highlighting specific issues related to safeguarding, or areas for wider review.

Following a review of referral process the Safeguarding team have now instigated a central secure email to ensure that they receive all copies of referrals that are made to the children's team (the team are unable to quality assure and record any referrals which are not sent to them, and continued communication work is underway to ensure all staff are aware of the need to send copies of all children's social care referrals to the Safeguarding Team).

This will act as a useful exercise in mapping levels of activity, establishing patterns of referrals and concerns relevant to partnership safeguarding activity and will enable the Safeguarding Team to quality assure all referrals so we know that information is being shared actively and proportionally with local authority partners. Currently approximately 80% of referrals to local authority children's social care departments originate from the Emergency Department. It is important to note that in the Emergency Department referrals

to the Local Authority may essentially be notifications (i.e. informing them of the nature of the admission and the source of concern following an ED attendance and subsequent discharge) referrals in relation to children or young people who are inpatients or outpatients are likely to be more detailed, and in general the Trust will expect to be part of the Safeguarding plan for as long as the child is a patient and where appropriate, beyond.

The majority of referrals from the Trust are from the Emergency Department, with whom the Safeguarding team holds regular operational meetings, and has an excellent working relationship. In the coming year it will be important to maintain these relationships whilst ensuring that the Safeguarding Team operates as a truly 'Trust wide' service. Internal safeguarding meetings benefit from the attendance of Wandsworth Children's Services (in respect of Wandsworth cases) and we are seeking to engage other local authorities in this process for their own cases.

The team has also contacted local Multiagency Safeguarding Hub (MASH) managers to request that they escalate any concerns they have about poor quality referrals to the Named Nurse for Safeguarding Children as an additional layer of quality assurance.

NB. The Children's Safeguarding Team can receive referrals in respect of domestic violence, which may or may not present alongside another safeguarding issue. The Lead Nurse works closely with the Clinical Nurse Specialist for Domestic Violence and reviews on a case by case basis who the most appropriate practitioner to respond to these referrals is.

April 2018 to March 2019 - Referrals to CSS from St George's ED

		Quarter 1	Quarter 2	Quarter 3	Quarter 4	TOTAL
London Boroughs	Barking & Dagenham	1	1	0	0	2
	Barnet	1	0	0	0	1
	Bexley	0	0	0	0	0
	Brent	0	0	0	0	0
	Bromley	1	1	1	1	4
	Camden	0	1	0	1	2
	City of London	0	0	0	0	0
	Croydon	18	9	15	17	59
	Ealing	1	1	1	1	4
	Enfield	0	1	0	0	1
	Greenwich	0	0	0	0	0
	Hackney	0	0	0	0	0
	Hammersmith & Fulham	2	0	0	0	2
	Haringey	1	0	0	0	1
	Harrow	1	0	0	0	1
	Havering	1	1	0	0	2
	Hillingdon	0	1	0	0	1
	Hounslow	1	0	2	1	4
	Islington	0	0	0	0	0
	Kensington & Chelsea	1	0	0	1	2
	Kingston Upon Thames	3	4	4	4	15
	Lambeth	16	12	13	15	56
	Lewisham	0	1	2	2	5
	Merton	52	48	34	39	173

		Quarter 1	Quarter 2	Quarter 3	Quarter 4	TOTAL
	Newham	0	0	0	1	1
	Redbridge	0	0	0	2	2
	Richmond Upon Thames	10	2	2	2	16
	Southwark	1	2	1	0	4
	Sutton	7	3	2	6	18
	Tower Hamlets	0	0	0	1	1
	Waltham Forest	0	0	0	0	0
	Wandsworth	74	63	62	49	248
	Westminster	0	1	0	0	1
Other	Kent	0	0	3	0	3
	Surrey	6	3	9	9	27
	Sussex	2	2	2	1	7
	Other	3	5	6	5	18

TOTALS		**203**	**162**	**159**	**158**	**681**

ST GEORGE'S ED - SAFEGUARDING CHILDREN - REFERRALS TO CSS PRIMARY REASON BREAKDOWN

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
Adult Alcohol/Drugs	10	15	12	14	51
Adult Assault	3	4	1	8	16
Adult Domestic Abuse	24	15	20	19	78
Adult Human Trafficking	0	1	0	0	1
Adult Medical Condition	1	2	1	1	5
Adult Mental Health	44	33	37	25	139
Adult Neglect of child	1	1	0	0	2
Adult Other	2	2	1	2	7
Adult Parental behaviour	0	2	1	2	5
Adult Total	**85**	**75**	**73**	**71**	**304**
Child Adult Alcohol/Drugs	2	3	1	2	8
Child Alcohol/Drugs	8	6	5	4	23
Child Assault/Stabbed/Shot	40	17	22	22	101
Child Behavioural	4	4	6	1	15
Child Bullying	1	0	0	0	1
Child Death	1	0	1	0	2
Child Delayed Attendance	0	1	2	1	4
Child Dog Bite	0	1	0	0	1
Child Domestic Abuse	4	3	2	0	9
Child Fall From Height	2	2	0	2	6
Child Human Trafficked	0	1	0	0	1
Child Major Trauma	2	3	8	2	15
Child Mental Health	18	9	8	10	45
Child Missing	1	0	2	2	5
Child Neglect	0	1	3	4	8
Child Non-compliant with medication	0	1	0	0	1
Child Non accidental injury	7	2	0	2	11
Child Other	9	7	3	8	27

St George's University Hospitals NHS
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	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
Child Adult Attendance	0	2	0	0	2
Child Parental Behaviour	4	9	1	1	15
Child Physical Abuse	1	1	0	1	3
Child Police Custody	1	2	1	0	4
Child Sexual Abuse	1	3	7	2	13
Child Social Reasons	0	3	3	2	8
Child Suicide Attempt	12	5	9	18	44
Child Unwitnessed Injury	0	0	2	2	4
Child Total	**118**	**87**	**86**	**87**	**378**
Number of Referrals to CSS	**203**	**162**	**159**	**158**	**682**

5. Internal Audit and Section 11 duties:

This is a combined section as it reviews both the internal and external audit activity in the Trust Children's Safeguarding team. The Trust has developed our internal audit programme in relation to Safeguarding, including conducting an audit of the quality of safeguarding referrals to local authority children's social care departments, which is a key area of safeguarding activity at the Trust. The first audit sample found that referrals were clear in recording Safeguarding concerns, but that the recording of consent (where applicable) was an area for development.

This audit will now form part of an audit cycle and kept under regular review. All local authority MASH teams with whom we work on a regular basis have been requested to escalate concerns about the quality of any individual referral to the Trust Safeguarding Team if this ever seems to be required. The Trust has now also completed an audit of Safeguarding practice in relation to FGM in our maternity services, which will be presented to the Wandsworth LSCB. This audit will also be repeated on a cyclical basis.

The Trust has obligations under section 11 of the Children Act 2004 to work with local partners to ensure our functions are discharged having regard to the need to safeguard and promote the welfare of children. The Trust has historically participated in the section 11 exercises convened by Merton and Wandsworth LSCBs in a range of different ways, and in the year ahead we intend to ensure that 'section 11 duties' are complied with in such a way as to closely link to children's outcomes. It is likely that the nature of our section 11 activity will change considerably linked to the transition to Safeguarding Children's Partnerships.

6. Serious Case Reviews/Learning Review/Partnership Working specific to Children's Safeguarding

This is the last Annual Safeguarding report which will address Serious Case Reviews, as these have been replaced, pursuant to the Children and Social Work Act 2017. The national governance system around Serious Case Review is changing significantly as a result of changes pursuant to the Child and Social Work Act 2017, and the transition to local safeguarding partnerships (from Local Safeguarding Children's Board) as outlined in Statutory Working Together Guidance (July 2018 version). With the advent of Safeguarding Children's Partnerships a system of Local and National Child Safeguarding Practice Reviews is being introduced. These new arrangements need to be implemented from 29 September 2019 at the latest.

For the Trust however, Child Safeguarding Practice Reviews will be similar to Serious Case Reviews in that they will require the collation and sharing of information, and an analysis of

practice, in instances in which a child has died or experienced serious harm, and there is reason to be concerned as to how agencies have worked together, with a focus on agency and system learning to reduce the likelihood of mistakes and system failures being repeated. However, this is the last Annual Report which will deal with 'Serious Case Reviews' and future reports will refer to Child Safeguarding Practice Reviews, which will sit in a changed and developing system of governance.

As is typical for a large Acute Trust, particularly for a tertiary referral centre, the Trust provides patient care services to children and young people who have been admitted to hospital as a result of injuries caused by deliberate harm or by an accident which has occurred in circumstances which indicate the need for a safeguarding intervention. The Trust also provides inpatient services to children and young people who have an illness or medical condition where the treatment profile is complicated by social factors. These circumstances mean that a relatively large number of children and young people whose circumstances lead to a Serious Case Review, are, or have been patients at the Trust. It also means there is a tendency for Serious Case Reviews to cover patients from a wider area than that to which the hospital also provide a District Hospital service.

Serious Case Reviews are formal, and often very detailed (anonymised) reports which are published by a Local Safeguarding Children's Board when a child has died or suffered serious harm and there is a concern about how agencies worked together to safeguard her or him. The intended purpose of Serious Case Reviews is for learning informing future practice to take place, as opposed to being an exercise in apportioning blame.

The formal guidance regarding Serious Case Reviews is copied below *(Working Together 2015)*

- The LSCB must undertake reviews of serious cases in specified circumstances. Regulation 5(1) (e) and (2) of the Local Safeguarding Children Boards Regulations 2006 set out the LSCB's function in undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

- A Serious Case Review must always be initiated when:
  a. Abuse or Neglect of a child is known or suspected; AND
  b. Either:
     i. The child has died; OR
     ii. The child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

- Thus cases meeting **either** of these criteria must always trigger a Serious Case Review:
  1. Abuse or Neglect of a child is known or suspected AND the child has died (including by suicide); OR
  2. Abuse or Neglect of a child is known or suspected AND the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child. In this situation, unless it is clear that there are no concerns about inter-agency working, a Serious Case Review must be commissioned.

The Trust is currently participating in a number of Serious Case Reviews, although as stated the fact that the Trust is a participant in a review does not indicate that practice at the Trust is in itself the subject of review. The Head of Safeguarding at the Trust has also Chaired a Serious Case Review on behalf of a Local Safeguarding Board, in response to a request to partner agencies for support with this role.

In order to best understand the nature of the Trust's involvement in Serious Case Reviews, it may be helpful to sub-divide reviews in which the Trust has an input into the following categories, although *it should be stressed that this is local guidance only, and is not part of the statutory guidance regarding Serious Case Reviews:*

Type A: Reviews in which services provided by the Trust, alongside other services, form part of the Serious Case Review (SCR) process and are the subject of review. This could include cases in which the Trust provides services prior to neglect or abuse being either identified or sufficiently addressed. One such review is currently in the process of being finalised, although the timing of publication is contingent on an ongoing criminal justice process.

Type B: Reviews relating to patients admitted to the Trust (potentially for considerable periods of time) *following* injuries or abuse sustained prior to admission, which subsequently become the subject of a Serious Case Review. The Trust is currently involved in two such reviews.

Type C: Reviews which take place relating to children who lived in an area which is served by a Local Safeguarding Board of which the Trust is a member (i.e. the London Borough of Wandsworth and the London Borough of Merton) and in which the Trust had no involvement, or minimal/historic involvement with the children and family in question. In these reviews the Trust might be asked to provide input in a 'partnership' capacity.

Due to reasons of confidentiality it is not possible within the context of this report to provide further information regarding any current serious case reviews in which the Trust is involved, and in terms of published reviews, the Trust is not always identified by name.

Local Safeguarding Children's Boards also make use of Learning Reviews, in which it is felt that the threshold for a Serious Case Review is not met, but in which partnership learning could usefully occur, and the Trust currently engages in these processes.

It should be noted that there may be Safeguarding related learning for the Trust in respect of Serious Case Reviews published at a national level, with which the Trust has not had any involvement. This is particularly so of Reviews in which the provision of acute hospital care was a component of services provided to the child, young person or to their family. Although the NSPCC maintain a national repository of Serious Case Reviews there is no fail safe mechanism for capturing all SCRs featuring acute trust services.

7. Training and Staff Knowledge

The Trust provides comprehensive training packages in place which are in line with the recommendations of the Safeguarding Children and Young People Intercollegiate Guidance (NB new version published January 2019). As nearly all face to face Training is provided directly by members of the Trust Safeguarding Children's Team (unlike some Trust we do not use external trainers), this is an area of some pressure. Both our local LSCBs provide Safeguarding Training, and this is an area which the Trust could arguably use more of, although the training is generic and not designed with the specific needs of staff providing care in an inpatient setting in mind.

Staff are assessed on what level of training is required depending on which department they will be working in, however, all staff at the Trust (regardless of their role) are required to have Level 1 training. Level 1 training is part of MAST on line and is mandatory for all staff, while level 2 children's safeguarding training is available as both face to face sessions and e-learning. As well as core training the team also deliver bespoke training for staff groups as required. During the course of the previous year, the Safeguarding team have expanded the

level of training offered on Domestic Abuse and Child Sexual Exploitation and incorporated CP-IS into bespoke training. It will be noted that the Trust's compliance with Prevent training has very substantially improved – the availability of Prevent training as an E-learning exercise has been a key component in enabling this.

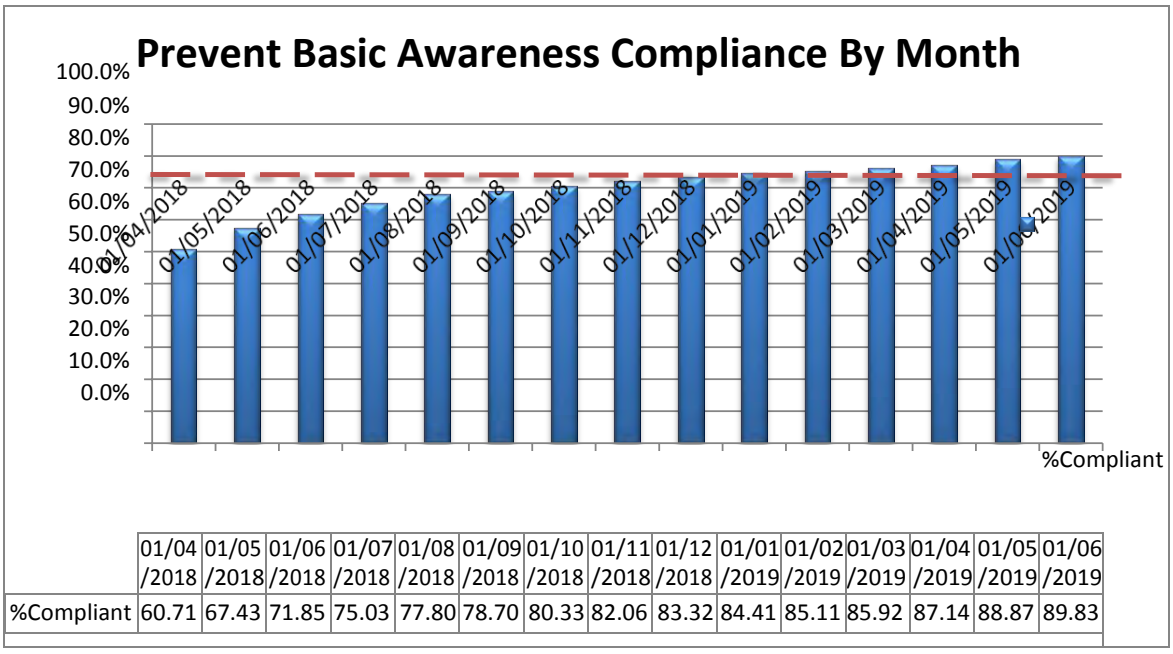
Please see the graphs below for performance on a month by month basis over the reporting year. Ensuring that sufficient Level 3 provision is offered, and that staff access training offered in a timely manner, remains the key training challenge for the team.

The table below provide an outline of the areas covered within safeguarding training:

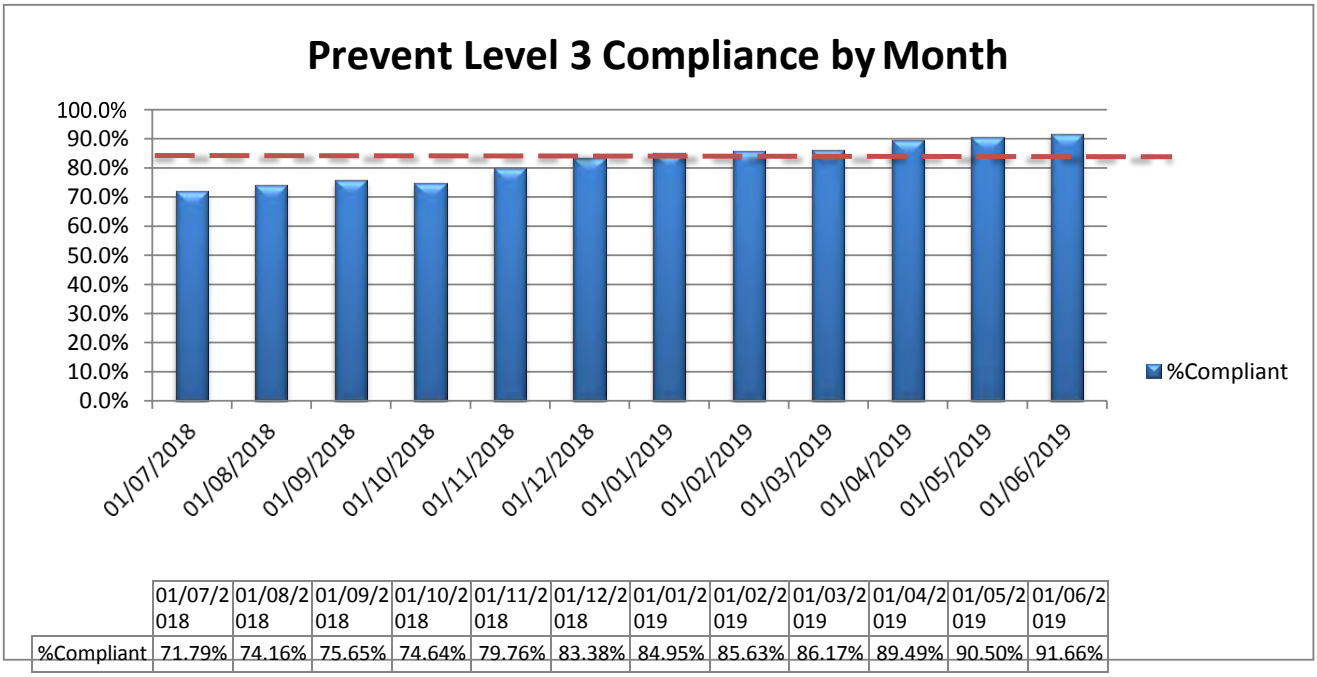
Training – topics covered	
Safeguarding policies, procedures and guidelines	Learning from Serious case reviews and individual management reviews
Signs of abuse	Role of LADO
Child sexual exploitation (CSE) and Human Trafficking	Fabricated Induced illness
Record keeping	Domestic abuse
How to make a referral	PREVENT
Female Genital Mutilation (FGM)	Private fostering
Managing allegations against staff	Mental Health

The compliance target is set at 85%. The tables below demonstrate the Trust quarterly and current performance for April 2017- March 2018.

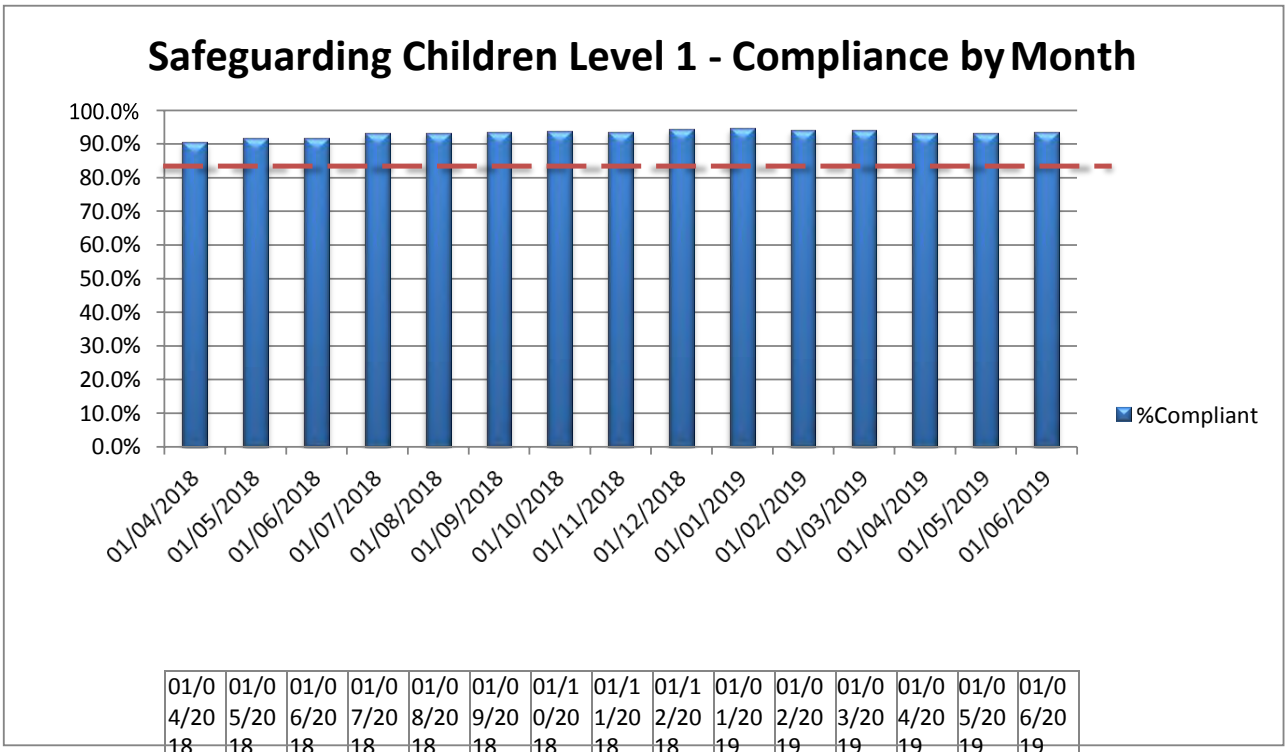
Please note that the training figures update overnight via the Trust ARIS system so the figures in this report are only correct at the time of extraction.



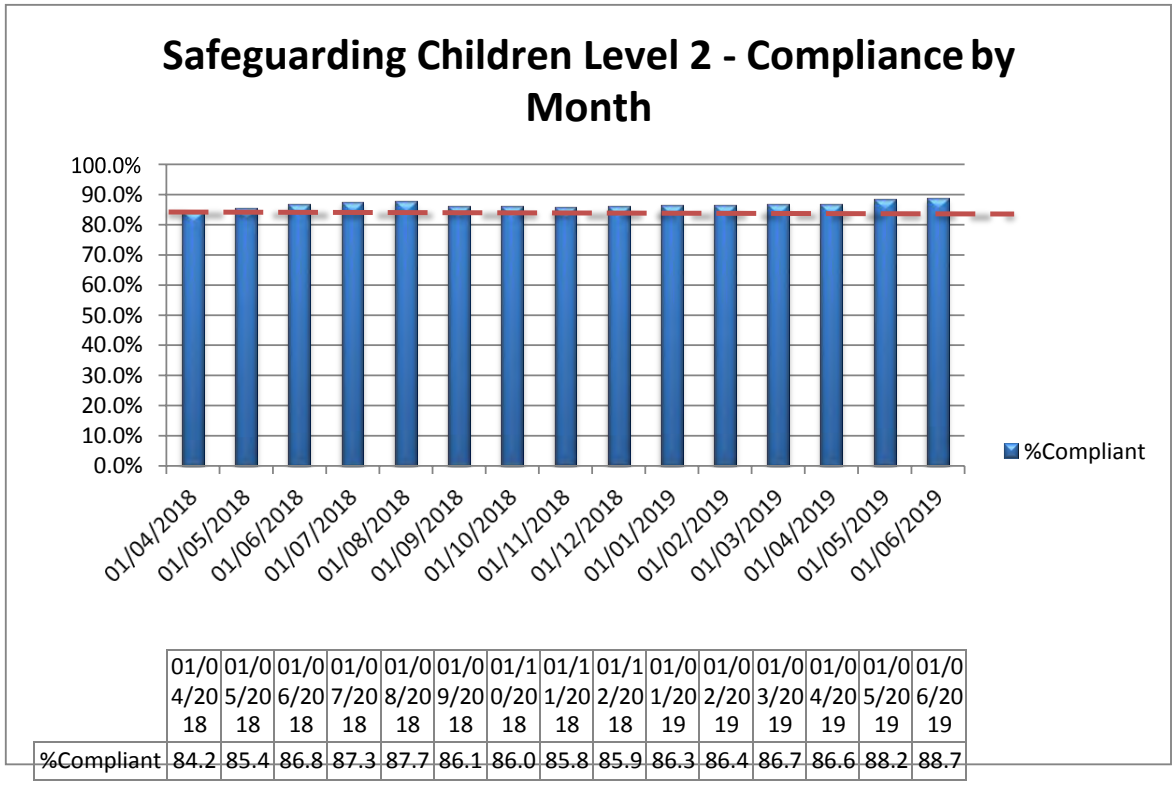
	01/04/2018	01/05/2018	01/06/2018	01/07/2018	01/08/2018	01/09/2018	01/10/2018	01/11/2018	01/12/2018	01/01/2019	01/02/2019	01/03/2019	01/04/2019	01/05/2019	01/06/2019
%Compliant	60.71	67.43	71.85	75.03	77.80	78.70	80.33	82.06	83.32	84.41	85.11	85.92	87.14	88.87	89.83



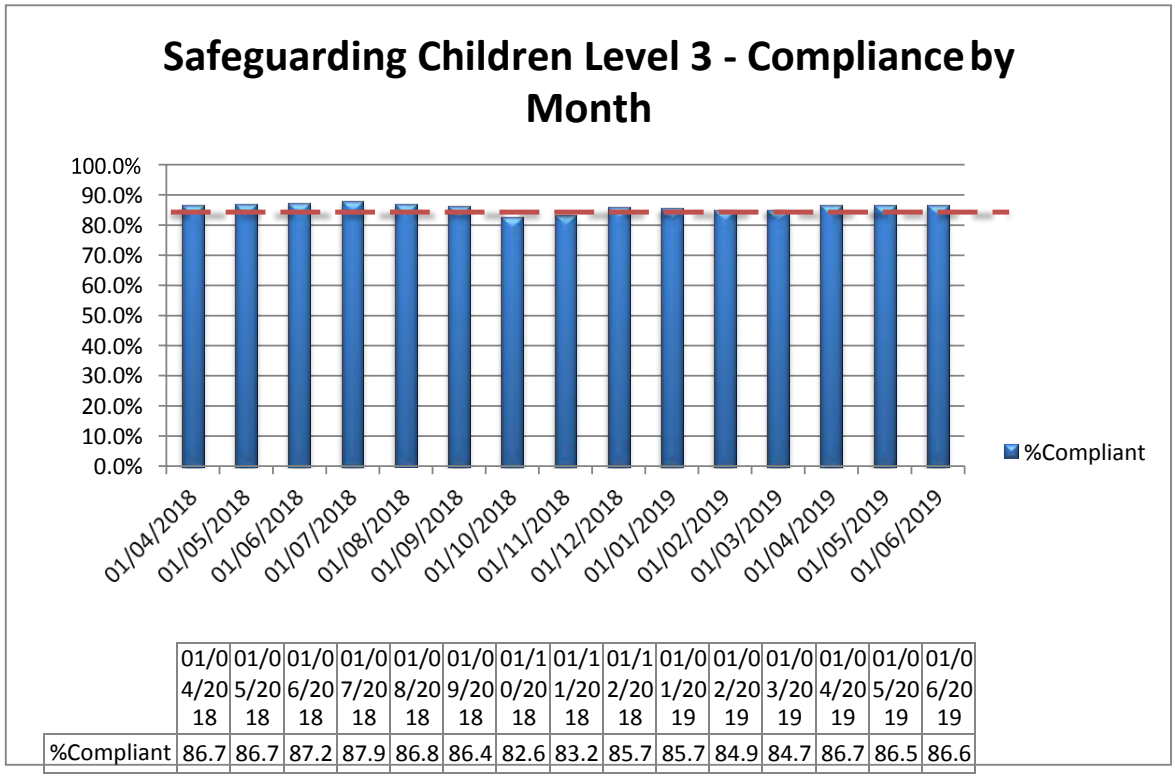
	01/07/2018	01/08/2018	01/09/2018	01/10/2018	01/11/2018	01/12/2018	01/01/2019	01/02/2019	01/03/2019	01/04/2019	01/05/2019	01/06/2019
%Compliant	71.79%	74.16%	75.65%	74.64%	79.76%	83.38%	84.95%	85.63%	86.17%	89.49%	90.50%	91.66%



	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	90.52	91.61	91.76	93.14	93.15	93.68	93.90	93.69	94.48	94.60	94.06	94.14	93.29	93.25	93.44



	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	84.2	85.4	86.8	87.3	87.7	86.1	86.0	85.8	85.9	86.3	86.4	86.7	86.6	88.2	88.7



	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	86.7	86.7	87.2	87.9	86.8	86.4	82.6	83.2	85.7	85.7	84.9	84.7	86.7	86.5	86.6

In addition the community SG named nurse provides half day sessions on FGM, CSE, DV and record keeping for all community practitioners.

In Maternity Level 3, is also a whole day session (7.5 hours) and staff have access to specialist topics e.g. FGM. Compliance is reported in the CWDT division data.

In the Acute services safeguarding children Level 3 has increased to a whole day session (7.5 hours) and incorporates specialist topics i.e. FGM, Child Sexual Exploitation (CSE) and raising an awareness of PREVENT.

Training compliance is monitored through the Trust Safeguarding Children's meeting and individual Divisional Performance Reviews. A list of staff that are non-compliant has been circulated to individual managers and a letter regarding expectation for compliance is drafted for circulation to staff by the Chief Nurse and Director of Infection Prevention and Control.

8. Supervision:

Health professionals are in a good position to identify safeguarding concerns and the needs of individual children. Effective safeguarding supervision can play a critical role in ensuring a clear focus on a child's welfare. Supervision should support practitioners to reflect on their decisions and the impact of their decisions on children and their family *(Working Together Safeguard Children March 2015).*

The RCN guidance for Nurses, *Safeguarding Children And Young People* (2014) states that local arrangements for safeguarding supervision must be robust, meet the specific needs of staff and demonstrate the effective discharge of NHS Trust statutory duties to safeguard and promote the welfare of children and young people

The 4 main functions of supervision are;

- **Management**: Supervision allows the opportunity to review how specific cases are managed within the Trust and assessing risk; ensuring that staff are competent and accountable for safeguarding practice.
- **Mediation:** Escalating concerns within the Trust and with partner agencies.
- **Developmental:** CPD - Reviewing the safeguarding training needs of the practitioner.
- **Supportive:** This function allows practitioners a time for reflection focusing on the impact of decision making and emotional resilience.

Following the expansion and centralisation of the Safeguarding Team a review of current supervision arrangements within the Trust is taking place. The Safeguarding Team is committed to supporting all staff working with children and young people across the Trust and we are in the process of developing a 'supervision group' model to most effectively support staff, commencing with Paediatrics and Emergency Department staff. The Named Nurse, is leading this work and is liaising internally, and with other Trusts to seek to harness available learning from colleagues on a regional basis. The team are also developing mechanisms to more effectively capture Safeguarding supervision as it occurs (in a similar way to which training compliance is logged via the ARIS system), so as to 'flag' staff members who have not had supervision for a sufficient period. This area of work is the single most significant, Trust-wide area of development for the Safeguarding Children's Team.

9. Partnership Working:

Following the passage of the Children and Social Work Act 2017 and the publication of updated Working Together Guidance in July 2018 this is an area of significant change. In summary, Local Safeguarding Children's Boards will cease to exist in September 2019, and will be replaced by Safeguarding Children's Partnerships, which are constituted by the Local Authority, the Police and 'Health' (as represented by the CCG). Both Wandsworth and Merton are in the process of publishing their final arrangements, which in each case involves Health being represented by the CCG at the Safeguarding Partnership. The Trust will likely continue to play a role in local partnerships through Sub-Groups and Committees, but the exact nature of these arrangements is still to be determined. In the view of the Trust Head of Safeguarding it will be important to continue to build local relationships with key safeguarding partners, which can be so important in addressing issues and concerns which might arise in relation to individual safeguarding practice.

During the previous reporting year, it should be noted that Wandsworth Council's Children's Services were re-inspected by OFSTED, and they now have a rating of 'Requires Improvement to be Good'.

At the Trust, we are fully committed to partnership working at an Operational and Strategic level. The Safeguarding Team frequently participate in two specific types of meeting, although they also take part in many others (such as child protection conferences for children and young people who are inpatients or where the Trust has significant information or analysis to contribute to a multiagency plan), these are detailed below:

Discharge Planning Meeting: These meetings occur to plan the care upon discharge which is needed for an individual child, and may take place for a number of reasons, and may occur following a Strategy Meeting (see below). Discharge planning meetings take place for a wide range of reasons; for example to plan support for parent(s) who have complex or vulnerable circumstances and a child with additional needs, or to help plan the care for a child who is going to enter foster care. Discharge planning meetings should normally involve the parents or carers, and the local authority.

Strategy Meeting: This is a specific meeting between agencies, and chaired by the local authority, which occurs under the auspices of section 47 of the Children Act 1989, and occurs when a local authority is investigating whether a child may have suffered, or be likely to suffer 'significant harm'.

Strategy meetings can agree that a 'single agency' investigation is led by the Local Authority or a 'joint agency' investigation occurs which is a joint investigation by the Local Authority and the Police. Trust staff will often provide specific information to partners in a strategy meeting to information their investigation, such as helping to understand a child's specific medical presentation, or to consider the potential causation of an injury. Strategy meetings do *not* directly involve the child or their parents/carers.

Escalations: a developing area of work in relation to Safeguarding is ensuring that Local Safeguarding Board Escalation Policies are properly applied and understood. Escalation is essentially raising (generally at a more senior level within an agency) concerns about the response from another agency, and is most likely to occur within a Trust context when the Safeguarding Team, in consultation with treating clinicians do not feel that the response from a local authority children's social care department is proportionate to the level of safeguarding need in a specific case. On our own part the team seeks to be open and transparent and are always receptive to queries or challenges from partners about any identified issues about Safeguarding practice in the Trust.

The Head of Safeguarding is seeking to develop contacts in local boroughs so that there are clearer routes for escalation in respect of such cases, when they do occur, although given the immense pressure on the housing market across London it seems unlikely this will be an area of work in which there are any obvious or easy solutions.

In respect of Policing, there are very substantial changes to the Metropolitan Police's response to Safeguarding in terms of the organisation of the Command dealing with Child Abuse, Domestic Violence and Sexual Offences. Whilst this should not have an impact on the day to day work of the Safeguarding Children's' team or of other Trust staff, it will be important to bear in mind when working with the Police on complex operational matters. The Head of Safeguarding will continue to monitor the potential impact of these developments at the Safeguarding Boards.

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 Children's Boards (although this may change following the full implementation of Safeguarding Children's Partnerships).

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) Kingston, Lambeth, Croydon and Surrey; these being areas in which we have fewer current links. Developing more effective operational and strategic links with these boroughs is a priority for the future.

Key activities during the reporting year has included a far more robust use of escalation strategies in instances when the Trust Safeguarding Team feels that appropriate Safeguarding action has not been undertaken by a Safeguarding partner. Normally this involves an escalation to a more senior level in a local authority, but has also involved a professional challenge to the Metropolitan Police on occasion. Often the Trust will request that a face to face meeting is convened to review the issues in a case, and in order to fully understanding the safeguarding risk and concerned. Although escalations (by the Named Nurse or the Head of Safeguarding) have involved a wide range of cases, there seems to be a substantial number involving the response of local authorities to older teenagers.

The Team is closely focused on ensuring that when required, that Local Authorities convened strategy meetings in respect of relevant cases; these should be hosted in hospital in respect of children who are inpatients, but the Trust is able to share information and take part in meetings following discharge where this is necessary and proportionate.

10. Child Protection Medicals:

The Trust is responsible for providing specialist Paediatric medical examinations of children and young people who may have experienced abuse or neglect (and where there is an indication of the need for a medical examination), and close partnership with Wandsworth Council's children's services is a key part of this role. It is highly likely children for whom the local authority applies to Court for an Interim Care Order will have had a child protection medical, and the medical can be important in helping determine whether or not a police investigation should proceed alongside a local authority led intervention. Therefore, these examinations have both 'welfare' and a 'forensic' components and effective, child-centred partnership working are of key important in this regard, and sensitivity to a children's wellbeing is essential for all involved in the process (i.e. examining doctors and social workers who attended the medicals generally alongside parents/carers).

A recent audit demonstrated that the Trust is responding promptly and effectively to requests for medical examinations from the Local Authority (referrals are made by Social Workers as

part of a 'section 47 child protection investigation) however it highlighted the need for referrals to be made promptly and efficiently. This important and sensitive area of work will be an important area for continued review.

11. Liaison with the Local Authority Designated Officer:

The Head of Safeguarding and the Named Nurse for Safeguarding Children work closely with the Wandsworth Council 'LADO' (Local Authority Designated Officer). The Trust has a duty to report to the LADO any instances in which it is alleged that a person who works with children (as an employee or as a volunteer) has;

- behaved in a way that has harmed, or may have harmed a child;
- possibly committed a criminal offence against or related to a child; or
- behaved towards a child or children in a way that indicates they may pose a risk of harm to children,

Whilst the Trust has a duty to inform the LADO of relevant cases (or to seek their advice regarding a referral), the LADO has a duty to provide advice, and to co-ordinate an Allegations and Staff and Volunteers Meeting (ASV meeting), the Trust retains ownership of all HR processes and procedures in this area.

This duty applies to allegations relating to the workplace, or in the employee's/volunteer's personal life. In the former category it will generally be the Trust who refers to the LADO, and in the latter category, unless the employee informs their manager directly, the LADO is likely to refer to the Safeguarding Team at the Trust. This is a complex and sensitive area of the Trust's work, and involves close liaison between the Trust Human Resource department and the safeguarding team. The Safeguarding Team are confident that we are compliant with all processes in this area, but are working with the Human Resources department in order to further develop agreed processes to deal with any related issues as they might arise.

During the reporting year the LADO has, when required, made contact with the Safeguarding team at the Trust to notify us about relevant information or to seek information or clarification. We hope to continue to build upon this important relationship in 2019/20.

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

There is also a Clinical Midwife Specialist for Domestic Abuse who 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 which is 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 anyparticular 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)*

13. Child Protection Information System (CP-IS)

The Child Protection Information Sharing project (CP-IS) is a national system designed to ensure that health staff working in unplanned care settings, such as emergency departments, are notified when a child or young person attends, who is the subject of a child protection plan anywhere in England, or is looked after by any English local authority.

At the time of the previous annual report, South-West London Local Authorities were a regional outlier, and had been slower to adopt CP-IS than authorities across the rest of London. This delay has now been addressed and all local boroughs are now live on CP-IS. There remains a need to ensure that staff are appropriately trained and refreshed in the use of the system.

It has been important to highlight to staff that the existence of a CP-IS indicator does **not** remove or change the need for a safeguarding referral to be complete in respect of cases in which this is warranted. At a Local Authority end, the child's social worker simply receives an electronic notification that the child attended the Trust, and does *not* receive further details via the CP-IS system itself regarding the reason for the attendance. Therefore this information still needs to be shared via phone / secure email.

The Trust continues to received regular lists of children subject of Child Protection plans, or who are looked after, from our local boroughs, so in practice this means that the main benefit of CP- IS is likely to be in cases in which a child's child protection/looked after status was not known, or was concealed from, unscheduled care staff, and these are more likely to be from outside the South London area.

Further information regarding CP-IS can be found on the NHS Digital website (see link below) or obtained from the Head of Safeguarding.

https://digital.nhs.uk/services/child-protection-information-sharing-project

14. Female Genital Mutilation (FGM):

The Trust 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. The consistency of practice in this area will be a priority for the incoming Named Midwife for Safeguarding Children to help address. Over and above the foregoing, the Safeguarding team also ensures that FGM is treated as a Safeguarding issue where required.

Partnership working is an essential part of the effective response to FGM and the Trust convenes a bimonthly Working Group, which is also attended by colleagues from Wandsworth Council. The Trust's response and that of other agencies, in respect of FGM related practice is also reviewed by the Local Safeguarding Children's Boards. The group has just agreed an audit process and outline timescale to provide an updated report on the Trust's FGM work to Wandsworth Safeguarding Children's Board.

FGM training is an important part of Level 3 Safeguarding Children's training and a more basic introduction to FGM forms part of the Trust Induction for all new starters to the Trust, whatever their role. We have also produced a leaflet for patients in partnership with Wandsworth Council, designed for patients who may have questions about FGM- the leaflet will be made available in key languages to increase its impact.

15. The Prevent Strategy

All NHS Trust's are obliged to adhere to the Government's Prevent strategy. Whilst the Prevent Duty is relevant to both our children and adult safeguarding functions, fuller commentary regarding the Prevent Strategy at the Trust can be found in the Adult Safeguarding report. In brief, the key achievement in relation to Prevent during the financial year was increasing the Trust's compliance levels from a low level to compliance to a very healthy state, considerably above the agreed 85% target.

16. The wider picture/contextual safeguarding

It is important to reference in this report that the multiagency Safeguarding system which has developed since the advent of the Children Act 1989 is most evolved, adept and resilient to safeguard children who are at risk of, or who have experienced, abuse or neglect *within a family setting.* It is important to note key continuities and differences between harm and abuse within a family setting, and harm and abuse that children and young people (frequently, but far from exclusively, teenagers) may experience in community settings, away from home, such as Child Sexual Exploitation or Peer on Peer violence. In essence, and in common with all statutory agencies, our Safeguarding systems are built around addressing child protection issues occurring within a family setting, and there is a considerable process of service development and evolution required for us to be equally confident that we are equally as adept at addressing 'non-familial' child safeguarding issues. There are a number of areas which are piloting new approaches in this area, and it is an area in which partnership working is of particular importance.

Both Merton and Wandsworth Local Authorities have undertaken considerable work in respect of contextual safeguarding during the reporting year, and the Safeguarding Team will be meeting the CSE/Contextual Safeguarding lead from Wandsworth in the near future. The Safeguarding Team are frequently involved in responding to case of children and young people who have presented to the Emergency Department following a violent injury sustained outside a family setting, and the staff at the Trust remain alert to Child Sexual

Exploitation, although it is important that the Safeguarding team collate and cascade information, research and training into areas in which the national learning profile is developing i.e. County Lines. It is important for the Trust to be mindful of the distinct role which Emergency Departments, and the accessible nature of the care which they provide, can have in relation to Contextual Safeguarding issues. During the reporting year staff at the Trust identified pertinent safeguarding issues in relation to a number of vulnerable young people and the Safeguarding team provided support to ensure that these were addressed as appropriate.

17. Key risks/challenges in respect of Children's Safeguarding

Key risks and challenges for the service at present include:

- Nationally and regionally (within London) there is an overall profile of rising levels of need and vulnerability amongst children and young people, and an increasing demand upon 'child protection' services, with the number of children coming into local authority care having rising almost every year since 2008 (although there is a relatively recent indication that this trend is now levelling off to a degree). Although community based services will be a the 'forefront' of responding to this trend, there is likely to be a continuing impact on the work of the Safeguarding team at the Trust, and also on Trust services themselves (for example, when local authorities ask for a 'social admission' of a children whilst an appropriate plan is put into place)

- There is much publicised national and regional increase in serious youth violence, which obviously has a direct impact Trust services, the Safeguarding team and our internal partners such as Redthread
- A number of local authorities with whom we work are experiencing significant issues in relation to the provision of Children's Services (specifically Croydon and Surrey) and there is a potential for considerable impact on the Safeguarding Team at the Trust. More positively Wandsworth Children's services are on an improvement profile and continue to maintain a sizeable team of social workers based at the Trust, which significantly enhances our capacity to responding swiftly and appropriately to Wandsworth Children with a Safeguarding need.

- There is a changing picture of legislation and regulation which will impact on the Safeguarding team, for example the abolition of Local Safeguarding Children's Boards. It will be important for the Trust to ensure that we maintain a visible presence in local safeguarding partnerships in what will be a time of transition and uncertainty.

- Serious Case Reviews have a significant time and resource impact of a small team, and are by way of definition difficult or impossible to 'plan' for. A 'surge' of Reviews would make potentially overwhelming demands on the team, and the methodology of grouping reviews into A, B and C categories will probably be of assistance in this respect.

- The Safeguarding team has particularly strong working relationships with colleagues who frequently liaise with Children's Services as part of their core duties, such as the staff in the Emergency Department and in Paediatrics. Importantly, the team is able to provide support and where necessary challenge, and also reflect upon feedback from frontline staff to further improve our own service. A key priority in the coming year is to develop equally strong links across the Trust, with all professionals and all departments, so that we are confident that we are providing Safeguarding support, challenge and assurance on a genuinely 'whole Trust' basis.

- Work on some recent cases has identified ways in which the Trust could work more proactively and cohesively with partner agencies in respect of children and young people with whom there is an identified and significant safeguarding need. Whilst we

are confident that all safeguarding duties have been complied with, review of cases has identified avenues for improved working in the future; for example instance in which information could have been shared on a more proactive basis, or where a comprehensive medical opinion in relation to a specific presentation could have been provided at a somewhat earlier stage. It is highly likely that all agencies working on individual, complex/high profile safeguarding cases could identify areas of improvement in a reflective audit, and it is important that in the Safeguarding team that we set a clear example for accountable and reflective practice in this regard.

18. Conclusion:

In essence the work of the Safeguarding Children' team encompasses four strands, and all areas will need to continue to be addressed and developed in the year ahead, which will need to take into account available resources.

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 Children's 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 Children's team, including CCG and local Safeguarding Children 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 Children's 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 Children's team, and provides assurance that there are appropriate structures and training in place to support high quality safeguarding practice across the Trust.

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

St George's University Hospitals NHS
NHS Foundation Trust

3.1

Meeting Title:	**Trust Board**		
Date:	25 July 2019	**Agenda No**	**3.1**
Report Title:	**Finance and Investment Committee (Core) Report**		
Lead Director/ Manager:	Ann Beasley, Chairman of the Finance and Investment Committee		
Report Author:	Ann Beasley, Chairman of the Finance and Investment Committee		
Presented for:	Assurance		
Executive Summary:	The report sets out the key issues discussed and agreed by the Committee at its meeting on the 18th July 2019.		
Recommendation:	The Board is requested to note the update.		
Supports			
Trust Strategic Objective:	Balance the books, invest in our future.		
CQC Theme:	Well Led.		
Single Oversight Framework Theme:	N/A		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A
Appendices:	N/A		

St George's University Hospitals NHS
NHS Foundation Trust

Finance and Investment Committee (Core) – July 2019

The Committee met on 18 July and in addition to the regular items on strategic risks, operational performance and financial performance, it also considered a paper on the Elective Care Recovery Programme , Costing and PLICS, updates on the Financial Planning for 2019/20, the CQC's planned review on 'Use of Resources', a Technical Releases update and Procurement report.

Committee members discussed the BAF risks on finance and IT and welcomed the new format. The overall conclusion was that the proposed mitigating actions were both necessary and sufficient to increase the level of assurance, once implemented, from limited to reasonable. The Committee welcomed the fact that for the second successive month, activity for both elective and day cases, as well as outpatients, were ahead of plan. Members noted that on RTT many indicators were ahead of trajectory and took assurance from the COO's explanation of the Cancer recovery plan which is in place and set to deliver in July. There remains work to be done on the ED recovery plan and challenges continue as the Trust moves towards winter. The Committee noted that the financial position is currently on plan but recognised the challenges with pay expenditure and the risks around the introduction of some block contracts. The committee members welcomed the procurement report and the positive work done by that team.

The Committee wishes to bring the following items to the Board's attention:

1.1 Finance Risks- the Chief Financial Officer (CFO) gave an update on financial risks. He noted a change to the scoring of two functional risks. The Committee concluded that while there are risks categorised as 'limited' assurance, the Committee has good assurance on the plans to mitigate these risks. The assurance will remain as limited assurance until the mitigations are in place.

1.2 ICT Risks- the Chief Financial Officer (CFO) gave an oral update on ICT risks. The Committee welcomed this update.

1.3 Activity- the Chief Transformation Officer (CTO) updated the Committee on the positive performance against activity targets in elective and daycase procedures in June. The Committee was encouraged by this information.

1.4 Cancer update - the Chief Operating Officer (COO) noted the challenge on both 62 day and two-week rule cancer targets in May, which is expected to improve for June. The Committee discussed the recovery plan in place which it was confident would return the Trust to an improved Cancer performance.

1.5 Emergency Department (ED) update - the COO noted the slightly improved Emergency Flow performance (87.0% in May). The Committee reflected that more work was required to give confidence in improved ED performance in the coming months.

1.6 RTT/ECRP Review- the COO updated the Committee on Referral to Treatment (RTT) targets. Performance of 86.6% against the 92% Incomplete Pathway target was ahead of agreed trajectory and June is expected to be ahead of trajectory as well. He also noted the 52 week performance as being ahead of trajectory.

The COO also observed that PTL reporting has seen significant improvement. There remains challenges in Outpatients owing to vacancies and sickness of the booking staff however the committee was informed that there has been recruitment in these areas. The Committee welcomed this progress.

1.7 Financial Performance- the Deputy CFO noted performance to date at month 3 was in line with plan showing a £21.7m Pre-PSF/FRF/MRET deficit. He explained some of the challenges on income estimation, from activity yet to be coded and the impact of block contracts with some commissioners. He also observed some of the work required on divisional pay expenditure overspends. The Committee noted these challenges.

1.8 Financial Forecast- the Deputy CFO provided an update for the committee on the trust's financial forecast and noted the current risks outlined in the paper that if left unmitigated would result in an adverse year end position. The Committee noted the commitment of members to delivering the financial plan in 2019/20.

1.9 Costing, SLR and PLICs – this update was noted by the committee. The Committee **delegated authority** for approval of the final submission of the National Cost Collection and Reference Cost return to the CFO. The Committee noted the Use of Resources update and an update on Technical releases.

1.10 Procurement report - The Committee was updated on the Procurement department's performance for Quarter 1, and noted good improvement. St Georges is reported to be the best Trust in SWL against the model hospital metrics. The Committee commented that this was a great improvement from last year and thanked the department for their achievements.

2.0 Recommendation

2.1 The Board is recommended to receive the report from the Finance and Investment Committee (Core) for information and assurance.

Ann Beasley
Finance & Investment Committee Chair,
July 2019

St George's University Hospitals NHS
NHS Foundation Trust

3.2

Meeting Title:	**Trust Board**		
Date:	25 July 2019	**Agenda No**	**3.2**
Report Title:	**Finance and Investment Committee (Estates) report**		
Lead Director/ Manager:	Tim Wright, Lead Non-Executive Director, Estates		
Report Author:	Tim Wright, Lead Non-Executive Director, Estates		
Presented for:	Assurance		
Executive Summary:	The report sets out the key issues discussed and agreed by the Committee at its meeting on the 18 July 2019.		
Recommendation:	The Board is requested to note the update.		
Supports			
Trust Strategic Objective:	Balance the books, invest in our future.		
CQC Theme:	Well Led.		
Single Oversight Framework Theme:	N/A		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A
Appendices:	N/A		

St George's University Hospitals NHS
NHS Foundation Trust

Finance and Investment Committee (Estates) – July 2019

This Part 2 FIC meeting has been set up on a monthly basis to provide more comprehensive assurance on Estates risks in the Trust. The Committee met for the third time on 18 July.

It was a constructive and helpful meeting at which members received the balance of Authorising Engineer (AE) reports for Estates domains. The Committee now has its first complete picture of the risk landscape and a better understanding in the higher risk areas of the nature of works required. There remains however significant work ahead to produce detailed work plans and schedules but the methodology that the team is developing with a single dashboard and short, medium and longer term plans per discipline is bringing together a consistent, time-based view which will be helpful to the Committee in confirming levels of assurance and statutory compliance.

It is clear that a lot of data on the current state is being collected and that progress is being made on collating this in a manner in which it can be maintained up-to-date. Following the award last month of the Procure22 contract capital works are being mobilised. There is concern about the internal capacity to manage this activity and additional resource is being sought.

The Committee wishes to bring the following items to the Board's attention:

1.1 Estate Management Group (EMG) Report from meeting 01/07/19 - the CFO introduced a report on the key actions and issues from the meeting. The committee noted good engagement with the team and the broad range of issues that are being covered. Clear focus is being given to high risk areas and issues of compliance whilst the team are also now scoping a 6-facet survey which will provide a more comprehensive update on the As-Is state.

1.2 Strategic Risk Review –The committee received a paper on the 2 key strategic risks SR9 "there is a risk that we are unable to deliver an estates strategy that supports the delivery of our clinical services strategy" and SR10 "there is a risk that we do not improve our estate to provide a safe environment for our patients and staff". There followed a good discussion on the appropriate level of risk decomposition and the need to ensure that the mitigations of these risks join up over time. Further work is to be done over the next 3 months to produce a schedule of risk reduction as detailed plans are developed for each discipline.

1.3 Premises Assurance Model (PAM) – the CFO introduced a paper on the progress of the Programme. The Tooting site review has been completed, with the final report to be presented to EMG, TEC and FIC [E] in August 2019 and Trust Board in September 2019**.** There is a plan to review PFI buildings and Community premises this summer.

1.4 CQC Deep Dive into Estates 08th July – The Committee received a report which drew together the outcomes of a CQC deep-dive. This included a summary of our compliance with HTM00 drawn from AE reports and a standardised dashboard for each discipline highlighting Issues, Drivers of issues and short, medium and long term mitigations. The Committee found this a very helpful 'summary on a page' and assurance of the systematic approach to risk mitigation.

1.5 Authorising Engineer (AE) Reports Overview- Reports for all disciplines have now been received and reviewed. The Committee welcomed the standard format summaries that have now been produced. It was noted that AE reports are an essential part of assurance, but do not of themselves provide a complete risk rating. From an assurance perspective the Committee wants to identify and understand the criticality of risk items and the difficulty of remediation. The CFO agreed the team would produce a summary of critical actions required for each report with a plan to resolve issues.

1.6 Water Safety: Points of Use (POU) Filters- the CFO introduced a paper with a detailed plan of how POU filters are being managed across the estate. The Chief Nurse confirmed that the procedures for managing filters was working very well, that clinical staff were aware of the importance of reporting missing or damaged filters quickly and that Estates were very responsive to requests for replacement.

1.7 Health & Safety - The Committee received a Health and Safety update from the Assistant Director of Health & Safety, Fire and Security. It was noted that full surveys are still in process and that a comprehensive risk-based fire safety action plan is being developed. The team are seeking to upgrade fire compartmentalisation protection to 60 minutes in all areas and the Committee discussed the challenge of achieving this in all buildings. The HSE action plan is being monitored and will be taken by the CFO to be reviewed by EMG and TEC and FIC E by exception.

1.8 Estates Strategy Update- the CFO introduced a paper on the approach to be taken to producing the Estates Strategy. The Committee noted the approach, issues, strategic priorities and system wide impacts that needed to be considered and looked forward to engaging further as the work goes forward.

1.9 Reflections- the Committee were grateful to the Estates team for the manner in which they presented often complex technical issues and welcomed the consistency that was being brought to the presentation of risks, issues and mitigations across all of the Estates disciplines which gave greater visibility of issues.

2.0 Recommendation

2.1 The Board is recommended to receive the report from the Finance and Investment Committee (Estates) on18 July 2019 for information and assurance.

Tim Wright
Lead Non-Executive Director, Estates
July 2019

St George's University Hospitals NHS
NHS Foundation Trust

3.3

Meeting Title:	**TRUST BOARD**		
Date:	**25 July 2019**	**Agenda No.**	**3.3**
Report Title:	**M03 Finance Report 2019/20**		
Lead Director/ Manager:	Andrew Grimshaw, Chief Financial Officer		
Report Author:	Michael Armour, Reporting Accountant Tom Shearer, Strategic Finance Manager		
Presented for:	Update		
Executive Summary:	The Trust has reported a deficit to date in M3 of £21.7m 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 £3.5m which is in line with plan. The Trust has recognised £5.9m of PSF/FRF/MRET funding YTD to Month 3 in line with plan. The Trust also recognised £0.5m of prior year PSF as discussed at the Finance & Investment Committee in June.		
Recommendation:	The Trust Board is asked to note the Trust's financial performance in M3 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 & Investment Committee	Date	18th July 2019
Appendices:	N/A		

TB Jul 19

3.3

Financial Report Month 03 (June 2019)

Chief Finance Officer

25th July 2019

Executive Summary – Month 03 (June)

St George's University Hospitals NHS
NHS Foundation Trust

3.3

Area	Key issues	Current month (YTD)	Previous month (YTD)
Target deficit	**The trust is reporting a Pre-PSF/MRET/FRF deficit of £21.7m** at the end of June, which is **on plan**. Within the position, income is adverse to plan by £1.4m, and expenditure is underspent by £1.4m. **M3 YTD PSF/MRET/FRF income of £5.9m** in the plan has **been achieved** in the Year-to-date position, as the Trust is delivering the Pre-PSF /MRET/FRF plan. **£0.5m of Prior Year PSF** is included in the position following a re-allocation of the General PSF after finalisation of annual accounts.	On plan	On plan
Income	Income is reported at £1.4m adverse to plan year to date. SLA income is £0.7m over plan, mainly due to increased Elective activity. Non-SLA income is £2.1m adverse to plan, which is mainly owing to shortfalls in Pharmacy and Pathology income, both of which are offset by lower costs.	£1.4m Adv to plan	£1.4m Adv to plan
Expenditure	Expenditure is £1.4m favourable to plan year to date in June. This is caused by Non Pay favourable variance of £1.2m which is offset in other income. Pay is favourable to plan by £0.3m to date, where non-clinical pay is underspent owing to vacancies.	£1.4m Fav to plan	£1.4m Fav to plan
CIP	The Trust planned to deliver £3.5m of CIPs by the end of June. To date, £3.5m of CIPs have been delivered; which is on plan. Income actions of £0.5m and Expenditure reductions of £3.0m have impacted on the position. A £3.3m gap remains in Green schemes identified against the £45.8m target.	On plan	On plan
Capital	Capital expenditure of £11.9m has been incurred year to date. This is to plan. The current month YTD position is £11.9m and the previous month YTD position is £5.2m	£11.9m To plan	£5.2m To plan
Cash	At the end of Month 3, the Trust's cash balance was £3.2m. Cash resources are tightly managed at the month end to meet the £3.0m minimum cash target.	£0.2m Fav to plan	£0.1m Fav to plan
Use of Resources (UOR)	At the end of June, the Trust's UOR score was 4 as per plan.	UOR score 4	UOR score 4

St George's University Hospitals NHS
NHS Foundation Trust

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1. Month 03 Financial Performance

St George's University Hospitals NHS
NHS Foundation Trust

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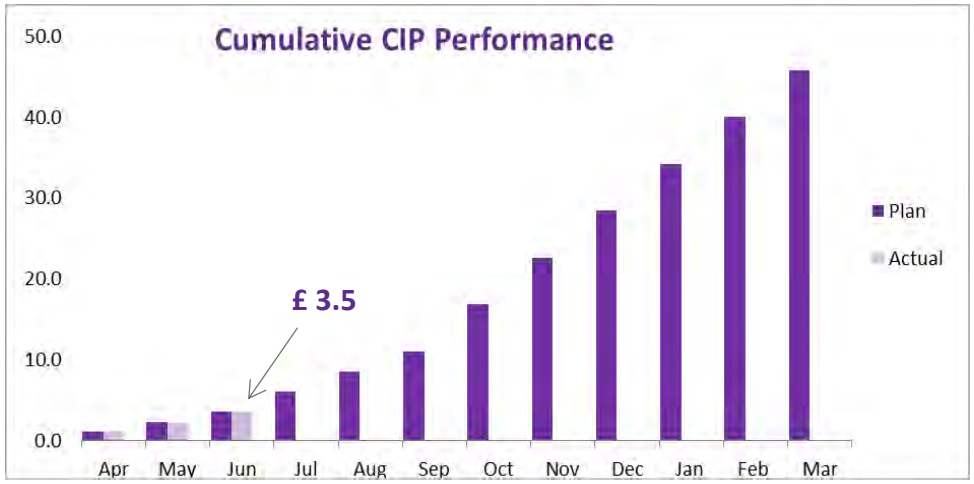
			Full Year Budget (£m)	M3 Budget (£m)	M3 Actual (£m)	M3 Variance (£m)	M3 Variance %	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)	YTD Variance %
Pre-PSF/FRF/MRET	**Income**	SLA Income	679.6	55.0	55.7	0.7	1.2%	166.4	167.1	0.7	0.4%
		Other Income	157.7	13.3	12.6	(0.7)	(5.3%)	39.6	37.5	(2.1)	(5.3%)
	Income Total		**837.3**	**68.3**	**68.3**	**(0.1)**	**(0.1%)**	**206.0**	**204.6**	**(1.4)**	**(0.7%)**
	Expenditure	Pay	(532.6)	(46.0)	(46.0)	0.1	0.2%	(139.3)	(139.0)	0.3	0.2%
		Non Pay	(306.1)	(26.4)	(26.5)	(0.1)	(0.3%)	(79.3)	(78.4)	0.9	1.1%
	Expenditure Total		**(838.7)**	**(72.5)**	**(72.5)**	**0.0**	**0.0%**	**(218.6)**	**(217.4)**	**1.2**	**0.5%**
	Post Ebitda		(36.3)	(3.0)	(2.9)	0.1	2.8%	(9.1)	(8.8)	0.3	3.0%
Pre-PSF/FRF/MRET Total			**(37.7)**	**(7.2)**	**(7.1)**	**0.0**	**0.5%**	**(21.7)**	**(21.7)**	**0.0**	**0.1%**
PSF/FRF/MRET			34.7	2.0	2.0	0.0	0.0 %	5.9	5.9	0.0	0.0 %
Total			**(3.0)**	**(5.2)**	**(5.2)**	**0.0**	**0.7%**	**(15.8)**	**(15.8)**	**0.0**	**0.2%**
Prior Year PSF			0.0	0.0	0.5	0.5	0.0 %	0.0	0.5	0.5	0.0 %
Grand Total			**(3.0)**	**(5.2)**	**(4.7)**	**0.5**	**10.4%**	**(15.8)**	**(15.3)**	**0.5**	**3.3%**

Trust Overview

- Overall the Trust is reporting a Pre-PSF deficit of £21.7m at the end of Month 03, which is on plan.
- **SLA Income** is £0.7m ahead of plan, after adjustment for block contract values. There remains a large level of estimation within the M3 income position due to delays in coding in some specialties.
- **Other income** is £2.1m under plan, which is owing to Pharmacy services income, and Pathology income, both of which are offset by reduced cost.
- **Pay** is £0.3m underspent. Non-Clinical pay underspend caused by vacancies is the main driver here.
- **Non-pay** is £0.9m underspent, mainly owing to reduced pass-through income.
- **PSF/FRF/MRET Income** is on plan at M03 YTD, at £5.9m. The Trust has met the pre-PSF control total target of a £21.7m deficit.
- **Prior Year PSF** of £0.5m is included in the position. This is the trust's element of the Post Accounts PSF adjustment for 2018/19.
- **CIP delivery** of £3.5m is on plan. Delivery to plan is:
  - Pay £0.3m favourable
  - Non-pay £0.1m adverse
  - Income £0.2m adverse

2. CIP Performance M03



YTD (£ m)			
Category	**Plan**	**Act**	**Variance**
Income	0.7	0.5	(0.2)
Pay	1.8	2.1	0.3
Non Pay	1.0	0.9	(0.1)
Total	**3.5**	**3.5**	**(0.0)**

2019/20 (£ m)			
Category	**Plan**	**Green Schemes**	**Variance**
Income	9.4	7.0	(2.4)
Pay	23.4	19.2	(4.2)
Non Pay	13.0	16.3	3.3
Total	**45.8**	**42.5**	**(3.3)**

CIP Delivery and Variance

- CIP delivery at the end of M3 is on track compared to plan
- CIP plan Green rating has improved by £0.7m to £42.5m from the position reported at June FIC which is 93% of the target

CIPs at Risk / Under Delivery

- The CIP delivery profile steps up at M7, by when the £3.3m gap to 100% Green will need to be closed, to assure 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 £42.5m
- In addition, all divisions have been asked to identify further CIP schemes that relate to discretionary spend.
- Divisions continue the work to translate existing amber, red and pipeline CIP schemes to Green

3. Balance Sheet as at Month 03

St George's University Hospitals NHS
NHS Foundation Trust

	Mar-19 Audited Account (£m)	Revised Y/E Plan 31.3.2020	YTD Revised Plan (£m)	YTD Actual (£m)	YTD Variance to Plan (£m)
Fixed assets	**390.5**	**408.8**	**393.2**	**396.3**	**3.1**
Stock	**7.8**	6.5	6.5	7.6	1.1
Debtors	**101.9**	84.2	96.1	93.1	-3.0
Cash	**3.2**	3.0	3.0	3.2	0.2
Creditors	**-122.4**	-86.5	-107.4	-109.1	-1.7
Capital creditors	**-4.3**	-3.6	-12.4	-12.4	0.0
PDC div creditor	**0.0**	0.0	0.0	0.0	0.0
Int payable creditor	**-1.2**	-1.2	-1.2	-2.3	-1.1
			0.0		
Provisions< 1 year	**-0.5**	-0.4	-0.4	-0.4	0.0
Borrowings< 1 year	**-57.6**	-82.5	-78.8	-73.5	5.3
Net current assets/-liabilities	**-73.1**	**-80.5**	**-94.6**	**-93.8**	**0.8**
Provisions> 1 year	**-1.0**	0.0	0.0	-1.0	-1.0
Borrowings> 1 year	**-284.3**	-299.3	-282.5	-284.9	-2.4
Long-term liabilities	**-285.3**	**-299.3**	**-282.5**	**-285.9**	**-3.4**
Net assets	**32.1**	**29.0**	**16.1**	**16.6**	**0.5**
Taxpayer's equity					
Public Dividend Capital	**133.4**	133.4	133.4	133.4	0.0
Retained Earnings	**-213.4**	-216.5	-229.4	-228.9	0.5
Revaluation Reserve	**110.9**	110.9	110.9	110.9	0.0
Other reserves	**1.2**	1.2	1.2	1.2	0.0
Total taxpayer's equity	**32.1**	**29.0**	**16.1**	**16.6**	**0.5**

M03 YTD Balance Sheet

- **The previous slide explains the variance between the previous and the revised plan, in this slide we are using the revised YTD plan as a comparison to YTD actual.**
- Fixed assets are £3.1m higher than year end. This includes depreciation charges and capital spend to month 3 .
- Stock is £1.1m higher than plan, mainly due to an increase in pharmacy area.
- Debtors is £3m lower than plan in month and has reduced by £8.8m from March 2019. target reduction of £ 18m by year end is being actively pursued.
- Creditors are £1.7m higher than plan in month. However have been reduced by £13.3m since March 2019.
- Capital creditors are matched to the plan. This includes accruals for commitments to June.
- £10.3m of capital loan was received as at June subject to an interest rate of 1.55%. The Trust has requested drawdown of capital loan in July of £2.1m with the same interest rate as in June.
- The cash position is £0.2m higher than planned. Cash resources are tightly managed at the month end to meet the £3.0m minimum cash target.
- The Trust requested and received working capital loan of £11.6m in April and May to fund the current year deficit as per submitted plan. No loan was drawn in June and July.
- The deficit financing borrowings are subject to an interest rate 3.5%.

4. Cash Flow summary M03

St George's University Hospitals NHS
NHS Foundation Trust

3.3

	Revised YTD Plan £m	YTD Actual £m	YTD Variance £m
Opening Cash balance	**3.2**	**3.2**	**0.0**
Income and expenditure deficit	-16.0	-15.5	0.5
Depreciation	6.0	6.1	0.1
Interest payable	3.2	3.0	-0.2
PDC dividend	0.0	0.0	0.0
Other non-cash items	0.0	0.0	0.0
Operating deficit	**-6.8**	**-6.4**	**0.4**
Change in stock	1.3	0.2	-1.1
Change in debtors	6.2	9.2	3.0
Change in creditors	-10.4	-13.2	-2.8
Net change in working capital	**-2.9**	**-3.8**	**-0.9**
Capital spend (excl leases)	-12.0	-3.8	8.2
Interest paid	-1.9	-1.9	0.0
PDC dividend paid	0.0	0.0	0.0
Other	-1.1	-0.2	0.9
Investing activities	**-15.0**	**-5.9**	**9.1**
Revolving facility - repayment	0.0	0.0	0.0
Revolving facility - renewal	0.0	0.0	0.0
WCF borrowing - new	20.0	11.6	-8.4
Capital loans	9.3	9.3	0.0
Loan/finance lease repayments	-4.8	-4.8	0.0
Cash balance 31.5.19	**3.0**	**3.2**	**0.2**

M01-M3 YTD cash movement

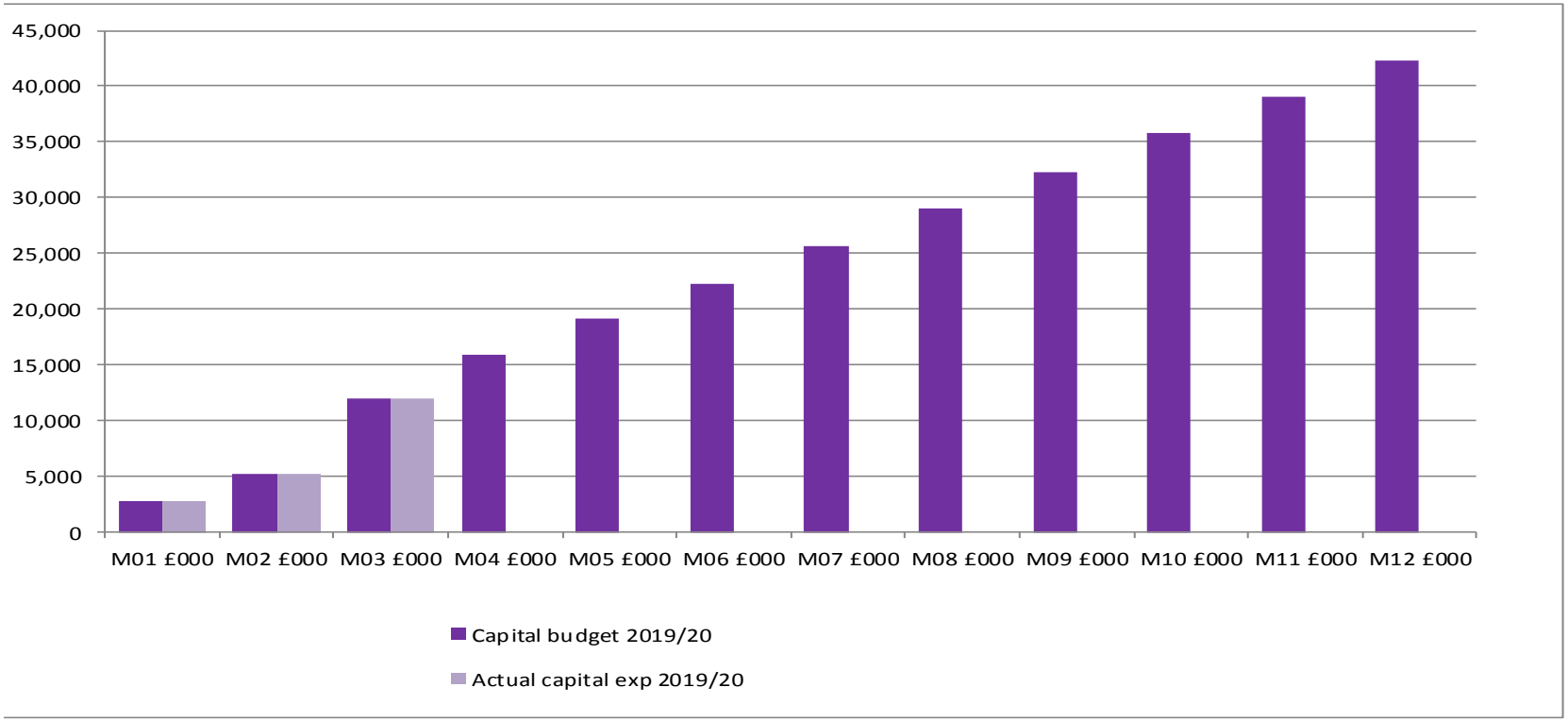
- The cumulative M3 I&E deficit is £15.5m, £0.5m better than plan. (*NB this includes the impact of donated grants and depreciation which is excluded from the NHSI performance total).
- Within the I&E deficit of £15.5m, depreciation (£6.1m) does not impact cash. The charges for interest payable (£3m) and are added back and the amounts actually paid for these expenses shown lower down for presentational purposes. This generates a YTD cash "operating deficit" of £6.4m.
- The operating deficit variance from plan is £0.4m.
- Working capital is worse than plan by £0.9m. The adverse variance comprises of £3m better on debtors, £2.8m worse on creditors and the change of stock level is £1.1m worse than plan. The difference on stock is caused by drug stock levels and will be raised with Pharmacy.
- The Trust has borrowed £11.6m to fund the YTD deficit. The Trust has received £9.3m for capital loan. The working capital borrowing is £8.4m lower than the YTD plan. The Trust has requested a drawdown of capital loan in July of £2.1m with an interest rate of 1.55%. The Trust can borrow up to £20m, however due to the phasing of the I&E at month 3, we have not requested any loans in June and July.

June cash position

- The Trust achieved a cash balance of £3.2m as at 30 June 2019, £0.2m higher than the £3m minimum cash balance required by NHSI and in line with the forecast 17 week cash flow submitted last month.
- **The Trust will remain dependent on monthly borrowing from DH given the higher I&E deficit.**

5. Capital budget and expenditure at M03

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 £11.938m in the first Three months of the year. This spend is against a capital plan of £11.938m but the spend includes a spend to plan accrual of £8.404m for commitments.

6. Finance and Use of Resources Risk Rating

St George's University Hospitals NHS
NHS Foundation Trust

3.3

Use of resource risk rating summary	Plan (M03 YTD)	Actual (M03 YTD)
Capital service cover rating	4	4
Liquidity rating	4	4
I&E margin rating	4	4
Distance from financial plan	n/a	1
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
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 June, 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 (7.50%) minus planned % YTD I&E deficit (7.50%). This value is 0.00% which generates a score of 1.

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.

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4.1

Meeting Title:	**Trust Board**		
Date:	25 July 2019	**Agenda No**	**4.1**
Report Title:	2019/20 Corporate Objectives – Quarter 1 Report		
Lead Director	Suzanne Marsello, Chief Strategy Officer		
Report Author:	Sarah Brewer, Head of Business Planning		
Presented for:	Assurance		
Executive Summary:	In April 2019 the Trust Board approved a new suite of Corporate Objectives for 2019/20, based on the domains of "Outstanding Care, Every Time." Progress against the objectives and their associated quarterly milestones is reported to Trust Board on a quarterly basis. Of the 18 objectives, 8 have been rated green, 7 amber, 2 red and 1 had no milestones for Q1.		
Recommendation:	The Trust Board is asked to : • Review the update • Consider the amended and additional milestones as set out in paragraphs 2.3 and 2.4 of the paper. • Approve the report.		
Supports			
Trust Strategic Objective:	1. Treat the patient, treat the person 2. Right care, right place, right time 3. Balance the books, invest in our future 4. Build a better St. George's 5. Champion Team St. George's 6. Develop tomorrow's treatments today		
CQC Theme:	1. **Safe**: you are protected from abuse and avoidable harm. 2. **Effective**: your care, treatment and support achieves good outcomes, helps you to maintain quality of life and is based on the best available evidence. 3. **Responsive**: services are organised so that they meet your needs. 4. **Caring:** staff involve and treat you with compassion, kindness, dignity and respect. 5. **Well Led:** the leadership, management and governance of the organisation make sure it's providing high-quality care that's based around your individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.		

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Single Oversight Framework Theme:	▪ Quality of Care (safe, effective, caring, responsive) ▪ Finance and Use of Resources ▪ Operational Performance ▪ Strategic Change ▪ Leadership and Improvement Capability (well-led)		
Implications			
Risk:	▪ Any risks associated with the corporate objectives are covered within the BAF, Trust Risk Register or local risk registers		
Legal/Regulatory:	As legal/regulatory issues associated with the Corporate Objectives are covered by the governance underpinning that particular area of delivery of the Trust's work programme		
Resources:	Delivery core business as usual of the trust, and supported by trust leadership cohort.		
Previously Considered by:	Trust Executive Committee	**Date:**	17th July 2019
Appendices:	Appendix 1 - Additional milestone for Objective 1 'Treat the patient, treat the person' and Objective 6 'Tomorrow's Treatments Today'.		

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2019/20 Corporate Objectives
Quarter One Report
Trust Board 25th July 2019

1.0 Purpose

1.1 In April 2019 the Trust Board approved a new suite of Corporate Objectives for 2019/20, based on the domains of "Outstanding Care, Every Time".

1.2 Progress against the objectives and their associated quarterly milestones is reported to TEC and Trust Board on a quarterly basis.

2.0 Progress against objectives in Q1

2.1 Corporate objectives for Q1 have been RAG rated on progress, as has each of the domains into which they are divided. Annex B sets out the methodology for arriving at RAG-ratings, which was previously agreed by Trust Board.

2.2 8 objectives have been rated green, 7 amber, and 2 red. 1 had no applicable milestones for Q1.

2.3 There are 3 milestones not met which relate to the timescales for Trust Board approval of supporting strategies – these are education, research and estates. It is recommended that the milestones be updated to reflect the now agreed programme of supporting strategies and progress monitored against these going forward. (See separate paper to Trust Board on the Supporting Strategies.) The only exception to this is timescale for the estate strategy which is still to be finalised by the Chief Finance Officer.

2.4 The Q2, Q3 and Q4 milestones and measures of success for objective 1 (Treat the patient, treat the person) have now been developed in line with the agreed objective for Q1 – these are set out in appendix 1 along with the updated milestones outlined in paragraph 2.3 above.

2.5 For objective 2 'Patients will not wait long for treatment', the metrics for cancer waiting times are only available to the end of May due to the time-lag in reporting on this.

Organisational Objective	Green	Amber	Red	N/a (for quarter)	Update outstanding	Consolidated Quarterly Position	YTD position (and change on previous Q)
Treat the patient, treat the person	2						
Right care, right place, right time		2					
Balance the books, invest in our future	1	2		1			
Build a better St. George's			2				
Champion Team St. George's	4	2					
Develop tomorrow's treatments today	1	1					
OVERALL	**8**	**7**	**2**	**1**			

3.0 Risks & mitigating actions

3.5 All deliverables not met as at Q1 are set out in Annex A, along with a progress update, mitigation and assessment of the extent to which not meeting the objective poses a material risk.

In summary these are**:**

- 2.1 Patients will not wait long for treatment
- 3.1 We are in financial balance
- 3.3 Investment requirements and potential sources of funding are defined
- 4.1 We have a clear estates strategy
- 4.2 Our environment is safe for our patients and our staff

4.0 Recommendations

4.1 The Trust Board is asked to:

- Review the update;
- Consider the amended and additional milestones as set out in paragraphs 2.3 and 2.4 above; and
- Approve the report.

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Annex A – Deliverables not met YTD

Objective	Responsible Officer	Deliverables not delivered & causing amber or red RAG rating	Progress update	Mitigation	Material risk? (Link to BAF)
	Right care, right place, right time				
2.1 Patients will not wait long for treatment	Chief Operating Officer	Accident and Emergency 94.3% at the end of month 3	Trust achieved 87.0% against the 94.3% A&E trajectory in June 2019, an improvement from 85.4% in April and 86.5% in May 2019	An improvement programme is in progress.	Yes – this is a BAF risk (SR3)
		Cancer – 2WW 93.7% at the end of month 3 .	Trust achieved 90.2% Cancer trajectory in May affecting 138 of 1,409 patients in total and a deterioration from 92.4% in April 2019.	A Recovery Plan is in place	Yes – this is a BAF risk (SR3)
		Cancer – 62 day GP referral 85.1% at the end of month 3	Trust achieved 71.4% against the 86.2% 62 day Cancer trajectory in May 2019; affecting 18 of 63 patients in total and a deterioration from 75.6% in April 2019.	A Recovery Plan is in place	Yes – this is a BAF risk (SR3)
2.2 Our IT is easier to use and supports our staff to provide the best care for patients	Chief Finance Officer	Doctors will be able to manage their referrals in a single integrated system.	Partially completed - iClip Triage has been rolled out across some specialties, but not all, due to pausing of Central Booking Service (CBS) restructure.	No mitigating actions as full roll-out is awaiting CBS staffing arrangements to be completed.	Not a material risk due to the progress being made but it is linked to BAF risk SR4
	Balance the books, invest in our future				
3.1 We are in financial balance	Chief Finance Officer	E&I is currently on plan	All thought the E&I is on plan the full year	Services continue to look for	Yes – although E&I is on plan for Q1 there

		CIP delivery on plan (not delivered)	quantum of CIPS has yet to be found	opportunities to identify CIP opportunities. Service development for 2019/20 not agreed until CIP target reached	remains a risk around CIP - is a BAF risk (SR7)
3.2 Our cost structures are understood and defined	Chief Finance Officer	Use of Resources (UoR) review completed and Action Plan agreed (subject to exact date from NHSI). Service Line Reporting programme in place and high value areas targeting for deep dive review. Programme to review information including GIRFT and Model Hospital data and Reference costs.	UoR review not yet completed and is planned for August	Material work underway to develop supporting pack and information. Deep dives and targeted benchmarking being developed by CIP team.	Not a material risk due to progress being made and planned action for August.
3.3 Investment requirements and potential sources of funding are defined	Chief Finance Officer	Schedule of approved investments for 19/20 updated at end of Quarter.	Not yet delivered – linked to CIP programme (see 3.1 above)	Investments under review as CIP programme not fully identified (see also mitigations for 3.1 above)	Yes- this is a BAF risk (SR8)
	Build a better St George's				
4.1 We have a clear estates strategy	Chief Finance Officer	Establish Estate Strategy planning group and associated work programme Review high level risks to inform the scope of the strategy Finalise estates strategy objectives	Detailed work on the estates strategy has not yet commences due to recent management re-organisation within the estates directorate and the need to re-prioritise activity.	The Deputy CEO is reviewing priorities and agree a realistic timescale for delivery of an estates strategy	Yes – BAF risk (SR()
4.2 Our environment is safe for our patients and our staff	Chief Finance Officer	Board review of the Premises Assurance Model (PAM) documentation	This has not progressed due to capacity within the estates directorate and associated pre-	A timescale for this will be agreed as part of the re-prioritisation	Yes – BAF risk (SR10)

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			prioritisation		
		Undertake risk review of Estates & Facilities	This has not been delivered	This is in progress	Yes – BAF risk (SR10)
		Complete estates resourcing review and agree recommendations; develop KPIs on PPM and reactive maintenance	This has not been completed. An External Governance Review is underway; anticipated completion date is 20 July 2019.	None anticipated – this will be completed in July	Not a material risk due to timeline for completion (although linked to BAF risk SR10)
		Produce 'State of the Nation' report for E&F and implement new communication protocols to educate Trust staff on issues and progress and provide regular updates to staff.	This has not been delivered due to capacity issues within the estates directorate.	The Deputy CEO is reviewing priorities and agree a realistic timescale for delivery	No
	Champion team St George's				
5.1 Listening, responding to and engaging our staff	Chief People Officer	Undertake all staff 'listening' events'	No staff listening events were scheduled for Q1	These are now being planned for the Autumn. Actions plans from staff survey results have been agreed at Directorate level	No due to progress being made on other initiatives
5.4 Working to deliver our Diversity and Inclusion strategy	Chief People Officer	Design diversity leadership programme Review of disciplinary cases to identify any imbalance Establish baseline figures for recruitment (shortlisted, interviewed, appointed) for ethnicity.	These are on track but other actions associated with this have not been progressed as they might	WEC agreed that an action plan be developed to progress the D&I Strategy	No
	Develop tomorrow's treatments today				
6.1 Produce a new education strategy aligned to the new clinical strategy that articulates the vision	Chief Medical Officer	Agree the scope of the education strategy including: •Engage staff from all disciplines and backgrounds to inform the scope of a	Some scoping work undertaken including engagement with staff from a range of disciplines, and scope on	None required.	No

and strategic aims		multi-disciplinary education strategy aligned to the clinical strategy •Undertake engagement with relevant staff to ensure a focus of the education strategy is to use inform and embed learning from patient safety issues •Following publication of the clinical strategy, identify any specific clinical areas to be specifically incorporated into the education strategy	track to be agreed in early Q2, but slight slippage from Q1 plan. A process and timescales have now been agreed.		

Annex B - approach to RAG-rating

1. The RAG ratings for 14 derived as follows. Each objective is shown as:

   - Green for Q1 if all its Q1 milestones have been delivered, or if the position is overwhelmingly close to that (e.g. 5 milestones delivered, 1 partially delivered but due for completion in early April).
   - Amber for Q1 if some of the associated Q1 milestones have been delivered, and some not, or if the milestones are partially delivered.
   - Red if the milestones for Q1 have not been delivered.

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

3. The RAG rating for the year-to-date position shows whether there is any slippage against what we set out to do year-to-date. For Q1 this is the same as Q1 position..

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Appendix 1 – Additional Milestones Agreed during Q1

Objective 1: Treat the Patient, Treat the Person

Aim	To ensure we improve the quality of care to patients				
Priority	**Quarter 1 milestones**	**Quarter 2 milestones**	**Quarter 3 milestones**	**Quarter 4 milestones**	**SMART Measures of Success**
Lead Directors: **Chief Medical Officer** **Chief Nursing Officer** **1.1 Reduce harm to patients:** • **emergency patients will have treatment escalation plans (TEP)** • **patients who lack mental capacity will have proper protection and care** • **inpatients who deteriorate will be recognised and treated promptly**	Through the Quality Improvement Academy we will establish a delivery trajectory and smart goals for each of these 3 priorities areas: **Treatment Escalation Plan (TEP):** Form available to order by clinical areas and copy sent to iclip (electronic patient record system). Funding approved for critical care outreach, and working group established. Mandatory training reported through Trust Executive Committee and Quality & Safety Committee for Basic Life Support (BLS), Intermediate Life Support (ILS) and Advanced Life Support (ALS) with an improvement trajectory	**TEP:** An electronic TEP will be developed in iClip for implementation in Q2 **MCA:** Templates will be developed for recording of capacity assessments and Best Interest decisions within iClip The Trust will achieve over 85% compliance for level 2 MCA training. Staff knowledge questions from the accreditation system will be included in the IQPR Implement staff quick reference cards within high risk ward areas. **Deteriorating Patient:** Achieve 85% compliance for resus training across all	**TEP** IT will produce an electronic audit facility based on the iClip TEP **MCA:** Launch of the electronic documentation for MCA and DoLs Develop Trust wide staff knowledge survey for all staff groups to be completed quarterly. **Deteriorating Patient*:*** Developing management level and monthly audit data with IT for NEWS2 in iCLIP in readiness for electronic audit facility anticipated by end of Q3 Start of phased implementation to the critical care outreach team.	**TEP** Additional performance metrics to be identified based on audit results. **MCA:** Report quarterly staff audit in IQPR Complete audit on use and completion of electronic documentation Reporting of results in IQPR **Deteriorating Patient:** Electronic reporting of NEWS 2 to be incorporated into IQPR which can be triangulated with number of TEP completed and cardiac arrest call information.	12 QI metrics associated with the 3 priorities areas are included in the IQ Performance Report and reported monthly: **Mental Capacity Act & Clinical Governance** • MCA and DoL - Level 1 90% compliant • MCA and DoL- Level 2 85% compliant • Total Datix incidents reported in month • Open SI investigation >60 days • Duty of Candour completed within 20 working days for all incidents at moderate harm or above 100% **Treatment Escalation**

	agreed to be reached by Q2. Currently ALS 73%, BLS 76%, ILS 72% **Mental Capacity Assessment (MCA):** Achieve 90% for level 1 MCA training Scoping exercise completed for electronic documentation and templates used in other Trusts. **Deteriorating Patient:** Implemented National Early Warning Score version 2 (NEWS2) across the Trust, including reconfiguration of observation machines. Responded to NHS/Patient Safety Alert/W/2018/009 Risk of harm from inappropriate placement of pulse oximeter probes completed.	levels. Achieve 85% compliance for EWS mandatory training. Recruit Resus champions to deliver in house resus training Job descriptions and service model to be agreed for critical care outreach team.			**Plan and Deteriorating Patients** • No of 222 calls/1000 adults ordinary inpatient admissions • No. of Cardiac Arrests/1000 adult admissions (to become avoidable cardiac arrests) • % of patients in ED with Red Flag sepsis receiving antibiotics within hours(adults)- 90% target • Compliance with appropriate response to EWS (adults) 85% target • Resuscitation BLS- 85% target • Resuscitation ILS- 85% target • Resuscitation ALS- 85% target
1.2 We will map, standardise, support and	Independent review of care group/department level	Deliver relevant actions in Mortality and morbidity,	Deliver relevant actions in Mortality and morbidity,	Deliver relevant actions in Mortality and morbidity,	**Q1 Update:** As per 'evidence of completion &

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improve our departmental-level governance of quality, safety and learning	safety governance and culture. Will report to CMO (end of April), Report and emerging action will be discussed at Trust Board at the end of May.	MDT and Clinical Governance action plan agreed by Trust Board in June 2019 (namely: all actions with exception of 3.5 and 14)	MDT and Clinical Governance action plan agreed by Trust Board in June 2019 (namely: action 3.5)	MDT and Clinical Governance action plan agreed by Trust Board in June 2019 (namely: action 14)	sustainability' section of Mortality and morbidity, MDT and Clinical Governance action plan agreed by Trust Board in June 2019

Objective 6 : Develop tomorrow's treatments today

Aim	• To ensure that our education programme supports the development of a multidisciplinary clinical workforce and supports the ambitions set out in our clinical strategy				
Objective	**Quarter 1 milestones**	**Quarter 2 milestones**	**Quarter 3 milestones**	**Quarter 4 milestones**	**SMART Measures of Success**
Lead Director: Chief Medical Officer **6.1 Produce a new education strategy aligned to the new clinical strategy that articulates the vision and strategic aims**	Agree the scope of the education strategy including: • Engage staff from all disciplines and backgrounds to inform the scope of a multi-disciplinary education strategy aligned to the clinical strategy • Undertake engagement with relevant staff to ensure a focus of the education strategy is to use inform and embed learning from patient safety issues • Following publication of the clinical strategy,	• Draft education strategy produced **Q1 Note**: this milestone has now been moved to Q3. Earlier milestones were put in place prior to the timetable for all the 'supporting strategies' being agreed. **Alternative milestones being proposed:** • Finalise scoping of the education strategy • Agree stakeholder engagement plan	**Additional milestone proposed:** • Draft education strategy produced	**Additional milestone proposed:** • Education strategy signed off by Board	Trust education strategy approved by Trust Board ***Note: other measures of success will be determined following agreement of the education strategy in Q2.***

	identify any specific clinical areas to be specifically incorporated into the education strategy	• Commence stakeholder engagement			
6.2 Produce a new research strategy aligned to the new clinical strategy that articulates the vision and strategic aims	Key themes and principles of the emerging research strategy to be reviewed against published clinical strategy Draft research strategy produced Research Forum to be held in June to consider the draft research strategy	• Research strategy agreed and published **Q1 Note:** This milestone has now been moved to Q3. Earlier milestones were put in place prior to the timetable for all the 'supporting strategies' being agreed. **Alternative milestones proposed:** • Continue with engagement plan • Draft research strategy produce	**Additional milestone being proposed:** • Research strategy signed off by Board		**Research strategy approved by Trust Board**

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4.2

Corporate support strategies

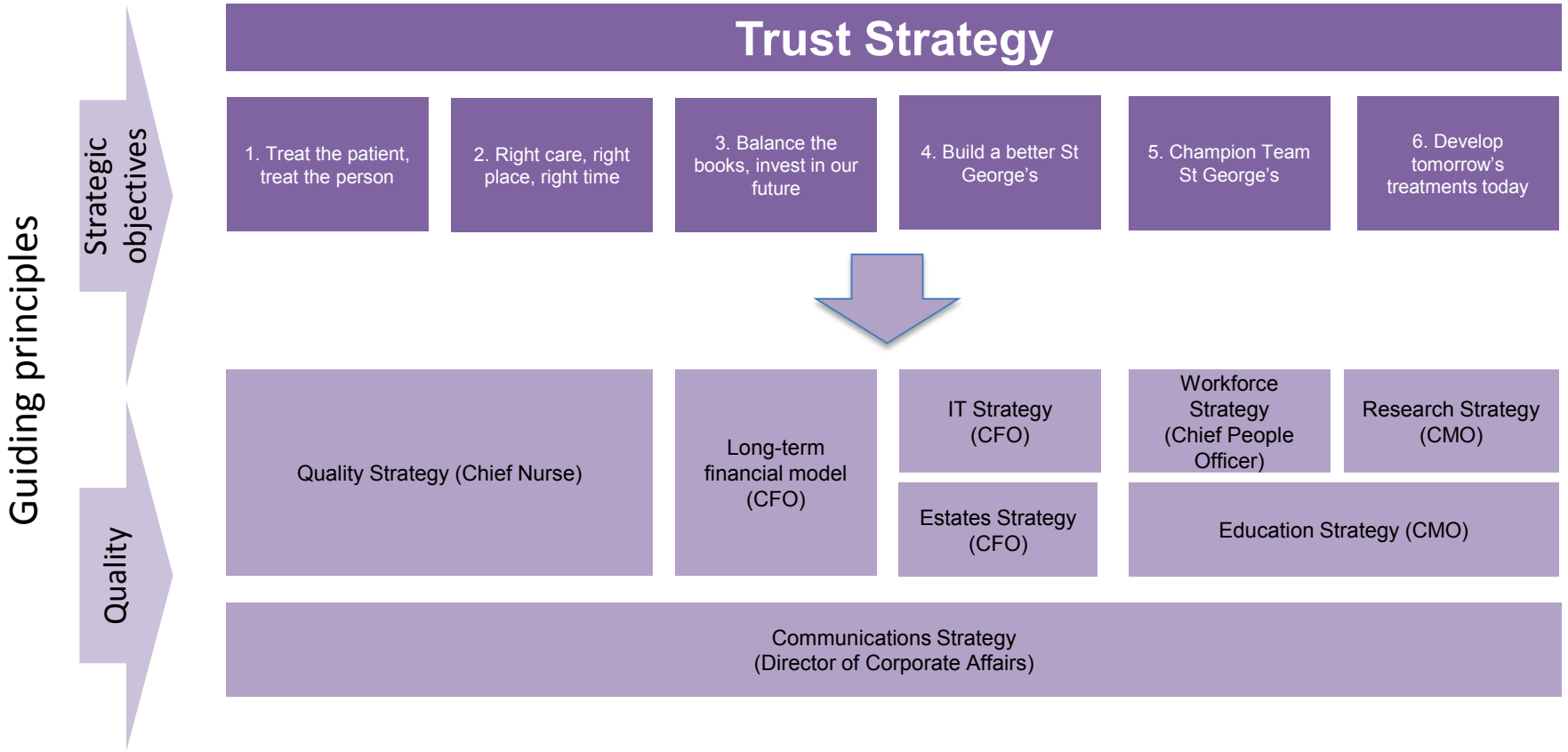
Trust Board, 25 July 2019

Contents

The purpose of this paper is to provide the Board with an overview of the process and timescales for the development of a range of corporate strategies. It covers:

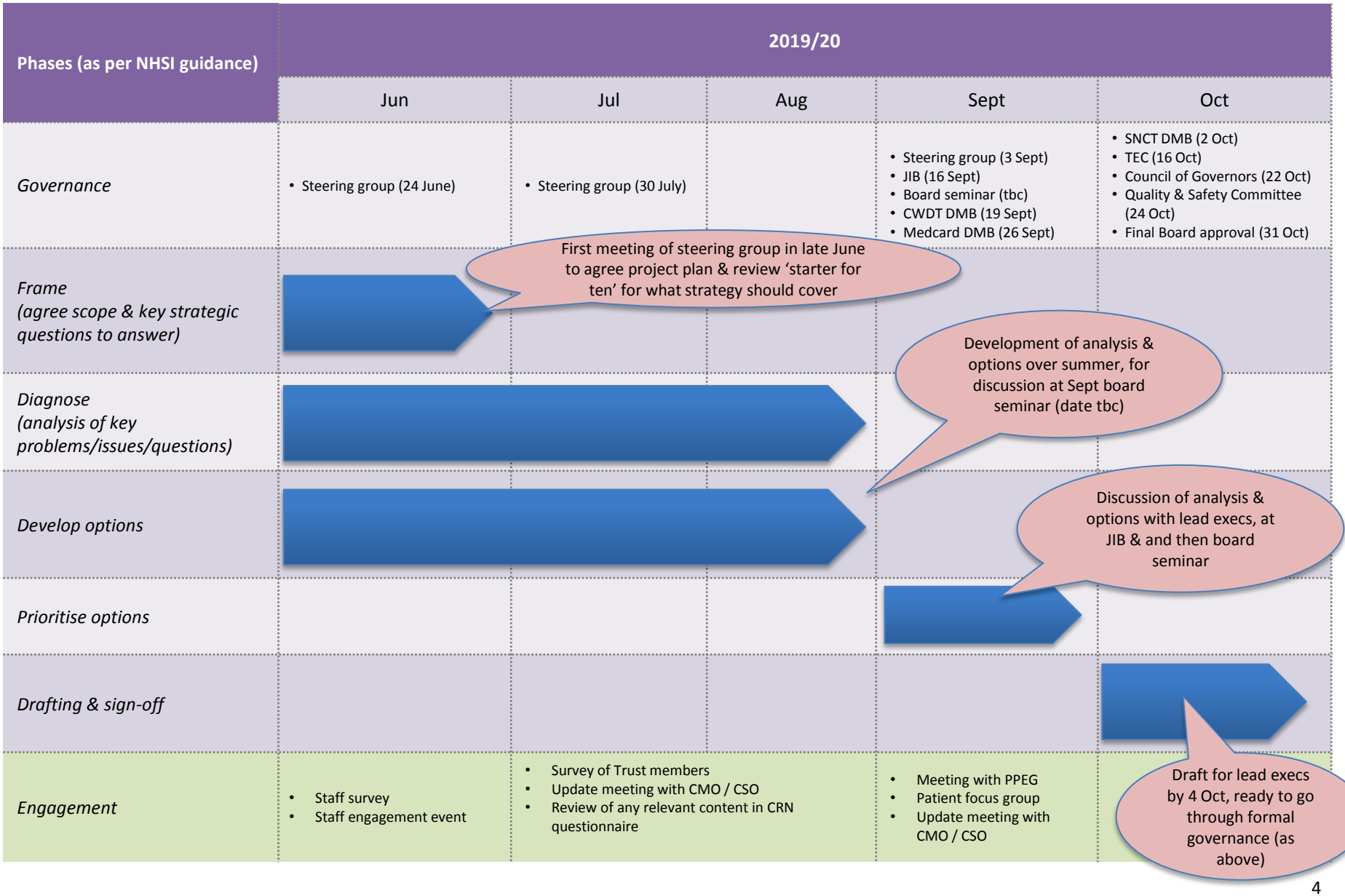
Developing support strategies

A number of support strategies are planned for development following publication of the clinical service strategy earlier this year.



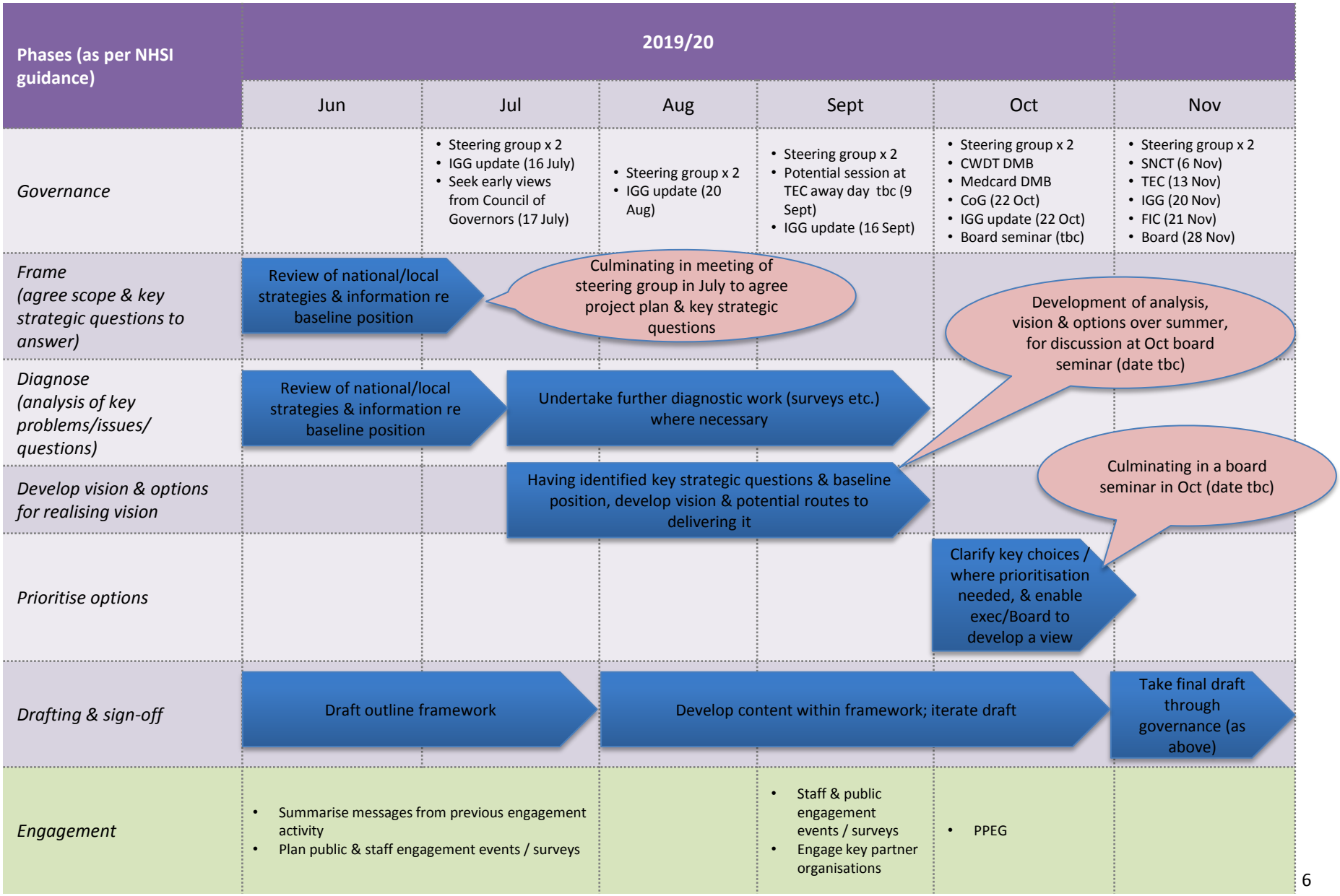
Research Strategy (Lead director: Chief Medical Officer)

Development of strategy to be overseen by a steering group chaired by the Associate Medical Director, reporting to the Quality Committee



Digital Strategy (Lead director: Chief Finance Officer)

Development of strategy overseen by dedicated steering group, reporting to Information Governance Group and then on to Finance and Investment Committee



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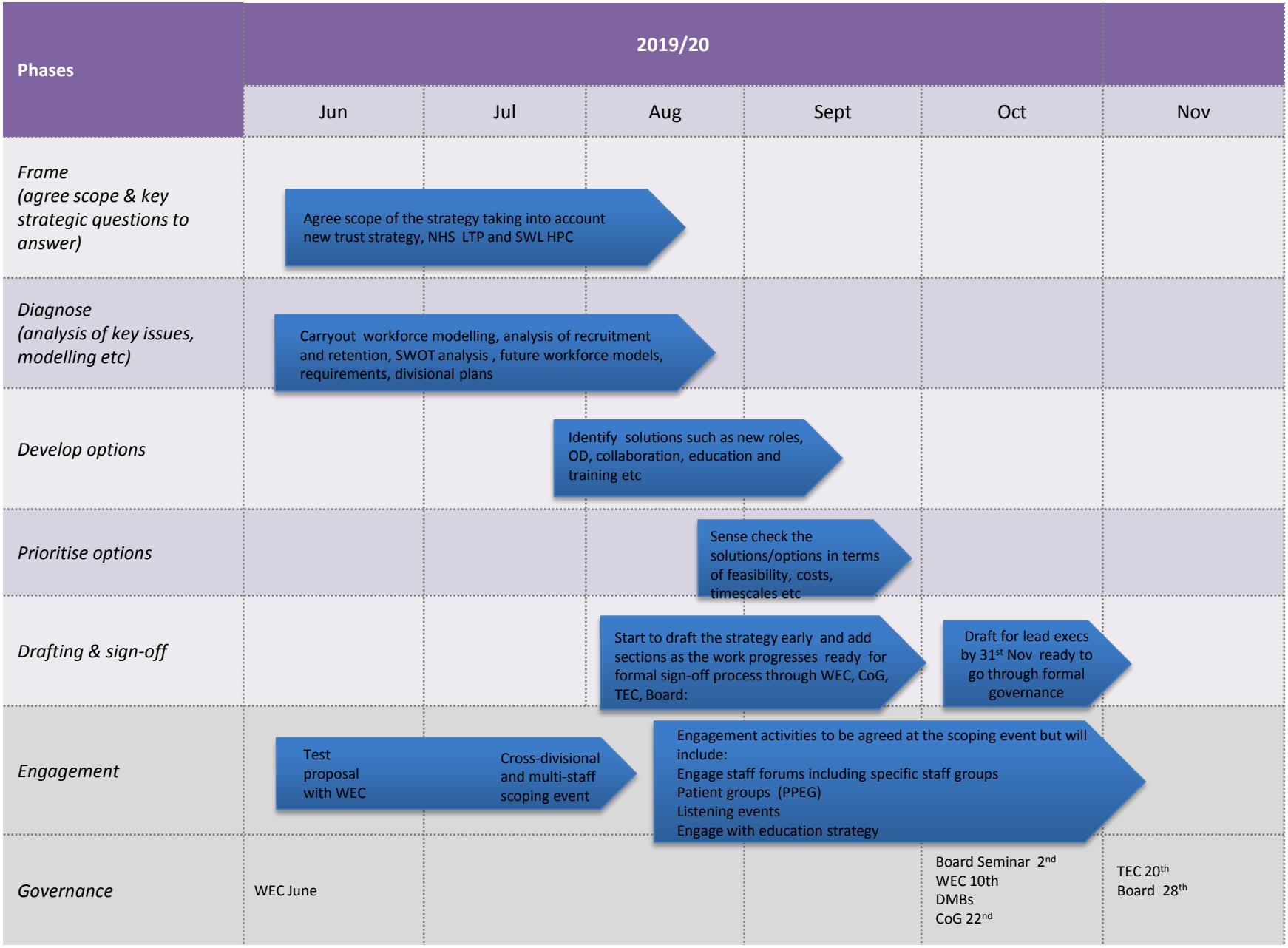
Workforce Strategy (Lead director: Chief People Officer)

Development of strategy overseen by Workforce and Education Committee



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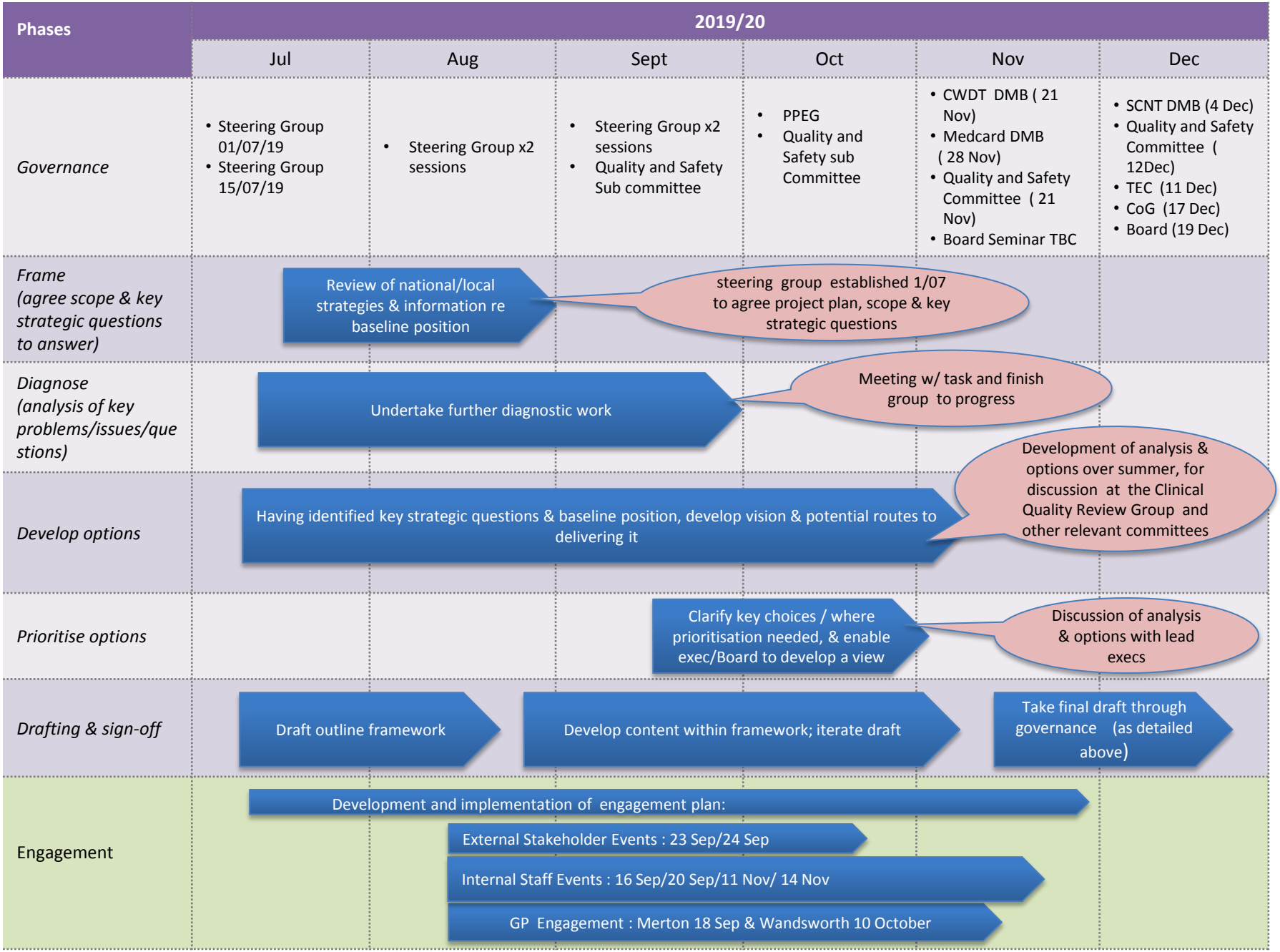
Quality Strategy (Lead director: Chief Nurse)

Development of strategy to be overseen by a steering group reporting to the Quality and Safety Subcommittee



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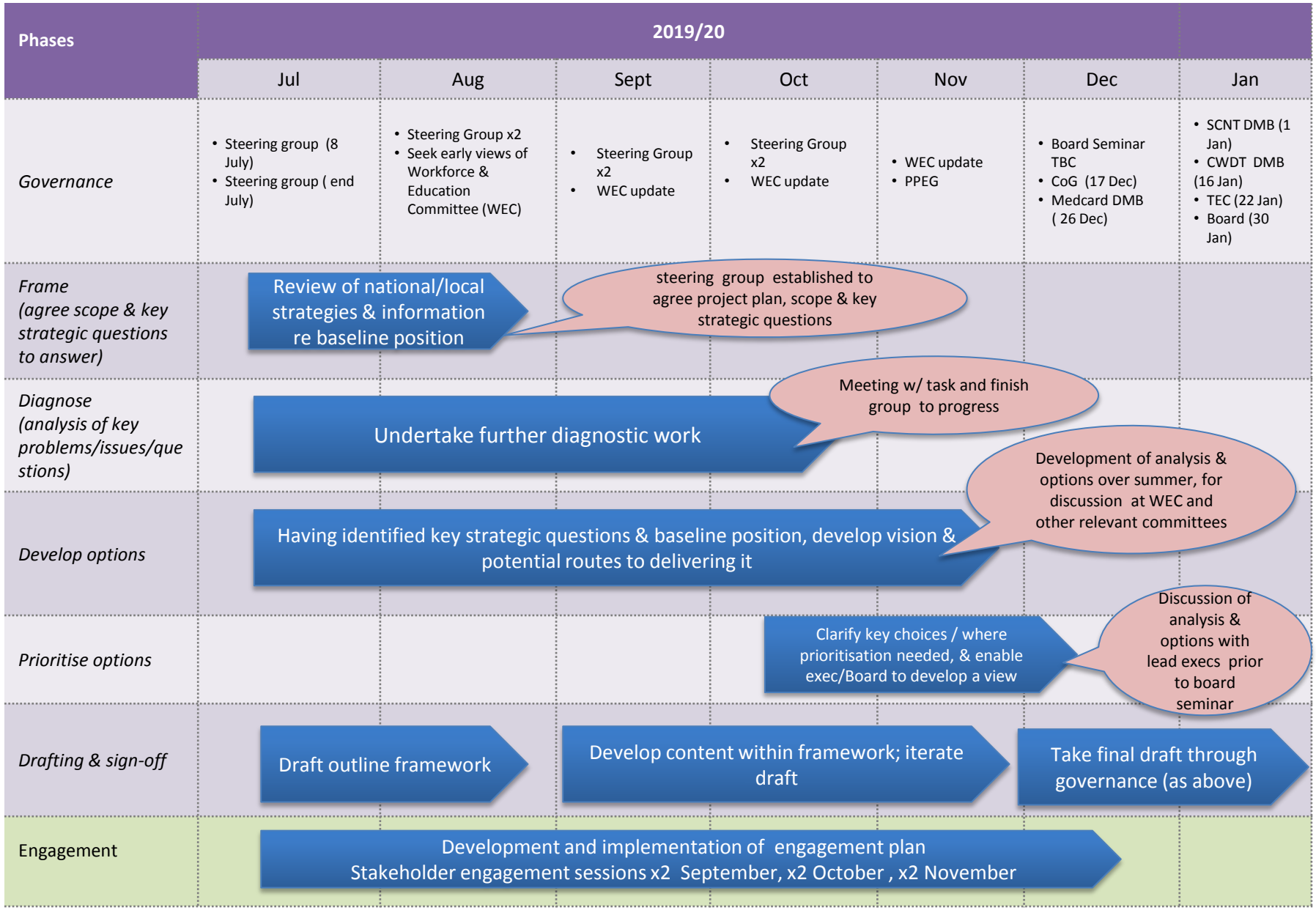
Education Strategy (Lead director: Chief Medical Officer)

Development of strategy to be overseen by a steering group reporting to the Workforce and Education Committee



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4.2

Development of an Estates Strategy (Lead Director: Chief Finance Officer)

Key drivers

Set out the "as is" condition of the estate

CURRENT/ EXISTING ISSUES

- *Covers all current operational locations.*
- *Refresh Six Facet Survey to ensure accurate understanding of current estate condition (Tooting site).*
- *Scope plan to identify areas for immediate improvement.*
- *Infrastructure brought to "acceptable" operational standards*

GROWTH AND TRENDS

DRIVERS

- *Impact of demographic change*
- *Requirements of NHS Long Term Plan, e.g. outpatient changes*
- *Workforce – emerging Strategy*
- *Changes within services, e.g. APC work and changes in technology*
- *SWL system issues*

To what extend does each of the issues drive or lead?

OTHER SITES

- *How do other sites contribute to the Strategy?*

BIG STRATEGIC PRIORITIES

CORE

- *Cancer Services*
- *Children's Services*
- *Neurosciences*

SUPPORT

- *Critical Care*
- *Diagnostics*

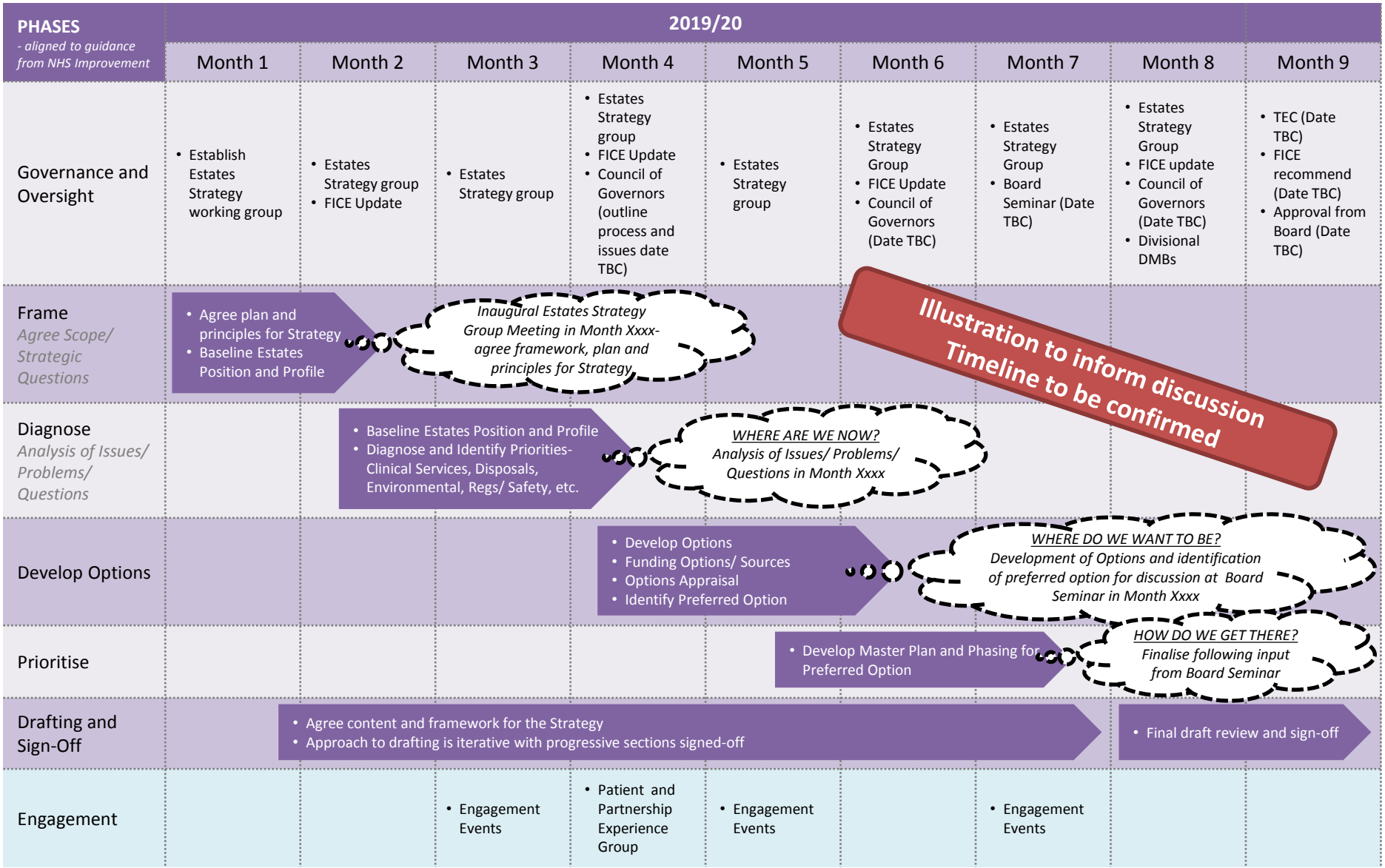
MAJOR PROGRAMMES

- *Emergency Floor*
- *ESTH*
- *SWL & national agenda*

PRINCIPLES FOR THE FUTURE

WHAT DOES THIS ALL MEAN TAKEN TOGETHER FOR THE ESTATES STRATEGY?

Development of an Estates Strategy: Indicative Timeline



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NHS Foundation Trust

4.3

Meeting Title:	Trust Board		
Date:	25 July 2019	**Agenda No**	**4.3**
Report Title:	**Outpatient Services Strategy**		
Lead Director/ Manager:	Ellis Pullinger, Chief Operating Officer Suzanne Marsello, Chief Strategy Officer		
Report Author:	Emilie Perry, DDO CWDT Rob Game, Director of Outpatient Improvement Ralph Michell, Head of Strategy		
Presented for:	Approval		
Executive Summary:	In April 2019 the Trust published its corporate strategy for the coming five years. One area where the strategy is likely to have a particular impact is on the Trust's outpatient services. This is also an area where the Trust's stakeholders (including local commissioners) are anxious for the organisation to move forward at pace. The Trust has made significant improvements to its outpatient services in recent times, seeking to ensure that outpatient services are safe, caring, responsive and well-led. But there is further to go, and engagement with a wide range of stakeholders (staff, patients, commissioners) suggests widespread support for change. Transformation of outpatient services is also a national priority, with the long-term plan describing the traditional model as 'outdated and unsustainable', and committing to a redesign that would avoid up to a third of face-to-face outpatient visits. The Trust expects that this commitment will need to be reflected in the implementation plan that South West London draws up over the summer/autumn to reflect the national long term plan. Having published its overarching strategy for the next 5 years, the Trust has therefore drawn up a strategy specifically for outpatient services. This paper seeks Board approval for that strategy. This paper describes the Trust's vision for outpatient services, with care designed around patients' lives, and supported by the latest technology – for instance through more virtual clinics, and fewer unnecessary trips to hospital. It also sets out some of the implications for estates, digital and workforce strategies that the Trust is developing over the course of 2019/20. The paper has been developed based on wide-ranging engagement. Discussion of outpatient services was a prominent feature of the programme of engagement events undertaken for the Trust Strategy, which engaged over 500 staff, patients and partners. During the early stage of drawing together this paper, drafts were discussed with a sample of care group leads/clinical directors in respiratory medicine, dermatology, infection, gastroenterology, rheumatology and outpatients. Subsequently it has gone through all three Divisional Management Boards and Trust Executive Committee.		

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4.3

Recommendation:	Board is asked to: • Approve the strategy for outpatient services • Agree the implications to be considered through the development of corporate support strategies in 2019/20		
Supports			
Trust Strategic Objective:	1. Treat the patient, treat the person 2. Right care, right place, right time 3. Balance the books, invest in our future 4. Build a better St. George's 5. Champion Team St. George's 6. Develop tomorrow's treatments today		
CQC Theme:	1. **Safe**: you are protected from abuse and avoidable harm. 2. **Effective**: your care, treatment and support achieves good outcomes, helps you to maintain quality of life and is based on the best available evidence. 3. **Responsive**: services are organised so that they meet your needs. 4. **Caring:** staff involve and treat you with compassion, kindness, dignity and respect. 5. **Well Led:** the leadership, management and governance of the organisation make sure it's providing high-quality care that's based around your individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.		
Single Oversight Framework Theme:	▪ Quality of Care (safe, effective, caring, responsive) ▪ Finance and Use of Resources ▪ Operational Performance ▪ Strategic Change ▪ Leadership and Improvement Capability (well-led)		
Implications			
Risk:	Key risks relate to the Trust's capacity to implement the proposed changes, particularly in relation to IT infrastructure and managerial capacity in the face of competing priorities. A separate paper to June Board outlined IT infrastructure required for outpatient transformation, and the DDO for CWDT has put in place new managerial capacity and governance structures to address the latter risk.		
Legal/Regulatory:	N/A		
Resources:	Implementation of the strategy may require investment of resource in future years, but this will be assessed through annual business planning / business case processes.		
Previously Considered by:	• Children's, Women's, Diagnostics and Therapies Divisional Management Board; • Medicine and Cardiovascular Management Board • Surgery, Theatres, Neurosciences and Cancer Divisional Management Board • Trust Executive Committee	**Date:**	20 June 2019 27 June 2019 3 July 2019 26 June 2019 & 17 July 2019
Appendices:	Outpatient strategy		

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Outpatient Services Strategy

Trust Board
25 July 2019

Ellis Pullinger, COO
Suzanne Marsello, Chief Strategy Officer
Emilie Perry, DDO, CWDT
Rob Game, Director, Outpatient Improvement
Ralph Michell, Head of Strategy

Excellence in specialist and community healthcare

Introduction & purpose

- In April 2019 the Trust published its corporate strategy for the coming five years.
- One area where the strategy is likely to have a particular impact is our outpatient services. This is also an area where our stakeholders (including local commissioners) are anxious for us to move forward at pace.
- This paper sets out the strategic context for outpatient services, the proposed strategy for outpatient services for the next five years, and some proposals for where a range of corporate support strategies (estates, digital, workforce) will need to ensure they support the delivery of the Trust's strategy for outpatient services.
- Board is asked to:
  - Approve the Trust strategy for outpatient services
  - Agree implications to be considered through the development of corporate support strategies in 2019/20

Where we are today: Outpatient services at St. George's

Summary / Key Facts:

Activity

- The Trust delivers over 630,000 outpatient appointments in a year
- 20 specialties account for 80% of total outpatient activity, this 80% of our outpatient appointments are routinely delivered on the main Tooting site; 15% at Queen Mary's Hospital; and the remainder at the Nelson.

Structure

- The Corporate Outpatient Service sits within the Children, Women, Diagnostics Therapeutics and Critical Care Division, but some specialties (e.g. neurosurgery) have their own outpatient booking function.

Market Share

- The Trust is the largest provider of outpatient services in South West London, but market share varies significantly from specialty to specialty. For instance, over 70% of outpatient activity for neurosurgery originating from SWL comes to St George's, vs approximately 20% of outpatient activity for obstetrics.

Quality

- Outpatient services at St George's were rated 'requires improvement' in the last CQC report (up from 'inadequate'), with a range of opportunities identified for improvement.

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement → ← Jul 2018	Not rated	Good → ← Jul 2018	Requires improvement ↑ Jul 2018	Inadequate → ← Jul 2018	Requires improvement ↑ Jul 2018

Where we are today: The Trust's improvement journey

Improving our outpatient offering has been a major priority for the Trust over the past two years, backed by a significant programme of activity.

ENSURING SERVICES ARE CARING

- Improving **customer service** through specific training and moving to an electronic display of waiting times in all areas.
- Driving up use of **self-check-in booths**: 18 booths are in place, with 18% of outpatient activity now checked in via a booth.

ENSURING SERVICES ARE SAFE

- Introducing a **workforce plan**, including training plans
- Increasing the number of patients with an **electronic record** as part of their appointment
- **Rolling out iClip** on the Tooting site, with QMH to follow

ENSURING SERVICES ARE RESPONSIVE

- Ensuring GPs have access to **electronic advice & guidance**.
- Switching to **electronic referrals** (eRS)
- Reminding patients of appointments by text (one way **text reminders** across majority of outpatient services; two-way texts live in some services with roll out planned for coming months)
- Maximising **call centre staff capacity** to book appointments
- Embedding closer working **relationships between the Outpatient and Specialty teams**
- Undertaking clinic moves to **decongest Lanesborough Wing**.
- Increasing use of **virtual clinics**: the proportion of follow-ups that are non-face-to-face has grown from 2.1% to 5.4%, and virtual consultations at the front end of the pathway introduced via Virtual Fracture Clinic, the Gastro Clinical Assessment Service, the Tele-Dermatology service.
- Delivering **non-consultant and non-hospital based services**: the Dermatology Intermediate Tier service, and the development of a joint SWL provider proposal for ENT Intermediate Tier services that is with the commissioners for consideration.
- Successfully trialling '**open access' follow-ups** in ENT and Plastics.

ENSURING SERVICES ARE WELL LED

- **Restructuring** the corporate outpatient service
- Improving **staff engagement**, with weekly meetings, monthly communication dates, walk-arounds, feedback boards and an open door policy.
- Driving **operational performance** improvement through weekly PTL challenge meetings and an Operational Delivery Group (focused on areas such as cashing up, eTriage, Clinic Utilisation and Clinic Cancellations and DNAs)

Where we are today: SWOT

STRENGTHS

- **Excellent clinical outcomes**
- **Increasingly solid foundations to build on –** e.g. recent improvements to our IT infrastructure, organisational restructure, clinic moves (see earlier slide)
- **Range of innovative new models of care to build on -** eg gastroenterology clinical assessment service; virtual fracture clinic; tele-dermatology service

WEAKNESSES

- **A largely traditional model of delivery,** despite recent innovations **–** described as "outdated and unsustainable" in the recent NHS Long Term Plan
- **IT –** despite recent improvements, continued reliance on paper in some areas, multiple fragmented systems, gaps/weaknesses in some software/hardware
- **Productivity –** peer comparisons suggest significant potential to boost productivity, and that outpatient transformation could be a major overarching opportunity area for cost improvement
- **Quality** – rated 'requires improvement' in latest CQC inspection, and the source of significant CQC concerns
- **Estates –** fragmentation of services across the estate (e.g. for infusions); overcrowding in some areas, criticised by CQC; underutilisation elsewhere (QMH and Nelson)

OPPORTUNITIES

- **Digitising outpatient services –** potential (reflected in our 19/20 plan to deploy Cerner at QMH & roll out virtual clinics) for greater use of virtual appointments, virtual triage, and integrated paperless patient note management, booking and communication, all contributing to more efficient, more responsive and safer care.
- **New workforce models –** potential for greater use of consultant nurses, physician associates and allied health professionals
- **Collaboration with primary/community care –**providing specialist input, advice and guidance for GPs, virtual MDTs, pre-assessment before patients see specialists, enhanced triage – thereby avoiding unnecessary hospital visits.
- **One stop clinics –** coordination of care activities (assessment, diagnostics, treatment) into single attendances; joint clinics for patients with multiple conditions
- **Rationalisation –** bringing together disparate services and colocating them to increase quality and efficiency (e.g. rationalisation of infusion suites); centralisation of outpatient bookings whilst ensuring booking staff are aligned to and develop expertise in particular services
- **Developing our specialist services & responding to population need –** using the workforce and estate capacity freed up through the above to develop/grow our more specialist services, and provide an outpatient offering more responsive to the needs of SWL patients

THREATS

- **IT infrastructure –** risk that lack of funding slows the pace of change
- **Change management capacity –** risk that limited capacity and operational pressures slow the pace of change, with innovations introduced to date reliant on investment of corporate support upfront (e.g. in the form of transformation team time, new pathway coordinator posts)
- **Commissioner realism/drive for savings** – the NHS Long Term Plan envisages 'avoiding a third of face to face outpatient visits', and local commissioners have ambitious QIPP plans for outpatient transformation. There is a risk of this being overambitious or translating into a drive to cut costs at the expense of quality.

Looking to the future: stakeholder views

In developing this strategy, we engaged with staff, patients and partners

- To help develop the Trust's five-year strategy, over 30 care groups undertook a SWOT analysis and presented their strategic vision to the Board. Many included a focus on the future of outpatient services
- A stakeholder event was held in November 2018 on the future of outpatient services, attended by approximately 80 Trust staff and external stakeholders (e.g. commissioners, patient representatives)
- As part of the development of the Trust's clinical strategy, a series of 26 engagement events were held for staff, patients and partners, with over 500 participants. A number of key themes related to outpatient transformation.

Key messages were that our stakeholders (staff, patients and partners) want us to…

- Make better use of technology (e.g. virtual clinics, patient-managed apps, patient portals),
- Provide more care in different settings (particularly in collaboration with primary care, or virtually);
- Streamline pathways (e.g. one-stop clinics, rapid access, collaboration with primary care, group outpatient sessions),
- Provide care through a different skill mix, with less reliance on consultants (e.g. through greater use of allied health professionals, physician associates, consultant nurses);

… but staff also talked about:

- Taking a menu-based approach to transformation rather than a 'one-size-fits-all' approach – with some services more suited to virtual working than others, greater scope for a different workforce mix in some than others, etc.;
- Anxiety about the Trust's ability to dedicate management capacity to implementing change in the context of operational pressures, our IT capability to deliver some of the changes envisioned, the capacity of the corporate outpatient department, and the need for investment in some cases.

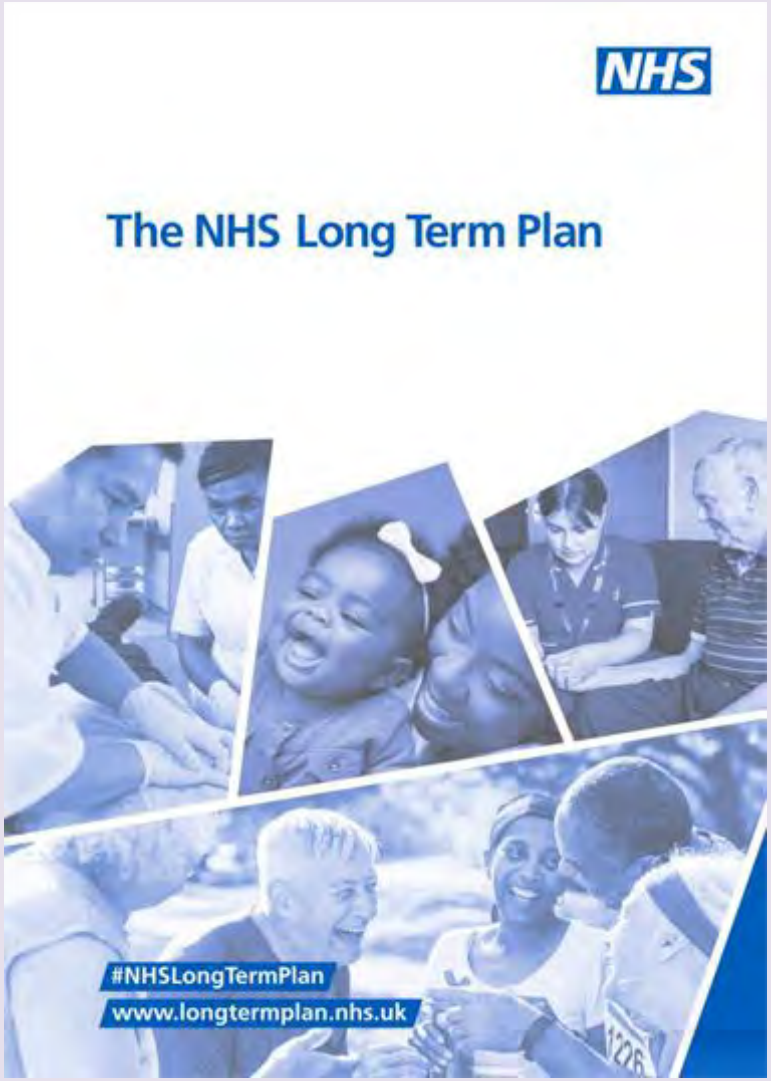
Looking to the future: the NHS Long Term Plan

The NHS Long Term Plan, published in early 2019, set out a commitment that **"digitally-enabled primary and outpatient care will go mainstream across the NHS".**

The Long Term Plan says that:

- "hospital outpatient visits have nearly doubled over the past decade from 54 to 94 million, at a cost of £8 billion a year."
- "the traditional model of outpatients is outdated and unsustainable."
- "In some hospitals patients are already benefitting from the redesign of outpatient services. These include better support to GPs to avoid the need for a hospital referral, online booking systems, appointments closer to home, alternatives to traditional appointments where appropriate including digital appointments and avoiding patients having to travel to unnecessary appointments. This is better for patients, supports more productive use of consultant time and enables the capacity of outpatient clinics to be used more efficiently."
- "Outpatient services will be fundamentally redesigned…. so that over the next five years patients will be able to avoid up to a third of face-to-face outpatient visits, removing the need for up to 30 million outpatient visits a year. This will save patients time and inconvenience, will free up significant medical and nursing time, will allow current outpatient teams to work differently, and will avoid spending an extra £1.1 billion a year on additional outpatient visits were current trends simply to continue. These resources will instead be used to invest in faster, modern diagnostics and other needed capacity."
- "Reforms to the payment system will move funding away from activity-based payments and ensure a majority of funding is population based"

We are starting to see the impact of this kind of thinking locally, as set out overleaf



Looking to the future: local commissioning context

We are already seeing some of the thinking in the NHS Long Term Plan in our local commissioning context.

- Our local CCGs have ambitious aspirations to reduce the number of hospital attendances for outpatient services, through greater use of virtual clinics and new models of care (such as the gastroenterology clinical assessment service launched in 2018/19). The local CCGs hope to achieve £5 million in savings in 19/20 as a result of this kind of service transformation, though this is subject to ongoing negotiation.
- Our local CCGs and NHS England have now moved to funding outpatient services through a block contract, replacing the current tariff arrangements. This will have the effect of shifting financial incentives on the Trust away from growing activity, and towards minimising unnecessary or inappropriate referrals, cost reduction, and maximising the proportion of outpatient activity that we see that leads to subsequent paid activity (e.g. elective day case / inpatient activity).

Vision for outpatient services (1)

The Trust's vision, as set out in the Trust's five-year strategy, is for **outpatient services that fit around our patients' lives, using the latest technology**

In terms of the care our patients experience, that means….

Patients' valuable time is treated with respect:	• *Patients' assessment, diagnosis, treatment and care is coordinated into a single attendance as far as possible.* • *Patients with multiple comorbidities (e.g. older people with multiple long-term conditions) are able to access joint clinics.* • *Patients are admitted for their surgery on the day where possible, at the right time, and with all pre-operative work completed in advance.*
Care is delivered closer to home.	• *Patients have the information and tools they need to manage their own health and care.* • *GPs have timely access to all of the information and tools that they need to support patient care within primary care as far as possible, including advice and guidance from St George's staff.* • *Patients who do not need to come to hospital receive their care virtually (e.g. by video, phone, letter or via a portal).*
Care is delivered when patients need it.	• *Patients with ongoing or urgent needs are able to access the right clinical expertise when they need it.* • *Patients can choose the date and time of their appointments*

Vision for outpatient services (2)

For the Trust, this vision should also mean:

Freeing up space and workforce	• *Provision of more virtual clinics, better use of the non-consultant workforce (allied health professionals, specialist nurses, associate physicians), and supporting more patients to be cared for at home/in primary care, freeing up space and workforce to develop and grow more innovative, specialist treatments for the people of south west London and beyond, enabling us to be responsive to changing patient demand.*
Improving our estate	• *Greater use of virtual clinics, and rationalisation of what is rovided where, supports improvement to the physical environment that patients and staff experience.*
Better use of resources	• *our workforce is deployed in a way that gets maximum patient benefit from every taxpayer pound we spend. Technology supports clinicians to review patient cases more efficiently (e.g. through virtual clinics, patient apps).*

Implications & next steps

Delivering this vision will mean:

- Fewer face-to-face outpatient appointments on our hospital sites, with clear estates implications
- A significant expansion in online or telephone communication with patients, with clear information management and technology implications
- Different workforce models, with a growing role for specialist nurses, allied health professionals and physician associates

Over the course of 2019/20, a number of corporate support strategies will be developed, which will need to help deliver the vision for outpatient services set out in the Trust strategy (see overleaf).

Implications & next steps

The digital strategy will be essential to delivering our vision for outpatient services, and will need to consider:

- The hardware needed to deliver digitally-enabled outpatient services
- The software needed to deliver digitally-enabled outpatient services
- How the Trust funds & implements these hardware/software changes at pace, in a context of limited capital and competing priorities

For the estates strategy, we will need to consider:

- how much space can be released through supporting more patients to be managed at home/in primary care/virtually, and over what timeframe that space can be released
- opportunities for rationalisation/colocation (e.g. infusion suites)
- how we best use our range of sites, and freed-up estate capacity, to a) pursue other strategic priorities, such as developing/growing those more specialist services that the Trust decides to prioritise in the clinical service strategy (with a final discussion on prioritisation planned for March 2019), or developing more ambulatory care space across the Trust, and b) ensure our outpatient clinics are delivered in an environment that supports provision of a safe, caring, effective service.

For the workforce strategy, we will need to consider:

- how we ensure the Trust is able to recruit the right workforce mix to deliver outpatient services in line with this vision (e.g. physician associates, consultant nurses, allied health professionals)
- how we ensure the Trust is able to retain and develop that mix of roles

Recommendations

Board is asked to:

- Approve the Trust strategy for outpatient services
- Agree implications to be considered through the development of corporate support strategies in 2019/20

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5.1

Meeting Title:	**Trust Board**		
Date:	25 July 2019	**Agenda No.**	**5.1**
Report Title:	**Clinical Negligence Scheme for Trusts (CNST) Scheme for Maternity**		
Lead Director/ Manager:	Avey Bhatia, Chief Nurse & Director of Infection Prevention and Control/		
Report Author:	Charlotte James, Director of Midwifery and Gynaecology Nursing (Outpatients) Austin Ugwumadu, Clinical Director Women's Services Julia Crawshaw, Maternity Transformation Programme Manager Justin Richards, Divisional Chair, CWDT		
Presented for:	Approval		
Executive Summary:	In 2018, NHS Resolution introduced the CNST maternity incentive scheme for the first time. In order to receive a rebate, Trusts were asked to demonstrate compliance with 10 safety standards for maternity care. St George's was able to demonstrate compliance with all 10 Maternity Safety Standards set out by NHS Resolution and received a total rebate of £1.4m from the CNST maternity incentive scheme. To continue its support for the safer delivery of maternity care, NHS Resolution is running the second year of the CNST maternity incentive scheme. Trusts that are again able to demonstrate compliance with all 10 safety standards, will be eligible to receive a rebate equivalent to their contribution to the maternity incentive fund (10% of CNST premium) plus a share of any unallocated funds. Trusts that do not meet all 10 standards will not recover this contribution, but may be eligible for a small discretionary payment to help them make progress towards compliance. This standard template report sets out St George's Maternity Services' progress towards these actions. The evidence available to demonstrate this progress is contained within the appendices. The maternity service can again demonstrate compliance against all ten standards and believe that we have gathered sufficient evidence to receive the rebate outlined above. However any rebate is entirely at the discretion of NHS Resolution based on a review of plans by The National Maternity Safety Champions and Steering Group NHS Resolution. This self-report of compliance will be validated against external data sources by NHS Resolution. The Board must give its permission for the Chief Executive to sign the Board declaration form prior to submission to NHS Resolution by 12 noon on Thursday 15th August 2019. The report will also be discussed with commissioners as set out in the guidance. Trusts will be notified of the results by the end of September 2019, with any payments to be made to the Trust communicated by the end of November 2019. Trusts are not required to submit their supporting evidence to NHS Resolution. The Board must be satisfied that the evidence provided to		

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	demonstrate achievement of the ten maternity safety actions meets the required standards as set out in the safety actions and technical guidance document. Trust submissions will be subject to a range of external verification points, these include cross checking with: MBRRACE-UK data (Safety action 1), NHS Digital regarding submission to the Maternity Services Data Set (Safety action 2), and against the National Neonatal Research Database (NNRD) for number of qualifying incidents reportable to the Early Notification scheme (Safety action 10). Trust submissions will also be sense checked with the Care Quality Commission (CQC). Although submission to NHSR required full Board approval, the Quality and Safety Committee is asked to review the report in order to provide assurance to the Board that the submission can be made.		
Recommendation:	The Board is asked to review the self-report of progress against the CNST safety standards and gives permission to the Chief Executive to sign the Board declaration form for submission to NHS Resolution.		
Supports			
Trust Strategic Objective:	Treat the patient, treat the person Balance the books, Invest in our future		
CQC Theme:	Safe, Well Led		
Single Oversight Framework Theme:	Quality of Care; Finance and Use of Resources; Leadership and Improvement Capability		
Implications			
Risk:	The 10 safety standards are designed to measure how safe a maternity service is; failure to meet the required progress towards these standards could demonstrate a safety / quality issue within the service.		
Legal/Regulatory:	Indemnity agreement with NHS Resolution		
Resources:			
Previously Considered by:	Quality & Safety Committee	**Date:**	18 July 2019
Appendices:	1. Declaration 2. Evidence for actions listed in a table at the end of the document.		

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Clinical Negligence Scheme for Trusts (CNST) incentive scheme for maternity
Trust Board – 25 July 2019

1.0 PURPOSE

1.1 This paper summarises each of the 10 CNST actions that are part of the incentive scheme to promote patient safety. The table below sets out Maternity's position in relation to each of the actions and details the evidential documents that accompany the report.

1.2 NHS Resolution expects trust Boards to self-certify declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of Board governance which the Advisory group will escalate within the system for further exploration. They will also take steps to recover in full any incentive payment that has been made under the scheme.

1.3 The expectation is that trusts will be able to demonstrate the required progress against **all 10** of the actions in order to qualify for a minimum rebate of their contribution to the incentive fund (calculated at 10% of their maternity premia).

2.0 BACKGROUND

2.1 This scheme was launched in 2018 to incentivise local services for taking steps to improve delivery of best practice in maternity and neonatal services.

2.2 Obstetric claims represent the scheme's biggest area of spend. Of the clinical negligence claims notified to NHS Resolution in 2017/18, obstetric claims represented 10% of the volume and 48% of the value of new claims reported.

2.2 The ten safety actions have been agreed with the national maternity safety champions, Matthew Jolly and Jacqueline Dunkley-Bent, in partnership with many other organisations including NHS Digital, NHS England and the CQC.

3.0 EVIDENCE OF TRUST'S PROGRESS AGAINST 10 SAFETY ACTIONS

Safety action – please see the guidance for the detail required for each action	Evidence of Trust's progress	Action met? (Y/N)
Safety action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?	**St George's is compliant with this standard.** a) Since 12 December 2018, all deaths of babies suitable for review using PMRT have been started within four months of their death. b) 71% of all deaths of babies who were born and died at St George's since 12 December 2018 have been reviewed by a multi-disciplinary and had a draft report produced within four months of their death.	**Y**

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Safety action – please see the guidance for the detail required for each action	Evidence of Trust's progress	Action met? (Y/N)
	c) The parents of 88% babies who were born and died at St George's were told that a review of their baby's death will take place and that their perspective and any concerns about their care and that of their baby have been sought. This is less than 100% because we have one safe-guarding case in which the panel felt it was inappropriate for the parents to be contacted. This was confirmed with PMRT on the 09/05/19 d) Quarterly reports have been submitted to the Trust Board which included details of all deaths reviewed and action plans arising from these review. **Available evidence:** Quarterly reports detailing all deaths reviewed and action plans Minutes of Mortality Review Meeting PMRT Tool	
Safety action 2: Are you submitting data to the Maternity Services Data Set to the required standard?	**St George's is compliant with this standard.** Data for January 2019 was submitted by the deadline of 31 March 2019, which met all of the three of the mandatory criteria and 16/19 of the other criteria (minimum of 14/19 required). The first month of MSDS2 data has been submitted for April 2019 by the required deadline. **Available evidence:** NHS Digital data Records of submission from Information Team	**Y**
Safety action 3: Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme?	**St George's is compliant with this standard.** a) The Trust has a guideline in place for transitional care which has been jointly approved by neonatal and maternity teams b) Data is recorded in Badgernet c) An action plan addressing local findings from ATTAIN has been agreed by the LMS and ODN d) Progress on this action plan has been shared with the Trust Board, LMS and ODN **Available evidence:** Guideline which references transitional care (Care of the Newborn) ATTAIN paper taken to LMS and ODN	**Y**

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Safety action – please see the guidance for the detail required for each action	Evidence of Trust's progress	Action met? (Y/N)
Safety action 4: Can you demonstrate an effective system of medical workforce planning to the required standard?	**St George's is compliant with this standard.** **** Need to submit to RCOG once this has been minuted **** a) No trainee gave the answer disagree or strongly disagree with the question *'in my current post educational/training opportunities are rarely lost due to gaps in the rota'.* Therefore no action plan is required. However the rota continues to be monitored regularly to ensure that gaps are covered quickly and that trainees continue to be afforded good educational opportunities. b) The Obstetric Anaesthesia unit meets all of the required ACSA standards. **Available evidence:** Board Report outlining compliance with both standards Email submission to RCOG GMC National Training Survey Results	**Y**
Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?	**St George's is compliant with this standard**. a) A Birthrate Plus review of midwifery staffing was completed in 2017 with staffing reviewed in 2019 b) The Labour Ward co-ordinator is on the rota as supernumerary and compliance with this is recorded on the Maternity Dashboard as one of the top 10 indicators c) Women receive one to one care in labour, in all areas d) A bi-annual report addressing staffing and safety issues has been submitted to the Board. **Available evidence:** Birthrate Plus report Policy stating supernumerary coordinator Midwifery staffing report Red flag report Nursing and Midwifery Establishment Board Report	**Y**
Safety action 6: Can you demonstrate compliance with all four elements of the Saving Babies' Lives care bundle?	**St George's is compliant with this standard** The Board has considered the Saving Babies Lives Bundle and each element has been implemented. **Available evidence:** Training slide on fundal height Dates of training Smoking cessation – document Fetal Monitoring – Abby's document	**Y**

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Safety action – please see the guidance for the detail required for each action	Evidence of Trust's progress	Action met? (Y/N)
	Board minutes for SBL Care Bundle – (previous submission)	
Safety action 7: Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?	**St George's is compliant with this standard** Users are involved in the development and improvement of maternity services in a variety of ways including: - Active Maternity Voices Partnership (MVP) which includes bi-monthly meetings and walk the patch event. Feedback arising from the MVP is considered and acted upon by the Trust - Co-design project to improve women's experience of birth in theatre - Feedback from women involved in research - MVP Chair standing member of Maternity Transformation (improvement) Programme - Parental involvement in investigations **Available evidence:** Minutes of MVP meetings New Beginnings project information Minutes of Maternity Transformation Steering Group SI Reports / PMRT Reports MatNeo Project Plan Maternity Transformation Terms of Reference	**Y**
Safety action 8: Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?	**St George's is compliant with this standard** 90% of each maternity unit staff group have attended in-house multi-professional training within the last year. This training has included fetal monitoring in labour and integrated team-working. **Available evidence:** Training spreadsheet	**Y**
Safety action 9: Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?	**St George's is compliant with this standard** a) The Executive Sponsor for the Maternity and Neonatal Health Safety Collaborative (Director of Delivery, Efficiency and Transformation) is actively engaged with both the Trust and LLS, attending Local safety events and as the SRO for the Maternity Transformation Programme. b) The Board Level safety champion attends a monthly feedback session for staff and is appraised of safety incidents relating to staffing c) Progress on actions taken to address safety concerns are fed back to staff through a variety of methods.	**Y**

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Safety action – please see the guidance for the detail required for each action	Evidence of Trust's progress	Action met? (Y/N)
	Available evidence: Minutes of Maternity Transformation Emails relating to MatNeo Safety Collaborative Wave 3 Monthly Transformation Reports to Board Details of attendance at National Learning Events Maternity Dashboard circulation emails Minutes of meetings recording staff safety concerns and actions taken Risky Business – You Said / We Did Monthly maternity and gynae newsletter	
Safety action 10: Have you reported 100% of qualifying 2018/19 incidents under NHS Resolution's Early Notification scheme?	**St George's is compliant with this standard** All known qualifying incidents which occurred in the financial year 2018/19 have been reported to NHS Resolution under the Early Notification Scheme. **Available evidence:** Trust reported data	**Y**

4.0 IMPLICATIONS

Risks

4.1 Only trusts that meet the required progress against all 10 maternity safety actions will be eligible for a payment of at least 10% of their contribution to the incentive fund. Trusts that do not meet the 10 out of 10 threshold may be eligible for a discretionary payment from the incentive fund to help them to make progress against one or more of the 10 actions. Such a payment would be at a much lower level than the 10% contribution to the incentive fund.

4.2 **Quality:** The 10 safety standards are designed to measure how safe a maternity service is; failure to meet the required progress towards these standards could demonstrate a safety / quality issue within the service.

Legal/Regulatory

4.3 CNST is the indemnity provided by NHS Resolution to manage claims against trusts when clinical incidents are alleged to have taken place

5.0 TIMELINE

5.1 Trusts must submit self-certification reports to NHS Resolution by 12 noon on Thursday 15 August 2019.

5.2 Review of final results/business cases by NHS Resolution is by the end of September, with processing of incentive scheme payments in November

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6.0 RECOMMENDATION

6.1 The Board is asked to review the self-report of progress against the CNST safety standards and gives permission to the Chief Executive to sign the Board declaration form for submission to NHS Resolution.

Author: **Charlotte James, Director of Midwifery and Gynaecology Nursing (Outpatients)**
Austin Ugwumadu, Clinical Director Women's Services
Julia Crawshaw, Maternity Transformation Programme Manager

Date: **03/07/2019**

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Appendix 1: Declaration

……..

For and on behalf of the Board of St George's University Hospitals NHS Foundation Trust confirming that:

- **The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets the required standards and that the self-certification is accurate.**
- **The content of this report has been shared with the commissioner(s) of the Trust's maternity services**
- **If applicable, the Board agrees that any reimbursement of CNST funds will be used to deliver the action(s) referred to in Section 6**

Position: **…….**

Date: **…….**

We expect trust Boards to self-certify the Trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of board governance which the Steering group escalate to the appropriate arm's length body/NHS System leader.

……..

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Appendix 2: LIST OF EVIDENTIAL APPENDICES

Applicable Action	Appendix Name
Action 1	CNST Action 1a: Quarterly reports detailing all deaths reviewed and action plans CNST Action 1b: Minutes of Mortality Review Meeting
Action 2	CNST Action 2a: Email confirming data submission
Action 3	CNST Action 3a: ATTAIN Paper CNST Action 3b: Transitional Care Guideline CNST Action 3c: List of cases ATTAIN paper taken to LMS and ODN – need minutes
Action 4	CNST Action 4a: Board Report outlining compliance with both standards CNST Action 4b: Board minutes CNST Action 4C: Email submission to RCOG
Action 5	CNST Action 5a: Nursing and Midwifery Establishment Board Report CNST Action 5b: Guideline for Supernumerary Coordinator CNST Action 5c: Red flag Report CNST Action 5d: Trust Board Minutes May 2019
Action 6	Board minutes for SBL Care Bundle – (previous submission)
Action 7	CNST Action 7a: Minutes of MVP meetings CNST Action 7b: New Beginnings Newsletters CNST Action 7c: Picker Results
Action 8	CNST Action 8a: Report on training
Action 9	CNST Action 9a Quarterly Transformation Report to Board Minutes of Maternity Transformation Emails relating to MatNeo Safety Collaborative Wave 3 Monthly Transformation Reports to Board Details of attendance at National Learning Events Maternity Dashboard circulation emails Minutes of meetings recording staff safety concerns and actions taken Risky Business – You Said / We Did Monthly maternity and gynae newsletter
Action 10	CNST Action 10a Each Baby Counts Submission

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Meeting Title:	Trust Board		
Date:	25 July 2019	**Agenda No**	5.2
Report Title:	Board Assurance Framework (BAF) 2019-2020		
Lead Director/ Manager:	Avey Bhatia, Chief Nurse and Director of Infection Prevention and Control		
Report Author:	Alison Benincasa, Quality Improvement Director		
Presented for:	Approval, Assurance		
Executive Summary:	Attached is the summary BAF for quarter 1 2019-2020 (appendix 1). Also attached is the full BAF for the strategic risks reserved for Board (SR 5 and SR 6) in appendix 2. **BAF Summary Assurance Rating** The summary page of the full BAF details the new strategic risks for 2019-2020 following the re-mapping exercise to align the existing risks on the corporate risk registers to the new strategic risks. This is still a work in progress as some of the corporate risks need redefining. The BAF summary gives an overview of the risk profile for the Trust and enables the Board to ensure its agenda is directed to improving control of the strategic risks. The BAF summary has been updated with the quarter 1 2019-2020 assurance rating, assurance statements and risk scores from the sub-committees of the Board. Nine risks have a 'partial' assurance rating and seven risks have a 'limited' assurance rating (see appendix 3 for definitions). **Strategic risks reserved for the Board – SR 5 & SR6** With reference to appendix 2 the Board is asked to discuss and agree the proposed risk score, assurance rating and the assurance statement for the strategic risks. When considering the current risk score the Board's attention is drawn to slide 2. When considering the assurance rating and assurance statement the Board's attention is drawn to slide 4. The risk reduction schedule at slide 3 will be completed following the Board's discussion and agreement on the proposed risk rating.		
	The Board is asked: 1. For strategic risks reserved to itself (SR5 and SR6) to: • Agree the risk rating • Agree the assurance rating • Agree the assurance statement (shown in italics) 2. For the 14 risks assigned to its assuring committees to: • Note the risk score, assurance rating and statement from the relevant		

5.2

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	assuring committee and highlight any issues that the Board would like the assuring committees to consider.		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	Well led		
Single Oversight Framework Theme:	Quality of Care Leadership and Improvement Capability		
Implications			
Risk:	The strategic risk profile		
Legal/Regulatory:	Compliance with Heath and Social Care Act (2008), Care Quality Commission (Registration Regulations) 2014, the NHS Act 2006, NHSI Single Oversight Framework, Foundation Trust Licence		
Resources:	N/A		
Previously Considered by:	Trust Executive Committee Quality and Safety Committee Finance and Investment Committee Finance and Investment Committee – Estates & IT	**Date**	17 July 2019 18 July 2019 18 July 2019 18 July 2019
Equality Impact Assessment:	N/A		
Appendices:	Appendix 1. Summary Board Assurance Framework (BAF) Appendix 2. Assurance Report for Q1 2019/20 on Trust Board Strategic Risks Appendix 3. Assurance ratings – definitions Appendix 4. Risk Grading, 5X5 matrix and calculation of risk score		

Appendix 1

BOARD ASSURANCE FRAMEWORK OVERVIEW QUARTER 1 2019-2020											
Strategic Objective	Risk appetite	Strategic Risk		Quarterly Assurance Rating				Reason for Current Assurance Rating	Executive Lead	Assuring Committee	Current Risk Score
				Q1	Q2	Q3	Q4				
1. Treat the patient, treat the person	Low	SR1	There is a risk that we do not create an environment and embed an approach to Quality Improvement which minimise the occurrence of harm to our patients					The committee has received assurance on the thematic analysis of serious incidents in Radiology and Maternity services, performance metrics within the IQPR and reporting committee reports. The Quality Improvement Academy is supporting the use of improvement methodology for service improvement initiatives. The assurance rating is currently partial as further assurance is required to ensure improvements and learning from incidents and complaints are consistently embedded in practice	Chief Nurse	Quality & Safety Committee	12
	Low	SR2	There is a risk that our clinical governance structures and how we implement them are neither clear nor robust and inhibit our ability to provide outstanding care.					The committee has received assurance from the Cardiac Surgery update reports on progress with the action being taken and reports on progress with the NHSI Mortality Review. There are further risks that need to be included in to the corporate risk register to reflect the recommendations from the governance review	Chief Medical Officer	Quality & Safety Committee	12
2. Right care, right place, right time	Low	SR3	There is a risk that our patients wait too long for treatment					The committee has received assurance on the 4hour operating standard and the management of patient pathways. The assurance rating is currently partial to reflect the need for further work and improvement. The committee has requested that the 4 hour operating standard risk is reviewed in terms of how it is presented and scored separating clearly patient safety risks from reputational risks	Chief Operating Officer	Quality & Safety Committee	12
	Low	SR4	There is a risk that our staff cannot provide outstanding care as IT does not become more reliable, easier to use and more integrated					The committee has received assurance on the improvement plans for delivery in Q2. The assurance rating is currently limited until there is evidence of actions being implemented	Chief Information Officer	Finance and Investment Committee	20
	Moderate	SR5	There is a risk that we fail to make progress in delivering our clinical services strategy					For Decision after discussion at Trust Board: The Trust strategy implementation plans were approved by Trust Board in June 2019. The assurance rating is currently limited until the first progress report is presented to Trust Board in October 2019.	CEO (Director of Strategy)	Board	15
	Moderate	SR6	There is a risk that we do not make progress in increasing integrated and transformed services as a system across SW London in line with the SWL Health and Care Partnership priorities.					For Decision after discussion at Trust Board: SWL Health and Care Partnership meetings are focussed on developing the Integrated Care System; this entails a very different way of working across the system. The committee is reasonably assured that controls are generally adequate but indicates a partial assurance rating in Q1 to reflect the expectation for different ways of working	CEO (Director of Strategy)	Board	9
3. Balance the books, invest in our future	Low	SR7	There is a risk that we do not develop plans to achieve unsupported financial balance within 3* years (*to be confirmed with regulators in conjunction with national planning guidance)					The committee has received assurance on the plans in place to achieve this objective. The assurance rating is currently limited pending clarity on the planning requirement set for the Trust	Chief Financial Officer	Finance and Investment Committee	20
	Low	SR8	There is a risk that the Trust is unable to source sufficient capital funds to support investment in areas of material risk					The committee has received assurance on the plans in place to achieve this objective. The assurance rating is currently limited as the Trust needs to secure additional capital funds. This has yet to be completed	Chief Financial Officer	Finance and Investment Committee	16
4. Build a better St George's	Low	SR9	There is a risk that we are unable to deliver an estates strategy that supports the delivery of our clinical services strategy					The committee has received assurance on the plans in place to achieve this objective. The assurance rating is currently limited with reference to strategic risk 8 above and will continue to be updated to reflect the strategic developments over time	Director of Estates & Facilities	Finance and Investment Committee	16
	Low	SR10	There is a risk that we do not improve our estate to provide a safe and compliant environment for our patients and staff					The committee has received assurance on the improved governance processes in place and plans to achieve this objective and the committee continues to lead this work. The assurance rating is limited to reflect the current condition of some of the estate. Actions are underway to mitigate risks. Long term solutions link to SR8	Director of Estates & Facilities	Finance and Investment Committee	20
5. Champion team St George's	Low	SR11	There is a risk that we are unable to achieve a significant shift in culture whereby staff feel engaged, safe to raise concerns and are empowered to deliver outstanding care					The committee has received assurance on the progress achieved to date in the development of the staff engagement plan for 2019-2020, the proposed implementation of new engagement methodology (GoEngage) planned for October 2019 and the new Raising Concerns at Work Policy to be implemented in August 2019. The assurance rating is currently partial; controls are generally adequate but the committee seeks assurance that controls will deliver demonstrable progress in some areas	Director of HR and OD	Workforce and Education Committee	12
	Low	SR12	There is a risk that we are not seen as a diverse and inclusive employer by our staff					The committee has received assurance on the launching of staff network groups for protected characteristics and had the opportunity to analyse workforce data associated with workforce relations cases. A Trust Board seminar is planned for August 2019. The assurance rating is currently partial to reflect the need for further work in some areas. The committee has requested a review of this risk in terms of how it is presented and scored	Director of HR and OD	Workforce and Education Committee	9
	Low	SR13	There is a risk that we are unable to sufficiently address issues of harassment and bullying					The committee has received assurance on the new Raising Concerns at Work Policy to be implemented in August 2019. The assurance rating is currently partial to reflect the need to measure the impact of the new policy in practice	Director of HR and OD	Workforce and Education Committee	12
	Low	SR14	There is a risk that we are unable to recruit, train and sustain (retain) an engaged and effective workforce					The committee has received assurance on the Trust vacancy rates and the impact of the Trust's participation in the NHSI National Retention Programme. However, the committee recognises on-going issues within some staff groups. The assurance rating is currently limited to reflect the need for further work	Director of HR and OD	Workforce and Education Committee	16
	Low	SR15	There is a risk that we are unable to develop new and innovative roles/ways of work to deliver our Trust clinical strategy					The committee has received assurance on the developing Workforce Strategy, with the first draft expected in September 2019, and the leadership development activity across the Trust. The assurance rating is currently partial to reflect the need for further work	Director of HR and OD	Workforce and Education Committee	12
6. Develop tomorrow's treatments today	High	SR16	There is a risk that we cannot compete against other key NHS organisations delivering large programmes of research, with a consequence that we lose research funding, are less able to attract high calibre staff and lose our reputation for clinical innovation.					The committee has received assurance on the significant improvement in the numbers of patients recruited to clinical trials. The assurance rating is currently partial to reflect the need to sustain the position and receive further updates at committee	Chief Medical Officer	Quality & Safety Committee	9

excellent
kind
responsible
respectful

St George's University Hospitals NHS
NHS Foundation Trust

5.2

Trust Board 25 July 2019

Assurance Report for Q1 2019/20 on Trust Board Strategic Risks 5 & 6

Chief Nurse and Director of Infection Prevention and Control
and Chief Strategy Officer

Individual risks contributing to strategic risks

St George's University Hospitals NHS
NHS Foundation Trust

		* Overall SR score is based on the highest risk score		
Risk short form title	**Description**	**Open Date**	**Initial Score***	**Current Score Q1 19/20***
SR5 - There is a risk that we fail to make progress in delivering our clinical services strategy				15
Capital availability to implement strategy	Risk that we do not have capital available to implement the strategy *(cross referenced to Finance risk: Maintaining a five year forward view)*	Jul 2019		12
Commissioners' support	Risk that the Trust does not have Commissioners' support to implement the strategy	Jul 2019		10
Capacity and capability to implement strategy	Risk that the Trust does not have capacity and capability to implement the strategy	Jul 2019		15
Other providers' strategies conflicting with Trust strategy	Risk that other providers' strategies are in conflict with the Trust's strategy and therefore unable to deliver	Jul 2019		15
SR6 - There is a risk that we do not make progress in increasing integrated and transformed services as a system across SW London in line with the SWL Health and Care Partnership priorities				**9**
Workforce - Non viable clinical rotas	Risk of non-viable clinical rotas	Jul 2019		9
Increase demand on provided services	Risk that services continue to see current or increase demand on provided services	Jul 2019		9
Clinical pathways variation	Risk we do not eliminate variation across clinical pathways leading to poor patient experience	Jul 2019		9

5.2

Risk Reduction schedule

St George's University Hospitals NHS
NHS Foundation Trust

Key		Extreme Risk		High Risk		Moderate Risk		Mitigated Risk		Expected changes	o	Original timescale	x	Subsequent timescale

Short form of risk description	Score	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	Apr 20
Capital to implement strategy***							12									
Commissioners support***							10									
Capacity and capability to implement strategy***							15									
Other providers' strategies in conflict with Trust strategy***							15									
Workforce - Non viable clinical rotas***							9									
Increase demand on services***							9									
Pathway variation***							9									

***** The risk reduction schedule for the strategic risks above will be completed following the Trust Board discussion and agreement on the current risk rating.**

5.2

Source of Assurances and Assurance Rating

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Strategic Risk	Risk Appetite	Assurance Statement	Assurance Rating 2019/20			
			Q1	Q2	Q3	Q4
SR5 - There is a risk that we fail to make progress in delivering our clinical services strategy	**Moderate**	Supporting strategies are being developed during 2019/20 to support delivery of the Trust Strategy. Implementation plans have been developed by the each Division and will report progress through their Divisional Management Boards. Trust Board has overview of the implementation plan and will receive reports every 6 months on progress – first report due October 2019. The Trust has secured commissioners' support for the strategy. The management capacity will be addressed within the recruitment planning by the COO SWL STP attended by chief executives. The Trust attends key meeting & forums attended by commissioners and other providers.	Limited			
SR6 - There is a risk that we do not make progress in increasing integrated and transformed services as a system across SW London in line with the SWL Health and Care Partnership priorities	**Moderate**	• The Acute Provider Collaborative meetings are chaired by the Trust CEO. The meeting has a focus on clinical pathway standardisation. • The Trust is represented at all SWL HCP meetings • The Acute Provider Collaborative meetings are attended at Director level • STP and Acute Provider Collaborative Forums allow general oversight of commissioner and provider plans to develop relationships outside the sector	Partial			

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Appendix 3 **Assurance ratings – definitions**

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

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Appendix 4

Risk Grading

SCORE	ACTION PRIORITY
15 - 25	EXTREME
10 - 14	HIGH
8 – 9	MEDIUM
4 – 6	LOW
1 – 3	VERY LOW

Calculating risk score

This section describes how to score risks by estimating severity of impact and likelihood of occurrence using a standard 5x5 matrix. Each risk can be measured by multiplying the severity of harm and the likelihood of that harm occurring. This calculation will produce a Residual Risk Score that refers to the amount of risk remaining after treatment. The Trust uses a standard 5 x 5 scoring matrix set out below.

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

*Use of relative frequency can be helpful in quantifying risk, but a judgment may be needed in circumstances where relative frequency measurement is not appropriate or limited by data.

5x5 MATRIX

X			SEVERITY			
		1	2	3	4	5
	1	1	2	3	4	5
LIKELIHOOD	2	2	4	6	8	10
	3	3	6	9	12	15
	4	4	8	12	16	20
	5	5	10	15	20	25

Consequence - Consequence is graded using a 5-point scale in which 1 represents the least amount of harm, whilst 5 represents catastrophic harm/loss. Each level of severity looks at either the

extent of personal injury, total financial loss, damage to reputation or service provision that could result. Consistent assessment requires assessors to be objective and realistic and to use their experience in setting these levels. Select whichever description best fits.

Likelihood - Likelihood is graded using a 5-point scale in which 1 represents a rare probability of occurrence, whilst 5 represents an almost certain occurrence. In most cases likelihood should be determined by reflecting on the extent and effectiveness of control in place at the time of assessment, and using relative frequency where this is appropriate.

Differing Risk Scenarios - In most cases the highest degree of severity (i.e. the worst case scenario) will be used in the calculation to determine the residual risk. However, this can be misleading when the probability of the worst case is extremely rare and where a lower degree of harm is more likely to occur. For example, multiple deaths from medication error are an extremely rare occurrence, but minor or moderate harm is more frequently reported and may therefore have a higher residual risk. Whichever way the residual risk score is determined it is the highest residual risk score that must be referred to on the risk register.

St George's University Hospitals NHS
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5.3

Meeting Title:	Trust Board		
Date:	25 July 2019	**Agenda No**	**5.3**
Report Title:	**St. George's Hospital Charity: Quarterly Update (Quarter 1 2019/20)**		
Lead Director	Suzanne Marsello, Chief Strategy Officer (Director sponsor for St George's Charity)		
Report Author:	Amerjit Chohan, CEO, St George's Hospital Charity Vivien Gunn, Grants Manager, St George's Hospital Charity		
Presented for:	Update		
Executive Summary:	At their meeting in May 2019 Trustees approved a total grant value of £264,678.14 with a further £35,511.80 approved through internal authorisation processes prior to the meeting. Trustees agreed to publish a fundraising target of £1,000,000 for the Renal Appeal towards the replacement of the Renal Dialysis Trailers on the Tooting site. The launch of the fundraising campaign takes place this month, July 2019. The charity is working in partnership with The Christian Blandford Charity, Momentum Charity and Samuels Charity. Together the Charity aims to raise £500k to fund the refurbishment of Nicholls, Freddy Hewitt and Pinkney wards. The charity is also being supported by a donor who has offered to provide air circulation and air cooling systems across all three wards.		
Recommendation:	The Trust Board is asked to note the report, and the investment that has been awarded by the Charity in support of Trust projects.		
Supports			
Trust Strategic Objective:	1. Treat the patient, treat the person 2. Right care, right place, right time 3. Balance the books, invest in our future 4. Build a better St. George's 5. Champion Team St. George's 6. Develop tomorrow's treatments today		
CQC Theme:	1. **Safe**: you are protected from abuse and avoidable harm. 2. **Effective**: your care, treatment and support achieves good outcomes, helps you to maintain quality of life and is based on the best available evidence. 3. **Well-Led**		
Single Oversight Framework Theme:	▪ Strategic Change		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	Trust Executive Committee	**Date:**	17th July 2019
Appendices:	N/A		

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St. George's Hospital Charity Quarter 1 2019/20 Update

1.0 Purpose

The report is provided to give the Trust Board an update regarding the activities of the Charity in Quarter 1 2019/20.

2.0 St George's Hospital Charity Grants Update

The Trustees met in May 2019 and approved a total grant value of £264,678.14.

(The key to the grant reference indicates the source of the funding: APP – Appeals, SPF – Special Purpose Fund, LEG – Legacy Donation, GEN – general funds.)

1)

Grant Ref.:	APP 19-20 001
Amount:	£26,730
Grant:	The purchase of a Video EEG system to monitor head injured and seizing children
Funds:	Raised through the Yutong Su Fund for Children - Code 11263

2)

Grant Ref.:	APP19-20 003
Amount:	£39,102.14
Grant:	Two year salary for a Young Onset Dementia Support Worker for Cognitive Neurology Clinic
Funds:	The Appeal for Young Onset Dementia – Code 11186

3)

Grant Ref.:	APP 19-20 005
Amount:	£50,000
Grant:	The Implementation of a Mobile Panic Alarm System in the Emergency Department for the Welfare and Protection of Patients, Staff and Visitors. This was following an in principle decision by trustees on 23rd November 2018. The project has started and is proceeding well.
Funds:	The A&E Appeal and A&E General Fund (Special Purpose Fund)

4)

Grant Ref.:	SPF 19-20 003
Amount:	£37,470
Grant:	The Evaluation of Ten Interventions to Improve End of Life Care. To address a Care Quality Commission Report in 2016 which concluded End of Life Care by the Trust was below standard. Application by the Joint Faculty of Kingston and St George's.
Funds:	The SPF General Community Fund – Code 18000

5)

Grant Ref.:	GEN 19-20 001
Amount:	£100,000
Grant:	Development of a new Intranet for St George's University Hospitals NHS Foundation Trust. The total budget is £150,000. The Trust is funding the remaining £50,000
Funds:	Redeployment of two previous funds

6)

Grant Ref.:	SPF 19-20 005
Amount:	£11,376
Grant:	12 Glideaway Beds for relatives/carers of dying patients with dementia to use overnight. Application fits with the End of Life Strategy 2016-2020 to improve end of life.
Funds:	The SPF General Community Fund

Trustees were made aware of the following approvals to the total value of £35,511.80. These approvals fall under the charity's internal authorisation processes falling outside of board meetings.

7)

Grant Ref.:	APP 19-20 002
Amount:	£3,750
Grant:	ParrotPlus Recorded Speech Material Test Equipment for Paediatric Audiology Dept.
Funds:	Children's Appeal Fund – Code 11193

8)

Grant Ref.:	SPF 19-20 002
Amount:	£11,521.44
Grant:	18 x Office Chairs for PICU for staff
Funds:	The SPF Paediatric ICU Appeal – Code 11039

9)

Grant Ref.:	Not applicable – via Purchase Requisition Application rather than grant
Amount:	£4,540.36
Grant;	Skin Cancer Dermatoscopes x 4
Funds:	The SPF Melanoma Foundation 11098

10)

Grant Ref.:	Not applicable – Via Purchase Requisition Application rather than grant
Amount	£4,200
Grant:	PDT Machine to treat dermatology pre-cancer- cancer patients'
Funds:	The SPF Skin Cancer Research Fund – Code -11026

11)

Grant Ref.:	LEG 19-20 001
Amount:	£11,500
Grant:	Paxman Scalp Cooling System to help prevent hair loss post chemotherapy
Funds:	The Burchill Legacy – Code 11281

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The Renal Appeal

Trustees agreed to set a fundraising target of £700,000 for the Renal Appeal. A Memorandum of Understanding is being drafted between the Charity and the Trust concerning the Renal Appeal and the corresponding grant application.

The grant application for the redevelopment of the Renal Dialysis Trailers will still be subject to formal approval by the Trustees as a fundraising campaign once the extent of the fundraising is confirmed.

Other Capital Projects

1) The Charity is working in partnership with The Christian Blandford Charity, Momentum Charity and Samuels Charity. Together the charity aims to raise £500k to fund the refurbishment of Nicholls, Freddy Hewitt and Pinkney wards. The charity is also being supported by a donor who has offered to provide air circulation and air cooling systems across all three wards.

2) Caesar Hawkins Ward refurbishment - £100,000 grant by Charity complete.

3) The refurbishment of the Surgical Assessment Lounge (SAL) – Grant application for £200,000 to be submitted to Trustees for their consideration on September 27th 2019. (This covers the entire budget requirement).

4) Maternity Transformation grant for refurbishment of Maternity Receptions £60,000 has not been drawn down as the refurbishment has not yet begun.

Fundraising by the Charity for the following projects continues:

1) Funds have been raised for the renovation and refurbishment of the Forget Me Not Suite for the Maternity Ward Level 1. The Charity is waiting for confirmation of the capital required for the refurbishment in order to progress the project.

2) There are two projects which the General Intensive Care Unit wishes to progress for which a combination of funds are available:
   a) Refurbishment of the General Intensive Care Unit 'Quiet Room':
      This room is intended to provide comfort and privacy for relatives and patients when difficult conversations are required. The Charity through patients' family and friends has raised some funds towards this project and separately the SPF Intensive Therapy Fund has a healthy balance which fund advisors are willing to use for the refurbishment.

   b) Creating a General Intensive Care Garden:
      The aim of this project is to improve the environment for relatives and patients: the relatives' waiting room and patients' rooms look out onto a roof. The intention is to create a garden for them to look at. The SPF Intensive Therapy Fund has a healthy balance which fund advisors are willing to use for the creation of the garden.

3) Creating a Roof Terrace Garden for the Neurosciences Intensive Care Unit for non-ambulatory and ventilated patients, with a separate section for staff. Approvals from PFI and risk assessments have been completed as part of a formal grant application to the Charity. The total budget required is £27,000. The Charity is assisting with fundraising; some funds have already been raised to assist with reaching the total target.

St George's University Hospitals NHS
NHS Foundation Trust

Special Purpose Funds

The Charity oversees in the region of 230 Special Purpose Funds with a value of c£6 million.

A piece of work to review all of these funds is underway to check that SPFs are aligned according to the Trust's divisional structure in terms of clinical services; to review listed fund advisors for accuracy; and to ensure that there is clarity re the availability of SPF funds.

Forthcoming Charity Trustee Board Meetings

Charity Trustees will next meet on 27th September 2019 and 22nd November 2019.

3.0 Recommendation

The Trust Board is asked to note the report and the investment that has been awarded by the Charity in support of Trust projects.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	25 July 2019	**Agenda No**	5.4
Report Title:	Horizon Scanning Report, Q1 2019/20		
Lead:	Stephen Jones, Chief Corporate Affairs Officer		
Report Author:	Stephen Jones, Chief Corporate Affairs Officer		
Presented for:	Information		
Executive Summary:	This report provides the first of a new series of quarterly updates on emerging political, legislative, policy and regulatory issues that have relevance to the Trust. This report focuses on key developments in Q1 2019/20, highlighting in particular developments in relation to: • The political and legislative environment • The NHS policy and institutional landscape • System and professional regulation • Topical issues from key stakeholders and updates on national partners' recent Board meetings. • Updates on new and on-going inquiries • Recent appointments to national bodies. The report is intended to support the Board in providing a regular and systematic review of national political, policy and regulatory developments. It is distinct from the strategy horizon-scanning work which focus on issues directly relating to the Trust strategy and supporting strategies and which will be presented to the Board in the autumn.		
Recommendation:	The Board is asked to note the report.		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	Well-Led		
Single Oversight Framework Theme:	Leadership and Improvement Capability (Well-led)		
Implications			
Risk:	As set out in the paper.		
Legal/Regulatory:	As set out in the paper.		
Resources:	As set out in the paper.		
Previously Considered by:	Trust Executive Committee	**Date**	17 July 2019
Appendices:	Horizon Scanning Report, Q1 2019/20		

5.4

5.4

Horizon scanning report, Q1 2019/20

Stephen Jones, Chief Corporate Affairs Officer
25 July 2019

St George's University Hospitals NHS
NHS Foundation Trust

1. Purpose

The NHS Leadership Academy identifies three essential 'building blocks' in helping NHS boards to exercise their roles of formulating strategy, ensuring accountability and shaping a healthy culture effectively. Effective boards are informed by the external context within which they operate. They are informed by and shape the intelligence on understanding local needs, trends and comparative information on organisational performance, and give priority to engagement with stakeholders and opinion formers.

This report seeks to provide the Board with a regular update on key developments in the Trust's external environment at the national level, particularly in relation to:

- **Political and legislative developments**: Current and emerging political and parliamentary developments at a national level with direct or indirect implications, or potential implications, for the Trust; Key changes, or potential future changes, to primary legislation and regulations.
- **NHS policy and institutional landscape**: Changes and developments in relation to significant new national policy as determined by the central NHS organisations, and changes to the national architecture and structures of the NHS and those organisations with which the Trust interacts.
- **System and professional regulation**: Changes and prospective changes to the regulatory landscape, of both system regulators and relevant professional regulators with potential relevance to the Trust.
- **Reports and updates from key stakeholders**: Topical reports from key national bodies and other stakeholders of potential relevance to the Trust, and highlights of recent Board meetings of key system partners.
- **Current inquiries**: Summary of key inquiries that are underway.
- **Appointments**: Key appointments to national bodies and other key stakeholders.

This is the first such report to the Board and the format and issues will be reviewed to ensure the Board receives, through this report, a comprehensive quarterly update on key issues relating to these areas. It is distinct from the strategy horizon scanning work that will be reported to Board in the autumn which will focus on issues directly relating to the Trust strategy and supporting strategies.

Source: NHS Leadership Academy

5.4

St George's University Hospitals NHS
NHS Foundation Trust

2. Themes and structure of this report

Political and legislative developments

NHS policy and institutional landscape

System and professional regulation

Reports and updates from key stakeholders

Current inquiries

New appointments

5.4

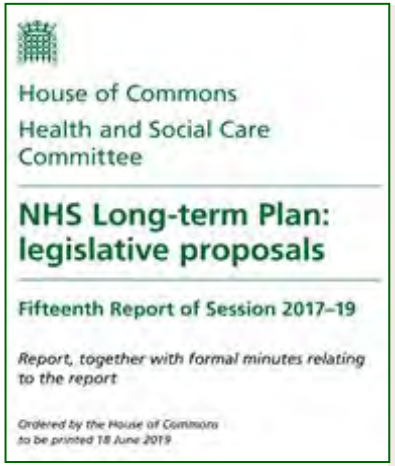
3

St George's University Hospitals NHS
NHS Foundation Trust

3. Political & legislative developments

UK withdrawal from the EU

- On 26 June 2019, the Government announced plans to lead a procurement exercise to secure an 'express freight service' to transport small medical supply consignments into the UK within 24 hours if the UK leaves the EU without a deal. The stated purpose of this plan is to support the uninterrupted supply of medicines and medical products where there is an urgent need or where a supplier's own logistics are disrupted. The Government also stated that medicines and medical products would be prioritised within a new freight capacity framework agreement for critical supply chains, the plans for which are being developed by the Department for Transport.
- The measures to prepare for a no deal Brexit include the building up of buffer stocks across a range of sectors including: medicines; medical devices and clinical consumables; blood and transplants; vaccines and countermeasures; supplies for clinical trials; and non-clinical goods and services. The Government wrote to suppliers on 26 June advising them to develop plans for balancing stockpiling and re-routing of medical devices and supplies.
- The Trust has an EU withdrawal working group which is considering contingency planning for the UK's withdrawal from the EU. The CFO and Deputy CEO is the Trust's SRO for 'Brexit'.



NHS Legislative Framework

- On 7 January 2019, NHS England and NHS Improvement published the NHS Long Term Plan. The Plan set out a number of changes to legislation required to ensure that NHS organisations, at both local and national level, are able to work together effectively to redesign care around patients. The legislative proposals were set out for consideration by Parliament.
- On 18 June 2019, the Health and Social Care Select Committee published the report of its inquiry into the legislative changes proposed in the LTP. Overall, the Committee welcomed the proposals and which it described as "a pragmatic set of reforms, which remove barriers to integrated care".
- The report particularly welcomed in principle the emphasis on promoting collaboration and the revocation of existing competition rules. It also supported the removal of the role of the Competition and Markets Authority in overseeing NHS mergers. In addition, it welcomed the intent behind the proposals to give commissioners greater discretion over when to conduct a procurement process.
- The Committee recognised that further progress in cooperation between national NHS bodies was "hampered" by the current legislative framework and it "supported in principle the proposal to merge NHS England and NHS Improvement into a single body", but also expressed concern at the level of central control that would result from such a merger.
- The Committee expressed reservations that the proposals were too NHS-centric and did not sufficiently consider the role of the wider system within which the NHS needs to integrate and called for greater clarity on the role of local authorities, the voluntary and wider community sector and independent providers. Linked to this, the Committee proposed that local authorities should be able in legislation to participate in joint committees with Trusts and CCGs.
- The next step would be for draft legislation to be prepared and to be reviewed by the Committee. There is no confirmation of the timing of this at present.

4. NHS policy and institutional landscape

NHS Patient Safety Strategy

- On 2 July 2019, NHS Improvement and NHS England published the new NHS Patient Safety Strategy. The strategy sets out a vision to continuously improve patient safety building on two foundations; developing a "patient safety culture" and a "patient safety system". It also sets out three strategic aims to achieve this vision:
  i. insight: improving understanding of safety by drawing intelligence from multiple sources of patient safety information;
  ii. involvement: equipping patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system; and
  iii. improvement: designing and supporting programmes that deliver effective and sustainable change in the most important areas. It places particular emphasis on the importance of improving the way in which NHS organisations learn, treat staff and involve patients.

- **Patient safety culture:** The strategy describes the importance of organisations establishing and embedding a "patient safety culture" – focusing on preventing incidents, avoiding blame, and adopting a systems approach to error. It goes on to describe the 'key ingredients' for healthcare organisations to develop such cultures:
  i. staff who feel psychologically safe;
  ii. valuing and reflecting diversity;
  iii. a compelling vision;
  iv. good leadership at all levels;
  v. a sense of teamwork, openness and support for learning.

  The strategy encourages NHS organisations to use existing culture metrics, like the NHS staff survey, to understand their safety culture and on staff perceptions of the fairness and effectiveness of incident management. It recommends organisations adopt the NHS Just Culture Guide or an equivalent. It states that progress will be monitored through the NHS staff survey metrics about fairness and effectiveness of reporting, and staff confidence and security in reporting.

- **Patient safety system:** The strategy also describes the key elements of a patient safety system, highlighting the importance of workforce, and the links between workforce capacity and capability and patient safety, and staff wellbeing. It highlights the need for effective and coordinated regulation across the NHS with a common understanding of safety. In addition, it emphasises the importance of digital and technology in supporting safety.

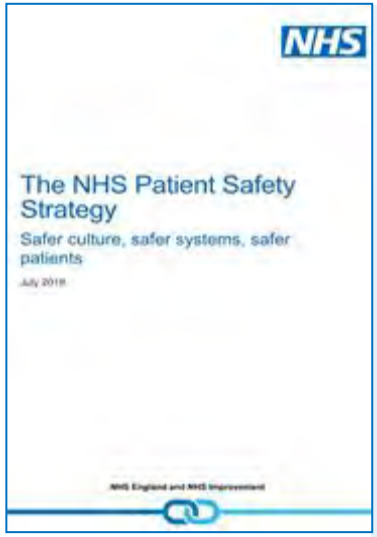
- **Patient Safety Incident Response Framework:** One notable change announced by the Strategy is the plan to introduce the new Patient Safety Incident Response Framework (PSIRF) which will replace the current Serious Incident Framework and support insight generation at the point of care.

  The PSIRF proposals would involve a broader scope as part of a system approach and greater transparency by informing, involving and supporting patients, families and staff. NHS organisations will be encouraged to develop their own patient safety incident review and investigation strategy to allow them to use a range of proportionate and effective learning in responses to incidents.

Continued on p.6

St George's University Hospitals NHS
NHS Foundation Trust

4. NHS policy and institutional landscape



NHS Patient Safety Strategy (continued)

- PSIRF Investigations would be focused on learning and not asked to judge 'avoidability', liability, fitness to practise or cause of death. Boards will be encouraged to play a greater role in overseeing investigations. Requirements around timescale would also shift – moving away from strict 60 day deadlines to timeframes based on an investigation management plan agreed where possible with those affected, particularly with patients and their families. National standards and standard reporting templates will also be introduced. Likewise, cross-setting investigations and regionally commissioned investigations will be supported, with clearer roles for NHS regional teams in supporting cross-system incidents. Further details of the new PSIRF framework are expected in autumn 2019.
- **Involvement:** The strategy proposes the establishment of 'patient safety partners' to play a key role in ensuring a strong patient voice up to and including at Board level, with support from a Board member. It also sets expectations around the involvement of patients in service and pathway design, the involvement of patient safety partners in relevant committees to support compliance monitoring responding to safety issues, and providing challenge to ensure learning. The strategy envisages NHS organisations developing 'patient safety specialists', broadly akin to the Caldicott Guardian or Freedom to Speak Up Guardian, as key leaders in the safety system with oversight of and support for patient safety activities across the organisation.
- As part of the Board's development plan for 2019/20, there will be a Board workshop on the NHS Patient Safety strategy and its potential implications for the Trust on 17 September 2019.

NHS Interim People Plan

- The NHS Interim People Plan was published on 3 June 2019. It sets out NHS England and NHS Improvement's vision for NHS staff to deliver the NHS Long Term Plan, with a focus on immediate actions. The Plan sets out cultural changes required to build the NHS workforce of the future health system, new roles and ways of working, and other measures to transform the NHS workforce.
- It set out six aims: (i) Make the NHS the best place to work; (ii) Improve leadership culture; (iii) Prioritise urgent action on nursing shortages; (iv) Develop a workforce to deliver 21st century care; (v) Develop a new operating model for the NHS workforce; and (vi) Take immediate action in 2019/20 while a full five-year plan is developed.
- The Trust's Workforce strategy, which is currently in development, will address the key aspects of the NHS Interim People Plan and the Workforce and Education Committee is scheduled to consider a first draft of the strategy at its August meeting.

NHS Accountability Framework 2019-20 and revised NHS Mandate

- In May 2019, the Department of Health and Social Care published *The Government's 2019-20 Accountability Framework with NHS England and NHS Improvement.* The Accountability Framework, which includes the Government's statutory mandate to NHS England, sets out the Government's expectations of NHSE&I in 2019-20 in delivering the first year of the NHS Long Term Plan and addressing the immediate needs associated with the UK's withdrawal from the EU. The Framework also confirms their budgets in line with the funding settlement. A new four-year Accountability Framework is expected to be published towards the end of the year.

St George's University Hospitals NHS
NHS Foundation Trust

5. System and professional regulation

Clinically-led Review of access standards

- In March 2019, the NHS England Medical Director published an interim report on the clinically-led review of NHS access standards. The review, which followed a request from the Prime Minister in June 2018, is focusing on looking at the core set of NHS access standards in the context of the model of service described in the NHS Long Term Plan and informed by the latest clinical and operational evidence. The final report will make recommendations on any required changes to the access standards. As part of this, the review is looking at how current targets operate and influence behaviour.

- The interim report, published in March 2019, sets out the initial proposals for testing changes to access standards in mental health services, cancer care, elective care, and urgent and emergency care. They are now being 'field tested' at a selection of sites across England before wider implementation. The trial started on 22 May 2019. The final recommendations of the review are expected in spring 2020. Any changes to the access standards that are set out in legislation, and in the NHS Constitution Handbook, will be subject to a public consultation.

- Key changes being considered by the review include:

  - Changes to the 4-Hour ED Operating Standard to introduce new metrics for: (i) time to initial clinical assessment in ED; (ii) time to emergency treatment for critically ill and injured patients; (iii) time in ED (measuring the mean waiting time for all patients); (iv) utilisation of same day emergency care to incentivise avoidance of overnight admission.

  - Changes to the 18-week RTT standard to introduce a maximum 6-week wait from referral to diagnostic tests, either a defined number of maximum weeks wait for incomplete pathways or average wait target for incomplete pathways, and introduction of a 26-week patient choice offer.

  - Changes to the cancer standards to include: (i) faster diagnosis standard (maximum 28-day communication of definitive diagnosis); (ii) 62-day wait to first treatment from GP referral; (iii) 31-day wait from decision to treat to treatment commencing.

  - Changes to mental health standards to include expert assessment within hour for emergency referrals and 1-hour referral to liaison psychiatry services.

Cooperation between the CQC and HSIB

- On 2 April 2019, the CQC and the Healthcare Safety Investigation Branch (HSIB) published a Memorandum of Understanding (MoU) setting out how they would work together to promote patient safety. HSIB was established in April 2017 to conduct independent investigations into patient safety concerns and it makes recommendations to providers aimed at improving systems and processes.

- The MoU provides for information sharing between the CQC and HSIB in relation to quality and safety, and regarding evidence of safety risks or emerging themes that could indicate wider safety issues. The two organisations will also cooperate on national safety reviews.

5. System and professional regulation

GMC to regulate Physician Associates and Anaesthesia Associates

- On 18 July 2019, the Department of Health and Social Care announced that the GMC will regulate physician associates and anaesthesia associates across the UK.
- The Government had conducted a public consultation on the Regulation of Medical Associate Professionals in 2018 and published its response to the consultation on 7 February 2019. The Secretary of State for Health had previously announced in October 2018 that physician associates and anaesthesia associates would be brought within the framework of statutory regulation, but the consultation was held to help determine which organisation should regulate them.
- In a Written Ministerial Statement on 18 July, the Government concluded that the GMC was best placed to undertake regulation of PAs and AAs, which it said "would enable these groups to work to their full potential and provide the very best care to patients as part of a multi-disciplinary clinical team, contributing to the development of a safe and flexible workforce". The Government stated that the decision was an important step towards meeting the workforce commitments set out in the Interim NHS People Plan in England.

Changes to GMC fitness to practise processes

- In April 2019, the General Medical Council announced changes to its fitness to practices processes aimed at reducing the number of full investigations into one-off mistakes by doctors – known as single clinical incidents – following a two-year pilot.
- The stated purpose of the change is to ensure the GMC deals with concerns about doctors quicker, reduce the impact on doctors and protect patients in a more timely manner. The GMC remains required by law to investigate any allegation that a doctor's fitness to practise is impaired, but the new process for investigating single clinical incidents is intended to keep the number of full investigations to a minimum by considering information – such as medical records, reports of independent experts, doctors' Responsible Officers, and doctors themselves – quickly to clarify whether there is any on-going risk to patients.
- Of 309 cases considered by the pilot, 202 of them where closed without the need for full investigation. The move has the potential to speed up the process by which decisions are taken following referrals to the GMC. However, changes to primary legislation would be required to fundamentally overhaul current processes and speed up fitness to practise referrals significantly.

Consultation on changes to patient feedback in doctors' revalidation

- The GMC is consulting on changes to medical revalidation. The consultation, which closes on 23 July 2019, aims to increase the value of patient feedback for doctors' learning and professional development and introduce more flexibility on how doctors can collect it – enabling doctors to use patient feedback they can already access, for example through their Trust, in order to avoid duplication and burden. It also aims to make it easier for patients to give their feedback and reduce barriers some patients can face in providing feedback.

5. System and professional regulation

GMC report on referrals of BAME doctors to fitness to practice processes

- On 25 June, the GMC published a report – *Fair to Refer* – which highlighted that employers, including NHS Trusts, refer BAME doctors to the GMC at more than double the rate of their white counterparts, meaning that they were more likely to be investigated and receive a warning or sanction from the regulator.
- The report found that:
  - some doctors do not have adequate induction or enough support in transitioning to new social, cultural and professional environments
  - doctors from diverse groups do not always receive effective, honest or timely feedback which could prevent problems later. This is because some clinical and non-clinical managers avoid difficult conversations, particularly where they are from a different ethnic group to the doctor
  - working patterns mean that some doctors working in isolated roles lack exposure to learning experiences, mentors and resources
  - some groups of doctors are treated as 'outsiders', creating barriers to opportunities and making them less favoured than 'insiders' who experience greater workplace privileges and support.
- The report also found that alongside these factors some organisational leadership cultures have a knock-on effect. Where leadership teams are remote and inaccessible, doctors struggle to approach them for advice and support, and may not be listened to and divisive cultures can develop. In addition, a focus on who to blame when things go wrong, rather than what needs to be learnt from an incident, compounds the disconnect between doctors and leaders.
- The report also found that the same workplace factors that created greater risk for BAME doctors and doctors who qualified overseas also, at the same time, provided a level of protection for their UK-qualified and non-BAME colleagues.

Developments in NMC fitness to practise processes

- The Nursing and Midwifery Council has made changes to its approach to dealing with fitness to practise cases. In July 2018, the NMC launched a new fitness to practise strategy which sought to ensure the NMC protected the public in a fairer, more effective, proportionate and consistent way, placing an emphasis on remediation, context of each case, and supporting Trusts to handle concerns at a local level.
- Between September 2018 and April 2019, the NMC ran a number of pilots to test its new approach. Feedback through the pilots suggested that Trusts welcomed the extra support and advice offered by the NMC to help them to understand and resolve concerns locally, and that the public found support from the NMC's specialty trained screening team valuable. The NMC has also developed new approaches to capturing evidence about the context within which incidents occur and to decide what action, if any, it needs to take.
- Further actions to reform the NMC's fitness to practise processes are expected to be announced in the coming months.

5. System and professional regulation

Nursing Associates

- On 7 June 2019, the NMC celebrated the fact that more than 1,000 people are registered as qualified nursing associates. The role currently only exists in England and bridges the gap between healthcare assistants and registered nurses.
- 7,000 students have begun training since the role was agreed in January 2017 and Health Education England plans to more than double that number and recruit a further 7,500 nursing associates in 2019.
- Developing the nursing associate role and recruiting more people is seen as a key part of delivering the new NHS Interim People Plan, published on 3 June 2019.

Reform of professional regulation

- The Department of Health published its response to its consultation on the reform of professional regulation on 9 July 2019. The consultation described the current model of regulation as increasingly complex, out dated, and adversarial. The key changes include:
  - Modernisation of regulators' fitness to practise processes: All regulators will be given the full range of powers to investigate and resolve complaints about their registrants' fitness to practise more quickly, with the aim of providing early resolution. The intention is to make the process more collaborative, less adversarial, and less bureaucratic.
  - Enable regulators to invest more of their resources in support to professionalism of registrants – enabling regulators to ensure registrants have maintain the right knowledge, skills and expertise to deliver safe, high quality care.
  - The governance of regulators will also be overhauled, with Councils replaced by Boards, with Executive and Non-Executive Directors, with a NED majority. The reforms mean there can be no registrant majority on those Boards, which the Government describes as completing the move away from professional self-regulation.
  - The Government will also consult on legislation intended to give effect to two recommendations set out in Sir Norman Williams' review of Gross Negligence Manslaughter, by removing the General Medical Council's (GMC) right to appeal decisions of the Medical Practitioners Tribunal Service (MPTS) to the High Court, and by modifying the GGMC's and General Optical Council's powers to require certain reflective practise information from registrants.
- The Government stopped short of taking action to reduce the number of professional regulators, having consulted on the possibility of reducing the number of regulators from nine to three or four.
- A number of the above changes will be given effect through changes to secondary legislation.

6. Reports and updates from key stakeholders

NHS Confederation report on diversity in Chair and NED appointments in the NHS

- A new report published by the NHS Confederation on 6 June 2019 examined the composition of the NED component of NHS Boards, concluding that they had become less diverse over the past 15 years, with fewer people of black and minority ethnic and women occupying the positions:
    - The report found that the percentage of chairs and non-executives of NHS Trusts from a BME background had nearly halved in the last decade, from 15% in April 2010 to 8% in 2019.
    - The percentage of women in chair and non-executive roles had also fallen over the same period from 47% to 38%.
    - There had been no increase in the proportion of non-executives with a disability, which had remained static at 5-6%.
- The report attributed the reduction in diversity to two potential factors; the abolition of the NHS Appointments Commission in 2012 and the creation of NHS foundation trusts in 2003, which placed responsibility for NED appointments on the Council of Governors without further scrutiny or oversight.
- The report, authored by a former Chair of Barking, Havering and Redbridge Trust, calls for a review of the current appointment progress and recommends that: the chairs of NHSE&I work with the Confederation to make recommendations to Ministers on addressing diversity in NHS Boards; a review of recruitment search firms is undertaken to ensure they are incentivised and can provide diverse shortlists for NHS organisations; and the NHS Leadership Academy and Regional Talent Boards expand their roles to include development and support for chairs and non-executives on governance and quality, diversity and inclusion. The report, however, does acknowledge that greater progress has been made on the diversity of executive members of Trust Boards.
- The Trust is shortly to begin currently recruiting to a number of NED roles and across all of these there is a focus on promoting greater diversity among the NED cohort on the Board.

Health Education England report on Enhancing Junior Doctors' Working Lives

- On 26 June 2019, HEE published a progress report setting out improvements that had been delivered through its Enhancing Junior Doctors' Working Lives programme, which was established to address some of the issues identified during the 2015/16 dispute over the new contract for doctors in training.
- The report highlighted expanded opportunities for training less than full time, flexible portfolio training and development of an Out of Programme Pause initiative which allows doctors the chance to take time out from their training as a first step towards establishing an evolved training system enabling greater flexibility to 'step out, step into' training. Progress in delivering the work on improving well-being of junior doctors and boosting morale is aligned with the commitments in the new NHS Interim People Plan (highlights of which were reported to the Workforce and Education Committee last month) to make the NHS 'the best place to work'.

6. Reports and updates from key stakeholders

Updates from NHS England and NHS Improvement joint Board meetings, 27 June 2019

- NHSE&I held one joint Board meeting during Q1 2019/20. The Chair reported on a roundtable discussion with BAME staff in the ambulance service suggesting more needed to be done to recognise the contribution of BAME staff. The CEO confirmed that the junior doctors' committee of the BMA had now voted in favour of the new junior doctors pay settlement.
- The report on the month 12 2018.19 financial position reported that the year end position across the NHS was a revenue underspend of £89m and a capital overspend of £330m. At year end, the overall position for NHS England was an underspend of £916m against the planned underspend of £265m. NHS providers recorded a deficit of £571m, which was £177m worse than planned. The provider sector spent £3.9bn on capital in 2018/19, £711m below plan but this expenditure exceeded the £2.56bn provider sector budget set by the Department of Health and Social Care for 2018/19.
- Performance against the ED 4-Hour Standard across the NHS for 2018/19 finished at 88%, 0.3% below 2017/18. Performance on RTT saw 86.5% of patients waiting less than 18 weeks for treatment in 2018/19.

Updates from CQC Board meetings, April – June 2019

- **19 June 2019:** The CEO's report highlighted that the CQC's revenue budget was over spent by £0.8m at year end. It also highlighted upcoming publications including the 2018 Inpatient Surveys and its Effective Staffing report
- **15 May 2019:** The performance report set out that in the last year: 23% of locations that were previously rated as good had deteriorated to required improvement or inadequate; 53% of locations previously rated as requires improvement had improved; 74% of locations previously rated as inadequate had improved. The Board also heard that the CQC had received a total of 8,878 whistleblowing enquiries in the past year.
- **24 April 2019:** The Chief Executive's report indicated that all CQC re-inspection targets were being met or exceeded. The performance report highlighted the work CQC was undertaking to work more closely with NHS England and NHS Improvement as they developed their new operating model. It also highlighted that CQC was placing greater emphasis on system-wide quality in its regulatory activity.

Updates from Health Education England Board meeting, 21 May 2019

- The performance report highlighted that although physician associate numbers were growing substantially across the UK, the expected target of 1,000 PAs working in primary care by 2020 would not be met; the vast majority work in secondary care.
- A paper on the learning disability workforce suggested that the 16% vacancies in learning disabilities nursing posts in 2018 would become more than 30% in the near future, and HEE was planning to work with partners to develop options to develop learning disabilities nursing careers and to pilot an apprenticeship approach.

St George's University Hospitals NHS
NHS Foundation Trust

7. Current inquiries

Inquiry into the care provided by Liverpool Community Health (LCH) NHS Trust

- On 6 June 2019, the Government announced a new independent investigation into the serious incidents at LCH between 2010 and 2014.
- The inquiry will be led by Dr Bill Kirkup, who led an earlier investigation into the Trust in 2018.
- New evidence has been identified by Mersey Care in which it is alleged that the Trust failed to investigate 150 patient deaths and 17,000 incidents in which patient safety was put at risk. The inquiry will identify individual patient safety incidents that were not reported or adequately investigated by the Trust and will also undertake a series of mortality reviews.
- Following this, the inquiry will fully investigate incidents identified in the earlier stages of its work to determine the scale of patient harm, and identify any local and national learning.
- The inquiry will advise NHS England and NHS Improvement where it believes senior leadership within the Trust may have contributed to the delivery of unsafe patient care, and identify any themes, trends or issues that require further investigation.
- The earlier Kirkup review, published in February 2018, described how over-ambitious cost improvement programmes as part of a bid for foundation trust status placed patient safety at risk, leading to serious lapses in care and widespread harm to patients. It concluded that a culture of bullying meant staff were afraid to speak up and safety incidents were ignored or went unrecognised

Infected Blood Inquiry

Infected Blood Inuqiry

- The Inquiry is examining why men, women and children across the UK were given infected blood and / or infected blood products; the impact on their families; how the authorities responded; the nature of any support provided following infection; questions of consent; and whether there was a cover-up.
- As has been reported on the national news, the inquiry has completed several weeks of hearing personal testimony of people who were infected with HIV, hepatitis C and other viruses as well as from families of those who died as a result of infection.
- The inquiry has requested documentation from a large number of NHS organisations and the Trust is engaging with the inquiry to provide the records it holds.

St George's University Hospitals NHS
NHS Foundation Trust

8. New appointments

NHS Chief Operating Officer

NHS England & NHS Improvement

Amanda Pritchard was announced as the new COO for NHS England and NHS Improvement on 5 June 2019. Currently Chief Executive of Guy's and St Thomas' NHS Foundation Trust, Amanda Pritchard takes up her new national role on 31 July 2019. The new COO role is directly accountable to the NHS Chief Executive, Simon Stevens. The role oversees NHS operational performance and delivery, as well as implementation of the service transformation and patient care improvements set out in the NHS Long Term Plan. The COO is accountable to the NHS Improvement Board as NHS Improvement's designated accountable officer with regulatory responsibility for Monitor.

Deputy Chief People Officer

NHS England & NHS Improvement

Professor Em Wilkinson-Brice was announced as NHSE&I's new Deputy Chief People Officer, reporting to Prerana Issar, Chief People Officer, on 22 July 2019. Professor Wilkinson-Brice joins NHSE&I from Royal Devon and Exeter NHS Foundation Trust where she was deputy chief executive and chief nurse. She will take up the position from October 2019.

Chief Medical Officer for England

Department of Health and Social Care

Professor Chris Whitty has been announced as the new Chief Medical Officer for England and the UK Government's Chief Medical Adviser. He will replace Professor Dame Sally Davies in October 2019. Professor Whitty is currently the Chief Scientific Officer for the Department of Health and Social Care and has responsibility for the National Institute for Health Research (NIHR) and life science strategy and is expected to continue to lead the NIHR when he takes up the post of CMO. He is a practising NHS consultant physician in acute medicine and infectious diseases at University College London Hospitals.

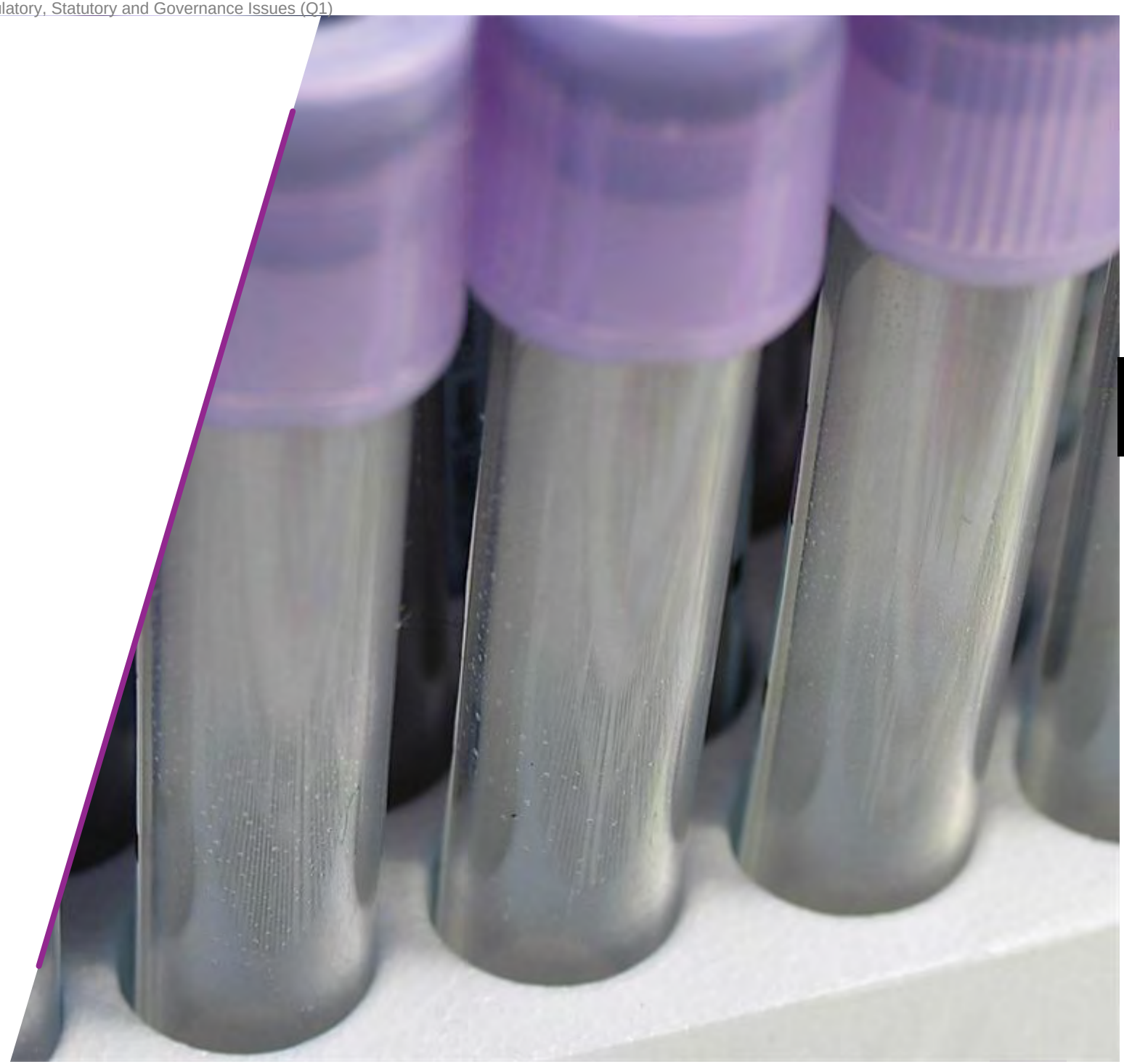
Deputy Chief Medical Officer

Department of Health and Social Care

Dr Jenny Harries was announced as the new Deputy Chief Medical Officer for England on 7 June 2019 and started in post on 15 July 2019, reporting to Professor Dame Sally Davies as CMO until October 2019 and thereafter to the new CMO, Professor Chris Whitty. Dr Harries is currently Deputy Medical Director at Public Health England and PHE's Regional Director for the South of England.

Chair of NHS Providers

Sir Ron Kerr was announced as the next Chair of NHS Providers on 11 July 2019. He will take on the role from 1 January 2020, when he succeeds Dame Gill Morgan, whose term as Chair ends on 31 December 2019. Sir Ron Kerr has held a range of senior health service management roles, including as Chief Executive of Guy's and St Thomas' NHS Foundation Trust between 2007 and 2015. He is a previous Chair of the Shelford Group of Trusts.



excellent
kind
responsible
respectful

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	25 July 2019	**Agenda No**	**5.5**
Report Title:	Workforce and Education Committee Terms of Reference		
Lead Director/ Manager:	Stephen Jones, Director of Corporate Affairs		
Report Author:	Stephen Jones, Director of Corporate Affairs		
Presented for:	Approval		
Executive Summary:	The Workforce and Education Committee undertook a review of its effectiveness earlier this year and, following this, approved a new terms of reference at its meeting on 13 June 2019 aimed at strengthening its work as an assurance Committee of the Board. The terms of reference reflect a comprehensive refresh and are attached for consideration by the Board. A revised forward plan of the Committee's work will be considered by the Committee at its meeting on 8 August 2019.		
Recommendation:	The Board is asked to approve the revised terms of reference for the Workforce and Education Committee.		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	Well Led		
Single Oversight Framework Theme:	Leadership and Improvement Capability (Well Led)		
Implications			
Risk:	Without appropriate terms of reference for its Committees, there is a risk that the Trust may not have effective decision-making structures which could result in either poor decisions or a delay in decision-making.		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	N/A	**Date**	N/A
Appendices:	Workforce and Education Committee Terms of Reference		

5.5

No Paper - Members of staff attended

St George's University Hospitals NHS
NHS Foundation Trust

Renal - Advance Care Planning: A Quality Improvement Project

Donna Morgan

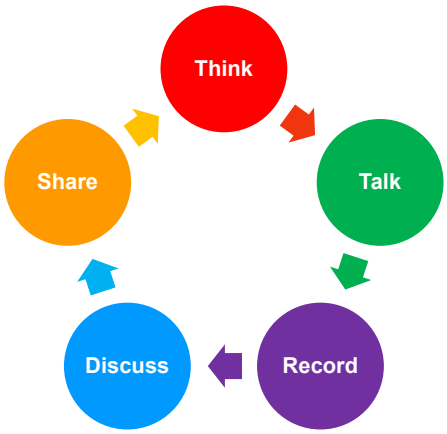
Senior Sister, Champneys Ward, Renal Unit, St, George's University Hospitals NHS Foundation Trust

Introduction

Why?

Advance care planning is:

- A structured discussion with patients and their families/carers about their wishes and thoughts for the future.
- The main goal is to clarify peoples' wishes, needs and preferences for their future treatment and care.
- Advance care planning is a way to think ahead, to describe what is important to the patient and to ensure other people know their wishes for the future.
- It is about helping people to live well right to the end of their life.



Goldstandards Framework

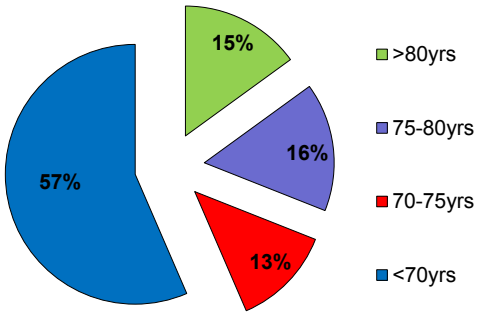
Thinking Ahead, discussing with others and writing things down means that peoples' wishes are known and respected, a person is more likely to receive the care and treatment they want and in their place of choice if the become unwell, or if they could no longer speak for themselves.

Renal Patients?

The number of older people developing End Stage Renal Disease is continuing to rise and we have more elderly patients commencing on treatment who previously would never have been considered for treatment. Renal patients who commence dialysis treatment have a life expectancy of 5 – 10 years. There is little evidence that suggests that there is any significant survival advantage between haemodialysis and peritoneal dialysis. Furthermore, there is no survival advantage between dialysis and non-dialysis for older frail patients. People over 80 years starting dialysis have poor prognosis and outcomes and are unlikely to survive past 12 months.

Up until now – survival has been the main outcome measure by which we have to assess different Renal Replacement Therapies, this is an easy measure but overlooks the Quality Of Life of the individuals.

Jassal, et al (2009), study showed that 75% of patients above 80 starting dialysis were fully independent, 6 months after staring treatment 30% of them required community support or transfer to a care home, at 12 months only 22% were still alive.



St. George's Dialysis Patients (343)

Plan

Aim: To give more renal patients the opportunity to complete an advance care plan.

How:

- To give all patients – who we would not be surprised if they died within 12 months – the opportunity to complete an advance care plan
- Monday & Thursday board rounds – ask the question – Would you be surprised if this patient died in the next 12 months
- If you would not be surprised – then give that patient the opportunity to complete an advance care plan.

Do:

- I am part of the Renal Operational Delivery Network (ODN) – there are 5 different areas of focus – I am part of the supportive care group.
- Within the supportive care group, one of the key things I have been involved with is the development of a Renal Advance Care Plan.
- This care plan, will be used for the purpose of this project as this will also allow to test the use of it.
- I have researched a lot in this topic – renal patients, supportive care and advance care planning.
- I presented this research along with my quality improvement project to wide range of multidisciplinary ream members at our renal academic meeting.
- This allowed all members of the team to come together and discuss their thoughts around the project and share their useful ideas.

Act

Measure:

➢ In the short term:

- Review the patients who were identified and if they have or have not completed an advance care plan
- If not completed – look at the reasons why – this will allow us to identify if there are any changes that need to be made or any training needs required.

➢ In the longer tem

- 1 year on – look at the identified patients and see how may have died.
- The ones that have passed away – did we achieve their wishes

Study

Initially, I had attempted to start this quality improvement project last year, however this was unsuccessful due to workload. Leading on this project takes a lot of time, dedication and motivation, in order for it to accomplish its full potential. Within St. George's, we do not have a renal supportive care nurse, we are the only Trust without this role and this has a big impact on achieving the intended outcomes – providing our patients with outstanding care, every time. However, from completing this programme, I have learned that engaging the staff within this project and giving staff key roles in it – keeps the momentum going and the shared goal in mind.

7.2

St George's University Hospitals NHS
NHS Foundation Trust

Roles and Responsibilities of a Nurse in-charge/Charge Nurse in Running a shift

Ma Rube Simba, Kent Ward

INTRODUCTION

A nurse in charge or charge nurses supports and supervise nursing staff. At times they also treat a limited number of patients. They are responsible for maintaining a high level of nursing care, evaluating of other nurses. They also act as educational resource for nurses. At times the nurse in charge or charge nurse assumes some managerial responsibilities for nurses and support staff on a particular shift.

My project is to create a NIC/SOP for the NIC in Kent Ward. As we all know that being a nurse in charge or charge nurse is not easy, so these guidelines will help them so that they can run the ward safely and effectively.

PLAN

Guidelines created for the NIC/Charge Nurse: Roles and Responsibilities of the Senior Staff Nurse or NIC in Running a Shift in Kent Ward

- Starts the handover on time. Incoming staff in their complete uniform & ready to take the handover.
- NIC of LD/N gives full handover: ward/practice/info update; Patient's name, consultant, mobility, plan, and update. Discuss any risk e.g. falls, infections etc.
- Allocation of patients: consider skills & skill mix, acuity & dependency. Ensure staffs uses the "Buddy System" during break time. Allocate fire warden, meal champion, ABCDE.
- Discuss staffing for the next 2 shifts with the finishing NIC. So be aware of the action to take.
- Ensure safe care is done by 08:00 and 20:00.
- Update the staffing board outside of the ward and check and update clinical room temperature. Check CD book is it has been done by the night shift.
- Update/check fire folder, enhance care folder and crash trolley. Don't forget you bay checks. This should be completed by 09:00/21:00.
- Make sure the hallway going to HASU is clutter free and tidy.
- Order patients meal for lunch and dinner. Adhere to protective mealtime and make sure Meal Time Champion knows her/his responsibilities.
- Ensure patients PDD is updated between 08:00-10:00. Admission and transfer patients should have a PDD before midnight. EDD remains as it is.
- See patients before morning doctors round: Gather info in anticipation of Doctors / MDM questions (discharges; who will pick them up, TTOs, DC letter).
- Liaise with Bed Manager proactively: anticipate bed movements, know the patient's, there safety and care needs; be prepared; consider contingency plan if required.
- Liaise with Discharge Coordinator in advance for S/W referral in timely manner.
- Inform/liaise with receptionist: discharges, transfers, transport bookings. Make sure to be clear and specific with the receptionist especially with transport bookings, discussing DNAR status, infection risk, patient's mobility, etc.
- Attend the MDM meeting which starts at 08:50 for HI/Level 1 then 09:00 for Neurology/ Outliers. Do not forget to discuss PDD, discharges, repats, TTOs, DC letter, referrals, admission for the day, etc.
- After the MDM inform / update nurses of what was discussed with clear plans and actions.
- Liaise with pharmacist regarding who is going to be discharge or for repat-make sure TTOs are ready on time.
- NIC should help with the nurses with DC letters, GP letters, dressings, IVAB administration, nursing transfer letter, etc. if time allows.
- NIC needs to make sure that I CLIP is up to date. All admission/transfers assessment is done within the 2 hours' time frame. Checking them visually.
- Making sure all task/care compasses are done, orders are initiated as well as document in plan are all updated and done in the I CLIP.
- Making sure that EWS assessment, bowel chart, fluid chart, food chart, lines/drains and tubes are up to date and filled in and done appropriately.
- Making sure all patients' care plan is up to date and done.
- Making sure all admissions, elective/emergency/transfers are admitted before the night shift starts with the exception of a few e.g. transport, bed issues etc.
- Making sure all equipment's are cleaned and have an "I AM CLEAN "tag.
- Making sure all staff helps with serving lunch and dinner and the meal champion carries out his/her responsibilities appropriately.
- NIC should update the hand over from the shift worked.
- NIC should be more available for team- help them, answering call bells as well.
- Making sure patient's DC survey are done by staff.
- NIC should treat everybody in the same level, help everybody equally – no favouritism.
- NIC should make sure that any faulty equipment's, broken stuff e.g. – should be reported. Teach and encourage staff on how to do this so they will not rely on the NIC at all times.
- Making sure daily audits are done – EWS, Hand Hygiene and Cleaning and Decontamination with the aim to get a 100% on each of this audit. 5 audit each for these per shift.
- In the event of sickness during out of hours, in the absence of the ward manager, matron. NIC needs to make sure staffing is sorted out so shifts are safe. Informing **Bleep 7228** and **Bleep 6007.**
- Making sure HCA knows there cleaning responsibilities.
- Making sure the ward/bays are clean and tidy before the end of your shift.
- Don't forget to delegate if needed and encourage all staff to work as a TEAM.

Additional Responsibilities for the NIC of the Night Shift

- Making sure CDs are checked, meal board is up to date, and medication fridge temperature is checked and up to date.

Additional Daily Responsibilities on any Specific Days

- **Monday –** attend Level 1 MDM meeting
- **Tuesday –** afternoon huddle
- **Wednesday –** Weekly Teaching
- **Thursday –** 11:00- Stranded/Superstranded Meeting. Clinical Supervision from 3-4PM.
- **Friday –** afternoon huddle

DO

I discussed and give these guideline to all the NIC/Charge Nurse in my ward last 07.02.19 and we agreed that these guideline will be used from 08.02.19. Every Friday I approach the Band 6s and Band 5 who takes charge of the ward and ask for feedbacks.

STUDY

Experience is a great factor. Staffs who have taken charge for more than 2 years have made the guidelines easy for them. They already are well versed with the guidelines and only a few bits to adjust. Staff that just started to takes charge recently or have been in charge less than 2 years, still struggle to follow the guidelines as they focus more on the patients admission/ discharge/transfers without realising that aside from these the NIC responsibilities is wider.

Organisational skill is very important as if the NIC/ Charge Nurse do not have this skill then everything will fall apart on a shift.

A very good knowledge of what a NIC/ Charge nurse is, and what is expected from them.

ACT

We will continue to use these guidelines. I will continue to get feedback every Friday from the NIC/Charge Nurses. I will be there support them. Opinions will be considered and I will continue to encourage my NIC/Charge Nurses to support and help each other. To walk on the same direction so that we will achieve our goals to give a safe and excellent care to our patients.

excellent kind responsible respectful

St George's University Hospitals NHS
NHS Foundation Trust

Ward & Department Manager Leadership Development Programme and Quality Improvement Projects

Excellence in specialist and community healthcare

St George's University Hospitals NHS
NHS Foundation Trust

Ward & Department Manager

Importance of the role…

- Pivotal in the management of services, improving patient outcomes and experience
- Effective leadership directly impacts on patient safety incidents
- Set the tone and culture of a ward/department, which impacts on staff morale, sickness and turnover
- Influence others across professional boundaries to work towards shared values
- Help deliver the Trust objectives and recovery plan to financial and quality special measures
- Monitor and evaluate the service provided
- Highly complex and challenging role, that can be rewarding

St George's University Hospitals NHS
NHS Foundation Trust

Course Content…

Over view…

- 8 days of study
- 7 taught modules covering 5 domains of leadership
- 4 action learning sets
- Quality Improvement project
- End of course presentation
- 360 degree feedback

Plus requirement to complete 2 day Passport to Management course .

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NHS Foundation Trust

Progress and Evaluation …

- 3 Cohorts have completed or due to complete
- *38 Ward/Department managers in total*
- *Cohort 4 planned September 2019*
- *Content matches ward manager handbook from NHSI*
- *Evaluation scores an average 4.5/5 for usefulness and content*

"I gained a greater insight into myself and how my style is different to others, finding ways to adapt and communicate effectively with people at different times"

"I now have a better understanding of how the healthcare system works, money, budget management and my responsibility and opportunities in this"

"Having the opportunity and support to learn about QI methods and try something in my clinical area to improve care has been valuable and rewarding"

Ward & Department Manager/ St George's University Hospitals NHS Foundation Trust

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Ward Manager QI project …

Donna Morgan (Champneys Ward): *Advanced Care Planning in Renal Services*

Ma Rube Simba (Kent Ward): *Roles and Responsibilities of the Nurse in-charge*